We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 29 MAY 2019
9.30am-12.45pm
Trust Conference Room

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

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

Wednesday 29 MAY 2019 time **9.30am – 12.45pm**

Trust Conference Room, Warrington Hospital

REF BM/19	ITEM	PRESENTER	PURPOSE	TIME	
	Patient story		**Film**	**9.30**	
BM/19/05/34	**Welcome, Apologies & Declarations of Interest**	**Steve McGuirk, Chairman**	**N/A**	**9.45**	**Verbal**
BM/19/05/35 PAGE 4	**Minutes of the previous meeting held on 27 March 2019**	**Steve McGuirk, Chairman**	**Decision**	**9.47**	**Encl**
BM/19/05/36 PAGE 16	**Actions & Matters Arising**	**Steve McGuirk, Chairman**	**Assurance**	**9.50**	**Encl**
BM/19/05/37 PAGE 17	**Chief Executive's Report** - **NHSI QRM feedback – April 2019** - **Summary of NHS Providers Board papers** - **CQC correspondence** - **Quality Account – Halton BC letter** - **Annual Report + Accounts - TO FOLLOW**	**Mel Pickup, Chief Executive**	**Assurance**	**9.55**	**Verbal**
BM/19/05/38 PAGE 33	**Chairman's Report** - **Trust Board Annual Effectiveness Survey**	**Steve McGuirk, Chairman**	**Information**	**10.05**	**Verbal**

Quality People Sustainability

BM/19/05/39 PAGE 54	**Operational Performance & Strategy Reports (IPR) and Assurance Committee Reports**	**All Executive Directors (CEO to Lead)**	**Assurance**	**10.15**	**Enc**
(a) PAGE104	- **Quality Dashboard including** - **March 2019 + April 2019 Month Nurse Staffing Report**				**Enc**
(b)PAGE 121	- **Key Issues report Quality Assurance Committee (7.05.2019)**	**Margaret Bamforth, Committee Chair**			**Enc**
(c)	**People Dashboard** - **Key Issues report Strategic People Committee (22.05.2019) TO FOLLOW**	**Anita Wainwright, Committee Chair**			**Enc**
	Sustainability Dashboard				**Enc**
(d)PAGE 129	- **Key Issues Finance and Sustainability Committee 20.03.2019 + 30.04.2019 + 22.05.2019**	**Terry Atherton, Committee Chair**			
(e)PAGE 139	- **Key Issues Audit Committee (26.04.2019)**	**Ian Jones, Committee Chair**			

Quality

BM/19/05/41	**CQC Update**	**Kimberley Salmon-Jamieson Chief Nurse**	**Assurance**	**11.25**	**PPT**
BM/19/05/42 PAGE 143	**Learning From Experience Q4**	**Kimberley Salmon-Jamieson Chief Nurse**	**To note**	**11.30**	**Enc**

BM/19/05/43 PAGE 151	DIPC Quarterly Report Q4	Kimberley Salmon-Jamieson Chief Nurse	To note	11.35	Enc
BM/19/05/44 PAGE 166	Quarterly Mortality Review Report Q4	Alex Crowe Deputy Medical Director	To note	11.40	Enc
BM/19/05/45 PAGE 178	Annual SIRO Report	Phillip James Chief Information Officer	Assurance	11.45	Enc

Sustainability

BM/19/05/46 PAGE 203	Quarterly Progress on Carter Report Recommendations and Use of Resource Assessment	Andrea McGee Director of Finance + Commercial Development	To note	11.55	Enc

People

BM/19/05/47 PAGE 242	NHS Staff Opinion Survey + action plan	Michelle Cloney Director of HR + OD	Information	12.00	Enc
BM/19/05/49 PAGE 250	Engagement Dashboard Year End	Pat McLaren Director of Community Engagement	Information	12.05	Enc

GOVERNANCE

BM/19/05/51 PAGE 257	Strategic Risk Register + BAF	Mel Pickup Chief Executive	Approval	12.15	Enc
BM/19/05/52 PAGE 265	Board Sub Committee ToR and Cycles of Business Cycle of Business – for approval (a) Finance + Sustainability Committee (b) Trust Board ((c) Audit Committee (d) Strategic People Committee (e) Quality Assurance Committee Terms of Reference – for approval (f) Finance+Sustainability Committee (g) Quality Assurance Committee (h) Strategic People Committee	Mel Pickup Chief Executive	Approval	12.20	Enc
BM/19/05/53 PAGE 267	Committee Chair's Annual Reports (a) Finance + Sustainability Committee (b) Strategic People Committee (c) Audit Committee	Terry Atherton, Cttee Chair Anita Wainwright, Ctte Chair Ian Jones, Ctte Chair	Approval	12.25	Enc
BM/19/05/54 PAGE 281	Amendment to the Constitution (Committees in Common	Head of Corporate Affairs	Approval	12.30	Enc
BM/19/05/55 PAGE 294	Compliance with Licence Annual Return	Head of Corporate Affairs	To note	12.35	Enc

BM/19/05/56 PAGE	Any Other Business	Steve McGuirk, Chairman	N/A		Verbal
	Date of next meeting: Wednesday 31 July 2019, 9.30am, Trust Conference Room, Warrington				

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 27 March 2019
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Chris Evans (CE)	Chief Operating Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Jean-Noel Ezingeard (JNE)	Non-Executive 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
John Culshaw (JC)	Head of Corporate Affairs
Lucy Gardner (LG)	Director of Strategy
Phillip James (PJ)	Chief Information Officer
Pat McLaren (PMcL)	Director of Community Engagement + Fundraising
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Jane Green, S Andrews, C Pearson	Specialist Dementia Nurse and members of the public (*Patient Story)*
Apologies Alex Crowe (AC)	Medical Director, Director of Medical Education + Clinical CIO
Observing	
Paul Bradshaw, Norman Holding, Alison Kinross, Peter Lloyd-Jones, Anne Robinson - Public Governors	
Prof John Williams	Partner Governor, University of Chester
Jonathan Driscoll	Care Quality Commission
Camilla Allen	Care Quality Commission
Andrew Corbett-Nolan	Good Governance Institute

BM/19/03	**Patient Story** The Chairman welcomed Jane Green, S Andrews and C Pearson to the meeting who shared a moving story of the care provided for mum both in the home, Warrington Hospital and the wider community. Particular recognition was given to B12 as a catalyst for change in mum's care due to the person-centred care that was provided to mum and family, all being involved in care plans throughout the care journey. To support care some initiatives were introduced eg, a Likes/Dislikes Communication Card and completion of Trust 'This is Me' documentation. Following feedback from staff family and patient, the Communication Card is to be rolled out Trust wide to use with patients with learning and communication difficulties. Mum is now settled, receiving care in a Nursing Home. The Chairman and CEO thanked the family for sharing their mum's journey with the Board and wished them continued wellbeing.
BM/19/03/17	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed observers from CQC, GGI, and CoG. Due to Purdah, the Chairman explained some items had been reserved for Part 2. Declarations of Interest: MC declared Joint HR&OD post with Bridgewater Community NHS FT and PJ Digital responsibility with One Halton and Warrington Together. No other

	declarations in relation to the agenda were noted.
BM/19/03/18	**Minutes of the meeting held 30 January 2019** Date of meeting to read 30 January 2019 Page 4 IPR Quality Measures, 2nd para to read .. Working with ANTT training … 3rd para to read .. Chairs weekly Gram Negative Blood Stream and CDiff meetings…. With these amendments, minutes of 30 January 2019 were agreed as an accurate record.
BM/19/03/19	**Actions and Matters Arising. Action log and rolling actions were noted.**
BM/19/03/20	**Chief Executive's report** CEO welcome observers explaining as part of the new CQC inspection regime, the Trust is to be inspected in 3 elements, Use of Resources, 4 April 2019, Core Services and Well-Led. The Core Services inspection had commenced on 26 March 2019 following notification of an unannounced visit that day. Well-Led inspection date tbc. CEO provided an update on service improvements and service developments that had progressed since the last Board. The CEO was delighted to report the Executive Team had approved the business case for staffing element of the Midwifery Led Unit, Capital investment had previously been approved whilst working up the clinical model to support delivery of services, circa £1m, in part in response to some actions agreed following the CQC Inspection in 2017. The MLU will provide choice for ladies either at home, hospital or MLU Developments continue relating to Eastern Sector Cancer Hub (ESCH). The DoS had attended a stakeholder feedback event including Governors to develop proposals to establish a Cancer Hub for Halton, Warrington, St Helens and Knowsley residents with options being considered to site either at Halton or St Helens Hospitals. Clinical model had been developed with service users, clinical and staff engagement from both organisations. Development of an options appraisal is being led by Knowsley CCG. The Trust is developing tender bid to provide two services in the UTC, in Halton, one in Widnes and one in Runcorn to offer a wider range of care options, in partnership with Bridgewater NHS CHFT and GP Federation. A Bidder dialogue session took place 15 March 2019, bids to be submitted 5 April 2019 to Halton CCG. Development of Stroke Services and Hyper Acute Stroke Services out of StH&KHT, in partnership with WHH, offering enhanced thrombolysis service, consolidating thrombolysis and hyper acute care, with Warrington patients receiving care at StH&KHT and repatriated back to WHH for longer term rehabilitation. The CEO had met with local MPs who fully support ESCH and Hyper Acute Centre developments. The CEO reported she had met with W McCarthy, NW Regional Director of NHSI/NHSE, who had attended the C&M Provider Group to understand wider health economy priorities and context of current services provided. Further meeting 28 March 2019 to discuss integrated care provision in Halton and Warrington from a Trust perspective. WMcC had endorsed the work of C&M Partnership and PLACE as a fulcrum for integration and is to meet with other C&M CEOs individually for a holistic perspective. From a Trust perspective, the CEO was pleased to report the appointment of 7 substantive

	Consultants in the last 2 months, 11 in the calendar year, some in nationally recognised difficult to recruit to posts of Care of Elderly and Acute Medicine. The success of the Frailty Unit had been acknowledged during a visit from AQuA with colleagues from the USA looking at integrated care, looking to adopt some of the pathway developments and best practice highlighted in the Trust. Summary of NHS Providers Board papers noted.
BM/19/03/21	**Chairman's Report** The Chairman provided an update on local, regional and national matter. Interviews for NED vacancy to take place on 3 April. Warrington Chairs, including health and other stakeholders continue to discuss developing infrastructure and local plan of Warrington BC. Chair had met with Chair of Bridgwater CH NHS FT to progress further collaborative working with a Board to Board planned next month to discuss further. Chair is to deliver 'Grand Round' on 29 March 2019 on the role of the Board and relationship with Clinical Governance Collaborative work continues with University of Chester. Programme of Ward/Department visits continue and CEO/Chair informal walk-rounds. 1:1 meetings continue with the Lead Governor and informal Q&A with the CoG. Themes at a recent National Providers event correlate with regional and WHH aspirations. The Chair to meet with the new Leader of Warrington Council over the coming months. .
BM/19/03/22 (a)	**IPR Dashboard** Quality measures. CEO asked SC to address Medication Safety incident and VTE performance and SJR Mortality Reviews within the report and mitigations in place to achieve trajectories. SC explained VTE assessments are completed electronically with a small number manually validated creating a time lag of validated data. There will hopefully be fewer manual validations with the development of Lorenzo and SC assured the Board there were no concerns to escalate and compliance was consistent at 95%. There had been significant changes in the 10 years since VTE guidelines had originally been introduced, revised processes will include extending to Paediatrics, and more prescriptive requirements for risk assessment, and revision to those assessments coming in after 1 April. In relation to Medication Safety Incidents, SC assured the Board there had been no long-term patient harm; one incident had been a transcription error resulting in patient being prescribed a drug twice for one week when it should only be given one (the drug is methotrexate); governance had been discussed at RO to RO level and moderate harm recorded. The second incident related to patient not receiving warfarin – this resulted in delayed discharge, no harm recorded. SC referred to the summary provided in letter format to Board members in relation to SJRs in response to previous CEO challenge about the number of SJRs scored overall '5' (excellent care); 2 examples were given where excellence in care had been determined. It was also noted the data could be skewed because of cases which are automatically escalated through the SI process as well as all the deaths in ED are included (most of which are simply

	assessment against resuscitation standards and protocols). In response to queries raised by SMcG and AW relating to manual recording of VTE, SC explained VTE will continue to be reported to PSCE, QAC and Trust Board through the IPR. Only a small number of manual validations will need to continue CEO asked the Chief Nurse to address variation in performance relating to SEPSIS in-patient screening, F&FT E&UC. KSJ explained F&FT January position 78% is measured quarterly and variation was primarily due to winter pressures. Focussed training by the Sepsis Team has been put in place for new starters, Preceptees and medical staff and assurance given to the Board that the validated position is 100% compliance for January 2019. An action plan had been developed with measures to improve response and recommendation rates. Current system is automated, elements from the former manual system is being reviewed to enable patients to provide written feedback. Other initiatives in place include an information leaflet given to all patients on arrival to A+E providing more information regarding waiting times and the patient pathway including waiting processes and prioritisation of treatment to enable patients to understand next steps for them. Support will be provided to ED by the Head of Patient Experience. Volunteers are supporting tea rounds for real-time patient feedback and also there will be a re-launch of conversation cafes on both sites to understand why recommendation rate continues to reduce. Progress of these initiatives will be provided at next Board. In response to query raised re: reason for drop in numbers, KSJ commented that feedback is being reviewed to identify particular themes. In relation to question from SC relating to use of antibiotics, KSJ continues to Chair weekly Gram Negative Blood Stream and CDiff investigation meetings and antiobiotic prescribing compliance has improved at 90.7%. The Deputy DIPC attends these meetings and feeds back to Consultants directly with the Chief Nurse and Medical Director as required. IJ asked for mitigations to reduce Pressure Ulcers (PU) and the variation in the Deep Tissue injuries. KSJ explained enhanced training packages for all new and existing Band 5 and 6 and Preceptees is being put in place which will include PU Management and Catheter Care training, phased as appropriate, which will form part of mandatory training for this cohort of staff. Systems are in place to ensure agency staff are appropriately trained both in the Trust processes and NHSP processes/standards. The Trust is part of the NHSI Collaborative on PU Management and the Quality Academy collaborative has commenced to support service improvement. KSJ was pleased to report that the two wards where 'Heels on Angels' PU Collaborative had been implemented had had no PU on those wards since August 2018 and plans to roll-out on other wards had commenced. MC added that the WHH Preceptorship Scheme had been recognised nationally as an exemplar of best practice. <u>Quality Assurance Committee Chairs Key Issues Report (5 March 2019) noted.</u> JNE reported assurance provided following request from Audit Committee relating to Adult + Children's safeguarding training; continued momentum of Quality Academy supporting quality improvement in a number of areas. MB highlighted initiatives implemented as part of the
(b)	

National Maternity and Neonatal Collaborative and plans in place for Wave 3 participation, with QAC continuing to monitor key quality indicators for triangulation of information, escalating to the Board as appropriate.

Access and Performance measures. CEO asked the COO to address areas of variation in performance and mitigations in place to achieve trajectories relating to AED challenges, Ambulance Handovers; total time in A&E, LLOS and DTOC, particularly improvements in these areas following the investment made.

In relation to A&E, CE reported improved position for March to date of c.78% - excluding Widnes UCC, which demonstrated continued improvement since January (74.35%) as reported to FSC on 20.3.2019. National position for the Trust had improved, 99 out of 139 providers, week ending 17.3.2019 regionally the Trust were second by 0.5%. Improved ambulance handovers correlates with investments to improve pathways in FAU/GPAU ED and Ambulatory Care

FAU – improvement month on month on utilisation and through put, saving in February of 620 bed days which equates to approximately 20 beds on a full year effect. GP pathways are live to FAU and direct referrals progressing with NWAS, 90%+ of patients are discharged from FAU with community support avoiding hospital admission.

Discharge Lounge – Current peak of 134 patients per week, with majority of arrivals at 11am, plans in place to bring this forward through Ward Manager meetings with the CN for to continue to promote early bed availability.

GPAU– 250 admissions in February, improvement reported in March despite winter pressures in A&E, which has unfortunately at times led to periods of un-availability due to requirement for additional in-patient capacity.

ED ACare – 350 patients, 80% discharged with no admission, assessment capacity for January and February 2109 compared to same period last year had seen an additional 493 attendances through GPAU with a decrease in admissions of 190 and increase in discharge of patients of 418 from assessment capacity with no admissions.

Ambulance Handovers - improvements continue in over 60 mins standard with reduction to 59 in February from 102 in January reflecting the support of the 24/7 practitioner.

ECIST collaborative to commence from May 2019 with focus on LLOS Super Stranded patients to develop a bespoke Trust approach.

Venn had identified circa need for 24 additional IMC beds in the system. BCF have funded Project Manager to review IMC across Warrington with medium and long term sustainable proposals whilst acknowledging interim plans may be required for winter 19/20.

AMcG referred to the limited resources available to support additional capacity. There is a temporary ward on site for up to 6 months and the usual pressure of winter. Plans will be required to close the capacity as quickly as possible using data supplied by Venn in conjunction with system partners.

In relation to query raised by KSJ re: A&E professional standards and effectiveness. SC explained that 12 internal standards have been implemented in U&EC and their effectiveness will be monitored via various mechanisms including audit. Each CBU will develop their own

(c)	IPS, and these are to be refined to be signed off by the Medical Cabinet prior to implementation. People measures. CEO asked the HRD+OD to address areas of variation in performance and mitigation and measures in place to achieve trajectories relating to sickness absence. In addition the CEO asked for an update on agency spend, particular AHP as this is an outlier according to the Weighted Activity Unit (WAU) provided by Model Hospital (NHSI) and referenced in the recent Use of Resources submission. Sickness Absence: In relation to sickness absence MC explained that the Trust Board requested at the last meeting for this be taken as a specific focused update to the Strategic People Committee (SPC). MC outlined the actions that had been taking place including a review of how the Trust policy is applied consistently across the Trust. This identified some best practice, shared with all Line Managers and some gaps in training for managers in application of the Policy. SPC was informed that the escalation process for the policy was reviewed by the HR team relating to trigger points and more senior HR support for Managers at these points to be put in place. SPC had requested the escalation of trigger point timeframes to be reduced and to bring this back to SPC. Review of absence over specific holiday periods and shift patterns, particularly Easter, to be undertaken in June to identify any themes and hot spot areas followed by further review of the Policy. In addition learning from the Nursing Pilot will be embedded. Agency Spend: All agency spend is monitored through the PPSRG including AHP activity with the Lead AHP in attendance. MC assured the Board that FSC had received an update on the reasons for the recent increase in Premium Pay Spend (Agency & Bank) at the March meeting. This increase in part related to an accounting matter (£100K) for late receipt of invoices and also related to the February 2019 decision by HRMC to change the tax rules for our Direct Engagement provider (Plus Us). The Trust Board were informed that an independent Due Diligence review is underway across a number of C&M Trusts (including our Trust) relating to the proposal to change our Direct Engagement model. The scale of the impact of the change to VAT rules was highlighted by TA at circa £100k per month. Agency Use by AHP workforce: In relation to UoR WAU information for AHPs, it is acknowledged that this is an outlier for comparison with our Peer Trust. AMcG commented that the Finance, HR and Commercial Development functions had undertaken a deep dive into this published data and that the data does not include all AHP activity. The information therefore provided by Model Hospital is not accurate for WHH and when the information of external activity is excluded we are in fact less costly than our Peer Average. Strategic People Committee Chairs Key Issues (20 March 2019) AW and MC highlighted the review of DRAFT Equality, Diversity & Inclusion (E, D & I) Strategy and that this had been confirmed for submission to Trust Board for approval. AW informed Trust Board that sickness absence and change in HRMC VAT rules has been reviewed and reflected on the BAF presented today and AW asked Trust Board to note the recommendation from SPC that the risk on staff engagement was de-escalated due to activity undertaken, including Listening

	into Action (LiA) progress. MC asked the Chair for permission to circulate the document: Quality Improvement through Staff Engagement – LiA 2018 and NHS Staff Survey 2018. MC stated that the Trust had already been placed in the Top Quartile when we started our Quality Improvement journey through engagement however it was extremely pleasing to note that the Trust when compared to all NHS Providers had significantly improved using the results of the National Staff Survey 2018. MC also commented on the excellent response by our staff in completing the LiA Pulse Check (response rate 73%) and to note that this survey will be repeated June 2019.
(d)	Finance + Sustainability Measures. CEO asked the DoF + Commercial Development to update the Board on the year end position and Control Total, cash challenges and sequential plans, change to 18-19 Capital Programme and update on contract round for 2019-20. AMcG was pleased to report, despite financial challenges throughout the year, Month 11 position, Trust deficit year to date is £18.6m which is £1.6m worse than plan. 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. As previously reported, a number of risks do however remain including shortfall in CIP, unfunded cost pressures underachievement of clinical income, contingency not achieved from Commissioners, with a number of improvements and mitigations in place to offset risk including management of winter pressures and non-pay controls. CIP improvements in year reported and preparation underway for 2019-20 supported by SLR data intelligence being used across all CBU and Corporate Divisions. AMcG reported the Trust had received formal notification from NHSI that the outstanding loan of £14.2m had been extended to November 2019 at the same interest rate. Post submission of Operational Plan, there will be further discussions with NHSI relating to all loans and expectations related to control total for 2019-20. AMcG referred to the proposed changes in the 2018-19 Capital Programme which had been supported at FSC on 20 March 2019. KSJ assured the Board following discussions at FSC and Risk Review Group, any items not funded for 2019-20 will be risk assessed, put on Datix and discussed at Risk Review Group before proposal for investment is made. AMcG explained the strengthened procurement processes supported by Procurement Strategy incorporating new legislation and guidance to support driving down of costs and streamline practices. Work as part of the C&M Collaborative will provide transparency and clarity of savings for constituent organisations as well as for the health economy through economies of scale. MC referred to workstreams being progressed as part of C&M Collaborative of starting rate for agency spend and review of occupational health services. The Chairman conveyed thanks on behalf of the Board to the DoF and her team to achieve the year end final position and agreement for sign-off of the 2019-20 contracts. • **The Board noted, reviewed and discussed the report.** • **The Board approved the changes to the 2018-19 Capital Programme.**

(e)	Finance + Sustainability Committee (FSC) Chairs Key Issues. January and February 2019 noted. TA provided a verbal update of pertinent matters discussed at March FSC including year end position, 2019-20 Financial and Operational Plan, temporary staff and locum costs. Detailed report received following stocktake of medical workforce by SC providing assurance of options being explored to reconfigure medical workforce recognising difficulty recruiting to substantive posts with continuing monitoring at FSC.
(f)	Audit Committee Chairs Key Issues, February. IJ reported MIAA Internal Audit Plan had been circulated to NEDs/EDs to prioritise areas for review as part of the 3 year rolling programme which had been sign-off at the February meeting. The External Audit Plan and Counter Fraud Annual Work plans had been approved. 5 MIAA reports received, 3 of Significant Assurance, 3 Moderate. Mechanism in place to track and monitor closure of follow-up actions prior to final sign-off supported by the Finance Team. Areas of non-compliance reflected on the BAF. Monthly Safe-staffing reports January and February. KSJ highlighted continued improvement of maintenance of CHPPD (7%). In January qualified Nurse Associates (NA) Pilot had completed and the NAs had substantially joined the Trust providing additional capacity across a number of wards. KSJ was pleased to report in February the Trust's Neonatal Unit is the only unit in C&M to achieve the BAPM standard for compliance for staffing establishment AMcG and MB queried % fill rate on A5, A6 and ICU. KSJ was pleased to report following focussed recruitment there are no current vacancies on ICU. There had been a number of retirees and leavers at similar time on A5 and A6, however KSJ assured the Board that there are 2x daily staffing meetings to review Trust staffing levels enabling staff to be speedily mobilised to appropriate areas, using SaferCare software. The Trust has been recognised as a national exemplar in the use of the SaferCare System with 4 Acute Providers attending WHH looking to adopt WHH process. • **The Board noted, reviewed and discussed the report.**
BM/19/03/23	**Performance Assurance Framework (PAF)** The Director of Finance highlighted key points for the Board to note following the annual review of the PAF and IPR which provide the mechanism for Ward to Board Reporting. AMcG explained that the QPS forum will meet bi-annually supported by a monthly KPI meeting chaired by the COO. This forum had replaced the Trust Operational Board (TOB) to allow a more thorough review of operational issues. AMcG assured the Board that performance monitoring will continue at the appropriate Board Sub Committees who can request a deep dive into any service at any time. In addition a rolling programme of review will continue in the 2019-20 MIAA Audit Programme. Proposed changes to the IPR following approval at the appropriate Sub-Committees were highlighted which included removal, updates and new KPIs aligning CQC, NHSI, local and contractual indicators. The presentation of the data has been amended to allow more information to be included to focus more on the 'forward look' of the metrics with more supporting information included in the Appendix. Committee Chairs added proposals had been discussed and supported whilst recognising the challenge to ensure that current and accurate data is reported to avoid data lag.

	• **The Board approved the Performance Assurance Framework and changes to the IPR.**
BM/19/03/24	**Ward to Board Assurance Visits** The Head of Corporate Affairs provided an update on the programme of visits that had taken place since April 2018 across the three hospital sites, highlighting themes of good practice and areas for development noted during these visits. A total of 31 visits had taken place to date with a programme planned to June 2019. The information is triangulated with Governor Observation visits and Ward Accreditation Rounds. The Board continues to support the programme of visits which enable instant feedback from staff and vice versa. • **The Board noted, reviewed and discussed the report.**
BM/19/03/25	**Hospital Volunteer Annual Report** The Chief Nurse explained how the Trust had developed the model working with staff, patients, service users and community partners to maximise opportunities for the role of Volunteers . There had been a significant increase in the number of volunteers from 30 in 2017 to 587 in 2019 and 2019. The role had been developed to include ward buddy, meet and greet, patient simulation, other successes included developing the Reader Initiative which had been funded by the Charitable Funds Committee, and developing Pets as Therapy during 2019. The Board acknowledged the role that Volunteers play, their impact within the Trust and the wide variation in age profile and their link with the wider Trust Strategy supporting community integration. MC added the Report had been submitted as an exemplar for best practice nationally by NHS Employers. • **The Board noted, reviewed and discussed the report.** • **The Board to receive an annual report. Cycle of business to be amended.**
BM/19/03/26	**Patient and Public Participation + Involvement Strategy** The Director of Community Engagement provided an overview on development of the Strategy which had been co-produced with the Trust Governors. Lead Governor explained the Governors had been fully involved in developing the Strategy and work plan which had been reviewed and developed at Patient Experience Committee and Governor Engagement Group as well as other public stakeholder groups to ensure members of the public, staff and external partners were fully engaged. The Governors continue to work to improve participation from these groups and to support a wide cross section membership of the Trust. PMcL assured the Board that monitoring of the Strategy and milestones will be through the GEG and Patient Experience Committee and the Council of Governors. • **The Board reviewed, discussed and approved the Strategy.** • **The Board to receive an annual report.** • **Quality Impact and Equality Assessments to be amended to include specific section of requirements for consideration of Patient and Public Participation + Involvement.**
BM/19/03/27	**Equality, Diversity and Inclusion Strategy** The Director of HR + OD highlighted key points for the Board to note within the report which had informed the Draft version presented today. The key to the strategy was that it had been developed through involvement and co-production by extensive engagement with key stakeholders, including, staff, Governors, service users and public. Feedback from these groups, the Patient Experience and E, D & I Sub Committees and Trust Board time out in April 2019 had been incorporated including link with population needs in both Warrington and

	Halton. The Strategy had been discussed in detail at the Strategic People Committee on 20 March 2019 who had requested amendments to pledges and What Does Success look Like statements which had been included in the Strategy presented today for approval. In addition key elements following the national staff survey had also been included. MC explained the delivery plan will be monitored through the E, D & I Sub Committee with progress and matters of escalation highlighted through the Chairs key issues report to Operational People Committee and onwards to SPC if appropriate. JNE raised 2 matters: 1. The significant improvement from the first draft. JNE noted that the Where Are We now section had included a statement about the majority of 9 Protected Characteristics but had not explicitly referred to gender reassignment. 2. The compliance target for training was 85% and therefore how had this figure been derived. MC stated that E, D & I training for staff was one of the Core Skills Framework reported to Trust Board and that an organisational target of 85% was agreed. The rationale for this was that the reported compliance includes all staff and therefore includes staff on sick leave, maternity leave etc. It should however be noted that the current CSFT compliance rate for the Trust is over 90%. AMcG asked how the Draft E, D & I strategy will be embedded within the Trust. MC explained compliance with E,D+I will become part of the annual appraisal process with PDRs not being signed off unless all mandatory training has been completed, and that work was currently underway to aligned E, D & I to the Trusts new Leadership Behaviours framework. Monitoring of compliance will be through the E, D & I Sub-Committee which has both staff and service user representatives as members. • **The Board reviewed, discussed and approved the Strategy recognising the profile of the local population.**
BM/19/03/28	**Educational Quality Monitoring Review** The Executive Medical Director highlighted key points for the Board to note within the report providing an update on progress following the initial HENW/GMC report in July 2018 and the subsequent visit in November 2018 when the risk had been reduced from a Category 2 to Category 3, with regular reports provided to Finance & Sustainability, Quality Assurance and Strategic People Committees due to the number of inter-related issues. Challenges to recruit to substantive medical speciality consultant posts and operational challenges the urgent and emergency care pathways acknowledged were. However the Trust had recruited to a number of Consultant posts as reported earlier by the CEO. SC provided a high level overview of the measures that had been put in place to address concerns raised, including: - Forums for Junior Doctors and Junior Doctors Experience Group both established, both Chaired by AC to maximise opportunities for operational and medical education interface and improved communication channels. - Work will continue to improve engagement with trainees and consultants with appointment of Chief Registrars being a conduit for improved engagement. - The HENW action plan will be updated further prior to final submission on 30 April 2019. - SC reported that the President of the RCP had visited the Trust on 15 March 2019 and acknowledged the progress made by the Trust relating to the medical rotas and teaching.

	• **The Board reviewed, discussed noted the report and assurance provided and the pivotal role of the Director of Medical Education.**
BM/19/03/29	**Strategy Development and Delivery Report** The Director of Strategy provided an overview on the governance and delivery of the Trust's strategic objectives as part of the bi-annual reporting to Trust Board to assess progress against the Trust strategic priorities within the 3-5 year strategy. 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. One indicator is not rated at this stage which relates to increase in internal promotions. MC explained that one of the workstreams through the Workforce Redesign Group will focus on retention and enablers to enable staff movement to retain skills. The Board were assured of the monitoring of KPIs and outcomes through the various Board Sub-Committees, as reflected in a number of discussions in today's meeting. Following a query from SMcG, it was agreed to include a cross reference in the IPR to indicators that are within the Trust Strategy. The Strategy report references which indicators are included in the IPR. JNE queried the indicators relating to Halton Campus and Warrington New Hospital as full delivery of these programmes is likely to be 5-10 years in the future. LG referenced the report to explain how we report progress against key milestones to measure delivery of longer-term programmes including the new hospitals. In relation to query raised by AMcG relating to system financial position in C&M, it was agreed the metric to relate to the Place Based systems position in future, rather than the whole of C&M. LG advised a Project Lead jointly appointed by WHH, Warrington Council and Warrington CCG is developing a business case for a new hospital. Progress and next steps will be reported to the Warrington H&WB Board on 28 March 2019. An initial meeting had taken place with Elective Care Lead at the Royal Hospital to consider Halton as an Elective 'hub' within C&M with a further meeting planned with T&O Consultants across C&M. • **The Board reviewed, discussed and noted the report.** • **IPR to include reference to indicators within the Trust Strategy.**
BM/19/03/30	**Strategic Risk Register and BAF** The Chief Executive provided an overview and Head of Corporate Affairs explained the proposed the changes to the SRR and BAF for approval by the Board. Proposals had been approved at the Quality Assurance Committee on 8 January 2019: - No new risks had been added to the BAF; - Four risks to be de-escalated from the BAF, assurance provided through deep dives, action plans and monitoring processes had been provided at the Quality Assurance Committee. - Four risks currently on the BAF to be reduced due to mitigating actions and monitoring processes in place, which had been discussed earlier in today's meeting. - Descriptions of three risks currently on the BAF to be amended as added clarity for further assurance, as requested by Audit Committee February 2019, had been provided to Quality Assurance Committee through action plans and monitoring mechanisms. - JC highlighted the update to Risk 134 on the BAF to include potential risk due to impact

	of VAT on agency staff which had been requested through Strategic People and Finance and Sustainability Committees. - MB and TA assured the Board of the robust risk management monitoring processes in place through Risk Review Group and assurance Sub Committees identifying risks with a mechanism to request deep dives into particular areas. In relation to GDPR assurance gaps, PJ assured the Board work is progressing in relation to GDPR requirements and gaps associated to timeframes complete technical fixes. • **The Board reviewed, discussed and approved the proposed amendments and the improved risk management processes identifying operational and strategic risks.**
BM/19/03/31	**Amendments to the Trust Constitution** The Chief Executive and Head of Corporate Affairs provided an overview of the proposals presented today, all of which had been discussed and agreed through a Governors Working Party and subsequently approved at the Governors Nomination and Remuneration Committee on 4 February 2019 and Council of Governors on 14 February 2019. The proposed amendments will strengthen succession planning and business continuity for Governors and Non-Executives. The proposed amendments were: - Section 12 (page 14) - **Extend the number of terms a Governor can serve from 2 to 3.** - 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** • **The Board reviewed, discussed and approved the amendments to the Constitution.**
BM/19/03/32	**Changes to the Scheme of Reservation and Delegation Table B** The Director of Finance highlighted proposed changes to Table B following a review of the approval process by the Charitable Funds Committee in November 2018, in that all bids will be presented to the Charitable Fund Committee to ensure all bids are prioritised appropriately from a quality and investment perspective. • **The Board reviewed, discussed and approved the changes to SORD/SFIs**
BM/19/03/33	**Any Other Business** The Chairman thanked Jean-Noel Ezingeard for his support and contribution to the Board and CoG during his tenure and wished him every success both personally and in his new role.
	Next meeting to be held: Wednesday 29 May 2019

Signed …….

Chairman …….

Date Approved ……..

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.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/19/05/36	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	29 May 2019

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/19/03/29	27.03.2019	Strategy Development and Delivery Report	IPR to include reference to indicators within the Trust Strategy	**Director of Strategy**	**29.05.2019**			
BM/19/03/22	27.03.2019	IPR – Quality measures	Progress of initiatives to improve F&FT recommendations.	**Chief Nurse**	**29.05.2019**			

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/07/57		Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Medical Director**	**Date TBC**		14.01.2019. Deferred to March 27.03.2019. Deferred to future BTO	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
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. 9.4.2019 Chief Officer, WCCG to provide update to Health Scrutiny Committee. Update iicorporated in CEO report to Trust Board.	
BM/19/03/26	27.03.2019	Patient +Public Participation and Involvement Strategy	Quality Impact + Equality Assessments to include specific section on requirements for P+PPI	**DoCE+ Fundraising**		**08.04.2019**	Documentation updated	
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	**27.03.2019**	27.03.2019 . Reviewed at SPC and reported to Board, minute BM/19/03/22.	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

RAG Key

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

Summary of board papers – statutory bodies

NHS England/NHS Improvement joint board meeting – 28 February 2019

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

Chief executive update

- From the 1 April NHS England (NHSE) teams within and NHS Improvement (NHSI) will begin merging together. Following this, there will be further changes in summer with a view to complete the restructure by the autumn.
- It is expected that in late April/early May the long term plan implementation framework will be published. This will set out a five year programme of change.

2018/19 finance and operational performance report

- The England-wide rollout of the NHS app is progressing. The app is currently enabled in over 1,500 GP practices and on track to be close to one third by the end of March. An intensive rollout period is scheduled from April – July 2019.
- The NHS has now recruited 110 doctors from overseas through the extended national programme and pilots. There is a further pipeline of doctors undergoing interviews and language assessments.
- During 2019/20 it is expected that primary care networks will establish themselves, laying the foundation for transformation. More information on PCNs can be found in the NHS Providers on the day briefing.
- A second wave of community perinatal mental health funding has been distributed to a further 35 Sustainability and Transformation Partnership (STP)-led sites, which gives expectant and new mothers experiencing mental health difficulties access to specialist perinatal mental health community services in every part of the country by April 2019.
- NHSE and NHSI are working with all systems across England to either set out a development path for an STP to become an Integrated Care System (ICS) or to support the further development and strengthening of ICSs.

Workforce implementation plan update

- The board noted some of the key themes from engagement on the workforce implementation plan:
  - Making the NHS a better place to work is a key theme.
  - There is an emphasis on flexible working and health and wellbeing.
  - There is a need to look at different generational leads.

- Importance of portfolio careers.
- Importance of the right leadership culture at all levels of the service.
- Importance of central bodies exhibiting the leadership they want to see.
- Nursing challenges have been identified as needing urgent action.

- An interim report is expected to be published later this year and will aim to set out a more detailed vision and will recommend some practical actions.

Establishing Integrated Care Systems by April 2021

- NHSE/I confirmed that support will be provided to STPs and ICSs for the following areas:
  - Boost out of hospital care to improve the link between primary and community services.
  - Re-design and reduce pressure on emergency hospital services.
  - Support people to get more control over their health.
  - Increase population health and local partnerships with local authority funded services.
  - Agree a long term plan implementation framework to establish priority areas for each system.
  - Deploy differentiated national support offers.
  - Reinforce system based behaviours within NHSE and NHSI.
- A maturity matrix system to assess STP/ICS progress will be developed. This index will:
  - Set out the system priorities for development and the corresponding regional/national support.
  - Establish the freedoms and flexibilities that correspond to a level of maturity.
  - Establish a clear set of entry criteria for achieving ICS status.
- To share best practise and learning, a development offer needs to be created and the key elements of this will include:
  - Assessing population health management maturity.
  - Creating a national learning network for health and care professionals.
  - Delivering an accelerator programme that provides hands on support to a small number of STPs.
  - Designing national consistent integrated models of care.
- NHSE and NHSI will also work to reinforce this approach systematically at a corporate level by:
  - Constructing a new ICS accountability and performance framework.
  - Ensuring financial flows support and incentivise system based collaborative working.
  - Developing an integration index to better measure and reflect system ambitions.
  - Developing a single population health dashboard.
  - Agreeing nationally consistent ICS governance structures.
  - Proposing legislative changes that would further support this direction of travel.

Health Education England board meeting – 19 March 2019

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

Performance report

- NHSE and Health Education England (HEE) are working collaboratively to deliver an effective transition and education programme for international GPs.
- There is a risk that the 1,000 physician associates (PA) target in primary care will not be met due to in part the lack of employment posts being developed. NHSE, NHSI, and HEE are working collaboratively to incentivise PAs into primary care.
- A programme aimed to support the increase in nurse training by 25% by 2021 includes a funding levers work stream.
- The development of a national Urgent and Emergency Care Workforce Strategy is underway, in partnership with NHSE and NHSI.
- The quarter three position shows 14,566 apprenticeship starts against a plan of 15,403 (94.6%).
- HEE is recruiting two patients' safety fellows in partnership with the Academic Health Science Network Patient Safety Collaborative.

HEE Mandate and Business Plan Update 2019-20

- HEE is working jointly with NHSI and The Department of Health and Social Care (DHSC) to develop its mandate for 2019/20 onwards. A draft is expected to be shared across HEE and NHSI's Boards in April.

HEE proposed budgets for 2019/20

- The workforce development budget will continue at £84.2m in 2018/19, supplemented with an additional £30m that is targeted at nursing development for those providers that take on trainee nursing associates.
- Discussions are ongoing with NHSE about their contribution to the growing cost of GP training.
- Due to the Leadership Academy transferring to NHSI in April 2019, HEE will lose both the allocation and planned expenditure of its current 2018/19 levels.

Care Quality Commission board meeting – 20 March 2019

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

Chief Executive's report

- A detailed paper on enforcement priorities will be presented to the executive team in April.

Chief Inspector of Hospital's report

- Since the publication of the report '*sexual safety on mental health wards*' in September 2018 the CQC has undertaken the following actions:
  - The establishment of an Arms Length Body oversight committee. The committee meets every other month and is attended by NHSI, NHSE, HEE, Royal College of Nursing and the Royal College of Physicians.
  - A brief guide has been co-produced with inspectors to support them implement the report's recommendations.

Recent publications

- Following the publication of the '*State of care in independent ambulances*' report the CQC will continue to work with the DHSC to close gaps in the regulation whereby services outside the CQC's remit are providing poor care.

Upcoming publications

- CQC will publish their legal scheme confirming the fees they will charge providers in 2019/20, along with their response to the consultation on these fees. These will aim to be published in week commencing 18 March and will be accompanied by supporting documents, including a regulatory impact assessment and an independent summary of the feedback received to the consultation.
- The '*independent doctors and clinics providing primary medical services – learning from good practice*' report enabled the CQC to understand the common issues identified in inspections, identify good quality practice, and look to improvements that could be found on follow-up inspections.

Healthwatch England update

- The CQC has secured £504,000 from NHSE to run an engagement exercise with the public on the long term plans that are being developed on a regional basis. This engagement exercise, that will take place in every part of England, presents the first opportunity to work in a co-ordinated way.
- NHS Digital has announced a plan to review the data for hospital readmissions and make it more meaningful. A review is being set up to look at how they can record and include other key data, such as the reason why someone is readmitted, as well as making the data definitions more consistent.

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Melany Pickup
Chief Executive
Warrington and Halton NHS Foundation Trust
Warrington Hospital
Lovely Lane
Warrington
WA5 1QG

8 April 2019

CQC Reference Number: INS2-5562359261

Dear MS Pickup

CQC inspection of Warrington and Halton NHS Foundation Trust

I write further to the feedback meeting on 2 May with myself, Jonathan Driscoll Camilla Allen and Mary Aubrey. I thought it would be helpful to give you written feedback of our preliminary findings as highlighted at the end of the well led assessment and given to you and your colleagues at the feedback meetings.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back and provides you with a basis to start considering what action is needed rather than waiting for the draft inspection report.

An overview of our preliminary findings

The feedback to you was:

We can see very clearly the links with your strategy to your aims and objectives at every level of the organisation, however, we would like to review your delivery plans.

You have met your control total in 2018-19 and as well as that you have made £9 million investment in year, however, we are aware that you face significant financial challenges in 2019-20.

We can see that you have made significant improvements in addressing the back log of complaints and that you are now focusing on the timeliness of responses for formal complaints.

We can see that you have made improvements to your risk management processes and that you are working with the Good Governance Institute to further evolve your risk management processes.

We have seen and heard that your staff feel supported, respected and valued and clearly proud to work at the trust, we have also seen evidence of this in the results of the staff survey.

We have seen and heard that there is a palpable ambition from the board to ward to get to good and move to outstanding.

We will send a draft inspection report will be sent to you after we complete our due processes. You will have the opportunity to check the factual accuracy of the report.

I would like to thank you for the hospitality during the core sere service inspection and well led assessment and especially to Ursula Martin and her team for looking after us and dealing with the enquiries.

If you have any questions about this letter, please contact Jonathan Driscoll on 07341888737 or jonathan.driscoll@cqc.org.uk.

Yours sincerely

Judith Connor

Head of Hospitals Inspection

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Melany Pickup
Chief Executive
Warrington and Halton NHS Foundation Trust
Warrington Hospital
Lovely Lane
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WA5 1QG

8 April 2019

CQC Reference Number: INS2-5562359261

Dear Ms Pickup

CQC inspection of Warrington and Halton NHS Foundation Trust

I write further to the feedback meetings on 28 March and 4 April with Jonathan Driscoll and Camilla Allen. I thought it would be helpful to give you written feedback of our preliminary findings as highlighted at the inspection and given to you and your colleagues at the feedback meetings.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back and provides you with a basis to start considering what action is needed rather than waiting for the draft inspection report. During the meeting we informed you that our surgery team would be returning to Halton General Hospital on 12 April 2019 with a specialist advisor to visit the theatres.

An overview of our preliminary findings

Warrington Hospital

Maternity

- We found it was a women-focused service.
- The ‘musts’ and ‘shoulds’ from the last inspection report appeared to have been acted on and resolved.
- We did not find any significant safety issues. There was a minor issue with patient group directives which was resolved during the inspection.

- We found the service managed an issue with an entrance door to the maternity ward well, keeping women and their babies secure and resolving the issue quickly.
- We observed staff being compassionate and caring to women and their families. Women gave good feedback about the service.
- The service had comprehensive bereavement services for women who had lost their babies.
- There appeared to be a good culture in the service, staff were passionate and positive about the leadership team.
- While the midwife led unit was limited at present, the service had exciting plans for a midwife led unit on the hospital site.
- The service's processes for managing risks and performance had improved since our last inspection.

Critical Care

- The 'musts' and 'shoulds' from the last inspection report appeared to have been acted on and resolved. The action in relation to pharmacy cover would be resolved within the coming weeks.
- The service was immaculately clean and the environment was spacious and airy with plans to develop extra side rooms.
- We saw a good understanding and application of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The Intensive Care National Audit & Research Centre data was positive.
- We observed staff being compassionate and caring to patients. We saw examples of staff going 'above and beyond' to support patients.
- Staff had lots of ways in which they supported patients who were and had been on the unit and their families, for example multi-faith memorial services.
- We saw a strong leadership team and there appeared to be a good culture.
- The service had lots of plans for new equipment from charitable funds.
- The service had reported mixed sex breaches.
- We saw a potential flow issue with the pathway for patients requiring tracheostomy care who needed to be cared on the respiratory ward (A7).
- During the inspection we saw multi-purpose cleaner for hard surfaces which was unsecured in housekeeper area 1.

Medicine

- The 'musts' and 'shoulds' from the last inspection report appeared to have been acted on and resolved.
- The service had processes to manage staffing across the division to keep patients safe.
- We observed staff being caring to patients and their families. We saw staff respecting the privacy and dignity of patients.
- We saw dementia friendly environments, notably the acute cardiac care unit and the frailty unit.
- All staff we spoke to were enthusiastic and very positive about working for the trust.

- Data around patient outcomes was mixed some of the audits (lung cancer audit and Sentinel Stroke National Audit Programme) were below national averages or targets.
- We saw a potential flow issue with the pathway for patients requiring tracheostomy care who needed to be cared on the respiratory ward (A7).
- We would be requesting further information about the treatment room on A8, which did not have a door.

Surgery

- The ‘shoulds’ from the last inspection report appeared to have been acted on and resolved.
- The service had processes to manage staffing across the division to keep patients safe.
- The service had actions in place to address audits which were lower than the England average or target. Staff told us that they had already seen improvements in the audits.
- We observed staff being caring and compassionate to patients. Patients gave us positive feedback about staff.
- Staff were supportive of anxious or nervous patients
- The referral to treatment times were generally in line or better than England averages.
- All staff were positive about working within the service and for the trust.
- All staff felt supported and valued and said the leadership team were approachable.

Other issues raised

- We raised an issue with the way in which pain scores were recorded on NEWS2. Staff told us they were acting on this.
- We saw evidence that applications for Deprivation of Liberty Safeguard had not been approved by the local authority within seven days. This did not appear to be an issue with the trust processes.

Halton Hospital

Outpatients

- We observed caring staff, including during a consultation with a patient with a learning disability.
- We found the resuscitation trolleys had been checked appropriately, which was an improvement since the last inspection.
- We saw evidence of the investment in the environment, which was a pleasant environment for patients and staff. We also saw that the environment was dementia friendly.
- While the leadership team was new, staff were positive about the leadership and working in outpatients.
- We noted that the team had won the trust’s award for team of the month in February 2019.

Surgery

- The ‘musts’ and ‘shoulds’ from the last inspection report appeared to have been acted on and resolved. Notwithstanding, we would be returning to look at theatres.
- We observed caring interactions between staff and patients.
- During the inspection we raised a concern about VTE assessments, but we had reviewed the response and found that the approach was acceptable.
- During the inspection we raised concerns about one of the anaesthetic rooms in the theatre suite. We would be considering the responses further, which we noted said that the practice was in line with Royal College of Anaesthetists guidance.
- During the inspection we raised a concern about two different sepsis pathway flowcharts being in existence. We noted that old posters had been removed and wanted to confirm all forms had been removed and staff had awareness about the correct pathway.
- The service was auditing all episodes of patients being escalated to Warrington Hospital.
- There were good outcomes for elective patients and the referral to treatment times were generally in line with or better than the National average.
- The link to accessible forms and leaflets on the internet and intranet were not working.
- Staff were positive about the services and many of them had worked at the hospital for a long time. Senior staff were visible at the hospital.
- Staff felt that Halton hospital was wholly part of the trust, despite being the ‘cold’ site.
- Learning from the spinal surgery incidents had been applied across the division.

Following our well led assessment a draft inspection report will be sent to you after we complete our due processes. You will have the opportunity to check the factual accuracy of the report.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and all your staff.

If you have any questions about this letter, please contact Jonathan Driscoll on 07341888737 or jonathan.driscoll@cqc.org.uk.

Yours sincerely

Judith Connor

Head of Hospitals Inspection

Donna please copy to Kimberley & Ursula and return to me! Donna 22/05/2019

HALTON
BOROUGH COUNCIL

WARRINGTON AND HALTON
HOSPITALS NHS FOUNDATION TRUST
CHIEF EXECUTIVE OFFICE

21 MAY 2019

FOR ACTION	FOR INFO

Our Ref EST/WHH

Mel Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
Cheshire
WA5 1QG

If you telephone 0151 511 7398
please ask for: Emma Sutton-Thompson

Date 16th May 2019

E-mail address Emma.Sutton-Thompson@halton.gov.uk

Dear Mel,

Quality Accounts 2018 - 2019

Further the Joint Quality Accounts event held on 10th May 2019 that your colleagues Kimberley Salmon-Jamieson and Ursula Martin attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2018/19 the Board were pleased to note that Warrington and Halton Hospitals NHS Foundation Trust (WHH) made progress against the following areas:

- The Launch of the WHH Quality Academy empowering staff to make changes to improve the quality of care;
- The Bereavement Service changes including the re-location of the office to Cheshire House and the purchase of z-beds to enable family members to stay overnight if they wish;
- E-prescribing went live at Ward B4 and Halton Theatres which included staff engagement, staff training and intensive staff support.

The Board were very pleased to view WHH video and thought it really captured some of the improvements that have taken place at the Trust over the last two years. It would be a useful tool to use in Halton to help promote WHH to residents.

HALTON
BOROUGH COUNCIL

The Board are pleased to note the following Improvement Priorities for 2019 – 2020 and look forward to hearing about progress on these next year:

- **Priority 1** - We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks;
- **Priority 2** - We will improve outcomes, based on evidence and deliver care in the right place, first time, every time; and
- **Priority 3** - We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, well fed and well cared for.

The Board would like to thank WHH for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

People Directorate
Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 511 6941

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/38**			
SUBJECT:	**Annual Committee Effectiveness Survey 2018-19**			
DATE OF MEETING:	29 May 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):	The Board undertakes a review of its effectiveness at annually Included in the report are the results of the survey conducted following the meeting that took place on 27 March 2019.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Board is asked to review and note the results of the survey.			
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			

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

We are WHH

And together we

make a difference

Warrington and Halton Hospitals NHS Foundation Trust

TRUST BOARD

Annual Effectiveness Survey

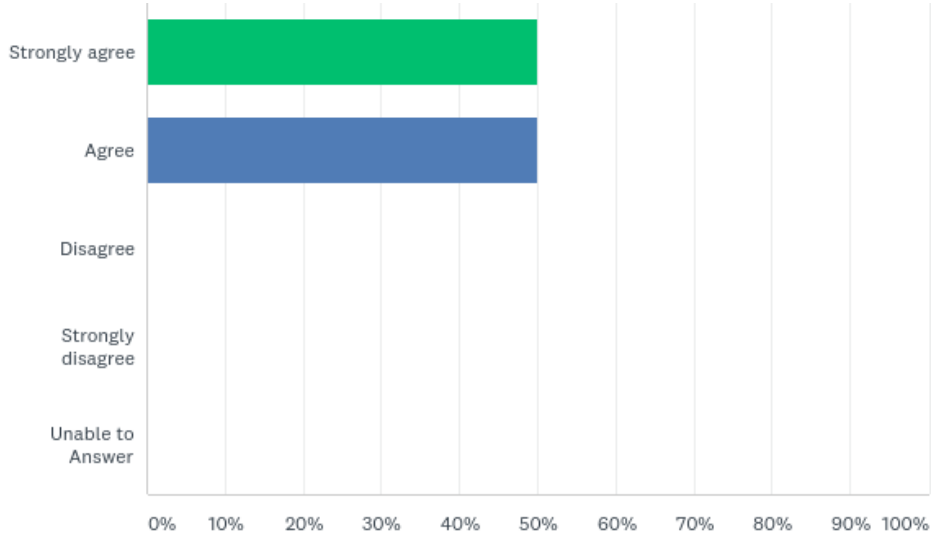
May 2019

Responses

- **Total Responses: 16**

Q1: Is the Trust Board delivering on its objectives

- Answered: 16 Skipped: 0



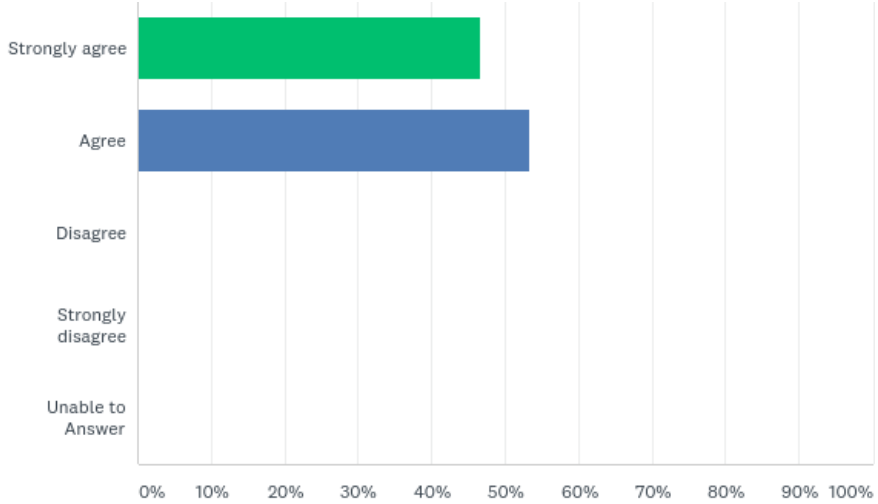
Comments

- The last Board had a good paper outlining clear and in many cases quantifiable evidence of progress against key objectives. A huge amount of work has gone in over the last two years to build a strategy and I feel we now have real clarity not just at the strategic level - the QPS level - but how we are going to deliver at the operational level; with a clear view about what success looks like.
- The Trust's financial objectives are an ongoing challenge but hard work is being done at Board level to make the best of a difficult scenario.

Q2: Do you fee the agenda is appropriate and reflects the assurance requirement

Warrington and Halton Hospitals NHS Foundation Trust

- Answered: 15 Skipped: 1

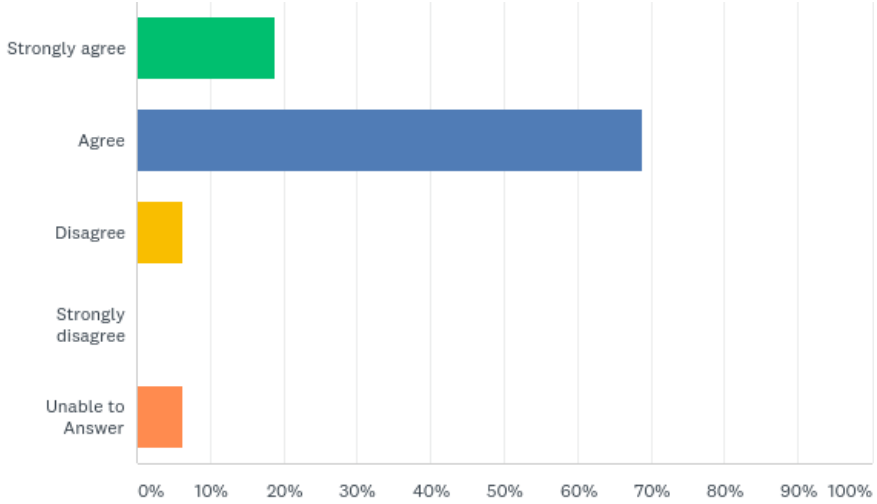


Comments

- The Board agenda continues to evolve to ensure focus is in the right places.
- The new way that the KPI Report is being delivered, presented & challenged is a very positive transparent step

Q3: Are the deep dives working well

- Answered: 16 Skipped: 0

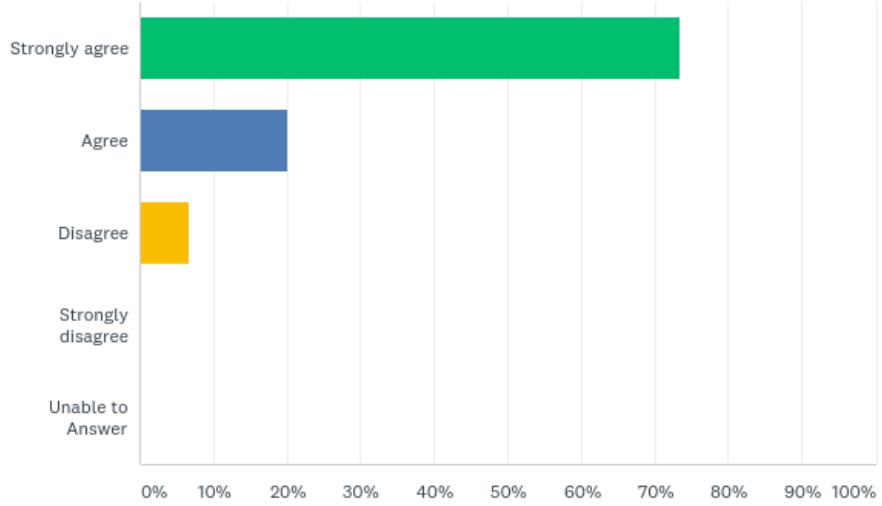


Comments

- Again good evidence at the last Board of the ward to board visits. Deep dives are more occurring at the governance committee level and we may benefit from looking at a couple of themes for a whole board deep dive. A good example that emerged from last board was the issue of exploring risk appetite - discussed as part of the BAF - and this may be something the GGI can assist with as part of the Board development programme.
- In Quality/Safety areas yes, but others not so much eg deep dive on staff sickness told us what we already knew and told us what the answer should be (managers) but no firm new actions or trajectories to bring it down.
- The Board is informed by the hard work done at Committee level and triangulation is robust.
- working well at Sub Committees with reporting/escalation in Chairs Key Issue reports.
- Is so far as they are undertaken.
- 'Deep Dives' appear sporadic; it would be useful to understand what criteria are being used to consider a 'Deep Dive' work stream.

Q4: Do you feel you are able to contribute to the discussion.

- Answered: 15 Skipped: 1



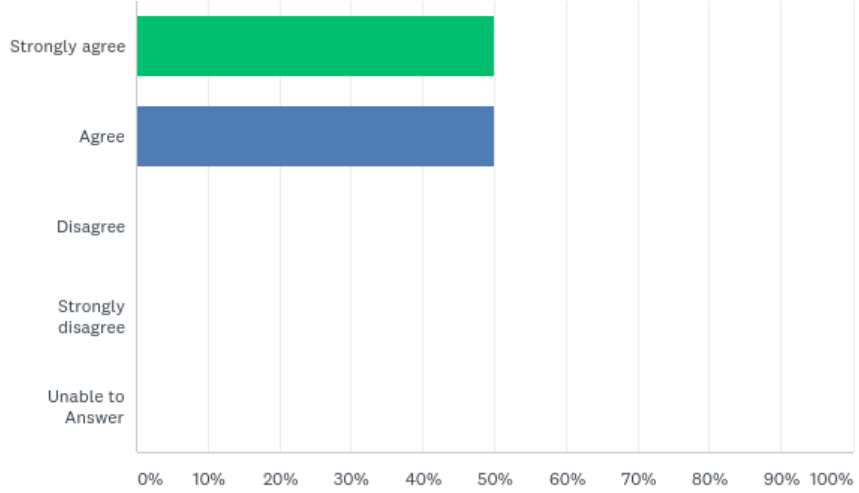
Comments

- In the event I feel I wanted to add something I didn't get chance to, I understand the Chair and the CEO meet regularly and I can connect with either or both to get any thing resolved - but ensuring the necessary governance if something needs to come back through the committee structure. That said I haven't felt the need to take that course of action.
- The agenda, for good reason, is quite heavy and there are occasions when discussion needs to be truncated but I have never felt 'short-changed' in the time available to make my relevant points on any agenda item.
- No problem here.

Q5: Is the escalation from the Board Sub Committees working as it should be (1)

Warrington and Halton Hospitals NHS Foundation Trust

- Answered: 6 Skipped: 0



Comments

- The last Board - observed by the CQC (but also by the Good Governance Institute (GGI)) - was a good example with the ability to track a key issues surfaced in the Audit Committee (via and MIAA Audit) then through to the Quality Committee with assurance about action being taken - then to Board for sign off that action had been taken with data to evidence that.
- The timings for some of the Sub-Committees is very close to the date for circulation of papers which can mean that some Chairs logs are submitted and others wait until the next meeting - this is challenging because the Sub-Committee can be monthly whereas Board is bi-monthly. The Chairs of the Sub-Committee do however provide a 'current' update verbally in the event this happens.

