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WHH

Warrington and
Halton Hospitals
NHS Foundation Trust

WHH Council of Governors

Thursday 20 July 2017
4:00pm – 6:00pm
Trust Conference Room, Burtonwood Wing
Warrington Hospital

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Warrington and Halton Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS (COG)
Thursday 20 July 2017 – 4.00pm to 6.15pm
Trust Conference Room, Warrington Hospital

AGENDA REF. COG/	ITEM	PRESENTER	PURPOSE		TIME
FORMAL BUSINESS					
COG/17/07/26	Opening Remarks & Welcome	Steve McGuirk, Chairman	-	-	4.00
COG/17/07/27	Apologies & Declarations of Interest	Steve McGuirk, Chairman	-	-	
COG/17/07/28 *Page 3 + 9*	Minutes of Previous meeting - 6 April 2017 and action log	Steve McGuirk	Approval	Enc	
PART 1	**GOVERNOR BUSINESS**				
COG/17/07/29	Lead Governor Update	Lead Governor – Anne Robinson, Public Governor to represent	Verbal	-	4.10
COG/17/07/30	Annual Appraisal of Trust Chairman following NARC on 26 June 2017 *(Chairman to leave room)*	Lead Governor – Keith Bland, Public Governor to represent	Approval	-	4.20
COG/17/07/31	Recommendations following NARC on 26 June 2017 • Extension of terms of office - NEDs • NED Pay Review	Lead Governor – Keith Bland, Public Governor to represent	Approval	-	4:35
PART 2	**TRUST BUSINESS**				
COG/17/07/32 *Page 10* *Page 12*	Chief Executive Update: - STP Briefing - Integrated Performance Dashboard	Mel Pickup, Chief Executive	Information Assurance	- Enc.	5.00
COG/17/07/33	Chairman's Update	Steve McGuirk, Chairman	Information	-	5.20
COG/17/07/34 *Page 41*	Annual Reports and Accounts 2016-17 *(attached separately)* including • Auditors letter and Report on Quality Account *(within Annual Report)*	Pat McLaren Director of CE&CA	Assurance	Enc.	5.30
PART 3	**GOVERNANCE**				
COG/17/07/35 *Page 42*	Elections Activity Bi-Annual Report : Vacancies & Governors Terms of Office	Pat McLaren Director of CE &CA	Assurance	Enc.	5.40
COG/17/07/36 *Page 46*	Compliance Trust Provider Licence (bi-annually)	Pat McLaren Director of CE &CA	Assurance	Enc.	5.45
COG/17/07/37 *Page 66*	Changes to the Constitution – - Addition of Lead Governor - Amendment to Public Constituency - Register of Members – compliance with forthcoming data protection regulations	Pat McLaren Director of CE &CA *(proposer / seconder required)*	Approval	Enc.	5.50
COG/17/07/38 *Page 72*	Proposal to change the Trust's Name *(proposer / seconder required)*	Pat McLaren Director of CE &CA	Approval	Enc.	6.00
COG/17/07/39 *Page 76*	Chairs Annual Audit Committee Report	Steve McGuirk, Chairman	Assurance	Enc.	6.05
CLOSING ITEMS					
COG/17/07/40	Any Other Business	Steve McGuirk, Chairman		-	6.10

DATE OF NEXT MEETING:
Thursday 19 October 2017 4pm-6.15pm, Trust Conference Room, Burtonwood Wing, Warrington Hospital

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COG/17/07/28

COUNCIL OF GOVERNORS
Draft Minutes of the Meeting held on Thursday 6 April 2017
4.00pm to 6.00pm, Education Centre, Halton Hospital

Present:

Steve McGuirk	Chairman (Chair)
Keith Bland MBE	Public Governor
Alf Clemo	Public Governor
Peter Harvey	Public Governor
Norman Holding	Public Governor
Alison Kinross	Public Governor
Peter Lloyd Jones	Partner Governor
Mel Pickup	Chief Executive
Anne Robinson	Public Governor
Louise Spence	Staff Governor
Mark Ashton	Staff Governor

In Attendance:

Terry Atherton	Non-Executive Director
Margaret Bamforth	Non-Executive Director
Andrea Chadwick	Director of Finance
Michelle Cloney	Interim Director of HR & OD
Simon Constable	Medical Director + Deputy Chief Executive
Alex Crowe	Deputy Medical Director
Ian Jones	Non-Executive Director
Jan Ross	Deputy Chief Operating Officer
Kimberley-Salmon-Jamieson	Chief Nurse
Thom Stokes	WRAG Commissioning Lead,WCCG
John Wharton	Lead Nurse WCCG
Ipsita Chatterjee	Clinical Nurse Lead, WCCG
Lesley Johnson	Warrington CCG
Peter Fink	Clinical Lead Triage, WCCG
Ian Cooper	Software Company
Malcolm Tyrer	GP Clinical Triage, Surgical Specialist + PLCP Lead WCCG
Julie Burke	Secretary to the Trust Board

Apologies:

Pat McLaren	Director of Community Engagement
Sue Kennedy	Public Governor
Mike Brownsell	Partner Governor
Lucy Gardner	Director of Transformation
Sharon Gilligan	Chief Operating Officer
Jim Henderson	Public Governor
Colin McKenzie	Public Governor
Jeanette Scott	Public Governor
Anita Wainwright	Non-Executive Director
Roger Wilson	Director of HR & OD
Pat Wright	Partner Governor

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COG17/04 /04 + 16 — Welcome, Apologies & Introductions

The Chairman welcomed all Governors', Staff, and Non-Executive Directors and colleagues from Warrington CCG, to the Council of Governors meeting.
Apologies - See above listing.

Declarations of Interest – in agenda items
There were no interests declared in relation to the agenda items for the meeting.

COG/17/04/15 — Warrington Referral Assistance Gateway (WRAG)

SMcG welcomed colleagues from Warrington CCG who presented a brief over of the WRAG.

- Priorities are improved outcomes for patients and standardisation of best practice, and processes and use of e-referrals.
- Improved quality of GP referral documentation.
- An anonymised patient journey was relayed to the CoG to highlight the delays experienced in the referral pathway and subsequent diagnosis.
- Professionals from a number of service areas form part of triage team including specialists, GPwSIs, secondary care consultants who are able to change referrals when triaged to ensure the patient is referred on the correct pathway.
- System is based on Integrated Care Gateway in Manchester and similar systems are in place across Cheshire and Merseyside, ie Halton, St Helens, Knowsley. Used across the wider STP footprint could potentially realise further savings.
- The system allows for scans and other documentation to be attached to the referral. Clinical triage takes place within48 hours by GPwSI.
- Booking team contact the patient to book an appointment through Choose and Book.
- 14 day window, if the patient cannot be contacted or the patient does not contact WRAG, an appointment will be sent out. If this appointment is not convenient, it can be changed.
- There is some variability in time from GP referral to the appointment which should be eradicated using this system.
- In response to governance reporting questions raised by the Chair, CEO and DoF, the CoG were advised that outcomes of the system, both financially and quality experience, are monitored and reported through the Warrington CCG Finance and Performance Committee, all this information is available to the public and informs the CCG commissioning intentions.
- **BES** quality premium as part of referral will be through WRAG and be allocated against QIPP targets.
- CCG colleagues were unable to confirm the cost when asked by the CEO but advised that since go live of the triage element in November 2015, savings had been identified through this process.
- AC recognised that WRAG is clinically driven, the WRAG will identify savings for the CCG but this will result in patients not coming into secondary care for treatment. AC had met with the CCG and as part of contract negotiations and will look at WRAG plans to identify where the expectations of savings are and when it can be closed off so that financial risk is not bourne by one organisation and to develop and a risk share and partnership agreement.
- There was a suggestion to convene an additional session in 3-6 months time if required.

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COG 17/04/17 — Minutes of Previous Meeting 19 January 2017

Page 6, last sentence - to read Cash balance of £1.2m in line within minimum requirement.
Page 7, 3rd sentence – to read The Trust deficit loan for 2016-17 is £7.9m.

With these amendments, the minutes of the meeting held on 19 January2017 were approved as a true and accurate record.
Actions/matters arising

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COG 17/04/18 Appointment of NED

The Governors Nominations and Remuneration Committee (GNARC) had approved the appointment of TW as Non-Executive Director. Regrettably, due to illness TW had withdrawn.

A GNARC was convened on 23 March 2017 to consider, review and recommend the appointment of Professor Jean-Noel Ezinguerd who had been selected from the panel of 4 candidates who went through the full assessment centre and interview process on 9 January 2017 and had performed strongly during this process. The Trust's Non-Executive Directors had met with JN on 3 March and are convinced of his suitability as well as adding a contributory skill set not wholly represented currently. Following the GNARC on 23 March 2017, the appointment of candidate JNE was approved for recommendation to appointment to the Council of Governors on 7 April.

