We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 27 MARCH 2019
9.30am-1.15pm
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 27 MARCH 2019 - **9.30am - 1.15pm**

Trust Conference Room, Warrington Hospital

Purdah – The Trust have been advised by NHS Improvement to be aware that a period of purdah starts from 26th March, 2019 until local elections on 2nd May, 2019. With this in mind, the Board agenda and papers have been reviewed and have been confined to matters that need a board decision or require board oversight.

REF BM/19	ITEM	PRESENTER	PURPOSE	TIME	
	Patient story 15 MINS		**Presentation**	**9.30**	**N/A**
BM/19/03/17	**Welcome, Apologies & Declarations of Interest**	**Steve McGuirk, Chairman**	**N/A**	**9.45**	**Verbal**
BM/19/03/18 PAGE 4	**Minutes of the previous meeting held on 30 January 2019**	**Steve McGuirk, Chairman**	**Decision**	**9.47**	**Encl**
BM/19/03/19 PAGE 14	**Actions & Matters Arising**	**Steve McGuirk, Chairman**	**Assurance**	**9.50**	**Encl**
BM/19/03/20	**Chief Executive's Report**	**Mel Pickup, Chief Executive**	**Assurance**	**9.55**	**Verbal**
BM/19/03/21	**Chairman's Report**	**Steve McGuirk, Chairman**	**Information**	**10.05**	**Verbal**

Quality People Sustainability

BM/19/03/22 PAGE 21	**Operational Performace & Strategy Reports (IPR) and Assurance Committee Reports**	**All Executive Directors (CEO to Lead)**	**Assurance**	**10.10**	**Enc**
a)	- **Quality Dashboard including** o **Monthly Nurse Staffing Report (January + February)**				**Enc**
(b)	- **Key Issues report Quality and Assurance Committee (5.03.2019)**	**Jean Noel-Ezingeard**			**Enc**
(c)	**People Dashboard** - **Key Issues Strategic People Committee (20.03.2019)**	**Anita Wainwright Committee Chair**			**Verb**
(d)	- **Sustainability Dashboard**				
(e)	- **Key Issues Finance and Sustainability Committee (23.01.2019, 20.02.2019)**	**Terry Atherton, Committee Chair**			**Enc**
(f)	- **Audit Committee (25.02.2019)**	**Ian Jones, Committee Chair**			**Enc**
BM19/03/23 PAGE 113	**Perfromance Assurance Framework Approval**	**Andrea McGee Director of Finance + Commercial Development**	**Approval**	**11.20**	**Enc**

Quality

BM/19/03/24 PAGE 132	**Ward to Board Assurance Visits**	**John Culshaw Head of Corporate Affairs**		**11.30**	**Enc**

BM/19/03/25 PAGE 137	Hospital Volunteer Annual Report	Kimberley Salmon-Jamieson Chief Nurse	Information	11.40	Enc
BM/19/03/26 PAGE 150	Patient and Public Participation + Involvement Strategy	Pat McLaren Director of Community Engagement + Fundraising & Norman Holding, Lead Governor	Approval	11.45	Enc

People

BM/19/03/27 PAGE 183	Equality, Diversity & Inclusion Strategy	Michelle Cloney Director of HR + OD	Approval	12.00	Enc
BM/19/03/28 PAGE 209	Educational Quality Monitoring Review	Alex Crowe Deputy Medical Director, Director of Medical Education and CCIO	Assurance	12.15	Enc

Sustainability

BM/19/03/29 PAGE 215	Strategy Development and Delivery Report	Lucy Gardner Director of Strategy	Assurance	12.30	Enc

GOVERNANCE

BM/19/03/30 PAGE 235	Quarterly Strategic Risk Register + BAF	Mel Pickup, Chief Executive	Assurance	12.40	Enc
BM/19/03/31 PAGE 246	Amendments to the Trust Constitution	Mel Pickup, Chief Executive	Approval	12.50	Enc
BM/19/03/32 PAGE 251	Changes to the Scheme of Reservation and Delegation Table B for Charitable Funds	Andrea McGee Director of Finance + Commercial Development	Approval	13.00	Enc

BM/19/03/33	Any Other Business	Steve McGuirk, Chairman	N/A	13.05	Verbal
	Date of next meeting: Wednesday 29 May 2019				

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 28 November 2018
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Chris Evans (CE)	Chief Operating Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Andrea McGee (AMcG)	Director of Finance and Commercial Development
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, Director of Medical Education + Clinical CIO
John Culshaw (JC)	Head of Corporate Affairs
Lucy Gardner (LG)	Director of Strategy
Phillip James (PJ)	Chief Information Officer
David Holden (DH)	Interim Governance Advisor
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Tracey Cooper (TC)	Head of Midwifery *(Patient Story item only)*
Irene Crowder (IC)	Governance Administrator *(Medicines Safety item only)*
Anne Robinson (AR)	Associate Medical Director, Patient Safety *(Medicines Safety item only)*
Nicola Hayes (NH)	Deputy Chief Pharmacist *(Medicines Safety item only)*
Dr Roy Bhati (RB)	Associate Specialist A&E *(Medicines Safety item only)*
Helen Penney (HP)	Medicines Safety Officer *(Medicines Safety item only)*
Apologies	
Jean-Noel Ezingeard (JNE)	Non-Executive Director
Pat McLaren (PMcL)	Director of Community Engagement + Fundraising
Observing	
Norman Holding	Public Governor
Louise Spence	Staff Governor
Jill Tomlinson	Deputy Ward Manager BI
Andrea Davies	Deputy Ward Manager B10
1 member of the public	

BM/9/01	**Patient Story Personalised Care in a Rainbow World.** T Cooper was welcomed to the meeting and shared a patient journey of a lady who had received complex care and treatment at Warrington from both hospital and community services which demonstrated collaborative working to ensure safe, qualitative and continuity of care, resulting in excellent patient experience for both herself and her extended family. **Presentation** AR and colleagues were welcomed to the meeting who provided an overview of the Stanford Project, following work with NHSI to achieve early resolution of claims and reduction in risk. AR explained the approach taken reviewing Trust processes relating to medication safety and

	drugs including drug administration, analysing claims for themes to improve methodology. WHH were one of 6 pilot sites in the UK and focussed training began across a number of workstreams. HP and NH explained examples of where reviews had been undertaken and outcomes relating to Medication Safety, resulting in a number of improvements in the process, resulting in an improvement in the number of harm incidents, with learning shared to achieve further reduction. In addition, the process for managing Diabetic patients had been reviewed, resulting in a number of easily accessible prompts for all medical staff, supporting a reduction in incidents. The same methodology will be used to review Controlled Drugs and Anti-Coagulation processes. RB provided an update on ePMA and the new process planned to ensure the correct medication information for all patients is available on admission. The pilot had been successfully rolled out in a number of Departments and Wards at Halton with a 76% reduction in medication/safety incidents. AW asked if indication of this success is easily available for patients accessing services at WHH. AR explained information is shared internally through a number of forums. SMcG proposed a press statement highlighting the success of the early trails. In relation to query from AW if GP Connect is already working providing access to GP medicine information, RB explained it is being progressed with NHS Digital, anticipating this will be available in 6-12 months through Lorenzo. The Chairman thanked colleagues for their presentation, reiterating the importance of promoting this and other good news stories where improvements have been identified and implemented successfully for the benefit of both patient care, patient experience. AR thanked the Board for their support in undertaking this project.
BM/19/01/01	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting, and introductions were made. Declarations of Interest: MC declared Joint HR&OD post with Bridgewater Community NHS FT. No other declarations in relation to the agenda were noted.
BM/19/01/02	**Minutes of the meeting held 28 November 2018** Page 2. 1st line to read.. SMcG asked have other hospitals implemented Ward Accreditation. KSJ explained it had been implemented in 30%-40% Trusts and Mid Cheshire are using WHH version of the Programme. Page 3. BM/18/11/105 4th para, last sentence to read... long term plan of 34,000 additional beds within the NHS as a whole. Page 4. BM/18/11/107 4th para, 1st line, delete the word Slight. Page 8. BM/18/11/114 penultimate para, 1st line, delete the word not. Page 10. BM/18/11/121 SORD 1st point, to read … reviewed by Directors. With these amendments, Minutes of 28 November 2018 were agreed as an accurate record.
BM/19/01/03	**Actions and Matters Arising** Action log and rolling actions were noted. Of specific note: BM/18/01/107 IPR People. MP referred to the update paper provided, highlighting a number of issues relating to attendance on particular days and periods in year, asking what can be done and of it is being aggressively managed. As the Assurance Committee with oversight, MP proposed a deep interrogation is undertaken, that processes and procedures are being utilised and assurance of mitigations to be presented to a future Strategic People Committee.

BM/19/01/04	**Chief Executive's report** CEO provided an update on matters for the Board to note since the last meeting both nationally and locally. MP had attended the launch of the NHS Long Term Plan which builds on the 5 Year Forward View and continued emphasis for greater provision of health and integration of health and social care, eg tackling health inequalities, variation in diagnostics and outcomes of some treatment groups, AED, endorsing the direction of travel for greater system integration. Locally, closer collaborative working relationships developing relating to Warrington Together and One Halton with open dialogue to establish direction of travel for a Provider Alliance. Relationship with BWC NHS FT as Community Provider progressing with Executive colleagues discussing opportunities for improved, seamless, patient journey Changes in the roles and functions of NHSE and NHSI highlighted with 7 Regional Directors. The NW Regional Director has a wealth of experience in health and academia, and MP is to meet to understand their expectations as a Regulator and expectations of WHH as a Foundation Trust during integration. Notification received in December from CQC of the next regime of inspections which will include Core Services, Well Led and Use of Resources (UoR). UoR will take place on 2 April 2019. Confirmation awaited for the next CQC inspection. PIR had been submitted, the Trust is moving into preparation stage to address recommendations within the CQC action plan from the last inspection. To support this, the Trust had undertaken a Mock CQC Inspection on 21 January with review teams made up of a wide variety of internal and external colleagues. Planning process is underway to agree the Trust 1 Year 2019-20 plan, agreeing levels of activity with Commissioners, final Plan to be approved by the Board prior to submission on 12 February. Operationally challenges continue; effective planning is supporting management of peaks in admission whilst meeting urgent care demand; challenges to discharge patients in a timely manager with a significantly reduced bed base to expedite discharges and shortfall of Intermediate Care capacity. MP requested Warrington LA and Commissioners to facilitate a workshop on how the system-wide problem can be tackled by all partners. Thanks conveyed to Execs and Ops Directors for their leadership during times of extreme pressure across the hospital. SMcG asked if and where the Board could provide any further support. MP explained discussions are on-going relating to benefits of an UCC as colleagues would be aware that Warrington remains one of the only towns that does not have either a Walk-in-Centre or an UCC. It is also the case that an independent review of out of hospital bedded services like intermediate care concluded that in Warrington there was a significant shortfall. The additional community capacity to manage patient flow and be able to have additional shortfall of beds would ensure patients are treated in the correct care environment with an improved patient experience LG advised other solutions, ie step up /step down facility had been discussed at the recent H&WBB. Commissioners to present proposals to support these options to the March

	H&WBB. Outcome to be shared at the Trust Board in March. IJ commented there seemed to be capacity at Warrington for an Intermediate Care facility and could this be an option whilst discussions were ongoing regarding an UCC. MP explained any options to increase capacity would need system-wide agreement. Capacity is constrained due to a number of factors, including the impact of the fire, capacity at Halton B3 which meant that the ward previously used as additional capacity over winter (Daresbury) was not now available as this was housing the ophthalmology department. Patients from C21 are planned to move to temporary 'ward' facility to enable work to commence for the Midwifery Led Unit.
BM/19/01/05	**Chairman's Report** The Chairman advised that building collaborative working relationships continue with University of Chester and he is attending a Roundtable forum with the CQC to inform requirements and expectations of the impending CQC inspection.
BM/19/01/016 (a)	**IPR Dashboard** Quality measures. CEO asked the Chief Nurse to address areas of variation in performance relating to improvement plans in falls and infection control and where improvements are being seen as the Trust is part of the National Falls Collaborative; MSA; CDiff and medication safety (CDs). In response KSJ explained plans are in place to monitor the themes and improvement in the action plans that are in place. Working with HR for A&TT training to be rolled out to support staff and senior nurses are being trained to take blood cultures. KSJ set up and Chairs weekly Gram Negative Blood Stream meetings for oversight and monitoring. Close monitoring continues of CDiff position of 25, annual target 26. KSJ was pleased to report a reduction in no harm falls in Janaury, demonstrating learning from the National Falls Collaborative, 2 wards are working with NHSI team for further learning. In relation to queries raised by AW relating to recording of 'total' Falls and if this included patient, staff and visitors and how many were patient falls. KSJ explained the dashboard is to be refreshed to show only patient falls, approximately 20 of the 'Total' falls are patient. Reduction reported last quarter in patient falls with the lowest number of falls recorded for a number of months, in November. Assurance provided of improvements made had been discussed in detail at the PSCE on 29 January. A low proportion of 'Total' falls are visitor related, all of which are reported to H&S Sub Committee. MSA – merging of A3 and CCU has supported improvement in this area. New draft guidance being reviewed, working with ITU on building and segregation of cubicle for MSA and infection control. Medication Safety (CDs) – mitigations include business case to provide analytical support to analyse status of medication safety themes. Nurses benchmarking CD incidences with other Trusts, increase in frequency of CD audits, improvement work in this area continuing.
(b)	Access and Performance measures. CEO asked the COO to address areas of variation in performance and mitigations in place relating to AED challenges, Ambulance Handovers; cancelled operations on the day; cancer screening within 62 days in month and measures to

	address shortfall of income and activity.
(c)	In response, CE assured the Board that metrics are routinely reviewed at a weekly Performance Review Group as well as oversight at the monthly KPI meeting. There have been a number of developments to support AED and patient flow including ED Ambulatory Care, GPAU, merging of A3 and CCU and benefits from Impact 5. Positive impact following go live of GPAU on 25.1.19 in Type 1 performance due to additional assessment capacity. Additional support confirmed by the CCG and local authority with the offer of 20 additional beds to support transfer of patients in to the community, 12 in one setting and 8 in another, both in Warrington which had seen a reduction in super stranded from 118 w/c 23.1.2019 to 98 on 25.1.2019. In addition a modular build will be available on site from early March to replace C21 and continue to support winter demands, which will allow work to C21 to be undertaken to begin work on the planned MLU. In relation to Ambulance Handovers COO explained mitigations in place to improve including 24/7 Handover Practitioner to support patient flow. Challenges remain especially when peaks in arrival. Focus continues on maintaining super stranded 21+ LoS patients below 100 to maintain GPAU functioning efficiently.
(d)	
(e)	SMcG asked to what extent the additional community capacity and GPAU would support improvement in AED, CE anticipated 5-10% increase each day, substantial improved performance and patient experience, particularly with Type 1 performance to achieve 70-80% consistently. This will be dependent upon maintaining super stranded numbers of less than 100 which will support maintain flow. SC commented that lack of assessment capacity impacts on A&E performance and patient experience and the ability to discharge at pace and scale is reliant operationally on collaborative working with partners. Referring to the additional community capacity, AW assured the Board that FSC has received assurance that sufficient measures had been taken to ensure appropriate support for the management and transfer of staff and patients had been undertaken.
	TA added that FSC had discussed impact of current pressures on A&E whilst not detracting from the performance of other indicators, asking how has reduced 4hr performance benchmarked against others. CE explained regional and national picture, the Trust being 112 of 137 nationally, weekly escalation call with NHSI & NHSE, commissioners, local authority had led to the support for the additional community capacity. At present the Trust is 106 of 137 nationally for type 1 performance and continues to strive to be below 100. For further reassurance, AC explained that HEE had identified patients waiting in incorrect area as a concern, GPAU has negated this risk with positive patient feedback for turnaround in receiving treatment.
	Cancelled Ops – CE explained overall performance improved since last year. Surgical transformation workstream reviewing all cancelled operations. No national standard but general consensus this should be no more than 1% of total activity of which WHH is below this tolerance. 80% (16) related Ophthalmology and high number of cases on a list, which could not be met due to sickness on the day and a further list being cancelled due to emergency cases taking priority. Mitigations discussed at KPI on 25.1.2019 and process to be

put in place to manage such emergencies.

Cancer, 2 breaches relating to cervical screening cases being treated at Liverpool Women's, this continues to be monitored. Under the new reallocation standards these would not be breaches come 1st April 19.

CE explained underperformance and income challenges are multi-faceted, in-year challenges have included Ophthalmology due to the fire in March 18, General Surgery due to retirement and Upper GI due to changes necessitated within the workforce. Breast surgery plan has been reviewed earlier in the year and understood. T&O activity and income is being analysed with market share plans progressing to increase activity across a number of areas particularly including utilisation of the CMTC. TA added that FSC had received market share data to support recovery position.

Following query relating to loss of activity in Ophthalmology due to the Fire from AW, AMcG explained that loss income is not covered, however costs relating to business continuity are covered through the insurance, for example, the modular build.

People measures. CEO asked the HRD+OD to address areas of variation in performance and mitigations in place relating to temporary staffing, agency spend and controls and measures in place to reduce.
MC explained savings of £165k for the Trust following the recommissioning of Direct Engagement providers in line with work completed with C&M Trusts as part of a procurement collaborative realised due to Centralised Bank for Medical and AHP temporary staffing. The team challenge rates for all agency bookings and ensure consistency, negotiation of agency rates, and relationship management. With effect from 31 January 2019 Admin & Clerical staff agency bookings will be dealt with through the centralised team based in HR. Future measures include, HR centralised team from 31 March to manage bank rates, again starting with Medical staff and then progressing on to all other staff groups. Across C&M work is ongoing to agree the rates of pay through agencies for Medical Staff, and this will be presented to C&M CEOs in order to seek support for collective rates from 1 April. In addition, Premium Pay Spend and Review Group will monitor E-Job Planning and E-Rostering to maximise internal resources.

AW highlighted key matters from the Strategic People Committee in January including ratification of the On-Call Policy, recruitment of Consultants to speciality areas, E&D Inclusion Strategy Engagement session requested for the Board Time out in February and assurance provided relating to progress against recommendations following recent HENW/GMC report.

Finance + Sustainability Measures. CEO asked the DoF + Commercial Development to address areas of variation in performance and mitigations and approach in place to address risk to financial position. AMcG explained £17.1m deficit delivered at the end of Q3, and the YTD control total (excluding PSF) is a £19.4m deficit in line with plan. Risks to plan include medical and other staff cost pressures and CIP delivery putting the forecast position at risk. The CIP is back loaded with some improvement but still risk to delivery. There is also risk to contingency due to Commissioner pressures. NHSI continue to be fully sighted on the Trust

	financial position and plans. AMcG explained mitigations to support to delivery of the plan including review of all business cases to identify what could be stopped/slowed down whilst maintaining optimum level of quality, conversion of CIP ideas into schemes, review of all non-catalogue spend with any requests related to CQC recommendations highlighted. The overall assessment of risks is c£6m, with c£4.5m mitigation plans identified. In addition the Capital Programme is being reviewed looking at capital and revenue costs. AMcG reassured the Board that quality, safety and patient experience is not compromised whilst trying to achieve savings and efficiencies and this is continually reinforced internally and externally. A loan of £14.2m was extended from May to November and the Trust is still awaiting an update from NHSI. If the plan is not delivered it will put further pressure on the cash position. **FSC had supported amendments to the Capital Programme which the Board approved.** **Key issues from the Assurance Sub Committees noted.** Monthly Safe-staffing reports November and December. KSJ highlighted improvement in Care Hours Per Patient Day of 7.1 on some wards, newly qualified Nurse Associates had joined the Trust this week providing additional capacity. Recent Governor Observation visits had also noted the improvement in ward staffing levels
BM/19/01/07	**CQC Update Progress Report** The Chief Nurse highlighted key points for the Board to note on progress: - 99% of the action plan had been delivered and is compliant, 1 outstanding action in Paediatrics, CBU are reviewing staff requirements which will be checked and challenged which may result in a business case for additional resources. - 100% compliance of all Must Do and Should Do actions. - Working with MIAA following second round of auditing actions deemed to be compliant, immediate actions and issues log presented to G2G - Improvement reported in Fundamental Breaches, MB asked what actions are being taken to improve IG compliance, KSJ explained spot checks had been undertaken, individual storage issues identified, meeting next week to review areas where solutions can be put in place quickly. In addition PJ added the importance of IG for all staff is reiterated through safety huddle and impromptu IG Manager's walk-arounds, in addition roll-out of use of 'Tap and Go' following successful pilot in A&E is being explored. - Feedback following the CQC Mock Inspection had been given to Managers and CBU teams, report will be presented to the next Quality Assurance Committee. High level next steps plan developed to support move to preparation stage for impending CQC inspection. SMcG acknowledged progress adding that himself and the CEO are continuing their ward/department visits • **The Board noted and approved the report, compliance achieved and assurance provided of progress made to date.**
BM/19/01/08	**Quarterly Progress on Carter Recommendations and Use of Resources Assessment (UoR)** The Director of Finance + Commercial Development explained that objectives within the NHS 10 Year Plan are being incorporated in the UoR. Preparation underway for submission of information by 22.2.2019 ahead of the UoR inspection on 2.4.2019 based on 5 KLOEs, clinical services, people, clinical support services, corporate services and finance. MP referred to the ability to always make a like for like comparison giving the example in the report of StH&KHT having a potential impact with sickness data due to lead employer status. IJ asked for future reports to include a snap shot of previous trajectories

	• **The Board noted the report. Reporting of non-compliance and assurance continues to be to be progressed via the appropriate Board Sub Committees.**
BM/19/01/09	**EPRR Compliance** The Chief Operating Officer highlighted key points for the Board. Following report in November reporting Partial compliance, an improvement plan was produced addressing the 10 partially compliant standards. A further self-assessment had taken place and 'Substantial' compliance achieved and reported. Plans in place to address 5 partially compliant standards including updated Trust-wide business continuity plans and staff booked onto CBRN training. **The Board noted the Report and improvement achieved to achieve substantial compliance.**
BM/19/01/10	**FTSU Bi-Annual Report** The Chief Nurse highlighted key points for the Board, the FTSU team had received 18 disclosures compared to 11 for 10 months in 2017-18. Types of disclosures were reviewed, KSJ assured the Board that actions had been taken where issues had been raised, with two staff dignity related disclosures part of on-going investigations for resolution. The Trust had completed its self-assessment with an action plan to support the 26 actions identified. IJ commented that following a recent ward visit and CQC Mock Inspection there appeared to be a low level of awareness amongst some ward staff, in part due to staff having support from line managers to raise and address concerns. KSJ explained that promotion and awareness of FTSU continues at various staff forums and team meetings. In response to a query by MB, KSJ added that disclosures were predominantly from nurse and HCA staff groups. • **The Board noted the report and conveyed thanks to the FTSU Guardian for her support.**
BM/19/01/11	**Guardian of Safe Working Q2 Report** The Medical Director highlighted key points for the Board to note within the report: - Increase in the number of Exception Reports (ER) in Q3 (35 to 45), and total number of incidents (58 to 76), compared with Q1 and Q2, reflecting the busier workload and higher acuity of patients in the winter months. - Lower numbers of ERs were submitted by senior trainees, and in this quarter, were predominantly in T+O. Requests for TOIL 41%. - The number of shifts requested had fallen, the difference between requested shifts and the number of shifts given to agencies is due to subsequent cancellations from CBUs. - In relation to reports not been signed off AC provided assurance that himself and the Guardian are providing additional support to trainees and supervisors to ensure sign-off. This issue is a regional challenge. - AC explained that an Educational Operational Strategy is being developed to understand current status, to show progress in this area ahead of a visit by the Royal College of Physicians on 15.3.19 and in preparation for the next National GMC Survey 17.3.19. • **The Board noted the Report and assurance provided and will continue to report any concerns to the Guardian.**
BM/19/01/12	**Strategic Risk Update** The Head of Corporate Affairs highlighted key points for the Board to note within the report - four new risks escalated to the BAF; the ratings of four risks amended (three reduced, one increased); the titles of two risks amended; eleven risks de-escalated from the BAF - New BAF circulated indicating trends and actions completed. Following discussion, FSC in

	January had requested Lead Committee for each risk to be highlighted. - As a Strategic Register, work continues to reduce the number of risks on the BAF to 5-7 to enable focussed strategic discussion and oversight. • **The Board noted and approved the amendments and the improved risk management processes identifying operational and strategic risks.**
BM/19/01/13	**WHH Clinical Strategy 2018-2023** LG and AC recorded their thanks to staff, patients and partners in developing the Trust Clinical Strategy which had been discussed and reviewed in detail at the December Board time out. LG referenced the engagement that had taken place to-date and the page which summarised this within the Strategy itself. Engagement will continue throughout the implementation and further development of the individual Clinical Strategies. There is a patient and public engagement session planned for February 2019. AC explained the milestones will be monitored through the Strategic Development + Delivery Sub Committee. AW asked for additional reference reflecting engagement had taken place with patients. • **The Board noted and approved the 5 year Clinical strategy.**
BM/19/01/14	**NHS 10 Year Plan** LG provided an overview of the 10 year plan and planned next steps to ensure the Trust Strategy and local Place and Regional Strategies are aligned to the National Plan. - Review of WHH organisational strategy against key aims of Long Term Plan to ensure complete alignment. Formulation of WHH internal response to any identified gaps. - Engagement with local system partners through Warrington Together and One Halton programmes to understand system-wide gaps and agree our collective response - Cohesive aggregation of all place-based plans and the outputs of individual organisations, led by C&MHCP to develop the C&M system-wide 5 year plan over the coming months. - Legislative "adjustments" as required which could impact on WHH to the Trust as a provider, ie Integrated care. **The Board noted the update. Provider Executive Summary and detailed presentation to be circulated for members.**
BM/19/01/14	**Changes to Scheme of Reservation and Delegation (SORD)/SFIs** The Executive Medical asked the Board to support and approve proposed changes within the SORD/SFIs following an annual review by all Executive Directors. • **The Board approved the changes to SORD/SFIs**
BM/19/01/15	**EU Exit Readiness Guidance** The COO assured the Board that the Trust continues pro-active EU Exit Planning in line with information guidance provided by the Department of Health + Social Care in the 7 key areas. AW asked that workforce indicator relating workforce planning be updated to reflect on-going work across C&M. **The Board noted the report.**
BM/19/01/16	**Any Other Business** No matters raised.
	Next meeting to be held: Wednesday 27 March 2019

Highlighted text reflects challenge

Signed …….

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

Chairman ……..

Date ……..

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/19/03/19	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	27 March 2019

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/11/118	28.11.2018	Guardian of Safe Working	Deep dive into agency usage, shift requests and opt issues to be reported to FSC February and SPC March to provide assurance regarding financial and people elements.	**Deputy Medical Director**	27.03.2019			
BM/18/11/115	28.11.2018	Mortality Review Report	Internal and External Peer review of SJRs to be undertaken	**Executive Medical Director**	27.03.2019		13.02.2019. Correspondence/ information circulated to Board members.	
BM/18/05/34 ii	24.05.2018	HEE visit 29 June 2018	Report following the visit on 29 June 2018	**Deputy Medical Director**	27.03.2019		Report not yet received from HEE 26.9.2018. Report still awaited. Defer to November. 12.11.2018. Defer to January 14.01.2019. Report not received, defer to March.	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/19/01/14	30.01.2019	NHS Year Plan	Provider Executive Summary and detailed presentation to be circulated.	**Director of Strategy**			Detailed presentation circulated 6.2.2019. EXEC Summary to follow	
BM/19/01/107	30.01.2019	IPR – People Element	Processes, procedures and mitigations to be taken through Strategic People Committee	**Director of HR&OD**	27.03.2019		Update to be provided following SPC in March.	
BM/18/07/57		Junior Doctor Update/Trainee	6 mth progress/update presentation.	**Medical Director**	27.03.2019		14.01.2019. Deferred to March Referred to future Board Time Out –	

		Engagement (Trello)					date TBC	
BM/19/01/??	30.01.2019		Update from H&WBB relating to Intermediate Care Proposals to March	**Director of Strategy**	27.03.2019		LG to provide verbal update when available.	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

Dear Trust Board Member

BM/18/11/15 Quarterly Mortality Review Report – "Excellence" in Care Rating according to Structure Judgement Reviews

At the Trust Board Meeting on 28th November 2018 I was challenged by the Chief Executive with regards to the relatively high number of Structured Judgement Reviews with a care rating of 5 – "excellent". I undertook to provide a further explanation of why this might be the case in the context of the peer review that occurs during the Mortality Review Group.

1. Background and Process for SJR

All acute, specialist, mental health and community Trusts were required to introduce a *Learning from Deaths Policy* on how we respond to and learn from deaths of patients in our care by September 2017. As part of this policy we decided which groups of patients we would review and the case record review method we would use for these reviews. This case record review method was required to be evidence based and we chose to use the Structured Judgement Review (SJR) method which had been piloted extensively and was introduced in conjunction with the Royal College of Physicians. They provided training and the documentation for the Reviews.

The SJR provides a standardised format that can be used across specialties. It also allows the reviewers to make comments on each phase of the care of the patient, and requires the reviewer to make a judgement in written form as well as providing a score on the care at the end of each section. The sections are divided up into "Phases of Care", of which there are 6 phases which are as follows:

1) Admission and Initial Management (approximately the first 24 hours)
2) Ongoing care
3) Care during a procedure (excluding IV cannulation)
4) Perioperative care
5) End of Life care
6) Overall assessment

For each of these sections the reviewer must assign a score based on his or her judgement of the standard of care and management:

1=very poor care
2=poor care
3=adequate care
4=good care
5=Excellent care

There are also a number of more specific questions after the phases of care review sections which ask for a simple yes or no answer. If the reviewer is satisfied that the sections and overall the scores are 3 or above and they feel that there are no significant lessons to learn or problems which require further discussion, this is signed off as complete. However if there are areas of poor or very poor care, or there are issues which the reviewer is unclear on or would like a wider discussion then the SJR comes to the Mortality Review Group (MRG) meeting for presentation to the group and discussion.

Reviewers are also asked to bring any cases where they feel that the patient has received excellent care to the group as there can also be learning from these cases. The "Excellent care" cases should have scores a "5" in most sections.

Cases where the scores are 1 or 2, all come to the group for discussion and if the group agree that the care is poor or very poor these cases are escalated to the Governance department for a more complete review. A Datix is completed with terms of reference for the review provided by the chair of the group. Similarly, cases where concerns are raised out with of any mortality review process, such as Serious Incident reporting, will bypass this stage of the MRG as they are investigated under different methodology. This may skew the distribution of care ratings.

The SJR method of reviewing mortalities was introduced in this Trust in January 2018. All of the reviewers received training and one of our MRG members is a qualified trainer. In order to understand how the MRG review and scores, this is best illustrated by two example cases as given below. These have been discussed at the MRG and considered by the reviewer and the wider MRG.

2. Example A

48 year old female with very poorly controlled Type 1 Diabetes (patient well known to the Trust diabetic team) was admitted to the Emergency Department(ED) in septic shock. She was known to have:

1) Renal failure and was on dialysis 3 days a week
2) Eye complications (diabetes related)
3) Peripheral neuropathy(diabetes related)
4) Severe peripheral vascular disease which had resulted in a below knee amputation on the right and multiple toe amputations on the left.
5) Congestive cardiac failure.

She had numerous previous hospital admissions and multiple previous stays on ITU.

Phase 1 - Admission and initial assessment

She was admitted via the ED in shock having become increasingly unwell over the previous 2 days. She was septic (likely from a fungal ear infection which was difficult to manage.

She had been reviewed by the ENT department). She had a CT scan of the brain, given oxygen, IV fluid and 2 antibiotics (to cover Chest and cerebral infections). She was responsive only to pain and NEWS was 9. Within 3 hours a central line was inserted and she was started on noradrenaline. A chest x-ray showed bilateral chest infections. She was moved from ED to ITU. This phase of care was rated as 5 as she had prompt and appropriate multidisciplinary ITU and ED care and was rapidly moved to ITU.

Phase 2 - Ongoing care

Progressively higher inotropic support needed for her septic shock; she was hypothermic and hypotensive and increasingly acidotic. DNACPR and Ceilings of care were in place;

- Input from Pharmacy and microbiology re optimisation of her antibiotic therapy.

- 2 further CT Brain scans were done.
- CT Chest performed.
- ECHO showed hypertrophic cardiomyopathy, left and right ventricular hypertrophy and thickened valves.
- IV insulin and NG feed with DSN input on day four.
- Developed DIC (disseminated intravascular coagulation) and haematology review as dropping platelets and white cell count.

This phase of care was scored 5 for excellent care. The patient was extremely unwell but had input from all the various specialties in helping with the diagnosis and management and this was all done quickly.

Phase 3 and Phase 4 - These phases of care are perioperative and procedural and were not assessed in this case as it was not required.

Phase 5 - End of life care was scored 5 as her management from her admission, although acute, was discussed with her family in detail and DNACPR and ceilings of care were agreed as she was so unwell and it was considered likely that she would not survive. This was done appropriately and in a timely fashion.

Phase 6 - Overall assessment.
Pre-admission this patient had end-stage diabetes and was admitted in severe septicaemic shock. From admission to hospital the reviewer could not see what could have been done better to prevent death, which was deemed inevitable.

This phase was scored 5 (excellent). In each phase of the patient's care her management was thought to be of the highest standard. This is the judgement of the reviewer, but the case was presented to the MRG as it was such a complex problem in a young patient. It was the view of the group also that the care was timely with rapid involvement of multiple specialties in her care. Everything that could have been done was done and that included an early discussion with the family about the gravity of the situation and the poor prognosis.

3. Example B

Twenty six year old female who had motor neurone disease and developed respiratory failure secondary to the disease.

Phase 1 - Admission and initial assessment
Multi-disciplinary involvement of emergency department, critical care, neurology, respiratory medicine and palliative care from the outset. The patient wished to die at home and a plan was formulated with her family to try to accommodate the patient's wishes. This was rated 5 (excellent care) as within a very short period there was excellent multidisciplinary team discussions and care.

Phase 2 - Ongoing care.
Became intolerant of NIV (non-invasive ventilation) and discussions between the patient and family took place. A plan for symptom control was agreed and NIV discontinued.

This was rated 5. This was the right management for this patient and involved the patient and the family in deciding her care.

Phase 3 and 4 - Not applicable.

Phase 5 - End of life care, Individual plan of care (IPOC). Full discussion with patient and family and the palliative care team were involved. This was scored 5. This was tailored and timely end of life care for this patient and her family.

Phase 6 - Overall assessment. Excellent care with good multi-disciplinary involvement in the planning of care and attempts to facilitate the patient's wishes. Rating of 5 - Excellent. This was a very sad case of a young woman with a fatal disease at end of life and the trust mobilised all of the specialties required to try to ensure she had excellent care at the end of her life.

4. Other factors

One of the groups of death we review are those patients who die without a DNACPR in place. We decided to include these patients as these are a group who are not "expected" to die and therefore we felt that it was appropriate to include them, however, this also includes all patients who come into the ED in cardiac arrest.

There are quite a number of this type of patient. As the outcome is often unsuccessful the review becomes simply that of the management of a cardiac arrest as there is no ongoing care and the patient is usually only in the department for a short period of time (up to an hour). The standard of resuscitation management, against clearly defined national protocols for which there is specific and standardised training, particularly in the ED, is of a high standard and as a result is usually rated 5 (excellent). This also has the effect of skewing the number of "excellent" outcomes. We have discussed this at MRG and wondered whether we should exclude this group of patients.

We are undertaking a review of all of the SJRs done since we started, now that the first year of this new process is complete. This will be presented to the MRG so that we can alter or improve any areas if we deem appropriate to do so. Cardiac arrest and resuscitation are audited separately by the Trust Resuscitation Committee.

I hope this provides assurance around the robustness and quality of assessment at SJR and the mortality review process.

Yours sincerely

Professor Simon Constable
Deputy Chief Executive/Executive Medical Director

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/22**			
SUBJECT:	**Integrated Performance Dashboard**			
DATE OF MEETING:	27th March 2019			
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Deputy Chief Executive & Medical Director Kimberley Salmon-Jamieson, Chief Nurse Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Chris Evans - Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has 71 IPR indicators which have been RAG rated as follows: **Red: 26 (decreased from 28 in January)** **Amber: 9 (increased from 8 in January)** **Green: 33 (increased from 32 in January)** **Non RAG Rated: 3 (the same as January)** The Trust deficit year to date is £18.6m which is £1.6m worse than plan. Of this variance, £1.3m relates to non-achieved PSF. Excluding PSF, the position is £21.6m deficit which is £0.4m from plan. Excluding PSF, the Trust is forecasting achievement of the control total. The Trust has received formal notification from NHSI that the outstanding loan of £14.2m has been extended to November 2019 at the same interest rate.			
PURPOSE: (please select as appropriate)	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **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/19/03/22

1. BACKGROUND/CONTEXT

The RAG rating for all 71 indicators from March 2018 to February 2019 is set out in **Appendix 1**. The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Board with assurance in relation to the delivery of all KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

- Red - 26 in February, decreased from 28 in January.
- Amber – 9 in February, increased from 8 in January.
- Green – 33 in February, increased from 32 in January.
- Not RAG rated – 3 in February, the same as January.

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

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

Quality

Quality KPIs

There are 8 indicators rated Red in February, a decrease from 9 in January.

The 7 indicators which were Red in January and remain Red in February are as follows:

- Incidents – the Trust had 11 open incidents over 40 days old in February, a reduction from 14 in January, against a target of 0.
- Healthcare Acquired Infections (MRSA) – two cases of MRSA have been reported YTD (April and December 2018), against a national zero tolerance threshold; this indicator will be Red for the remainder of the year.
- Healthcare Acquired Infections (Gram Negative), 4 cases of Ecoli were reported in February, a decrease from 6 in January.
- Medication Safety – there was 1 incident of harm reported in February, (1 in January), there is zero tolerance for this indicator.
- Friends & Family Test (A&E and UCC) – the Trust achieved 77.0% in February, an improvement from January's position of 76.0%, against a target of 87.0%.
- Mixed Sex Accommodation Breaches (MSA) – there were 6 Mixed Sex Accommodation Breaches in February (9 in January), against a target of 0.

There are 3 indicators which have moved from Red to Green in month as follows:

- Healthcare Acquired Infections (CDif) – there were 0 reported cases of CDif in February, a decrease from 2 in January against a threshold of less than 2.
- Total Falls & Harm Levels – there were 62 total falls reported in February, a decrease from 85 for the same period in 2019/20.
- Friends & Family Test (Inpatients) – the Trust achieved 96.0% in February, an improvement from January's position of 94.0%, against a target of 95.0%.

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

- VTE Assessment – the Trust achieved 92.3% for January's validated position, a decrease from December's validated position of 95.1% against a target of 95.0%.
- Sepsis Inpatient Screening – the Trust achieved 78.0% in January's validated position against a target of 95.0%.

There is 1 Sepsis indicator which cannot be RAG rated this month, due to validation timescales.

Access and Performance

Access and Performance KPIs

There are 7 Access and Performance indicators rated Red in February, a reduction of 2 in month.

The 7 indicators which were Red in January and remain Red in February are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 79.4% including walk ins in February, an improvement from January's performance of 77.9%, against the target of 95.0%.
- A&E Waiting Times Improvement Trajectory – the Trust's improvement trajectory for February was 90.0%; therefore the Trust did not achieve this in month.
- Ambulance Handovers 30>60 minutes – there were 182 patients who experienced a delayed handover in February, a decrease from 235 in January.
- Ambulance Handover at 60 minutes or more – there were 59 patients who experienced a delayed handover in February, a decrease from 102 in January.
- Discharge Summaries % sent within 24 hours – the Trust achieved 87.1% in February, an improvement from January's position of 86.8% against a target of 95.0%.
- Cancelled operations on the day (for non-clinical reasons) – there were 20 cancelled operations in February, an increase from 14 in January against a target of 0.
- Super Stranded Patients – the Trust had 109 super stranded patients at the end of February, an increase from 99 in January, against a trajectory of 86 patients.

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

- Cancer 62 Days Urgent – the Trust achieved 90.2% for January's validated position, an improvement from December's validated position of 82.7% against a target of 85.0%.
- Cancelled Operations on the Day for Non-Clinical Reasons, not booked in within 28 days – there were zero patients in February, reduced from 1 in January, against a target of zero.

PEOPLE

Workforce KPIs

There are 5 indicators rated Red in February, an increase of 1 from January.

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

- Sickness Absence – the Trust's achieved 5.0% in February, a decrease from January's performance of 5.6% against a target of less than 4.2%.
- Agency Nurse Spend – this has decreased to £0.3m in February, however this exceeds expenditure for the same period last year of £0.2m.

- Average Length of Service (Top 10 agency workers) – this has increased from to 32 months in February, from 29 months in January.

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

- Agency Medical Spend - this has increased to £0.7m in February and exceeds expenditure for the same period last year of £0.5m.
- Agency AHP Spend - this has increased to £0.2m in February and exceeds expenditure for the same period last year of £0.1m.

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

- Average cost of the Top 10 agency workers – this has decreased to £20k in February, from £21k in January.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 6 Red rated Finance and Sustainability indicators in February.

The 6 red indicators are as follows:

- Operating Surplus/Deficit – the actual deficit to 28th February 2019 is £18.6m. This is £1.6m above the planned deficit of £17.0m. PSF funding of £1.3m 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 £21.6m deficit which is £0.4m away from the plan. The current position assumes £1.3m income from insurers in respect of the capital costs associated with the Kendrick Wing Fire.
  The current variance on clinical income is £0.8m above plan.
  Excluding the £2.7m additional income from the Department of Health for the additional costs of the Agenda for Change pay award, the income variance is £3.5m below plan which is mainly due to elective under performance.
- Capital Spend – the actual spend is £6.3m which is £3.0m below the planned spend of £9.3m.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a year to date performance of 51% which is 44% below the national standard of 95%.
- Agency Spending – the actual year to date spend is £10.3m which is £2.3m above the year to date ceiling of £8.0m.
- Cost Improvement Programme – CIP schemes have been assessed at £4.4m which is £2.6m below the £7.0m CIP target. Year to date savings of £3.9m have been achieved against a target of £5.9m

- Cost Improvement Programme (Recurrent) – £2.5m of the CIP schemes have been assessed as recurrent. Further work is being undertaken to identify recurrent schemes for 2019/20.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in **Appendix 4**.

The forecast outturn has been updated to reflect the position at Month 11. The Trust is in a good position to deliver the control total (excluding PSF). There still remain a number of risks including shortfall in CIP, unfunded cost pressures, underachievement of clinical income and reduction in contribution towards the financial position from local commissioners. The risks are being offset with a number of improvements and mitigations including the management of winter pressures and non-pay controls.

The Trust has received formal notification from NHSI that the outstanding £14.2m loan has been extended to November 2019 at the same interest rate.

Capital Programme

The 2018/19 capital programme, approved by the Board in February 2018 was £7.5m. This has increased to £10.5m to reflect a high level estimate of £2.4m for the Kendrick Wing restructure and £0.6m for externally funded schemes.

This months proposed changes to the capital programme are summarised in Table 1:

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

Scheme	**Value £000**
Additional Funding Requirements	
Upgrade to Butterfly Suite (1)	20
ITU UPS Replacement (1)	68
Falsified Medicines Directive (1)	83
IT Servers (1)	27
Pharmacy Licence (funded by Department of Health)	12
Video Lagyrnoscope (funded by Health Education England)	9
Tomosynthesis Software (funded by External Charity)	64
EPR developments (funded by Department of Health)	81
Sub Total	**364**
Funded by	
Externally Funded	(166)
Trust Contingency	(198)
Sub Total	**(364)**
Total	**0**

(1) Emergency Approval by Director of Finance and Commercial Development and Deputy Chief Executive.

The actual spend for the year to date is £6.3m (£2.3m relates to the fire expenditure) which is £3.0m below the year to date plan. The main reasons for the under spend is due to scheme slippage. This includes a number of IM&T and Estates schemes, together with the removal of the MRI scanner scheme and delays on the fire related schemes pending the outcome of discussions with insurers. The forecast outturn for capital is a £0.7m underspend.

The opening 2018/19 capital programme included a contingency of £0.6m. After the changes resulting from the CQC, ward accreditation, PLACE inspection work and funding of emergency schemes the balance as at 28 February has reduced to £0.4m.

An updated capital programme is attached in **Appendix 5**.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Trust Operational Board
- Strategic 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 March 2018 – February 2019

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

Appendix 1 – KPI RAG Rating March 2018 – February 2019

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

Appendix 1 – KPI RAG Rating March 2018 – February 2019

	KPI		Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19
	WORKFORCE													
50	Sickness Absence	↓ (% Monthly Performance)	↑	↓	↓	↓	↑	↑	↓	↓	↑	↑	↑	↓
51	Return to Work	↑ (% Monthly Performance)	↓	↑	↑	↓	↓	↓	↓	↓	↓	↓	↓	↓
52	Recruitment	↓ (Number of Days)									↓	↔	↑	↓
53	Turnover	↓ (% Monthly Performance)	↑	↓	↓	↑	↑	↑	↑	↓	↑	↓	↓	↑
54	Non Contracted Pay	↓ (% of Budget)	↑	↔	↑	↓	↑	↓	↑	↔	↓	↑	↓	↓
55	Agency Nurse Spend	↓ (Monthly agency spend)	↑	↑	↓	↑	↑	↑	↓	↑	↑	↑	↑	↓
56	Agency Medical Spend	↓ (Monthly agency spend)	↓	↓	↑	↓	↓	↓	↑	↑	↑	↑	↓	↑
57	Agency AHP Spend	↓ (Monthly agency spend)	↑	↑	↓	↓	↑	↓	↓	↑	↑	↓	↓	↑
58	Core/Mandatory Training	↑ (% Monthly Performance)				↑	↑	↑	↑	↑	↑	↑	↓	↓
59	PDR	↑ (% Monthly Performance)	↑	↑	↑	↑	↑	↓	↓	↓	↑	↓	↑	↓
60	Average cost of the top 10 highest cost Agency Workers	↓ (Monthly Cost)	↓	↓	↑	↑	↓	↓	↑	↓	↓	↓	↑	↓
61	Average length of service of the top 10 longest serving agency workers	↓ (Monthly Length of Service)	↓	↑	↓	↑	↑	↓	↔	↓	↑	↔	↑	↑
	FINANCE													
62	Financial Position	↑ (Cumulative against plan)	↑	↑	↑	↑	↑	↑	↓	↑	↑	↓	↓	↑
63	Cash Balance	↑ (Balance against plan)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
64	Capital Programme	↑ (Performance against plan)		↑	↑	↓	↑	↑	↓	↓	↓	↓	↓	↓
65	Better Payment Practice Code	↑ (Monthly actual against plan)		↑	↑	↓	↑	↑	↓	↓	↓	↔	↑	↓
66	Use of Resources Rating	↑ (Rating against plan)	↔	↔	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔
67	Fines and Penalties	↓ (Value of fines/penalties)			↓	↔	↔	↔	↔	↔	↔	↔	↔	↔
68	Agency Spending	↓ (Monthly planned vs actual)		↑	↓	↑	↓	↓	↓	↑	↓	↓	↓	↑
69	Cost Improvement Programme – Performance to date	↑ (Monthly vs target)		↑	↓	↓	↓	↓	↓	↓	↑	↑	↓	↓
70	Cost Improvement Programme – Plans in Progress (In Year)	↑ (Monthly vs plan)				↓	↓	↓	↓	↓	↓	↑	↓	↓
71	Cost Improvement Programme – Plans in Progress (Recurrent)													

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

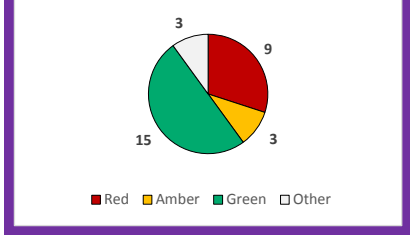
Warrington and Halton Hospitals NHS
NHS Foundation Trust

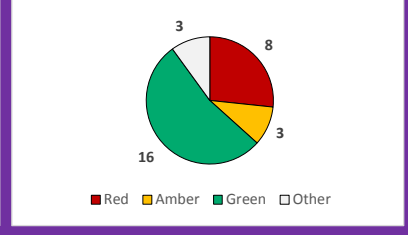
Integrated Dashboard - February 2019

Appendix 2

Key Points/Actions

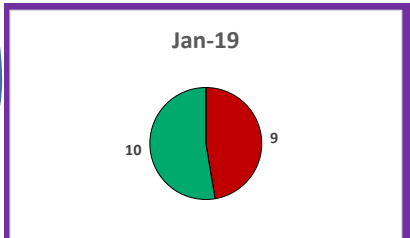
Quality Improvement

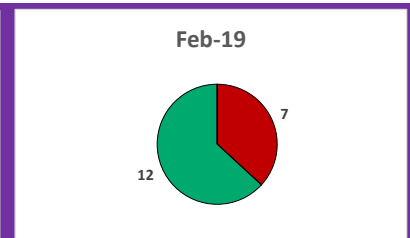




As at 28th February, there were 338 open incidents that required review and sign off. Whilst this continues to reduce in line with the improvement trajectory, work is ongoing to ensure that this remains a focus for staff. Compliance in month in relation to Duty of Candour remains 100%. Gram negative bloodstream infections in February : E. coli 4 hospital onset cases; Klebsiella - 1 hospital onset case. The overall number of reported falls has decreased from 70 to 62, with a 6% reduction noted YTD. There were no category 3 or 4 pressure ulcers reported in February. There was 1 medication incident relating to harm.

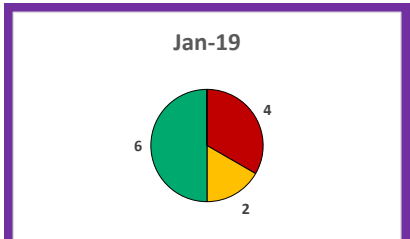
Access & Performance

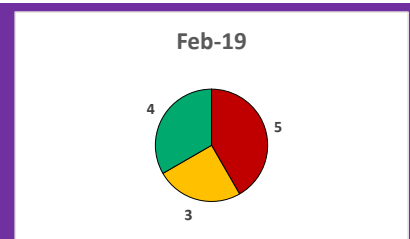




In February 2019, 12 out of the 19 indicators were RAG rated as Green. The Trust has continues to achieve the RTT and 6 weeks diagnostic standards in month. The Trust has achieved all cancer standards for January 2019. The Trust did not meet the 4 hour A&E standard or improvement trajectory; however there has been improvement in the position and actions are in place to improve further. The number of ambulance handovers between 30-60 and 60+ minutes has reduced for the 2nd consecutive month and remains a focus. There continues to be improvement in the number of discharge summaries sent within 24 hours. Cancelled operations for non-clinical reasons is less than 1% which benchmarks favourably with local Trusts, with no patients not rebooked within 28 days. The Trust continues to work with system partners to address the number of stranded and super stranded patients.

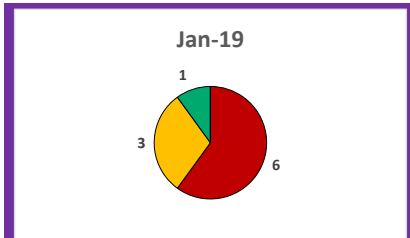
Workforce

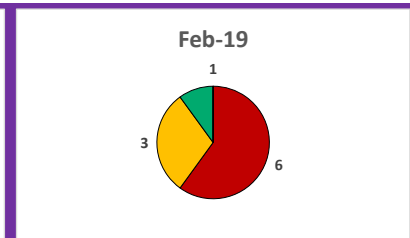




The Trust has seen a decrease in sickness absence in month to 5.03%, several actions are underway to address. Return to work compliance has reduced to 79.07%. Recruitment timeframes have increased to an average of 67.7 days. Turnover remains positive and is below the 13% threshold. Pay spend is below budget which is due to a decrease in contracted pay spend. Core Skills Training compliance continues to be positive at 91.52%. PDR compliance is below the target in month at 80.30%. The average cost of the Top 10 agency workers has reduced from last month.