Q5: Is the escalation from the Board Sub Committees working as it should be (2)

Warrington and Halton Hospitals NHS Foundation Trust

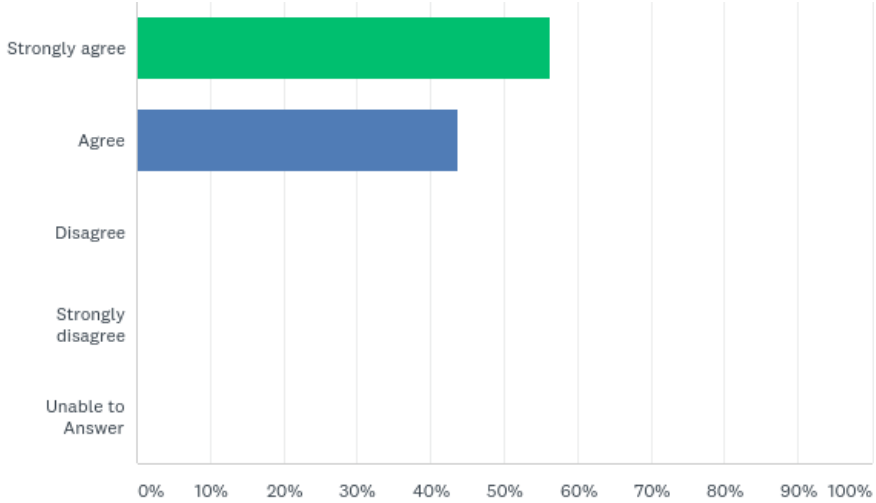
- Answered: 6 Skipped: 0

Comments

- The Committee Chairs have all been in post for several years and this shows through in the experienced manner in which they report to Board.
- Improved reporting from Sub Committees showing triangulation of information.
- Yes seems to be working very well

Q6: Are the risks to patient safety captured sufficiently

- Answered: 16 Skipped:

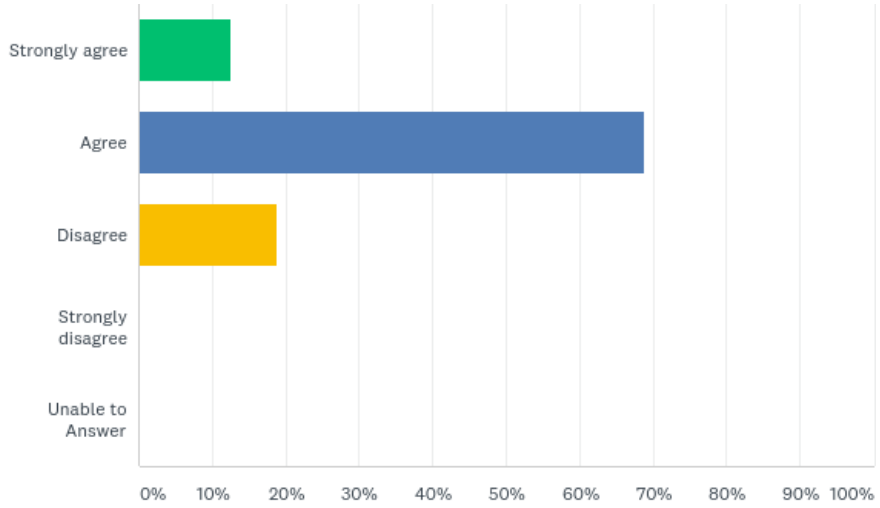


Comments

- Good feedback from Committees and the Quality Assurance Group Chaired also by the Chairman is effective at adding a qualitative enhancement to looking at complaints management and to inform patient safety aspects. I also think the role of the governors has grown well and their involvement on the Patient experience and involvement strategy has been really good.
- Given the volumes of patients and procedures, there will always be challenges in respect of patient safety but much hard work has been put in to limit the vulnerabilities.
- Last meeting ran over and the agenda felt rushed at times due to the volume of business.
- Discussions about Quality of Care and Patient Experience underpin the majority of discussion points.

Q7: Is the length of the meeting about right

- Answered: 16 Skipped: 0



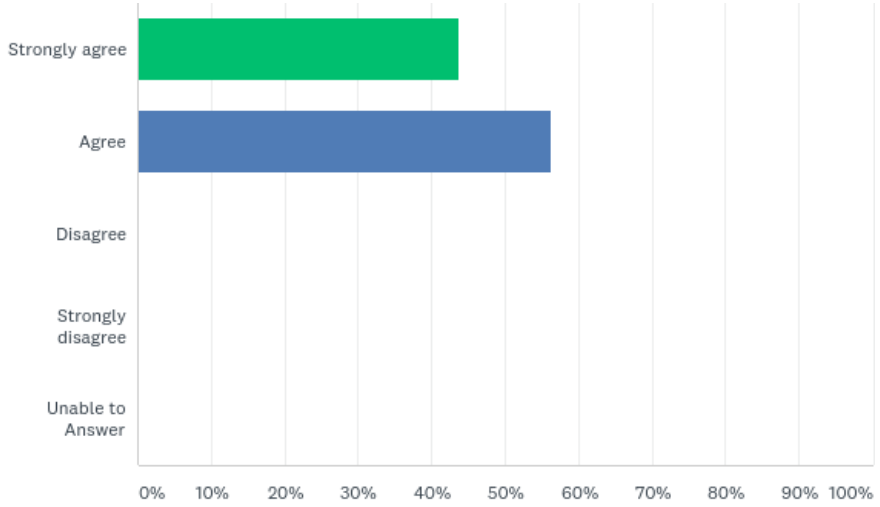
Comments

- Having gone to five meetings a year it is inevitable that there will be full days and packed agenda but I do not feel that there has been a reduction in quality or that having extra meetings added extra value.
- Still considerably longer than other Boards I have been part of, too much coming to Board that could be dealt with at Sub-Committee level and reported through Chairs logs. More time needs to be given to Chairs logs.
- There is so much ground to cover that, on occasions, the agenda could be stretched by several hours but the balance is generally about right.
- Some agendas can be too lengthy due to receiving papers that have already been presented and approved at Sub Committees, some duplication. Sometimes insufficient time to debate the real issues.

Q8: Is the frequency of the meeting sufficient to ensure that assurance can be provided to the Board.

Warrington and Halton Hospitals NHS Foundation Trust

- Answered: 16 Skipped: 0

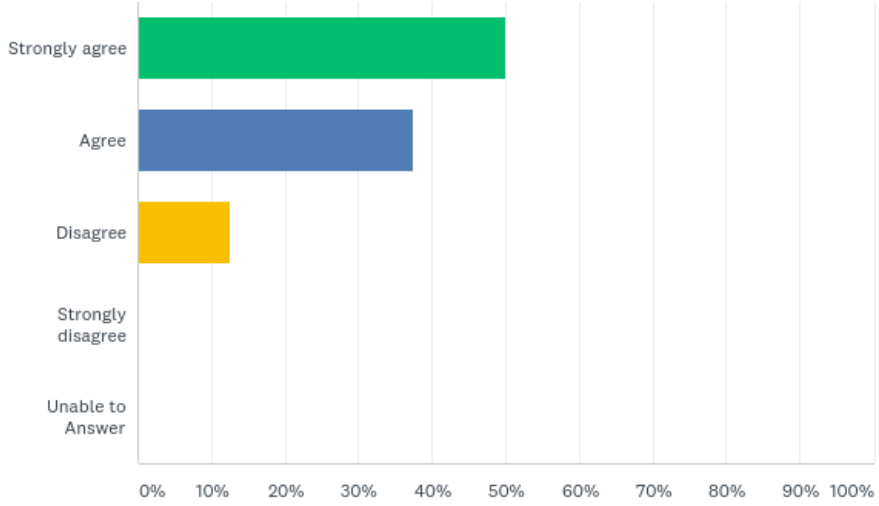


Comments

- As Q7, having gone to five meetings a year it is inevitable that there will be full days and packed agenda but I do not feel that there has been a reduction in quality or that having extra meetings added extra value.
- The Board Time Outs and the Committee meeting frequency, coupled with Board, Public and Private, allow us sufficient time to process the wide range of assurance reports and data.
- Why not consider one Trust Board meeting on a Saturday (per year) to show support for 7 day working to the WHH organisation?
- The bi-monthly full Board meetings are working well; I would note however that the extent of business means that we end up having to need a private/extraordinary Board meeting around the time of Board development sessions anyway.

Q9: Is the level of information and detail within papers correct and/ or sufficient

- Answered: 16 Skipped: 0



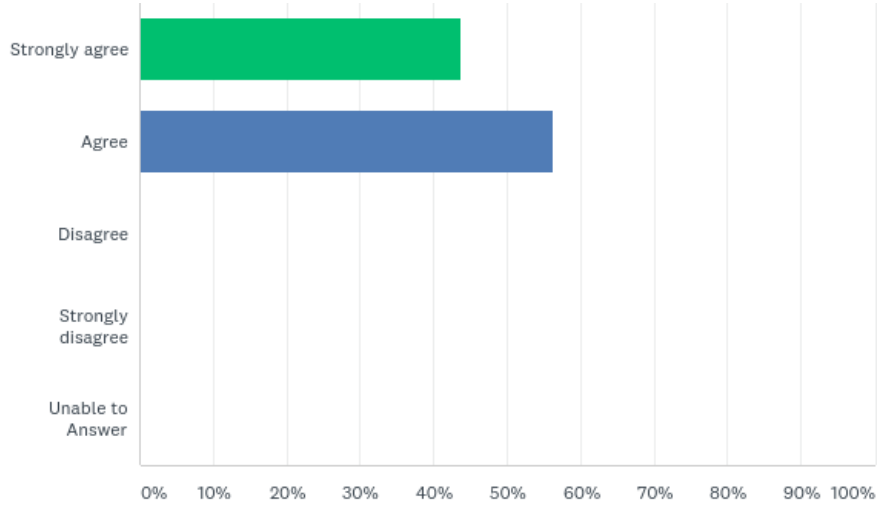
Comments

- I still believe we can go further in terms of ensuring summaries accurately capture the essence of extensive papers and ensure any people observing (or the public) can get to the central issues.
- Still seeing huge variation between portfolios.
- There is a balance to be made in respect of how much paper is submitted to give effective oversight. On occasions the papers can be too lengthy but Board, under our efficient Chair, has the ability to 'cut to the chase'.
- Some papers are not clear on what is required of the Board and the Exec summary not clear, sometimes meaning that large documents have to accompany the main reports.
- Yes, though when issues arise between bi-monthly Board Meeting it is sometimes a challenge to elevate & to cover off Governance.
- But we do need to get a better way of presenting it electronically. PDFs are not a great way of presenting so many agenda items. Need an electronic tool for Board Meetings.

Q10: Each agenda item is 'closed' off with clear conclusion on action, who is doing what, when, how and how it is being monitored

Warrington and Halton Hospitals NHS Foundation Trust

- Answered: 16 Skipped: 0

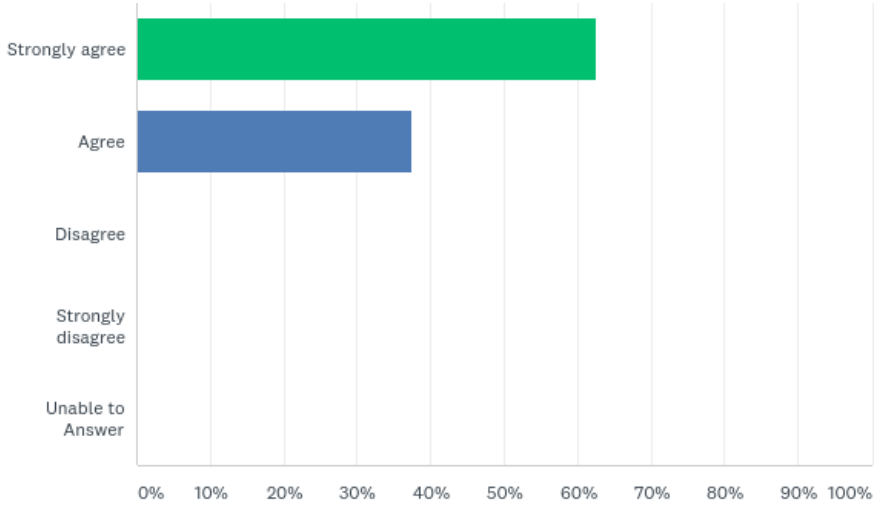


Comments

- The Board has worked on an ongoing improvement in the manner in which the Secretariat deal with Minutes and Action Points.
- Action log is not always reviewed for updates on outstanding actions

Q11: The Board has the right balance of knowledge and experience

- Answered: 16 Skipped: 0

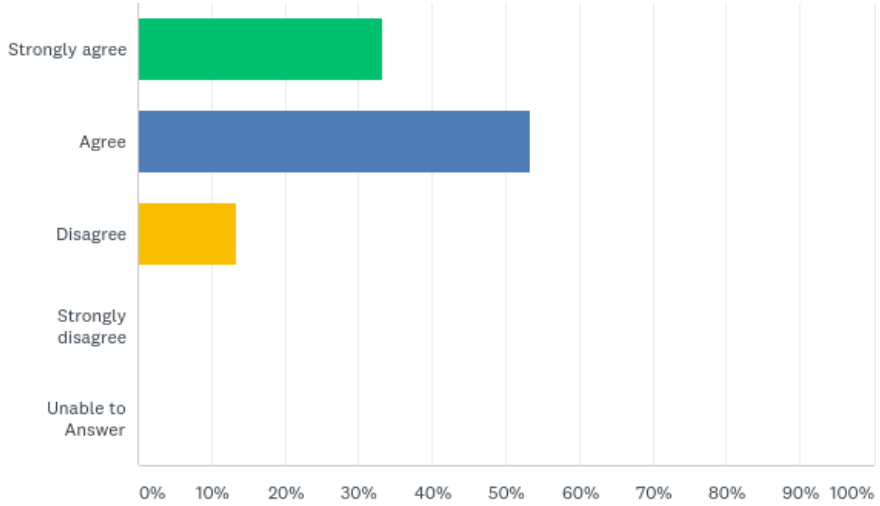


Comments

- It would be helpful to periodically review past experience/skills of all Board members to ensure good skill mix - there are only one or two with innovation/commercial development/entrepreneurship skills and experience which is a challenge given our need to grow and diversify in the future.
- The Executive and Non-Executive Directors have the right mix of skills, at the moment.
- Consider Leadership 360 degree feedback exercise to support Trust Board professional development.

Q12: The Chair allows debate to flow and conclusions reached, discussions not stifled or cut short with members being able to provide real and genuine challenge. (1)

- Answered: 15 Skipped: 1



Comments

- As there are always big agenda it is necessary for the Chair to ensure the momentum of the meeting is maintained. On occasions this may require politely cutting short some commentary that may not be adding value. On occasions also there has been previous discussion which enables a quicker decision. There is a risk that it might appear that the Chair could be summarising and offering an opinion before other board members have made all their contribution. The Chair does regularly ask for feedback in this respect and is alive to the risk and I think that overall - as a Board - we manage this well. I think shifting to the CEO leading the performance overview in the last few months has assisted board dynamics get even better.
- Although much better he could work on tendency to always have to have a view, doesn't always add any further value to the discussion.

Q12: The Chair allows debate to flow and conclusions reached, discussions not stifled or cut short with members being able to provide real and genuine challenge. (2)

Warrington and Halton Hospitals NHS Foundation Trust

- Answered: 15 Skipped: 1

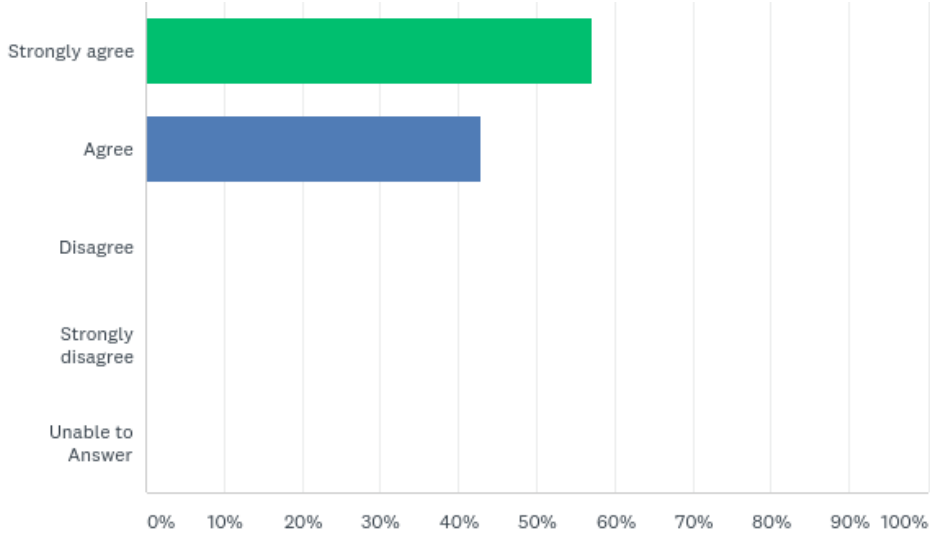
Comments

- The debates are always robust but there are inevitably occasions when clear differences of opinions between Board members surface but these are always aired in a respectful way and the Chair ensures that items are closed off professionally.
- Neither agree or disagree, sometimes Chair's view is given before debate is opened wider to the Board.
- Yes, much improved with the CEO very visible on Performance Issues.
- Trust Board Chair does sum up discussions well.

Q13: There is a formal annual appraisal of the Board's effectiveness, evidence based to take into account views of its members.

Warrington and Halton Hospitals NHS Foundation Trust

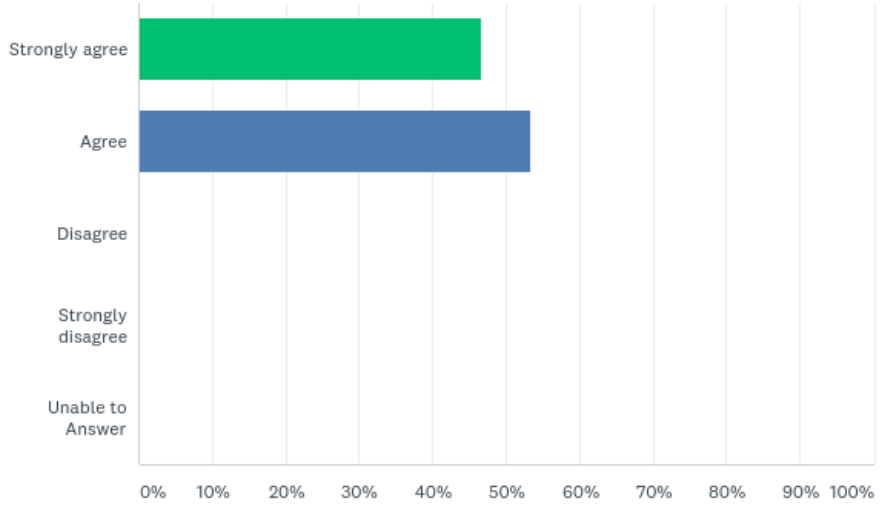
- Answered: 14 Skipped: 2



Q14: The Chair has a positive impact on the performance of the Board and Chairs the Board effectively.

Warrington and Halton Hospitals NHS Foundation Trust

- Answered: 15 Skipped: 1



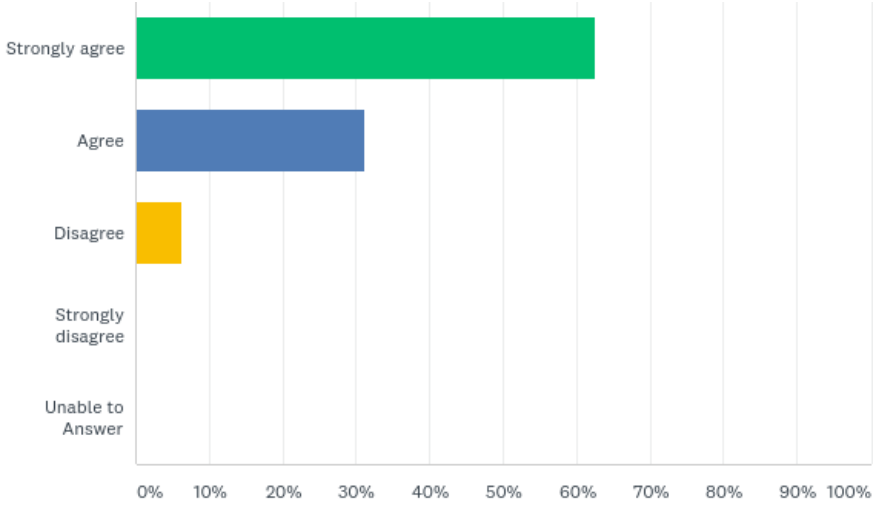
Comments

- See first point Q12, It is a difficult balance to strike - getting through a big and challenging agenda and enabling a very large Board with opinionated Directors to feel they have had their say. But the Board collectively works hard at achieving the balance and I feel is successful and the Chair's role and approach helps this.
- The Chair has put a good deal of focus on strategic issues and has helped to shape the Board into an effective scrutineer, strategic development Forum and decision maker.
- On occasion can let discussion run on. Recent meetings where the CEO has introduced the IPR and asked colleagues for assurance /mitigations to specific items is working well.

Q15: The Chair is visible within the organisation and considered approachable.

Warrington and Halton Hospitals NHS Foundation Trust

- Answered: 16 Skipped: 0



Comments

- The Chair sought the support of Board before undertaking an outside role with the Grenfell Public Inquiry. The Board unanimously supported the role recognising the potential for some impact. However, the Chair has worked hard to ensure that any impact is minimal and in reality had I not been made aware I would not have noticed any appreciable difference in commitment. The use of social media/ twitter is also helpful here.
- He avoids being overly intrusive in operational issues but is sufficiently close to the day to day workings of the hospitals to have a good understanding of the pressures and challenges. He and the NEDs have made good progress in increasing visibility with both wards and departments.
- The Chairman is very active and visible within the Trust, approachable to all staff.
- Trust Board Chair is very supportive towards clinical services.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/19/05/39
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	29th May 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 in April as follows: **Red: 18 (decreased from 22 in March)** **Amber: 13 (increased from 8 in March)** **Green: 33 (decreased from 39 in March)** **Non RAG Rated: 7 (increased from 2 in March)** The Trust deficit for the period April 2019 is £2.3m, which is on plan. The actual control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is £3.2m which is on plan. The Trust has two working capital loans due for repayment in 2019/20. The 2015/16 loan of £14.2m is due for repayment and has been extended to November 2019 and the 2016/17 loan of £7.9m is due for repayment in January 2020. The Trust is awaiting a response from NHSI to confirm arrangements for these loans.

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

RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **2.** Note 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 May 2018 to April 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 - 18 in April, decreased from 22 in March.
- Amber – 13 in April, increased from 8 in March.
- Green – 33 in April, decreased from 39 in March
- Not RAG rated – 7 in April, increased from 2 in March.

Please note, the Trust Board approved the proposed amendments to KPIs for 2019/20 at the Board meeting in March, therefore the number of KPIs for each section are now as follows:

	2018/19	2019/20
Quality	30	30
Access & Performance	19	21
Workforce	12	11
Finance	10	9

Due to validation and review timescales for Cancer and VTE, the RAG rating on the dashboard for these indicators is based on March's validated position. The 5 Sepsis indicators are reported quarterly and are therefore not RAG rated this month.

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

Statistical Process Control (SPC) charts have been included on some of the indicators. A new strategy badge indicating metrics aligned to the Trust Strategy has been added.

Quality

Quality KPIs

There are 6 indicators rated Red in April, an increase from 5 in March.

The 3 indicators which were Red in March and remain Red in April are as follows:

- Medication Safety – there was 2 incidents of harm reported in April, an increase from 1 in March, there is zero tolerance for this indicator.
- Friends & Family Test (A&E and UCC) – the Trust achieved 82.00% in April, an improvement from March's position of 80.00%, against a target of 87.00%.
- Mixed Sex Accommodation Breaches (MSA) – there were 7 Mixed Sex Accommodation Breaches reported in April (3 in March), against a target of 0.

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

- Incidents – the Trust had 6 open incidents over 40 days old in April, an increase from 0 in March, against a target of 0.
- Maternity Safety Thermometer – the Trust achieved 56.30% in April, a decrease from 90% in March against a target of 74.00%.
- Pressure Ulcers – there were 9 category 2 pressure ulcers reported in April, an increase from 5 in March against a target of less than 7.

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

- Children's Safety Thermometer – the Trust achieved 80.80% in April, a decrease from 100% in March against a target of 85.00%.

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

- Healthcare Acquired Infections (MRSA) – there were no cases of MRSA reported in April.

Access and Performance

Access and Performance KPIs

There are 6 Access and Performance indicators rated Red in April, a reduction of 1 in month.

The 4 indicators which were Red in March and remain Red in April are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 82.03% including walk ins in April, a decrease from March's performance of 82.37%, against the target of 95.00%.
- Ambulance Handovers 30>60 minutes – there were 163 patients who experienced a delayed handover in April, an increase from 143 in March.
- Ambulance Handover at 60 minutes or more – there were 34 patients who experienced a delayed handover in April, a decrease from 52 in March.
- Discharge Summaries % sent within 24 hours – the Trust achieved 87.78% in April, an improvement from March's position of 86.23% against a target of 95.00%.

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

- Breast Symptomatic 14 Days – the Trust achieved 91.11% for March's validated position, a decrease from February's validated position of 96.51% against a target of 93.00%.
- Cancelled Operations (not rebooked within 28 days) – there was 1 patient in April 2019, increased from 0 in March against a 0 target.

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

- A&E Waiting Times Improvement Trajectory – the Trust's improvement trajectory has been reset for 2019/20, for April this was 74.00%; therefore the Trust achieved this in month.
- Super Stranded Patients – the Trust had 100 super stranded patients at the end of April, a decrease from 124 in March, which is on the trajectory for March 2020.

As part of the 2019/20 IPR refresh, the cancelled operations for non-clinical reasons indicator has moved to be a % of elective activity (0.73% in April), this was previously rated Red in March.

PEOPLE

Workforce KPIs

There are 2 indicators rated Red in April, a decrease from 4 in March.

The 2 indicators which were Red in March and remain Red in April are as follows:

- Sickness Absence – the Trust's achieved 4.70% in April, an improvement from March's position of 4.87% against a target of less than 4.20%.
- Monthly Pay Spend – the Trusts monthly pay spend was 0.20% above budget in April.

In March, the Agency Nurse Spend and Average Cost of the Top 10 Agency Workers indicators were rated Red; however these indicators have been removed from the IPR dashboard in 2019/20.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 4 red indicators are as follows:

- Capital Programme - the actual spend is £0.5m which is £0.4m below the planned spend of £0.9m. This is due to an underspend in relation to the fire.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a monthly performance of 48% which is 47% below the national standard of 95%.
- Cost Improvement Programme (value of recurrent schemes) – Recurrent schemes have been assessed at £2.7m which is £4.8m below the £7.5m target. The schemes identified include medium risk schemes at £0.7m and high risk schemes at £1.4m.
- Cost Improvement Programme (delivery against plan) – Savings of £0.1m have been achieved which is a shortfall of £0.1m against the £0.2m target.

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

The Trust has signed up to a break even control total. There are a number of risks that need to be mitigated to ensure delivery of the control total, these include; identification and delivery of the cost savings targets, management of the unfunded cost pressures, achievement of clinical activity and income targets and delivery of services within the agreed budgets.

Capital Programme

The 2019/20 capital programme approved by the Board in March 2019 was £11.7m as summarised in **Table 1**.

Table 1: Initial Capital Plan 2019/20

Narrative	£m
2018/19 forecast underspend carried forward (planned)	1.7
2019/20 Internally Generated Depreciation (estimate as at 28th February 2019)	6.5
2019/20 Kendrick Wing Fire (funded by revenue income)	3.5
Total	**11.7**

Since approval by the Board there has been an increase in the budget to reflect the increased depreciation charges resulting from the change in RICS guidance on asset lives (£0.6m) and finalisation of the 2018/19 underspend (the underspend increased by £1.2m and is carried forward to 2019/20).

These changes propose to increase the 2019/20 capital budget to £13.5m as summarised in **Table 2.**

Table 2: Revised Capital Plan 2019/20

Narrative	£m
Board approved budget 2019/20	11.7
Increase in depreciation resulting from change in RICS guidance*	0.6
Increase due to finalisation of 2018/19 underspend	1.2
Total	**13.5**

*to be added to the contingency fund, the contingency fund is now set at £1m.

There are changes to the capital programme this month as summarised in **Table 3.**

Table 3: Changes to the 2019/20 capital programme.

Scheme	Value £000
Additional Funding Requirements	
ICE System Upgrade (1)	31
Ultrasound Transducers (1)	13
Sub Total	**44**
Funded by	
Trust Contingency	(44)
Sub Total	**(44)**

Net Impact	**0**

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

The actual spend for the year to date is £0.5m (£0.1m relates to the fire expenditure) which is £0.4m below the monthly plan.

The 2019/20 capital programme has a contingency of £1.0m to cover emergency requests and changes in the capital programme. This has reduced to £0.9m following the approved emergency requests. There is no provision in the capital programme to cover the cost of the CT scanner should purchase be the preferred option following a value for money assessment. The capital programme approved by the Board in March 2018 included £1.4m to cover the cost of an electrical substation and estates work associated with the radiology redesign programme.

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. Note the amendments to the Capital programme.

Appendix 1 – KPI RAG Rating May 2018 – April 2019

	KPI	Performance Improvement Direction	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 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	Sepsis AED Screening (quarterly)	↑ (In month compliance)												
13	Sepsis Inpatient Screening (quarterly)	↑ (In month compliance)												
14	Sepsis AED Antibiotics (quarterly)	↑ (In month compliance)												
15	Sepsis Inpatient Antibiotics (quarterly)	↑ (In month compliance)												
16	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 May 2018 – April 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	A&E Waiting Times – Over 12 Hours	↓												↔
37	Cancer 14 Days	↑ (% Monthly Performance)	↓	↓	↑	↑	↑	↑	↓	↑	↓	↓	↑	↓
38	Breast Symptoms 14 Days	↑ (% Monthly Performance)	↓	↓	↑	↓	↑	↑	↓	↓	↑	↑	↓	↓
39	Cancer 31 Days First Treatment*	↑ (% Monthly Performance)	↓	↑	↓	↑	↑	↔	↓	↑	↔	↔	↔	↓
40	Cancer 31 Days Subsequent Surgery*	↑ (% Monthly Performance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
41	Cancer 31 Days Subsequent Drug*	↑ (% Monthly Performance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
42	Cancer 62 Days Urgent*	↑ (% Monthly Performance)	↑	↓	↑	↓	↑	↔	↑	↓	↓	↑	↓	↔
43	Cancer 62 Days Screening*	↑ (% Monthly Performance)	↔	↔	↔	↓	↑	↔	↔	↓	↑	↓	↑	↓
44	Ambulance Handovers 30 to <60 minutes	↓ (Number of patients)	↓	↑	↑	↑	↑	↑	↓	↑	↓	↓	↓	↑
45	Ambulance Handovers at 60 minutes or more	↓ (Number of patients)	↓	↓	↑	↑	↑	↑	↓	↑	↓	↓	↓	↓
46	Discharge Summaries - % sent within 24hrs	↓ (% Monthly Performance)	↓	↕	↑	↓	↓	↑	↓	↓	↑	↑	↓	↑
47	Discharge Summaries – Number NOT sent within 7 days	↔ (Number of patients)	↑	↕	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
48	Cancelled Operations on the day for a non-clinical reasons	↓ (Number of Cancellations)												↔
49	Cancelled Operations– Not offered a date for readmission within 28 days	↓ (Number of Cancellations – not rebooked))	↓	↔	↑	↓	↔	↑	↓	↔	↑	↓	↔	↑
50	Urgent Operations – Cancelled for a 2nd time	↓												↔
51	Super Stranded Patients	↓ (Number of patients)						↓	↑	↑	↓	↑	↑	↕

Appendix 1 – KPI RAG Rating May 2018 – April 2019

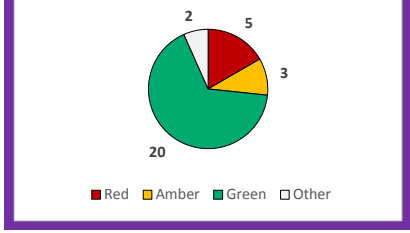
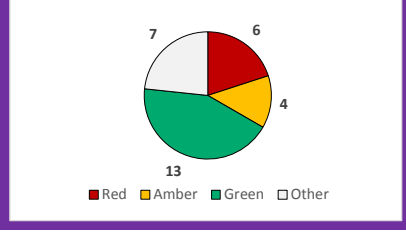
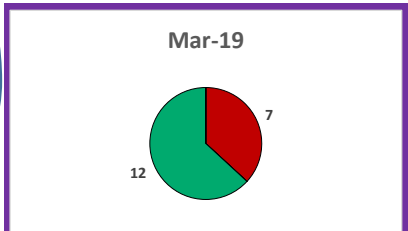
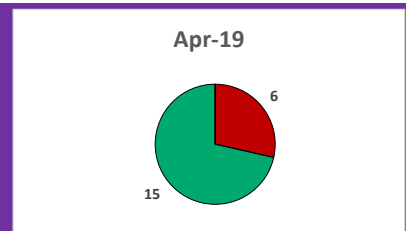
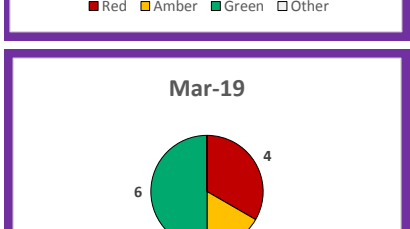
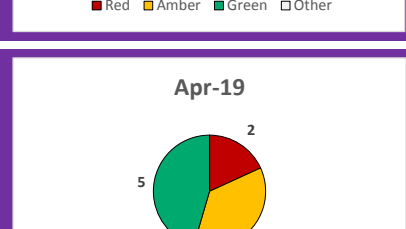
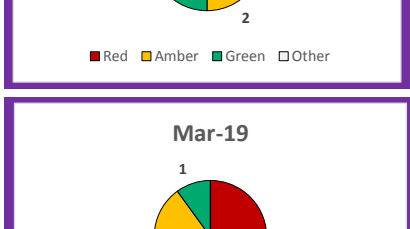
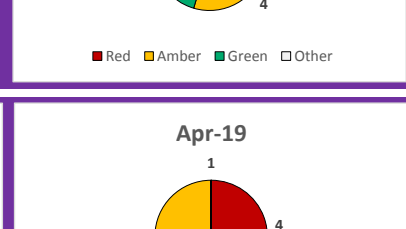
	KPI		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19
	WORKFORCE													
52	Sickness Absence	↓ (% Monthly Performance)												
53	Return to Work	↑ (% Monthly Performance)												
54	Recruitment	↓ (Number of Days)												
55	Vacancy Rates	↓												
56	Retention	↕												
57	Turnover	↕ (% Monthly Performance)												
58	Bank & Agency Reliance	↓												
59	Agency Shifts Compliant with the Cap	↕												
60	Monthly Pay Spend (Contracted & Non-Contracted)	↕ (% of Budget)												
61	Core/Mandatory Training	↑ (% Monthly Performance)												
62	PDR	↑ (% Monthly Performance)												
	FINANCE													
63	Financial Position	↑ (Cumulative against plan)												
64	Cash Balance	↑ (Balance against plan)												
65	Capital Programme	↑ (Performance against plan)												
66	Better Payment Practice Code	↑ (Monthly actual against plan)												
67	Use of Resources Rating	↑ (Rating against plan)												
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 - April 2019

Appendix 2

	Mar-19	Apr-19	Key Points/Actions
Quality Improvement			There are 68 open incidents that required review and sign off; a 38% reduction on the previous month. Compliance in month in relation to Duty of Candour remains 100%. Gram negative bloodstream infections in February : There were 2 cases of C-DIFF and 4 cases of E-coli reported in month. Falls; a reduction of 18% is noted against the previous month. There were no category 3 or 4 pressure ulcers but 9 category 2 pressure ulcers reported in month. There were 2 medication incidents relating to harm reported.
Access & Performance			In April 2019, 14 out of the 21 indicators were RAG rated as Green. The Trust has continues to achieve the RTT and 6 weeks diagnostic standards in month. The Trust did achieved all cancer standards for March 2019 with the exception of Breast Symptomatic. The Trust did not meet the 4 hour A&E standard, however the improvement trajectory was met. The number of ambulance handovers between 60+ minutes has continued to reduce. Cancelled operations for non-clinical reasons is less than 0.73% in month. There was 1 patient who's operation was cancelled and not rebooked within 28 days in month. The Trust continues to work with system partners to address the number of stranded and super stranded patients.
Workforce			The Trust has seen a decrease in sickness absence in month to 4.7%, this continues to be an area of focus. Return to work compliance has reduced to 81.01%, there is an issue with the timeliness around recording of the RTW interviews. Recruitment timeframes have continued to reduce. Turnover and Vacancy rates remain positive. Pay spend is slightly above budget in month. Core Skills Training compliance continues to be positive at 92.48%. PDR compliance is below the target in month at 82.94%, work in ongoing to embed PDR compliance. Agency shift compliance pay cap is at 52.7% which is better than the 49% target.
Finance			In month, the Trust recorded a deficit of £2.3m which is on plan. The monthly control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency tariff funding) is a £3.2m deficit which is on plan. Monthly income is £0.3m better than plan, expenditure is £0.3m worse than plan and non operating expenses are on plan. Capital spend is £0.5m which is £0.4m below the planned capital spend of £0.9m. Due to the historic and current operating position the cash is £1.2m which is in line with the planned cash balance and the minimum cash requirement under the terms and conditions of the working capital loan. The year to date performance against the Better Payment Practice Code is 48% which is 47% 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
Trust Strategy

Quality Improvement - Trust Position

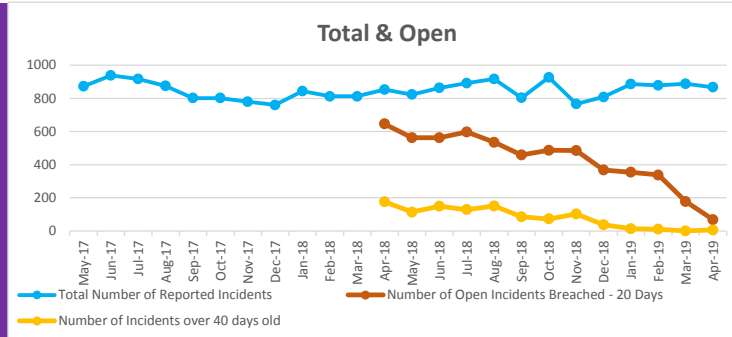
Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?

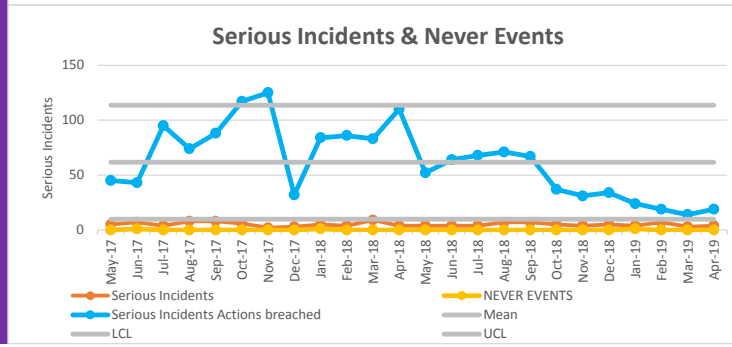
Patient Safety

Incidents

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

There were no never events reported in month. There were 6 incidents over 40 days old open in month.





There has been a marked improvement over the past 12 months in terms of breached incidents and breached SI actions. This improvement has been driven by scrutiny at Patient Safety & Effectiveness Sub Committee and weekly Meeting of Harm.

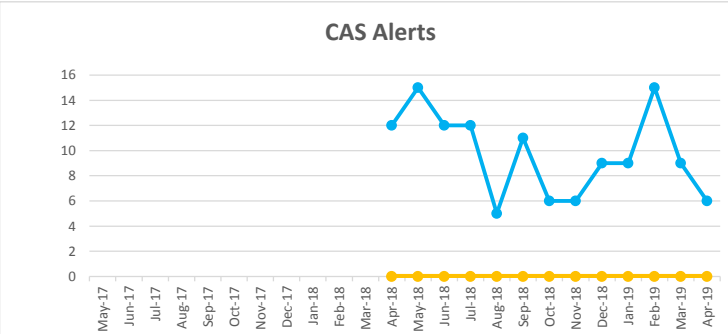
Continue with daily scrutiny of open incidents by the Clinical Governance Department / CBU Leads.

The Trust 'Reporting to Improve' campaign continues with 169 managers trained on the use of Datix for incident reviewing.

Concise RCA investigations are now reviewed and signed off and the weekly Meeting of Harm is 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 6 new CAS Alerts received in month. There were no CAS alerts which breached the timescale in month.



The Trust has been 6 alerts received in month with no breaches.

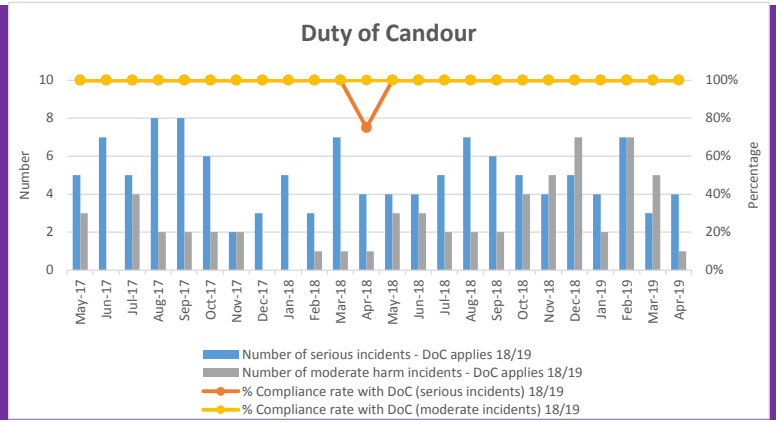
There is a audit being undertaken to seek evidence that actions from previous CAS alerts are fully embedded. This will report to Patient Safety and Effectiveness Sub Committee.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
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 clinical governance training.** **Weekly scrutiny and monitoring in place with the Director of Clinical Governance.**



Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
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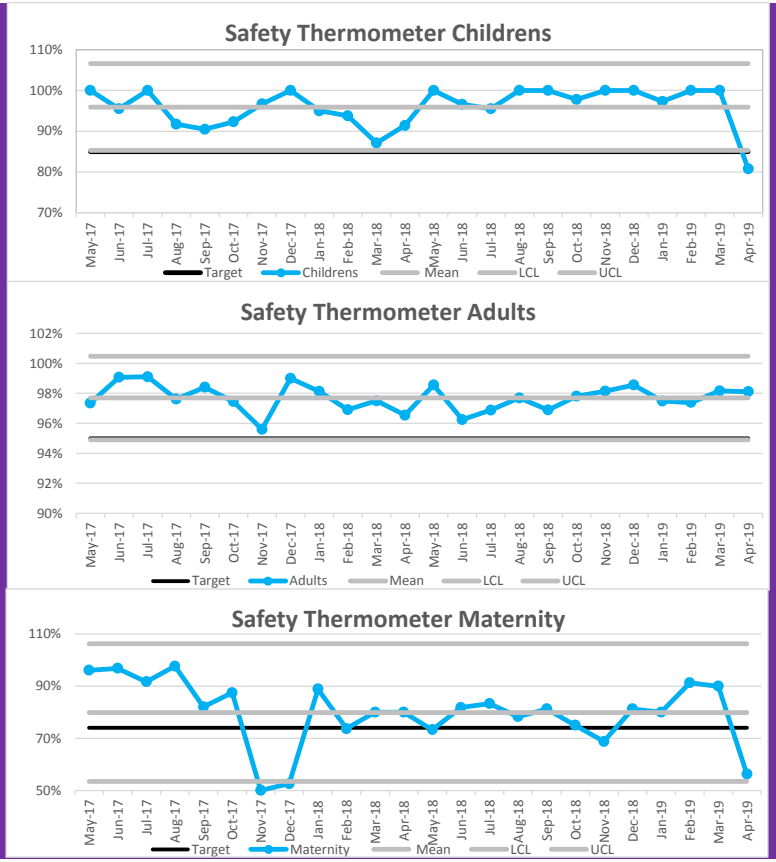
Care Quality Commission
Trust Strategy

Quality Improvement - Trust Position

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

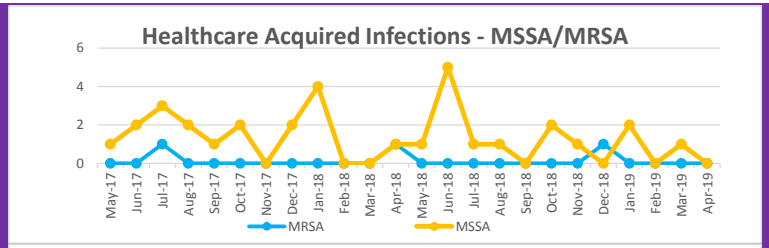
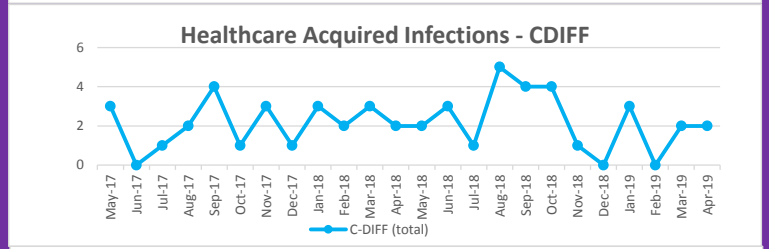
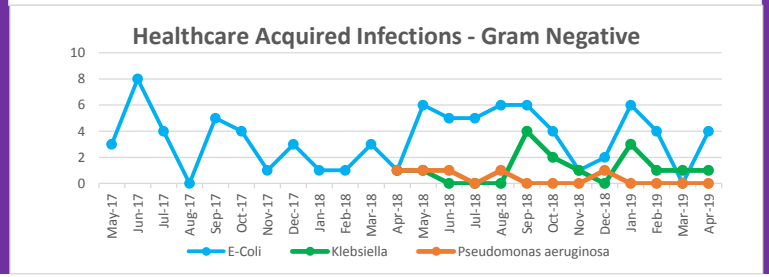
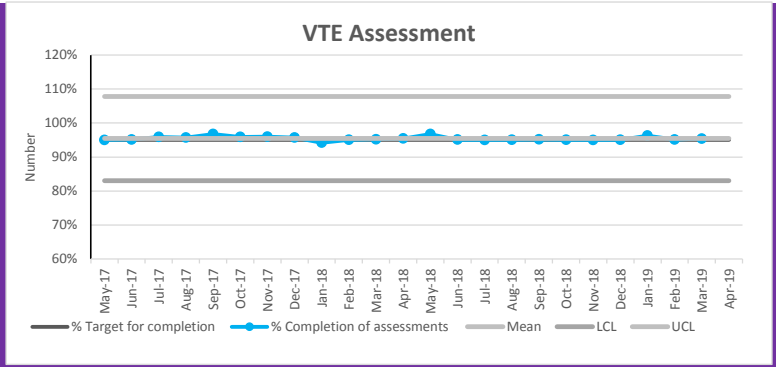
Maternity Safety Thermometer
Red: Less than 70%
Amber: 70% to 73%
Green: 74% or more

Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
The Trust achieved 98.11% on the Adult Safety Thermometer, 80.80% on the Children's Safety Thermometer and 56.3% on the Maternity Safety Thermometer in month.		Adult - 2 Falls, 2 Catheter Associated UTIs, 2 VTEs and 2 Pressure Ulcers. No wards of particular concern with all wards above the threshold. Children's – 80.8% - action plan in place. Maternity – 56.3%, 10 patients reviewed; 2 UTIs and 2 postpartum haemorrhage.	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
Trust Strategy

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections MRSA Red: 1 or more Green: 0 Healthcare Acquired Infections C-Difficile Red: More than 44 YTD Green: Less than 44 YTD Healthcare Acquired Infections - Gram Negative E-Coli Red: More than 27 YTD Green: Less than 27 YTD	There have been 0 MRSAb cases reported YTD. There were 2 cases of C-Difficile reported in month. There were 4 cases of E-coli reported in month. There was 1 case of Klebsiella reported in month. There was 0 cases of Pseudomonas reported in month.	  	E-Coli is above trajectory with 4 cases year to date against a target of 36. CDI is 2 cases against a trajectory of 44. MRSAb 0 cases year to date against a target of 0.	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 for CDI, increasing from an annual threshold of 27 in 2018/19 to 44 in 2019/20.
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	The Trust achieved 95.39% for VTE assessments in March 2019.		The Trust has continuously achieved over 95% compliance.	The policy has been agreed with an electronic system to ensure that timely risk assessments are in place. A Trust VTE Awareness week was held in March 2019.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

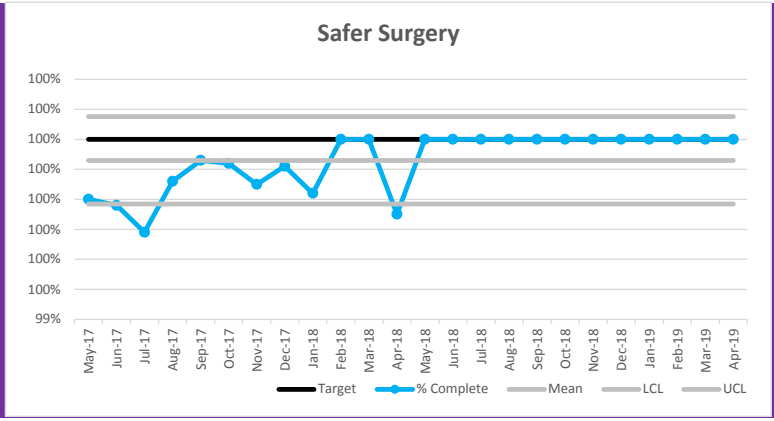
Key:

Single Oversight Framework SOF

Care Quality Commission CQC

Trust Strategy S

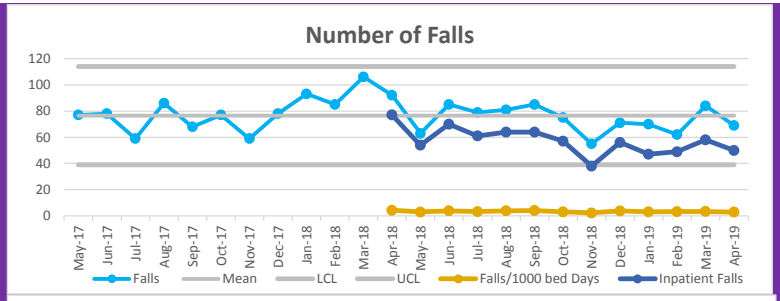
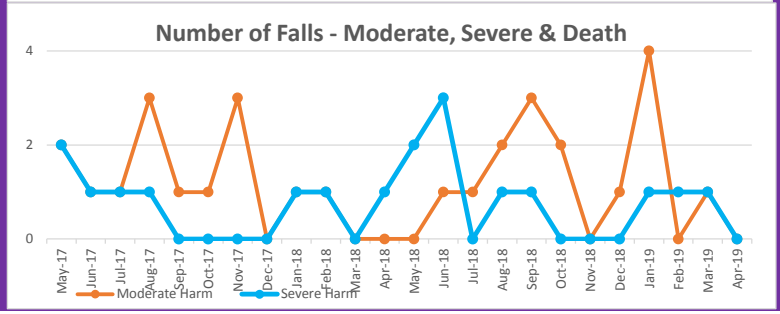
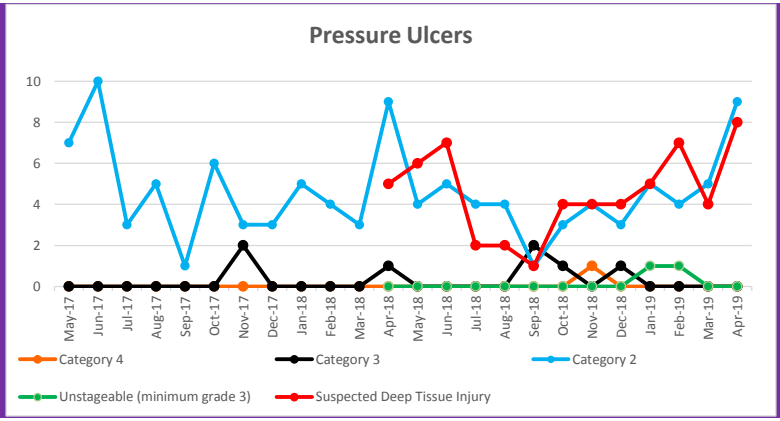
Quality Improvement - Trust Position

	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.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework (SOF)
Care Quality Commission (CQC)
Trust Strategy (S)

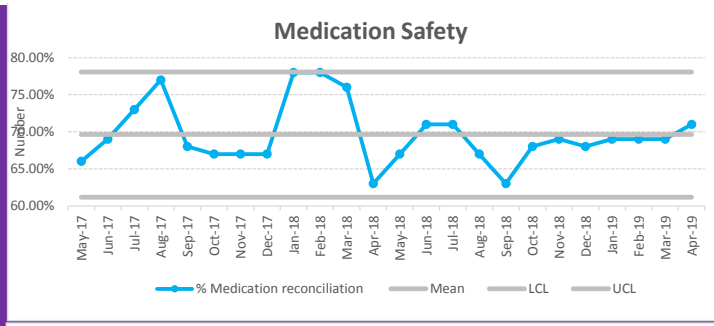
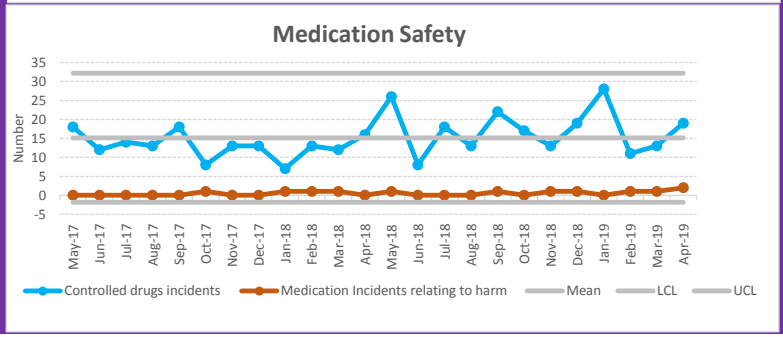
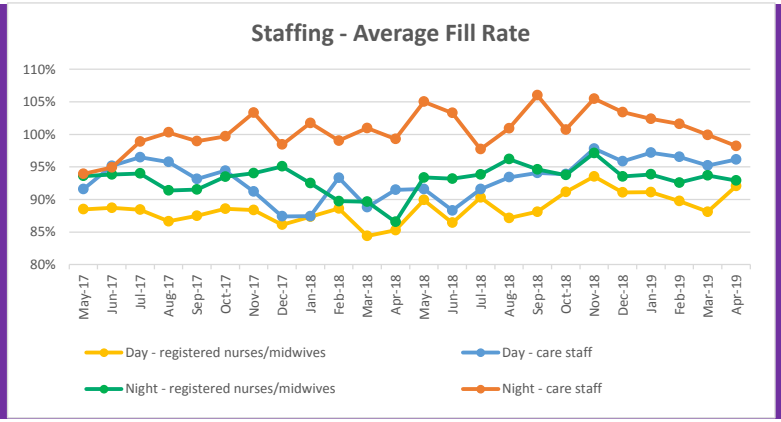
Quality Improvement - Trust Position

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 18/19** **Green >20% decrease from 18/19**			
There were a total of 69 falls in month of which 50 were inpatient falls.	 	The Trust recorded 1 serious harm as a result of an inpatient fall in April 2019. A reduction of inpatient falls is noted, reducing from 58 to 50 from March to April 2019.	Evidence based assessment and care planning documentation was successfully rolled out across the organisation, with a follow up launch on 23rd May in conjunction with the Trust QI falls collaborative. An enhanced care audit has been completed with associated actions in place. Practice is monitored in clinical areas where harm occurred.
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 9 Category 2 pressure ulcers reported in month.		An in month increase is noted in the incidence of category 2 pressure ulcers. A thematic review is underway with Lead Nurses and Matrons.	Face to face training has commenced in the high incidence areas with increased presence of TVN team. A device monitoring record is to be introduced and daily senior nurse oversight of risk patients is underway. There will be ward collaborative to support improvement.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

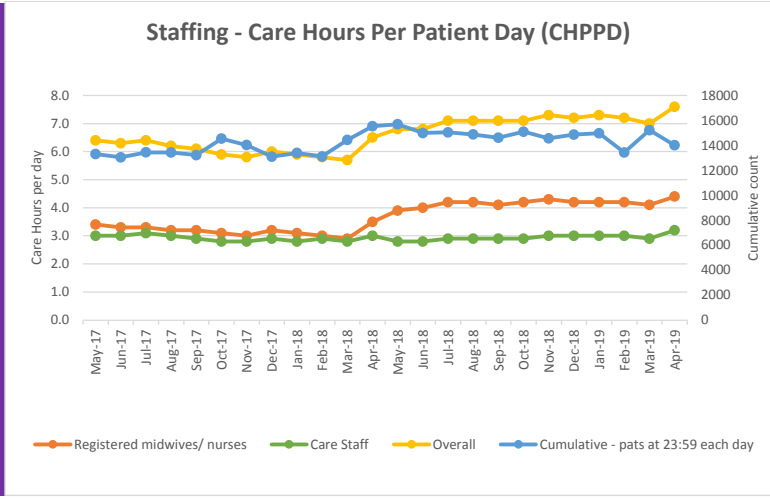
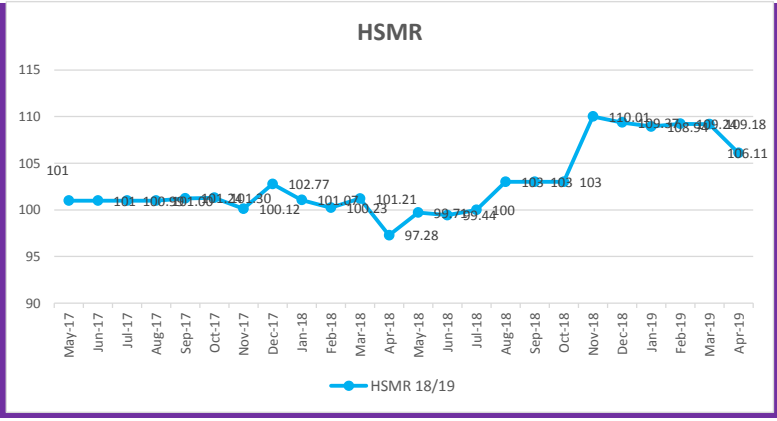
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Medication Safety Red - any incidents of harm. Green - no incidents of harm.	There were 2 incidents of harm relating to medication safety in month.	 	In April, there were 2 reported harm incidents. These incidents are currently under review.	One harm incident involved an external organisation (interface issue), the Trust harm incident is under review. Short term, we will continue to review and feedback learning from incidents and work with medical staff on improving communication of learning from medication incidents. Long term: Implementation of EPMA and 7 day on ward pharmacy service to improve safety.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	In month the average staffing fill rates were: Day (Nurses/Mwife) 92.07% Day (Care Staff) 96.13% Night (Nurses/Mwife) 92.92% Night (Care Staff) 98.21%		Any ward that falls below 90% provides mitigation to ensure it is safe and that high quality care is consistently delivered in those areas.	This position will improve as 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
Trust Strategy

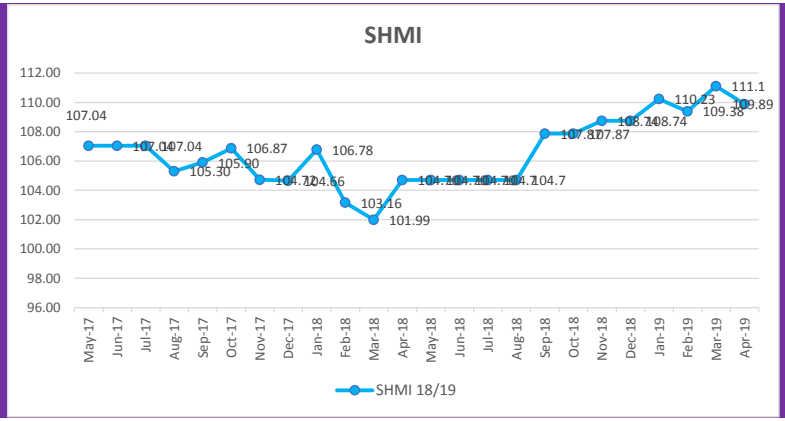
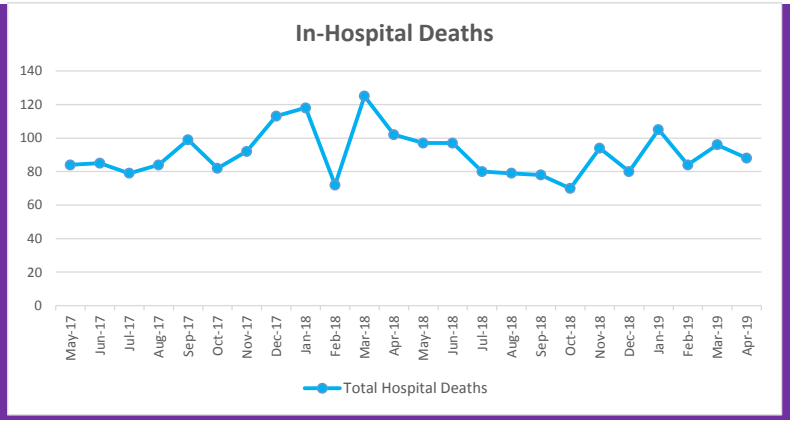
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD)	In month, the average CHPPD were: Nurse/Midwife: 4.4 hours Care Staff: 3.2 hours Overall: 7.6 hours		The overall Trust CHPPD continues to maintained as is monitored monthly by the senior nursing team.	Ward staffing data continues to be systematically reviewed, which includes Planned vs Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	The HSMR ratio in month was 106.11		The most recent HSMR/SHMI are still within the expected range. Work continues at Mortality Review Group to undertake 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 these have the potential to impact these results.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

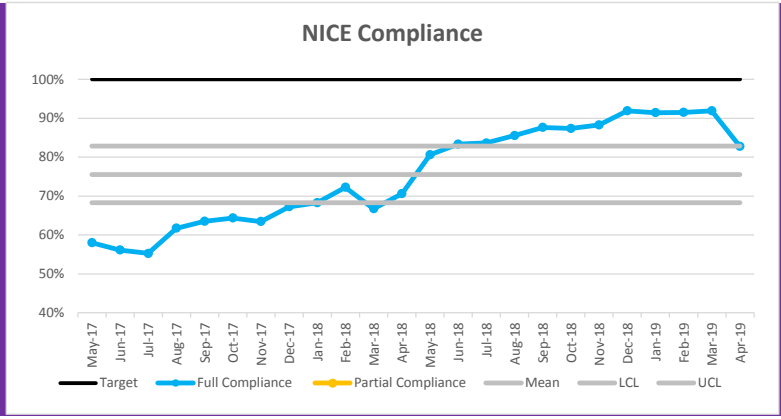
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	The SHMI ratio in month was 109.89		The most recent HSMR/SHMI are still within the expected range. Work continues at Mortality Review Group to undertake 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 these have the potential to impact these results.
Total Deaths	There were 88 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.	

