
People

W&HHFT/TB/14/125 (i)

BOARD OF DIRECTORS

Paper Title	Human Resources / Education & Development Key Performance Indicators (KPIs) Report
Date of Meeting	30 July 2014
Director Responsible	Karen Dawber
Author(s)	Mick Curwen
Purpose	This report focuses on the KPIs which are felt to give a good indication to the Board on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Paper previously considered	**Committee**	**Date**
HR / E&D KPIs Reports	Trust Board meetings	25 June 2014
HR / E&D KPIs Reports	Strategic People Committee	9 June 2014

Relates to which Trust objectives — **Appropriate**

- Ensure all our patients are safe in our care
- To be the employer of choice for healthcare we deliver √
- To give our patients the best possible experience
- To provide sustainable local healthcare services √

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
Mandatory training rates are largely unchanged but appraisal rates for non-medical staff have increased slightly	Pages 2 - 4 / Section 2.1 & 2.2
12 more doctors revalidated	Page 4/Section 2.3
Sickness absence – slight reduction in month and stable	Pages 4 – 5 / Section 2.4
Turnover showing an upward trend. Vacancy rate stable. Headcount falling.	Page 4 & 5 / Section 2.5 & 2.6
Temporary staffing expenditure – increase of £126k but offset with some expenditure on intermediate care beds	Pages 5 & 6 / Section 2.7
All main Equality and Diversity targets achieved for 2014 and reasonable progress on training target	Page 6 & 7 / Section 2.8

Recommendation(s)

The Board is asked to consider the key points above and the detailed report attached (Appendix 1)

Appendix 1

Human Resources / Education & Development
Key Performance Indicators Report July 2014

1.0 Introduction

This report focuses on the KPIs which are felt to give a good indication on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Some KPIs lend themselves to monthly monitoring whilst others are bi-monthly, quarterly, bi-annually or annually and this is indicated on the 'dashboard' attached. With all of the KPIs the performance is shown under the traffic light system of Red, Amber or Green against the target and the threshold criteria. This should enable Board members to see at a glance the progress being made and to allow a greater focus on those areas which are red or amber. This 'dashboard' is part of a wider number of KPIs which are monitored at the Strategic People Committee and their links to CQC/NHSLA compliance.

The dashboard attached to this report shows the progress on KPIs, focussing on the position at June 2014, where applicable.

2.0 HR and E&D Trust Workforce Standards KPIs Overview

2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been very little change to the mandatory training rates but there was an increase for Health and Safety. The trend in recent months of little change has therefore continued. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

Completion rates for the Divisions are as follows (figures in brackets denotes the month of May 2014):

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	74% (73%) (Amber)	90% (88%) (Green)	60% (60%) (Red)
Unscheduled Care	73% (74%) (Amber)	86% (86%) (Green)	74% (73%) (Amber)
Women's & Children's	77% (78%) (Amber)	90% (89%) (Green)	77% (77%) (Amber)
Estates	85% (87%) (Green)	100% (100%) (Green)	98% (98%) (Green)
Facilities	80% (79%) (Amber)	81% (81%) (Amber)	81% (80%) (Amber)
Corporate Areas	83% (81%) (Amber)	97% (96%) (Green)	87% (88%) (Green)

The only area achieving all of the targets is Estates.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well and an impressive 99% of staff attended corporate induction during June 2014.

2.1.1 Health & Safety (Green)

There has been a slight increase of 1% from the previous month and the rate is 89% and green. The target for 2014/15 is being achieved.

2.1.2 Fire Safety (Amber)

There was a slight decrease of 1% from the previous month and the rate is 76% and amber.

As previously reported, Dave Wood, Fire Officer has now returned to the trust and commenced 2 June 2014.

2.1.3 Manual Handling – Patient / Non-Patient Combined (Amber)

There has been no change from the previous month and the rate is 74% and amber. The rate has been the same now for the last 3 months.

2.1.3.1 Manual Handling Patient Training Only (Red)

There has been no change from the previous month and the rate is 67% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Green)

There has been no change from the previous month and the rate is 85% but the status is still green and the target is being met.

2.2 Staff Appraisals

The target for completed PDRs is 85%.

Although there was no change in the rate for medical staff, there was a slight increase for non-medical and it is at its highest rate since November 2011.

Completion rates for the Divisions for non-medical staff are as follows (figures in brackets denotes the month of May 2014):

Division	PDR Rate
Scheduled Care	83% (81%) (Amber)
Unscheduled Care	75% (73%) (Amber)
Women's and Children's	71% (74%) (Amber)
Estates	87% (72%) (Amber)
Facilities	91% (84%) (Amber)
Corporate Areas	66% (60%) (Red)

All Areas/Divisions with the exception of Women's and Children's increased their rates and there are two areas achieving the target which are Estates and Facilities which showed significant increases of 15% and 7% respectively. Although the Corporate Areas are showing Red, there was an increase of 6%.

2.2.1 Non-Medical Staff (Amber)

For the period up to June 2014 the percentage of non-medical staff having had an appraisal increased slightly by 1% and is 76% and the status is amber.

Divisions have been reminded at the bi-lateral meetings that priority must still be given to appraisal rates despite the financial position and it is pleasing that this has been recognised in improved rates in many areas/departments over the last couple of months.

2.2.2 Medical & Dental Staff (Amber)

The combined rate for Consultant staff and Middle Grade doctors, up to June 2014 has remained the same at 79% and the position has not changed for 3 months. The rate for Consultants increased by 1% to 87% and other M&D fell by 1% to 64%.

This means that the target of 85% was not achieved and the status is 'amber'.

2.3 Revalidation for Medical and Dental Staff (Green)

The Revalidation Decision Making Group last met on 3 July 2014. 63 doctors have been approved for revalidation by the GMC with 14 doctors deferred, making the rate 82%. This means that 12 more doctors have been revalidated since the last meeting in May.

The next Decision Making Group meeting will take place on 16 September 2014.

2.4 Sickness Absence

2.4.1 Sickness Absence Rates (Amber)

The new sickness absence target for 2014/15 is 3.75%.

Sickness absence for June 2014 showed a marginal improvement in month from the previous month to 3.98%. The cumulative rate for April – June 2014 improved to 4.09%.

Sickness absence continues to be closely monitored and managed in all areas in the Trust in line with the Attendance at Work Policy. The number of staff being managed either through the Short Term Absence or Long Term Absence Sections of the policy, remains at well over 300 staff.

2.4.2 Return to Work Interviews (RTW) (Red)

The target for this KPI is 85% and is only reported on a quarterly basis. The rate for Q1 was 53% which was an increase of 11% from Q4. There is a steady increase from when this rate was first reported in Q1 in 2013 which was 30% but is still well below the target and the status is Red. At training sessions and when completing eSVLs, managers are reminded of the need to undertake RTW interviews and record these on ESR. It is still believed that more RTW interviews are actually taking place but managers are failing to record this on ESR.

2.5 Turnover Rate (Amber)

The target for this KPI is min 8% or max 9%. This is designed to reflect that both a high and a low figure could be detrimental to the interests of the trust. A high figure could indicate dissatisfaction with the trust and lead to increased recruitment and training costs. A low figure could indicate a 'stagnant' workforce with potential lack of new ideas and inspiration.

The rate for the previous 12 months up to June 2014 increased to 9.29% and the status is amber. Since December 2013 a steady upward trend has been developing. This is probably due to a combined effect of some staff not being replaced due to the financial constraints and staff in post figures falling.

2.6 Funded Establishment / Staff In Post / Vacancies (Green)

The Trust FE FTE was 3682 and staff in post 3371 FTE. This means the vacancies FTE has increased to 8.44% and the status is 'green'. The relatively high number of vacancies (311) is

mostly due to pressure on some managers to not fill vacancies to contribute to the sustainability challenge for 2014/15 and additional investment in posts from the beginning of the year which have yet to be filled and staff commence in post. This has some bearing on turnover rates as mentioned above.

The headcount of 4134 was a reduction of 21 from the previous month. From a peak of 4201 in January 2014 there have now been reductions in each of the last 5 months.

2.7 Expenditure on NHSP Bank/Agency/Medical Locum (Red)

The threshold for this KPI is 4.5% of total pay bill. Total spend in June 2014 increased by £126k and was £966k, which represents 7.59% of the pay bill for the month and cumulatively for April – June 2014 the rate is 6.96%. Against the agreed threshold for 2014/15 of 4.5% the status, therefore, is 'Red' and was not achieved.

Details of the main areas of expenditure for June are as follows:

Nurse Bank and Agency Nursing - £418k (£326k for May)
Agency (exc Medical & Nursing Agency) - £202k (£125k for May)
Medical Locums and Medical Agency - £347k (£390k for May)

Nurse Bank /Agency increased by £92k and Agency by £77k. Medical Locums/Agency decreased by £43k

NB In order to staff the additional intermediate care beds funded by Warrington CCG, the trust had to recruit staff predominantly from agencies which was an additional cost of £81k which is included in the above increase but will be re-charged to Warrington CCG. The 'net' position is therefore an increase of £45k.
Total expenditure for the period April – June 2014 is as follows:

Nurse Bank and Agency Nursing - £1.1m
Agency (exc Medical and Nursing Agency) - £437k
Medical Locums and Medical Agency - £1.1m

The main focus of attention remains on Nurse Bank/Agency and Medical Locum/Agency expenditure.

The Temporary Staffing Group met on 23 July 2014 and received progress reports on the following initiatives/projects designed to reduce temporary staffing expenditure:

<u>Nursing Recruitment</u>
Rolling adverts have been introduced for Unscheduled Care with an emphasis on A&E/AMU and within Scheduled Care. A similar approach for Theatre vacancies is being pursued. So far this has been very successful with many qualified nurses being appointed and in relation to the E&Y work stream of recruiting up to 40 wte qualified nurses, the trust is c75% complete. However, it should be noted that a reduction in temporary staffing expenditure will only be realised once staff commence in post which is likely to be over the next couple of months.

<u>International Recruitment</u>
The trust is working with an agency called Globalmedirec to try and recruit Consultant Radiologists as the trust will shortly have 6 wte vacancies. From a list of 6 CVs the trust expressed a wish to contact 4 candidates, one of which was able to attend for a face to face interview who did not prove suitable, but the other 3 were interviewed via Skype and made a favorable impression to the extent that face to face interviews have provisionally been arranged for 11.8.14. The trust is therefore optimistic that appointments can be made which will mean that the necessity for WLIs in this department would significantly reduce.

Recruitment Process
The trust is working on a number of initiatives to streamline the recruitment process. A system called TRAC which works alongside NHS Jobs 2 has been demonstrated at an external event but a local presentation has provisionally been planned for 7.8.14. Work is continuing on putting in place a revised ECF process using Share Point. Discussions are taking place with the Executive Team about recruiting to over establishment in some areas eg, Pharmacy and Radiography, to recognize regular turnover and difficult to fill posts. Use of Social media is being explored to complement the normal means of recruitment.

Dashboards
In order to monitor progress and triangulate workforce issues with quality standards and finance, a new dashboard is being considered and some progress has been made.

E-Rostering
Approximately 10 wards/areas have now gone live with a further 3 areas over the next 3 weeks as part of the planned roll out. This has generally gone well and some work has commenced on quantifying the benefits realisation. One of the areas includes A&E and if the escalated area for CDU was discounted, A&E would be in budget and actually showing an under spend.

It is worth highlighting that since the intermediate care facility was withdrawn from Daresbury by Warrington CCG, patients have had to be accommodated in escalation areas which has had a detrimental effect on Scheduled Care and WCSS who have constantly been escalating their beds to accommodate these patients. These beds are not funded and explains to a large extent, why temporary staffing expenditure remains high.

Work is continuing on the Admin Review and the Medical Productivity work streams.

Discussions and monitoring of progress continue on all of the above issues at the bi-lateral divisional review meetings.

2.8 Equality & Diversity

2.8.1 E&D Specialist in place (Green)

A new SLA for an E&D Specialist Adviser SLA with the Countess of Chester Hospital Trust has now been agreed from June 2014 for a period of 2 years.

2.8.2 Annual Workforce Equality Analysis Report published (Green)

This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is ‘green’.

2.8.3 Annual Equality Duty Assurance report published (Green)

This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is ‘green’.

2.8.4 Annual Equality Objectives published (Green)

This was achieved for 2014 and the status is ‘green’.

2.8.5 Annual Equality Strategy published (Green)

This was achieved for 2014 and the status is ‘green’

2.8.6 Staff have access to E&D information and resources (Green)

Trust staff do have access to E&D information and resources.

2.8.7 Staff have undertaken E&D Mandatory Training (Red)

This is normally only reported bi-annually but information has been produced to report the position at 30.6.14 and the rate has increased by 6% and is 62%.

Warrington and Halton Hospitals NHS Foundation Trust

Governance & Workforce Division

Human Resources / Education & Development Workforce Key Performance Indicators

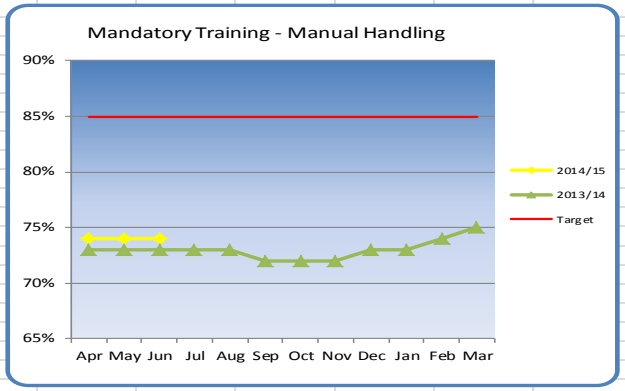
2014/15			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status Green	Amber	Red
Training & Development	Mandatory Training	Heallth & Safety	85% staff trained in last 3 years	Monthly	88%	88%	89%										**89%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	76%	77%	76%										**76%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	67%	67%	67%										**67%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			86%	85%	85%										**85%**			
		Manual Handling - Total			74%	74%	74%										**74%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	70%	75%	76%										**76%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			79%	79%	79%										**79%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	81%	81%	82%										**82%**	85 - 100%	70 - 84%	< 70%
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.18%	3.99%	3.98%										**4.09%**	3.75%	3.76-4.49%	> 4.50%
	Return to work interviews (wef 2013/14)		85%	Quarterly			53%										**53%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	9.0%	9.1%	9.3%										**9.3%**	8 - 9%	5 - 7.9% / 9.1 - 12%	< 5% / > 12%
	Establishment / SIP	Funded WTE (see NB 1 below)	Min 6.5% or Max 10% FE / SIP gap	Monthly	3686	3676	3682										**3682**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3392	3391	3371										**3371**			
		Staff in Post Headcount (see NB 2 below)			4171	4155	4134										**4134**			
		Vacancies WTE (see NB 1 below)			294	285	311										**311**			
		Vacancies %			7.97%	7.75%	8.44%										**8.44%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	6.6%	6.7%	7.6%										**7.0%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly													**Achieved**	Achieved	Work in progress	No progress
		Annual Workforce Equality Analysis report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Duty Assurance report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Objectives published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Strategy published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Staff have access to E&D information and resources	Achieved	6-monthly													**Achieved**	Achieved	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly			62%										62%	85 - 100%	70 - 84%	< 70%

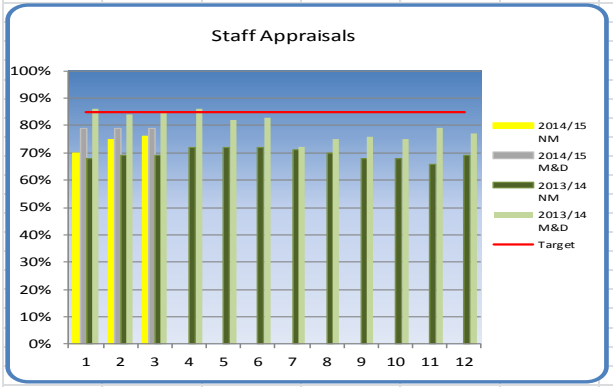
NB 1 Figures from Finance Ledger

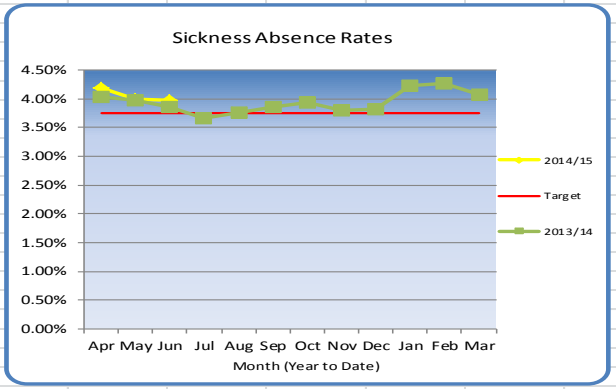
R Red **A** Amber **G** Green

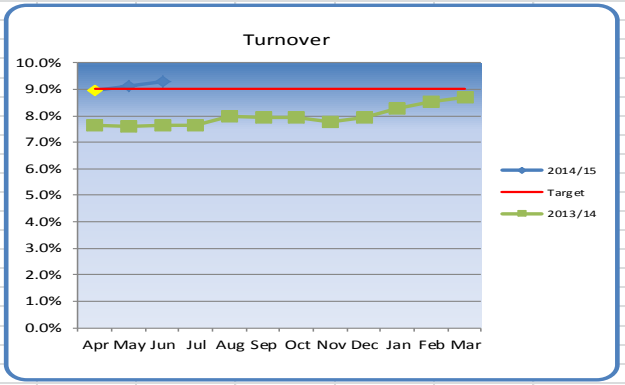

Mandatory Training - Health & Safety
90%
89%
88%
87%
86%
85%
84%
83%
82%
81%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

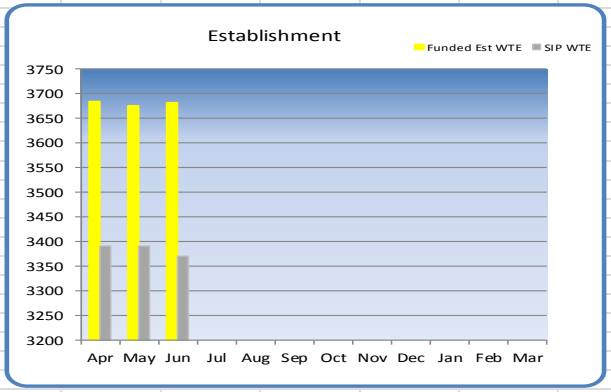

Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

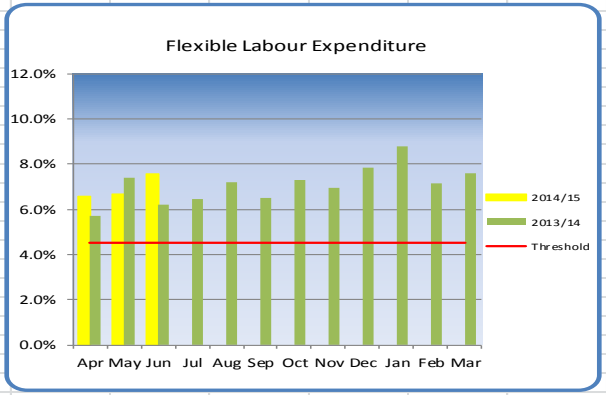

Mandatory Training - Manual Handling
90%
85%
80%
75%
70%
65%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


Staff Appraisals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 2 3 4 5 6 7 8 9 10 11 12
2014/15 NM
2014/15 M&D
2013/14 NM
2013/14 M&D
Target


Sickness Absence Rates
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month (Year to Date)
2014/15
Target
2013/14


Turnover
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14


Establishment
Funded Est WTE
SIP WTE
3750
3700
3650
3600
3550
3500
3450
3400
3350
3300
3250
3200
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Flexible Labour Expenditure
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Threshold

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/125(ii)

BOARD OF DIRECTORS

Paper Title	Publication of Staffing Data and Exception Report June 2014
Date of Meeting	29th July 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Deputy Director of Nursing
Purpose	The purpose of this paper is to provide an overview of the monitoring and management of nursing and midwifery staffing during June 2014. In addition it provides information as to the occurrence of harm related to VTE, falls, hospital acquired pressure ulcers and catheter associated urinary tract infections. It must be noted that the data related to harm is subject to change following final approval: it is the Quality Dashboard that the Board must use for this assurance. Additionally, due to reporting mechanisms currently in place, the sickness and absence data reported here relates to May 2014.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

- To show the board the planned and actual staffing levels for the trust
- To identify if there are any correlations between the staffing levels and patient harm
- An extra column has been added to show the percentage of negative or positive variance in the planned staffing levels.
- For the board to review June's data before it is published on the trusts website.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

Publication of Staffing Data and Exception Report May 2014

Publication of Staffing Data and Exception Report May 2014

Introduction

This is our second staffing data and exception report, the first followed receipt by the Board relating to its commitments regarding its collective responsibility for managing nursing, midwifery and healthcare assistant staffing capacity and capability. This briefing paper also outlined process for publishing and displaying staffing data as described in Hard Truths the government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry and the National Quality Board (NQB) guidance issued in November 2013.

The research shows that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor quality care. Furthermore it stipulates that patients and the public have a right to know how the hospitals they are paying for are being run.

Publication of Staffing Data - recommendations and actions

As stated the Board is required to receive a report which describes, the staffing capacity and capability, following an establishment review, using evidence based tools where possible every six months. The Trust is compliant with this recommendation in that the Board has already received several reports covering elements of these requirements and it is agreed that the next full report will be in September 2014 which will ensure compliance with the required full six monthly staffing review and report to Board going forward.

The Trust is also required to provide information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level. Again this action has been implemented, in that all areas have been involved in the production of the How Are We Doing? Boards. All general wards are now displaying their data, with the rollout continuing to critical care and other areas. Below, C22 proudly display their 'How Are We Doing?' board.

The Trust is required to produce a Board report containing details of planned and actual staffing on a shift by shift basis at ward level for the previous month. This report is to be presented to the Board every month, and must also be published on the Trust's website, The Trust will be expected to link or upload the report to the webpage on NHS Choices. The attached report has been developed to comply with this recommendation and has as required been published on the Trust website.

The report provides information on our staffing levels - looking at the staff hours assigned to each ward and how many hours were worked in that month.

We are committed to ensuring that levels of nursing staff, which include registered nurses, midwives and unregistered health care assistants (HCA's), match the acuity and dependency needs of patients within clinical ward areas in the trust. This includes an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios' and the number of staff per shift required to provide safe and effective patient care.

Real time management of staffing levels to mitigate risk

In the event of shortfalls of staff or unexpected increases in patient acuity and dependency requirements, the agreed staffing levels are reviewed with escalation actions specified if levels are not as expected. Please note that the term 'ward' includes critical care areas, and accident and emergency department for ease of understanding. The report contains information of variance from expected staffing levels.

Safe staffing levels are managed on a daily basis. At the daily staffing meetings, the matrons and ward managers, supported by the associate director of nursing discuss the overall view of their wards for the next 3 shifts by registered and unregistered workforce numbers and ratios. Consideration is given to acuity and dependency on the wards, as well as bed capacity and operational activity within the trust which may impact on safe staffing. The detailed report is attached at Appendix 1.