Finance





In month, the Trust recorded a deficit of £0.3m which increases the cumulative deficit to £18.6m which is £1.6m above plan. Of this, £1.3m relates to the non achievement of PSF due to A&E performance. The year to date control total (excluding PSF) is a £21.6m deficit which is £0.4m above plan. Year to date income is £1.5m above plan, expenditure is £2.9m above plan and non operating expenses are £0.1m above plan. Capital spend is £6.3m, which is £3.0m below the planned capital spend of £9.3m. 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 Trust has received formal notification from NHSI that the outstanding £14.2m loan has been extended to November 2019 at the same interest rate. The year to date performance against the Better Payment Practice Code is 51% which is 44% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Quality Improvement - Trust Position

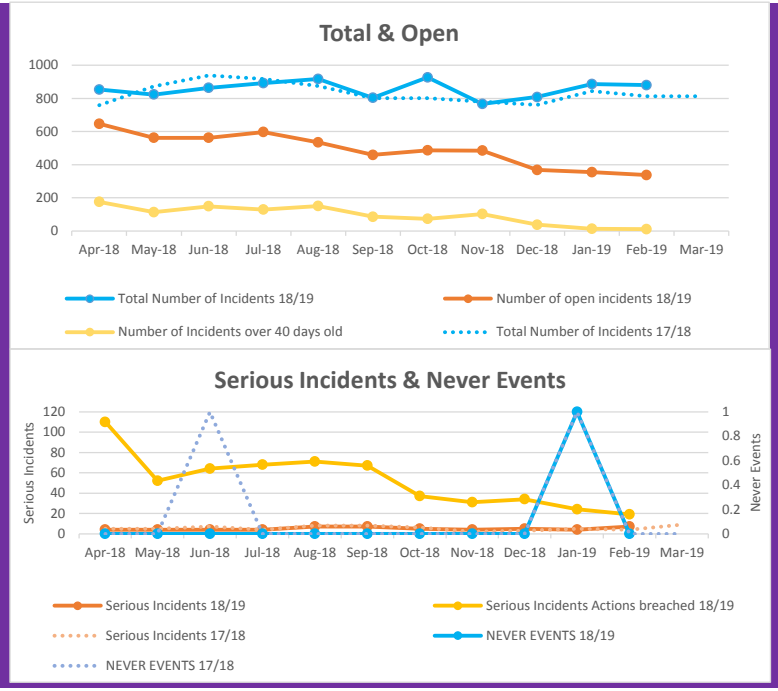
Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?

Patient Safety

Incidents

Red: 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

There were no never events reported in month.



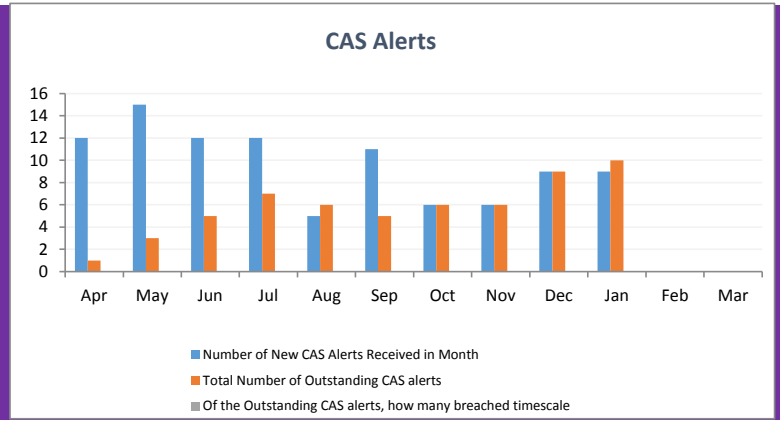
There has been a marked improvement over the past 12 months in this area (for example breached SI actions have improved by 82% since April 2018). The Trust will continue to focus on this until actions are completed in a timely way. This improvement has been driven by scrutiny at Patient Safety & Effectiveness Sub Committee and weekly Meeting of Harm.

The Trust 'Reporting to Improve' campaign continues with 168 managers trained on the use of Datix for incident reviewing. Training will continue in March 2019.

Concise RCA investigations are now reviewed and signed off and Weekly Executive Meeting of Harm in line with the approach for Serious Incident Investigations.

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

There were 15 new CAS Alerts received in month. There were no CAS alerts which breached the timescale in month.



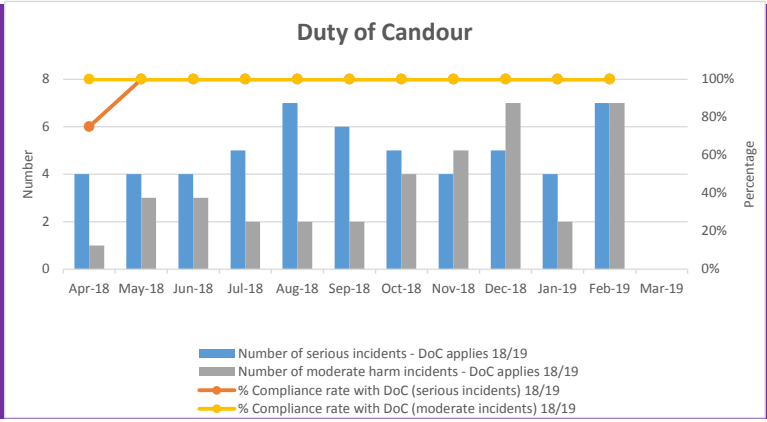
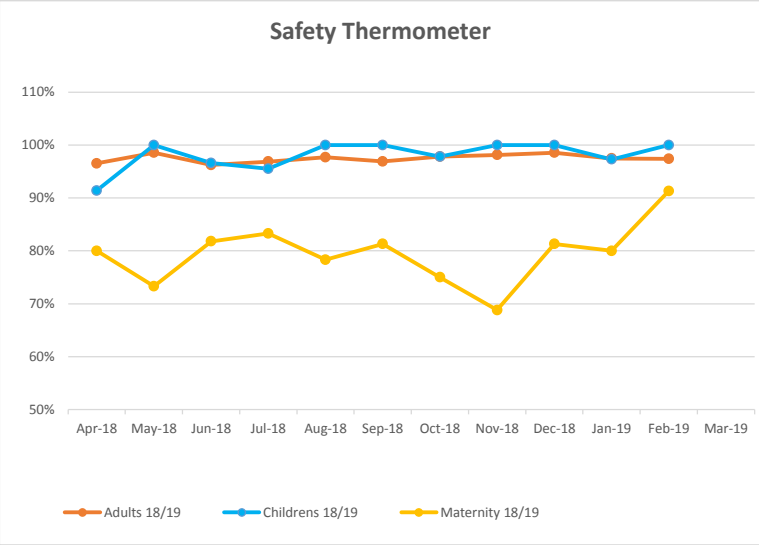
The Trust has 15 alerts currently being assessed for compliance. None have breached their timescale.

The Trust is currently auditing compliance with CAS alerts, seeking evidence that actions from previous CAS alerts are fully embedded. This will report to April Patient Safety and Effectiveness Sub Committee.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

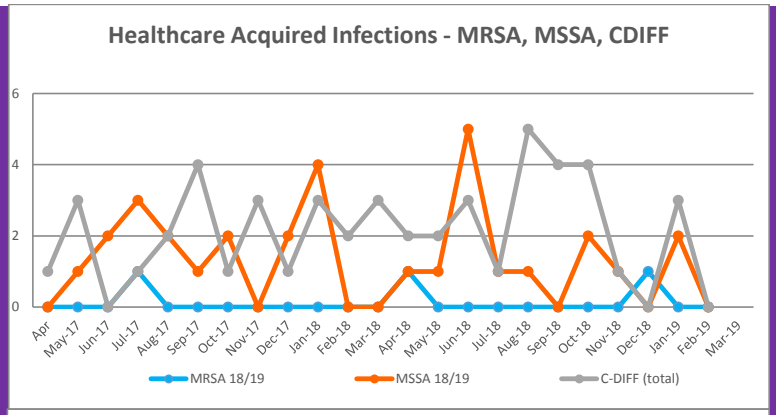
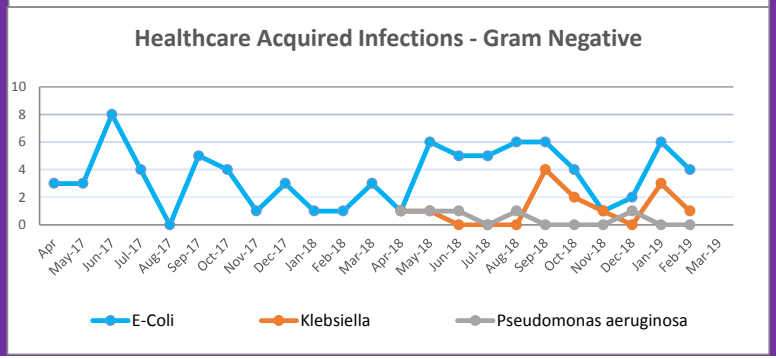
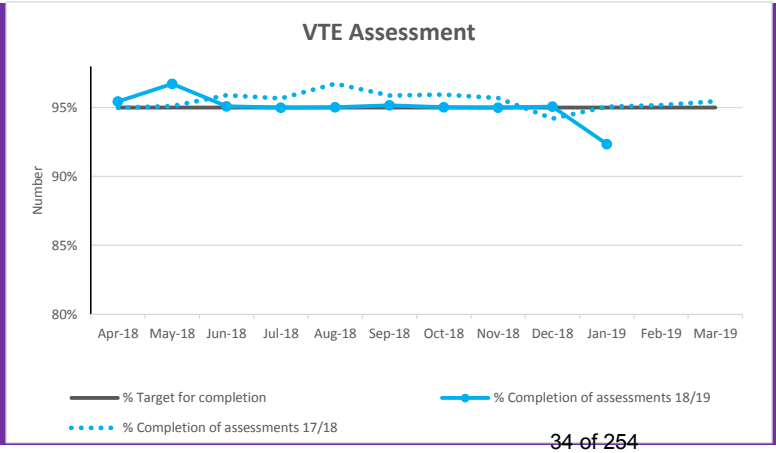
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Duty of Candour Red: <100% Green: 100%	The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy and continues to be supported through monitoring via the Datix system and oversight by the clinical governance department in relation to all correspondence/contact.	A new E-Learning training package will be launched shortly and training for senior managers and clinicians continues as part of the clinical governance TNA. Weekly scrutiny and review of Duty of Candour by Director of Clinical Governance.
Adult Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more **Childrens Safety Thermometer** Red: Less than 80% Amber: 81% to 84% Green: 85% or more **Maternity Safety Thermometer** Red: Less than 70% Amber: 70% to 73% Green: 74% or more	The Trust achieved 97.39% on the Adult Safety Thermometer, 100% on the Children's Safety Thermometer and 91.30% on the Maternity Safety Thermometer in month.		The Maternity figure has improved. Others are within normal limits.	There is a continued focus to consistently achieve the standards across all areas of the Safety Thermometer.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

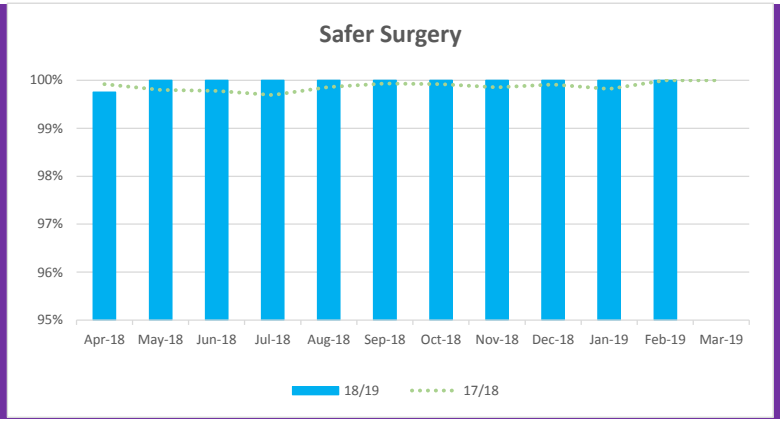
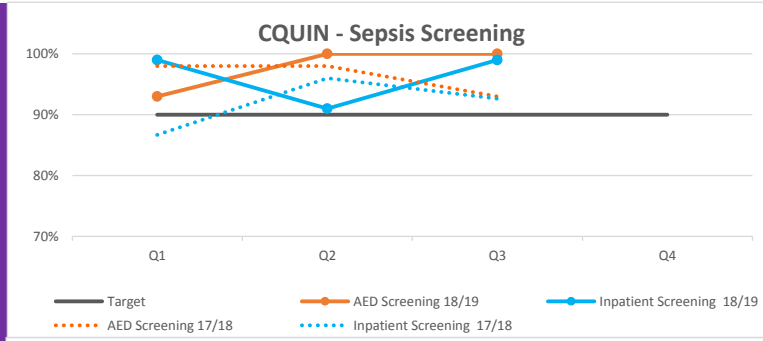
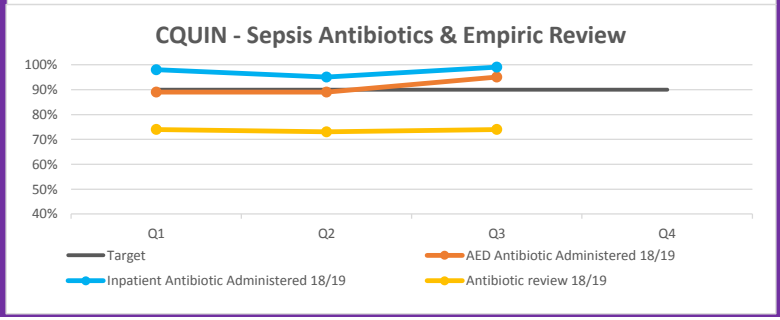
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections **MRSA** **Red: 1 or more** **Green: 0** **Healthcare Acquired Infections** **C-Difficile** **Red: More than 2** **Amber: 1 to 2** **Green: 0** **Healthcare Acquired Infections - Gram Negative** **E-Coli** **Red: More than 2** **Amber: 1 to 2** **Green: 0 OR** **Klebsiella/Pseudomonas** **Red: More than 1**	SOF CQC **There have been 2 MRSAb cases reported YTD. There were 0 cases of C-DIFF reported in month. There were 4 cases of E-coli reported in month. There was 1 case of Klebsiella/Pseudomonas reported in month.**	 	**E-Coli is above trajectory with 44 cases year to date against a target of 36. Themes are relating to catheter acquired infection. CDIFF is 25 cases against a trajectory of 26. Themes are in relation to timely screening and sampling. MRSAb 2 cases year to date against a target of 0. Themes relate to timely screening on admission.**	**Workstreams related to the reduction of healthcare acquired infections continue with oversight at Patient Safety Sub Committee and Quality Assurance Committee. New trajectories have been agreed.**
VTE Assessment **Red: <95%** **Green: 95% or above based on previous months' figures due to timescales for validation of data**	SOF **The Trust achieved 92.35% for VTE assessments.**		**Data is one month in arrears due to a requirement to validate.**	**Policy agreed and electronic system to ensure timely risk assessment in place.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

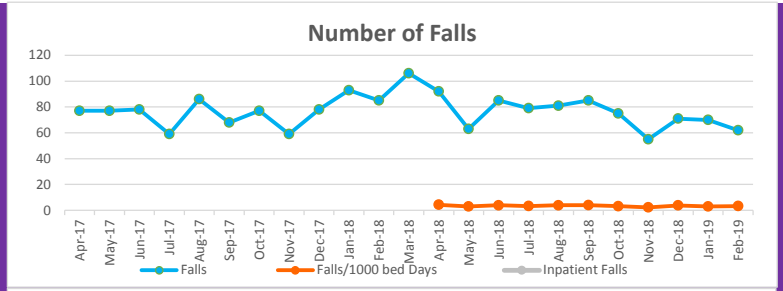
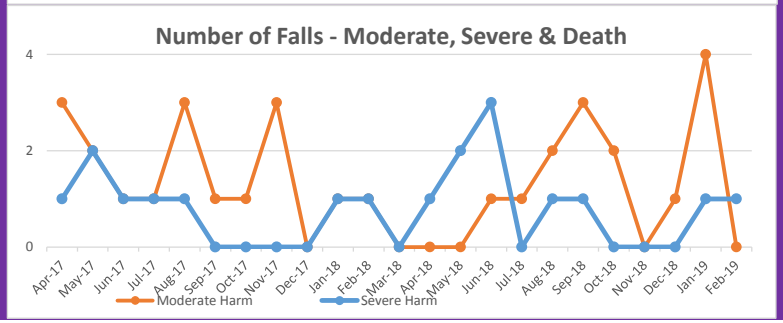
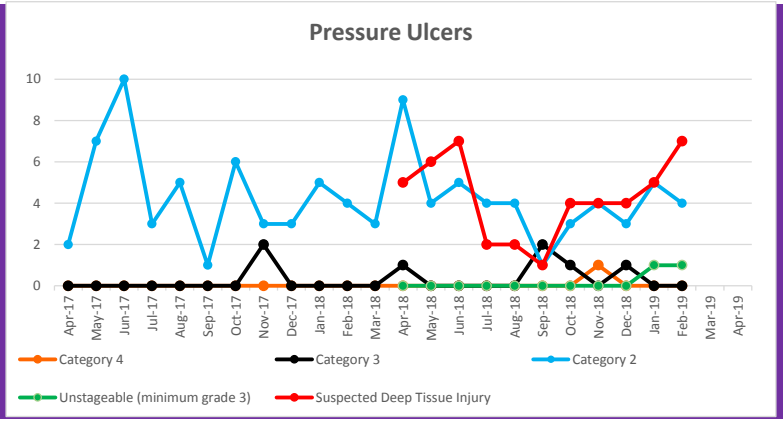
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Safer Surgery Red: <100% Green: 100%	The Trust achieved 100% for Safer Surgery in month.		The Trust has maintained 100% compliance levels for the WHO checklist.	Theatres have set up a quality group which is looking at the safe surgery improvements via human factors benchmarked to reduce repetitive questions and increase engagement with clinicians. In addition to the review of the WHO checklists, the Trust conducts approximately 60 observational audits per month.
CQUIN - Sepsis AED Screening Red: Less than 90% **CQUIN - Sepsis Inpatient Screening** Red: Less than 90% Green: 90% or more **CQUIN - Sepsis AED Antibiotics Administration** Red: Less than 90% **CQUIN - Sepsis Inpatient Antibiotics Administration** Red: Less than 90% **CQUIN - Sepsis Antibiotic Review**	The Trust achieved: 100% for Sepsis AED Screening. 78% for Sepsis Inpatient Screening. 100% for Sepsis AED Antibiotics Administration. 97.87% for Sepsis Inpatient Antibiotics Administration. 74% for CQUIN Sepsis Antibiotic Review as this is submitted quarterly.	 	Validation process underway to determine root cause of variation in compliance.	An electronic version of the Sepsis pathway has been developed for Trust wide roll out.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

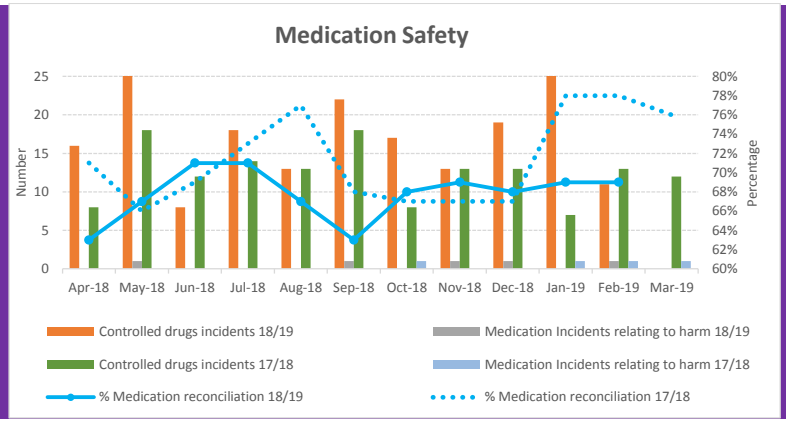
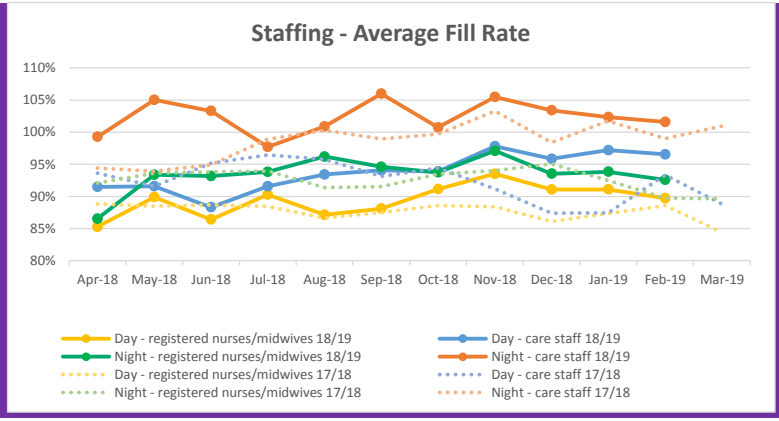
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Total number of Falls & harm levels Red: <20% decrease from 17/18 Green >20% decrease from 17/18	There were a total of 62 falls in month.	 	A reduction of 6% is noted YTD against inpatient only falls for the same reporting period last year.	The risk assessment and care plan, aligned to NICE guidance, has been approved and will be rolled out across the organisation by the end of April. The enhanced care process is reinforced and oversight is maintained by senior nursing staff to ensure appropriate care is in place.
Pressure Ulcers Category 4 Red: 1 or more Category 3 Red: More than 3 Green: 3 or less Category 2 Red: More than 7 Green: 7	There were 0 Category 4 pressure ulcers, 0 Category 3 pressure ulcers and 4 Category 2 pressure ulcers reported in month.		Themes noted are assessment and recognition of risk.	Increased focussed staff training in high incidence areas including face to face and e-learning teaching packages. The Trust Quality Academy collaborative has commenced.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework SOF
Care Quality Commission CQC

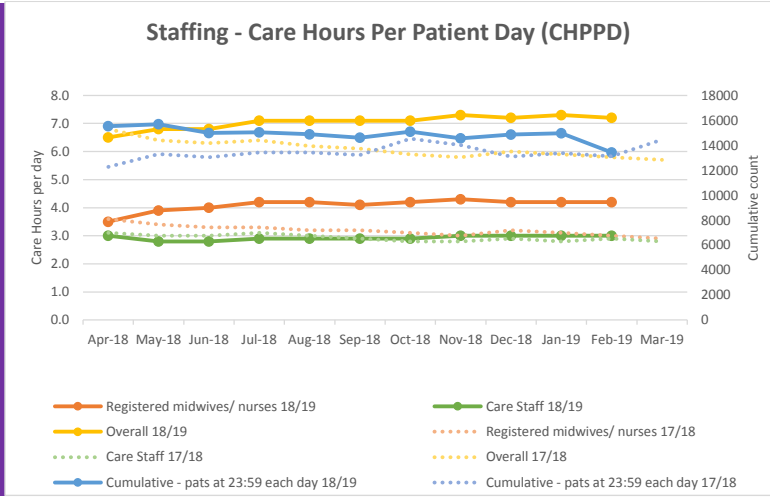
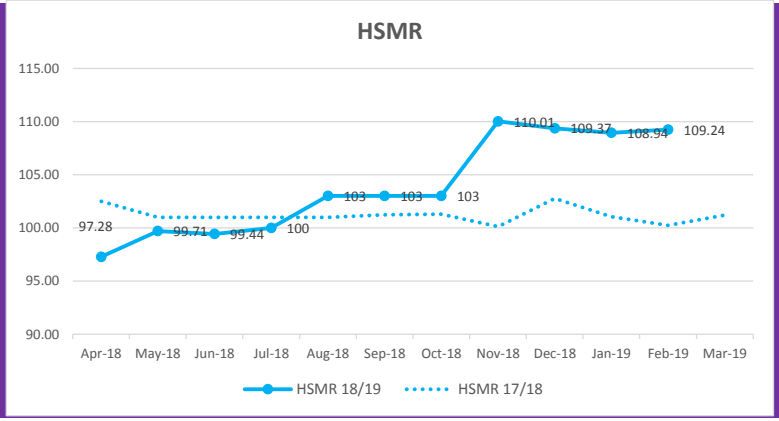
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Medication Safety **Red - any incidents of harm.** **Green - no incidents of harm.**	There was 1 incident of harm relating to medication safety in month.		There was 1 incident of harm relating to medication safety in February relating to a error on the medication chart.	Continue to review and feedback learning. Implementation of ePMA to improve safety & 7 day Pharmacy service.
Staffing - Average Fill Rate **Red: 0-79%** **Amber: 80-89%** **Green: 90-100%**	In month the average staffing fill rates were: Day (Nurses/Mwife) 90% Day (Care Staff) 96.56% Night (Nurses/Mwife) 92.59% Night (Care Staff) 101.59%		Any ward that falls below 90% provides mitigation to ensure safe, high quality care is consistently delivered in those areas.	This position will improve as we continue to make progress in the Trust wide Recruitment and Retention Strategy and implement the recommendations of the nurse staffing business case.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

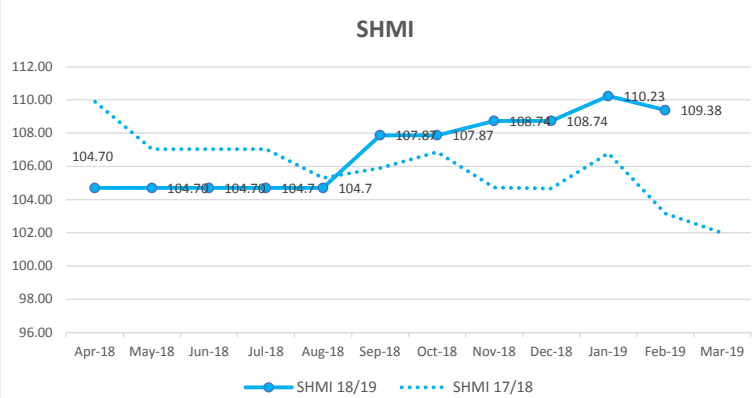
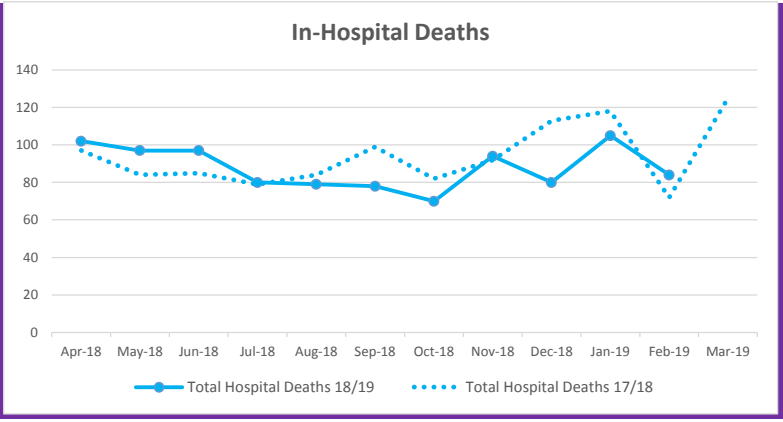
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD)	**In month, the average CHPPD were: Nurse/Midwife: 4.2 hours Care Staff: 3 hours Overall: 7.2 hours**		**The overall Trust CHPPD continues to maintained and is monitored monthly by the senior nursing team, the January CHPPD position is 7.3 with a 2018/19 current rate of 7.0.**	**The Trust is currently lower than the national median, which is related to the number of staff vacancies and the number of escalation beds that were opened during the winter months, which has an impact on nurse staffing numbers.**
Mortality ratio - HSMR **Red: Greater than expected** **Green: As or under expected**	**The HSMR ratio in month was 109.24**		**The most recent HSMR/SHMI are still within the expected range. Work continues at Mortality Review Group undertaking deep dives and also continuing with Standard Judgement Reviews.**	**Two key areas of improvement are underway: The Ward Round Accreditation will review the quality of documentation which impacts on these results.** **Clinical Coding are looking at R codes as they are believed to have impacted on these results.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	The SHMI ratio in month was 109.38		The most recent HSMR/SHMI are still within the expected range. Work continues at Mortality Review Group undertaking deep dives and also continuing with Standard Judgement Reviews.	Two key areas of improvement are underway: The Ward Round Accreditation will review the quality of documentation which impacts on these results. Clinical Coding are looking at R codes as they are believed to have impacted on these results.
Total Deaths	There were 84 number of deaths reported in month.		The Trust reports on the total number of deaths in month as we use this data for triangulation with the HSMR and SHMI data and for consideration when looking at the monthly variance levels.	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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Single Oversight Framework
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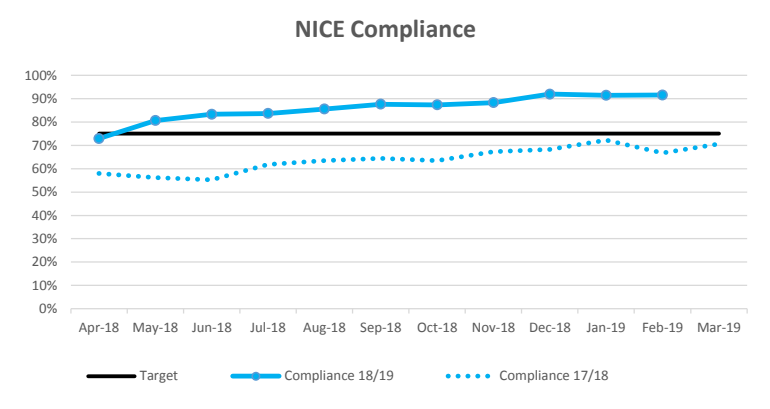
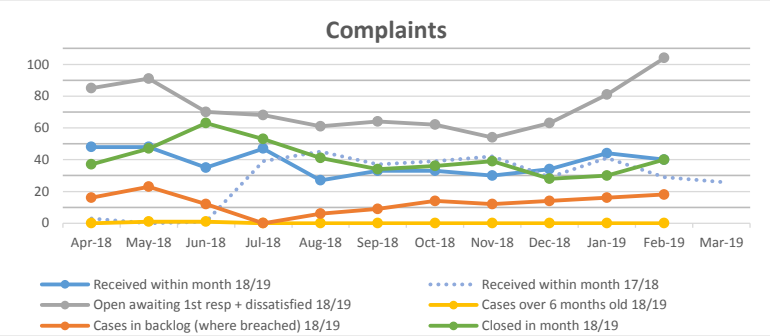
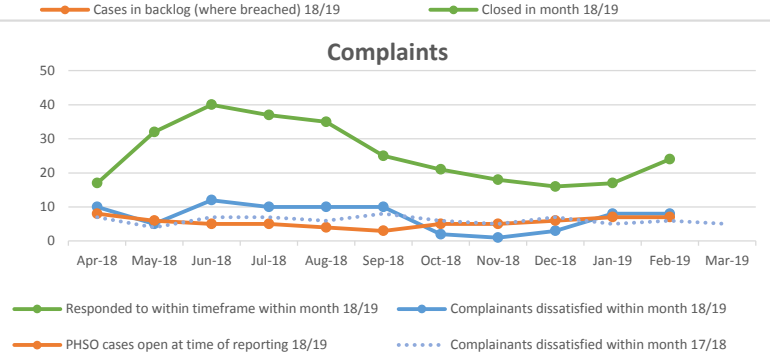
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The Trust achieved 91.53% in month.		The Trust is currently showing 91% compliance for Trustwide NICE guidance. This has shown increased improvement over the year.	The Trust is currently risk assessing all partial compliance NICE Guidance and ensuring that any risks are elevated to the risk register with robust action plans to ensure compliance is in place. This reports to Patient Safety and Effectiveness Sub Committee in April.

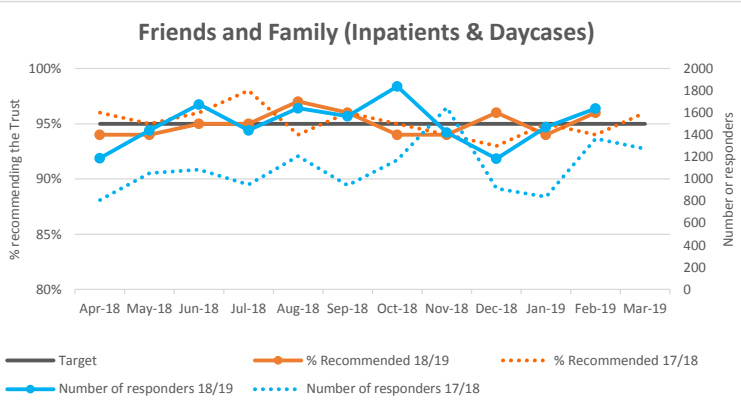
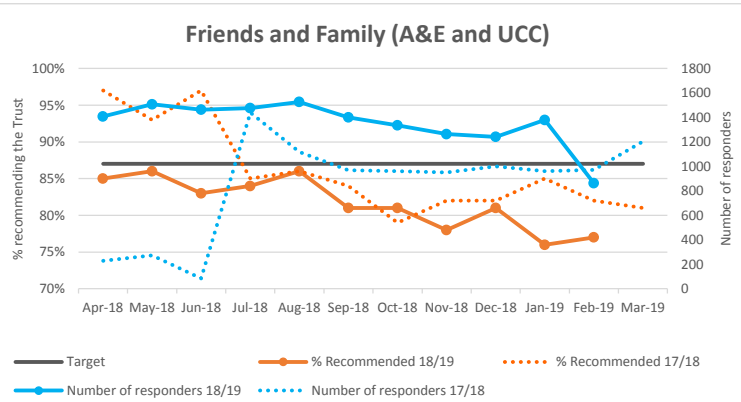
Patient Experience

Complaints Red: Complaints over 6 months old/not meeting trajectory Amber: No complaints over 6 months old, meeting trajectory Green: No backlog, complaints responded within agreed timescale	There were no complaints over 6 months old.	 	The Trust now holds no complaints over 6 months and has 18 complaints that have breached their deadline, which is an increase on last month. The Trust received an above average number of complaints in month. There has been an improvement in February in responding to complainants within timeframes; going from 17 in January to 24 in February.	The complaints team are targeting breached complaints and liaising with the CBUs in order to close these cases. A quality account priority has been agreed for 2019/20 on improving timeliness of complaint responses with a standard of achieving 90% of complaints responses to timeframe.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	The Trust achieved 95% in month.		The Trust has achieved this standard in month.	The Trust continues to promote FFT response rate & feedback utilising the following methods. New FFT cards in April 2019 including. QR code. Ability to provide feedback using link to internet- improving accessibility. New Trust website – accessibility tools, providing easy access.
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	The Trust achieved 77% in month.		The Trust acheived a 77% recommendation rate against a target of 87% improved by 1% on previous month. Response rate – 15.9% reduced from 17.4% in January 2019. Halton UCC recommendation rates – those "not recommending our service" has been in double figures (%) since October 2018 with a corresponding reduction in patients recommending HCC UCC.	A review is being undertaken by the CBU and Head of Patient Experience reporting to April 2019 PESC. A UED action plan with aims to improve both the response rate and recommendation rate is being developed. GP hours has been reduced at Halton UCC, this will be escalated to the Commissioners at the Clinical Quality Focus Group.

Warrington and Halton Hospitals NHS
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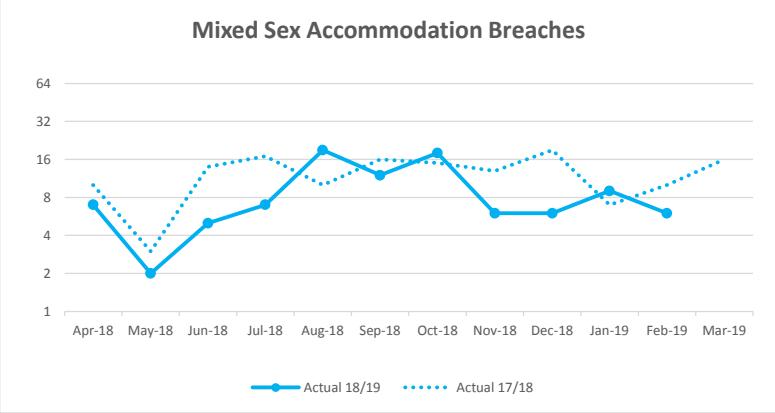
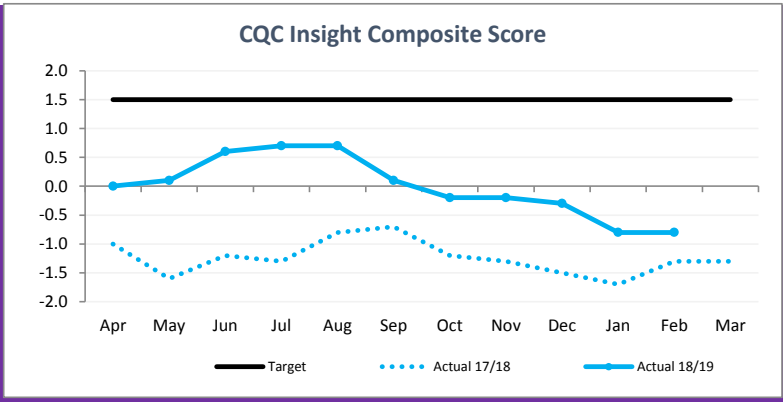
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	There were 6 mixed sex accommodation breaches reported in month.		6 MSA breaches for February, reduced from 9 in the previous month.	Critical Care Admission/Discharge Policy is being introduced. RCA process to support investigation. Noted actions and themes reported into Patient Experience Committee.
CQC Insight Composite Score Red (inadequate): <-3 Amber (req improvement): >-2.9 - 1.5 Green (good/outstanding): >1.5	There Trust CQC Insight Composite Score is -0.8.		Underperformance in relation to the 'Patients spending less than 4 hours in major A&E' target. Areas where we have improved are in; Flu vaccination uptake, Patient-led assessment of environment for dementia care, Proportion of reported patient safety incidents that are harmful and Deaths in Low-Risk Diagnosis Groups.	The Trust had a CQC Emergency Department inspection in February and is currently responding to the draft report with regard to factual accuracy and actions to be taken in response.

CQC

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Key:
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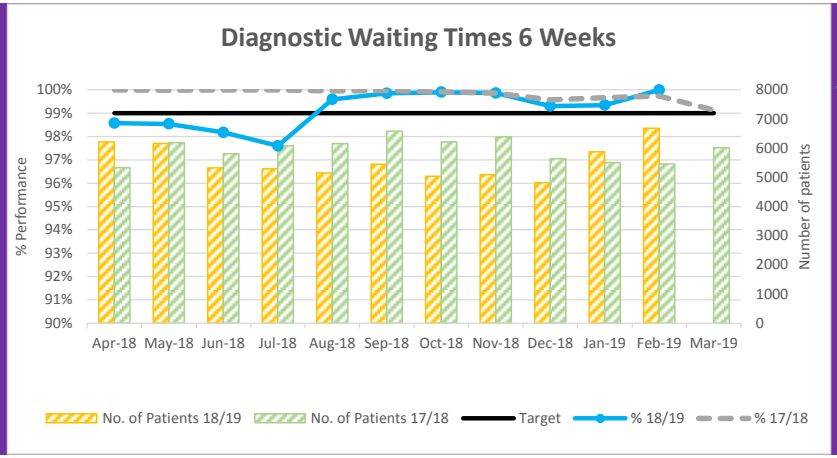
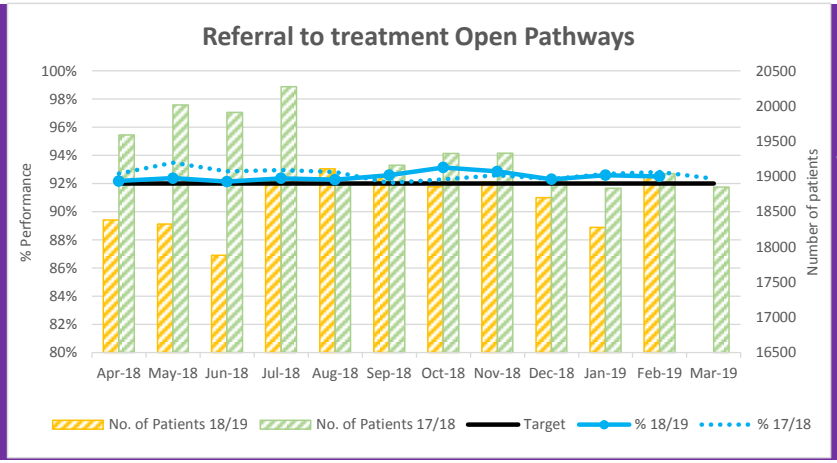
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	The Trust achieved 100% in month.		The Trust met the Diagnostic 6 week standard in February 2019 achieving 100% against a target of 99%. Compliance against this standard is routinely monitored at the weekly Performance Review Group (PRG) and monthly Key Performance Indicators (KPI) Meeting.	Maintain compliance against the diagnostic standard.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or	The Trust achieved 92.51% in month.		The Trust met the 18 week referral to treatment standard, achieving 92.51% against a target of 92%; this is a difficult target and remains challenging.	Maintain compliance against the RTT standard. Monitor T&O recover plan via PRG / KPI meeting to achieve the standard at sub-speciality level.
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red				

Key:
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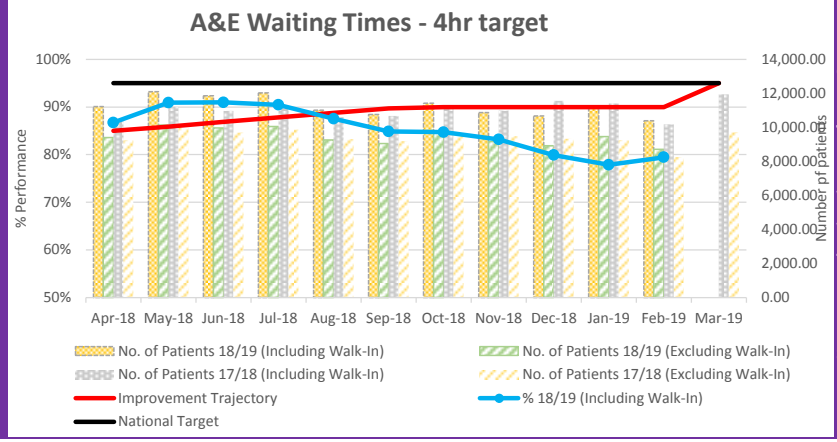
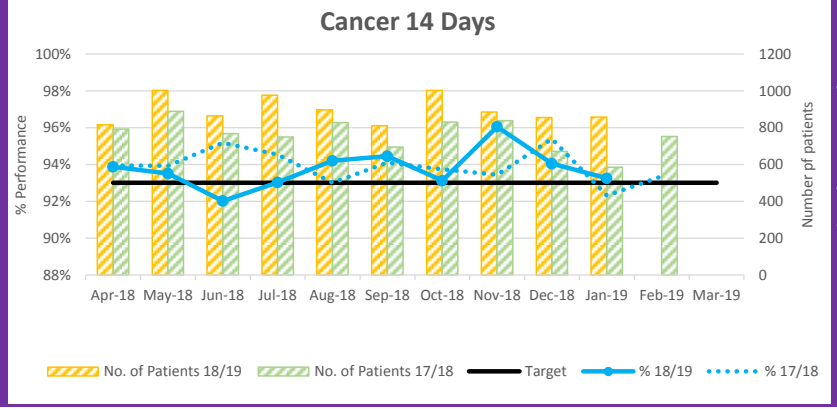
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above Four Hour Standard Waiting Times - STP Trajectory Red: Less than	The Trust achieved 79.45% including walk in month.		Performance has remained challenging throughout February 2019 and continues to be below the Trust agreed trajectory for 2018/19. Performance exluding Widnes UCC, which achieved 75.84% in February, which is a marginal improvement from that achieved in January (74.35%). This is a positive indication of agreed actions supporting patient experience and performance.	It is essential for new assessment areas to remain ambulant (GPAU was bedded for periods of time in February). Reduction of super stranded patients with system partners to be between 86-100 will support Trust improvement.
Cancer 14 Days Red: Less than 93% Green: 93% or above	The Trust achieved 93.24% in January 2019.		The Trust achieved the Cancer 14 Day target in January 2019. The February data is in draft format and will only be released once fully validated and uploaded in March 2019.	Maintain compliance against the 2WW standard.

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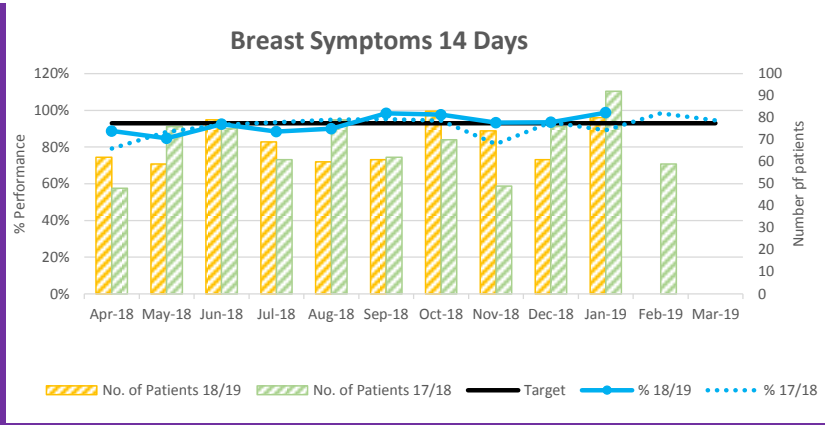
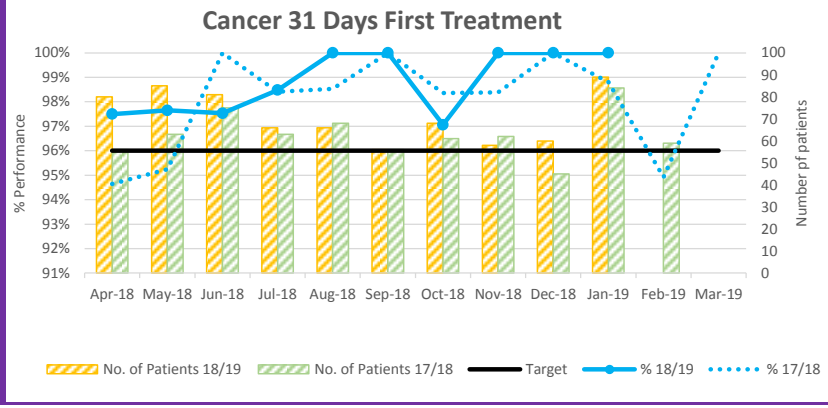
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	The Trust achieved 98.75% in January 2019.		The 2 week wait for Breast Symptomatic has been met with the Trust achieving 98.75% in January 2019. 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.	Maintain compliance against the Breast 2WW standard.
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	The Trust achieved 100% in January 2019.		The Trust achieved 100% in January 2019.	Maintain compliance against the 31 day first treatment standard.

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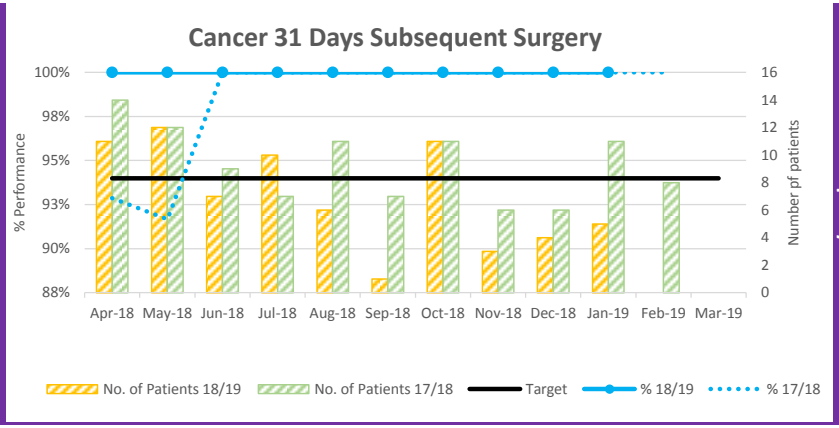
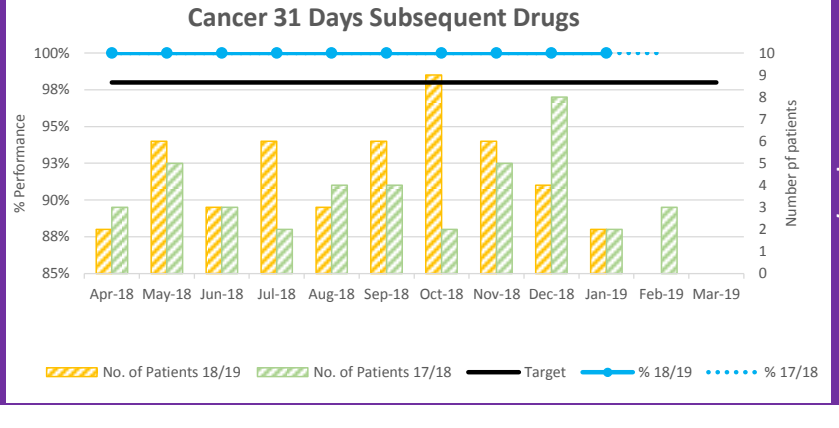
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	The Trust achieved 100% in January 2019.		The Trust achieved 100% in January 2019.	Maintain compliance against the 31 day subsequent treatment standard.
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	The Trust achieved 100% in January 2019.		The Trust achieved 100% in January 2019.	Maintain compliance against the 31 day subsequent drug standard.

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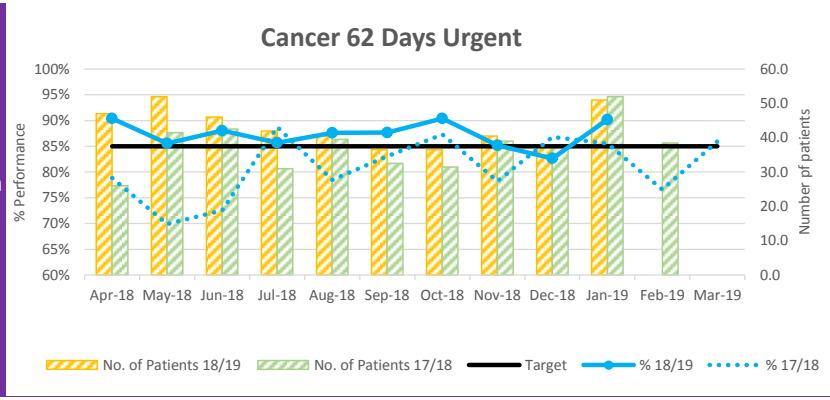
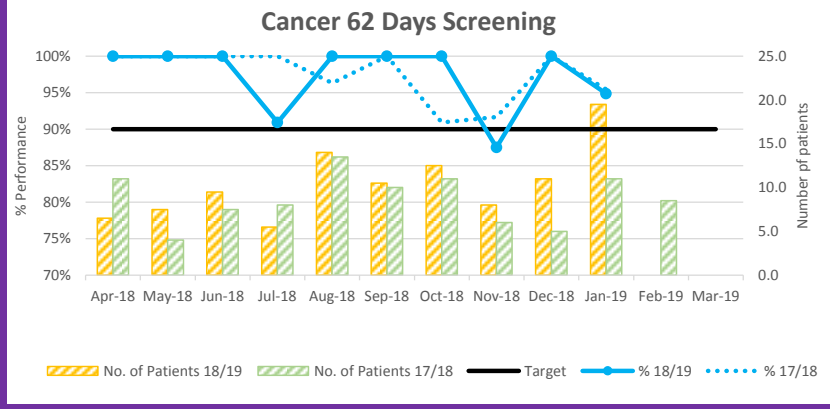
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	The Trust achieved 90.2% in January 2019.		The Trust achieved 90.2% in January 2019.	Maintain active monitoring of multiple Trust pathways as additional funding is made available by the cancer alliance, in particular to treat urology patients which has the potential to have a negative impact on performance due to other Trusts treating those patients who have breached the standard.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	The Trust achieved 94.87% in January 2019.		The Trust achieved 94.87% in January 2019.	Maintain compliance against the 62 day screening standard.