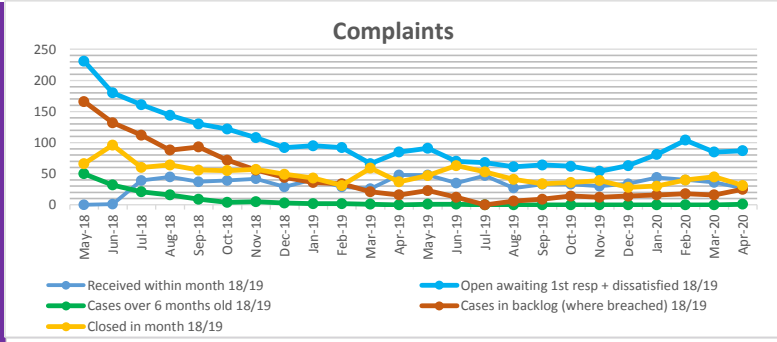
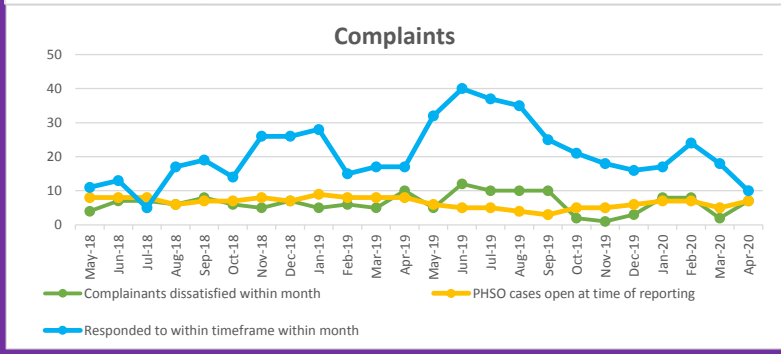
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The Trust achieved 82.78% in month.		The overall Trust compliance level is currently showing as 82.78%.	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.

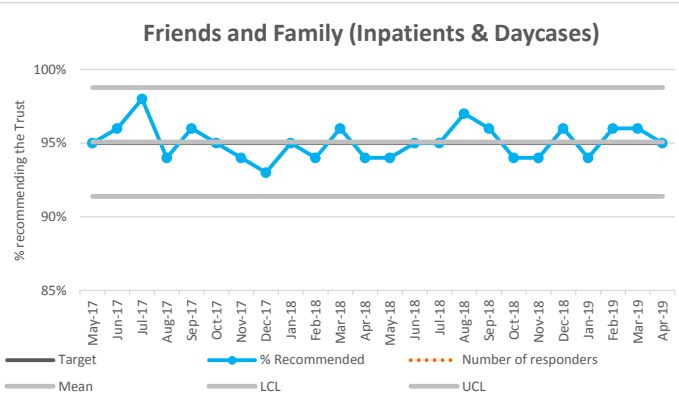
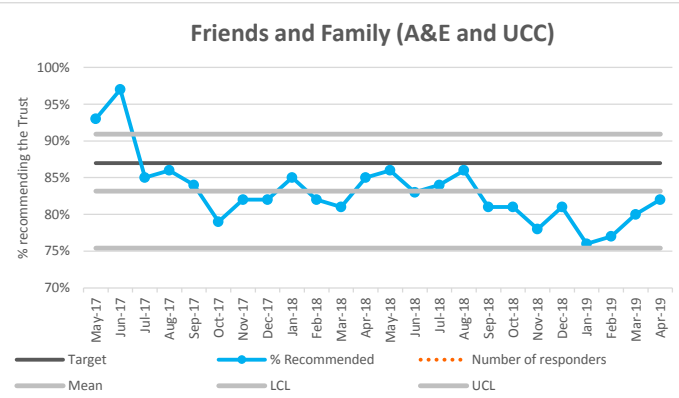
Patient Experience

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.	 	There was 25 complaints that breached their deadline, which is an increase on last month. The Trust has received a lower than average amount of complaints in month and is closing less complaints per month based on the amount received / closed over the past year.	The complaints team are targeting breached complaints and liaising with the CBUs in order to close these cases. There is also ongoing scrutiny at the weekly Meeting of Harm and the monthly Complaints Quality Assurance Group.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

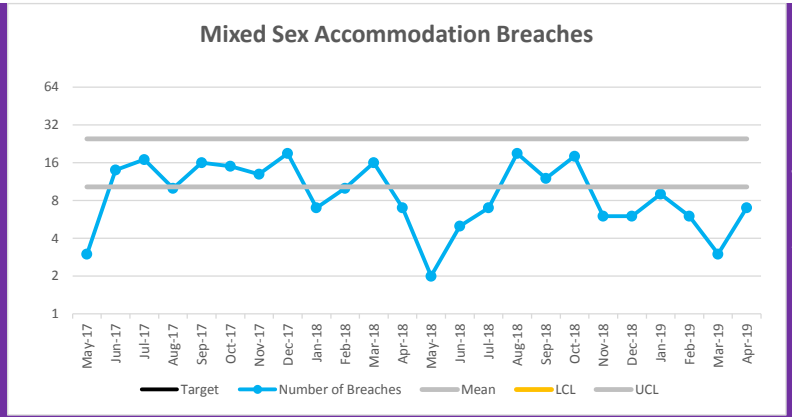
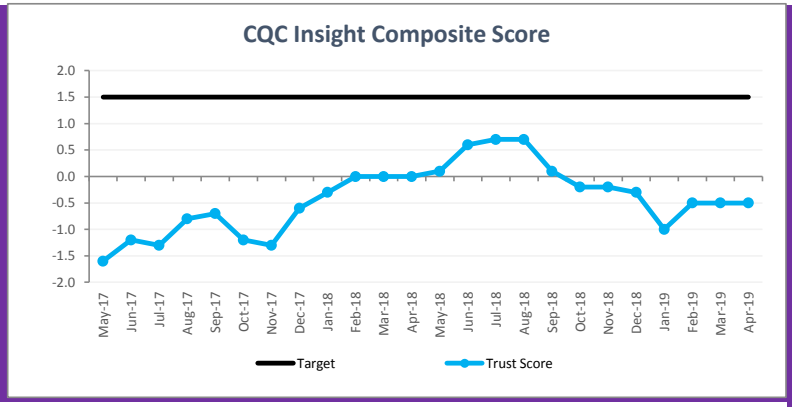
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
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 with a 95% recommendation rate. The response rate was 27.2%.	#ExpofCare week April 2019 was used as a focus to enhance awareness of the importance of patient feedback at WHH. "What matters to me?" conversation cafes were held at Halton and Warrington. This was the Safety Huddle "Topic of the week" from 22nd to 25th April with daily briefs on how to encourage feedback and hearing the patients voice.
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	The Trust achieved 82% in month.		82% recommendation rate against a target of 87% improved by 5% on previous month. Response rate – 16.6% increased from 15.9% in March 2019.	There were Conversation Cafés held in ED at Warrington and Halton restaurant in April 2019 to appreciate patients "What matters to you?" A UED action plan with aims to improve both the response rate and recommendation rate is in progress with weekly performance monitoring by Deputy Chief Nurse and monthly via PESC.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

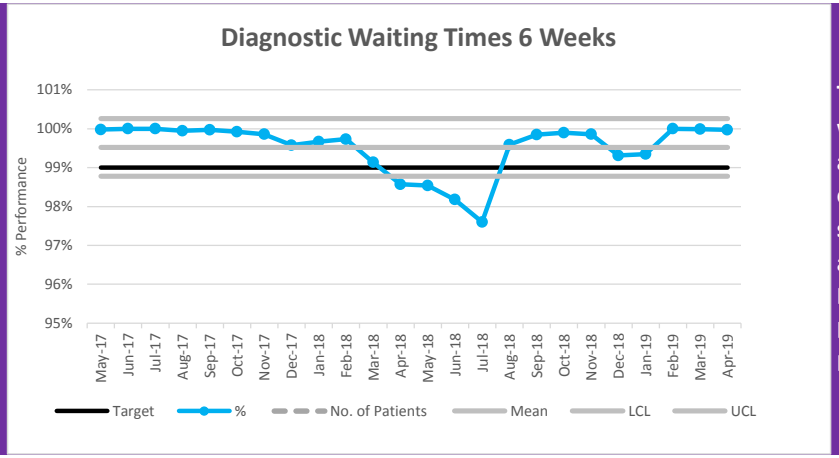
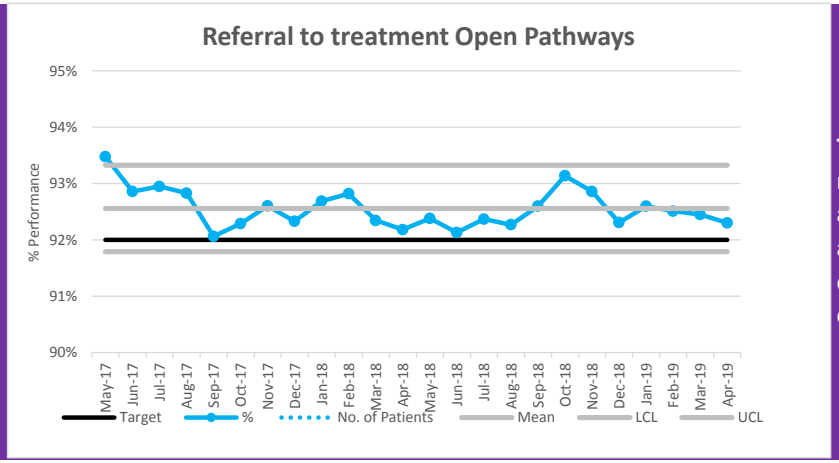
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	There were 7 mixed sex accommodation breaches reported in month.		There were 7 MSA breaches for April, an increase on the previous month. Action plan is being monitored.	Timely escalation of potential patients for step down via operational teams and through Silver Command. Escalation plans to be implemented as per Trust process and RCAs completed. The actions to be monitored within the Critical Care Operational Delivery Group.
CQC				
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 -0.5.		Underperformance in relation to the 'Patients spending less than 4 hours in major A&E' target. Areas where we have improved are in; Never Events, Proportion of reported patient safety incidents that are harmful and Deaths in Low-Risk Diagnosis Groups, Patient-led assessment of environment for dementia care, Inpatient response rate.	The Trust had a CQC Emergency Department inspection in February and is responded to the report, and has submitted an action plan to the CQC. An Improvement Committee is being established which will report into Getting to Good, Moving to Outstanding Steering Group, Operational Bard and Quality Committee.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

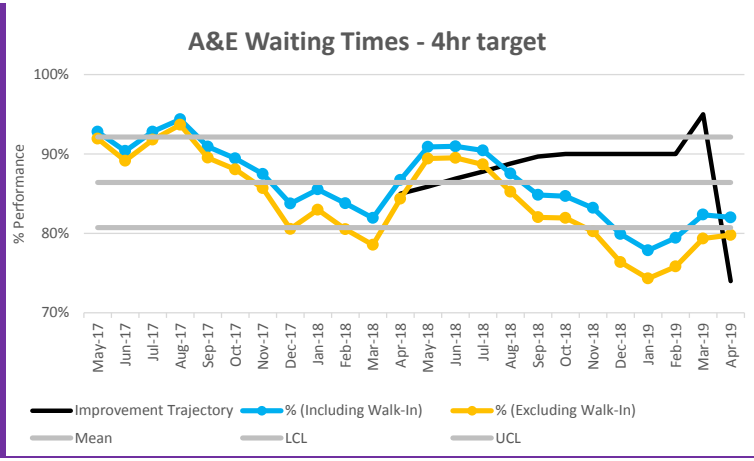
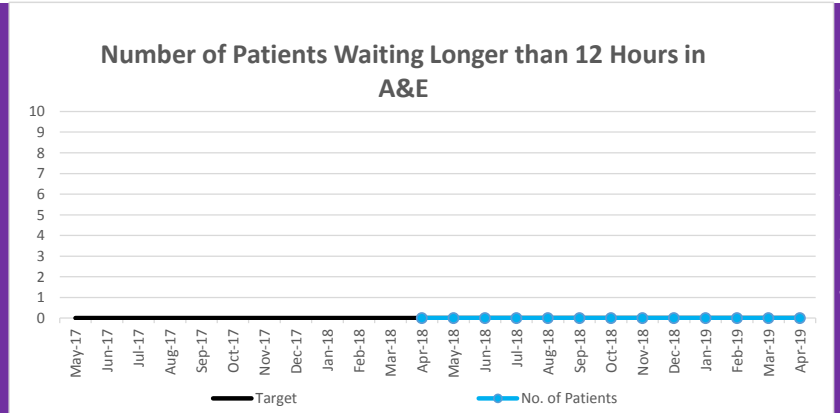
Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	The Trust achieved 99.97% in month.		The Trust met the Diagnostic 6 week standard in April 2019, achieving 99.97% 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 above	The Trust achieved 92.30% in month.		The Trust met the 18 week referral to treatment standard, achieving 92.30% in April 2019, 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 by September 2019.
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red				

Key:
Single Oversight Framework
Care Quality Commission

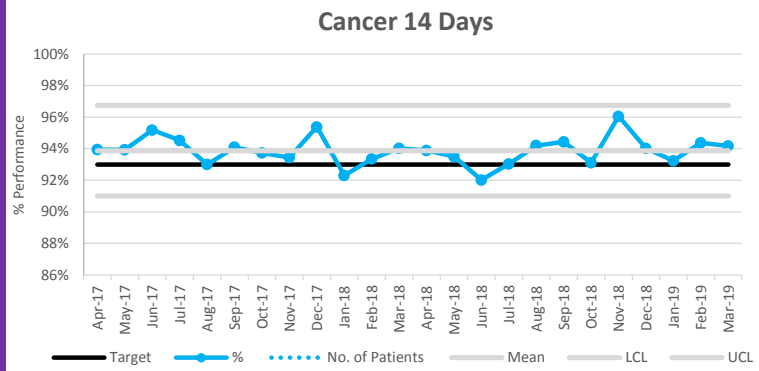
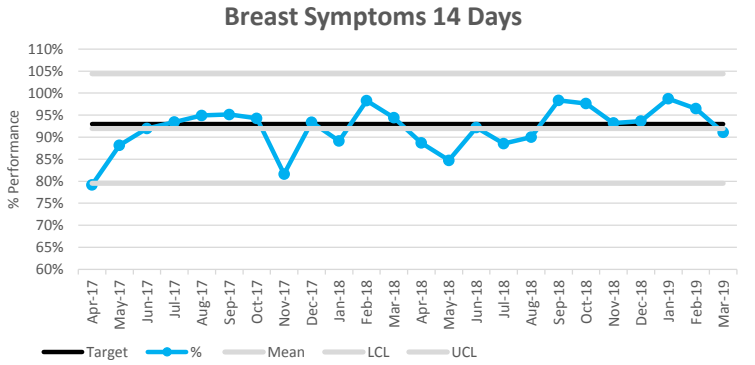
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	The Trust achieved 82.03% including walk in month.		Performance has remained challenging throughout April 2019, however, the Trust has achieved its agreed trajectory for 2019/20 in Month 1. Performance excluding Widnes UCC, which achieved 79.81% in April, continues to be an improvement from previous months. This is a positive indication of agreed actions supporting patient experience and performance.	An Urgent Care Improvement Committee has been established with the inaugural meeting planned for May 2019. This committee will focus on; CQC Report, Acute Medicine, Assessment Capacity / Environment, Decision to Admit and Collective Decision Making to ensure continued improvement.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard in not having any patient wait longer than 12 hours from the decision to admit in April 2019. This has been consistently achieved over time.	Maintain compliance against the 12 hour standard from decision to admit.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

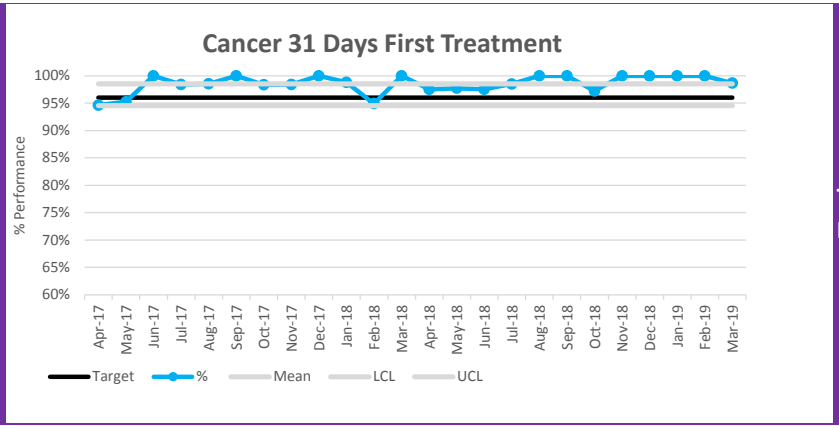
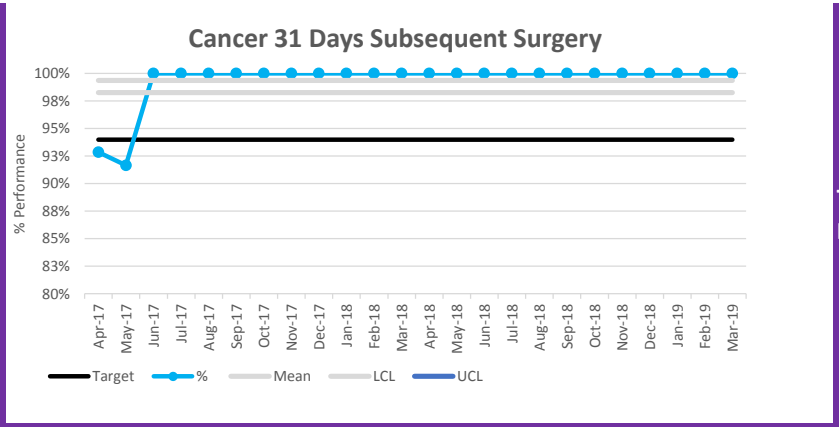
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above	The Trust achieved 94.17% in March 2019.		The Trust achieved the Cancer 14 Day target in March 2019. The April data is in draft format and will only be released once fully validated and uploaded in May 2019.	Maintain compliance against the 2WW standard.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	The Trust achieved 91.11% in March 2019.		The 2 week wait for Breast Symptomatic was not met in March 2019 with the Trust achieving 91.11% against the 93% standard. This was attributable to patient choice and the Trust subsequently incurred 7 breaches. This standard can fluctuate due to a small patient cohort.	The standard has recovered in April 2019 and achieved at aggregate level for 2018/19 as a whole.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

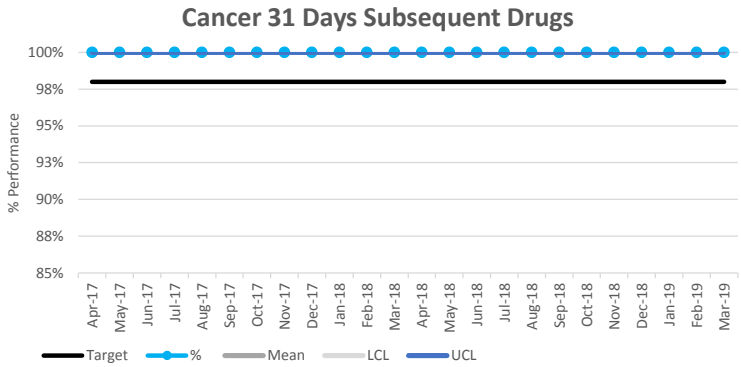
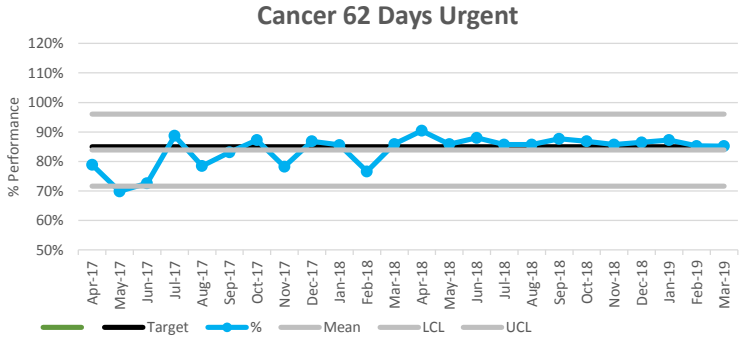
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	The Trust achieved 98.67% in March 2019.		The Trust achieved 98.67% in March 2019.	Maintain compliance against the 31 day first treatment standard.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	The Trust achieved 100% in March 2019.		The Trust achieved 100% in March 2019.	Maintain compliance against the 31 day subsequent treatment standard.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	The Trust achieved 100% in March 2019.		The Trust achieved 100% in March 2019.	Maintain compliance against the 31 day subsequent treatment standard.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	The Trust achieved 85.23% in March 2019.		The Trust achieved 85.23% in March 2019.	Maintain active monitoring of all pathways to maintain compliance against the 62 day standard. Positively, this standard has consistently achieved throughout 2018/19 which has only been possible through full engagement with the CBU Teams and supportive leadership via the Cancer Team.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

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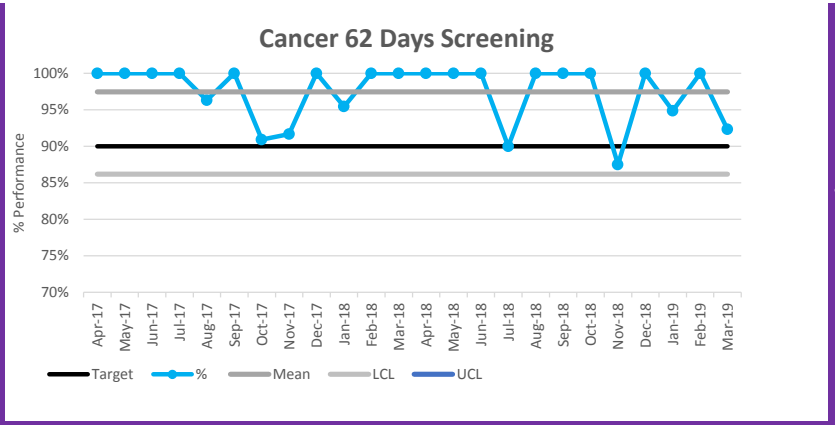
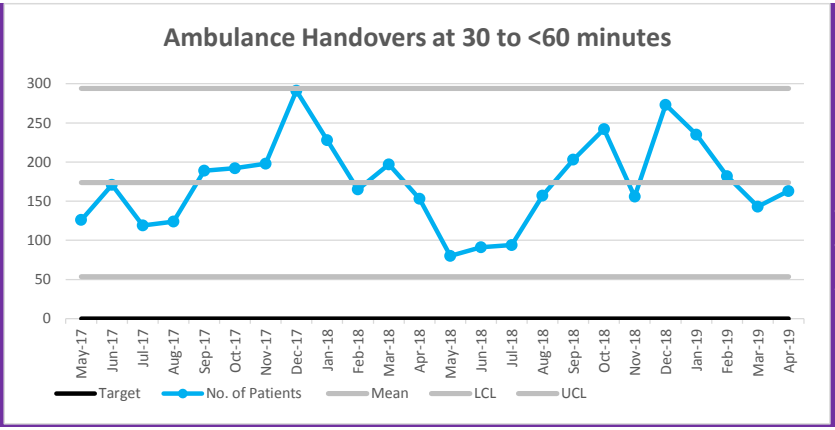
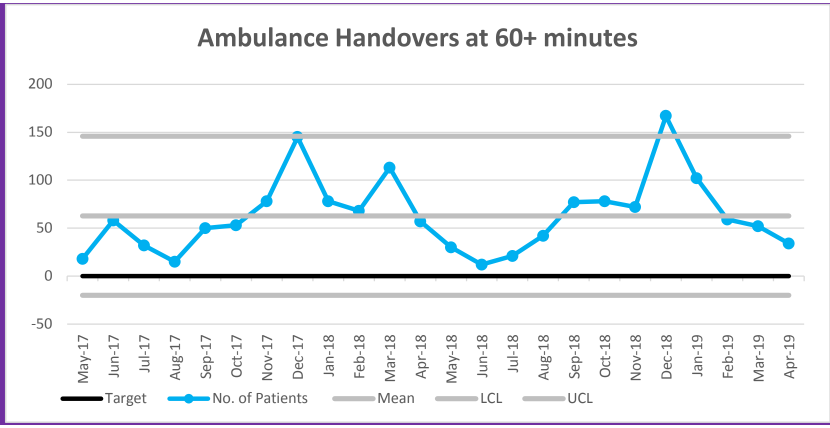
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	The Trust achieved 92.31% in March 2019.		The Trust achieved 92.31% in March 2019.	Maintain compliance against the 62 day screening standard.
Ambulance Handovers 30 to <60 minutes Red: More than 0	There were 163 patients waiting between 30 and 60 minutes for handover in month.		Significant improvement has continued against the 30-60 minute handover standard. Focus has remained 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 protocols to ensure appropriate and timely escalation at times of surge.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

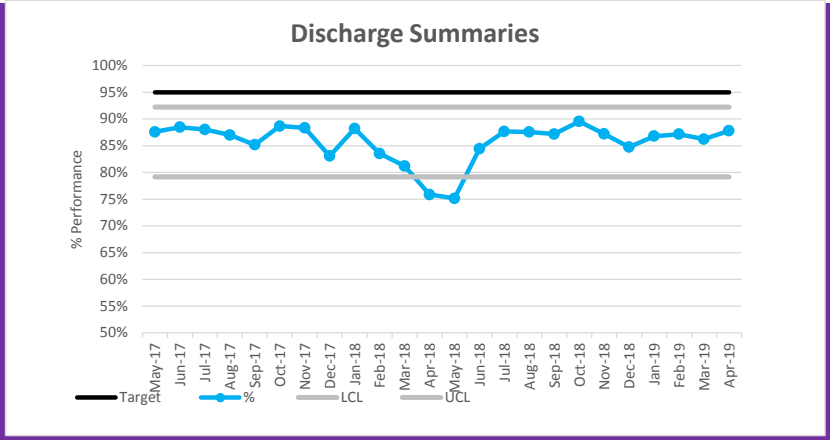
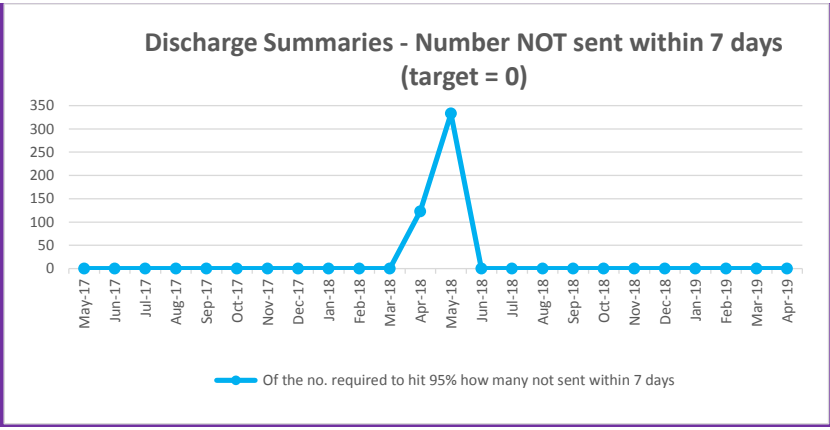
Key:
Single Oversight Framework SOF
Care Quality Commission CQC

Access & Performance - Trust Position

Trust Performance		Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	There were 34 patients waiting over 60 minutes for handover in month.		Significant improvement has continued against the 60+ minute handover standard which benchmarks positively against peers within Cheshire & Merseyside. Focus has remained 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:
Single Oversight Framework
Care Quality Commission

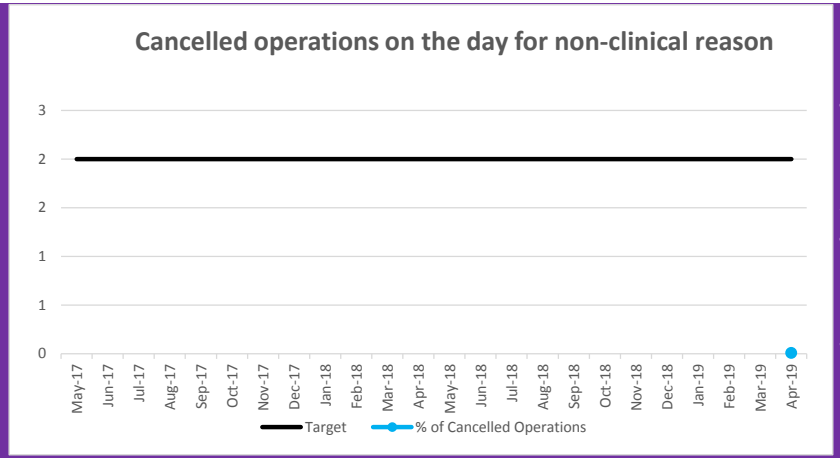
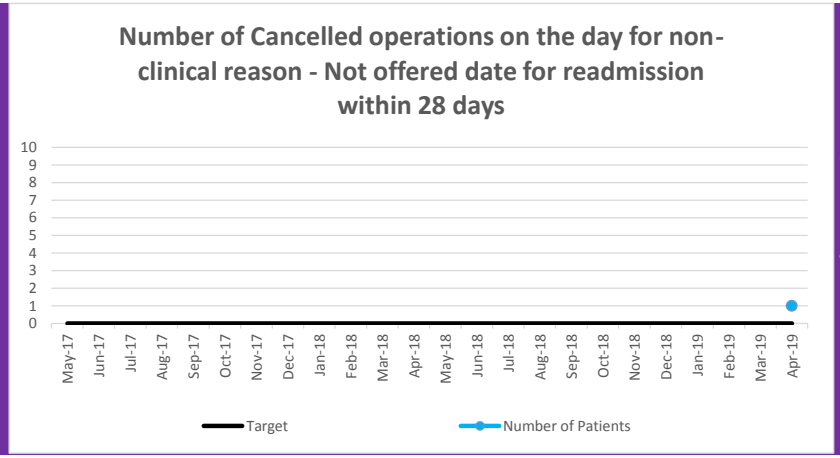
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust achieved 87.78% in month.		The Trust continues to monitor compliance across all CBUs. This is monitored via the weekly PRG & monthly KPI meetings. An SoP has been in place however, this is being reviewed in conjunction with the medical teams to ensure effective processes are embedded.	This standard remains challenging for the Trust with performance remaining static in recent months. Although an SoP has been in place, a review has been requested via the monthly KPI forum in conjunction with the medical team to improve current processes and drive improvement.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	There were 0 discharge summaries not sent within 7 days which was above the 95% threshold.		The Trust achieved compliance against the 7 day discharge summary standard in April 2019.	The Trust KPI group will continue to monitor at a CBU level to maintain performance against this standard.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

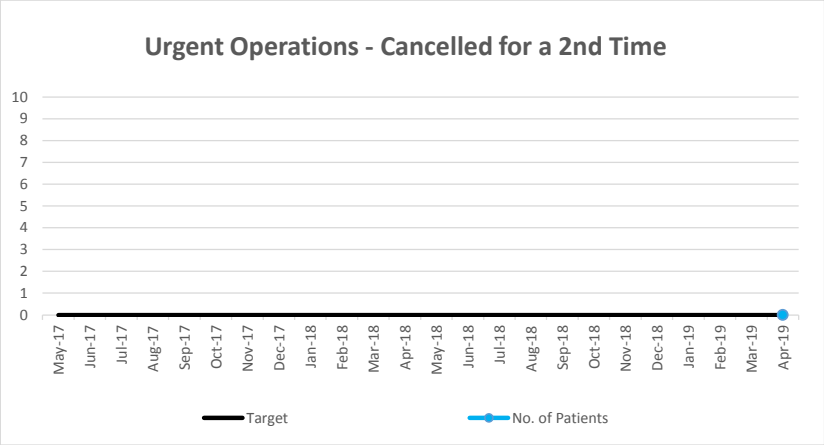
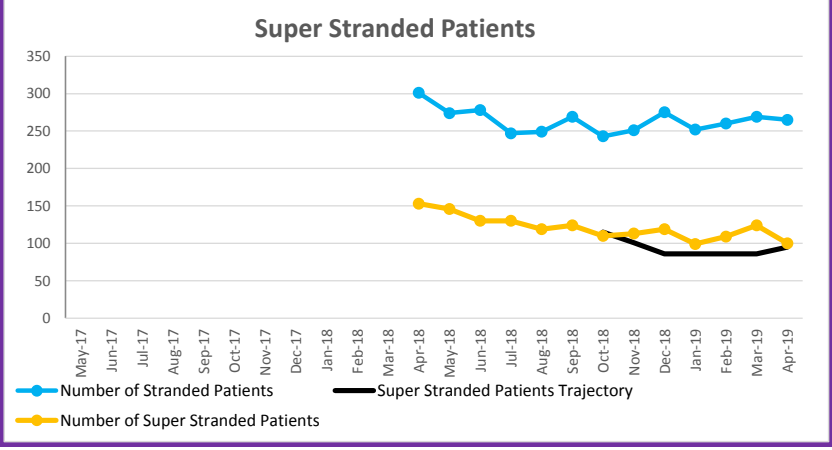
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason Red: > 2%	0.73% operations were cancelled on the day for non clinical reasons in month.		The Trust 0.73% cancelled operations on the day for non-clinical reasons. Benchmarking would suggest that although the Trust continues to maintain a zero tolerance to cancellations, a rate of less than 1% compares favourably.	A dedicated sub-group of the Theatre Productivity Group to focus on reducing cancellations on the day remains in place focusing on the escalation process, reporting and validation. A deep dive into non-clinical cancellations to inform actions has been undertaken which is supporting improvement.
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.		Unfortunately, there was one case whereby a cancelled operation for non-clinical reasons was not re-admitted within 28 days. This was due to a piece of equipment needing repair and although loan equipment had been arranged, the manufacturer sent the wrong item on the day.	Maintain compliance against the 28 day rule standards. RCA's undertaken whereby breaches of this standard occur. Monitored via weekly PRG and monthly KPI meetings.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month.		This is an additional standard to enhance monitoring of cancelled operations.	Maintain the standard that operations are not cancelled for a second time.
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 265 stranded and 100 super stranded patients at the end of the reporting period.		The Trusts objective is to have no more than 95 super stranded patients (LoS of 21 + days) by March 2020. The Trust has achieved compliance against the trajectory for Month 1. 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 3 weekly reviews by a senior MDT (Monday, Wednesday & 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 which commenced in May 2019.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Workforce - Trust Position

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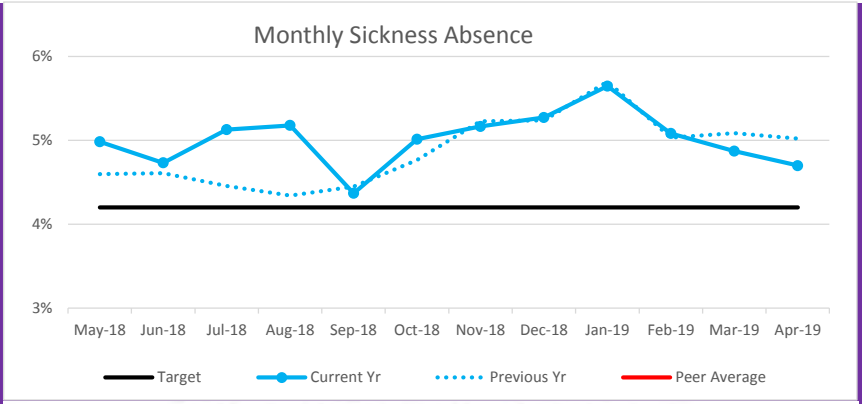
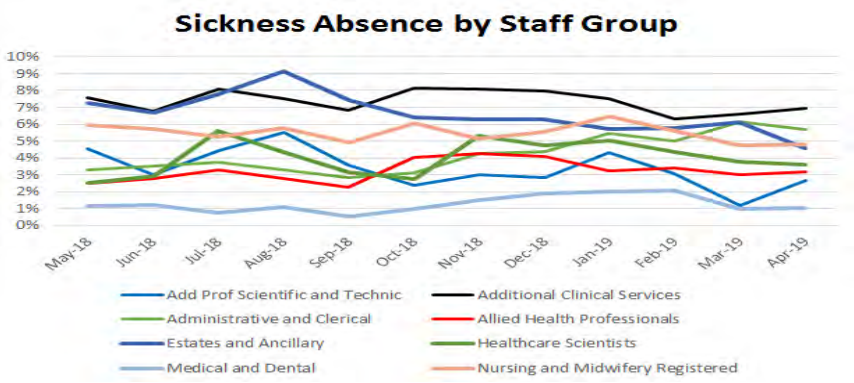
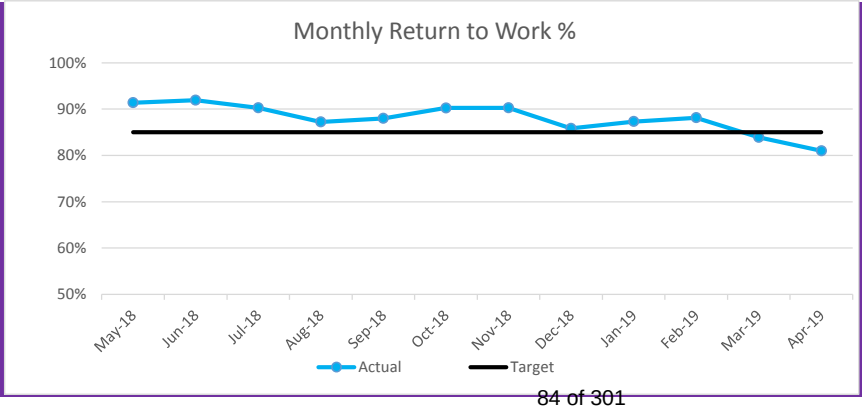
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	The Trust's sickness absence was 4.7% in month.	 	For the first part of the year, the Trust performance in relation to sickness absence was worse than the same period in the previous year. From September 2018 the position has been recovered and although sickness absence has continued to increase, this is in line with the trend from the previous year. Acknowledging that absence rates have remained higher than our peers and therefore there is opportunity to decrease, significant strategic and operational work has been undertaken to improve the position and from March 2019 the sickness absence rates have dipped below the 2018/19 rate. This improvement has continued in April 2019.	• A case conference protocol is being developed in relation to long term absences. • An attendance Management Module of the essential managers training has been reviewed and rolled out. • A difficult conversations Module has been introduced to the essential managers training. • The Executive Team have supported a proposal to implement a Sickness Absence Reduction Programme, in collaboration with Bridgewater Community NHS Foundation Trust.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	The Trust's return to work compliance was 81% in month.		The late and retrospective recording of return to work interviews impacts on the monthly reporting position, for instance, in January and February 2019 the position was reported as below target but additional interviews have been recorded since the reporting for those months, improving the position.	• A review of essential manager training has been completed and is now running - this includes information about the importance of timeliness of policy application. • The revised training also includes a session on 'Difficult Conversations' to help managers feel confident in completing RTWIs and to get the best out of the interviews. • There is 1:1 Coaching by the HRBP team with line managers on an ongoing basis.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Workforce - Trust Position

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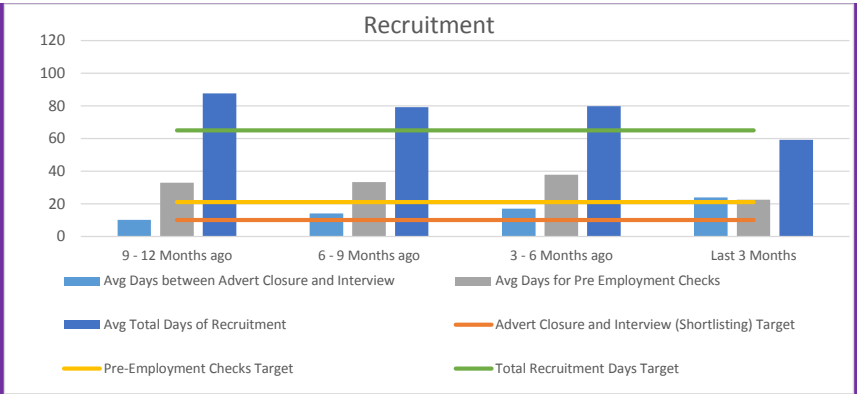
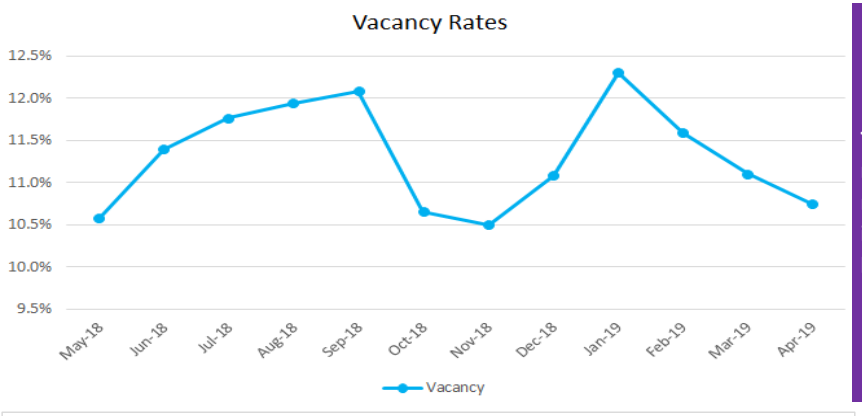
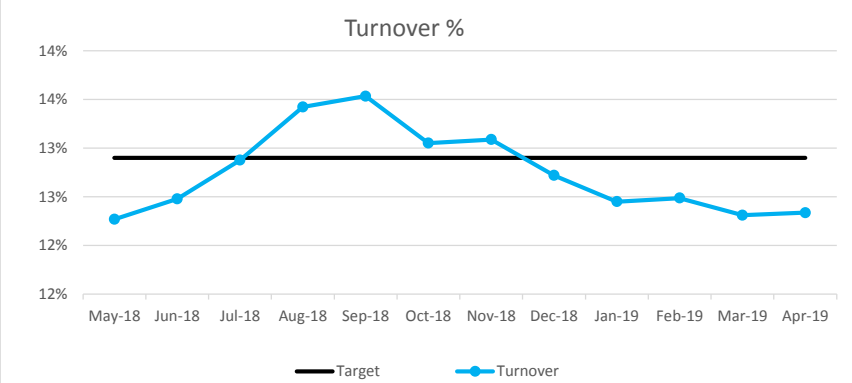
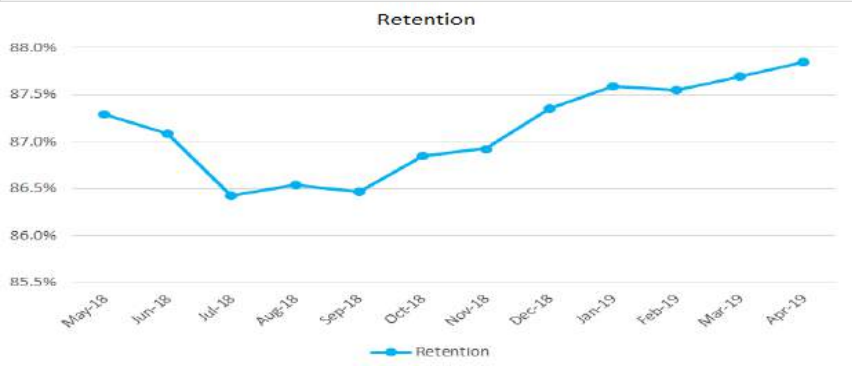
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below	The average number of working days to recruit is 60, based on the last 12 months average.		Time to hire has reduced due to continued improvements in processes.	• The recruitment team are currently reviewing the recruitment processes and utilising NHS Jobs to streamline processes further. • Recruitment and Retention Champions will be launched at the Career Café on 22nd May 2019. These will be our experts, with the aim to improve the recruiting managers understanding about the recruitment processes. • In the longer term, work with IM&T colleagues to improve the on-boarding system for our new candidates.
Vacancy Rates Red: 11% or Above Amber: 11% to 9% Green: 9% or Below	UoR Trust vacancy rate was 10.74% in month.		The continued reduction in vacancy rate is linked to improved retention/turnover and improvements in average time to hire.	The Trust Recruitment and Retention Group continue to focus on opportunities to increase attraction and recruitment. In addition, the Workforce Redesign Group supports managers to identify opportunities to utilise their workforce differently in order to address labour market challenges. The introduction of new roles such as Nurse Associates and Physician Associates, as well as the utilisation of apprenticeships, are key to this.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

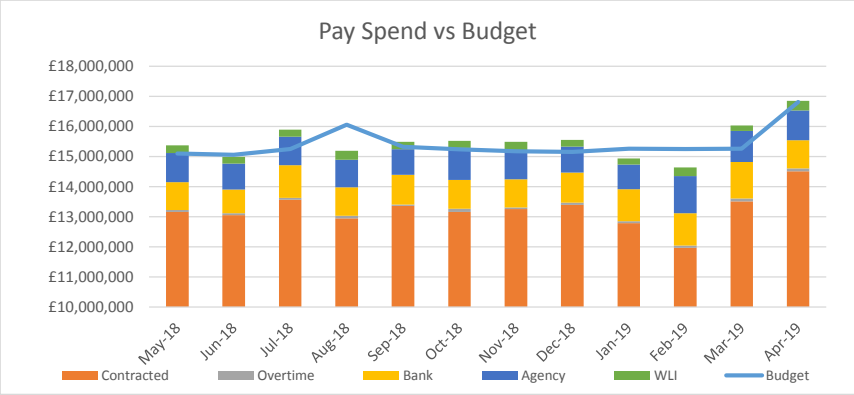
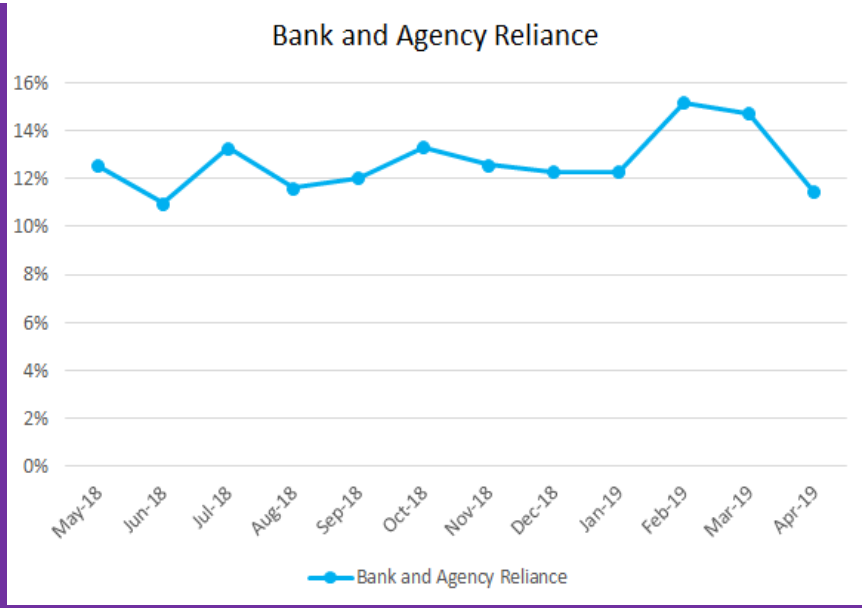
Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	Trust turnover was 12.44% in month.		Turnover has remained below target (positive) and continues to reduce. This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and LIA pulse check survey results) and to the work commenced as part of the NHSI Retention Programme.	• Implementation of the NHSI nursing retention programme and roll out to other staff groups. An action plan is in place following review of all data by NHSI. This includes: o Improve our workforce's ability to achieve a better work life balance o Support our staff to explore and pursue career progression within the Trust o Recognising and Valuing Experience (RAVE) o Develop and empower our Line Manager's to retain their staff • Work has already begun on encouraging experienced staff to remain in our employment - RAVE (recognising and valuing experience) initiative is being explored by the NHSI retention programme delivery group. As part of this a review of the Trust's retire and return policy will be required. • Careers cafés have been set up throughout the year, the next one is arranged for the 22nd May 2019.
Retention Red: Below 80% Amber: 80% to 85% Green: Above 86%	Trust Retention was 87.85% in month.		Retention remains above target (positive). This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and LIA pulse check survey results) and to the work begun as part of the NHSI Retention Programme.	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

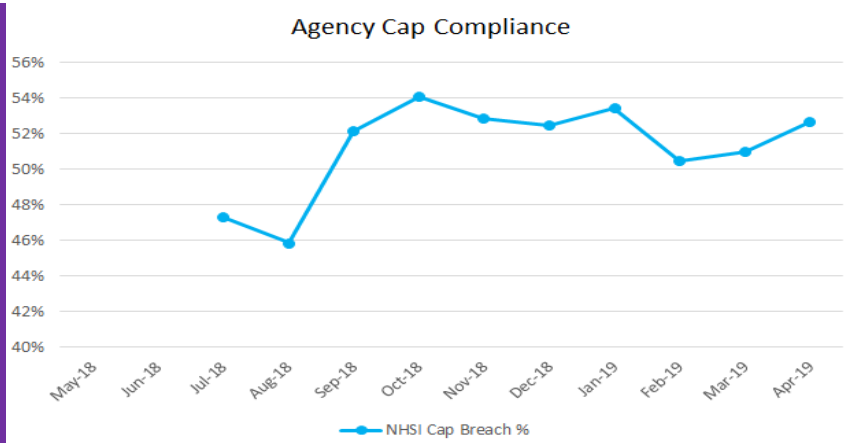
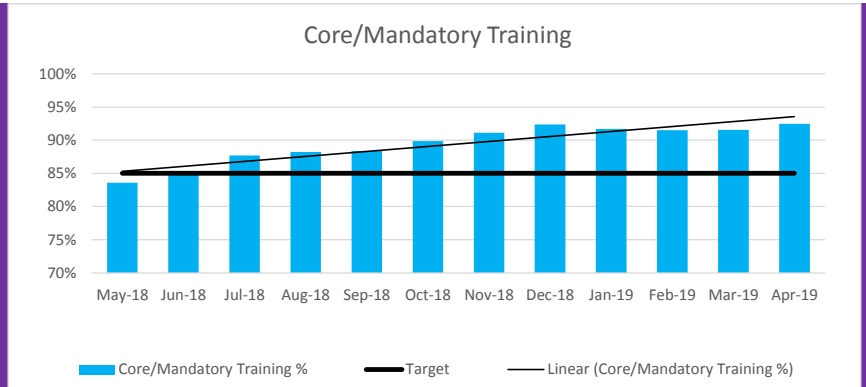
Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Pay Red: Greater than Budget Green: Less than Budget	UoR SOF Trust pay was 0.2% above budget.		Total pay spend in April 2019 was £16.85m against a budget of £16.81m Contracted pay spend was £14.5m and the remaining £2.3m was spent on temporary staffing including agency, bank, overtime 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 of 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.
Bank and Agency Reliance Red: 11% or Above Amber: 11% to 9% Green: 9% or	UoR Bank and Agency Reliance reduced to 11.46% in month.		The most common reason for temporary staffing usage is vacancy.	• The Trust Premium Pay Spend Review Group has developed a programme of work to support CBUs to review their highest cost and longest serving agency workers each month. • In relation to the 20% VAT charges, the Bank and Agency Team have been working with +US and regional partners to implement a new Direct Engagement (DE) model, which will mean VAT is not charged. • Bank and Agency team are refining the agency booking processes to allow for greater control from July 2019. • Actions outlined above relating to nursing attraction, recruitment and retention will positively impact this indicator, as substantive posts are filled. In order to reduce agency spend through increased bank fill rate, the Bank and Agency Team will launch the centralised bank by 1 August 2019 (This project has been delayed due to the requirement to react to the HMRC ruling).

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

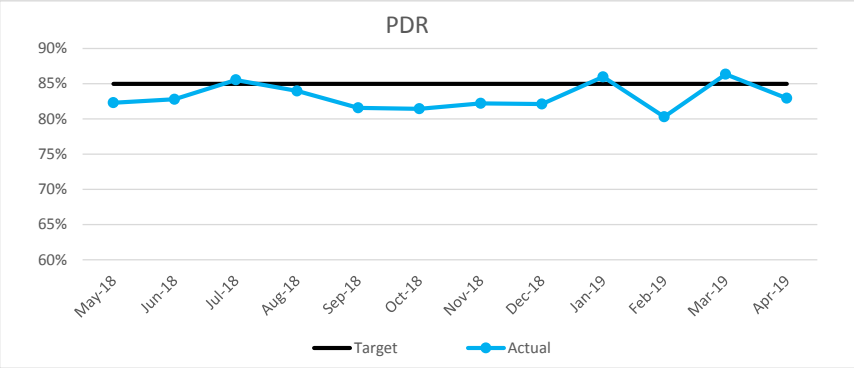
Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Agency Shifts Compliant with the Cap Red: Above 49% Green: Below 49%	**52.7% of shifts were compliant with the NHSI Price Cap.**		**The majority of shifts that are not compliant with the NHSI Price Cap relate to Medical and Dental agency bookings.**	**• The Trust is part of the Cheshire and Mersey Collaborative group, which has been working to create a new rate card (Medical and Dental Staff) for implementation across the region. Whilst these will initially be higher than the cap rates, they will be a step change towards the cap rates.** **• A Task and Finish Group has been setup to review the potential impact of the C&M rate card and how we can use the information to negotiate further with agencies at a Trust level, based on supply and demand of agency shifts.**
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	**Core/Mandatory training compliance was 92.48% in month.**		**Mandatory Training compliance has remained above target (positive) since June 2018. The Trust approach to Mandatory Training has been reviewed and expectations clarified. Compliance with Mandatory Training has now become 'business as usual' for staff and managers.**	**• Compliance with Mandatory Training is closely monitored at CBU/Department and topic level via Educational Governance Committee and by Subject Matter Experts.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

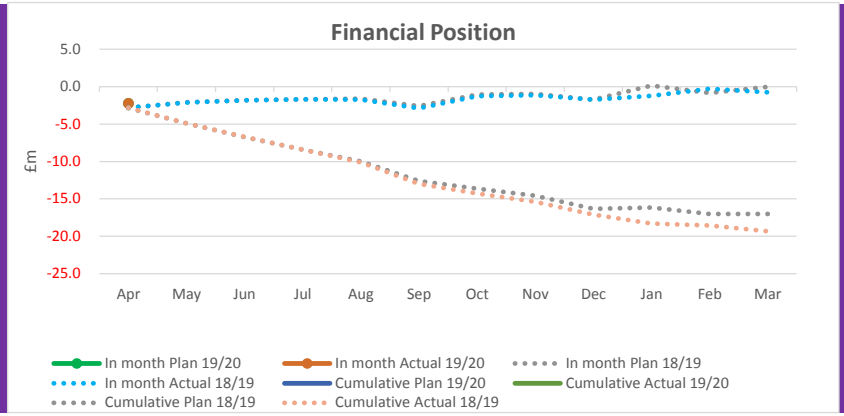
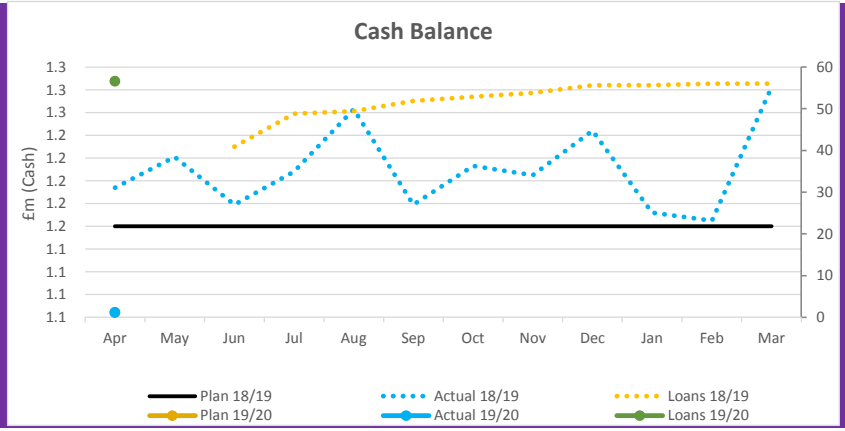
Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	PDR compliance was 82.94% in month.		PDR compliance was above target in March 2019 (positive) recognising the significant focused effort applied in the context of year end. The drop in April reflects previous compliance patterns demonstrated and that PDR compliance is not yet embedded across the organisation as usual.	• Continued sharing of monthly data used to discuss compliance at a local CBU/Department level. • Increased and continued focus to 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. • Review of Appraisals to be commenced in Qtr 1 2019/20 as per People Strategy Year 2 Delivery Plan. • Please note that the information provided includes medical staff PDR rates (15 month compliance period).

