W&HHFT/TB/14/178

BOARD OF DIRECTORS

Paper Title	Human Resources / Education & Development Key Performance Indicators (KPIs) Report
Date of Meeting	26 November 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	29 October 2014
HR / E&D KPIs Reports	Strategic People Committee	10 November 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
Both mandatory training and PDR rates are largely unchanged with minor fluctuations	**Pages 2 - 4 / Section 2.1 & 2.2**
The revalidation rate has increased and 18 more doctors have been revalidated	**Page 4 / Section 2.3**
Sickness absence – further deterioration	**Pages 4 / Section 2.4**
Turnover rate has stabilized. Vacancy rate improved. Headcount has increased.	**Pages 4 - 5/ Section 2.5 & 2.6**
Temporary staffing expenditure – minor increase of £23k	**Pages 5 - 7 / Section 2.7**
All main Equality and Diversity targets achieved for 2014 and reasonable progress on training target	**Page 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 November 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 October 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 little change to the mandatory training rates with Health and Safety remaining the same and slight decreases for Fire and Manual Handling. 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 September 2014):

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	69% (70%) (Amber)	92% (91%) (Green)	57% (55%) (Red)
Unscheduled Care	69% (70%) (Amber)	87% (87%) (Green)	64% (65%) (Red)
Women's & Children's	75% (76%) (Amber)	91% (91%) (Green)	76% (77%) (Amber)
Estates	87% (87%) (Green)	100% (100%) (Green)	97% (98%) (Green)
Facilities	87% (87%) (Green)	81% (81%) (Amber)	66% (74%) (Amber)
Corporate Areas	85% (86%) (Green)	99% (99%) (Green)	84% (84%) (Amber)

The only area achieving all of the targets is Estates although the Corporate areas are only just below the target for Manual Handling. There was a noticeable reduction for Facilities for Manual Handling for the second month in succession.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well and an impressive 100% of staff attended corporate induction during October 2014.

2.1.1 Health & Safety (Green)

There has been no change from the previous month and the rate remains at 90% and green.

The target for 2014/15 is being achieved.

2.1.2 Fire Safety (Amber)

There was a decrease of 1% from the previous month and the rate is 75% and amber.

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

There was a decrease of 2% from the previous month and the rate is 69% and red.

2.1.3.1 Manual Handling Patient Training Only (Red)

There was an increase of 1% from the previous month and the rate is 65% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Amber)

There was a reduction of 4% from the previous month and the rate is 76% and amber.

2.2 Staff Appraisals

The target for completed PDRs is 85%.

During October there was a slight increase for Medical and Dental staff and a slight decrease for Non-Medical staff.

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

Division	PDR Rate
Scheduled Care	68% (72%) (Red)
Unscheduled Care	64% (65%) (Red)
Women's and Children's	76% (78%) (Amber)
Estates	72% (79%) (Amber)
Facilities	89% (89%) (Green)
Corporate Areas	74% (75%) (Amber)

Other than Facilities which stayed the same, all other Areas/Divisions saw a reduction in their rates. The only area achieving the target is Facilities. There is considerable room for improvement within both Unscheduled Care and Scheduled Care which are showing Red.

2.2.1 Non-Medical Staff (Amber)

For the period up to October 2014 the percentage of non-medical staff having had an appraisal fell by 2% and is 73% and the status is amber.

2.2.2 Medical & Dental Staff (Green)

The combined rate for Consultant staff and Middle Grade doctors, up to October 2014 has increased by 1% to 85%. The rate for Consultants increased by 2% to 90% and other M&D decreased by 1% to 74%.

This means that the target of 85% was achieved and the status is green.

Divisions have been reminded at the bi-lateral meetings that priority must still be given to appraisal rates despite the financial position and these are regularly reviewed.

2.3 Revalidation for Medical and Dental Staff (Amber)

The Revalidation Decision Making Group met on 12 October 2014 as planned and 18 more doctors were approved for revalidation. Therefore in total 91 doctors have been approved for revalidation by the GMC with 17 doctors deferred, making the rate 84%. The trust has also reported one doctor to the GMC for non-engagement in the process.

The next meeting of the Decision Making Group is on 20.01.15.

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 October 2014 was the highest in month rate for more than 12 months at 4.90% which was the second month in succession of being the highest in month figure. . Consequently the cumulative rate for April – October 2014 increased to 4.25%.

Following some analysis to explain the increase it appears on initial investigation that this is partly due to a genuine increase in sickness rates but also due to under-reporting within the nursing wards/areas. This latter issue has manifest itself through the implementation of e-rostering which is now live on 18 wards/areas and initial dual running with ESR records which showed that not all absence recording has been entered onto ESR. It is difficult to state with any certainty how long this may have been the case but it is likely that there may have been some un-reporting for some time. The positive aspect is that there is now more accurate recording of sickness absence.

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 high at over 250 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 Q2 was 59% which was an increase of 6% from Q1.

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 October 2014 showed a very slight increase 0.07% to 9.44% and the status is amber. After a steady increase in rates since December 2013 the rates do seem to have stabilized over the last couple of months. Nonetheless it is still of some concern particularly as both Unscheduled Care (11.01%) and Scheduled Care (10.99%) are showing quite

high rates. Both of these Divisions are undertaking further analysis of leavers by personal interviews to understand in more detail why staff are leaving.

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

The Trust FE FTE was 3696 and staff in post 3399 FTE. This means the vacancies FTE has improved to 8.03% but the status remains as 'green'. The number of vacancies has reduced to 297.

The headcount of 4172 was an increase of 20 from the previous month.

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 October 2014 increased slightly by £23k and was £938k, which represents 7.33% of the pay bill for the month and cumulatively for April – October 2014 the rate is 7.23%. 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 October are as follows:

Nurse Bank and Agency Nursing - £449k (£370k for September)
Agency (exc Medical & Nursing Agency) - £199k (£201k for September)
Medical Locums and Medical Agency - £290k (£343k for September)

Two areas showed a decrease as follows: Medical Locums /Agency by £53k and Agency by £2k. Nurse Bank/Agency increased by £79k.

Total expenditure for the period April – October 2014 is £6.5m broken down as follows:

Nurse Bank and Agency Nursing - £2.8m
Agency (exc Medical and Nursing Agency) - £1.3m
Medical Locums and Medical Agency - £2.4m

NB In order to staff the additional intermediate care beds which were opened earlier this year the trust had to recruit staff predominantly from agencies and some of these staff have continued to be needed to meet additional staffing pressures. The total additional expenditure which is being met externally from Warrington CCG is now £245k which is included in the above amounts. However, the CCG have now indicated that funding for therapy staff can be made permanent which will allow staff to be appointed on AfC pay and conditions rather than more expensive bank/agency rates and the recruitment process has commenced.

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

The main 'Hot Spot' areas of expenditure during October were as follows:

<u>Nurse Bank and Agency Nursing</u>
Elderly and Stroke - £106k (£63k on unqualified staff)
A&E - £98k (£81k on agency)
Acute Medicine – £45k (£22k on agency)
Critical Care - £42k
Surgery - £41k
Specialty Medicine - £31k
Women's Health - £28k
T&O - £23k

Agency
Therapies - £103k
PMO – £48k
Pharmacy - £31k

Medical Locums/Agency
T&O - £77k
A&E - £18k
Surgery - £57k
Elderly and Stroke - £142k
Specialty Medicine - £27k
Critical Care - £17k

The Additional Staffing Group met on 18 November 2014. The Divisions were asked to identify their 'Top 3' areas of expenditure and concern and to develop action plans to improve the position. These were discussed and progress noted. Support was identified for consideration of international recruitment for wards/areas in both Unscheduled Care and Scheduled Care and for both of these Divisions to draw up plans to recruit to over establishment recognizing the constant number of vacancies in these Divisions. Business cases will now be developed. The Group were also pleased to note progress on a number of workforce initiatives as follows:

Vacancy Control Process
A new vacancy control process was implemented on 27 October 2014. This will apply to all posts.

Nursing Recruitment
Rolling adverts are in place in Unscheduled Care and Scheduled Care with an emphasis on AMU and Theatres. 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 has easily been surpassed. Virtually all of the vacancies in A&E have now been filled and staff are awaiting commencement dates. Additional unqualified staff have also been recruited.

International Recruitment
The trust is working with an agency called Globalmedirec to recruit Consultant Radiologists. From the first round of interviews one doctor accepted an offer of employment and commenced on 10.11.14. Another doctor was interviewed but the trust were not able to meet the demands of the doctor and the doctor withdrew from the appointment process. Two further doctors have been interviewed by Skype and one was deemed suitable to be invited for a traditional interview, to be arranged. Currently the Department has a trainee doctor who will not qualify until February 2015 and it is hoped that this doctor can be persuaded to apply for a post. An SOP has been produced to assist with any future international recruitment.

Recruitment Process
The trust is working on a number of initiatives to streamline the recruitment process which will be implemented early in 2015. Discussions and training for the Divisions will commence in January 2015. Work is also continuing on putting in place a revised ECF process using Share Point. Discussions have also taken place externally with a company who have an electronic system for DBS Checks. Training for this system is scheduled for 19.11.14 with implementation immediately afterwards. This should save at least 2 weeks on the average recruitment time to complete recruitment checks.

The Executive Team agreed to recruit to over establishment for Radiography to recognize regular turnover and difficult to fill posts and this has implemented. This approach could be used in other areas such as Pharmacy, Theatres and indeed some ward areas as mentioned above.

E-Rostering

18 wards/areas have now gone live with another ward scheduled in November as part of the planned roll out. This has generally gone well and work continues on quantifying the benefits realization.

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 which are not funded.

Work is continuing on the Admin Review and the Medical Productivity work streams. A new Job Planning Policy for Consultants has been agreed and the trust is working with Allocate on a pilot in Anesthetics to implement job plans in line with the new policy. This has been completed and the results are being quantified but in the interim an options appraisal paper is being prepared for consideration by Executives in early December 2014.

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)

There has been an increase of 1% from Q1 to 63% at Q2.

Warrington and Halton Hospitals NHS Foundation Trust

Governance & Workforce Division

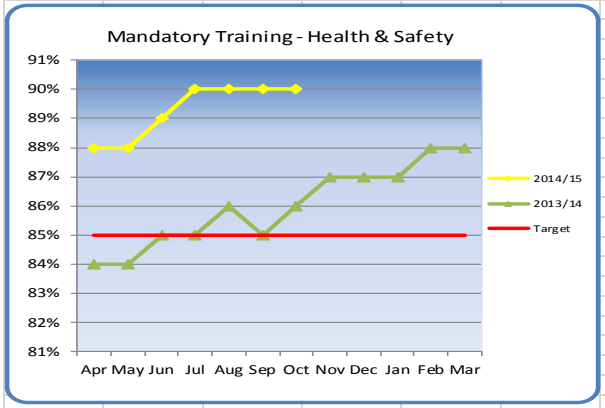
Human Resources / Education & Development Workforce Key Performance Indicators

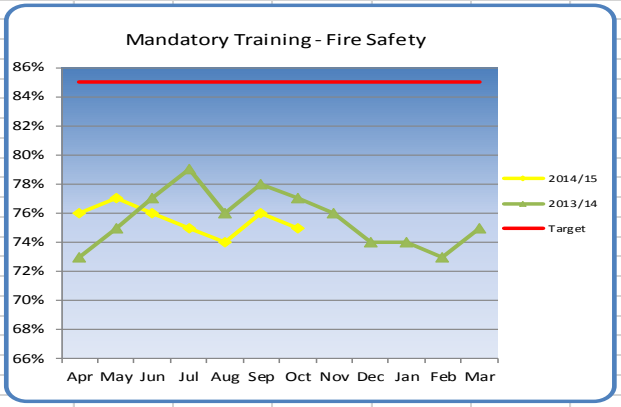
2014/15			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status: Green	Amber	Red
Training & Development	Mandatory Training	Healllth & Safety	85% staff trained in last 3 years	Monthly	88%	88%	89%	90%	90%	90%	90%						**90%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	76%	77%	76%	75%	74%	76%	75%						**75%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	67%	67%	67%	68%	65%	64%	65%						**65%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			86%	85%	85%	83%	82%	80%	76%						**76%**			
		Manual Handling - Total			74%	74%	74%	74%	72%	71%	69%						**69%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	70%	75%	76%	75%	76%	75%	73%						**73%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			79%	79%	79%	83%	86%	84%	85%						**85%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	81%	81%	82%	82%	82%	82%	84%						**84%**	85 - 100%	70 - 84%	< 70%
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.18%	3.99%	3.98%	3.94%	3.70%	4.31%	4.90%						**4.25%**	3.75%	3.76-4.49%	> 4.50%
	Return to work interviews (wef 2013/14)		85%	Quarterly			53%			59%							**59%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	9.0%	9.1%	9.3%	9.3%	9.7%	9.4%	9.4%						**9.4%**	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	3674	3695	3700	3696						**3696**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3392	3391	3371	3375	3424	3382	3399						**3399**			
		Staff in Post Headcount (see NB 2 below)			4171	4155	4134	4143	4156	4152	4172						**4172**			
		Vacancies WTE (see NB 1 below)			294	285	311	299	271	318	297						**297**			
		Vacancies %			7.97%	7.75%	8.44%	8.13%	7.33%	8.59%	8.03%						**8.03%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	6.6%	6.7%	7.6%	6.7%	7.9%	7.3%	7.3%						**7.2%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly						Achieved							**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**	Achieved	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly			62%			63%							62%	85 - 100%	70 - 84%	< 70%

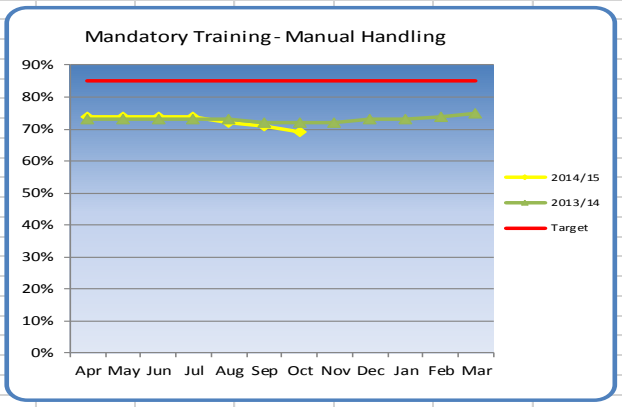
NB 1 Figures from Finance Ledger

NB 2 Figures from HR ESR

R	Red	A	Amber	G	Green


Mandatory Training - Health & Safety
91%
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
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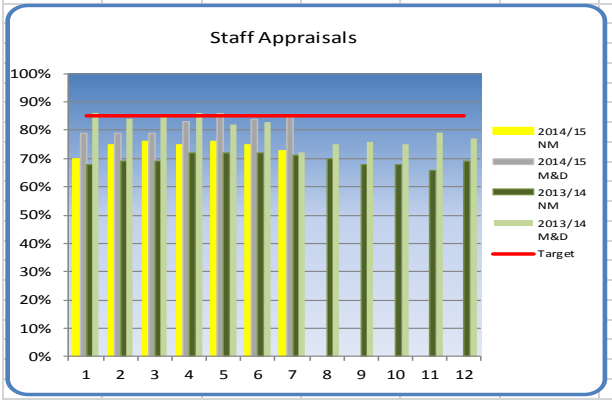
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


Staff Appraisals
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80%
70%
60%
50%
40%
30%
20%
10%
0%
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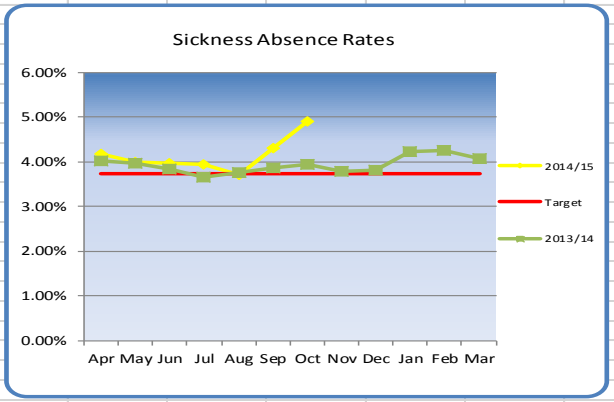
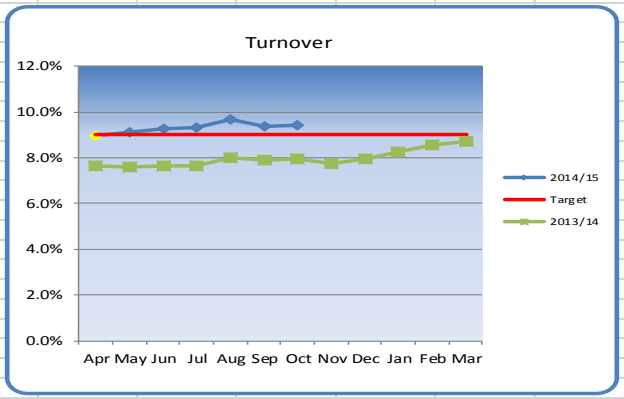
2014/15 NM
2014/15 M&D
2013/14 NM
2013/14 M&D
Target


Sickness Absence Rates
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14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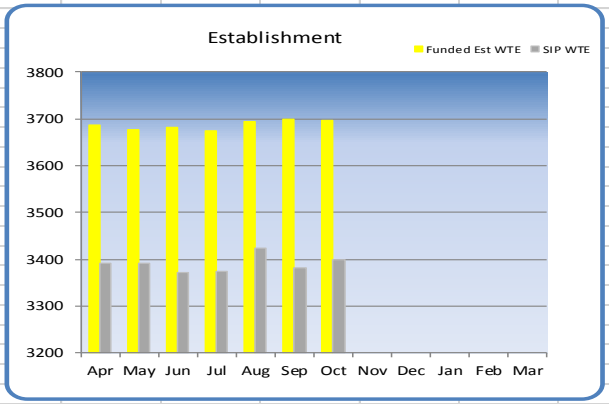
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14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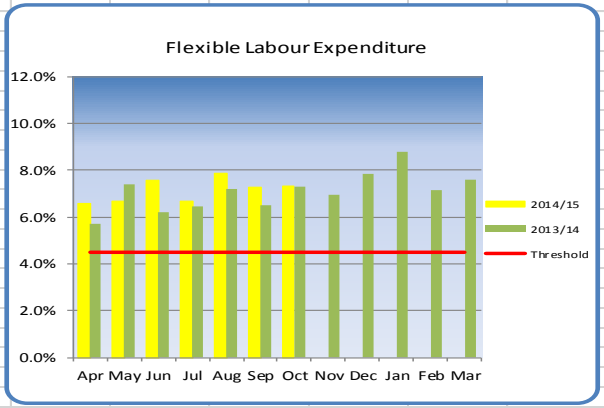
3700
3600
3500
3400
3300
3200
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


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

W&HHFT/TB/14/179

BOARD OF DIRECTORS

Paper Title:	Publication of Staffing Data and Exception Report October 2014
Date of Meeting	26th November 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 October 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 September 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
•		

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

The Board is note the contents of this paper and the Exception report for October 2014 contained in Appendix 1

Introduction

The purpose of this exception report is to advise the Board of shifts within the Trust's in-patient areas where staffing levels fell below planned requirements and due to being regarded as unsafe, were escalated to senior nurses or site managers who employed contingency plans.