Key:
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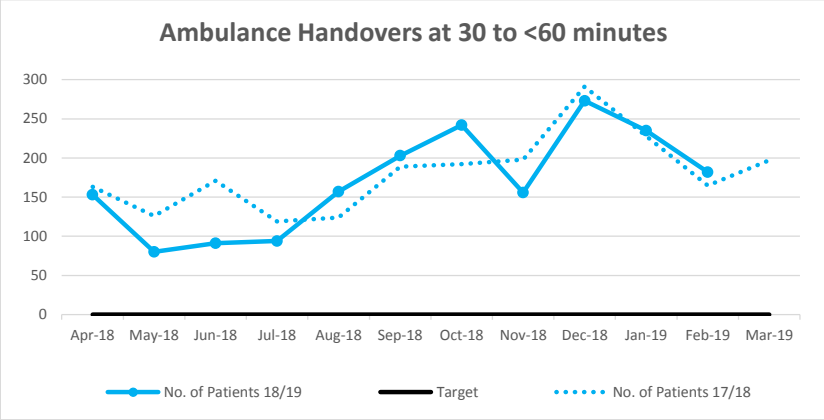
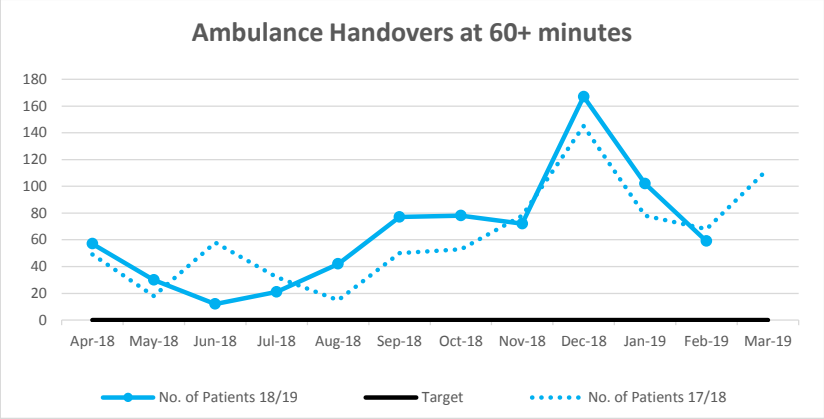
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers 30 to <60 minutes Red: More than 0	There were 182 patients waiting between 30 and 60 minutes for handover in month.		This is the 2nd consecutive month that the Trust has improved against the 30-60 minute handover standard. A significant focus has been undertaken within the ED to ensure timely handovers can take place. A dedicated handover practitioner is in place to ensure continued improvement.	Ensure handover practitioner is in situ at all times. Ensure flow is maintained within the ED so there is capacity to always receive handovers in a timely manner. Adherence to full capacity protocol's to ensure appropriate and timely escalation at times of surge.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	There were 59 patients waiting over 60 minutes for handover in month.		This is the 2nd consecutive month that the Trust has improved against the 60+ minute handover standard. A significant focus has been undertaken within the ED to ensure timely handovers can take place. A dedicated handover practitioner is in place to ensure continued improvement.	Ensure handover practitioner is in situ at all times. Ensure flow is maintained within the ED so there is capacity to always receive handovers in a timely manner. Adherence to full capacity protocol's to ensure appropriate and timely escalation at times of surge.

Key:
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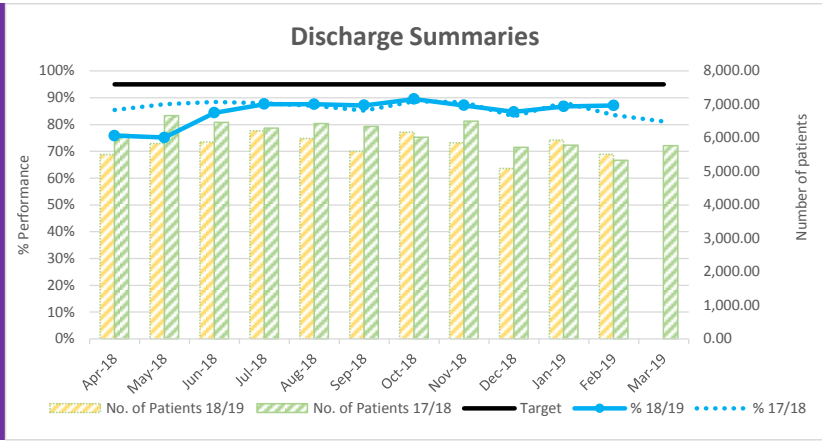
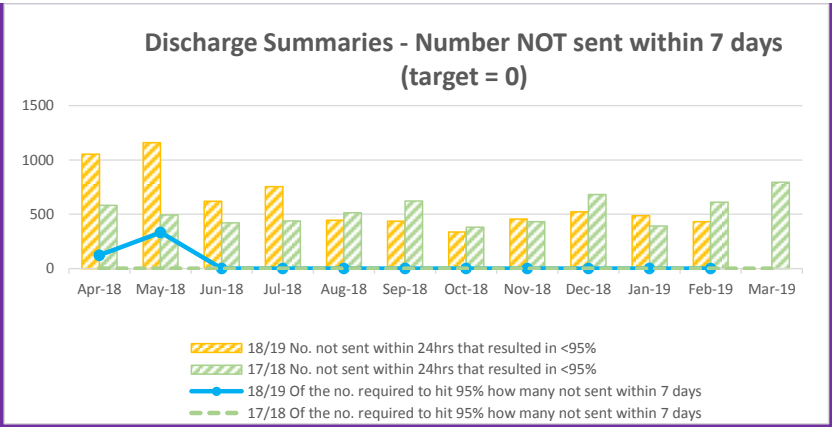
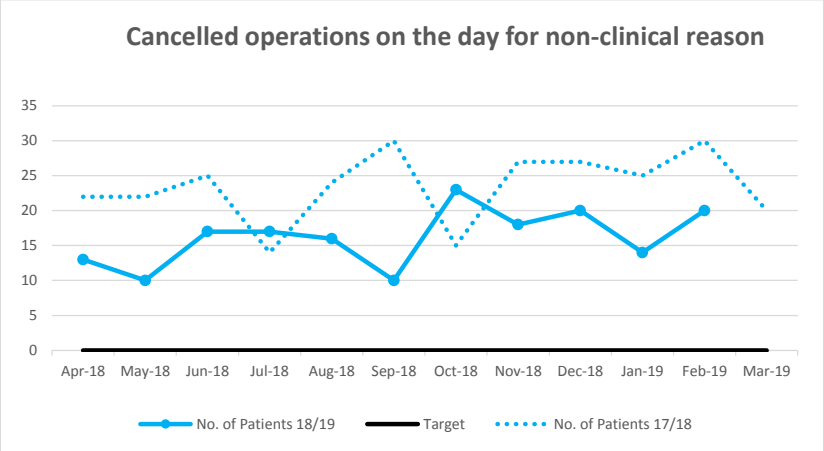
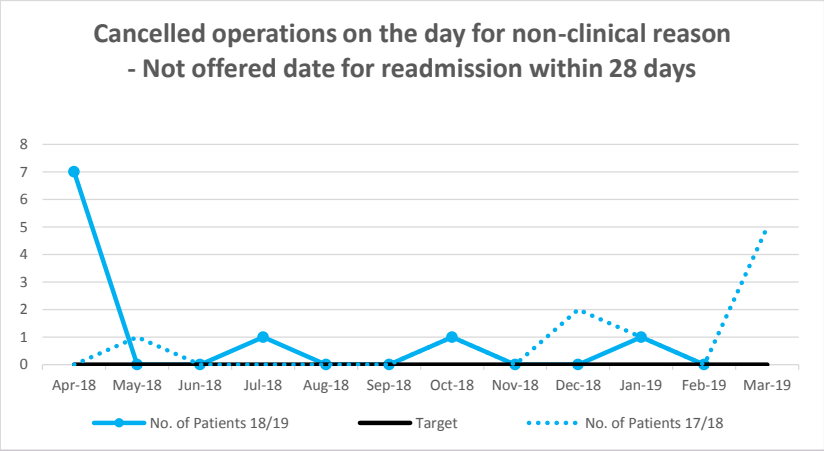
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust achieved 83.54% in month.		The Trust continues to drive compliance improvement across all CBUs. This is monitored via the weekly PRG & monthly KPI meetings. There is an SoP in place to support compliance against this standard.	This standard is particularly challenging for the Trusts ambulant/assessment areas due to high attendance and discharge rates. The Trust will be a pilot site for the new Same Day Emergency Care Data Set (SDEC) to support more granular monitoring in such areas. To commence from April 2019.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	There were 0 discharge summaries not sent within 7 days which was above the 95% threshold.		The Trust achieved compliance against the 7 day discharge summary standard.	Maintain compliance against this standard.

Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: Above zero	There were 20 cancelled operations on the day for non clinical reasons in month.		The Trust had 20 cancelled operations on the day for non-clinical reasons which equates to 0.81%. Benchmarking would suggest that although the Trust continues to maintain a zero tolerance to cancellations, a rate of less than 1% compares favourably. The main driver for on the day cancellations relates to unforeseen surgeon absence.	A dedicated sub-group of the Theatre Productivity Group to focus on reducing cancellations on the day, has been established to drive improvement against this standard. This is monitored via the weekly PRG and monthly KPI meetings. A revised escalation process has been implemented to ensure senior review before any cancellation takes place.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There were 0 cancelled operations on the day for non clinical reasons in month, where the patient was not booked in within 28 days.		The Trust achieved compliance against the 28 day rule.	Maintain compliance against the 28 day rule standards. Monitored via weekly PRG and monthly KPI meetings.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
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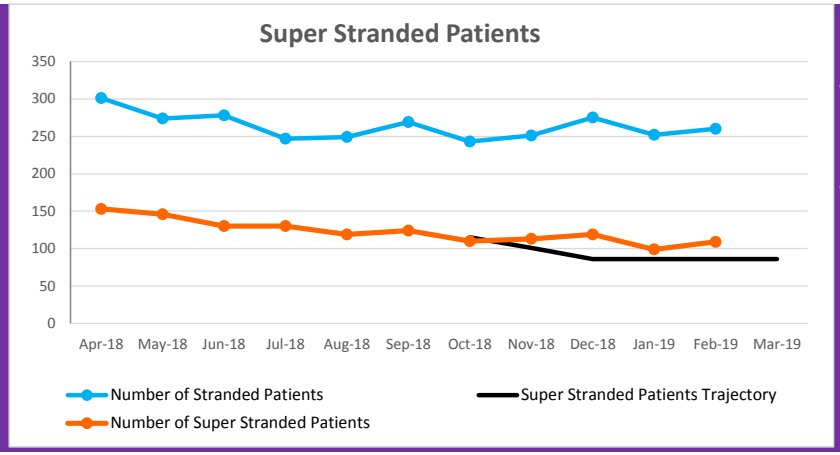
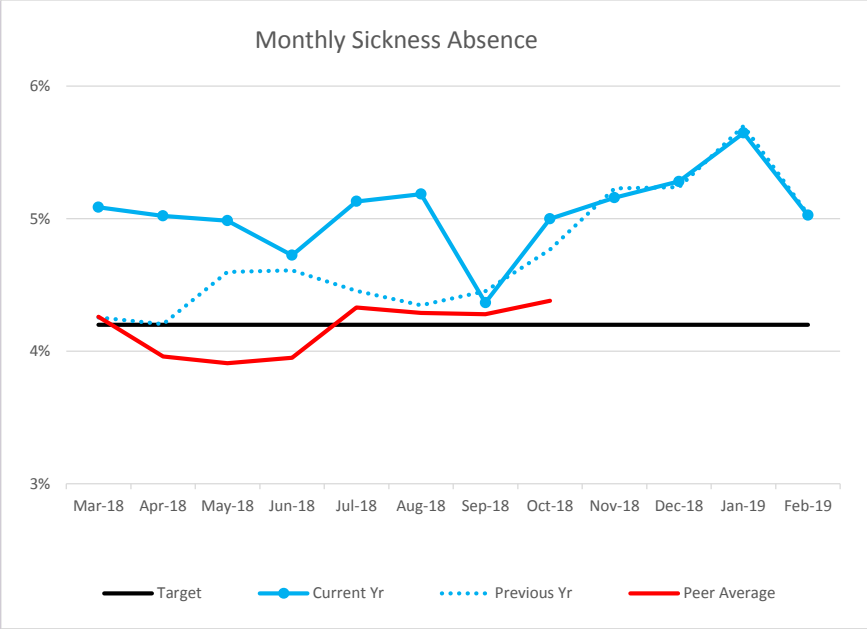
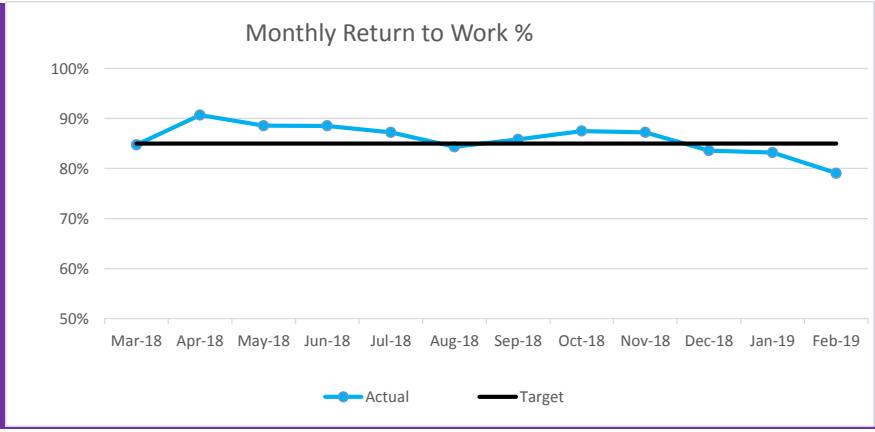
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 260 stranded and 109 super stranded patients at the end of the reporting period.		The Trusts objective is to have no more than 86 super stranded patients (LoS of 21 + days). This requires system partner support and cannot be achieved independently. Many of those with significant LoS require complex care packages/placements.	Enhanced monitoring of stranded and super stranded patients has been implemented. This includes twice weekly reviews by a senior MDT (Tuesday & Thursday) led by the Associate Director Integrated Care and Clinical Director Integrated Medicine & Community. The Trust is also participating in an NHSI collaborative to support further reduction.

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

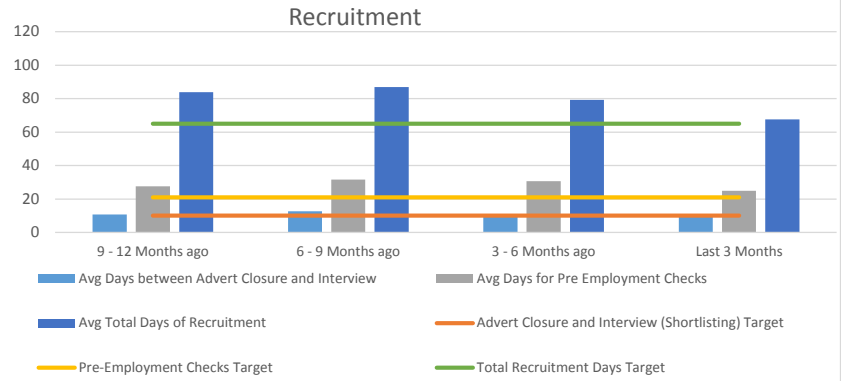
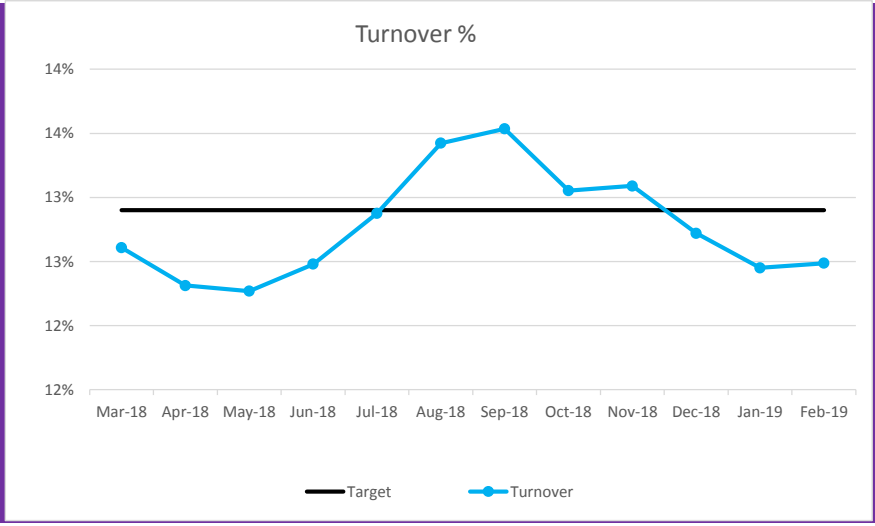
Workforce - Trust Position

Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%			
The Trust's sickness absence was 5.03% in month.		**CBU's with highest rates of sickness are Women's and Children's and Urgent and Emergency Care.** **The main reasons for absence were anxiety/stress/depression and musculoskeletal illnesses.** **Long term sickness in February 2019 was 3.3% and short term sickness was 1.7%.** **WHH YTD sickness absence is currently 5.1%.** **To achieve the trust target of 4.2%, a focus is required on managing long term sickness.**	**Key work to be delivered in 2019/20 under the People Strategy includes a refreshed mental health services delivery plan and roll out of the refreshed Fit to Care Programme.** **Mental health First Aid training (currently 75 trained staff) will continue, along with the introduction of Mental Health Awareness Sessions for Line Managers.** **The WHWB Service has worked with the Moving and Handling Trainer and the Health and Safety Team to take a new approach in utilising information on incidents and sickness absence to provide targeted support.** **The UEC CBU has been supported by their HRBO to undertake a deep dive analysis of sickness absence and identify appropriate actions.** **The WCH CBU has introduced fortnightly attendance management and is exploring Workplace Health and Wellbeing Team drop-ins across the CBU.**
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%			
The Trust's return to work compliance was 79.07% in month.		**Return to Work compliance is below target, this is due to operational pressures during the winter period, however this remains a focus.**	**A review of essential manager training has been completed and new programme is to be run from April 2019.** **The line manager guidance document has been produced and circulated reminding managers of responsibilities and importance of RTWI.** **1:1 Coaching by the HR Business Partner team with line managers is ongoing.** **A letter from Director of HR&OD has been sent to all line managers to clarify expectations relating to absence management.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below	The average number of days to recruit over the last 3 months was 67.7 days.		The trend of achieving around 71-74 days in Time to Hire has been maintained. The volume of recruitment currently ongoing stretches the administrative resource available to achieve the 65 day target.	The Trust will utilise the updates within the NHS Jobs system to streamline our processes further. Improvement of the recruiting managers understanding about the recruitment processes is also a focus area. In the longer term, work with IT colleagues to improve the on-boarding system for our new candidates is required.
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	Trust turnover was 12.59% in month.		Turnover remains below the 15% threshold. Analysis from the NHSI retention programme has suggested that lack flexible working options is a key reason for nurses to consider leaving the organisation. Turnover of healthcare support workers is significantly higher than many other groups.	The Trust will continue engagement with the NHSI nursing retention programme and will begin to roll out to other staff groups. Action plans are in development following review of all data by NHSI and will be completed in March 2019. Work has already began on encouraging experienced staff to remain in our employment - the RAVE (recognising and valuing experience) initiative is being explored by the NHSI retention programme delivery group. A careers Event held on 12th March 2019 which promoted development opportunities within the Trust and launched the Nursing Career Pathway. A review of the induction and a development programme for Healthcare Support Workers has taken place.

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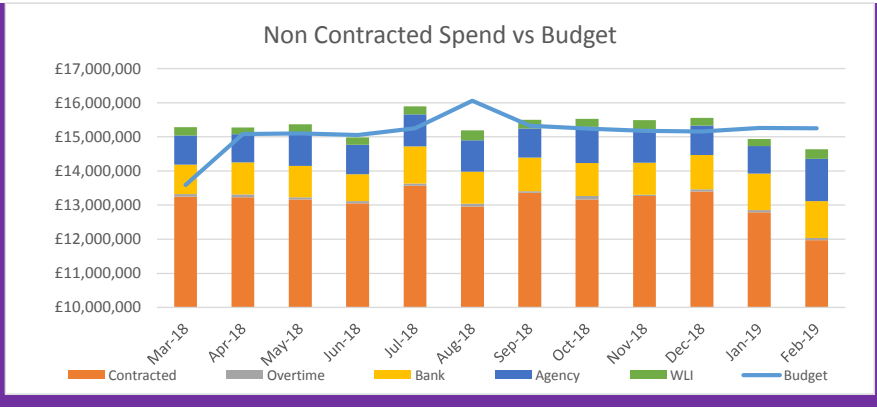
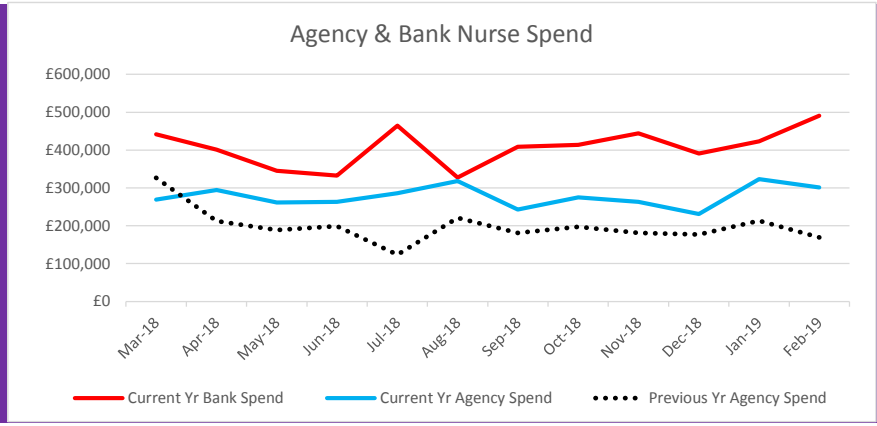
Use of Resources Assessment

Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	Trust non-contracted pay was below budget at 14.53%.		The Trust has seen a reduction in our contracted spend in February 2019, resulting in an overall underspend on pay. However there has been an increase in Bank, Agency and WLIs.	The 2019/20 Workforce Plan has been developed alongside the Business Plans for CBUs. The result is a robust plan which takes account turnover, retention, workforce transformation and future business plans. Progress against the 2019/20 Workforce Plan will be monitored via the Trust Operational People Committee and will support the Trusts intention to control pay costs through increased substantive recruitment, increased retention, reduction in non-substantive pay costs and workforce transformation.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	Agency Nurse Spend was £301k in month. Agency bank spend was £490k in month.		Agency Nurse spend was £301k in month and remains consistant. Bank Nurse spend has risen to £490k, replicating the same increase in the previous year.	The Trust is part of the Cheshire and Mersey Collaborative group, which is reviewing AfC temporary staffing rates to provide standardisation. Actions outlined relating to nursing attraction and recruitment and retention will positively impact this indicator, as substantive posts are filled.

Key:
Single Oversight Framework
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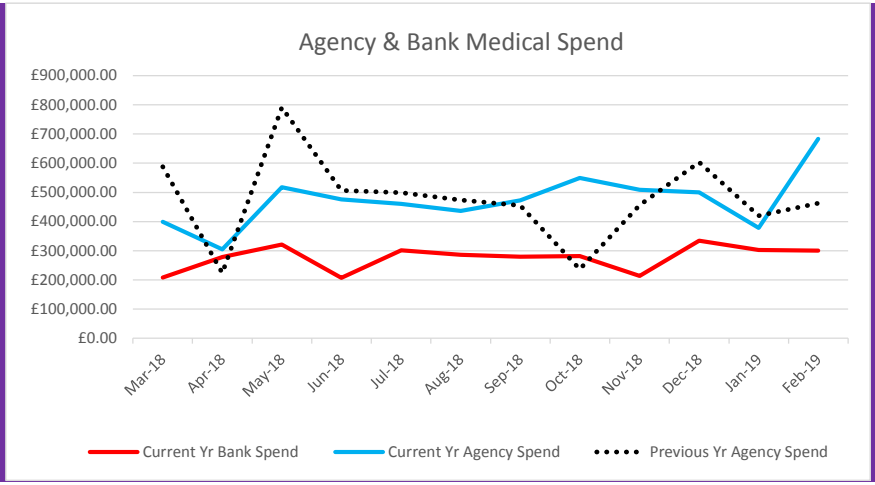
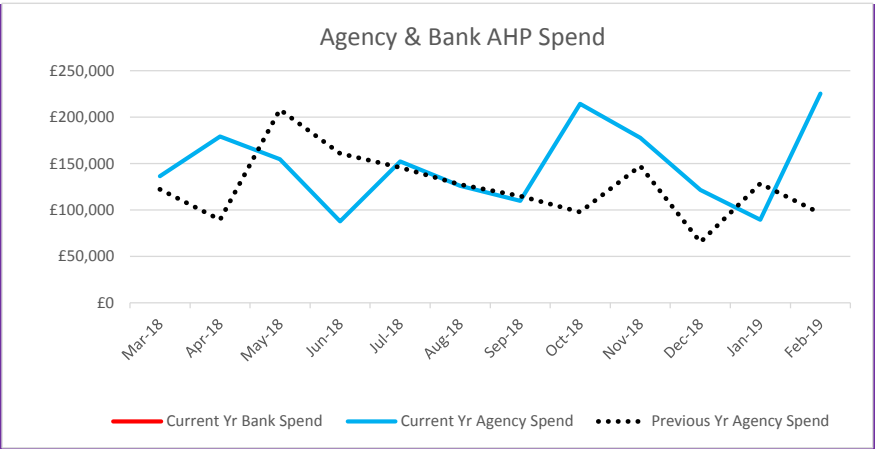
Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	Agency Medical Spend was £683k in month. Bank Medical Spend was £300k in month.		Agency Medical spend was £683k in month. This reflects the 20% VAT charge now in place (based on HMRC ruling). Bank Medical spend was £300k in month and remains consistant.	The Trust is part of the Cheshire and Mersey Collaborative group, which continues to review medical staffing agency rates and has submitted a proposal for a new rate card to DoHR, DoFs and CEOs for approval. In relation to the 20% VAT charges, the Bank and Agency Team is working with +US and regional partners to implement a new Direct Engagement (DE) model, which will mean VAT is not charged. The 4 week implementation process will begin upon receipt of some outstanding information from HMRC.
Agency AHP Spend Red: Greater than Previous Yr Green: Less then Previous Yr	Agency AHP Spend was £225k in month.		Agency AHP spend was £225k in month. This reflects the 20% VAT charge now in place (based on HMRC ruling).	The Trust is part of the Cheshire and Mersey Collaborative group, which continues to review medical staffing agency rates and has submitted a proposal for a new rate card to DoHR, DoFs and CEOs for approval. In relation to the 20% VAT charges, the Bank and Agency Team is working with +US and regional partners to implement a new Direct Engagement (DE) model, which will mean VAT is not charged. The 4 week implementation process will begin upon receipt of some outstanding information from HMRC.

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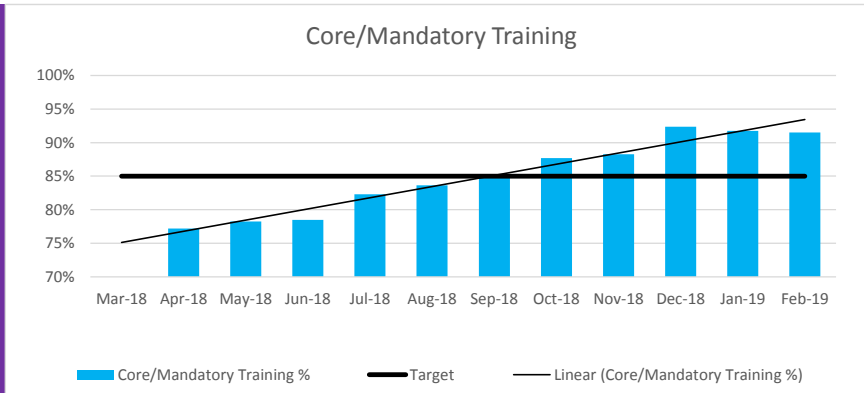
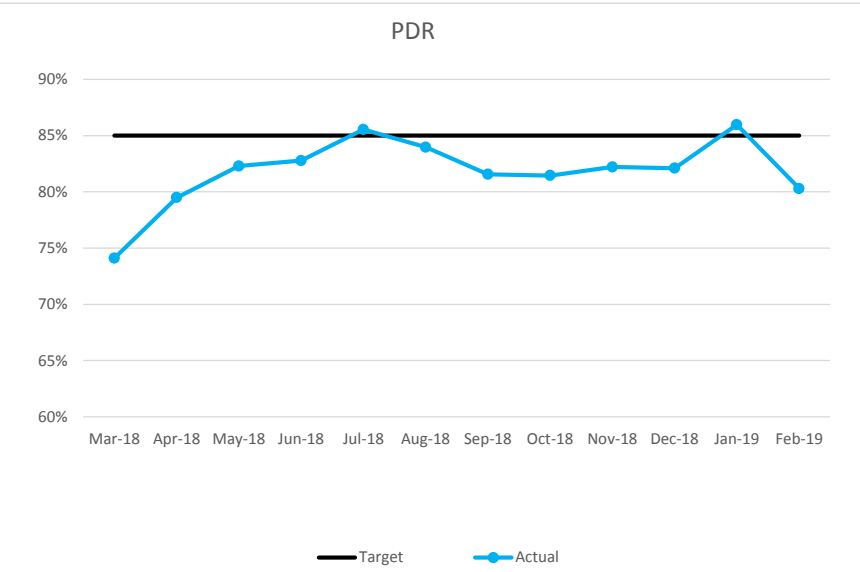
Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	**Core/Mandatory training compliance was 91.52% in month.**		**The importance of mandatory training compliance is embedded with managers after a prolonged effort to improve compliance.**	**Sharing of monthly data used to discuss compliance at a local CBU/Department level. Longer term changes to the pay progression policy will increase focus on compliance with mandatory training, as this will be considered when assessing employees for performance related pay.**
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	**PDR compliance was 80.3% in month.**		**PDR compliance is below target, this is due to operational pressures during the winter period, however this remains a focus.**	**To support embedding of PDR compliance as 'business as usual' additional resource will be allocated so that weekly reports of compliant/non-compliant staff are issues to managers for a period of 6 weeks. Sharing of monthly data used to discuss compliance at a local CBU/Department level. Increased focus to improve and maintain compliance is required. Longer term changes to pay progression policy will increase focus on compliance with PDRs as this will be considered when assessing employees for performance related pay. The information provided does not include medical staff PDR rates. They are reported separately due to the different GMC requirements. Of the 31 required in the calendar year to date, 19 had been completed.**

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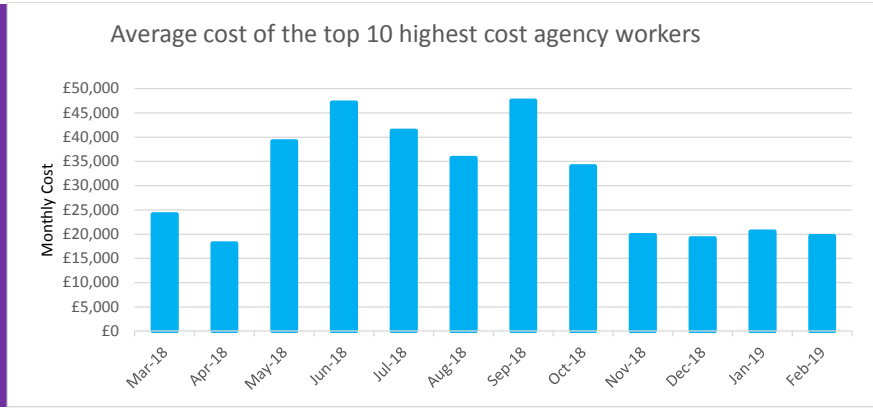
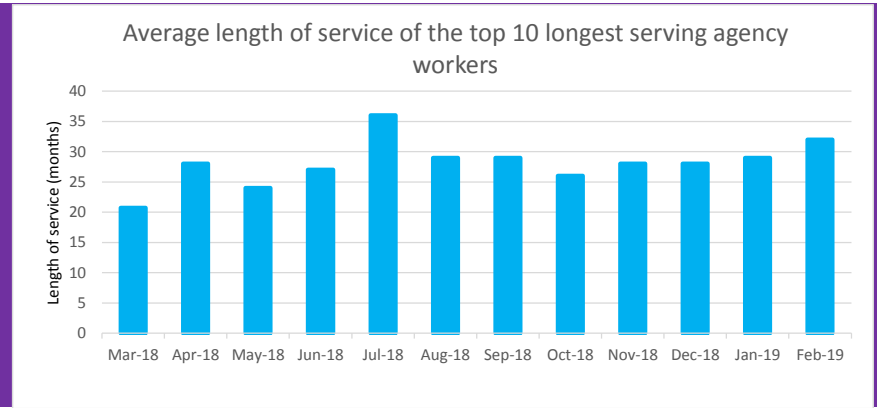
	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than previous month	UoR SOF **The average cost of the top 10 agency workers was £20k in month.**		**All of the highest cost agency workers are within the Medical and Dental workforce as these are the areas with a high number of vacancies and hard to recruit posts.**	**The actions outlined in relation to medical agency and bank spend will positively impact this indicator.**
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month Green: Less than	UoR SOF **The average length of service for the top 10 agency workers during the reporting period was 32 months.**		**On-going gaps in the substantive workforce relating to vacancies and sickness absence is driving this position.**	**This indicator will be positively impacted by the actions outlined in relation to reducing the need for temporary workers and increasing controls when temporary workers are required.**

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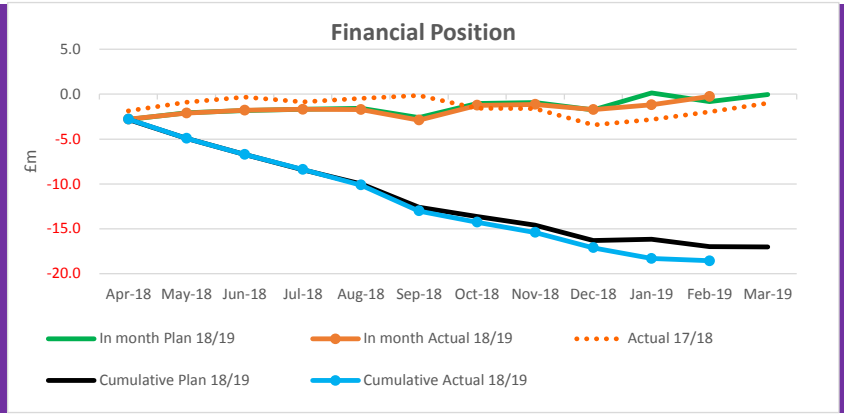
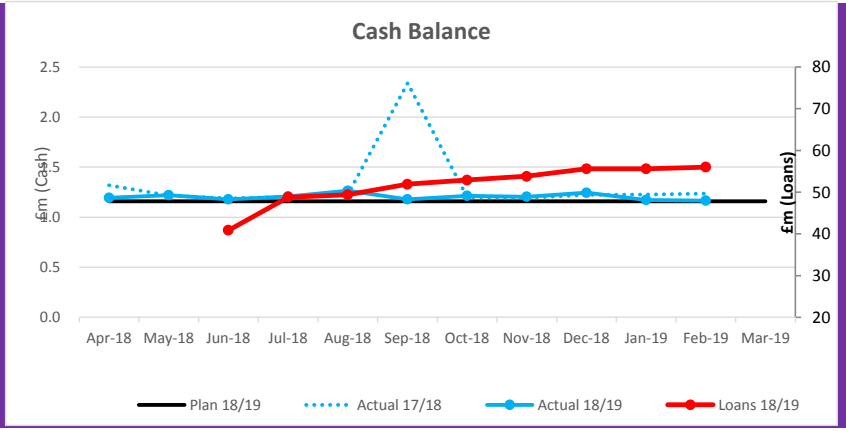
Finance & Sustainability - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position	UoR SOF The actual deficit in month is £0.3m which increases the cumulative deficit to £18.6m.		The cumulative deficit of £18.6m is £1.6m below plan. Of this, £1.3m relates to the non achievement of PSF relating to A&E performance. The year to date control total (excluding Provider Sustainability Funding) is a £21.6m deficit which is £0.4m below plan.	A Executive review of non catalogue spend is currently underway.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	UoR SOF 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.	The Trust will continue to support CBUs to improve the operating position which will result in improved cash.

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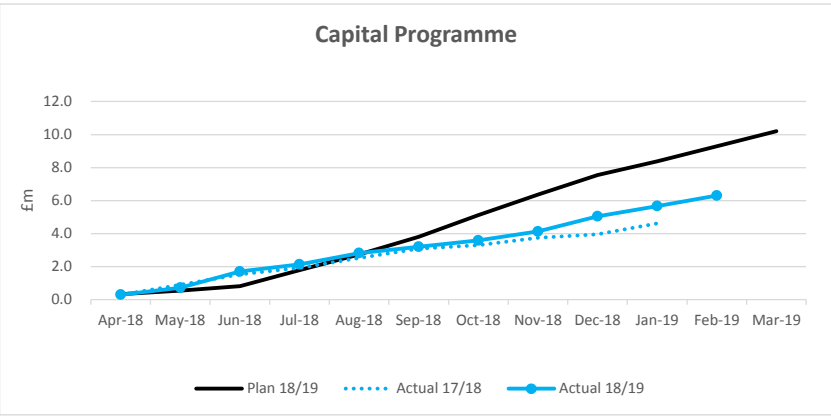
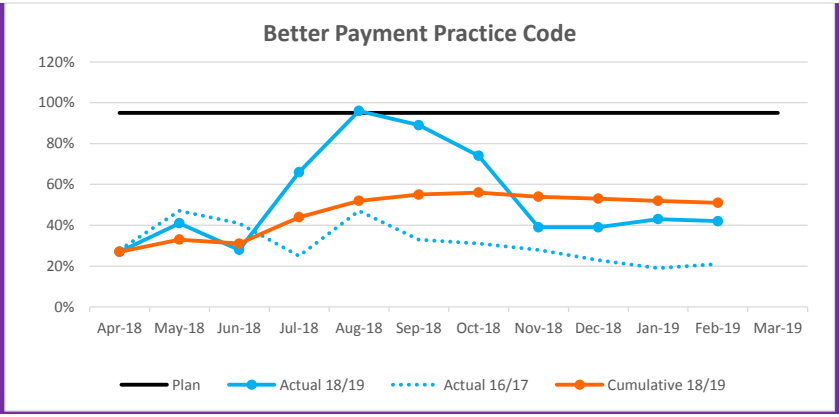
Finance & Sustainability - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR SOF The actual capital spend in the month is £0.7m which increases the cumulative spend to £5.7m.		The cumulative capital spend of £6.3m is £3m below the planned capital spend of £9.3m. The phasing of the capital expenditure relating to the Kendrick Wing fire and scheme slippage is the main reason for the current position.	The monitoring of capital spend through the Capital Management Group ensures the most effective use of the limited capital resource.
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	UoR SOF In month the Trust has paid 42% of suppliers within 30 days which results in a year to date performance of 51%.		The Trusts cash position restricts the ability to achieve the 95% standard.	Cash is closely managed on a day to day basis to ensure suppliers are paid as efficiently as possible and to minimise any late payment charges.

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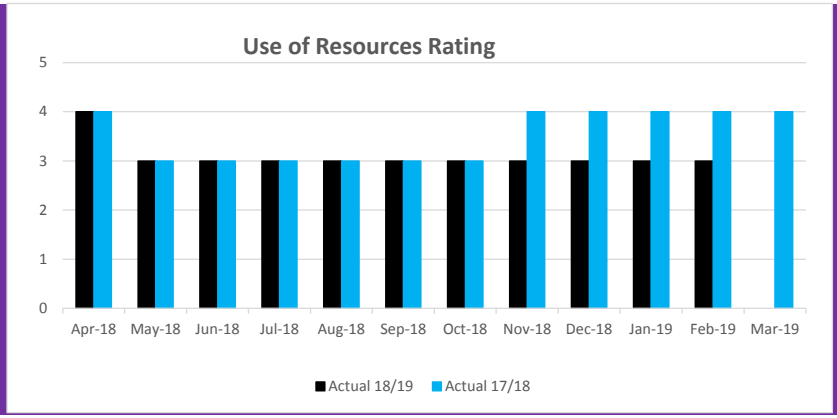
	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	**The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity, I&E margin are scored at 4 and Agency Ceiling is a 4 and Performance against Control Total is scored at 2.**		**The current Use of Resources Rating of 3 which is the planned rating.**	**The Trust will continue to monitor the Use of Resources Rating to maintain a rating of 3.**
Fines and Penalties Red: Greater than zero Green: Zero	**There were no fines or penalties levied by commissioners in month.**		**There were no fines or penalties levied by commissioners in month.**	**The Trust will continue to work with CCG commissioners on the sustainability contract.**

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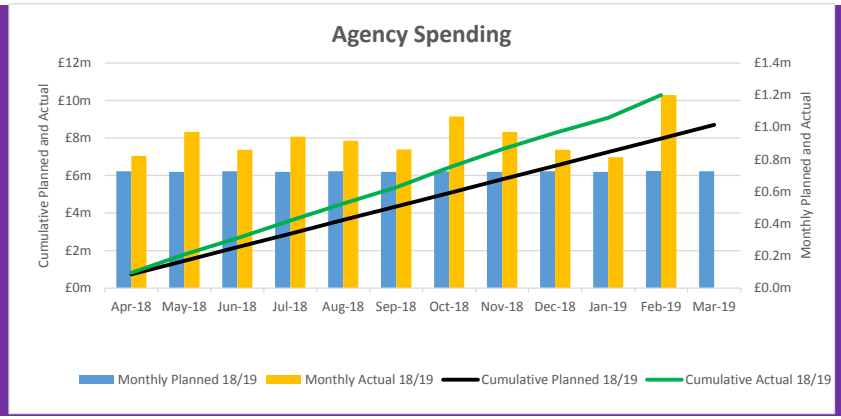
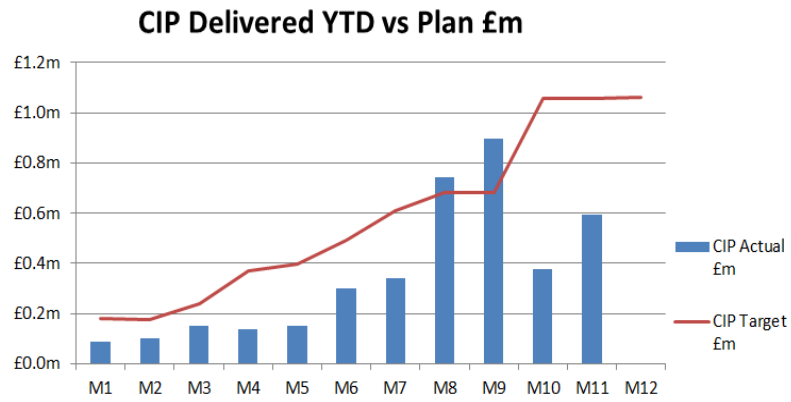
	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	UoR SOF **The actual agency spend in the month is £1.2m which increases the cumulative spend to £10.3m.**		**The Trust has incurred VAT on medical and AHP agency staffing in February following the transfer to a new service provider.**	**A new model for the provision of medical and AHP agency staffing is being evaluated which will reduce the cost of the workforce. The process regarding monthly cost allocation has been reviewed.**
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	**The savings delivered in month are £0.6m which increases the cumulative delivery to £3.9m.**		**Whist there have been workshops which have improved the position YTD, the delivery is £2.0m below plan. CBUs continue to focus on identifying opportunities, however these may not be realised in 2018/19.**	**The Trust will continue to support CBUs with CIP schemes utilising all tools available to the Trust such as Model Hospital, GIRFT, NHSI support.**

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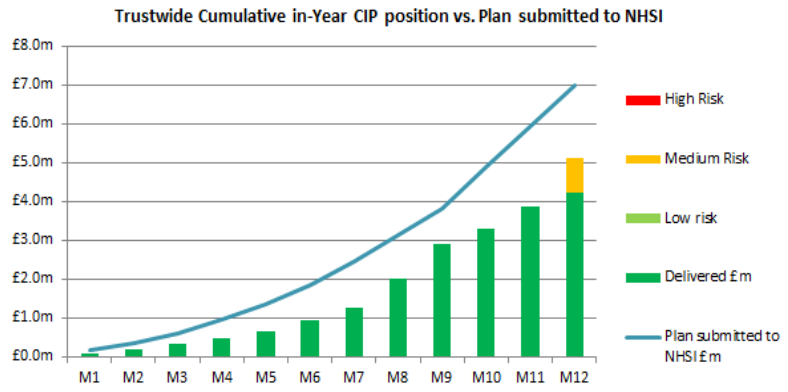
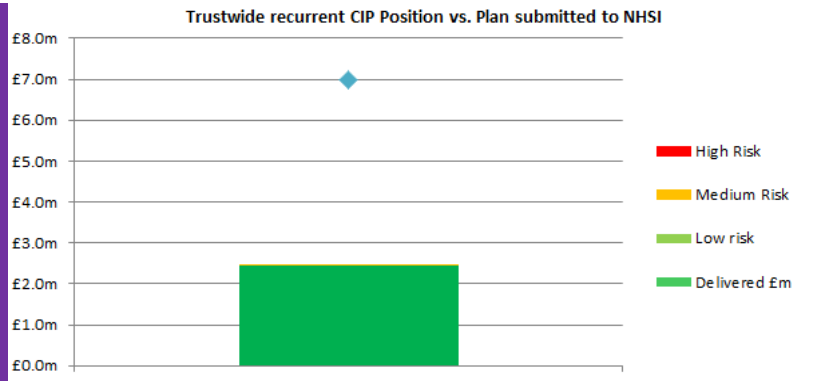
Finance & Sustainability - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	**The best case forecast annual cost savings are £5.1m.**		**Whist there have been workshops which have improved the position YTD, the delivery is £1.9m below plan. CBUs continue to focus on identifying opportunities, however these may not be realised in 2018/19.**	**The Trust will continue to support CBUs with CIP schemes utilising all tools available to the Trust such as Model Hospital, GIRFT, NHSI support.**
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	**The best case forecast recurrent cost savings are £2.5m.**		**Whist there have been workshops which have improved the position YTD, the delivery is £4.5m below plan. CBUs continue to focus on identiflying opporuntites, however these may not be realised in 2018/19.**	**The Trust will continue to support CBUs with CIP schemes utilising all tools available to the Trust such as Model Hospital, GIRFT, NHSI support.**

Appendix 3 – Trust IPR Indicator Overview

Indicator	Detail
Quality	
Incidents	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.
CAS Alerts	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependent upon the specific CAS alerts.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Adult, Children's and Maternity Safety Thermometer	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.
Healthcare Aquired Infections (MRSA, CDIFF and Gram Negative)	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli, Klebsiella, Pseudomonas aeruginosa - A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.
Safer Surgery	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.
CQUIN Sepsis	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.
Total Falls & Harm Levels	Total number of falls per month and their relevant harm levels (Inc Staff Falls).
Pressure Ulcers	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.
Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours Per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
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.
NICE Compliance	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.
Friends and Family Test (Inpatient & Day Cases)	Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
Friends and Family (A&E and UCC)	Percentage of AED (Accident and Emergency Department) patients recommending the Trust: Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?
CQC Insight Composite Score	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.

Access & Performance	
Diagnostic Waiting Times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
RTT Open Pathways and 52 week waits	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Four hour A&E Target and STP Trajectory	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge.

Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	Number of operations cancelled on the day or after admission for a non-clinical reason.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Turnover	A review of the turnover percentage over the last 12 months.
Non-Contracted Pay	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date.
Agency Nurse Spend	A review of the monthly spend on Agency Nurses.
Agency Medical Spend	A review of the monthly spend on Agency Locums.
Agency AHP Spend	A review of the monthly spend on AHP Locums.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.
Average cost of the top 10 agency workers	Monthly costs for the top 10 highest cost Agency Workers.
Average length of service of the top 10 agency workers	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.
Finance	
Financial Position	Operating surplus or deficit compared to plan.
Cash Balance	Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.
Fines and Penalties	Monthly fines and penalties.

Agency Spending	Agency spend compared to agency ceiling.
Cost Improvement Programme – In Year Performance	Cost savings schemes deliver Year to Date (YTD) compared to plan.
Cost Improvement Programme – Plans in Progress (In Year)	Cost savings schemes in-year compared to plan.
Cost Improvement Programme – Plans in Progress (Recurrent)	Cost savings schemes recurrent compared to plan.