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance & Sustainability - Trust Position

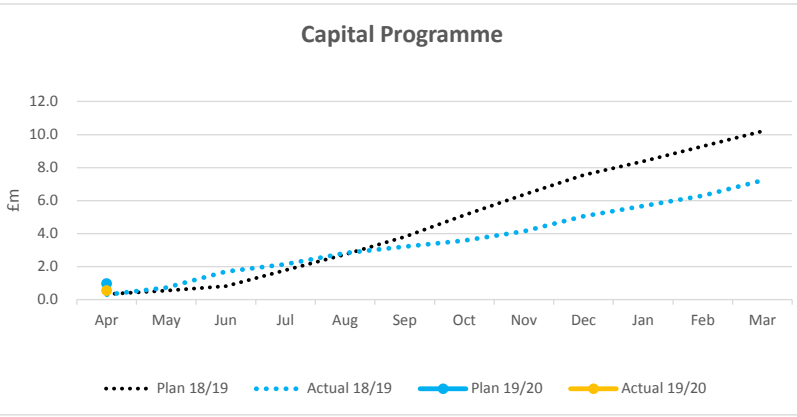
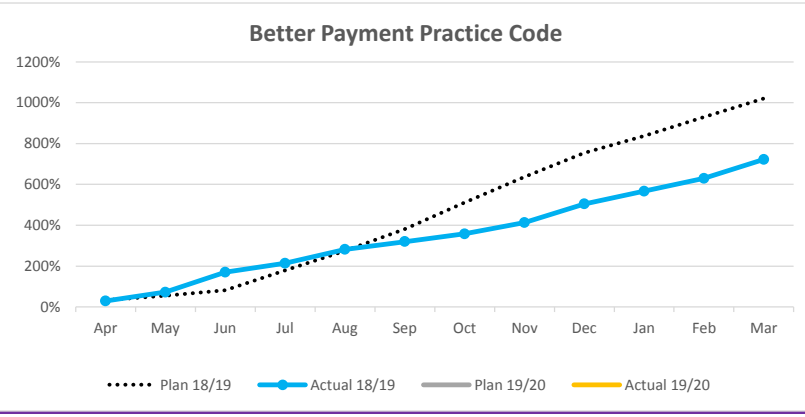
Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment
Trust Strategy

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position	The actual deficit in month is £2.3m.		The monthly deficit of £2.3m is in line with plan. The monthly control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is a £3.2m deficit which is in line with plan.	Monthly review of CIP and cost pressures in FSC. Monthly deep dive in the Executive Team Meeting.
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	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.	Daily monitoring and management of cash position to ensure continued ability to make payments.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance & Sustainability - Trust Position

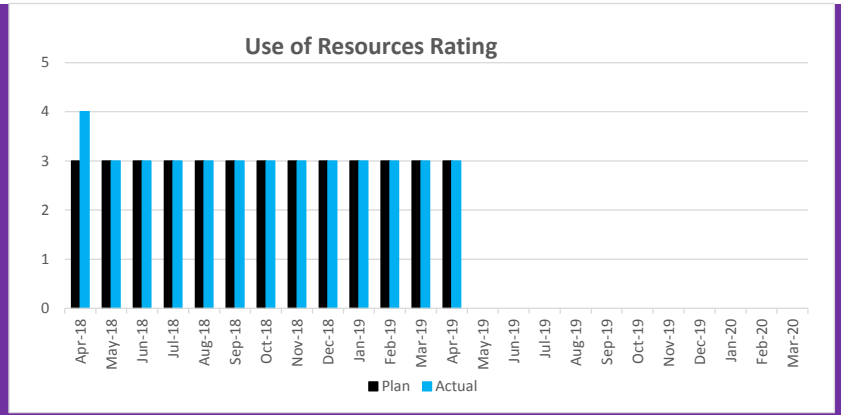
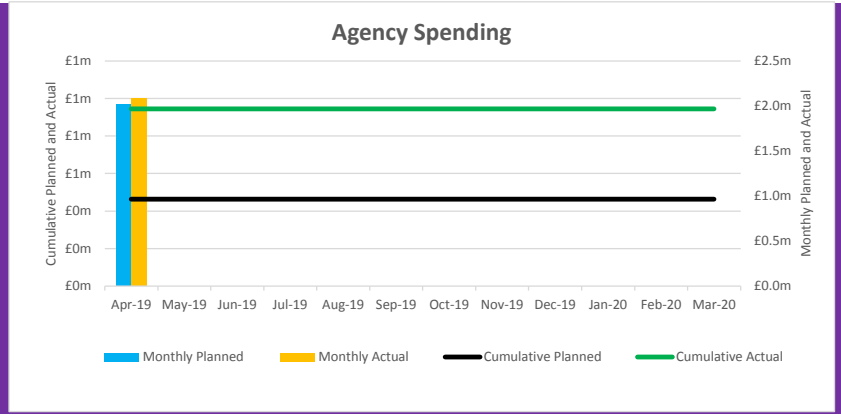
Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment
Trust Strategy

Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR SOF **The actual capital spend in the month is £0.5m.**		**The monthly capital spend of £0.5m is £0.4m below the planned capital spend of £0.9m.**	**The introduction of variance reporting in the Capital Reference Group with escalation to FSC when required.**
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 48% of suppliers within 30 days.**		**The monthly performance of 48% is 47% below the national standard of 95%, this is due to the cash balance and the need to manage cash very closely.**	**Daily management to deliver the best performance with the funds available to avoid additional interest charges.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
The current Use of Resources Rating is 3 (Capital Servicing Capacity, Liquidity, I&E margin are 4, Agency Ceiling is 2 and Distance from Financial Plan is 1).		**The current Use of Resources Rating of 3 which is the planned rating.**	**To monitor, report and manage financial performance to improve all Use of Resources metrics and achieve the planned rating of 3.**
The actual agency spend in the month is £1.0m.		**The monthly agency spend of £1.0m is £0.033m (3%) above the monthly agency ceiling.**	**To monitor and report the use and spend of agency and use VAT efficient models to reduce costs.**

Use of Resources Rating
Red: Use of Resource Rating 4
Amber: Use of Resource Rating 3
Green: Use of Resource Rating 1 and 2

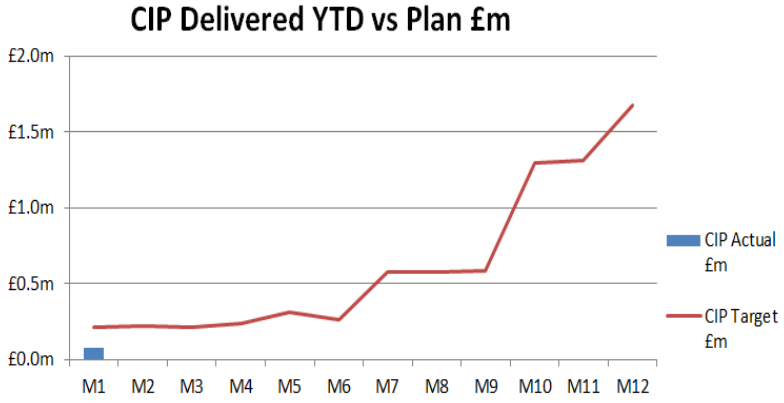
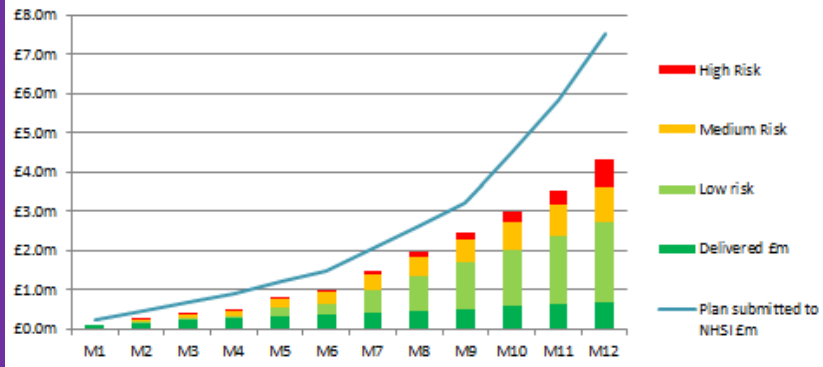
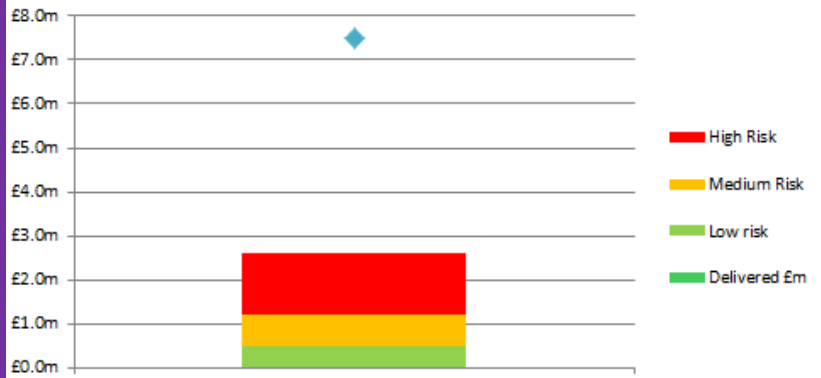
Agency Spending

Red: More than 105% of ceiling
Amber: Over 100% but below 105% of ceiling
Green: Equal to or less than agency ceiling.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance & Sustainability - Trust Position

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

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	UoR The savings delivered in month are £0.1m (37% of target).		The savings delivered in month are £0.1m which is £0.1m below the planned target.	
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	UoR Best case in-year forecast for CIP is £4.3m (58% of target).		Best case in-Year forecast for CIP is £4.3m which is £3.2m below the £7.5m target.	Monthly review the FRG, FSC and Trust Executive Team Meetings with fortnightly reporting to NHSI.
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	UoR Best case recurrent forecast for CIP is £2.7m (36% of target).		Best case recurrent forecast for CIP is £2.7m which is £4.8m below the £7.5m target.	

Appendix 3 – Trust IPR Indicator Overview

Indicator	Detail
Quality	
Incidents	Number of Serious Incidents and actions breached. Number of open incidents is the total number of incidents that we have awaiting review. As part of the 2018 - 2021 Trust Quality Strategy, the Trust has pledged to Increase Incident Reporting to ensure that we don't miss opportunities to learn from our mistakes and make changes to protect patients from harm.
CAS Alerts	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependent upon the specific CAS alerts.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Adult, Children's and Maternity Safety Thermometer	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.
Healthcare Aquired Infections (MRSA, CDIFF and Gram Negative)	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli, Klebsiella, Pseudomonas aeruginosa - A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.
Safer Surgery	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 cases per month by Head of theatre services.
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.
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the

	patients discharge.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.
Finance	
Financial Position	Operating surplus or deficit compared to plan.
Cash Balance	Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.

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

Appendix 4

Income Statement, Activity Summary and Use of Resources Ratings as at 30th April 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	2,654	2,348	-306	2,654	2,348	-306
Elective Excess Bed Days	14	6	-8	14	6	-8
Non Elective Spells	5,400	5,744	344	5,400	5,744	344
Non Elective Excess Bed Days	257	103	-154	257	103	-154
Outpatient Attendances	2,771	2,985	214	2,771	2,985	214
Accident & Emergency Attendances	1,121	1,153	32	1,121	1,153	32
Other Activity	5,677	5,554	-123	5,677	5,554	-123
Sub total	**17,893**	**17,893**	**-1**	**17,893**	**17,893**	**-1**
Non NHS Clinical Income						
Private Patients	23	7	-16	23	7	-16
Non NHS Overseas Patients	6	9	3	6	9	3
Other non protected	86	74	-12	86	74	-12
Sub total	**115**	**90**	**-25**	**115**	**90**	**-25**
Other Operating Income						
Training & Education	609	614	5	609	614	5
Provider Sustainability Fund (PSF)	243	243	0	243	243	0
Financial Recovery Fund (FRF)	601	601	0	601	601	0
Marginal Rate Emergency Tariff (MRET)	81	81	0	81	81	0
Miscellaneous Income	1,137	1,408	271	1,137	1,408	271
Sub total	**2,671**	**2,947**	**276**	**2,671**	**2,947**	**276**
Total Operating Income	**20,679**	**20,930**	**251**	**20,679**	**20,930**	**251**
Operating Expenses						
Employee Benefit Expenses	-16,817	-16,851	-33	-16,817	-16,851	-33
Drugs	-1,256	-1,302	-46	-1,256	-1,302	-46
Clinical Supplies and Services	-1,653	-1,819	-166	-1,653	-1,819	-166
Non Clinical Supplies	-2,404	-2,437	-33	-2,404	-2,437	-33
Depreciation and Amortisation	-592	-567	25	-592	-567	25
Total Operating Expenses	**-22,722**	**-22,975**	**-252**	**-22,722**	**-22,975**	**-252**
Operating Surplus / (Deficit)	**-2,043**	**-2,045**	**-2**	**-2,043**	**-2,045**	**-2**
Non Operating Income and Expenses						
Interest Income	3	7	4	3	7	4
Interest Expenses	-75	-75	0	-75	-75	0
PDC Dividends	-147	-147	0	-147	-147	0
Total Non Operating Income and Expenses	**-219**	**-215**	**4**	**-219**	**-215**	**4**
Surplus / (Deficit)	**-2,262**	**-2,260**	**2**	**-2,262**	**-2,260**	**2**
Adjustments to Financial Performance						
Add Depreciation on Donated & Granted Assets	13	16	3	13	16	3
Total Adjustments to Financial Performance	**13**	**16**	**3**	**13**	**16**	**3**
Performance against Control Total inc PSF, FRF & MRET	**-2,249**	**-2,243**	**6**	**-2,249**	**-2,243**	**6**
Less PSF, FRF & MRET Funding	-925	-925	0	-925	-925	0
Performance against Control Total exc PSF, FRF & MRET	**-3,174**	**-3,168**	**6**	**-3,174**	**-3,168**	**6**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,804	2,692	-112	2,804	2,692	-112
Elective Excess Bed Days	51	20	-31	51	20	-31
Non Elective Spells	3,029	3,049	20	3,029	3,049	20
Non Elective Excess Bed Days	985	386	-599	985	386	-599
Outpatient Attendances	23,500	25,114	1,614	23,500	25,114	1,614
Accident & Emergency Attendances	9,598	9,443	-155	9,598	9,443	-155
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics						
Capital Servicing Capacity (Times)				-6.52	-6.63	-0.10
Liquidity Ratio (Days)				-43.2	-44.1	-1.0
I&E Margin - Metric (%)				-10.88%	-10.72%	0.16%
I&E Margin - Distance from financial plan (%)				0.00%	0.16%	0.16%
Agency Ceiling (%)				0.00%	3.41%	3.41%
Ratings						
Capital Servicing Capacity (Times)				4	4	0
Liquidity Ratio (Days)				4	4	0
I&E Margin - Metric (%)				4	4	0
I&E Margin - Distance from financial plan (%)				1	1	0
Agency Ceiling (%)				1	2	1
Use of Resources Rating				**3**	**3**	**0**

Appendix 5

2019/20 Capital Programme

Description	Original Programme approved by Board	Increase due to carry forward and depreciation	Revised Programme Value	Programme Adjustments	Final Programme	Amendments Month 1	Revised Programme
	£000	£000	£000	£000	£000	£000	£000
Property & Estates Schemes							
Replacement Lift - Phase 1 Halton 68944	250		250		250		250
Staffing	177		177		177		177
Backlog - All areas, fixed installation wiring test 68982	150		150		150		150
Halton 30 Minute Fire Compartmentation	150		150		150		150
Appleton Wing 60 Minute Fire Doors	100		100		100		100
Warrington & Halton Gas Meter Replacement	100		100		100		100
Backlog - Water Safety Compliance 68959	50		50		50		50
Backlog - Appleton Wing, replace 5 No LV changeover switches	40		40		40		40
Backlog - HV Annual Requirements 7 Maintenance	40		40		40		40
Backlog - Patient Environment Improvements	100		100		100		100
Induction of Labour Ward (CQC)			0		0		0
Six Facet Survey (annual rolling programme) to include dementia & disability 68965	60		60		60		60
Backlog - Asbestos re-inspection & removals	30		30		30		30
Halton Endoscopy Essential power supply to rooms 1 & 2 68942			0	20	20		20
Backlog - Air Con/ Cooling Sys upgrade. Ph1-Survey 68948			0	12	12		12
Automatic sliding / entrance doors across all sites 68960			0	20	20		20
External Fire Escapes Replace (Kendrick & Appleton) 68950			0	81	81		81
Estates Minor Works 68955			0	12	12		12
Estates Dept Fire Doors 68969	20		20		20		20
Estates Dept Fire Compartmentation of Risk Areas 68979	10		10		10		10
High Voltage Maintenance 68938			0	20	20		20
Substation B air circuit breakers and HV ring main unit 68998	202		202	404	606		606
Electrical Infrastructure Upgrade 68961			0	42	42		42
North Lodge fire compartmentation 68988			0	150	150		150
North Lodge Basement - Fire Compartmentation Part 2/2	100		100		100		100
North Lodge & Catering Emergency Lighting 68992	50		50		50		50
Appleton Wing fire doors 68981			0	100	100		100
Thelwall House emergency escape lighting 68973			0	4	4		4
Thelwall House - Improvements to Fire Alarm System	20		20		20		20
Cheshire House fire doors 68919			0	23	23		23
Installation of Dishwashers 68996			0	1	1		1
CCU relocation to Ward A3			0	8	8		8
Discharge Lounge/Bereavement Office 68922			0	17	17		17
Essential Power Supply - Halton Pharmacy 68920			0	6	6		6
Pharmacy Fire Doors	30		30		30		30
Bathroom A9			0	0	0		0
Bathroom A4 68910			0	24	24		24
Bathroom A8 68932			0	24	24		24
N20 Exposure 68952			0	100	100		100
Catering EHO Works 68957			0	9	9		9
CQC (Environmental Improvements) 68962	554		554	393	947		947
CQC (MLU) 68903	78		78	522	600		600
Halton Outpatients Refurbishment 68906			0	69	69		69
Halton Residential Blocks 2 & 3 Fire Doors	25		25		25		25
Emergency Generator Repairs - Halton 68967			0	7	7		7
Daresbury Plant Room - Alternative Fire Escape	20		20		20		20
Cheshire House Emergency Lighting	20		20		20		20
Butterfly Suite 68911			0	19	19		19
ITU UPS Replacement 68926			0	7	7		7
AER Machines (4 W 2 H) 68839	350		350	350	700		700
	2,726	**0**	**2,726**	**2,444**	**5,170**	**0**	**5,170**
IM&T Projects							
Technology & Devices refresh and developments			0	141	141		141
Security (Stonesoft firewall replacement/renewal)			0	2	2		2
VDI Roll Out			0	117	117		117
IPPMA/ePrescribing/ePMA			0	69	69		69
EPMA	250		250		250		250
EPMA - E Prescribing/Drugs Trolleys	229		229		229		229
Meditech Restoration			0	5	5		5
Deontics Pathway Development			0	8	8		8
Falsified Medicines Directive			0	83	83		83
BI Interactive Screens			0	11	11		11
Ice Upgrade			0	0	0	31	31
	479	**0**	**479**	**436**	**915**	**31**	**946**
Equipment Schemes							
Oral Surgery Dental Chair x1			0	1	1		1
Door Lock (FAU)			0	5	5		5
Bladder Scanner (FAU)			0	8	8		8
Ultrasound Rheumatology			0	29	29		29
ECG stress test system			0	31	31		31
Replacement Anaesthetic Machines & Monitors	260		260		260		260
Recovery Monitors	390		390		390		390
Ultrasound Machines	150		150		150		150
Replacement Patient Monitoring System in ED	300		300		300		300
Anaesthetic Ultrasound for Vascular	70		70		70		70
Patient Transfer Ventilators	55		55		55		55
NIV Machines	47		47		47		47
Laparoscopic Video Imagery Systems	160		160		160		160
Diagnostics Business Case	1,365		1,365		1,365		1,365
Ultrasound Transducer			0	0	0	7	7
Curvilinear Transducer			0	0	0	6	6
	2,797	**0**	**2,797**	**74**	**2,871**	**13**	**2,884**
Contingency	498	661	1,159	**-269**	890	-44	846
estimate of carry forward	1,700	1,182	2,882	**-2,882**	0		0
Total Trust Funded Capital	**8,200**	**1,843**	**10,043**	**-197**	**9,846**	**0**	**9,846**
Externally Funded							
Tomosynthesis (Boot Out Breast Cancer)			0	10	10		10
Training Simulation Equipment (HEE)			0	10	10		10
Outdoor Play Area (Phase 1)			0	5	5		5
EPR Developments WA Digital Maturity (PDC)			0	81	81		81
CANTREAT Modifications (Donated £86k)			0	84	84		84
Cancer Trans Prog - MDT Equipment (PDC)			0	7	7		7
	0	0	0	197	197	0	197
Kendrick Wing Fire							
Kendrick Wing Fire	3,500		3,500	0	3,500		3,500
Kendrick Wing Fire Total	**3,500**	**0**	**3,500**	**0**	**3,500**	**0**	**3,500**
Totals	**11,700**	**1,843**	**13,543**	**0**	**13,543**	**0**	**13,543**

We are WHH

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/39**			
SUBJECT:	**Safe Staffing Assurance Report**			
DATE OF MEETING:	29 May 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**	Finance and Sustainability Committee		
	Committee	Strategic People Committee		
	Agenda Ref.	SPC/19/05/55		
	Date of meeting	22 May 2019		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

We are WHH

NAME OF COMMITTEE

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/05/38

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 March 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 March 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 March 2019, which has seen a slight decrease in the CHPPD in March 19 to 7.0 the overall rate for the year remains at 7.0.

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
	Mar	15215.5	4.1	2.9	7.0
2018/19 Total		178849.97	4.1	2.9	7.0

Key Messages

Although some areas are above the 90% fill rate 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 and retention remains a priority for the senior nursing team. Further recruitment events planned for both registered nurses and health care assistants.

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

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

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

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months.

Additional bed capacity was opened to support the winter operational pressures in the Trust, Ward C21 (24 beds) is currently being used as an additional ward and Ambulatory Care (16 beds) on occasions is being used as an inpatient overnight facility, both these areas 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.

Maternity Workforce Development

A workforce document produced by HEE England (2019) outlines the challenges to provide improved outcomes for women and babies through Continuity of Carer (CoC) models, the document has been reviewed by the Head of Midwifery and an update has been provided for the report. To support the development of a CoC model the Trust has received funding via The Local Maternity System over a 6 month period for a midwife to lead on implementation.

Development of an integrated staffing model around our new alongside midwifery led unit, due to open the end of 2019, is currently taking place which incorporates a review of the requirements to provide the CoC model. Developing these types of models can lead to many workforce challenges, such as a change in staff working patterns and a review of on call payments. In return the evidence shows many benefits to women and babies, including reduction in pre-term birth and fetal loss, which would have a positive impact financially.

The document describes how the workforce for maternity will be viewed as a whole Local Maternity System, with the ageing population of midwives being identified as a specific area of concern regionally. With this in mind there is a requirement to increase student placements. As a Trust student placements in Maternity will be increased by 29% for 2019 with a further 10% the following year, above the 25% required.

Strengthening leadership and changing the culture of birth to be woman and family focused is a focus of the document. We have made huge strides at WHH to work on changing the culture using funding creatively to develop a new Midwifery Led Unit Manager and a second Matron post in order to strengthen leadership and drive change.

Patient Harm by Ward

In March 2019 we have reported 1 category 2 pressure ulcer, which is currently being investigated. 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 March 2019

We have had 1 case of MSSA bacteraemia reported in March 2019 on ward A4. A full RCA has been undertaken into this case.

Appendix 1 **MONTHLY SAFE STAFFING REPORT – March 2019**

Monthly Safe Staffing Report – March 2019

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	CHPPD			
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	Overall
		= above 100%		= above 90%			= above 80%			= below 80%							
DD	SAU	840	832	652	585	99%	89.7%	-	-	-	-	-	-	-	-	-	-
DD	Ward A5	1782.5	1374.25	1426	1404	77.1%	98.5%	1069.5	1058	1069.5	1058	98.9%	98.9%	992	2.5	2.5	4.9
DD	Ward A6	1782.5	1305.25	1426	1253.5	73.2%	87.9%	1069.5	1000.5	1069.5	1035	93.5%	96.8%	992	2.3	2.3	4.6
DD	Ward B4	740	642.5	704	704	86.8%	100%	230	195.5	230	195.5	85%	85%	39.5	21.2	22.8	44.0
DD	Ward A4	1667.5	1491	1426	1341	77.1%	98.5%	1069.5	1058	1069.5	1058	98.9%	98.9%	992	2.4	2.4	4.9
MSK	Ward CMTC	1104	1074.5	743.5	722.5	97.3%	97.2%	667	667	448.5	448.5	100%	100%	336	5.2	3.5	8.7
MSK	Ward A9	1782.5	1571	1426	1360.5	88.1%	95.4%	1069.5	1058	1426	1426	98.9%	100%	986	2.7	2.8	5.5
W&C	Ward B11	2841.2	2725.5	787.5	809.2	95.9%	102.8%	1649.2	1649.2	197.6	180.36	100%	91.3%	465	9.4	2.1	11.5
W&C	NNU	1782.5	1626	356.5	356.5	91.2%	100%	1782.5	1472	356.5	278	82.6%	77.4%	226	13.7	2.8	16.5
W&C	Ward C20	977.5	788.4	644	621	80.7%	96.4%	644	644	0	0	100%	-	371	3.9	1.7	5.5
W&C	Ward C23	1426	1168.75	713	616	82%	88.4%	759	759	713	644	100%	90.3%	356	5.4	3.5	9.0
W&C	Birth Suite	2495.5	2375	356.5	266.5	95.2%	74.8%	2495.5	2418.5	356.5	276	96.9%	77.4%	212	22.6	2.6	25.2
UEC	Ward A1	2325	1935.7	1937.5	1828.5	83.3%	94.4%	1575	1555.5	976.5	945	98.8%	96.8%	1045	3.3	2.7	6.0
UEC	Ward A2	1426	1329.5	1426	1302.9	93.2%	91.4%	1069.5	1012.5	1069.5	1092.5	94.7%	102.2%	868	2.7	2.8	5.5
IM&C	Ward C22	1182	990	1069.5	1236	83.8%	115.6%	713	713	713	989	100%	138.7%	651	2.6	3.4	6.0
IM&C	Ward A8	1426	1328.5	1426	1759.5	93.2%	123.4%	1426	1253.5	1069.5	1143	87.9%	106.9%	1054	2.4	2.8	5.2
IM&C	Ward B12	1069.5	1042.5	2495.5	2188	97.5%	87.7%	713	713	1782.5	1782.5	100%	100%	651	2.7	6.1	8.8
IM&C	Ward B14	1426	1274	1426	1463.5	89.3%	102.6%	713	713	1069.5	1104	100%	103.2%	744	2.7	3.5	6.1
IM&C	Ward B18	1426	1168.5	1414.5	1378	81.9%	97.4%	1069.5	770.5	1069.5	1283	72%	120%	744	2.6	3.6	6.2
IM&C	Ward B19	1069.5	1042	1382.9	1426	97.4%	103.1%	713	713	1069.5	1035	100%	96.8%	744	2.4	3.3	5.7
MC	Ward A7	1782.5	1446	1426	1374.5	81.1%	96.4%	1426	1322.5	1069.5	1350	92.7%	126.2%	1023	2.7	2.7	5.4
MC	ACCU	2495.5	2078	1069.5	1065	83.3%	99.6%	1782.5	1679	1069.5	1069.5	94.2%	100%	1222	3.1	1.7	4.8
MC	ICU	4991	4496.5	1069.5	816.5	90.1%	76.3%	4991	4600	1069.5	534.75	92.2%	50%	502	18.1	2.7	20.8

Appendix 2

March 2019 - Mitigating Actions

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

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

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
SAU	99%	89.7%	-	-	**Vacancy:** - band 5 1.0 wte **Sickness rate** 9.82% **Action taken:** - Attendance management policy followed. Vacancy filled
Ward A5	77.1%	98.5%	98.9%	98.9%	**Vacancy:** Band 5 0.62 wte band 2 1.43 wte **Sickness rate:** 4.99% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment plans in place
Ward A6	73.2%	87.9%	93.5%	96.8%	**Vacancy:** - Band 5 5.07 wte Band 2 1.53 wte **Sickness rate** – 8.02% **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 plan in place
Ward B4	86.8%	100%	85%	85%	**Vacancy**: band 6 1.20wte band 2 1.74wte **Sickness rate** – 5.83% **Action taken:** Daily staffing review against acuity and activity. Recruitment plan in place. Sickness absence reduced in month and being managed in line with Trust policy.
Ward A4	77.1%	98.5%	98.9%	98.9%	**Vacancy:** - Band 5 2.31 wte band 2 0.49 **Sickness rate** – 2.5% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward CMTC	97.3%	97.2%	100%	100%	**Vacancy:** all vacancies filled – awaiting start dates **Sickness rate –** 3.58% **Action taken**: All vacancies filled and awaiting start dates. Sickness absence being managed in line with the Trust policy.

Ward A9	88.1%	95.4%	98.9%	100%	**Vacancy:** band 5 – 2.09wte band 2 4.58wte **Sickness rate** – 5.72% **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy. All RN posts recruited to - due to quality March / Sept 2019. 3.12 wte band 2 posts recruited to and awaiting start dates
Ward B11	95.9%	102.8%	100%	91.3%	**Vacancy:** all vacancies filled **Sickness Rate:** 4% **Action taken:** - recruitment process in place. Staffing reviewed daily and support provided if necessary.
NNU	91.2%	100%	82.6%	77.4%	**Vacancy rate:** all vacancies filled **Sickness Rate:** 6.7% **Action taken:** sickness is managed via the Trust policy. Staffing reviewed daily and support provided if necessary.
Ward C20	80.7%	96.4%	100%	-	**Vacancy: :** 2.25wte band 2 1.03 wte Sickness rate – 2.88% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. RN vacancies filled. Sickness is being managed in line with Trust policy.
Ward C23	82%	88.4%	100%	90.3%	**Vacancy:** band 5 1.06 wte band 2 0.6 wte **Sickness rate** – 10.3% **Action taken:** all vacancies filled. Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness is being managed in line with Trust policy.
Delivery Suite	95.2%	74.8%	96.9%	77.4%	**Vacancy:** - 4.0wte Band 5. **Sickness rate** – 4.24% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A1	83.3%	94.4%	98.8%	96.8%	**Vacancy :** - 3.67wte Band 5 **Sickness Rate:** 1.56% **Action taken:** Recruitment ongoing with Rotational posts introduced. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	93.2%	91.4%	94.7%	102.2%	**Vacancy:** Band 5 3.68wte, band 2 3.18wte **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Band 2 posts recruited to via central recruitment. Sickness being managed in line with Trust policies.
Ward C22	83.8%	115.6%	100%	138.7%	**Vacancy :-** Band 5 0.54 wte Band 2 3.5 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	93.2%	123.4%	87.9%	106.9%	**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	97.5%	87.7%	100%	100%	**Vacancy :** - 2 wte RN 4wte HCA vacancies **Action taken**: - Recruitment plan in place, with a number of staff recently recruited to the vacancies awaiting start dates. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	89.3%	102.6%	100%	103.2%	**Vacancy :-** 1.0 Band 5, 1.0 band 2 **Action taken:** - Staffing reviewed daily against acuity and activity.
Ward B18	81.9%	97.4%	72%	120%	**Vacancy :** -1.0 wte band 7, 3.0wte band 5 2 5.5 wte band 2 **Action taken:** - Recruitment ongoing, band 2 posts recruited to via central recruitment, band 7 post recruited to awaiting start dates. staffing reviewed on daily basis by matron and ward manager
Ward B19	97.4%	103.1%	100%	96.8%	**Vacancy :** -2.0wte RN and 2.76 wte HCA , recruitment process underway. **Action taken:** - all vacancies filled awaiting start date Ward reviewed daily for acuity and staffing.
Ward A7	81.1%	96.4%	92.7%	126.2%	**Vacancy :** B5 1.0wte 2.61wte band 2 **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway.
ACCU	83.3%	99.6%	94.2%	100%	**Vacancy :** B5 4.72 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
ICU	90.1%	76.3%	92.2%	50%	**Vacancy :** – 4.5wte band 5 **Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. Recruitment plan in place

3. ASSURANCE COMMITTEE

The monthly staffing report is received at the Strategic People Committee

4. RECOMMENDATIONS

Board asked to recommend and note the contents of this report

Kimberley Salmon-Jamieson
Chief Nurse and DIPC
March 2019

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/39**			
SUBJECT:	**Safe Staffing Assurance Report**			
DATE OF MEETING:	29 May 2019			
AUTHOR(S):	Rachael Browning, Associate Chief Nurse, Clinical Effectiveness			
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**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

NAME OF COMMITTEE

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/05/39

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 April 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 April 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 data at the start of the financial year for April 2019 demonstrating a Trust overall position of 7.6.

Chart 1 – CHPPDD 2019

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

Key Messages

Although some areas are above the 90% fill rate 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 and retention remains a priority for the senior nursing team. Further recruitment events planned for both registered nurses and health care assistants.

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

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

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

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months.

Additional bed capacity continues be used to support the winter operational pressures in the Trust, Ward K25 (19 beds) is currently being used as an additional ward and Ambulatory Care (16 beds) on occasions is being used as an inpatient overnight facility, both these areas 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 April 2019 we have reported 9 category 2 pressure ulcers on wards A2, A5, A6, A7, A9 x3, B12 and ITU, which is an increase in previous months. Each of these cases are currently being investigated, with additional support and training for these wards. There has been 1 patient fall with catastrophic harm on AMU. An SI investigation is underway.

Infection Incidents
No cases of MRSA bacteraemia have been reported in April 2019

No cases of MSSA bacteraemia reported in April 2019.

Appendix 1		MONTHLY SAFE STAFFING REPORT – April 2019															
Monthly Safe Staffing Report – April 2019																	
	Day		Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	CHPPD			
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	Overall
		= above 100%		= above 90%			= above 80%			= below 80%							
DD	SAU	840	832	652.5	585	99%	89.7%	0	0	0	0	-	-				
DD	Ward A5	1782.5	1345.5	1426	1437.5	75.5%	100.8%	1069.5	1058.5	1069.5	1126	99%	105.3%	959	2.5	2.7	5.2
DD	Ward A6	1782.5	1449	1246	1295.5	81.3%	90.8%	1069.5	1035	1069.5	1104	96.8%	103.2%	959	2.6	2.5	5.1
DD	Ward B4	774	662	673	673	85.5%	100%	184	126.5	218.5	138	68.8%	63.2%	30	26.3	2.7	53.3
DD	Ward A4	1667.5	1351.3	1426	1391.5	81%	97.6%	1069.5	1035	1069.5	1035	96.8%	96.8%	960	2.5	2.5	5.0
MSK	Ward CMTC	966	940.5	713	696	97.4%	97.6%	598	598	345	345	100%	100%	224	6.9	4.6	11.5
MSK	Ward A9	1725	1536	1380	1318.5	89%	95.5%	1035	1035	1380	1380	100%	100%	939	2.7	2.9	5.6
W&C	Ward B11	2783.2	2806.4	1337.5	1342.1	100.8%	100.3%	1596	1596	392.8	417.8	100%	106.4%	340	12.9	5.2	18.1
W&C	NNU	1725	1572.5	345	253	91.2%	73.3%	1725	1368.5	345	276	79.3%	80%	172	17.1	3.1	20.2
W&C	Ward C20	1012	1069.5	690	655.5	105.7%	95%	690	448.5	-	-	65%	-	406	3.7	1.6	5.4
W&C	Ward C23	1380	1134	690	578	82.2%	83.8%	747.5	724.5	690	655.5	96.9%	95%	323	5.8	3.8	9.6
W&C	Birth Suite	2415	3088.5	345	305	127.9%	88.4%	2415	2079.5	345	230	86.1%	66.7%	246	21.0	2.2	23.2
UEC	Ward A1	2250	1875	1862.5	2225	83.3%	119.5%	1575	1564.5	1260	1050	99.3%	83.3%	976	3.5	3.4	6.9
UEC	Ward A2	1380	1289	1460.5	1347	93.4%	92.2%	1035.9	1069.5	1219	1092.5	103.2%	89.6%	868	2.7	2.8	5.5
IM&C	Ward C22	1140	985.5	1035	1151	86.4%	111.2%	690	690	690	1035	100%	150%	630	2.7	3.5	6.1
IM&C	Ward A8	1380	1320	1380	1432	95.7%	103.8%	1432	1432	1035	1264	100%	122.1%	1020	2.7	2.6	5.3
IM&C	Ward B12	1035	980.5	2415	2073.5	94.7%	85.9%	690	690	1725	1667.5	100%	96.7%	630	2.7	5.9	8.6
IM&C	Ward B14	1380	1331	1380	1253	96.4%	90.8%	690	690	1035	966	100%	93.3%	720	2.8	3.1	5.9
IM&C	Ward B18	1380	1081.9	1713.5	1467.5	78.4%	85.6%	1035	781.9	1368.5	1299.5	75.5%	95%	720	2.6	3.8	6.4
IM&C	Ward B19	1035	964.5	1380	1447.5	93.2%	104.9%	690	690	1035	1046.5	100%	101.1%	720	2.3	3.5	5.8
MC	Ward A7	1725	1455.7	1380	1269.5	84.4%	92%	1380	1322.5	1035	1138.5	95.8%	110%	990	2.8	2.4	5.2
MC	ACCU	2415	2279.5	1035	1063.75	94.4%	102.8%	1725	1713.5	1035	1035	99.3%	100%	702	5.7	3.0	8.7
MC	ICU	4830	4375.75	1035	868.25	90.6%	83.9%	4830	4243.5	1035	747.5	87.9%	72.2%	474	18.2	3.4	21.6

Appendix 2

April 2019 - Mitigating Actions

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

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3 and K25)

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
SAU	99%	89.7%	-	-	**Vacancy:** - band 5 1.0 wte **Sickness rate** 11.54% **Action taken:** - Attendance management policy followed. Vacancy filled awaiting start date
Ward A5	75.5%	100.8%	99%	105.3%	**Vacancy:** Band 5 3.54 wte band 2 2.48 wte **Sickness rate:** 6.10% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment plans in place
Ward A6	81.3%	90.8%	96.8%	103.2%	**Vacancy:** - Band 5 5.4 wte Band 2 1.53 wte **Sickness rate** – 13.81% **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 plan in place
Ward B4	85.5%	100%	68.8%	63.2%	**Vacancy**: band 6 1.20wte band 5 2.01wte band 2 1.74wte **Sickness rate** – 12.45% **Action taken:** Daily staffing review against acuity and activity. Recruitment plan in place. Sickness absence reduced in month and being managed in line with Trust policy.
Ward A4	81%	97.6%	96.8%	96.8%	**Vacancy:** - Band 5 3.92 wte band 2 0.49 **Sickness rate** – 4.51% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward CMTC	97.4%	97.6%	100%	100%	**Vacancy:** all vacancies filled – awaiting start dates **Sickness rate –** 5.27% **Action taken**: All vacancies filled and awaiting start dates. Sickness absence being managed in line with the Trust policy.

Ward A9	89%	95.5%	100%	100%	**Vacancy:** band 5 – 4.09wte band 2 5.58wte **Sickness rate** – 5.72% **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy. All vacancies filled and awaiting start dates.
Ward B11	100.8%	100.3%	100%	106.4%	**Vacancy:** all vacancies filled **Sickness Rate:** 4.78% **Action taken:** - recruitment process in place. Staffing reviewed daily and support provided if necessary.
NNU	91.2%	73.3%	79.3%	80%	**Vacancy rate:** 1.0wte band 5 **Sickness Rate:** 5.35% **Action taken:** sickness is managed via the Trust policy. Staffing reviewed daily and support provided if necessary. Recruitment process in place
Ward C20	105.7%	95%	65%	-	**Vacancy: :** 1.67wte band 2 1.03 wte **Sickness rate** – 3.84% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. RN vacancies filled. Sickness is being managed in line with Trust policy.
Ward C23	82.2%	83.8%	96.9%	95%	**Vacancy:** band 5 0.45 wte **Sickness rate** – 5.9% **Action taken:** all vacancies filled. Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness is being managed in line with Trust policy.
Delivery Suite	127.9%	88.4%	86.1%	66.7%	**Vacancy:** - 0.45wte Band 5. **Sickness rate** – 4.69% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A1	83.3%	119.5%	99.3%	83.3%	**Vacancy :** - 8.67wte Band 5 **Sickness Rate:** 1.56% **Action taken:** All vacancies filled awaiting start dates Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	93.4%	92.2%	103.2%	89.6%	**Vacancy:** Band 5 3.68wte, band 2 3.18wte **Sickness Rate:** 6.98% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Band 5 recruitment plans in place. Band 2 posts recruited to via central recruitment. Sickness being managed in line with Trust policies.
Ward C22	86.4%	111.2%	100%	150%	**Vacancy :-** Band 5 0.54 wte Band 2 3.5 wte **Sickness Rate:** 6.97% **Action taken:** - All vacancies filled awaiting start dates. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A8	95.7%	103.8%	100%	122.1%	**Vacancy :** - band 5 – 4wte, band 2 4.0wte **Action taken:** Recruitment process in place with 2.0 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	94.7%	85.9%	100%	96.7%	**Vacancy :** - 1 wte band 5 4wte band 2 vacancies **Action taken**: - RN Recruitment plan in place, all band 2 vacancies filled awaiting start dates. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	96.4%	90.8%	100%	93.3%	**Vacancy :-** 1.0 Band 5, 1.0 band 2 **Action taken:** - recruitment plan in place Staffing reviewed daily against acuity and activity.
Ward B18	78.4%	85.6%	75.5%	95%	**Vacancy :** -3.0wte band 5 2 5.5 wte band 2 **Action taken:** - Recruitment ongoing, band 2 posts recruited to via central recruitment, staffing reviewed on daily basis by matron and ward manager
Ward B19	93.2%	104.9%	100%	101.1%	**Vacancy :** -3.0wte RN and 4.37 wte HCA , recruitment process underway. **Action taken:** - all vacancies filled awaiting start date Ward reviewed daily for acuity and staffing.
Ward A7	84.4%	92%	95.8%	110%	**Vacancy :** B5 2.61wte band 2 1.61wte **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway.
ACCU	94.4%	102.8%	99.3%	100%	**Vacancy :** B5 4.72 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
ICU	90.6%	83.9%	87.9%	72.2%	**Vacancy :** – 4.5wte band 5 **Sickness rate** – 9.86% **Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. Recruitment plan in place

3. ASSURANCE COMMITTEE

The monthly staffing report is received at the Strategic People Committee

4. RECOMMENDATIONS

Board asked to recommend and note the contents of this report

Kimberley Salmon-Jamieson
Chief Nurse and DIPC
April 2019

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 19/05/39 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29th May 2019

Date of Meeting	7th May 2019
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

The Quality Assurance Committee met on 7th May 2019. The following matters were discussed:

- An update on the implementation of additional cubicles was received;
- A Patient Story was received;
- An update was received on the CQC U&EC Quality Review and CQC inspection;
- The Committee reviewed the Committee Annual Effectiveness Survey
- The Committee reviewed the Quality Dashboard and associated KPIs;
- A HLB was received from the Patient Safety and Clinical Effectiveness Sub-Committee, the Safeguarding Sub-Committee, the Health and Safety Sub-Committee, the Complaints Quality Assurance Group, the Patient Experience Sub-Committee, the Infection Control Sub-Committee, the End of Life Steering Group & Strategy, 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 from Experience Quarter 4 report was received;
- Also received was the SI Lessons Learned Q3 & Q4 Audit Report
- The Director of Infection Prevention and Control quarter 4 report was received;
- The Medicines Management / Controlled Drugs Annual Report was received;
- The Learning from Deaths Review Q4 report was received;
- The Clinical Audit Quarter 4 report was received,
- The GMC Training Survey results (relating to safety) were presented
- The Dementia Strategy Q3, Q4 and Annual Reports were received;

- The Complaints Annual Report was received;
- The QIA Assessment and CIP Q4 report was presented;
- The Quality Account was presented.
- The Strategic Risk Register and Board Assurance Framework were reviewed and considered;

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/ 05/63	Action Log/Matters arising	• It was reported that the plan for implementation of additional cubicles is being worked through with Estates**.** • It was agreed that Maternity Quality of Care Indicator to be added to the IPR with Board approval.	Proposal for updated Quality Indicator to be made to Trust Board	**QAC July 2019**
QAC/19/ 05/65	Getting to Good (G2G) Steering Group update	<u>CQC Urgent & Emergency Services Report and Action Plan</u> • The Committee received and update on the U&EC Services Report and Action Plan. Improvement Committee (IC) is to be established, with oversight of Action Plan of Must and Should Dos, monitored through G2G. • The Committee received assurance that from a regulatory perspective, the staffing model was correct. • It was explained that a process had been put in place to ensure triage data was recorded correctly in department. • It was reported that Triage waiting times had improved • The Committee were informed that an ED Dashboard had been developed showing level of activity, demand and pressure hot spots, bed meetings had been increased to 2 hourly to support full utilisation in other departments. <u>CQC Inspection Informal Feedback</u> • The Committee received an overview of feedback received following the recent Unannounced visits to Halton and Warrington sites and the Well Led Inspection w/c 30	The Committee supported the establishment of an Improvement Committee and the Board are asked to note the update	**QAC July 2019**

		April. • It was explained that the CQC action plan will continue to be monitored through G2G with focussed areas to M2O.		
QAC/19/05/66	CQC Urgent + Emergency Services Report	The Committee did not receive assurance following the CQC Quality report relating to Urgent and Emergency Care and will escalate to the Trust Board	The Committee did not receive assurance and this will be escalated to the Board	**Trust Board May 2019**
QAC/19/05/68	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: • Slight increase in month of open incidents; however, overall reduction continues; • Small increase in outstanding complaints; • Friends & Family – A&E and UCC – 80% recommendation rate – 3% improvement on previous month; • Improvement in Mixed Sex Breaches due to improvement in data quality and the strengthening of the operational escalation process;	The Board will review the full IPR as part of the meeting today	**Trust Board May 2019**
QAC/19/05/69	High Level Briefing - Patient Safety + Clinical Effectiveness Sub Committee	The Committee particularly noted the following matters: • Update on the Cervical Screening Visit that took place in November 2018. Monitoring continue at Patient Safety & Clinical Effectiveness Sub-Committee and reporting to Quality Assurance; • Improvement reported in medication reconciliation.	Further updates to be presented at next meeting	**QAC July 2019**
QAC/19/05/70	High Level Briefing - Safeguarding	The following key points were noted by the Committee: • Safeguarding Training Adult level 3 compliance achieved. • Training and education pathway relating to MH Paediatrics underway.	Further updates to be presented at next meeting	**QAC July 2019**

	Sub Committee – March and April 2019	• Implications of closure of local Young People's unit highlighted, the Committee were advised that support had been offered by third sector partners		
QAC/19/05/71	High Level Briefing – Health and Safety Sub Committee (March) incl Sharps Audit	The Committee particularly noted the following matters: • Smoking survey by PHE full compliance achieving 7/7 standards. • Site car parking was discussed. • Increase in incidents relating to aggression reported in areas such as CAMHS. Additional Conflict Resolution Training provided for staff; • Discussion took place regarding the Mental Health First Aiders. It was confirmed over 100+ had been trained by the Stress Counsellor The Committee received an update on the Sharps Audit noting: • Of the 54 wards and departments visited, 26 areas were compliant. • Others areas were noted to be non-compliant for a number of reasons e.e no labels completed, temporary lids open. • Daniels Healthcare Limited to carry out a further in depth Sharps Audit 13-17 May 2019. • The individual action plans will be audited quarterly to continually monitor compliance. This will then be graded and each Ward/Department will know their level of compliance through a rag rated system.	The Committee were not assured following the Sharps Audit and will be escalated to the Board	**Trust Board May 2019**
QAC/19/03/72	High Level Briefing - Complaints Quality Assurance Group	The Committee escalated the following items: • There are 92 open complaints, with 0 over 6 months' old and 20 complaints that have breached their deadline. • Three PHSO cases resolved in the last quarter, leaving 4 currently open which are being tracked and monitored • Further support/training for CBUs to be carried out including reinforcing personal responsibility to try and resolve any complaints by telephoning patients before a formal complaint is lodged.	Further update to be presented at next meeting	**QAC July 2019**

QAC/19/03/73	High Level Briefing – Patient Experience Sub Committee:	The following key points were highlighted for the Committee to note: • A number of positive ward visits had been conducted by Healthwatch and Governors • Improvement in 2018 Maternity Survey Results • Improvement in A&E and UCC Friends and Family • Friends & Family Test - one third fewer text messages sent by external company due to national technical error. Assurance from external company that processes now in place to mitigate further risk occurring.	Members are asked to note the continued improvement in the survey results.	**Trust Board May 2019**
QAC/19/03/74	High Level Briefing Infection Control Sub Committee	The following key points were noted by the Committee: • Above trajectory for CDiff. Weekly meetings continue to monitor and learning shared through CBU Govenance meetings. • CDiff annual threshold increased from 26 to 44 with changes to apportionment algorithm	Further update to be presented at next meeting	**QAC July 2019**
QAC/19/03/75	High Level Briefing – Risk Review Group March 2019	The following key points were highlighted for the Committee to note: • Screening Service and Colposcopy action plan, assurance provided that robust monitoring system in place to de-escalate risk. • A risk was highlighted relating to a gap of an IT Manager in Pathology. It was reported to the group reported that plan in place to identify resource within the current Pathology team. • Critical systems, progress report requested at next Risk Review Group which will be reported to QAC through the HLB report in July.	Further update to be presented at next meeting	**QAC July 2019**
QAC/19/03/76	GPDR action plan Information Governance + Corporate Records High Level Briefing	The following key points were noted by the Committee: • Brexit continuity plans continue no indication that key IT systems have data flows from the EU or data stored in data centres will be affected. • 2 incidents reported to NHS Digital highlighted, one reported externally and reported to the ICO	Further update to be presented at next meeting	**QAC July 2019**

QAC/19/03/77	High Level Briefing End of Life Steering Group	The Committee particularly noted the following matters: • New electronic palliative care co-ordination system, being developed with CCG and Trust IT department. • Continued vacant Palliative Care Medical Consultant post. The Committee were advised that the job description had been revised and will be advertised imminently. • Final EoL Strategy to be presented to the July QAC	Further update to be presented at next meeting	**QAC July 2019**
QAC/19/03/78	High Level Briefing Quality Academy	The following key points were highlighted for the Committee to note: • 300 staff had been trained and Practitioner QA level training commenced. • 2 Clinical Fellows for R&D and Innovation recruited to support research. • Co-hosting QA summit on 21 June where Innovation Hub will be launched.	Further update to be presented at next meeting	**QAC July 2019**
QAC/19/03/79	Maternity Update/Maternity Safety Champion update	The Committee particularly noted the following matters: • ATAIN action plan – full compliance reported including 6% reduction by 2020 in NNU term admissions. • MSDS Data Quality – compliance achieved for March 2019	Further update to be presented at next meeting	**QAC July 2019**
QAC/19/03/80	Learning from Experience Q3 Report	The Committee noted the following matters: • Reporting of SI investigations increased in Q4 • Security - MH incidents, increase in reported incidents in paediatrics • Increase in incidents in Radiology • Increase in Moderate Harm incidents in Q4 • SHMI/HMSR Amber, within expected range. • February saw the highest number of SIs declared in the quarter with 3 incidents relating to delays in treatment. These incidents have been identified following a look back at a number of trauma incidents. A review of trauma pathways and education is being undertaken to address these incidents and further updates will be provided in subsequent meetings	The Committee received good assurance and all matters continue to be monitored closely across several meetings and Sub-Committees. Trauma will be monitored through PSCESC	**QAC July 2019 &**

			and QAC	
QAC/19/03/81	SI Lessons Learned Audit Q3 and Q4 Report	The Committee noted the following matters: • Q3 and Q4 learning audited, 104 actions relating to RCA investigations reviewed, 95% compliance with evidence that action had taken place or was partially compliant	Further update to be presented at next meeting	**QAC July 2019**
QAC/19/03/82	DIPC Q4 Report	The following key points were highlighted for the Committee to note: • National Increase in Gram negative, the Trust is not an outlier. • Focus in Q4 in A&E, assurance that environmental issues highlighted in audits had been addressed. •	Further update to be presented at next meeting	**QAC July 2019**
QAC/19/03/84	Learning From Deaths Q4 Report	• Assurance provided that all deaths are scrutinised through MRG and SJRs governance processes. • SJRs – no cases of avoidable harm in Q4 to date, 2 outstanding SIs subject to inquest	Further update to be presented at next meeting	**QAC Sept 2019**
QAC/19/03/87	Dementia Strategy Annual Review and Q3 Quarterly Report	The Committee noted the following: • Screening assessments – consistently achieved above 90%, increase in dementia training • Dementia Strategy to be refreshed • Trust wide work plan for Delirum being developed which will include training	Further update to be presented at next meeting	**QAC July 2019**

QAC/19/ 03/88	Complaints Annual Report	The Committee received the Complaints Annual Report that highlighted: • 455 complaints received during reporting period, a decrease of 1 from 2017-18 • Themes highlighted included clinical treatment and Attitude and Behaviour, • Decrease in PALs activity correlating with additional training to support local resolution of concerns at source.	Further Complaints updates to be provided in the next LFE report	**QAC Sept 2019**
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 two risks were de-escalated from the BAF, but would be tracked through the risk management processes; • It was agreed that the rating of one risk currently on the BAF was reduced; • 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**

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CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/03/39 d	**COMMITTEE OR GROUP:**	Finance & Sustainability Committee	**DATE OF MEETING**	20 March 2019

Date of Meeting	20 March 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/19/03/41	Corporate Performance Report	• February A&E performance is 75.84% which continues to be low but is in line with other local providers • Diagnostics, RTT and Cancer targets for January met • Super stranded numbers are creeping up after a reduction over winter, 110 average per day with LOS greater than 21 days • B3 remains open while alternatives are discussed, the Trust has invoiced accordingly • Discussed the position of 4 hour target across the whole of the North and why the North East are performing better.	The Committee reviewed, discussed and noted the report.	FSC April 2019
FSC/19/03/46	Urgent Treatment Centre	• The Committee received a presentation on the UTC Tender, noted the contribution to overheads. Further clarity on Widnes figures and contribution values will be produced before presenting to Trust Board	Noted the progress and supported presenting to the Trust Board.	Presentation to Trust Board March 2019

FSC/19/03/37	Pay Assurance Dashboard Monthly Report	• Total pay spend in February 2019 was £14.6m against a budget of £14.7 of which £2.6m was temporary staff – note escalation beds and facilities are having significant impact on this. • Agency is £1.2m in month, an increase of £0.4m on last month which relates to late January invoices, VAT and CBU issues. • Feedback from Premium Pay Spend Review group including discussion on the recent MIAA review of compliance to the overtime policy. • Employer contribution increase was discussed in detail and the increase from 14.3% to 20.6% will be funded centrally but will have implications for some staff members. Concerns on cashflow were raised.	The Committee reviewed, discussed and noted the report.	FSC April 2019
FSC/19/03/38	Terms of reference and cycle of business	• Minor changes noted	The Committee approved the changes	FSC March 2020
FSC/19/03/39	Risk Register	• No other additions to BAF this month • Changes in current risks noted	The Committee reviewed, discussed and noted the report.	FSC April 2019

FSC/19/03/40	Key Performance Indicators / Performance Assurance Framework	• Changes to the PAF noted • Discussion about the timeliness of data and fitting with the Committee and Trust Board timetable	The Committee noted the changes to the PAF	FSC March 2020
FSC/19/03/42	Monthly Finance report	• The year to date deficit is £18.5m. The year to date control total deficit excluding PSF is £21.6m which is £0.4m over plan. • The position includes £1.3m non recurrent support from the fire • The use of Resources rating has improved to a score of 3 • CIP is £2.0m behind plan • PSF included excludes A&E monies. • The loan due to be repaid has been extended to November 2019 • Agency is higher in month as discussed in pay assurance • The proposed changes to the capital spend were agreed • There are still risks in the position but it is anticipated that the Trust will achieve the control total.	The Committee reviewed, discussed and noted the report and the financial challenges faced.	FSC April 2019
FSC/19/03/46	Sexual Health Tender	• The Committee received a presentation on the Sexual Health Tender. • Noted the contribution to overheads, further work to understand current contribution and risks required • Contract to work with other providers is still to be developed • Understanding of future efficiencies and CIP required	The Committee supported the tenders for Board approval	Executive Meeting 21 March 2019 and Trust Board 27 March 2017
FSC/19/03/43	Medical staffing review	• The Committee discussed the report which was shared following detailed spreadsheet last month • Focus on next steps and potential impact on cost pressures	The Committee discussed the data presented and agreed to review in 6 months.	FSC 6 monthly review
FSC/19/03/44	CIP allocation	• Reviewed the suggested methodology of the CIP allocation for	The committee supported the	Trust Board

	2019/20	2019/20 based on reference cost. • Methodology supported although further refinement of the data was required	methodology	March 2019
FSC/19/03/45	Capital	• Capital update was noted and draft capital plan was supported. • Concerns on the lack of capital resource was discussed	The committee noted the paper	FSC April 2019
FSC/19/03/47	Update on Operational Plan 2019/20	• Discussion of process so far and next steps including taking revised options back to Executive and Final Plan to Board. • Challenge of CIP level and investment in cost pressures	Committee noted the challenge, the need for a realistic plan and the risk of not accepting the Control Total.	Executive 21 March 2019 and Trust Board 27 March 2019
FSC/19/03/48	Key issues for escalation	• Risk with forecast outturn • Impact of Employers contribution increase to cash flow • Performance data to Committees and Board needs to be timely, the number of committees and when they are scheduled are not always compatible which may lead to the data being out of date by the time of the meeting.		

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NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/05/39 d	**COMMITTEE OR GROUP:**	Finance & Sustainability Committee	**DATE OF MEETING**	29 May 2019

Date of Meeting	30 April 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/19/04/52	What should FSC focus on in 2019/20	• Break out into 3 groups • Focus on:- • Pay – enhanced work usage and rates use C&M rates to monitor against • Pay – monitor keep within agency target • Pay – Managers who frequently do paperwork later to be held to account • Activity recovering market share • Financial impact of quality failings with indicative costs • Benefits realisation • Early review of opportunities	The Committee discussed ideas and suggestions.	FSC May to July 2019
FSC/19/04/53	Pay Assurance Dashboard Monthly Report	• Total pay spend in March 2019 was £16m against a budget of £14.9m of which £1m was temporary staff – £11.4m YTD 31% above ceiling peers are 10.4% in Model Hospital • Bank £1.2m in March £11.9m YTD	The Committee reviewed, discussed and noted the report.	FSC May 2019

		• Agreed total spend will be broken down for ease to compare with Model Hospital. • Checklist reviewed with 9 of the 10 ambers due to be resolved • Sickness levels noted through UoR questioning will be monitored through Strategic People Committee		
FSC/19/04/54	Risk Register	• No additions to BAF linked to strategic objective 3 this month • Risk 145 updated for future Women's and Children's provision	The Committee reviewed, discussed and noted the report.	FSC May 2019
FSC/19/04/55	Chairs Annual report	• Noted		FSC April 2020
FSC/19/04/56	Committee annual effectiveness survey	• Noted		FSC April 2020
FSC/19/04/57	Corporate Performance	• February A&E performance is 79.36% which continues to be low but is in line with other local providers. April looking like 80 – 81% • Diagnostics, RTT and Cancer targets for February met • Super stranded numbers for March 114 average per day with LOS greater than 21 days, home for Easter saw us reduce to 100 • Discussed the Warrington A&E was commissioned for circa 200 attendance but the Tuesday after bank holiday was 300 attends with great mix of ambulance attends • Ambulance Handover is improving	The Committee noted the report.	FSC May 2019

FSC/19/04/58	Monthly Finance report	• Received overview of the year from rejecting the initial control total to obtaining a bonus at the end of the year. • Year end position excluding impairments and control total adjustments £15.0m deficit against budget £16.9m deficit. • As a result of the year end position and bonus not all of the £16.8m loan was required, discussed option to pay an element back • Further discussion on what the bonus should be spent on. • Market assessment work is ongoing, targeted work with GPs – Pats team responsible for marketing • Agency is a priority for 2019/20	The Committee reviewed, discussed and noted the report and the financial challenges faced.	FSC May 2019
FSC/19/04/59	CIP and unfunded cost pressures 2019/20	• Reviewed the revised CIP Target still using the methodology based on reference cost as agreed at March FSC. • Discussed additional CIP of £500k on sickness • Discussed the unfunded cost pressures and process to monitor • Agreed monthly update to FSC	The committee supported the increase in target and monthly reporting of CIP and Unfunded cost pressures.	FSC monthly update May 2019
FSC/19/04/60	Tariff update	• Paper discussed including profile of payments of MRET, FRF and PSF and the targets set to access the funds.	The Committee noted the paper	No further update
FSC/19/04/61	Key issues for escalation	• New areas highlighted for FSC focus in 2019/20 • Agency on going challenge to work within the target • A&E delivery and challenge of managing the peaks		

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NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/05/39 d	**COMMITTEE OR GROUP:**	Finance & Sustainability Committee	**DATE OF MEETING**	29 May2019

Date of Meeting	22 May 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/19/05/66	Pay Assurance Dashboard Monthly Report	• Agency is 3.4% above ceiling in April due to escalation beds, plans in place to close K25 on 6th June • Simon is reviewing Medical and dental vacancies monthly to support reduction in agency / locums • B3 is still open impacting on use of agency but overall appointed 45 nurses to start before end September. HCA vacancies down to 30 • Sickness levels, recruitment, retention all improving • Focusing on centralised booking and rate card utilisation for nursing. Temporary staffing is being looked at through the Collaboration at Scale team across the whole of Cheshire and Mersey • Reduction in consultant PAs and willingness to undertake WLI due to pension changes was discussed at length	The Committee reviewed, discussed and noted the report.	FSC June 2019

FSC/19/05/67	Risk Register	• Reviewed the report • Discussed the suggestion to deescalate the Brexit risk until there is clarity on situation	The Committee reviewed, discussed and noted the report.	FSC June 2019
FSC/19/05/68	Corporate Performance	• April A&E performance is 82.03% May is currently 81.45% • Diagnostics, RTT and Cancer targets for February met with exclusion of Breast due to patient choice of 7 patients • 62 day achieved every month for 2018/19 • Super stranded numbers for April 104 average compared the April 2018 163 • Discussed the actions following the CQC report on A&E • Discussed the CCG view on bring Warrington patients back to Warrington	The Committee noted the report.	FSC June 2019
FSC/19/05/69	Monthly Finance report	• M1 is on plan and assumes £0.9m PSF, FRF and MRET • Discussed the risk in the position including CIP not being achieved the overspend on Agency • Discussed the reduction in Elective against both plan and same period last year which will be monitored through FRG • Discussed the sustainability contract including Stroke • Discussed 121 • Supported changes to the Capital plan • Noted the approval of 2 items of urgent capital • Discussed the expiring loans of £14.2m and £7.9m • Escalation from FRG re taxation/pension issue which has potential to impact on staffing resources – a review is underway led by Human Resources	The Committee reviewed, discussed and noted the report and the financial risks.	FSC June 2019
FSC/19/05/70	National cost	• Process and timetable reviewed and approved	The Committee approved the	FSC August

	collection		report	2019
FSC/19/05/71	CIP and unfunded cost pressures 2019/20	• Reviewed the limited progress from April Committee but discussed the progress reported at Mondays FRG • Agreed to continue monthly update to FSC in format presented today	The Committee noted the report and emphasised the need for pace.	FSC monthly update June 2019
FSC/19/05/72	Combined finance report	• Paper discussed outturn, issues with CCG over performance on other contracts and future reporting	The Committee noted the paper	Quarterly update for July 2019
FSC/19/05/73	Outputs from priority discussion	• Reviewed outputs and noted teams to be invited back in October	The Committee noted the outputs	FSC October 2019
FSC/19/05/74	Key issues for escalation	• Agency on going challenge to work within the target • Impact of Pension changes on Trust • De-escalation on Brexit risk		

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM 19 05 39 e	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29th May 2019

Date of Meeting	**Monday 26th April 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/19/04 /27	Update from Chairs of Quality Assurance (QAC), Strategic People (SPC) and Finance + Sustainability (FSC) Committees	• Quality Assurance Committee – The Committee received report and action plan on 'R' Codes to continue monitoring if this is a coding issue	The Audit Committee noted the update	**n/a**
AC/19/04 /28	Changes or updates to the BAF	The Committee received the following update: • 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. The Committee received assurance that the mechanism for escalating	Actions to be completed in the Quality Assurance Committee	**Quality Assurance Committee May 2019**

		risk to the BAF supported immediate escalation if necessary.		
AC/19/0211	Progress Report on Internal Audit Follow-Up Actions to 31 December 2018	The Committee particularly noted: • Overtime Payments Review – Limited Assurance Concern was expressed that the process and policy was not always implemented and followed correctly by managers. It was agreed that the Chair of the Committee would email the Chief Nurse, COO and Director of HR & OD to support moving to conforming to policy and procedure of pre-approval. Updates would be reported to both TOB and FSC. • Bank & Agency (Medical Locum) Review – Moderate Assurance • Data protection & Security Toolkit review – Moderate Assurance	The Committee noted and discussed the report and requested that updates on OT Payments should to be reported to TOB & FSC	**Audit Committee, TOB and FSC ongoing**
AC/19/04/30	Head of Internal Audit Opinion	The Head of Internal Audit provided an **overall opinion** for the period 1st April 2018 t0 31st March 2019 of **Moderate Assurance** It was highlighted that the overall opinion of moderate assurance was reflective of the Trust requesting reviews of challenging and complex areas.	The Audit Committee noted the update	**Audit Committee ongoing**

AC/19/04 /32	Assurance Framework	It was reported that the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.	The Audit Committee noted the update	**Audit Committee ongoing**
AC/19/04 /35	Counter Fraud Annual Report 2018-19	The Committee the Counter Fraud Annual Report and particularly highlighted the following: • Submission of the self-assessment against the NHS Counter Fraud Authority (CFA) standards for providers resulted in an overall rating of **GREEN.**	The Audit Committee noted the update	
AC/19/04 /36	Counter Fraud Work Plan 2019-20	The Committee approved the Counter Fraud Work plan	The Committee approved the Counter Fraud Work plan	
AC/19/02 10	Review of Quotation and Tender Waivers	The Committee particularly noted: • In the quarter there had been 17 waivers at a value of £821,991. • In the quarter there were 13 quotation waivers (none were greater than £40k) and 4 tender waivers (3 were greater than £80k). • In comparing the period 1st June 2018 to 31st March 2019 to 1st June 2017 to 31st March 2018 the waivers reduced from 84 to 61, the number of retrospective waivers reduced from 54 to 22 and the value reduced from £5.0m to £2.7m (46% reduction).	The Audit Committee noted the update	**Audit Committee August 2019**

AC/19/04 /39	2018-19 Going Concern Report	The Audit Committee reviewed and approved the report and supported recommendation for the accounts to be prepared on the going concern basis and that the accounts include the statement in Section 7 of the report.	The Audit Committee approved the report.	
AC/19/04 /43	GDPR Action Plan and Risk Register update	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 November Audit Committee	**Audit Committee November 2019**

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/42**	
SUBJECT:	**Learning from Experience Report - Q3 2018/19**	
DATE OF MEETING:	29 May 2019	
ACTION REQUIRED	**Note the report**	
AUTHOR(S):	Ursula Martin, Director Integrated Governance + Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT	The following report relates to implementation of the Trust's Learning Framework.	
EXECUTIVE SUMMARY (KEY ISSUES):	This is the quarterly integrated "Learning from Experience" (LFE) report. It focuses on the learning from incidents, complaints, claims and inquests over Quarter 4, 2018/19 (July - September).	
RECOMMENDATION:	The Board is asked to; • Note and approve the contents of the report • Receive assurance that the Learning from Experience process continues within the organisation. • The presentation of the data is included within the slide deck provided.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality + Assurance Committee
	Agenda Ref.	
	Date of meeting	April 2019
	Summary of Outcome	Assurance provided
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report Q2	AGENDA REF:	BM/19/05/42

1. BACKGROUND/CONTEXT

This report relates to the period 1st January 2019 to end March 2019. It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) and includes incidents, complaints, claims and inquests. The report includes a summary of key issues identified in Q4 and makes specific recommendations in respect to the findings, which will be followed up in the next report.