This report is provided in accordance with the expectations set out in the National Quality Board Guidance published in November 2013, that Trust Boards take full responsibility for nursing and care staffing capacity and capability

October 2014

All general in-patient areas (with the exception of Maternity) have reported the details of their staffing levels on a shift by shift basis for the month of October 2014.

During October 2014, there were a total of were a total of 6,609.8 (11.5 hour) shifts available.

Of these, 3.65% (520) shifts reported actual as lower than planned for either a registered nurse or a healthcare assistant.

The highest number of unfilled shifts was in Ward A7 where 41 shifts were below planned, which represents 20.6% of available shifts. The matron explained that this is due to a mixture of vacancies, sickness and maternity leave. Attempts were made to fill the vacant shifts with temporary staff or staff from other areas but this was not possible. Sickness is being managed in line with Trust policy and recruitment of both temporary and permanent posts is underway. To better understand the potential risk to patient safely of this shortfall in planned to actual staffing, the team assess acuity and dependency on a daily basis and are supported by the matron to do this. During this time 2 new VTE's were reported on this ward. It is important to note that new leadership has been introduced to the ward which has seen a great improvement in areas of patient experience with reduction in number of complaints.

In ITU were 20.3% of shifts were not filled (208 shifts) the ward manager explained that 10 RN's are on long term sick leave, 5 have just commenced maternity leave and 3 HCA's are also on long term sick. Sick leave is being managed appropriately through Trust policy and the unit has successfully recruited an additional 9 RN's who come into post during December and January. In the meantime the departments own staff provide additional cover through NHSP and on a daily basis the senior nursing team assess the acuity and dependency of their patients. Although this has been difficult for staff they have been supported to manage the situation in the best possible way. During this time there have been 2 hospital acquired device related pressure ulcers.

Ward A3 required additional 1:1 carer cover for 22 days in October due to patient need and this accounts for the percentage of overfilled shifts.

Recommendation(s)

The Board is asked to discuss / note the contents of this paper.

Staffing Levels

Oct-14

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

This column will automatically calculate the number of shifts

			Day									Night													
									Registered midwives/nurses			Care Staff			Registered midwives/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 Sep-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	Falls	Hospital acquired pressure ulcers	Catheter associated UTIs	New VTEs	Associate Director of Nursing/Matrons Assurance Statement
Scheduled Care	W-A4 - Ward A4	28	12.90	0.00	0.00	7.70	0.00	6.73%	1:8	1069.5	1069.0	713.0	713.0	1:8	713.0	713.0	356.5	356.5	-0.5	11.5	0.0	-0.02%	0	0	0	1	
	W-A5 - Ward A5	28	21.10	4.60	0.00	14.60	0.00	9.41%	1:7	1782.1	1669.0	1069.5	1022.0	1:9	1069.5	1069.5	713.0	713.0	-160.6	11.5	-14.0	-3.47%	0	1	0	0	
	W-A6 - Ward A6	28	18.60	0.60	0.00	13.60	1.40	7.24%	1:7	1426.0	1407.0	1069.5	108.5	1:9	1069.5	1046.5	713.0	960.0	-756.0	11.5	-65.7	-17.67%	0	0	0	0	
	W-A9 - Ward A9	28	17.80	2.80	2.00	15.50	1.00	3.65%	1:7	1426.0	1323.5	1426.0	1376.5	1:9	1069.5	1046.5	713.0	690.0	-198.0	11.5	-17.2	-4.27%	0	0	0	0	
	W-B19 - Ward B19	18	14.30	2.60	1.60	9.30	0.00	4.22%	1:6	1069.5	1035.0	713.0	713.0	1:6	713.0	713.0	713.0	713.0	-34.5	11.5	-3.0	-1.08%	0	0	0	1	
	W-B4-H - Ward B4 - Halton	27	12.20	1.27	0.00	6.00	0.00	5.82%	1:9	1069.5	828.0	356.5	544.5	13.5 :1	356.5	552.0	356.5	322.0	107.5	11.5	9.3	5.03%	0	0	0	0	
	W-CM1-H - Ward 1 - CMTC Treatment Centre	30	26.60	5.38	0.00	14.00	1.80	4.01%	1:5.5	1978.0	1951.5	1196.0	1196.0	10 : 1	966.0	966.0	644.0	644.0	-26.5	11.5	-2.3	-0.55%	0	0	0	0	
	W-ICU - Intensive Care Unit	18	76.74	2.21	9.00	12.52	1.00	5.05%	1:1 Level 3 1:2 Level 2	4991.0	4174.5	1069.5	701.5	1:1 Level 3 1:2 Level 2	4991.0	4128.5	713.0	368.0	-2392.0	11.5	-208.0	-20.33%	0	2	0	0	
Total		205	200.24			93.22		5.57%											-3460.6		-300.9						
Unscheduled Care	AED			5.77	2.00	13.02	2.99	4.97%		4464.0	4232.7	1162.5	978.8		3205.1	3284.6	896.5	752.7	-479.3	12.5	-38.3	-4.93%	0	0	0	0	12 days escalation filled during the month
	W-A1A - Ward A1 Asst	29	41.40	13.44	0.00	22.10	4.40	4.45%	5.5	2325.0	2312.5	1550.0	1327.5	0.0	1953.0	1904.5	651.0	609.0	-325.5	12.5	-26.0	-5.02%	0	0	0	0	DVT clinic had 172.5 hours staffed and 509 hours of AAP on ward
	W-A2A - Ward A2 Admission	28	18.83	1.10	0.00	12.90	2.00	3.84%	5.6	1426.0	1357.0	1069.5	1097.0	9.3	1069.5	1035.0	713.0	1000.0	211.0	11.5	18.3	4.93%	0	0	0	0	
	W-A3OPAL - Ward A3 Opal	34	18.83	2.28	1.00	15.50	0.16	12.55%	8.5:1	1426.0	1323.0	1426.0	1695.0	0.0	1069.5	100.5	713.0	1035.0	-481.0	11.5	-41.8	-10.38%	0	0	0	0	1:1 carer requested for 22 days during the month
	W-A7 - Ward A7	33	18.80	0.39	0.00	15.50	1.33	2.47%	8.3:1	1426.0	1393.5	1426.0	1445.0	0.0	1069.5	1.6	713.0	839.5	-954.9	11.5	-83.0	-20.60%	0	0	0	2	
	W-A8 - Ward A8	34	18.80	1.00	0.00	15.50	2.40	6.63%	8.5:1	1472.0	1402.0	1645.0	1570.0	0.0	1092.0	1092.0	1035.0	1575.5	395.5	11.5	34.4	7.54%	0	2	0	1	
	W-B12 - Ward B12 (Forget-me-not)	21	13.68	1.00	0.00	15.50	4.85	4.83%	7.0:1	1069.5	1034.0	1426.0	1389.5	0.0	713.0	713.0	713.0	885.5	100.5	11.5	8.7	2.56%	1	0	0	0	
	W-B14 - Ward B14	24	18.80	2.00	0.00	12.90	2.20	5.17%	6.0:1	1426.0	1194.5	1069.5	1023.5	8.0	1069.5	1012.0	713.0	969.0	-79.0	11.5	-6.9	-1.85%	0	1	0	0	Weekday review of staffing by Matron against cohort ward activity to ensure safety of patients
	W-B18 - Ward B18	24	18.80	2.41	5.63	18.00	4.15	5.70%	6.0:1	1426.0	1242.5	1426.0	1351.5	0.0	1069.5	1012.0	1069.5	1006.5	-378.5	11.5	-32.9	-7.58%	0	0	0	0	
	W-C21 - Ward C21	24	13.68	-0.9	0.0	11.30	1.20	7.09%	8.0:1	1069.5	1035.0	816.5	690.0	0.1	713.0	690.0	839.5	575.0	-448.5	11.5	-39.0	-13.04%	0	0	0	0	
	W-C22 - Ward C22	21	13.68	8.00	1.60	12.90	0.00	3.39%	7.0:1	1069.5	1069.5	1069.5	987.0	0.1	713.0	713.0	713.0	713.0	-82.5	11.5	-7.2	-2.31%	0	0	0	0	
	W-CCU - Coronary Care Unit	8	21.2	0.9	0.0	2.6	1.0	2.00%	2.0:1	1426.0	1488.5	356.5	244.5	0.0	1069.5	1058.0	0.0	0.0	-61.0	11.5	-5.3	-2.14%	0	0	0	0	
Total		280	216.47			167.73		5.30%											-2583.2		-219.0						
WCSS	W-B11B/W-B11C - Ward B11	24	29.50	1.40	2.00	15.92	4.66	3.02%	1:1 level3 1:2 Level2	2100.0	2100.0	930.0	930.0	0.0	1488.2	1488.2	0.0	0.0	0.0	7.5 day 10.63 night		0.00%	0	0	0	0	
	W-NHDU/W-NITU/W-NSC - Neonatal Unit	18	24.38	2.20	0.00	6.52	2.20	4.20%	7.5:18	1092.0	1092.0	798.0	798.0	7.5:18	942.8	942.0	240.0	240.0	-0.8			-0.03%	0	0	0	0	
	W-C20 - Ward C20	12	12.63	2.40	2.40	5.00	0.00	3.74%	1:4	1232.5	1087.5	675.0	787.5	1:6	581.3	600.8	0.0	67.8	54.8			2.20%	0	0	0	0	
	W-C23 - Ward C23	22	97.92	4.60	4.60	18.93	11.60		1:7.33	1348.5	1106.7	899.0	892.5	1:11	581.3	523.3	290.6	399.6	-197.3			-6.32%	0	0	0	0	
Total		76	164.43	10.60	9.00	46.37	18.46	3.45%											-143.3		0.0		0	0	0	0	
Grand Total		561	581.14	10.60	9.00	307.32	18.46												-6187.1		-520.0		0	0	0	0	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/180

BOARD OF DIRECTORS

Paper Title	Finance Report as at 31st October 2014
Date of Meeting	26th November 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 31st October 2014

1. Purpose

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

2. Executive Summary

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	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	18.5	18.7	0.2	122.5	123.2	0.7
Operating expenses	(16.9)	(17.9)	(1.0)	(120.6)	(122.3)	(1.7)
EBITDA	1.7	0.8	(0.8)	1.9	0.9	(1.0)
Non-operating income and expenses	(0.9)	(0.8)	0.1	(6.0)	(5.9)	0.1
I&E surplus / (deficit)	0.8	0.0	(0.7)	(4.1)	(5.0)	(0.9)
Cash balance	-	-	-	4.6	6.5	1.9
CIP target	0.9	0.7	(0.2)	3.1	2.7	(0.4)
Capital Expenditure	0.9	1.0	(0.1)	4.3	3.1	1.2
Continuity of Services Risk Rating	4	4	0	2	2	0

3. Income and Expenditure (Appendix C)

In month the Trust recorded a surplus of £72k which reduces the year to date deficit to £4,985k, which is £873k worse than the planned deficit of £4,111k.

This cumulative deficit is comprised of the following variances:

- operating income is £762k above plan (favourable).
- operating expenses are £1,721k above plan (adverse).
- non operating income and expenses are £86k below plan (favourable).

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

The October surplus of £72k is £727k below the planned surplus of £798k. This shortfall against the planned surplus is derived from £202k over recovery against income, £1,016k over spend against operating expenses and £85k underspent against non operating income and expenses. Despite a reduction in the deficit cumulative position remains a major concern, given the significant increase in the cost savings target from October onwards.

Operating Income

Year to date operating income is £762k above plan due to an over recovery on other operating income (£1,003k) partially offset by an under recovery on NHS clinical income (£236k) and non NHS clinical income (£5k).

Operating Expenses

Year to date operating expenses are £1,721k above plan due to over spends on pay, clinical supplies and non clinical supplies, partially offset by under spends on drugs.

Non Operating Income and Expenses

Non operating income and expenses is £86k below plan due the underspend against depreciation resulting from the slippage in the capital programme

4. Cost Improvement Programme

The Trust has an annual savings target of £11,931k and value of schemes identified to date is shown in the table below.

Narrative	**In Year £000**	**Recurrent £000**
Annual Target	11,931	11,931
Value of schemes identified	10,571	13,393
Over / (Under) Achievement against target	**(1,360)**	**1,462**

For the period to date the planned savings for the identified schemes equate to £3,108k, with actual savings amounting to £2,735k which results in an under achievement of £372k. The cost savings programme is materially skewed towards the second half of the year, so in the period November to March savings equating to £9,196k are required for the Trust to achieve the full annual target.

5. Cash Flow (Appendix D)

The cash balance is £6,482k which is £1,885k above the planned cash balance of £4,597k, with the monthly movements summarised in the table below.

Cash balance movement	**£000**
Opening balance as at 1st October	5,056
Cash related EBITDA	72
Increase in receivables	(293)
Increase in payables	2,881
Capital expenditure	(960)
Other working capital movements	(274
Closing balance as at 31st October	**6,482**

The planned cash balances detailed in the cashflow were based on a forecast year end cash balance as at 28th February but the actual cash balance was higher as a number of commissioners settled outstanding invoices in March.

The cash balance of £6,482k equates to circa 11 days operational cash. Under the continuity of services risk rating the liquidity metric is -8.1 days which now reduces the scores to a 2. The calculation of the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

This 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) is only 70% in the month (54% 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 cash balance has reduced from £12,956k on 1st April to £6,482k on 31st October, which is a reduction of £6,474k. This is mainly driven by the accumulated deficit (£4,985k) and the PDC Dividends payment (£2,065k), although the under spend on the capital programme and the management of other working balances has provided some mitigation. Even though the cash balance has increased in the month and is £1,885k above the planned cash balance, a repeat of the operating performance in the second half of the year will mean a severe reduction in the capital programme or a significant increase in creditors to avoid the Trust running out of money.

6. Statement of Financial Position (Appendix E)

Non current assets have increased by £426k in the month, as the monthly capital expenditure has exceeded the depreciation cost.

Current assets have increased by £2,116k mainly due to the increase in cash and accrued income.

Current liabilities have increased by £2,650k in the month mainly due to the increase in payables and deferred income, partially offset by the decrease in accruals.

Non current liabilities have increased by £177k in the month.

7. Capital

The capital programme has been increased as a result of Halton CCG's agreement to fund the costs associated with the development of the Urgent Care Centre, although this has been partially offset by the reduction in contingency funding to cover the funding shortfall. The approved programme for the year now stands at £10.4m and to date the Trust has spent £2.1m against the budget of £3.4m, 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	5.6	2.4	1.3	1.1
IM&T	2.8	1.5	1.2	0.3
Medical Equipment	1.3	0.3	0.6	(0.3)
Contingency	0.7	0.1	0.0	0.1
Total	**10.4**	**4.3**	**3.1**	**1.2**

8. Contract Risk

For the period ending 31st October the Trust has recorded a deficit of £4,985k, which is £873k worse than plan. Against this deficit a number of financial risks still remain 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.

The cumulative deficit includes the contractual fines or penalties associated with A&E breaches, Mixed Sex Accommodation breaches, MRSA occurrences, discharge summaries (24 hour target only), contract challenges for incomplete or invalid patient data and a contingency for 7 day discharge summaries. The total included within the current deficit is a fine / penalty of £856k.

The current deficit does not however include contractual fines or penalties associated with all the potential discharge summaries (7 day target only) and activity query notices (spinal services).

9. Forecast Outturn

Monitor wrote to all Foundation Trusts on 15th September stating that due to the emerging signs of pressures on NHS finances during the current year all trusts are now required to provide Monitor with its forecast yearend outturn position in respect of:

- Surplus / deficit (before any impairments).
- Capital expenditure (on an accruals basis).

The forecast position for the Trust remains at a £4.0m deficit with the variance to the planned deficit summarized in the table below:

Narrative	**£m**
Planned deficit	(1.5)
Increase in clinical income	0.4
Less fines and penalties	(2.0)
Less reduction in winter monies	(0.8)
Less IM&T funding	(0.3)
Increase in other operating income	2.1
Urgent Care Centre allocation	0.5
Reduction in operating expenses	1.0
Shortfall against cost savings target	(3.8)
Reduction in depreciation cost	0.5
Other items	(0.1)
Forecast deficit	**(4.0)**

In respect of the capital expenditure, it is still the view that at this stage of the year the full value of the capital programme will be spent, including the estates rationalization programme.

The submission to Monitor requires Board approval so the Finance & Sustainability Committee approved the revised forecast deficit and capital expenditure in the table below prior to the Monitor submission deadline which was 21st November.

Narrative	Plan £m	Forecast £m	Variance £m
Surplus/(Deficit)	(1,500)	(4,000)	(2,500)
Capital Expenditure	9,946	10,377	431

The Financial Statements have not been amended to reflect the forecast deficit at this stage but a deterioration of £2.5m in the planned deficit will reduce the retained earnings by £2.5m, the planned cash by £2.5m (unless this is mitigated by an increase in creditors or other working balances) and result in a Continuity of Services Risk Rating 2.