Appendix 4

Income Statement, Activity Summary and Use of Resources Ratings as at 28th February 2019

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,679	2,333	-347	31,080	27,610	-3,470
Elective Excess Bed Days	8	6	-2	92	96	3
Non Elective Spells	4,916	4,686	-231	53,866	54,479	613
Non Elective Excess Bed Days	168	148	-20	1,837	2,152	316
Outpatient Attendances	2,650	2,676	26	30,740	30,905	165
Accident & Emergency Attendances	1,044	1,112	68	12,224	13,204	980
Other Activity	5,958	5,951	-7	63,036	63,650	614
Sub total	**17,424**	**16,911**	**-512**	**192,875**	**192,096**	**-779**
Non NHS Clinical Income						
Private Patients	20	10	-10	132	108	-24
Non NHS Overseas Patients	4	1	-3	40	61	20
Other non protected	95	82	-13	1,045	941	-104
Sub total	**119**	**93**	**-26**	**1,217**	**1,110**	**-107**
Other Operating Income						
Training & Education	641	579	-62	7,052	7,142	90
Donations and Grants	0	0	0	0	177	177
Provider Sustainability Fund (PSF)	577	810	233	4,365	3,056	-1,309
Miscellaneous Income	2,111	2,135	25	18,392	21,805	3,413
Sub total	**3,328**	**3,525**	**196**	**29,809**	**32,180**	**2,371**
Total Operating Income	**20,871**	**20,529**	**-342**	**223,902**	**225,386**	**1,484**
Operating Expenses						
Employee Benefit Expenses	-14,862	-14,643	219	-164,323	-168,383	-4,060
Drugs	-1,410	-1,039	371	-15,615	-14,704	911
Clinical Supplies and Services	-1,675	-1,802	-127	-18,904	-19,504	-600
Non Clinical Supplies	-3,025	-2,541	484	-33,844	-33,043	801
Depreciation and Amortisation	-501	-508	-7	-5,506	-5,457	50
Restructuring Costs	0	0	0	0	-17	-17
Total Operating Expenses	**-21,473**	**-20,533**	**940**	**-238,193**	**-241,108**	**-2,915**
Operating Surplus / (Deficit)	**-602**	**-4**	**598**	**-14,291**	**-15,722**	**-1,431**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	6	6	0	-112	-112
Interest Income	3	6	3	33	77	44
Interest Expenses	-53	-53	0	-759	-764	-5
PDC Dividends	-181	-181	0	-1,995	-1,995	0
Net Impairments	0	-35	-35	0	-63	-63
Total Non Operating Income and Expenses	**-231**	**-258**	**-26**	**-2,721**	**-2,855**	**-135**
Surplus / (Deficit)	**-833**	**-262**	**572**	**-17,012**	**-18,578**	**-1,566**
Donations & Grants Income	0	0	0	0	-177	-177
Depreciation on Donated & Granted Assets	13	14	1	143	151	8
Income and Expenditure Impairments	0	35	35	0	63	63
Performance against Control Total inc PSF	**-820**	**-212**	**608**	**-16,869**	**-18,540**	**-1,672**
Less PSF	-577	-810	-233	-4,365	-3,056	1,309
Performance against Control Total exc PSF	**-1,397**	**-1,022**	**375**	**-21,234**	**-21,596**	**-362**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,856	2,688	-168	33,135	30,971	-2,164
Elective Excess Bed Days	33	26	-7	381	396	15
Non Elective Spells	3,089	2,689	-400	33,849	30,757	-3,092
Non Elective Excess Bed Days	690	626	-64	7,559	8,967	1,408
Outpatient Attendances	24,703	25,008	305	286,552	287,573	1,021
Accident & Emergency Attendances	8,917	8,757	-160	104,394	103,789	-605

Use of Resources Ratings	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric
Metrics						
Capital Servicing Capacity (Times)				-3.12	-3.28	-0.16
Liquidity Ratio (Days)				-10.3	-34.1	-23.8
I&E Margin (%)				-7.53%	-8.23%	-0.70%
Performance against control total (%)				0.00%	-0.70%	-0.70%
Agency Ceiling (%)				0.00%	29.44%	29.44%
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 5

2018/19 Capital Programme

Proposed Amendments

Description	Approved Programme 2018/19	Approved Amendments M1 - M10 2018/19	Proposed Amendments M11 2018/19	Total Revised Programme 2018/19
	£000	£000	£000	£000
Estates				
Backlog - Replace emergency back-up generators	400	7	0	407
Staffing	177	0	0	177
Fire - Appleton Wing, Fire Damper Second Phase, Installation	0	16	0	16
Backlog - All areas, fixed installation wiring test	50	0	0	50
Backlog - footpath, road and car park surface repairs	0	2	0	2
Six Facet Survey (annual rolling programme) to include dementia & disability	60	0	0	60
Backlog - Asbestos re-inspection & removals	30	0	0	30
Halton Endoscopy Essential power supply to rooms 1 & 2	20	0	0	20
Backlog - Air Con/ Cooling Sys upgrade. Ph1-Survey	12	0	0	12
Automatic sliding / entrance doors across all sites	20	0	0	20
External Fire Escapes Replace (Kendrick & Appleton)	40	3	0	43
Estates Minor Works	50	3	0	53
High Voltage Maintenance	40	0	0	40
Substation C air circuit breakers	404	(202)	0	202
Electrical Infrastructure Upgrade	200	0	0	200
North Lodge fire compartmentation	150	0	0	150
Appleton Wing fire doors	100	0	0	100
Thelwall House emergency escape lighting	100	0	0	100
North Lodge & Kendrick lightening protection works	100	0	0	100
Cheshire House fire doors	25	0	0	25
CCU relocation to Ward A3	703	0	0	703
B4 Enabling Works Re A3 Conversion	25	0	0	25
Removal of redundant chillers - Croft Wing	30	0	0	30
Replacement Combi Oven (Halton Kitchems)	0	9	0	9
Ophthalmic Flat Roof Replacement	0	23	0	23
Discharge Lounge/Bereavement Office	0	208	0	208
Essential Power Supply - Halton Pharmacy	0	6	0	6
Bathroom A9	0	28	0	28
N20 Exposure	0	100	0	100
Urology - Minor Refurb	0	7	0	7
B3 Door	0	5	0	5
Catering EHO Works	0	35	0	35
CQC (Environmental Improvements)	0	566	0	566
CQC (MLU)	0	600	0	600
Halton Outpatients Refurbishment	0	69	0	69
Bin Store Demolition	0	8	0	8
Emergency Generator Repairs - Halton	0	42	0	42
Cheshire House Drainage	0	11	0	11
Butterfly Suite	0	0	20	20
ITU UPS Replacement	0	0	68	68
	2,736	**1,546**	**88**	**4,370**
Medical Equipment				
AER Machines (4 W 2 H)	700	(350)	0	350
Warrington MRI Scanner (replacement)	1,200	(1,200)	0	0
ICU Ventilators	250	(11)	0	239
NICU Incubators	108	(108)	0	0
Spectrophotometer	0	10	0	10
Oral Surgery Dental Chair x1	158	(91)	0	67
Ultrasound Machine (Ex Demo)	0	58	0	58
Anaerobic Cabinet	0	20	0	20
Transducer - Baby Hips	0	7	0	7
Ultrasound Anaesthetic Machines LOGIQER7 x 2	0	56	0	56
DR Mobile X-Ray Detector	0	43	0	43
Door Lock (FAU)	0	5	0	5
Bladder Scanner (FAU)	0	8	0	8
Defibs	0	266	0	266
Ultrasound Rheumatology	0	29	0	29
Neonatal Monitors	0	35	0	35
CMAC Video Laryngoscope	0	9	0	9
ECG stress test system	0	31	0	31
ENT Otology Drill	0	94	0	94
Sleep Study System	0	30	0	30
	2,416	**(1,059)**	**0**	**1,357**
IM&T				
Technology & Devices refresh and developments	500	12	0	512
SAM	30	7	0	37
Security (Stonesoft firewall replacement/renewal)	200	0	0	200
Server refresh	100	0	0	100
VDI Roll Out	150	0	0	150
SIP Setup Costs	15	(15)	0	0
BI Tool	27	0	0	27
IPPMA/ePrescribing/ePMA	250	0	0	250
Meditech Restoration	0	22	0	22
Deontics Care Pathway	0	8	0	8
Falsified Medicines Directive	0	0	83	83
BI Tool Physical Servers	0	0	27	27
	1,272	**34**	**110**	**1,416**
EXTERNALLY FUNDED				
Delamere Centre (Can Treat) Enhancements (ext. funded)	0	84	0	84
Video MDT (PDC) (ext. funded)	0	100	0	100
Training Simulation Equipment (HEE) (ext. funded)	0	77	0	77
Obstretrics Simulation Monitors (HEE) (ext. funded)	0	7	0	7
Pharmacy Clinical Trials Room (Externally Funded)	0	16	0	16
Outdoor Play Area (Phase 1)	0	45	0	45
Techotherm Cooling Blanket	0	19	0	19
Bladder Scanner B14 (LOF)	0	9	0	9
Bladder Scanner AMU (LOF)	0	9	0	9
Define Licence & EU Exit Monitoring (DH)	0	0	12	12
Cmac Video Laryngoscope (HEENW)	0	0	9	9
Tomosynthesis (Boot Out Breast Cancer)	0	0	64	64
EPR Developments WA Digital Maturity (PDC)	0	0	81	81
	0	**366**	**166**	**532**
CQC Reserve	**500**	(500)	0	**0**
Contingency	**624**	(17)	(198)	**409**
Total Trust Funded Capital	**7,548**	**370**	**166**	**8,084**
KENDRICK WING FIRE				
Kendrick Wing Fire Balance	**2,400**	(1,956)	(1,399)	**(955)**
Kendrick Wing Fire - Estates	0	1,006	1,412	2,418
Kendrick Wing Fire - F & F	0	54	(3)	51
Kendrick Wing Fire - Miscellaneous	0	227	(17)	210
Kendrick Wing Fire -Medical Equipment	0	441	7	448
Kendrick Wing Fire - IT	0	228	0	228
Kendrick Wing Fire Total	**2,400**	**0**	**0**	**2,400**
Totals	**9,948**	**370**	**166**	**10,484**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/22**			
SUBJECT:	**Safe Staffing Assurance Report**			
DATE OF MEETING:	27 March 2019			
AUTHOR(S):	**Rachael Browning – Associate Chief Nurse**			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	All			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas.			
PURPOSE: (please select as appropriate)	Information	Approval	**To note**	Decision
RECOMMENDATION:	It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance 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)***	Choose an item.			

NAME OF COMMITTEE

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/03/22

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report

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

2. KEY ELEMENTS

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

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

Care Hours Per patient Day

Warrington and Halton Hospitals NHS Trust currently collect and report CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight.
The January Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates this data to January 2019, which continues to show a sustained improvement. Since July 2018 we have seen an improvement in the CHPPD which is an increase on the overall time spend on direct patient care by our staff. This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD over 2018 /19– month by month

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
	Oct	15093.97	4.2	2.9	7.1
	Nov	14558	4.3	3.0	7.3
	Dec	14861	4.2	3.0	7.2
	Jan	14964	4.2	3.0	7.3
2018/19 Total		150212.47	4.1	2.9	7.0

We have a number of trainee nurse associates in the Trust who are due to register in March 2019. We have reviewed the guidance from NHS Improvement (NHSI), Safe, Sustainable and Productive Staffing an Improvement Resource for the deployment of Nursing Associates in Secondary Care (NHSI 2019) and have undertaken a Quality Impact Assessment process to ensure that we have all the workforce safeguards in place for this new role in our organisation (See appendix 1).

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. Further recruitment events planned for both registered nurses and health care assistants including an external RCN event in February 2019.

Additional bed capacity was opened at the end of January 2019 to support the operational pressures in the Trust, Ward C21 (24 beds) and Ambulatory Care (16 beds) on occasions are currently being used and require nurse staffing. Both areas are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

Patient Harm by Ward

In January 2019 we reported a total of 7 pressure ulcers. These comprised of 6 grade 2 pressure ulcers on wards A6, A7, A9, B19, B3 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 fall with moderate harm and 1 patient fall with major harm reported this month.

Infection Incidents

No cases of MRSA bacteraemia have been reported in January

We have had 2 cases of MSSA bacteraemia reported in January on wards A9 and A6. Full RCA's have been initiated into both cases

Monthly Safe Staffing Report – January 2019

	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	630	99.2%	90.3%	0	0	0	0	-	-	0	-	-	-
SWC	Ward A5	1782.5	1420.5	1302	1276.5	79.7%	98%	1069.5	1012	713	115.5	94.6%	156.5%	989	2.5	2.4	4.9
SWC	Ward A6	1782.5	1345.5	1302	1351.25	75.5%	103.8%	1069.5	1046.5	1069.5	1081	97.8%	101.1%	990	2.4	2.5	4.9
SWC	Ward CMTC	1161.5	1140.5	736	701.5	98.2%	95.3%	690	690	425.5	425.5	100%	100%	328	5.6	3.4	9.0
SWC	Ward B4	953.5	951	478.5	476	99.7%	99.5%	253	241.5	264.5	253	95.5%	95.7%	75	15.9	9.7	25.6
SWC	Ward A9	1782.5	1559.5	1426	1288	87.5%	90.3%	1069.5	1069.5	1426	1426	100%	100%	988	2.7	2.7	5.4
SWC	Ward B11	2713	2700.3	775	755	99.5%	100%	1649.2	1649.4	322.4	322.4	100%	100%	457	9.5	2.4	11.9
SWC	NCU	1782.5	1577	356.5	310.5	88.5%	87.1%	1782.5	1344	356.5	333.5	75.4%	93.5%	282	10.4	2.3	12.6
SWC	Ward C20	966	1007	713	701.5	104.2%	98.4%	713	713	0	0	100%	-	421	4.1	1.7	5.8
SWC	Ward C23	1426	1206	713	541.5	84.6%	75.9%	770.5	759	713	678.5	98.5%	95.2%	319	6.2	3.8	10.0
SWC	Delivery Suite	2495.5	2337.4	356.5	352.5	93.7%	98.9%	2495.5	2383	356.5	345	95.5%	96.8%	198	23.8	3.5	27.4
ACS	Ward A1	1937.5	2072	1937.5	1922	106.9%	99.2%	1627.5	155.5	976.5	923	95.6%	94.5%	1066	3.4	2.7	6.1
ACS	Ward A2	1426	1250.1	1529.5	1496.5	87.7%	97.8%	1069.5	1035	1069.5	966	96.8%	90.3%	868	2.6	2.8	5.5
ACS	Ward C22	1212	1100	1069.5	1182.5	90.8%	110.6%	713	713	713	1069.5	100%	150%	744	2.4	3.0	5.5
ACS	Ward A4	1690.5	1514	1426	1218	89.6%	85.4%	1069.5	943	1069.5	1104	88.2%	103.2%	990	2.5	2.3	4.8
ACS	Ward A8	1426	1334	1426	1596	93.5%	111.9%	1426	1311	1069.5	1115.5	91.9%	104.3%	1054	2.5	2.6	5.1
ACS	Ward B12	1069.5	1000.5	2495.5	2318.95	93.5%	92.9%	713	711	1782.5	1736.5	99.7%	97.4%	651	2.6	6.2	8.9
ACS	Ward B14	1426	1282	1426	1380	89.9%	96.8%	713	713	1069.5	1035	100%	96.8%	744	2.7	3.2	5.9
ACS	Ward B18	1426	1250.5	1414.5	1473	87.7%	104.1%	1069.5	897	1069.5	1276.5	83.9%	119.4%	744	2.9	3.7	6.6
ACS	Ward B19	1069.5	995.5	1449	1483.5	93.1%	102.4%	713	713	1069.5	1092.5	100%	102.2%	744	2.3	3.5	5.8
ACS	Ward A7	1782.5	1507.5	1426	1495	84.6%	104.8%	1426	1391.5	1069.5	1291	97.6%	120.7%	1013	2.9	2.8	5.6
ACS	Ward C21	1069.5	874	1058	1023.4	81.7%	96.7%	713	713	1069.5	1035	100%	96.8%	558	2.8	3.7	6.5
ACS	CCU	1426	1327.5	356.5	282.5	93.1%	79.2%	1069.5	1046.5	0	0	97.8%	-	233	10.2	1.2	11.4
ACS	ICU	4991	4519.5	1069.5	908.5	90.6%	84.9%	4991	4450.5	1069.5	563.5	89.2%	52.7%	508	17.7	2.9	20.6

Appendix 2

January 2019 - 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%	90.3%	-	-	**Vacancy:** - fully established **Sickness rate** 7.47% **Action taken:** - Attendance management policy followed
Ward A5	79.7%	98%	94.6%	156.5%	**Vacancy:** Band 5 1.12 wte band 2 4.29 wte **Sickness rate:** 7.27% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment
Ward A6	75.5%	103.8%	97.8%	101.1%	**Vacancy:** - Band 5 6.07 wte Band 2 2.53 wte **Sickness rate** – 7.93% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment
CMTC	98.2%	95.3%	100%	100%	**Vacancy**: all vacancies filled – awaiting start dates **Sickness rate** – 12.29% **Action taken:** Daily staffing review against acuity and activity. Posts advertised. Sickness absence reduced in month and being managed in line with Trust policy.
B4	99.7%	99.5%	95.5%	95.7%	**Vacancy:** - Band 6 1.29wte band 5 2 wte Band 2 1.74 wte **Sickness rate** – 4.1% **Action taken:** Staffing and activity reviewed daily. recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward A9	87.5%	90.3%	100%	100%	**Vacancy:** all vacancies filled – awaiting start dates **Sickness rate –** 8.51% **Action taken**: All vacancies filled and awaiting start dates. Sickness absence being managed in line with the Trust policy.
Ward B11	99.5%	100%	100%	100%	**Vacancy:** HCA 0.6wte. band 5 1.2wte – recruited due to quality Sept 2019 **Sickness rate** – 5.72% **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy.
NCU	88.5%	87.1%	75.4%	93.5%	**Vacancy:** 1.0wte Band 5. **Action taken:** - recruitment process in place. Staffing reviewed daily and

					support provided if necessary.
Ward C20	104.2%	98.4%	100%	-	**Vacancy rate:** 1.0 wte HCA **Sickness Rate:** 0.66% **Action taken:** Staffing reviewed daily and support provided if necessary.
Ward C23	84.6%	75.9%	98.5%	95.2%	**Vacancy: :** 2.54wte midwives 0.99 wte MSW Sickness rate – 5.64% **Action taken:** 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	93.7%	98.9%	95.5%	96.8%	**Vacancy:** 1.0 wte band 7 and 1.0 wte MSW **Sickness rate** – 4.56% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness is being managed in line with Trust policy.
Ward A1 - AMU	106.9%	99.2%	95.6%	94.5%	**Vacancy:** - 1.0wte Band 6 and 10.87.0wte Band 5. This is predominantly due to a funded increase in the bed base on the ward **Sickness rate** – 6.60% **Action taken:** – Recruitment ongoing with x2 RN'S commencing in post in March, 1RN in September. 3.0 HCA recruited going through employment checks. Rotational posts introduced. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	87.7%	97.8%	96.8%	90.3%	**Vacancy :** - 4.0wte Band 5, 5 WTE HCA Sickness Rate: 1.56% **Action taken:** Recruitment ongoing with x1 RN'S commencing in post in March, 3RN in September. 4.0 HCA recruited going through employment checks. Rotational posts introduced. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward C22	90.8%	110.6%	100%	150%	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 A4	89.6%	85.4%	88.2%	103.2%	**Vacancy :-** Band 5 2.3 wte Band 2 2.4 wte **Sickness Rate:** 2.5% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A8	93.5%	111.9%	91.9%	104.3%	**Vacancy :** - RN 4wte band 5 **Sickness rate** - 2.0wte LTS minimal ST sickness throughout the month of January 2019 **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)	93.5%	92.9%	99.7%	97.4%	**Vacancy :** - 2 wte RN 4wte HCA vacancies **Action taken**: - Recruitment plan in place, with a number of staff recently

					recruited to the vacancies. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	89.9%	96.8%	100%	96.8%	**Vacancy :-** 2.5wte Band 5 and 2.05wte HCA **Action taken:** - following recent recruitment HCA vacancies are now all filled with applicants going through pre-employment checks. Staffing reviewed daily against acuity and activity.
Ward B18	87.7%	104.1%	83.9%	119.4%	**Vacancy :** -1.0 wte band 7, 3.0wte RN 2 1.0 wte HCA **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	93.1%	102.4%	100%	102.2%	**Vacancy :** -2.0wte RN and 2.76 wte HCA **Action taken:** - band 5 post filled with a February start date. Ward reviewed daily for acuity and staffing.
Ward A7	84.6%	104.8%	97.6%	120.7%	**Vacancy : -** RN 3.22wte band 6. **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway.
Ward C21	81.7%	96.7%	100%	96.8%	**Action taken:** ward merged with CCU therefore information below
Coronary Care Unit	93.1%	79.2%	97.8%	-	**Vacancy :** 1.76 B6 vac / B5 3.68 WTE **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. All vacancies recruited to awaiting start dates
Intensive Care Unit	90.6%	84.9%	89.2%	52.7%	**Vacancy :** – All vacancies accounted for with new starters and conversion of Band 5 vacancies to Band 6 **Sickness rate** –7.31% **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
January 2019

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To note the contents of the report

4. ASSURANCE COMMITTEE

5. RECOMMENDATIONS

NATIONAL QUALITY BOARD

Safe, Sustainable and Productive Staffing Improvement Resource for the Deployment of Nursing Associates in Secondary Care

RECOMMENDATIONS AND ACTION PLAN – EDUCATION

No.	RECOMMENDATION	CURRENT POSITION	ACTIONS	TIMESCALES
1.	Adopt a systematic approach using an evidence-informed decision support tool, triangulated with professional judgement and comparison with relevant peers.	WHH have Safe Care (SNCT) in place to record patient acuity. CHPPD reported in the monthly Board report. Model Hospital comparative data is available. 6 monthly staffing reviews are in place in the Trust led by the Chief Nurse.	CHPPD is part of the workforce dashboard presented at the Trust Recruitment and Retention meeting. Full Trust wide staffing review has been undertaken by the Chief Nurse. 6 monthly acuity assessment undertaken and will be presented in the Board report.	Completed and on-going
2.	Take staffing decisions in the context of the wider senior registered multi-professional team.	6 monthly updates provide for Trust Board. A trust wide strategic staffing review has been undertaken by the senior nursing team, Chief Nurse and Transformation Manager. A business case has been drafted following this review with regards to Nurse and Health Care Support worker staffing. A business case has been drafted to extend the implantation of the role across the Trust.	Review of skill mix in all areas to identify where the role can be best utilised. Identify ward / department establishment. Review of those area that have NA in their skill mix to, related to QIA. Monitor the impact of the role through • The patient experience • Friends and family test • Case studies • Service improvement • To be defined based on clinical setting e.g. inpatient measurement of medication errors.	Monitored through the Nursing Recruitment and Retention meeting .

			• Staff evaluation /survey monkey • Staff retention data • Supervision • Audit of career pathways • Sickness data • Vacancy data	
3.	Consider safe staffing requirements, workforce productivity and financial viability as an integral part of the deployment process.	A twice daily staffing meeting is undertaken to review trust wide staffing requirements. This includes a review of ward acuity utilising the Safe Care system. A template of ward staffing is available on the shared drive, with an overall RAG rating of Nurse staffing across the trust. Any changes with staffing levels require engagement with relevant stakeholders and as appropriate a business case. All NA are required to be supervised or delegated by a RN The NA training requirements – TNA – has been developed to meet the core skill framework. The NA role has identified positions within ESR and E-Rostering.	Returns of safe staffing levels	Monitored through the NR&R meeting

4.	Ensure there is a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision making.	Any operational and /or service redesign undertakes a Failure Modes Analysis process. This includes an assessment of staffing and staff management, to ensure a staffing model and that staff with the necessary skills are in place.		Completed
5.	Ensure the organisation is familiar with the NMC standards of proficiency and with individual nursing associate competencies.	• TNA's undertake a skills inventory to evidence expected skills and proficiencies required by the NMC at point of registration. These are signed of by with ward / department supervisors. • The Job description for the TNA role is a national profile and the Qualified JD has been mapped to the national profile. • The role of the NA is addressed at mentor updates. • Information shared at ward manager meetings. • Individual NA competencies discussed with ward/service leads as part of QIA process • Medicines policy has been reviewed • Addressed at placement educational audit • Celebration Event	• Meet with individual ward managers. • Circulate communications regarding nursing associate role. (Nursing associate leaflet prepared, waiting formatting). • Other clinical policies to be updated to include nursing associate role • Update on nursing associate role at Educational Governance this will include any incidents or concerns reported through Datix. • Address at Grand Round • Address at NPAG • Career Day 12th March	Reviewed at NR&R meeting
6.	Ensure there is an appropriate escalation process in cases where issues arise because of	All reported incidents of patient safety are escalated through the Trust Datix system and forwarded to both Education and Senior Nurses to	• As part of the preceptorship programme they have group	Monitored at NR&R meeting

	deployment.	action and monitor. The Education Practice Educator is the link for the NA now they are qualified to support them and the areas in practice. They will work with them and the Ward Manager to support and action issues as appropriate.	clinical supervision. • They have access to one to one Clinical Supervision if they wish.	
7.	Investigate staffing related incidents, their impact on staff and patients and ensure action and feedback.	Daily staffing template with rationale for decision making recorded, is updated twice daily and stored on the shared drive. All incidents are monitored by education as well as the CBU / lead nurse; we are monitoring this as part of the ongoing evaluation of the role.	Operational staffing meetings include the E-Rostering KPI's. The Quality dashboard is presented monthly.	Monitored through NR&R meeting
8.	Develop guidelines to ensure that staff are aware of the rationale for deployment, the role's risks and benefits and process for escalating concerns.	As per the QIA the wards and departments that have NA with clear guidelines as to what the NA can and cannot do. Escalation process in place for nurse staffing. Daily staffing meetings in place.		Monitored through NR&R
9.	Complete a full quality impact assessment before there is any substantial skill-mix change or deployment of new role.	A quality impact assessment has been undertaken for the new role of the Nursing Associate. Copy of QIA 191218x.xlsx	KSJ to sign off	Completed

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/22 a**			
SUBJECT:	**Safe Staffing Assurance Report**			
DATE OF MEETING:	27 March 2019			
AUTHOR(S):	**Rachael Browning – Associate Chief Nurse**			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	All			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas.			
PURPOSE: (please select as appropriate)	Information	Approval	To note	Decision
RECOMMENDATION:	It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance 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)***	Choose an item.			

NAME OF COMMITTEE

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/03/22 a

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report

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

2. KEY ELEMENTS

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

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

Care Hours Per patient Day

Warrington and Halton Hospitals NHS Trust currently collect and report CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight.

The February Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates this data to February 2019, which continues to show a sustained improvement. Since July 2018 we have seen an improvement in the CHPPD which is an increase on the overall

time spend on direct patient care by our staff. This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD over 2018 /19– month by month

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
	Nov	14558	4.3	3.0	7.3
	Dec	14861	4.2	3.0	7.2
	Jan	14964	4.2	3.0	7.3
	Feb	13422	4.2	3.0	7.2
2018/19 Total		163634.47	4.1	2.9	7.0

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. Further recruitment events planned for both registered nurses and health care assistants.

Additional bed capacity was opened at the end of February 2019 to support the operational pressures in the Trust, Ward C21 (24 beds) and Ambulatory Care (16 beds) on occasions are currently being used and require nurse staffing. Both areas are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

Neonatal Unit Staffing Update

The Neonatal Unit (NNU) staffing levels are defined by British Association of Perinatal Medicine (BAPM) guidance. The table below demonstrates the impact of the Trust-wide staffing business case. It is pleasing to note the NNU staffing establishment ensures compliance with commissioned activity and BAPM guidance making us one of the only units in Cheshire and Merseyside to achieve this standard.

	% Shifts staffed to BAPM recommendations		
	2016/17	2017/18	18/19 (This year)
WHH	46.03	57.48	80.31
National average	56.93	61.62	67.91

Patient Harm by Ward

In February 2019 we reported a total of 5 pressure ulcers. These comprised of 4 grade 2 pressure ulcers on wards A6, A8, A9, B19, and 1 grade 3 pressure ulcer on ward B19. 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 0 patient falls with moderate harm and 1 patient fall with major harm reported this month.

Infection Incidents

No cases of MRSA bacteraemia have been reported in February 2019

Monthly Safe Staffing Report – February 2019

	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	840	832	652.5	585	99.0%	89.7%	0	0	0	0	-	-				
SWC	Ward A5	1610	1236.25	1176	1265	76.8%	107.6%	966	863	644	931.5	89.3%	144.6%	896	2.3	2.5	4.8
SWC	Ward A6	1610	1150	1176	1190.25	71.4%	101.2%	966	920	966	966	95.2%	100%	896	2.3	2.4	4.7
SWC	Ward CMTC	988.5	959.5	701.5	667.5	97.1%	95.2%	644	644	299	299	100%	100%	205	7.8	4.7	12.5
SWC	Ward B4	816.5	768.5	663	428.5	94.1%	64.6%	213	213	213	213	100%	100%	74	13.3	8.7	21.9
SWC	Ward A9	1610	1408	1288	1206.5	87.5%	93.7%	966	966	1288	1426	100%	110.7%	892	2.7	3.0	5.6
SWC	Ward B11	2491.9	2490	700	684.6	99.9%	97.8%	1489.6	1473.2	291.2	270.4	98.9%	92.9%	411	9.6	2.3	12.0
SWC	NCU	1610	1435.5	322	310.5	89.2%	96.4%	1610	1265	322	299	78.6%	92.9%	282	9.6	2.2	11.7
SWC	Ward C20	908.5	870.4	575	575	95.8%	100%	575	575	0	0	100%	-	333	4.3	1.7	6.1
SWC	Ward C23	1288	1040.5	644	513.4	80.8%	79.7%	690	678.5	644	621	98.3%	96.4%	307	5.6	3.7	9.3
SWC	Delivery Suite	2254	2130.5	322	244.5	94.5%	75.9%	2254	2079.5	322	299	92.3%	92.9%	246	17.1	2.2	19.3
ACS	Ward A1	1750	1732.5	1750	1918.5	99.0%	109.6%	1687.5	1291.5	882	850.5	76.5%	96.4%	959	3.2	2.9	6.0
ACS	Ward A2	1288	1048	1414.5	1278.5	81.4%	90.4%	966	897	966	943	92.9%	97.6%	784	2.5	2.8	5.3
ACS	Ward C22	1086	958	966	1047	88.2%	108.4%	644	644	644	966	100%	150%	588	2.7	3.4	6.1
ACS	Ward A4	1518	1309.5	1288	1224	86.3%	95%	966	770.5	966	885.5	79.8%	91.7%	924	2.3	2.3	4.5
ACS	Ward A8	1288	1196	1288	1380	92.9%	107.1%	1288	1242	966	1069.5	96.4%	110.7%	952	2.6	2.6	5.1
ACS	Ward B12	966	915.5	2254	2030	94.8%	90.1%	644	644	1610	1506.5	100%	93.6%	588	2.7	6.0	8.7
ACS	Ward B14	1288	1129.5	1288	1249.5	87.7%	97%	644	644	966	851	100%	88.1%	672	2.6	3.1	5.8
ACS	Ward B18	1288	1119.5	1288	1329.5	86.9%	103.2%	966	724.5	966	1219	75%	126.2%	672	2.7	3.8	6.5
ACS	Ward B19	966	874	1288	1345	90.5%	104.4%	614	655.5	966	964	106.8%	99.8%	672	2.3	3.4	5.7
ACS	Ward A7	1610	1354	1288	1322.4	84.1%	102.7%	1288	1242	966	1150	96.4%	119.0%	924	2.8	2.7	5.5
ACS	ACCU	2254	1934.5	971.5	949.9	85.8%	97.8%	1552.5	1575.5	966	897	101.5%	92.9%	706	5.0	2.6	7.6
ACS	ICU	4508	4094	966	690	90.8%	71.4%	4508	4197.5	966	460	93.1%	47.6%	439	18.9	2.6	21.5

Appendix 2

February 2019 - 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	99.0%	89.7%	-	-	**Vacancy:** - band 5 1.0 wte **Sickness rate** 7.47% **Action taken:** - Attendance management policy followed
Ward A5	76.8%	107.6%	89.3%	144.6%	**Vacancy:** Band 5 1.12 wte band 2 4.29 wte **Sickness rate:** 7.27% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment with 3.28 wte band 2 vacancy filled via central recruitment – awaiting start dates
Ward A6	71.4%	101.2%	95.2%	100%	**Vacancy:** - Band 5 6.07 wte Band 2 2.53 wte **Sickness rate** – 7.93% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment with 1.0 wte band 2 vacancy filled via central recruitment – awaiting start date
CMTC	97.1%	95.2%	100%	100%	**Vacancy**: all vacancies filled – awaiting start dates **Sickness rate** – 11.25% **Action taken:** Daily staffing review against acuity and activity. Posts advertised. Sickness absence reduced in month and being managed in line with Trust policy.
B4	94.1%	64.6%	100%	100%	**Vacancy:** - Band 6 1.29wte **Sickness rate** – 4.1% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward A9	87.5%	93.7%	100%	110.7%	**Vacancy:** all vacancies filled – awaiting start dates **Sickness rate –** 8.22% **Action taken**: All vacancies filled and awaiting start dates. Sickness absence being managed in line with the Trust policy.
Ward B11	99.9%	97.8%	98.9%	92.9%	**Vacancy:** band 5 - 5.0wte – All posts recruited to - due to quality Sept 2019 **Sickness rate** – 5.72% **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy.

NCU	89.2%	96.4%	78.6%	92.9%	**Vacancy:** 2.0wte Band 5. **Sickness Rate:** 6% **Action taken:** - recruitment process in place. Staffing reviewed daily and support provided if necessary.
Ward C20	95.8%	100%	100%	-	**Vacancy rate:** 1.0 wte HCA **Sickness Rate:** 0.66% **Action taken:** Staffing reviewed daily and support provided if necessary.
Ward C23	80.8%	79.7%	98.3%	96.4%	**Vacancy: :** 2.54wte midwives 0.99 wte MSW Sickness rate – 7% **Action taken:** 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	94.5%	75.9%	92.3%	92.9%	**Vacancy:** 1.0 wte band 7 and 1.0 wte MSW **Sickness rate** – 4.56% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness is being managed in line with Trust policy.
Ward A1 - AMU	99.0%	109.6%	76.5%	96.4%	**Vacancy:** - 1.0wte Band 6 and 8.67wte Band 5. This is predominantly due to a funded increase in the bed base on the ward **Sickness rate** – 7.06% **Action taken:** – Recruitment ongoing with x2 RN'S commencing in post in March, 1RN in September. 3.0 HCA recruited going through employment checks. Rotational posts introduced. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	81.4%	90.4%	92.9%	97.6%	**Vacancy :** - 4.0wte Band 5, 5 WTE HCA Sickness Rate: 1.56% **Action taken:** Recruitment ongoing with x1 RN'S commencing in post in March, 3RN in September. 4.0 HCA recruited going through employment checks. Rotational posts introduced. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward C22	88.2%	108.4%	100%	150%	**Vacancy:** Band 5 0.54wtc, band 2 3.5wte **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 A4	86.3%	95%	79.8%	91.7%	**Vacancy :-** Band 5 2.4 wte Band 2 2.4 wte **Sickness Rate:** 2.5% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Ongoing recruitment
Ward A8	92.9%	107.1%	96.4%	110.7%	**Vacancy :** - band 5 – 4wte, band 2 4.0wte **Action taken:** Recruitment process in place with 3.0 RN and 3.0 HCA recruited

					awaiting start dates. Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12 (Forget-me-not)	94.8%	90.1%	100%	93.6%	**Vacancy :** - 2 wte RN 4wte HCA vacancies **Action taken**: - Recruitment plan in place, with a number of staff recently recruited to the vacancies. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	87.7%	97%	100%	88.1%	**Vacancy :-** 2.5wte Band 5 **Action taken:** - all posts recruited to following recent recruitment awaiting start dates Staffing reviewed daily against acuity and activity.
Ward B18	86.9%	103.2%	75%	126.2%	**Vacancy :** -1.0 wte band 7, 3.0wte RN 2 5.5 wte HCA **Action taken:** - Recruitment ongoing, band 2 posts recruited to via centra recruitment – awaiting start dates. staffing reviewed on daily basis by matron and ward manager
Ward B19	90.5%	104.4%	106.8%	99.8%	**Vacancy :** -2.0wte RN and 2.76 wte HCA , recruitment process underway. **Action taken:** - band 5 post filled with a February start date. Ward reviewed daily for acuity and staffing.
Ward A7	84.1%	102.7%	96.4%	119.0%	**Vacancy : -** B6 1wte, B5 2.6wte 3 **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway.
Acute Coronary Care Unit	85.8%	97.8%	101.5%	92.9%	**Vacancy :** 1.76 B6 vac / B5 3.68 WTE **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. All vacancies recruited to awaiting start dates
Intensive Care Unit	90.8%	71.4%	93.1%	47.6%	**Vacancy :** – All vacancies accounted for with new starters and conversion of Band 5 vacancies to Band 6 **Sickness rate** –7.16% **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
February 2019

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To note the contents of the report

4. ASSURANCE COMMITTEE

5. RECOMMENDATIONS

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 19/03/22 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27th March 2019

Date of Meeting	5th March 2019
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Jean-Noel Ezingeard (*Margaret Bamforth, the substantive Chair was unable to attend due to bereavement)
Was the meeting quorate?	Yes

The Quality Assurance Committee met on 5th March 2019. The following matters were discussed:

- An update on the Cholecystectomy Review and NED/Exec Ward & Departments Visits were received;
- A Patient Story was received;
- An update was received form the Getting to Good Steering Group;
- A Deep Dive review on Equipment & Medical Devices was received;
- The Committee reviewed the Quality Dashboard and associated KPIs;
- A High Level Briefing (HLB) was received from the Infection Control Sub-Committee
- A HLB was received from the Patient Safety and Clinical Effectiveness Sub-Committee, the Safeguarding Sub-Committee, the Complaints Quality Assurance Group, the Patient Experience Sub-Committee, the End of Life Steering Group & Strategy, the Risk Review Group and the Information Governance & Corporate Records Sub Committee.
- An update was provided on Maternity Services and on the Maternity Safety Champions work
- The Learning form Experience Quarter 3 report was received;
- Also received was the joint Adult & Children's Safeguarding b-annual report
- The 6 monthly Nurse Staffing report was presented
- The Director of Infection Prevention and Control quarter 3 report was received;
- The Mortality Review Q3 report and Mortality Coding review was presented;
- The Committee received the NEWS2 Implementation Audit Report;
- The Clinical Audit Quarter 3 report was received, including an update of the Clinical Audit forward plans

- The Quality Priorities for 2019/20 were presented
- The Strategic Risk Register and Board Assurance Framework were reviewed and considered;
- The Research & Development Quarter 3 Report was received

The ratified minutes of the committee meeting will be available for information in the May Board pack.

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/19/ 03/33	Getting to Good (G2G) Steering Group update	• The Committee received an updated report on the work to ensure the Trust receives a CQC rating of 'Good' overall. Included within this report was an issues log, outlining the work being undertaken to finalise preparation for the assessment. • The Trust had received a visit to the ED on 18th February, 2019 from the CQC. The draft report had been received on 1st March, 2019 and is currently being reviewed for factual accuracy.	The Board are asked to note the good progress made on the work on getting to good	**QAC May 2019**
QAC/19/ 03/34	Deep dive review/Service review – Equipment and Medical Devices	• The Committee received a presentation providing assurance against compliance relation to regulation 12. The Committee noted the improvements against compliance in training levels, competency assessments, categorisation of devices and development of the E-Quip system. This is being carefully monitored at Getting to Good Steering Group, with a weekly report insitu.	The Board are asked to note the positive progress made	**QAC May 2019**
QAC/19/ 03/35	Quality Dashboard and Review and refresh of KPIs	The Committee received the Quality Dashboard which highlighted the following matters which are included in the IPR which will be received by the Trust Board at this meeting. Of particular note were the following matters: • Decrease in open incidents • Reduction in Serious Incidents. Unfortunately however, the reporting of one Never Event was noted and is currently being investigated.	The Board will review the full IPR as part of the meeting today	**Trust Board March 2019**

		• Off trajectory on C-Diff and MSSA • Decrease in falls - 1 Serious Incident fall reported during January 2019 on ward B14. Falls have decreased from 71 to 57 which is a 19.7% decrease • Overall % of medicines reconciliation has increased. • MSA breaches occurred as a result of demand for inpatient beds and infection control pressures due to increased incidence of flu. • The Trust is just 1% point off it's 95% target for patients recommending inpatient and day case services in the Friends and Family test. • The Committee reported a decrease in the CQC composite score due primarily due to the performance in ED due to winter pressures. **Quality KPI Recommendations** The Committee supported the recommended amendments to the Quality Indicators that will be presented to the Trust Board in March 2019.		
QAC/19/03/37	High Level Briefing - Patient Safety + Clinical Effectiveness Sub Committee	The Committee particularly noted the following matters: • A total of 9 SIs have been reported in this time period. A number of the SIs relate to diagnostic and treatment delays and the Committee were assured that a further review was underway of these, to assess any common themes or trends. • Emerging theme 2018/19 is the involvement of locum staff involved in SI investigations. Two actions had taken place – all relevant incidents report to Medical Director via Trust Triangulation meeting and a review of local induction for temporary staff has commenced, being reported through Getting to Good. • A number of trauma incidents are under review. • The Trust has two out of date policies at this point, having taken forward a policy improvement and review plan, previously reported to the Committee.	Further updates to be presented at next meeting	**QAC May 2019**
QAC/19/03/40	High Level Briefing - Complaints Quality Assurance	The Committee escalated the following items: • There are 86 open complaints, with 0 over 6 months' old and 20 complaints that have breached their deadline. The number of complaints received continues to reduce from the same period as last year. • Learning from complaints is now being audited as part of the Trust's Lessons Learned	Further update to be presented at next meeting Members will	**QAC May 2019**

	Group	work and the second audit has been completed. • Two further complaints relating to historical spinal cases have been received, one of which requires an external review. • 2 complaints in December 2018 and 1 in January 2019 have been declared a Serious Incidents. • The Trust currently has 7 open PHSO cases, which are being tracked and monitored • We will continue to improve our timeliness in complaints responses and this has been selected as a Quality Priority for 19/20.	wish to note that a report providing and update on Spinal Services will be presented to Board today.	
QAC/19/ 03/41	High Level Briefing – Patient Experience Sub Committee:	• Healthwatch Halton conducted 'Enter and View' visits in four areas of WHH in Nov and Dec 2018 which provided unbiased feedback on the patients experience in our hospitals. There was a great deal of positive feedback from patients with 23/24 patients rating their treatment as either 4 or 5 out of 5 (Good/Excellent). • FFT feedback for Urgent & Emergency Care CBU has not achieved the WHH set recommendation rate target of 87%. Actions have been assigned to ensure that the target will be met in the next quarter.	Members are asked to note the continued improvement in the survey results.	**Trust Board March 2019**
QAC/19/ 03/41 & QAC/19/ 03/53	End Of Life Steering Group & End of Life Strategy	• The Committee asked that the EoL report be updated to provide assurance relating to DNACPR • The Committee reviewed the EoL strategy, advising that this required further work before being presented to the Board • The Committee wish to escalate the continued lack of a substantive Palliative Care Consultant. Cover is currently provided by another Trust and recruitment processes are underway.		
QAC/19/ 03/43	GPDR action plan Information Governance + Corporate Records High	• The risks of a no deal Brexit affecting key data flows to and from the EU is being assessed and work is underway with asset owners to establish if there are any risks to their various IT systems. • MIAA will be performing the Phase 2 of the annual IG audit against the new Data Protection and Security Toolkit in March 2019. • The most recent baseline return for the new Data Protection and Security Toolkit	The board will wish to note from the actions listed, the GDPR BAF risk has been de-escalated	**The matter continues to be reviewed at all QAC**

	Level Briefing	showed that there are 15 of the Mandatory Assertions (requirements) that the Trust is currently not able to meet. • There are 5 risks relating to GDPR and Information Security which are being progressed and reviewed on a routine basis. • Cyber Essentials Assessment – assurance provided achieving 86 of 100 standards • Assurance provided relating to continued patching work.		**meetings.**
QAC/19/ 03/44	**Maternity Update/Maternity Safety Champion update**	• CNST Year 2 evidence is being collated. • Quarterly reports of still births reviewed with action plans are being submitted • Action plan to Avoid Term Admissions in Newborns (ATAIN) to be agreed. • Maternity Services Data Set (MSDS) – several data quality issues have been identified. This poses a risk to our compliance with the CNST Safety Action relevant to this. • Action plan to reduce term admissions to NNU for neonatal with revised national trajectory of 6% to be added to action plan for sign-off at next QAC.	Further progress updates to be presented at next meeting.	**QAC May 2019**
QAC/19/ 03/45	**Learning from Experience Q3 Report**	The Committee noted the following matters: • Reporting of SI investigations decreased in Q3 • Incidents relating to falls and medication decreased in Q3 • There was a decrease in complaints opened Trust wide in Q3 • There was a small decrease in incident reporting from Q2 • Incidents relating to pressure ulcers and clinical care increased. • Delay in diagnosis accounted for the highest number of serious incidents- as stated above, a cluster review is underway, to assess themes or trends. • During this Quarter, there were 19 sharps related incidents with the majority reported in Theatres- work continues regarding sharps training and awareness. • The Trust currently has 20 breached complaints (none over 6 months)- a plan is in place to reduce this over the forthcoming weeks.	All matters continue to be monitored closely across several meetings and Sub-Committees	**QAC May 2019**
QAC/19/ 03/46 & QAC/19/	**Safeguarding Bi-Annual Report & 6**	• Business case approved for LD nurse to support patients identified with LD and communication difficulties. • There is no deficit in nursing staff in comparison to the previous 6 monthly Board	Staffing continues to be monitored on the BAF and in	**Ongoing across several**

03/47	**monthly staffing Report**	Staffing Report which reported a deficit of 58.06 Whole Time Equivalent (WTE). • Despite making significant improvements in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity establishments of 643.93 WTEs, the actual number of staff in post is currently 510.3 leaving the number of nurse vacancies across the Trust at -133.63. • The ongoing Trust Nursing Recruitment and Retention Strategy continues to be delivered at pace which has resulted in a further 95 RNs and 92 HCAs. • The Trust has recently joined the NHSI retention collaborative.	the IPR	**meetings and Sub-Committees**
QAC/19/03/48	**DIPC Q3 report**	The Committee especially noted the following matters: • The increases in instances of Norovirus are being managed in line with the Trust's policies and procedures. • 7 E. coli bacteraemia cases in Q3. The Trust has reported 36 cases for Q1 – Q3 and is above the planned annual trajectory (30 cases) by 6 cases • 1 MRSA bacteraemia in Q3. The Trust has reported 2 cases for the financial year (case 1 on ward A7 in April 2018 and case 2 on ward A4 in December 2018) • 3 MSSA bacteraemia cases in Q3. The Trust has reported 12 cases for Q1 – Q3. • 5 Clostridium difficile cases in Q3. The Trust has reported 22 cases for Q1 – Q3. The trust is above the planned in year trajectory by 3 cases but remains below the financial year set threshold of 26 cases	On behalf of the Trust Board, the Committee received, reviewed and discussed the report.	**Ongoing across several meetings and Sub-Committees**
QAC/19/03/49	**Mortality Review Q3 Report and Mortality Coding Review**	• HSMR is showing signs of deterioration; however, the Trust is not an outlier for SHMI for the period September 2017 – August 2018, being within the expected range, according to the over dispersed model used by NHS Digital. • Weekend / weekday mortality shows that weekend HSMR is slightly higher than weekday. However, the result is not statistically significantly high. • Mortality Coding Review had been undertaken to provide further information relating to impact on denominator for SHMI and R codes usage. Some operational and documentation issues identified rather than coding issues e.g. the impact of the fire in Kendrick Wing, which displaced the coding team.	On behalf of the Trust Board, the Committee received, reviewed and discussed the report.	**Ongoing across several meetings and Sub-Committees**

QAC/19/03/55	**Strategic Risk Register & BAF**	The Committee received and discussed the Strategic Risk Register & BAF agreeing the following amendments: • There are no new risks that have been added to the BAF; • It was agreed that four risks were de-escalated from the BAF, but would be tracked through the risk management processes; • It was agreed that the ratings for four risks currently on the BAF were reduced; • It was agreed that the descriptions of three risks currently on the BAF were amended. • The updated Board Assurance Framework will be presented to the Trust Board today.	The BAF will continue to be developed in line with the Trust strategy and policy and with considerations of risk appetite and tolerance.	**QAC May 2019**

Strategic People Committee Chair's Report

Agenda Ref	BM 19 03 22 c	COMMITTEE OR GROUP:	Strategic People Committee	DATE OF MEETING	20 March 2019	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
John Culshaw	Head of Corporate Affairs
Kimberley Salmon-Jamison	Chief Nurse
Alex Crowe	Medical Director
Jane Hurst	Deputy Director of Finance
Hillary Stennings	CBU Manager

Apologies

Chris Evans	Chief Operating Officer
Mick Curwen	Head of Strategic HR Projects
Andrea McGee	Director of Finance
Simon Constable	Executive Medical Director
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
SPC/19/03/21	Director of HR and	Equality, Diversity and Inclusion Strategy	**Decision**

	OD		The Strategy was approved and escalated to Board for ratification.
SPC/19/03/24	Chair	Terms of Reference and Cycle of Business	**Decision** Pay Terms and Conditions Report removed from Cycle of Business as this is now a business as usual, operational matter. Any operational issues will be raised via Operational People Committee.
SPC/19/03/27	Deputy Director of HR and OD	BAF and Risk Register (Workforce)	**Decision** Recommendations to de-escalate risk 133 from BAF Action to escalate risk 200 in relation to Sickness absence
SPC/19/03/31	Deputy Director of HR and OD	Employee Relations	**Assurance** MHPS cases are now included in the report to give a comprehensive overview Analysis was undertaken and found that there is no correlation between increased FTSU and increase ER cases Employee tribunal activity remains high, in line with national trends, and the Committee are monitoring this. There is a process in place to ensure lessons learned are shared and embedded.
SPC/19/03/33	Deputy Director of HR and OD	Equality and Diversity – Regulated Reports • Equality Delivery System 2 (EDS") • Gender Pay Gap Report	**Decision** The Committee approved both reports for publication.
SPC/19/03/35	Chief Nurse	Sickness Absence Pilot Review	**Assurance** The pilot has been reviewed, including feedback from NHSI. Whilst there was an initial reduction in absence, this trend has not continued and therefore the pilot will not be taken forward and had been superseded by other activities.
SPC/19/03/36	Deputy Director of	Proposed Changes to Workforce IPR	**Decision**

	HR and OD		Proposed changes were approved
SPC/19/03/38	Director of HR and OD	Engagement and Recognition Annual Report	**Assurance** Staff Survey 2018 results were shared with the Committee and will be presented to Trust Board in May 2019, which will include information on actions to be taken in respect of the results.
SPC/19/03/39	Medical Director	Educational Quality Monitoring Review	**Assurance** Update provided in relation to the Enhanced Monitoring status around Junior Doctors. A paper will be provided to Trust Board in March 2019.
SPC/19/03/41	Deputy Director of HR and OD	Premium Pay Spend Review Group Chair Log	**Assurance** Job planning compliance was escalated to the Committee as 38% compliant for 1.4.19. The Committee was assured by the Medical Director that compliance has now increased and are significantly improved from last year and in comparison to other Trusts. Plans are in place to deal with any job plans not signed off by 1.4.19 through mediation and ECF 'break glass' process.
Any Other Business	Deputy Director of HR and OD	Outstanding Practice	The HR and OD Directorate have been shortlisted for 2 categories within the HPMA awards: • Rising Star Award – Georgia Stokes, HR Business Partner shortlisted • HR Analytics Award – Pay Assurance Dashboard and programme of work in Premium Pay Spend Review Group shortlisted.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

TRUST BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/19/03/22e	COMMITTEE OR GROUP:	TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 March 2019

Date of Meeting	23 January 2019
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/19/01/05	Pay Assurance Dashboard Monthly Report	• Temporary staff has reduced in December from 14.4% to 13.9% • Agency ceiling remains a concern and high reliance on temporary and premium rate continues, this is being reviewed through SPC. Ceiling is lower than last year but still 28% above. • Off framework agency was required on 31 December and 1 January the approval process was followed and further use is not anticipated	The Committee reviewed, discussed and noted the report.	FSC February 2019
FSC/19/01/06	Risk Register	• Presentation given to Committee explaining the process and scoring. • The report was in a new style which the Committee reviewed and was satisfied it gave them the information they required. • Report highlighted 2 new risks escalated to the BAF:- o Brexit potential impact on procurement, workforce and costs o Achieving Emergency access standard	The Committee reviewed, discussed and noted the report.	FSC February 2019

FSC/19/01/07	Corporate Performance Report	• December A&E performance is 79.9% Q3 was 82.67% • Diagnostics, RTT and Cancer targets for November met • Discussed the Emergency Department challenge was focussing on the whole system not just the Trust • CCG has just announced they are paying for 20 additional community beds • Ambulance handover times have been improving over January	The Committee reviewed, discussed and noted the report.	FSC February 2019
FSC/19/01/08	Monthly Finance report	• The year to date deficit is £17.1m which is £1.0m off control total (£0.0m excluding PSF). • Month 9 CIP over achieved in month by £0.2m but YTD still £0.9m behind plan • All PSF included except Q1 A&E and Q2 A&E and Q3 A&E • The reduction in activity was discussed and the need to reduce costs if undertaking less activity • Forecast risk discussed in detail along with possible mitigations	The Committee reviewed, discussed and noted the report and the financial challenges faced.	FSC February 2019
FSC/19/01/10	Quarterly unfunded cost pressures report	• Highlighted progress made over the year to reduce the unfunded pressures • Committee discussion on remaining pressures that relate to recruitment	The Committee reviewed, discussed and noted the report	FSC April 2019
FSC/19/01/11	Strategy Delivery	• Overview of all schemes the Trust is involved in including Bridgewater meetings, Pathology, breast screening, Wirral activity at CMTC, Halton Healthy New Town and a new project manager for Warrington Hospital project.	The Committee reviewed, discussed and noted the update	FSC February 2019
FSC/19/01/12	Financial Strategy	• Presentation given noting the last 10 years and review of the 2017 strategy • Discussion on the ability to achieve breakeven by 2023/24 through the use of GIRFT, model hospital and SLR data	The Committee noted and discussed the content	Board Development Day February 2019. Private