The Council of Governors approved the appointment of J N Ezinguerd to the role of Non-Executive Director.

COG 17/04/19 Chairman's Briefing

The Chairman provided an update since the last Council of Governors:

- STP - A further revised plan is being developed as part of the Sustainability Transformation Plans (STP) across Cheshire and Merseyside. The CEO, Medical Director and Director of Finance are leading on particular work streams across the STP in partnership with a number of organisations to develop long term, sustainable health services. These include back office functions such as procurement, HR and payroll in addition to pharmacy and other specialist areas.
- Well Led Review – positive feedback received from Deloitte following the recent review, with particular recognition to the Executives in the current challenging climate. Final draft report awaited. The Chairman echoed these sentiments within the draft report.
- PLJ referred to potential opportunities to 'ear-mark' and 'protect' land within the borough for a health facility in the future. SMcG added that the CEO had met with Warrington Borough Council CEO, who had subsequently visited Warrington to see first hand the condition of the current estate which would support any future discussion regarding the feasibility of a new health care facility for the borough of Warrington.

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COG/17/04/20 Chief Executive's Report

The CEO provided an update since the last Council of Governors:

- The CEO of Warrington Borough Council (SB) had visited a number of departments across Warrington Hospital site with MP. He had concurred with comments made by MP at the recent Overview and Scrutiny Committee regarding the current condition of some of the hospital estate and that it would not necessarily fit or meet the requirements for future modern health services. He agreed to support discussions when they commence regarding the potential for a new hospital site for Warrington.
- MP had had a positive meeting with H Jones MP following recent media activity. HJ had agreed that there is a need to look at facilities out of which health care services are provided in Warrington in the future. HJ supported the view that the current facilities are not sufficient to meet the health needs of a growing population but asked that there would be an open and transparent debate, supported with a full consultation when discussing future location proposals.
- The recent CQC inspection had seen 53 inspectors on site over a 3 day period, commencing 7 March. CQC had provided initial observations and verbal feedback on Friday 10 March reporting that noticeable change had been noted since the last inspection, there had been a high level of engagement from staff, a change of culture had been evident and the inspection team had been warmly welcomed into the Trust by staff

who had been honest and transparent in conversations. The inspectors had noted the significant improvement within Maternity Services, culminating in the Maternity Team winning a national award from the Royal College of Midwives.
- A successful annual staff awards ceremony had taken place where the Maternity Team received the Team of The Year Award.
- The Chair, Baroness Cumberledge and Vice Chair of the National Maternity Review team visited the Trust whilst CQC were on-site, providing further recognition of the transformation and achievement of the Maternity Unit.
- Significant challenges to meet performance trajectories especially in A&E. Improvement set trajectory by NHSI of 90% achieved overall at year end for the first time in 18 months.
- The CEO thanked the Deputy COO and all the team for the efforts to achieve this. The Five Year Forward View (5YFV) is now 2.5 years into its programme and the CEO had attended the national launch of A&E Improvement where priorities for the remaining 2.5 years of the 5YFV where shared by the CEO of NHSE. WHH were identified as the most improved Trust nationally to achieve A&E performance standards.

COG 17/04/21	**Integrated Performance Report**	

The Chief Nurse highlighted key points for the Council to note relating to Quality indicators:
- Governors Quality in Care meeting had met on 27 February and had reviewed the quality Dashboard in detail.
- Work plans for Falls Prevention and Falls Improvement Plan developed and will be monitored through the QiC and Quality Committee.
- In depth falls analysis to be completed following occurrences of 9 fracture neck of femurs and the recent appointment of Falls Nurse specialist will support this agenda.
- In depth Tissue Viability review undertaken and improvement plan in place including assessment of beds and mattresses in use.
- 2 surgical never events recorded and a full review is underway.
- Governors Quality in Care meeting had prioritised safer surgery as a trust priority and had been included in the Quality Accounts for 2017-18.

The Deputy Chief Operating Officer highlighted key points for the Council to note relating to Performance indicators:
- Access and performance standards throughout the year where challenging but the Trust had meet set standards.
- Significant challenges relating to the 4 hour wait standard which had been sustained to December. January and February provided further challenge due to a number of factors including winter pressures with the Trust achieving 85%. In March Improvement trajectory of 90% set by NHSI was achieved with year to date performance at 90%.
- Challenges relating to Ambulance Turnaround experienced due to pressures within A&E which are intrinsically linked and impact on patient flow through the hospital.