Tim Barlow
Director of Finance & Commercial Development
20th November 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance headlines as at 31st October 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	18,534	18,736	202	122,482	123,244	762	213,746	213,746	0
Operating Expenditure	-16,880	-17,894	-1,014	-120,604	-122,325	-1,721	-204,977	-204,977	0
EBITDA	**1,654**	**842**	**-812**	**1,878**	**919**	**-959**	**8,769**	**8,769**	**0**
Financing Costs	-856	-770	86	-5,990	-5,904	86	-10,269	-10,269	0
Net Surplus/(Deficit)	**798**	**72**	**-726**	**-4,112**	**-4,985**	**-873**	**-1,500**	**-1,500**	**0**
Continuity of Services Risk Rating	4	4	0	2	2	0	3	3	0
Capital Expenditure	893	960	67	4,337	3,095	-1,242	10,377	10,377	0
Cash Balance				4,597	6,482	1,885	6,731	6,731	0
Cost Savings	894	719	-175	3,095	2,735	-360	11,931	11,931	0

Summary Position

The reported position for the period is an actual deficit of £4,985k which is £873k worse than the planned deficit of £4,112k and this delivers a Continuity of Services Risk Rating 2 which is in line with plan. Year to date income is £762k above plan mainly due to overperformance on non elective activity that is 1,282 spells (£598k) above plan, outpatients that is 9,509 attendances (£424k) above plan and other operating income that is £1,003k above plan, although this is partially offset by other NHS activity that is £1,166k below plan. Year to date expenditure is £1,721k above plan mainly due to overspends on pay (£1,365k), clinical supplies (£695k) and non clinical supplies (£118k), althought this is partially offset by an underspend on drugs (£456k). Year to date non operating income and expenditure is £86k below plan due to an underspend on depreciation.

Cost savings performance is below plan by £360k, which is a concern as the target is backdated towards the second half of the financial year.

Forecast Outturn

The forecast outturn for the year remains at £4.0m deficit which will result in a Continuity of Services Risk Rating 2.

Key Variances

Operating Income - £762k above plan (favourable).
Operating Expenditure - £1,721k above plan (adverse).
Non operating income and expenses - £86k below plan (favourable).
Cost savings - £360k below plan (adverse)
Cash balances - £1,885k 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 - £1,242k 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.
The operating performance of the trust adversely affects the cash position and its ability to pay creditors on a timely basis and a continuation of the operating performance will result in the trust running out of money.

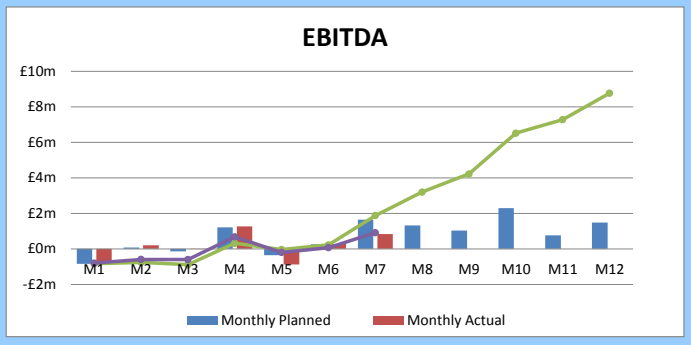
Other matters to be brought to the attention of the Board

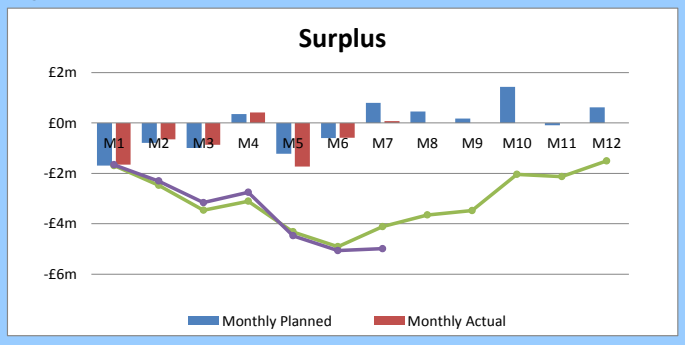
Monitor now require all trusts to submit forecast revenue and capital outturns on a monthly basis.
The trust has agreed a contract with Betsi Caldwaladr for the provision of cataract activity and the activity has now commenced.
EY have now finished the contract but the trust must ensure that the initiatives identified to maximise opportunities for cost reduction are realised.

Warrington & Halton Hospitals NHS Foundation Trust

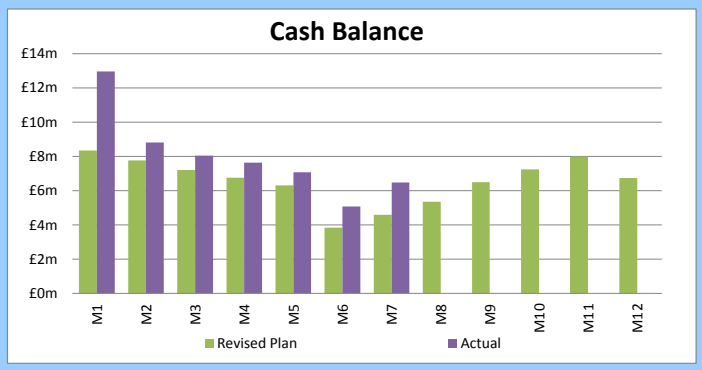
Finance Dashboard as at 31st October 2014 (Part A)

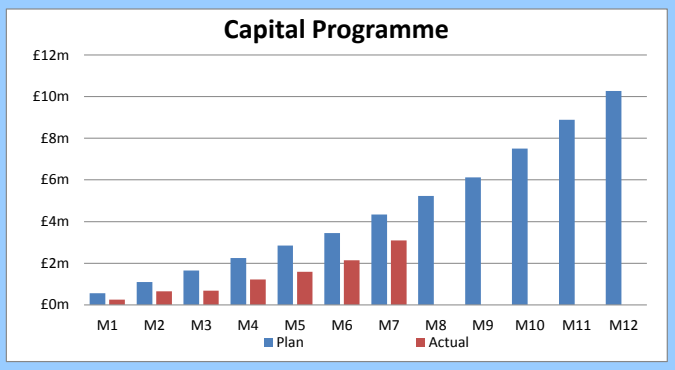
Profitability



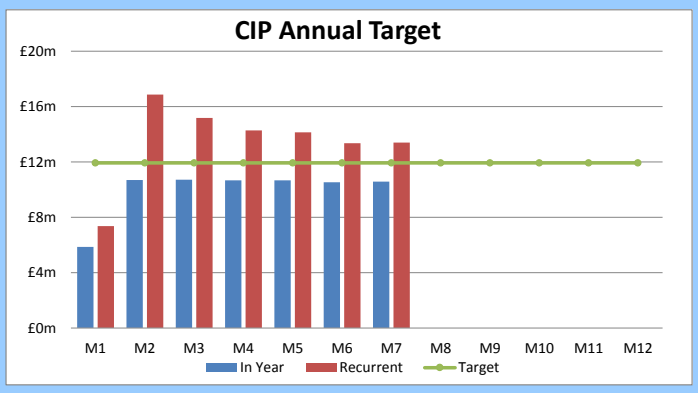


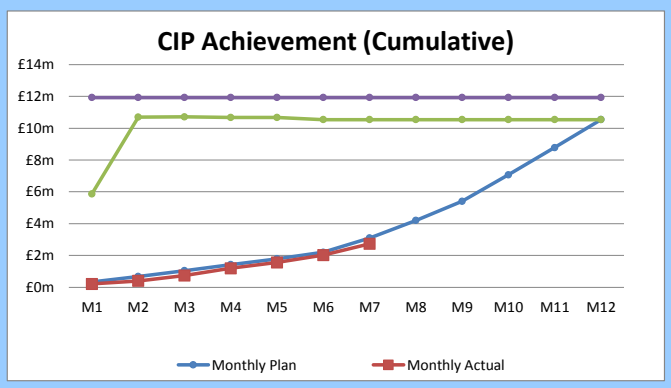
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Scheduled Care	56,064	4,739	4,806	-67	-1.4	32,997	33,186	-189	-0.6
Unscheduled Care	43,438	3,672	3,730	-58	-1.6	25,647	26,160	-513	-2.0
Womens, Children & Support Services	58,461	5,204	5,119	85	1.6	35,210	34,875	335	1.0
Corporate									
Operations - Central	462	66	57	9	13.6	345	289	56	16.2
Operations - Estates	7,551	604	585	19	3.1	4,144	3,996	148	3.6
Operations - Facilities	8,036	669	653	16	2.4	4,693	4,646	47	1.0
Commercial Development	569	47	38	9	19.1	331	278	53	16.0
Finance	9,354	775	774	1	0.1	5,444	5,437	7	0.1
Governance & Workforce	4,705	390	378	12	3.1	2,756	2,529	227	8.2
Information Technology	4,064	404	465	-61	-15.1	2,416	2,409	7	0.3
Nursing	1,865	156	159	-3	-1.9	1,086	1,084	2	0.2
Trust Executive	2,161	187	181	6	3.2	1,400	1,350	50	3.6
Total	**196,730**	**16,913**	**16,945**	**-32**	**-0.2**	**116,469**	**116,239**	**230**	**0.2**

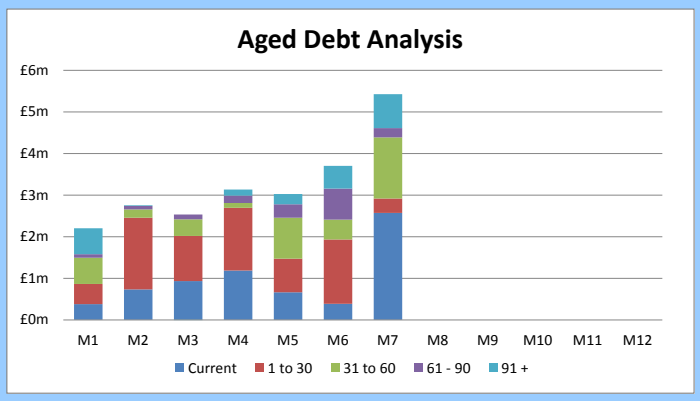
Positive variance = underspend, negative variance = overspend.

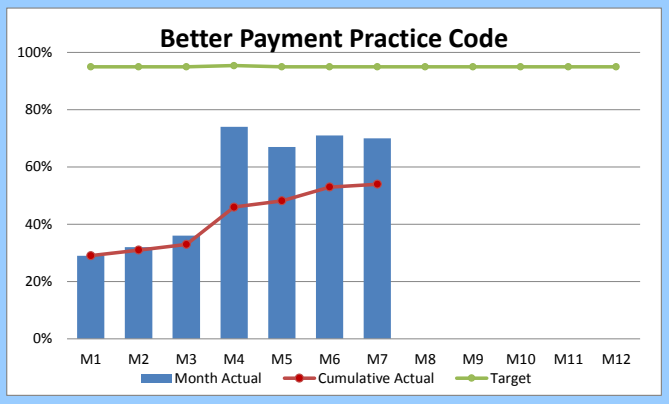
Continuity of Services Risk Rating

Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-8.1	2
Capital Servicing Capacity (times)	0.4	1
Overall Risk Rating		**2**

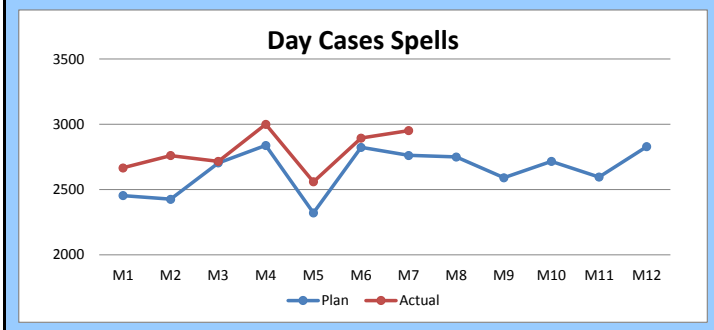
Finance Dashboard as at 31st October 2014 (Part B)

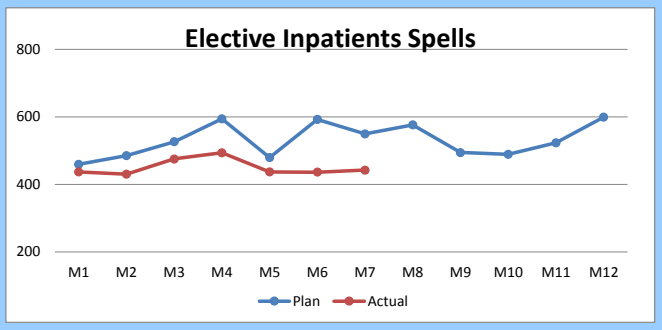
Balance Sheet and Liquidity

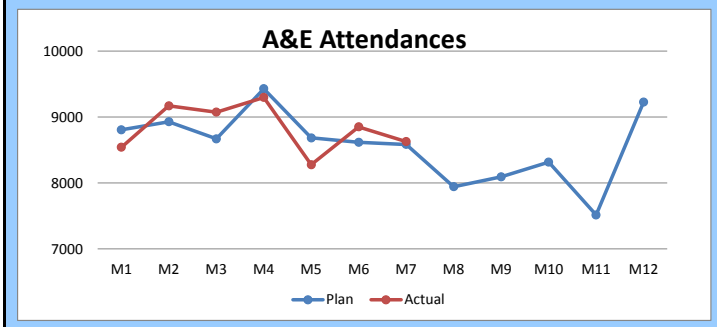


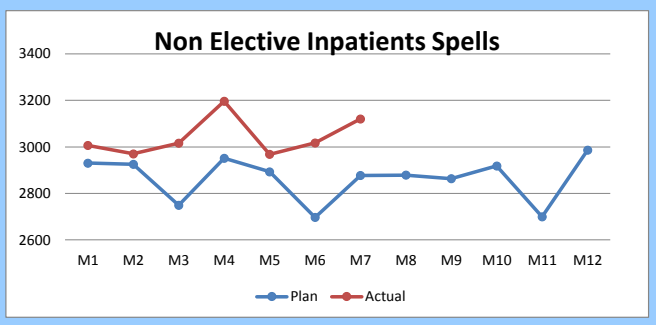


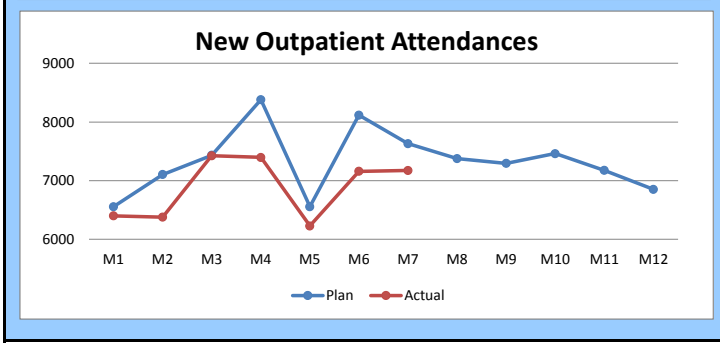
Activity Analysis

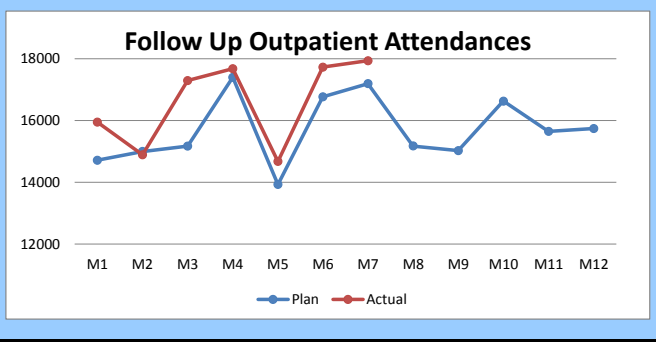












Warrington & Halton Hospitals NHS Foundation Trust **Appendix C**

Income Statement, Activity Summary and Risk Ratings as at 31st October 2014

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Activity Income						
Elective Spells	3,513	3,266	-248	22,140	22,165	25
Elective Excess Bed Days	21	9	-12	140	172	32
Non Elective Spells	4,346	4,543	197	30,496	31,093	598
Non Elective Excess Bed Days	308	337	29	2,172	1,946	-227
Outpatient Attendances	3,094	3,047	-47	19,105	19,529	424
Accident & Emergency Attendances	850	877	26	6,114	6,192	78
Other Activity	5,067	5,036	-31	32,978	31,812	-1,166
Sub total	**17,200**	**17,115**	**-85**	**113,145**	**112,909**	**-236**
Non Mandatory / Non Protected Income						
Private Patients	13	16	3	89	54	-35
Other non protected	107	107	0	749	780	31
Sub total	**120**	**122**	**3**	**838**	**833**	**-5**
Other Operating Income						
Training & Education	641	641	0	4,489	4,487	-2
Donations and Grants	0	0	0	0	0	0
Miscellaneous Income	573	858	285	4,011	5,015	1,005
Sub total	**1,214**	**1,499**	**285**	**8,500**	**9,503**	**1,003**
Total Operating Income	**18,534**	**18,736**	**202**	**122,482**	**123,244**	**762**
Operating Expenses						
Employee Benefit Expenses (Pay)	-12,062	-12,769	-707	-87,439	-88,804	-1,365
Drugs	-1,205	-1,302	-97	-8,223	-7,766	456
Clinical Supplies and Services	-1,621	-1,609	12	-11,044	-11,739	-695
Non Clinical Supplies	-1,991	-2,213	-223	-13,898	-14,016	-118
Total Operating Expenses	**-16,880**	**-17,894**	**-1,014**	**-120,604**	**-122,325**	**-1,721**
Surplus / (Deficit) from Operations (EBITDA)	**1,654**	**842**	**-812**	**1,879**	**920**	**-959**
Non Operating Income and Expenses						
Interest Income	3	3	-1	23	23	0
Interest Expenses	0	0	0	0	0	0
Depreciation	-524	-438	86	-3,665	-3,579	86
PDC Dividends	-336	-336	0	-2,349	-2,349	0
Restructuring Costs	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-856**	**-770**	**85**	**-5,990**	**-5,904**	**86**
Surplus / (Deficit)	**798**	**72**	**-727**	**-4,111**	**-4,985**	**-873**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,309	3,394	84	22,014	22,701	687
Elective Excess Bed Days	89	40	-49	578	750	172
Non Elective Spells	2,875	3,120	245	20,011	21,293	1,282
Non Elective Excess Bed Days	1,362	1,502	140	9,600	8,666	-934
Outpatient Attendances	28,837	30,633	1,796	188,177	197,686	9,509
Accident & Emergency Attendances	8,585	8,628	43	61,719	61,838	119
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)	1.2	-0.8	-2.0	-10.5	-8.1	2.4
Liquidity Ratio - Rating	4	3	-1	2	2	0
Capital Servicing Capacity - Metric (Times)	4.9	2.5	-2.4	0.8	0.4	-0.4
Capital Servicing Capacity - Rating	4	4	0	1	1	0
Continuity of Services Risk Rating	**4**	**4**	**0**	**2**	**2**	**0**