Recommendation

The Board are asked to note this report

Appendices

Appendix 1

Safer Staffing Exception Report June 2014

Staffing-Levels-2014 15-06-Jun-Vs2.xls

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Staffing Levels

Jun-14

The columns in bold contain the figures that are submitted to the DoH via the Unify portal (A&E figures excluded)

									Day					Night											
									Registered midmives/nurses			Care Staff		Registered midmives/nurses			Care Staff								
Division	Ward	Non-escalation Beds	Budgeted Registered staff	Vacancies including maternity leave	Posts appointed to but not yet started	Budgeted Unregistered staff	Vacancies including maternity leave	Sickness & Absence for May-14	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Agreed nurse to patient ratios	**Total monthly planned staff hours**	**Total monthly actual staff hours**	**Total monthly planned staff hours**	**Total monthly actual staff hours**	Number of hours above or below planned	Length of a shift in hours	Number of shifts above or below planned	Variance (actual vs planned)	Falls	Hospital acquired pressure ulcers	Catheter associated UTIs	New VTEs	Associate Director of Nursing/Matrons Assurance Statement
Scheduled Care	W-A4 - Ward A4	28	17.80	0.00	0.00	14.70	0.00	5.99	1:7	1069.5	1027.5	713.0	648.5	1:9	713.0	713.0	356.5	356.5	-106.5	11.5	-9.3	-3.73%	0	0	0	0	on urgent care center
	W-A5 - Ward A5	28	21.10	4.60	0.00	14.60	0.00	5.22	1:7	1782.1	1625.1	1069.5	1069.5	1:9	1069.5	954.5	713.0	713.0	-272.0	11.5	-23.7	-5.87%	0	0	0	0	Permanently escalated by 6 beds
	W-A6 - Ward A6	28	18.60	0.60	0.00	13.60	1.40	9.40	1:7	1426.0	1350.0	1069.5	1046.5	1:9	1069.5	1000.5	713.0	678.5	-202.5	11.5	-17.6	-4.73%	0	0	0	0	
	W-A9 - Ward A9	28	17.80	2.00	0.00	15.50	0.00	1.56	1:7	1426.0	1361.5	1426.0	1418.5	1:9	1069.5	1069.5	713.0	713.0	-72.0	11.5	-6.3	-1.55%	0	0	0	0	Over 50% escalation beds from +1 - +4
	W-B19 - Ward B19	18	14.30	2.00	0.00	13.90	3.30	1.39	1:6	1069.5	1069.5	713.0	713.0	1:6	713.0	713.0	713.0	701.5	-11.5	11.5	-1.0	-0.36%	0	0	0	0	
	W-B4-H - Ward B4 - Halton	27	12.20	0.40	0.00	6.00	0.00	9.69	1:9	874.0	765.0	552.0	483.0	13.5 :1	552.0	438.0	322.0	322.0	-292.0	11.5	-25.4	-12.70%	0	0	0	0	The staff levels alter according to activity and flexes up and down accordingly. Staff are moved regularly to support the wards at Warrington, but only when is is safe to do so.these shifts are not included in these figures.
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	1.40	0.00	14.00	0.00	4.68	1:5.5	1978.0	1936.0	1196.0	1152.0	10 : 1	966.0	966.0	644.0	621.0	-109.0	11.5	-9.5	-2.28%	0	0	0	0	The staff levels alter according to activity and flexes up and down accordingly. Staff are moved regularly to support the wards at Warrington, but only when is is safe to do so. At the CMTC there is also a forward wait which is staffed as the day ward is not mixed sex , requiring 3 RN's to staff the 2nd floor.
	W-ICU - Intensive Care Unit	18	76.74	6.91	3.00	12.52	1.00	5.66	1:1 Level 3 1:2 Level 2	4830.0	4249.5	1035.0	718.5	1:1 Level 3 1:2 Level 2	4830.0	4105.5	690.0	448.5	-1863.0	11.5	-162.0	-16.36%	0	0	0	0	18 beds funded but used flexibly depending on dependency of patients (ie. can be at full capacity at 16 beds if 10 Level 3 and 6 Level 2) Monthly planned hours worked out on 31 day month 14 Q nurses required per shift but if dependency/occupancy reduced then less nurses would still provide agreed nurse:patient ratios
Total		205	205.14	17.91	3.00	104.82	5.70	43.59											-2928.5		-254.7		0	0	0	0	
Unscheduled Care	AED			5.77	2.00	13.02	2.99	5.42		4320.0	4183.6	1125.0	1169.8		3101.7	3146.8	837.6	608.9	-275.2	12.5	-22.0	-2.93%	0	0	0	0	escalated for 5 days in the month - CDU2 open .
	W-A1A - Ward A1 Asst	29	41.40	8.50	6.00	22.10	1.20	3.63	5.5	2250.0	2103.5	1500.0	1237.5	0.0	1890.0	1765.0	630.0	609.0	-555.0	12.5	-44.4	-8.85%	0	0	0	0	(DVT RGN 208.5 hrs) (APP 584 hrs)
	W-A2A - Ward A2 Admission	28	18.83	1.10	0.00	12.90	2.00	4.87	5.6	1380.0	1351.0	1035.0	1123.0	0.0	1035.0	1012.0	690.0	816.5	162.5	11.5	14.1	3.93%	0	0	0	0	12 shifts needed extra staff for bay tagging
	W-A3OPAL - Ward A3 Opal	34	18.83	1.30	0.60	15.50	0.20	18.75	8.5:1	1426.0	1304.5	1426.0	1309.0	0.0	1069.5	1023.5	713.0	713.0	-284.5	11.5	-24.7	-6.14%	5	0	1	0	
	W-A7 - Ward A7	33	18.80	-0.10	2.20	15.50	4.30	0.69	8.3:1	1426.0	1412.5	1426.0	1267.0	0.0	1069.5	974.5	713.0	736.0	-244.5	11.5	-21.3	-5.28%	2	0	0	0	1-1 days and nights for 21 days =483 hours csw 2 full time staff on maternity leave .supernumery staff nurse on 26 hours per week
	W-A8 - Ward A8	34	18.80	1.30	0.00	15.50	1.70	7.34	8.5:1	1484.0	1452.0	1759.5	1360.0	0.0	1069.5	1023.5	1046.5	955.0	-569.0	11.5	-49.5	-10.62%	1	0	1	0	13 days of 1:1 nursing on 1 or more individuals
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	0.50	0.00	15.50	4.90	3.92	7.0:1	1035.0	1035.0	1552.5	1398.5	0.0	690.0	690.0	1127.0	943.0	-338.0	11.5	-29.4	-7.67%	1	0	0	0	
	W-B14 - Ward B14	24	18.80	-1.60	0.00	12.90	2.20	7.57	6.0:1	1380.0	1286.5	1035.0	1035.0	0.0	1035.0	1006.5	690.0	667.0	-145.0	11.5	-12.6	-3.50%	1	0	0	0	
	W-B18 - Ward B18	24	18.84	3.00	0.00	18.00	8.00	4.93	6.0:1	1380.0	1102.0	1380.0	1279.0	0.0	1035.0	1000.5	1035.0	736.0	-712.5	11.5	-62.0	-14.75%	0	0	0	0	Weekday review of staffing by Matron against cohort ward activity to ensure safety of patients
	W-C21 - Ward C21	24	13.68	-0.90	0.00	11.30	1.20	4.74	8.0:1	1035.0	1035.0	690.0	690.0	0.1	690.0	690.0	690.0	345.0	-345.0	11.5	-30.0	-11.11%	1	0	1	0	Revised Telford which has increased staffing levels at night from 1 carer to 2 - these are being recruited into a presernt time. Safety assessed during daily staffing meetings NHSP staff have been requested
	W-C22 - Ward C22	21	13.68	0.60	1.00	12.90	1.80	0.61	7.0:1	1069.5	919.5	1069.5	1069.5	0.1	713.0	713.0	713.0	678.5	-184.5	11.5	-16.0	-5.18%	0	0	1	0	
	W-CCU - Coronary Care Unit	8	21.17	0.90	0.00	2.60	0.00	1.37	2.0:1	1380.0	1368.5	345.0	207.0	0.0	1035.0	1035.0	0.0	11.5	-138.0	11.5	-12.0	-5.00%	0	0	0	0	
Total		280	216.51	20.37	11.80	167.72	30.49	63.84											-3628.7		-309.8		11	0	4	0	
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	7.10	3.00	9.20	1.80	5.19	1:1 level3 1:2 Level2	2100.0	1680.0	840.0	790.0	0.0	1488.2	1347.0	0.0	0.0	-611.2	7.5 day 10.63 night		-13.80%	0	0	0	0	NB Paeds operates a rota system to cover the whole unit. Staff work flexibly to cover PAU A&E B10 and COPD. Rota uses annualised hours and summer and winter staffing levels B10?B11 budget also contains community staff and nurse specialist roles
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	1.00	0.00	6.52	0.00	4.13	7.5:18	1092.0	1092.0	798.0	798.0	7.5:18	942.8	942.8	240.0	240.0	0.0			0.00%	0	0	0	0	Rotational staff working long days (12.5 hrs) short shifts (7.5hrs) and nights (10.714hrs) dependancy avaraged out as itu = 1:1 (3 cots) hdu= 1:2 (3 cots) special care 1:4 (12 cots) BAPM 2011. figures calculated on minimun safe staffing numpers of 3 qualified and 1 unregistered support worker.
	W-C20 - Ward C20	12	12.63	0.60	0.00	5.00	0.00	3.53	1:4	1232.5	1231.0	675.0	675.0	1:6	581.3	581.3	0.0	0.0	-1.5			-0.06%	0	0	0	0	C20 is funded for 12 in-patient beds, however is constantly esclated to +2 and often to +6. The staffing is based on the 12 in-patient beds and the 4 day ward beds/ gynae emergency beds. If these extra beds were taken into consideration the staffing ration would change. The length of the shifts are as follows: Early 7hrs, late 7.5hrs, night 9.375hrs.
	W-C23 - Ward C23	22	97.92	2.40	0.60	18.93	0.00		1:7.33	1348.5	1282.0	899.0	891.5	1:11	581.3	581.3	290.6	290.6	-74.0			-2.37%	0	0	0	0	The staffing budget for C23 is part of the entire midwifery staffing budget, as unlike other ward areas it is not broken down into each individual area. This staffing budget also includes specialist midwives. The length of the shifts are as follows: Early 7hrs, Late 7.5hrs Night 9.375. The planned and actual hours entered against C23 are based on their staffing numbers
Total		76	164.43	11.10	3.60	39.65	1.80	12.85											-686.7		0.0		0	0	0	0	
Grand Total		561	586.08	49.38	18.40	312.19	37.99	120.28											-7243.9		-564.4		11	0	4	0	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/126

BOARD OF DIRECTORS

Paper Title	2014/2015 Workforce Plan Submission to Health Education England – North West
Date of Meeting	30th July 2014
Director Responsible	Karen Dawber
Author(s)	Roger Wilson
Purpose	For Formal Approval by the Board

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

- Following on from the Board Update papers on the Workforce Transformation Project in April, May and June, the attached papers are an important element of the Workforce Planning work stream of the Workforce Transformation Project.

  All NHS organisations are required to submit their workforce plans on an annual basis. The Trust submission was made (in accordance with the deadline for submissions) to Health Education England – North West on 15th July 2014, subject to final approval by the Board. The submission highlights our future workforce needs and helps to inform Higher Education Commissions/Training Places, it also helps to flag up areas of challenge in our current workforce in terms of supply.

  The attached papers are the Trust narrative, which highlights the context we work in and the future challenges and opportunities for our workforce, also attached is our Education Strategy. The workforce future projections which have been submitted are in line with Trust Strategic Plan that was approved by the Board in June 2014. Copies of the workforce future projections can be provided on request.

  Further work and engagement with the Divisions is on-going to help them to prepare for the 2015/2016 submission and update reports will provided to the Strategic People Committee as part of its work plan.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

It is recommended that the Board approves the submission.

Health Education North West

Workforce Planning 2014/15 to 2018/2019
A summary Trust Workforce Narrative

Executive Sign-off (N.B Formal sign off will take place after the 30th July Trust Board Meeting)

Chief Executive	Medical / Clinical Director	Director of Nursing
HR / Workforce Director	**Director of Finance**	**Staff Side Representative**
Date: 15th July 2014		
Organisation: Warrington and Halton Hospitals NHS Foundation Trust		

The narrative section of the workforce plan is to provide detail against the heading and prompts of all workforce issues effecting the organisation.

Please include any workforce strategy, workforce plan, workforce development and education and learning strategies with your submission.

Please include any other information that would underpin your workforce demand, supply, risks and narrative.

Organisation:	**Warrington and Halton Hospitals NHS FT**
Author of the report:	**Roger Wilson**
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Click on the Topic to jump to the relevant section

1. Strategic Intent / Service Transformation

Please describe any major service, workforce, financial, or other changes that will impact on the workforce required for your organisation over the next 5-10 years

The Trust has a track record of delivering high performing clinical services for the communities within the boroughs of Warrington and Halton. This continued success delivered throughout six years as a Foundation Trust is due to our dedicated staff, financial stability and investment programme, robust governance processes and the joint commitment and assurance by our Board of Directors and Council of Governors to:

Provide high quality, safe integrated healthcare to all our patients every day

Over the last 12 months, working with our governors and external stakeholders, we have defined the long term vision for the Trust in a simple statement supported by a set of strategic objectives and underpinned by a set of core aims which are increasingly at the heart of determining the way in which we approach their delivery. These chime with the changing ethos within the wider NHS which reflects the learning from a range of national work but most particularly the public inquiry into the failings at Stafford Hospital led by Sir Robert Francis QC.

We aim to build on this solid foundation to deliver our **Vision** for the sort of hospital we want to be:

The most clinically and financially successful healthcare provider in the mid-Mersey region

In order to achieve our vision we believe we need to focus on the **QUALITY** of our services, on the **PEOPLE** who deliver them and on ensuring our organisation's **SUSTAINABILITY**, within the wider LHE in which we operate.

This triple aim is what we call our '**QPS'** framework – it is the underpinning strategic framework for everything that we do and provides our core strategic aims:

- **QUALITY:** Delivering excellence for our patients.
- **PEOPLE:** Committed to and caring for our staff
- **SUSTAINABILITY:** Being here for our communities, now and going forward

Our triple aim is supported by **nine strategic objectives** and a series of detailed enabling strategies that set out the specific steps we will take to achieve each aspect, and by when.

We are clear that achieving our vision will be challenging. We have thoroughly assessed the financial and non-financial challenges ahead of us and put simply we are going to have to reinvent what a district general hospital does and at its core that means over the next five years we are going to need to:

1. Restructure the delivery of urgent and emergency healthcare provided by the Trust
2. Restructure the delivery of elective healthcare provided by the Trust
3. Develop more community based care
4. Improve our productivity and sustainability
5. Improve our estate and physical infrastructure
6. Modernise our IM&T platforms

7. Re-invent our brand, image and reputation to distinguish us from the rest
8. Pursue a range of strategic collaborations, partnerships and grow in areas where it makes sense to do so.

Our future plans are therefore based on delivering these eight priorities.

We are now at a crossroads in our development and our future sustainability depends on our ability to deliver three core things: transformed and modern urgent and emergency healthcare; modern and excellent elective healthcare; and increasing amounts of community based care. We will need to take three steps to deliver these three outcomes over the next five years and our strategy is structured to reflect these three steps:

1. **Transformational programme** focused on ensuring profitability and efficiency over years 1 and 2 by improving our productivity, controlling costs more effectively, improving our estate and physical infrastructure, modernising our IM&T platforms and repatriating activity wherever possible. This will endure over the full five years life of this strategic plan with the early years work enabling further development and modernisation.

2. **Modernisation programme** which encompasses modest service level growth, growing levels of collaboration and where appropriate integration with others.

3. **Strategic change programme** in order to deliver stability beyond year 5, which includes the development of a range of strategic partnerships and/or merger and/or acquisitions.

The development of workforce strategies / plans are closely aligned to the business planning process and strategic financial planning. Includes changes linked to the following:

- Changes to future roles as envisaged in the 'NHS Next Stage Review – A High Quality Workforce'
- Future provision of services in line with the Francis Report
- Medical productivity
- Health Education North West: Five Year Workforce Skills and Development Strategy
- Staff growth through agreed service developments, investments in the quality agenda, increased activity, governance improvements and to meet legislative requirements (e.g. EWTD)
- Staff reductions through proposed efficiency savings and transformation
- Skill mix changes through services re-design to meet the pressures of the modernisation agenda, i.e. clinical pathways and competency based workforce.

The Trust values its staff and is committed to staff health and wellbeing and will continue its investment in supporting strategies in this area.

The Trust has developed an Education Strategy to mirror the Nation Education Outcomes Framework and ensuring compliance with the Learning and Development Agreement.

Overall the workforce projections have been applied in line with the Trust's FT Plan, including recent workforce submissions to Monitor, and previous forecasts which have been rolled forward where appropriate.

Commissioning

Warrington CCG
Warrington CCG – our main and lead commissioner - is seeking like all CCGs to improve outcome for patients across the five national outcome domains, which means helping live longer, healthier lives and when they do need care that it is provided safely and gives a good experience.

Strategically, to achieve change in all of these areas, it will implement the Primary Care Home model of working as a key building block to achieve these outcomes for the population. It will seek to cement primary

care as the home of care coordination, where the care plan and care co-ordination systems around the registered population will deliver: real integration; teams structured around the person; and individually tailored responses whether from health, social care or third sector services.

Operationally it will focus on pathway improvements across 10 key areas including urgent care but in the first 2 years it will focus primarily on redesigning care in seven areas:

- Urgent Care;
- Long Term Conditions / Frail Older People;
- Mental Health;
- End of Life;
- Children's Services;
- Preventing Premature Death / Public Health;
- Primary Care

Halton CCG

Similarly, Halton CCG is seeking to ensure that people live longer, healthier and happier lives. But over the next five years NHS Halton CCG, Halton Borough Council face significant financial challenges, which are driving them to do things differently and transform all aspects of health, social care and wellbeing in Halton. By redesigning primary care access it aims to enable 7 day GP access same day appointments. Integrating Acute and Community services means it can align clinical pathways enabling a seamless approach to patient care. Focusing on the vulnerable through multi-disciplinary teams will allow for significant efficiencies. 'Joined-up Care' is the theme for Halton and it wishes to develop integrated commissioning and integrated provision as a vehicle to enable a greater degree of care to be provided out of hospital settings. This also provides a major opportunity for the Trust to collaborate or vertically integrate services. Halton CCG's allocation forecast also indicates a relatively flat situation for acute funding with investment monies being used to deliver improved community based service provision and specifically the development of Urgent Care Centres within the borough.

Quality

The Francis Report is the final report into the care provided by Mid Staffordshire NHS Foundation Trust. The report's chair, Robert Francis QC, concluded that patients were routinely neglected by a Trust too focused on financial targets, so much so that it lost sight of its responsibility to provide safe care. The report contains 290 recommendations which have implications for all levels of the health service and all who work in the NHS.

Many of the recommendations following the Francis, Berwick, & Keogh reports that define quality care as providing Patient Safety, Patient Experience, and Effectiveness of care, are already in the process of being implemented at the Trust. In order to develop an action plan, the report and its recommendations have been shared widely with groups of staff, the Trust Board, and other key stakeholders to gain a wide range of ideas for implementation. These ideas formed an initial action plan which was approved by the Board earlier in the year and is monitored regularly by the Quality Assurance Group.

The Trust is keen to use these reports as a springboard to providing better quality care and a number of themes have stimulated planned action:

- Focus on a culture of caring: There will be an increased focus on nurse training, education and professional development on the practical requirements of delivering compassionate care.
- Improving leadership: Develop a programme for leaders in Band 3-7 designed to enable them to lead departments and enable all nursing staff to complete skills lab training and continue to work to ensure that matrons spend at least 60% of their time on the ward, and undertake patient safety culture survey.
- Communication with Patients: Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds, and all staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.

BCF

The Better Care Fund is being implemented locally in the context of an ageing population and an increasing number of people who have one or more long-term conditions. These two factors mean that the needs of patients and service users increasingly cut across multiple health and social care services. Increasing demand and financial pressures mean there is a need to focus on prevention, reducing the demand for services and making the most efficient and effective use of health and social care resources.

The overarching aim in order is *"to move from a reactive hospital based system of unplanned care to a preventative, anticipatory, whole person approach to care. Services will be integrated across the health and social care spectrum and redesigned with the patient and their carers at the centre, with the intention/aim that they are easy to navigate and promote equity, accessibility and choice. Our aim is to enable people to be self-sufficient, providing necessary care and support to people in their own homes and communities".*

Our commissioners expect the overall implications for the acute sector to be:

- Reduction in emergency admissions
- Reduction in A&E attendances and admissions
- Appropriate admissions into acute sector
- Reduction in the need for emergency bed days
- Reduction in the lengths of stay

Furthermore, the shifts in activity will deliver shifts in resources too from acute settings into the community. There is a role for the Trust to play for our acute provider to help provide services closer to home where they may have traditionally been provided in the hospital setting. This requires careful consideration in relation to the establishment of the Primary Care Home model and 2014/15 will provide a year in which the Trust can start to work more closely with commissioners to redefine the model of district general hospital provision.

Overall through the BCF, commissioners plan as a minimum to reduce inappropriate A&E attendances by 15% across 4 years and reduce inappropriate non elective admissions into secondary care by 15% over 4 years, moving emergency activity closer to home and increasing diagnostic activity in urgent care centres. This will also allow the CCGs to re-invest in care closer to home.

Strategic Collaboration

The Trust will also continue to explore potential opportunities for collaboration (partnership / joint venture) with other providers in the local health economy as this will still be important to achieve further efficiencies, improve the quality of services provided to patients an d ensure clinical service stability resulting from ever increasing pressures from sub specialisation.

In 2014 we will establish a provider-led clinical development forum with neighbouring acute Trusts to explore how collectively the medical directors and senior clinical leads believe that the challenges nationally will change how to take the service forward and what should be done in a collaborative way in order to respond to the likely outcomes of the mid-Mersey strategic review.

We recognise that it is inherently difficult to implement collaborative opportunities without a strong programme infrastructure aligning people and organisations behind joint goals. Therefore, we will establish this infrastructure during FY 2014/15 as our acute provider Joint Partnership Board. There is a willingness from neighbouring providers to co-operate. This will enable a targeted alliance to develop in order to get the benefits of collaboration but without the loss of autonomy required by merger/acquisition. Our initial testing with our commissioners indicates that they are supportive of this approach.

We envisage that this will lead to the development and/or exploitation of clinical network models / hub and spoke arrangements / federated service models / alternative service provision and we will start by exploring opportunities around stroke and cardiology services. In essence we see an end outcome being the

establishment of Health Care Groupings arrangement - an overarching legal structure to support a more collaborative management model of acute service provision.

This will leverage new opportunities to reduce acute sector costs and drive through efficiencies whilst also bringing about quality and safety improvements throughout the LHE but it may not bridge the LHE sustainability gap and therefore we will also establish our strategic step change programme.

However, we have also commenced early discussions with two neighbouring tertiary providers to explore the possibility of strengthening services clinically and locally.

These relate specifically to potential new partnerships with firstly, The Walton Centre to ensure better local access to specialist spinal treatments and secondly, Alder Hey around paediatrics. We are also entering into discussions with neighbouring acute Trusts in Manchester regarding capacity although these remain at an even earlier stage of discussion.

From the strategic options considered two have emerged as likely to be viable in the future, either the development of an integrated care model with the Trust at the heart of it or integration with another acute provider to either create a 'hot and hotter' model or a 'hot and cold' acute model.

Given the stated aim of introducing new models of care in the community, such as a Primary Care Home model in Warrington, and the focus on 10 areas of pathway change and adjustment by our commissioners, the development of an integrated care model, is the Trust's preferred option.

We are committed to reinventing the model of district general hospital provision and firmly see an opportunity to think about a *'hospital without walls'*, which aligns to our lead commissioner aspirations for its health system.

We have therefore agreed to start the redesign process with the Lead Commissioner and assess and implement benefits of pathway integration across the acute, community and social care. In this way we can achieve a joint provider - commissioner view of potential quality improvements and cost efficiencies e.g. reducing hospital length of stay over the long term. We believe the benefits for patients are significant.

However, we recognise that progress to prosecute strategic change depends on wide scale support outside of the Trust and thus is dependent upon a variety of factors outside of the Trust's control. The development of a robust case for change will be required and we will work with our commissioners on the development of this throughout the next two years.

We intend to do this through a Local Health Economy-wide Transformation Board which we call the Integrated Transformation Board. This is commissioner driven and will need to develop an agreed work programme during 2014, however, it is now firmly established as a system-wide board, aligning all organisations - providers and commissioners - to a common vision and agenda around the creation of integrated, person centre care.

2. Workforce: Assurance and Patient Safety

Please describe how through your workforce you are delivering around workforce assurance and patient safety

The Trust has in place a number of initiatives/processes in place to support this critical workstream, some of these have been identified in the above section of the narrative.

The Board seeks and receives assurance on a monthly basis across all of these critical areas. The Trust is currently working with Clinical Divisions to assess the impact of the move towards 24/7 working, as part of its revised approach to Workforce Planning in the Trust.

The Workforce Dashboard incorporates all of the key KPI's to ensure that the Trust is maintaining safe staffing levels – this is reviewed through the robust governance structures of the Trust.

A robust Training Needs Analysis is in place to ensure all staff receive appropriate training and development.

The Trust is developing a behavioural framework that will be embedded in all recruitment, training, development and policies.

The Trust is actively involved in the eWIN and AQUA networks, including the use of benchmarking services to support performance management arrangements.

The Trust has implemented training guidelines for Healthcare Support Workers in line with the minimum training standards. The Trust is currently reviewing the role of the Nursing Assistant.

With a population of 313,000 the Trust operates on the lower end of the "ideal scale" for a full range of District General Hospitals ideally a 450,000 - 500,000 population base. The Trust is surrounded by Trusts all with population sizes of <350,000 providing the full range of services.

The transfer of vascular services, increasing subspecialisation and reduction in junior doctor numbers staffing rotas will be challenging for WHHFT as well as for the other Trusts around our LHE. The scale of activity for some of the Trust's specialties and neighbouring Trusts is in the lower quartile when compared to Trusts across the country.

The clinical viability of some of WHHFTs services into the future is questionable; therefore, it is vital that we secure clinical and financial viability of the organisation into the future. Analysis of the financial and clinical contribution of services identified that there are a number of specialties that currently make a negative contribution to overheads.

In addition, there are number of specialties that make a loss particularly when point of delivery is factored into the analysis. Pace and collaboration with local providers will be required to deliver in tight timescales to ensure a clinically and financially viable service model for WHHFT.

There are a number of core business opportunities open to the Trust (which the Trust can implement independently) including site reconfiguration, new model of ambulatory care, new model for complex discharges and service expansion. These opportunities will support the reduction in the cost base and deliver income generation.

A thorough benchmarking of internal variation of theatres, beds, outpatients and job plans indicates the potential to improve performance and reduce costs by moving to mean performance in the Trust. A focused programme to drive performance in these areas will be executed and form the basis of early years CIP delivery.

Workforce and estates benchmarking was undertaken using a peer group of similar trusts to identify further areas for consideration. This again showed the potential to reduce costs and will be explored further to support the CIP delivery in years one and two. The total functional productivity gain (excluding medical productivity) is identified to be in the range of £5m-16m however, pushing to upper quartile would yield further benefit.

Additionally, a review of income per DCC per PA per consultant identified significant variation in a vast range of specialties. A programme of medical productivity will need to be designed and executed to unlock the potential – this will require a change in behaviours in the Trust and will be required to unlock the functional productivity potential, estimated to be between £1.3m and £5.7m impact.

The scale of the potential from internal productivity gains alone is between £5.9m and £20m (although the higher end assumes that extra capacity created through improved productivity results in increased income which will be dependent upon commissioners) most of this potential is for mean performance and thus by pushing to upper quartile there may be opportunity for greater gains particularly in terms of beds. The focus of years one and two will be on unlocking the productivity gain identified through a structured strong programme of execution centred upon driving medical productivity whilst planning the delivery of the Service Transformation.

However, productivity gain alone will not tackle the full range of risks to sustainability given increasing subspecialisation and reduction in junior doctor numbers and staffing rotas. Taken together these issues alone indicate that it is clear that the Trust has to change however, it cannot implement major transformational change alone.

3. Workforce Transformation

Please describe the workforce implications for: Workforce Modernisation / New Roles / Enhanced Roles, apprenticeships, non-medical consultant posts, non-medical prescribing and perceived impact of modernising careers framework as an organisation

Some of the initiatives outlined in Section 1 of the narrative refer to our working on the whole Workforce Transformation agenda.

The Trust has recently invested in additional senior resource to address this key work stream.