The purpose of the report is to:

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

2. KEY ELEMENTS

2.1 Issues for Assurance:

- There was an increase in incident reporting within the Trust in Q4 (2501 in Q3 vs 2651 in Q4)

- The 'Reporting to Improve' campaign continues across the Trust and will continue to be highlighted in 19/20.
- The Trust reported 311 incidents as open in CBUs in Q3. In Q4 (to date) that has further reduced to 216 due to the focus of managers on investigating and closure.
- Halton UCC has seen a significant decrease in the reporting of staffing issues in Q4.

- There are no complaints over 6 months old and there was an increase in complaints closed in the Trust in Q4 (102 in Q4 V 95 in Q3). - The complaints action plan continues to be progressed to ensure that delays in responding and meeting deadlines are monitored and addressed by the CBUs.

- There was a decrease in the number of complaints received Q4 compared to Q3 regarding clinical treatment (overall increase). Concerns include inadequate follow up care, pc nursing care and concerns regarding clinical treatment whils patient is waiting for discharge etc. Medical Care, Digest Diseases and Diagnostics and Out-patients saw a decrease the number of complaints received in Q4.

- Regular Internal quality audits of the complaints process a taking place within the complaints team to measure compliance against policy and auditing of actions from complaints takes place to ensure that they have made the desired change.

- As part of the mortality review process the majority of Structure Judgement Reviews conducted in Q4 have found that our overall standard of care is rated as “Good” or “Excellent.” There was has been ‘no poor or very poor ‘ratings for Q4 to date.

- There were 392 non clinical incidents reported in Q4 Security incidents = 117 and Infrastructure/Health and Safety incidents = 122- Discussion of lessons learned have been taken through the Health, Safety and Wellbeing Sub Committee. Due to the increase in incidents relating to patients who have mental health needs, a task and finish group, Managing Patients with Clinically Challenging Behaviour has been convened to review policies, procedures and training in place to ensure staff have the right skills to keep patients and themselves safe.

2.2 Items escalated to Quality Assurance Committee

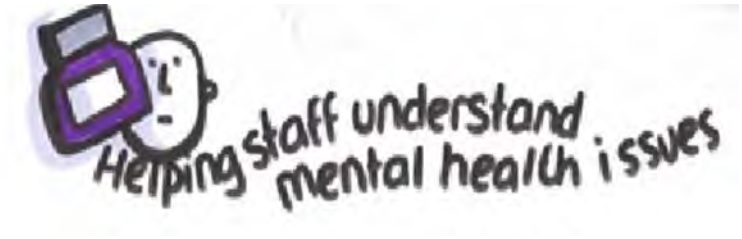
- There was an increase in incidents causing Moderate to Catastrophic harm in Q4 (35 in Q3 vs 48 in Q4), but the Trust continues to review information from a number of resources including complaints, claims and mortality review.

- Incidents relating to staffing and clinical care decreased in Q4; however, those relating to pressure ulcers and medication increased and with 1 SI commenced in Q4 related to a Grade 3 pressure ulcer.

- Patient falls incidents are highest on C21 the Winter Ward (opened on 28/12/2018) in Q4. Falls continues to be monitored on a daily/weekly and monthly basis at Patient Safety & Effectiveness Sub Committee. Phase two of the Falls Collaborative is being launched, with the Quality Academy on 24th May. The innovation wards are A1, A4, A7, A9, B19, which represents some of our highest risk regarding falls.

- A&E Majors and Resuscitation areas along with A2 have seen an increase in reporting in Q4-work is also underway to look at incidents relating to triage. February saw the highest number of SIs declared in the quarter with 3 incidents relating to delays in treatment. These incidents have been identified following a look back at a number of trauma incidents- A review of trauma pathways and education is being undertaken to address these incidents and further updates will be provided in the months ahead.

- The management and care of young patients with mental health problems is an emerging issue both in ED and paediatrics. Review of recent incidents has identified the need to address how these young patients are assesses and care for and paediatrics are making some specific changes.



- There had been several incidents where requests for Radiology examinations had been made for the incorrect patient. Although some of these were near misses, several patients received an unintended radiation dose, which was reportable to the CQC IR(ME)R team. A number have required RCA investigations. Radiology are encouraging all staff to talk to their patients about why they were at the hospital and what examination they were expecting to have to highlight any incorrect referrals, using a prompt ‘What’s brought you to the hospital today?’ in each x-ray room. Along with a Trust wide safety alert they have introduced a training session about the Radiology Department at medical induction, to include how to avoid incidents of this type.

- A number of obstetric ultrasound appointments had been booked outside the recommended timescales (as determined by the foetal abnormality screening programme). These were found to be partly due the booking process, which used an ‘obstetric calculator wheel’ which can be inaccurate to a day or two. Radiology and the Booking service have introduced an Excel based ‘obstetric calculator’ which has been made available to all members of the Booking team with a training session.

The calculator provides a very accurate method of determining the exact date when each scan needs to be performed.

- There has been a moderate harm incident where an inpatient was administered a methotrexate overdose due to methotrexate being prescribed daily instead of weekly on their prescription chart. Methotrexate dosage errors can result in serious adverse reactions, including death. Advice/ guidance are being reviewed by Pharmacy and training has also been delivered along with a Trust wide safety alert.

- The Information Governance Team identified that the Antenatal screening QA assessment was submitted to Public Health England containing 14 dates of birth which are person identifiable information. As a result all documents being sent to PHE are to be thoroughly checked by the Antenatal team for any embedded documents which may contain patient identifiable information (PII) and any further embedded documents are checked. PHE system is a secure IT platform and any documentation with personal identifiers is deleted by the PHE QA advisor and the Trust is notified.

- There was an increase in complaints opened Trust wide in Q4 (122) V 97 in Q3). Some CBUs saw an increase in the number of complaints received in Q4 (Urgent & Emergency Care, Integrated Medicine & Community, Estates and Facilities, and Women and Children's Services).

- The PHSO has commenced 1 investigation into the Trust in Q4; however, they are provisionally proposing to investigate 2 complaints. The PHSO closed 2 investigations during Q4.

- In Q4 payments for claims settled with damages totalled £253.910.38 (including costs). W&C, MSK, UEC and DD CBUs have the highest number of actual and potential claims. Claims Governance Group will continue to review and advise on the Trust claims profile.

- Quarter 4, identified that lack of a DNACPR order continues to be the largest trigger for SJR. This will explain the themes around a lack of earlier recognition of end of life. There were 24 triggers identified in the reviews.

- SHMI and HSMR, although within the expected range, are both showing signs of deterioration. Analysis of 2018/19 data is underway in relation to learning from all deaths within the Trust and this will be reported in both the Q4 Learning from Deaths report and the annual Quality Account.

2.3 Learning from investigations that has been communicated to staff from Q4

- SOPs and protocols for management of Primary Percutaneous Coronary Intervention must be adhered to during emergency situations.
- Clear communication of information between the Trust and external clinicians is an important and key issue in all patient referrals and transfers.

- If an SOP/ guideline requires updating or modifying, then this must be addressed at a suitable time, through the appropriate CBU channels and not in an emergency situation.
- Staff must complete an individualised falls care plan to facilitate appropriate falls prevention measures for their patients and complete the falls risk assessments every 7 days or where there is a change in the patient's condition.
- All staff must document contemporaneous patient assessments and plans, to be clear regarding the direction of patient care.

- Staff must remain in enhanced bays at all times or alert colleagues to changes if required to support a patient within the enhanced bay for continued supervision.
- Raise awareness with staff that certain medical devices can cause pressure damage and ensure that advice is sought from the specialist team when managing a patient with a medical device. Seek advice from the Tissue Viability team.
- Importance of effectively communicating the risk of skin/ tissue breakdown following admission to the Trust.
- Awareness and education needs to be addressed in relation to the risks of neurological limb deficit resulting in pressure ulcers.
- A pressure relieving mattress must be put in place following a high waterlow risk assessment without delay.
- Adult patients who require a Thomas splint (following certain types of fracture of the upper leg) as part of their treatment will be now be cared for on Ward A9 to ensure specialist care can be provided.
- The use of different means of documenting information regarding a patient's treatment and care prevents a full picture of the patient's progression being viewed by clinicians.
- The non-recording on radiology reports of normal variants prevents clinicians from comparing their changes.
- Not physically seeing a patient in ED but working from the clinical history and x-ray prevents the clinician from having the opportunity of discussion with the patient and their family to provide a more complete picture and to document their findings and considerations.

- Children with significant injury such as comminuted fractures, fracture displacement or complex fractures should have an early referral to the local physiotherapy service if not Alder Hey. The local physiotherapy service must have a low threshold for referral onwards if things are not progressing as planned.
- Recovery diaries should be issued to the patient by the physiotherapy team to allow all staff treating them to view their progress.
- A standardised universal handover question asked by all consultants of all juniors at the end of a clinic i.e. 'Are there any patients or decisions which you feel a little unsure of or would like to discuss with me?' May highlight any instances where healing is not following the expected trajectory.
- If advice is received from a specialist centre, it is crucial that it is not only documented but referred to and communicated by clinicians further on in the patient's journey.
- A patient discharged from hospital without a definitive diagnosis should always have a clinical plan working towards making a diagnosis and not be left for the general practitioner to sort out. This includes making cross specialty referrals.
- Clinicians should be alerted to changes or development of symptoms and signs over time, with a view to reconsidering a diagnosis.
- No matter how senior a clinician is who has reviewed a patient, it is always right to question a diagnosis or action if the clinical picture does not appear to fit.
- A Datix incident should be raised at the time of an incident or within 24 hours of it happening to allow appropriate and timely investigation.
- Urgent escalation for resuscitation should occur immediately (regardless of DNACPR status) for any patient where occlusion of the airway due to food/ FB is suspected or identified.

- Providing a thorough induction and orientation to the patients and the ward is essential for all temporary staff.
- Maintaining key skills and attending annual training for resuscitation is essential for all clinical staff.

- Clear and contemporaneous documentation of care plans and treatment is essential to support effective communication and handover.
- The SOP for Management of patients with dysphagia (Swallowing Difficulties) when Speech & Language Therapy (SALT) is not available will be converted to policy and will be ratified via the Clinical Policies Group and place on the Hub.
- Processes for monitoring heparin infusions on the ICU are underway and staff have been required to complete the competencies related to this.
- Radiology is developing a pathway on escalation regarding cancellation for imaging for acutely unwell patients.
- Radiology to raise awareness of rare pathologies as a cause of common presentations and the importance of escalation to specialist clinical teams if no improvement of symptoms after standard care.

- ICU are developing a pathway and audit to ensure that multidisciplinary input occurs for patients commencing haemo-diafiltration and will include the role and responsibilities for a pharmacist when providing this treatment.
- The process for validating and reporting positive MRSA results over the weekend and during the bank holidays is under review to make it safer and easier to monitor.
- Clinicians need to seek outstanding infection control screening results as a priority.
- The Interventional Radiology team are reviewing the skin preparation processes in conjunction with the Infection Control team.
- Improvements need to be made to completion of the Interventional Radiology Care Pathway.
- Ward staff need to complete the observations as required for a post IR procedure as they would a post-operative patient and VIP charts need to be completed and monitored in line with Trust Policy.

3. Recommendation

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/43**			
SUBJECT:	**Infection Prevention and Control**			
DATE OF MEETING:	**Wednesday 29 May 2019**			
AUTHOR(S):	Lesley McKay Associate Chief Nurse for Infection Prevention and Control/Associate DIPC			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse/DIPC Choose an item.			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services			
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 4 (Q4) of the 2018/19 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. The Trust reported:- • 13 E. coli bacteraemia cases in Q4. The Trust has reported 49 cases for the financial year and is above the planned annual trajectory (30 cases) by 19 cases • Nil return for MRSA bacteraemia in Q4. 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 Q4. The Trust has reported 15 cases for the financial year There is no national reduction target • 5 Clostridium difficile cases in Q4. The Trust has reported 27 cases for the financial year. The Trust is above the annual threshold by 1 case Overall compliance for attendance at mandatory infection control training is 90%. Urgent and Emergency Care and Digestive Diseases CBUs are just below the 85% compliance threshold and have plans in place to improve compliance.			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The Board is asked to note the contents of the report, exceptions highlighted and progress made.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/19/05/82		
	Date of meeting	7 May 2019		
	Summary of Outcome	Submit to Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

SUBJECT	Infection Prevention and Control	AGENDA REF:	

1. BACKGROUND/CONTEXT

This report describes the overview of infection prevention and control activity for Quarter 4 (Q4) of the 2018/19 financial year (FY) and a summary of the year end position. The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets, learning from incidents and an update on activity for audit, education, surveillance and policy reviews.

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

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

There is a national ambition to reduce gram-negative bloodstream infections (GNBSIs) by 50% by March 2021. The initial focus is on E. coli bloodstream infections as these organisms represent a large proportion (55%) of all GNBSIs.

2. KEY ELEMENTS

HCAI data

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

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	J	A	S	O	N	D	J	F	M	Total
C. difficile	≤26	Over trajectory	2	2	3	1	5	4	4	1	0	3	0	2	**27**
MRSA bacteraemia	Zero tolerance	Over trajectory	1	0	0	0	0	0	0	0	1	0	0	0	**2**
MSSA bacteraemia	No target	No target	1	1	5	1	1	0	2	1	0	2	0	1	**15**
E. coli bacteraemia	10% reduction	Over trajectory	1	6	5	5	6	6	4	1	2	6	4	3	**49**
Klebsiella spp. bacteraemia	10% reduction	Over trajectory	1	1	0	0	0	4	2	1	0	3	1	1	**14**
P. aeruginosa bacteraemia	10% reduction	Over trajectory	1	1	1	0	1	0	0	0	1	0	0	0	**5**

Breakdown by ward is included at appendix 1. Comparative data across the northwest in included at appendix 2.

Clostridium difficile

- 5 hospital onset cases reported in Q4. The trust is 1 case over the annual threshold at 27 cases
- All 22 cases from Q1 – Q3 were assessed for lapses in care by the CCG review panel who concluded: 16 unavoidable, 4 avoidable and 2 undetermined cases
- Cases for Q4 will be assessed in May 2019 by the CCG review panel
- 1 period of increased incidence noted on ICU in March (2 cases). Ribotyping results have shown a unique strain (not previously seen in this Trust) for 1 case and C. difficile was not recovered from the

second case. No crossover (separate areas within ICU) between the cases was identified and the cases are not thought to be linked

Additional actions have been implemented including: enhanced environmental hygiene using chlorine based disinfectants and Matrons and Lead Nurses are supporting peer challenge in relation to hand hygiene practices. Daily antibiotic ward rounds are conducted on ICU.

The Chief Nurse/DIPC chairs a meeting weekly, where HCAI investigation reports are reviewed. Learning from these meetings is shared with clinical teams via CBU Governance meetings. Action taken as a result of these meetings includes the Chief Nurse/DIPC raising antibiotic prescribing concerns directly with consultants where justification for non-compliance with the Trust Antibiotic Formulary is not provided.

Bacteraemia Cases

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- A nil return was submitted for Q4

For the 2018/19 financial year the Trust has reported 2 hospital onset cases. Both cases underwent a post infection review. Case 1 occurred on ward A7 in April 2018 and findings suggested the patient was admitted with this infection, which was undetected due to a delay in blood culture sampling. A comprehensive incident investigation has been completed. Additional training has taken place with the Emergency Department to support timely blood culture sampling. The Urgent and Emergency Care CBU are reporting 71% of staff in the Emergency Department are trained in this clinical skill, which should support timely sampling.

Case 2 occurred on ward A4 in December 2018 and findings showed a laboratory system issue whereby the positive MRSA screen was not reported timely, resulting in a delay in prescribing skin suppression treatment. The Microbiology Laboratory Manager has implemented an additional step in the result validation process to ensure timely reporting to the Infection Prevention and Control Nurses and provided further training to laboratory staff. A comprehensive incident investigation is in progress.

Both these incidents were related to delays in either sampling or reporting of results and were not associated with poor patient care.

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 3 hospital onset cases in Q4
- 15 hospital onset cases for the financial year
- A4 had the highest number of cases. No recurring themes were identified in relation to primary source
- No national reduction target/threshold

Areas for care improvement have been noted from root cause analysis investigations in relation to cannula management.

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 13 hospital onset cases in Q4

- 49 hospital onset cases for the financial year

Klebsiella Spp.

- 5 hospital onset cases in Q4
- 14 hospital onset cases for the financial year

Pseudomonas aeruginosa

- 0 hospital onset case in Q4
- 5 hospital onset cases for the financial year

National data shows a 6 - 8% year on year increase in Gram Negative Blood Stream Infection, with a higher number of cases over summer months. Within the Trust the GNBSI reduction group has been established to tackle this issue. The GNBSI reduction action plan has been revised and is working in partnership with the Quality Academy. The newly appointed Quality Improvement Practitioner is supporting Quality Improvement training at ward level and tests of change have commenced on wards A7, A8 and ICU. These include a focus on patient hydration and patient hand hygiene and the introduction of sub-glottic suctioning in ICU (for patients on ventilators).

A review of the Safety Thermometer data has highlighted the Trust is above the national average for the proportion of patients with a urinary catheter. In 2018 the national average urinary catheterisation rate was 12% – 14 %; the Trust catheterisation rate ranged between 17% – 21%. Actions implemented in Q3 to review and challenge urinary catheter use on a daily basis continues. Feedback on this activity is positive and urinary catheters are being removed appropriately. The safety thermometer data will be used to measure reduction in catheterisation rates and prevalence surveys are being used to monitor and ensure continuous improvement.

Comparative data on HCAI cases and rates across the Northwest is included in appendix 2. Appropriate comparison with other similar Trusts (local delivery system partners), over the financial year shows similar case numbers and rates per 100,000 for C. difficile and MRSA and a significantly lower number of cases and rate for E.coli and Klebsiella spp. than one of our Local Delivery System partners.

Outbreaks

Norovirus

- In Q4 Norovirus was detected on 7 wards AMU, A2, A6, A7, B19, C21 and ACCU
  - Wards A2 and A7 had single cases that were effectively isolated
  - Wards C21, A6 and ACCU were partially closed
  - Ward AMU and B19 were fully closed

Table 2: Norovirus incidents by month

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Outbreaks	0	0	0	0	0	0	1	0	4	0	1	6

Influenza

Uptake of influenza vaccination in the Trust was 87% for frontline staff, the second highest in Cheshire and Merseyside. During the influenza season (December to March) the Trust Microbiology Laboratory reported

154 positive influenza results. The Infection Control Team supported daily census reporting to NHSI, on laboratory confirmed inpatient cases, showing ICU admissions ranging from 0 – 5 patients daily and other wards combined 0-14 inpatient cases daily. Due to the high number of cases admitted to the Trust, it was necessary to close bays with confirmed cases on wards AMU, A2 A7 and C20. Influenza exposed patients were reviewed and where appropriate given antiviral prophylaxis.

Surveillance Systems

To support improvements in surveillance, a meeting has been held with the Laboratories IT system company. There are a number of control measures currently in place to provide surveillance including: local databases for alert organisms (those microorganisms with a potential to cause outbreaks of infection) and HCAI cases and functionality to undertake a retrospective review of microbiology results. The risk register score has been reduced to 12.

A Registered Nurse with a Specialist Interest in infection control has been seconded to the Infection Control Team and completed data collection on surgical site infection for breast surgery, cholecystectomy and in Q4 C. section. Due to the success of this, a full time surveillance nurse post has been advertised. Surveillance will continue by the Registered Nurse with a Specialist Interest in the meantime and an agreed programme of surveillance of surgical site infection will be in place by June 2019.

Infection Prevention and Control Training

- Overall compliance is currently 90%

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

Infection Prevention and Control Audits

- A total of 7 audits were completed in Q4 with a focus on the Emergency Department. Findings are shown in Table 3

Table 3: Infection Prevention and Control Audit Results Q4

Ward	ED	AMU	ED Paed	ED Minors	ED Ambulatory	ED Majors	CDU
Environment	81%	81%	64%	56%	61%	55%	62%
Ward Kitchens	86%	86%	N/A	N/A	N/A	N/A	83%
Handling/Disposal of Linen	100%	100%	84%	100%	100%	89%	84%
Departmental Waste	100%	100%	100%	100%	100%	94%	94%
Safe Handling Disposal of Sharps	92%	92%	100%	100%	100%	92%	96%
Patient Equipment (General)	86%	86%	88%	89%	95%	74%	73%
Patient Equipment (Specialist)	100%	100%	100%	100%	100%	100%	100%
Personal Protective Equipment	100%	100%	100%	100%	100%	82%	75%
Short Term Catheter Management	100%	100%	100%	n/a	100%	100%	n/a
Enteral Feeding	100%	100%	N/A	N/A	N/A	N/A	N/A
Care of Peripheral Intravenous Lines	100%	100%	100%	N/A	100%	100%	100%
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	100%	100%	100%	100%	100%	100%	83%
Hand Hygiene	90%	90%	97%	97%	97%	88%	86%
Overall Compliance	95%	95%	93%	92%	95%	88%	85%

- Environmental concerns have been discussed at the IPC operational group and action taken by the Estates Department in partnership with ED to implement improvements including: flooring replacement, wall repairs and redecoration
- Audit reports are returned to Ward Mangers who are responsible for developing action plans to address areas requiring improvement. Action plans are monitored at the Infection Control Operational Group Meetings
- Ward kitchens have been added to the capital programme. Two kitchens per annum will be upgraded over the forthcoming years

Environmental Hygiene

- Cleanliness monitoring is carried out by the Facilities team
- A high number of terminal cleans including curtain changes and use of Hydrogen Peroxide Vapour were carried out in Q4
- Monitoring reports show overall compliance of 96 – 98% for domestic cleaning in high and very high risk areas

Infection Control Policies

Updated policies ratified by the Infection Control Sub-Committee in Q4 include:-

- Contractors information leaflet
- Viral Haemorrhagic Fevers Policy
- Isolation of Immunosuppressed Patients Guidelines
- Ward Closure Guidelines
- Major Outbreak of Infection Guidelines
- Waste Segregation, handling and disposal at ward/departmental level guidelines
- Blood Culture Sampling Policy
- Deceased Patient Infection Control Guidelines
- Influenza Guidelines
- Isolation Policy
- Spillage Guidelines

ANTIMICROBIAL STEWARDSHIP

- Quarterly point prevalence audit (February) showed overall compliance of 90% with the Trust's Antibiotic Formulary
- 7 wards had less than 90% compliance (A1, ACCU, A4, A6; A8; B12 B19). The audit results are reported directly to Consultants' in charge of patients', the Executive Medical Director and the Chief Nurse/DIPC for action
- Additional challenge has been implemented by the Chief Nurse/DIPC in response to findings from HCAI review meetings

The newly appointed Consultant Medical Microbiologists have commenced in post in February 2019. Job plans have been agreed and this will strengthen the existing antimicrobial stewardship agenda. Additional Antibiotic Ward Rounds are being undertaken.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Work continues to meet the recommendations of the external review of Infection Prevention and Control undertaken in 2018.

- The Infection Prevention and Control Nursing Team staffing review has been completed and surveillance Nurse Post has been advertised
- An E-Learning package for Aseptic Non-Touch Technique (ANTT) has been added to the E-Learning system. This will be in used in conjunction with implementation of annual competency assessments for staff undertaking procedures requiring ANTT
- A Ventilation Assurance Group is being established, to ensure there is effective management of all ventilation systems across the Trust. An external review of the theatre ventilation systems has been carried out by which showed the operating theatre ventilation systems do not conform to current Health Technical Memorandum guidance but does conform to earlier guidance and the air handling units will require replacement within the next five years. Remedial works have been carried out door seals and air balancing vents to improve air flow pressures
- The Infection Prevention and Control Strategy is due to be revised and work is in progress to engage staff, patients, carers, the public and stakeholders to produce and deliver a clear and agreed strategy aligned to the Trust foundations of Quality, People and sustainability and values.

4. IMPACT ON QPS

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

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

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2019/20 has been increased from ≤26 to ≤44 cases. The apportionment algorithm has changed (reduction in one day from admission i.e. samples taken from 3rd day of admission onwards will be apportioned to the Trust – previously this was from 4th day). Any cases arising within 28 days of a patient discharged will be classified as community onset/ healthcare associated and will also be apportioned to the Trust
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place
- Due to the increase in the number of GNBSI cases a 5% E. coli bacteraemia internal reduction target has been set as a priority within the Quality Strategy

Work streams will continue to:-

- Progress GNBSI reduction
- Reduce the incidence of Clostridium difficile infection
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing

- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Monitor invasive device management/bacteraemia reduction
- Roll out the ANTT E-Learning package and ANTT competency assessments
- Review infection control surveillance systems
- Support staff training in Infection Prevention and Control where compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Support assessment of decontamination standards
- Complete actions set following receipt of the report from the external review including review human resources for the Infection Prevention and Control Team
- Set up a surveillance programme linked to Getting It Right First Time

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

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

8. TIMELINES

2018/19 Financial Year

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

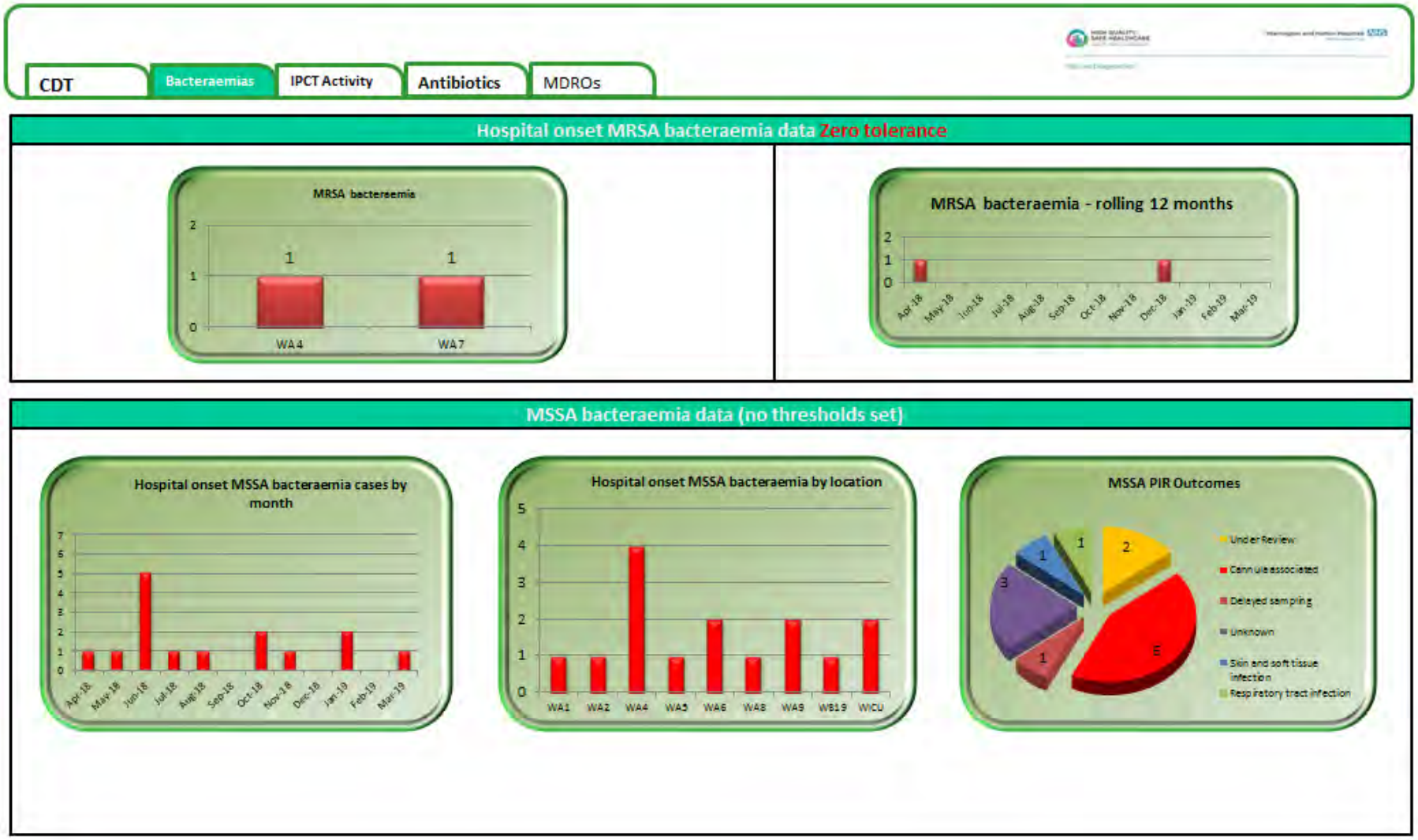
10. RECOMMENDATIONS

The Quality Assurance Committee is asked to note the content of the report, the exceptions reported and the progress made.

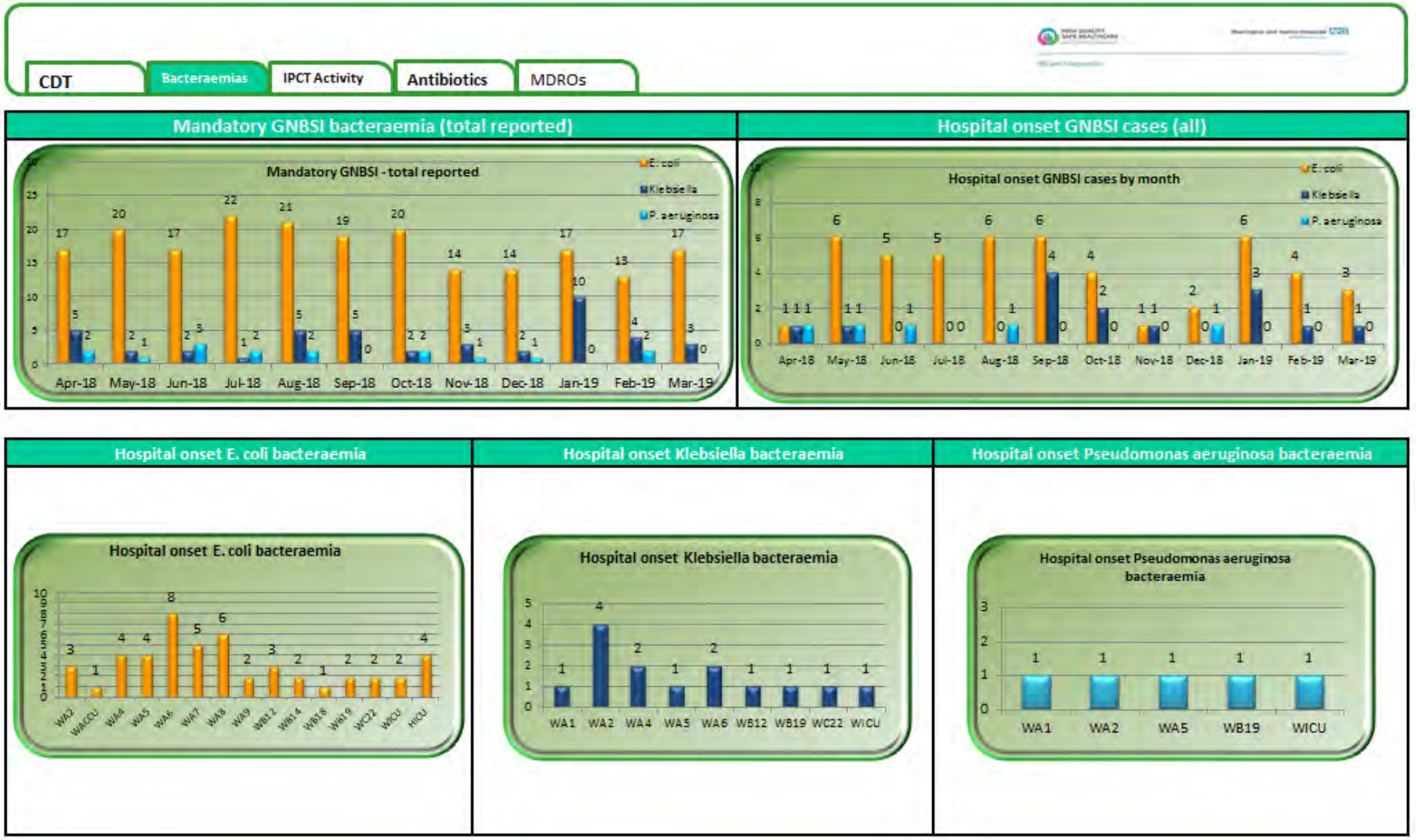
APPENDIX 1 HEALTHCARE ASSOCIATED INFECTION DATA 2018/19

Clostridium difficile Cases

Gram Positive Bacteraemia Cases



Gram Negative Bacteraemia Cases



APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST 2018/2019

Public Health England

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

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

Organisation Name	April 2018 to March 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	39	15.5
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.4
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	35	13.5
BOLTON NHS FOUNDATION TRUST	20	9.8
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	30	15.9
EAST CHESHIRE NHS TRUST	12	11.1
EAST LANCASHIRE HOSPITALS NHS TRUST	26	8.3
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	51	17.2
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	4.3
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	125	19.1
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	24	14.0
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	22	12.2
PENNINE ACUTE HOSPITALS NHS TRUST	40	10.3
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	35	13.1
SALFORD ROYAL NHS FOUNDATION TRUST	28	10.9
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	12	9.1
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	25	10.2
STOCKPORT NHS FOUNDATION TRUST	30	13.3
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	20	13.1
THE CHRISTIE NHS FOUNDATION TRUST	14	24.5
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	2	9.8
THE WALTON CENTRE NHS FOUNDATION TRUST	6	11.5
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	29	13.7
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	27	14.8
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	81	33.0
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	11	7.1
North West	747	13.9

Public Health England

MRSA annual tables: Trust cases & rates

MRSA: Trust Cases

Organisation Name	April 2018 to March 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	2	0.8
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0
BOLTON NHS FOUNDATION TRUST	1	0.5
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3	1.6
EAST CHESHIRE NHS TRUST	1	0.9
EAST LANCASHIRE HOSPITALS NHS TRUST	1	0.3
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	9	1.4
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	1.7
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	1	0.6
PENNINE ACUTE HOSPITALS NHS TRUST	3	0.8
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	2	0.8
SALFORD ROYAL NHS FOUNDATION TRUST	5	1.9
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0	0.0
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	1	0.4
STOCKPORT NHS FOUNDATION TRUST	0	0.0
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	6	3.9
THE CHRISTIE NHS FOUNDATION TRUST	1	1.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0	0.0
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	2	1.1
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4	1.6
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2	1.3
North West	47	0.9

Public Health England

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

MSSA: Hospital Onset Cases

Organisation Name	April 2018 to March 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	28	11.1
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	14	20.1
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	27	10.4
BOLTON NHS FOUNDATION TRUST	22	10.7
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	6.4
EAST CHESHIRE NHS TRUST	12	11.1
EAST LANCASHIRE HOSPITALS NHS TRUST	36	11.5
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	19	6.4
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	9	19.1
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.3
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	81	12.4
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	9	5.2
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	18	10.0
PENNINE ACUTE HOSPITALS NHS TRUST	24	6.2
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	31	11.6
SALFORD ROYAL NHS FOUNDATION TRUST	25	9.7
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	12	9.1
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	31	12.7
STOCKPORT NHS FOUNDATION TRUST	12	5.3
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	11	7.2
THE CHRISTIE NHS FOUNDATION TRUST	13	22.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	2	9.8
THE WALTON CENTRE NHS FOUNDATION TRUST	12	22.9
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	26	12.3
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	15	8.2
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	20	8.1
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	22	14.2
North West	545	10.2

Public Health England

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

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

Organisation Name	April 2018 to March 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	87	34.5
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	6	8.6
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	62	24.0
BOLTON NHS FOUNDATION TRUST	39	19.0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	33	17.5
EAST CHESHIRE NHS TRUST	13	12.0
EAST LANCASHIRE HOSPITALS NHS TRUST	66	21.1
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	67	22.7
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	7	14.9
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	7	25.7
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	148	22.6
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	28	16.3
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	30	16.6
PENNINE ACUTE HOSPITALS NHS TRUST	51	13.1
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	70	26.3
SALFORD ROYAL NHS FOUNDATION TRUST	53	20.6
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	31	23.6
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	62	25.3
STOCKPORT NHS FOUNDATION TRUST	38	16.8
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	24	15.7
THE CHRISTIE NHS FOUNDATION TRUST	33	57.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	6	29.5
THE WALTON CENTRE NHS FOUNDATION TRUST	10	19.1
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	42	19.8
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	49	26.9
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	52	21.2
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	28	18.0
North West	1142	21.3

Public Health England

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

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

Organisation Name	April 2018 to March 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	29	11.5
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	8	11.5
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	21	8.1
BOLTON NHS FOUNDATION TRUST	12	5.9
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	7	3.7
EAST CHESHIRE NHS TRUST	12	11.1
EAST LANCASHIRE HOSPITALS NHS TRUST	23	7.3
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	7	2.4
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	4.3
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.7
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	93	14.2
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	12	7.0
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	11	6.1
PENNINE ACUTE HOSPITALS NHS TRUST	28	7.2
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	26	9.8
SALFORD ROYAL NHS FOUNDATION TRUST	26	10.1
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	10	7.6
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	22	9.0
STOCKPORT NHS FOUNDATION TRUST	15	6.6
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	12	7.8
THE CHRISTIE NHS FOUNDATION TRUST	13	22.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	14.7
THE WALTON CENTRE NHS FOUNDATION TRUST	2	3.8
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	14	6.6
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	14	7.7
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	16	6.5
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	8	5.2
North West	447	8.3

Public Health England

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

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

Organisation Name	April 2018 to March 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	10	4.0
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.4
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	7	2.7
BOLTON NHS FOUNDATION TRUST	2	1.0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	5	2.6
EAST CHESHIRE NHS TRUST	5	4.6
EAST LANCASHIRE HOSPITALS NHS TRUST	8	2.6
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	9	3.0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	2.1
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.7
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	24	3.7
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	1	0.6
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	5	2.8
PENNINE ACUTE HOSPITALS NHS TRUST	2	0.5
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	2	0.8
SALFORD ROYAL NHS FOUNDATION TRUST	10	3.9
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	3	2.3
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	9	3.7
STOCKPORT NHS FOUNDATION TRUST	5	2.2
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	2	1.3
THE CHRISTIE NHS FOUNDATION TRUST	6	10.5
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0
THE WALTON CENTRE NHS FOUNDATION TRUST	1	1.9
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	9	4.2
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	5	2.7
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	7	2.8
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2	1.3
North West	142	2.6

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/44**			
SUBJECT:	Learning From Deaths Report Quarter 4 2018-19			
DATE OF MEETING:	29 May 2019			
AUTHOR(S):	Dr P Cantrell, Lead Clinician for Mortality H. McCaffrey, Head of Clinical Effectiveness & Quality			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Executive Medical Director/Deputy CEO			
LINK TO STRATEGIC OBJECTIVES:	Choose an item.			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	This briefing paper overviews Trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce Trust mortality rates and the Trust mortality ratio figures.			
PURPOSE: (please select as appropriate)	Information	Approval	To note	Decision
RECOMMENDATION:	Board is asked to note the contents of the briefing paper and discuss and approve the recommended options.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/ 19/05/84**		
	Date of meeting	7th May 2019		
	Summary of Outcome	For Assurance		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

SUBJECT	Trust Mortality

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

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

2.1 Structured Judgement Reviews

Particular groups of patients are reviewed at the MRG:

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

- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

Structured Judgement Reviews are presented to the MRG, an assessment of problems in care is made and any actions or lessons to be learned are sent to the appropriate fora.

2.2 Focused Reviews

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

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

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

2.3 Mortality Data Analysis

There are three main types of overall data used:

2.3.1 Crude Mortality Rates

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

2.3.2 HSMR (Hospital Standardised Mortality Ratio)

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

Adjustments are made for:

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

2.3.3 SHMI (Summary Hospital Mortality Indicator)

All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities.

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

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

3. MEASUREMENTS/EVALUATIONS

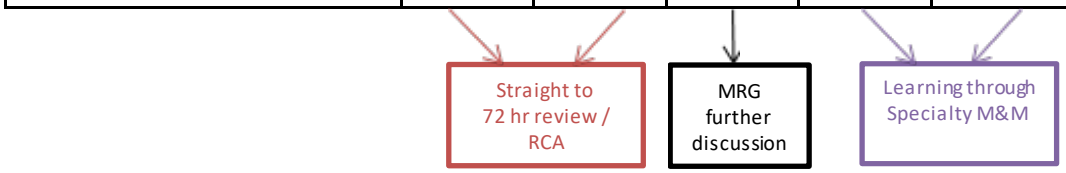
3.1 Structured Judgement Reviews

There have been **47** mortalities that have triggered a Structured Judgement Review by a member of MRG during Quarter 4. **30** Structured Judgement Reviews that been completed between January 2019 and March 2019.

3.2

3.2.1 Dashboard for Structured Judgement Review Ratings

Time Period	Overall Assessment Care Rating Following SJR					Total SJRs
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
Jan / Feb / Mar 19	0	2	6	17	5	30



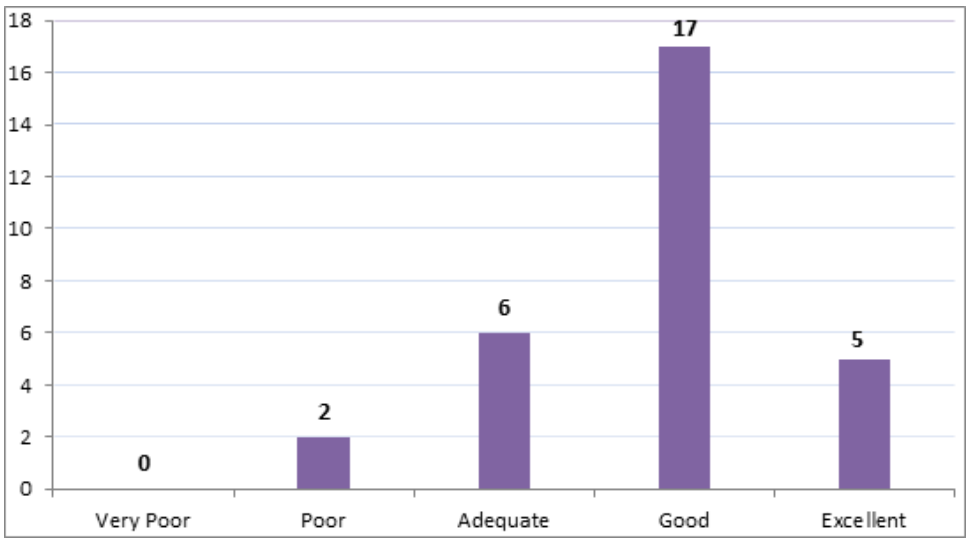


Figure 1: Overall Care Rating Following SJR January 2019 to March 2019.

3.1.2 Previous Quarter's RCA Outcome

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

The following data gives information for Quarters 1-4;

Quarter	Deaths subject to RCA which have concluded in Quarter
1 (2018/19	3
2 (2018/19)	5
3 (2018/19)	8
4 (2018/19)	6

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

The following cases were deemed as avoidable for Quarters 1 to 4;

STEIS Reference	INC Description	Avoidable
Q1 – There were no cases of avoidable harm.		
Q2		
2018/7418	The patient (a 66 year old female) underwent spinal surgery on 24/09/2015. The patient suffered a cardiac arrest during surgery and was resuscitated after 3 cycles of CPR. The patient was stabilised, the surgery was completed, and the patient was transferred to ITU. Following a 4 day stay on ITU, the patient sadly passed away.	Yes
Please note that one case which was previously deemed avoidable was since undeclared due to still births not been included in avoidable deaths statistics. This case was reported as a Serious Incident and investigated.		

Q3		
2018/19775	The patient was getting up from commode and back into bed when she grabbed for the chair to help her balance and then fell to the floor. The patient sadly hit her head as she fell. The patient was examined for any injuries and then assisted up off the floor and back into bed. Observations were commenced and ibleep created for review. Observations at this time were normal and an urgent CT head scan was requested. At 05:30 a met (Medical Emergency Team) call was put out at the patient's GCS dropped to 3/15. The CT scan of the patient's head shown a large subdural haematoma and the patient was noted to be showing signs of 'coning'. The decision was therefore made for palliative treatment as intubation is thought to be unlikely to change the patient's outcome.	Yes
2018/21090	Patient had a witnessed fall after attempting to stand up and mobilise from his chair without assistance and unfortunately lost balance and fell to the floor. A CT scan was requested and shown intraparenchymal haemorrhage within the right temporal lobe and an associated subdural haematoma along the right frontal, parietal and temporal regions.	Yes
2018/17592	The patient was admitted to hospital on 6/7/18 with abdominal pain. Reviewed by Consultant surgeon on 7/7/18 and CT scan performed. CT scan showed a small bowel perforation. Conservative management decided upon. The patient deteriorated around 21:00 on 7/7/18 and needed surgery. Another patient was in theatre until 00:45 on 8/7/18. Further review of the CT suggested evidence of significant fluid in the abdomen secondary to a small bowel perforation. On arrival in theatre at 02:20 the patient was severely unwell. Surgery performed and was admitted to ICU post-op but continued to deteriorate and died later on 8/7/18.	Yes
2018/19771	The patient was found collapsed with breathing difficulties. The patient was transferred from the Halton ward to the Warrington Emergency Department (ED). The patient was reviewed on arrival to ED by the consultant. Initial tests showed respiratory failure and appropriate treatment were commenced despite a poor prognosis for the patient. The patient was kept comfortable and sadly passed away in the department. Whilst an inpatient on the ward at Halton, it is thought that the patient had potentially been taking illegal substances on several occasions. On transfer to Warrington, it was noted that the patient had illegal substances on his possession.	*Subject to inquest
2018/23088	Patient was initially admitted with symptoms of being generally unwell for three days. Patient was treated with transfusions for thrombocytopenia and seen by the oncology team. Following this patient sustained a small intraparenchymal haemorrhage in the left temporoparietal region with an associated small left subdural haematoma following a fall on the ward.	Yes
Q4 - There were no cases of avoidable harm to date. However, 2 are awaiting Inquest.		
2018/26921	The patient had a past medical history of Alzheimer's disease, COPD, myeloma, hypothyroidism and a 6 month history of weight loss and was admitted through WHH ED under GP referral for overnight delirium suffering from hallucinations on 12/09/18 the patient was transferred to Halton with a plan for discharge. On the morning of 04/11/18, the staff nurse in charge of the patient's care	*Subject to inquest

	identified that the patient appeared drowsier. Medication had been taken, however the patient struggled to eat and began coughing when attempting to eat. On the afternoon of 04/11/18, an NHS Professionals (NHSP) Health Care Assistant (HCA) arrived on the ward to begin a shift and received handover and induction. The HCA was asked to assist the patient with eating. The patient was observed being assisted with feeding by the HCA, but when staff went into the bay (approximately 1-2 minutes later), the patient was found to have died and food was seen inside and around their mouth. The patient was DNACPR.	
2018/23091	The patient was found collapsed at home by his wife having fallen down the stairs after developing chest pain. An ambulance was called and the patient had a cardiac arrest in the ambulance. Resuscitation commenced and the NWAS team diverted to WHH Emergency Department (ED). On arrival at ED the Consultant made the decision that the patient needed to be transferred immediately to Liverpool Heart and Chest Hospital (LHCH) for Percutaneous transluminal coronary angioplasty (PPCI.) The patient was the taken to LHCH, but sadly died.	*Subject to inquest

3.1.3 Themes from Structured Judgement Reviews

Appropriateness of Care/End of Life Care

Appropriateness of Care, especially in relation to transition from active to end of life care was a recurrent theme throughout the SJR's during quarter 4. We reiterate the following actions that were also highlighted in quarter 3.

- **Action:** There is a new Rapid Discharge Home to Die Policy now on the Hub which provides staff with further guidance in relation to this topic.
- **Action:** Staff are being referred to the Amber Care Bundle on the Hub for further guidance.

Documentation – Retrospective documentation

77yr old female, admitted with chest pains who collapsed and although underwent extensive resuscitation, died in A&E.

- **Learning:** The notes in Lorenzo were predominantly retrospective. The aassessment could have been more thorough in relation to the patient's medical history as this would have prompted medical team input more promptly; although the outcome would not have changed.

3.1.4 Areas of Good Practice

Documentation and Co-ordinated teamwork between several specialties

Patient diagnosed with obstructing cancer that had surgery and was a patient on ICU for an extended period of time. The review completed for this case highlighted that the documentation by the consultant surgeon showed every key decision-making moment in this patient's journey, over several weeks, there were detailed notes and evidence of going the extra mile to ensure that communication was maintained with the patient and his family.

The ICU notes were thorough and detailed, and, even though the patient sadly died, this case was a good example of well co-ordinated teamwork between several specialties.

3.2 Focused Reviews

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

Diagnosis Group	Trigger	Observed deaths/ expected deaths	Date due for completion	Learning Identified
Intestinal Infections	SHMI	22/12	March 2019	Full report to be presented to Mortality Review Group in March 19; learning detailed below.

Intestinal Infections

Intestinal Infections triggered as an outlier for being statistically significantly high for SHMI within this group, over a 12 month rolling period; Jan 17 to Dec 17.

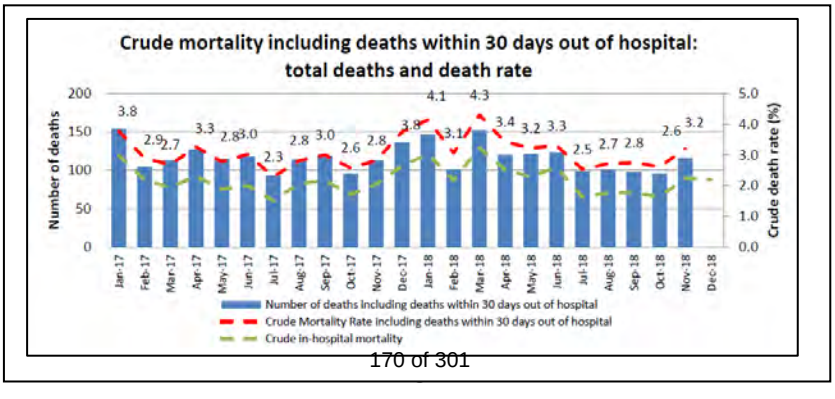
An overview of the 22 cases was conducted in November 2018 and a full report with actions and learning is due to be presented at the Mortality Review Group by March 2019.

Learning from this review showed that this group are patients who are admitted with a diagnosis of an Intestinal Infection, either due to a specific pathogen e.g. E- Coli (bacterial) or virus or NEC (Necrotising Enterocolitis) secondary to a pathogen. There is clearly quite a crossover between infective and Ischaemic colitis in this group of patients and in some cases the inability to make a definitive diagnosis of Ischaemic Colitis has resulted in the default diagnosis of 'infective' colitis.

Learning will be disseminated through the M&M meetings for each CBU.

3.3 Crude Mortality

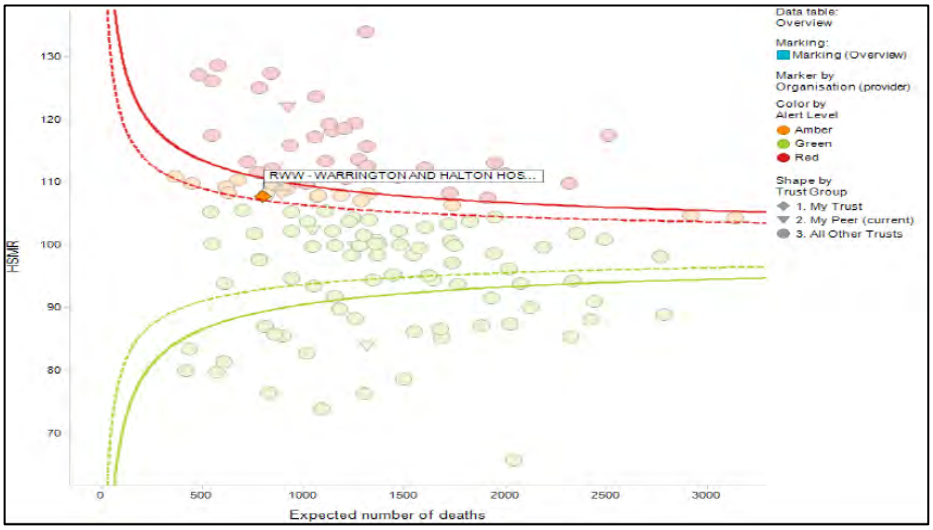
Crude mortality should be viewed with caution, as it does not take into account the complexities of the patients, but it is useful to monitor numbers of observed deaths. The data below shows Crude Mortality data from January 2017 to November 2018.



3.4 HSMR

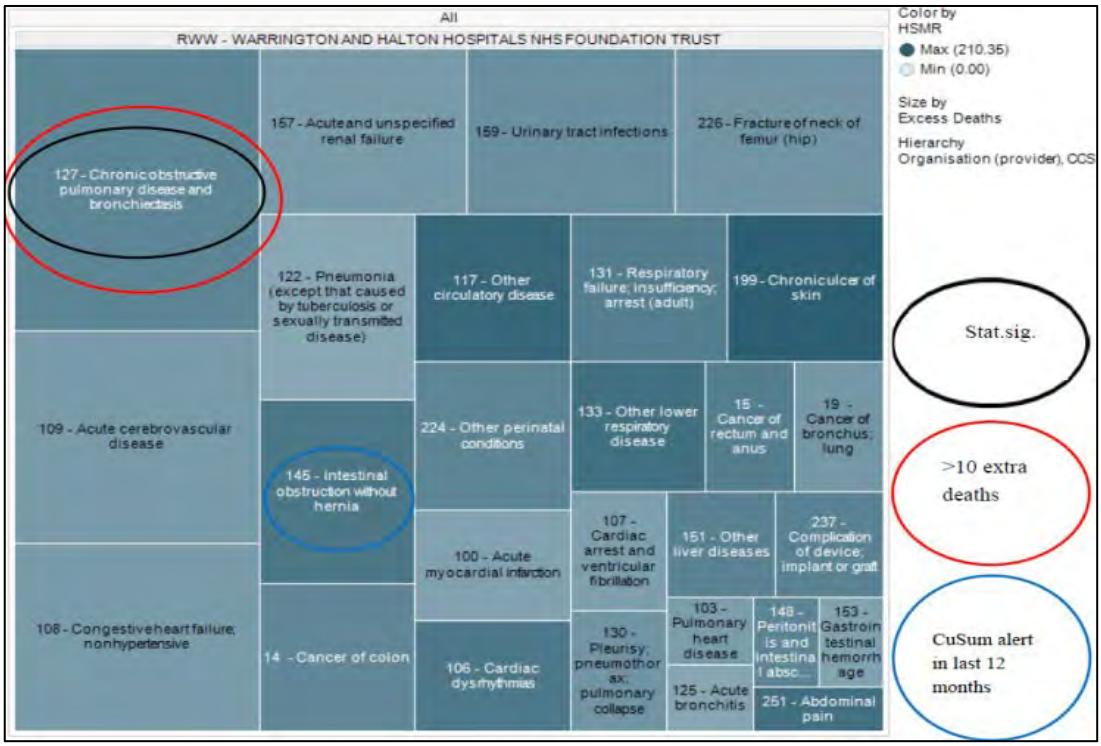
- **We are not a national outlier, with a HSMR of 107.70 for December 2017 to November 2018.**

Quarter 4 HSMR (December 2017 to November 2018):

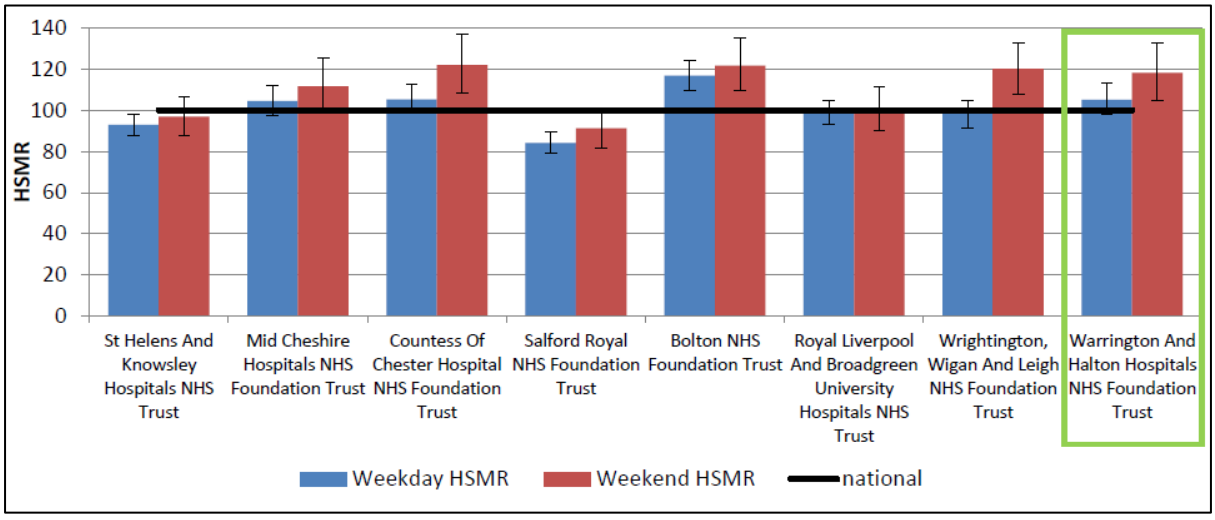


3.4.1 HSMR by diagnostic grouping

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



3.4.2 Weekend/Weekday HSMR

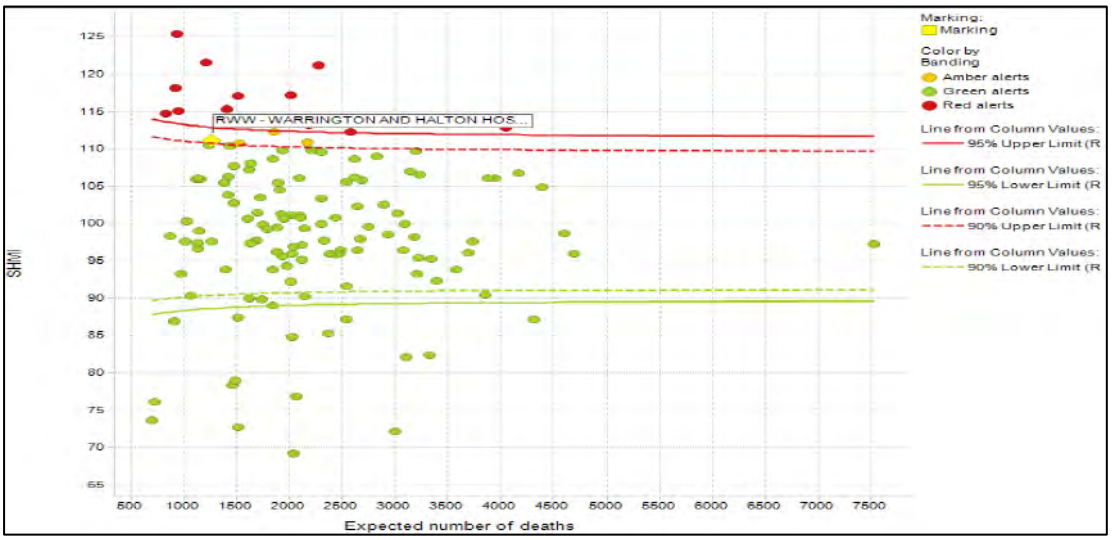


- This graph shows weekend HSMR is higher than weekday HSMR for Warrington over the last 12 months, and the weekend result is statistically significantly high.