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

Cash Flow Statement as at 31st October 2014

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Actual September £000's	Actual 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)**	**(647)**	**(858)**	**414**	**(1,726)**	**(587)**	**72**	**461**	**172**	**1,441**	**(90)**	**1,503**	**(1,500)**
Non-cash flows in operating surplus/(deficit)													
Depreciation and amortisation	523	525	523	523	524	524	438	524	523	524	524	609	6,284
Impairment losses/(reversals)													0
(Gain)/loss on disposal of property plant and equipment													0
PDC dividend expense	336	335	336	335	336	336	336	335	335	336	335	333	4,024
Other increases/(decreases) to reconcile to profit/(loss) from operations	(16)	9	(3)	(19)	6	(16)	40	8	8	8	8	7	40
Non-cash flows in operating surplus/(deficit), Total	**843**	**869**	**856**	**839**	**866**	**844**	**814**	**867**	**866**	**868**	**867**	**949**	**10,348**
Operating Cash flows before movements in working capital	**(812)**	**222**	**(2)**	**1,253**	**(860)**	**257**	**886**	**1,328**	**1,038**	**2,309**	**777**	**2,452**	**8,848**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	(36)	(93)	68	52	141	(254)	(68)						(190)
(Increase)/decrease in NHS Trade Receivables	775	(332)	869	(991)	504	(618)	(346)						(139)
(Increase)/decrease in Non NHS Trade Receivables	154	(430)	(121)	203	(257)	(47)	248						(249)
(Increase)/decrease in other related party receivables	(235)	(75)	181	(237)	206	(11)	(161)						(331)
(Increase)/decrease in other receivables	(1)	303	144	(102)	137	(20)	(35)						425
(Increase)/decrease in accrued income	261	417	(231)	(542)	(220)	364	(647)	(270)	395	(49)	657	(134)	0
(Increase)/decrease in prepayments	(1,833)	507	(386)	(165)	872	(291)	253	171	171	171	171	359	0
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	(243)	612	(14)	18	344	64	1,359						2,141
Increase/(decrease) in Current provisions	5	(11)	12	7	8	8	0	(11)	(11)	(11)	(11)	(11)	(26)
Increase/(decrease) in Trade Creditors	2,508	(3,205)	(351)	(1,190)	(1,086)	1,182	2,944	(1,482)	5	(549)	449	(182)	(957)
Increase/(decrease) in Other Creditors	167	(407)	61	(27)	85	95	(63)						(89)
Increase/(decrease) in accruals	(189)	(568)	(645)	1,702	7	(448)	(2,162)						(2,303)
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	(4)	94	(120)	64	(62)	15	35						22
Increase/(Decrease) in working capital, Total	**1,329**	**(3,188)**	**(533)**	**(1,208)**	**679**	**38**	**1,359**	**(1,592)**	**560**	**(438)**	**1,266**	**32**	**(1,696)**
Increase/(decrease) in Non-current provisions	(27)	13	14	(27)	16	15	(177)						(173)
Net cash inflow/(outflow) from operating activities	**490**	**(2,953)**	**(521)**	**18**	**(165)**	**310**	**2,068**	**(264)**	**1,598**	**1,871**	**2,043**	**2,484**	**6,979**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	0	0	0	0	0	0	0	(323)	(323)	(665)	(625)	(663)	**(2,599)**
Property - maintenance expenditure	(158)	(115)	(35)	(207)	(241)	(132)	(444)	(362)	(363)	(523)	(816)	(819)	**(4,215)**
Plant and equipment - Information Technology	(39)	(165)	(23)	(283)	(92)	(245)	(322)	(167)	(168)	(223)	(187)	(599)	**(2,513)**
Plant and equipment - Other	(45)	(119)	27	(61)	(23)	(179)	(194)	(40)	(41)	(141)	(93)	(141)	**(1,050)**
Increase/(decrease) in Capital Creditors	(171)	(865)	(171)	124	(58)	315	271						(555)
Net cash inflow/(outflow() from investing activities, Total	**(413)**	**(1,264)**	**(202)**	**(427)**	**(414)**	**(241)**	**(689)**	**(892)**	**(895)**	**(1,552)**	**(1,721)**	**(2,222)**	**(10,932)**
Net cash inflow/(outflow) before financing	**77**	**(4,217)**	**(723)**	**(409)**	**(579)**	**69**	**1,379**	**(1,156)**	**703**	**319**	**322**	**262**	**(3,953)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received	0												0
PDC Dividends paid	0					(2,065)						(1,959)	(4,024)
Interest (paid) on non-commercial loans	0												0
Interest received on cash and cash equivalents	4	2	6	3	3	3	3	3	3	3	3	4	40
Drawdown of non-commercial loans							0	0	400	400	400	400	1,600
Repayment of non-commercial loans	0												0
(Increase)/decrease in non-current receivables	(84)	65	(38)	(4)	9	(2)	24	27	27	30	27	31	112
Net cash inflow/(outflow) from financing activities, Total	**(80)**	**67**	**(32)**	**(1)**	**12**	**(2,064)**	**27**	**30**	**430**	**433**	**430**	**(1,524)**	**(2,272)**
Net increase/(decrease) in cash	**(3)**	**(4,150)**	**(755)**	**(410)**	**(568)**	**(1,994)**	**1,406**	**(1,126)**	**1,133**	**752**	**752**	**(1,262)**	**(6,225)**
Opening cash	**12,956**	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**6,482**	**5,356**	**6,489**	**7,241**	**7,993**	**12,956**
Closing cash	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**6,482**	**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	7,638	7,070	5,076	6,482	5,356	6,489	7,241	7,993	6,731
Variance	4,611	1,031	846	887	769	1,237	1,885	0	0	0	0	0

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

Statement of Position as at 31st October 2014

Narrative	Audited position as at 31.3.14 £000	Actual Position as at 30.09.14 £000	Actual Position as at 31.10.14 £000	Monthly Movement £000	Forecast Position as at 31.3.15 £000
ASSETS					
Non Current Assets					
Intangible Assets	316	376	469	93	155
Property Plant & Equipment	132,588	131,685	132,043	358	134,972
Other Receivables	1,233	1,297	1,317	20	1,900
Impairment of receivables for bad & doubtful debts	-195	-205	-249	-44	-465
Total Non Current Assets	**133,942**	**133,154**	**133,580**	**426**	**136,562**
Current Assets					
Inventories	2,769	2,891	2,959	68	2,569
NHS Trade Receivables	3,052	2,845	3,191	346	1,164
Non NHS Trade Receivables	573	1,070	822	-248	338
Other Related party receivables	200	370	531	161	606
Other Receivables	1,960	1,500	1,535	35	1,153
Impairment of receivables for bad & doubtful debts	-355	-335	-380	-45	-188
Accrued Income	884	836	1,483	647	764
Prepayments	1,727	3,023	2,770	-253	1,016
Cash held in GBS Accounts	12,937	5,032	6,455	1,423	6,720
Cash held in commercial accounts	0			0	0
Cash in hand	19	44	27	-17	11
Total Current Assets	**23,766**	**17,277**	**19,393**	**2,116**	**14,153**
Total Assets	**157,708**	**150,430**	**152,973**	**2,543**	**150,715**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-1,513	-1,260	-2,466	-1,206	-1,732
Non NHS Trade Payables	-5,728	-3,839	-5,577	-1,738	-2,694
Other Payables	-1,755	-1,729	-1,666	63	-800
Other Liabilities (VAT, Social Security and Other Taxes)	-2,678	-2,665	-2,700	-35	-2,678
Capital Payables	-1,386	-560	-831	-271	-1,124
Accruals	-5,986	-6,009	-3,776	2,233	-6,222
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-49	3	-332	-335	0
Deferred Income	-1,353	-2,135	-3,494	-1,359	-1,140
Provisions	-282	-311	-311	0	-317
Loans non commercial	0			0	0
Total Current Liabilities	**-20,730**	**-18,503**	**-21,153**	**-2,650**	**-16,707**
Net Current Assets (Liabilities)	**3,036**	**-1,227**	**-1,760**	**-533**	**-2,554**
Non Current Liabilities					
Loans non commercial		0	0	0	-1,600
Provisions	-1,510	-1,514	-1,337	177	-1,471
Total Non Current Liabilities	**-1,510**	**-1,514**	**-1,337**	**177**	**-3,071**
TOTAL ASSETS EMPLOYED	**135,468**	**130,413**	**130,483**	**70**	**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	-5,055	-4,985	70	-1,500
Sub total	**99,660**	**94,605**	**94,675**	**70**	**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**	**130,413**	**130,483**	**70**	**130,937**

W&HHFT/TB/14/181

Board of Directors

Paper Title	Corporate Performance Report
Date of Meeting	26 November 2014
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 October 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

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-
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Recommendation(s)

The Board is asked to note the contents of this paper

Warrington and Halton Hospitals NHS
NHS Foundation Trust

CORPORATE PERFORMANCE REPORT
October 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 31st October 2014.

2.0 Performance

In overall terms, based on the performance in month 7, 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 AED performance continues to fail in achieving the 95% target. Across Merseyside the unadjusted performance for all trusts saw our performance as the second highest indicating that every Hospital is struggling to deliver the target but many of these include off site walk-in activity to bolster the performance to around the 95%.

The contract review into the performance was not able to correct the underperformance and a formal recovery plan has been requested by Warrington CCG for November 18th.

Key pressures include:

- Volume and acuity in late evening causing delays and queues in the AED resulting in breaches
- D&V closing up to 24 beds restricting access
- Managerial sickness weakening the operational team
- Poor complex discharge levels
- Poor clinical ownership of the issues

Key actions:

- External clinical review from Prof Higginson (ECIST)
- Appointment of the new ADD in Unscheduled care
- Agreement to extend the admission criteria for Intermediate care beds
- Extend the consultant shifts to finish at 0100am from November
- Senior management on site until 2100 Monday to Friday
- Agreements on standards for delivery of the Frail elderly 7 day pathway from all providers

Future Action:

- Use of winter funding to open 16 sub-acute beds

- Increase the urgent care clinics available for GP access to 9 per week
- Take over the front end management of the GP model from December
- New streaming nurses and escalation at the front of AED during surges of attendance
- New bed management policy
- Electronic ward boards

AED performance has flat lined during the past three months at around 93% discussions continue to include ambulatory and walk-in activity into the numerator (approximately 1% point). New leadership changes, concluding staff consultation on changes, discharges occurring earlier in the day, winter contingency funding will all have a positive impact on the performance and every effort is being made by the operational teams to deliver a full sustainable recovery of this target. Changes in domiciliary care, assessment standards, and changes in access for intermediate care will also have a big impact on rising the performance and alleviating queues for discharge.

3.2 Clostridium Difficile

The current performance is 4 above a straight line apportionment of the 26 target for the first 7 months (15).

3.3 CQC

The incidents in maternity and the subsequent reviews and inspections have generated a moderate concern following their recommendations. Significant activity is currently underway regarding the service strategy for low risk births and how the unit and team ensure the service available represents the national guidance and offers mothers confidence and personalized care provision now and in the future.

All other national targets are being met in full.

Mr Simon Wright

Chief Operating Officer

November 2014

Oct-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	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%	93.21%	93.58%	92.91%	90.70%	90.34%	92.04%	91.04%	92.07%							
	Non-admitted patients	95%	1.0	98.03%	97.63%	98.54%	97.83%	97.79%	97.72%	98.14%	97.89%	97.62%							
	Incomplete Pathways	92%	1.0	94.55%	94.56%	94.94%	94.55%	94.88%	95.29%	94.94%	95.03%	94.50%							
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%	95.01%	93.97%	91.74%	93.54%	93.26%	92.74%	93.00%							
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0	90.00%	82.14%	85.07%	85.45%	86.81%	82.16%	88.50%	85.19%	86.00%							
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%	1.0	100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	99.00%	99.00%	100.00%							
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		90.00%	88.46%	85.07%	87.91%	86.52%	80.26%	85.71%	85.45%	86.00%							
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	100.00%	99.00%	100.00%							
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%	100.00%	100.00%	100.00%	100.00%	100.00%							
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	98.00%	99.33%	100.00%	100.00%	100.00%	100.00%	100.00%							
	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%	98.00%	99.00%	100.00%	99.00%	98.00%							
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%	93.80%	92.70%	93.80%	93.50%	93.50%							
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.05%	93.00%	93.10%	93.05%	93.75%	91.90%	93.90%	93.30%	92.99%							
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	26 (for the Yr)	1.0 **	1	2	3	3	3	3	3	3	3							
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			2	5	7	7	8	15	16	16	19							
	Under Review			1	3	4	4	5	12	13	13	16							
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No							

Cumulative
Qtr1: 7 Qtr2: 13
Qtr3: 20 Qtr4: 26

Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	Report by Exception	No	No	No	No	No	No	No	No	No							
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No							
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No							
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No							
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	No	No	No	No	No	No	No	Yes							
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	No	No	No	No	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	No	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	No	No	No	No	No							
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No	No	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	1.0	0.0	1.0	1.0	1.0	1.0	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. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks
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.

W&HHFT/TB/14/182

BOARD OF DIRECTORS

Paper Title	Emergency Preparedness Assurance 2014-15
Date of Meeting	Trust Board, 26th November 2014
Director Responsible	Simon Wright, Chief Operating Officer
Author(s)	Emma Blackwell, Resilience Manager
Purpose	To provide the Trust Board with a progress report on the assurance provided by the Trust to NHS England with regard to emergency preparedness.

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 (please include up to eight bullet points and reference page/paragraph as appropriate).

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

The Board is asked to note the assurance provided to date by the Trust in relation to emergency preparedness response and recovery.

CONTENTS AND PAGE NUMBER

1. INTRODUCTION

Changes were introduced nationally in 2013 with regard to the emergency preparedness, resilience and response (EPRR) arrangements. Providers of NHS funded care are responsible for providing assurance to their local Clinical Commissioning Groups and Area Teams that they have appropriate arrangements in place in line with the new national guidance.

This paper provides the Trust Board with a report on the current position with regard to the Trust's compliance with these arrangements and the progress made in relation to the annual work plan for 2014-15.

2. PURPOSE

The purpose of the report is to; -

- Provide an overview of the assurance arrangements for EPRR in 2014-15.
- Summarise the current position within the Trust.

3. EPRR STRUCTURE

NHS England provide leadership and coordination of the NHS, including provision of information on the NHS position during national emergencies. It will participate in national multi-agency planning processes, including risk assessments, exercising and assurance. The Chief Operating Officer for NHS England has executive lead responsibility for EPRR nationally.

27 Local NHS England Area Teams have been established across the country. Their principal role will be to ensure that local NHS organisations have integrated plans for emergencies in place across their local area. In the event of an emergency in the Cheshire region, the Area Team for Cheshire, Warrington and Wirral will lead the NHS response as part of their incident response plan.

Local Health Resilience Partnerships (LHRP) have been established as part of the new planning arrangements to deliver national EPRR strategy in the context of local risks. This will bring together the health sector organisations involved in emergency preparedness and strengthen cross-agency working. The LHRP, supported by a Practitioners Sub Group, will provide strategic direction to local organisations in preparing their response to emergencies and will be the main vehicle for taking forward the EPRR agenda.

4. ASSURANCE PROCESS

The 2014/15 EPRR Assurance Process is based on the revised NHS England Core Standards for EPRR. To comply with the national requirements, the Cheshire, Warrington & Wirral LHRP requires the following:

1. All providers of NHS funded care to undertake a self-assessment against the revised core standards identifying the level of compliance for each standard (red, amber, green).

2. An action plan to be submitted addressing any areas of improvement required.

3. A statement of compliance to be completed identifying the organisations overall level of compliance.

4. The above outcomes to be presented to the Trust Board or through appropriate governance arrangements where the board has delegated their responsibility for EPRR.

5. STATEMENT OF COMPLIANCE

Warrington and Halton Hospital has undertaken a self-assessment against required areas of NHS England Core Standards for EPRR. Following assessment, the organisation has been self-assessed as demonstrating the **SUBSTANTIAL** compliance level against the core standards. Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the Organisations EPRR governance arrangements.

A copy of the completed self-assessment, statement of compliance and improvement plan are embedded below for information.


EPRR Core Standards 2014.xlsx


Statement of compliance signed


EPRR core standards improvem

6. RECOMMENDATION

The Board is asked to note the 2014/15 EPRR assurance process and the 'substantial' compliance level given to the Trust in relation to emergency preparedness response and recovery

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/183

BOARD OF DIRECTORS

Paper Title	Part 1 Risk Register
Date of Meeting	November 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, Control Measures 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 Safety and Risk Sub Committee CG, Audit and Quality Sub Committee	October 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
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. The risks of 15-25 result in the Board of Directors 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 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, check their Control measures are in place and actions plans reviewed and updated. A Simple Guide to the Risk Register has been produced and in addition to this the AD Governance is undertaking a number of Risk Register sessions with Senior Managers and Clinicians.	
Process for RR	• Source of the Risk (financial, incident, external review, national guidance) as examples • Control measures in place to try and manage the Risk. If these do not work as the Risk continues then an …….. • Action Plan is set up which includes a number of……. • Actions points to clearly identify the steps in the Action Plan to mitigate the risk	
Risks for updating	All risk shave been updated in the required timescale	
Estates	Reviewed and number of risks moved to Part 2 RR. No new risks	
IM&T	2 new risks 00866 and 0867	
Unscheduled Care	Risk 00647 and 00165 moved from Part 2 to Part 1 Risk Register	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)
To review and accept the Part I Risk Register, Controls, Action Plan and Action points still open

Your simple guide to the Risk Register process

The risk register contains the prioritised log of risks affecting services which are at trust wide level and or those affecting locally the Divisions and Corporate Departments.