Examples of progress in this area are: -

- Implementation of career pathways in Theatres, Cardio-Respiratory, Pharmacy and Radiology through the implementation of Apprenticeships, Assistant and Advance Practitioner Roles. These pathways are being introduced to address skill mix, staff retention and difficult to recruit to roles.
- The Trust aims to increase numbers of Advanced Practitioners in Emergency Care to assist in patient flow and address gaps in the workforce.
- Introduction of Clinical Fellows for anaesthetics to maintain appropriate middle-grade cover.
- Continued development of senior nursing and therapies staff, in relevant roles, to become non-medical prescribers, work under Patient Group Directions and perform Verification of Expected Death, will enhance individual roles, support community working and improve overall patient experience.
- All staff in bands 1 - 4 are offered the opportunity to undertake a relevant apprenticeship to ensure the Trust has a competent workforce and provide opportunities for individuals to progress. Development opportunities such as these also assist with the retention of staff.
- A competency based workforce programme has commenced within the organisation. This

commenced with Outpatients and a revised staffing model is operational following this work. The Trust is currently working on a roll out –plan for this work, closely aligned to those areas where it is incurring additional spend on Bank, agency, Overtime etc

- Plans are being developed to introduce a rotational nursing post across Mental Health and Acute Care of the Elderly.
- A Transfer of Care Alliance is in place to aid partnership working in discharge.
- The embedding of Enhanced Recovery across the organisation, linking into competency based workforce.
- We are currently discussing and reviewing the potential role of Assistant Practitioners in the organisation, as we review our patient pathways.

4. Workforce, Education and Learning

This section should be read in conjunction with the requirements of the Education Commissioning Strategy 2013/14-2015/16, (https://northwest.ewin.nhs.uk/knowledge/resource/910/North-West-Education-Commissioning-Plan-201314-to-201516) the Learning and Development Agree (LDA) and the process for collecting Continuous Professional Development (CPD) requirements
Please describe the implications of sections 1 to 6 above on education and learning within your organisation

Again, some areas in this section have been covered elsewhere in the narrative. The Trust is currently reviewing medical staffing issues across the organisation, in terms of current capacity and productivity and reviewing capacity in job plans for Training and Education, to specifically name but two areas. The Trust is currently working with Clinical Divisions to review and refresh how we do Workforce Planning and Development – in line with developing a conversation around our strategic development. Elements that remain in place and are well-established are as follows: -

- Training needs analysis is in place to address essential training requirements for all staff groups. Annual learning needs analysis is currently in development.
- Whole workforce education strategy has been developed in line with the Education Outcomes Framework.
- Apprenticeships are offered to all current bands 1 – 4 staff.
- Increase in requests for work experience in clinical settings could potentially impact on student capacity in these areas.
- Implementation and roll out of 'human factors' training to multi-disciplinary teams.

5. Additional Information

Please note any other relevant information around workforce planning, workforce development and workforce modernisation

All work undertaken under the umbrella of our Workforce Planning Project is assesses using our internal E&D Impact Assessment process. The Trust takes very seriously it's Corporate and Social Responsibility in this area.

We have been working closely on our approach to Workforce Planning with Emma Hood from NW HEE and we will continue this engagement and dialogue into the future.

Please describe the profile of your non-medical workforce who are currently undertaking higher level post-graduate research degrees
Prompts to include:

- The numbers of people studying for a PhD
- The number of people who have completed a PhD
- The professional backgrounds of the above

Please describe the strategy you have in place to support the career development of your doctoral and post-doctoral staff from non-medical professions

This information to follow

6. Workforce Risks / Issues / Shortages and Actions

As has been mentioned previously, we are currently reviewing a range of workforce challenges within the organisation. The following is a key indicator of the work we are currently involved in tackling.

- Hard to fill posts in Accident and Emergency, Critical Care, specialist Radiographers
- High level of temporary staffing expenditure
- Release of staff to access CPD, training and development
- Succession planning / talent management
- 12 month experience for pre degree nursing students could impact staff turnover rate at band 2 in the organisation.
- We are currently employing rolling adverts, appointing to over establish, international recruitment to address these concerns, the Trust is happy to share their Learning with NW HEE as we move through the Workforce Transformation Project.

Workforce Solutions and Actions for your organisation

The Trust is currently exploring how we may develop strategic alliances with other local healthcare providers to address some of these issues, in order to develop a sustainable healthcare model for the communities we serve.

- See above and some other examples are as follows: -
- Development and implementation of new roles and career pathways from apprentice to advance practitioner.
- Development of competency based job descriptions
- Education strategy in place
- Development of a more informed Learning Needs Analysis

Workforce Solutions and Actions for the LETB / LWEG and Support Team
What are the planned solutions including (please see prompts not an exhaustive list):

- See above and other initiatives include
- Support with development and implementation of Advance Practice roles
- Support with funding to backfill non nursing advanced practice programmes e.g. radiology

Warrington and Halton Hospitals NHS
NHS Foundation Trust

High Quality, Safe Healthcare
Quality People Sustainability

EDUCATION STRATEGY 2014 - 2017

"To inspire the workforce of the future to deliver high quality, safe healthcare through Education and Development"

Document Title:	**Education Strategy**
Document Ref:	**01/2014**
Author:	**Education Governance Officer**
Document History:	**Version 1 2014 - 2017**
Intranet Location:	
Accountable Director:	**Associate Director of Education and Development**
Trust Committee:	**Education Governance Committee**
Date Ratified:	
Review Date:	

CONTENTS AND PAGE NUMBER

EDUCATION STRATEGY

Contents

EXECUTIVE SUMMARY

This Education Strategy has been developed in order to demonstrate the strategic vision for the education and development of the Warrington and Halton Hospitals NHS Foundation Trust workforce over the next 3 years and beyond.

The strategy is intended to set out plans for both the future and existing healthcare workforce and provides an opportunity to reaffirm the principles and values of the NHS Constitution.

NHS Constitution

The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed

This is the first over-arching Education Strategy which has been produced, which will build upon existing procedures. The strategy document sets the high level strategic intent to support the delivery of the Trust's vision and key objectives and embed the Trust values in everything we do. The goal is therefore to build upon and maintain the required culture, capacity, capability and processes.

Warrington and Halton Hospitals NHS Foundation Trust recognise that staff are its most valuable resource and are committed to provide, deliver and co-ordinate high quality education and training in order that the delivery of services, the patient experience and that of staff and learners is continually improved.

Karen Dawber
Director of Governance and Workforce

INTRODUCTION

The single most important determinant of the quality of care patients receive is the quality of the frontline staff who deliver it.

Through its aims, this strategy will highlight the imperative of ensuring that workforce and education programmes are fit for purpose, represent value for money and are delivered in such a way that they are directly informed by and responsive to employer demand. It will also highlight the significant contribution education governance makes in the quality of education and training, and thus improving patient care.

By addressing the education and learning challenges and strategic priorities, the required improvement in healthcare services through education and learning can be enabled.

The strategy framework also supports the Trust strategic objectives:

- **Ensure all our patients are safe in our care**
- **To give our patients the best possible experience**
- **To be the employer of choice for the health care we deliver**
- **To provide sustainable local health care services**

STATEMENT OF PURPOSE AND SCOPE

The purpose of this strategy is to ensure that the Trust effectively manages its education and development activities within a robust governance structure, and accountabilities framework, underpinned by a comprehensive reporting process for key performance indicators. The strategy sets out an approach to ensure that all our educational workstreams are accountable for their quality and performance.

The strategy framework will provide guidance for the management of education and development, which will enable the organisation to meet the requirements of the Learning and Development Agreement (LDA), Care Quality Commission (CQC), National Health Service Litigation Authority (NHSLA), Monitor and other governance frameworks.

This framework supports a commitment to continuous improvement in education and development with a robust approach to governance and management. It will provide assurance regarding the management of educational quality and performance, highlighting areas of good practice and risks and providing a firm basis for accountability and control. The strategy will be achieved through a culture of enhancement with 6 strategic aims:

1. **Develop a positive culture of shared leadership across the organisation**
2. **Ensure the Trust Learning Needs Analysis links to current and future job roles for all staff**
3. **Our learning environments will be effective, efficient, flexible and conducive to learning**
4. **Ensure learning outcomes are monitored and measured with clear links to patient safety through a risk management framework**
5. **Ensure the provision of a comprehensive advice and guidance service**
6. **Facilitate staff access to best available evidence and practice**

EDUCATION FRAMEWORK

To enable the Trust to effectively deliver a robust Educational framework, it is necessary to have in place clear structures and procedures within the organisation. This is achieved as

follows:

- At the heart of the Educational Framework is the Education Governance Committee, which has primary responsibility for ensuring robust quality management arrangements. It is responsible for strategic oversight of the development, implementation and review of educational standards and quality enhancement mechanisms.

- Through the integration of effective reporting structures from within Divisions, reporting through to the Education Governance Committee, Strategic People Committee and ultimately Trust Board.

- Through the continuing development of a performance management system which supports the recording and monitoring of educational activity with resulting action plans.

- Through the continuing compliance with all appropriate legislative and statutory requirements, including Monitor, Care Quality Commission Essential Standards for Quality and Safety, NHSLA Risk Management Standards, Learning and Development Agreement, to ensure that an effective integrated Assurance Framework is in place.

- Continuing to embed systems to ensure effective learning is drawn from educational governance processes, evaluation, clinical audit and staff and patient surveys.

- Integration of a robust iterative process for learning from clinical incidents, clinical audit and service reviews, identifying learning needs and providing appropriate course provision.

- Empowering staff to report risks and register concerns through an open and safe culture supported by effective Human Resources and Risk Management Policies and Procedures.

KEY STRATEGIC AREAS AND OBJECTIVES

STRATEGIC AIM 1 – (Link to EOF Domains 4, 5) **DEVELOP A POSITIVE CULTURE OF SHARED LEADERSHIP ACROSS THE ORGANISATION**	
To achieve this we will:-	**Timescales**
➢ Implementation of the Trust Leadership Strategy in order to formalise leadership development, mentoring and coaching of staff.	**December 2014**
➢ Assess capability of current service line leaders and develop a programme identifying current needs and future requirements.	**September 2014**
➢ Ensure a coaching infrastructure is developed and underpinned by a core group of NLP Coaches and coaching essentials training.	**June 2014**
➢ Ensure a toolkit and behavioural programme is implemented to support the embedding of the behavioural framework.	**December 2014**

STRATEGIC AIM 2 – (Link to EOF Domain 1,2)

ENSURE THE TRUST LEARNING NEEDS ANALYSIS LINKS TO CURRENT AND FUTURE JOB ROLES FOR ALL STAFF

To achieve this we will:-	**Timescales**
➢ Ensure named operational leads within the organisation have clear responsibility for the delivery of the Education and Learning Plan with clear links to the Learning Needs Analysis.	**Annually**
➢ Build upon National Frameworks, including Skills for Health, Leadership Framework and the Education Outcomes Framework domains in order to ensure the best possible outcomes for staff, patients and service users.	**Annually**
➢ Ensure continued proactive approaches to educational commissioning that meets current and future service needs through the LDA	**Annually**
➢ Ensure each staff group has a robust and updated TNA and ensure staff awareness of mandatory requirements	**Annually**
➢ Appoint and develop staff with strengths and potential in teaching and supporting learning with research relevant to the post	
➢ Ensure equality of access to training with the continuation and further development of flexible learning interventions for staff	
➢ Develop and implement competency based job descriptions to ensure staff have an awareness of development required for developing skills and knowledge to enable career progression	
➢ Develop and implement new roles (Apprenticeships, Assistant Practitioners, Advanced Practitioners) to facilitate appropriate skill mix and career pathways	
➢ Ensure continuing professional development opportunities are accessible to staff to enable development into advanced roles	

STRATEGIC AIM 3 – (Link to EOF Domains 1&3)

ENSURE OUR LEARNING ENVIRONMENTS ARE EFFECTIVE, EFFICIENT, FLEXIBLE AND CONDUCIVE TO LEARNING

To achieve this we will:-	**Timescales**
➢ Establish systems to enable us to anticipate student learning needs so that physical structures, IT infrastructure, on line and library resources respond to changes in demand and behaviour	**Annually**
➢ Deliver high quality, efficient and effective learning spaces, learning resources and environments	
➢ Invest in IT infrastructure, on line resources and integrated e-learning environments so that courses are delivered using the most appropriate technology and resources	**Annually**
➢ The virtual learning environment, e-learning tools and mobile learning technology will be enhanced to provide a modern, efficient, flexible and engaging learning environment for all learners	**Monthly**
➢ Ensure the continuation of effective communication and networking with stakeholders in order to strengthen local and national learning and development networks	**Annually**
➢ Continually monitor allocated resources to enable delivery of activities as outlined in the LDA and to meet required national standards for training provision	**Annually**
➢ Ensure continued compliance with LQAF standards for library services accreditation	**Monthly**
➢ Deliver and achieve Education Service Quality indicators as per monthly reporting via Education Governance Lead	

STRATEGIC AIM 4 – (LINK TO EOF DOMAIN 1)

ENSURE LEARNING OUTCOMES ARE MONITORED AND MEASURED WITH CLEAR LINKS TO PATIENT SAFETY

THROUGH A RISK MANAGEMENT FRAMEWORK

To achieve this we will:-	**Timescales**
➢ Continue to develop clear links with Trust Clinical Governance processes and procedures to maintain a risk management approach with transparent reporting processes, clear action plans and emphasis placed on outcomes for learning	**Monthly**
➢ Ensure senior management and executive level engagement to ensure all education and learning activity has Board representation	**Quarterly**
➢ Continued robust reporting of mandatory training, PDR compliance, induction and Education Governance key performance indicators at specific committee meetings	**Quarterly**
➢ Develop a culture to ensure on-going commitment with evaluation where staff understand how their feedback impacts within the overall framework	**Quarterly**
➢ Ensure high visibility of the Education Strategy, framework and principles and processes within the organisation with reporting at key Trust meetings	**Annually**
➢ Ensure the successful delivery of Undergraduate Education in our Trust; demonstrate the quality of service via site visits and surveys for medical student cohorts	**Annually**
➢ Ensure delivery of Foundation Training throughout the Organisation – demonstrate the quality of service via AAV site visit, Rotation Surveys, GMC NT Survey and CEO Forums	**Quarterly**
➢ Drive to improve the support for Medical Education by the Medical Workforce – demonstrate the delivery of programmes of learning that deliver the required knowledge and skills to competently supervise all trainees	**Annually**
➢ Meet the GMC requirements for Trainer Recognition	
➢ Deliver on requirements to support ST Trainees rotating into our Trust with robust delivery of teaching based on current curriculum	**Monthly**
➢ Manage the process for delivering medical appraisals for all the medical workforce; ensure all GMC requirements are adhered to and doctors are fully engaged and supported to move through GMC Revalidation	**Monthly**

STRATEGIC AIM 5 – (Link to EOF Domain)

ENSURE THE PROVISION OF A COMPREHENSIVE ADVICE AND GUIDANCE SERVICE

To achieve this we will:-	**Timescales**

➢ Ensure staff receive the appropriate training in order to underpin the care which is delivered to patients through a robust mandatory training system with a comprehensive TNA and LNA	**Monthly**
➢ Ensure the Education Team remain up to date with best practise to facilitate the provision of advice and guidance. Through the attendance at networking events and other appropriate educational events	**Quarterly**
➢ Continue to maintain strong partnerships with external Education organisations to support the facilitation of guidance including Health Education NW, AQuA and the Northwest Leadership Academy	**Monthly**
➢ Develop an electronic solution, via The Hub, to provide Trust staff with the ability to log a query or ask educational advice. This solution will then route it to the appropriate person(s) to deal with. The queries logged will form, where deemed appropriate and not breaking confidentiality, the basis of a Frequently Asked Questions section on The Hub	**Monthly**
STRATEGIC AIM 6 – (Link to EOF Domain) **FACILITATE STAFF ACCESS TO BEST AVAILABLE EVIDENCE AND PRACTICE**	
To achieve this we will:-	**Timescales**

➢ Provide electronic access to a range of resources, which support the delivery of evidence-based practice.	**Annually**
➢ Provide all staff with a literature search service, providing them with the best available evidence, both published and best practice to support their continuing professional development.	**Quarterly**
➢ The development of bespoke team/departmental knowledge updates within the Hub Communities to keep our Trust staff informed of the latest evidence.	**Annually**
➢ Work with the Trust Chief Knowledge Officer (CKO) to promote the sharing of learnings amongst colleagues gained via study leave.	**Annually**

IMPLEMENTATION AND MONITORING

Implementation of the Strategy

This Education Strategy brings together, for the first time, the direction setting and decision making for all elements of corporate governance, workforce planning, development and management to support the Trust's strategic intent. It is therefore a high level strategic document and not a detailed plan.

The strategy is also a 'live document' and as such will be reviewed and refreshed to take into account feedback and comments, changes in the business environment and the needs of the Trust and to take advantage of new opportunities, ideas and innovations.

The next step will be to develop an implementation workplan detailing the key work streams and initiatives with allocated leads to deliver all the elements of the strategy. Timelines for implementation, milestones and key measures will be identified for each work stream and initiative. These will be used to monitor and evaluate success.

Ultimate responsibility for the implementation of the strategy will rest with the Trust Board. The Board will receive progress reports via the Strategic People Committee and the Education Governance Committee which will have the operational responsibility for monitoring the delivery of the strategy.

Monitoring of the Strategy

Internal

The Education Governance Committee will receive quarterly reports which will include:

- Exception Report informing the committee of the current status of compliance against Key Performance Indicators.
- Performance Report informing the committee of quarterly statistics following a systematic measurement of education and learning activity.
- Specific workstreams to inform progress with the Education Governance Framework.
- Update of progress of the Education Workplan.
- New Training Programmes.
- New Policies and Procedures.
- Educational Risk Register Updates.
- NHSLA / CQC / NCEPOD Compliance Updates.
- GMC Updates
- Health Education England / North West Updates

Where appropriate, the Committee will request further information and a specific action plan will be produced. The Committee will then review progress and report accordingly.
The minutes from the Education Governance Committee are then reported to the Strategic People Committee.

External

The Trust will use the assessments of such external bodies as the Care Quality Commission, NHSLA Risk Management Assessment processes, HE North West Learning and Development Agreement, OFQUAL, Health Academy North West, GMC and Commissioners in order to assist in the monitoring processes and performance.

Progress in compliance against external standards and against any action plans developed as a result of an assessment process will be monitored via the Education Governance Committee, Strategic People Committee and other relevant committees as appropriate.

REFERENCES

- Making Education Governance a Reality in the North West 2009 – NHS North West
- Learning and Development Agreement – HE North West 2014
- Five Year Workforce Skills and Development Strategy – Health Education North West 2013
- Warrington and Halton Hospitals NHS Foundation Trust – Leadership Strategy 2013 - 2016
- Education Outcomes Framework – Department of Health 2013
- Monitor Forward Plan Strategy for Warrington & Halton Hospitals NHS Foundation Trust Plan for y/e 31.3.12 (and 2013, 2014)

APPENDICES

APPENDIX1

EQUALITY IMPACT ASSESSMENT

To be completed and attached to any policy or procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1	Does the policy / guidance affect one group less or more favourably than another on the basis of:		
	Physical Disability	NO	
	Learning Difficulties / Disability or Cognitive Impairment	NO	
	Mental Health	NO	
	Race	NO	
	Carer	NO	
	Nationality	NO	
	Ethnic origins (including gypsies and travellers)	NO	
	Culture	NO	
	Religion or belief	NO	
	Gender (Male, Female and Transsexual)	NO	
	Sexual Orientation including lesbian, gay and bisexual people	NO	
	Age	NO	
2	Is there any evidence that some groups are affected differently?	NO	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	NO	
4	Is the impact of the policy/guidance likely to be negative?	NO	
5	If so can the impact be avoided?	NO	
6	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this document, please refer it to the Equality and Diversity Co-ordinator, together with any suggestions as to the action required to avoid/reduce this impact.

APPENDIX 2

DOCUMENT INFORMATION BOX

ITEM	VALUE
Type of Document	Strategy
Title	Education Strategy
Published Version Number	01
Publication Date	
Review Date	
Author's Name and Job Title	Sharon Harper - Education Governance Officer
CQC Standard Measure	
NHSLA General Standard	
Consultation Body / Person	Education Governance Committee
Consultation Date	
Approval Body	Strategic People Committee
Approval Date	
Ratified by	Strategic People Committee
Ratification Date	
Author Contact	Sharon Harper Ext 5684
Librarian	Sharon Harper – Education Governance Officer
Division/Corporate Services	Education & Development
Specialty (if local procedural document)	NA
Ward / Department (if local procedural document)	NA
Readership (Clinical Staff, All Staff)	All Staff
Information Governance Class (Restricted / Unrestricted)	Unrestricted

Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/128

BOARD OF DIRECTORS

Paper Title	Finance Report as at 30th June 2014
Date of Meeting	30th July 2014
Director Responsible	Tim Barlow, Director of Finance & Commercial Development
Author(s)	Steve Barrow, Deputy Director of Finance
Purpose	To provide a performance update against the annual financial plan.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives **appropriate**

- Ensure all our patients are safe in our care √
- To be the employer of choice for healthcare we deliver √
- To give our patients the best possible experience √
- To provide sustainable local healthcare services √

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- Please refer to Executive Summary.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the contents of the report.

Finance Report as at 30th June 2014

1. Purpose

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 30th June 2014 and the forecast outturn as at 31st March 2015.

2. Executive Summary

Monthly and year to date performance against key financial indicators is provided in the table below further supplemented by Appendices A to E attached to this report.

Key financial indicators

Indicator	June Plan £m	June Actual £m	June Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	17.2	17.5	0.3	51.2	51.4	0.2
Operating expenses	(17.3)	(17.5)	(0.2)	(52.1)	(52.0)	0.1
EBITDA	(0.1)	0.0	0.1	(0.9)	(0.6)	0.3
Non-operating income and expenses	(0.9)	(0.9)	0.0	(2.6)	(2.6)	0.0
I&E surplus / (deficit)	(1.0)	(0.9)	0.1	(3.5)	(3.2)	0.3
Cash balance	-	-	-	7.2	8.0	0.8
CIP target	0.4	0.3	(0.1)	1.0	0.7	(0.3)
Capital Expenditure	0.6	0.0	0.6	1.6	0.7	0.9
Continuity of Services Risk Rating	2	2	0	2	2	0

3. Income and Expenditure (Appendix B)

The reported position for the year to date period is a deficit of £3,161k, which is £301k lower than the planned deficit of £3,462k.

This deficit position is comprised of the following variances:

- operating income is £141k above plan (favourable).
- operating expenses are £157k below plan (favourable).
- non operating income and expenses are £2k below plan (favourable).

The Continuity of Services Risk Rating is a 2 which is in line with plan.

While the in-month result is a significant deficit, it reflects the expected lower levels of activity and income in the month but the position is still marginally ahead of plan. In addition, the year to date performance reflects the planned profile of the cost improvement savings, the delivery of which is weighted towards the second half of the year.

4. Cost Improvement Programme

The Trust has an annual savings target of £11.9m and schemes have been identified to achieve this target, as shown in the table below.

Narrative	In Year £m	Recurrent £m
Annual Target	11.9	11.9
Value of schemes identified	10.7	15.2
Over / (Under) Achievement against target	**(1.2)**	**3.3**

For the period to date the planned savings for the identified schemes equate to £1,046k, with actual savings amounting to £736k which results in an under achievement of £310k. The cost savings programme is materially skewed towards the second half of the year, so it is vital that in the first half of the year planned savings are identified as it will become more difficult to identify and achieve any shortfalls as the year progresses.

5. Cash Flow (Appendix C)

The cash balance is £8.0m which is £0.8m above the planned cash balance of £7.2m, with the monthly movements summarised in the table below.

Cash balance movement	£m
Opening balance as at 1st June	8.8
Cash related EBITDA	0.9
Decrease in receivables	1.1
Decrease in payables	(0.6)
Capital expenditure	0.0
Other working capital movements	(1.9)
Closing balance as at 30th June	**8.0**

The planned cash balances detailed in the cashflow were based on a £10.3m forecast year end cash balance but the actual cash balance was £13.0m as a number of commissioners settled outstanding invoices in March.

The cash balance of £8.0m equates to circa 14 days operational cash. Under the continuity of services risk rating the liquidity metric is -3.8 days which scores at a 3, which reflects a reasonably strong liquidity position but the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance continues to have an adverse effect on the cash position and creditor payments. In order to maintain a reasonable cash balance payments to creditors must be extended, however performance against the non NHS Better Payment Practice Code (BPPC) has improved to 36% in the month (33% year to date).This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

The Board needs to be aware that until there is a significant improvement in the operating position of the Trust, the management of cash and the prompt payment of creditors will continue to be problematic. This may result in interest charges, refusal to provide goods and services by suppliers and the need to reduce the planned capital expenditure next year.

6. Statement of Financial Position (Appendix D)

Non current assets have decreased in the month by £425k, as capital expenditure is less than depreciation cost.

Current assets have decreased by £1,279k mainly due to the reduction in receivables and cash used for creditor payments.

Current liabilities have decreased by £860k in the month mainly due to the reduction in payables, accruals and PDC Dividend creditor.

Non current liabilities have increased by £14k in the month.

7. Capital

The approved capital programme for the year stands at £10.3m and to date the Trust has spent £0.7m against the budget of £1.1m, which is mainly due to delays in the commencement of various schemes.

Category	Annual Budget £m	Budget to date £m	Actual to date £m	Variance to date £m
Estates	6.4	0.8	0.3	0.5
IM&T	2.5	0.7	0.2	0.5
Medical Equipment	1.0	0.1	0.2	(0.1)
Contingency	0.4	0.0	0.0	0.0
Total	**10.3**	**1.6**	**0.7**	**0.9**

8. Risk and Forecast

For the quarter ending 30th June the Trust has recorded a deficit of £3,161k and although this is £301k better than plan, there are still a number of financial risks that need to be avoided or mitigated, namely:

- Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines or penalties.
- Divisions fail to deliver services within available resources.
- Clinical divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in budget setting process e.g. spinal or repatriation.
- Cost savings target not fully identified and delivered in in accordance with profile.
- Increase in readmissions resulting in bed blockages and payment to commissioners for exceeding current agreed threshold.
- Failure to manage escalation or partner's inability to provide services to withdraw medically fit patients from the hospital.
- Failure to continue to reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.
- Reduced level of anticipated winter funding.