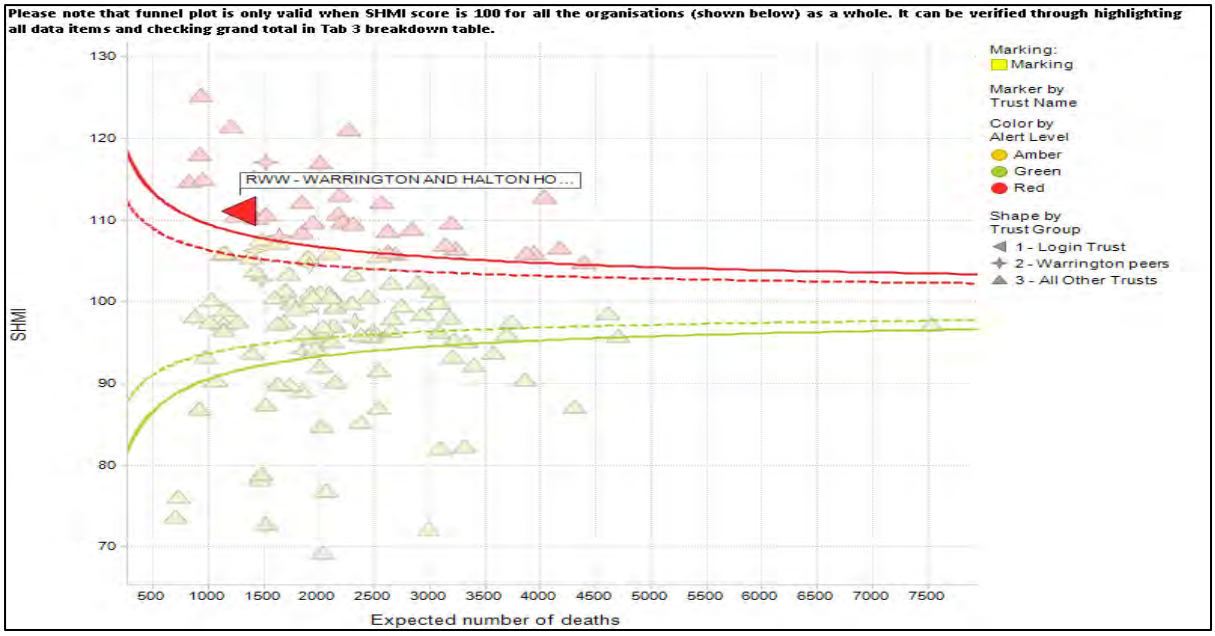
3.5 SHMI

The trust is given a 'green rating' for this indicator using the over-dispersion limits as reviewed by NHS Digital, with a SHMI of 110.23 for September 2017 – August 2018. This trust is not an outlier for the indicator on this basis. However, HED also uses a stricter 'early warning system' method using the Poisson distribution, and on this basis Warrington would be given a 'red rating' for this time period.

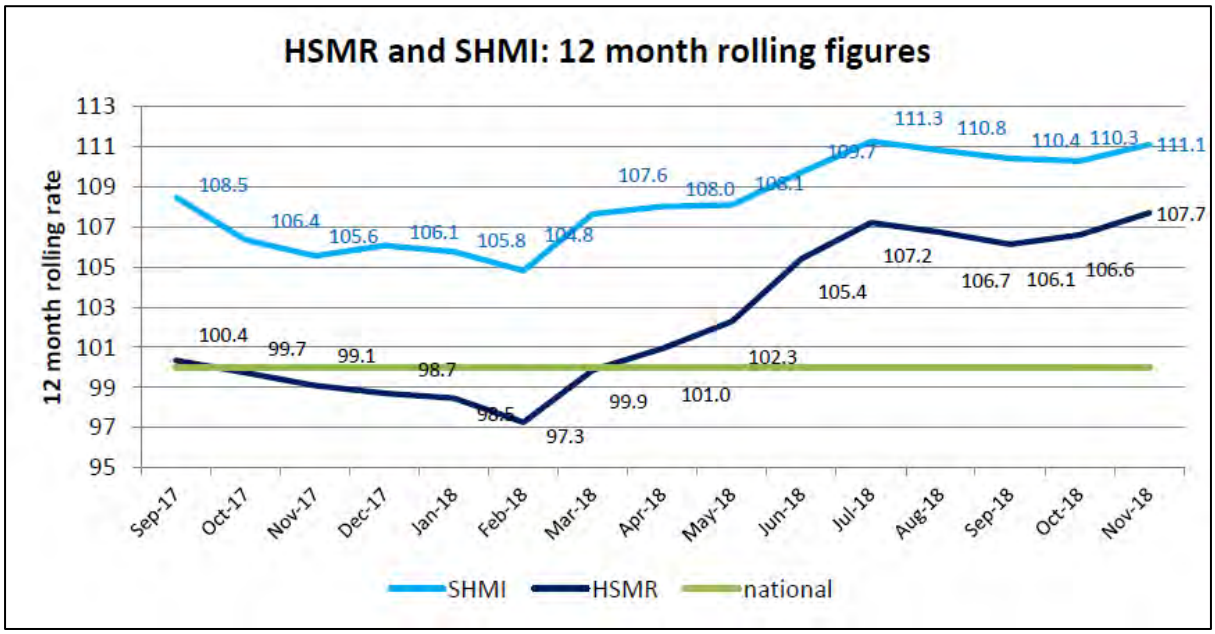
SHMI Funnel Plot (December 2017 - November 2018) (Over-dispersion funnel plot)



SHMI Funnel Plot (December 2017 - November 2018) (Stricter Poisson model)



12 month rolling HSMR & SHMI (September 2017 to November 2018)



3.6 Summary

- HSMR has been showing signs of deterioration, and both the standard 56CCS HSMR and the all CCS HSMR give an Amber warning for the period December 2017 – November 2018
- The latest figures of the weekend SHMI are slightly higher than the weekday SHMI figures, and both weekend and weekday results are statistically significantly high.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/45**			
SUBJECT:	**Annual Report Of The Senior Information Risk Owner**			
DATE OF MEETING:	29th May 2019			
AUTHOR(S):	Mark Ashton, Information Governance And Corporate Records Manager			
EXECUTIVE DIRECTOR SPONSOR:	Phillip James, Chief Information Officer			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
EXECUTIVE SUMMARY (KEY ISSUES):	The purpose of this report is to provide assurance that information risks are being managed effectively and that the SIRO is active and informed of key points: • Structure and governance • Audits and actions • Cyber security assurance • IG incident reporting and actions • DSPT compliance and plan • Data/cyber security risks and plan • SIRO decisions.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Board is recommended to note the information risk activities and assurances.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 40(2) – data protection			

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

May 2019

Annual Report of the Senior Information Risk Owner

Phill James, Chief Information Officer

Warrington and Halton Hospitals NHS Foundation Trust

Contents

1. Introduction

The ‘Review of Data Security, Consent and Opt-Outs 2016’ led by the National Data Guardian (NDG), Dame Fiona Caldicott, set out three Leadership Obligations and ten Data Security Standards that are applicable to all health and care organisations.

The Review made it clear that the NDG expects CEOs and Boards (and equivalent) of health and care organisations to put effective information risk management high on their list of priorities.

Organisations that have access to NHS patient information must provide assurances that best practice data security and protection mechanisms are in place. The Trust is contractually obliged to undertake Data Security and Protection Toolkit (DSPT) assessments on an annual basis. The DSPT assessments are supplied to NHS Digital and contribute to the Trust’s evidence base during the CQC Well Led Framework inspection of key line of enquiry (KLoE) 6-Information.

The purpose of this report is to provide assurance that information risks are being managed effectively. It is also designed to demonstrate that the SIRO is active and informed of plans to improve data security as per the requirements of domain 9.4 of the NHS Digital DSPT.

2. Structure and Governance

The Senior Information Risk Owner (SIRO) is an executive Board / senior management team member who is familiar with information risks and provides the focus for the management of information risk at that level. The Trust SIRO must provide the Trust Board with assurance that information risk is being managed appropriately and effectively across the organisation and for any services contracted for by the organisation.

Support for the SIRO (Chief Information Officer) and the Information Governance agenda more widely within the organisational structure is provided by:

- Caldicott Guardian (Deputy Medical Director / Chief Clinical Information Officer)
- Information Governance and Corporate Records Manager
- Head of Information/Data Quality (Deputy Director of IT)
- IT Manager
- Medico Legal/Claims (Subject Access requests under the Data Protection Act 2018 and requests made under the Access to Health Records Act 1990)

- Communications Team (Freedom of Information)

In addition, Information Asset Owners for IT systems containing person identifiable information have been identified. IAOs are responsible for ensuring that information within systems is managed in accordance with Information Governance policy and for mitigating any associated risks.

The Information Governance and Corporate Records Sub-Committee (herein after referred to as the IGCRSC) is accountable to the Quality Assurance Committee and is attended by the SIRO, Caldicott Guardian and Data Protection Officer (DPO).

The IGCRSC is tasked with ensuring that:

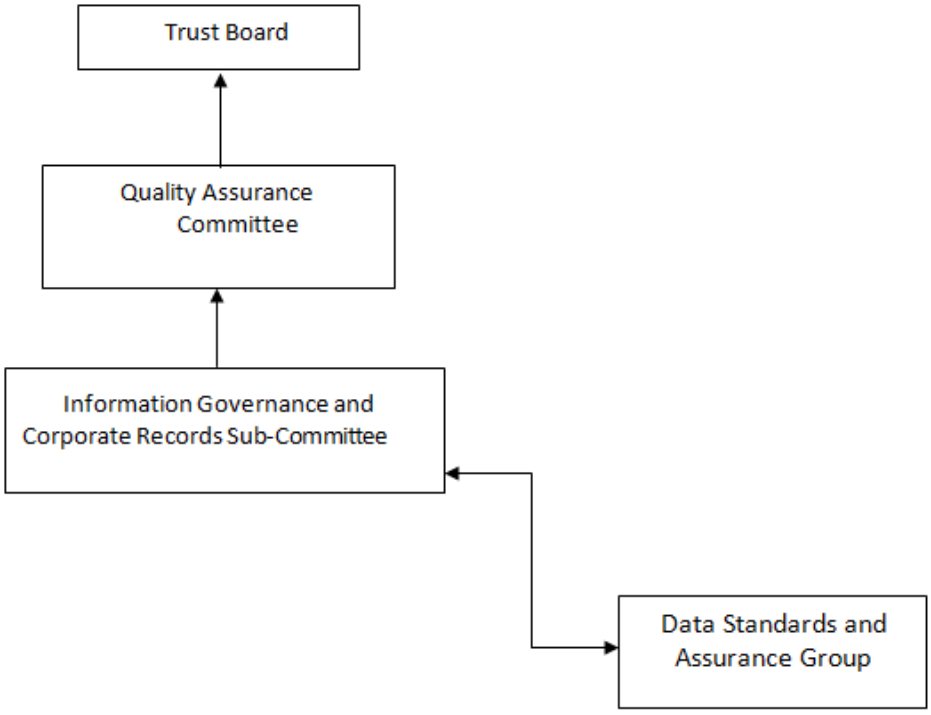
- Information Governance has a profile that is recognised throughout the organisation and that escalation of data security and protection risks are escalated to the Quality Assurance Committee.
- Reports relating to performance in the areas of confidentiality/Caldicott issues, information risk management, information and cyber security developments, information sharing protocols, data protection impact assessments, data quality, records management and information rights are routinely received as part of the annual Information Governance work plan.
- Action plans are scrutinised in order to improve performance against the NHS Digital Data Security and Protection Toolkit. Performance against the Toolkit assertions is monitored by NHS Digital three-times annually.
- Work is undertaken to embed a positive Information Governance culture across the Trust.

The IGCRSC is authorised by the Quality Assurance Committee to explore any activity within its terms of reference. The terms of reference of the IGCRSC was re-authored and approved in April 2019. In addition to the terms of reference the core membership and reporting structures were revised and approved in April 2019.

2.1 Core membership of the IGCRSC

(Chief Information Officer / SIRO) (Chair)
Caldicott Guardian / Deputy Medical Director
Deputy Director IM&T (Data Quality / Information)
Head of Enterprise Solutions
Chief Information Officer for Nursing & AHPs
Clinical Informatics Matron
IT Manager
Outpatients and Medical Records Service Manager
Registration Authority Lead
Information Governance and Corporate Records Manager

2.2 IGCRSC Reporting Structure



3. Information Governance Assurance

The 2018/19 MIAA DSPT Assurance review was conducted between October 2018 and March 2019 in a two phase audit. The objective of the review was to deliver an opinion on the framework developed by the Trust to maintain and monitor its data/cyber security and protection arrangements.

The review focused on the returns submitted by the Trust for the mandatory elements of the following domains:

- Personal Confidential Data
- Managing Data Access
- Responding to Incidents
- Accountable Suppliers

In total the Trust was audited on 62 mandatory assertions (standards) within DSP Toolkit which represents an audit sample of 62% of the total mandatory assertions. The assurance statement provided by MIAA asserted that the Trust "*has demonstrated that it has implemented an adequate Information Governance framework which is active*".

The overall assurance level provided based upon the audit of the sample size indicated above is Moderate Assurance.

The report in Appendix A contains the findings of the 2018/19 MIAA Data Security and Protection Toolkit Assurance review.

3.1 Improvements to Information Governance Processes 2018/19

The following improvements have been implemented:

- Procurement of an information asset register to record details of systems that hold person identifiable information (PII) and data flows. This system has been populated with 132 IT assets that contain PII.
- Completion of a review of all Information Governance policies in preparation for the 2019 CQC inspection.
- A programme of confidentiality audits has been implemented across all wards on both sites during 2018/19 with the results disseminated to the SIRO, Caldicott Guardian and all ward managers. Areas were RAG rated and re-audited to measure improvements.
- Spot checks of wards implemented in order to embed a positive Information Governance culture with the introduction of the 'You Didn't Think Privacy' yellow card scheme.
- Revised data protection privacy notices for both staff and patients and new data protection materials.
- IT Health Check and Vulnerability assessment completed with actions to resolve identified cryptographic insecurities and SSL issues. The Health Check was conducted to assess the security posture of the WHHFT network and to assess the security threat posed to it.
- Terms of reference for the Information Governance Corporate Records Sub-Committee re-drafted and 2019/20 annual work plan approved.
- An increase in the quantity of servers patched with the latest security patches. The level of patched servers was increased to 97% as of April 2019.
- Vulnerability check completed on the Trust's network with actions in progress.

4. 2018/19 Confidentiality Audits

In March 2018 a casenote storage audit was conducted across 50 areas of the Trust across the Warrington, Halton and CMTC sites. The objective of the audit was to identify areas where the storage of records did not meet the requisite information governance best practice. The audit was conducted in response to CQC findings which concluded that improvement in the security of the storage of paper records in clinical areas was required.

During September/October 2018, 45 areas were re-audited on the Warrington, Halton and CMTC sites in order to establish compliance levels with data security and protection best practice. The audit was also designed to report upon the

progress of work undertaken to address the CQC findings in relation to the secure storage and use of clinical records. The audit results and actions taken to address areas of weakness will be used to evidence performance against the CQC Key Line of Enquiry W6 and the NHS Digital Data Security and Protection Toolkit standards 1.5.2 & 1.5.3. The results of the audits were disseminated widely and to members of the Quality Assurance Committee, the Information Governance and Corporate Records Sub-Committee and attendees of the Ward Managers meeting.

The areas audited in September/October 2018 were re-audited in December 2018 and January 2019 at the request of the Director of Integrated Governance and Quality. The wards, departments and outpatient areas were assessed against general Data Security good practice with an emphasis on:

- Secure use of smartcards and passwords
- Security of computer screens that are left unattended
- Security of paper records and the correct use of newly installed keypads to secure health records
- Securing access to electronic information by locking screens and anonymising e-whiteboards where necessary
- Secure siting of confidential waste.

In total 46 areas were audited and the results were finalised and reported in February 2019.

- 28.8% of areas audited displayed good practice and were awarded a significant assurance rating.
- 66.6% of areas audited were awarded and amber (limited assurance) rating
- 4.4% of areas audited were awarded a red (no assurance) rating.

In order to drive improvements in compliance with IG best practice a yellow card scheme for infractions has been implemented. The yellow card ‘You Didn’t Think Privacy’ initiative has built awareness by highlighting areas of poor IG practice in clinical areas. The results of audits and summaries of infractions identified are distributed to ward managers so that messages around IG best practice can be disseminated to staff.

5. Information Access Performance 2018/19

The Trust’s information access arrangements are managed by the Governance and Communication’s Teams respectively. The Trust is legally obliged to answer requests made for corporate information under the Freedom of Information Act 2000. The Data Protection Act 2018 and the Access to Health Records Act 1990 create access rights to health data.

5.1 Freedom of Information Requests 2018/19

The total of requests received under the Freedom of Information Act 2000 during 2018/19 financial year was 687. Of these requests 459 (66%) were answered within the 20 working day statutory timescale.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total	57	62	53	76	62	45	55	62	32	69	71	43
Answered within the statutory time limit	31	45	40	66	48	32	34	29	12	45	51	26

Reasons for delays in responses to FOI requests are recorded by the Trust's Communications Team for assessment and action. It should be noted that the total number of requests answered within statutory timescales would not be of the requisite standard if the ICO targets imposed upon nine government departments for timely FOI responses are used as a measure. The ICO target for timely responses imposed upon government departments was increased in April 2018 from 85% to 90%.

5.2 Subject Access Requests 2018/19

Figures provided by the Trust's Medico-Legal team indicate that there was a significant increase in subject access requests made in the 2018/19 financial year. The increase in requests is most likely to be attributable to the abolition of administration fees for handling subject access requests when the Data Protection Act 2018 came into force in May 2018.

DPA 2018 and AHRA Access Requests 2018/19

Financial Year	Complaint	Other Hospital	Paediatric Safeguarding	Patient	Pension	Police	Solicitor	Grand Total
2017/2018	7	207	74	222	37	18	1487	2052
2018/2019	38	312	42	317	25	26	1325	2085

*data on the quantity of DPA 2018 and AHRA requests completed within the statutory timescales are not currently available

6. Cyber Security

Since the WannaCry ransomware attack which affected the NHS in 2017 there has been significant investment within the NHS in improving cyber security. Cyber risks are an ongoing threat to all organisations.

The NHS Digital Data Security Centre issues cyber threat intelligence bulletins (CareCERT alerts) which contain information about known threats to cyber and data security. CareCERT alerts are routinely acted upon by our technical staff, and in the

event of a high severity CareCERT alert being issued, details of mitigation measures are supplied to NHS Digital.

The work undertaken at WHH to improve cyber defences during 2018/19 is detailed below.

6.1 Server Patching

The server patching cycle is now regarded as business as usual and the latest position as at 25/04/19 can be seen in the table below. The position for April 2019 has been compared with November 2018 to demonstrate the level of improvement.

Servers are placed into categories dependent upon their importance. The categories are:

Tier 1. Server can be patched in business hours - no impact
Tier 2. Server can be patched out of business hours - no impact
Tier 3. IT should arrange downtime in business hours
Tier 4. IT should arrange downtime out of business hours
Tier 5. Critical Server – requires Event Planning group approval.

Server Patching November 2018	Server Patching April 2019
Tier 5 - 41% (Critical Servers)	Tier 5 - 93% (Critical Servers)
Tier 4 - 28%	Tier 4 - 100%
Tier 3 - 39%	Tier 3 - 92%
Tier 2 - 43%	Tier 2 - 100%
Tier 1 - 100%	Tier 1 – 100%
Overall - 57%	Overall – 97%

There has been an increase of 40% in the total of servers patched with the latest security patches since November 2018.

6.2 IT Health Check and Vulnerability Assessment - March 2019

In March 2019 Mersey Internal Audit Agency conducted a vulnerability assessment of the Trust's network. The resulting report indicated 1 high risk, 7 medium risk and 3 low risk findings. The current status of progress against the risks identified is included in the table below which shows that 36% of risks identified have been addressed as of May 2019.

An action plan is in place to address the findings of the MIAA vulnerability assessment and is monitored at the Digital Operations Group.

Risk	Category	Progress
5.1.1 The remote service encrypts traffic using a protocol with known weaknesses.	High Risk	In Progress
5.2.1 The remote web server is not configured or is improperly configured.	Medium Risk	Complete
5.2.2 The remote web server may fail to mitigate a class of web application vulnerabilities	Medium Risk	Complete
5..2.3 The remote Internet Key Exchange (IKE) version 1 service seems to support Aggressive Mode with Pre-Shared key (PSK) authentication. Such a configuration could allow an attacker to capture and crack the PSK of a VPN gateway and gain unauthorised access to private networks.	Medium Risk	Complete
5.2.4 The Microsoft Exchange Client Access Server (CAS) is affected by an information disclosure vulnerability. A remote, unauthenticated attacker can exploit this vulnerability to learn the server's internal IP address.	Medium Risk	In Progress
5.2.5 The remote host supports the use of SSL	Medium Risk	Complete

ciphers that offer no encryption at all. Note: This is considerably easier to exploit if the attacker is on the same physical network.		
5.2.6 The remote host is affected by a man-in-the-middle (MitM) information disclosure vulnerability known as POODLE.	Medium Risk	In Progress
5.2.7 The remote host supports the use of SSL ciphers that offer medium strength encryption.	Medium Risk	In Progress
5.3.1 The remote host supports the use of RC4 in one or more cipher suites. The RC4 cipher is flawed.	Low Risk	In Progress
5.3.2 It was possible to obtain sensitive information from the remote host with TLS-enabled services.	Low Risk	In Progress
5.3.3 Remote host vulnerabilities may allow an attacker to recover the plaintext or potentially violate the integrity of connections.	Low Risk	In Progress

7. Information Governance Incidents

The total IG incidents reported on Datix increased dramatically during the period from May 2018 to March 2019 when compared with data from the previous financial year. During the period April 2017 to April 2018 a total of 69 incidents were reported. The period from May 2018 to March 2019 saw 209 incidents reported. This represents an increase of 202% in the total of IG incidents reported during the 2018/19 financial year despite the fact that data is not yet available for the March-April period of the year.

There was a noticeable increase in IG incidents reported on the Datix system from June 2018 onwards. This may indicate increased awareness amongst staff relating to the importance of incident reporting post GDPR coming into force via the UK Data Protection Act in May 2018.

The top 5 sub-categories of IG related incident by totals are:

Sub-Category	Total (since April 2017)
Smartcard Loss	48
Data Quality	43
Incorrectly Addressed Mail	26
Dropped/Lost Paper Records	23
Other	23
Total	163 incidents which represents 58.6% of the total number of incidents during this period.

7.1 IG Incident Data April 2017 to March 2019

The information in the table below was extracted from the Datix system and provided by the Trust's Governance Administration Coordinator.

Lessons learned are recorded against Datix incidents. It should be noted that the additional workload associated with the increased volume of reported incidents, reflective of improved staff reporting culture, is being monitored.

	Incidents by Sub Category and Reported	
2		
3		Total
4	Dropped / Lost Confidential Information	10
5	Unauthorised/Inappropriate Access to IT Systems	3
6	Awareness/Training	3
7	Bogus Caller contacting Hospital	3
8	Other Bogus Caller	1
9	Suspicious phone caller requesting personal information	1
10	Cyber Security Incident	1
11	Data Quality	43
12	Lost Confidential Electronic Information (disc, PC, laptop, tablet)	3
13	Hospital Policy	2
14	Health, Staffing, Business Confidential Information	6
15	Incorrectly Addressed Mail	26
16	Insecure Information Sharing, Transfer, Transport Issue	5
17	Information Quality	2
18	Information System Interruption/Disruption	2
19	IT System Security Compromised	4
20	Medical legal company contacting patients	1
21	Non compliance with legislation	2
22	Other Security Issue	1
23	Other	23
24	Post, e-mail, internet, intranet, hand, phone, fax	5
25	Dropped/Lost Paper Records Containing Confidential Information	23
26	Username/Password/Smartcard Sharing Issue	2
27	Use of personal information	4
28	PI Information not stored securely	4
29	Records Management Issue	2
30	Insecure Information Sharing (Email, IT Systems, Paper Flows)	18
31	Smartcard Loss	48
32	Insecure Storage of Confidential Information	18
33	Username/Password Issue/Code Issue	4
34	Visible PI Information	4
35	Misfiling of documents	4
36	Totals:	278

One incident has been reported to the Information Commissioner's Office (ICO) in 2019/20. The incident relates to a Friends and Family Test message which was sent to an individual that was not the intended recipient. Whilst no sensitive detail was included in the FFT message the decision to report to the ICO was taken due to safeguarding concerns for the child that the FFT message related to. A 72 hour review of the incident was conducted and all the requisite background information has been supplied to the ICO. This incident continues to be managed by due clinical governance process.

8. Data Security and Protection Toolkit Non-Compliance Plan & Planning for 2019/20

The improvements made in DSPT mandatory standards compliance from February to April 2019 are included in the table below. The work conducted since February 2019 has resulted in a 46% reduction of standards with a not met status.

Assertion Ref	Assertion Details	Action	Lead	Due	Progress	Toolkit Compliance Met / Not Met
Domain 1.Personal Confidential Data						
1.4.2	Have information flows been approved by the SIRO or equivalent local method?	Complete the data flow mapping linked to information assets in the electronic Information Asset Register.	Mark Ashton	31/10/19	Data flow mapping will commence once all the assets have asset owners assigned to them in the new electronic system.	Not Met
1.4.3	Date of when information flows were approved by the Board or equivalent.	Approval to be sought at Information Governance and Corporate Records Sub-Committee when complete.	Mark Ashton	31/10/19	Approval will be sought on completion of the data flow mapping.	Not Met
1.7.2	The scope of the data quality audit was in line with guidelines.	The audit approach needs to be approved locally and sense checked against the guidelines.	Mark Ashton	N/A	Evidence agreed by MIAA in March 2019	Met
Domain 2. Staff Responsibilities						
2.1.2	The list of all systems/information assets holding or sharing personal confidential information has been approved as being accurate by	Mechanism for recording approval of accuracy by the SIRO to be agreed and evidenced.	Mark Ashton	11/06/19	Report to June 2019 IGCRSC that this work is complete by using reports from asset	Not Met

	the SIRO or equivalent local method				register	
Domain 3. Training						
3.3.1	Percentage of Staff Successfully Completing the level 1 Data Security Awareness training (95% in year)	Routine communication required to publicise and target non-compliance in key areas to improve scores. In year totals to be monitored at DSP Toolkit assessment submission to	HR/ Mark Ashton	31/10/19	March 2019 totals for IG training attendance are 85.02%. Figures for entire 2018/19 financial year requested.	Not Met
Domain 4. Managing Data Access						
4.1.2	For each system holding personal and confidential data the organisation understands who has access to the information	Up to date list of systems and owners for systems containing PID to be completed. Information Asset Owners (IAO's) of systems containing PID to input key information onto the centralised Trust Information Asset Register.	Mark Ashton Mark Ashton/IAOs	11/06/19 11/06/19	As of April 2019 all systems containing person identifiable information (PII) have been added to the asset register and all but one system owners (IAOs) have been identified.	Not Met
4.3.1	All system administrators have signed an agreement which holds them accountable to the highest standards of	System Managers Agreement on standards of use to be produced.	Mark Ashton/ Steve Deacon	N/A	Agreement distributed and evidence agreed by MIAA in March 2019	Met

	use	Information Asset Owners for systems holding PID to sign the new Agreement that holds them accountable.	Mark Ashton/ All IAO's	N/A		
4.3.4	List of all systems to which users and administrators have an account, plus the means of monitoring access	Mechanism for monitoring to be devised to enable lists of all systems to which users and administrators have an account to be managed.	Mark Ashton/ Steve Deacon	31/10/19	The new Information Asset Register is being reviewed to see how it can fulfil this requirement and reference the latest lists of system users	Not Met
Domain 8. Unsupported Systems						
8.2.2	Where it is not possible to upgrade/update software, reasons are given		Steve Deacon	31/03/20	Windows Server 2000 project to contact each department for a migration plan. This commenced in October 2018	Not Met
8.3.3	How often, in days, is automatic patching typically being pushed out to remote endpoints?		Steve Deacon	N/A	Evidence agreed by MIAA	Met
Domain 9. IT Protection						
9.1.2	A penetration test has been conducted in the last 12 months, which confirmed that all networking components have had their default passwords changed	Undertake a Penetration Test within agreed timescales.	Steve Deacon	N/A	Completed March 2019 and report produced by MIAA	Met

9.3.1	The annual IT penetration testing is scoped in negotiation between the business and the testing team, and uploaded	Penetration Test scope agreed with the COO, CIO, CCIO and the testing team. Penetration Test undertaken and uploaded.	Steve Deacon Steve Deacon	N/A	Completed March 2019 and report produced by MIAA	Met
9.3.2	The SIRO confirms the scope of the annual IT penetration testing is adequate, and that actions from the previous penetration testing are complete or ongoing (with reasons for non-completion)	Agree the scope of the annual IT Penetration Test with the SIRO.	Steve Deacon	N/A	Completed March 2019 and report produced by MIAA	Met
9.3.3	The date the penetration test was undertaken	Date of the Penetration Test.		N/A	Completed March 2019 and report produced by MIAA	Met
Domain 10. Accountable Suppliers						
10.1	The organisation has a list of its suppliers that handle personal information, the products they deliver, their contact details and the contract duration	List of the Trust's suppliers that handle personal information, the products they deliver, their contact details and the contract duration.	Alison Parker/ Phill James/ Mark Ashton	31/10/19	Procurement have supplied a list of the Trust's suppliers which can be used to establish which suppliers sign the standard NHS contractual terms and conditions.	Not Met

9. Data/Cyber Security Risks Action Plan

Risk Ref	Assertion Details	Action	Lead	Due	Progress	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	Implement a robust Information Asset Register.	Mark Ashton	31/10/19	Population of the asset register beyond critical systems is still on going.	12 - High Risk
		GDPR Action Plan to deliver gaps in compliance.	Mark Ashton	Complete	An action plan to deliver areas of non-compliance has been developed with progress reporting into the IG & Corporate Records Group and the Quality Assurance Committee.	
		Audit Programme to monitor compliance against data protection and IG policy and guidance.	Mark Ashton	Complete	There have been a series of audits performed by MIAA on the current DSP Toolkit. In addition an Audit Programme is being devised that will include spot checks and ward rounds undertaken with support supplemented by IM&T leads and digital champions. Progress will be reported into the IG & Corporate Records Group and Quality Assurance Committee.	
135	Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	Undertaken a Training Needs Analysis for key clinical systems that includes Locum staff.	Sue Caisley	28/2/19 **Complete**	Training Needs Analysis has been completed and includes all key systems.	16 - Extreme Risk
		ICE System – Installation and configuration of infrastructure improvements to provide greater resilience.	Stephen Deacon	31/05/19	A technical options appraisal has taken place and has been discussed with the ICO. Capital form to be raised for April's Capital Meeting.	

143	Failure to deliver 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.	WHHT to collaborate with partnership Trusts in the STP to create a Cyber Business Case to deliver complex security measures.	Stephen Deacon	31/05/19	Business Case is written and submitted to NHS Digital and awaiting outcome of proposals.	12 – High Risk
		Put in place a Business As Usual Cycle of Server Patching	Stephen Deacon	29/03/19 **Complete**	Patching is now part of BAU, all servers apart from 15 are now patched automatically the other 15 are patched manually.	
		Deploy Protective Bubble for securing Medical devices	Stephen Deacon	31/03/20	VPN has been set up, required 3rd parties help move the medical devices over to the new VPN	
220	Failure to implement the requisite NIS Directive (Networks and Information Systems) policies, procedures and processes caused by lack of resources and monies resulting potential unplanned downtime for systems without resilience being investigated with possible fines.	Review of IM&T Business Continuity Plans	Stephen Deacon	31/05/19	SLT have met regarding the Business Continuity Plans. The documentation has been reviewed by the CIO and provided feedback to the IT Manager. IT Manager to go through the feedback and make modifications.	12 - High Risk
		Increase the availability of the ICE System	Stephen Deacon	31/05/19	A technical options appraisal has taken place and has been discussed with the ICO. Capital form to be raised for April's Capital Meeting.	
		Complete Server Patching with the latest patches.	Stephen Deacon	31/03/19 **Complete**	Patching is now part of BAU, all servers apart from 15 are now patched automatically the other 15 are patched manually.	
370	Failure to restore data beyond a month caused by enough capacity to retain up to one month result in potential loss of data.	Upgrade to the Servers Backup Software	Stephen Deacon	31/03/19 **Complete**	All servers are now using the new backup system.	12 - High Risk

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.	Undertake an IM&T Department workforce review to take into consideration requirements to deliver Information Security and Information Governance compliance	Mark Ashton	31/10/19	The Chief Information Officer is reviewing the IM&T Department structure and resources committed to Information Governance /Information Security to respond to the demand.	12 - High Risk

10. SIRO Decisions 2018/19

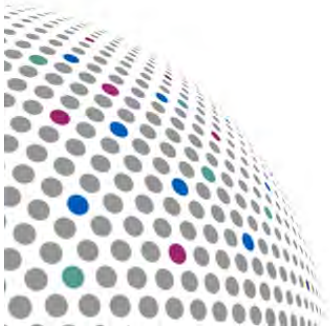
Confirmation was received from NHS Digital on 23rd January 2019 that the national SIRO register had been updated on the 23rd January 2019 to reflect the fact that Phillip James was registered as the Senior Information Risk Owner for WHH and has completed the NHS Digital self-service SIO training within the last 12 months.

Date of Decision	Subject	Description
05/03/2019	Review of existing risks	De-escalation of GDPR risks from the Board Assurance Framework
20/03/2019	Review of Brexit no-deal preparations	SIRO agreed with approach outlined and completion of impact template for the Brexit sub-group
26/03/2019	E Whiteboards	Agreement on the approach to the use of e-whiteboards
27/03/2019	Serious incidents	Request from SIRO to members of IT to resolve and close incidents open for more than 20 days
26/04/2019	Data Processing agreement with DXC	Approval and signature of SIRO required for data processing agreement with Trust's PAS system supplier.

Appendix A

Data Security and Protection Toolkit Assurance 2018/19

Warrington & Halton Hospitals NHS Foundation Trust



MIAA
IMPROVE THE OUTCOME

Introduction

There continues to be well publicised data breaches and service disruptions, including high-profile public sector data losses that have resulted in over one million pounds in monetary penalties being issued to NHS organisations by the Information Commissioner.

As of 2018 the IG toolkit was refreshed and replaced with the new Data Security and Protection Toolkit (DSPT). Whilst the standards have been updated it remains a tool which allows organisations to measure their compliance against law and central guidance and helps identify areas of partial or non-compliance. In addition, there is a contractual obligation for providers to complete the DSPT and they are subject to audit against it and must:-

- Inform the coordinating commissioner of the results of the audit; and,
- Publish the audit report both within the NHS Data Security and Protection Toolkit and on their website.

Objectives & Scope

The objective of the review was to provide an opinion on:

- The governance process, policies, and systems in place to complete, approve and submit the DPST Toolkit submisson;
- The validity of the assertions of the DPST submission based on the evidence available at time of audit for the reviewed sample; and,
- Any wider risk exposures and / or mitigations brought to light by review of that evidence.

Assurance Statement

The Trust has demonstrated that it has implemented an adequate Information Governance framework which is active. It has demonstrated evidence to confirm its assertion in the toolkit, or plans to reach compliance before final submission. The Trust have 'work in progress' regarding supplier contract management and due diligence activities and dataflows. However, there are formal work plans to address these areas which will be monitored via the IGCRSC and ultimately the QAC.

There is an adequate system of internal control, however, in some areas, weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.

Based upon the opinions on the following page, the overall assurance level provided in relation to information governance within the Trust, and within the limits of the scope described above is:-.

Moderate Assurance

Basis of Assurance –

Area	Rating	Rationale
Governance		The Trust has demonstrated that has implemented a robust, active, framework to progress its Information Governance agenda. The Information Governance and Corporate Records Sub Committee (IGCRSC) meets bi-monthly and is chaired by the SIRO, Chief Information Officer and attended by the Caldicott Guardian, Deputy Medical Director and Data Protection Officer, together with other key staff co-opted on the Group as required e.g. Information Asset Owners. The IGCRSC report into the Quality Assurance Committee (QAC), which is a sub committee of the Trust Board.
Validity		We have been able to agree the validity of the majority of the sample of assertions reviewed at this point in the Trust's submission development. However, the Trust have acknowledged further work is required around dataflows which has been detailed in an Improvement Plan submitted with the toolkit. In addition, work is still in progress around accountable suppliers that handle personal, identifiable data but again this will be progressed through the IGCRSC 2019/20 Work Plan. A detailed working action plan showing our assessments, recommendations, risk ratings and responses by responsible officers have been shared under separate cover for the Trust to track progress prior to final submission.
Wider-Risk		As noted above, the Trust have 'work in progress' regarding supplier contract management and due diligence activities and dataflows. However, there are formal work plans to address these areas which will be monitored via the IGCRSC and ultimately the QAC.

Assurance Definitions and Risk Classifications

Risk Rating		Rationale
Critical		Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High		Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives.
Medium		Control weakness that: • has a low impact on the achievement of the key system, function or process objectives; • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low		Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/19/05/46			
SUBJECT:	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)**			
DATE OF MEETING:	29th May 2019			
AUTHOR(S):	Marie Garnett, Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust had its first Use of Resources Assessment (UoRA) on 2nd April 2019. This was supported by a submission of evidence pre and post assessment. The Trust has received positive feedback following the assessment. A full report is expected in line with the CQC inspection process. While the Trust is performing well against the majority of the indicators, work continues to improve the position across all metrics. NHSI have highlighted that organisations that are in receipt of working capital support will be impacted on their ability to attain a "good" rating.			
PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

PROGRESS ON THE CARTER REPORT RECOMMENDATIONS & USE OF RESOURCE ASSESSMENT

1. BACKGROUND/CONTEXT

In May 2018, as part of the Trust's Getting to Good, Moving to Outstanding programme, a UoRA workstream was established. The UoRA is designed to improve understanding of how effectively and efficiently the Trust uses its resources. The UoRA is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance. The UoRA workstream has prepared a narrative for each KLOE and has developed a dashboard. This forms the basis from which to review and improve each KLOE indicator.

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

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

Collaboration at Scale

The Trust is engaged with organisations across the Cheshire & Mersey STP whom are working on the Collaboration at Scale programme to identify and work though opportunities where major efficiency benefits can be gained across the footprint. This programme includes work around back office functions, pharmacy and pathology.

The vision of the collaboration is "*deliver effective, efficient and commercially sustainable corporate service operations to support front-line staff in delivering quality patient care,".* The level of benefits expected from greater collaboration and consolidation of corporate services is expected to be between £30-£50m across the footprint. This will be achieved by removing unnecessary duplication and by standardisation.

2. KEY ELEMENTS

This paper presents the quarterly update report for Quarter 4. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator and the progress against the Lord Carter recommendations can be found in **Appendix 2**. The majority of the Lord Carter recommendations are either complete or are on track.

The Trust's Use of Resources Assessment Day took place on 2nd April 2019 with a further evidence submission on 16th April 2019. The Trust received positive feedback in its approach to the day. The Trust UoRA will continue to meet on a monthly basis and will develop an action plan to focus on areas where improvements can be made.

3. RECOMMENDATIONS

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

Andrea McGee
Director of Finance and Commercial Development
22nd May 2019

Appendix 1 – Benchmarking Performance against the National Median

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

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

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

Lead Director: Director of Human Resources & Organisational Development

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development and Approval of People Strategy and Dashboard	• The refreshed People Strategy was signed off by the Trust board in Q2 2018/19. Quarterly reports will be presented to the Strategic People Committee.	• Ongoing monitoring and management of the dashboard.	Trust Board, TOB, Strategic People Committee	Complete
Restructure of HR Directorate	• The HR department restructure is complete and key posts in the Senior Management Team have been recruited to.		Trust Board, Strategic People Committee	Complete
HR Polices reviewed to ensure they are clear, simple and transparent	• The Human Resources & Organisational Development (HR&OD) Directorate has a policies and procedures group with management and staff side members. All HR policies are taken through this group and then progressed to JNCC. • Policies reviewed and ratified to date include; the Disciplinary Policy, the Relationships at Work Policy, and the Special Leave Policy.	• The Trust is undertaking a programme to review and where required, simplify HR policies. This will be monitored by the Strategic People Committee. Policies to be review in Q1 2019/20 include the Secondment policy, the Annual Leave policy and the Disability Quality Policy. • A review and refresh of the essential managers training is to be undertaken during Q1 2019/20. Historically this training has been about introducing managers to key polices. Moving forward, the focus will be on how to utilise HR processes to get the best out of staff. An example of this is the Difficult Conversations training. This will build people management capacity across the organisation.	Strategic People Committee	Ongoing Monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
"Fit to Care" Heath & Wellbeing Programme	• The Trust has a wide range of wellbeing approaches aimed at supporting staff back into work, with several wellbeing initiatives established including; a Weight management clinic, Healthy Topics, Drop in sessions for healthy hearts and Wellbeing clinics. • In Q1 2018/19 the Trust launched its Mental Health first aid courses which aim to help managers spot the signs of mental health and signpost colleagues to support. • The Health and Wellbeing Team have consulted with the workforce to seek their feedback on the Fit to Care programme, with suggestions for improvement and overall input with regards to supporting staff wellbeing.	• Wellbeing initiatives will continue to be offered and monitored for effectiveness. • The rollout of the refreshed fit to care programme will begin in Q1, 2019/20. The Trust is building on the previous approach of educational/informative campaigns, to adopt an impact based approach e.g. Know Your Heart Age event in April 2019, where staff will be offered a range of screening tests and access to a Consultant Cardiologist where appropriate.	Strategic People Committee	Rolling Programme
Development of Workforce Streaming Programme across the North West	• The Trust has worked with colleagues across the North West to agree unified ways or working and to reduce bureaucracy. • Key actions included: o Implementation of factual references. o Streamlining of notice periods for new starters. o Agreed honorary contract process and streamlining of mandatory training across the region. o Values based recruitment. • Region wide TUPE guidelines have been agreed. • The programme worked through the agreed milestones for year 3 for the following workstreams (Training, Occupational Health, PREP, Recruitment, Medical Staffing and Systems).	• The streamlining programme is now complete with benefits realisation to be signed off by Strategic Peoples Committee in May 2019.	Operational People Committee	Ongoing
Staff Opinion Survey	• The 2017/18 Staff Opinion Survey (SOS) closed in December 2017. The Trust response rate was 46% compared to 38% for the 2016 survey. • Themes from the 2017/18 staff survey were used to develop the refreshed People Strategy. • Results from the SOS have been received by the Trust and a proposed change in approach was presented to and approved by the Trust board in March 2018. • A staff engagement event "The Perfect Day" took place in early May 2018 and outputs are linked to Listening in to Action (LIA). • The 2018 Staff Opinion Survey 2018 has now closed. The Trust achieved a very positive response rate of 50.6%, a 4.6% improvement on the previous year.	• The Trust has received the results from the 2018/19 Staff Opinion Survey. The Trust achieved average or above average for 9/10 of the key themes as well as statistically significant improvements in safety culture and staff engagement. The CBU level results have been shared for local implementation and the Trust level results will be mapped to the delivery of key strategies such as the People strategy and EDI strategy.	Trust Board, TOB, Strategic People Committee	Rolling Programme

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. Links have been made with Junior Doctors and the People Champions as this agenda continues to embed. • The Trust performed in the upper quartile in the 2017 staff survey in relation to bullying and harassment in comparison with other Acute Trusts. The survey did highlight a need to look into the number of staff experiencing physical violence from other staff. • The Trust has reviewed the SOS results against other employee relations metrics around bullying and harassment and has analysed the areas where we are doing well to look how learning can be shared across other areas. This will be focused specifically around; managers training, standards, policy implementation and reward. It was identified that the approach in leadership style within these areas was similar. This learning has been incorporated into the essential managers training. • Work has been undertaken with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this. • An Equality, Diversity and Inclusion Strategy has been produced, the first draft was presented to the Equality and Diversity sub-committee in Q3 2018/19. Additional engagement will take place in January 2019 and the Strategy will be submitted to Trust Board for ratification in March 2019.	• The Trust Board signed off the EDI strategy in March 2019. The Trust has the culture and infrastructure to address bullying and harassment and this is supported by the latest staff survey results.	Strategic People Committee	Ongoing Monitoring
Ensure Staff have regular performance reviews	• The number of staff with a valid PDR is 86% (March 2019) against a target of 85%. • The PDR process has been reviewed, with a particular focus on engaging staff and condensing timescales to avoid winter pressures. • Proposals around strengthening reporting arrangements for nursing staff have been made.	• HR Business Partners will continue to work with the CBU managers to further improve PDR compliance. • The Trust has implemented the Trust new pay progress policy. As per the national policy, this is currently for new starters to the Trust only.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring
Improving Sickness Absence	• Sickness absence was 4.8% in March 2018. • An audit has been completed on compliance with the Trust's Attendance Management Policy and a number of recommendations are being implemented. • Promotion and improvement of flu vaccination uptake took place in Q3/4. • Mental Health "Train the Trainer" training is complete. • A new clinical supervision framework has been rolled out which will help to address some of the stress/anxiety related absences. •An ongoing programme of Mental Health first aid training is being rolled out across the Trust.	• An action plan resulting from the review of sickness absence management in comparator Trusts is currently being implemented. Q1 2019/20 actions include; analysis of individual absence patterns relating to key holiday periods and auditing of outcomes of attendance management hearings. In March 2019, sickness absence reduced to 4.8% and dipped below the same period in the previous year.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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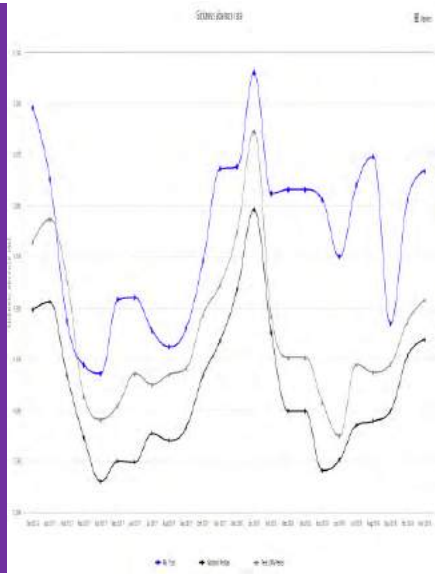
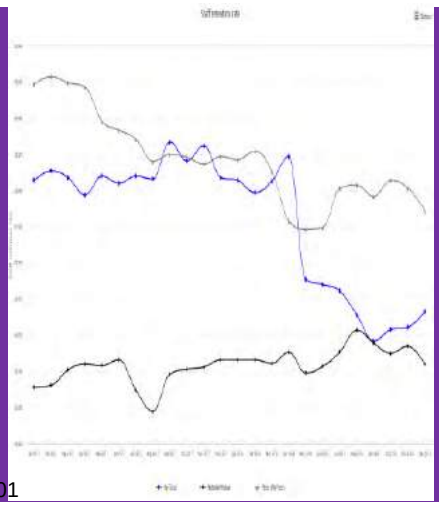
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

KLOE 2 - People

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Sickness Absence Rate	UoR Percentage of staff FTE sick days.	**National Median = 4.27%** Peer Median = 4.44% 1. STHK 2.64% 2. N Lincolnshire 4.26% 3. Sunderland 4.28% 4. Mid Cheshire 4.32% 5. Chester 4.43% 6. North Tees 4.44% **Source: HSCIC - NHS Digital iView Stability Index** **Monitoring - Trust Board, TOB, SPC (from March 2019)**	**October 2018** 7. Gateshead 4.48% 8. Bournemouth 4.80% 9. WHH 5.03% 10. Wirral 5.24% 11. Southport 6.34%		For the first part of the year 2018/19, the Trust performance in relation to sickness absence was worse than the same period in the previous year. From September 2018, the position had recovered and although sickness absence has continued to increase, this is in line with the trend from the previous year. Acknowledging that absence rates have remained higher than our peers, there is opportunity to decrease this. Significant strategic and operational work has been undertaken to improve the position and from March 2019 the sickness absence rates have dipped below the 2018/19 rate.	• 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 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.	
Staff Retention Rate	UoR The percentage of staff that remained stable over 12 months period.	**National Median = 85.9%** Peer Median = 88.0% 1. N Lincolnshire 89.1% 2. Wirral 88.9% 3. STHK 88.5% 4. Sunderland 88.3% 5. Gateshead 88.1% 7. Southport 88.0% **Source: HSCIC - NHS Digital iView Stability Index** **Monitoring - SPC (from March 2019)**	**November 2018** 8. Mid Cheshire 87.2% 9. North Tees 86.6% 10. Bournemouth 86.4% 11. WHH 86.1% 12. Chester 85.7%		• NHSI nursing retention programme and roll out to other staff groups. An action plan has been developed following review of all data by NHSI. This includes: o Improve our workforce's ability to achieve a better work life balance. o Support our staff to explore and pursue career progression within the Trust. o Recognising and Valuing Experience (RAVE) o Develop and empower our Line Managers to retain their staff.	• Work has already begun 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. As part of this, a review of the Trust's retire and return policy will be required. • Careers cafés have been set up throughout the year, the next one is arranged for May 2019.	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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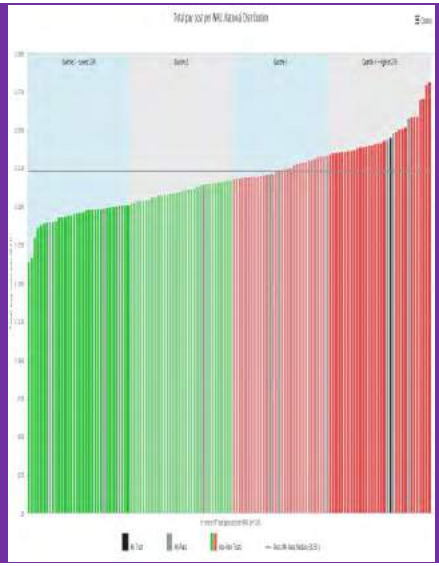
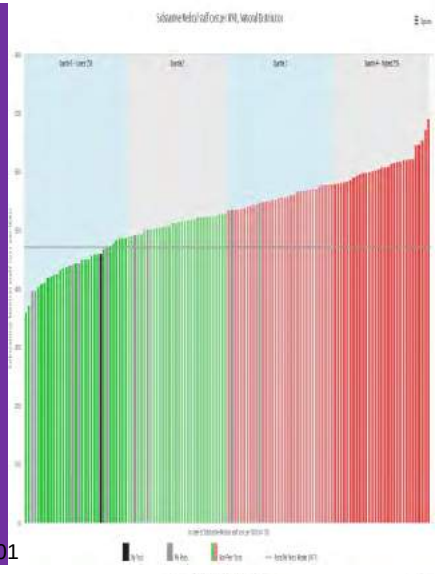
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pay Costs per Weighted Activity Unit	UoR **National Median = £2180** Peer Median = £2231 Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a Trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity. **Source: Trust consolidated annual accounts and reference cost data.** **Monitoring - Trust Board, SPC (From March 2019), FSC, TOB.**	**2017/18** 1. Sunderland £1904 2. STHK £1995 3. Bournemouth £2010 4. Gateshead £2151 5. Wirral £2219 6. North Tees £2242 7. Chester £2336 8. Mid Cheshire £2442 9. WHH £2455 10. N Lincolnshire £2482 11. Southport £2577		Pay Costs per WAU exceeds the Peer and National Medians. The below shows the WAU Staff Costs per staff group and the percentage difference compared to our peers: When removing AHP costs associated with external SLA, this impacts positively on the overall position.	The key actions focus on reducing reliance and improving value for money for temporary staff (AHP explained below). > The temporary staffing team continue to support the CBUs to improve locum fill and pay rates. > Process medical bank bookings through the Brookson system, improving fill rate and compliance.
Medical Costs per WAU	UoR **National Median = £533** Peer Median = £471 Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity. **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	**2017/18** 1. Gateshead £398 2. Mid Cheshire £399 3. Sunderland £442 4. North Tees £444 5. WHH £461 6. Wirral £471 7. Bournemouth £493 8. Chester £502 9. Southport £536 10. N Lincolnshire £548		The Trust is below the national and peer median, however the large number of vacancies within this workforce will have contributed to this. As we seek to recruit to these vacant posts, we could see costs per WAU increase. To mitigate this, we're currently completing a Medical Establishment Review, using the RCP Medical Safe Staffing Methods as our guide this will continue until the end of Q4.	The key actions relate to the Medical Establishment Review include: > Analyse the established medical model and the proposed effective establishment, within the context of RCP Safe Medical Staffing Guide. > Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. > Working with WWL to recruit Drs Internationally.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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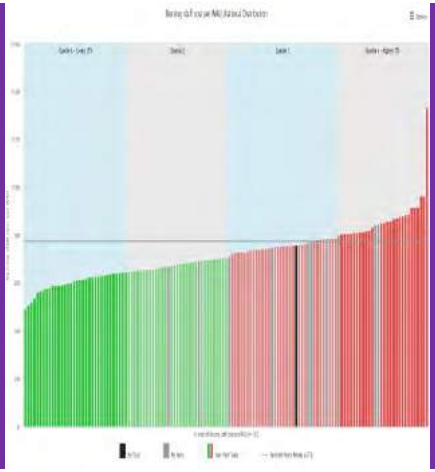
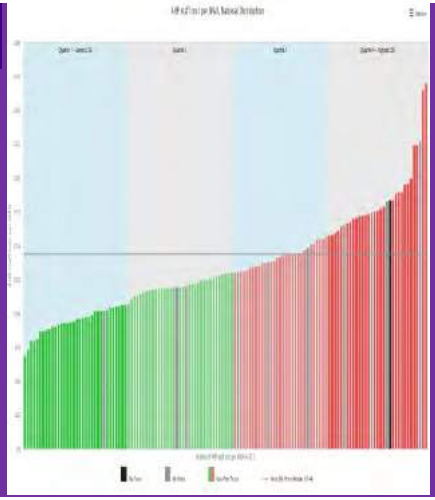
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Nursing Cost Per WAU	UoR Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £710** Peer Median = £775 1. Bournemouth £671 2. Sunderland £694 3. STHK £711 4. Gateshead £750 5. WHH £761 6. Wirral £772 **2017/18** 7. Chester £778 8. N Lincolnshire £789 9. North Tees £801 10. Southport £845 11. Mid Cheshire £848 **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC (from March 2019)**		The Trust is below the peer median for our Nursing Costs per WAU which is positive, however again the large number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the nursing workforce, advanced practice and specialist interest roles.	The key actions are: > Working alongside the WHH Recruitment and Retention group, develop retention strategy and NHSI. > Continue the successful Staff Nurse recruitment open days. The Trust has been in contact with NHSI to look at conflicting data points, which has been escalated to national level within NHSI. The Trust has also been in contact with other Trusts who have the same data issue.	
AHP Cost per WAU	Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £130** Peer Median = £144 1. STHK £103 2. Wirral £120 3. Bournemouth £121 4. Chester £131 5. Sunderland £138 6. Gateshead £149 **2017/18** 7. N Lincolnshire £166 8. Southport £175 9. Mid Cheshire £183 10. WHH £184 11. North Tees £228 **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC (from March 2019)**	UoR 	Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This is not our activity - we receive SLA income for these and this should offset against the costs. This means that they should not be included in the pay cost per WAU. • For example, we have Therapists working as 'first point of contact' in GP surgeries. Rather than seeing a GP first, patients with musculoskeletal issues are triaged by a Therapist and either discharged, treated or referred to secondary care. • Finance have used an estimate for this value to produce a revised cost per WAU for AHPs of £123 which would bring the Trust under the national median.		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 2 - NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care. **Lead Director(s):** Medical Director & Chief Nurse			
Care hours per patient	• The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016. • The data is included in the monthly safe staffing and assurance report presented by the Chief Nurse at the Trust Board.	• Care Hours are reviewed each month as part of the Integrated Performance Report (IPR). In 2018/19 this went from 6.2 to 7.6 CHPPD. • Data is submitted monthly to NHSI via the Trust Information team.	Trust Board, TOB	Ongoing Monitoring
Electronic roster and safe care module – six week rosters submitted to NHSI, process for improvement, cultural change and communications	• Implementation of Electronic Roster & Safe Care – all core wards are now live on the system with over 50 wards or departments. • The corporate nursing team has taken over management of the e-roster team. • The E-Rostering team is co-located with the operational management team in a centralised location. • Capacity and demand meetings are held after the bed meetings and the staffing template updated in real time. • The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster. • Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review. • The Trust has shared its achievements with Safe Care and Health Roster products with 4 Trusts in the region and continues to be seen as an exemplar by Allocate for Nurse Rostering & SafeCare.	• Continue to support the Matron daily safe staffing meetings, allows for early identification of hotspots/issues. • Future rollouts for Outpatient Nursing, Administration Staff, Medical Staff and Corporate Functions.	Trust Board	Ongoing development and daily monitoring with Senior Nurse Oversight

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NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Consultant job planning - improving analysis of consultant job plans and better collaboration within and between specialist teams	• The Trust uses Allocate Software for e-Job planning. • 2019/20 Job planning round was launched in August 2018. There have been several consistency panels held to support the process across the eight Clinical Business Units. Of 209 clinicians (both Consultant & SAS doctors) 186 job plans have been released for review and 121 of these have achieved full sign and implemented on 1st April 2019. Of the 65 still progressing 48 are Consultants and 17 are SAS doctors. • The project involving Programmed Activity (PA) corporate budgets for Medical Leadership, Education & Training, Quality & Governance and Appraisal & Revalidation has been completed. The Trust has provided an SOP to detail the revised process for the financial management of PAs. • The renewed Job planning policy for Consultants was agreed with Staff Side via our JLNC and was implemented on 19th June 2018. • The Trust is actively drafting a new Job planning policy for the SAS doctors. • A proposal for reducing sign off levels from 3 to 2 was accepted. • The language used within the e-Job planning software has been improved to allow more effective reporting and easier inputting.	• Job planning progress will continue to be monitored on a regular basis. • Job planning compliance is scrutinised at a fortnightly HR meeting when data is presented to the Head of Medical Staffing & Education and concerns are escalated. • Updates are provided regarding progress to the Trust Joint Local Negotiating Committee. • Mediation meetings are in the process of being scheduled for outstanding job plans. • Consistency panels will be convened as and when needed. • It has been recognised that earlier escalation is needed in terms of missed deadlines and this is being improved.	Operational People Committee	Ongoing development and daily monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

Recommendation 3 - Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost, coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities.

Lead Director(s): Medical Director & Chief Nurse

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local level	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement. • The HPTP was completed in May 2017.	• Model hospital metrics are monitored at the Trust's Medicines Governance Committee.	Trust Board	Complete
Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)	• Electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee in Q1 2018/19 • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users has been received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019.	• The Trust is working with the ePMA supplier on further developments to ensure flow between A&E and non-elective wards is robust. Previously it was thought this would have to be version 2.17, however it has been agreed the current version 2.16 will be sufficient to rollout. • Planning for rollout at Warrington Hospital has commenced and discussions around the approach with operational management is taking place. It is anticipated that rollout will be over 4 phases (Surgical, Long Term Medical, Acute Medical and ITU/Maternity)	Trust Board/IM&T Committee	Project expected completion – March 2020

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

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Ensuing that coding of medicines are accurately recorded	• The Trust continues to work on improving data quality with workshops held to identify gaps, issues and areas for improvement with plans to address. • PHE SACT data has been reviewed, based on this the Trust is achieving current data quality targets. • A Blueteq drop in presentation day to be held in January 2018 to demonstrate the system and inform clinicians about the contractual requirements to obtain prior approval for the patient pathway before commencing treatment – commencing 1st April 2018. • Q1 2018/19 – Blueteq was implemented for endocrinology drugs.	• The Trust continues to monitor the contents of the Schedule 6 schema reports to address any data quality issues. A meeting with NHSE is scheduled for May 2019. • A new rollout plan for Blueteq has been agreed with the CCG. Rheumatology have commenced using the system and this implementation will continue into Q1. Further rollout will be discussed with the CCG/CSU.	Medicines Governance Committee	Ongoing Work Programme
80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits	• The Trust is achieving the recommendation for pharmacists. • The Trust is aiming to increase time that pharmacy assistants and technicians spend on ward / with inpatients. • All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post. • The ward medicines management technician role has been reviewed with the Associate Directors of Nursing. • Midwifes are screening for regular medication so that pharmacy resources can be focused on those specific patient, this has resulted in an increase in medicines reconciliation within the Womens & Childrens CBU.	• The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration. • Three wards now have a pharmacy technician administering medicines to patients. Funding has been agreed for the wider rollout, however, the role of the nursing associates is being considered in relation to this project to ensure that wider rollout will be effective.	Quality & Assurance Committee	Ongoing Monitoring
Reduce stockholding days from 20 to 15, deliveries to less than 5 per day and ensure 90% orders and invoices are sent and processed electronically	• The Trust's current stockholding days are 18, which is below the national and peer median. • Average number of deliveries to the Trust per day is 14 which is below the national median. • 97% orders are carried out electronically.	• Reducing stockholding days or number of deliveries to the Trust per day any further would carry an unacceptable level of risk. The Trust continues to monitor performance against our peers.	Medicines Governance	Ongoing Monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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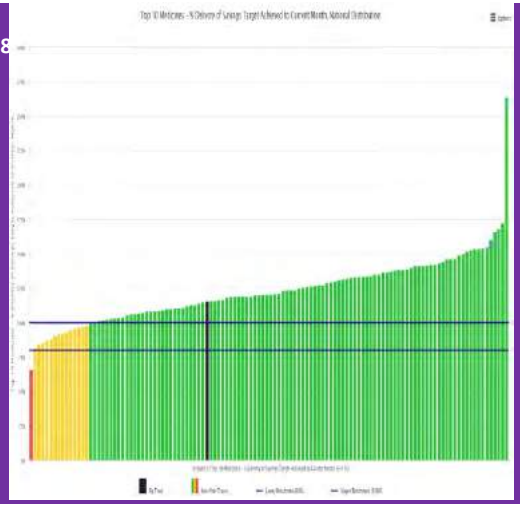
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

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

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NHS Foundation Trust

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

Recommendation 4 - Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.