Completing the risk register enables executives, senior managers and clinicians to work through how they can prioritise, manage or treat the risks they face. Keeping such a record of risks helps them to review and check whether risks have changed or if new risks need to be added. Each division and corporate service maintain their own area specific risks registers, which are used to inform the trust wide Risk Register.

The Steps to the Risk Register:

1. **Identify the source of the risk.** Examples includes:

   - Risk assessments
   - Incident and 'near miss' reporting and investigation including root cause analysis (RCA)
   - Claims, complaints and Patient advice and Liaison (PALS) reports
   - HM coroner inquests
   - Central Alert System (CAS)
   - External assessments e.g. Care Quality Commission, Health & Safety Executive, Environmental Health (EHO), Mersey Internal Audit Agency
   - Internal assessments including review of National Guidance including NICE Guidance and NCEPOD recommendations, High Level Enquiries, Inspection and Accreditation, Audit Outcomes and Audit Committee reports.
   - Patient and Public Involvement Forums
   - Patient and Staff surveys
   - Media reports

2. **Assess the risk:** Risks need to be assessed to determine to the actual and or potential for harm to patient and staff safety, the achievement of local objectives and the strategic objectives of the Trust

3. **Identify the controls already in place to try and manage the risk:** Examples include:

   - Training and Education
   - Policy and Guidance documents
   - Specialist and Personal Protective Equipment
   - Safety checks
   - Internal Inspections and audit programmes

4. **Assess if the controls are effective:** if they are not and it is felt nothing else can be done the risk needs to be escalated to the senior Manager and or Executive. At this stage the manager/ Executive can review and see if he/she can support the Division/ Corporate Service in making some local operational and or provide additional resources

5. **Develop an action plan:** this is required with Leads and timescales for review in order to try and manage the Risk.

6. **Action Points:** identify what individual things need to be done to complete the Action Plan to try and reduce/manage the risk

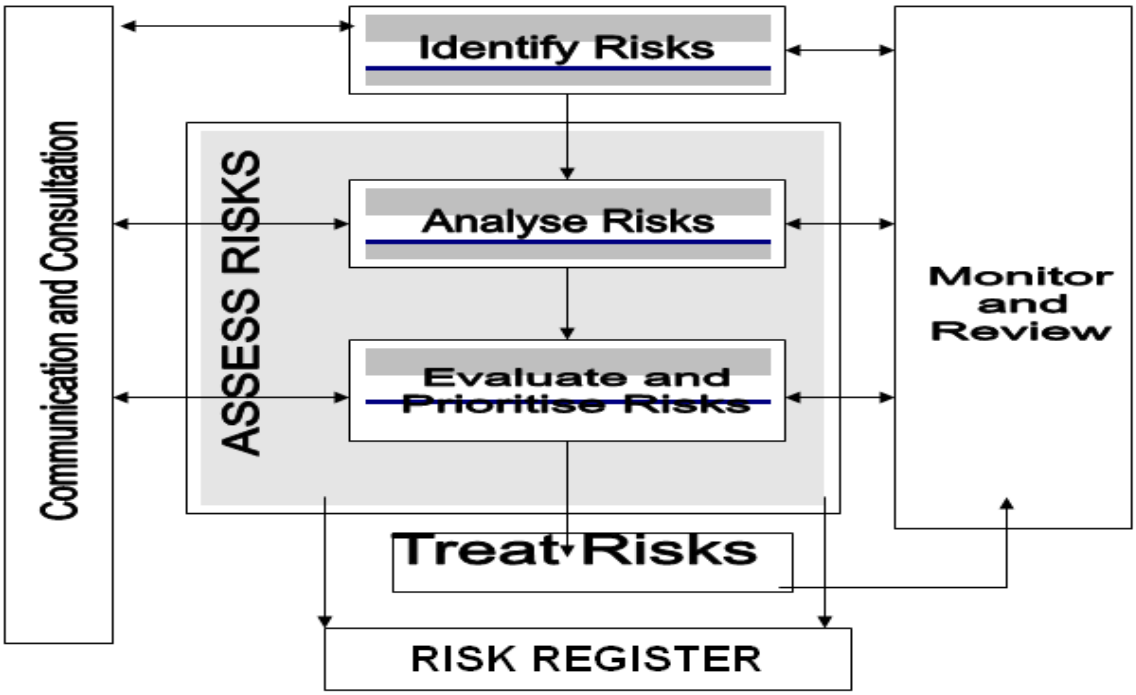
7. **Evaluate the Action Plan**: there should be a regular review date when the Action Plan is reviewed

8. Monitoring the risk:

- **Risks scored at 12-15** form what is known as the Part 2 Risk Register. These risks are monitored at Divisional/Corporate Services meetings and at least 3 times a year by the Safety and Risk Sub Committee
- **Risks 15 and above** are those which require monitoring by Executive and Corporate level. This is in addition to the Divisional/ Corporate Service meetings. Examples of the forums includes, Board of Directors, Governance Committee, Safety and Risk Sub Committee.

Note: All patient safety risks are provided as part of a monthly report to the Clinical Governance, Audit and Quality Sub Committee

Flowchart to the International Risk Management Documented Process
Source: Controls Assurance Risk Management Standard (based on the AS/NZ standard 4360:1999).



Useful contacts for help, support and advice

- Associate Director of Governance **ext 2484**
- Head of Safety and Risk **ext 2047** or **3288**

Divisional Governance Managers/ Risk Midwife

- Scheduled Care **ext 2689**
- Unscheduled Care **ext 5447**
- WCSS **ext** 2359
- Risk Midwife **ext 5224**

Part 1 Risk register 20 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: Estates												
000134	External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 2 at Halton site (Phase 1 completed)	Estates	Risk Assessment	31/01/2009	Extreme risk 16	Patterson, Ron; Capital Projects Manager; EST	03/11/2014	4 - Major	Extreme risk 16	31/12/2014	31/12/2014	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	03/11/2014	4 - Major	Extreme risk 16	31/12/2014	31/03/2015	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	12/11/2014	5 - Catastrophic	Extreme risk 15	12/12/2014	01/04/2015	6
000726	Éclair product at end of life and is no longer technically supported	Information Technology	External Review	22/07/2014	High risk 9	Davies, Wendy; Head of AHP & Technical Services; WCSS	11/11/2014	4 - Major	Extreme risk 16	08/12/2014	31/03/2015	2
000866	R005-Risk that the project will not meet agreed go-live timescales due to current insufficient deployment resources	Information Technology	Risk Assessment	12/11/2014	Extreme risk 16	DaCosta, Jason; Director of Information Technology; IT	14/11/2014	4 - Major	Extreme risk 16	12/12/2014	30/11/2015	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
000867	R016-Risk that slippage to the go-live date would result in a go-live over the Winter pressure months	Information Technology	Risk Assessment	12/11/2014	Extreme risk 16	DaCosta, Jason; Director of Information Technology; IT	14/11/2014	4 - Major	Extreme risk 16	12/12/2014	30/11/2015	8
Group: Scheduled Care												
000797	Risk of failure to meet statutory cancer targets due to changes in the reallocation process.	Scheduled Care Division	Committee Review	06/10/2014	Extreme risk 16	Fields Delaney, Shelia; Acting Business Support Manager; WHH	07/11/2014	4 - Major	Extreme risk 16	27/11/2014	31/12/2014	6
000857	Potential risk of failure to meet required contracted income plans in Surgery, ENT, T&O specialties.	Scheduled Care Division	Committee Review	07/11/2014	Extreme risk 16	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	07/11/2014	4 - Major	Extreme risk 16	18/12/2014	01/04/2015	6
000858	Potential risk to disruption of service due to obsolete Corneal Topography machine	Ophthalmology	Risk Assessment	07/11/2014	Extreme risk 16	Freeman, Graham; Principal Opotometrist; OPH	07/11/2014	4 - Major	Extreme risk 16	31/12/2014	31/12/2014	4
Group: Trust Wide												
000111	Operational, financial and potential patient safety risks associated with sustained use of escalation beds	Warrington and Halton Hospitals NHS Foundation Trust	Risk Assessment	01/08/2010	Extreme risk 15	Wood, Dawn; Assistant General Manager - Unscheduled Care; UCD	17/11/2014	4 - Major	Extreme risk 16	17/12/2014	26/02/2015	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	14/11/2014	5 - Catastrophic	Extreme risk 15	11/12/2014	30/04/2015	10

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
000681	Risk of being unable to submit AQ data as part of CQUIN requirement whilst database unavailable	Warrington and Halton Hospitals NHS Foundation Trust	Risk Assessment	27/03/2014	Extreme risk 15	Ramakrishnan, Subramaniam; Consultant; GASTRO	19/11/2014	3 - Moderate	Extreme risk 15	27/11/2014	18/12/2014	6
Group: Unscheduled Care												
000165	Risk to patient safety and performance targets due to no beds being available for review and assessment and delays with senior review within AED	Emergency Care	Risk Assessment	15/10/2012	Extreme risk 16	Franklin, Sue; Senior Manager; UCD	18/11/2014	4 - Major	Extreme risk 16	17/12/2014	31/12/2014	9
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	19/11/2014	4 - Major	Extreme risk 16	17/12/2014	31/12/2014	4
000647	Failure of patients to have Consultant review within 12 – 14 hours of admission as recommended nationally	Acute Medicine	Audit	23/10/2013	High risk 10	Robinson, Anne; Divisional Medical Director - Unscheduled Care; UCD	18/11/2014	3 - Moderate	Extreme risk 15	17/12/2014	31/12/2014	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. Linked to 0003	Pharmacy	Risk Assessment	31/01/2011	Extreme risk 16	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	11/11/2014	4 - Major	Extreme risk 16	09/12/2014	31/12/2014	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
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; RAD	11/11/2014	4 - Major	Extreme risk 16	09/12/2014	31/03/2016	8
000709	Risk of reduced safe standard of care due to reduced midwifery staffing levels.	Women's Health	Risk Assessment	29/06/2014	High risk 12	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	11/11/2014	3 - Moderate	Extreme risk 15	09/12/2014	31/01/2015	6
000724	Risk of Non Compliance with NHS England Directive 'Improving Medication Incidents Reporting and Learning'.	Pharmacy	Committee Review	15/05/2014	Extreme risk 16	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	11/11/2014	4 - Major	Extreme risk 16	09/12/2014	31/03/2015	2
000805	Appointments : Risk of escalating costs and poor clinic efficiency due to a significant increase in WLI OPD which are being arranged at short notice.	Outpatients Department (Halton and Warrington)	Risk Assessment	14/09/2014	Extreme risk 15	Robinson, Gordon; Head of Medical Records; MR	11/11/2014	5 - Catastrophic	Extreme risk 15	09/12/2014	31/03/2015	10

All Trust Risks - with controls 59 Items

Monitoring Committee equals: "Safety & Risk Sub-Committee"

Organisation Group equals:

Risk Score greater than or equal to:

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Organisation Group: Estates							
External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 2 at Halton site (Phase 1 completed)	000134	Estates	Patterson, Ron; Capital Projects Manager; EST	03/11/2014	Extreme risk 16	Fire Safety Training	Fire safety training will reflact that there is a loack of emergency lighting coverage in some areas.
						Install Emergency Lighting	Estates will install emergency lighting as part of the 2012 / 2013 fire precautions works
						Good Housekeeping	Estates will continue to monitor that good housekeeping and observation are in place.
						Target Completion	Target completion will be April 2013 - thereafter a review will be undertaken and additional funding sought as required.
						Local Evacuation Plans	Local evacuation plans should identify / reflect that emergency lighting is not in place.
						RRFSO Risk Assessments	Estates will list non-compliance details upon RRFSO RAs
External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing	000170	Estates	Patterson, Ron; Capital Projects Manager; EST	03/11/2014	Extreme risk 16	Current provision	Essential Lighting will be powered by hospital generator in the event of incoming (PES utility supply) mains faliure (15 second delay) - however no escape lighting would be provided in the event of local electrical failure. THIS CURRENT SITUATION IS AS PER THE ORIGINAL DESIGN - AND HAS EXISTED SINCE APPLETON WING OPENED
Organisation Group: Information Technology							

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Éclair product at end of life and is no longer technically supported	000726	Information Technology	Davies, Wendy; Head of AHP & Technical Services; WCSS	11/11/2014	Extreme risk 16	Daily the queues are resent. Over the weekend they will be left until Monday. Telephone Lab for results.	
						ILS service is restarted on the webseerver when it occurs. Telephone Lab for results.	
						Laboratory will communicate results that breach critically abnormal limits.	
						Records are corrected when identified. Telephone the Lab for missing results.	
						System supported by a maintenance contract but development of the system is not covered.	
R005-Risk that the project will not meet agreed go-live timescales due to current insufficient deployment resources	000866	Information Technology	DaCosta, Jason; Director of Information Technology; IT	14/11/2014	Extreme risk 16	composition of detailed resource plan to be approved 09/12/14	resource plan sign-off
R016-Risk that slippage to the go-live date would result in a go-live over the Winter pressure months	000867	Information Technology	DaCosta, Jason; Director of Information Technology; IT	14/11/2014	Extreme risk 16	Project controls, governance and gate reviews are in place.	Project governance to mitigate risks of go-live date slippage
Risk of unsupported, ageing IT infrastructure which is technically unable to support the Trust's IT requirements	000482	Information Technology	Garnett, Joe; IT Systems Manager; IT	12/11/2014	Extreme risk 15	Recycling servers	using old servers to house information/ systems
						Additional SAN member temporarily loaned to WHH by DELL	Extra 3TB of capacity which should last for 2-3 months until circa July
Organisation Group: Scheduled Care							

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Risk of failure to meet statutory cancer targets due to changes in the reallocation process.	000797	Scheduled Care Division	Fields Delaney, Shelia; Acting Business Support Manager; WHH	07/11/2014	Extreme risk 16	Timed pathways for cancer services. All patients to be referred to tertiary centre by day 42.	
						Quality account audits being conducted. Acting AGM reports monthly to the Trust Board. Report includes the Trust position at the time.	
						Network policy in place. Internal escalation process.	
						Divisional representation at the weekly cancer fast tract meetings. Monthly meetings with CCG where breaches are discussed if they occur.	
Potential risk of failure to meet required contracted income plans in Surgery, ENT, T&O specialties.	000857	Scheduled Care Division	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	07/11/2014	Extreme risk 16	Monitor/review elective activities in Scheduled Care by the Executive Team.	Monitor/review weekly elective activities and associated income by the Executive Team.
Potential risk to disruption of service due to obsolete Corneal Topography machine	000858	Ophthalmology	Freeman, Graham; Principal Opotometrist; OPH	07/11/2014	Extreme risk 16	Corneal topography machine serviced annually, no problems at present with operation.	
						Daily checks of the Corneal Topography machine prior to use.	
Organisation Group: Trust Wide							

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Operational, financial and potential patient safety risks associated with sustained use of escalation beds	000111	Warrington and Halton Hospitals NHS Foundation Trust	Wood, Dawn; Assistant General Manager - Unscheduled Care; UCD	17/11/2014	Extreme risk 16	Medical outliers on surgical beds will be reviewed daily.	
						Weekly monitoring of the operational and financial risk associated with the sustained use of escalation beds at the Division's SMT meeting. Monthly monitoring at the BiLateral meetings.	Monitored by the Senior Management Team for the Division at daily meeting with the Operations Manager for the Trust. Monitored at the weekly meeting of the Director of Nursing and the Division's Associate Director of Nursing.
						Daily bed management meetings to monitor the escalation process and minimise the cancellation of patients.	
						Bed Meetings	Daily review of escalation and Medical patients in Scheduled Care beds.
						Medical review	All outlying patients are medical reviewed to ensure appropriate care plan is in place.
Inability to replace ageing resuscitation equipment through no budget being identified which could result in equipment failing at point of use.	000216	Warrington and Halton Hospitals NHS Foundation Trust	Kelsey, Sallie; CPD and Business Support Manager; ED	14/11/2014	Extreme risk 15	Education and Training programmes	FR2 AED's are currently in place. They are reliable and easy to use. Staff who may be expected to use one will have the opportunity to practice with one in resuscitation training sessions. There are only 16 or so FR2 AED's in the Trust.
Risk of being unable to submit AQ data as part of CQUIN requirement whilst database unavailable	000681	Warrington and Halton Hospitals NHS Foundation Trust	Ramakrishnan, Subramaniam; Consultant; GASTRO	19/11/2014	Extreme risk 15	The Data Entry Clerk will collect and hold data until database situation is closed.	
Organisation Group: Unscheduled Care							

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Risk to patient safety and performance targets due to no beds being available for review and assessment and delays with senior review within AED	000165	Emergency Care	Franklin, Sue; Senior Manager; UCD	18/11/2014	Extreme risk 16	Nurse co ordinator to access patient in majors A - G (as per flow chart)	
						Progress chaser in post	AED from 1 pm - 9 pm has a progress chaser to ensure timely progress through AED.
						Close working with Patient Flow Team to enable flow of patient out.	
						Escalate to management/on - call team involvement and support via SOP and flow chart.	
						Ambulance Triage Nurse 11am - 11pm undertaking ambulance triage for initial assessment of potential deteriorating patients. To be continued at night shift handover. Patient to remain in the care of NWAS until off loaded.	
						Streaming Nurse to make EPUA appointments for early pregnancy as per flow chart.	
						Escalate to AEDCDU as space allows and it is appropriate for the patient.	
						Streaming Nurse to refer to AED GP ad Ambulatory care 10 am - 10:30 pm	
						Consultant presence in AED	Consultant AED Doctor now present within AED until 1 am 7 days a week.
Delay in clincial Assessment due to unpredictable volume and acuity of the Patients in the GPAMU; Potential for undetected deteriorating Patient	000542	Acute Medicine	Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD	19/11/2014	Extreme risk 16	Appropriate staffing within GPAMU	AMU co ordinator must be made aware by staff within GPAMU if patient acuity and/or number are not managable. This must be escalated within the division as required.
						GPAMU Standard Operating Procedure	SOP in place on the hub to ensure appropriate assessment of medical patient within A&E and GPAMU.
						Policy of the escalation of the deteriorating patinet	The Trust has a policy that ensure all patient who are found to be deteriorating as escalated to ensure appropriate review and treatment

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Failure of patients to have Consultant review within 12 – 14 hours of admission as recommended nationally	000647	Acute Medicine	Robinson, Anne; Divisional Medical Director - Unscheduled Care; UCD	18/11/2014	Extreme risk 15	Esclating deteriorating patients.	Hospital out of hours plan with critical care outreach nurses and night nurse practitioners responding to deteriorating patients. Hospital escalation policy. ibleep now in place.
						Review of ill patients	Critical care out reach review all patients prior to consultant ward round where required. The deteriorating patient are escalated to the Matrons
						Bed Meeting	All patient outlying requiring urgent review is discussed at the bed meeting
Organisation Group: WCCSS							
Risk that key objectives may not be met / risk to patient safety due to ward services being reduced due to Pharmacy Staffing issues. Linked to 0003	000089	Pharmacy	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	11/11/2014	Extreme risk 16	Risk assess level of risk to patients from prescription issues on wards to enable prioritisation and allocation of staff resources - may be assessed on a daily basis (acute staffing problem) or for ongoing gaps in capacity-demand	Wards are assessed and categorised by potential for medication safety issues. This determines which wards do not receive a ward pharmacist visit, which wards do not receive a visit when staffing levels do not permit and which wards receive a visit on weekdays
CT Unit Environment : Lack of space, lack of privacy & dignity, poor ventilation & distractions which can lead to mistakes/errors, misdiagnoses.	000695	Radiology	Holland, Neil; Principal Radiographer - MRI and CT; RAD	11/11/2014	Extreme risk 16	Utilisation of Available Space in Reporting Room	Furniture and equipment kept to a minimum. No of staff kept to a minimum - Radiollogists covering list may choose to report elsewhere. Slidings doors installed.
						Aim to Maintain Privacy as far as possible in waiting room.	OP may use US waiting area. IP have timed appts and these have been reduced to every 30mins - but it is noted that this has a detrimental effect on the capacity of the unit. Additonal IP waiting areas are available in main xray but due to the distance these are only used as a last resort.
						Measures to Enable use of Cannualtion room	As there is no drinking water plastic beakers are filled with water from the staffroom. Beakers are taken to staff room to be washed. Water cooler has been ordered.