Based on the financial position as at 30th June and the revised governance and processes introduced to increase financial rigor and scrutiny, the Trust is forecasting achievement of the planned deficit, continuity of services risk rating and all other key financial indicators.

Tim Barlow
Director of Finance & Commercial Development
23rd July 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance Headlines as at 30th June 2014

Key Financial Metrics	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,238	17,507	269	51,217	51,358	141	213,746	213,746	0
Operating Expenditure	-17,371	-17,512	-141	-52,112	-51,954	158	-204,977	-204,977	0
EBITDA	-133	-5	128	-895	-596	299	8,769	8,769	0
Financing Costs	-856	-854	2	-2,567	-2,565	2	-10,269	-10,269	0
Net Surplus/(Deficit)	**-989**	**-859**	**130**	**-3,462**	**-3,161**	**301**	**-1,500**	**-1,500**	**0**
Continuity of Services Risk Rating	2	2	0	2	2	0	3	3	0
Capital Expenditure	551	31	-520	1,653	672	-981	10,208	10,208	0
Cash Balance				7,202	8,048	846	6,731	6,731	0
Cost Savings	371	333	-38	1,046	736	-310	11,931	11,931	0

Summary Position

The reported position for the period is a deficit of £3,161k which is £301k lower than the planned deficit of £3,462k. This delivers a Continuity of Services Risk Rating 2 which is in line with plan. Income is £141k above plan mainly due to overperformance on elective activity that is 430 spells (£407k) above plan, outpatients that is 4,855 attendances (£357k) above plan and miscellaneous income that is £252k above plan, although this is partially offset by other activity that is £921k below plan. Expenditure is £158k below plan mainly due to a £333k drugs underspend that is partially offset by a £14k pay overspend and a £154k clinical supplies overspend.

Cost savings performance is below plan by £310k, which is a concern as the target is backdated towards the second half of the financial year.

Forecast Outurn

Based on the financial position as at 30th June and the revised governance structure and processes introduced to increase financial rigor and scrutiny, the Trust is forecasting achievement of the planned deficit,the continuity of services risk rating and all other key financial indicators.

Key Variances

Operating Income - £141k above plan (favourable).
Operating Expenditure - £158k below plan. (favourable).
Cost savings - £310k below plan (adverse)
Cash balances - £981k above plan but the plan was based on a forecast year end cash balance of £10.3m (actual cash balance as at 31st March was £13.0m).
Capital expenditue - £981k below plan due to slippage but forecasting that all slippage is recovered by year end.

Key Risks

Divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in the budget setting process.
Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines and penalties.
Cost savings target not fully identified and delivered in accordance with profile.
Failure to significantly reduce bank, agency, locum, overtime and waiting list initiative expenditure.

Other matters to be brought to the attention of the Board

EY have now finished the contract but the trust must ensure that the initiatives identified to maximise opportunities for cost reduction are realised.

Warrington & Halton Hospitals NHS Foundation Trust **Appendix B**

Income Statement, Activity Summary and Risk Ratings as at 30th June 2014

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	3,175	3,204	29	8,793	9,200	407	39,884	39,884	0
Elective Excess Bed Days	20	13	-7	53	58	5	242	242	0
Non Elective Spells	4,162	4,485	323	13,080	13,177	96	52,145	52,145	0
Non Elective Excess Bed Days	294	327	33	936	885	-51	3,701	3,701	0
Outpatient Attendances	2,665	2,874	209	7,726	8,083	357	33,480	33,480	0
Accident & Emergency Attendances	859	914	55	2,615	2,629	14	10,184	10,184	0
Other Activity	4,730	4,156	-574	14,010	13,089	-921	58,103	58,103	0
Sub total	**15,904**	**15,971**	**67**	**47,215**	**47,122**	**-93**	**197,738**	**197,738**	**0**
Non Mandatory / Non Protected Income									
Private Patients	13	13	0	38	22	-16	152	152	0
Other non protected	107	114	7	321	321	0	1,284	1,284	0
Sub total	**120**	**126**	**7**	**359**	**342**	**-17**	**1,436**	**1,436**	**0**
Other Operating Income									
Training & Education	641	642	0	1,924	1,924	0	7,696	7,696	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Miscellaneous Income	573	768	195	1,719	1,971	252	6,876	6,876	0
Sub total	**1,214**	**1,410**	**195**	**3,643**	**3,894**	**252**	**14,572**	**14,572**	**0**
Total Operating Income	**17,238**	**17,507**	**269**	**51,217**	**51,358**	**141**	**213,746**	**213,746**	**0**
Operating Expenses									
Employee Benefit Expenses (Pay)	-12,618	-12,766	-147	-37,855	-37,869	-14	-147,753	-147,753	0
Drugs	-1,170	-1,100	69	-3,509	-3,176	333	-14,242	-14,242	0
Clinical Supplies and Services	-1,583	-1,628	-44	-4,752	-4,906	-154	-19,154	-19,154	0
Non Clinical Supplies	-2,000	-2,019	-19	-5,995	-6,003	-8	-23,827	-23,827	0
Total Operating Expenses	**-17,371**	**-17,512**	**-141**	**-52,112**	**-51,954**	**157**	**-204,977**	**-204,977**	**0**
Surplus / (Deficit) from Operations (EBITDA)	**-133**	**-5**	**128**	**-895**	**-596**	**299**	**8,769**	**8,769**	**0**
Non Operating Income and Expenses									
Interest Income	3	5	2	10	12	2	40	40	0
Interest Expenses	0	0	0	0	0	0	0	0	0
Depreciation	-524	-523	0	-1,571	-1,571	0	-6,283	-6,283	0
PDC Dividends	-336	-336	0	-1,007	-1,007	0	-4,026	-4,026	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-856**	**-854**	**2**	**-2,567**	**-2,566**	**2**	**-10,269**	**-10,269**	**0**
Surplus / (Deficit)	**-989**	**-859**	**130**	**-3,462**	**-3,161**	**301**	**-1,500**	**-1,500**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,232	3,192	-40	9,056	9,486	430	38,181	38,181	0
Elective Excess Bed Days	82	54	-29	223	249	26	1,003	1,003	0
Non Elective Spells	2,747	3,016	269	8,600	8,992	392	34,367	34,367	0
Non Elective Excess Bed Days	1,301	1,464	164	4,140	3,930	-209	16,354	16,354	0
Outpatient Attendances	26,155	29,491	3,336	76,917	81,772	4,855	283,035	283,035	0
Accident & Emergency Attendances	8,669	9,074	405	26,404	26,784	380	102,814	102,814	0
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)	-2.4	-3.6	-1.2	-8.8	-3.8	5.0	-9.0	-9.0	0.0
Liquidity Ratio - Rating	-2	-4	-1	2	3	1	2	2	0
Capital Servicing Capacity - Metric (Times)	-0.4	0.0	0.4	-0.9	-0.6	0.3	2.2	2.2	0.0
Capital Servicing Capacity - Rating	1	1	0	1	1	0	3	3	0
Continuity of Services Risk Rating	**2**	**2**	**0**	**2**	**2**	**0**	**3**	**3**	**0**

Warrington and Halton Hospitals NHS Foundation Trust **Appendix C**

Cash Flow Statement as at 30th June 2014

	Actual April £000's	Actual May £000's	Actual June £000's	Forecast July £000's	Forecast August £000's	Forecast September £000's	Forecast October £000's	Forecast November £000's	Forecast December £000's	Forecast January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,655)**	**(648)**	**(859)**	**(526)**	**(526)**	**(527)**	**479**	**479**	**481**	**654**	**654**	**494**	**(1,500)**
Non-cash flows in operating surplus/(deficit)													
Depreciation and amortisation	523	524	523	524	524	524	524	524	523	524	524	523	6,284
Impairment losses/(reversals)	0												0
(Gain)/loss on disposal of property plant and equipment	0												0
PDC dividend expense	336	336	336	336	335	335	335	335	335	336	335	334	4,024
Other increases/(decreases) to reconcile to profit/(loss) from operations	5	4	11	1	2	3	2	2	2	3	2	3	40
Non-cash flows in operating surplus/(deficit), Total	**864**	**864**	**870**	**861**	**861**	**862**	**861**	**861**	**860**	**863**	**861**	**860**	**10,348**
Operating Cash flows before movements in working capital	**(791)**	**216**	**11**	**335**	**335**	**335**	**1,340**	**1,340**	**1,341**	**1,517**	**1,515**	**1,354**	**8,848**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	(36)	(93)	68										(61)
(Increase)/decrease in NHS Trade Receivables	775	(332)	869										1,312
(Increase)/decrease in Non NHS Trade Receivables	154	(430)	(121)										(397)
(Increase)/decrease in other related party receivables	(235)	(75)	181										(129)
(Increase)/decrease in other receivables	(1)	303	144										446
(Increase)/decrease in accrued income	261	417	(231)	(972)	605	(21)	(607)	(270)	395	(874)	657	640	0
(Increase)/decrease in prepayments	(1,833)	507	(386)	(100)	(100)	(100)	333	333	333	333	333	347	0
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	(243)	612	(14)										355
Increase/(decrease) in Current provisions	5	(11)	12	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(93)
Increase/(decrease) in Trade Creditors	2,472	(3,205)	(351)	25	(705)	(80)	306	(32)	(320)	933	(596)	390	(1,163)
Increase/(decrease) in Other Creditors	163	(313)	(59)										(209)
Increase/(decrease) in accruals	(159)	(538)	(613)										(1,310)
Increase/(decrease) in Other liabilities (non charitable assets)													0
Increase/(Decrease) in working capital, Total	**1,323**	**(3,158)**	**(501)**	**(1,058)**	**(211)**	**(212)**	**21**	**20**	**397**	**381**	**383**	**1,366**	**(1,249)**
Increase/(decrease) in Non-current provisions	(27)	13	14										0
Net cash inflow/(outflow) from operating activities	**505**	**(2,929)**	**(476)**	**(723)**	**124**	**123**	**1,361**	**1,360**	**1,738**	**1,898**	**1,898**	**2,720**	**7,599**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	0	0	0	(38)	(38)	(38)	(323)	(323)	(323)	(342)	(342)	(832)	**(2,599)**
Property - maintenance expenditure	(158)	(115)	(35)	(318)	(318)	(318)	(362)	(362)	(363)	(630)	(630)	(501)	**(4,110)**
Plant and equipment - Information Technology	(39)	(165)	(23)	(210)	(210)	(209)	(167)	(167)	(168)	(223)	(223)	(709)	**(2,513)**
Plant and equipment - Other	(45)	(119)	27	(32)	(32)	(31)	(40)	(40)	(41)	(241)	(241)	(215)	**(1,050)**
Increase/(decrease) in Capital Creditors	(171)	(865)	(171)										(1,207)
Net cash inflow/(outflow() from investing activities, Total	**(413)**	**(1,301)**	**(239)**	**(598)**	**(598)**	**(596)**	**(892)**	**(892)**	**(895)**	**(1,436)**	**(1,436)**	**(2,257)**	**(11,552)**
Net cash inflow/(outflow) before financing	**92**	**(4,230)**	**(715)**	**(1,321)**	**(474)**	**(473)**	**469**	**468**	**843**	**462**	**462**	**463**	**(3,953)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received	0												0
PDC Dividends paid	0					(2,012)						(2,012)	(4,024)
Interest (paid) on non-commercial loans	0												0
Interest received on cash and cash equivalents	4	3	5	4	3	3	3	3	3	3	3	3	40
Drawdown of non-commercial loans							266	267	267	266	267	267	1,600
Repayment of non-commercial loans	0												0
(Increase)/decrease in non-current receivables	(99)	77	(46)	21	20	20	21	20	20	21	20	17	112
Net cash inflow/(outflow) from financing activities, Total	**(95)**	**80**	**(41)**	**25**	**23**	**(1,989)**	**290**	**290**	**290**	**290**	**290**	**(1,725)**	**(2,272)**
Net increase/(decrease) in cash	**(3)**	**(4,150)**	**(756)**	**(1,296)**	**(451)**	**(2,462)**	**759**	**758**	**1,133**	**752**	**752**	**(1,262)**	**(6,225)**
Opening cash	**12,956**	**12,953**	**8,803**	**8,048**	**6,752**	**6,301**	**3,839**	**4,598**	**5,356**	**6,489**	**7,241**	**7,993**	**12,956**
Closing cash	**12,953**	**8,803**	**8,048**	**6,752**	**6,301**	**3,839**	**4,598**	**5,356**	**6,489**	**7,241**	**7,993**	**6,731**	**6,731**

Forecast cash position as per Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	6,489	7,241	7,993	6,731
Actual cash position	12,953	8,803	8,048	6,752	6,301	3,839	4,598	5,356	6,489	7,241	7,993	6,731
Variance	4,611	1,032	846	0	0	0	0	0	0	0	0	0

Warrington and Halton Hospitals NHS Foundation Trust **Appendix D**

Statement of Position as at 30th June 2014

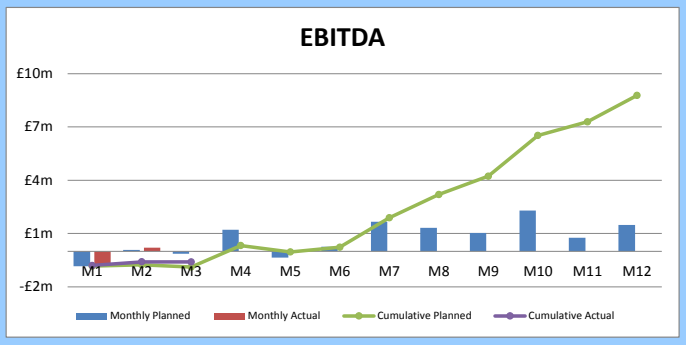
Narrative	Audited position as at 31.3.14 £000	Actual Position as at 31.05.14 £000	Actual Position as at 30.06.14 £000	Monthly Movement £000	Forecast Position as at 31.3.15 £000
ASSETS					
Non Current Assets					
Intangible Assets	316	305	340	35	155
Property Plant & Equipment	132,588	132,253	131,755	-498	134,972
Other Receivables	1,233	1,255	1,301	46	1,900
Impairment of receivables for bad & doubtful debts	-195	-198	-206	-8	-465
Total Non Current Assets	**133,942**	**133,615**	**133,190**	**-425**	**136,562**
Current Assets					
Inventories	2,769	2,898	2,830	-68	2,569
NHS Trade Receivables	3,052	2,609	1,740	-869	1,164
Non NHS Trade Receivables	573	849	970	121	338
Other Related party receivables	200	510	329	-181	606
Other Receivables	1,960	1,658	1,514	-144	1,153
Impairment of receivables for bad & doubtful debts	-355	-356	-356	0	-188
Accrued Income	884	206	437	231	764
Prepayments	1,727	3,053	3,439	386	1,016
Cash held in GBS Accounts	12,937	8,784	8,029	-755	6,720
Cash held in commercial accounts	0			0	0
Cash in hand	19	19	19	0	11
Total Current Assets	**23,766**	**20,230**	**18,951**	**-1,279**	**14,153**
Total Assets	**157,708**	**153,845**	**152,141**	**-1,704**	**150,715**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-1,513	-1,673	-1,094	579	-1,732
Non NHS Trade Payables	-5,728	-4,871	-5,099	-228	-2,694
Other Payables	-4,433	-4,283	-4,224	59	-3,478
Capital Payables	-1,386	-350	-179	171	-1,124
Accruals	-5,986	-5,289	-4,676	613	-6,222
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-49	-720	-1,056	-336	0
Deferred Income	-1,353	-1,722	-1,708	14	-1,140
Provisions	-282	-276	-288	-12	-317
Loans non commercial	0	0	0	0	0
Total Current Liabilities	**-20,730**	**-19,184**	**-18,324**	**860**	**-16,707**
Net Current Assets (Liabilities)	**3,036**	**1,046**	**627**	**-419**	**-2,554**
Non Current Liabilities					
Loans non commercial		0	0	0	-1,600
Provisions	-1,510	-1,496	-1,510	-14	-1,471
Total Non Current Liabilities	**-1,510**	**-1,496**	**-1,510**	**-14**	**-3,071**
TOTAL ASSETS EMPLOYED	**135,468**	**133,165**	**132,307**	**-858**	**130,937**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,063	90,063	90,063	0	90,014
Retained Earnings prior year	12,446	9,597	9,597	0	8,743
Retained Earnings current year	-2,849	-2,303	-3,161	-858	-1,500
Sub total	**99,660**	**97,357**	**96,499**	**-858**	**97,257**
Other Reserves					
Revaluation Reserve	35,808	35,808	35,808	0	33,680
Sub total	**35,808**	**35,808**	**35,808**	**0**	**33,680**
TOTAL TAXPAYERS AND OTHERS EQUITY	**135,468**	**133,165**	**132,307**	**-858**	**130,937**

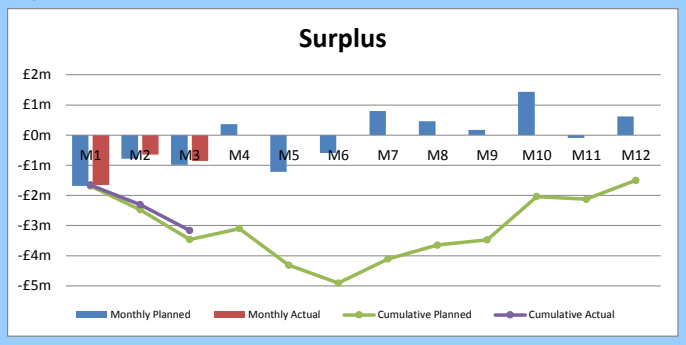
Warrington & Halton Hospitals NHS Foundation Trust

Appendix E

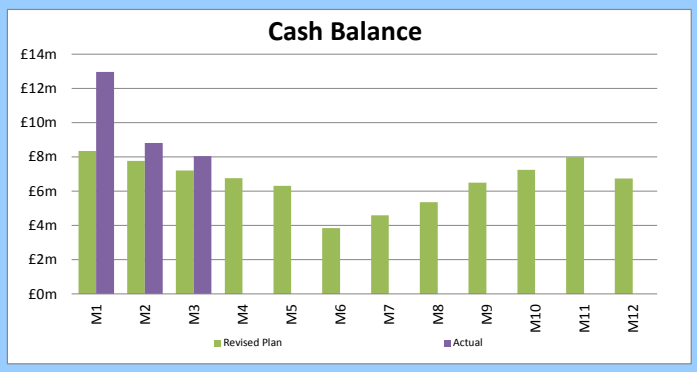
Finance Dashboard as at 30th June 2014 (Part A)

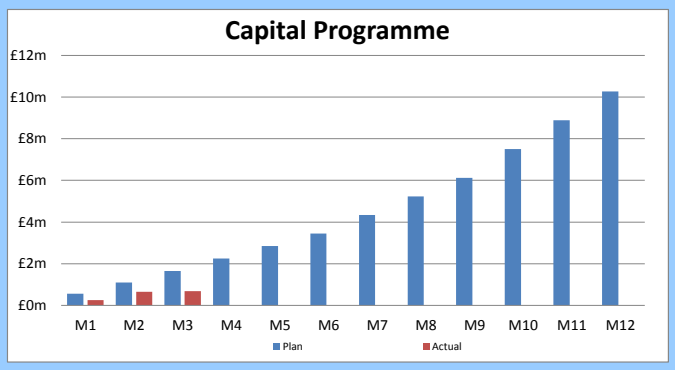
Profitability



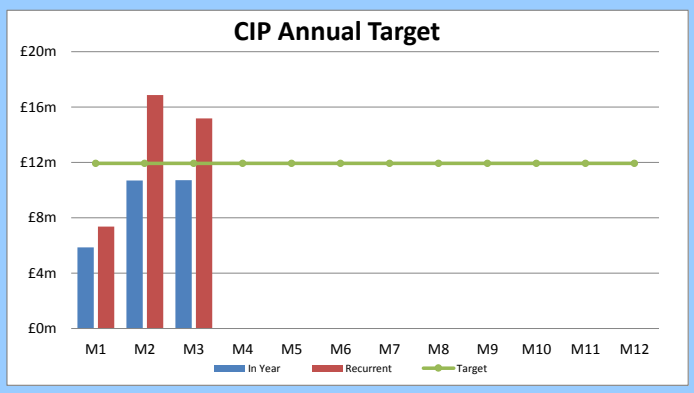


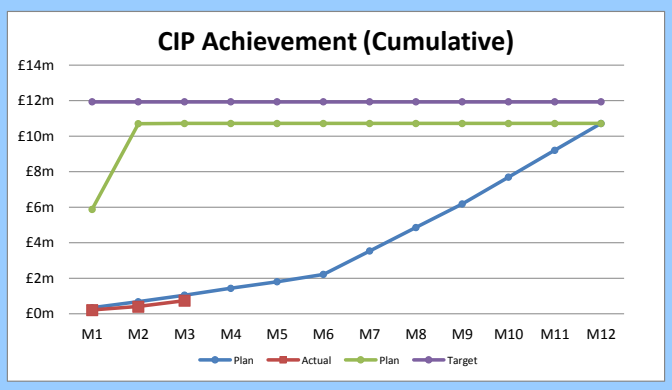
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical					
Scheduled Care	56,485	14,194	13,969	225	1.6
Unscheduled Care	42,951	11,006	11,207	-201	-1.8
Womens, Children & Support Services	56,405	14,978	14,759	219	1.5
Corporate					
Operations - Central	323	114	82	32	28.1
Operations - Estates	7,559	1,814	1,722	92	5.1
Operations - Facilities	8,096	2,017	2,037	-20	-1.0
Business Development	569	141	111	30	21.3
Finance	9,330	2,331	2,334	-3	-0.1
Governance & Workforce	4,679	1,175	1,073	102	8.7
Information Technology	3,985	1,005	966	39	3.9
Nursing	1,879	468	461	7	1.5
Trust Executive	2,108	775	741	34	4.4
Total	**194,369**	**50,018**	**49,462**	**556**	**1.1**

Continuity of Services Risk Rating

Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-3.8	3
Capital Servicing Capacity (times)	-0.7	1
Overall Risk Rating		**2**

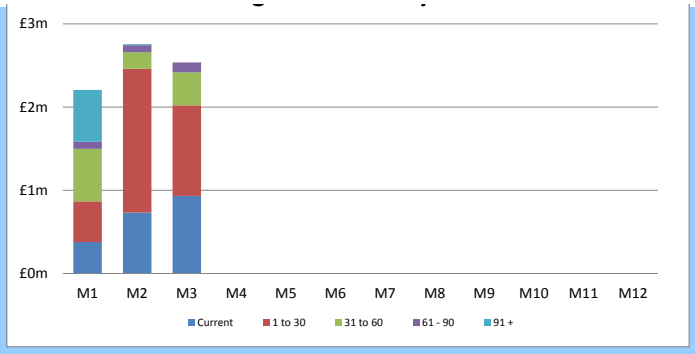
Finance Dashboard as at 30th June 2014 (Part B)

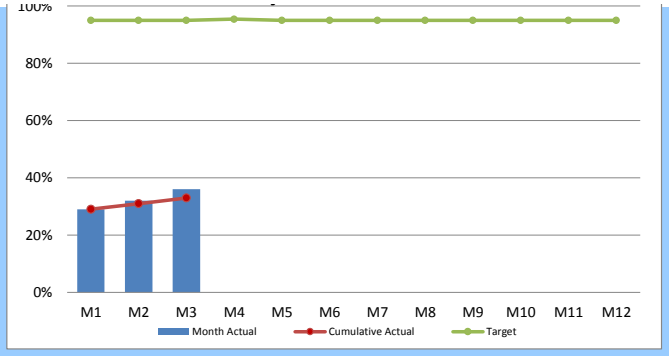
Balance Sheet and Liquidity

Aged Debt Analysis

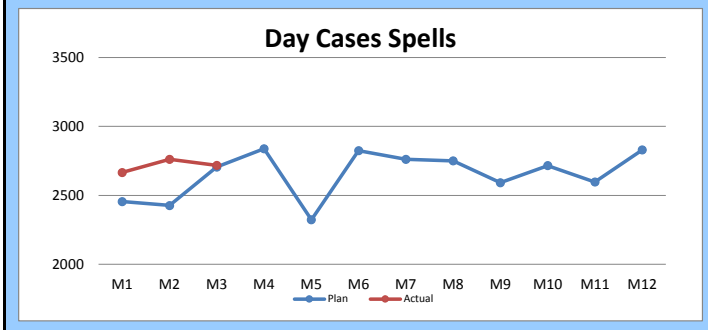
Better Payment Practice Code

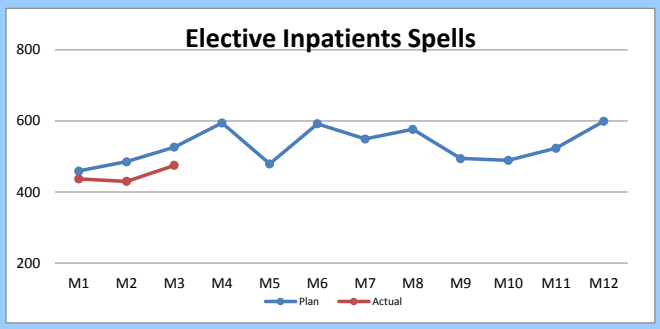
100%

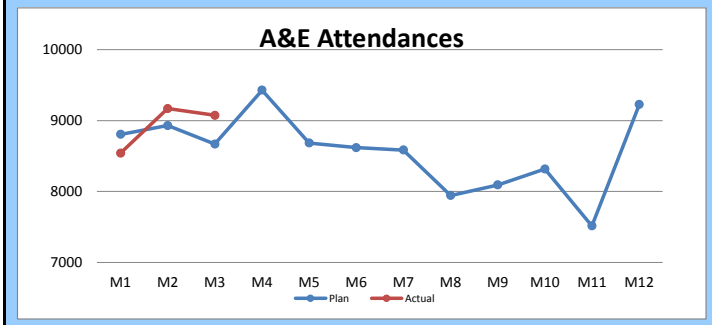


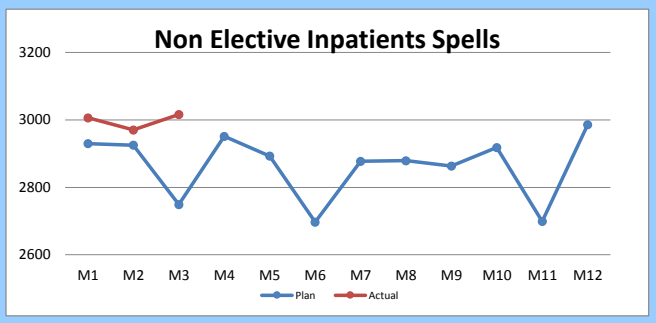


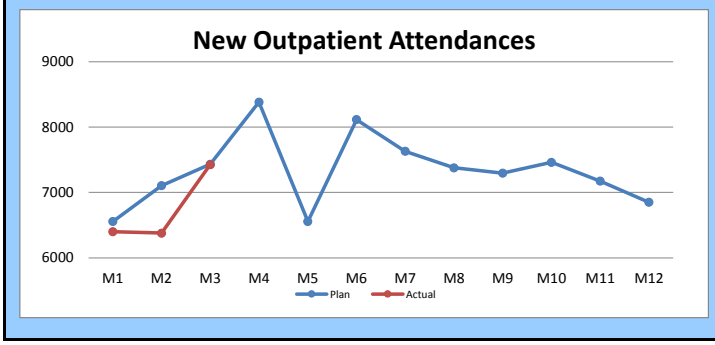
Activity Analysis

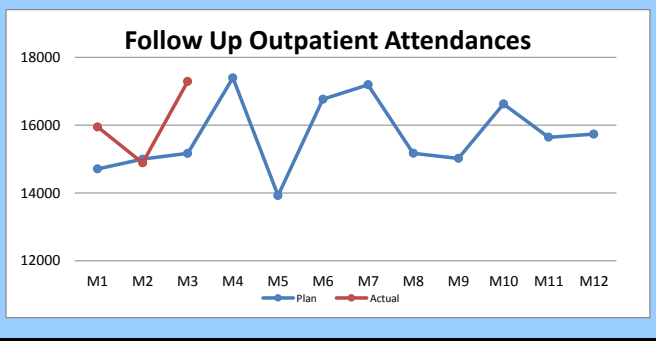












Board of Directors

Paper Title	Corporate Performance Report
Date of Meeting	
Director Responsible	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Author(s)	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Purpose	To update the Board on the Trust's operational performance for the month of June 2014

Paper previously considered	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper

Page/Paragraph Reference

- AED performance under 95% for the quarter (awaiting confirmation on walk-in activity inclusion which would address the shortfall in performance if approved)

Recommendation(s)

The Board is asked to note the contents of this paper

Warrington and Halton Hospitals NHS
NHS Foundation Trust

CORPORATE PERFORMANCE REPORT
June 2014

EXECUTIVE SUMMARY

1.0 Introduction

This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 30th June 2014.