The Director of Finance and Commercial Development highlighted key points for the Council to note relating to financial indicators:
- The trust is on track to deliver its deficit budget of £8.8m against a planned deficit budget of £8.9m.
- Maintaining cash position is monitored on a daily basis.
- If £7.9m control total deficit is achieved, and other financial targets achieved, the Trust will be eligible for a share of STP funds in April 2017. Thanks were extended to the finance team and other trust colleagues to achieve this financial position in a challenging financial climate.

The Interim Director of HR& OD highlighted key points for the Council to note relating to HR indicators:

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	- Significant improvement relating to completion of PDRs across the Trust reflecting engagement of staff and teams working together to support staff. - Sickness absence and attendance management policy will support staff and the reduction in agency and recruitment spend. - Measures and safeguards in place to manage agency spend, including specialist medical and nursing spend. Current figures correlate with the pressures experienced to manage winter pressures and the need to open escalation wards and additional capacity. - Staff turnover – performance indicator not achieved but lots of work on-going to support this agenda, including information taken exit interviews, on-boarding when staff are appointed to maximise opportunities for retaining staff which will reduce reliance on agency and temporary staff. - IR35 – new legislation regarding IR35 and tax implications for the self employed. The Trust had received some requests from agency staff to ask if staffing would increase but the Trust are working with organisations across the health economy to ensure that rates are held at the appropriate level. The Trust uses agencies selected from an approved framework and agency spend is scrutinised and monitored by NHSI with the Trust submitting weekly reports. MC, JR, KSJ and PLJ left the meeting at this point.	
COG 17/04/	**Trust Operational Plan**	
	The Director of Finance and Commercial Development highlighted key points for the Governors to note: - The planning cycle for 2017-18 had been brought forward and the Trust was required to submit a two year plan for 2017-18 and 2018-19. - The plan had been reviewed and approved by the Finance and Sustainability Committee on 20 December 2016 and the Trust Board on 22 December 2016. The plan was submitted to NHSI Improvement on 23 December 2016. - The deficit control total within the plan for 2017-18 is £3.657m and £0.916m in 2018-19 with the Cost Improvement Plan (CIP) of £10.5m. **The Council of Governors noted the report.**	
COG 17/04/23	**Reports from Governor Sub-Committees**	
	The Governors were asked to note the agenda and minutes of the Governors Quality in Care Group (QIC) held 27 February and the Governors Engagement Group (GEG) held 23 February 2017. - Governor observation visits are continuing which support the Front Line Visits carried out by the Board to ensure triangulation of information. - Dates proposed for the Annual Members Meeting in September. **Dates to be confirmed by P McLaren.** **The Council of Governors noted the reports.**	
COG 17/04/24	**Proposal to reschedule Governors Quality In Care**	
	PMcL had proposed to reschedule the date of the October Quality in Care Group to **19 October 2-4pm from 3 October 2017** to enable the Chair, MB, to be present. **The rescheduled date was supported. JB to communicate.**	
COG 17/4/25	**Annual Appraisal of Non-Executive Directors -plan**	
	SMcG summarised the process for the Chairman's Annual Appraisal process which will commence in May, as follows: a. A questionnaire will be sent to all Governors and Board Members to be completed on a non-attributable basis – there will be an online survey or paper version for you to choose from. b. A report will be prepared for the Governors' Nomination and Remuneration Committee to	

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	consider- this will be supported by the Senior Independent Director (Ian Jones) and the lead governor (Norman Holding). A date will be circulated shortly but will be early June. We require a minimum of 2 public governors, 1 staff governor and 1 partner governor to convene the GNARC. c. The Chairman's appraisal will be received at the COG at the 20th July meeting – the Lead Governor will present this item.	
COG 17/01/14	**Any Other Business**	
	Post meeting note, Annual Members meeting confirmed Tuesday 12 September 4pm, Halton Hospital AClemo had asked the Chair for the possibility of a Q&A session at Board to allow questions to be asked. SMcG commented that due to the number of business items that the Board have to consider, the CoG meeting and Chairman's briefing are the best forums to provide an opportunity for open debate within provider Trusts. **Date of next meeting: Thursday 20 July, 4pm, Warrington Hospital**	

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COUNCIL OF GOVERNORS ACTION LOG