				Board March 2019
FSC/19/01/13	Combined Cost Collection	• Highlighted key points data is shared with clinicians and CBUs • Reference cost is 99 which below the national average but an increase in the previous year	Committee noted some deterioration since the last report and requested analysis of the data.	FSC March 2019
FSC/19/01/14	ePMA	• PH highlighted key points within the report, seeking additional support for project capital funding of £230k to facilitate the on-going deployment of the ePMA solution • The Committee discussed the report in detail noting their concerns that all costs were not included in the original business case. • Estimated costs £50k and a new business case would be presented to FSC for support as required. • AMcG added that next year's Capital Programme will be discussed at Executive's. • Whilst the Chair of FSC confirmed his endorsement of this business case, it had not yet been considered by the Executive. Assuming it was supported at their meeting to be held on 25 January, then FSC Members would be advised by e-mail & the endorsement of the full Committee would be sought to allow matters to progress to the next stage.	The Committee noted and discussed the content	Trust Board for approval in March 2019.
FSC/19/01/15	Draft Operational Plan	• AMcG highlighted key points including requirement to achieve breakeven by 2023/24, non-reliance on FRF (PSF) over 5 years, working through each element of the control total, working with draft tariff data (final release expected 15 March), bi-weekly meetings with CCG continue • Planning Timetable was reviewed	The Committee noted the report, supporting the methodology and amendment to the Internal Planning Timetable	Extraordinary Board 7 February 2019

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NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/03/22 e	COMMITTEE OR GROUP:	TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 March 2019

Date of Meeting	20 February 2019
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/19/02/22	Pay Assurance Dashboard Monthly Report	• January pay was £14.9m against a budget of £15.3m of which £2.1m was temporary staff – note FAU and B3 having significant impact on this • Agency 25.3% above ceiling, central team impact on compliance and applying challenge • January saw recruitment of 47 registered nurses and 50 HCA • NHSI feedback on sickness suggested looking at age profile, short and long, seasonal and consider national scheme of recognising and valuing experience. • Medical appointment include 2 Acute Consultants, 1 D&E / Medicine and 1 Geriatrician / Clinical Director. • HMRC ruling on VAT for Brookson was discussed at length including considering adding to the BAF as increased costs could exceed £100k per month	The Committee reviewed, discussed and noted the report.	Escalation to Board in February and review FSC March 2019

FSC/19/02/23	Risk Register	• No other additions to BAF this month • Advice from STP that large capital bids will not be supported and discussion that an alternative strategy should be discussed at the next Board timeout	The Committee reviewed, discussed and noted the report.	FSC March 2019
FSC/19/02/24	Corporate Performance Report	• January A&E performance is 78.22% which is the lowest it has been for a long time several possible reasons discussed including GPAU being bedded down and reductions in UCC activity. • Diagnostics, RTT and Cancer targets for January met • Discharge issues being reviewed • Reduction in cancelled operations • Acknowledgment that CMTC needs to be used more • B3 should be closed at the end of February but progress on the exit plan has been slow. The Trust is contacting Commissioners daily	The Committee reviewed, discussed and noted the report.	Escalation to Board in February and review FSC March 2019
FSC/19/02/25	Monthly Finance report	• The year to date deficit is £20.6m which is £0.7m off control total excluding PSF. • The position includes £1.3m non recurrent support from the fire • CIP is £1.6m behind plan • PSF excludes Q1 A&E ,Q2 A&E and Q3 A&E. No PSF assumed for month 10 • Work on 121 preparation for court continues • No answer from NHSI on the loan due to be repaid and potential for further loan requirements should the position deteriorate • Royal institute of chartered surveyors have recommended that asset lives potentially need further depreciating and there is a risk of £0.25m in year hit and £1m FYE	The Committee reviewed, discussed and noted the report and the financial challenges faced.	FSC March 2019

FSC/19/02/26	Combined position	• Noted unfunded pressures, CIP and activity issues • Potential mitigations of £4m plus further un-costed CIP	The Committee discussed and noted the presentation.	FSC March 2019
FSC/19/02/27	CIP allocation 2019/20	• Reviewed the suggested methodology of the CIP allocation for 2019/20 based on reference cost. • Methodology supported although further refinement of the data was required	The committee supported the methodology	FSC March 2019
FSC/19/02/27	Capital	• Capital update was noted and draft capital plan will be presented at the next committee.	The committee noted the paper	FSC March 2019
FSC/19/02/28	Service Line Reporting	• Quarterly update presented noting the use of SLR across the Trust and the audit of data submitted placing the Trust 13 out of 101	The Committee noted the paper	FSC July 2019
FSC/19/02/29	Medical staffing review	• Detailed spreadsheet was shared • Focus on Doctors funded, number required and number needed due to processing inefficiencies	The Committee discussed the data presented	Future FSC
FSC/19/02/30	Key issues for escalation	• Risk with forecast outturn • VAT issues with Brookson • 4 hour wait performance deterioration • Waiting information on loan extension		

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Warrington and Halton Hospitals NHS
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CHAIRS KEY ISSUES REPORT

AGENDA REF	BM 19 03 22	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 March 2019

Date of Meeting	**Monday 25th February 2019**
Name of Meeting + Chair	**Audit Committee – Ian Jones, Chair**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
AC/19/02 05	Update from Chairs of Quality Assurance (QAC), Strategic People (SPC) and Finance + Sustainability (FSC) Committees	• Quality Assurance Committee – no matters to escalate • Strategic People Committee – A review of risks and mitigations in relation to training for junior doctors would take place in the next meeting • Finance and Sustainability Committee o Loss of Commissioner contributions, loss of PSF funding and CIP Shortfall o Ongoing matter relating to bad debtors. The matter has been escalated to NHSI & NHSE and meetings requested with both and the Commissioners. The matter would continue to be monitored in FS&C and escalated to the Trust Board as appropriate.	The Audit Committee noted the update	**n/a**

AC/19/02 06	Changes or updates to the BAF	• four new risks have been escalated to the BAF; • the ratings of four risks have been amended (three reduced, one increased); • the titles of two risks have been amended; • eleven risks have been de-escalated from the BAF The Risk descriptions relating to #695 and #241 were discussed and a request made to provide greater clarity in the description of the risk.	Actions to be completed in the Quality Assurance Committee	**Quality Assurance Committee March 2019**
AC/19/02 09	Review Losses and Special Payments Period 11.10.2018-31.12.2018	The Committee particularly noted: • Stock losses £3.5k pharmacy and £22k theatre stock which had been due to a requirement to hold specific items of stock in the case of emergencies which can then go out of date. The Committee were assured that the Supplies Team had undertaken a review of their processes in December 2018. • Improved position compared to cumulative total at Q3 last year, Total (net) Q3 2017-18 £273,679 and Q3 2018-19 £141,440	The Audit Committee noted the update	**Audit Committee April 2019**
AC/19/02 10	Review of Quotation and Tender Waivers Period 1.10.2018-31.12.2018	The Committee particularly noted: • Compared to the same period last year there had been a 28% reduction in the volume and 42% reduction in the value of waivers. • Since the implementation of the revised waiver process on 1st June 2018, there has been a reduction in waivers submitted retrospectively from 69% to 40%.	The Audit Committee noted the update	**Audit Committee April 2019**
AC/19/02 11	Progress Report on Internal Audit Follow-Up Actions to 31 December 2018	The Committee particularly noted: • There are 6 audits with 13 outstanding management actions, of which 12 are overdue. The Committee reviewed and discussed the rolling tracker of actions and progress to conclude outstanding actions • The Committee discussed that Executive Leads should be invited to the Committee to provide assurance on the progress	The Audit Committee reviewed, discussed and noted the report and supported the recommendations.	**Audit Committee ongoing**

		of the actions • The Committee approved the closure of recommendation 4.1 Capital Assets		
AC/19/02 12	Internal Audit Plan 2019-20 + Fees	The Committee reviewed the report and approved Audit Plan 2019-20 and associated fees of £72,450	The Audit Committee approved the audit plan and fees	**Audit Committee ongoing**
AC/19/02 13	Internal Audit Progress Report	The Committee noted the reports that had been issued and reports issued for discussion with management • Financial Systems Review – Substantial Assurance • Data Quality Review - Substantial Assurance • Care and Comfort Rounds Review – Substantial Assurance • MCA/DOLs Review – Moderate Assurance • Safeguarding (Adults) – Moderate The Committee discussed the remedial actions and recommendations required for MCA/DOLs and Safeguarding (Adults) agreed to request an update from the Chief Nurse to be given to the Quality Assurance Committee on 5 March relating to training systems and processes in place.	The Audit Committee reviewed, discussed and noted the report	**Audit Committee ongoing**
AC/19/02 16	External Audit Plan + Fees	The Committee received the proposed 2018/19 External Audit Plan and associated fees.	The Audit Committee reviewed, discussed and noted the report, approved the 2019-20 Audit Plan and fees	**Audit Committee ongoing**
AC/19/02 18	Annual Counter Fraud Plan	The Committee received the proposed Anti-Fraud Workplan outlining the rationale for the Audits, including the frequency, planned delivery dates and Executive and Management Leads.	The Audit Committee reviewed, discussed	**Final Counter Fraud Plan**

			and supported the 2019-20 Draft Annual Counter Fraud Plan and fees	**to April Audit Committee for approval.**
AC/19/0219	Counter Fraud Progress update report November 2018-January 2019	The Committee particularly noted: • The completion of the MIAA and Counter Fraud joint Overtime Review who were with HR Team to enhance and strengthen existing arrangements in respect of timely authorisation of overtime. Overtime Policy to be updated to include Counter Fraud statement. • A referral relating to an investigation of an employee who had been working at another organisation whilst off sick from the Trust. • The Committee supported the inclusion of Counter Fraud Awareness training as part of the Trust Mandatory Programme	The Audit Committee reviewed, discussed and noted the report.	**Audit Committee ongoing**
AC/19/0223	GDPR Action Plan	The Committee received an update from the Chief Information Officer on the progress of the GDPR action plan noting that action being taken to ensure the correct resources are in place to support the actions.	The Audit Committee noted the update and asked that a further update be provided at the next meeting	**Audit Committee April 2019**

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/23**			
SUBJECT:	**Performance Assurance Framework Review**			
DATE OF MEETING:	27th March 2019			
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Deputy Chief Executive & Medical Director Kimberley Salmon-Jamieson, Chief Nurse Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Chris Evans - Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	The Performance Assurance Framework (PAF) and Integrated Performance Report (IPR) key performance indicators are reviewed on an annual basis. A key change to the PAF is the introduction of a Quality, People and Sustainability (QPS) full service review for each CBU. It is proposed the CBU level performance reports are part of the QPS full service review arrangements.			
PURPOSE: (please select as appropriate)	Information	Approval X	To note	Decision
RECOMMENDATION:	The Trust Board is asked to support the recommended amendments to the Trust PAF and IPR key performance indicators set out in this paper.			
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	Performance Assurance Framework Review	AGENDA REF:	BM/19/03/23

1 BACKGROUND/CONTEXT

The Performance Assurance Framework (PAF) sets out the approach the Trust will take in ensuring there are effective systems in place to monitor and manage performance. This paper outlines the proposal for changes to how performance is monitored and managed at CBU level. In addition, this paper outlines proposed changes to Trust level key performance indicators which have been agreed at the relevant committees.

The PAF has been updated to reflect changes in the governance and management structure (See Appendix 1).

2 KEY ELEMENTS

Updates to the Performance Assurance Framework

Following approval by the Trust Board, the PAF was rolled out to CBUs ensuring they were aware of how performance would be monitored and managed throughout the organisation, to include the introduction of Segmentation and Support Classification.

The Executive Committee meets with CBU Managers to review performance when performance is not at the required level. There have been occasions when a CBU has been temporarily placed in mandated support where performance levels continued to fall below the required standard.

The terms of reference of the Trust Operational Board (TOB) have been updated and has removed the CBU Integrated Performance Report (IPR) as an agenda item from that meeting. Therefore, the revised PAF proposal will see performance reporting take place within the monthly KPI sub-committee chaired by the Trust's Chief Operating Officer and twice yearly at the QPS full service review. Performance monitoring will also take place at the Trust Board sub-committees and at the Trust Board. The Trust Board and sub-committees can at any time, request a deep dive in to performance for any areas of concern.

The internal audit programme has been updated to reflect the annual review of KPIs to support external validation of the accuracy of the information reported. In 2018/19 the KPIs that were reviewed (Diagnostic 6 Weeks, Safety Thermometer and Sickness Absence) resulted in an outcome of substantial assurance. Further reviews will take place as part of the 2019/20 audit programme.

The Trust Accountability, Responsibility and Information Reporting Structure – Ward to Board has been updated in **Appendix 2** to reflect the proposed changes to the performance reporting structure. **Appendix 3** shows the previous Ward to Board Reporting Structure.

2019/20 Key Performance Indicator Refresh

The Integrated Performance Report (IPR) dashboard brings together indicators from a range of areas including contractual standards and indicators relating to NHSI's Single Oversight Framework. This dashboard provides assurance and oversight of performance at Trust Board level. The IPR is reviewed at each Trust Board meeting under the headings of Quality, Access & Performance, Workforce and Finance & Sustainability. In line with the PAF, key performance indicators are reviewed annually.

The Contracts & Performance Team has met with Executive and Operational leads to review current indicators and to ascertain requirements for new indicators. In addition, the 2019/20 NHS standard contract and Single Oversight Framework have been reviewed to understand changes which may affect performance monitoring. The recommendations below have been approved by; Quality & Assurance Committee (Quality), Strategic People Committee (Workforce) and the Finance & Sustainability Committee (Access & Performance & Finance).

The following tables contain the recommended removals, updates and new KPIs:

Indicators Removed

KPI	Proposed Changed	Rationale
Quality		
None		
Access & Performance		
None		
Workforce		
Top 10 – High Cost Agency Workers	Removal from Trust IPR.	These indicators will be replaced with the Bank & Agency Reliance and Agency Shift Compliance indicators outlined in the new indicators table. The new indicators will help to better manage and monitor agency usage. Agency spend is also monitored in the Finance section of the IPR.
Top 10 – Longest Serving Agency Workers	Removal from Trust IPR.	
Agency/Bank Medical Spend	Removal from Trust IPR.	
Agency/Bank Nursing Spend	Removal from Trust IPR.	
Agency/Bank AHP Spend	Removal from Trust IPR.	
Finance		
Fines & Penalties	Removal from Trust IPR.	The Trust has signed up to a CEP lite contract with CCG commissioners in which it has been agreed not to levy local fines and penalties.

Indicators Updated

KPI	Proposed Changed	Rationale
Quality		
Incidents	Remove "Number of Open Incidents" as a line on the graph. Include the "Number of Open Incidents breached – 20 days" Change the "Total Number of Incidents" to "Total Number of Reported Incidents". Remove "Never Events" from the RAG rationale.	To ensure performance is reviewed in line with the Trust's incident management policy.
CAS Alerts	Remove the "Total Number of Outstanding CAS Alerts" from the graph.	This change will focus the CAS alerts on those which have breached.
Healthcare Acquired Infections – Gram Negative Ecoli, Klebsiella, Pseudomonas	Change the RAG rating to be based on the annual agreed threshold for each infection. The RAG rating will only go Red if the Trust surpasses the agreed threshold.	This change will ensure the thresholds are in line with new standards and that the performance against the RAG rating is monitored more effectively.
Sepsis	Remove the word CQUIN from the indicator.	Sepsis is not a CQUIN in 2019/20; however Sepsis remains a contractual indicator.
Total Falls	Change the RAG rating to profile 20% reduction on 18/19 – indicator will not go Red unless the Trust is unable to achieve the 20% reduction in 19/20.	This change will align the indicator with the Trust's Quality Strategy.
Pressure Ulcers	Category 4 – no change Category 2 & 3 –confirmation regarding the thresholds. This should be an YTD position.	This change will ensure the RAG rating is monitored more effectively and will align the indicator with the Trust's Quality Account.
NICE Compliance	To report both partial and non-compliance as part of the indicator.	This change will ensure compliance is monitored thoroughly.
Complaints	Set timeliness indicator to 90%.	This change will ensure that we are better able to monitor improvement timelines.
Access & Performance		
Cancelled Operations	Amend the indicator to show a % of patients with a cancelled operation rather than a number. The threshold to be set at 2%.	This indicator is not contained within the NHSE standard contract or single oversight framework; however it remains an important measure. The change will bring the Trust in line with peers.
Workforce		
Monthly Pay Spend (Contracts & Non Contracted)	Additional graph against the KPI which shows monthly Bank, Agency, Overtime and WLIs.	Additional detail to clarify the breakdown of pay spend. This proposal mirrors the information presented to Finance and Sustainability Committee.

Staff Group Sickness Absence	Additional graph against the KPI which shows sickness broken down by staff group.	Additional information to clarify the breakdown of sickness absence across staff groups – not to be RAG rated.
Finance		
None		

New Indicators

KPI	Proposed Changed	Rationale
Quality		
None		
Access & Performance		
Urgent operations cancelled for a second time	A new indicator which shows the number of patients who has had an urgent operation cancelled for a second time.	This requirement is set out in the NHS standard contract.
Waits in A&E no longer than 12 hours	A new indicator which shows the number of patients who has experienced a wait in A&E longer than 12 hours.	This requirement is set out in the NHS standard contract.
Workforce		
Vacancy Rates	% of Trust vacancies against whole time equivalent. RAG rating to be based on 9% target (current National Median on NHSI Model Hospital).	Vacancies across the workforce are the most commonly occurring reason for use of temporary staffing, as well as impacting a number of other metrics such as sickness absence.
Retention	Staff retention rate % over the last 12 months. RAG rating to be based on 86% target (current National Median on NHSI Model Hospital).	This measure is included within Use of Resources and it is therefore recommended that the Trust Board have oversight of compliance with target and mitigating actions in place/planned.
Bank & Agency Reliance	Trust reliance on bank/agency staff against the peer average. RAG rating to be based on 9% target (current Peer Median on NHSI Model Hospital – please note that National Median is not currently available).	Bank and agency reliance impacts the Trust financial position, as well as impacting across the 'Quality' and 'People' agendas. It is therefore recommended that the Trust Board have oversight of reliance, compliance with target and mitigating actions in place/planned.
Agency Shifts Compliant with the Cap	% of agency shifts compliant with the Trust cap against peer average. RAG rating to be based on 49% ceiling (current National Median on NHSI Model Hospital).	Agency shift compliance with the price cap impacts the Trust financial position, as well as impacting across the 'Quality' and 'People' agendas. This information is reported to NHSI. It is therefore recommended that the Trust Board have oversight of reliance, compliance with target and mitigating actions in place/planned.

These changes will result in following number of indicators:

	2018/19	2019/2020
Quality	30	30
Access & Performance	19	21
Workforce	12	11
Finance	10	9
Total	**71**	**71**

3 ACTIONS REQUIRED/RESPONSIBLE OFFICER

Once approved by the Trust Board, these changes will be implemented from 1st April 2019.

4 RECOMMENDATIONS

The Trust Board is asked to support the proposed amendments to the PAF and updates to the Trust IPR key performance indicators as set out in this paper.

Appendix 1
Proposed Performance Assurance Framework

Warrington and Halton Hospitals
NHS Foundation Trust

Performance Assurance Framework

Performance Assurance Framework

1. Introduction

1.1 Background

This Performance Assurance Framework has been developed to provide clarity of accountability and responsibilities from Ward to Board, and to effectively manage and improve performance.

The Performance Assurance Framework will ensure that an integrated approach to managing performance is embedded throughout the Trust and there are clear lines of accountability from Board to Ward/All departments. The Board and other key stakeholders need to understand, monitor and assess the Trust's performance, and to identify appropriate action to be taken when performance deteriorates. Information must be timely, accurate and complete and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

1.2 Scope

The Performance Assurance Framework covers all performance requirements set out in the Trust's Operational Plan, NHS Improvement Single Oversight Framework, NHS Standard Contract and Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff makes to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust Performance Management Policy/Incremental Pay Progression Policy.

1.3 Dependencies

To continually develop the performance culture of the organisation through an increased use of broader business intelligence, including outcome measures which provide a wider insight beyond headline KPIs, delivery against the Performance Assurance Framework will be dependent upon the production of information dashboards and reports by the Trust's Information Team.

1.4 Associated Polices and Strategies

Whilst the Performance Assurance Framework incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures that will contribute to the delivery of this Performance Assurance Framework. The Performance Assurance Framework will support achievement of the Trust's vision, mission, objectives and values (**Appendix 1**).

2. Role and Function of the Performance Assurance Framework

2.1 Main Purpose

This Performance Assurance Framework sets out the approach the Trust will take in ensuring there are effective systems in place to track and monitor performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate remedial actions put in place to bring performance back to an acceptable level. The Performance Assurance Framework will:

- Set out clear lines of accountability and responsibility for delivery of KPI's from Board to Ward/all departments.
- Provide assurance to the Board, Governors, stakeholders and the public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Support the achievement of the Trust's objectives.

- Support the delivery of the requirements of the Trust's Foundation Trust Licence, NHS Improvement Single Oversight Framework and the NHS Standard Contract.

- Support the delivery of high quality patient care.

- Provide focus on and assurance of best value for money ensuring that services provided meet the needs of the local population and local health economy.

- Support the delivery of an engaged, motivated workforce with the right skills and numbers to provide consistent good quality care.

3. Approach to Performance Management in the Trust

3.1 **Ward to Board Accountability Structure**
The accountability structure provides a line of sight from ward to Board and Board to ward as set out in **Appendix 2** and is detailed as follows:

3.2 **CBUs/Wards/Departmental Meetings**
The CBUs/Wards/Departments will be able to access performance information to enable them to monitor performance and ensure the required levels of performance are being delivered. The CBUs/departments are required to take corrective action to improve areas of underperformance.

3.3 **KPI Sub-Committee**
The KPI sub-committee chaired by the Trust's Chief Operating Officer will review CBU performance and hold the CBUs to account for performance delivery. The sub-committee will agree remedial action plans to address areas of concern.

3.4 **Quality, Performance and Sustainability (QPS) Full Service Review by Executive Committee**
The QPS will be chaired by the Chief Executive and will scrutinise the performance of CBUs in all areas. CBUs will be required to attend QPS at least twice a year for a full service review. Actions from QPS will be recorded in the minutes and by a member of the Performance team, who will also be in attendance. If urgent actions are required the CBU will provide an update to the next available QPS meeting and will not wait until their next bi-annual review. All actions will be monitored by the Performance team and progress will be reported at the monthly KPI sub-committee to ensure action plans are being progressed and performance is improving.

3.5 **Board Committees**
Executive directors and senior leaders of the Trust will present updates on performance as appropriate at Trust Board Committees. The Committees can request improvement trajectories and deep dives from the Executives and senior leaders where there are any performance concerns. Any concerns are escalated to the Trust Board via the committee Chair reports.

3.6 **Trust Board**
The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with explanation by the Executive Directors. The report highlights reasons for any under performance and/or performance deterioration, and assurance that investigations are taking place together with the implementation of appropriate remedial action plans for recovery of underperformance.

3.7 **Performance Team**

The Performance team will provide training to the CBUs so that all staff have sight and understanding of the performance KPIs they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.8 **Adverse Performance**

All actions and interventions relating to adverse performance will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support recognising any organisation wide resource needs.

3.9 **Remedial Action Plans**

A standardised remedial action planning process will be utilised for all KPIs that are underperforming to ensure there are clear remedial action plans.

4. Performance Reports

4.1 Trust Board

The production of quality, meaningful and timely performance information is fundamental to the delivery of the Performance Assurance Framework (PAF). The Trust has developed and produces a monthly integrated performance report (IPR) for the Board. Each Committee identifies the KPIs which will be reported on. These will include all Single Oversight Framework and contractual indicators as well as specified CQC indicators. Each committee, executive directors and senior leaders of the Trust will review the Board IPR and make recommendations for amendments. The Board will receive the proposed amendments for approval. **Only once Board has approved and minuted a change to its KPIs will it be included, amended or removed from the Board IPR.** The KPIs will be reviewed and refreshed at least annually prior to reporting on the new financial year. When any change has been approved, as set out above, the respective Executive Lead will liaise with the Performance team to action in partnership with the Information Team.

4.2 Board Committees

Each Committee receives regular performance reports as part of its agenda. The KPI's contained in the Committee reports can be changed by approval of committee members as there may be occasions where the committee wants to report at a more granular level. Any changes to KPIs need to triangulate to the Board IPR. All changes must be minuted to include the rationale for the change

4.3 QPS Service Review

Prior to the QPS service review, the Performance team will prepare a report which contains performance information relating to quality & governance, operational performance, people and finance. The report will also include information about current issues, risks and future plans.

4.4 KPI Sub-Committee

The monthly KPI sub-committee receives a CBU level IPR. This information is used by the Trust's Chief Operating Officer, Deputy Chief Operating Officer and all CBU Managers to review CBU performance, agree any remedial action plans, and prepare for the QPS service review.

5. Structure and Governance to ensure delivery

5.1 Accountability, Responsibility and Reporting Structure

The Trust's Accountability, Responsibility and Information reporting structure is set out in Appendix 2. Each Committee has a Terms of Reference, setting out clear roles and responsibilities, objectives and membership and the devolved responsibilities.

5.2 **Earned Autonomy Framework**

There is a vision to further enhance the Performance Assurance Framework by developing a culture where good performance is recognised and rewarded. One way of achieving this is by introducing an Earned Autonomy Framework across the Trust. Earned autonomy focuses on empowered leadership and devolving levels of decision making to Divisions and the Clinical Business Units in recognition of sustained good performance. The possibility of a Trust Earned Autonomy Framework that is aligned to the performance segmentation classifications will be explored further with a recommendation being presented to Trust Board for approval.

6.0 Next Steps

This updated Performance Assurance Framework will be presented to the Trust Board in March 2019 along with the proposed IPR for 2019/20.

Our Vision: 'To be the most clinically and financially successful healthcare provider in the Mid-Mersey region'

Our Mission: 'To provide high quality, safe integrated healthcare to all our patients'

Our Strategic Objectives - (*What we need to do):*

4. 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.

5. To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.

6. To deliver well managed value for money, sustainable services.

7. To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.

Our Core Values - (*How we need to do it):*

Working Together: 'We promise an environment where patient care is paramount and our staff matter'

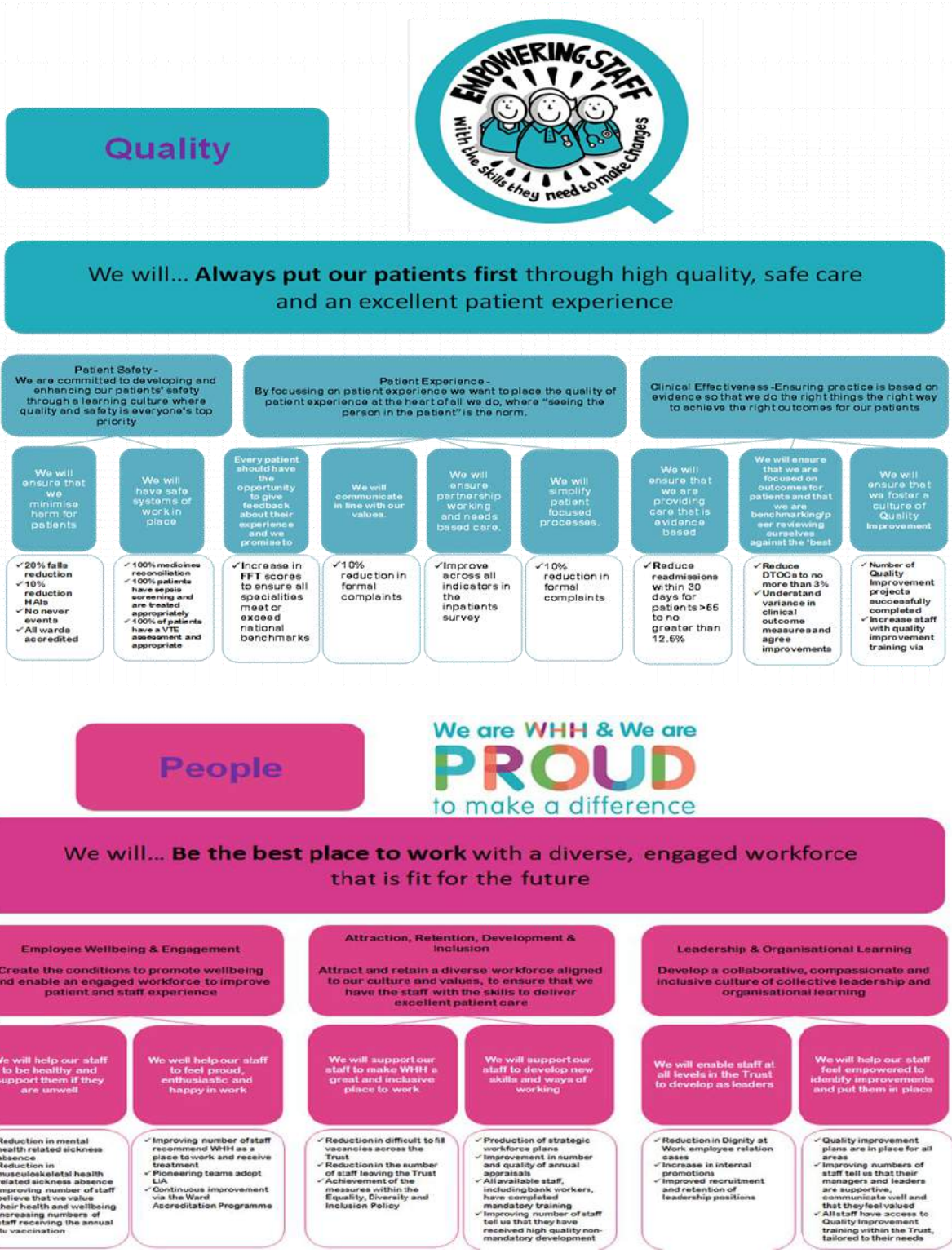
Excellence: 'We ensure excellence across our teams in providing the best care for our patients'

Accountable: 'We make sure that everyone is involved in making decisions'

Role Models: 'We inspire and innovate through great leadership to provide excellent care for our patients'

Embracing Change: 'We are open to new ideas from patients, the public and everyone in our team'

Our QPS Aims and Objectives:



Sustainability

We will... **Work in partnership** to design and provide high quality, financially sustainable services

Play a central role in our healthcare economies to support integrated place based care.

- Provider of integrated services, intermediate care and care home services.
  - ✓Grow proportion of services delivered in the community.
- Improved pathways for local residents so everyone receives the right support, care and treatment at the right time.
  - ✓Level of acute activity (non-elective admissions) to remain the same or reduce, in environment of growing
- Strong relationships and collaborative working with all partners
  - ✓Success of One Halton, Warrington Together and Cheshire and Mersyside health and care partnership

Work with other acute care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable.

- Ensure services meet the demand of our populations.
  - ✓Repatriate Warrington and Halton activity to priority services.
- Provide services on behalf of others where our services are clinically and financially superior.
  - ✓Number of services which we deliver on behalf of partners
- Disinvest in or transform services which are not financially sustainable and do not currently provide high quality
  - ✓Retain and where appropriate, grow priority services.
- Share best practice and collaborate to ensure best outcomes for our populations.
  - ✓Understand unwarranted variation in clinical outcome measures across all specialities, measure and agree improveme
- Maintain and then improve financial position.
  - ✓Improve profitability of services.
  - ✓Maintain and then improve system financial position

Provide our services in an estate that is fit for purpose, supported by technology, and aligned to the needs of our developing populations.

- New hospital and wellbeing campus in Halton.
  - ✓Secure funding.
  - ✓Delivery of milestones on trajectory, including Strategic Outline Case.
  - ✓Updated
- New hospital in Warrington.
  - ✓Secure funding.
  - ✓Delivery of milestones on trajectory, including Strategic Outline Case.
  - ✓Identify site
- Recognised digital exemplar.
  - ✓Delivery of milestones in IM&T strategy on trajectory.

Appendix 2 – Proposed - Trust Accountability, Responsibility and Information Reporting Structure – Ward to Board

Ward

CBU/Ward/Departmental Meetings

- CBUs/Wards/department leaders
- Review performance at granular level weekly and take corrective action as appropriate.
- CBU Managers report up to KPI

KPI Sub-Committee

- Full review of performance at CBU level specific
- Identify any risk/issues and agreement of remedial action plans.
- Preparation for bi-annual OPS review
- Monitoring of remedial actions arising from QPS

Quality, Sustainability and People (QPS) Full Service Review with Executive Committee

- Executive Committee holds CBUs to account
- QPS performance reports at CBU Level
- Meeting is held monthly with Monthly with CBUs attending bi-annually on a rotational basis.

Board Committees

- Executive Director/Senior Leaders attend meetings
- Board Committees review their performance reports/dashboards
- Deep dives requested by Committee where concerns about performance
- Committee assures Board through key issues reports and escalates any issues to Trust Board

Trust Board

- Integrated Performance Report presented by Executive Directors
- Receiving concerns raised by Committee Chairs
- Board request additional actions and assurance where necessary
- Bi-Monthly meeting

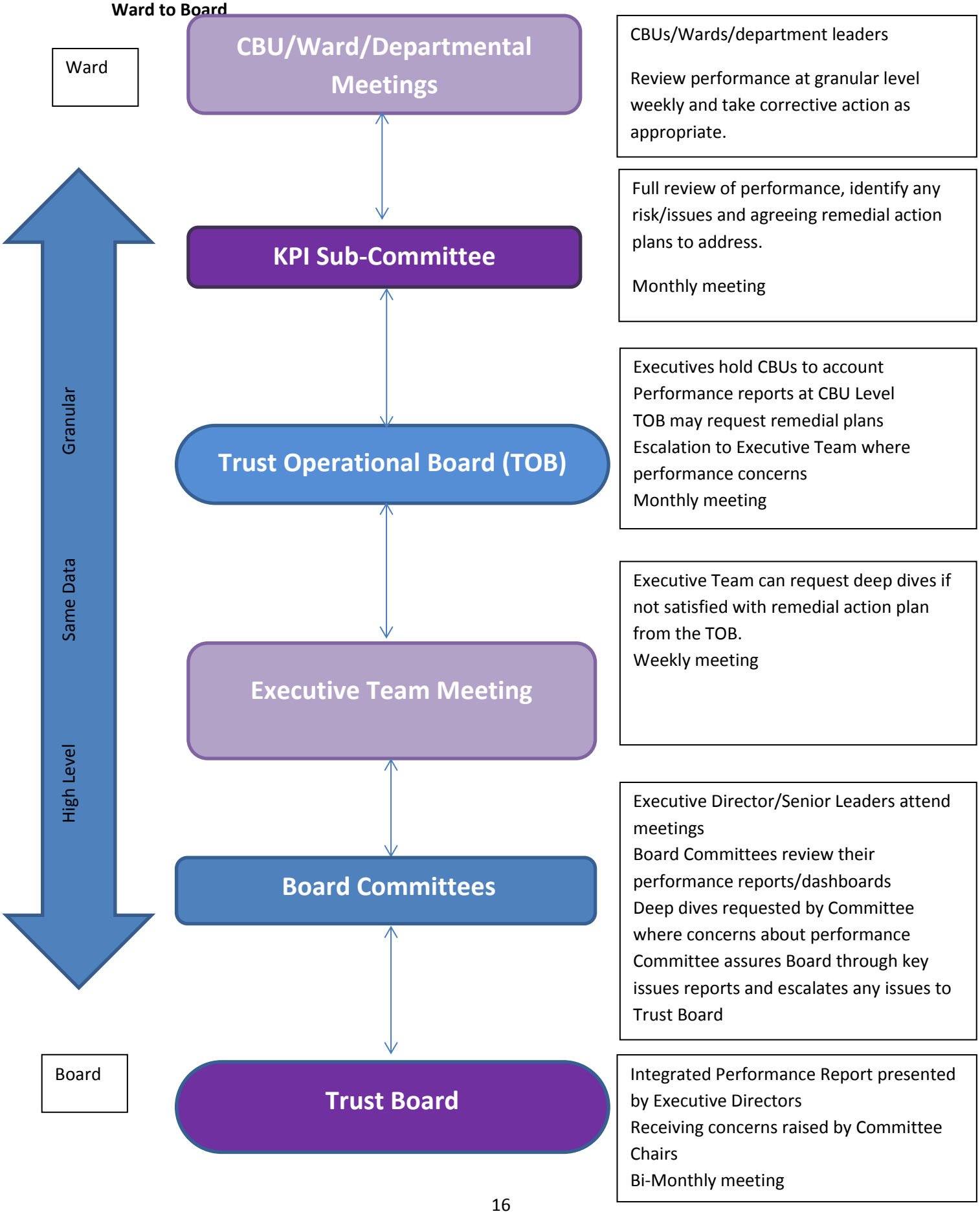
Granular

Same Data

High Level

Board

Appendix 3 – Current - Trust Accountability, Responsibility and Information Reporting Structure – Ward to Board



Appendix 4 – 2018/19 Trust KPIs

	2018/19 KPIs	Target/Threshold/Tolerance
	Quality Improvement	
1.	Incidents	Never Events – Zero Tolerance, No Incidents opened over 40 days
2.	CAS Alerts	All actions to be completed within timescales
3.	Duty of Candour	Zero Tolerance
4.	Adult Safety Thermometer	95%
5.	Children's Safety Thermometer	85%
6.	Maternity Safety Thermometer	74%
7.	Health Care Acquired Infections – MRSA	Zero Tolerance
8.	Health Care Acquired Infections – CDIFF	Zero Tolerance
9.	Health Care Acquired Infections – Gram Negative Blood Infections	Zero Tolerance
10.	VTE Assessment	95%
11.	Safer Surgery	Zero Tolerance
12.	CQUIN Sepsis AED Screening	90%
13.	CQUIN Sepsis Inpatient Screening	90%
14.	CQUIN Sepsis AED Anti-biotics	90%
15.	CQUIN Sepsis Inpatient Anti-biotics	90%
16.	CQUIN Sepsis Anti-biotic review	90%
17.	Total Fall & Harm Levels	20% reduction for 2018/19 using 2017/18 as a baseline
18.	Pressure Ulcers	Category 4 - Zero Tolerance Category 3 – less than 3 Category 2 – less than 7
19.	Medication Safety	Incidents of Harm - Zero Tolerance
20.	Staffing Average Fill Rates	90%
21.	Care Hours Per Patient Day	N/A

22.	Mortality Ratio - HSMR	Within expected range.
23.	Mortality Ratio - SHMI	Within expected range.
24.	Total Deaths	N/A
25.	NICE Compliance	100%
26.	Complaints: • Received • Dissatisfied • Total cases open • Total cases over 6 months old	Improvement Trajectory
27.	Friends & Family Test – Inpatients	95%
28.	Friends & Family Test – A&E	87%
29.	Mixed Sex Accommodation	Zero Tolerance
30.	CQC Insight Composite Score	1.5
	Access & Performance	
31.	Diagnostic Waiting Times 6 Weeks	99%
32.	RTT Open Pathways	92%
33.	RTT Number of Patients Waiting 52 Weeks +	Zero Tolerance
34.	A&E Waiting Times – National Target	95%
35.	A&E Waiting Times – STP Trajectory	Improvement Trajectory
36.	Cancer 14 Days	93%
37.	Breast Symptoms 14 Days	93%
38.	Cancer 31 Days First Treatment	96%
39.	Cancer 31 Days Subsequent Surgery	94%
40.	Cancer 31 Days Subsequent Drug	98%
41.	Cancer 62 Days Urgent	85%
42.	Cancer 62 Days Screening	90%
43.	Ambulance Handovers 30 – 60 Minutes	Zero Tolerance
44.	Ambulance Handovers – 60 Minutes or more	Zero Tolerance
45.	Discharge Summaries - % sent within 24 Hours	95%
46.	Discharge Summaries not sent within 7 Days	5% Tolerance
47.	Cancelled Operations on the Day for Non-Clinical Reasons	Zero Tolerance
48.	Cancelled Operations on the Day for Non-Clinical Reasons – not readmitted within 28 days.	Zero Tolerance
49.	Super Stranded Patients	Improvement Trajectory
	Workforce	
50.	Sickness Absence	Below 4.2%
51.	Return to Work	85%
52.	Recruitment	Below 65 days
53.	Turnover	Below 13%
54.	Non-Contracted Pay	Within budget
55.	Agency/Bank Nurse Spend	Less than 2018/19
56.	Agency/Bank Medical Spend	Less than 2018/19
57.	Agency AHP Spend	Less than 2018/19
58.	Core/Mandatory Training	85%
59.	PDR	85%
60.	Top 10 - High Cost Agency Workers	Less than previous month

61.	Top 10 – Agency Worker Length of Service	Less than previous month
	Finance	
62.	Financial Position	On plan and in a surplus position
63.	Cash Balance	On or greater than plan
64.	Capital Programme	Within 90 – 100% of plan
65.	Better Practice Payment Code	95%
66.	Use of Resources Rating	Use or Resources Rating 1 and 2
67.	Fines & Penalties	Zero Tolerance
68.	Agency Spending	Equal to or less than agency ceiling
69.	Cost improvement Programme Performance to Date	On or above plan
70.	Cost Improvement Programme Plans in Progress (In Year)	On or above plan
71	Cost Improvement Programme Plans in Progress (Recurrent)	On or above plan

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/24**
SUBJECT:	**Ward to Board Visits**
DATE OF MEETING:	27th March 2019
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive
LINK TO STRATEGIC OBJECTIVES:	All
	Choose an item.
	Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	In April 2018, the Trust re-introduced its Ward to Board Assurance visits. The visits are undertaken by both Non-Executive Directors and Executive Directors and complement and support the visits already undertaken by the Council of Governors, the Executive walk rounds and the Chair & Chief Executive joint visits. The report includes details of the 31 visits undertaken, examples of areas of good practice and areas for development identified and examples of actions taken as a consequence

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

RECOMMENDATION:	The Board is asked to note the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

Board of Directors

SUBJECT	Ward to Board Visits	AGENDA REF:	BM 19/03/XXX

1. BACKGROUND/CONTEXT

The purpose of the report is to update the Board on the Ward to Board Assurance visits.

In April 2018, the Trust re-introduced its Ward to Board Assurance visits. The visits are undertaken by both Non-Executive Directors and Executive Directors and complement and support the visits already undertaken by the Council of Governors, the Executive walk rounds and the Chair & Chief Executive joint visits.

The schedules of visits include both Wards and Departments, clinical and non-clinical and take place across both Warrington and Halton Hospitals, and the Cheshire & Merseyside Treatment Centre.

The aim of the visits is to aid triangulation and test the information gathered and reported through the Governance Committees, Governor Visits, Friends and Family Tests, Staff Surveys, complaints, compliments and PALs feedback.

The visits further help ensure there is comprehensive coverage of the hospital and supports enhancing the visibility of the Board of Directors throughout the Trust.

2. KEY ELEMENTS

All Non-Executive Directors and Executive Directors have taken part in the visits.

To date, 31 visits have taken place and Wards/Departments are detailed below:

Ward/Dept	CBU
Ward B18	Spec Med
Ward A9	MSK
CMTC	MSK
HDU	Medical Care
CRITICAL CARE	Medical Care
C21	Medical Care
Radiology	Diagnostics
Ophthalmology	Specialist Surgery
Maternity	Women's & Children's
Main Outpatients	Diagnostics & Outpatients
Pathology	Diagnostics & Outpatients

B19	Integrated Medicine & Community
Audiology	Specialist Surgery
Estates	
Ward B11	Women's & Children's
Pharmacy	
Fracture Clinic, Physio & Therapies	MSK
Palliative Care	Integrated Medicine & Community
Programme Investigation Unit [PIU] (Halton)	Digestive Diseases
Pathology WARRINGTON	Diagnostics & Outpatients
Frailty Assessment Unit (FAU)	Integrated Medicine & Community
Mortuary	Diagnostics & Outpatients
ITU	Medical Care
C20	Women's & Children's
FAU	Integrated Medicine & Community
Cheshire & Merseyside Treatment Centre (CMTC)	MSK
B18	Integrated Medicine & Community
Pathology HALTON	Diagnostics & Outpatients
Halton Site Visit	General Site Visit
B18 Confirmed	Integrated Medicine & Community
ICU	Medical Care

A further 9 visits are currently confirmed up to the end of June 2019.

As part of the visits, the Non-Executive Directors and Executive Directors look for areas of good practice, areas for development and may take the opportunity to ask patients, carers and staff about their experiences.

Good Practice Themes

There have been a number of clear themes relating to areas of good practice that have been reported across several Wards and Departments. These include:

- Clean and tidy environment
- Welcoming and warm attitudes
- Sharing of Lessons Learned
- Staffing – either low turnover or improved staffing levels
- Excellent patient care

Other notable areas of good practice reported include the response to the Ward Accreditation Programme and Safeguarding processes.

Areas for Development - Themes

Only one recurring theme for development has been reported across the Trust sites and that is related to the old estate.

Many of the other development areas identified were 'local' to that specific ward or department; examples of which are detailed below:

- Empty hand gel dispensers
- Anxiety about the Ward Accreditation process
- Lack of Storage of clinical equipment and housekeeping goods
- IT (ICE system vs Paper)
- Staffing Levels

Areas of good practice and areas for development are fed back to the relevant executive lead for appropriate action to be taken. Examples of these actions include:

- Empty hand gel dispensers – there is ongoing hand hygiene and infection control audits in place, which are conducted regularly. Where hand gels are empty on ward visits, this has been escalated appropriately on the day of the visit and rectified
- Anxiety about the Ward Accreditation process – all wards have now been accredited through the Ward Accreditation Scheme and staff have responded more positively. When staff do have a bronze award, support is available to help get an action plan in place. This support is given from the senior nursing team, but also Quality Improvement training is being rolled out across the Trust via the Trust Quality Academy
- Lack of Storage of clinical equipment and housekeeping goods – Ward Accreditation has supported this area – as there has been a programme of prioritised ward estates works agreed at a senior level – this has included storage and this work is to be completed by end March 2019.
- IT (ICE system vs Paper) – the Trust has invested in the ICE system and reviewed the Trust's Diagnostic Policy and procedures – so that the majority of diagnostic tests are reported through ICE. This is part of the Trust's wider clinical Informatics strategy
- Staffing Levels – This has prompted reviews and investments into key areas of identified risk within the Trust, including a £3million investment into nurse staffing agreed by the Board. In addition key investments have been made in medical staffing and other areas like pharmacy and microbiology and we have piloted and recruited in to new roles like the Nurse Associate. We have also invested in key safety roles within the Trust to lead the agenda; Associate Medical Director and Associate Chief Nurse, Patient Safety and Safety Nurse roles. We manage daily risks through safety huddles, escalation processes and ensuring patient safety is not compromised by ensuring safe staffing numbers.
- Nomination of an individual for a role model badge
- Purchase of additional lockable trollies for case notes
- Increase in communications relating to the Freedom to Speak up Guardian

3. RECOMMENDATIONS

The Board are asked to note the report.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/25**
SUBJECT:	**Hospital Volunteers Annual Report – "Making a difference at WHH"**
DATE OF MEETING:	27 March 2019
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
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	Wellbeing Enterprises have provided day to day operational management of the Trust's Volunteer Service for the last 3 years. The attached report identifies the work undertaken over this time with key highlights to be noted as: - Overhauled the Trust's volunteer recruitment process and recruited 587 volunteers offering over 300 volunteer hours per week, increasing volunteer numbers from 30 in 2016 to 587 in 2019; a 91% increase. - Worked with the Chief Nurse & Deputy Chief Nurse to develop a range of new volunteering opportunities that support Trust quality and safety priorities with 57 different role opportunities created such as ward buddy, discharge support, way finder, patient simulation, meet and greet, courtesy calling and friends & family testing. - Currently developing roles with regard to the Reader project and aim to introduce Pets as Therapy during April 2019. - Provide a specific induction programme - Implemented an electronic volunteer management portal enabling volunteers to track their progress, record their volunteering hours and training along with access to available roles and relevant information.

	It is intended to extend the current contract with Wellbeing Enterprises for a further year, with a re-tender process being undertaken in early 2020.			
PURPOSE: (please select as appropriate)	Information	Approval	To note x	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

VOLUNTEERING

Making a difference at WHH

We are WHH VOLUNTEERS

Halton & St Helens Voluntary and Community Action

Wellbeing enterprises

FORWARD

We are immensely proud of our volunteers who, like our staff continue to support our hospitals with great care and compassion. Working with Wellbeing Enterprises and Halton & St Helens VCA has enabled us to grow our pool of local volunteers.

Volunteers generosity and kindness impacts each and every day on patients' care experiences, being invaluable in providing a helping hand and a listening ear to patients receiving treatment.

Our volunteers have also brought many creative ideas and a positive energy onto the wards and departments, helping to lift the spirits of patients and staff.

From all the staff at the Trust, thank you to each volunteer who has generously gifted their time to help others. Your generosity is an asset that we all value immensely.

Mel Pickup
Chief Executive

INTRODUCTION & BACKGROUND

In 2016, Wellbeing Enterprises CIC (WE) and Halton & St Helens VCA were awarded the contract to deliver the Volunteer Management Programme at Warrington & Halton Hospitals NHS Foundation Trust. The Trust had a bold ambition to transform and modernise its volunteering pathway and our vision for how to do that captured the imagination of the Trust's leadership team.

WE is an award winning social enterprise, having won the Health Service Journal Award for Primary Care Innovation in 2015 and an Askoka Fellowship in 2017 for contributions to health and care innovation. They have over 10 years' experience delivering community wellbeing approaches to enhance patient outcomes and support demand management strategies in primary and secondary healthcare services.

VCA and our Volunteer Centre offer holds the national Volunteer Centre Quality Accreditation, which it has gained again for the 4th consecutive time in 2016, with special reference from the independent standardisation panel for a high quality submission in particular for our training delivery work with WE around developing the skills for volunteer management for H&SC settings. Over the past 20 years the Volunteer Centre's have helped recruit more than 10,000 volunteers for local groups and projects.

We wanted to support the Trust to achieve an increase in volunteer numbers, to modernise and enhance the volunteer recruitment process, but more importantly we felt we could support the Trusts ambition to be a health promoting Trust, using a trained and supported volunteer workforce to promote wellbeing, enhance the quality of services, add value to the work of staff and support the improvement of patient experiences whilst in hospital or accessing hospital services.

It was our intention to demonstrate that volunteering and the award-winning wellbeing approaches delivered by WE could set out a new way of working for the Trust, closely aligned with work to transform clinical services by utilising social and voluntary action as a way of enhancing NHS services

WHAT HAVE WE DONE?

This began for us in June 2016 after we signed and agreed our contracts. Both WE and VCA support the volunteering work in the hospital trust. Between our two organisations we employ 2 members of staff who lead this work. They are based mostly at Warrington hospital site, but they also provide cover to the Halton Hospital site too.

IN THE PAST 2 YEARS WE HAVE:

- Overhauled the Trust's volunteer recruitment process and used our understanding and knowledge of good practice in volunteer management and the feedback from volunteers and staff using the process to support the development of a new way of working. This has helped us speed up the time it takes, ensure that volunteers are aware of what it is happening and are trained, checked and ready to go when they have identified a role. This was particularly important in light of the Saville Review and it ensured the Trust was compliant.

- Contacted every volunteer registered on the Trust's system to ensure they knew about the changes to the service, were able to contact the new staff team and we could establish current levels of interest in volunteering.