2.0 Performance

In overall terms, based on the performance in month 3, the Trust has an **Amber/Green** rating, as highlighted in Appendix 1.

3.0 National Key performance indicators

3.1 Accident and Emergency Department

The declared performance for June is pre-validation as the entire quarter has been reviewed and upon completion will refine the declared position. This will lift June over 95% and current discussions are taking place with NHS England about the inclusion of walk in activity against the AED performance as is occurring in Aintree, St. Helens and Knowesley, UHNS etc if approved this will lift the overall performance to over 95% and is related to the Trusts leadership role in managing the transformation of both the Widnes and Runcorn units into UCC services.

Internally the Trust has undertaken a number of actions including:

- Weekly point prevalence
- Daily live patient delays information
- Introduction of Ward Discharge facilitators across medicine

In addition to this the Trust has seen a 5% increase in attendances (over 1000) and a similar figure for emergency admissions which has impacted on the bed availability placing yet further pressure on declared delays in patient discharges.

The declared position on patients who have completed their acute episode of care and are awaiting discharge has been constantly 100 or 30% of medicines acute bed stock.

Crisis meetings have been held in June with the LA and CCG to highlight the system problems which resulted in the Trust opening Intermediate care beds for a 4 week period which have now closed due to funding being fixed at 4wks.

Finally the AED manager is now on long term sickness and the Trust has appointed a temporary manager starting August 11th to support the team.

The continued pressures facing medicine have not abated since the end of the winter period and are continuing to impact on performance as we move into Q2.

All other performance targets are being fully met and the Trust is using non recurrent RTT funding to yet further improve the elective waiting times for our patients throughout July and August.

The cancer manager post remains vacant and plans are being drawn together to approach specific clinical leaders to attract the right candidate.

Mr Simon Wright

Chief Operating Officer

July 2014

Jun-14

Monitor Governance Risk Rating - 2014/15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%	93.21%	93.58%	92.91%												
	Non-admitted patients	95%	1.0	98.03%	97.63%	98.54%	97.83%												
	Incomplete Pathways	92%	1.0	94.55%	94.56%	94.94%	94.55%												
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	94.54%	92.66%	94.95%	93.95%												
All Cancers:62-day wait for First treatment	From Urgent GP Referral for Suspected Cancer **(Open Exeter Position)**	>85%	1.0 (Failure for either = failure against the overall target)	88.90%	89.00%	86.00%	87.50%												
	From NHS Cancer Screening Service Referral	>90%		100.00%	100.00%	98.00%	99.33%												
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	96.00%	98.00%	97.00%	97.00%												
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	98.00%	99.33%												
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	96.00%	96.00%	98.00%	96.67%												
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.10%	92.90%	93.05%	93.00%												
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.05%	93.00%	93.10%	93.05%												
Clostridium Difficile	Hospital Acquired (Cumulative Qtr1: 6.5 Qtr2: 13 Qtr3: 19.5 Qtr4: 26)	26	1.0 **	2	3	2	7												
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No												

Target or Indicator	Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	Report by Exception	No	No	No	No												
CQC compliance action outstanding	N/A		No	No	No	No												
CQC enforcement action within last 12 months	N/A		No	No	No	No												
CQC enforcement action (including notices) currently in effect	N/A		No	No	No	No												
Moderate CQC concerns or impacts regarding the safety of healthcare provision	N/A		No	No	No	No												
Major CQC concerns or impacts regarding the safety of healthcare provision	N/A		No	No	No	No												
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A		No	No	No	No												
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A		No	No	No	No												
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No												
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			1.0	2.0	1.0	1.0												

Additional Notes:

18 Weeks Referral to Treatment

Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.
Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Compliance Framework.
Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.
Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile**

Monitor's annual de minimis limit for cases of C-Diff is set at 12.
Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit	No
If a trust exceeds the de minimis limit, but remains within the in-year trajectory# for the national objective	No
If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective	Yes
If a trust exceeds its national objective above the de minimis limit	Yes (and a red rating will be applicable)

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).
Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/130

BOARD OF DIRECTORS

Paper Title	Part 1 Risk Register with Action Points within the Action Plan still open
Date of Meeting	July 2014
Director Responsible	Karen Dawber, Director of Nursing and OD
Author(s)	Millie Bradshaw, Associate Director of Governance
Purpose	To inform the Board to the latest Part I Risk Register and Action points within the relevant actions plans which are still open

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Governance Committee DIGG meetings IT Program Board Safety and Risk Sub Committee CG, Audit and Quality Sub Committee for review Thursday 31st July 2014	8th July 2014 July 2014 Monday 14th July Thursday 10th July 2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Risk Rating	EXTREME (15-25): In all cases, where the risk of personal injury or damage is imminent, immediate remedial action must be taken. The risk is applied to the Part 1 Risk Register on CIRIS. The risk will be reviewed at the Safety and Risk sub-Committee on a monthly basis. An appropriate Lead is identified for each risk to ensure regular assessment of the risk and the development and implementation of action plans. It is accepted that, in some cases, required actions will have resource implications and that this could take considerable time to achieve. It is recognised that it is neither realistic, nor practicable; to eliminate all risks and the emphasis will be upon managing and controlling significant risks. Particularly risks of 15-25. The Board of Directors has the ultimate responsibility for deciding where resources are to be allocated and which risks are to be considered acceptable.

	NB. Where it is not possible to treat the risk at the prescribed level, the risk is communicated up through the management structure which includes Bilateral meetings. The Risk Register is reviewed by the Safety and Risk Sub Committee and the Clinical Governance, Audit and Quality Sub Committee on a monthly basis. Any amendments and/or recommendations requested by either Committee are carried out by the relevant Lead. The amended Risk Register is reviewed at the Governance Committee bi-monthly and any amendments and/or recommendations or given to the Associate Director of Governance, who is responsible for contacting by email and phone the relevant lead to ensure these amendments are made. The completed risk register is reviewed by the Trust Board bi-monthly, following on from the Governance Committee.
Actions for managers	Monthly emails are sent by the Associate Director of Governance to all Leads to remind them to update their Risk Register entries and actions plans ready for review at Safety and Risk Sub Committee & Governance Committee. The last email circulated 2nd July 2014
Addition to RR	As part of the action from comments made during the CQC responsive visit that RR entries should now have Controls to be included as this is the 'quality' aspect they look at and would expect to see added now to all Trusts processes that they Inspect. As a result of this comment and for all future reviews of the RR to the Board, Governance Committee, sub committees and bilateral meetings a new report will be provided to members. The outcome will then for members to see; • Risk Register • Control measures in place (new report set up) • Actions points still open in the risk action plan to try and mitigate the risk
Risks for updating	RR for WCSS was due for update 21st July but the DIGG meeting was postponed. The next meeting of the DIGG will be in August 2014
Estates risk commentary	Additional comments relating to Estates Risks

Risk ID	Risk Title	Risk Rating	Comments
000170	External fire audit has identified a risk due to inadequate emergency escape lighting – Warrington Appleton Wing – various locations	16	This risk was added following receipt of an action plan notification receive from Cheshire Fire Rescue Service. The majority of the deficient areas have been addressed, and the remainder will be completed by 30th September 2014, at which time the risk will be removed from the risk register.
000134	External fire audit has identified a risk due to inadequate emergency escape	16	This risk was added following receipt of an action plan notification receive from Cheshire Fire Rescue Service.

		lighting – Halton Ph.1 & Ph.2 buildings		The Ph.1 building has been completed, and work on the Ph.2 building is currently underway. It is expected that this work will completed by 31st December 2014, at which time the risk will be removed from the risk register.
	000025	Risk due to aging and falling windows – Warrington Appleton Wing	16	This risk was added after a window failed structurally and fell into a patient bay narrowly missing a patient in the room. All 9 wards in Appleton were affected and a programme of replacement is underway. The final ward will be completed on 11th October 2014 (pending any further delays outside of Estates control), at which time the risk will be removed from the risk register.

Medicines and Pharmacy risks	The service is under pressure due to an increase in workload in a number of areas. This is resulting in the need to reduce cover provided to acute wards; consequently there has been a reduction in inpatient pharmacist contact time which has resulted in delays in the correction of prescribed medicines

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

To review and accept the Part I Risk Register with the Action Points still Open

Part 1 Risk register 21 Items

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
Group: Corporate Nursing												
000549	Risk due to limited time/ human resource of Antimicrobial Pharmacist	Infection Control	External Review	03/12/2013	High risk 12	Dawber, Karen; Director of Nursing; DNU	25/06/2014	4 - Major	Extreme risk 16	05/08/2014	30/09/2014	12
Group: Estates												
000025	Risk Due to Ageing & Failing Windows - Warrington - Appleton Wing	Estates	Risk Assessment	29/02/2012	Extreme risk 20	Patterson, Ron; Capital Projects Manager; EST	26/06/2014	5 - Catastrophic	Extreme risk 15	31/08/2014	30/11/2014	5
000134	External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 1 & Phase 2 at Halton site	Estates	Risk Assessment	31/01/2009	Extreme risk 16	Patterson, Ron; Capital Projects Manager; EST	26/06/2014	4 - Major	Extreme risk 16	31/08/2014	30/09/2014	4
000170	External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing	Estates	Risk Assessment	31/01/2009	Extreme risk 16	Patterson, Ron; Capital Projects Manager; EST	26/06/2014	4 - Major	Extreme risk 16	31/08/2014	31/10/2014	4
Group: Information Technology												
000482	Risk of unsupported, ageing IT infrastructure which is technically unable to support the Trust's IT requirements	Information Technology	Incident	04/10/2013	Extreme risk 16	Garnett, Joe; IT Systems Manager; IT	22/07/2014	5 - Catastrophic	Extreme risk 15	25/08/2014	20/06/2014	4
000482		Information Technology	Incident	04/10/2013	Extreme risk 16	Garnett, Joe; IT Systems Manager; IT	22/07/2014	5 - Catastrophic	Extreme risk 15	25/08/2014	01/09/2014	6
Group: Scheduled Care												

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
000111	Operational and financial risks associated with sustained use of escalation beds causing surgical patients to be cancelled and increase in budget	Wards (SCD)	Risk Assessment	01/08/2010	Extreme risk 15	Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD	23/07/2014	4 - Major	Extreme risk 16	28/08/2014	30/09/2014	6
Group: Trust Wide												
000035	Potential risk to staff and patients in the care and management of plus size patients due to limited bariatric equipment and training.	Warrington and Halton Hospitals NHS Foundation Trust	Incident	14/06/2012	Extreme risk 16	Wynn, Helen; Health and Safety Manager; HS	20/07/2014	4 - Major	Extreme risk 16	14/08/2014	27/02/2015	8
000144	Potential risk to Patient Safety due to poor management of patient casenotes & reputational risk following NHSLA/CQC Inspection & Assessment	Warrington and Halton Hospitals NHS Foundation Trust	Risk Assessment	01/02/2012	High risk 12	DaCosta, Jason; Director of Information Technology; IT	22/07/2014	4 - Major	Extreme risk 16	11/09/2014	30/10/2014	6
000216	Inability to replace ageing resuscitation equipment through no budget being identified which could result in equipment failing at point of use.	Warrington and Halton Hospitals NHS Foundation Trust	Risk Assessment	29/11/2012	Extreme risk 15	Kelsey, Sallie; CPD and Business Support Manager; ED	12/06/2014	5 - Catastrophic	Extreme risk 15	08/08/2014	30/01/2015	10
Group: Unscheduled Care												
000542	Delay in clincial Assessment due to unpredictable volume and acuity of the Patients in the GPAMU; Potential for undetected deteriorating Patient	Acute Medicine	Risk Assessment	15/10/2013	Extreme risk 16	Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD	18/06/2014	4 - Major	Extreme risk 16	20/08/2014	27/08/2014	4
Group: WCCSS												
000089	Risk that key objectives may not be met / risk to patient safety due to ward services being reduced due to Pharmacy Staffing issues	Pharmacy	Risk Assessment	31/01/2011	Extreme risk 16	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	23/06/2014	4 - Major	Extreme risk 16	21/07/2014	31/07/2014	8

Risk ID ▲	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
000266	MOLIS : Laboratory Information System (Vision4Health) Current software unable to embrace new technologies which could affect future requirements	Pathology	Risk Assessment	21/03/2013	High risk 12	Davies, Wendy; Head of AHP & Technical Services; WCSS	23/06/2014	3 - Moderate	Extreme risk 15	21/07/2014	31/10/2014	3
000373	Potential risk to harm patients due to overheating MRI Scanner	Radiology	Risk Assessment	17/07/2013	Extreme risk 16	Holland, Neil; Principal Radiographer - MRI and CT; TBA	23/06/2014	4 - Major	Extreme risk 16	21/07/2014	31/01/2015	8
000380	Anaerobic atmosphere cabinet has potential to fail due to certain parts becoming obsolete & irreplacable	Pathology	Risk Assessment	01/08/2013	Extreme risk 15	Davies, Wendy; Head of AHP & Technical Services; WCSS	29/08/2014	3 - Moderate	Extreme risk 15	21/07/2014	31/10/2014	6
000381	Risk of poor patient experience due to ward C20 being escalated with medical & surgical pts. Elective cases are being cancelled at short notice	Women's Health	Risk Assessment	06/08/2013	Extreme risk 16	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	25/06/2014	4 - Major	Extreme risk 16	21/07/2014	30/09/2014	8
000604	Potential risk to business continuity from Pharmacy JAC computer system failure due to the withdrawal of support for Windows XP & current JAC version	Pharmacy	Risk Assessment	13/01/2014	Extreme risk 25	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	23/06/2014	5 - Catastrophic	Extreme risk 15	21/07/2014	31/07/2014	6
000641	Inability to programme hearing aids for adults/ children leaving them vulnerable due to equipment failure. Unable to access AQP reports.	Audiology	Risk Assessment	12/02/2014	Extreme risk 15	Atherton, Paula; Audiology Service Manager; TBA	23/06/2014	3 - Moderate	Extreme risk 15	21/07/2014	31/08/2014	3
000645	Risk of missing CFT targets, breaching National wtg list targets due to aging MRI Scanner.	Radiology	Risk Assessment	23/11/2013	Extreme risk 16	Holland, Neil; Principal Radiographer - MRI and CT; TBA	23/06/2014	4 - Major	Extreme risk 16	21/07/2014	01/12/2015	8

Risk ID ▲	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
000695	CT Unit Environment : Lack of space, lack of privacy & dignity, poor ventilation & distractions which can lead to mistakes/errors, misdiagnoses.	Radiology	Risk Assessment	07/05/2014	Extreme risk 16	Holland, Neil; Principal Radiographer - MRI and CT; TBA	23/06/2014	4 - Major	Extreme risk 16	21/07/2014	31/03/2016	8
000710	Risk of serious capacity issues from August 2014 due to inadequate number of consultant radiologists.	Radiology	Risk Assessment	30/06/2014	Extreme risk 15	Holland, Neil; Principal Radiographer - MRI and CT; TBA	23/06/2014	3 - Moderate	Extreme risk 15	21/07/2014	31/03/2015	6

Action Points for Risks 26 Items

Risk Status equals: "Open"
Organisation Group equals:
Risk Monitoring Committee equals: "Safety & Risk Sub-Committee"
Action Status equals:
Action Status not equal to: "Completed"

Risk ID	Risk Title	Residual Risk Score	Description	Action Lead	Cost (£)	Action Status	Target date for action to be completed
Name: Corporate Nursing							
000549	Risk due to limited time/human resource of Antimicrobial Pharmacist	Extreme risk 16	Limited support provided to Consultant Microbiologists from Pharmacy to perform antimicrobial prescribing rounds. Buisness case in production.			In progress as at 31/01/2014	
Name: Estates							
000134	External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 1 & Phase 2 at Halton site	Extreme risk 16	Install adequate Emergency Lighting	Gee, Brian; Estates Officer; EST		In progress as at 26/06/2014	30/09/2014
000170	External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing	Extreme risk 16	Design and install appropriate emergency light fittings in line with current standards			In progress as at 26/06/2014	31/10/2014
000025	Risk Due to Ageing & Failing Windows - Warrington - Appleton Wing	Extreme risk 15	Ideally the existing Appleton Wing windows require replacement. Capital scheme to replace windows is currently in progress.	Patterson, Ron; Capital Projects Manager; EST		In progress as at 26/06/2014	30/11/2014
Name: Scheduled Care							
000111	Operational and financial risks associated with sustained use of escalation beds causing surgical patients to be cancelled and increase in budget	Extreme risk 16	Consideration being given to more elective work being undertaken at Halton to mitigate impact	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD		In progress as at 23/07/2014	29/08/2014
Name: Trust Wide							

Risk ID	Risk Title	Residual Risk Score	Description	Action Lead	Cost (£)	Action Status	Target date for action to be completed
000035	Potential risk to staff and patients in the care and management of plus size patients due to limited bariatric equipment and training.	Extreme risk 16	Write further case of need and include implementation Plan	Bradshaw, Millie; Associate Director of Governance; GOV		Required as at 22/07/2014	02/09/2014
			Specialist Bariatric Training by 2 staff members in the Health and Safety Team	Caldwell, Peter; Manual Handling Advisor; HS		Required as at 22/07/2014	30/01/2015
000144	Potential risk to Patient Safety due to poor management of patient casenotes & reputational risk following NHSLA/CQC Inspection & Assessment	Extreme risk 16	Implementation Group for casenote roll out	Bradshaw, Millie; Associate Director of Governance; GOV		In progress as at 06/05/2014	01/09/2014
000216	Inability to replace ageing resuscitation equipment through no budget being identified which could result in equipment failing at point of use.	Extreme risk 15	Acquire funding to standardise defibrillators and have a rolling replacement programme, through business case development.	Kelsey, Sallie; CPD and Business Support Manager; ED		In progress as at 12/03/2014	29/08/2014
Name: Unscheduled Care							
000542	Delay in clincial Assessment due to unpredictable volume and acuity of the Patients in the GPAMU; Potential for undetected deteriorating Patient	Extreme risk 16	Review datix report from 1st Jan to find evidence to support risk rating	Storah, Mark; Clinical Governance Manager - Unscheduled Care; UCD		In progress as at 16/07/2014	29/08/2014
Name: WCCSS							
000695	CT Unit Environment : Lack of space, lack of privacy & dignity, poor ventilation & distractions which can lead to mistakes/ errors, misdiagnoses.	Extreme risk 16	Capital scheme to be worked up for inclusion in the Capital Porgramme 2015/2016.	Holland, Neil; Principal Radiographer - MRI and CT; TBA		In progress as at 23/06/2014	31/12/2014
			Redesign and extent the CT Unit to include : Larger reporting area, Separate inpatient and outpatient waiting areas Separate male/femal IP waiting areas Patient care area Kitchen area with drinking water Sufficient storage and workspace areas	Holland, Neil; Principal Radiographer - MRI and CT; TBA		In progress as at 23/06/2014	31/03/2016
000645	Risk of missing CFT targets, breaching National wtg list targets due to aging MRI Scanner.	Extreme risk 16	Provide imaging using a mobile unit as an addition to using the CMTC	Holland, Neil; Principal Radiographer - MRI and CT; TBA		In progress as at 23/06/2014	31/07/2015
			Seek capital funding for equipment replacement for 2014/15.	Holland, Neil; Principal Radiographer - MRI and CT; TBA		In progress as at 23/06/2014	31/03/2015
000381	Risk of poor patient experience due to ward C20 being escalated with medical & surgical pts. Elective cases are being cancelled at short notice	Extreme risk 16	Bed availability - Alternative beds to be identified when elective patients cannot be accommodated.	Goodwin, Ann; Clinical Risk Midwife; WomH		In progress as at 30/09/2014	30/09/2014

Risk ID	Risk Title	Residual Risk Score	Description	Action Lead	Cost (£)	Action Status	Target date for action to be completed
000373	Potential risk to harm patients due to overheating MRI Scanner	Extreme risk 16	Provide imagings using a mobile unit either as an alternative to the CMTC scanner or in addition to.	Holland, Neil; Principal Radiographer - MRI and CT; TBA		In progress as at 23/06/2014	31/01/2015
			Purchase new MRI scanner for CMTC in Q4 2014/15	Holland, Neil; Principal Radiographer - MRI and CT; TBA		In progress as at 23/06/2014	31/01/2015
000089	Risk that key objectives may not be met / risk to patient safety due to ward services being reduced due to Pharmacy Staffing issues	Extreme risk 16	Ward visiting rota to be reviewed each day when staffing levels are known. In the event that the routinely visited wards cannot be given full coverage, undertake a risk assessment to determine which wards should be dropped. Ensure the ward is informed so that prescription charts can be sent to the dispensary if prescription review/supply of medicines is needed.	Hayes, Nicola; Deputy Chief Pharmacist - Pharmacy; PHARM		In progress as at 22/07/2014	31/03/2015
000710	Risk of serious capacity issues from August 2014 due to inadequate number of consultant radiologists.	Extreme risk 15	Manage demand by efficient use of WLI. Utilise off-site reporting providers. Attempt to recruit to locum radiologist staff. Present proposal for the creation of a number of new Advanced Practice Radiographic roles.			In progress as at 23/06/2014	31/08/2014
			Utilise off site reporting provides. Utilise locum staff. Attempt to recruit radiologist staff/benchmark against other Trusts to aid recruitment. Ensure radiologist staff are supported to deliver service as far as poss by having sufficient porter, nurses, radiographers, etc. Ensure the environment is appropriate, safe and fit for purpose in order to support recruitment/retention.			In progress as at 23/06/2014	31/12/2014
			Implement plans for a number of new advanced practice radiographic roles which will replace some of the tasks currently performed by radiologist staff. This will require significant training/input from remaining radiologists. Ensure the department is an attractive employer, providing the full range of services expected of a DGH and utilising the skills of the radiologists to maximum effect.			In progress as at 23/06/2014	31/03/2015
000641	Inability to programme hearing aids for adults/children leaving them vulnerable due to equipment failure. Unable to access AQP reports.	Extreme risk 15	Replace old equipment - funded from Oticon hearing aid rebate system.			In progress as at 23/06/2014	31/08/2014
000604	Potential risk to business continuity from Pharmacy JAC computer system failure due to the withdrawal of support for Windows XP & current JAC version	Extreme risk 15	JAC System upgrade scheduled	Keeley, Maria; Chief Pharmacy Technician - Pharmacy; PHARM		Created as at 22/07/2014	30/09/2014
			Pharmacy computer replacement scheduled	Keeley, Maria; Chief Pharmacy Technician - Pharmacy; PHARM		Created as at 22/07/2014	31/10/2014
000380	Anaerobic atmosphere cabinet has potential to fail due to certain parts becoming obsolete & irreplacable	Extreme risk 15	To procure a replacement facility.	Marshall, Graham; Microbiology Manager - Microbiology; TBA		In progress as at 23/06/2014	31/10/2014

Risk ID	Risk Title	Residual Risk Score	Description	Action Lead	Cost (£)	Action Status	Target date for action to be completed
000266	MOLIS : Laboratory Information System (Vision4Health) Current software unable to embrace new technologies which could affect future requirements	Extreme risk 15	Purchase and instal new equipment.	Green, Jeff; Histology Manager - Histopathology; TBA		In progress as at 23/06/2014	31/10/2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/131

BOARD OF DIRECTORS

Paper Title	Board Assurance Framework (BAF)
Date of Meeting	30 July 2014
Director Responsible	Executive
Author(s)	Trust Secretary/Executive
Purpose	To review and note the Trust's Board Assurance Framework

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives

	√ appropriate
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- The BAF and compliance against the Provider Licence will be reviewed by the Audit Committee in line with its terms of reference and has also been reviewed by the Finanance and Sustainability Committee with regard to those risks that relate to the Committees Terms of Reference
- The Provider Licence checklist usually provided with the BAF is to be reviewed to assess whether it is fit for purpose. A report will be provided at the end of Q2.
- The BAF is updated to take into account gaps in controls and assurance

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to Review and taking into account the review of the Corporate Risk Register confirm that the BAF and the Corporate Risk Register:

i. **covered the Trust's main activities and adequately identified the principal objectives the organisation was seeking to achieve;**
ii. **adequately identified the risks to the achievement of those objectives;**
iii. **confirm adequate assurance systems were in place to ensure the systems of control were effective and efficient in controlling the risks identified.**

ASSURANCE FRAMEWORK

June 2014

Quality

Strategic Objective 1
ENSURE ALL PATIENTS ARE SAFE IN OUR CARE

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Assurance/Controls
1.1 **COO**	**Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework**	~~3~~ 4 x 4 ~~(12)~~ (16)	Operating Framework reviewed annually, and annual plan is prepared to demonstrate ability to deliver targets effectively.	3 x 4 (12)	Board involved in the Annual Planning process and subsequent reports to monitor progress of delivery against this plan.	
			Governance structure		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board.	
			Performance management system (eg Bi Laterals, diagnostic meetings each month)		Assurance that Performance management systems is operating effectively as designed.	
			Engagement with staff		Board confirmation that all appropriate staff are effectively engaged.	
			Awareness raising programme undertaken in relation to targets.		Confirmation that Awareness raising programme has been delivered in full.	
			Corporate Performance and Quality Dashboard Reports to Board on a monthly basis, including infection control reports.		Internal Audit provide a range of independent assurances through the audit plan Other assurances from independent organisations eg data assurance. Management assurances around the accuracy of information provided.	
			Executive and Non-Executive ward and services visits (Walkabouts)		Programme and results have been designed and reviewed effectively and outcomes feed into Trust programme.	
			3 yearly governance review		Monitor implementation of recommendations arising from the review	
			Monitor trends that are relevant to triggering a governance concern.		Results of monitoring.	