Lead Director(s): Chief Operating Officer & Director of Strategy

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Establishment of a shared pathology across the local economy	• NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. • STP Cheshire & Mersey Pathology Board – the CEO of Aintree Hospital NHS Trust has been named Executive lead for the relaunched group. • A Transition Management Team has been established (Wirral Chester, Aintree, Liverpool and Southport & Ormskirk). A project manager has been appointed by the STP. • Branch work stream meeting established to look at equipment with a view to joint procurement opportunities and contract alignments. • Several drafts of the strategic outline case have been developed. The final case was approved by the Executive Oversight Group on 20th December 2018.	• The strategic business case has been agreed, the next stage will be to engage Directors of Finance and to progress to the outline business case by the end of Q2 2019/20. • The project will appoint a Clinical Director and Director of Operations during Q1. These post have been advertised but not yet appointed to. • The project will begin to explore options around IT interoperability. A number of working groups have been established. Discipline specific groups are being set up. • LTS has been commissioned by the project to review data to ensure consistency of how data is recorded and reported across all organisations.	Strategic Development and Delivery Committee	Project – expected completion 2021
Development of pathology service specification	• The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board.	N/A	N/A	N/A
Introduce the Pathology Quality Assurance Dashboard (PQAD) by July	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented from November 2016.	• Monthly data indicators continue to be submitted. • PQAD data is reviewed monthly at the KPI sub-committee. • The Trust continues to review quarterly and bi-annual indicators, however we understand that the indicators are under review and a new dashboard is under development. New version anticipated for 2019/20.	KPI Sub-Committee	Rolling Programme

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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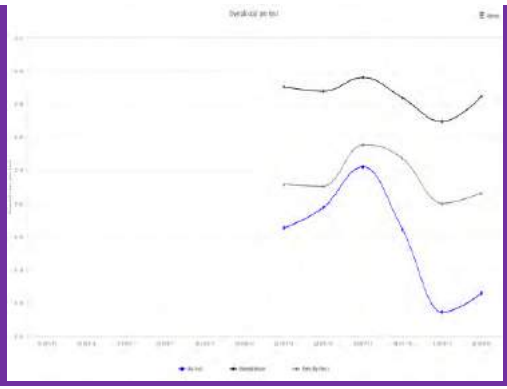
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 3 - Clinical Support Services						
Pathology - Cost Per Test	UoR The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median = £1.92** Peer Median = £1.57 1. North Tees £0.95 2. WHH £1.33 3. Chester £1.57 4. Bournemouth £2.88 **Source: NHSI Q Pathology Data Collection 17/18** **Monitoring - Pathology Business Meeting**	**Q2 2017/18**		The Trust benchmarks well against peer and the national median and also against Trusts within our STP footprint. Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. Cost per Test for Cellular Pathology and Staffing costs were raised the Use of Resources assessment as an area for improvement.	The Trust is working with STP partners as part of the Lord Carter recommendations to look at how further efficiencies can be made across the footprint. > The Trust is continuing to engage with the network consolidation, and a number of activities are going to operationalise the new model by 2021.	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

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

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NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Adoption plan for Scan4Safety	• The Trust adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards has been drafted, the procurement lead for the project is the Deputy Head of Procurement. • Scan4Safety has been presented to a number of forums throughout the Trust. • A draft PID has been developed and will continue to be refined whist the project is being established. The Trust has made progress in a number of areas: • been allocated our 10,000 GLN's by GS1 has agreed a way to assign a GLN to all of the locations within the Trust. This will be complete within Q4. • agreed in principle that the issue relating to GSRN will be dealt with by replacing all staff ID Badges with a badge which as well as a photograph will contain a barcode linked to the member of staffs payroll number. • The inventory management systems offered by the main providers in this area have been evaluated. This area along with the associated hardware and software represents the biggest cost to the Trust, so care is required to ensure that the solution we select meets our requirements not only currently but also into the future. This is proving particularly difficult given the changing landscape. This work is ongoing and represents a significant part of the feasibility study.	• A senior project lead with executive sponsorship is in the process of being identified. This role will be supported by a project group which is currently being established. The initial focus of the group will be to develop a feasibility study to be considered by the Trust Board. This will be followed by the development of an outline and full business cases.	Trust Board, Trust Operational Board	Project Implementation
NHS Standards of Procurement - to achieve level 1 by October 2016, develop improvement plan to meet target by March 2017	• The Trust has achieved NHS Standards of Procurement Level 1 accreditation. • The procurement team has identified and collated evidence in order to meet the criteria for Level 2 accreditation. • The Trust submitted the evidence to the Procurement Skills Development Network (FSD) in October.	• Assessors have now been appointed and the Trust's initial assessment is scheduled for June 2019, with a full assessment taking place shortly thereafter.	Finance & Sustainability Committee	Project Implementation
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 31/135 Trusts – placing the Trust in the best upper quartile. • A review has taken place for each of the model hospital procurement metrics which looks at how far the Trust is from reaching with upper quartile. • The procurement team has produced a strategy to look at the feasibility of the Trust reaching the upper quartile for each metric and actions needed to get there.	• The procurement team will continue to work through actions to improve its position against the Model Hospital metrics as part of a rolling programme. • The procurement team has developed a tracker to review progress against the key metrics.	Finance & Sustainability Committee	Ongoing

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NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Key Procurement Metrics	• Target of 80% addressable spend transaction volume on catalogue - Trust currently is at 93% (Q4 2018/19). • Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 96% (Q4 2018/19). • 90% addressable spend by value under contract - Trust currently at 83% (Q4 2018/19).	• Addressable Spend Transaction Volume Even though the target has been achieved, this continues to be monitored on a monthly basis. For suppliers where spend that is not transacted via a PO , these are placed on a 100% PO rule i.e. if they do not have an order number their invoice will be rejected. • Addressable Spend under Contact The procurement team has recently reviewed processes around the Contract Register with a view to improve addressable spend under contract.	Finance & Sustainability Committee	Ongoing Monitoring

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NHS Foundation Trust

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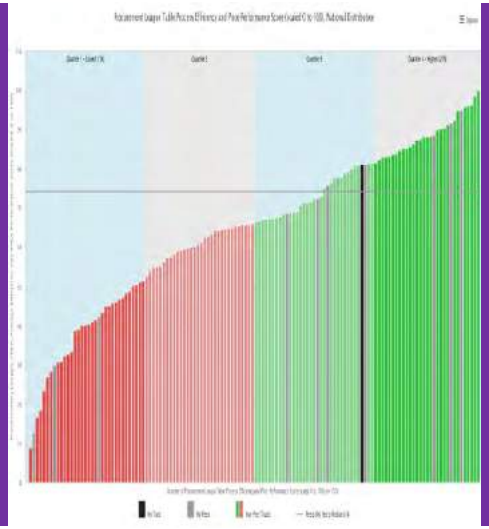
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Procurement Process Efficiency and Price Performance Score Clinics	**KLOE 4 - Corporate Services** UoR This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median = 57** Peer Median = 66 1. Bournemouth 82 2. Wirral 74 3. STHK 72 4. N Lincolnshire 70 5. North Tees 68 6. Southport 64	**Q4 2017/18** 7. WHH 62 8. Chester 61 9. Mid Cheshire 41 10. Gateshead 39 11. Sunderland 14		The Trust is above the National Median but below the peer median. The latest procurement league table has the Trust at a weighted score of 76.5 which puts the Trust in the best quartile. The Procurement Team has in place a strategy for improving performance that is reviewed on a monthly basis.	The Trust has undertaken a review of all procurement metrics and track this on a monthly basis. The key actions are as follows: > Undertake a monthly review of a rolling top 25 by spend to identify and implement any areas of opportunity producing a monthly summary report. > Undertake an analysis of all non-pay spend to understand what is not applicable to PPIB and why. > Submitted for Level 2 of the Procurement Standards with the assessment taking place in Summer 2019.	

Source: Purchase Price Index and Benchmark (PPIB) tool

Monitoring: Senior Procurement Meeting

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. **Lead Director:** Chief Operating Officer			
Strategic estates strategy inc cost reduction based on benchmarks and in the longer term plan for investment/reconfiguration	• The Trust has an estates strategy in place to meet the overall Trust strategy. The strategy is phased 1, 2, and 3. Phase 1 is to explore immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives. • Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and the STP estates strategy. • A draft estates and facilities strategy aligned with the Trusts clinical strategy has been developed and submitted to the Director of Strategy for review. • The Associate Director of Estates and Facilities has been nominated as co-chair for the One Halton estates enabler sub-group.	• The Trust continues to explore internal and partnership collaboration opportunities for relocation of back office and clinical support functions with Bridgewater Community NHS Trust with a joint executive estates working group to move forward this agenda. During Q1 information around current estates heads, locations and space utilisation for both Trusts will be analysed and next steps will be jointly agreed. • A final estates and facilities strategy was submitted and agreed by the Trust Operational Board. • A 12 month estates and facilities workforce plan is currently in development.	Estates and Facilities sub-Committee, TOB, Strategic Development and Delivery Committee	Ongoing management and monitoring of the plan
Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems	• The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings. • Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. • The Trust has realised saving of £140k from the CHP contract which has been used for the departments CIP target.	• A survey being carried out around fans and controls within all our air handling units for which it is anticipated that there should be additional energy efficiency and reduce our Carbon Footprint.	Estates and Facilities Sub-Committee	Complete
Estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• Estates and Facilities costs are incorporated into the PLICS system. Quarterly service line reports are provided to CBUs by the financial planning team. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2.		Estates and Facilities Sub-Committee	Complete

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Model Hospital & Effectiveness of Estates	• The Trust continues to review the effectiveness of its estate and monitors cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. • A business case outlining the resources required to meet the CQC recommendations was approved during Q3 to carry out action against 2018 PLACE assessment and CQC environmental requirements. • A PLACE assessment took place in June 2018; results have been developed into an action plan which is monitored by the estates and facilities operational board and the quality assurance committee.	• The model hospital data for 2017/18 shows the Trust favourable when benchmarking against peer and national medians. In Q1 2019/20, the Trust is exploring opportunities for further improvement in the Trust benchmarking against the indicators.	Estates and Facilities Sub-Committee/TOB/ Quality Assurance Committee	Ongoing Monitoring
All trusts (where appropriate) have a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner	• Model hospital data for 2018/19 reports the Trust utilises 38.7% of its estate for non-clinical use and has 0.9% of empty space. Whilst efforts to minimise the use of trust accommodation for non-clinical purposes has been made, it is difficult given the complexities of the numerous corporate function and the estate footprint. • The current estate strategy aims to address the under-utilised space by rationalising the estate. Better use of under-utilised estate will result in a reduction in the size of the estate and the amount of estate used by non-clinical functions.	• The estates and facilities function is fully involved in the Halton Healthy New Towns and New Hospital for Warrington initiatives. Changes to the estate are cantered around patient care.	Strategic Development and Delivery Committee	Ongoing Monitoring

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NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

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

KLOE 4 - Corporate Services

Estates & Facilities Costs (£ per m2)

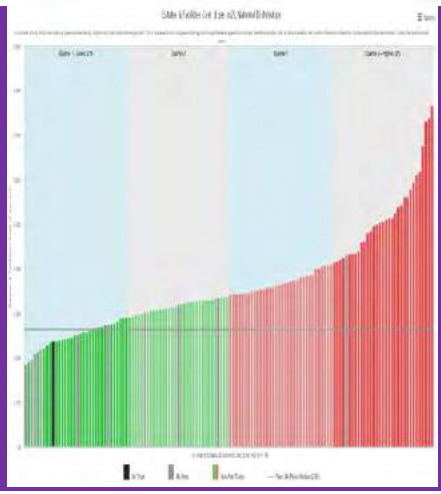
UoR

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

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

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

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



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

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 7 - All trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner. **Lead Director(s):** Director of HR & OD, Director of Finance & Commercial Development and Chief Information Officer			
Rationalisation of corporate and administration functions	• The Trust's corporate and administration functions current costs are 7.4% of income based on planned income as of Q4 2018/19. This includes Finance, HR, IM&T, Communications, Research, Transformational and Executive costs. • The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required. • Reports for each corporate function have been compiled using the latest NHSI Model Hospital data and distributed to corporate service leads for them to use as a start point for internal service reviews. • NHSI operational productivity team visited the Trust on 16th August 2018 to look at the whole of the model hospital and identify opportunities. • As a follow up to the NHSI productivity session, a specific corporate service session is arranged for 17th October 2018 which will focus on IM&T, Finance and HR. • Corporate Services are utilising NHSI Corporate Service Productivity Programme to review opportunities around Chart of Accounts, Journal Policy, Budget Holder Support, Accounts Payable Automation, Sharing Ledger Costs, Policies and Procedures and Financial Reporting. The Trust is working with Mid-Cheshire Hospitals NHS Trust to review structures as part of a wider benchmarking exercise.	• The Trust Deputy Directors have been tasked with taking forward this metric. • The Trust is reviewing WTE costs and benchmarking against Model Hospital data. • Following consultation with MIAA and the NHSI productivity team, Finance & HR have revised their original cost submissions to ensure consistency with other Trusts nationally. This has brought both services below the national median for costs per £100m turnover.	Strategic Development and Delivery Committee	Rolling Programme
Corporate CIP Targets	• All corporate divisions have been assigned costs savings targets in 2019/20. The targets and the progress to date in identifying schemes to meet the targets are summarised. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage cost figures.	• Corporate CIP performance for 2018/19 as at M12 is £1.97m in-year CIP delivered against £1.11m target. • Collaboration at Scale activity is now seen as key to future gains and aims to identify future procurement opportunities.	Finance & Sustainability Committee	Rolling Programme

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NHS Foundation Trust

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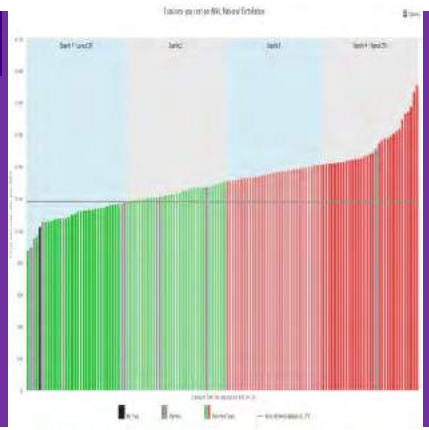
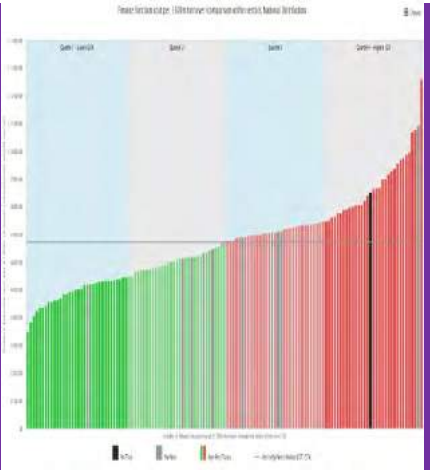
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 4 - Corporate Services					
Non Pay Costs per WAU	Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity. **Source: HSCIC - NHS Digital iView Stability Index**	**National Median = £1307** 2017/18 **Peer Median = £1179** 1. Chester £898 2. Mid Cheshire £954 3. WHH £1027 4. Gateshead £1058 5. Wirral £1078 6. Southport £1172 7. N Lincolnshire £1187 8. Bournemouth £1213 9. STHK £1218 10. North Tees £1280 11. Sunderland £1518	 The Trust is performing in the upper 25 percentile nationally. The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality.	All departments across the Trust are continuously looking at ways to reduce costs as part of day to day business as well as via CIP.	
Finance Costs per £100m Turnover	Total finance cost divided by trust turnover multiplied by a £100m **Source: Trust consolidated annual accounts and NHSI improvement 17/18 data collection template.**	**National Median = £676k** 2017/18 **Peer Median = £672k** 1. Sunderland £522k 2. Chester £617k 3. STHK £621k 4. N Lincolnshire £636k 5. Mid-Cheshire £651k 6. Wirral £692k 7. Bournemouth £710k 8. Gateshead £711k 9. North Tees £711k 10. WHH £852k 11. Southport £1.1m	 Following consultation with MIAA and the NHSI productivity team, Finance & HR have revised their original cost submissions to ensure consistency with other Trusts nationally. This has brought both services below the national median for costs per £100m turnover.	As part of the Lord Carter recommendations, each Corporate service will carry out a review to look at potential opportunities as identified within the model hospital and the national benchmarking exercise.	

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NHS Foundation Trust

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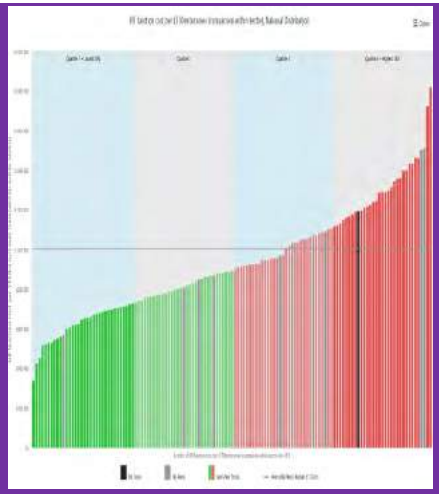
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Human Resource Costs per £100m Turnover	UoR HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median = £898k** Peer Median = £1.01m 1. Sunderland £575k 2. STHK £812k 3. Chester £854k 4. Bournemouth £875k 5. Wirral £974k 6. Mid Cheshire £1.04m	**2017/18** 7. Gateshead £1.07m 8. North Tees £1.09m 9. WHH £1.2m 10. Southport £1.5m 11. N Lincolnshire £1.5m **Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.**		Following consultation with MIAA and the NHSI productivity team, Finance & HR have revised their original cost submissions to ensure consistency with other Trusts nationally. This has brought both services below the national median for costs per £100m turnover.	As part of the Lord Carter recommendations, each Corporate service will carry out a review to look at potential opportunities as identified within the model hospital and the national benchmarking exercise.	

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NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway. **Lead Director(s):** Chief Operating Officer and Director of Strategy			
Variation in Theatres and Outpatients	• A new theatre scheduling process was launched in November 2017 and is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Theatre listing meetings immediately follow '6-4-2' scheduling meetings and examine the patients on each individual list for the following week. • Theatre '6-4-2' scheduling meetings introduced in October 2017 and are now fully established entering the financial year 2018/19. Theatre sessions are now 'locked down' at two weeks. • A new list planning process has been launched with the aim of formally introducing expected list timings into the discussion to ensure all scheduled lists are planned to run at or close to maximum operating time available. • The Demand and Capacity work is complete and the model is now fully functional. Clinic templates for all specialties are being validated to ensure the accuracy of all outcomes. • The KPI Sub-Committee continue to monitor Theatre utilisation, Late starts and Cancellations. • A Theatre Transformation Board to be chaired by the CBU Manager for Digestive Diseases has been established. • The Transformation Team have developed a capacity and demand summary which CBU managers will monitor. • A programme of work around improving Theatre Utilisation and Late Starts has commenced. Full analysis and benchmarking with peers has been undertaken regarding late starts and improvements have been made.	• The Theatre productivity group has been established with a sub-group focusing specifically on cancellations with a view to address the number of cancelled sessions. • The Associate Director of Elective Care Performance has established a project around pre-operations and will present findings during Q1. • Proposals are being developed to host a scanning and surgical until at the CMTC co-locating Breast Screening and Orthopaedics. • Harmonisation of pre-op at Halton and the CMTC is taking place with a view to bring these together.	Trust Operational Board	Ongoing

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NHS Foundation Trust

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Not started/Awaiting further information/New actions parameters to be established

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Emergency Care Improvement Programme	• An Improvement Programme around improvements in patient flow has agreed a number of key work streams across mid Mersey following a system review, these work streams feed into the Mid-Mersey A&E delivery board. • The Trust has its own internal flow board which focuses on 9 key work streams to support improvements in flow. • Red 2 Green patient data is now collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is now in place with partner organisations expected to respond with actions in place to reduce the delays. • Frailty work stream – strategy document ratified by the Trust Board sub-committees in November 2017 and Frailty Assessment Unit completed. • The Emergency Care Improvement Programme visited the Trust in May and June. There was an NWAS challenge for all conveyances and a walk through of the urgent/emergency care system. Positive informal feedback was received. • The FAU has been extended to 5 days per week utilising agency staff with the plan to have substantive staff in post during Q4. • As a result on the system wide capacity and demand review carried out by the Venn Group, the Trust has agreed with partners to approve capacity and flow in the short term. • ED Ambulatory Care opened January 2019. This has resulted in increased assessment throughput and a reduction in direct admissions from ED. • The Trust will continue to focus on Super Stranded Patients with system partners the trajectory for 2019/20 is > 95 patients. • Ambulance Handovers over 30 and 60 minutes continues to reduce month on month.	• Estate has been identified for the Integrated Discharge Team, with co-locating taking place in May 2019. • The Trust will continue to work with One Halton and Warrington Together to ensure proposals are developed consistently with an integrated approach. This includes FAU/Frailty Hub (Acute & Community) and Halton Integrated Care Team. • The Trust is working with NHSI around SAFER/LLOS Collaboration to commence in May 2019.	A&E Delivery Board Flow Board	Ongoing

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Specialty level reviews across local delivery system	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Implementation of plans to reduce variation within pathways across the LDS. • Initial specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. • A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign. • A new clinical strategy is being developed and was launched early in 2018/19. This will support delivery of the Trusts objectives by the clinical teams. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting has commenced. • The Trust is working with Cheshire and Mersey Cancer Alliance to develop optimal pathways beginning with Colorectal, the Trust is supported by Aqua. A one stop show has been launched.	• A new clinical model around the Stroke Pathway has been agreed, the Trust with system partners, is currently working to agree the financial model. Phase 2 implementation to take place in April 2019. • GIRFT reviews continue to take place within a number of specialities across the Cheshire & Mersey footprint. • The Trust has signed up with NHSI to carry out a length of stay evaluation programme, this is included in the SAFER collaboration. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a 3 times per week corporate flow meeting. • All 33 clinical services now have 3-5 year clinical strategies agreed and prioritised. The Clinical strategies seek to address variation and target improvement.	QPS, Strategic Development and Delivery Committee	Ongoing

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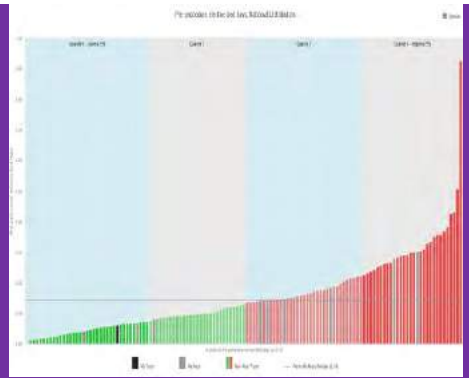
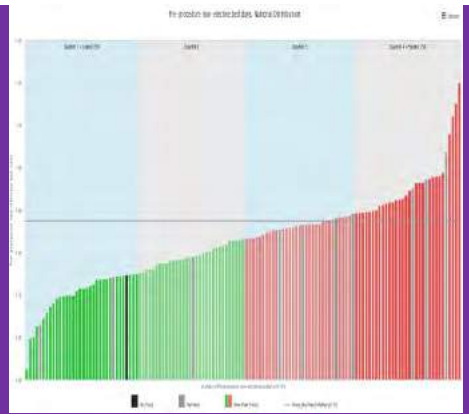
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance				Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 1 - Clinical							
Pre Procedure Elective Bed Days	UoR	National Median = 0.13 Peer Median = 0.14 1. North Tees 0.02 2. Bournemouth 0.04 3. WHH 0.06 4. Mid Cheshire 0.07 5. Wirral 0.08 6. STHK 0.14 Monitoring : KPI Sub-Committee Source: Hospital Episode Statistics	Q3 2018/19 7. Sunderland 0.14 8. Southport 0.15 9. N Lincolnshire 0.18 10.Chester 0.28 11. Gateshead 0.30		The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	
Pre Procedure Non Elective Bed Days	UoR	National Median = 0.66 Peer Median = 0.75 1. Bournemouth 0.26 2. North Tees 0.49 3. WHH 0.50 4. Wirral 0.58 5. Sunderland 0.71 6. Mid Cheshire 0.73 Monitoring: KPI Sub-Committee Source: Hospital Episode Statistics	Q3 2018/19 7. Chester 0.76 8. STHK 0.78 9. N Lincolnshire 0.91 10. Gateshead 0.95 11. Southport 1.07		The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	

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NHS Foundation Trust

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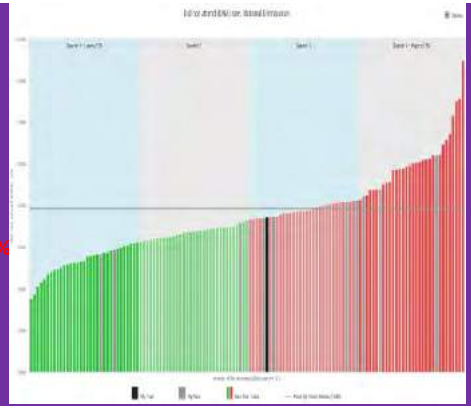
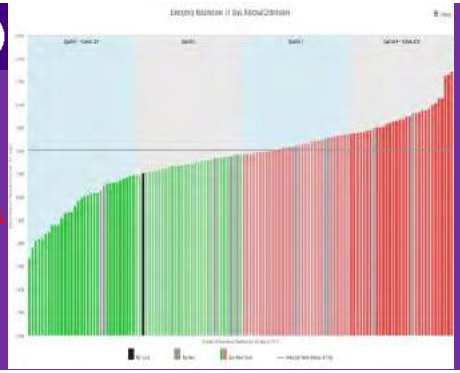
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Did Not Attend (DNA) Rate	UoR Rate of patients not attending their outpatient appointment.	**National Median = 7.32%** Peer Median = 7.86% 1. Chester 5.69% 2. Mid-Cheshire 5.91% 3. Southport 7.19% 4. Bournemouth 7.42% 5. WHH 7.47% 6. N Lincolnshire 7.51% **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q3 2018/19** 7. North Tees 8.20% 8. Gateshead 8.25% 9. Wirral 8.45% 10. Sunderland 8.82%% 11. STHK 10.44%		In May 2018, the Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. The Trust has dipped below the national median in Q3 2018/19, however we continue to focus on how the DNA rate can be improved.	The Trust has continued to implement improvements in the interface with patients. Further improvements in the interface are being implemented via the Outpatient Steering group, which is intended to improve the position further.
Emergency Readmission (30 Days)	This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median = 7.86%** Peer Median = 8.05% 1. Chester 6.31% 2. N Lincolnshire 6.51% 3. WHH 7.05% 4. Wirral 7.73% 5. Bournemouth 7.80% 6. Sunderland 7.85% **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	UoR **Q3 2018/19** 7. STHK 8.25% 8. Gateshead 8.55% 9. Southport 8.59% 10. Mid Cheshire 9.01% 11. North Tees 9.68%		Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to review any inappropriate discharges and ensure lessons are learned.	The Trust will continue to review the improvement through the Trust clinical governance processes to ascertain if there is a need to review discharge procedures.

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NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 9 - All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives. **Lead Director:** Chief Information Officer			
Electronic Patient Record & Structured Clinical Notes	• The Trust implemented Lorenzo EPR in December 2015. • The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs. This project is monitored by the Digital Board. • The Trust continues to upgrade Lorenzo in line with the development roadmap. • The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record. This project is making excellent progress. The team is pulling together conceptual designs to support future state for the selected pathways ' Head Trauma and Diabetes'. • Electronic Maternity Nursing Observations (MEWS) went live during Q4 2018/19. • The Trust was successful in their bid to HLSI to support implementation of Inpatient nursing observations.	• The Trust in collaboration with the C&M H&SCP Digital Programme is developing two delivery plans to demonstrate viability of the preferred option. • Lorenzo Digital Exemplar - Head Trauma and Diabetes current state mapping is complete. Stage 1 is on track for completion for end of Q1. • The Warrington Care Record order placement to "patient knows best" (PKB) was paused in early 2019. A strategic options appraisal was established in light of recent advances in Cheshire & Merseyside H&SCP Digital Programme. Two delivery plans (original and C&M H&SCP DPB plans) and financial profiles to demonstrate viability of the preferred option are being drafted. • Work has commenced of the GP viewer which will give Trust clinicians access to Warrington GP records via Lorenzo. Following testing it is now anticipated this functionality will be available during Q2. • The Trust has been selected to be First of Type for NHS Digital GP Connect project, to enable patient medications from GP systems to be integrated to Lorenzo. High level designs are being drafted. It is anticipated testing will take place during Q2 2019/20.	IM&T Sub-Committee/ Trust Board	Project Implementation – expected completion – Plan up to 2020 on track.
Electronic Document Management System	• A business case for an Electronic Document Management System has been developed. • Due to the development of the LDE business case and the feedback received from clinicians and medical records staff a review of actual requirements now Lorenzo has been live for 3 years is to be undertaken to ensure the investment required is for the right solution.	• The Trust will tender for EDMS system; once this has been completed a full implementation plan will be developed with the successful bidder. • The CIO for Nursing and AHP has been looking at components of EDMS that are actually required to enable paperless by 2020 • This will lead to a revised business case to consider all elements outstanding to achieve a paperless Trust by 2020. • Solution options are still being considered to support paperless 2020 strategy namely Electronic Document system.	IM&T Sub-Committee	Project Implementation – Initiation

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NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
ePMA	• Electronic prescribing and medicines administration (EPMA) Business case and PID signed off by Trust Board and NHS Digital – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • ePMA pilot commenced on CDU in March with a further pilot in Halton Urgent Care centre commencing at the end of March. Learning from all pilots will be used in the development of new functionality and develop fixes to any issues identified. • Successful implementation of ePMA on B4 and Theatres in December 2018. • Electronic prescribing and medicines administration (EPMA) pilot at Halton completed Q4 2018/19. Rollout plans for Warrington are being developed. Go live plan is expected to be approved by Digital Board and Trust Operational Board during Q1 2019/20.	• Rollout to Halton and CMTC sites are now complete. • Planning for rollout on the Warrington site has now commenced.	IM&T Sub-Committee	Project Implementation

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

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

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

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

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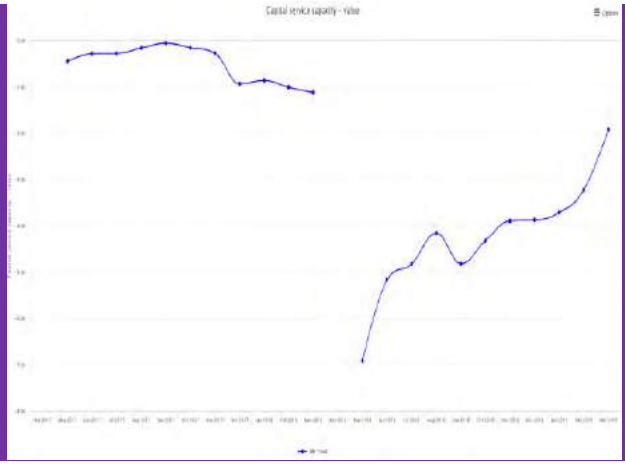
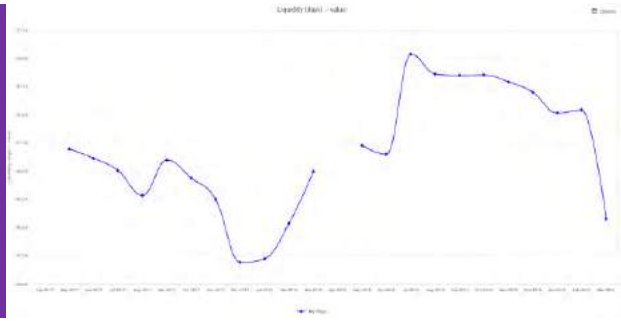
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 5 - Finance					
Capital Services Capacity	UoR The degree to which the provider's generated income covers its financial obligations **Monitoring: FSC/Trust Board**	**WHH Model = -3.22 (Feb 2019)** **WHH Current = -6.63 (April 2019)**		The operating performance of the Trust results in an operating deficit so the Trust is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.	> CBUs and Corporate Divisions continue to explore all opportunities to identify cost savings, increase activity at minimal cost, reduce cooperating costs. > The Trust continues to work with commissioners on the current and future sustainability of services. > The new Trust Financial Resource Group (FRG) continues to review performance though SLR, Benchmarking and the Model Hospital.
Liquidity (Days)	UoR Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown. **Monitoring: FSC/Trust Board** **Source: Provider returns**	**WHH Model = -34.58 days (Feb 2019)** **WHH Current = -44.10 days (April 2019)**		The historic and current operating and financial performance has resulted in reduced cash and the need for additional working capital loans. The Trust manages the cash position very closely to maintain liquidity and meet its financial obligations.	The Trust is working to improve liquidity in the number of ways including the strengthening of treasury management, reduction in aged debt, extension of creditor payments, management of capital programme and access to working capital loans.

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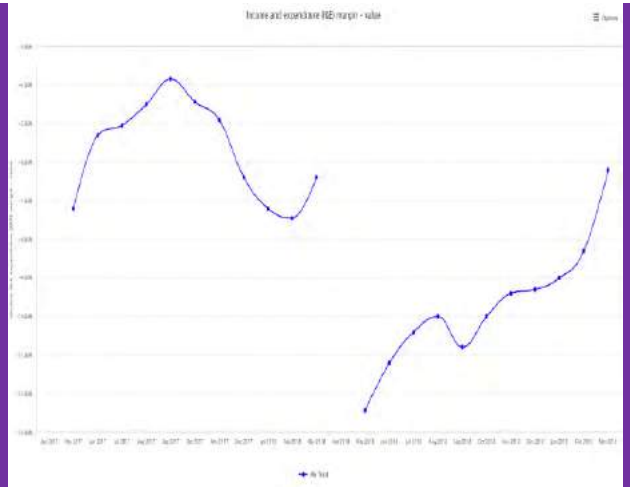
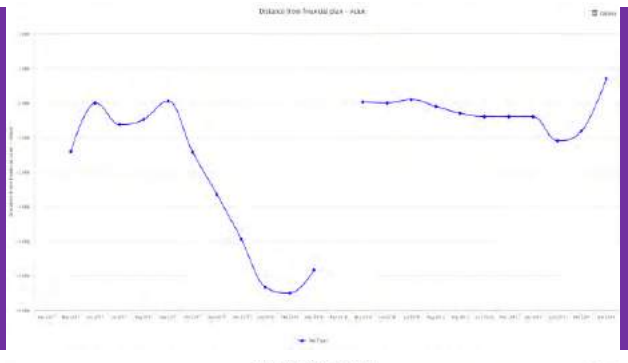
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Income & Expenditure Margin	UoR The income and expenditure surplus or deficit, divided by total revenue.	**WHH Model = -8.30% (Feb 2019)** **WHH Current = 10.72% (April 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The operating performance of the Trust results in an operating deficit so the Trust is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.	> CBUs and Corporate Divisions continue to explore all opportunities to identify cost savings, increase activity at minimal cost, reduce cooperating costs. > The Trust continues to work with commissioners on the current and future sustainability of services. The new Trust Financial Resource Group (FRG) continues to review performance though SLR, Benchmarking and the Model Hospital.
Distance from Financial Plan	UoR Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	**WHH Model = -0.80% (Feb 2019)** **WHH Current = 0.16% (April 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is marginally ahead of the planned deficit but is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.	The Trust achieved the plan and control total in 2018/19 and continues to monitor and manage the plan.

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NHS Foundation Trust

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 4 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Agency Spend - Cap Value	UoR The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	**WHH Model = 29.03% (Feb 2019)** **WHH Current = 3.41% (April 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is marginally above the agency ceiling due to the continued reliance of agency staff to cover gaps from vacancies.	The Trust continues to explore all opportunities to reduce its reliance on agency by recruiting to substantive roles, focusing on retention, innovative workforce models and international recruitment.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/47**			
SUBJECT:	**Staff Engagement- Staff Opinion Survey 2018**			
DATE OF MEETING:	29th May 2019			
AUTHOR(S):	Michelle Cloney, Director of HR & OD			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD			
LINK TO STRATEGIC OBJECTIVES:	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	To provide an update on the results of the 2018 Staff Opinion Survey results and update the Board on next steps. The final response rate for the 2018 survey was 51% compared to an average 44% response rates for Acute Trusts and compared to the Trust's 2017 response rate of 46%. Overall, the Trust has performed well and the survey results evidence a workforce that is engaged. The Trust has performed above average (compared to Acute Trusts) in 8 out of the 10 key themes, has performed in line with the Acute Trust average in 1 of the ten themes and below average in 1 of the ten themes. In line with best practice as advocated by NHS Employers, CBUs and Departments will be expected and supported to take local ownership of their survey results, building on existing work on-going and/or creating bespoke interventions where required. In addition, and recognising the importance of a Trust-wide approach to the key themes highlighted by the results, the results will be mapped against key Trust strategies to inform and steer programmes of work.			
PURPOSE: (please select as appropriate)	Information x	Approval	To note	Decision

RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/19/03/39
	Date of meeting	20th March 2019
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

TRUST BOARD

SUBJECT	Staff Engagement – Staff Opinion Survey 2018	AGENDA REF:	BM/19/05/47

1. BACKGROUND/CONTEXT

Employee engagement is a key element of the People Strategy 2018-2021 and cuts across all aspects of the work programme. The WHH Employee Engagement Framework is based on publications from the Kings Fund, NHS Employers and CIPD and the national staff opinion survey is a key measurement tool in relation to staff experience.

This paper sets out the key findings from the 2018 Staff Opinion Survey and describes the measures and actions to be taken.

2. KEY ELEMENTS

2.1. 2018 Staff Opinion Survey Campaign

The 2018 staff survey was launched in the Trust on 24th September 2018 remained open to staff to respond until 30th November 2018.

The approach taken was particularly successful. The final response rate for the 2018 survey was **51%** compared to an average **44%** response rates for Acute Trusts and compared to the Trust's 2017 response rate of **46%**. 51% response rate is the highest ever achieved by the Trust.

The key elements of the campaign were:-

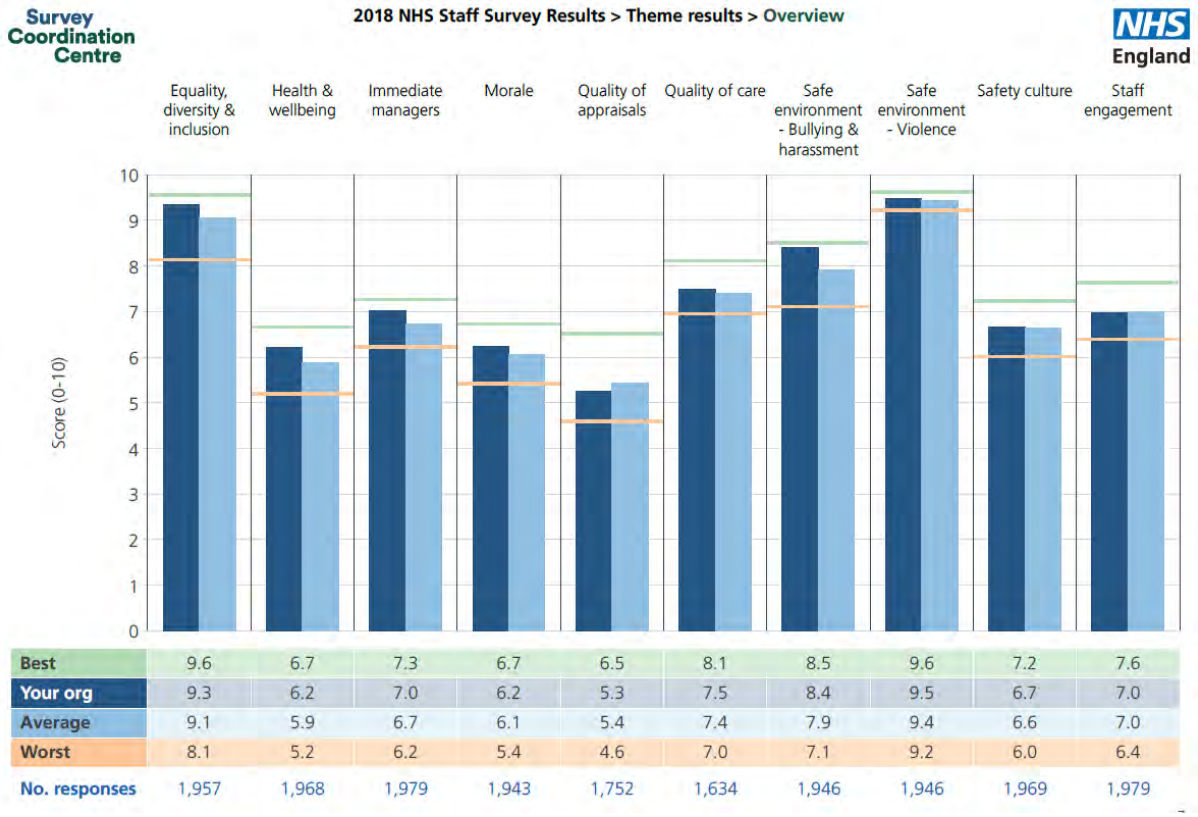
- **'Keep Talking'** – messages are highlighting to staff the importance of their continuing dialogue with the Trust to maintain momentum around making changes.
- **Confidentiality** – issues around survey confidentiality are common amongst staff. Frequently asked question and a video explaining how the survey is maintained was available on the staff extranet news page.
- **Incentives** – a range of prizes and incentives were available to staff that completed the survey.
- **Local Ownership** - it was recognised that the best response rates are achieved where local managers take ownership of ensuring that staff have the opportunity to complete their survey. To facilitate this, HR Business Partners worked with Department and CBU leads to ensure that there was a local plan in place for each area.

2.2. 2018 Staff Opinion Survey Results

Staff Survey results are presented in ten key themes, the results of which are displayed in the graph below.

Overall, the Trust has performed well and the survey results evidence a workforce that is engaged.

The Trust has performed above average (compared to Acute Trusts) in 8 out of the 10 key themes, has performed in line with the Acute Trust average in 1 of the ten themes and below average in 1 of the ten themes.



	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
No. responses	1,957	1,968	1,979	1,943	1,752	1,634	1,946	1,946	1,969	1,979

2.2.1. Areas of Success

The Trust has performed above average in relation to the following themes:

- Equality and Diversity
- Health and Wellbeing
- Immediate Managers
- Morale
- Quality of Care
- Safe Environment – Bullying and Harassment
- Safe Environment – Violence

- Safety Culture

The Safety Culture theme asked questions in relation to the reporting of errors and incidents and how secure staff felt about reporting issues and concerns and how confident they felt that the Trust will act on these concerns. Overall the Trust improved on every question in this theme.

2.2.2. Areas to Build On

The Trust scored in line with the Acute Trust average for the Employee Engagement Theme. Whilst the national average score has not increased in year, the Trust did achieve a statistically significant increase, demonstrating the work undertaken throughout 2018 and beyond. This score evidences a workforce that is engaged. More staff reported looking forward to coming to work and being enthusiastic about their job. There was also an improvement in the number of staff reporting they would recommend WHH as a place to work and receive care.

This remains a key area of focus to continue to improve and achieve our ambition of moving beyond national average to be the best place to work.

2.2.3. Areas Requiring Additional Focus

Whilst the results demonstrate an improvement in all but 1 of the questions answered in relation to the quality of appraisals, the Trust was below the Acute Trust average for this theme. This is a priority delivery area within year 2 (2019/2020) of the People Strategy.

2.3. Next Steps – Actioning the 2018 Staff Opinion Survey

Following the successes of the 2017 approach to actioning the staff survey results (i.e. moving away from very operational action plans), the Executive Team and Strategic People Committee have endorsed a similar approach. In line with best practice as advocated by NHS Employers, CBUs and Departments will be expected and supported to take local ownership of their survey results, building on existing work on-going and/or creating bespoke interventions where required. In addition, and recognising the importance of a Trust-wide approach to the key themes highlighted by the results, the results will be mapped against key Trust strategies to inform and steer programmes of work.

2.3.1. Local Ownership

Results have been shared at a local level and CBU/Department leads have been asked to analysis their results and triangulate the data with other information sources to ensure that key actions are being developed and aligned to other service improvement projects.

Although the responsibility for utilising the data and deciding on appropriate actions for each area sits with local management teams, the HR and OD team are providing support and guidance on how to analyse and make best use of the results.

Progress in relation to agreed actions and 'quick wins', which may be mapped to the LiA programme, will be monitored through the LiA sponsor group.

2.3.2. Mapping of Results to Key Trust Strategies

The results of each question under the 9 key themes have been analysed to identify any individual questions where the Trust has performed below average compared to other Acute Trusts. Where performance below average is identified this has been mapped to the relevant Trust Strategy. In addition to analysing the data by individual question, the HR and OD Team are also analysis the results according to the equality monitoring data provided by respondents. The Equality, Diversity and Inclusion Strategy delivery plan will then be assessed against the analysis. This piece of work is on-going and will be reported to the next Equality, Diversity and Inclusion Sub-Committee.

The purpose of these exercises is to seek assurance that any issues identified in the survey results are covered as part of strategy delivery plans and to provide additional information to strategy leads to support in the execution of the plans.

For the purpose of this high level paper, an update has been given below on the 2 areas where the Trust is not yet above the Acute Trust average score, however this detailed analysis is being undertaken across all of the themes.

2.3.3. Employee Engagement

There are 9 questions in the Staff Opinion Survey which relate to Employee Engagement. When compared with 2017 results, the Trust score increased in 8 of the 9 questions. As stated above, the Trust score is in line with the Acute Trust Average.

Where the Trust has scored below the Acute Trust Average for individual questions within this theme, analysis has shown that each area is addressed within either the People Strategy or the Quality Strategy.

This theme falls within the following Trust 'People Pledges':

- *'We will create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience'.*
- *'We will develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning'.*
- *'We will attract and retain a diverse workforce aligned to our culture and values'.*

Key work streams which will address these include:

- ✓ Listening into Action – launched and on-going
- ✓ Quality Academy – launched and on-going
- ✓ Retention Action Plan– launched and on-going
- ✓ Developing High Performing Teams (Afina Model) – first teams to be launched in Q2 2019/20
- ✓ WHH Leadership Model – work complete, to be launched in Q2 2019/20

2.3.4. Quality of Appraisals

There are 4 questions in the Staff Opinion Survey which relate to Quality of Appraisals. When compared with the 2017 survey results the Trust score increased in all but 1 of these questions however the Trust scored below the Acute Trust average for this theme.

This theme falls within the following Trust 'People Pledges':

- *'We will develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning'.*
- *'We will attract and retain a diverse workforce aligned to our culture and values'.*

The table below sets out the Trust and average results for each of the 4 questions

Question	WHH SOS result	Average Acute Trust
It helped me improve how I do my job	23.1%	23%
It helped me agree clear objective for my work	33.2%	34.7%
It left me feeling that my work is valued by my organisation	29.8%	32.3%
The values of my organisation were discussed as part of the appraisal process	30.1%	35.1%

Key work streams which will address these include:

- ✓ Essential Manager Training Review: Performance Management – launched and on-going
- ✓ Essential Manager Training Review: Difficult Conversations - launched and on-going
- ✓ WHH Leadership Model – work complete, to be launched in Q2 2019/20
- ✓ Development of Trust behaviours aligned to values – part of People Strategy delivery year 2 (2019/20), work to commence in Q1 and due to complete in Q3
- ✓ Review of appraisal process – part of People Strategy delivery year 2 (2019/20), work to commence in Q1 and due to complete in Q3.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Director of HR&OD is the responsible officer for Staff Engagement.

Trust Board is asked to note the progress to date.

4. IMPACT ON QPS?

Staff Opinion Survey is a key measure of staff engagement across the Trust and is directly linked the Trust objective of 'We will… be the best place to work with a diverse, engaged workforce that is fit for the future.

The Staff Opinion Survey also asks questions in relation to other elements of staff experience at work and these are linked to other key Trust strategies.

5. RECOMMENDATIONS

Trust Board is asked to note the content of the report.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/49**
SUBJECT:	**Trust Engagement Dashboard 2018-19**
DATE OF MEETING:	29th May 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
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has launched its first **patient and public participation and involvement strategy** for 2019-21, a measure of the success of the deployment of this strategy is the attached Engagement Dashboard. The Dashboard addresses: - Level of success in **managing the Trust's reputation** in the media and across digital and social platforms and where the Trust's Communications team works to ensure that balance is maintained by feeding positive news and events into the mix - Our **engagement with patients, staff and public** via our social media platforms continues to grow again due to sustained proactive action building a strong virtual community - The Trust's **new, accessible and mobile-enabled website** went live in Sept 2018 and engagement with this key platform continues to build with monthly visitors peaking at nearly 40K in October and maintaining increased activity, up from a regular 25K visitors per month. Greater accessibility is a key contributor to this as the platform is easy read on mobile devices – the key platform from which visitors search for us. In addition, content by the services continues to develop and we are working on this in 2019-20. Interestingly, enquiries via our website which come to the Communications Team have spiked in the last quarter of the year yet there are no common

<table>
<tr><td></td><td colspan="4">themes. While handling this service is demanding it also gives an opportunity to continue to refine content on the website since most enquiries should be able to be directed to various service links. We work very closely with PALS on this activity.
- Patient feedback on the independent platforms is also up in terms of ratings with Warrington Hospital achieving 4* rating for the first time in at least three years of being 3.5* Our work now is to increase postings to these sites
We have, at Governors request, included the annual complaints dashboard for triangulation purposes for the first time.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information

X</td><td>Approval</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">• The Board receives and notes the 2018-19 Engagement Dashboard .
• The Board notes the amended Cycle of Business to bring the Dashboard on a quarterly basis for assurance on progress with Patient & Public Participation and Involvement through a new PPP&I section</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Council of Governors</td></tr>
<tr><td colspan="2">Agenda Ref.</td><td colspan="2">COG/19/05/28</td></tr>
<tr><td colspan="2">Date of meeting</td><td colspan="2">16 May 2019</td></tr>
<tr><td colspan="2">Summary of Outcome</td><td colspan="2">Present to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
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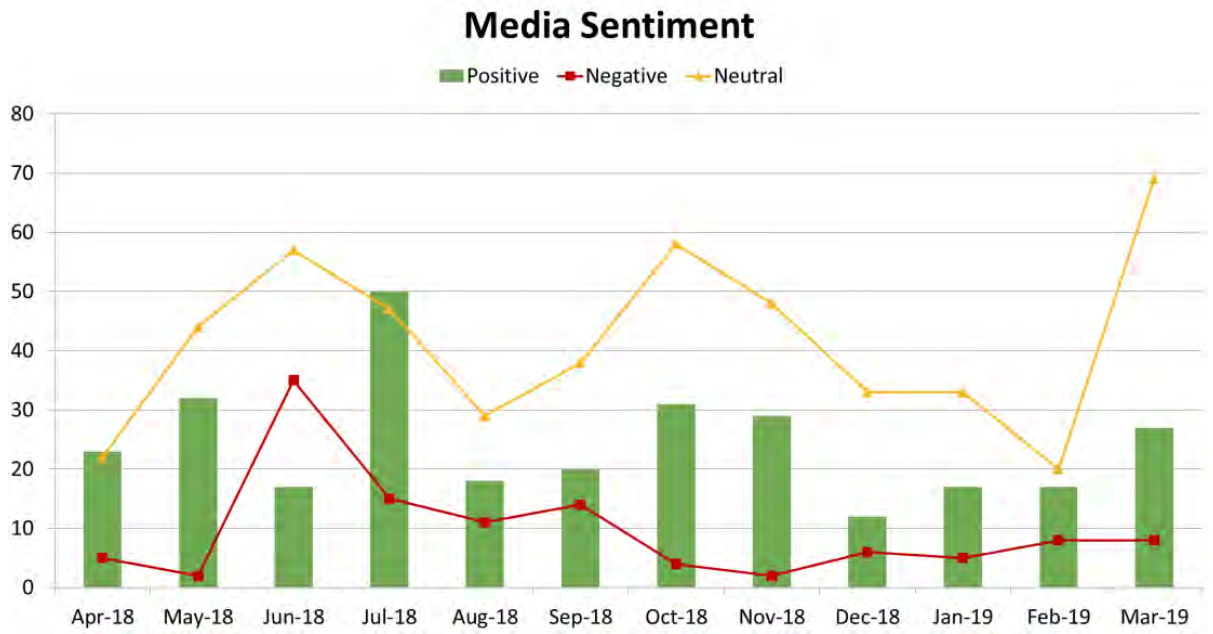
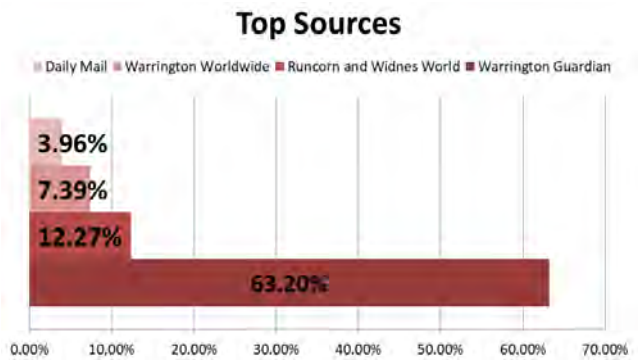
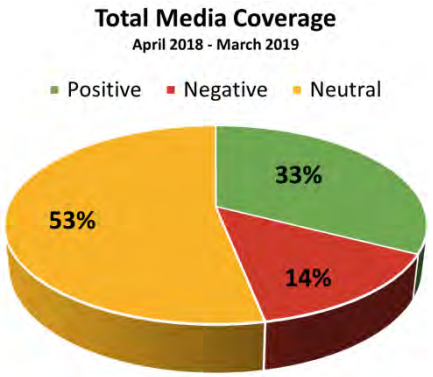
Media Sentiment:
April 2018 – March 2019