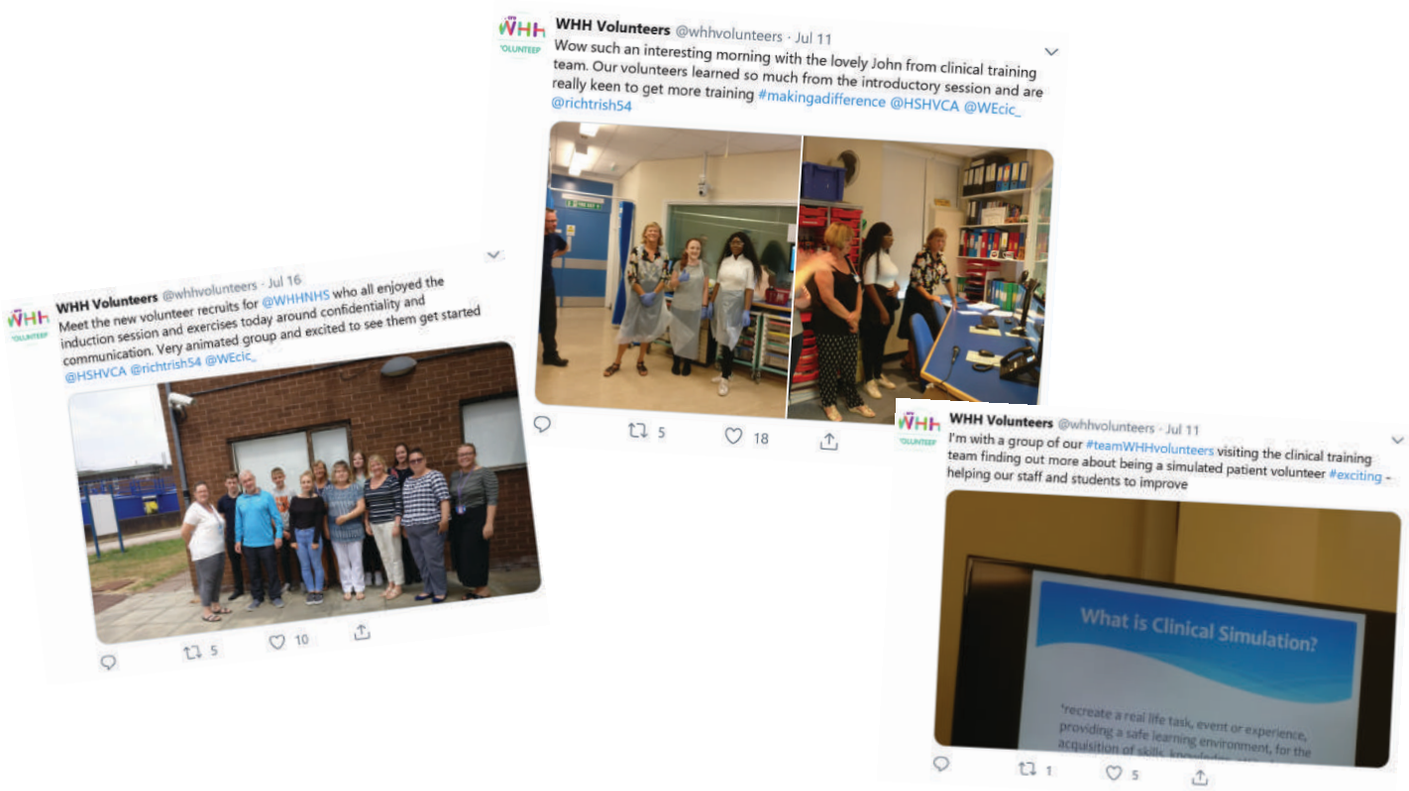
- We have written and facilitated a volunteer specific part of the Trust induction, ensuring volunteers know what to expect, what their role is and what the responsibilities are for them and the Trust.

- Implemented a new volunteer management portal. Volunteer Kinetic enables the volunteer, our staff and the Trust to streamline the process of getting volunteers engaged with activities. It assists volunteers to self-manage. They can track their progress, record their volunteering hours and training, it also allows easy access to available roles, relevant information and is a great way for us to make sure everyone recognises the contribution volunteers and their volunteering is making to the Trust.

- Worked with staff in the Trust on developing a range of new volunteering opportunities that support the overall priorities on patient safety, improving quality, reducing demand and improving patient flow and wellbeing. These include: Volunteer Readers, Dining Companions, Ward Buddies, Discharge Support, Way Finders, Pets as Therapy Volunteers, Breast Clinic Volunteers, Patient Simulation Volunteers, Theatre Volunteers, Front Entrance Meet & Greet Volunteers, Friends and Family test volunteers.

- We have introduced a Wellbeing & Social Intervention training module to the volunteer induction, that supports our ambition that the volunteer workforce are implementing evidenced wellbeing approaches and top tips for promoting self care.

- We have sponsored the Volunteering Category at the Trust's Staff Awards for the past two years. This has given us a great opportunity to ensure that volunteering has a profile within the organisation and that staff can recognise good volunteering and the impact it has by nominating the volunteers that support their work. Alongside this volunteers have received working together badges linking to the values and behaviours of the Trust and have nominated volunteers for local and national awards to recognise the contribution they make to patients, systems and improvements.



KEY FIGURES

OUR REACH OF PEOPLE KEEN TO SUPPORT THROUGH VOLUNTEERING

587 VOLUNTEERS

80% FEMALE

40% AGES 16 - 25

32% AGES 26 - 44

20% AGES 45 - 64

8% AGES OVER 65

PER WEEK **300** VOLUNTEER HOURS

57 OPPORTUNITIES LISTED

INCLUDING SOME SHORT TERM, ONE OFF OPPORTUNITIES

We are WHH

FEEDBACK ON THEIR VOLUNTEERING EXPERIENCE

"The activities coordinator who showed me around was brilliant and taught me a lot. I am really looking forward to going back onto the ward."

"This has been an excellent starting point for my volunteering. I was paired up with a volunteer named Barry who has been volunteering for over a year. Making people's waiting time in the outpatient department go quicker and hearing some interesting life stories was worth it. I would recommend to anyone who is a good talker or who wants to get more familiar with the volunteering role. Thanks."

"I enjoyed getting to know my way around the hospital and all the different areas, it's a good way to get an overview of the hospital as a whole and how it runs."

"I really enjoyed meeting the friendly staff and patients and found the day very interesting".

"I love volunteering on the ward. It's lovely to chat to the patients particularly those that don't have any or many visitors. It's good to feel we are making a difference."

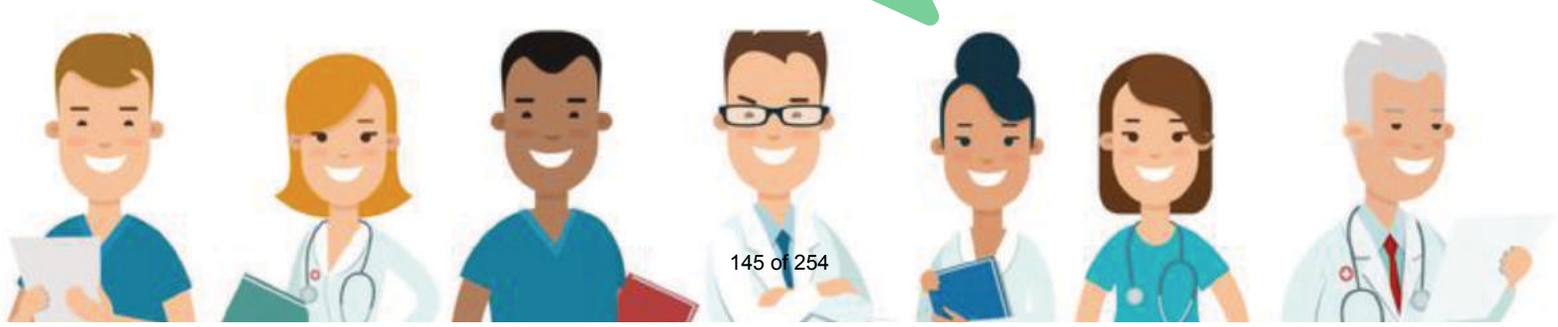
FEEDBACK FROM OUR STAFF

"Joe has made a good start to volunteering on the FMNU. He is approachable and friendly to the patients."

"Bethany has been of great help to the Discharge Lounge supporting patients as they leave the hospital."

"Matthew is an excellent volunteer. He has been diligent, tenacious and meticulous with the task he has been asked to carry out. Matthew is able to get on with the tasks require without any supervision and has proved to be a real asset to the team."

"Clare Thank you for all your help in Dr Chikthimmah Clinic when we had a Patient who was having a sever Hypoglycaemic event. Clare your care and compassion was amazing and all staff including Dr Chikthimmah are very grateful for your assistance."



SUCCESS STORIES...

IRAM

Gained full time employment as Sterile Services assistant in Theatres after volunteering for 18 months 3 times a week in a variety of roles.

JOE

Accepted onto degree as a mature student to study medicine at Warwick University.

LAUREN

Gained employment as a carer after supporting the Ward Buddy role.

EMMA

Found part time employment with another trust in administration after supporting Medical Education

LIZ

Gained employment within Speech and Language after supporting the team as a volunteer.

We are WHH

NEXT STEPS

We have laid solid foundations, and developed trusted partnerships with staff at all levels of the Hospital Trust to enable the Volunteering Programme to continue to flourish over the coming years. We are looking forward to working with the Trust to further co-design and co-deliver the programme working with staff, patients and local people. These opportunities will include:

ONE:

Expanding the repertoire of volunteering opportunities available within the Trust ensuring that the skills and talents of local people can be harnessed alongside staff to provide wider wellbeing support for patients. These volunteering roles will provide opportunities for patients to learn new skills, meet new people and enhance their physical and mental wellbeing.

TWO:

We want to support efforts to kickstart a social movement for wellbeing in the Trust. We will deliver a project that provide small grants and specialist support for staff and volunteers who have ideas that could improve the health and wellbeing of the patients and the workforce. These projects may include wellbeing self-help groups, health promotion campaigns or hobby and interest groups.

THREE:

We will continue to raise the profile of the Trust as a trailblazing volunteering organisation. We will showcase the work of volunteers in the Trust, and celebrate their achievements through awards and showcasing their achievements. We will also enter the programme for regional and national awards.

FOUR:

We will ensure that the volunteering offer is an integral part of the newly proposed Health Campus and we will work with Trust leaders and clinical staff to ensure that every patient will be able to access the invaluable support provided by trained volunteers.

FIVE:

We will seek to expand the resources allocated to volunteering opportunities by working with the Trust to pursue regional and national grant funding and specialist support.

IN CONCLUSION

WHH NHS Trust is exemplary in recognising the value that volunteering can bring to enhancing patients' experiences of care by complementing the work of clinical staff on the wards. By mobilising **'volunteer power'** the Trust has made excellent progress in kickstarting a social movement for wellbeing and in realising its ambitions to become a health promoting Trust.

There are so many people we have to thank for their support thus far. Thank you to Kimberley, John and Pat for their mentorship and guidance, to Trish who has been integral in the development of the initiative, the Exec Team for their belief in this initiative, and for recognising the added value that the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector would bring in co-designing and co-delivering this initiative, and most importantly of all, a huge, huge thanks to all the inspiring, selfless, dedicated volunteers and staff who have poured their heart and soul into this initiative so far.

We are indebted to you all to be able to call on your support as we move into an exciting new chapter with this initiative!

THANK YOU...

We are WHH

WHH Volunteers @whhvolunteers · Jul 11

Wow such an interesting morning with the lovely John from clinical training team. Our volunteers learned so much from the introductory session and are really keen to get more training #makingadifference @HSHVCA @WEcic_ @richtrish54

5 18

Warrington&HaltonNHS @WHHNHS · Nov 15

Very proud of Margot and Maureen our fabulous WHHVolunteers finalists at the WG Inspiration awards - enjoy and good luck ladies ❤️ @whhvolunteers @WHHCharity @warringtonnews

WHH Volunteers Retweeted

Mel Pickup @Mel_Pickup · Mar 23

@WHHNHS Volunteer of the year award goes to 🍒.... Tony Weetman 👏👏👏 #staffawards2018

WHH Volunteers @whhvolunteers · Nov 7

Here's some of our new volunteers ready for patient moving and escorting training with Greg from clinical skills today. #patientfocused #beinghelpful @WHHNHS @richtrish54 @HSHVCA @WEcic_

1 1 9

WHH Volunteers @whhvolunteers · Jul 16

Not my best drawing skills but good suggestions for our super volunteer today. To be a volunteer you need #empathy #confidence #passion #communicationskills #enthusiasm and be #adaptable and #eagertolearn @WHHNHS @HSHVCA @WEcic_ @richtrish54

Trish Richardson @richtrish54 Following

#alwaysevent @nhs70 @WHHNHS @paulaevans486 @whhvolunteers @Kimberley_S_J

WHH Volunteers @whhvolunteers · Oct 29

Meet Gemma one of our new volunteers learning from Barry who has been volunteering as meet and greet in our busy outpatients dept for over a year now. Enjoy the first of many sessions to come @WHHNHS @richtrish54 @HSHVCA @WEcic_

4 13

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/26**			
SUBJECT:	**Patient and Public Participation & Involvement Strategy 2019-22**			
DATE OF MEETING:	27 March 2019			
AUTHOR(S):	Pat McLaren, Director of Community Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO3: We will .. Work in partntership to design and provide high quality, financially sustainable services			
EXECUTIVE SUMMARY (KEY ISSUES):	This strategy, co-produced with our FT Governors, sets out our vision for best-practice patient and public involvement which enables true and meaningful 'co-production' and therefore increases the success or improves the outcomes of change or improvement programmes. Keenly, it ensures that no-one is left behind and embeds PPP&I in our 'business as usual' through a simple adjustment to our existing Equality Analysis and Quality Impact Assessment. Registration, monitoring and reporting will be via a centrally held secure database (GDPR regulations apply) owned by those whose core role is patient and public involvement, experience and participation. The annual work plan will be reported on via the Patient Experience Committee on a monthly basis together with feedback (via programme leads) on PPP&I input. We look forward to achieving best practice in the way we engage and involve those for whom we provide care and services in our communities – because the NHS belongs to those very people.			
PURPOSE: (please select as appropriate)	Information	Approval X	To note	Decision
RECOMMENDATION:	That the Board approves the PPP&I Strategy for 2019-22.			
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	

Trust Board

SUBJECT	Patient and Public Participation & Involvement Strategy 2019-22	AGENDA REF:	BM 19 03 26

1. BACKGROUND/CONTEXT

The Trust has sought to involve patients and the public in the development of and/or change to its services, however this has not always been achieved in a systematic, consistent or accountable way across the organisation. Further, the involvement of patients and public sometimes takes place once projects are already under way.

The CQC's Well Led Framework sets a benchmark for best practice participation and involvement: '***The people who use services, the public, staff and external partners are engaged and involved to support high-quality sustainable services.'***

- *People's **views and experiences are gathered and acted on** to shape and improve the services and culture, this include people in a range of equality groups*
- *People who use services, those close to them and their representatives **are actively engaged and involved in decision- making** to shape services and culture including people in a range of equality groups*.

This strategy has been co-produced during 2018 with the Foundation Trust Governors, working through the Governors' Engagement Group (GEG). As well as providing a template for excellence and consistency in participation and involvement, it has enabled the Governors and Trust to draw in the expiring Membership strategy. FT members are now systematically included in participation and involvement opportunities where our focus is on representation of our local communities and addressing shortfalls in some hard-to –recruit-to constituent groups.

This strategy has been co-produced through the GEG, tested through our Patient Experience Cttee (which has a large external partner membership including advocacy groups for those with Protected Characteristics) and used as a blueprint for our first engagement event of the year – *Equality, Diversity and Inclusion*: *What Matters to Me and My Individual Needs*? We are grateful to the many groups and individuals who have provided valuable input to ensure that all future participation and involvement is representative and accessible.

We look forward to deploying our annual work plan and achieving best practice in the way we engage and involve those for whom we provide care and services in our communities – because the NHS belongs to those very people.

2. KEY ELEMENTS

2.1 This strategy sets out our vision and blueprint for best-practice patient and public involvement to enable true and meaningful 'co-production' which will therefore increase the success or improve the outcomes of service change or improvement programmes

2.2 Keenly, it ensures that no-one is left behind and embeds PPP&I in our 'business as usual' through a simple adjustment to our existing Equality Analysis and Quality Impact Assessment

2.3 **Registration** of patients, carers, families, visitors, communities and advocacy groups will be maintained and refreshed centrally - adhering to GDPR principles – and identifying individuals and groups by their registered 'interests'

2.4 **Event planning** will be via the Communications and Engagement and Patient Experience Team to ensure consistency and full involvement and accessibility. This service will support local events such as specific service engagement focusing on particular change or improvement elements

2.5 **Feedback** will be gathered systematically and both maintained for future access by other services (anonymised) and provided back to those whom have given their time to work with us

2.6 **Reporting** will be through the Patient Experience Committee and through the Governors Engagement Group as well as through the Strategy Development and Delivery Group by service leads where appropriate

2.7 We will produce an annual report on our patient and public involvement and participation each year to the Patient Experience Committee and Council of Governors and shared with our registered supporters and partners.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

3.1 The Trust's Leads for patient and public participation and involvement are the Director of Community Engagement (public, partners, other stakeholders, members) and the Head of Patient Experience (patients, carers, visitors)

3.2 The leads will support deployment of and report on Trust and local involvement and participation

3.3 The Director of Community Engagement retains responsibility for the Foundation Trust Membership working with the Foundation Trust Office.

4. IMPACT ON QPS?

4.1 This strategy underpins our Quality objective: *We will always put our patients first through high quality safe care and an excellent patient experience* and where *focusing on patient experience we want to place the quality of patient experience at the heart of all we do where 'seeing the person in the patient' is the norm* and

4.2 our Sustainability objective: *We will work in partnership to design and provide high quality, financially sustainable services.*

5. TRAJECTORIES/OBJECTIVES AGREED

5.1 Deploy work plan for 2019

5.2 Promote strategy to clinical business units and services

5.3 Secure formal agreement by services for registration of programmes according to SOP

5.4 Provide training and coaching where appropriate

5.5 Celebrate Success

6. MEASUREMENTS/EVALUATIONS

6.1 Successful deployment of our work plan as described: achieved/representation

6.2 Engagement by services – recorded and reported

6.3 Increased engagement with and participation and involvement of our wider public and advocacy partners – measured in numbers and representation
6.4 Attendance at training/coaching events
6.5 Delivery of celebration event(s)
6.6 Evidence of patient and public involvement and participation and their views in all service change programmes.
6.7 Monitoring of involvement of hard to reach individuals and groups and those with protected characteristics.

7. MONITORING/REPORTING ROUTES

7.1 Patient experience committee
7.2 Governors Engagement Group

8. TIMELINES

Development milestones

- Co-creation WHH Governors during 2018
- Governors Engagement Group final input 6.2.19
- Patient Experience Committee input and ratification 12.2.19
- Multi-stakeholder engagement event (testing) 14.2.19
- Trust Board 27.3.19 – Publish
- Deploy work plan

9. ASSURANCE COMMITTEE

- Patient Experience Committee
- Governors Engagement Group
- Council of Governors
- Trust Board (Receive annual report)

10. RECOMMENDATIONS

That the Trust Board approves the Patient and Public Participation and Involvement Strategy for 2019-22 and notes the intention to present annual report in March 2020 for the cycle of business.

PMc
March 2019

Warrington and Halton Hospitals NHS Foundation Trust

We are WHH

Patient and Public Participation and Involvement Strategy 2019-2022

Draft for Approval

“Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.”

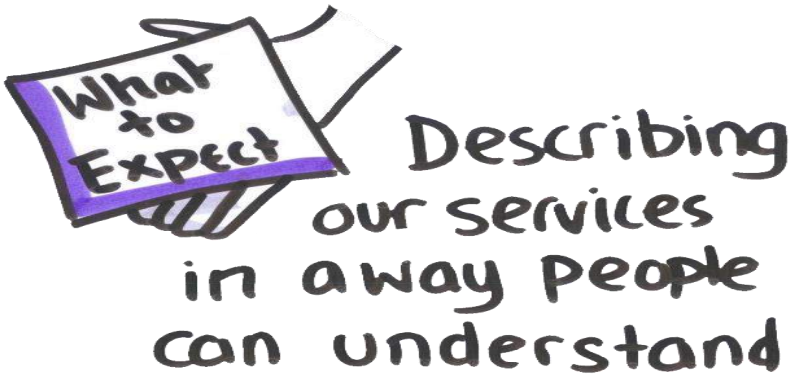
NHS Constitution: Our Values

Foreword

We believe that fostering good relations and maintaining on-going dialogue with our patients, the public and other stakeholders is essential to the quality of care we give to our patients, the experiences of our staff and sustainability of our services.

We recognise that our patient and public participation and involvement strategy needs to constantly evolve to keep pace with population changes and advances in technology. We aim to continuously learn from and share our experience of participation, to maximise its impact.

We acknowledge that different levels of involvement will be appropriate in different circumstances and that an appropriate and proportionate approach will be required accordingly. As well as involving patients and public in service redesign and experience we also wish to draw potential future Governors from these populations to represent geographical constituencies where service users, or those passionate about local services, may join the Foundation Trust as 'Members'



We know that we must provide clear and accessible information to patients and the public in a variety of ways to suit their different needs, and to make arrangements as necessary to facilitate their involvement in our work.
We are committed to both asking people how they want to be involved and to provide feedback on their contribution and how it has informed our service development or transformation.

Our elected, staff and partner Foundation Trust Governors, are committed to being a conduit for our communities' voices, to ensure that the Trust provides the opportunities for those voices to be heard and for that valuable input to be integral to service improvement and development.

Thank you for taking the time to share our vision, remember that these are your local hospitals and services so please do get involved in any format that suits you.

Kimberley Salmon-Jamieson
Chief Nurse

Norman Holding
Lead Governor
On behalf of the Foundation Trust
Council of Governors

Who We Are

Warrington and Halton Hospitals NHS FT comprises three acute (secondary) care hospitals across two sites in the Boroughs of Warrington and Halton, making us part of the mid-Mersey health economy.

Warrington Hospital is the home of all of our emergency and complex surgical care and maternity services while Halton General Hospital in Runcorn is a centre of excellence for planned routine surgery. The Cheshire and Merseyside Treatment Centre (CMTC) is home to our orthopaedic surgery services based on the Halton General site.

Although each hospital focuses on particular aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton sites so patients can access their appointments closer to home wherever possible. We also provide some outpatient services in the local community.

In delivering the Five Year Forward View we are part of the Cheshire and Merseyside Health and Care Partnership, the second largest in the country and are integral in both *One Halton* and *Warrington Together* 'place based' health and social care systems.

We serve a population of 330K across both boroughs and employ over 4,200 staff comprising 52 nationalities. We became a Foundation Trust in 2008 and have over 15K 'members' across the boroughs of Warrington, Halton and surrounding areas and occasionally beyond. These members are represented by our Council of Governors comprising public (elected), staff and partner governors who are committed to representing the views of service users and public within their constituencies.

What guides us - Our Values

Our Mission is:
We will be OUTSTANDING for our patients, our communities and each other

We are committed to achieving our mission together with our patients (our experts by experience), their carers and families; our staff and volunteers, our partners and members of the public - in fact everyone who uses or works within our services or may do so in the future.

This means a commitment to creating opportunities for the participation of all groups, ensuring that ways and means to engage are accessible to all and that all voices are heard and views are considered and incorporated wherever possible in service delivery, design and transformation. We recognise the links between staff engagement and public engagement, and value of the contribution that our staff make.

At the same time we are committed to ensuring that when care is needed, that patients, their families and carers have the best possible experience. We have set out our goals in our Patient Experience Strategy:

1. *We believe every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services*
2. *We believe our patients should be first in everything we do and we promise to communicate based on what matters most to you*
3. *We believe our patients should always experience care that is based on their specific needs and we promise to work in partnership with you and your carers to achieve best possible outcomes*
4. *We believe every patient should experience care and treatment in the right environment and we promise to continuously improve what you can see, do, hear and feel during your stay.*
5. *We believe that our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand*

Replying to @whhvolunteers and @drtraceyc
Fantastic. The staff on the labour ward saved my daughters life so I would love to help wherever I could. Especially after #MatExp 😄x

MatExpo: Involving Women (and their children!) in developing our Maternity Service

Our Commitment to Participation and Involvement

This strategy underpins the Trust's strategy and supports delivery of the Quality and Patient Experience strategies. It sets out our commitment to participation through innovative communication, engagement and involvement and our guiding principles are as set out in the NHS Constitution:

The patient will be at the heart of everything the NHS does

We will strive to ensure that our services reflect, and are coordinated around and tailored to, the needs and preferences of our patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. We will actively encourage feedback from the public, patients and staff, welcome it and use it to improve our services.

Our responsibilities:

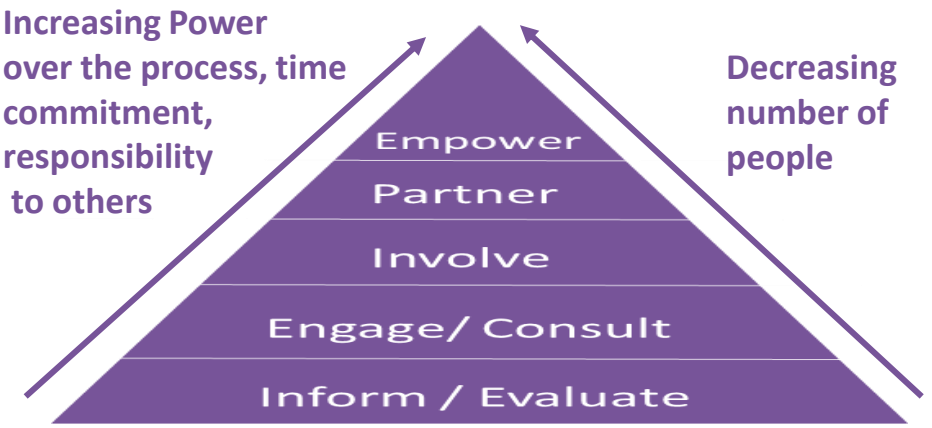
- Ensuring that the need for patient and public participation is considered and appropriate action is taken by those who manage our services
- Promoting an organisational culture in which patient and public participation is 'everyone's business'
- Contributing to the monitoring, evaluation and reporting of our effectiveness in strengthening patient and public participation

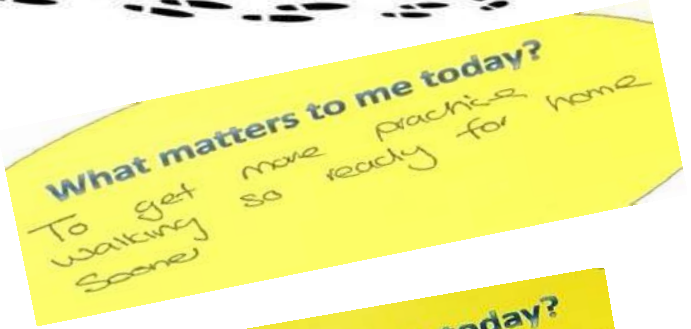
We are committed to listening to our patients and making improvements to our services in response to their views. We encourage feedback from our patients, relatives and visitors, both positive and negative, and use this to review services and make any appropriate changes to meet patients' needs.

Practical Participation

What we will do:

1. **Listen** to patients' views: learn about their needs and experiences and identify specific areas for improvement
2. **Involve** patients, public and Foundation Trust Governors and Members in service design and research so that their views inform design and adaptations to better meet the needs of individual patients and patient groups
3. **Ensure** that our staff know and understand their responsibility to involve patients and carers so that local involvement can take place and PPI is integrated into service redesign plans
4. **Measure** how we are doing: we can see how our improvement plans and activities are progressing and report on this through the Trust's Patient Experience Committee and the Governors' Engagement Group



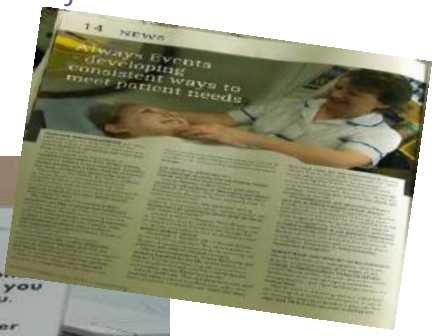


Inform/ Evaluate	• Providing information: Posters and leaflets, market places and exhibitions, local press and social media • Reviewing process and outcomes to drive improvements
Engage/ Consult	• Getting information: questionnaires and surveys, focus groups, text responses, telephone interviews
Involve	• Ongoing engagement and dialogue
Partner	• Partnership working, co-design/ co- production
Empower	• Change driver, leader, stakeholder

What Matters to YOU?

Always Events® are "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system."
Always Event© WHH joins Cohort 6

Working with patients in Radiology to co-design their journey produced significant care and experience improvements.



Co-design, Co-Production

Considerations	Actions
Accessibility	• Make participation accessible • Promote equality and diversity, and encourage and respect different beliefs and opinions • Work with advocacy groups to support patient involvement
Reach	• Go to our patients, public and community groups – don't ask them to come to hospital
Target	• Proactively seek participation from people who experience health inequalities and poor health outcomes
Value	• Recognise that 'Lived experience' is the most valuable resource we will harness this and not make assumptions
Open and Honest	• Share the evidence base for decisions and be clear about decisions, resource limitations and any other restraints eg confidentiality
Planning	• Plan and budget for participation at the start so we can involve people at the earliest opportunity
Measurement	• Review participation experiences (positive and negative) and learn from it to continuously improve how people are involved
Recognise and reward	• Recognise, record and celebrate people's contributions and give feedback on the results of involvement; show people how they are valued
Feedback	• Close the loop whenever the views of patients and the public are sought in the formats that people ask for
Governance	• Where possible, include people's views on Board or committee reporting templates. • We will consider including lay representatives on key committees

Co-production is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches

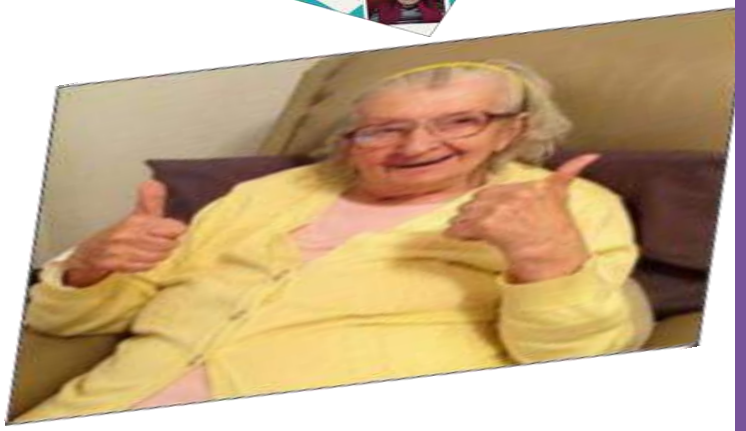
Co-production is a way of working that involves patients, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.

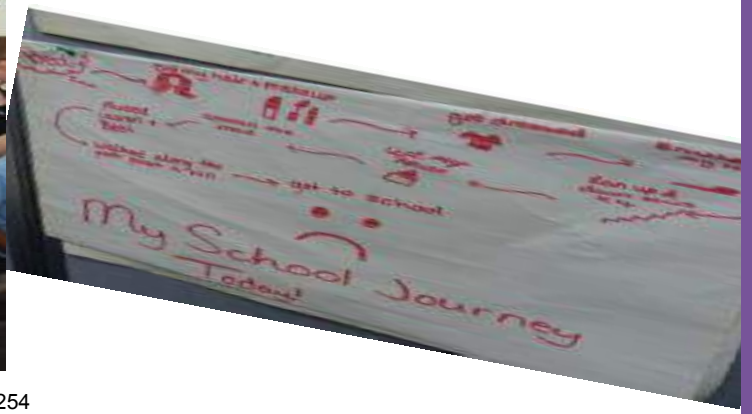
Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives.

Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

Our Participation Model

1. With our Governors develop an **annual participation and involvement work plan** and report on progress through the Patient Experience Committee and Council of Governors
2. Use **transparent, accessible approaches to recruit a range of people** who use our services, carers and communities, taking positive steps to include under-represented groups.
3. We will actively work to **diversify our Foundation Trust membership** o ensure that it mirrors and is representative of our patient populations and support people to be passive, involved or highly involved in our work as they chose.
4. Put systems in place **that feedback on** and **recognise and reward** the contributions people make
5. **Identify areas of our clinical strategy** and existing services where **co-production can have a genuine impact**, and involve patients in the very earliest stages of project design
6. Develop **standard operating procedures** for patient and public involvement to ensure co-production is part of our work programmes until it becomes 'how we work'
7. **Train and develop staff and citizens**, so that everyone understands what co-production is and how to make it happen
8. **Regularly review and report back on progress**. Plan to move from "You said, we did," to "We said, we did"





Our PPP&I Objectives

Our PPP&I Objectives

1. Develop and deploy a work plan for 2019 building upon the PHE annual health promotion calendar, key events requested by our FT Governors, service changes and developments; collaborations, milestone surveys etc. and celebrations
2. Promote the PPP&I Strategy to clinical business units and services including the new Standard Operating Procedure. Secure agreement by services for registration of programmes **in advance** according to SOP and linked to completion of Quality Impact Assessment.
3. Seek appropriate training opportunities, working with established groups (such as National Association for Patient Participation, Patient Voices, Patients Association, AQUA, etc.) and drawing on our own Quality Improvement and Quality Academy resources.
4. Celebrate Successes and milestones – recognise contributions, reward participants through training and recognition scheme.

Measuring Outcomes

1. Successful deployment of our work plan as described: Achieved/representation
2. Engagement by services – recorded and reported, evidenced in outcome reporting
3. Increased engagement with and participation and involvement of our wider public and advocacy partners – measured through recruitment in numbers and representation
4. Attendance at training/coaching events
5. Delivery of celebration event(s)
6. Reported evidence of patient and public involvement and participation and their views in all service change programmes.
7. Monitoring of involvement of hard to reach individuals and groups and those with protected characteristics.

Public involvement in strategy development: User groups, workshops, consultations

Public involvement in service transformation: Programme boards, user groups, workshops, business planning, Patient Experience Committee

Public engagement and communications: *Your Hospitals*, WHH.nhs.uk, @WHHNHS social media, *Your Health Matters*, Carers Cafes, What Matters to Me Conversation Cafes

Public (lay member) involvement in governance - Opportunities: Board meetings, Quality Committee, Patient Experience Committee, Annual General Meeting, Committees and programme boards, Council of Governors and Governors' Engagement Group- GEG, FT Member. Specific skills of a lay member representative include:

- demonstrable understanding of the local arrangements for listening and responding to the voices of patients, carers and patient organisations
- have a track record of successfully involving patients carers and the public in the work of a public sector organisation
- have an understanding of effective involvement and engagement techniques, and how these can be applied in practice
- live within the local community or be able to demonstrate how they are otherwise able to bring that perspective to the governing body
- able to give an independent view on possible conflicts of interest
- be competent to chair meetings or workshops

Annual Work plan 2019

Month	Event
January	• **Carers Cafes** • **Accessible Information Standard Programme launch** • **Member Engagement WMTM/new Governors**
February	• **Equality, Diversity & Inclusion - WMTM and My Individual Needs**
March	• **Launch of C&YP Strategy and Young Person's Ambassador** • Emergency Department/Urgent Care Centre conversation cafes • **Nutrition and Hydration focus and awareness**
April	• Pressure Ulcer Collaborative 2.4.19 – recruit patients/Public • Experience of Care Week Festival 21-26 April: Recruit *Lived Experience* patient panels • A new Midwifery Led Unit - engagement
May	• Falls Collaborative 23.5.19 – recruit patients/Public • Dementia Awareness Month ➢ Your Health Matters – Dementia focus with Alzheimer's Assn ➢ Formal opening FMN Garden • Stroke Awareness Month - Make May Purple • QI Training for Governors via Governors' Engagement Group
June	• Diabetes Awareness Month ➢ Your Health Matters – Diabetes with Diabetes UK • **The Big Bed Push** - A New Hospital for Warrington at Thelwall Rose Queen Festival 17th June • Promote Governor Elections
July	• Disability Awareness Day (with the Stroke Association) Child focus and SMART HEART; Apprenticeships and Work Placements and Walking Aids amnesty • Accessible Information Standard P&P Involvement review
Aug	• QI Training for Panels
September	• Halton Vintage Rally - Children's focus and SMART HEART 28-29 Sept • Annual members meeting 2019 date tbc
October	• Your Health Matters WINTER: Sepsis/Flu Jab and Choose Well
November	• Governor Elections
December	• Sepsis aware • Stay well this winter/Choose Well

Programme subject to change dependant on availability.

Further events to be added including specific community events and festivals.

Public Health England Health Promotion Calendar

MONTH	HEALTH PROMOTION
January	• Dry January (Alcohol Concern) • Cervical cancer prevention week (22nd -28th) (Jo's Trust) • Sepsis aware
February	• National Heart Month (British Heart Foundation) • Sepsis aware
March	• Cancer Awareness month
April	• Bowel Cancer Awareness month • Male cancer awareness week (2nd – 8th) Orchid)
May	• Mental Health Awareness Week (14th – 20th) • Make May Purple – Stroke Awareness Month (Step out for Stroke) • Dementia Awareness Week
June	• Diabetes Awareness date tbc (Diabetes UK) • National Blood Week – 18th - 24th
July	• Safe in the Sun • Blood in Pee
August	• Safe in the Sun • Blood in Pee
September	• Prostate Cancer Awareness month • Migraine Awareness Week – 3-9 September (The Migraine Trust) • Blood pressure checking (Blood Pressure Association's Know your Numbers campaign) 10th-16th • Flu vaccination campaign • Blood in Pee
October	• Breast cancer awareness month • Flu vaccination campaign • World Mental Health Day – 10th October • Stoptober – smoking cessation campaign • Stay well this winter
November	• Cold and flu information • Stay well this winter/Choose Well
December	• • Cold and flu information • Sepsis aware • Stay well this winter/Choose Well


Warrington&HaltonNHS
@WHHNHS
Following
Do you have a primary school year 4 pupil local? Why not follow our FB page @WHHSmartheart and invite us to present.
Warrington and Halton Hospitals NHS
Make your heart smart!


G.S.M.C.
K.E.M.H
NON SIBI SED OMNIBUS


Wellbeing
enterprises


#I ♥ myODP

Surveys and Engagement Index

Stakeholder Group	Survey/Engagement
Women's experience of Maternity Care	2017 Maternity Survey- Quality Health Survey of Women's Experiences 2017- CQC WHH Facebook Survey WHH Facebook Maternity – Facebook the Midwife
Learning Difficulties Audit	ED local audit - Staff
Whose Shoes? – Midwifery	Maternity Expo – Service Users Group
Smart Heart	Schools-based education (public health – smoking/obesity)
Carers Cafes	Bi monthly cafes (one each site)
What Matters to Me?	Continuous engagement in Radiography Periodic themed Conversation Cafes – topic specific
Annual Members Meeting	Annually in September
Your Health Matters Events	Bi Monthly recommencing in 2019
WREN Unit	Ward based engagement in April – May 2018 and ongoing
Frailty Assessment Unit	Unit based engagement - ongoing
Children and Young People's Voice	Informing C&YP Strategy - ongoing
Equality and Diversity Group	Quarterly Meetings
Dementia – audit and inclusion	'All About Me'
WHH Governors	Ward observation visits and patient/public involvement
Patient Experience Committee	Monthly – all welcome

Who are our Patient and Public Partners?

Group/Individual (this list is not exhaustive)	
WHH Foundation Trust Governors and Members	Warrington Voluntary Action
WHH Patient Experience Committee	Warrington Together and One Halton
Healthwatch Warrington and Healthwatch Halton	Warrington and District Society for Deaf People
Warrington Ethnic Communities Association	Diabetes UK
Deafness Resource Centre	Alzheimer's Society
Halton Carers	League of Friends Warrington
Wired Carers	League of Friends Halton
Warrington Disability Partnership	Warrington Voluntary Action
Speak Up Warrington, Speak Out Halton	
Wellbeing Enterprises CIC	
Age UK	
Papyrus – prevent young suicide	
WHH Maternity Voices	
Halton People's Health Forum	
LGBTQ+ and Network Warrington	
Red Cross	
Macmillan	
The Stroke Association	
British Heart Foundation	
Speak Out Halton	

Participation Communication tools - Accessibility

Tool	Inform	Engage	Involve/ Consult	Empower	Evaluate/ improve
After action review					√
Patients, Carers and Public Panel	√	√	√	√	√
Comments Cards		√			√
Conversation Cafes	√	√	√		√
Digital stories		√			√
Displays/Exhibitions	√	√			√
Questionnaires and Surveys		√	√		√
Electronic voting		√	√	√	√
Focus Groups	√	√	√		√
Infographics/film	√	√			√
Mystery shopping		√			√
Patient Diaries/stories		√			√
Presentations	√	√			√
Process Mapping	√	√	√		√
Public Meetings	√	√			
Workshops	√	√	√		√
Task and Finish Groups				√	√
Storytelling	√	√			√
Service Voices				√	√
Written Information	√			√	

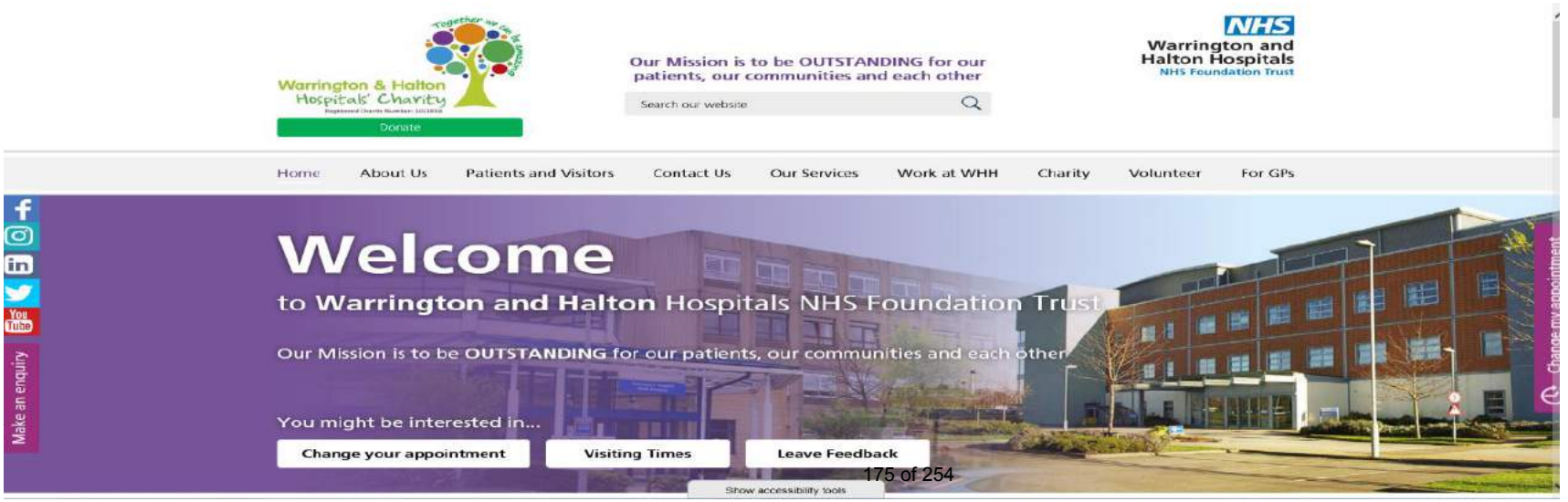
e-Participation refers to the ability to engage with patients, carers and communities using online technology or social media. It involves “the people formerly known as the audience”12 as active co-participants, and represents a shift away from *broadcasting* towards *conversation*.

e-Participation describes a range of web-based tools used to share information, promote discussion and build relationships. These tools enable people to create and share content, including text, images and videos, and connect directly with others.

- blogs and microblogs (e.g. WordPress and Twitter)
- social networking sites (e.g. Facebook and LinkedIn)
- content communities (e.g. YouTube and Flickr)
- collaborative projects (e.g. Wikipedia), and
- internet forums and online discussion boards.

These tools are normally publicly accessible and allow many people to see, comment on or co-produce materials. They are usually free or low-cost and simple to use. Most importantly, content is designed to be shared, and it is usually possible to forward, link to or re-publish information with just a few clicks. The barriers to entry are very low and the potential audience is very wide.

e-Participation can enable patients, carers and communities to access information; provide peer support for the self-management of long-term conditions; make complaints or give feedback; influence local service development; or take part in a dialogue with their local health and care providers. The tools allow public bodies to disseminate information; connect with a wider range of audiences; provide feedback to people about how their views have helped improve services; and build relationships



Standard Operating Procedure

SOP Involving Patients and Public in Service Design, Change or Improvement

Author: Pat McLaren (Director of Community Engagement and Fundraising)

Audience: Senior Managers, Service Leads, Specialty Leads, Managers and Team Leaders

Purpose: To ensure that the involvement of patients and public in service design, change or improvement is embedded, is taken into account, is systematically captured and recorded , is supported and is reported via assurance cttees.

Appropriate governance meeting: Patient Experience Committee

Approval Date: February 2019 Review Date: February 2020

WHH Documents to be read in conjunction with: Patient and Public Participation and Involvement Strategy, PPP&I Workplan, Patient Experience Strategy

1. Purpose & Scope

Purpose: The purpose of this SOP is to provide structure and guidance to support effective Patient and Public Involvement and Participation in service design, change and/or improvement

Scope: Senior Managers, Service Leads, Specialty Leads, Managers and Team Leaders

2. Training Needs Analysis

- Coaching/Briefing provided by Patient Experience Manager/Director Community Engagement on request
- The Lived Experience Expert – QI Foundation Training - Quality Improvement Specialist
- National advocates and bodies – training opportunities as arise
- Any additional support refer to Organisation Development lead

3. Appendices

- Patient and Public Participation and Involvement Strategy
- PPP&I Workplan
- Patient Experience Strategy
- Quality Impact Assessment

1. Equality Analysis and Quality Impact Assessment

All proposals for service change, redesign or creation are accompanied by a Quality Impact Assessment. WHH QIA is being changed to include a mandated section on PPP&I to ensure process is embedded.

2. Register Programme

Register your requirement for Patient/Public involvement with Head of Patient Experience trish.richardson1@nhs.net and Quality Improvement Specialist alison.schofield2@nhs.net Programme registered and held centrally for involvement with reporting through PEC

3. Recruit to Panel

Briefing prepared for Communications and Membership team for Governor, Member and Public Recruitment and for Service Leads for Patient Recruitment. Special focus on mobility, ability to access, any reasonable adjustments required – accessible information std. Over-recruit.

4. Welcome event for P&Ps, Training needs analysis

Meet team, presentation on aims and objectives – supported involvement (LIA-style) Be clear on requirements – what's in, what's not and what the time commitment/length of involvement is likely to be. Provide any necessary training.

5. Systematic capture of input, feedback

- Register outcomes in reports to assurance committees. Hold in central database for other groups to access (Anonymised)
- Send feedback to participants
- End of Involvement Celebration
- Recruit to next event

SOP Embedding PPP&I

Quality Impact Assessment

QUALITY IMPACT ASSESSMENT Answer positive, neutral or adverse (P/N/A) against each area. If Adverse, score the impact, likelihood and total in the appropriate box					
Impact question	**P/N/A**	**Impact**	**Likelihood**	**Score**	**Rationale**
Quality Objectives					
Patient Safety					
Clinical Effectiveness					
Patient Experience					
People Objectives					
Attract and retain a diverse workforce					
promote wellbeing and an engaged workforce					
Collective leadership and organisational learning					
Sustainability Objectives					
Support integrated place based-care					
Services are best possible, clinically/financially sustainable					
Fit for purpose estate and technology					
Approvals					
Stage 1, QIA to be signed by 2 of the 3 triumvirate leads or 1 Corporate Service lead Stage 2, QIA to be signed by appropriate Executive Director(s). Above £100k or RAG rated RED					
Has this project/programme been registered for Patient and Public Participation and Involvement? **Yes (Date)** **No (insert rationale)**					
Post implementation review required on scheme?: YES ☐ NO ☒ If YES, how long after the scheme is delivered?					

EQUALITY ANALYSIS

Scheme title and brief description:

What is being considered?

☐ Service change or development
☐ Policy
☐ Guideline
☐ Decision
☐ Other (please state)

Who may be affected?

☐ Patients
☐ Staff
☐ Carers
☐ Public
☐ Partners/Other agency
☐ Other

Have you registered for Patient and Public Participation and Involvement?

Yes (insert Date)
No (please state rationale)

Is there ~~potential for an adverse impact against the protected groups below~~?

Age	Disability
Gender Reassignment	Marriage & Civil Partnership
Pregnancy & Maternity	Race
Religion & Belief	Sex (Gender)
Sexual Orientation	Human Rights Articles

Does the scheme comply our Public Sector Equality Duty by….

- Addressing potential disadvantage or reduce access to healthcare for any individual regardless of if they share a protected characteristics
- Consulting with any external stakeholders or independent advisors who can help reduce any negative impact to the above groups.

With regard to the general duty of the Equality Act 2010, the above function is deemed to have ***no equality relevance/ the above function is deemed to have equality relevance*** highlighted and passed to Equality Specialist for recommendations.

Being Representative

WHH FT Membership

- Historic *Monitor* Target- 4% of population which is equivalent to 13,192 members – under represented BUT Focus now is on being representative rather than numbers
- We are under represented by men by at least 15%
- We are under represented by 15-19 year olds by at least 5%
- We are most under-represented by white non-British and Mixed ethnic groups
- "Your Hospitals" published 3 times per year and posted once to households each summer
- Greater but local contact with membership led by constituency governor; define membership as 'passive, engaged, heavily involved'
- Diversify hospital panels and promote accordingly (eg new hospitals, MLU, Dementia, Diabetes, Carers etc.)

Latest data source NOMIS Warrington and Halton Boroughs	Membership - Public 2018		
	Target	Actual%	Actual #
Population	**13192**	**100**	**11166**
Males	49.3	34.4	3840
Females	50.7	65.6	7326
15 to 19	5.9	0.3	35
20+	75.8	99.7	11131
White	95.6	95.7	10700
White Non British	2.2	1.5	166
Mixed/multiple ethnic groups	1.1	0.5	52
Asian/Asian British	1.8	1.6	176
Black/African/Caribbean/Black British	0.3	0.2	22
Other ethnic group	0.2	0.5	50

References

a. NHS Constitution
b. NHS England Patient and Public Participation Policy
c. The Patients Association
d. National Association for Patient Participation
e. Healthwatch
f. Coalition for Collaborative Care

If you would like to receive this document in another format, please do not hesitate to contact us.

Cantonese:
如果你希望以另外一種格式接收該資訊，請和我們聯絡，不必猶豫。

Gujarati:
જો તમને આ માહિતી બીજી રચના કે ફોર્મેટમાં મેળવવાની ઈચ્છા હોય, તો કૃપા કરી અમારો સંપર્ક કરતા અચકાશો નહિ.

Hungarian:
Kérjük, vegye fel velünk a kapcsolatot, ha más formában kéri ezt az információt.

Polish:
Jeżeli chciał(a)by Pan/Pani otrzymać niniejsze informacje w innym formacie, prosimy o kontakt.