AGENDA REFERENCE:	CoG/17/07/28	SUBJECT:	COUNCIL OF GOVERNORS ACTION LOG	DATE OF MEETING	20 July 2017

1. ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress report	RAG Status
COG/17/04	**6 April 2017**	**WRAG presentation**	Further session to planned for 3-6 months	**P McLaren**				

3. ACTIONS CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress report	RAG Status
COG/17/04/23	**6 April2017**	**Reports from Governor Sub Committees**	Date for the Annual Members Meeting to be confirmed.	**P McLaren**	**ASAP**		**Confirmed as 12 September 2017**	

4. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

RAG Key

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

By email: all NHS Providers member chairs

17 May 2017

Dear colleague,

Governor involvement in sustainability and transformation plans

You may be aware that, in addition to our work supporting the leadership of NHS provider organisations, we also support the work of councils of governors. We recently held a conference for approximately 200 governors from around the country.

As you will know, governors play a crucial role in service change, both through their statutory duties and by representing and engaging with the local community about proposed changes. For this reason, one of the main items for debate at our Governor Focus conference was the governor role in Sustainability and Transformation Partnerships (STPs). Formal presentations were followed by a vibrant round table discussion. We committed to sharing the key themes that arose during the discussions with trust chairs and STP leaders across the country. These themes have been summarised below and should assist STP footprints during the development and implementation of plans.

Ongoing engagement and meaningful engagement with governors
Governors expressed a wish to play an appropriate role within their trust and their footprint to support the implementation of changes needed at a local level. Central to this will be that governors are well informed, particularly, but not exclusively about the proposed role for their own trust in delivering its part of the local plan. Governors want to have the opportunity to debate what is proposed for their area and to feed back their views. To support this, a standing item on the council of governor meeting agendas would be helpful. We also understand that in some trusts a sub-group of governors come together on a regular basis to discuss strategic projects and are kept informed about the detail of their local STP. This is in addition to keeping the council informed about the overall direction of travel.

Clarity around governors' role in STPs, beyond their statutory duties
While there will be some acquisitions and significant transactions being proposed, much of what is proposed by STPs will fall below the significant transaction threshold. Notwithstanding this, governors are keen to exercise their statutory duty to represent the interests of members of the foundation trust and of the public. They are therefore keen to understand what their local communities want from the NHS, to have the opportunity to feedback and to have their views taken into account. This will be extremely helpful when STPs are ready to engage and involve the public, both informally and through formal consultations, as governors can play a unique role in acting as a conduit between the trust and the local community.

Bringing governors together across each footprint
Governors are keen to work together with other governors and shadow governors across the footprint of their STP so that they are better equipped both to reflect the views of the public across communities and to hold their own boards locally to account. Governors are keen to identify what works well elsewhere and to engage with and learn from those who use NHS services across their local area.

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Forging links with other bodies
While governors play a key role of working within NHS foundation trusts to hold their boards to account, they acknowledge the role played by external bodies such as patient groups and HealthWatch. They will be looking for the opportunity to form links with local organisations and will be looking for a structured way in which to do that.

We hope that this information is helpful. If you would like any further information on the role of governors, or need any support in implementing any of these suggestions, please do get in touch. We are also always keen to hear of interesting local practice and we would welcome examples of how governors are engaging in the development and implementation of your STP, so that we can share good practice across the country. I look forward to hearing from you.

Yours sincerely,

Chris Hopson, Chief Executive

Gill Morgan, Chair

cc: All STP leads
Simon Stevens, chief executive, NHS England
Jim Mackey, chief executive, NHS Improvement

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/06/72 a**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	28th June 2017
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Jan Ross – Chief Operating Officer (interim) Michelle Cloney – Director of Human Resources & Organisational Development (interim) Andrea Chadwick - Director of Finance & Commercial Development Simon Constable – Medical Director Lucy Gardner – Director of Transformation
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	This month there has been a significant shift in indicators moving from white, (not rag rated) to red and green. In April there were a number of indicators (22) that were shown as white as they were not yet rag rated; this was due to some awaiting validation. Following validation white indicators have now decreased to 9 in May. All indicators that remain white are under review and awaiting RAG parameters. The relevant subcommittee will make a future proposal to the Board once RAG parameters have been agreed.