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Assurance/Controls
			Annual Governance Statement		Independent assurance that the annual governance statement is reliable and robust	
			Whole System Management meeting [Overall health system risk that has impact on the Trust]		Warrington wide response to emergency demand	Reponses from external stakeholders/providers is too slow and lacks sophistication. Actions to be undertaken by the Trust to address gaps include: 1) New whole system dashboard 2) Senior leader escalation meetings 3) Measurable metrics to be available daily across health system
1.2 **DON**	**Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust.**	4 x 5 (20)	Executive Directors responsibility for CQC Outcomes, with identified operational leads reporting via Board Committee	2 x 5 (10)	Governance Committee assurance that accountabilities and processes have been discharged with a focus upon understanding reductions of harm.	New reporting systems & sub Committees to Quality Governance Committee have been reviewed and require review after 12 months to assess effectiveness (Sept 2014)
			Clinical Effectiveness and Patient Experience Strategy		One strategy: Monitor and progress reporting against Clinical Effectiveness and Patient Experience Strategy	
			Implementation of the national CQUIN for the NHS Safety Thermometer		Targets for reducing harm have been achieved eg avoidable pressure ulcers, UTIs, VTE, medication errors and 'never events'.	
			Accountability through governance structures including Bi Lateral review at divisional level.		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.	
			Trust policies and procedures including completion of CQC		In house" CQC inspections MIAA audits	Patient Complaints service reviewed June 2013. Assess effectiveness in 12 months.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Assurance/Controls
			Assurance Templates by leads and service managers		CQC unannounced inspection report March 2013 from visit held in January 2013 Care Quality Commission rating. CQC Risk rating Governor inspections Assurance on completion of action plans Benchmarking Complaints and Patient Feedback HED data	
			Strategy setting process eg People and Quality.		Appropriate assurance that key strategies are designed and delivered effectively.	
1.3 DON	**Failure to achieve infection control targets in accordance with the Risk Assessment Framework**	4x4 (16)	Infection control strategy including policies and procedures.	2x4 (8)	Process in place for approval of strategy to ensure that it is robust and confirmation of subsequent delivery, taking account of the number of bed days as against threshold tolerance in the RAF Threshold higher for Cdiff for 2014/15 than 2013/14 and move in profile nationally	
			Governance and Accountability arrangements		Board oversight of committee operations Quarterly infection control reports	
1.4 **COO**	**Failure to comply with effective business continuity plans.**	4 x 5 (20)	Emergency preparedness strategy produced annually and presented to Board	~~2~~1 x 5 ~~(10)~~(5)	Board review and monitoring of delivery of strategy including formal testing, training etc	
			Business continuity plans - in all depts.		Results of annual review of all business continuity plans overseen by Business Continuity Group and reported to Board.	
			Business Continuity plans for key external agencies are received to determine any risks to the continuity of essential services		Results of review overseen by Business Continuity Group and reported to Board. • 10 Event Planning meetings held looking at continuity • External validation of Systems • Series of live exercises to test resilience	
			Civil Contingencies Act requirements monitored.		Assurance report provided to Board to confirm compliance against legislation.	

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Assurance/Controls
			Appropriate Governance Structure in place - including Event Planning Meetings and PRHL Regional Group meetings		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.	
1.5 **DON**	**Failure to comply with Health & Safety Legislation.**	4 x 5 (20)	Appropriate Governance Structure in place	2 x 5 (10)	Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes. Results of Internal incident reporting	
			Health & Safety Strategy		Process for approval of strategy and monitoring of delivery of strategy. Health & Safety Annual Report HSE visits and inspections and associated internal progress reports	
			Mandatory training programme delivered and monitoring of attendance.		KPIs being reported regularly to the Strategic Workforces Committee.	

Strategic Objective 2
TO BE THE EMPLOYER OF CHOICE FOR HEALTHCARE WE PROVIDE

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
2.1 **DON**	**Failure to engage and involve our workforce in the design and delivery of our services.**	4 x 5 (20)	Appropriate Governance Structure in place, including Strategic People Committee and Council of Governors and Members Joint working with Staff Side/JLNC	2 x 5 (10)	Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes including staff survey results, monthly KPIs, patient feedback. Divisional DIG and temperature checks Assurances on how duty of candour has been discharged. Staff Survey results	• Staff FFT to be embedded in 14/15 • Staff not always got access to intranet – requirement to develop team briefing processes to enable to reach all staff
			People Strategy		Sign off of strategy and subsequent monitoring of implementation of strategy.	
			Cost Transformation processes		Assurance Reporting on staff and patient impact from Cost Transformation processes.	
2.2 **DON**	**Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned.**	5x5 (25)	Control systems in place to support risk: • Strategic People Committee • Education Governance • NMAC • National WFP • Medical Education Committee • OD Strategy • People Strategy • Talent Management • Recruit & Selection Policies and Procedures • ICC and Workforce Transformation	3x5 (15)	• Board Workforce KPI reports • Educational Governance Reports to SPC • Workforce analysis & Workforce Plans • External Medical Education and Nurse Education reviews • Compliance with CQC & NHSLA Standards and Audits • Staff Survey • Staff engagement & wellbeing reviews	• Require the development of robust workforce plans linked to capacity and demand and activity profile of the changing strategic direction of the Trust • Need to strengthen the links between business planning and workforce through the FSC and SPC • Vacancy freeze to be enabled • Additional HR professional to be brought in to lead on temporary staffing and workforce plan.

Strategic Objective 3
TO GIVE OUR PATIENTS THE BEST POSSIBLE EXPERIENCE

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
3.1 **COO /DOF**	**Failure to ~~develop an effective~~ implement agreed Estates Strategy to meet service priorities and Trust patient environment quality standards.**	3 x 4 (12)	~~Estates Strategy being developed by Keir Construction in line with Board direction.~~ Estates Strategy being developed with assistance from Keir Construction in line with Board direction. Full Business case in course of preparation for approval December 2014.	3x 3 (9)	Board approval and subsequent monitoring of delivery of strategy via updates to Board and Board workshops (including understanding of clinical and business drivers)	~~Understanding future provision of clinical services and the footprint for hospital services from (1) Commissioners perspective and (2) political position – May 2015 elections.~~
			Committee Structure		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.	
			Capital Programme including plan to address backlog maintenance		Assurance on progress of delivery of capital programme including; • Rationalisation and optimisation of non-clinical buildings • Migration of secondary care services to community services	
3.2 **DoIT**	**Failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care**	4 x 4 (16)	Overarching Strategy and implementation plan	(3 x 4) (12)	Board approval and subsequent monitoring of delivery of strategy via updates to Board with an assurance focus upon the twin national challenge of providing information to our patients by 2015 and moving to paperless by 2018.	Inability to provide funding and resources to enable fit for purpose systems and implementation of strategy
			Governance Structure; IM&T Programme Board Data Quality and Management Steering Group		KPI meeting held fortnightly Medical Records Strategy Group reports and minutes.	

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
			Information Governance and Corporate Records Group. OPD User Group. Diagnostic Users Group Benchmarking Review Group Finance and Sustainability Committee.		Internal audit review and reports and management action plans IT systems project implementation progress reports to Board. Reporting through committee structure (new Finance and Sustainability Committee)	
3.3 **DON**	**Failure to provide staff, public and regulators with assurances post Francis and Keogh review**	5 x 5 (25)		2 x 5 (10)	Board approval and monitoring of implementation of strategy. (particularly focusing assurance of patient experience and outcomes, rather than performance management)	
					Assurance over delivery and impact on the patient experience and outcomes.	
			• High level briefing papers and action plans • Board Development Review • Governance Structure • Internal/External Audit		• Effective operation of Assurance Committees. • Outcomes from work of Assurance Committees are reported to Board eg Quality Dashboard reporting to the Board • Quality Improvement Committee exception reporting to the Board • Patient Survey results • Patient Reported Outcome Measures (PROMS) reporting • CQUIN progress reports to Board • Mortality Outlier Reports • Governor ward visits • Impact of new nursing structure changes • Patient Advisory Group. • LINKs feedback • Membership feedback • Compliance reporting on; • Reduced admissions, compliance with end of life care and Advancing Quality Targets • Quality Account/Report • Board workshop presentation on CQC inspections • Processes in place through Governance Department on Keogh Review inspections including across trust drop in sessions and training. The Sessions are to raise awareness amongst staff to the new Care Quality	New process for CQC inspections still to be fully understood

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
					Commission Inspection Framework and what the impact of this for staff and the Trust	
			Quality Improvement themes		Board oversight of delivery of quality improvements	
			Communications and marketing		Board is assured on how effective the Trust has been in understanding their communities.	
			Whistle blowing arrangements		Effective learning on whistle blowing case studies	
			Friends and Family Test		Board & Governor overview of results of friends and family test.	
			Duty of Candor		• Briefing paper to the Board. Attached. • A Staff information was produced and distributed to all wards and depts.(attached) in addition to Trust induction for all new starters • Educational sessions arranged within all DIGGs/Specialties, Governance Committee, CG, Audit and Quality and Safety and Risk SC • The Incident and Investigations Policy was revised to include DoC and Approved under Governance arrangements (can be found on the Hub) • All Level One and Two Investigations has a DoC Checklist and is QC for audit purposes • Commissioners monitor level 2 Investigations as part of the Quality Contract	

Sustainability

Strategic Objective 4
TO PROVIDE SUSTAINABLE LOCAL HEALTHCARE SERVICES

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ Gaps in Assurance
4.1 DOF	**Failure to agree and implement a focussed and robust business development strategy to achieve the strategic aims of the Trust.**	4 x 4 (16)	• ~~Strategy Committee~~ Finance and Sustainability Committee to take forward and develop the recommendations of our external Strategic Review and determine our future strategy. • Monthly Divisional Bilateral Meetings. • ~~Strategy Committee replaced by the~~ Finance and Sustainability Committee (FSC) in place from February 2014.	3 x 4 (12)	Board approved 'Business Development Strategy' that describes the Trust objectives and approach to collaboration, service reconfiguration and partnership working. Quarterly reports to the FSC evidencing actions and approach support the delivery of the strategy and its expected outcomes. Monthly meetings of the FSC Committee to agree and oversee the implementation of the annual business development workplans. 5 Year Strategic Plan 2014-19 Strategic Plan toolkit to be utilised to develop Board awareness.	To refresh the Trust's Business Development Strategy in light of the Ernst and Young Strategic Study and develop robust annual workplans to support implementation and delivery. Establishment of Commercial Development Team to develop and support implementation of the Trusts Strategic Plan/Strategy
4.2 **DOF**	**Failure to:** ▪ **CoS rating of at least 3** ▪ **remain at all times a going concern** ▪ **maintain a sufficient liquidity ratio or capital servicing capacity** ▪ **ensure the ~~3~~ 5 year financial projection adequately reflect the Trust's financial stability**	4 x 5 (20)	▪ Monthly detailed and dash board report to the Board: I&E, activity, Balance Sheet performance metrics and 2 year cash profile. ▪ CoS risk rating assessment current and forecast ▪ Reporting other compliance metrics ▪ PMO arrangements ▪ Divisional management and governance accountability structures ▪ Standing financial instructions and scheme of delegations	~~4~~ 3 x ~~4~~ 5 ~~(16)~~ (15)	▪ Audit Committee reporting to the Board ▪ Internal audit reports ▪ Annual Head of Internal Audit opinion ▪ SIC ▪ Statutory External Audit of accounts ▪ Audit Commission PbR audits ▪ Monitor risk assessment and level of involvement ▪ Internal Audit Programme ▪ Financial and Sustainability Committee formed ▪ Monthly Board reporting ▪ Budget and Annual Plan 14/15 and 15/16	Updated risk Realigned controls and assurances

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ Gaps in Assurance
	▪ **Failure to comply with G6 of Provider licence**		▪ Legal contracts agreed with CCG.			
4.3 **DOF**	**Failure to agree and manage key contracts appropriately resulting in contract penalties or reduction in service standards (provision and receipt of services).**	4 x 5 (20)	Monthly Divisional Bilateral Meetings. Quality Group meetings with Warrington CCG Contract Risk Report Monthly Contract meetings with Warrington CCG	3 x 5 (15)	FSC to receive contract risk reports. Evidence of contract performance (provision of service) and contract management (receipt of service) provided through Divisional Bilateral Reports.	Establishment of a contract (including SLA) register with identified responsible leads for each contract. Proactive management of contracts for receipt of services between operational teams, finance, procurement and business development. Proactive management of contract performance and delivery for provision of services between operational teams, finance, procurement and business development.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/132

BOARD OF DIRECTORS

Paper Title	Governance Statement Quarter 1 14/15
Date of Meeting	30th July 2014
Director Responsible	Tim Barlow, Director of Finance & Commercial Development
Author(s)	Steve Barrow, Deputy Director of Finance
Purpose	To approve the Quarter 1 14/15 governance statement for submission to Monitor.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives

	appropriate
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
• To review and agree the recommended Board Statements for Q1.	Pages 1-3
•	
•	
•	
•	
•	
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•	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to approve governance statement for submission to Monitor.

Warrington and Halton Hospitals NHS Foundation Trust

Monitor In Year Governance Statement

Quarter 1 2014/15 (1st April 2014 – 30th June 2014)

1. Background

In accordance with the Risk Assessment Framework published by Monitor on 27th August 2013, Boards of NHS Foundation Trusts are required to respond to the following statements (see attachment 1).

2. Statements (per Quarter 3 Monitoring Returns)

2.1 Finance Statement

The Board anticipates that the Trust will continue to maintain a continuity of services risk rating of at least 3 over the next 12 months.

2.2 Governance Statement

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forwards (see attachment 2).

2.3 Otherwise

The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 diagram 8 and the Risk Assessment Framework page 21 diagram 6) which have not already been reported. (Attachment 3).

3. Conclusion and recommendations

Finance

The planned continuity of services risk rating as at 30th June 2014 is 2 and the actual risk rating achieved to date is 2.

The annual plan submitted to Monitor on 4th April 2014 covering the two financial years 14/15 and 15/16 showed that in both years the planned risk rating for quarters 1 to 3 is 2 but this increases in quarter 4 to 3, as summarized in the table below:

Rating	Q1	Q2	Q3	Q4
14/15	2	2	2	3
15/16	2	2	2	3

The finance statement requires the Board to confirm that it anticipates it will maintain a continuity of services risk rating of 3 for “at least over the next 12 months” which therefore runs to Quarter 1 15/16. The table above shows that based on current

projections it will achieve not achieve a risk rating of 3 until quarter 4 14/15 but will then return to a risk rating of 2 in Q1 15/16.

Therefore based on current and planned performance it is recommended that the Board states that whilst it is has plans to deliver a continuity of services risk rating of 3 by the end 14/15, at this stage, it cannot confirm that it anticipates maintaining a risk rating of at least 3 over the next 12 months.

Governance

Monitor has amended some of the targets and indicators in the templates with effect from Quarter 1 and Foundation Trusts are now required to report:

C Diff

- Total C Diff cases year to date
- C Diff cases under review
- C Diff due to lapses in care year to date.

Cancer 62 day waits for first treatment

- Pre local breach allocation
- Post local breach allocation

In Quarter 1 all targets and indicators were achieved with the exception of A&E Clinical Quality – total time in A&E under 4hours and Cancer 62 day waits for first treatment (from urgent GP referral) – post local breach re-allocation (see template for details). Each of these targets scores 1 point against the governance risk rating.

The Trust has had 7 cases of C Diff in the quarter but is awaiting a decision from the commissioners that lapses in care did not occur. Therefore the 7 cases have been recorded as under review.

Therefore the Board is requested to consider and recommend whether it declares confirmed or not confirmed as to whether it is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets and a commitment to comply with all known targets going forwards.

Otherwise / Exception reporting

- Based on the fact that there are no actual or prospective material changes which may affect the ability to comply with any aspect of authorization and which have not been previously notified to Monitor, it is proposed that the board confirms the otherwise statement.

Tim Barlow
Director of Finance & Commercial Development
25th July 2014

Worksheet "Targets and Indicators"

Declaration of risks against healthcare targets and indicators for 2014-15 by Warrington and Halton Hospitals

These targets and indicators are set out in the Risk Assessment Framework
Definitions can be found in Appendix A of the Risk Assessment Framework
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Scoring under Risk Assessment Framework	Quarter 1 Actual Performance	Achieved/Not Met	Any comments or explanations	Scoring under Risk Assessment Framework
	Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	No		92.9%	Achieved		
	Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	No		97.8%	Achieved		
	Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	0	94.6%	Achieved		00/01/1900
	A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	No	0	94.0%	Not met		1
AMENDED	Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	No		84.5%	Not met		
AMENDED	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No	0	99.3%			1
NEW	Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					87.5%			
NEW	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					99.3%			
	Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		97.0%	Achieved		
	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		99.3%	Achieved		
	Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	0.0%	Not relevant		0
	Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	0	96.7%	Achieved		0
	Cancer 2 week (all cancers)	93%	1.0	No		93.0%	Achieved		
	Cancer 2 week (breast symptoms)	93%	1.0	No	0	93.1%	Achieved		0
	Care Programme Approach (CPA) follow up within 7 days of discharge	95%	1.0	No		0.0%	Not relevant		
	Care Programme Approach (CPA) formal review within 12 months	95%	1.0	No	0	0.0%	Not relevant		0
	Admissions had access to crisis resolution / home treatment teams	95%	1.0	No	0	0.0%	Not relevant		0
	Meeting commitment to serve new psychosis cases by early intervention teams	95%	1.0	No	0	0.0%	Not relevant		0
	Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	1.0	No	0	0.0%	Not relevant		0
	Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	1.0	No	0	0.0%	Not relevant		0
	Ambulance Category A 19 Minute Transportation Time	95%	1.0	No	0	0.0%	Not relevant		0
AMENDED	C.Diff due to lapses in care	7	1.0	No	0				0
NEW	Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					7			
NEW	C.Diff cases under review					7			
	Minimising MH delayed transfers of care	<=7.5%	1.0	No	0	0.0%	Not relevant		0
	Data completeness, MH: identifiers	97%	1.0	No	0	0.0%	Not relevant		0
	Data completeness, MH: outcomes	50%	1.0	No	0	0.0%	Not relevant		0
	Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	No	0	0.0%	Achieved		0
	Community care - referral to treatment information completeness	50%	1.0	No		0.0%	Not relevant		
	Community care - referral information completeness	50%	1.0	No		0.0%	Not relevant		
	Community care - activity information completeness	50%	1.0	No	0	0.0%	Not relevant		0

	Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No		No	
AMENDED	CQC compliance action outstanding (as at time of submission)	N/A		No		No	
AMENDED	CQC enforcement action within last 12 months (as at time of submission)	N/A		No		No	
AMENDED	CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No		No	
AMENDED	Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No		No	
AMENDED	Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No		No	
AMENDED	Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No		No	

Results left to complete 0 2
Total Score 0 2

Worksheet "Governance Statement"

Click to go to index

In Year Governance Statement from the Board of Warrington and Halton Hospitals

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

		Board Response
	For finance, that:	
4	The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Not Confirmed
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	
	Otherwise:	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.	Confirmed
NEW	**Consolidated subsidiaries:** Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature		Signature	
Name	Mel Pickup	**Name**	Tim Barlow
Capacity	Chief Executive	**Capacity**	Director of Finance
Date	30th July 2014	**Date**	30th July 2014

Notes: *Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.*

In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.

This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.

Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C

Attachment 3

Risk Assessment Framework page 21, diagram 6

Examples of exception reports

Continuity of Services (all licensees)

- Unplanned significant reductions in income or significant increases in costs
- Discussions with external auditors which may lead to a qualified audit report
- Future transactions potentially affecting the continuity of services risk rating
- Risk of a failure to maintain registration with the Care Quality Commission (CQC) for Commissioner Requested Services (CRS)
- Loss of accreditation of a CRS
- Proposals to vary CRS provision or dispose of assets including
  - cessation or suspension of CRS
  - variation of asset protection processes
- Proposed disposals of CRS related assets

Financial Governance (NHS Foundation Trusts)

- Requirements for additional working capital facilities
- Failure to comply with the statutory reporting guidance
- Adverse report from internal auditors
- Significant third party investigations that suggest potential material issues with governance
- CQC responsive or planned reviews and their outcomes
- Other patterns of patient safety issues which may reflect poor governance (eg serious incidents, complaints)
- Performance penalties to commissioners

Governance (NHS Foundation Trusts)

- Third party investigations that could suggest material issues with governance (eg fraud, CQC concerns, medical Royal Colleges' reports)
- CQC responsive or planned reviews and its outcomes / findings
- Other patient safety issues which may impact compliance with the license (eg serious incidents)

Other risks

- Enforcement notices or sanctions from other bodies implying potential or actual significant breach of a license condition (eg Office of Fair Trading)
- Patient group concerns
- Concerns from whistleblowers or complaints

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/133(i)

BOARD OF DIRECTORS

Paper Title	Verbal update on activity of Board Committees
Date of Meeting	30 July 2014

Board Committee Verbal Update

a) Quality Governance Committee held on 8 July 2014 – Mike Lynch
b) Finance and Sustainability Committee held on 24th July 2014 – Carol Withenshaw
c) Audit Committee held on 21st July 2014 – Rory Adam
d) Charitable Funds Committee held on 21st July 2014 – Lynne Lobley

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/111 (ii)

BOARD OF DIRECTORS

Paper Title	Board Committee Minutes for noting only
Date of Meeting	30th July 2014
Director Responsible	Chair of Board Committees
Author(s)	
Purpose	The Board had received verbal updates from the Chair of each Committee regarding the meetings held. The minutes are for noting only

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	None	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the Board Committee minutes:

a) ***Quality Governance Committee held on 13th May 2014***
b) ***Audit Committee held on 6 May and 23rd May 2014***
c) ***Charitable Funds Committee held on 6th May 2014***
d) ***Finance and Sustainability Committee held on 17th June 2014***

Warrington and Halton Hospitals NHS
NHS Foundation Trust

QUALITY GOVERNANCE COMMITTEE

Minutes of the Meeting held on Tuesday 13th May 2014 at 9:00 am
Annex, Halton Education Centre, Halton Hospital

Present:

Mike Lynch	Non-Executive Director (Chair)
Tim Barlow	Finance Director
Alison Lynch	Deputy Director of Nursing
Amanda Risino	Associate Director of Operations, Unscheduled Care
Diane Matthew	Chief Pharmacist, represented by Nicola Hayes
Rory Adam	Non-Executive Director- representing Carol Withenshaw
Mel Pickup	Chief Executive
Millie Bradshaw	Associate Director of Governance and Risk
Paul Hughes	Medical Director
Mel Hudson	Associate Director of Nursing, WC&SS Head of Midwifery
Rachael Browning	Associate Director of Nursing, Scheduled Care
Simon Wright	Chief Operating Officer/Deputy Chief Executive
Emma Buckley	Governance Compliance Manager
Helen Wynn	Head of H&S
Wendy Davies	Represented by S. D Walker for AHP, WC&SS

In Attendance:

Jennie Taylor	Executive PA (minutes)

	WHHFT/GC/14/034 - Apologies for Absence and Introductions	Responsibility and Target date
1	Apologies received from: Carol Withenshaw, Non-Executive Director (represented by Rory Adam) John Wharton, Nurse Quality Lead, CCG, Karen Dawber, Director of Nursing and OD Jan Snoddon, Chief Nurse, Halton CCG, Kate Warbrick, Associate Director of Operations, Scheduled Care Richard Brown, Associate Director of Operations, WCSS Wendy Davies, Assistant General Manager, WC&SS, AHP lead	
	WHHFT/GC/14/035 – Declarations of Interest	
2	There were no declarations of interest made in relation to the agenda items for the Governance Committee meeting.	
	WHHFT/GC/14/036 – Minutes of the previous meeting held on 11th March 2014	**Members**
3	The minutes of the meeting held on 11th March were agreed as an accurate record with an amendment to paragraph 64 as follows. *A new resistant organism CPE and the detection of will involve rectal swabs, or stool samples if patients refuse, routinely on transfers only. Awaiting guidance from Public Health England, started the work against the toolkit provided.*	
	WHHFT/GC/14/37 Action Plan	

4	<u>WHHFT/GC/14/006 – Risk 00027 Pathology</u> The Associate Director of Governance and Risk advised that ICE has been procured which will utilise one system instead of the current three. The Chief Executive would like to see this rolled out and a SOP produced around it. The Medical Director explained the Divisional Medical Directors will have good professional processes around checking results and will be linked to the clinicians' appraisals. The Chief Executive advised she had received an e-mail from Junior Doctors saying that paper reporting is very poor. The Chief Operating Officer explained that it is our stated intention to remove paper and case notes are also being reviewed to reflect that with results being accessed electronically. The Associate Director of Governance and Risk advised that she is looking at a proper implementation plan and that IM&T will be leading on this. M. Lynch, Non-Executive Director/ Chair recommended having consultants involved with the IM&T process. **Anti-Coagulation** – the Medical Director reported that a thorough Risk Assessment has been undertaken and a paper is ready to be submitted to Executive Team. **Workforce Quality Report** – in progress **I-Bleep usage** – Associate Director of Governance and Risk explained that she had received a comprehensive report from Tracy Mason, item to be on July agenda.	**Exec PA July 2014**
	WHHFT/GC/14/038 – Maternity Document submitted to CQC following letter received 17th April 2014	
	The Associate Director of Governance and Risk had attached this document for information. She reported that the CQC are pleased with the information provided. M. Lynch, Non-Executive Director/Chair advised that the Board had received a comprehensive report and were pleased with the assurance around the investigation. The Chief Operating Officer explained that new guidelines around maternity were announced today supporting maternity units. The good practice unearthed during the investigation should provide reassurance to staff involved that practices are sound.	
	WHHFT/GC/14/039 - Complaints Summary Report	
	The Deputy Director of Nursing submitted this report for information and explained that it is a report requested by the CCG.	