Punjabi:
ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਇਹ ਜਾਣਕਾਰੀ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰਨ ਤੋਂ ਨਾ ਝਿਜਕੋ।

Urdu:
اگر آپ اس معلومات کو کسی اور صورت میں حاصل کرنا چاہتے ہیں تو برائے مہربانی ہم سے رابطہ کرنے میں ہچکچاہٹ محسوس نہ کریں۔

Communications and Engagement Team
Kendrick Wing
Warrington and Halton Hospitals
Lovely Lane, WA5 1QG email: whh.communications@nhs.net
web: www.whh.nhs.uk tel: 01925 664222

Ratified: 12.2.19 for review February 2020

Contact your Governors at:
Foundation Trust Office
Warrington and Halton Hospitals
Whh.foundation@nhs.net
Whh.nhs.uk/about us

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/27**			
SUBJECT:	**Equality, Diversity & Inclusion Strategy (Draft)**			
DATE OF MEETING:	27 March 2019			
AUTHOR(S):	Michelle Cloney, Director of HR & OD			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services			
EXECUTIVE SUMMARY (KEY ISSUES):	The Draft Equality, Diversity and Inclusion Strategy is presented to Trust Board for approval. The Draft Equality, Diversity & Inclusion Strategy has been co-produced through a significant range of engagement activities, including engagement with our Patient & Community Voice; Patient Experience Group; and Equality, Diversity & Inclusion Sub Committee. It draws on analysis of our regulatory submissions for Equality, Diversity and Inclusion, such as EDS 2, WEAR, EDAR, Census (2011) and NHS Staff Survey (2017 and 2018).			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	Trust Board are asked: • To receive the Draft Equality, Diversity & Inclusion Strategy for approval. • To note the co-production activities which have resulted in the version presented. • To receive the Strategy for a 3 year period from 1 April 2019 to 31 March 2022. • To note that a Strategy Delivery Plan will be developed through the Equality, Diversity & Inclusion Sub Committee to oversee the delivery of the Patient and Staff Pledges. A Chairs Log is presented to the			

	Operational People Committee detailing achievement, issues or items for escalation. Any items for Escalation will be reported to the Strategic People Committee. • To note that the Regulatory requirements for Equality, Diversity and Inclusion are included on the Strategic People Committee Annual Workplan.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/19/03/21
	Date of meeting	20 March 2019
	Summary of Outcome	Approved by Strategic People Committee for progression to Trust Board.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Trust Board

SUBJECT	Equality, Diversity & Inclusion Strategy (Draft)	AGENDA REF:	

1. BACKGROUND/CONTEXT

1.1 The Trust Board acknowledged that the Equality, Diversity and Inclusion Strategy was under review when it endorsed the People Strategy.

1.2 The Strategic People Committee received regular updates on progress with the development of a refreshed Equality, Diversity and Inclusion Strategy up to and including 20 March 2019 which resulted in the recommendation that the draft version was included in the Trust Board Development Session on 27 February 2019.

1.3 All feedback has been collated and included in the Draft version presented to Strategic People Committee (20 March 2019). The version tabled for Trust Board was endorsed by the Equality, Diversity & Inclusion Sub Committee on 15 March 2019.

2. KEY ELEMENTS

2.1 Patient Experience Group:

2.1.1 Draft Equality, Diversity & Inclusion Versions 1-2 presented to the Patient Experience Group and circulated to wider stakeholders for comments via Healthwatch representative on the Group. The Deputy Chief Nurse and Head of Patient Experience provided an update to the development of Draft Version 2 in readiness for further development following the Public Engagement Event (14 February 2019)

2.2 Public Engagement Event (14 February 2019)

2.2.1 Engagement Event aimed at harnessing the Patient and Community Voice and supporting the co-production of the Equality, Diversity and Inclusion Strategy.

WMTM EDI Engagement Event total guests	**47**
Partner Organisations attending	11
Individuals	12
Advocates or special interest – protected characteristics	24

Organisation and/or Individual

WHH Governors
Healthwatch
Deafness Resource Centre
Red Cross
Individuals or Advocates
Papyrus prevention young suicides
Peace Centre

Warrington Market
WVR Collegiate
Wired Carers
Warrington Disability Partnership
Warrington Speak Up
WHH FT Members
WHH

Protected Characteristics represented (where declared)
Disability (physical, mental)
Sex
Age
Pregnancy and maternity
Sexual orientation
Race
Religion or belief
Marriage and civil partnership

2.2.2 The event was published via social media and targeted to Advocates or Special Interest Groups (Appendix 1 – Programme).

2.2.3 The event was opened by the Chief Nurse who welcomed all the attendees The Director of Strategy provided an overview of the Trusts overall Strategy and invited attendees to visit her stall during lunch to provide feedback on the Clinical Strategy for the Trust. The Deputy Chief Nurse provided an overview of the Carers Strategy and also invited attendees to visit the Carer stall to give feedback and suggestions on what mattered to them as carers. And then the main agenda item was opened by the Director Human Resources & Organisational Development with a presentation on the context of the Trusts response to Equality, Diversity and Inclusion over the last 3 years and the Public Sector Equality Duties which must underpin the refreshed strategy (Appendix 2). Group work was facilitated and for one of the groups Sign Language experts were in attendance to support attendees as required.

2.2.4 All attendees were asked to provide specific feedback on;

2.2.5 What Matters to You when you access Emergency support; or when you access Planned Admission support or generally to help you improve their health & wellbeing.

2.2.6 The feedback was collated (Appendix 3) and the Equality, Diversity and Inclusion Draft version 2 was updated to include the ideas, comments and suggestions provided by the representatives at the event. The information was then shared with the Director of Community Engagement & Fundraising to distribute to the attendees along with Next Steps.

2.3 Trust Board Development Session (27 February 2019)

2.3.1 Draft Equality, Diversity and Inclusion Strategy Version 2 presented to Trust Board Development session. Presentation included at Appendix 4

2.3.2 The key elements requested by Trust Board

- To include further detailed information on the Health Inequalities within the boroughs of Warrington & Halton
- To include an overarching vision for the strategy which demonstrated the Trusts ambitions to tackle inequality for patients and staff, specifically for the 9 Protected Characteristics, through accreditation of national recognition / award schemes
- To review the Success Measures to ensure they were sharper in terms of highlighting the key performance outcomes required

2.3.3 Trust Board were informed that following approval of the Draft Strategy that a Delivery Plan would be developed to oversee the achievement of the strategy. The Delivery Plan would be overseen by the Equality, Diversity and Inclusion Sub Committee.

2.4 Equality, Diversity & Inclusion Sub Committee (15 March 2019)

2.4.1 Draft Version 3 of the Strategy captured all of the feedback to date. This draft version was presented to the Equality, Diversity & Inclusion Sub Committee with a page turning exercise to go through the full strategy.

2.4.2 A number of changes were agreed:

- Include the NHS Staff Survey 2018 details on Equality, Diversity and Inclusion and Bullying & Harassment to provide further context on the Workforce Profile of the Trust.
- Include further details on the aim of the strategy to reference local, regional and national accreditation and the specific attention to be given to the 9 Protected Characteristics and those with carer responsibilities.
- Better Health Outcomes for all – Debate was had regarding the wording and whether the term ‘Partners’ should be inserted. The committee members agreed that this would not be included as the objective related specifically to the Trust
- Patient Pledges:
    - Better Health Outcomes for all - Include a further Success Measure on improved Carer involvement in Care Planning through year on year improvement in the Patient Survey results.
    - Improved Patient Access and Experience – To restate the following success measure – Equality data will be presented as part of the patient survey results and year on year improvement across all 9 Protected Characteristics.
- Staff Pledges:
    - Empowered, engage and well supported staff – To include in the Success Measures achievement of the ‘Leader Status in Disability Confidence’ and involvement in the Warrington MELA event
    - Inclusive Leadership, at all Levels – The Head of Organisational Development & learning as for the reference to ‘reciprocal mentorship’ to be removed as the Trust was not currently in a position to offer this. The potential to reinstate this will be discussed at future Equality, Diversity &

Inclusion Sub Committees as part of the oversight of the 3 year Delivery Plan.

2.5 **Strategic People Committee (20 March 2019**)

2.5.1 The Strategic People Committee accepted the Draft Equality, Diversity and Inclusion Strategy, and acknowledged the significant work undertaken to engage on the development of the strategy to date. The Committee approved the draft Strategy for onward progression to Trust Board for approval, with the following amendments:

- Patient Pledge – Improved Patient Access & Experience - What does Success Look Like? Amended to: *CBU level patient equality data reports will be presented and monitored locally at CBU level to support achievement of targets and demonstrate year on year improvement*.
- Staff Pledge – Empowered, Engaged & Well Supported Staff – What does Success Look Like? Amended to: *Recognition as a partner in the NHS Employer Partners programme.*
- Staff Pledge – Empowered, Engaged & Well Supported Staff – What does Success Look Like? Amended to: *Staff networks established and meeting regularly and report as effective by members*.

2.6 The Strategy will be underpinned by a 3 year Delivery Plan overseen by the Equality Diversity and Inclusion Sub Committee.

2.7 If the Strategy is approved by Trust Board it will be effective from 1 April 2019 until 31 March 2022.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

3.1 Trust Board are asked to approve the Strategy.

4. ASSURANCE COMMITTEE

4.1 Strategic People Committee

5. RECOMMENDATIONS

5.1 Trust Board are asked:

- To receive the Draft Equality, Diversity & Inclusion Strategy for approval.
- To note the co-production activities which have resulted in the version presented.
- To receive the Strategy for a 3 year period from 1 April 2019 to 31 March 2022.
- To note that a Strategy Delivery Plan will be developed through the Equality, Diversity & Inclusion Sub Committee to oversee the delivery of the Patient and Staff Pledges. A Chairs Log is presented to the Operational People Committee detailing achievement, issues or items for escalation. Any items for Escalation will be reported to the Strategic People Committee.
- To note that the Regulatory requirements for Equality, Diversity and Inclusion are included on the Strategic People Committee Annual Workplan.

Warrington and Halton Hospitals NHS Foundation Trust

Equality, Diversity and Inclusion Strategy 2019-2022

We are WHH & We are PROUD to make a difference

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Foreword

Mel Pickup, Chief Executive Officer

People

We are WHH & We are PROUD to make a difference

We will... **Be the best place to work** with a diverse, engaged workforce that is fit for the future

As an NHS organisation, we have both a legal and moral duty to demonstrate fairness and equality to our patients, service users, their carers and families, and to our employees.

This strategy explains and responds to the Trust's statutory duties to promote equality amongst all groups of people. It replaces and builds on our previous Equality Strategy 2013 - 2017

The Equality, Diversity & Inclusion Strategy (2019 – 2022) will guide practical work within the organisation aimed at continuing to implement the commitment to equality and as such, will be reviewed and monitored on a regular basis.

We have involved all stakeholders (including staff, patients, carers, partners, governors and members of diverse communities and their representatives) in the development of this Strategy.

We will also ensure that all stakeholders have a real influence in implementing the Strategy in order to achieve demonstrable benefits for everyone.

The General Public Sector Equality Duty:

- **Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act.**
- **Advance equality of opportunity between people who share a protected characteristic and those who do not.**
- **Foster good relations between people who share a protected characteristic and those who do not**

Content Page

Halton Patient Population Profile

(Halton JSNA Summary 2017 and Census 2011)

The patient profile of Halton is published in Halton Borough Council Joint strategic needs assessment. The analysis of this information, the national patient survey and the local census data provides key sources of data which has informed the priorities contained within this strategy. Analysis shows the following:-

- BME of Halton is **2.2 %** in JSNA much lower proportionally to other areas in the NW and nationally
- **21.5%** of Halton's population has reported themselves disabled
- The LGB local population is estimated at **5-7%**
- Christianity accounts for over **70%** of the population of Halton
- Greater proportion of aged 50-69 in the population than nationally, pronounced ageing population, by 2039 it is projected that 1/5th of the population will be over 74, lower male and female life expectancy and disability free life expectancy than average
- Higher rate of economically inactive in Halton than in comparison to the NW and England
- Higher rate of conceptions to females under 18 than nationally
- Lower breastfeeding rates than nationally
- Higher rate of childhood obesity and adult obesity than nationally
- Higher rate of premature deaths, cancer deaths and cardiovascular deaths than national average
- Higher rates of chlamydia than national average
- Higher rate of alcohol related admissions than average
- Higher number of residents claiming long term job seekers allowance

Our Patient Population Warrington

Warrington Patient Population Profile

(Sources JSNA demographic chapter 17/18 and Census 2011)

The patient profile of Warrington is published in Warrington Borough Council Joint strategic needs assessment. The analysis of this information, and the local census data provides key sources of data which has informed the priorities contained within this strategy. Analysis shows the following:-

- The BME population of Warrington is **7.1 %** (lower proportion than nationally and the NW), there are low migration figures. Largest minority group at **2.3%** is other white (includes Europeans), **1.9%** of households do not have English as a main language
- **50.45%** of the population are female, the life expectancy for men and women is lower than the national average
- **18%** of the population have reported themselves disabled
- The LGB local population is estimated at **5-7%**
- **19%** of the population are under 15, **63 %** are age 16-64 and **18%** of the population are over 65 (higher growth rate of over 65's than nationally and regionally)
- **7.6%** of the population are striving families low income below national average, higher unemployment, **8.6%** are young hardship families
- Christianity accounts for over **70%** of the population (a higher proportion than in the NW and nationally)
- Smoking prevalence is below the national average
- The proportion of binge drinking is higher than the national average as are alcohol related and substance misuse admissions for under 18's
- The proportion of adults eating 5 a day is below the national average and obesity rates are higher than average with 2/3rds of adult population an unhealthy weight
- Mortality rates are higher in deprived areas of Warrington, new cancers are higher than average
- Breastfeeding rates are lower than average

Staff and Population Profile

(Sources WEAR 2019, 2017 NHS Staff Survey Census 2011, NHS Staff Survey 2018)

In line with the Public Sector Equality Duty, the workforce profile of the organisation is published on the Trust's website on an annual basis in the Workforce Equality Analysis Report (WEAR). The analysis of this information, the Staff Opinion Survey and the local census data provides key sources of data which has informed the priorities contained within this strategy. Analysis shows the following:-

- **86%** of staff are White British. **13%** are from a BME background. BME population of Warrington and Halton is **7.1%** and **3.6%** respectively
- Currently BME staff are under represented in the workforce at a senior level
- BME candidates are less likely to be appointed from a shortlist than White candidates
- Only **75%** of BME staff believe that the Trust provides equal opportunities in relation to career progression and promotion compared to **90%** of White staff
- **80%** of staff are female compared to **50.45%** in the local population. However, the Trust has a mean gender pay gap of **24.27%** in favour of males
- Only **2%** of staff have declared they have a disability, with **44%** of staff shown as unknown. **18%** of Warrington and **21.5%** of Halton population have reported themselves disabled. The number of staff who are carers is unknown. According to the National Staff Survey 2018, **17.3%** of respondents indicated that they had had a physical or mental health condition, disability or illness that have lasted or are expected to last for 12 months or more
- **61%** of staff report as heterosexual, **1%** as LGB and the sexuality of **38%** of staff is unknown The LGB local population is estimated at **5-7%**
- **43%** of staff are Christian, **17%** are from other religions and the religious beliefs of **40%** of staff are unknown. Christianity accounts for over **70%** of the population of both Warrington and Halton

Warrington and Halton Hospitals NHS Foundation Trust

This organisation is benchmarked against:

Acute Trusts

Organisation details

Completed questionnaires	1,990
2018 response rate	51%

2018 benchmarking group details

Organisations in group: 89

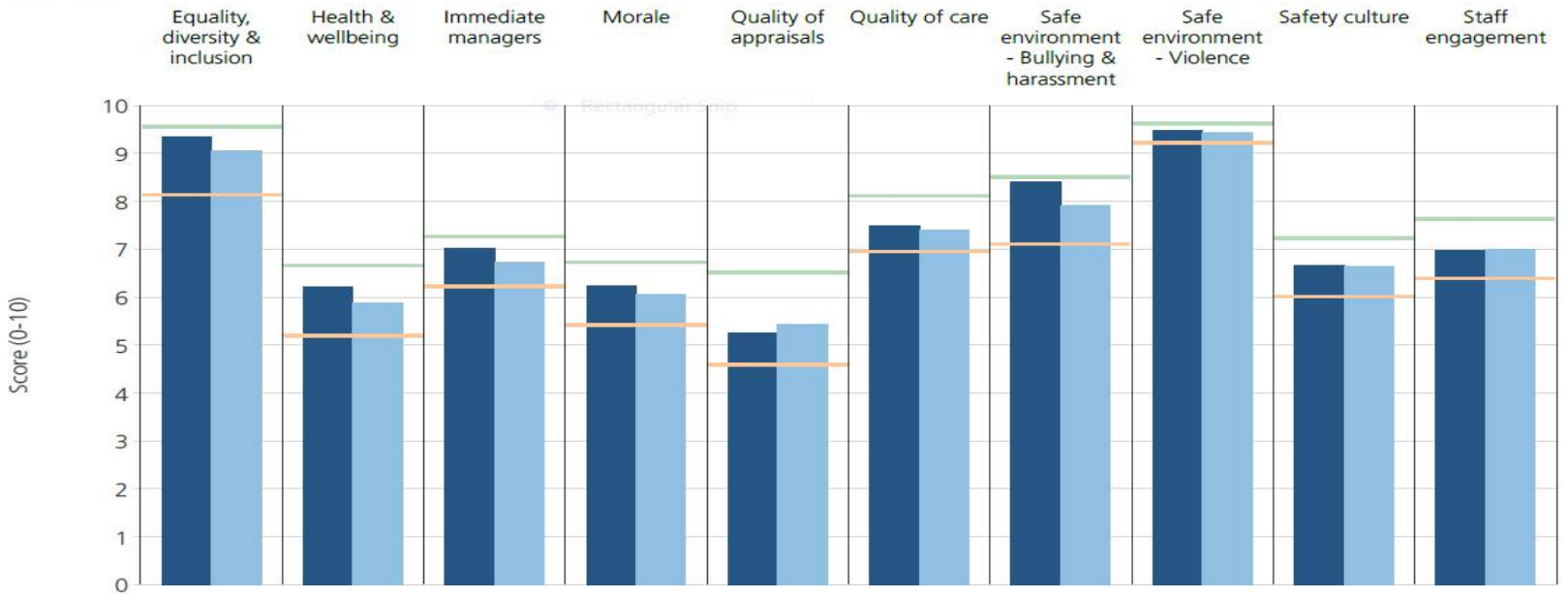
Average response rate: 44%

No. of completed questionnaires: 232,401

Survey Coordination Centre

2018 NHS Staff Survey Results > Theme results > Overview

NHS England

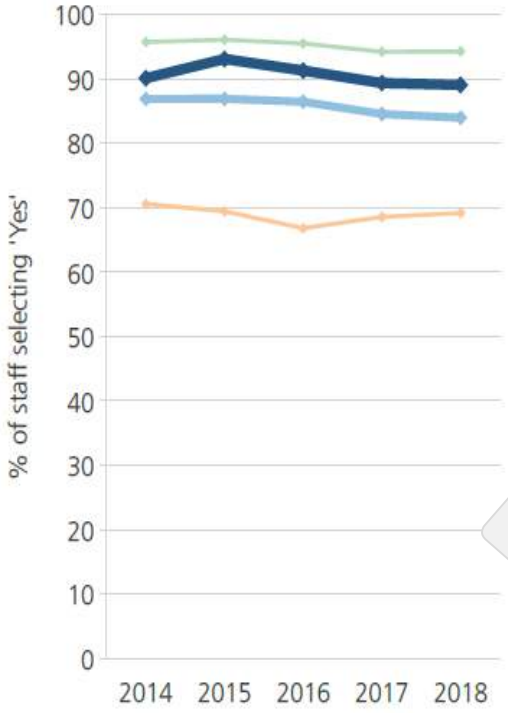


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.3	6.2	7.0	6.2	5.3	7.5	8.4	9.5	6.7	7.0
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4

NHS Staff Survey

(Sources NHS Staff Survey 2018 – Equality, Diversity and Inclusion & Bullying & Harassment Results)

Q14
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

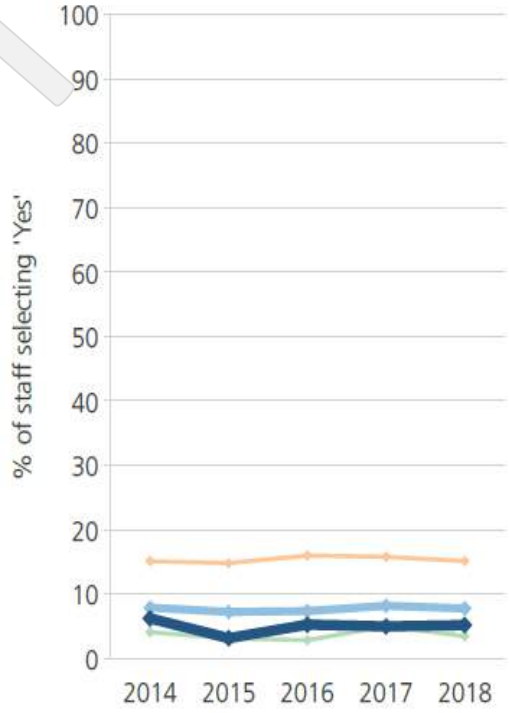


	2014	2015	2016	2017	2018
Best	95.7%	96.1%	95.5%	94.2%	94.3%
Your org	90.1%	93.1%	91.3%	89.3%	89.1%
Average	86.9%	86.9%	86.4%	84.5%	83.9%
Worst	70.6%	69.4%	66.8%	68.6%	69.2%

Q15a
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?

	2014	2015	2016	2017	2018
Worst	12.2%	13.8%	13.8%	16.1%	16.4%
Your org	2.9%	4.9%	3.9%	3.7%	3.8%
Average	5.6%	5.2%	5.8%	6.1%	6.1%
Best	2.2%	1.8%	1.8%	2.9%	2.7%

Q15b
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



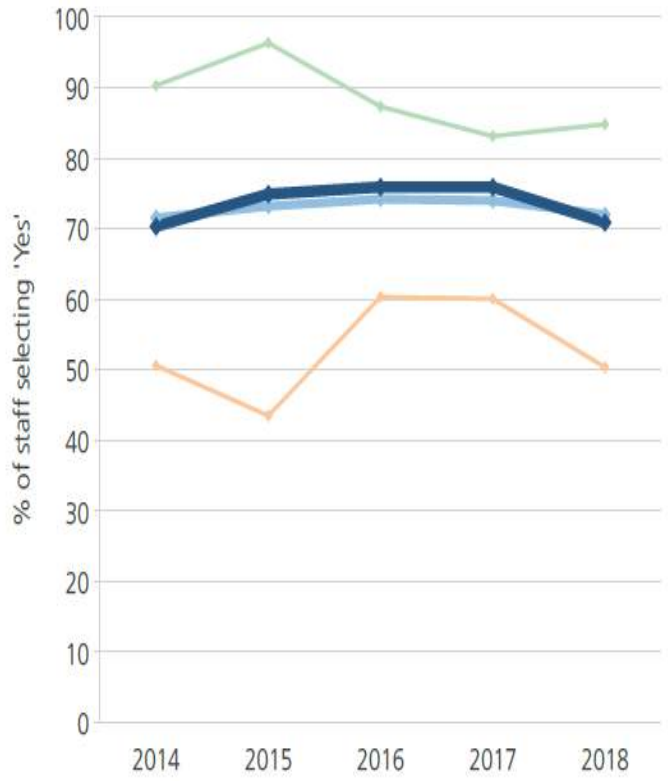
	2014	2015	2016	2017	2018
Worst	15.1%	14.8%	16.0%	15.8%	15.1%
Your org	6.2%	3.1%	5.2%	5.0%	5.2%
Average	7.9%	7.2%	7.3%	8.2%	7.7%
Best	4.1%	3.1%	2.8%	5.0%	3.4%

NHS Staff Survey

(Sources NHS Staff Survey 2018 – Equality, Diversity and Inclusion & Bullying & Harassment Results)

Q28b

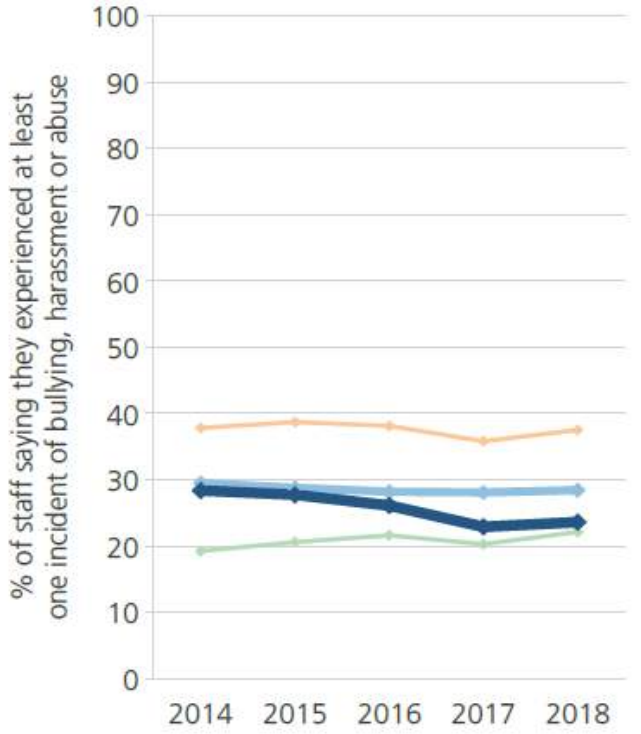
Has your employer made adequate adjustment(s) to enable you to carry out your work?



	2014	2015	2016	2017	2018
Best	90.3%	96.3%	87.3%	83.1%	84.8%
Your org	70.3%	74.9%	75.9%	75.9%	70.9%
Average	71.5%	73.2%	74.2%	74.0%	72.0%
Worst	50.6%	43.5%	60.3%	60.0%	50.4%

Q13a

In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?

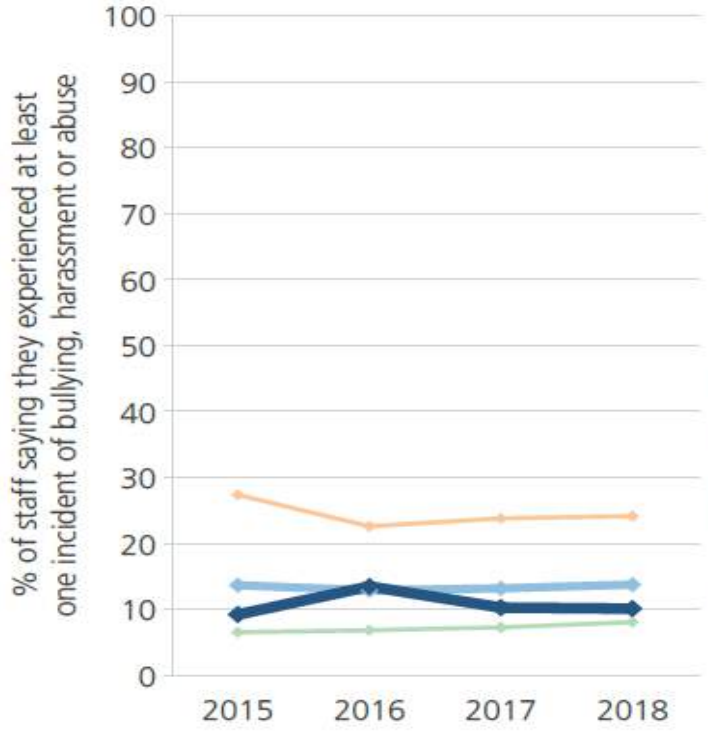


	2014	2015	2016	2017	2018
Worst	37.8%	38.7%	38.1%	35.8%	37.5%
Your org	28.4%	27.7%	26.1%	22.9%	23.6%
Average	29.5%	28.8%	28.2%	28.1%	28.4%
Best	19.2%	20.6%	21.6%	20.3%	22.1%

NHS Staff Survey

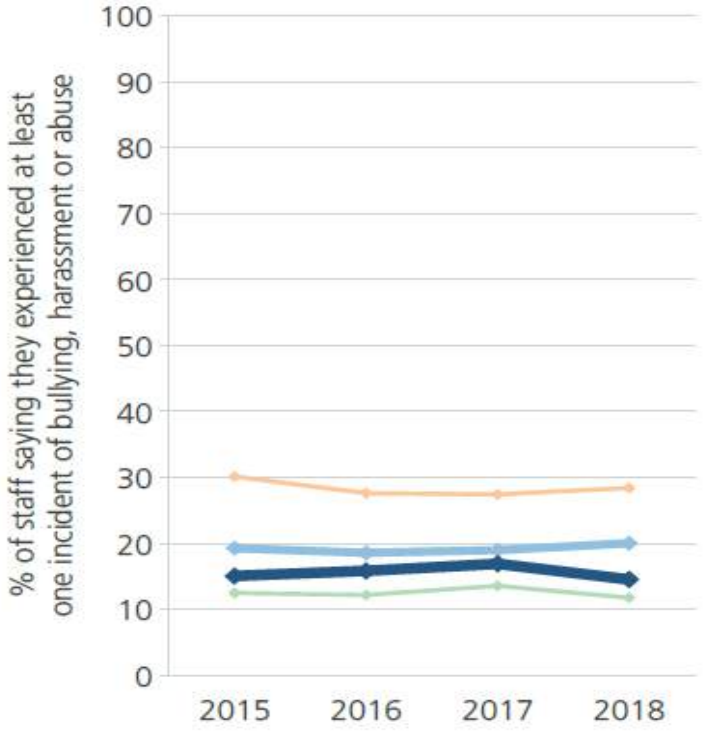
(Sources NHS Staff Survey 2018 – Equality, Diversity and Inclusion & Bullying & Harassment Results)

Q13b
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018
Worst	27.3%	22.6%	23.8%	24.1%
Your org	9.2%	13.5%	10.3%	10.1%
Average	13.6%	12.9%	13.2%	13.7%
Best	6.5%	6.8%	7.3%	8.0%

Q13c
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018
Worst	30.1%	27.6%	27.4%	28.4%
Your org	15.1%	15.8%	16.9%	14.5%
Average	19.3%	18.6%	19.0%	20.0%
Best	12.5%	12.2%	13.6%	11.7%

What have we achieved?

The Trust Equality and Diversity Strategy 2013-2017 focused on 5 key areas:

- Communication & Awareness
- Data Quality & Reports
- Community Engagement
- Internal Governance
- Accessible and Equitable Services

Under this Strategy, the Trust has made a number of advances in supporting our workforce and patients, including:

Communication & Awareness

Established disability and BME Focus Groups
Support of various Awareness Days/Weeks
Embedded Equality & Diversity Training
Briefings to internal governance structures
Stakeholder involvement at equality groups
Achieved Disability Confident Status

Accessible & Equitable Services

Dementia Ward/Services opened May 2014
Dementia Strategy developed & Training for staff given
Continuous interpretation & translation services
Quiet Room in A&E
Signed up to Accessible Warrington Pledge

Internal Governance

New Equality Impact Assessment Board updated on requirements, recommendations and publications.
Presentation to people strategic committee (EDSC reports to)
Council of Governors updated bi-annually on WRES

Data Quality & Reports

Adhered to all Statutory reports
Positive EDS2 Outcomes
Maintained high reporting of Ethnicity Status

Community Engagement

Stakeholder Engagement activities i.e. attending Warrington Disability Event/ attendance at EDSC
Engagement with carers centres locally i.e. WIRed
External Stakeholder support in EDS2 Assessment

2017 EDS2: Rated "Achieving" in 16 and "Excelling" in 2, out of 18

Equality Delivery System for the NHS (EDS2)

Where Are We Now?

Our new **strategy for 2019-2022** will build on our previous achievements and focus on areas for further ambition based on **our current context…….**

- The Trust has achieved **positive Equality Delivery System 2 Results**, which will offer the **platform to improver further** and develop under this Strategy.
- The Trust has maintained **high reporting levels for staff ethnicity**, and is **largely reflective of the local populations**, though we have higher numbers of staff identifying as Indian, Pakistani and Other Asian, compared to our local population .
- Our reporting for protected characteristics varies, though is mainly in line with the local population; many individuals **do not disclose their disability** which is evident for both staff and our local population. The Trust also has a **higher non-disclosure rate** than the North West Region **for Sexual Orientation**.
- The local population reflects the Trust staff age profile with over **60% being over the age of 40** (both staff and local population). This is also **reflective of there being 36,861 carers** within the Warrington and Halton population, with the data indicating that those aged between **45 and 64 are at peak age for providing unpaid care**. In the 2011 Census, more than **21,000** unpaid carers were identified as living in Warrington, and more than **15,000** living in Halton
- The number of carers is also likely reflective of the number of those identifying as having a **disability in the local population (19.96% across Warrington & Halton** – though the data indicates this number is much higher).

With the launch of the refreshed WHH Strategy and the People Strategy, with a defined Equality, Diversity & Inclusive Objective, this has given the opportunity to review the strategy and extend our focus as a reframed ***Equality, Diversity and Inclusion Strategy***, to build on our current work and develop a focus on new areas which require further attention.

(This comparative data is sourced from NHS Employers – Measuring up data comparison tool - which compiles statistics from Office for National Statistics (ONS), National Online Manpower Information System (NOMIS) and the 2011 Census. The Staff Data is compiled from our staff list as of June 2018.)

9 Protected Characteristics

1. Race
2. Disability
3. Sex
4. Sexual Orientation
5. Gender Reassignment
6. Marriage & Civil Partnership
7. Pregnancy & Maternity
8. Age
9. Religion or Belief

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Our Mission, Vision, Values Aims and Objectives

NHS Warrington and Halton Hospitals NHS Foundation Trust

Our Mission

We will be OUTSTANDING for our patients, our communities and each other

Our Vision

We will be the change we want to see in the world of health and social care

Our Aims/Objectives

Quality

We will... **Always put our patients first** through high quality, safe care and an excellent patient experience

People

We are WHH & We are PROUD to make a difference

We will... **Be the best place to work** with a diverse, engaged workforce that is fit for the future

Sustainability

We will... **Work in partnership** to design and provide high quality, financially sustainable services

We will do this by:

Continuously improving, exploring new opportunities and technology and being creative and innovative in redesigning and developing all we do.

Our Values

Working Together | Excellence | Accountable | Role Model | Embracing Change

Our Equality, Diversity and Inclusion Vision

WHH Strategic Equality, Diversity & Inclusion Vision

At Warrington and Halton Hospitals NHS Foundation Trust we believe that an essential ingredient to achieving our mission of being outstanding for our patients, our communities and each other is to be an organisation that is truly inclusive, celebrates diversity and eliminates discrimination.

That's why we aim to be a **leading organisation, which is recognised locally, regionally and nationally, for promoting Equality, Diversity and Inclusion** (E,D&I) for our patients and our workforce, focusing on the 9 Protected Characteristics and those with carer responsibilities.

We want to create a positive culture where all our patients will experience outstanding care which meets their specific needs, with a workforce where no-one will feel compelled to conceal or play down elements of their identity for fear of stigma, where people can be authentic and their unique perspective, experiences and skills seen as a valuable asset to the Trust.

To help us achieve this vision we have set out 4 Equality, Diversity and Inclusion objectives:

Our Equality, Diversity and Inclusion Objectives

WHH Strategic Equality, Diversity & Inclusion Objectives

PATIENTS

We will work to reduce health inequalities and ensure that our services meet the needs of all our patients.

We will provide equal access to our services and improve the experience of our patients with protected characteristics.

WORKFORCE

We will build and maintain a diverse and representative workforce that is empowered, engaged and supported to demonstrate inclusive behaviours.

We will work to ensure that the Trust has inclusive and diverse leadership across all levels of the workforce.

Our **Equality, Diversity & Inclusion Strategy** sets out what each of these objectives mean for our patients and our workforce, how we will deliver them and what success looks like.

We will work to reduce health inequalities and ensure that our services meet the needs of all our patients.

Our Patient Pledges

We will work with hard to reach groups in our communities to ensure they are part of shaping our services.

We will work to meet the individual needs of our patients.

Our Patient Priorities

- To build on and improve established links with third sector and community services and ensure we are regionally recognised as being fully engaged with all hard to reach groups.
- Establish an annual programme of engagement in partnership with local specialist organisations.
- Review our approach to service redesign, ensuring that equality and inclusion are central to community engagement, consultation and decision making to ensure that the patient voice is heard.
- Through development of the Carer's Strategy we will ensure involvement of carers and family members in care planning and decision making (with patient consent).
- Ensure that we train all staff appropriately regarding patients with protected characteristics and monitor training compliance rates on a monthly basis.
- We will request feedback from patients, carers and local community groups about our communication methods at each engagement event.
- We will ensure the Accessible Information Standard is embedded

What Does Success Look Like?

- Monitor and report attendance at community and networking events through the Trust's Equality, Diversity & Inclusion Sub Committee on a monthly basis.
- We will create an evidence portfolio of Patient and Service User Engagement activities bespoke to each CBU.
- Carer activity of involvement in Care Planning demonstrated through year on year improvement in Patient Survey Results.
- Equality Impact Assessments are completed for all service redesign and there is evidence that these have informed decision making.
- Trust wide training compliance rates will be consistently above 85%.
- Positive outcomes from audit of the adherence to the Accessible Information Standard (AIS).
- Positive feedback through a number of routes; reduction in complaints, improved survey scores and compliments.

We will provide equal access to our services and improve the experience of our patients with protected characteristics.

Our Patient Pledges

We will record equality monitoring information about patients accessing our services and take action where inequality is identified.

We will work in partnership with our patients, carers and communities to improve the experience of our patients.

Our Patient Priorities

- Review how patient equality data is captured and reported across the organisation.
- We will ensure that patient equality data is reported at CBU level in order to inform service redesign.
- Embed E,D&I into all clinically related policies and initiatives across the Trust, such as Listening into Action and Quality Academy programmes.
- Ensure that equality data is captured in all patient surveys and results are reviewed and actioned.
- Implement innovative technologies to enhance existing feedback methods to ensure feedback is received from hard to reach groups.
- External organisations will be requested to support training, to enhance ED & I knowledge and skills of our staff.

What Does Success Look Like?

- Evidence of a completed gap analysis about patient equality data capture and associated action plan is reported and monitored through ED&I sub committee.
- CBU level patient equality data reports will be presented and monitored locally at CBU level, to support achievement of targets and demonstrate year on year improvement.
- Audit of policies, Quality Academy programmes and LIA will show compliance with embedded ED&I.
- Equality data will be presented as part of the patient survey results and year on year improvement across all 9 Protected Characteristics
- Evidence of technological implementation through reports to ED&I sub committee and improved response rates.
- External organisations will produce an annual report identifying the support they have provided.

Our Staff Pledges

We will build and maintain a diverse and representative workforce that is empowered, engaged and supported to demonstrate inclusive behaviours.

Our Staff Pledges

We will develop an inclusive and supportive environment where staff feel confident and comfortable to disclose personal information on protected characteristics.

We will actively promote positive relations between staff who have protected characteristics and those who do not.

Our Staff Priorities

- To be recognised regionally as a best practice inclusive employer.
- To improve the representation and experience of staff with protective characteristics across our workforce.
- Increase staff disclosure of personal information on protected characteristics, by raising awareness on how data is collected stored and used.
- Embed E,D&I into all workforce related policies, training and development provision across the Trust.
- Introduce Equality, Diversity and Inclusion Champions throughout the workforce.
- To empower and engage staff with advancing equality issues by establishing staff networks and forums to give all staff a voice.
- Celebrate difference and promote diversity both within the organisation and by increasing our presence in the community.
- Build relationships with external stakeholders to build expertise and knowledge across the organisation.

What Does Success Look Like?

- Membership and accreditation by key organisations to establish the Trusts position to achieve excellence and national endorsement for E, D & I e.g. Employer Network for Equality & Inclusion (ENEI), Stonewall, Race Charter, Business Disability Forum, and Leader Status in Disability Confidence
- Recognition as a partner in the NHS Employer Partners programme.
- Staff disclosure of protected characteristics at 0% unknown/unanswered and <25% do not wish to disclose
- No statistically significant differences in staff survey outcomes and monitoring data (e.g. WRES, WDES, EDS2, Gender Pay Gap, local surveys) for staff with protected characteristics when compared to those without improved representation of staff with protected characteristics within our workforce.
- Policies and procedures developed in partnership with staff side colleagues which create a Just Culture for all staff
- Equality and diversity champions in place in all CBUs and Departments across both sites.
- Staff networks established and meeting regularly and reported as effective by members
- Establish a calendar of events linked to national celebration and awareness campaigns.
- Active involvement in community activities such as PRIDE , DAD and Warrington MELA events.
- E,D & I in employment policy introduced and development of manager toolkits.

Our Staff Pledges

We will work to ensure that the Trust has inclusive and diverse leadership across all levels of the workforce

Our Staff Pledges

We will create the condition for supportive environments which are free from discrimination, harassment, victimisation and bullying.

We will support the leadership development of staff with a protected characteristic, across all levels in the organisation.

Our Staff Priorities

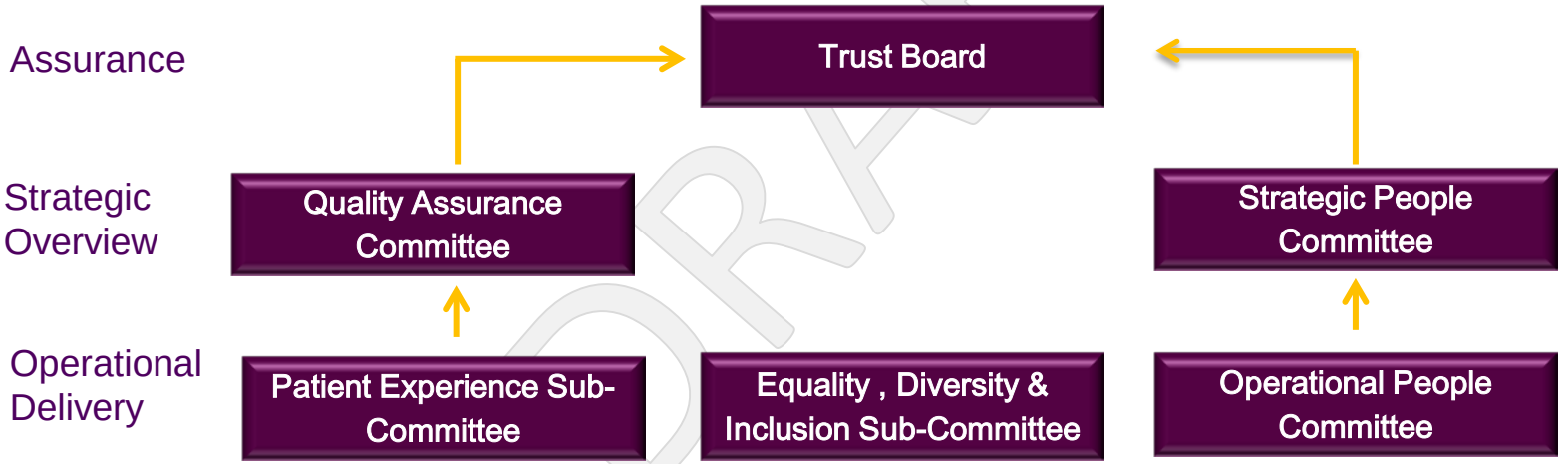
- To promote 'Zero Tolerance' in relation to discrimination, harassment, victimisation and bullying.
- Encourage engagement of staff with protected characteristics in key roles, such as People Champions and Freedom to Speak Up Champions.
- Review current line manager training provision in relation to equality, diversity and inclusion.
- Review our approach to attraction, retention and development to ensure that processes are fair, equitable and promote diversity.
- Leaders across the Trust engage and utilise the staff networks to encourage inclusivity in decision making.
- Provide support to staff with protected characteristics to reach their potential, e.g. leadership development programmes participation.
- Include diversity and inclusion as a key element of developing the Trust Succession Planning and Talent Management Framework.
- Increase the number of staff from a BME background and with a disability in senior roles

What Does Success Look Like?

- Implementation of a Zero Tolerance campaign.
- Create a dedicated workspace on extranet for E,D&I
- A reduction in any statistically significant differences in staff survey results between those that hold protected characteristics.
- Improvements in the diversity of People Champions and FTSU champions.
- E ,D &I training for managers package developed and delivered.
- Increased number of staff with protected characteristics accessing leadership development.
- Improved representation of staff with protected characteristics in leadership roles.
- Implementation of Talent Management programme that specifically addresses diversity and inclusion.
- Involvement of the staff network in the development of services, policies and organisational change.
- Statutory report and local experience surveys (e.g. WRES, WDES, EDS2, Gender Pay Gap), evidences positive recruitment outcomes and experiences for staff with protected characteristics when compared to those without.

Governance

We will deliver our Equality, Diversity & Inclusion Strategy over a 3 year period through partnership working with internal and external stakeholders. Delivery plans will be introduced to underpin each of the pledges outlined. Patient Experience Group will oversee the delivery plan for the Patient Pledges and Operational People Committee will oversee the delivery plan for the Workforce Pledges. Progress will be reported to the Equality, Diversity & Inclusion Sub-Committee which will monitor all the operational aspects of this Strategy.



Statutory Reports 2019-2022

- WRES
- WDES
- EDS2
- WEAR
- EDAR
- Gender Pay Report

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/28**
SUBJECT:	**Educational Quality Monitoring Review**
DATE OF MEETING:	27th March 2019
AUTHOR(S):	**Dr Alex Crowe Director of Medical Education / Spencer Mckee Head of Medical HR and Medical Education**
EXECUTIVE DIRECTOR SPONSOR:	**Dr Alex Crowe Deputy Medical Director**
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY (KEY ISSUES):	**Each year the GMC undertakes a survey of all Doctors in Training that are placed at all NHS Trusts, including WHH. The survey seeks the views of Trainees with regards to their training placements. The results are published in July of each year, and these are available to the wider public domain.** **The GMC results in July 2018 did highlight a number of serious concerns and WHH remains under continued Special Measures with HEE NW and is under 'Enhanced Monitoring'. WHH has been under enhanced monitoring for a number of years.** **WHH is therefore required to address these concerns in order for HEE NW to be able to remove WHH from the Special Measures, and also address any related risks.** **Full details regarding this matter were provided at SPC in November 2018 and with an updated report provided in January and March 2019**. **This paper provides a progress report, as requested by Trust Board. It is important to note that on the 31st January 2019 WHH received formal Action Plan requests from HEE NW regarding these matters. WHH must respond by the 30th April 2019.**

PURPOSE: (please select as appropriate)	**Information**	Approval	To note	Decision
RECOMMENDATION:	**1) For Information;** **2) For Discussion;** **3) For discussion and any additional recommendations from Trust Board;** **4) For Assurance to Trust Board.**			
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**		
	Agenda Ref.	**SPC 19.03.39**		
	Date of meeting	**20.03.2019**		
	Summary of Outcome	**Report endorsed**		
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**			

BOARD OF DIRECTORS

SUBJECT	Educational Quality Monitoring Review	AGENDA REF:	BM/19/03/28

1. BACKGROUND/CONTEXT

Full details regarding the background to this matter have been provided at SPC.

Key points to update SPC on in March are provided below:

1. **HEENW had held their Formal Annual Assessment Visit in June 2018. Due to some of the negative feedback from this visit and the 2018 GMC Survey this was later followed up with a CMT Visit in November 2018.**

   <u>Update:</u>

   A. **WHH received a formal HEE NW Action Plan (Appendix 1) for both visits on the 31st January 2019. A copy of this is provided with this paper with 'interim updates';**

   B. **Medical Education overseen by Dr Alex Crowe Director of Medical Education are addressing each point raised within the Action Plan;**

   C. **HEE NW require a formal response to the reports by the <u>30th April 2019</u>;**

   D. **The Developing Junior Doctors Experience Group chaired by Dr Alex Crowe continues to meet monthly and has a formal action plan (Appendix 2) to assist with ensuring that all actions are completed;**

   E. **Likewise the Junior Doctors Forum chaired by Dr Alex Crowe continues to meet monthly and has a formal action plan (Appendix 3) to assist with ensuring that all actions are completed.**

2. **The 2019 GMC Survey is scheduled from 19th March 2019 – 1st May 2019;**

3. **The next HEE NW formal visit will be in September 2019;**

4. **This matter is recorded on the risk register.**

2. KEY ELEMENTS

A. **WHH received a formal HEE NW Action Plan (Appendix 1) for both visits on the 31st January 2019, with an interim updated provided with this paper;**

Key Findings of the Report/Action Plan:

I. **HEE NW utilised both the visit findings and also the GMC National Trainee Survey Results from July 2018;**
II. **The run dates for the Annual GMC Survey are important to note in that there have been many operational issues that have been resolved and progressive improvements for Trainees during this time;**
III. **We have reduced our overall risk from category 2 to category 3 with only 1 action still graded at category 3;**
IV. **This represents an overall improvement in our HEENW/GMC risk category score.**

HEE NW also noted a range of good practice e.g.:

V. **Ward accreditation to include a template for ward rounds;**
VI. **Emergency Medicine Educators responding to the needs of Trainees picking up shifts to allow time for learning and Emergency Medicine Consultants commended for provision of a stable supporting learning environment;**
VII. **HEENW commended for dramatically improving scores for Trainees working in Surgery, Anaesthetics and Paediatrics, with stable and continued success in O&G and Radiology.**

B. **Medical Education overseen by Dr Alex Crowe are overseeing the response to the Action Plan to ensure all actions are being completed;**

C. **HEE NW require a formal response to the reports by the 30th April 2019;**

D. **The Developing Junior Doctors Experience Group chaired by Dr Alex Crowe continues to meet monthly and has a formal action plan (Appendix 2) to assist with ensuring that all actions are being completed;**

E. **Likewise the Junior Doctors Forum chaired by Dr Alex Crowe continues to meet monthly and has a formal action plan (Appendix 3) to assist with ensuring that all actions are completed.**

F. **The 2019 GMC Survey is scheduled from 19th March 2019 – 1st May 2019;**

G. **The next HEE NW formal visit will be in September 2019;**

H. **This matter is recorded on the risk register.**

I. The Royal College of Physicians London visited the Trust on the 15th March 2019 and reported back that the Trainees fed back there were improvements being made within the organisation and those matters still requiring further development are being addressed via the Developing Junior Doctors Experience Group, Junior Doctors Forum and also Medical Education Weekly Huddles that Dr Crowe has now introduced.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Trust Board is asked to take note of this report and moving forwards monitor and review the Action Plans being undertaken.

4. IMPACT ON QPS?

Failure to address the GMC / HEE NW concerns may potentially lead to:

A. Withdrawal of Trainees;
B. Recruitment and Retention concerns for the wider Medical Workforce;
C. Increased expenditure on agency/locums;
D. Poor moral;
E. Increased absence;
F. Reputational risk;
G. Potential Patient Safety Concerns.

5. MEASUREMENTS/EVALUATIONS

Developing Junior Doctors Experience Group Meetings along with the Junior Doctors Forum and Medical Education Weekly Huddles will assist with covering and addressing:

A. 2018 GMC Survey Results;
B. HEE NW Annual and CMT Visits;
C. HEE NW Report for the CMT Visit;
D. HEE NW Action Plan for the 2018 Assessment Visits;
E. Interim 'Pulse Check Surveys'.

6. TRAJECTORIES/OBJECTIVES AGREED

Professor Simon Constable has established a Developing Junior Doctors Experience Group monitor and address the HEE NW Concerns. This is chaired by Dr Alex Crowe Director of Medical Education.

7. MONITORING/REPORTING ROUTES

It is recommended that the Developing Junior Doctors Experience Group Meeting along with the Junior Doctors Forum provides the Group Action Plans to SPC Group to monitor and review.

8. TIMELINES

Monthly Developing Junior Doctors Experience Group Meetings along with the Junior Doctors Forum and Medical Education Weekly Huddles to take place to ensure Action Plans monitor and addresses concerns.

9. ASSURANCE COMMITTEE

Trust Board is asked to note this report and review Action Plans being undertaken via the Developing Junior Doctors Experience Group Meetings along with the Junior Doctors Forum and Medical Education Weekly Huddles, pending the 2019 GMC Survey and to ensure that all steps are being taken regarding all HEE NW Action Plan requirements.