NHS
Warrington and Halton Hospitals
NHS Foundation Trust







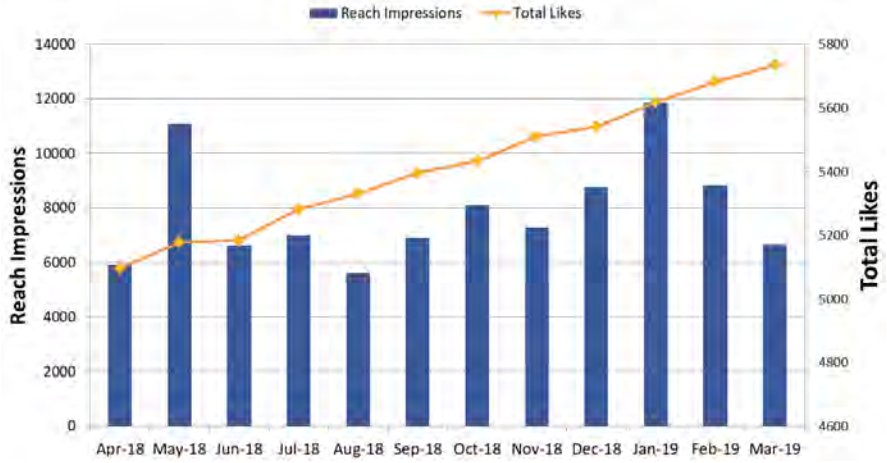
Social Media:
April 2018 – March 2019

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

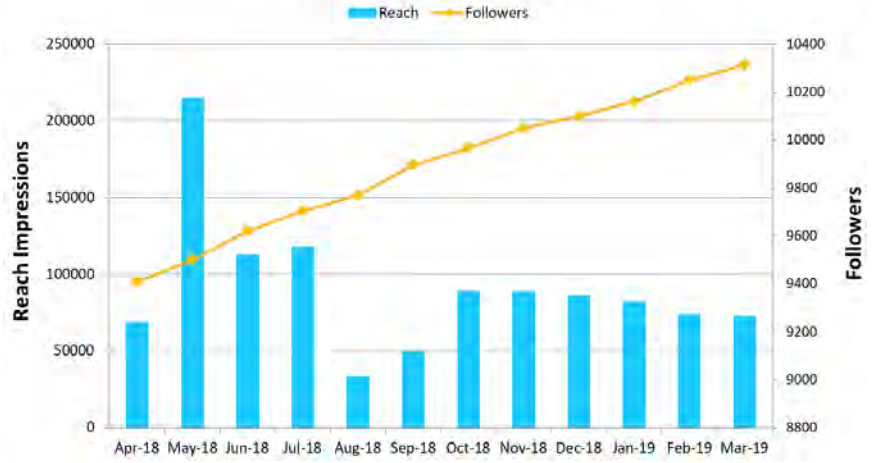
facebook

twitter

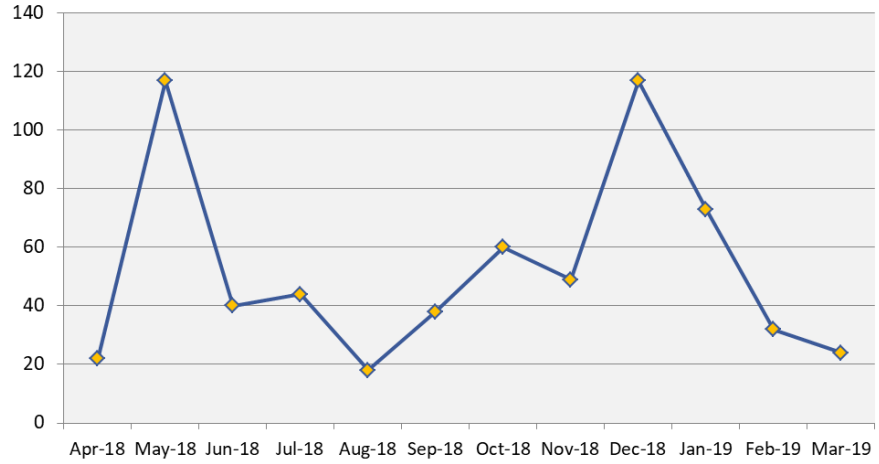
FACEBOOK ENGAGEMENT



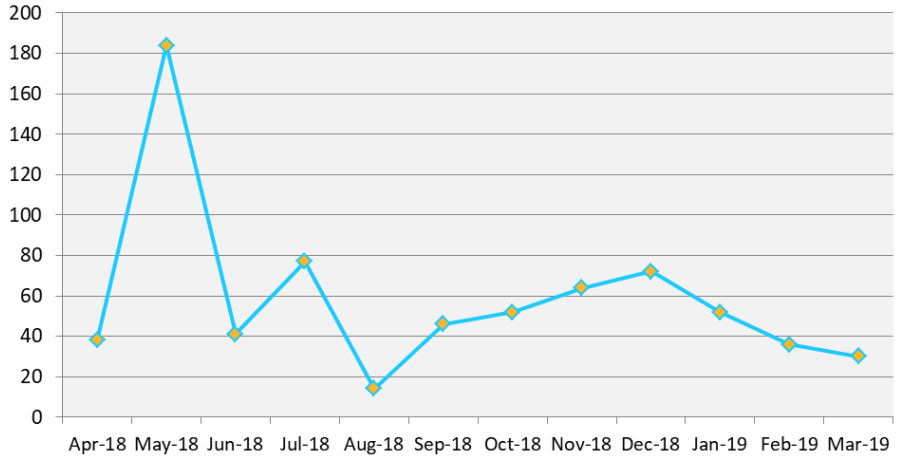
TWITTER ENGAGEMENT



WHH Posts



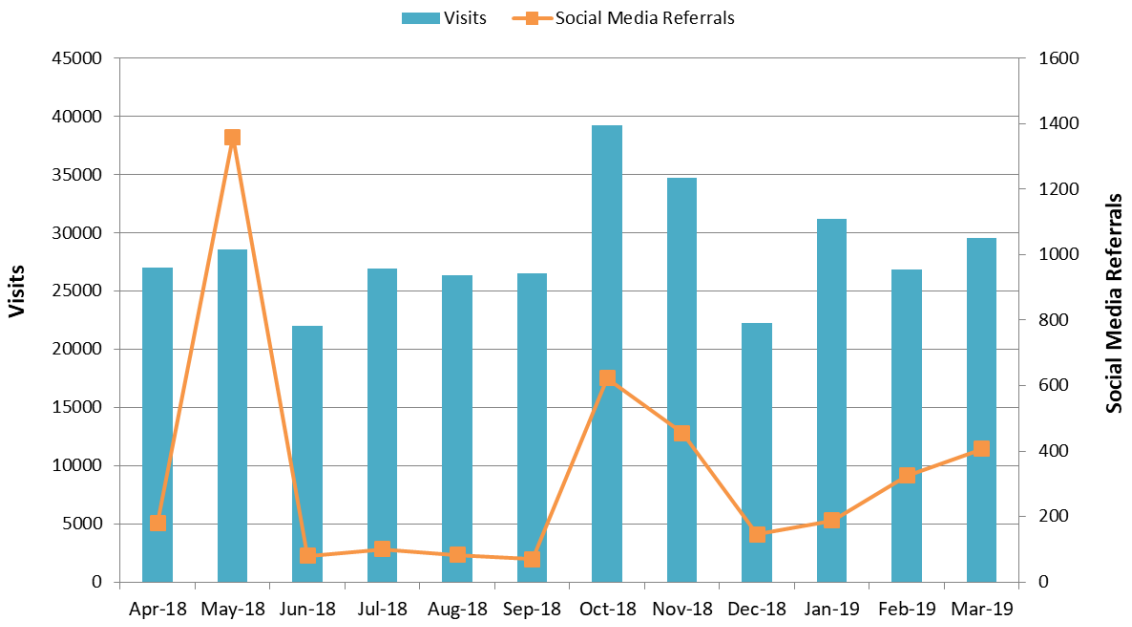
WHH Tweets



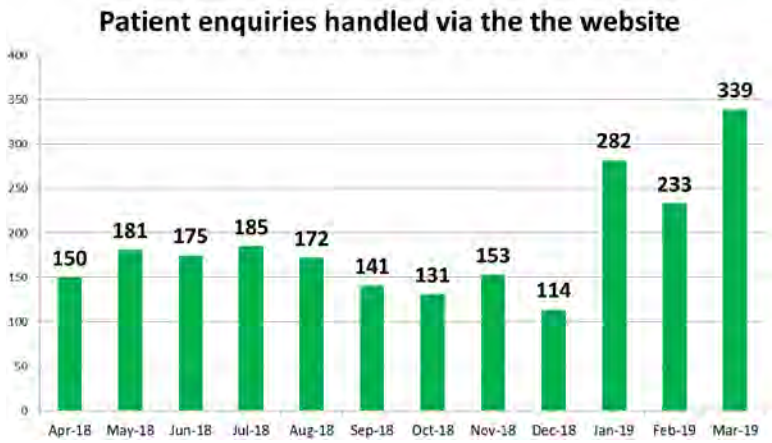
WHH Website:
April 2018 – March 2019

Warrington and Halton Hospitals NHS Foundation Trust

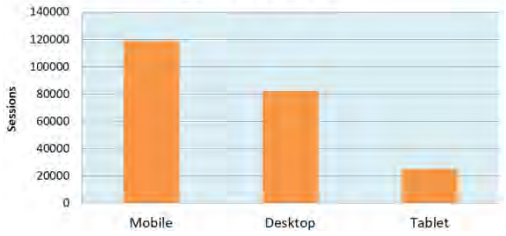
WEBSITE ENGAGEMENT

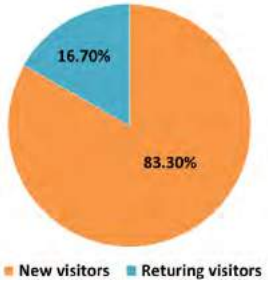


Patient enquiries handled via the the website



DEVICE USAGE





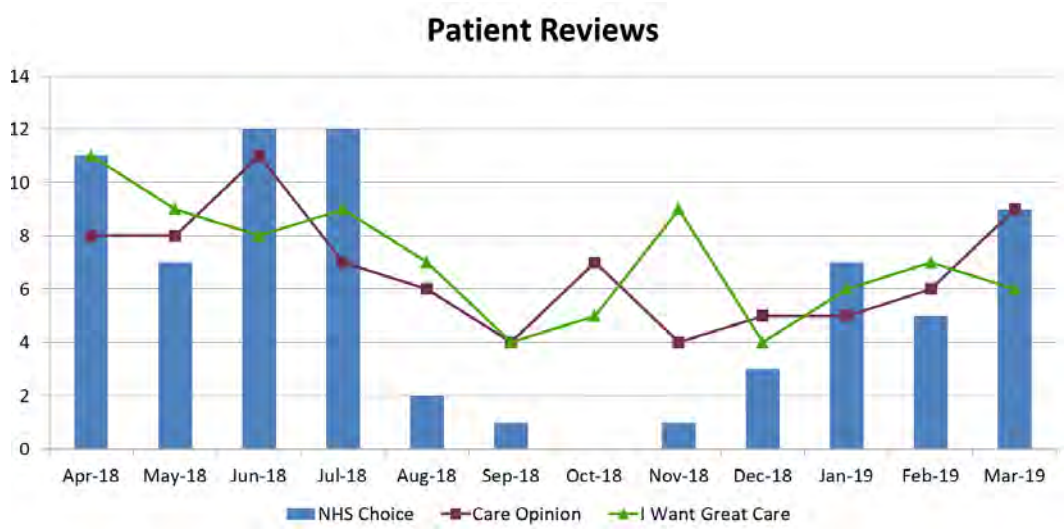
SESSION DURATION

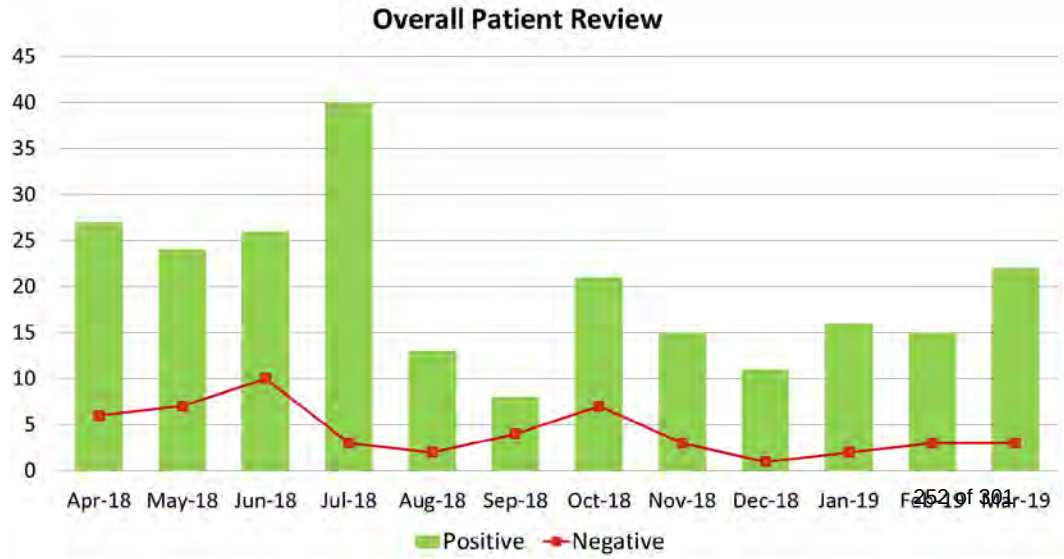
1m 38s

↑ 3% FROM MARCH 2018

Patient Experience:
April 2018 – March 2019

Warrington and Halton Hospitals NHS Foundation Trust





Feedback Rating by NHS Choices

4
Average rating at Warrington

5
Average rating at Halton

4.5
Average rating at CMTC

Feedback Rating by Care Opinion

3.5
Average rating at Warrington

4
Average rating at Halton

4
Average rating at CMTC

Feedback Rating by iWantGreatCare

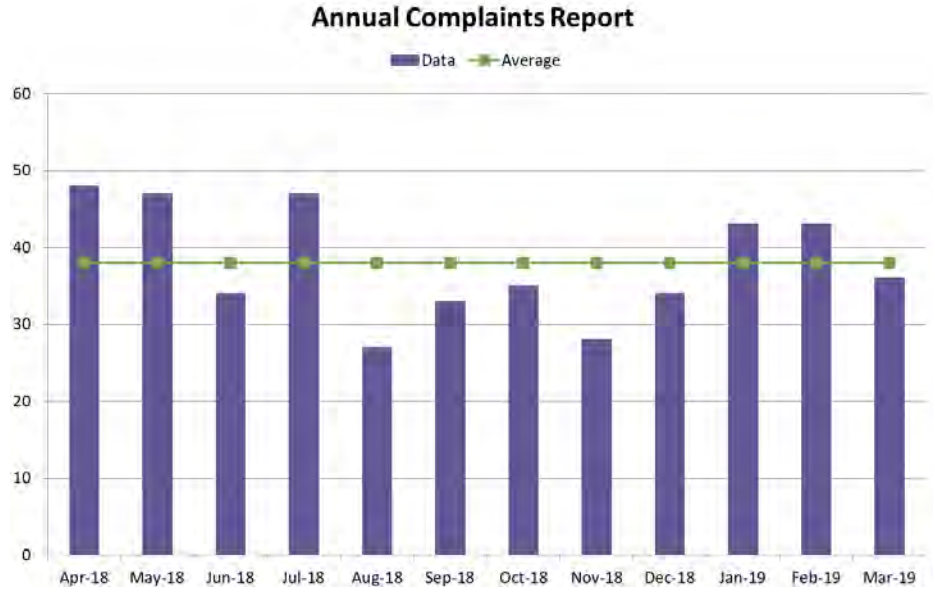
5
Average rating at Warrington

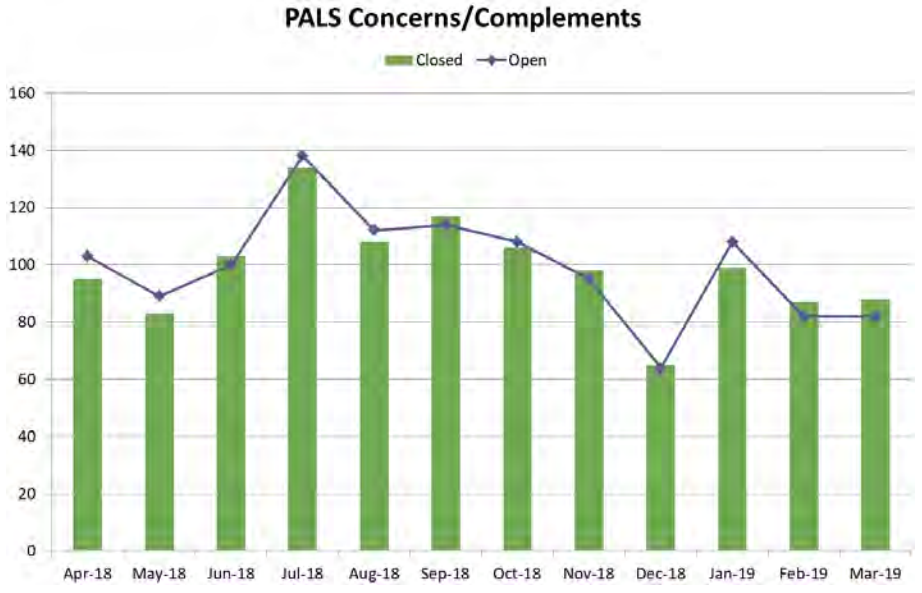
5
Average rating at Halton

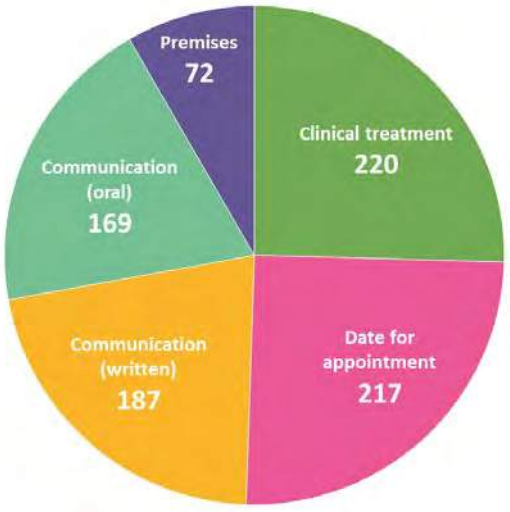
5
Average rating at CMTC

Complaints and PALS:
April 2018 – March 2019

Warrington and Halton Hospitals NHS Foundation Trust







Complaints Common Theme	No.
Clinical treatment	214
Attitude and behaviour	66
Communication (oral)	53
Admissions / transfers / discharge procedure	25
Premises	16
Personal records	14
Communication (written)	13
Date for appointment	13
Patient privacy / dignity	7
Patient property / expenses	7
Test results	6
Outpatient and other clinics	6
Date of admission / attendance	4
Failure to follow agreed procedures	4
Competence	2
Bed shortages	2
Shortage / availability	1
Catering	1
Consent to treatment	1
Totals:	**455**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/51**			
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**			
DATE OF MEETING:	29th May 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):	Since the last meeting: • There are no new risks that have been added to the BAF; • It was agreed that two risks were de-escalated from the BAF; • It was agreed that the rating of one risk currently on the BAF was reduced; • There are no amendments to risk descriptions. 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/19/05/92		
	Date of meeting	7th May 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/19/05/51

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, no risk titles on the BAF have been amended.

2.3 Amendments to risk ratings

Since the last meeting, the risk rating on one risk on the BAF has been reduced.

Risk #**117**	**Risk: Failure to successfully counter the regulatory and contractual consequences, caused by the suspension of spinal services in September 2017, resulting in significant reputational damage.**
Initial Risk Rating	20 (4x5)
Previous Risk Rating	16 (4x4)
Amended Risk Rating	8 (4x2)

Following the conclusion of the final inquest and confirmation from the CQC that they would not be proceeding with criminal proceedings, it was agreed that the risk be reduced to the target rating of 8.

2.4 Removal of Risks

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

RISK 117: *Failure to successfully counter the regulatory and contractual consequences, caused by the suspension of spinal services in September 2017, resulting in significant reputational damage.*

The current risk rating is 16 (4x4); however, it was agreed that this be reduced to 8 (4x2) following the conclusion of the final inquest and confirmation from the CQC that they would not be proceeding with criminal proceedings. As 8 is the target score, it was agreed that the risk be de-escalated from the BAF.

RISK 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*

It is agreed that this risk is de-escalated from the BAF due to the work and investment undertaken with LiA, the positive Staff Survey results and the agreement at the last Quality Assurance Committee meeting to reduce the risk rating to the target score of 6.

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.	• Retention plan in place and submitted to NHSi end of March 2019. The plan commits to reduce registered nurse turnover by 1.5% in the next 12 months. Progress will be monitored monthly at the Recruitment & Retention Group. • The Retention Plan is being monitored at the Recruitment and Retention Group and we have seen a reduction in Registered Nurse Turnover for the past 4 months the current rate is 12.91% which is less than the National rate of 13%. • Current vacancies are as follows: Registered Nurses 92 vacancies with 72 nurses having accepted an offer of a post at WHH and are due to commence no later than Sept 19 • HCA 88 vacancies with 47 staff currently undergoing pre-employment checks and are commencing with the Trust in the next month • Further recruitment events are planned as part of the recruitment calendar	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
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	• A TNA analysis and plan is currently being developed for critical systems. The TNA for critical systems is now available and due to be published with supporting guidance for managers. • The ICE infrastructure has been migrated to an existing server however this only adequate in the short term. A paper on the options for the medium to long-term was prepared which included an option for external hosting and covered - Using the current new internal hardware, Improving the current new internal hardware with extra resilience, providing new hardware • A paper on the potential options and preferred solution was presented at the Digital Board on 18/3/19. Following the meeting the preferred option is to be presented to Execs in April for consideration. • Approval secured to procure teo new servers to create a resilient platform for the ICE system which supports disaster recovery.	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	• Following recruitment of additional staff, the Department has now got the capacity to respond to demands for focussed analytics. Information Analysts have been aligned to CBUs and are now attending CBU Meetings	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data.	to support with analysis and reporting. • The work on the BI Road Map will continue to provide the prioritised dashboard and insight reports including Ward Dashboards. • ED Flow Dashboard live pilot commenced providing increased visibility.	
224	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience	• Long Length of Stay Collaborative in association with ECIST / NHSI. Bespoke approach for the Trust in embedding and sustaining LLoS review. To commence May 19 through until September 19. • Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. Co-location of teams approved in April 19. This will support harmonisation of pathways and increase integrated working between health and social care. • Co-location of teams to take place in May 2019 (Kendrick Wing) • Urgent Care Improvement Committee to commence form May/June 2019 focussing on 5 priorities: o CQC Actions o Acute Medicine o Assessment Capacity/Environment o Decision to admit o Collective decision making • The Committee will report to the Quality Assurance Committee and Exec Team • New ED 'at a glance' dashboard gone live – supports organisational visibility and proactive response from specialties. • Participating as a pilot site for recording of Same Day Emergency Care (SDEC) in association with NHSi & NHSE	No impact on risk rating
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.	• Daily SitReps are being submitted to the DHSC. • May 2019 - the Government has agreed an EU Exit extension to the 31st October 2019. If the Withdrawal Agreement is ratified earlier the UK will leave the EU earlier, but it would be with a deal. All reporting has been	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		stood down and the planning that had been in place will be adapted to support the extension. A debrief session has taken place to capture lessons learnt and has been shared with the regional EU exit team and will be used to support our preparations closer to the leave date.	
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	• Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. • NHSE supportive of draft strategy for breast screening.	No impact on risk rating
143	Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	• A robust patching regime has been implemented and automated using Solar Winds software which allows time to be spent on the complex areas for patching. Patching completion has increased to 96%. • Network Penetration Tests - MIAA have completed an external penetration testing of our network and we are awaiting the formal report. The Trust has also purchased software that will test any internal vulnerabilities on our servers. The server has been set up and software has been installed and the next steps are to do the server configuration. • The movement of medical devices in to	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		a VLAN bubble remains incomplete due to the work required to move medical devices across to within the protection. This requires co-ordination between the operational teams in Pathology and Radiology, external suppliers and adequate IT resources all of which are impacting on the completion of this task • Encryption of backups – The encryption software has been switched; however, sense checks are to be undertaken before this can be completed.	
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.	• New IM&T Department structure developed. The increase in support for IG and Information Security has been recognised.	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	• The audit of all women diagnosed between 2013 and 2018 is in progress and ongoing. • The current gap in assurance is the unknown results of all of the audit as it is still in progress with a completion date set by SQAS of November 2019 • The current gap in assurance is the unknown results of all of the audit as it is still in progress with a completion date set by SQAS of November 2019.	No impact on risk rating
241	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• High level briefing paper submitted to QAC (7.5.19). • Trust wide work stream for rota management. • Clinic attendance for trainees to ensure they can be released from wards to attend – record log in place and escalation process if not occurring. Subsequent plans to improve training available clinics. • 3 substantive consultant appointments	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		in Acute Medicine, 1 consultant in Care of the Elderly who is also Clinical Director for Integrated Medical and Social Care CBU. • Ward Round Accreditation quality improvement work stream. • Access for trainees to Quality Academy and Quality Improvement work streams. • Fortnightly Medical Education newsletter	
117	Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputation damage and potential regulatory and contractual issues.	• The final inquest now concluded without a PFD outcome. • Discussions are ongoing with RLBUHT for a future clinical model • Confirmation from the CQC on 26th April 2019, that the they did not intend to proceed with any criminal investigations.	Recommend to reduce risk from 16 to 8 and de-escalated from the BAF

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

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/52**			
SUBJECT:	**Terms of Reference and Cycle Of Business 2019-20 Sub Committees of the Trust Board** - **Finance + Sustainability Committee** - **Quality Assurance Committee** - **Strategic People Committee** **Cycle of Business 2019** - **Trust Board** - **Audit Committee** - **Finance & Sustainability Committee** - **Strategic People Committee** - **Quality Assurance Committee**			
DATE OF MEETING:	29 May 2019			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive			
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):	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. Each ToR and CoB has been reviewed and approved by the relevant committee.			
PURPOSE: (please select as appropriate)	Information	Approval **X**	To note	Decision
RECOMMENDATION:	The Trust Board is required to ratify the Terms of Reference and 2019-20 Cycles of Business of the Quality Assurance Committee, Audit Committee and Trust Board			
PREVIOUSLY CONSIDERED BY:	**Committee / date**	Quality Assurance Committee: 8 January 2019 Ref: QAC/19/01/17 Audit Committee: 25 February 2019 Ref: AC/19/02/22 Strategic People Committee 20 March 2019 Ref:/SPC/19/03/23 Finance & Sustainability Committee 20 March 2019 Ref FSC 19/03/38		

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

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/53**			
SUBJECT:	**Committee Chair's Annual Reports** - **Finance + Sustainability Committee** - **Strategic People Committee** - **Audit Committee**			
DATE OF MEETING:	29 May 2019			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD			
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services			
EXECUTIVE SUMMARY (KEY ISSUES):	This report seeks to deliver assurance to the Trust Board that the Committee's detailed above, have met their Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: (please select as appropriate)	Information	**Approval √**	To note	Decision
RECOMMENDATION:	To approve the Committee Chair's Annual Reports			
PREVIOUSLY CONSIDERED BY:	30 April 2019 - Finance + Sustainability Committee, Agenda Ref FSC/19/04/55 - approved 20 March 2019- Strategic People Committee, Agenda Ref SPC/19/03/25 -approved 21 May 2019 – Audit Committee, Agenda Ref AC/19/05/53 - approved			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/19/04/55**			
SUBJECT:	**Committee Chairs Annual Report 2018-19**			
DATE OF MEETING:	30 April 2019			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE DIRECTOR SPONSOR:	Terry Atherton, Non-Executive Director, Committee Chair			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Finance and Sustainability Committee that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	**The Finance and Sustainability Committee is asked to review the document and ensure it meets its purpose.**			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

SUBJECT	Annual Report of the Finance and Sustainability Committee 2018-19

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Finance and Sustainability Committee (FSC) Annual Report which covers the reporting period 1st April 2018 to 31st March 2019.

The Committee is responsible on behalf of the Board for reviewing financial and operational planning, performance and strategic and business development.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has primarily been composed of two Non-Executive Directors with a quorum of two (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence. I have been the Chair of the Committee since February 2015.

The Finance and Sustainability Committee attendance record is attached in Appendix 1.

Regular attendees at the Committee meetings are the Director of Finance and Commercial Development, Medical Director, Executive Medical Director, Chief Nurse, Director of Human Resources and Organisational Development, Director of Strategy, Chief Operating Officer, Deputy Director of Finance and the Head of Corporate Affairs.

Terms of Reference

The Committee's Terms of Reference were reviewed again during Quarter 4 of 2018 /19 to ensure they continued to remain fit for purpose with amendments approved 20 March 2019 to the Section 6 Core Attendees and Section 9 Reporting sections.

Frequency of Meetings and Summary of Activity

The Committee met 13 times during the year, including an Extra Ordinary FSC in January 2019 to review the Draft Initial Operating Plan 2019/20. A summary of the activity covered at these meetings follows:

Reporting

In terms of reporting to the Finance and Sustainability Committee, the following key reports were submitted in 2018/2019.

- **Pay Assurance Dashboard - monthly**
  Including all pay spend, whilst maintaining a focus on temporary staffing. The revised dashboard also includes factors which influence pay spend such as activity, bed escalation and gaps in the workforce, the Committee requested inclusion of agency ceiling metric in August 2018.

- **Pay Assurance Checklist – quarterly**

The Pay Assurance Checklist details the position against a number of key areas of best practice aimed at reducing temporary staffing spend. Progress against the checklist is managed on a monthly basis at Premium Pay Spend Review Group and quarterly updates are submitted to the Committee. The Committee received regular updates relating to collaborative bank and medical bank arrangements across Cheshire and Mersey.

- **Premium Pay Spend Review Group**

  The Premium Pay Spend Review Group was established in March 2018 and continues to review all spend and put in place controls and mitigation. Focus in 2018-19 refocused to premium pay spend, in order to ensure that high impact projects in place. The group monitors progress of projects which include:

  - Development of WHH Bank
  - Development of Centralised Temporary Staffing Team
  - Review of WLI Rates and Payment Mechanisms
  - Review of Job Planning
  - Review of Local On-Call Arrangements
  - Review of Overtime Arrangements

The Committee received reports on and monitoring of Brookson Medical Care Systems which had won the regional tendering exercise for a Direct Engagement System at a fee of 3%, compared to the Trust current provider, Liaison, who charged a fee of 8.5%.

- **Financial Resources Group**

The Financial Resources Group (FRG) was established to replace the Innovation and Cost Improvement Committee (ICIC) and extended the remit beyond costs savings to understand the financial challenges and pressures faced by the Trust. The group is responsible for monitoring and managing financial performance of all CBUs and Corporate divisions to ensure the provision of high quality healthcare within the resources available. An example agenda will review

- Financial Performance
- Productivity and Efficiency
- Patient Level Costing
- Service Line Reporting

The first meeting of the FRG took place on 17th September 2018.

Risk Register

The Committee received updates on the key risks affecting the Trust's Financial and Sustainability position at each meeting. Examples of the risks and gaps in controls that emerged during the year include:

- Aged Debt
- Impact of Brexit on procurement, workforce and costs
- CIP Management
- CCG pressures and potential impact on the Trust Control Total

- Emergency Access Standard
- Forecast Outturn
- VAT issues relating Brookson
- General Data Protection Regulation (GDPR)
- Implications of the National Pay Award
- Kendrick Wing Fire
- Recruitment following the Nurse Staffing Business Case
- Extension of the loan repayment

Finance

The Trust recorded a £16.0m deficit for the year, which included £6.8m Provider Sustainability Funds (PSF). The deficit was £1.0m lower than plan and the Trust recorded a performance against control total exc PSF monies of £21.8m which was in line with plan. The Trust received the finance element of PSF monies (£3.5m) but did not achieve the A&E element of PSF monies (£1.5m). The Trust received an additional £3.3m in respect of incentive PSF monies.

The Trust achieved CIP savings of £5.6m, a shortfall of £1.4m against the £7.0m target

The annual Capital Programme was £7.5m and increased over the financial year to £10.5m, which was partly due to the Kendrick Wing Fire (£2.4m) and externally funded schemes (£0.6m). The actual capital expenditure was £7.2m. A number of emergency requests were supported by the Committee for recommendation to the Trust Board for ratification

The Committee reviewed the operational plan for 2019/20, the budget and capital programme for 2019/20. The operational plan reflects the control total of breakeven set by NHS Improvement This means the Trust is able to access the Marginal Rate Emergency Tariff (MRET) of £0.97m, Provider Sustainability Fund (PSF) of £4.9m and Financial Recovery Fund (FRF) of £12.0m. To support transformation of services for our patients and to improve financial sustainability the Trust has entered into a second year of a sustainability contract (based on a block contract approach) with main commissioners for 2019/20. The two main Clinical Commissioning Groups (Warrington and Halton CCGs) continue to work together to improve the sustainability of the local health economy.

An Extra Ordinary Finance and Sustainability Committee convened January 2019 to review Initial activity based Operational Plan for 2019/20 prior to presentation to Trust Board.

During the year the Committee received and reviewed the following:

- Dashboard setting out key finance and procurement metrics and performance
- Monthly, year to date and forecast financial performance (including income and expenditure by type and divisional budgetary position).
- Monthly and year to date activity performance (by type and specialty).
- Monthly and year to date contract performance.
- Monthly, year to date and forecast capital expenditure.
- Monthly, year to date and forecast cash balances including short term cash flow.
- Control Total and ability to access PSF funds.

- Current and forecast Use of Resources Rating.
- Monthly, year to date and forecast cost savings performance.
- Monthly review of aged debt and aged creditors.
- Quarterly cost pressure reports from August 2018.
- Strategy Delivery exception reports which transferred to the DoF portfolio from 1.09.2018.
- Revised WLI SOPs process supported
- Outcomes from Medical Stocktake review received February 2019
- Enhanced pay controls
- Initial Operating Plan 2019-20, Draft and Final Operating Plan 2019-20
- Financial Strategy 2019-2023
- Cheshire &Merseyside Financial Position
- Monthly and year to date performance against the Better Payment Practice Code.
- Details and impact of working capital and capital loans and associated interest impact.
- Risks and mitigating actions to financial position.
- Performance against operational and contractual targets / standards and CQUINs fines and penalties.
- Updates on Cost Transformation Programme, Service Line Reporting and Reference Costs.
- Local system financial performance information.
- NHSI Updates.
- Supported Integrated Care Providers consultation

Outstanding loan of £14.2m extended to November 2019. Post submission of Operational Plan, there will be further discussions with NHSI relating to all loans and expectations related to control total for 2019-20.

Performance

The Committee has reviewed and where appropriate challenged performance across all performance indicators including:

- Referral to treatment (18 week RTT)
- Cancer all standards.
- 4 hour standard.
- Diagnostic waiting time.
- Ambulance handover times.
- All NHSI Updates.

Nationally the target is 95% against the 4 hour standard. The majority of acute Trusts have struggled to achieve this target in year. While the Trust performed well compared to peers it did not achieve the 95% national standard and closed with a performance of 85.11% (inc. Widnes Walk-in-Centre). The Committee continued to monitor and seek assurance relating to the actions that have supported performance, these have included investment and development of a Discharge Lounge, GP Assessment Unit, ED Ambulatory Unit and successful funding via the Health & Care Partnership to develop a Frailty Hub in association with a Frailty Assessment Unit (FAU) on site. All these development have supported the increase of assessment capacity and reduction of direct admissions from our Emergency Department.

The Referral to Treatment (RTT) operational standard for England focused on the number of incomplete pathways less than 18 weeks. The Trust achieved the 18 week referral to treatment

target consistently throughout 2018-19, against a target of 92%; this is difficult and challenging but supports care being delivered in a timely manner. Once again, the Committee regularly monitored and sought assurance against this performance target. In addition, the Trust maintained the waiting list size throughout 2018/19 without growth and continued to not have any patients wait over 52 weeks for elective treatment.

Cost Improvement Programmes (CIP)

The delivery of the CIP programme for 2018/19 was reviewed in detail at each meeting. The development of the 2019/20 CIP target, distribution and scheme identification was presented to and reviewed by the Committee. CIP transferred to Director of Finance and Commercial Development's portfolio from September 2018, and the Committee reviewed and supported revised CIP allocation methodology.

The 2019/20 draft plan assumed £5m and methodology reviewed. The final plan submitted in March 2019, highlighted further CIP would be required circa £7m to be reviewed further by the Executive Team prior to Board approval and subsequent submission.

Other issues considered / Reviewed during the year

An estates condition briefing paper was reviewed including an overview of the Trust across the 6 domains of:-

- Physical condition
- Functional suitability
- Space utilisation
- Quality
- Statutory compliance
- Environmental management

Review and refresh of Performance Assurance Framework (PAF) and Integrated Performance Report (IPR) approved.

Winter Pressures were monitored throughout the winter period with an update on funding and the health economy

Updates received on On-Call Harmonisation MIAA Audit findings, Medical Stocktake review, Specialist Medicine (Elderly Services review) Service Line Reporting (SLR) Deep Dive, unfunded cost pressures and Pay Award.

Information Management and Technology

Key updates received were noted to be in respect of:

- Lorenzo Digital Exemplar Bid and benefits realisation presentation May 2018
- Developments in establishing a Warrington Care Record presentation June 2018 which the Committee approved.
- The Committee approved ePMA IT Devices and Drug Trolleys (Warrington) capital funding request for 2019/20 for inclusion in the 2019/20 proposed capital programme. (Jan 2019)

Further to the updates, the Committee received and supported the commencement of a feasibility study for Scan4Safety.

Strategy Delivery

A regular report was provided demonstrating progress against all key strategic programmes and in particular those aligned to or with an impact on the sustainability aim.
Key Updates received were noted in respect of:

- Warrington Together and One Halton
- Clinical strategies
- Community services collaboration
- Warrington New Hospital and Halton Healthy New Town.
- £20k secured from NHSE to undertake feasibility study of Halton site.
- Successful in STP revenue bids to support Frailty Assessment Unit.
- Bids relating to One Public Estate to support business case preparation for Warrington and Halton new hospital/campus projects.
- C&M Pathology reconfiguration
- Breast screening
- CMTC activity

Issues Carried Forward

Each Finance and Sustainability Committee considers whether any business matters discussed should be escalated to the Board. The following were raised by the Finance and Sustainability Committee to the Board:

- The ability of the Trust to repay current and future loans, putting into question the if the Trust is a going concern (this risk was added to the risk register);
- A&E Performance
- Financial position and impact of non-receipt of STF funding
- Winter pressures / escalated beds
- CIP achievement
- Sustainability contract
- Liaison / Brookson issues
- Payment of loans
- Brexit and potential impact on supply chain/procurement/medicines
- Escalation of pay costs, agency spend versus capacity and impact on Use of Resources
- Capital Programme – CQC recommendations
- Deliverability of the Operational Plan
- Costs related to Kendrick Wing Fire
- Debtor position

The Committee will continue its work to ensure the overall financial governance system of internal controls and the assurance processes remain robust.

The Committee continued to receive and consider Sub Committee minutes, namely:

- Finance Resource Group

- Premium Pay Spend Review Group
- Capital Planning Group
- Commissioner Contract Group

Summary

The Committee encourages frank, open and regular dialogue between regular attendees to the meetings. I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Terry Atherton
Chair of Finance and Sustainability Committee
April 2019

Finance and Sustainability Committee Attendance Record 2018-19

	2018									2019			% attendance Excl, Deputy	% attendance Incl, Deputy
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March		
CORE MEMBERSHIP														
Terry Atherton, Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100%	
Anita Wainwright, Non-Executive Director	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	91.6%	100%
IN ATTENDANCE														
Alex Crowe, Medical Director *(to December 2018)*	✓	✓	A	✓	✓	✓	✓	A	A				66.6%	100%
Andrea McGee, Director of Finance + Commercial D'vpment	✓	✓	✓	✓	A/D	✓	✓	✓	✓	✓	✓	A/D	83.3%	100%
Lucy Gardner, Director of Strategy	A/D	✓	✓	✓	✓	✓	A/D	✓	NR	✓	NR	A	75%	91.6%
Jane Hurst, Deputy Director of Finance (Strategy)	✓	✓	✓	✓	A/D	✓	A/D	✓	✓	✓	✓	✓	83.3%	100%
Simon Constable, Medical Director + Deputy CEO	A/D	A/D	✓	✓	A/D	✓	A/D	✓	✓	✓	✓	✓	66.6%	100%
Michelle Cloney, Director of HR + OD	✓	✓	A/D	✓	A/D	✓	A/D	✓	✓	✓	✓	✓	75%	100%
Kimberley Salmon-Jamieson, Chief Nurse	A/D	A/D	A/D	✓	✓	✓	A/D	✓	✓	A/D	A/D	✓	50%	100%
Chris Evans, Chief Operating Officer	✓	✓	✓	✓	✓	A/D	✓	✓	✓	✓	A/D	✓	83.3%	100%
John Culshaw, Head of Corporate Affairs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A/D	91.6%	100%
Julie Burke, Secretary to Trust Board (Minutes)	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	A		
NED / EXECUTIVE / DEPUTY ASKED TO ATTEND														
Ian Jones Non-Executive Director						✓	✓							
Karen Foster Deputy DoIM&T/Hd Information Data Quality														
Mel Pickup, Chief Executive														
Phill James, Chief Information Officer										✓				
David Holden,Interim Senior Governance Advisor (wef Dec 18)											✓	X/D		
Steve Barrow, Deputy DoF					✓									
Stephen Bennett, Head of Transformation	X/D		X/D		✓		X/D							
Rachel Browning, Associate Chief Nurse, Clinical Effectiveness			X/D											
John Goodenough, Deputy Chief Nurse	X/D						X/D			X/D	X/D			
Ali Kennah, Associate Chief Nurse, Patient Safety		X/D												
Dan Moore, Deputy Chief Operating Officer					✓	X/D								

Val Doyle, Associate Director Elective Care Performance Halton											X/D			
Sally Proffitt, Head of Financial Planning					✓		X/D							
Deborah Smith, Deputy Director HRD			X/D		X/D									
Mick Curwen, Head HR Strategic Projects							X/D							

Key: A = Apologies A/D = apologies with deputy attending X/D = Attendance as Deputy Xp = Part R = Left Trust	NR = December condensed meeting, full attendance not required

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/19/03/25**
SUBJECT:	**Director HR & OD Annual Report (2018/19)**
DATE OF MEETING:	20 March 2019
ACTION REQUIRED	Assurance
AUTHOR(S):	Michelle Cloney, Director HR & OD
EXECUTIVE SUMMARY	The Strategic People Committee was established in September 2018. The Committee meets on a bi-monthly basis and reports through a Chairs Log Report to the Trust Board (Public) Meeting. The draft Terms of Reference and work plan for the committee was approved in September 2018 and has been a standing item at each committee (September 2018 to March 2019). The Director HR & OD Report provides an opportunity to highlight key workforce matters which have a national, regional or local context and are not captured on the work plan. This report seeks to confirm with members whether the topics covered are appropriate, responsive to the changing people healthcare landscape and the content is fit for purpose.
RECOMMENDATIONS:	Strategic People Committee are asked to: • Note the content of the annual report for 2018/19 • Acknowledge the breadth and scope of the varied topics covered from September 2018 to March 2019. • Acknowledge the relevance of the topics to the national, regional and local workforce agenda. • Evaluate how each topic relates to the agenda of other corporate committees such as Finance & Sustainability, Audit Committee and Quality Assurance Committee and issues have been appropriately escalated to Trust Board within the Chairs Log. • Acknowledge how these topics support the Terms of Reference (TOR) for the Strategic People Committee, and • Suggest alternative approaches / topics if relevant to address any concerns raised at the Strategic People Committee meeting in March 2019 which could be added to the Strategic People Committee work plan 2019/20.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Director HR & OD Annual Report (2018/19)	AGENDA REF:	SPC/19/03/25

1. BACKGROUND/CONTEXT

The Director HR & OD Annual Report is an overview on HR and OD activity presented to the Strategic People Committee within an annual cycle (normally April to March). The Strategic People Committee was established following a governance review of the Workforce Committee presented to Audit Committee. As a result the Strategic People Committee was formed as a sub-committee of the Trust Board.

The Trust Board receives a Chairs Log Report. In addition, the committee receives a Director HR & OD Report each meeting which is intended to highlight key areas of activity or items which need to be flagged as an area requiring attention, information, discussion or escalation. These items may have a local, regional or national context.

2. KEY ELEMENTS

2.1 The Strategic People Committee are asked to:

- Consider the relevance of the topics to the national, regional and local workforce agenda,
- Evaluate how each topic relates to the agenda of other corporate committees such as Finance & Sustainability, Audit Committee and Quality Assurance Committee.
- How these topics support the Terms of Reference for the Strategic People Committee, and
- Suggest alternative approaches / topics if relevant to address any concerns raised at the Strategic People Committee meeting in March 2019 which could be added to the committee work plan 2019/20.

2.2 During the period in question (September 2018 to March 2019) members were provided with information, reports and updates on the following topics:

September 2018

- Draft Terms of Reference for approval
- Draft Workplan for 2018/29
- National Agenda for Change Pay Deal – overview of organisational readiness for full implementation
- Director HR & OD Report:
  - Listening into Action Progress Update on moving into Phase Two
  - Brexit – Trust a Pilot for European Union Settled Status and Preparation for a No Deal
  - Agenda for Change – Organisational Readiness
- People Strategy Draft – engagement with Committee Members prior to presenting to Trust Board
- Board Assurance Framework (People) and Risk Register
- Care Quality Commission (CQC) Getting to Good, Moving to Outstanding (Staff) -
  1. PDR Compliance
  2. Mandatory Training Compliance
  3. Role Specific Training Compliance
  4. Customer Service Training
  5. Resuscitation Training

- Medical Appraisal and GMC Revalidation Annual Report
- Policies and Procedures Report – Ten policies/procedures approved until 31 March 2019:
  1. Clinical Excellence Awards Policy
  2. Medical Illustration Policy
  3. Annual Leave Policy for Consultant Medical and Dental Staff
  4. Performance Improvement Policy
  5. Professional Clinical Registration Policy
  6. Career Break Policy
  7. Disciplinary Policy
  8. Shared Parental Leave Policy
  9. Study Leave Funding Policy
  10. Study and Professional Leave Policy for Non-Training Grade Medical Staff
- Pay and Terms & Conditions –National and Regional Policy updates
- Freedom to Speak Up Report from Guardian
- Equality and Diversity – Workforce Race Equality Standard (WRES) Report
- Facilities Time Out Annual Report – New national report required to be published on extranet
- Trust Board Monthly Staffing Report – Key Issues Report on Nursing Safer Staffing
- Trust Strategic Projects – Exception Report (People)
- Premium Pay Spend +Review Sub Committee 7.08.2018
- On-Call/Harmonisation Report
- Triangulation Meeting for Medical Staff

Members approved the TORs and Workplan with an amendment to the CQC Getting to Good, Moving to Outstanding to focus on the people Key Lines of Enquiry (KLOE 1, 3, 7 & 8)

November 2018

- Board Assurance Framework (People) and Risk Register
- Director HR & OD Report covering:
  - Developing the long-term plan for the NHS
  - We are the NHS – national recruitment campaign
  - NHS Improvement and NHS Employers: Retention programme one year on
  - Nurse Associate Training
  - Supporting EU staff - Settled Status (Brexit)
  - Pension Saving Statements – annual allowance
  - Terms and Conditions Refresh 2018
  - Closing band 1 to new entrants
  - Junior Doctor Contract Review
  - Streamlining Staff Movement Resource Hub
  - Flu Fighter campaign
- CQC Getting to Good, Moving to Outstanding (Staff) covering:
  - (KLOE)1: Leadership, capacity, capability to deliver high quality sustainable care
  - (KLOE)3: Culture of high quality sustainable care
  - (KLOE)7: Are people who use services, public, staff and external partners engaged and involved to support high quality sustainable services.
  - (KLOE)8: Robust systems and processes for learning, continuous improvement and innovation
- HENW/GMC Annual Reports, including:
  - GMC Survey Response Report
  - HENW Local Education Provider (LEP) Report
  - HENW Monitoring Visit (Annual Assessment visit)
  - GMC National Trainee Survey

- Policies and Procedures Report:
  - Annual Leave Policy for Consultant Medical and
  - Dental Staff
  - Career Break Policy
  - Medical Illustration Policy
  - Performance Improvement Policy
  - Shared Parental Leave Policy
  - Special Leave Policy Extract: Update on Parental Leave
- Employee Relations Report
- Pay and Terms & Conditions –National and Regional Policy updates
- Guarding Quarterly Report Safe Working Hours for Junior Doctors in Training
- Equality and Diversity – Strategy Update
- Trust Board Monthly Staffing Report – Key Issues Report Safer Staffing (September, + October)
- Trust Strategic Projects (People Exception Report)
- Operational People Committee Chairs Log 26.11.2018
- Premium Pay Spend +Review Sub Committee Chairs Log 9.10.2018
- Triangulation Meeting for Medical Staff

Members approved an amendment to the for the CQC Getting to Good, Moving to Outstanding update report to focus on the people aspects within **all** Well Led Key Lines of Enquiry (KLOE 1 - 8)

January 2018

- Director of HR & OD Report including Streamlining report:
  - HR Director joint role with Bridgewater Community Healthcare NHS Foundation Trust
  - Long Term Plan – Workforce
  - Cheshire and Merseyside – Strategic Workforce programme - 6 priority areas:
    - Creating a sustainable supply of staff (paid and unpaid)
    - Up-skilling, re-skilling and training of our workforce
    - New ways of working, including the introduction of technology and the creation of a digital workforce
    - Employee wellbeing – ensuring that our staff are healthy and well and that we support them when they become unwell or have additional demands placed on them because of family illness or carer responsibilities
    - New models of employment and engagement
    - Talent management and leadership development
  - Cheshire and Merseyside Streamlining Project Update
- Board Assurance Framework (People) and Risk Register
- CQC Getting to Good, Moving to Outstanding (Staff) covering all 8 KLOES:
  - (KLOE)1: Leadership, capacity, capability to deliver high quality sustainable care
  - (KLOE)3: Culture of high quality sustainable care
  - (KLOE)7: Are people who use services, public, staff and external partners engaged and involved to support high quality sustainable services.
  - (KLOE)8: Robust systems and processes for learning, continuous improvement and innovation
- Policies and Procedures Report covering:
  - Professional Clinical Registration Policy
  - Non-Medical Study Leave/Funding Policy
  - On Call Policy
  - Extract from Consultant Job Planning Policy – Core Supporting Professional Activity (attached)
  - Extract from Performance Improvement Policy (attached)

  - Temporary Staffing Policy: Medical Staff, Professions Allied to Medicine and Admin and Clerical Staff
- Employee Relations Report
- Pay and Terms & Conditions –National and Regional Policy updates including progress report on pay deal (from Nov SPC
- Equality and Diversity – Regulated Reports:
  - Equality Duty Assurance Report
  - Workforce Quality Assurance Report
  - E&D inclusion strategy
- Trust Board Monthly Staffing Report – Key Issues Report Safer Staffing (November + December)
- Guardian of Safe working Q3 Report
- Trust Strategic Projects – Exception Report (People)
- Freedom to Speak Up Report
- HENW/GMC Progress Report
- Operational People Committee Chairs Log 11.01.2019
- Premium Pay Spend +Review Sub Committee Chairs Log 9.01.2019
- Triangulation Meeting for Medical Staff

Members approved an amendment to the for the CQC Getting to Good, Moving to Outstanding update report to include an update on the Use of Resources KLOEs.

March 2018

- Director of HR & OD Report, including:
  - Long Term Plan – Overview
  - Workforce Implementation Plan
  - Talk Health and Care Portal http://dhscworkforce.crowdicity.com/
  - Staff Opinion Survey 2018 - Overview
- Board Assurance Framework (People) and Risk Register
- WHH People Strategy and Trust Strategy (People)
- Guardian Quarterly Report Safe Working Hours for Junior Doctors including
- Guardian of Safe Working deep dive shift/agency/opt out (requested at November Board)
- Equality and Diversity – Regulated Reports
  - Equality Delivery System 2 (EDS2)
  - Gender Pay Gap Report for approval to proceed to Trust Board for publication
- Sickness Absence Pilot Review (deferred from January 2019)
- Proposed changes to Integrated Performance Report (People)
- VIP + Celebrity Visits Policy Annual Report
- Draft Equality Diversity and Inclusion Strategy for approval to proceed to Trust Board for publication
- CQC Getting to Good, Moving to Outstanding (Staff) covering all 8 Well Led KLOES and Use of Resources Update:
  - KLOE) 1: Is there the leadership, capacity and capability to deliver high quality sustainable care?
  - (KLOE) 2: Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?
  - (KLOE) 3: Is there a culture of high quality, sustainable care?
  - (KLOE) 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?
  - (KLOE) 5: Are there clear and effective processes for managing risks, issues and performances?

- (KLOE) 6: Is appropriate and accurate information being effectively processed, challenged and acted on?
- (KLOE) 7: Are people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
- (KLOE) 8: Are there robust systems and processes for learning, continuous improvement and innovation?
- Use of Resources Update on Inspection and Submission of evidence for UoR KLOEs
  - Operational People Committee 22.2.19
  - Premium Pay Spend +Review Sub Committee 5.02.19 and 5.03.19
  - Triangulation Meeting for Medical Staff

3. ASSURANCE COMMITTEE

Trust Board (Public Meeting)

4. RECOMMENDATIONS

Strategic People Committee are asked to:

- Note the content of the annual report for 2018/19
- Acknowledge the breadth and scope of the varied topics covered from September 2018 to March 2019
- Acknowledge the relevance of the topics to the national, regional and local workforce agenda
- Evaluate how each topic relates to the agenda of other corporate committees such as Finance & Sustainability, Audit Committee and Quality Assurance Committee
- Acknowledge how these topics support the Terms of Reference for the Strategic People Committee
- Suggest alternative approaches / topics if relevant to address any concerns raised at the Strategic People Committee meeting in March 2019 which could be added to the Committee work plan 2019/20.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

AUDIT COMMITTEE

AGENDA REFERENCE:	**AC/19/05/53**			
SUBJECT:	**Audit Committee Chairs Annual Report 2018/19**			
DATE OF MEETING:	21 May 2019			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE DIRECTOR SPONSOR:	Ian Jones, Non-Executive Director, Committee Chair			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Board and Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls.			
PURPOSE: (please select as appropriate)	Information	**Approval** ✓	To note	**Decision** ✓
RECOMMENDATION:	**The Committee reviews the document and ensure it meets its purpose.**			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: *State whether this report needs to be referred to at another meeting or requires additional monitoring*	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Section 22 – information intended for future publication			

AUDIT COMMITTEE REPORT 2018-19

The Committee

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and, where necessary, highlighting any areas of concern. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2018 - 31 March 2019.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda, and are in support of the achievement of the Trust's objectives.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of at least three Non-Executive Directors with a quorum of two. I have been the Chair of the Committee since 1st December 2014.

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by myself, the Chair of the Committee and the details of my biography can be found on page 22 (*of the Annual Report and Accounts*).

Member	Attendance (Actual v Max)
Ian Jones, Non-Executive Director & Chair	5/5
Margaret Bamforth, Non-Executive Director	5/5
Terry Atherton, Non-Executive Director	5/5
Anita Wainwright, Non-Executive Director	5/5
Jean-Noel Ezingeard, Non-Executive Director	3/5

Regular attendees at the Committee Meetings were Grant Thornton (External Auditors), Mersey Internal Audit Agency ("MIAA") (Internal Audit & Anti-Fraud Services), the Director of Finance & Commercial Development and the Director of Community Engagement & Corporate Affairs (Company Secretary Designate).

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in October 2018 to ensure they continue to remain fit-for-purpose.

Frequency of Meetings & Summary of Activity

The Committee met five times during the year. A summary of the activity covered at these meetings follows:

Governance & Risk Management

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and the Quality Assurance Committee on a bi-monthly basis. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Moderate Assurance** rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Committee and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting. The assurance level for each audit completed during the year are listed below:

Substantial Assurance	Moderate Assurance	Limited Assurance	Advisory Support and Guidance Provided to:
• Data Quality • Combined Financial Systems • Care and Comfort Round	• Data Protection & Security Toolkit • Mental Capacity Act/Deprivation of Liberty • Safeguarding • 5 Steps to Safer Surgery • Medical Locums	• Review of Servers • Temporary Staffing – Non-Clinical • Overtime Payments.	• Continued to support the Trust's own internal tracker for Internal Audit recommendations. • CQC Action Plan • Cyber Security • GDPR Regulations • Bank and Agency (Medical Locums)

It was also confirmed that the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

Reports have been issued for discussion with management:

- CBU and Speciality Governance Review;
- Overtime Payments Review.

The Internal Audit reports include detailed recommendations to improve systems and address weaknesses identified. Based on these recommendations, actions are agreed with Line Management and the Audit Committee tracks the implementation of the agreed actions to ensure implementation within an appropriate timeframe.

An Assurance Framework opinion test against NHS best practice was undertaken and the standards were met.

External Audit

Grant Thornton commenced its 3-year term as Auditors to the Trust in January 2017 following a competitive procurement exercise and review and recommendation by the Council of Governors.

During the year the Auditors reported on the 2017-18 Financial Statements and Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy. The Audit Committee received regular progress reports from the AFS and also received an annual report. No significant cases or issues of Anti-Fraud took place or were identified during the year.

Issues Carried Forward

The Audit Committee will continue its work to ensure the overall system of internal controls and the assurance processes remain robust.

In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.

Whilst the outcomes of the Clinical Audit programme falls under the remit of the Quality Committee and are reported and challenged in that forum, this Committee will review its approach purely from an audit perspective and to obtain assurance of methodology and approach as well as its contribution to improving quality.

With respect to the Internal Audit plan for 2019-19, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the 2019-20 Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

During 2018-19, alongside the Audit Committee, three main Board assurance committees were in place: (1) Quality, (2) Finance & Sustainability and (3) Strategic People. All of these Committees were chaired by Non-Executive Directors and each Committee included at least two Non-Executive Directors. This structure gave strong visibility and focus at Non-Executive level on the key issues facing the Trust. The NEDs meet several times a year to assess a wide range of Trust issues including the appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

Summary

In year, the Committee has considered a wide range of issues in relation to financial statements, operations and compliance and has sought to gain assurance on each element by working closely with Internal Audit, the other Board Committees and key individuals across the Trust.

Throughout the reporting period, the Chair of the Committee reported in writing on the nature and outcomes of its work to the Board of Directors highlighting any area that should be brought to its attention through a Chair's Key Issues Report.

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in August 2019

The Committee has also assessed its own performance during the year and will report to the Board of Directors in January 2020.

The Audit Committee acknowledges the significant amount of work carried out by the Quality Committee, the Chief Nurse and Director of Integrated Quality and Governance in continuing to refresh and embed the Trust's governance and risk management systems.

I would also like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Ian Jones
Chair of Audit Committee
April 2019

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/54**
SUBJECT:	**Amendments to the Constitution**
DATE OF MEETING:	29th May 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):	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 an amendment to the following area of the Constitution: • Annex 7 – Board of Directors Standing Orders • Section 6.1 Appointment of Committees (Page 98) The amendment is to allow the appointment of Committees in Common and Joint Committees with other NHS organisations. For clarity, section 13 of Annex 7 states: ***13. Changes to Board Standing Orders*** *For the sake of clarity, future amendments to these Standing Orders by the Board are to be regarded as a change to the Trust's Constitution.*

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 v3.7	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	**COG /19/05/33**
	Date of meeting	15th May 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/19/05/54

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

Currently the Constitution states the following:

6 Committees

6.1 Appointment of Committees

6.1.1 The Board may appoint other committees of the Board subject to 5.1 and 5.3, consisting wholly or partly of Directors of the Trust

6.1.2 A committee so appointed may appoint sub-committees consisting wholly or partly of members of the committee but consisting of at least one Director of the Board

6.1.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board.

6.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board) as the Board shall decide from time to time following reviews of the terms of reference, powers and conditions. Such terms of reference shall have effect as if incorporated into these Standing Orders.

6.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

6.1.6 The Board shall approve the appointments to each of the committees that it has formally constituted. Where the Board determines that persons, who are neither Directors nor Officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

6.1.7 Where the Trust is required to appoint persons to a committee, which is to operate independently of the Trust, such appointment shall be approved by the Board.

In order to allow the appointment of Committees in Common and Joint Committees with other NHS organisations, it is proposed that the section 6.1.1 of the Constitution be amended to the following:

6.1.1 The Board may appoint other committees of the Board subject to 5.1 and 5.3, consisting wholly or partly of Directors of the Trust. This may include, the appointment of Committees in Common and Joint Committees[i] with other NHS organisations

For clarity, sections 5.1 and 5.3 referenced above are described below:

5.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee of Directors, or by a Director or an Officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

*5.2 **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.*

*5.3 **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees of Directors, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.*

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.

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[i] **Committees in Common** = To operate, several requirements must be met:
• Each committee must have its own agenda, although they may be identical • Each committee must take its own decisions and these must be recorded in its own minutes • Note that there is more than one committee. The committees should be referred to as "committees in common"
• It must be technically possible for each committee in the arrangement to reach a different decision although this will be unlikely • There must be clear terms of reference for each committee and clear reporting lines back to each Trust Board. For committees in common to run smoothly, each committee needs to have the same agenda. Only one discussion takes place about each agenda item and then each committee makes its own decision.

Joint Committees – Each separate organisation nominates its representative(s) and the committee would have delegated authority from members respective boards to make binding decisions on behalf of the organisations involved.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/05/55**			
SUBJECT:	**Compliance with Licence**			
DATE OF MEETING:	29th May 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):	NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Self-Certification for the items is attached and the Committee is asked to note compliance with G6, FT4 and CoS7 as approved by the Audit Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee		
	Agenda Ref.	**AC/19/05/52**		
	Date of meeting	21st May 2019		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Self-Certification Template - Condition FT4

Warrington and Halton Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These Declarations are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is satisfied. The Annual Governance Statement approved by Trust Board 23rd May 2019 outlines the main arrangements to ensure the Trust applies the principles systems & standards of good corporate governance. Following the CQC inspection on 2017, the Trust set up the Getting to Good, Moving to Outstanding
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board reviews/discusses this at both the Board meetings and at planned Board development sessions.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	A robust governance structure is in place and this is reviewed regularly. Board Committees are guided by Terms of Reference reviewed annually, together with Cycles of Business updated to reflect the changing needs of the organisation. Issues of concern are escalated through Chair key issues reports. 'Ward to Board' governance is via escalation/reporting by exception with CBUs accountable to the Trust Operations Board
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board is satisfied. Where risks to the organisation are identified these are featured on the risk register and mitigations are identifed. The Board receives a current, integrated performance dashboard monthly which is RAG rated and trends-focused, this is supported by key issues reports from the various assurance committees. A process of business planning is established and a two-year operational plan is in place with the Trust working at least one year in advance. The Trust's Board Assurance Framework is reviewed at each Board and specific, targeted updates are discussed in other Committees such as Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness. The Director of Finance is tasked with leading the 'Carter at Scale' programme as well as chairing the Trust's Use of Resources workstream

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	The Board had a full complement of Non-Executive and Executive Directors during 2018-19. This included the Board members who have clinical, financial, managerial, strategic, communications and HR expertise. The Board includes a clinical non-executive director, a Medical Director and Chief Nurse who are accountable for assurance of and delivery of the quality agenda. Quality metrics are scrutinised at the Quality Assurance Committee and assurance provided to the Board via the Chair's key issues report. Quality is further prioritised by the involvement of the Foundation Trust Governors via unannounced ward/service visits and a Quality in Care governor group which report to the Council of Governors quarterly. The Quality dashboard is reviewed at a number of levels before being presented for assurance to the subcommittee of the Board.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	The Board is satisfied. During 2018-19, the Trust has established a Committee to ensure that the Trust would continue to be compliant with its NHS FT Licence Agreement. The Gettting to Good, Moving to Outstanding Committee has overseen the work to ensure that the Trust meets all its CQC and NHSi regulatory requirements. The Board had a full complement of Non-Executive and Executive

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name Steve McGuirk, Chairman	**Name** Mel Pickup, Chief Executive

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve McGuirk	**Name**	Mel Pickup
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Self-Certification Template - Conditions G6 and CoS7

Warrington and Halton Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These Declarations are set out in this template.

Templates should be returned via the Trust portal.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust recorded a £16.0m deficit (including £1.1m net impairment costs). This also included £6.8m Provider Sustainability Funding. The control total set by NHSI was £16.9m deficit and after the exclusion of impairments and other technical adjustments the Trust recorded an actual control total deficit of £15.0m, £1.8m better than plan
The Finance and Sustainability Committee scrutinised the financial position of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. The Board reviewed the position and challenged mitigations at each Board meeting.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve McGuirk	**Name**	Mel Pickup
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Summary of Licence Conditions

General Licence Conditions (G)

Ref	Condition	Summary
G6	Systems for compliance with licence conditions and related obligations	Requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements

Self-certification response to condition G6: Confirmed

Continuity of Services (CoS)

Ref	Condition	Summary
CoS7	Availability of Resources	Requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services

Self-certification response to condition CoS7: Confirmed with the following note:

The Trust recorded a £16.0m deficit (including £1.1m net impairment costs). This also included £6.8m Provider Sustainability Funding. The control total set by NHSI was £16.9m deficit and after the exclusion of impairments and other technical adjustments the Trust recorded an actual control total deficit of £15.0m, £1.8m better than plan
The Finance and Sustainability Committee scrutinised the financial position of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. The Board reviewed the position and challenged mitigations at each Board meeting.

NHS Foundation Trust Conditions (NHSFT)

Ref	Condition	Summary
NHSFT4	NHS Foundation trust governance arrangements	Enables Monitor/NHSI to continue oversight of governance of NHS Foundation Trusts.

Self-certification response to condition FT: Confirmed with the following notes:

The Annual Governance Statement approved by Trust Board 23rd May 2019 outlines the main arrangements to ensure the Trust applies the principles systems & standards of good corporate governance. Following the CQC inspection on 2017, the Trust set up the Getting to Good, Moving to Outstanding Steering Group, the purpose of which was to catalyse the cultural and operational changes that would enable the organisation to achieve its objectives and in doing so facilitate the achievement of an improved CQC rating to 'Good' and ultimately 'Outstanding' through performance management of the CQC action plan. As part of this steering group, a specific Well-Led workstream was developed to deliver the evidence required to support compliance with the 8 Well-Led KLOEs and CQC/NHSI Well-Led inspection; and oversee and improve the systems that facilitate a Ward to Board golden thread of governance. The Trust will shortly receive the outcome of its most recent NHSi/CQC inspection and Well-Led Review.

Where risks to the organisation are identified these are featured on the risk register and mitigations are identified. The Board receives a current, integrated performance dashboard monthly which is RAG rated and trends-focused, this is supported by key issues reports from the various assurance committees. A process of business planning is established and a two-year operational plan is in place with the Trust working at least one year in advance. The Trust's Board Assurance Framework is reviewed at each Board and specific, targeted updates are discussed in other Committees such as Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness. The Director of Finance is tasked with leading the 'Carter at Scale' programme as well as chairing the Trust's Use of Resources workstream.

The Board had a full complement of Non-Executive and Executive Directors during 2018-19. This included the Board members who have clinical, financial, managerial, strategic, communications and HR expertise. The Board includes a clinical non-executive director, a Medical Director and Chief Nurse who are accountable for assurance of and delivery of the quality agenda. Quality metrics are scrutinised at the Quality Assurance Committee and assurance provided to the Board via the Chair's key issues report. Quality is further prioritised by the involvement of the Foundation Trust Governors via unannounced ward/service visits and a Quality in Care governor group which report to the Council of Governors quarterly. The Quality dashboard is reviewed at a number of levels before being presented for assurance to the subcommittee of the Board.

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
2018			
Wednesday 28th November	Wednesday 7th November	Monday 19th November	**Wednesday 21st November**
2019			
Wednesday 30th January	Wednesday 9th January	Monday 21st January	**Wednesday 23rd January**
Wednesday 27th March	Wednesday 6th March	Monday 18th March	**Wednesday 20th March**
THURSDAY 23 May YR END	Thursday 2 May (EXECS)	Tuesday 14 May	**THURSDAY 16 May**
Wednesday 29 May	Thursday 9 May (EXECS)	Monday 20 May	**Wednesday 22 May**
Wednesday 31 July	Thursday 11 July (EXECS)	Monday 22 July	**Wednesday 24 July**
Wednesday 25 September	Thursday 5 Sept (EXECS)	Monday 16 September	**Wednesday 18 September**
Wednesday 27 November	Thursday 7 Nov (EXECS)	Monday 18 November	**Wednesday 20 November**
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**