	WHHFT/GC/14/040 – Summary of Changes/Corporate Risk Register (15+) Review and Update **000536 – Clostridium Difficile threshold** The Finance Director explained that the CCG did not extract penalty from us and therefore this risk should be closed today. **000269 – Temporary Staffing** R. Adams, Non-Executive Director commented that reporting on this risk is out of date. He queried how Non-Executives can feel assured that risk is being mitigated. The Chief Operating Officer explained that much has been done but is not reflected. The Associate Director of Governance and Risk explained that she e-mails the risk lead managers every month, normally the register is discussed fully at Safety and Risk Sub Committee but the recent meeting was cancelled in order to allow attention to be placed on 'Perfect Week' exercise. A discussion took place around the accuracy of wording and it was agreed to raise updates at Bi-Lateral meetings. It was agreed the Associate Director of Governance and Risk would submit details prior to Bi-Lateral agenda being produced. It was agreed not to continue reviewing the Risk Register as so many have not been updated and it does not reflect the amount of work being undertaken.	**Associate Director of Governance and Risk July 2014**
	WHHFT/14/041 – Governance Report	
	The Associate Director of Governance and Risk explained that we are a high reporting organisation, she wished to highlight: • Additional learning and improvements within the report showed a lot of work being done in A&E around fractures. • Police Community Support presence now on site at Warrington • Transfusion SUI downgraded to level 1 from never event. This was queried by the Chief Executive as she felt it was more serious. Following discussion around the definition of a never event it was agreed that the downgrading was appropriate. • Complaints – Deputy Director of Nursing explained that targets for the past two months have been achieved around receiving response within timescale. M. Lynch, Non-Executive Director/Chair asked how do we demonstrate learning within divisions following complaints investigations. The Deputy Director of Nursing explained there is a quarterly report to Board on learning from complaints. • Claims – no backlog currently but the Associate Director of Governance and Risk is concerned the department is struggling to cope with demand. • Coroners Inquests are up 69% following Frances Report. • Pressure Ulcers showing significant reduction.	

	WHHFT/14/042– Quality Report	
	The Deputy Director of Nursing explained that this is version 7 draft report with the final version nearing completion. She explained that improvement priorities mostly achieved. M. Lynch, Non-Executive Director/Chair explained the report had been well received at both Board and Governors meeting. The Deputy Director of Nursing advised that the report had been presented at Halton and Warrington and had been well received at both. The results show a pride in working at WHHFT.	
	WHHFT/CG/14/43 – Serious Incident Completed Level Two Investigations	
	One new SUI reported in April – Pressure Ulcer Two SUI investigations completed in April	
	WHHFT/GC/14/044 – Health and Safety Annual Report (reviewed out of sequence during meeting)	
	H. Wynn, Head of Health and Safety attended meeting to present her report. Highlighted items: • Royal Society of the Prevention of Accidents (RoSPA) Award – Silver achieved in March 2014. • Three policies reviewed and approved over past twelve months. • Training Review – figures reported show % based on the whole Trust when only some staff members have to complete level 2 • Health and Safety Guidance – produced and available on the HuB. • Inspections taking place quarterly and are revealing good housekeeping and maintenance. • Smoking – enforcement team were going to come to Warrington and fine smokers for littering but it was agreed not to proceed as often people have received bad news etc. It was agreed they would now attend and offer smoking cessation advice. • There were 22 RIDDOR incidents • Manual Handling – 75 departments audited • Plus Size Patients – business case completed and awaiting news on funding • External Agency Visits – radioactive incident – SOP approved and action plan completed. • HSE – no visits although defective lift was reported.	

	• Needlestick incidents – significant work undertaken, there has to be zero tolerance around incorrect disposal. This is being monitored by Safety and Risk Sub Committee. Chief Executive enquired if the 111 incidents were benchmarked against similar trusts to see if high or low. • Risk Management Framework – 166 audits completed. • Health and Safety training will be done in-house. • Dashboard reports per division by quarter and corporate areas will be covered separately M. Lynch, Non-Executive Director/Chair expressed his appreciation with the report and commented on the enormous progress being made with compliance. The Committee thank Health and Safety for all the work they have done this past year. The Chief Executive agreed stating that there were 21 enforcement notices when she joined the Trust and there are now none.	
	WHHFT/CG/14/0045– Incident and Investigations Annual Report	
	E. Buckley, Head of Legal Services and Patient Safety presented her report in relation to: Incident Reporting Incident Investigations Supporting Staff Being Open/Duty of Candour Main items to note are: • We will not be audited by NHSLA in 2014. • Trust wide usage of Datix is very good • Total of 7358 NRLS incidents reported, we are in the top 20% of trusts reporting • MHRA – reporting not kept centrally in WC&SS or Scheduled Care • There were 19 Level 2 or 3 SUIs reported via StEIS and timescales met • 187 incidents interfaced with other trusts with some being more responsive than others. • There were 61 level 1 investigations recorded in CIRIS for tracking and are managed in Division. They appear on DIGG agenda and are taken seriously as commissioners can penalise for non-completion of investigations. • There were 137 safety alerts issued this year • Wards are using safety briefings • Newsletters are regularly produced Duty of Candour – department is looking at producing patient guidance to provide information to patients and/or their families should they be involved in an incident.	

	Staff Support letters to staff involved in level 2 investigations. Occupational Health keep a record. The Associate Director of Governance and Risk explained that following the maternity investigation a template is being produced around staff involvement. The Finance Director queried MHRA divisional split. The Head of Legal Services and Patient Safety responded that this is being challenged. The Chief Operating Officer asked how do we know that awareness is improved following STEIS. The Head of Legal Services and Patient Safety responded that action plans are audited there is a focus on closing loop and providing evidence in an accurate and focused way. M. Lynch, Non-Executive Director/Chair stated that this report does provide assurance, there has been a tremendous amount of work and diligence and thanked the department for this. The report is accepted by the Quality Governance Committee.	
	WHHFT/CG/14/0046– Revised Risk Management Strategy	
	Terms of Reference for the Quality Governance Committee The Associate Director of Governance explained we need to be able to demonstrate that Senior Clinicians support the governance of the organisation. Discussion took place about medical representation now that the Medical Director is in post and also whether by having very senior staff attend it was considered necessary to also have Associate Directors from divisions attending. The Chief Executive commented that we need to demonstrate triangulation, the reports received to the Committee are good and attendees are able to leave this meeting and implement any recommendations or changes therefore making a difference without having to seek guidance or approval from further up the chain. It was agreed the Associate Director of Governance and Risk would revisit the Terms of Reference but all agreed that it is important for the development of Associate Directors to attend high level meetings like this. The Revised Risk Management Strategy was received by the Quality Governance Committee.	**Associate Director of Governance and Risk July 2014**
	WHHFT/CG/14/0046– Quarterly CQC Compliant Assessment for the Essential Standards 1st January to 31st March 2014	
	The Associate Director of Governance and Risk advised that she is requesting support around the 'red' areas of the compliance assessment as this demonstrate non-submission. M. Lynch, Non-Executive Director/Chair stated that this report demonstrates a process issue in providing the evidence that would in turn make all these areas green.	

	The Associate Director of Governance and Risk explained that when CQC visited last week they explained that having access to CIRIS would be very effective but only if the evidence is there. The process was more difficult historically but is much simpler now. The Chief Executive advised that it is important to have a responsible individual identified within the divisions.	
	Items for Review and Discussion	
	WHHFT/CG/14/049 – Quarterly Publication of Never Events 1st April to 31st December 2013	
	Report noted by Quality Governance Committee.	
	WHHFT/CG/14/50 – CQC Consultation submitted to Board April 2014	
	Report noted by Quality Governance Committee	
	WHHFT/CG/14/051 – Pandemic Flu Plan	
	Policy ratified by the Quality Governance Committee	
	HIGH LEVEL BRIEFING AND MINUTES FROM REPORTING COMMITTEE CHAIRS	
	WHHFT/CG/14/051 – Information Governance and Corporate Records	
	There was no report as no meeting has taken place since last Quality Governance Committee meeting.	
	WHHFT/CG/14/052 – Safety and Risk Sub Committee	
	The notes of the meetings on 13th February and 13th March were noted by the Quality Governance Committee.	
	WHHFT/CG/14/053 Strategic People Committee	
	The minutes of the meeting of 10th February were noted by the Quality Governance Committee.	
	WHHFT/CG/14/054 – Event Planning Group and Local Health Resilience Group	
	The High Level Report was noted by the Governance Committee.	
	WHHFT/CG/14/055 – Clinical Governance, Audit and Quality Sub Committee	
	The minutes of the Clinical Governance, Audit and Quality Sub Committee meeting held on 24th April were noted by the Quality Governance Committee.	

	WHHFT/CG/13/056– Infection Control Sub Committee	
	The High Level Briefing Paper from the Infection Control Sub Committee meeting was noted by the Quality Governance Committee.	
	W&HHFT/GC/14/057 - Any Other business	
	M. Lynch, Non-Executive Director/Chair explained that Non-Executive Directors are out and about in the hospitals but don't evidence these visits formally. He believes that reporting would strengthen the triangulation process and give evidence of good practice. The Associate Director of Governance and Risk agreed they could be covered the same way as Safety Walkabouts and someone from Governance could accompany the Non-Executive Director to take notes. It was agreed the Associate Director of Governance would send framework to M. Lynch and that Non-Executive Directors would participate in these formally.	
	Date and time of next meeting: 8th July at 9am in the Trust Conference Room	

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.

W&HH/AC/14/35(i)

AUDIT COMMITTEE MEETING
Draft Minutes of the meeting held on 6th May 2014, 0830hrs
Daresbury Meeting Room, Warrington Hospital

Present:

Rory Adam	Non-Executive Director (Chair of the Committee)
Carol Withenshaw	Non-Executive Director
Clare Briegal	Non-Executive Director & Deputy Chair
Lynne Lobley	Non-Executive Director

In attendance:

Tim Barlow	Director of Finance and Commercial Development
Karen Spencer	Head of Financial Services
Steve Barrow	Deputy Director of Finance
Colin Reid	Trust Secretary
Roger Causer	Counter Fraud Officer
Tim Crowley	Mersey Internal Audit Agency
Sarah Blackwell	Mersey Internal Audit Agency
Louise Thornton	PWC

Apologies:

Mike Lynch	Non-Executive Director

WHHFT/AC/14/16

1 **Apologies -** See above listing.

2 **Declarations of Interest – in agenda items -** None

WHHFT/CFC/14/17 – Minutes of Previous Meetings

3 The minutes of the meeting held on the 2nd February 2014 were approved subject to amendments.

WHHFT/AC/14/18 – Action Plan – Review Actions and update

4 All actions were either complete or on the agenda for consideration.

WHHFT/AC/14/19 (i) - DRAFT; (a) Annual Reports; (b) Quality Report; (c) Annual Accounts 2013/14; and (d) Review of Code of Governance

5 The Chairman referred to the papers (a) Annual Reports; (b) Quality Report; (c) Annual Accounts 2013/14; and (d) Review of Code of Governance distributed to the Committee members under a separate cover to the Committee meeting papers and advised that they would not be reviewed at this meeting. The Chairman asked that the Committee members and attendees review the papers in their own time and provide any comments to the Trust Secretary before 23rd May 2014. He explained that the Committee would review in full all the Reports at the special meeting of the Committee on 23rd May 2014.

WHHFT/AC/14/19 (ii) - External Audit verbal update

6 Louise Thornton, PwC provided a verbal update on the external audit being undertaken within the Trust. She advised that the actual audit had not as yet commenced although discussions surrounding the timetable had been completed.

7 The Director of Finance and Commercial Development thanked Steve Barrow and Karen Spencer for the work they had done to bring together the set of accounts in readiness for the audit. The Chairman asked whether there were any potential areas of concern or underlying issues that would need addressing as part of the Audit. In response the Director of Finance and Commercial Development advised that the recoding of partially completed spells would need to be addressed during the audit, other than that he did not believe there were any material concerns.

8 The Chairman thanked Louise Thornton for her update report.

WHHFT/AC/14/20 – Anti-Fraud

9 **(i) Anti-Fraud Annual Report 2013/14**
Roger Causer, MIAA Anti-Fraud presented the Anti-Fraud Annual Report 2013/14 and advised that Anti-Fraud Annual Report offers the Audit Committee the opportunity to review in totality the work completed by the Trust's Local Counter Fraud Specialist (LCFS) during the period April 2013 to March 2014.

10 Roger Causer reported that during the year 2013/14 the LCFS had completed the agreed plan days over the range of key anti-fraud objectives, and had involvement in fraud related referrals at the Trust. The work continued to embed anti-fraud arrangements, securing sound foundations for conducting anti-fraud work across the full range of actions (e.g. protocols, policies, culture).

11 Roger Causer reported that during the year under review the LCFS had continued to deliver and meet the self-assessment level which places a requirement for compliance against all the elements of the new fraud standards. Furthermore the LCFS had completed a local fraud risk assessment as part of the work plan process to identify levels of risk as outlined in the standards. The activities undertaken during the reporting year had been aimed at measuring the Trust's compliance and demonstrating the effectiveness of the LCFS actions. The anti-fraud performance in this and in the previous year had provided a robust platform for the future.

12 Roger Causer advised that the LCFS acknowledges the continued strong executive support from the Director of Finance and Commercial Development and that of the Audit Committee in anti-fraud activity which supports effective fraud and corruption work and protects valuable NHS resources.

13 The Committee reviewed the Report noting the actions that would be undertaken and included in the Work Plan 2014/15 that would address the gaps in compliance with national standards, guidance and best practice within the current anti fraud systems so as to enhance and develop the anti-fraud work across the Trust.

14 **(ii) Work Plan 2014/15**
Roger Causer presented the Anti-Fraud Work Plan 2014/15 for approval and referred in particular to the actions to support the gaps in compliance with national standards, guidance and best practice earlier in the meeting.

15 The Committee reviewed and approved the overview of the 2014/15 Anti-Fraud work plan based on identified risks allocated across the four NHS Protect key principles and noted that regular Anti-Fraud Progress Reports would continue to be provided to Audit Committee which would detail work and outcomes delivered as the year progressed.

16 The Chairman thanked Roger Causer for his reports.

WHHFT/AC/14/21 – Mersey Internal Audit Agency

17 **i) MIAA Internal Audit Progress Report**

18 Sarah Blackwell, MIAA Internal Audit presented the Internal Audit Progress Report detailing the conclusions of reports which had been finalised, and provided an update in relation to the on-going reviews. With regard to the key areas from our work and the actions to be delivered by Trust management, Sarah Blackwell reported that all had an assurance level of significant with some management actions being identified and timescales agreed.

19 With regard to the assurance Framework the Trust had met the mandatory requirements which was designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principle risks identified by the organisation.

20 MIAA Internal Audit Progress Report was noted by the Committee.

21 **ii) Director of Audit Opinion 2013/14**

22 Tim Crowley, Director; MIAA Internal Audit presented Director of Audit Opinion for the financial year 2013/14 and advised that "Significant Assurance can be given that that there was a generally sound system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of particular objectives at risk."

23 Tim Crowley advised that the Director of Audit Opinion provides assurance surrounding the Trust's Annual Governance Statement and provides detail of the work undertaken by Internal Audit over the past financial year and assurance provided against each piece of work referring to the appendices contained in the Opinion.

24 Carol Withenshaw referred to the position on mandatory training and recognised that systems and processes were in place however the Trust continued to underachieve in terms of number of staff attending. Sarah Blackwell recognised that one of the problems the Trust was having was in getting staff to physically attend the training due to other pressure that impacted on attendance, however the systems and processes within the trust to deliver the mandatory training was very good. Lynne Lobley referred to the recoding of mandatory training in ESR and asked whether the ESR system recorded appropriately. Sarah Blackwell advised that as part of the audit the recording of training was looked at and no problems within the ESR system was found. The Director of Finance and Commercial Development advised that whilst there was no data was missing in ESR there was a delay in recording of between 4-6 weeks between completing the training and entering it on the ESR system.

25 The Chairman thanked Tim Crowley for his opinion which was noted.

iii) MIAA Internal Audit Annual Plan 2014/15

26 Sarah Blackwell presented the Internal Audit Plan 2014/15 for approval.

27 The Committee considered the plan and approved the content. With regard to Maternity Services, Clare Briegal asked whether it would be appropriate to undertake an audit of the service give the issues that had arisen recently. The Director of Finance and Commercial Development advised the issues were clinical and would not necessarily fall within the remit of the internal audit process. He advised that there were a significant number of clinical reviews being undertaken to assess the maternity service and the findings of these reviews would be reported to the Board.

WHHFT/AC/14/22 – Tender Waivers - Quarter 4

28 The Head of Financial Services presented the review of Quotation and Tender Waivers for the Quarter 4, for the consideration. The Committee reviewed the tender waivers questioning the reasons behind them.

29 Clare Briegal referred to the Order no. 133252265 submitted by IT relating to the maintenance of printers on site and felt that the Trust should have processes in place to manage timeframes so that tender waivers would not be required. The Deputy Director of Finance advised that systems were in place and in the future the Trust would be aware in advance when IT contracts came up for renewal. The Director of Finance and Commercial Development advised the IM&T function was 6 people down in terms of staffing and this had an impact on what the function could do. He advised that the Director of IM&T was looking to recruit into post as quickly as possible all 6 vacant posts which would help in supporting the Trust's IT requirements. Carol Withenshaw asked if the recruitment problems within IM&T were historical. In response the Director of Finance and Commercial Development advised that historically the right structure had not been in place to support the IT aspirations of the Trust and the Director of IM&T was seeking to address the structure such that it was fit for purpose.

30 The Committee having satisfied itself of the reasons for the tender waivers noted the content of the paper.

WHHFT/AC/14/023 – Losses & Special Payments – Quarter 4

31 The Committee reviewed and noted the Losses and Special Payments for Quarter 4.

WHHFT/AC/14/24 – Bad debt write-off – Quarter 4

32 This agenda item had been reported in the paper WHHFT/AC/14/023.

WHHFT/AC/14/25 – Changes to the SORD

33 The Committee considered and approved the proposed changes to the SORD.

WHHFT/AC/14/26– Changes to the Scheme of Reservation and Delegation

34 The Trust Secretary presented amended scheme of reservation and delegation for recommendation for approval by the Board and reported on the amendments with included:

35
- Amendments to the SoRD previously agreed by the Committee in relation to individual delegations.
- Job titles have been amended to take account of changes made during the year.
- In accordance with the Monitors Code of Governance, the role and responsibility of the Council of Governors have been included under section 2.
- Changes have been made to the use of the Trust's Common Seal (Delegated matter 38, page 26). This change reflects the use of the seal in the private sector.

36 The Deputy Director of Finance advised that there were a number of instances where his job title had changed to include 'and Commercial Development' and asked that this be changed prior to seeking Board approval.

37 The Committee considered the revisions made to the Scheme of Reservation and Delegation and recommended them for approval by the Board.

WHHFT/AC/14/27– Board Committee Report

38 **Governance Committee:** no issues required reporting

39 **Charitable Funds Committee:** no issues required reporting

40 **Strategic People Committee:** no issues required reporting

41 **Finance and Sustainability Committee (FSC):** Carol Withenshaw, Chair of the provided an introductory update on the activity of the FSC since its first meeting in February. She reported that the Committee was still finding is feet in terms of activity and assurance given a lot of its work has concentrated on year end matters such as the financial position, Strategic and Operational Plans and budgeting. The Committee would in due course review the commercial aspects of the business and would receive reports on performance against Commissioner Contact and Strategic plan as well as reviewing the activity of the ICIC and Estates. The Committee members recognised the importance in terms of assurance the FSC provided the Board and asked that for the foreseeable future that all Non-Executive Directors receive a set of papers for each meeting. The Trust Secretary was asked to undertake sending out the complete set of papers to all Non-Executive Directors.

WHHFT/AC/14/28 – Audit Committee Annual Report

42 The Chairman reported that he had reviewed the Audit Committee Annual Report 2013/14 provided by the Trust Secretary and was satisfied that it covered the reporting requirements and work undertaken by the Committee. He asked that, as with the (a) Annual Reports; (b) Quality Report; (c) Annual Accounts 2013/14; and (d) Review of Code of Governance, the Committee members review the Report and feedback any comments to the Trust Secretary before 23rd May 2014.

WHHFT/AC/14/29 – Any Other Business

43 *Louise Thornton PwC was asked to leave the meeting for the next item*

44 **External Audit:** The Director of Finance and Commercial Development reported that the term of office of the external auditor was due to expire on 30 September 2014. He advised that PricewaterhouseCoopers (PwC) had been appointed the Trust External Auditor, following a tender exercise, by the Council of Governors from 1 October 2011.

45 The Director of Finance and Commercial Development advised that the appointment allowed for an extension of up to two years. The Audit Committee needed to consider whether it would be appropriate to extend the term of office and if appropriate to recommend the extension to the Council of Governors through the Governor Monitor Quarterly Reporting Committee.

46 The Director of Finance and Commercial Development advised that the current audit cost was £57,000 for 2013/14 and it was anticipated that this would increase by RPI in accordance with the initial agreement with PwC. He reported that PwC had indicated that the costs of providing the service continued to increase more than RPI due to increased requirements placed on them by regulators and there may be a small movement in the charge over RPI. With regard to Quality of Service, the Director of Finance and Commercial Development PwC continued to provide a high quality audit service to the Trust, there was a good professional working relationship which has developed and built up over the last three years and this was supported by the Deputy Director of Finance and Head of Financial Service. The Director of Finance and Commercial Development referring to the original tender exercise advised that the Trust had received such a good competitive price at the time and felt that should the Trust move to a tender exercise for the work that there was a strong possibility that the price could increase significantly. He also felt that moving to a new provider with no prior trust experience may result in an increased price in order to get an understanding of the working of the Trust.

47 The Chairman thanked the Director of Finance and Commercial Development and the Deputy Finance Director and Head of Financial Services for their comments and sought agreement from the Committee to propose to the Council of Governors through the Monitor Quarterly Reporting Committee that the Trust to extend PwC's period of office for a further period of two years. The Committee approved the proposal.

48 There being no further business the Chairman closed the meeting.

Date of Next Meeting : 21 July 2014 at 1500hrs, Trust Conference Room Warrington Hospital

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.