10. RECOMMENDATIONS

1. **Trust Board is asked to note this report and review Action Plans being undertaken via the Developing Junior Doctors Experience Group Meetings along with the Junior Doctors Forum and Medical Education Weekly Huddles, pending the 2019 GMC Survey and to ensure that all steps are being taken regarding the HEE NW Action Plan requirements;**

2. **Importantly, WHH will be required to formally respond to the HEE NW Action Plans issued on the 31st January 2019 and therefore this report requests the views of the group regarding formal sign off of the report.**

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/29**			
SUBJECT:	**WHH strategy – Governance and delivery progress summary**			
DATE OF MEETING:	27th March 2019			
AUTHOR(S):	Lucy Gardner, Director of Strategy			
	Carl Mackie, Halton Healthy New Town Lead			
	Deborah Smith, Deputy Director of HR and OD			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides an update on the governance and delivery of the Trust's strategic objectives, included in the Trust's strategy which was approved in May 2018. The report is provided twice yearly to assess progress against our strategic priorities within our 3 year strategy. This report shows that at the end of Q3 2018/19 the Trust is on track to deliver the outcome/KPI over the 3 year period on 17 indicators and ahead of plan on 29 indicators. There is 1 indicator which is not rated at this stage.			
PURPOSE: (please select as appropriate)	Information	Approval	**To note**	Decision
RECOMMENDATION:	The board notes the progress made against delivery of the strategic objectives and the governance arrangements in place			
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			

Strategy Development and Delivery sub-committee

SUBJECT	Strategy Delivery Assurance	AGENDA REF:	BM/19/03/29

1. BACKGROUND/CONTEXT

On 27th May 2018, the Trust Board approved a refreshed strategy, which is summarised below.

The refreshed strategy includes 3 strategic objectives for each of our Quality, People and Sustainability aims. Delivery of each strategic objective is measured against agreed outcomes, the monitoring of which is supported by a series of KPIs, which are expected to continue to evolve over the three year timeframe of the strategy.

The table below summarises the objectives and outcomes agreed.

Aim	Objective	Outcomes
Quality	Patient Safety - We are committed to developing and enhancing our patients' safety and learning culture where quality and safety is everyone's top priority	We will have safe systems of work in place We will ensure that we minimise harm for patients
	Clinical Effectiveness is about ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients	We will ensure that we providing care that is evidence based We will ensure that we are focused on outcomes for patients and that are benchmarking/peer reviewing ourselves against the 'best in class'. We will ensure that we foster a culture of Quality Improvement
	By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.	Every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services. We will communicate in line with our values. We will ensure partnership working and needs based care. We will simplify patient focused processes.

Aim	Objective	Outcomes
People	Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience	Staff will be supported to be healthy and supported if they are unwell Staff will feel proud, enthusiastic and happy in work
	Attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to deliver excellent patient care	WHH will be a great and inclusive place to work Staff will be supported to develop new skills and ways of working
	Develop a collaborative, compassionate and inclusive culture of collective leadership at all levels and organisational learning.	Staff at all levels in the Trust are able to develop as leaders Staff feel empowered to identify improvements and put them in place

The people objectives and outcomes summarised above are those refreshed and approved in September 2018 in the refreshed people strategy.

Aim	Objective	Outcomes
Sustainability	Play a central role in our healthcare economies to support integrated place based care	Provider of integrated services, intermediate care and care home services Improved pathways for local residents to ensure that everyone receives the right support, care and treatment at the right time Strong relationships and collaborative working with all partners, including councils, CCGs, mental health and community services providers and the voluntary sector
	Work with other acute care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable	Ensure services meet the demand of our populations Provide services on behalf of others where our services are clinically and financially superior Disinvest in or transform services which are not financially sustainable and do not currently provide high quality outcomes Share best practice and collaborate to ensure the best outcomes for our populations Maintain and then improve financial position
	Provide our services in an estate that is fit for purpose, supported by technology, and aligned to the needs of our developing populations.	New hospital and wellbeing campus in Halton New hospital in Warrington Recognised digital exemplar

2. GOVERNANCE

Delivery against each of the strategic objectives and associated outcomes/KPIs is regularly monitored and managed via the Committees and Sub-committees of the Trust board.

The table below summarises the governance arrangements in place.

Aim	Outcomes	Proposed KPIs	Committee/Sub-committee	Frequency of Monitoring	Integrated Performance Report
Quality	We will have safe systems of work in place We will ensure that we minimise harm for patients	• 20% reduction in falls	Patient Safety and Clinical Effectiveness Quality Assurance Committee	Monthly Bi-monthly	Yes
		• 100% medicines reconciliation	Patient Safety and Clinical Effectiveness Quality Assurance Committee	Monthly Annually	Yes
		• 10% reduction in hospital acquired infections	Patient Safety and Clinical Effectiveness Infection Control Sub-Committee Quality Assurance Committee	Monthly Monthly Bi-monthly	Yes
		• 100% of patients have sepsis screening and are treated appropriately	Patient Safety and Clinical Effectiveness Quality Assurance Committee	Monthly Bi-monthly	Yes
		• 100% of patients to have a VTE assessment and appropriate treatment	Patient Safety and Clinical Effectiveness Quality Assurance Committee	Monthly Bi-monthly	Yes
	We will ensure that we providing care that is evidence based We will ensure that we are focused on outcomes for patients and that are benchmarking/peer reviewing ourselves against the 'best in class'.	• Reduce DTOCs to no greater than 3%	KPI Meeting Finance and Sustainability Committee	Monthly Bi-monthly	No

	We will ensure that we foster a culture of Quality Improvement	• Reduce readmissions within 30 days for patients >65 to no greater than 12.5%	KPI Meeting	Monthly	No
		• Understand variance in clinical outcome measures across all specialities, measure and agree improvements	Quality, People and Sustainability Trust Operational Board	Bi-monthly Monthly	No
		• Number of Quality Improvement projects successfully completed	Quality Academy Board Quality Assurance Committee	Quarterly Quarterly	No
		• Increase number of staff with quality improvement training via Quality Academy	Quality Academy Board Quality Assurance Committee	Quarterly Quarterly	No
	Every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services. We will communicate in line with our values.	• Increase in Friends and Family Test scores to ensure all specialities meet or exceed national benchmarks	Patient Experience Sub-committee Quality Assurance Committee	Monthly Bi-monthly	Yes
	We will ensure partnership working and needs based care. We will simplify patient focused processes.	• Improve across all indicators in the inpatients survey • Improve across all indicators in the inpatients survey	Patient Experience Sub-committee Quality Assurance Committee	Monthly Bi-monthly	No
		• 10% reduction in formal complaints	Complaints Quality Assurance Group Patient Experience Sub-committee Quality Assurance Committee	Monthly Monthly Bi-monthly	Yes

Aim	Outcomes	Proposed KPIs	Committee/Sub-committee	Frequency of Monitoring	Integrated Performance Report
People	Staff will be supported to be healthy and supported if they are unwell	• Reduction in mental health related sickness absence	Strategic People Committee	Quarterly	No
		• Reduction in musculoskeletal health related sickness absence	Strategic People Committee	Quarterly	No
		• Improving number of staff believe that we value their health and wellbeing	Strategic People Committee	Quarterly	No
		• Increasing numbers of staff receiving the annual flu vaccination	Strategic People Committee	Quarterly	No
	Staff will feel proud, enthusiastic and happy in work	• Improving number of staff recommend WHH as a place to work and receive treatment	Strategic People Committee	Quarterly	No
		• Pioneering teams adopt LIA	Strategic People Committee	Quarterly	No
		• Continuous improvement via the Ward Accreditation Programme	Strategic People Committee	Quarterly	No
	WHH will be a great and inclusive place to work	• Reduction in difficult to fill vacancies across the Trust	Strategic People Committee	Quarterly	Yes
		• Reduction in the number of staff leaving the Trust	Strategic People Committee	Quarterly	Yes
		• Achievement of the measures within the Equality, Diversity and Inclusion Policy	Strategic People Committee	Quarterly	No
	Staff will be supported to develop new skills and ways of working	• Production of strategic workforce plans	Strategic People Committee	Quarterly	No
		• Improvement in number and quality of annual appraisals	Strategic People Committee	Quarterly	Yes
		• All available staff, including bank workers, have completed mandatory training	Strategic People Committee	Quarterly	Yes
		• Improving number of staff tell us that they have received high quality non-mandatory development	Strategic People Committee	Quarterly	No
	Staff at all levels in the Trust are able to develop as leaders	• Reduction in Dignity at Work employee relation cases	Strategic People Committee	Quarterly	No
		• Increase in internal promotions	Strategic People Committee	Quarterly	No
		• Improved recruitment and retention of leadership positions	Strategic People Committee	Quarterly	No

	Staff feel empowered to identify improvements and put them in place	• Quality improvement plans are in place for all areas	Strategic People Committee	Quarterly	No
		• Improving numbers of staff tell us that their managers and leaders are supportive, communicate well and that they feel valued	Strategic People Committee	Quarterly	No
		• All staff have access to Quality Improvement training within the Trust, tailored to their needs	Strategic People Committee	Quarterly	No

Aim	Outcomes	Proposed KPIs	Committee/Sub-committee	Frequency of Monitoring	Integrated Performance Report
Sustainability	Provider of integrated services, intermediate care and care home services Improved pathways for local residents to ensure that everyone receives the right support, care and treatment at the right time Strong relationships and collaborative working with all partners, including councils, CCGs, mental health and community services providers and the voluntary sector	• Level of acute activity (non-elective admissions) to remain the same or reduce, in environment of growing and ageing population, supporting left-shift	KPI Meeting Finance Resources Group Finance and Sustainability Committee	Monthly Monthly Monthly	No
		• Grow proportion of services delivered in the community	Quality, People and Sustainability Strategy Development and Delivery Sub-committee Trust Operational Board	Bi-monthly Monthly Monthly	No
	Ensure services meet the demand of our populations Provide services on behalf of others where our services are clinically and financially superior	• Understand unwarranted variation in clinical outcome measures across all specialities, measure and agree improvements	Quality, People and Sustainability Trust Operational Board	Bi-monthly Monthly	No
	Disinvest in or transform services which are not financially sustainable and do not currently provide high quality outcomes	• Improve profitability of services	Finance Resources Group	Monthly	No

	Share best practice and collaborate to ensure the best outcomes for our populations Maintain and then improve financial position	• Maintain and then improve system financial position	Finance and Sustainability Committee Finance Resources Group	Monthly Monthly	No
		• Retain and where appropriate grow priority services	Finance and Sustainability Committee Quality, People and Sustainability Strategy Development and Delivery Sub-committee Trust Operational Board	Monthly Bi-monthly Monthly Monthly	No
		• Repatriate Warrington and Halton activity to priority services	Finance Resources Group Strategy Development and Delivery Sub-committee Quality, People and Sustainability Trust Operational Board	Monthly Monthly Bi-monthly Monthly	No
	New hospital and wellbeing campus in Halton New hospital in Warrington Recognised digital exemplar	• Delivery of milestones on trajectory, including SOCs • Secure funding	Halton Healthy New Town Steering Group Strategy Development and Delivery Sub-committee One Halton Board	Bi-monthly Monthly Bi-monthly	No
		• Identify site for Warrington new hospital	Strategy Development and Delivery Sub-committee Trust Operational Board Warrington New Hospital Meeting	Monthly Monthly Bi-monthly	No
		• Updated Estates and Facilities strategy	Strategy Development and Delivery Sub-committee Trust Operational Board	Annually Annually	No

		• Delivery of milestones in IM&T strategy on trajectory	Digital Operations Group Trust Operational Board	Monthly Monthly	No

3. SUMMARY OF DELIVERY AGAINST STRATEGIC OBJECTIVES Q2/Q3 2018/19

A summary of performance against strategic objectives, outcomes and KPIs is shared at Trust board every 6 months, making it easier to assess overall strategy delivery in a single document. Below is the first of these assessments.

Indicator Key:

RAG	Meaning
Red	The Trust is behind plan with significant challenges to recovery
Amber	The Trust is on track to deliver the outcome/KPI over the 3 year period
Green	The Trust is ahead of plan to deliver the outcome/KPI over the 3 year period
White	KPI not currently rated

Arrow	Descriptor
⬆	The KPI has improved upwards from the baseline
⬇	The KPI has improved downwards from the baseline
➡	The KPI has not changed from the baseline or is not available
⬆	The KPI was worsened upwards from the baseline
⬇	The KPI has worsened downwards from the baseline

Aim	Outcomes	Proposed KPIs	Current Indicator		Current Position	Baseline	Indicator Description (Refined)	Commentary
Quality	We will have safe systems of work in place	• 20% reduction in falls	-0.9%	↓	340	343	Variance of inpatient-only falls Q2&Q3 18/19 (Current Position) against total falls Q2&Q3 17/18	Enhanced care policy has been introduced with visual aids to identify patients at high risk. Themes and actions from inpatient falls discussed daily at Trust-wide safety brief. Weekly review of all falls is held with senior staff.
		• 100% medicines reconciliation	68%	↓	68%	69%	Meds reconciliation Q2&Q3 2018/19 (Current Position) against Q2&Q3 2017/18	% of Medicine Reconciliations increased over year from 20% to 26% and within 48 hours from 38% to 46% but is still falling short of the target of 80% within 24 hours. The overall % medicines reconciliation has increased from 63% to 68%. The number and % achieved are affected by pharmacy staff availability, especially at weekends. A business case has been approved to support 7 day ward pharmacy cover.
	We will ensure that we minimise harm for patients	• 10% reduction in hospital acquired infections	12.5%	↑	45	40	Variance in MRSA, MSSA, C-DIFF, E-Coli infections Q2&Q3 18/19 (Current Position) against Q2&Q3 17/18 (40)	E-Coli is above trajectory with 44 cases year to date against a target of 36. Themes are relating to catheter acquired infection. CDIFF is 25 cases against a trajectory of 26. Themes are in relation to timely screening and sampling. MRSA 2 cases year to date against a target of 0. Themes relate to timely screening on admission. Workstreams related to the reduction of healthcare acquired infections continue with oversight at Patient Safety Sub Committee and Quality Assurance Committee. New trajectories have been agreed.
		• 100% of patients have sepsis screening and are treated appropriately	98%	↑	98%	95%	AED and Inpatient Sepsis Screening rate, Q2 & Q3 2018/19 (Current Position) against Q2&Q3 2017/18	Both Emergency Department and inpatient performance for assessment and administration of antibiotics are above 95% with ED performing consistently well at 100% for both parts. A reduction in compliance for the review of antibiotics is noted in October impacting on Trust Q3 overall performance due to a delay in consultant review. Actions in place to improve compliance include audit, attendance at medical handover and escalation through senior clinical colleagues.

		• 100% of patients to have a VTE assessment and appropriate treatment	95.1%	↓	95.1%	95.7%	Proportion of VTE assessments carried out Q2&Q3 2018/19 (Current Position) against Q2&Q3 2017/18	The Trust achieved 95.08% compliance with VTE assessment. Patient Safety Improvement Nurse currently reviews all confirmed PE's and DVT's to validate the receipt of appropriate treatment with a process to escalate for investigation where concerns are raised.
	We will ensure that we providing care that is evidence based	• Reduce DTOCs to no greater than 3%	3.73%	↓	3.7%	4.8%	Average % of patients with a Delayed Transfer of Care (DTOCs) over Q2 & Q3 2018/19 (Current Position) against Q2 & Q3 2017/18	
	We will ensure that we are focused on outcomes for patients and that are benchmarking/peer reviewing ourselves against the 'best in class'.	• Reduce readmissions within 30 days for patients >65 to no greater than 12.5%	8.40%	↓	8.4%	9.9%	Number of readmissions over 65 against the number of total patients over 65 Q2 & Q3 2018/19 (Current Position) compared with Q2&Q3 2017/18	
		• Understand variance in clinical outcome measures across all specialities, measure and agree improvements		↑	9	0	Specialties undertaken GIRFT visits 2018/19.	9 specialties have undergone visits from the Girft programme, with quality improvement work underway or complete in 6 to date. Model hospital data, GIRFT, Agreed improvements through CBU Plans-on-a-page for key variances
	We will ensure that we foster a culture of Quality Improvement	• Number of Quality Improvement projects successfully completed		↑	8	-	The number of active quality improvement projects across the Trust as a whole has not been formally measured previously. 8 therefore represents a minimum number over the last 9 months. This will be formally tracked via the Quality Academy going forwards.	A number of quality improvements have been undertaken and completed in the Trust over the past 9 months. These include the creation of the Acute Coronary Care Unit, the Diabetes Foot Clinic, Enhanced Recovery Pathways in MSK, colorectal straight-to-test. Additional quality improvement projects have commenced, including Falls Collaborative and Tissue viability.
		• Increase number of staff with quality improvement training via Quality Academy		↑	271	-	Number of staff to-date undertaken Quality Improvement Training	Quality Improvement training is now delivered to all staff at induction.
	Every patient should have the opportunity to give feedback about their experience and we promise to use this to	• Increase in Friends and Family Test scores to ensure all specialities meet or exceed national benchmarks	95.3%	↑	95.3%	94.9%	% recommended Q2 & Q3 2018/19 (Current Position) against Q2 &Q3 2017/18	

	improve care and services.							
	We will communicate in line with our values.	• Improve across all indicators in the inpatients survey	42	↑	42	8	Number of improved indicators across the National Inpatients Survey between 2017 (Current Position) and 2016	The Trust showed improvement on 42 questions overall in 2017 compared with 8 questions in 2016. The Trust performed significantly better on 9 questions than the national average in the highest scoring 80% threshold compared to 1 question in 2016. There were no questions in which the Trust worsened by 5% or more, which is significantly better than the 2016 survey, where 18 questions fell in this category. There has been recognised improvement in the number of questions falling within the lowest 20% national threshold (8 in 2017 compared to 32 in 2016
	We will ensure partnership working and needs based care. We will simplify patient focused processes.	• 10% reduction in formal complaints	-12%	↓	204	231	Complaints received Q2&Q3 2018/19 (Current Position) against complaints received Q2&Q3 2017/18 (231)	

Aim	Outcomes	Proposed KPIs	Current Indicator		Current Position	Baseline	Indicator Description (Refined)	Commentary
People	Staff will be supported to be healthy and supported if they are unwell	• Reduction in mental health related sickness absence	1.4%	↑	1.4%	1.3%	% mental health sickness absence Dec 2018 (Current Position) against Dec 2017	Mental health related absence continues to increase and will remain a priority work stream for 2019/20. A review of mental health support services within the Workplace Health and Wellbeing Service, including staff counselling, has been completed. This has included a review of best practice and engagement with the workforce to gather feedback on how the Trust supports staff. This review has informed the delivery plan for 2019/20. The refreshed delivery plan is in line with the recently published NHS Staff and Learners' Mental Wellbeing Commission Report (Health Education England, February 2019).

		• Reduction in musculoskeletal health related sickness absence	0.8%	↓	0.8%	0.9%	% musculoskeletal sickness absence Dec 2018 (Current Position) against Dec 2017	The Physio Team in our Health and Wellbeing Service have worked with the Moving and Handling Trainer and the Health and Safety Team to take a new approach in utilising information on incidents and sickness absence to provide targeted support. A recent review found that the service currently provided meets the needs and expectations of the organisation and our staff; however additional work to promote the service across the workforce is required, which will be a focus in 2019/20.
		• Improving number of staff believe that we value their health and wellbeing		→	6.2	6.2	Score out of 10 for Health and Wellbeing indicator in the NHS Staff Survey 2018 against 2017 (N.B. National Average is currently 5.9)	The Trust Fit to Care Programme aims to support the health and wellbeing of our workforce. Reviewing this programme was a key priority for 2018/19. This has now been complete, in consultation with the workforce, and a refreshed programme of work for 2019/20 has been produced.
		• Increasing numbers of staff receiving the annual flu vaccination	2111	↑	2111	2055	Seasonal flu doses given to frontline workers Q3 2018/19 against Q3 2017/18	
	Staff will feel proud, enthusiastic and happy in work	• Improving number of staff recommend WHH as a place to work and receive treatment	77.7%	↑	77.7%	72.8%	Staff Friends and Family Test - % recommended Q2 2018/9 (Current Position) against Q2 2017/18	
		• Pioneering teams adopt LIA		↑	11	-	Number of pioneering teams to-date (Programme established 2018/19)	
		• Continuous improvement via the Ward Accreditation Programme		↑	29	-	Number of wards accredited to-date (Programme established 2018/19)	Of 29 wards accredited to January 2019, 16 have achieved silver award status and the remaining 13 wards have received bronze awards/

	WHH will be a great and inclusive place to work	• Reduction in difficult to fill vacancies across the Trust	10.85%	↓	10.9%	11.2%	Vacancy Factor December 2018/19 (Current Position) against Year-to-date average 2018/19	New approaches to attraction and retention have been introduced and an overarching Recruitment and Retention Group has been set up, to share and embed learning from the already established Nursing and AHP groups. The Group is also be used to share and discuss recruitment and retention issues, share best practice and focus on all staff groups. Key elements of the programme of work include: • Enhancing the 'Work at WHH' web presence • Improving recruitment processes and reducing time to hire • Introducing Recruitment and Retention champions • Introducing Candidate Coffee Club Key successes to date include the 'Earn, Learn and Return' scheme and a number of new roles such as Nursing Associates, Apprentice Healthcare Assistants and Physician Associates have been rolled out.
		• Reduction in the number of staff leaving the Trust	3	↑	293	290	Leaver headcount Q2 & Q3 2018/19 (Current Position) against Q2 & Q3 2017/18	The Trust is participating in the NHSI Retention Direct Support Programme. The programme aims to support Trusts to improve their retention rates by facilitating learning between Trusts and provide Trusts with the knowledge and tools to improve retention. A Trust-wide Recruitment and Retention group has been established which will share learning and take action for the benefit of all staff groups. Workforce data has been analysed and engagement with the workforce has taken place. This information has been used to draft initial initiatives (below), which will be the basis for the Trust Retention Action Plan to be produced by 31.03.2019.

		• Achievement of the measures within the Equality, Diversity and Inclusion Strategy		↑				An initial draft of the Equality, Diversity and Inclusion Strategy has been produced, taking into account the information from the Workforce Equality Analysis 2017, Gender Pay Gap Reporting 2018 and Workforce Race Equality Standard 2018. The workforce elements of the draft strategy were presented to a workforce focus group on 6 November 2018 and were well received, with constructive feedback and suggestions given. Additional engagement has taken place with community groups in February 2019. The Strategy will be submitted to Trust Board for ratification in March 2019.
	Staff will be supported to develop new skills and ways of working	• Production of strategic workforce plans		↑				The Trust's 2019/20 Workforce Plan has been developed alongside the Business Plans for Clinical Business Units (CBUs). The result is a robust plan which takes account of turnover, retention, workforce transformation and future business plans. Delivery of the plan will be driven through the Workforce Redesign Group, Recruitment and Retention Groups and Premium Pay Spend Review Groups. Progress against the 2019/20 Workforce Plan will be monitored via the Operational People Committee.
		• Improvement in number and quality of annual appraisals	82.1%	↓	82.1%	82.6%	PDR Compliance December 2018/19 (Current Position) against year-to-date average 2018/19	The quality of annual appraisals forms part of the work on Talent Management and Succession Planning, which is a key focus within the People Strategy for 2019/2020. Work head already begun with a refresh of the Appraisal Policy.
				↑	5.3 / 10	5.2 / 10	Quality of appraisals score (out of 10) from NHS Staff Survey Results 2018 (Current Position) against 2017	
		• All available staff, including bank workers, have completed mandatory training	92.4%	↑	92.4%	87.9%	Substantive Staff - Mandatory Training Compliance December 2018/19 (Current Position) against year to date 2018/19	The centralisation of bank processes via the Bank and Agency Team is planned for Q1/Q2 2019/20. This will mean that training compliance will be managed centrally and a significant increase in compliance is expected. In preparation for this, the HR and OD Team are undertaking a data cleansing exercise and will be writing to bank staff to set out expectations regarding mandatory training.
			55.0%	↑	55.0%	54.0%	Bank Staff - Mandatory Training Compliance December 2018/19 against year to date 2018/19	

		• Improving number of staff tell us that they have received high quality non-mandatory development	66%	⬇	66.0%	66.9%	% of staff selecting yes in NHS Staff Survey to Q20 (Have you had any (non-mandatory) training, learning or development in the last 12 months?) 2018 (Current position) against 2017	The Trusts workforce redesign group will be utilised to identify areas where there is scope for workforce transformation, introduction of new roles and upskilling of existing staff working in conjunction with our apprenticeship and training and development teams, ensuring that we continue our workforce development and transformation. A Nursing Career Pathway will be launched at our Career Development Event on 12 March 2019. This will be rolled out to all staff groups in 2019/20. Feedback from the Career Development Event will be utilised to design and implement 2 monthly Career Cafes, where employees can learn about the various career pathways and development opportunities available.
	Staff at all levels in the Trust are able to develop as leaders	• Reduction in Dignity at Work employee relation cases	11	⬆	11	5	Open Dignity at Work cases Q2 & Q3 2018/19 (Current Position) against Q2 & Q3 2017/18	The increase in Dignity at Work cases relates to a cluster of cases in November 2018, relating to the same incident. Work underway to impact this indicator includes: • Review of essential managers training programme. • 'Difficult conversation' course to be available during 2019/20. • Review of the Dignity of Work Policy during 2019. • Promotion of Freedom to Speak up, including review of template letters to include signposting. • Development of Trust leadership behaviours model during 2019/20. • Development of Trust behaviour standards to complement Trust values during 2019/20.
		• Increase in internal promotions					Formal recording of this metric is in development.	
		• Improved recruitment and retention of leadership positions	4.3%	⬇	4.3%	5.2%	Leadership vacancy factor as December 2018 (Current Position), improved against average vacancy factor Apr-Dec 2018 (Baseline)	

	Staff feel empowered to identify improvements and put them in place	• Quality improvement plans are in place for all areas	9	↑	9	0	Specialties undertaken GIRFT visits 2018/19.	9 specialties have undergone visits from the Girft programme, with quality improvement work underway or complete in 6 to date. Model hospital data, GIRFT, Agreed improvements through CBU Plans-on-a-page for key variances
		• Improving numbers of staff tell us that their managers and leaders are supportive, communicate well and that they feel valued	73.0%	↑	73.00%	69.50%	% of staff selecting 'Satisfied'/'Very Satisfied' in NHS Staff Survey to Q5b (The support I get from my immediate manager) 2018 (Current position) against 2017	
		• All staff have access to Quality Improvement training within the Trust, tailored to their needs		↑	271		Number of staff to-date undertaken Quality Improvement Training	

Aim	Outcomes	Proposed KPIs	Current Indicator		Current Position	Baseline	Indicator Description (Refined)	Commentary
Sustainability	Provider of integrated services, intermediate care and care home services	• Level of acute activity (non-elective admissions) to remain the same or reduce, in environment of growing and ageing population, supporting left-shift	-0.14%	↓	18,642	18,668	Non-elective admissions Q3&Q4 18/19 (18642) against non-elective admissions Q3&Q4 17/18 (18668)	This is a Cheshire and Merseyside Health and Care Partnership target. The Trust's NEL admissions have reduced very slightly, though it is not a significant trend.
	Improved pathways for local residents to ensure that everyone receives the right support, care and treatment at the right time Strong relationships and collaborative working with all partners, including councils, CCGs, mental health and community services providers and the	• Grow proportion of services delivered in the community		↑			Additional services provided by WHH and delivered in non-hospital settings	Over the past 9 months, a number of initiatives have developed and launched that extend the provision of WHH services in the community. These include the Halton COPD service, the frailty assessment service, ECG in GP practices, and Smart Heart.

	voluntary sector							
	Ensure services meet the demand of our populations	• Understand unwarranted variation in clinical outcome measures across all specialities, measure and agree improvements		↑	9	0	Specialties undertaken GIRFT visits 2018/19 (Current Position) against 2017/18	9 specialties have undergone visits from the GIRFT programme, with quality improvement work underway or complete in 6 to date. We also now have access to model hospital and other comparative data sources, the outputs of which have contributed to a number of projects outlined within each CBU's plan-on-a-page.
	Provide services on behalf of others where our services are clinically and financially superior	• Improve profitability of services		☐	-£13m	-	Total profit/loss of clinical service lines. Currently robust data is only available for Q1 & Q2 2018/19	SLR team and systems now in place to allow robust and comparative data regarding service line profitability. Robust data only available from Q1 & Q2 18/19 and as such comparison is not yet possible
	Disinvest in or transform services which are not financially sustainable and do not currently provide high quality outcomes	• Maintain and then improve system financial position	-£142m	↓	-£142m	-£74m	Forecast outturn for Cheshire and Merseyside system at month 9 2018/19 against month 9 2017/18	
	Share best practice and collaborate to ensure the best outcomes for our populations	• Retain and where appropriate grow priority services		↓	50%	55%	Overall market share of Warrington CCG and Halton CCG activity undertaken by WHH (inpatient and outpatient first attendances combined)	There has been some growth in core business areas over past two years, including Orthodontics and Oral Surgery, Urology, Max Fax, Gynaecology; but loss of market share in majority of specialties across inpatient and outpatient domains. Significant work underway, as detailed within CBU business plans-on-a-page to reverse trends in key areas.
	Maintain and then improve financial position	• Repatriate Warrington and Halton activity to priority services		↑				Repatriation of certain paediatric cases from Alder Hey has been successful due to the expertise of Dr Melling. Conversations are underway to explore the potential of establishing Halton as a regional elective site.
	New hospital and wellbeing campus in Halton	• Delivery of milestones on trajectory, including SOCs		↓				The Trust has not been awarded any capital funding from the latest allocation of government capital in relation to its bid for £40m to commence the redevelopment of the Halton site. The trust awaits formal feedback via Cheshire & Merseyside Health & Care Partnership on the reasons behind the decision not to award any funding to the project on this

								occasion. A review of the Strategic Outline Case is in progress, ensuring land value is maximised, costs are minimised and all options are considered.
		• Secure funding		➡				KPMG have been engaged to explore alternative funding options for both the Halton Hospital and Wellbeing Campus. They are currently engaging with a number of partners to understand potential funding streams, and are due to report back their findings in March 2019. This piece of work is funded through NHS England.
	New hospital in Warrington	• Identify site for Warrington new hospital		⬆				The Trust, in partnership with Warrington Borough Council and Warrington CCG, has recruited a project manager for the Warrington Hospital project, who joined WHH early March.
		• Updated Estates and Facilities strategy		⬆				Estates and Facilities Strategy is currently in draft, awaiting progression and approval through the committee process.
	Recognised digital exemplar	• Delivery of milestones in IM&T strategy on trajectory	84%	⬆	84%		IM&T Projects RAG rated as blue or green (26) against total number of projects on IM&T Programme (31) in December 2018 (Current position)	As December 18, there were 31 projects governed through the IM&T Programme Board. Of these, 2 are rated "Complete", 24 are rated "On Target", 5 are rated "At Risk" and 0 are rated "Not Achievable".

4. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The board is asked to note the progress against delivery of the strategic objectives and the governance arrangements in place.

5. IMPACT ON QPS?

Delivery of our strategy enables the Trust to deliver our aims under Q, P and S, and it is essential that this is monitored for assurance and escalated where necessary.

6. MEASUREMENTS/EVALUATIONS

The strategy delivery summary is provided to Trust board every six months by the Director of Strategy. Key strategic developments will be discussed at each Trust board as appropriate.

7. TRAJECTORIES/OBJECTIVES AGREED

The KPIs support the delivery of the Trust Strategy over three years.

8. MONITORING/REPORTING ROUTES

The governance for each strategic objective is outlined in section 2.

9. RECOMMENDATIONS

The board is asked to note the progress against delivery of the strategic objectives and the governance arrangements in place.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/30**			
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**			
DATE OF MEETING:	27th March 2019			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	Since the last meeting: • There are no new risks that have been added to the BAF; • It was agreed that four risks were de-escalated from the BAF; • It was agreed that the ratings for four risks currently on the BAF were reduced; • It was agreed that the descriptions of three risks currently on the BAF were amended. Also included in the report are notable updates to existing risks.			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/19/01/15		
	Date of meeting	8th January 2019		
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/19/03/30

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

The latest Board Assurance Framework (BAF) is included as Appendix 1.

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting, no new risks have been added to the BAF.

2.2 Amendments to risk titles

Since the last meeting, the risk titles of three risks on the BAF have been amended.

I. **Risk #224** currently states:

Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience

It was agreed that it was amended to:

Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.

II. **Risk #695** currently states:

Failure to meet NHS Cervical screening programme standards for failsafe of backlog of cervical cancer patients screening reviews.
Caused by lack of a implementation of a policy for undertaking the invasive cancer audit and disclosure. NHSCSP guidance issued in 2013

Resulting in non-compliance with cervical screening specification 2018/2019 and NHSCSP guidance

It was agreed that it was amended to:

Failure to keep the national invasive cancer audit up to date to comply with NHS Cervical screening programme standards; which caused a backlog of cervical screening reviews which resulted in a non-compliance with the cervical screening specification 2018/2019.

III. **Risk #241** currently states:

Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision

It was agreed that it was amended to:

Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.

2.3 Amendments to risk ratings

Since the last meeting, the risk ratings of four risks on the BAF have been reduced.

Risk #**133**	**Risk: Failure to successfully engage the Workforce, caused by the potential for an adverse working culture 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**
Initial Risk Rating	20 (4x5)
Previous Risk Rating	8 (4x2)
Amended Risk Rating	6 (3x2)

The Risk rating was 8(4x2); however, it was agreed that it should be reduced to 6 (3x2) due to the work and investment undertaken with LiA and the NHS Staff Survey results that indicate statistically significant improvement in both staff engagement and safety culture.

Risk #**241**	**Risk: Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.**
Initial Risk Rating	12 (4x3)
Previous Risk Rating	12 (4x3)
Amended Risk Rating	8 (4x2)

The Risk rating was 12(4x3); however, it was agreed that it should be reduced to 8 (4x2) due to the mitigations and assurances put in place such as Senior management presence at Medical handover to review any safety issues, Weekly Educational Huddle, Business Case currently being developed to support the recruitment of substantive consultant physicians.

Risk #**695**	**Risk: Failure to keep the national invasive cancer audit up to date to comply with NHS Cervical screening programme standards; which caused a backlog of cervical screening reviews which resulted in a non-compliance with the cervical screening specification 2018/2019.**
Initial Risk Rating	9 (3x3)
Previous Risk Rating	15 (3x5)
Amended Risk Rating	9 (3x3)

The Risk rating was 15(3x5); however, it was agreed that it should be reduced to 8 (3x3) due to the development and return of the action plan to SQAS on 22nd February 2019, SQAS agreeing to work with the Trust to complete the action plan within 12 months, and the monitoring of progress through the setting up of a specific task and finish group and via Patient Safety & Clinical Effectiveness Sub-Committee.

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.**
Initial Risk Rating	16 (4x4)
Previous Risk Rating	16 (4x4)
Amended Risk Rating	12 (4x3)

The risk rating was 16 (4x4); however, it was agreed that this be reduced to 12 (4x3). A Working Group established to address the risk. After consultation with the company who supply the lab system MOLIS, it is believed that the information required can be extracted from the existing system. Review of MOLIS system to be undertaking to determine if upgrades are required.

2.4 Removal of Risks

Following a review of the risks, it was agreed that four risks are de-escalated from the BAF:

RISK 186: *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.*

The risk rating was 16 (4x4); however, it was agreed that this be reduced to 12 (4x3). A Working Group established to address the risk. After consultation with the company who supply the lab system MOLIS, it is believed that the information required can be extracted from the existing system. Review of MOLIS system to be undertaking to determine if upgrades are required.

RISK 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.*

The risk rating was 12 (4x3), which is the target rating. It was agreed that due to meeting the target rating, the overall reduction in falls, continued monitoring at Trust & CBU level and there have been no recent serious harm falls resulting in a patient death that the risk is de-escalated from the BAF but maintained on the Trust-wide risk register.

RISK 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*

The risk rating was 12 (4x3); however, following two MIAA reports offering moderate assurance and the process commencing to recruit an LD Specialist Nurse, it was agreed that the risk was de-escalated from the BAF.

RISK 88: *Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by increased competing priorities due to an outdated IM&T workforce plan resulting in areas of Data Protection non-compliance*

The risk rating was 12 (3x4). Due to the recent action and mitigations that have been taken and the monitoring that is taking place, it was agreed that the risk was de-escalated from the BAF.

2.5 Existing Risks - Updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• Number of staff and workforce developments in place across the Trust. • 28 staff currently undertaking the Advanced Clinical Practice Course • 3 Staff working with specialist teams as part of the Registered Nurse with Special Interest initiative • 8 Nursing Associates register in January 2019 and a further 8 are due to commence their training in March 2019 • First site meeting with NHSi in February 2019 – Plan to be submitted in March 2019 • Nursing & Midwifery Dashboard reviewed monthly at the Recruitment & Retention Group • Retention Strategy Completed and will be presented on 15th March 2019 • Nursing and Midwifery Turnover monitored at the Recruitment & Retention Group and reduction is in line with the plan.	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Staffing escalation Audit Update. Staffing escalation audit was undertaken in October and presented to the Recruitment and Retention Group in November. Recommendations have been undertaken and a further audit will be undertaken in April 2019.	
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	• HMRC changed its view regarding the VAT treatment of the model of services provided by Plus Us with effect from 11 February 2019 resulting in the Trust paying VAT on Medical and AHP agency bookings. Financial impact c£100k per month. Service commenced August 2018. • Cheshire and Merseyside Healthcare Partnership Task and Finish Group setup to review and resolve the impact of VAT on Agency staff. Tax advice is being procured via the STP. Legal advice being obtained regarding potential termination of contract. Plus Us have an alternative model which may be introduced, 3-4 weeks implementation following decision to proceed.	No impact on risk rating
135	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• Senior management presence at Medical handover to review any safety issues • Weekly Educational Huddle • Business Case currently being developed to support the recruitment of substantive consultant physicians	No impact on risk rating
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.	• Clinical Strategy approved by Trust Board • CBU specialty level strategies complete and incorporated in business plans • Successful in One Public Estate revenue funding bid for Halton • Initial talks held with Elective Care STP Lead in relation to the suitability of Halton as a potential Elective Care Hub	No impact on risk rating
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	• NHSI LD standards are supported by the immanent appointment of an LD nurse ensuring the Trust is committed to the LD agenda and to improving the care of patients who have an LD. • Training compliance for DoLS was reported in Jan 19 up to the 31/12/18 at	De-escalated from the BAF

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	patient safety and cause the Trust to breach regulations	76% and MCA is almost 97% • Prevent referrals have increased following the enhanced program of training, WRAP and prevent compliance is almost 94% • The number of medical staff seeking advice regarding MCA / best interest processes has increased • Safeguarding Notifications of all categories together via ICE from ward teams are increasing month on month the bi-annual report demonstrated 426 Ice notifications in the 6 months between April to September 18 compared with 689 for the whole of 17/18 reporting year. • LD in patient flagging has increased the number of calls for advice regarding the care provision of patients with an LD	
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.	• The TNA for critical systems is now available and due to be published with supporting guidance for managers.	No impact on risk rating
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.	• The new ED patient flow dashboard has been developed which will support urgent care with monitoring urgent care patient flow and provide the means to respond in real time for some indicators. Currently awaiting the provision of a robust enough server to deploy the pilot dashboard for use prior to final adjustments and deployment.	No impact on risk rating
224	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust	• Warrington Together Board have asked for focussed work to take forward outputs from the Venn Work • Regular monitored at the Mid Mersey A&E Board	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	reputation, financial impact and below expected Patient experience	• Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput.	
701	Failure to provide continuity of services caused by the scheduled March 2019 EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non clinical consumables. The associated risk of increase in cost.	• The actions in the EU Exit Operational Readiness Guidance issued by the DHSC have been completed. • A readiness tracker has been produced and is being monitored by the Brexit Working Group which meets on a fortnightly basis. • Key leads for each work stream identified by DHSC attend the Brexit Working Group. • The Procurement department completed the national self-assessment contract review tool and continues to review suppliers which are out of the national scope. • Service level business continuity plans continue to be refreshed. • The IT department currently looking at key IT systems and if any will be affected by data flows from and to the EU. • Nationally a 6 week stockpile of goods will be maintained.	No impact on risk rating
695	Failure to meet NHS Cervical screening programme standards for failsafe of backlog of cervical cancer patients screening reviews. Caused by lack of a implementation of a policy for undertaking the invasive cancer audit and disclosure. NHSCSP guidance issued in 2013 Resulting in non-compliance with cervical screening specification 2018/2019 and NHSCSP guidance	• Developed and returned action plan to SQAS on 22nd February 2019 • SQAS agreed to work with the Trust to complete the action plan within 12 months. • Monitored monthly in Patient Safety & Clinical Effectiveness Sub-Committee	Reduced risk from 12 to 9
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	• Reduction in total falls and total inpatient falls • Bathroom environmental review completed – Estates to undertake work	De-escalated from the BAF

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	experience, may prolong their length of stay, and give rise to complaints and claims against the trust.		
241	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• Senior management presence at Medical handover to review any safety issues • Weekly Educational Huddle • Business Case currently being developed to support the recruitment of substantive consultant physicians	Reduced from 12 to 8
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	• Network Manager has begun pre work on the VLAN protective bubble • 18 servers have been migrated to the new backup system. The 6 SQL servers issues with truncation of their logs has also been resolved. • Reviewed with other members of the STP Cyber Group internal server vulnerability scanning options. Nessus was the recommended option. The purchase of the software approved and is on order. • Have contacted MIAA regarding performing a yearly external network penetration test. As it has to be fit for purpose to ensure it passes the Data security & protection Toolkit.	No impact on risk rating
414	Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches.	• Follow up audit on IG compliance completed across all wards. Reports provided to Ward Managers and CQC G2G meetings. Key messages disseminated at Safety Huddle and 'You Didn't Think Privacy' unannounced mini-audit initiative launched.	No impact on risk rating
88	Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by increased competing priorities due to an outdated IM&T workforce plan resulting in areas of Data Protection non-compliance	• Action plan in place that identifies the gaps in compliance against the mandatory assertions in the Data Security and Protection Toolkit. • Trust local inspection process in place to audit compliance and report breaches. The local inspections/audits will be undertaken by a number of IM&T staff under the direction of our IG & Corporate Records Manager for consistency.	De-escalated from the BAF

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Any breaches of compliance against IG policies and procedures are identified and a 'You Didn't Think Privacy' yellow notice placed within the ward in the area of non-compliance. The key issues are also discussed and fed back to Ward Managers for learning in accordance with the IG/Data Security Inspection Process put in place. Persistent breaches will be escalated to Senior Clinical and Operational Leads if warranted. • An action plan is being formulated to review eWhiteboards and how information is displayed to address potential breaches. • The IG risks are reviewed routinely and monitored via reporting into the Information Governance & Corporate Records Committee and the Quality Assurance Committee. IG risks are also included on the risk reviews via the Trust's Digital Board.	
133	Failure to successfully engage the Workforce, caused by the potential for a adverse working culture 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	• NHS Staff Survey results indicate statistically significant improvement in both staff engagement and safety culture	Reduce from 8 to 6
186	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	• Working Group established to address the risk • After consultation with the company who supply the lab system MOLIS it is believed that the information required can be extracted from the existing system. • Review of MOLIS system to be undertaking to determine if upgrades are required.	Reduced from 16 to 12

2.6 Risk Management Strategy Updates

We will continue to review the Board Assurance Framework, streamlining it to highlight focused strategic risks, against the Trust's revised clinical strategy and operational plan that

will emphasise the matters that pose the most significant threat to the Trust. This process will continue to take place with appropriate input from the Committees of the Board and their Sub-Committees, with considerations of risk appetite and risk tolerance.

3 RECOMMENDATIONS

Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/31**
SUBJECT:	**Amendments to the Constitution**
DATE OF MEETING:	27th March 2019
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The paper proposes amendments to the following areas of the Constitution: • Section 12 (page 14) - **Extend the number of terms a Governor can serve from two to three** • Section 25 (pages 17 & 18) – **Extend the tenure of Non-Executive Directors beyond the current two terms of office** • Annex 5 (page 63) – **Strengthening of eligibility criteria to be a Governor and strengthening of requirements for Governor attendance at meetings.** • Replacement of references to *S/he, his/her* with *they & their* as appropriate to ensure the document is gender neutral – **Ensuring the documents is gender neutral**

PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Board is asked to consider the requested amendments to the constitution and to approve, by recorded vote, these amendments which will be entered to create v3.6			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	CoG/19/02/13		
	Date of meeting	14th February 2019		
	Summary of Outcome	More than half of the members of the Council of Governors of the Trust voted to approve the amendments.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

BOARD OF DIRECTORS

SUBJECT	Amendments to the Constitution	AGENDA REF:	BM/19/03/31

1. BACKGROUND/CONTEXT

Following the Council of Governors meeting on 16th August 2018, a Governor Working Group was established, in part, to review the Constitution. Several areas for consideration were identified and reviewed, and as appropriate, considered in the Governor's Nomination and Remuneration Committee (GNARC) which took place on 4th February 2019 and the Council of Governors meeting on 14th February 2019.

In order to make amendments, the Trust's Constitution states:

45. Amendment of the constitution

45.1. The Trust may make amendments to its constitution if:

45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and

45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.

At the meeting of the Council of Governors on 14th February, more than half of the members of the Council of Governors of the Trust voted to approve the amendments.

The proposed amendments are set out below.

2. KEY ELEMENTS

1. Council of Governors – tenure

Currently the Constitution states the following:

12.1 Subject to the provisions of paragraphs 12.2 and 12.3 below, an elected Governor may hold office for a period of up to three years. A Governor shall be eligible for re-election or re-appointment at the end of his/her initial term, for one further term.

12.2 Not less than one half of the initial Public Governors and Staff Governors (comprising those who polled the highest number of votes if elections took place, and otherwise to be chosen by lot) will serve a term of office of three years. The remaining initial Public Governors and Staff Governors will serve a term of office of two years.

12.3 Those initial Governors serving a term of office of two years shall be eligible for re-election at the end of the two year term for one further term and such re-election may be for a period of up to three years.

12.4 An elected Governor shall cease to hold office if he ceases to be a member of the Constituency or Class by which he was elected.

In order to mitigate the number of Governor vacancies and support continuity, it is proposed that the Constitution be amended to the following:

12.1 Governors may hold office for a period of up to three years. A Governor shall be eligible for re-election or re-appointment at the end of his/her initial term, for two further terms.

12.2 An Elected Governor shall cease to hold office if he or she ceases to be a member of the constituency or class by which he or she was elected.

12.3 Subject to paragraph 12.5 below, an Elected Governor shall be eligible for re-election at the end of his or her term.

12.4 Subject to paragraph 12.5 below, an Appointed Governor shall be eligible for reappointment at the end of his or her term.

12.5 Elected Governors and Appointed Governors may hold office for a maximum of 9 consecutive years.

12.6 Subject to any provision in this Constitution in respect of eligibility or disqualification of Governors, once an elected Governor has reached their maximum term or has been removed under paragraph 13, they shall only be eligible for appointment again after a period of three (3) years.

2. <u>Non-Executive Directors – tenure</u>

Currently the Trust's Constitution does not expressly state the maximum tenure of office for a Non-Executive Director.

The following proposal has been recommended for approval by the GNARC that took place on 4th February 2019:

It is proposed that the Trust's Constitution is amended to include the following:

25.5 Any term beyond six years (eg, two three-year terms) for a Non-Executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-Executive Directors may, in exceptional circumstances for business/continuity reasons, serve longer than six years (eg, two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-evaluation and re-appointment and is subject to ratification by the Council of Governors in line with terms detailed in section 5.4 of the Council of Governors Nominations and Remuneration Committee. Serving more than six years could be relevant to the determination of a non-executive's independence. Non-executive Directors may hold office for a maximum of 9 years.

3. <u>Annex 5 – Eligibility to be a Governor</u>

Annex 5, Section 14 of the Constitution currently states:

14. S/he has previously been removed from office as a Governor of the Trust in accordance with the provisions of paragraph 8 below under the section titled 'Termination of office and removal of Governors'.

It is suggested that it should be amended to reflect removal of office from any Trust:

14. S/he has previously been removed from office as a Governor of any Trust in accordance with the provisions of paragraph 8 below under the section titled 'Termination of office and removal of Governors'.

4. Annex 5 – Termination of office and removal of Governors

In order to encourage more regular attendance and support the effectiveness of the Council of Governors meetings, it is suggested that attendance requirements be strengthened. The Constitution currently states:

A person holding office as a Governor shall immediately cease to do so if:
3. S/he fails to attend three meetings in any financial year, unless the other Governors are satisfied that:
a) The absences were due to reasonable causes; and
b) S/he will be able to start attending meetings of the Trust again within such a period as they consider reasonable;

As an alternative, the following is proposed:

A person holding office as a Governor shall immediately cease to do so if:
3. a Governor fails to attend two consecutive meetings of the Council of Governors, unless the Council of Governors is satisfied by a 75% majority that:
   3.1 the absence was due to a reasonable cause; and
   3.2 the Governor will resume attendance at meetings of the Council of Governors again within such a period as it considers reasonable.

4. Notwithstanding the provisions of paragraph 3 above, if a Governor fails to attend any of the next two consecutive meetings of the Council of Governors and they have previously been the subject of a decision in his favour under paragraph 3 above, that Governor's tenure of office is to be terminated immediately.

5. Replacement of pronouns to create a gender neutral document

All references to *s/he* or *his/her* have been replaced with *they* or *their* as appropriate, to ensure the document is gender neutral

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The Council of Governors

5. RECOMMENDATIONS

The Board note the request for amendments and vote accordingly.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/03/32**			
SUBJECT:	**Changes to the Scheme of Reservation and Delegation Table B for Charitable Funds**			
DATE OF MEETING:	27 March 2019			
AUTHOR(S):	Karen Spencer, Head of Financial Services			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	A full comprehensive review of the SORD was approved by the Board in November 2018. This update is in respect of Charitable Funds, following a review of the approval process by the Charitable Funds Committee in November 2018.			
PURPOSE: (please select as appropriate)	Information	Approval Yes	To note	Decision
RECOMMENDATION:	The Board of Directors is asked to approve the revised Table B of the SORD.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee		
	Agenda Ref.	CFC/18/11/37c		
	Date of meeting	15 November 2018		
	Summary of Outcome	Agreed by Charitable Funds Committee for Board approval		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

BOARD OF DIRECTORS

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) in respect of Charitable Funds.

2. KEY ELEMENTS

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

A full comprehensive review of the SORD was approved by the Board of Directors in November 2018. This update is to reflect changes in respect of Charitable Funds, following a review of the approval process by the Charitable Funds Committee in November 2018.

The pertinent extract of Table B is included in Appendix A.

3. RECOMMENDATION

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

Appendix A

Extract of Current SORD

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

Proposed Changes to SORD

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
1. CHARITABLE FUNDS		
Charitable Spend - Non Emergency Items (designated, restricted and unrestricted)	Any Value	Charitable Funds Committee (quarterly basis)
Charitable Spend - Emergency Items (designated, restricted and unrestricted)	Up to £2,000	Director of Finance & Commercial Development and Director of Nursing
	£2,001 - £5,000	Chairs Action
	Over £,5000	Extraordinary Board (in accordance with terms of reference this can be a conference call)

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Trust Board

DATES 2019-2020

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2019			
Wednesday 30 January	Wednesday 9 January	Monday 21 January	Wednesday 23 January
Wednesday 27 March	Wednesday 6 March	Monday 18 March	Wednesday 20 March
Thursday 23 May YR END	Thursday 2 May	Tuesday 14 May	Thursday 16 May
Wednesday 29 May	Thursday 9 May	Monday 20 May	Wednesday 22 May
Wednesday 31 July	Thursday 11 July	Monday 22 July	Wednesday 24 July
Wednesday 25 September	Thursday 5 Sept	Monday 16 September	Wednesday 18 September
Wednesday 27 November	Thursday 7 Nov	Monday 18 November	Wednesday 20 November
2020			
Wednesday 29 January	Thursday 9 January	Monday 20 January	Wednesday 22 January
Wednesday 25 March	Thursday 5 March	Monday 16 March	Wednesday 18 March