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Risk of Non Compliance with NHS England Directive 'Improving Medication Incidents Reporting and Learning'.	000724	Pharmacy	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	11/11/2014	Extreme risk 16	TOR of Medicines Safety Commitee in order to comply with Alert.	
						Medicines Safety Committee-review of incidents	Quarterly review of medicines incidents by the Divisional Risk leads and learning disseminated by newsletter & safety alerts as appropriate
						Chief Pharmacist has been designated as the interim medicines safety officer	
Risk of reduced safe standard of care due to reduced midwifery staffing levels.	000709	Women's Health	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	11/11/2014	Extreme risk 15	Weekly meeting are held by Maternity managers to review sickness and absence and redeploy staff where staffing levels fall below the acceptable minimum	
						Midwifery Staffing Audit completed annually	Safe staffing levels are audited each year and presented at the Departmental Audit Meeting
						Midwifery Staffing Audit completed annually	Safe staffing levels are audited each year and presented at the Departmental Audit Meeting
						Commissioning of Birthrate Plus staffing assessment	Maternity service has commissioned Birthrate Plus study to assess case mix and acuity to support identification of correct midwife to birth ratio. Study to begin in January 2015
Appointments : Risk of escalating costs and poor clinic efficiency due to a significant increase in WLI OPD which are being arranged at short notice.	000805	Outpatients Department (Halton and Warrington)	Robinson, Gordon; Head of Medical Records; MR	11/11/2014	Extreme risk 15	Medical Records double check that the referral is the correct one beforfe putting into the record. However, an increasing number of letters have escaped the MR check due to volume	
						When appointing patients to short notice appts, staff will endeavour to make two attempts to contact the patient by phone. However, the sheer volume of WLIs is resulting in staff cnfirming appts by letter which inceases the possibility of DNAs.	
						We expect >6 weeks notice to cancel or reduce a clinic. However, due to the nature of WLI clinics the focus is on managing the additional clinics rather than the scheduled.	

Risk Action Points - All 22 Items

Risk Monitoring Committee equals: "Safety & Risk Sub-Committee"
Organisation Group equals:
Resp. Org. Unit equals:
Risk ID equals:
Action Status equals:
Action Status not equal to: "Completed"

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
Organisation Group: Estates						
Risk Score: 16						
Risk ID: 134						
Risk Title: External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 2 at Halton site (Phase 1 completed)						
001583	Install adequate Emergency Lighting	Gee, Brian; Estates Officer; EST	In progress as at 03/11/2014	30/11/2014		Extreme risk 16
Risk ID: 170						
Risk Title: External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing						
006552	Design and install appropriate emergency light fittings in line with current standards		In progress as at 03/11/2014	31/03/2015		Extreme risk 16
Organisation Group: Information Technology						
Risk Score: 16						
Risk ID: 726						
Risk Title: Éclair product at end of life and is no longer technically supported						
019172	Decommission Eclair system December 2014 and train circa 1,700 users on the ICE system.	Egerton, Deborah; ICE Systems Manager; IT	In progress as at 11/11/2014	05/01/2015		Extreme risk 16
Risk Score: 15						
Risk ID: 482						

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
	Risk Title: Risk of unsupported, ageing IT infrastructure which is technically unable to support the Trust's IT requirements					
019174	Migrate data from existing SAN to new SAN	Garnett, Joe; IT Systems Manager; IT	In progress as at 12/11/2014	16/02/2015		Extreme risk 15
Organisation Group: Scheduled Care						
Risk Score: 16						
Risk ID: 797						
	Risk Title: Risk of failure to meet statutory cancer targets due to changes in the reallocation process.					
019379	Division will use control measures in place at present to manage the risk.	Fields Delaney, Shelia; Acting Business Support Manager; WHH	In progress as at 07/11/2014	31/12/2014		Extreme risk 16
Risk ID: 857						
	Risk Title: Potential risk of failure to meet required contracted income plans in Surgery, ENT, T&O specialties.					
020079	Consider other alternative model of delivering additional activities such as the Whiston model/cost per case/HBS model.	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 07/11/2014	01/04/2015		Extreme risk 16
020075	Use extended sessions to increase productivity.	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 07/11/2014	01/04/2015		Extreme risk 16
020076	Split out non pay budgets that relate to T&O from theatre budget to enable cost controls.	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 07/11/2014	01/04/2015		Extreme risk 16
020077	Secure retrospective and prospective spinal top up income	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 07/11/2014	01/04/2015		Extreme risk 16
Risk ID: 858						
	Risk Title: Potential risk to disruption of service due to obsolete Corneal Topography machine					
020121	Submit business case to capital planning group for replacement machine	Freeman, Graham; Principal Opotometrist; OPH	In progress as at 07/11/2014	14/11/2014		Extreme risk 16
020122	Await decision from capital planning re: replacement machine	Freeman, Graham; Principal Opotometrist; OPH	In progress as at 07/11/2014	31/12/2014		Extreme risk 16
Organisation Group: Trust Wide						
Risk Score: 15						

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
	Risk ID: 216					
	Risk Title: Inability to replace ageing resuscitation equipment through no budget being identified which could result in equipment failing at point of use.					
003388	Write further business case	Kelsey, Sallie; CPD and Business Support Manager; ED	In progress as at 14/11/2014	11/12/2014		Extreme risk 15
	Organisation Group: Unscheduled Care					
	Risk Score: 16					
	Risk ID: 542					
	Risk Title: Delay in clincial Assessment due to unpredictable volume and acuity of the Patients in the GPAMU; Potential for undetected deteriorating Patient					
017291	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		Extreme risk 16
	Risk Score: 15					
	Risk ID: 647					
	Risk Title: Failure of patients to have Consultant review within 12 – 14 hours of admission as recommended nationally					
013105	Review of consultant working arrangements following appointment of 3 consultant physicians.		In progress as at 26/02/2014	30/09/2014		Extreme risk 15
	Organisation Group: WCCSS					
	Risk Score: 16					
	Risk ID: 695					
	Risk Title: CT Unit Environment : Lack of space, lack of privacy & dignity, poor ventilation & distractions which can lead to mistakes/errors, misdiagnoses.					
016421	Capital scheme to be worked up for inclusion in the Capital Porgramme 2015/2016.	Holland, Neil; Principal Radiographer - MRI and CT; RAD	In progress as at 11/11/2014	31/12/2014		Extreme risk 16
015705	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; RAD	In progress as at 11/11/2014	31/03/2016		Extreme risk 16
	Risk ID: 724					

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
	Risk Title: Risk of Non Compliance with NHS England Directive 'Improving Medication Incidents Reporting and Learning'.					
020455	Recruit to new post	Hayes, Nicola; Deputy Chief Pharmacist - Pharmacy; PHARM	Created as at 18/11/2014	30/04/2015		Extreme risk 16
018899	Resource implications being discussed centrally with the Chief Pharmaceutical Officer and NHS England. On the agenda. When available, information will be fedback.	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	In progress as at 14/10/2014	30/11/2014		Extreme risk 16
	Risk Score: 15					
	Risk ID: 709					
	Risk Title: Risk of reduced safe standard of care due to reduced midwifery staffing levels.					
016633	All incidents involving staffing levels to be reviewed by senior managers and reported as part of incident reporting to MRMG monthly	Goodwin, Ann; Clinical Risk Midwife; WomH	In progress as at 30/11/2014	30/11/2014	09/10/2014 - No incidents reported that have had staff as a contributory factor	Extreme risk 15
018822	HOM to produce a plan - short, medium and long term.	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	In progress as at 03/11/2014		09/10/2014 - bank staff used for a short term contingency plan whilst longer term plans can be developed	Extreme risk 15
	Risk ID: 805					
	Risk Title: Appointments : Risk of escalating costs and poor clinic efficiency due to a significant increase in WLI OPD which are being arranged at short notice.					
019433	Consider all alternatives to WLIs.	Hollins, Colette; Outpatient Access Manager; OPD-MR	In progress as at 14/10/2014	31/03/2015		Extreme risk 15
019432	Staff to be asked to complete the Stress Questionnaire.	Hollins, Colette; Outpatient Access Manager; OPD-MR	In progress as at 14/10/2014	30/11/2014		Extreme risk 15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/184

BOARD OF DIRECTORS

Paper Title	Board Assurance Framework (BAF)
Date of Meeting	26th November 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**
	FSC	19 November 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
• The BAF and compliance against the Provider Licence will be reviewed by the Audit Committee in line with its terms of reference.	
• The BAF is updated to take into account gaps in controls and assurance	
• 1.1 : 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 – ***The FSC (at meeting on 19 November 2014) assessed this risk and asked the Executive to consider whether the risk core and residual risk was appropriate given the impact of A&E on delivery of national and local targets.***	Page 4
• 1.2: Risk of harm through failure to comply with Care Quality Commission National core healthcare standards. ***The Board agreed (29 October 2014 meeting) that the likelihood residual score to revert back to 2.***	Page 5
• 3.2: Failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care. ***Amendment provided by Director of IT following Board review on 29 October 2014.***	Page 9
• 4.2-4.4: Sustainability Risks. ***These risks have been amended to take account of comments raised at the Board meeting on 29th October 2014 and have since been reviewed and agreed by the FSC at meeting on 19th November 2014.***	Page 13-14

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 that adequate assurance systems are in place to ensure the systems of control were effective and efficient in controlling the risks identified.

ASSURANCE FRAMEWORK

2014/15

Glossary of Terms

Term	Definition
Assurance	Confidence, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved.
Assurance Framework	A structure within which a board of directors identifies the principal risks to the Trust meeting its principal objectives, and through which they map out both the key controls to manage them and how they have gained sufficient assurance about the effectiveness of those controls
Control Systems	These are actions that are intended to manage risk by reducing its impact, its likelihood of occurrence, or both and should be genuine, practicable and realistic
Gaps in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or structures on which reliance is placed are operating effectively
Gaps in Controls	Failure to put in place sufficiently effective policies, procedures, practices or structures to manage risks and achieve objectives
Residual Risk Score	The likelihood and impact of the risk occurring after the controls are in place
Principal Risks	The risks which threatens the achievement of the strategic objectives
Initial Risk Score	The likelihood and impact of the risk occurring.
Strategic Objectives	Strategic objectives set by the Board of Directors

Likelihood and Impact Assessment

Likelihood and Impact Assessment

LIKELIHOOD (L)	IMPACT (I)					
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
	Almost Certain (5)	Low (5)	Significant (10)	High (15)	High (20)	High (25)
	Likely (4)	Low (4)	Significant (8)	Significant (12)	High (16)	High (20)
	Possible (3)	Low (3)	Low (6)	Significant (9)	High (12)	High (15)
	Unlikely (2)	Very Low (2)	Low (4)	Significant (6)	Significant (8)	Significant (10)
	Rare (1)	Very Low (1)	Very Low (2)	Low (3)	Low (4)	Low (5)

Likelihood score (L)	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Impact/Consequence score (I)	**1**	**2**	**3**	**4**	**5**
	Negligible Impact	**Minor Impact**	**Moderate Impact**	**Major Impact**	**Catastrophic Impact**

Strategic Objective 1
ENSURE ALL PATIENTS ARE SAFE IN OUR CARE

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk 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**	4 x 4 (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.	
			Effective operation of 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	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk 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] • Lobby for non-recurrent financial support •		Warrington wide response to emergency demand Aligning entre pathway under Trusts control Greater Control of Urgent Care Centre's (Halton) and provision of GPAU .	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 4) Finding availability impacts from external health & Social Care
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) CQC Inspection planned for January 2015 CQC Inspection to maternity services – action required – work and action plan on going
			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.	

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
			Trust policies and procedures including completion of CQC Assurance Templates by leads and service managers		In house" CQC inspections MIAA audits 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	Patient complaint service reports and review approved by Trust Board
			Strategy setting process eg People and Quality.		Appropriate assurance that key strategies are designed and delivered effectively.	Quality Strategy in process of being reviewed, to be presented to November Board
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.	3x4 (12)	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	1 x 5 (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.	

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
					• 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.	
			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.	

People

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 Staff engagement events planned once per quarter, first session in October 14.	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.	Strategy is fragmented and needs to be brought together under one overarching "HR" strategy – planned by March 2015
			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 • Staff FFT • NHS top 100 employers	• 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 • Additional HR professional to be brought in to lead on temporary staffing and workforce plan. • HR restructure to be finalised in Q3

Quality

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 ~~implement~~ develop an agreed Estates Strategy to meet service priorities and Trust patient environment quality standards.**	3 x 4 (12)	Estates Strategy being developed with assistance from Keir Construction in line with Board direction. Full Business case in course of preparation for approval March 2015.	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)	
			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. Programme board established to monitor progress reporting into FSC. Lorenzo Board established to deliver PAS replacement programme reporting into FSC. Capital programme in place to deliver the strategy.	~~Inability to provide funding and resources to enable fit for purpose systems and implementation of strategy~~

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
					External funding being sourced to secure addition investment. Additional resources secured and new structure being put in place aligned to delivery programme.	
			Governance Structure; IM&T Programme Board Data Quality and Management Steering Group Information Governance and Corporate Records Group. OPD User Group. Diagnostic Users Group Benchmarking Review Group Finance and Sustainability Committee.		KPI meeting held fortnightly Medical Records Strategy Group reports and minutes. 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.	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
					• 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 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 • Receipt of Board paper for CQC duty of Candour Regulations (2nd Oct 2014)	

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
			CQC Fit and Proper Person Test for Directors/Mangers – Linked to 1.2		• Board presentation on requirements of CQC Fit and Proper Person Test 2nd October 2014. • Process being adopted to provide assurance that directors are Fit and Proper Persons.	Awaiting CQC/FTN guidance on future CQC expectations so that they are consistent across the all healthcare providers.