W&HH/AC/14/35(ii)

AUDIT COMMITTEE MEETING

Minutes of the meeting held on Friday 23rd May 2014, 1300hrs
Trust Conference Room, Warrington Hospital

Present:

Rory Adam	Non-Executive Director (Chair of the Committee)
Carol Withenshaw	Non-Executive Director
Clare Briegal	Non-Executive Director & Deputy Chair

In attendance:

Tim Barlow	Director of Finance and Commercial Development
Mel Pickup	Chief Executive
Karen Dawber	Director of Nursing and Organisational Development
Simon Wright	Chief Operating Officer and Deputy Chief Executive
Paul Hughes	Medical Director
Karen Spencer	Head of Financial Services
Colin Reid	Trust Secretary
Rebecca Gissing	PWC
Louise Thornton	PWC

Apologies:

Mike Lynch	Non-Executive Director
Lynne Lobley	Non-Executive Director

	WHHFT/AC/14 – Apologies & Declarations of Interest – in agenda items
1	Apologies are set out above, there were no declarations of interest reported.
	WHHFT/AC/14/30 – External Audit Report
2	Rebecca Gissing, PWC introduced the External Audit Report and explained that the report sets out any significant findings from audit of the Trust's financial statements for 2013/14, together with any matters that auditing standards required the auditor to report to those charged with Governance of the Trust. She explained that as with last year the audit had been conducted with transparency and openness and had gone very well and thanked the Trust for their co-operation during the audit.
3	Rebecca Gissing updated the Committee on a number of matters that were still being audited referring to the audited areas within the remuneration report and discussions on the treatment of plant and equipment. These matters would be concluded prior to sign off by the Board on 28th May 2014.
4	Rebecca Gissing reported on the key points from within the report noting in particular the accounting treatment of the Charitable Funds fund which had not been consolidated due to materiality and the accounting treatment of partially completed spells. Rebecca Gissing referred the Committee to page 6 of the report which set out the audit view on the Trust's going concern assumptions and reported that PwC agreed with that the annual report had been prepared on a going concern basis was

	appropriate. She further advised that as part of the audit PwC applied a stress test to the assumptions.
5	The remaining parts of the External Audit Report were discussed and in particular reference was made to the annual governance statement, quality report and fraud. With regard to fraud the Committee members were asked whether there were any matters that it was aware of that should disclosed. The Committee members responded to the negative.
6	The Chairman thanked PwC for the presentation and asked the Committee to note the Report. The Committee noted the report and recognised the need to provide letters of representation set out in the agenda.
	WHHFT/AC/14/31 – Monitor Code of Governance
7	The Chairman asked that the Committee review the paper. The Trust Secretary advised that the Code of Governance had been rewritten by Monitor and the review had been undertaken to assess the Trust's compliance with the new Code and where noncompliance existed this needed to be included within the Annual Report. The Committee reviewed the Code of Governance, in particular challenging the compliance statements made.
8	The Committee agreed to the reporting by exception in the Annual Report, the statement made regarding code provision B.6.2 which required that there should be an external evaluation of the Board of Directors at least every three years. This was a new provision of the code that came into effect from 1st January 2014. The Trust Secretary reported that Monitor had undertaken a consultation process which would inform the publication of guidance on Board Leadership and Governance Framework. He advised that following publication of the guidance the board would need to look to implement best practice as appropriate.
	WHHFT/AC/14/32 – Annual Reports and Accounts 2013/2014
9	**i) Annual Report/ Remuneration Report/Annual Governance Statement** The Chairman referred the Committee to the Annual Reports for consideration and advised that following Audit Committee review the Reports would be presented to the Board for formal approval.
10	The Committee considered the Annual Report, Remuneration Report and Annual Governance Statement and a number of amendments (including typographical, grammatical and formatting) were suggested throughout the Report. In particular the Chief Executive suggested that the Remuneration Report should be amended to provide detail on savings made as a consequence of the consolidation of roles within the Executive. The Committee recognised that this information was included within the Accounts section however agreed that a statement should be added. With regard to the Annual Governance Statement the Committee noted that the structure of the statement had changed and now required additional reporting to previous years to further enhance reporting on the corporate governance of the Trust. The Committee recommended the to the Board approval
11	***The Committee following review recommended the Annual Report, Remuneration Report and Annual Governance Statement for approval of the Board of Directors.***
12	**ii) Quality Report**
13	Rebecca Gissing reported that the Quality Report had been audited by PwC for format consistency and content checked and PwC were happy with the document. It was noted that there were a small

	number of items within the report that needed to be finalised, in particular the Chief Executive Report and finalisation of the stakeholder responses to the Report. The Director of Nursing and Organisational Development referred the Board to the dementia CQUIN and in particular that this had been rated as amber. This was due to the Trust cancelling the dementia conference which had been agreed with the CCG to take account of financial pressures on the Trust. She advised that the Trust would recover the position when the conference is held in 2014/15.
14	The Director of Nursing and Organisational Development thanked Ros Harvey, Hannah Gray and Alison Lynch for all their hard work in producing the Quality Report, recognising that the Report was constrained by format and content.
15	***The Committee following review recommended the Quality Report for approval of the Board of Directors.***
16	**iii) Annual Accounts 2013/14** The Director of Finance and Commercial Development presented the Annual Accounts 2013/14 and advised that they had been prepared in accordance with International Financial Reporting Standards and guidance issued by Monitor. He advised that the Accounts had not fundamentally changed from the draft accounts submitted to the Committee at its meeting on 28th April 2014.
17	***The Committee reviewed the Annual Accounts 2013/14 and recommended them to the Board for approval.***
18	**iv) Letters of Representation**
19	The Committee reviewed the letters of representation and recommended then to the Board for approval.
20	The Director of Finance and Commercial Development asked that the Committee record his thanks to PwC and to the finance team for all their effort in producing the Accounts and in conducting the audit in an open and transparent manner.
	WHHFT/AC/14/33 – External Auditors Draft External Assurance on the Trusts Quality Report
21	Rebecca Gissing, PWC presented the External Assurance Report on the Trusts Quality Report. She advised that the Report would be finalised once a number of outstanding matters had been concluded. Rebecca Gissing ran through the report and explained - the scope of the work undertaken; the limited assurance opinion required in relation to the content and consistency of the Quality Report; the mandated performance indicators and the local performance indication required to be looked at by the Governors' Council.
22	The Committee noted the draft Report which when finalised would require presenting to Council of Governors.
	Date and time of next meeting
23	21st July 2014, at 1500hrs Trust Conference Room

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.

Warrington & Halton Hospitals' Charity

WHHFT/CFC/14/24

CHARITABLE FUNDS COMMITTEE MEETING

Minutes of the meeting held on Monday 6th May 2014
Daresbury Meeting Room, Warrington Hospital

Present:

Clare Briegal	Non-Executive Director (Chair of the Committee)
Lynne Lobley	Non-Executive Director
Carol Withenshaw	Non-Executive Director
Rory Adam	Non-Executive Director
Tim Barlow	Director of Finance and Commercial Development
Mike Barker	Deputy Director - Strategy & Commercial Development
David Ellis	Public Governor
Karen Spencer	Head of Financial Services
Chris Horner	Associate Director of Communications

In attendance:

Colin Reid	Trust Secretary

Apologies:

Mike Lynch	Non-Executive Director
Karen Dawber	Director of Nursing and Organisational Development
Alison Lynch	Deputy Director of Nursing

1	**WHHFT/CFC/14/10 – Apologies** Apologies were noted as above.
2	**WHHFT/CFC/14/11 – Declarations of Interest – in agenda items** There were no declarations of interest in the agenda items.
3	**WHHFT/CFC/14/12– Minutes of the previous meeting held on the 2nd February 2014** The minutes of meeting held on 2nd February 2014 were approved subject to minor amendments.
4	**WHHFT/CFC/14/13 – Action Plan** All actions were either completed, on the agenda or held over to a future meeting with exception of action CFC/14/05. The Head of Financial Services advised that the ticket prices were for tickets

	bought for two members of staff and were higher than anticipated as they had been bought as open tickets. The Committee noted that it was now Trust policy that only timed tickets are purchased unless there was a valid reason to acquire an open ticket.
	WHHFT/CFC/14/14 – Financial Position as at 31st March 2014
5	The Head of Financial Services presented the Financial position report as at 31 March 2014 and advised that the reports format had changed to address the requirement of the Committee discussed at the last meeting. She reported that since the last meeting a piece of work had been undertaken to consolidate the funds and reported that there was now four restricted and one unrestricted which includes six that are designated within the unrestricted. All fund holders had been advised of the benefits of having a single General fund rather than a large number of smaller funds. The Head of Financial Services advised that donors were also being asked not to restrict the donation to single services and to donate to the general fund so can be used for the benefit of the trust as a whole.
6	The Head of Financial Services referred the Committee to the Report that provides the opening balance, income and expenditure of all funds before the consolidation work took place. The mergers and transfers column takes into account the movements required to consolidate the relevant funds. This column also contains other in year mergers and transfers.
7	The Head of Financial Services advised that the closing balance was in line with the new format of funds and an additional column had been added to reflect any committed expenditure. Rory Adam advised that there was a need to ring fence committed expenditure so that the fund does not over commit and asked that any commitments approved by the Committee or the Director of Finance and Commercial Development be included in future reports. The Head of Financial Services advised that the total fund balance held as at 31st March 2014 was £668k, covering the restricted funds of £161k, unrestricted of £507k, of which £113k related to unrestricted designated funds. The Committee noted that donations received during the period 1st January 2014 to 31st March 2014 totalled £156k and expenditure incurred during the same period was £71k.
8	Carol Withenshaw referred to the tables within the report and asked what the available balance for the general Fund was at end of March 2014. The Head of Financial Services advised that this amounted to £394k. The Chair reminded the Committee that it had set a minimum balance under which the overall reserves should not fall. The Committee noted that that was currently set at £200k.
9	The Committee reviewed the remainder of the report noting that actions were underway to recover from the Inland revenue tax from gift aid donations.
10	The Committee noted the financial position of the Charity as at 31 March 2014.
	WHHFT/CFC/14/15 – Strategy
11	1. **Our story so Far and Looking Forward:** The Associate Director of Communications provided a short verbal update on the changing face and strategy of the Charity. He reported that structure of the charity was now such that it can move forward, however there was still some outstanding matters that needed to be finalised, in particular how the Charity would be managed when Sarah Klaveness's the contract ends and this would be discussed later in the meeting.
12	Lynne Lobley recognised the amount of work that had been done and asked whether it would be appropriate to establish milestones so that the Committee can see achievements.

13 2. **Charitable Funds Structure:** The Director of Finance and Commercial Development provided an update on the current structure and resourcing requirements of the Charity, referring to the two papers that had been distributed with the packs. He advised that with the Deputy Director – Strategy and Commercial Development on board he hoped to bring together the salient parts of his team to support the strategy of the Charity going forward. The Director of Finance and Commercial Development advised that there was a need to develop an operation plan that would inform a three year strategy and picking up on the comments raised by Lynne Lobley earlier, this would have quarterly and half year milestones covering big ticket items. He felt that once this was in place a resource structure could be devised to deliver it. The Director of Finance and Commercial Development also felt that the charitable strategy would need to align with the Trust's strategy.

14 The Committee agreed that an outline strategy was needed and asked that this be brought to a future meeting of the Committee. David Ellis referring to the staffing of the charity asked whether there was a conflict between the expectations of the charity and that of the Trust. In response the Deputy Director – Strategy and Commercial Development advised that mission creep can occur and therefore there was a need to balance requirements.

Action CFC/14/15: Deputy Director – Strategy and Commercial Development to develop an operation plan for presentation to the Committee.

15 The Chair thanked the Director of Finance and Commercial Development, Deputy Director – Strategy and Commercial Development and Associate Director of Communications for their reports which was noted.

WHHFT/CFC/14/16 Funding and Initial Funding Proposals

Funding Proposals:

16 i. TIA - Ward B14 – Stroke Fund

17 *Proposal:* John Quinn, Senior Manager Unscheduled Care presented the proposal for an innovative approach to transforming the care patients by using a previously defunct space on B14 and adapting this as a TIA Assessment Area. John Quinn ran through the proposal highlighting the key areas. The Director of Finance and Commercial Development advised that the finding would be a one off cost with no additional recurrent requirements. He further advised that the adapting the area would provide additional patient benefits that fitted within the objectives of the Charity

18 *Outcome:* The Committee agreed the funding of £32k from the Stroke restricted fund to cover the adapting of B14 as a TIA Assessment Area.

19 ii. MDT Approach for the new Forget Me Not Unit – General Fund

20 *Proposal:* John Quinn, Senior Manager Unscheduled Care presented the proposal to fund an MDT Approach for the new Forget Me Not Unit, a newly designed dedicated ward for those Patient's suffering with Dementia. The Committee noted the requirement and questioned whether patient benefit could be accrued from the proposal. The Chair questioned whether enough data could be obtained over a short period of time (6months) and also asked what would happen to the staff if the initiative was to terminate after the 6 months. John Quinn responded that he would be able

	to put together a team that would recognise those risks and was confident that 6 months was enough time to get the data sets necessary in order to persuade the CCG of the patient benefits the service would provide. Lynne Lobley raised concern that the CCG may not buy into the service and asked what was being done to clear the way for this to happen given historically this had been a problem for the Trust. John Quinn reported that the evidential data could be used to inform on the Trusts current structure in working with patients and providing better patient experience.
21	*Outcome:* The Committee agreed 6 months funding equating to £76K, following rewrite of proposal. There was concern with the wording of the proposal that had a feel that it was business driven rather than research innovative. The Committee felt that there needed to be an indication in funding the proposal that there would be a clear improvement in patient experience. The Committee also expressed concern that the CCG may not invest following trial period and therefore would the proposal fail to provide the patient benefit that the proposal showed.
22	The Committee agreed that, following John Quinn's additional explanation, the data collection was outside normal Trust business and provided for additional added value service to patients with dementia. The Committee, in agreeing the 6 month funding period, felt that the restricted time period provided enough time to obtain the required data as advised by John Quinn. There was concern that however that the CCG may not feel that 6 months data was sufficient for them to finance the service further. David Ellis advised that there may be a possibility that financial support could be obtained from social impact bonds and CCG may be able to access part of the better care fund to support the service.
	Initial Funding Proposals:
23	iii. Warrington Hospital Front of House
24	*Proposal:* The Director of Finance and Commercial Development presented Warrington Front of House proposal and advised that this had been produced to support patient experiences and that of their family and friends whilst visiting the Hospital. He advised that this was complimentary to the work due to start on the food court and advised on the structural changes that would be needed. The Committee recognised that there was benefit to patients, families and carers using the hospital however this was a grey area. The Committee also wondered whether the funding could be found from other sources.
25	*Outcome:* Deferred to a later meeting – so that additional 'financial costing' for structural requirements can be obtained. The Committee felt that there may be options to fund some of the works where clear patient benefits could be shown.
	WHHFT/CFC/14/17 – Dementia Funding Bid – Healey Trust
26	The Committee noted the application for funding from the Healey Trust. Any outcome arising from the application would be reported to the Committee.
	WHHFT/CFC/14/18 - Update on Association of NHS Charities
27	The Chair provided a short verbal brief on the activities within the Association of NHS Charities which was noted.

	WHHFT/CFC/14/19 – Any Other Business
28	Carol Withenshaw advised the Committee that this would be Clare Briegal's last meeting and thanked her on behalf of the Committee and the Board for her hard work commitment and perseverance developing the strategy for Charity.
29	There being no further business the Chair closed the meeting.
	Date and time of next meeting
30	The next meeting will take place on Monday 21st July 2014, 1300hrs in the Trust Conference Room, Warrington Hospital.

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.

FSC/14/42

FINANCE AND SUSTAINABILITY COMMITTEE

Minutes of Meeting of the Committee held on 17th June 2014

Present

Carol Withenshaw	Non-Executive - Chair
Rory Adam	Non-Executive Director
Mel Pickup	Chief Executive
Tim Barlow	Director of Finance and Commercial Development
Simon Wright	Chief Operating Officer/ Deputy Chief
Karen Dawber	Director of Nursing and Organisational Development
Jason DaCosta	Director of IT
Steve Barrow	Deputy Director of Finance
Mike Barker	Deputy Director – Strategy & Commercial Development
George Creswell	Associate Director Estates & Facilities

In attendance

Colin Reid	Trust Secretary

Apologies:

Paul Hughes	Medical Director

Apologies and Declarations of Interest – FSC/14/34

1 Apologies: As stated above
Declarations: None

Minutes of meeting & Actions – FSC/14/35

2 The minutes of the meeting held on 21st May 2014 were amended and approved.

3 Action Plan: Action FSC/14/26: The Committee noted that this action was ongoing and proposals would come back to the Committee at its September meeting.

Financial Position May 2014 (prior to going to Board) – FSC/14/36

The Deputy Director of Finance presented the financial position as at 31 May 2014 and reported that year to date the trust had a deficit of £2,303k, which was £170k lower than the planned deficit of £2,473k. The Deputy Director of Finance advised that the deficit position comprised of variances against budget which saw operating income below plan (£128K) however this was more than offset by a reduction in operating expenses (£298K).

With regard to CIP, Rory Adam referred to the table in the report that set out the value of schemes identified against annual target and noted that most of the schemes had been identified. He asked what assurance was there that the shortfall of £1.2m would be delivered in year. In response the Deputy Director of Finance advised that the shortfall will need to be recovered through the increase in savings for current schemes or the identification and

delivery of new schemes. The sustainability target of £2m was included in the current plan of £10.7M

The Chair asked whether there were any concerns over delivery of the value of schemes identified. In response the Chief Operating Officer advised that he believed the Trust would be able to deliver against £8m of the schemes, however there was a concern that slippage of around 10% could occur, recognising that historically a 10% slippage had occurred in the past. He felt that there was a need to have a robust contingency of 10% of the overall in year CIP and if this was identified then he would be confident of delivery of the full year CIP.

The Director of Finance and Commercial Development reported that the Executive continued to receive an update from EY on confidence levels on delivery of the schemes and there was concern regarding a potential 10% shortfall. EY were looking to support the PMO and Divisions in identification of contingency in order to plug the gap should it be required.

With regard to a question from the Chair regarding the PMO, the Director of Finance and Commercial Development advised that Gill Gail had been appointed to the role of interim Project Management Officer and was focusing on staff within the divisions who were accountable for delivery of the schemes. The Chair asked whether the divisions were motivated to deliver the schemes, the Chief Operating Officer advised that they had all accepted accountability for delivery and were motivated to do so recognising that they had greater accountability and responsibility to deliver a budget they had developed. He referred to AED who were having a torrid time at present, however there was a feeling that even with the pressures on the service they were still engaged in delivery of their budget and schemes. The Director of Finance and Commercial Development referred the Committee to the appendices in the Report which provided each divisional dashboard that were discussed at the bi-laterals. He felt that the whole divisional teams were fully engaged in the financial position including SLR and the focus on individual specialties. The Director of Finance and Commercial Development advised on a note of caution that having a planned deficit brings, in particular the potential for changes in the national and local political picture or subtle changes in the activity within the Trust which could increase the deficit. Activity was ongoing to improve early warning systems to identify any potential impact to delivery of budgets and CIP.

The Committee noted the potential increases in pay costs arising from external pressure and that reviews were being undertaken weekly to identify any weaknesses. The Director of Nursing and Organisation Development reported on the weaknesses that had been identified in AED where the process for the authorisation of medical staff needed to be strengthened. The Chief Operating Officer advised that E-Rostering had shone a light on these weaknesses and these were being addressed.

The Chief Executive referred to the lower than planned activity that took place during August 2013 and advised that there needed to be a mechanism in place in late June to address any potential dip. The Chief Operating Officer advised that this was being addressed so that the Trust would be fully aware of the order book by the end of June and the staffing of areas to deliver the activity so that the dip would not occur this year.

The Committee noted the content and format of the Financial Position May 2014.

Strategic Plan 2014-19 (prior to going to Board) – FSC/14/37

The Director of Finance and Commercial Development introduced the Strategic Plan 2014-2019 and advised that the Plan was due to be submitted to Monitor by 30 June 2014.

The Committee reviewed the Strategic Plan noting that the Plan conforms to the requirements set by Monitor and that the approach taken in development of the Plan had been agreed with the Board and Monitor following Monitors request that all FTs should further review their submissions.

The Director of Finance and Commercial Development advised that the Plan had been discussed with the commissioners, although there was not the full engagement with Warrington CCG as the Trust would have liked. He reported that there was a feeling that Warrington CCG did not want to fully engage with the Trust as they were engaged in developing their own strategy for the provision of health services. In response to a question from the Chair on whether the hospitals were part of the Commissioners future plans, the Deputy Director - Strategy & Commercial Development advised that it was his view that it was however there was a clear need from both sides to understand in detail the transformational structure for health services envisaged by the CCG. The Chief Executive recognised that the strategy being developed by Warrington CCG was challenging and that it may not materialise, with this in mind she felt that there needed to be a contingency should it not materialise and a sharing of views surrounding contingencies with the local authority so that any impact could be mitigated.

The Committee recognised that the Trust vision had been updated to use 'integrated' so that the Trust's core purpose was to provide "high quality, safe ***integrated*** healthcare". It was felt appropriate to incorporate integrated into the vision in order the re-enforce the Trust's view of its role in the health economy.

The Director of Finance and Commercial Development ran through the financial strategy and planning assumptions that made up the financial part of the Plan covering the period 2016/17 to 2018/19 which covers the balance of the 5 year Financial Plan not previously approved by the Board.

With regard to capital requirements, the Director of Finance and Commercial Development advised that it was his intention to bring to the Committee at its September meeting a 10 year plan that would indicate what capital investment the Trust would need to deliver its activities.

Action FSC/14/37: the Director of Finance and Commercial Development to bring to the Committee at its September meeting a 10 year plan that would indicate what capital investment the Trust would need to deliver its activities.

The Committee:

1. agreed that there should be no changes to the 15/16 projections included in Phase 1 of the annual plan submission;
2. approved the assumptions and resulting financial plans for 16/17 to 18/19 included in this presentation;
3. agreed that the 16/17 to 18/19 plans will form the basis of Phase 2 of the annual plan submission to Monitor; and
4. approved the draft strategic plan 2014/19 and recommended it to the Board for final approval.

The Chief Executive referring to the Monitors document on 'Challenges facing small acute NHS hospitals' recognised the need for greater collaborations with other service providers such as co-operation with for example the Walton Centre for spinal services and Alder Hey for paediatrics. Collaboration had been identified within the Plan as an important part of the Trust strategy.

The Director of Finance and Commercial Development asked that if there were any additional comments that needed to be addressed within the Plan could the Committee members please provide these by COP on Wednesday 18th June so that the paper can be issued to the Board as part of the Board packs.

Corporate Performance Report – June 2014 (prior to going to Board) – FSC/14/38

The Chief Operating Officer presented the corporate performance report and advised that there were a number of matters that were causing some concern in delivering performance against the national and local indicators.

The Chief Operating Officer advised that the main concern centred on delivery of the A&E 4hr target for quarter 1. He advised that the Trust had underperformed in both April and May and that there was a likelihood that unless significant improvements was seen the trust would not achieve the 4hr target for quarter 1. The Chief Operating Officer advised that this was a very disappointing position and reported on the pressures that had resulted in the underperformance.

The Chief Operating Officer advised that the entire acute health system had been in difficulty over the last quarter and had seen a significant number of A&E service providers failing to deliver the national target. This pressure coupled with additional pressures arising from such things as: the withdrawal by commissioners of re-ablement funded schemes from the beginning of April had impacted on discharge rates; home care provision difficulties impacting on social cares ability to manage certain patients at home; and intermediate care access for home and bed based transfers had been under severe pressure with queues growing from 2/3 to over 36 causing flow problems. The Chief Operating Officer advised that one example were intermediate care access was not working was at Padgate House which was currently working at only 64% capacity. Padgate house, the Chief Operating Officer reminded the Committee was run by the local authority and Bridgewater.

The Chief Operating Officer advised that over the coming days to the end of the quarter a number of measure had been adopted to improve performance including: the introduction of Ward Liaison Officers and Silver control following the findings of the perfect week; commissioner support had agreed to establish 16 additional Intermediate Care beds to arrest the current pressure and had agreed to review the baseline capacity during the summer to prevent problems in the winter months; and commissioner support to re-introduce the re-ablement schemes associated with admission avoidance and early discharge for a 3 month period then review their success. The Chief Operating Officer advised that other interventions were being undertaken however felt that it was unlikely that the Trust would deliver the quarter 1 target. The Chief Operating Officer advised that one area that was being considered that may have a significant impact on improved performance was the inclusion of category 1 walk in activity from the Widnes Urgent Care Centre in the Trust's AED performance. This was

still being discussed with Bridgewater and he hoped for a decision in time for the June Board meeting.

The Chief Operating Officer ran through the remainder of the report highlighting areas of potential concern including delivery of 18 weeks referral to treatment; the cancer 62 day pathway; LOS; and DNA's.

With regard to the Cancer targets the Chief Operating Officer advised that Clatterbridge was currently failing to deliver the pathway within the required timeframes. He reported that as a result this would impact on the Trust's patients who the Trust was obligated to provide treatment within the national thresholds. He advised that he was working with the cancer team to make sure that such breaches did not occur.

Rory Adam referred the DNA performance and asked what was being done to manage the indicator. The Chief Operating Officer advised that a lot of the time it comes down to the patient deciding they feel better or where children are concerned the parent or guardian feeling that there was not a need to attend because of improvements in health. There was a need to communicate with patients on attendance so that the Trust can better manage the process. The Chief Executive asked whether the Trust had considered over booking surgeries so as to mitigate DNA's. The Chief Operating Officer advised that this was being considered however there was recognition of the risks of doing this. He further advised that the Trust had implemented a partial booking system where patients were required to ring the hospital to confirm a booking. The Chief Operating Officer advised that it was too early to say whether this was improving the position.

The Committee reviewed the remainder of the Corporate Performance Report, its contents were noted.

Review of Committees and Groups – FSC/14/39

Minutes of Meetings:

i. Capital Planning Group
ii. Innovation and Cost Improvement Committee minutes and Dashboard
iii. KPI notes of meeting – to provide additional information to the Corporate Performance Report.

Members of the Committee reviewed and noted the minutes of the meetings.

Any Other Business – FSC/14/40

There being no further business the Chair closed the meeting.

Date and time of next meeting

Thursday 24th July 2014 at 11.30 am in the Trust Conference Room, Warrington Hospital

Action List

Finance and Sustainability Committee

Paper Reference	Action	Responsibility & Target Dates
FSC/14/26 21 May 2014	***The Chief Operating Officer would assess whether an early warning dashboard could be developed that provided potential financial consequences and report back to a future meeting following discussions within the Executive.***	***Chief Operating Officer***
FSC/14/37 17 June 2014	***the Director of Finance and Commercial Development to bring to the Committee at its September meeting a 10 year plan that would indicate what capital investment the Trust would need to deliver its activities.***	***Director of Finance and Commercial Development***

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/134

BOARD OF DIRECTORS

Paper Title	**Any Other Business**
Date of Meeting	30th July 2014