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)	• 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. • 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 work plans. 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 work plans 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:** ▪ **Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis.** ▪ **Remain a going concern at all times / remain solvent.**	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 ▪ Detailed discussion and papers to the FSC	3 x 5 (15)	▪ Financial and Sustainability Committee reviews all relevant financial and strategic reports ▪ Strategy Roll out to staff and stakeholders undertaken (Oct 2014) ▪ 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	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
	▪ **Comply with section G6 of the provider licence.** ▪ ~~**CoS rating of at least 3**~~ ▪ ~~**remain at all times a going concern**~~ ▪ ~~**maintain a sufficient liquidity ratio or capital servicing capacity**~~ ▪ ~~**ensure the 5 year financial projection adequately reflect the Trust's financial stability**~~ ▪ ~~**Failure to comply with G6 of Provider licence**~~		▪ Executive Meeting Monthly Review ▪ Divisional management and governance accountability structures ▪ Standing financial instructions and scheme of delegations ▪ Legal contracts agreed with CCG.		▪ ▪ Monthly Board reporting ▪ Budget and Annual Plan 14/15 and 15/16	
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); and failure of operational processes to deliver service to agreed contract targets, outputs or standards. ~~.~~**	~~4~~ 5 x 5 (~~20~~25)	Monthly Divisional Bilateral Meetings and KPI meetings. Quality Group meetings with Warrington CCG Contract Risk Report Monthly Contract meetings with Warrington CCG and monthly correspondence with CCG. Finance and Sustainability Committee monthly Reviews ~~undertaken~~	~~3~~4 x 5 (~~15~~20)	FSC to receive contract risk reports and actions outstanding issues to provide Board assurance. Contract Team in place – Robust challenge of all penalties and service delivery queries Evidence of contract performance (provision of service) and contract management (receipt of service) provided through Divisional Bilateral Reports. Operational review process through Bi-lateral; Quality and FSC meetings	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~~ operational performance and delivery for provision of services between operational teams, finance, procurement and business development.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ Gaps in Assurance
4.4 **DOF**	**Failure to conclude/reach agreement on year end contract or future year value and enter into Arbitration process; and in year disputes regarding contract that require a entering into Arbitration.**	4x5 (20)	National guidance Contract meeting with CCG Executive Directors Review of contract position Monthly monitoring and reporting of contract through FSC.	3x5 (15)	Contract team and Finance team review with Executive Director Approach adopted by other trusts and central guidance Reports to Board and Board Committees	Trust has limited control over whole system and no control over how Commissioners allocate resources

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/185(i)

BOARD OF DIRECTORS

Paper Title	Verbal update on activity of Board Committees
Date of Meeting	26 November 2014

Board Committee Verbal Update

a) Quality Governance Committee held on 11 November 2014 & Action Plan arising from the CQC Report on Maternity — ***Mike Lynch***

b) Finance and Sustainability Committee held on 19 November 2014 — ***Carol Withenshaw***

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/185(ii)

BOARD OF DIRECTORS

Paper Title	Board Committee Minutes for noting only
Date of Meeting	26 November 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
•		

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 9 September 2014***

b) ***Finance and Sustainability Committee held on 22 October 2014***

Warrington and Halton Hospitals NHS
NHS Foundation Trust

QUALITY GOVERNANCE COMMITTEE

Minutes of the Meeting held on Tuesday 9th September 2014 at 9:00 am
Trust Conference Room, Warrington Hospital

Present:

Mike Lynch	Non-Executive Director (Chair)
Tim Barlow	Finance Director
Simon Wright	Chief Operating Officer, Deputy Chief Executive
Amanda Risino	Associate Director of Operations, Unscheduled Care
Diane Matthew	Chief Pharmacist, represented by Nicola Hayes
Terry Atherton	Non-Executive Director representing Lynne Lobley
Richard Brown	Associate Director of Operations, WC&SS
Karen Dawber	Director of Nursing and OD
Paul Hughes	Medical Director
Mel Hudson	Associate Director of Nursing, WC&SS Head of Midwifery
Claire Fozard	Clinical Fellow
Kate Warbrick	Associate Director of Operations, Scheduled Care
Wendy Davies	Assistant General Manager, WC&SS, AHP lead
Millie Bradshaw	Associate Director of Governance and Risk

In Attendance:

Jennie Taylor	Executive PA (minutes)

	WHHFT/GC/14/80 Apologies for Absence and Introductions	**Responsibility and Target date**
1	Apologies received from: Jason DaCosta, Director of IT Mel Pickup, Chief Executive Rachael Browning, Associate Director of Nursing, Scheduled Care Alison Lynch, Deputy Director of Nursing Millie Bradshaw, Associate Director of Governance and Risk Lynne Lobley, Non-Executive Director, represented by C.Withenshaw John Wharton, Nurse Quality Lead, CCG, Emma Buckley, Governance Compliance Manager Jan Snoddon, Chief Nurse, Halton CCG,	
	WHHFT/GC/14/081– Declarations of Interest	
2	There were no declarations of interest made in relation to the agenda items for the Governance Committee meeting.	
	WHHFT/GC/14/082– Minutes of the previous meeting held on 8th July 2014	**Members**
3	The minutes of the meeting held on 8th July were agreed as an accurate record with no amendments.	

	WHHFT/GC/14/082 - Action Plan	
	<u>WHHFT/GC/14/064 Risk Register</u>	
4	Associate Director of Governance and Risk advised that column added showing the date risk identified but explained that the additional column showing date first notified to this Committee was not to be added as it will add confusion as the Risk Register is reviewed at other meetings. M.Lynch, Non-Executive Director/Chair appreciated the improvements already made and all agreed it is a live and much better document, there has been a significant refreshment to this document. – action complete.	
	<u>WHHFT/GC/14/074 Information Governance Meeting</u>	
5	M.Lynch, Non-Executive Director/Chair feels that some dynamism is needed and the Execs agreed to encourage attendance, the meeting though was scheduled to take place yesterday unfortunately the Director of IT was unwell and the meeting was cancelled and will be reconvened as soon as possible. Discussion took place around chair of this meeting and Chief Operating Officer/Deputy CEO agreed to raise the topic at the next Exec meeting. Director of Nursing and OD explained that she chaired this meeting before appointment of Director of IT and it is a difficult agenda and the Execs do need to support this meeting.	**Chief Operating Officer /Deputy CEO**
6	M. Lynch, Non-Executive Director/Chair believes this group needs to be galvanised and the Board do need assurance that this area of Governance is being addressed.	**Director of IT**
7	Further update to be provided at next meeting.	
	<u>WHHFT/GC/14/075 – Safety and Risk Sub Committee</u>	
8	Associate Director of Governance and Risk advised that there had not been a meeting in August. In July a virtual meeting was held as a result of the Perfect Week. The Terms of Reference are to be reviewed to include virtual meetings and to move to 11 meetings a year. Poor attendance from Unscheduled Care has been communicated to the Operational Divisional Director. M. Lynch, Non-Executive Director/Chair noted this is a recurrent theme and is aware of pressures but other divisional management have similar issues. Chief Operating Officer/Deputy CEO explained that a number of discussions are taking place around pressure affecting other areas of work in the hospital.	
	WHHFT/GC/14/084 – Complaints Summary Report	
9.	Director of Nursing and OD explained that this report covers quarter 1 and will in future contain details of shared learning which will provide clarity on where the organisation stands on improving.	
10	M. Lynch, Non-Executive Director/Chair complimented this outstanding document, it brings examples to life and compliments ought to be included too. It shows that complaints are owned by a particular group and they are getting much closer to the areas involved. He was keen to find out what divisional management are doing to ensure the information is cascading through the relevant areas.	

11	Associate Director of Operations, WC&SS explained that consultants are very interested in complaints as they are now discussed at appraisals. Complaints are always discussed at DIGG meeting in depth and a good example is where a complaint was received regarding poor attitudes in breast screening. This was discussed, area targeted and now compliments are being received following improvements in Patient Experience.	
12	Director of Nursing and OD explained that the complaints department has increased and improved and also produces a weekly bulletin which features high risks.	
13	Chief Operating Officer/Deputy CEO explained that improvements are obvious following a safety walk about in breast screening.	
14	Unscheduled Care do have the highest number of complaints but also have the highest number of compliments. The report shows a positive response and clearly demonstrates complaints are taken seriously and improvements made as a result of lessons learnt.	
15	The immediacy of resolving ward based complaints is also a positive move and is a benefit to complainants.	
16	T. Atherton, Non-Executive Director asked where Warrington and Halton stand in the ratings and what are the trends.	
17	Director of Nursing and OD responded that Halton hospital is always rated higher and explained that all NHS Choices comments are responded to. Warrington Hospital does score well against other District General Hospitals with A&E departments.	
18	T. Atherton, Non-Executive Director asked about benchmarking and trend analysis. Director of Nursing and OD responded that this detail can be added to the report in future.	
19	Director of Finance agreed this was a good report with the right mixture of content but agrees that a quarterly comparison would be useful. He added that complaints around attitude of staff is always on the weekly report and given the pressure that staff are under this is probably why. He asked if training etc is in place to target individuals who are being identified.	
20	Director of Nursing and OD described the system in place to target individuals SCHWARTZ rounds will commence in October which give staff the chance to honest and truthful about circumstances that add to stress levels. Chief Operating Officer explained that sickness levels are reducing and it appears to be as a result of the work Director of Nursing and OD is implementing. WHHFT was named last week as one of the Top 100 NHS places to work, this is based on staff survey results and should be celebrated.	
21	M. Lynch, Non-Executive Director/Chair agreed that benchmarked data will be helpful.	

22	Director of Nursing and OD advised that PALS have been visiting A&E during peak periods and although this has proved useful it is not possible to increase this service due to staff levels.	
	WHHFT/GC/14/085 - Risk Register	
23	The Director of Nursing and OD advised that Clostridium Difficile (Cdif) cases has a low threshold and we have now had 7 hospital acquired cases. The target has changed to a Cdiff objective and the emphasis has changed to show that as long as you haven't done anything to contribute to allow Cdiff case then an appeal can be made and the CCG has been contacted. M. Lynch, Non-Executive Director/Chair explained that patients testing positive are usually vulnerable and need antibiotics to treat illness. Director of Nursing and OD informed the meeting that every avenue of cross contamination is being looked at and hand hygiene campaign is being relaunched.	
24	Director of Nursing and OD raised issue around impact of medical outliers and the effect this has on quality of care. We know that constant state of escalation leads to risk and is frustrating. Associate Director of Operations, Unscheduled Care explained that outliers are reviewed regularly and we have a serious number of patient residing in our beds that ought not to be there too. Chief Operating Officer/Deputy CEO explained that weekly point prevalence report is evidencing patients that should not be in acute beds. Discussion took place around the impact these outliers has on the three divisions but it was agreed the risk would be owned by Unscheduled Care.	
25	Associate Director of Governance and Risk explained that risk control measures have been added and the overall document has been improved.	
26	Director of Finance queried progress area on the CIRIS report and where it shows the date on action status. He asked how can we have assurance that progress on risks is being made but not showing the progress of the mitigation taken on this report. Associate Director of Governance and Risk agreed to discuss this at Safety and Risk Sub Committee.	**Associate Director of Governance and Risk**
27	Discussion took place around how does the Board obtain assurance that risk activity is being accurately reported. Director of Nursing and OD explained that CQC visited recently and picked up that although we are doing much around quality and safety we are not good at documenting this. Associate Director of Governance and Risk explained the Risk Methodology which included identification of the risk, control of the risk, action plan and evaluation. The members all agreed the background and Mike Lynch reiterated the CQCInspectors will look at paperwork and not at the electronic copy therefore it is important to show the progress that has been made and the dates any reviews have taken place.	
	WHHFT/GC/14/086 – Quarterly Governance Report (April – June)	
28	Associate Director of Governance and Risk presented her report which shows we are still a high reporting organisation	

29	Areas to note are:	
30	Data from Quarter 4 has been assessed and the total number of clinical incidents has increased by 31 due to incidents being reported retrospectively after the running of the Governance report data. In severity ratings the increase has been to No and Low harm incidents.	
31	Moderate harm incidents have been decreased by 7 to 12 and Major harm incidents have decreased to 3 due to incidents being reassessed during the investigations.	
32	1 new Non-Clinical incident was reported retrospectively with the severity rating Minor harm and 3 Moderate harm incidents were reassessed as Minor Harm Incidents.	
33	1 new Serious Untoward Incident was included in the updated figures for last quarter due to a pressure ulcer that was reported on 28th March 2014.	
34	Associate Director of Governance and Risk advised that claims are increasing, mainly due to Duty of Candour resulting in reports that are given to families being passed to legal firms to pursue.	
35	Medical Director advised that we have a professional obligation where anything has gone wrong but we appear (not just WHHFT but the NHS in general) to provide too much detail on a personal level. Associate Director of Governance and Risk advised that in future CQC will no longer warn around Duty of Candour for moderate or major harm or death but will instead go straight to prosecution if found an organisation had not applied the Regulation.	
36	Director of Nursing and OD explained that harm and neglect are two different issues and she does not think it is going to be possible to solve locally. There was agreement that more needs to be done around training and serving the interests of patients, serving the organisation and fulfilling Duty of Candour.	
37	The Associate Director of Governance and Risk reported that there has been an increase in coroners inquests due to Francis report	
38	M. Lynch, Non-Executive Director/Chair stated that this report clearly demonstrates that increased reporting is resulting in improved learning and organisational improvement. He requested that members read the report and raise any queries at the next meeting.	
	WHHFT/14/087– Serious Incident completed Level Two Investigations	
39	The Associate Director of Governance and Risk advised no new SUIs reported in July or August.	
40	The Medical Director commented that in the endocarditis incident communication at handover was lacking and has highlighted the resilience of pathways for some patients.	
	WHHFT/14/06088 – Quality Dashboard	
41	Director of Nursing and OD presented the Quality Dashboard and explained that good reporting has been recognised.	

42	The KPIs in the Quality Dashboard have been reviewed in line with the revised requirements for 2014/15 from the • CQUINs • CQUIN monitoring group • Quality Contract • Quality Account – improvement priorities • Quality account – quality indicators • Sign up to Safety • Open and Honest.	
	WHHFT/CG/14/89 – CQC Quarter1 Essential Standards Compliance Assessment and Outcome	
43	No areas of Major Concern.	
	WHHFT/CG/14/090 – Heatwave Plan	
44	Plan has been ratified externally and is ratified by Quality Governance Committee.	
	WHHFT/CG/14/091 – Business Continuity Plan	
45	This has been externally scrutinised and scored highly in compliance. Ratified by Quality Governance Committee.	
	HIGH LEVEL BRIEFING AND MINUTES FROM REPORTING COMMITTEE CHAIRS	
	WHHFT/CG/14/092 – Information Governance and Corporate Records	
46	There was no report as no meeting has taken place since last Quality Governance Committee meeting. Discussed under Action Plan.	
	WHHFT/CG/14/093 – Safety and Risk Sub Committee	
47	The notes of the meetings on 12th June were noted by the Quality Governance Committee.	
	WHHFT/CG/14/094 - Strategic People Committee	
48	The minutes of the meeting of 9th June were noted by the Quality Governance Committee.	
	WHHFT/CG/14/095 – Event Planning Group and Local Health Resilience Group	
49	The Chief Operating Officer explained that this group is the forum for managing events and demonstrates our resilience. We will be inviting consultants to future meetings where considered appropriate.	
	WHHFT/CG/14/096 – Clinical Governance, Audit and Quality Sub Committee	
50	The minutes of the Clinical Governance, Audit and Quality Sub Committee meeting held on 26th June and 31st July were noted by the Quality Governance Committee.	

51	Medical Director advised there was nothing to report by exception but he hoped that by the next meeting he would be able to report that panel meetings will be in place below this committee as the agenda has too much content. M. Lynch, Non-Executive Director/Chair asked where the assurance is that all NICE guidance is being complied with.	
52	He requested some high level dashboards to demonstrate what has been learned and what changes are required, there needs to be some evidence of audits being undertaken. It was agreed that the Medical Director would look at these issues.	**Medical Director**
53	Associate Director of Governance and Risk explained that a meeting has been scheduled this month where triangulation of reporting can be arranged. .	
	WHHFT/CG/13/097– Infection Control Sub Committee	
54	The minutes of the Infection Control Sub Committee meeting of 19th August was noted by the Quality Governance Committee.	
	W&HHFT/GC/14/098 - Any Other business	
55	The Director of Nursing and OD advised the meeting that following the CQC visit to maternity a report had been received that was disappointing as it focussed on only one issue, that of continuous CTG monitoring. There are two schools of thought, obstetricians felt it was not appropriate. Following discussions at a number of meetings continuous CTG monitoring was implemented and the reasoning applied within the Response back to the CQC.	
56	The RCoG visit provided a positive feeling to all involved and the response is awaited. The overall impression is that we are a safe service with a dedicated group of staff. Unfortunately the Trust experienced a cluster of incidents.	
57	M. Lynch, Non-Executive Director/Chair asked if the CQC felt the response to this cluster was appropriate. He explained the Board supported the decision for continuous monitoring as maximum safety based on evidence provided.	
58	Director of Nursing and OD advised that several changes are planned to improve the service. Employing consultant midwife Business Case for Midwifery led Unit Process for Band 7 Development plan Competence training.	
59	Director of Nursing and OD reported that confidence in the department was low although a vision for a midwife led department within the next two years will go some way to reinvigorate everyone.	
60	The Medical Director confirmed the unit is safe and CTG has not caused harm. The cluster has not been a result of failure of our staff, the department has gone through a difficult time and a Midwife Led Unit is the way forward.	

61	The Head of Midwifery reported that as a result of CTG monitoring there has been 36% caesareans compared to the usual 27%. In low risk situations CTG monitoring is not beneficial and went against national guidance.	
62	The Medical Director explained there is a difference between individual and population evidence and does not accept that harm was caused to the monitored mothers.	
63	Head of Midwifery advised some midwives have lost confidence in their ability to not monitor women who are considered low risk, a supportive mechanism has been put in place to assist these midwives.	
64	M. Lynch, Non-Executive Director/Chair explained that the Board want every success for this department and there needs to be appropriate investment in the service to allow this to happen.	
65	The Chief Operating Officer suggested having an 'open day' in a few months to demonstrate the service and reassure expectant mothers.	
	Date and time of next meeting: 11th November 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.

FSC/14/69

FINANCE AND SUSTAINABILITY COMMITTEE

Minutes of Meeting of the Committee held on 22 October 2014

Present

Rory Adam	Non-Executive Director - Chair
Lynne Lobley	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
Mike Barker	Deputy Director – Strategy & Commercial Development
Steve Barrow	Deputy Director of Finance

In attendance

Colin Reid	Trust Secretary
Ian Jones	Non-Executive Director
Terry Atherton	Non-Executive Director
Chris White	Head of Information for items FSC/14/57- FSC/14/58 only

Apologies:

Carol Withenshaw	Non-Executive Director
Paul Hughes	Medical Director
George Creswell	Associate Director Estates & Facilities

Apologies and Declarations of Interest – FSC/14/57

1 Apologies: As stated above
Declarations: None

Minutes of meeting & Actions – FSC/14/58

2 The minutes of the meeting held on 17th September 2014 were approved.

3 Action Plan:
FSC/14/37: The Director of Finance and Commercial Development advised that the 10 year Capital Plan would be presented to the October meeting following its review at the Capital Planning Group later this month. *See agenda item FSC/14/61.*

4 FSC/14/55: The Chief Operating Officer to report back to the Committee on the proposed action plan to support patient data collection at admissions. The Chief Operations Officer reported on the quick fixes implemented to address data collection at source, in particular the provision of laminated sheets that provides details of the required patient information and script, this would allow for consistent information to be obtained.

5 Chris White, Head of Information reported on the processes being undertaken within the Trust to address the gaps in collection of patient data at admissions. He provided details of

the Spine Mini Service that allows the Trust with access to the national Person Demographic Service (PDS), explaining that the Trust could verify or look-up patient NHS numbers, and provide key patient demographics such as address, contact and GP details and went on to explain how the Trust was utilising the Spine Mini Service in order to obtain missing patient data. The Chairman noting that improvements would now be made in the obtaining and recording of patient data, asked whether the trust would be able to recover the position with the CCG for past months data in order to reduce potential penalties. The Director of Finance and Commercial Development advised that each month, the Trust had requested that the CCG hold open the queries to allow the Trust the opportunity to address the incorrect or incomplete data. He advised that although requests had been made, to date the CCG had not responded. The Director of Finance and Commercial Development advised that he could not therefore guarantee that the CCG would allow the additional time to address the data and therefore there was the potential that penalties would be imposed. Terry Atherton referring the comments raised by the Director of Finance and Commercial Development asked whether Halton CCG took the same approach was Warrington CCG. In response Chris White advised that they did as was their right under the contract. He did however advise that it was only recently that a penalty had been imposed; advising that in previous years both CCGs had not imposed penalties for this requirement under the contract.

6 Chris White advised that on the resource availability to rectify data and explained that one person was responsible to make amendments however due to other pressures this person had been moved to another area of work. He advised that on reflection this was an error and that following an acknowledgement that the CCG would be imposing penalties under the contract the individual member of staff had been directed back into the checking role.

7 The Chief Executive noting that changes had now been made to address the obtaining of patient data and the checking of such data, recognised that this had been a perennial problem which had only become a real issue since the CCG had decided to impose the penalties. The Chief Executive asked why it had taken so long to address the queries raised by the CCG. In response the Director of Finance and Commercial Development reported that the query letters from the CCG had been received monthly stating that a penalty would be imposed. Following receipt of the query letter the Trust had sent a holding letter and that only in month 5 had the issue of imposing a penalty become a reality. He explained that the CCG had always written to the Trust to advise that a penalty would be imposed however had never implemented the penalty. The Chief Executive asked whether the Trust had acted quickly enough and robustly enough following the imposing of the penalty, given the financial risks arising from it and questioned whether the Trust had responded quickly in putting in place the work around. The Director of IM&T advised that only since the penalties had been imposed had the financial risk been acknowledged, before this he advised that given previous precedents the Trust had no reason to believe the CCG would impose the penalty.

8 The Chairman recognised the concern of the Chief Executive, referred to previous meeting of the Committee at which the matter of the penalty had been raised and challenged by the Non-Executive Directors and questions had been asked on whether additional staff should be made available to address the backlog of missing data. Lynne Lobley asked whether there was a system in place, should the person responsible to obtaining the missing data go on leave or off sick for periods of time. The Director of IM&T advised that advised that with the necessary technology and manpower in place the issues of the past would not be replicated in the future. The Chairman noted the comment of the Director of IM&T however felt that his concern and he believed that of a number of the Committee was that if the Trust had

addressed the issues earlier than it had, then the amount of penalty may well have been much lower.

Terry Atherton referring to the first query letter for April 2014 noted that, in terms of time frames, the Trust had only 5 days to respond to the letter and felt that such a short time would
9 be very difficult deliver a response. The Director of Finance and Commercial Development advised that this was the case, however the Trust was currently negotiating extending the response period to 10 days.

The Chairman closed the discussion on this action and recognised work was underway to mitigate any future penalties arising from gaps in patient data collection at admissions but
10 was disappointed that there may not be anything that can be done to mitigate penalties arising earlier in the year.

The Chairman thanked Chris White for this attendance to provide further details on the patient data collection at admissions.

11

Corporate Performance Report – September 2014 (prior to going to Board) – FSC/14/59

12 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.

13 The Chief Operating Officer advised that all targets had been met with the exception of: A&E 4hr target; NWAS times; and C.Diff which was slightly above trajectory at 16 against a mid-year trajectory of 13.

14 The Chief Operating Officer advised that A&E continued to see a worsening position with a Q2 performance of 92.74%. This gave a year to date performance of 93.36%. The Chief Operating officer provided details of actions undertaken within AED to address the performance. He reported however, that although actions had been taken the increasingly high volume of A&E traffic and the difficulties in bed availability due to intermediate care would continue to put pressure on delivery of the 4 hr target.

15 The Chief Operating Officer summarised the actions being taken within the AED which included the external reviews by Professor Higgins AED consultant and ECIST who had observed the clinical pathways and practice. The final reports were not yet available, however initial findings had indicated that there were no significant areas that required addressing other than managing the floor. He advised that if additional findings from the reviews identified areas of improvement these would be considered and if appropriate action plans put in place to address the shortcomings. The Chief Operating Officer reported further on the other actions being taken concluding that although a number of areas for improvement can be made he felt that delivery of the 4hr target was not solely in the gift of the Trust and that it required a whole system solution to be found as reported to the Board at the meeting on 2 October 2014.

16 The Chairman felt that the staff were key to improving performance and asked whether they were engaged in the actions required to be undertaken and aware of the pressures from external sources. The Chief Operating Officer advised that it was important not to create a

negative climate within AED and advised that staff were working extremely hard in very difficult circumstances to find solutions that were in the gift of the Trust to deliver. The Chief Operating Officer advised that the Staff had been very proud of the performance history in delivering the 4hrs target and were fully engaged to finding solutions. He explained that all the issues surrounding A&E was not limited to the Trust and that most trusts were failing across the sector.

17 The Director of Nursing and Organisational Development noted the actions being undertaken within AED and across the pathways to improve performance and agreed with the Chief Operating Officer that any significant improvement could only be delivered through a whole system change.

18 The Chief Executive referring to improvements in discharges referred to the work undertaken by the Governors led by David Ellis where they found issues regarding TTOs that required addressing. These findings needed to be included in any action plans to improve patient flow. The Chief Executive referred also to the consultant ward round and in particular the pressures that can come to bear if there were delays in the ward round that meant that those patients that were well enough to be discharged could only be discharged once they were seen by the Consultant, such a delay could have a knock on delay in the discharge process. The Chief Executive felt that as a Trust, she felt that the Trust's medical community weren't as proactive in undertaking ward rounds and felt that it may be appropriate to put in place a more ridged approach to ward rounds so that patients are discharged in the shortest possible time. The Chief Executive cited Mid staffs experiences, following Francis, where ward rounds are started and finished within set timeframes and if they were not then meetings arranged with the Executives and the medical staff to identify why this was not the case. The Chief Executive felt that the messages she was getting seems to imply that there was not the same level of urgency surrounding discharge within the medical community than that exercised the Executive. The Chief Executive advised that there needed to be a revolutionary change and increased awareness in the minds of the medical community in the way they undertake ward rounds such that patients are discharged as quickly as possible and this needed to be tackled from within the medical community.

19 The Committee noted the contents of the Corporate Performance Report.

Financial Position 30 September 2014 (prior to going to Board) – FSC/14/60

20 The Director of Finance and Commercial Development presented the financial position as at 30th September 2014 and reported on the current financial status of the Trust. He advised that the Trust continued to be in line with the CoS rating 2 even though there was a greater reported deficit due in part to a provision for penalties arising from the contract with the CCG. The Director of Finance and Commercial Development ran through the standard part of the Report highlighting variances against the plan. The Committee noted the position as at 30th September 2014.

21 The Chairman asked the Director of Finance and Commercial Development to report on the Forecast Outturn requested by Monitor referred to in section 10 of the Report.

22 The Director of Finance and Commercial Development reported that Monitor had written to all Foundation Trusts on 15th September requesting that, due to the emerging signs of pressures on NHS finances during the current year, all trusts were required to provide Monitor

with a forecast year-end outturn position in respect of: Surplus / deficit (before any impairments); and Capital expenditure (on an accruals basis). To this end an assessment of the forecast outturn had been completed and based on a best case and worst case assessment the outturn ranged from a £3m surplus to £13m deficit. The Director of Finance and Commercial Development reported on the assumptions made in order to report the best and worst case scenarios and advised that in considering the best and worst case range, a view had been taken on what the probable forecast outturn. He explained that the anticipated forecast outturn was a £4m deficit which was based on based on a continuation of contract performance; Commissioners levy fines/penalties that equate to £2m (£2m more than plan); Winter monies received amount to £0.75m (£0.75m less than plan); IM&T Funding received amounts £0.6m (£0.4m less than plan); Cost savings delivered amount to £8.0m (£4.0m less than plan); and Depreciation costs amount to £5.8m (£0.5m less than plan).

23 In respect of the capital expenditure, the Director of Finance and Commercial Development reported that it was still the view that at this stage of the year that the full value of the capital programme would be spent, including the estates rationalisation programme and to support CIP.

24 The Director of Finance and Commercial Development advised that the submission to Monitor required Board approval however due to the timeframes involved in submitting the forecast it would not possible to hold a Board meeting in time and therefore it was appropriate that the Committee approve the revised forecast deficit and capital expenditure in the table below prior to the Monitor submission deadline on 24th October.

Narrative	Plan £m	Forecast £m	Variance £m
Surplus/(Deficit)	(1,500)	(4,000)	(2,500)
Capital Expenditure	9,946	10,377	431

25 The Director of Finance and Commercial Development distributed additional spreadsheets to the Committee for review.

26 With regard to reduced income figure for T&O, Lynne Lobley asked why this was the case noting that T&O had not been performing well for a while. The Chief Operating Officer reported that this was primarily due to the management of the service which was being addressed. Lynne Lobley referred to the issues surrounding training and criticism that had been directed at the service following the visit with Health Education North West. The Chief Operating Officer advised that there were some issues with Junior doctors and Registrars which had been symptomatic of the split site working. He also advised that it was anticipated that planned income would be delivered by the end of the year and that the service would be undertaking a recruitment campaign so that it would be at full complement which would also help support the planned delivery of the service. The Chief Operating Officer advised that meetings have been put in place with the management of the service in order to make the step change necessary to recover the position.

27 Terry Atherton felt there were three issues that needed to be considered by the Committee, the first related to the £8m cost savings; the second related to the continued over spend in pay costs; and three, the assumption that Warrington CCG would continue to accept over performance of the contract to a significant degree. He clarified the third point feeling that if Warrington CCG continued to impose penalties on the Trust then why would they not also

challenge the over performance.

28 With regard to CIP, the Chief Executive responded that the figure of £8m was a realistic assessment of delivery against the schemes identified. She explained that there would be some slippage in time delivery and that some schemes would deliver in the next financial year. She advised that there was no intention not to deliver the schemes at all. It was agreed that a revised schedule of CIP schemes would be provided to the Board so that it could understand the basis of the best/worst case scenarios on delivery.

Action FSC/14/60: The Director of Finance and Commercial Development to present to the Board a revised schedule of CIP schemes that included best/worst case scenarios on delivery

29 With regard to pay costs the Chief Executive advised that unlike last year the Divisions were more accountable and had greater control over their own requirements. This should see a better performance in terms of pay overspend. The Chief Operating Officer advised that where there would be a likely overspend in AED arising from the requirement to deliver the national target. However, this overspend would be offset by the winter monies to be received from DH, so long as the CCG did not put any caveats on it before it was paid over. The Director of Finance and Commercial Development advised that it was understood that the winter monies would be paid directly to the Trust rather than through the CCG as last year. This however had not been confirmed. With regard to the CCG year-end position, The Director of Finance and Commercial Development advised that it was his view that the CCG would seek to at least break even and would not look to achieving the best possible outcome for both the Trust and itself. He therefore agreed that the CCG may well seek to either recover any overspend from increased activity through imposing of all penalties in the contract or seek to address the amount of referrals by GPs.

30 Terry Atherton asked, when the Trust submits its forecast position, whether with the submission the Trust was able to provide caveats around the forecast such as those matters outside the control of the Trust. In response the Deputy Director of Finance advised that all Monitor require was a snapshot of the potential forecast at the end of the year and therefore had not asked for any assumptions to be included in the submission. The Committee discussed the requirements to submit noting that the forecast position was a £4m deficit. The Chairman set out for the record how the £4m deficit was made up:

	£m
FYF budget	(1.5)
increased clinical income	3.1
increased other operating income	0.5
reduced depreciation	0.5
fines and penalties	(2.0)
CIP shortfall	(4.0)
IM&T funding shortfall	(0.4)
other smaller items	(0.2)
revised FYF agreed for Monitor report	(4.0)

31 The Director of Finance and Commercial Development advised that he would be speaking with Monitor before submitting the forecast to make them aware of the worsened position. The

Director of Finance and Commercial Development further advised that the addition of the winter monies would bring the deficit down, however this money would be needed to support winter pressures.

32 The Committee following careful consideration of the proposed forecast position approved the deficit of £4m and capital spend of £10.4m for submission to Monitor by 25th October 2014. Terry Atherton recognising that he and Ian Jones were not members of the Committee and therefore not party to the decision, but being members of the Board of Directors advised that although he had some reservations on the uncertainty of the figure presented, supported the collective view. He did feel that although the Committee was in support of submitting the forecast position to Monitor he felt that the views of the Chairman of the Trust should be obtained before submitted. The Director of Finance and Commercial Development advised that he would be discussing the forecast position with the Chairman before submission.

33 The Chairman thanked Terry Atherton for his comment and felt that the Committee had been able to review the proposed forecast and had opportunity to challenge the basis of the assumptions. He thanked the Director of Finance and Commercial Development and the Executive for their diligence in producing a rational forecast position.

10 Year Capital Plan - FSC/14/61

34 The Chairman asked that the 10 year Capital Plan paper be taken as read.

35 The Director of Finance and Commercial Development explained that this was a great piece of work and contributions had been received across the divisions. The Plan clearly identified that there had been a lack of investment on estates and IM&T over the last 10 years and consequently the Plan was seeking to redress that through massive investments in capital spend in the next few years in order to maintain ongoing operations.

36 The Director of Finance and Commercial Development reported on the proposal to finance the capital spend referring to the financial strategy contained in the paper.

37 The Committee noted the content of the paper and recognised the need to develop a financial strategy in order to deliver the capital requirements of the Trust for the next 10 years.

Contract Performance and Risk Assessment Report – FSC/14/62

38 The Director of Finance and Commercial Development presented the Contract Performance and Risk Assessment Report and advised that the penalties identified in the report were best estimates as the Trust had not received a letter from the CCG setting out their position.

39 The Chief Operating Officer referring the A&E penalties, reported that these would be reduced should it be agreed that the walk in centre figures are allowed to be used in the Trust's 4hr target figures.

40 With regard to the penalties arising from the discharge summaries the Chief Operating Officer advised that actions had been taken by the Divisions to make sure that there was no future exposure, he did however recognise the need to retro-fit discharge summaries since April 2014. The Director of Finance and Commercial Development advised that the CCG's view was that for the first 6 months the discharge penalties incurred by the Trust would be in the region

of £100k per month. He advised that the Trust would be challenging this on the basis that the penalty was grossly disproportionate to the actual offence. The Committee noted this view which it supported.

41 Lynne Lobley recognising the potential impact of penalties on the sustainability of the Trust asked whether the Trust had the necessary expertise to challenge not only the penalties under the current contract but also in protecting the Trust position in negotiating future contracts. The Director of Finance and Commercial Development advised that the Trust had always had the necessary expertise in this area, it was however naivety on behalf of the Trust that the CCG would never impose penalties given previous precedents. He advised however that the Trust had appointed a new contracts manager who had previously working within commissioning.

42 The Chief Executive referring back to the discussion at the start of the meeting on reconciliation letters felt that there needed to be an understanding as to why the Trust did not assess the risks that penalties could be imposed even though precedent dictated otherwise.

43 The Committee noted the Contract Performance and Risk Assessment Report and recognised the actions being taken to minimise the potential penalties and fines arising from the contractual terms.

Business Planning Update - FSC/14/63

44 The Deputy Director of Commercial Development presented the approach for business planning for 2015/16 which the Committee was asked to note. He explained that it provided the Committee with a draft document for discussion regarding the business and planning rules and seeks input from members of the Committee.

45 The Deputy Director of Commercial Development advised that Monitor Guidance on the process and submission dates had not as yet been provided and therefore the timetable could still be amended. The Trust Secretary advised that there was a need to build into the process, engagement with the Council of Governors and membership.

46 The Committee reviewed the paper which was noted.

Commercial Development Update - FSC/14/64

47 The Deputy Director of Commercial Development ran through his presentation on the commercial development in the Trust which was noted.

48 The Chief Executive referred to an initiative that was undertaken by the Trust some 18 months ago which was offering self-funding no frills procedures of limited clinical value called 'Your Choice'. The Director of Finance and Commercial Development advised that this initiative had been looked at and was found not to have financial benefit. He did however feel that this could be looked at again to see if there was any value in proceeding.

49 The Committee discussed other opportunities that could be looked into in developing the services including endoscopy given the closure of the service at the Countess of Chester and rehabilitation.

Review of Committees and Groups – FSC/14/65

Minutes of Meetings:

50 i. ICIC Minutes and Dashboard – August/September 2014
The Chief Executive reported that she was now Chair of the ICIC and provided an update on the work being carried out by the ICIC and Project Management Office. The Committee noted the minutes and dashboard of the ICIC recognising that an action arising from the meeting would be escalated for Board discussion on the forecast position of the delivery of the CIP for 2014/15.

51 ii. Capital Planning Group – August/October 2014
The Committee noted the minutes of the Capital Planning Group, noting that the 10 Year Capital Plan would be presented to its meeting in September and presented to this Committee in October.

52 iii. Lorenzo Project Board – October 2014
The Committee agreed that it would receive updates through the Lorenzo Project Board for the duration of the project and noted the minutes of the Lorenzo Project Board for October 2014.

Any Other Business – FSC/14/66

53 There being no further business the Chair closed the meeting.

Date and time of next meeting

54 Wednesday 19th November 2014 at 1400hrs in the Trust Conference Room, Warrington Hospital

Action List

Finance and Sustainability Committee

Paper Reference	Action	Responsibility & Target Dates
FSC/14/60	The Director of Finance and Commercial Development to present to the Board a revised schedule of CIP schemes that included best/worst case scenarios on delivery	**Action Completed** See Board agenda for 29th October 2014