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	As a result of data validation green indicators increased from 21 in April to 28 in May which is attributed to the achievement of the Trust's Cancer targets, with the exception of the 14 Day Breast Symptomatic target which remains red. Red indicators increased from 13 in April to 18 in May which is partially attributed to a deterioration in performance in the following areas: • Agency Medical Spend • Financial position is £0.5m below plan in May with a deficit of £2.7m versus plan of £2.2m deficit • VTE The Ambulance Handovers 30 and 60 min indicators also moved from white (not validated) in April to red in May due to non-achievement of both targets; however in month the position has improved. The number of amber indicators increased from 7 to 8 in May as a result of the Sickness Absence indicator deteriorating from green to amber as performance slipped from 4.16% in April to 4.32% in May. This decline must be addressed with immediate effect to prevent the position worsening and to achieve the 4.2% Trust target.
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.

PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Integrated Performance Dashboard	**AGENDA REF:**	

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1. BACKGROUND/CONTEXT

The Integrated Performance Dashboard has been produced to provide the Board with assurance in relation to the delivery of all KPI's across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

The Trust Board approved 57 indicators for the 17/18 dashboard. This has increased to 63 because the Sepsis CQUIN KPI has been split in to 5 indicators, the Cancelled Operations on the Day KPI has been split in to 2 indicators and the Staffing Average Care Hours has an additional indicator for Staffing Average Fill Rate, all of which provide additional detail.

In month there has been a movement in the rag ratings of a number of indicators:

- White indicators have reduced from 22 in April to 9 in May.
- Green indicators have increased from 21 in April to 28 in May.
- Amber indicators have increased from 7 in May to 8 in April.
- Red indicators have increased from 13 in April to 18 in May.

Quality

Quality KPIs

There are 4 Quality indicators rated red, an increase of 1 in month (the indicator was not validated in April). The 4 are:

1. Duty of Candour (DOC) – of the 16 "moderate harm" incidents where DOC applies, 25% of those were completed within the 10 working days target.
2. VTE – the Trust achieved 94.10% in May against a target of 95%
3. Nice Compliance – the Trust achieved 56.13% in May against a target of 75%
4. Mixed Sex Accommodation (MSA) – there is a national zero tolerance approach to MSA breaches. There have been 3 MSA breaches in month.

There are 2 Quality indicators rated amber in month. The amber indicators are:

1. Staffing Average Fill Rate – The Trust target is 90% with registered nurse/midwives in the day below target at 87.33%, however responsive plans are in place to ensure the delivery of safe patient care.
2. Sepsis Inpatient Screening – the target is measured quarterly.

Access and Performance KPIs

There are 7 Access and Performance indicators rated red, an increase of 2 in month. The 2 additional indicators relate to Ambulance Handovers 30-60 and Over 60 minutes. Both of these indicators were not validated in April due to the Cyber-attack. The 7 indicators are:

1. A&E Waiting Times 4 Hour 95% National Target – the Trust achieved 92.79% in month which is an improvement on April 91.41% and above the STP trajectory 90.5%.
2. Breast Symptomatic 14 Days – the Trust achieved 88.16% in month against a target of 93%. This was an improvement on April performance 79.59%.
3. Ambulance Handovers 30 Minutes – The Trust has seen an improvement in the number of delayed handovers between 30 and 60 minutes from 163 in April reducing to 126 in May.
4. Ambulance Handovers 60 Minutes - The Trust has seen an improvement in the number of delayed handovers over 60 minutes from 49 in April reducing to 18 in May.
5. Discharge Summaries % Sent Within 24 Hours – the Trust has failed to achieve the target of 95% reporting performance for May at 87.93%. A remedial action plan has been put in place to improve performance.
6. Total Number of Cancelled Operations on the Day (for non-clinical reason). The Trust has a zero tolerance approach to breaches. There were 22 breaches reported for the Trust in April and again in May. An action plan is now in place to reduce the occurrence of breaches and will be monitored via this report.
7. Total Number of Cancelled Operations on the Day (for non-clinical reason) not offered a date for readmissions within 28 days – there is a national zero tolerance approach to this target. The Trust has had 1 breach in month. Route cause analysis is being carried out to identify why this breach occurred and lessons learnt to prevent future breaches.

People

Workforce KPIs

There are 3 Workforce indicators rated red, an increase of 1 in month. The 3 indicators are:

1. Agency Medical Spend – performance against this indicator has deteriorated in month from green to red. The Trust's spend in May is £403k, £52k higher than the same period last year.
2. Recruitment – the time taken to recruit has increased to 78.8 days in May from 73.7 days in April, against a Trust target of 65 days.
3. Turnover – the Trust has a target of 7-10%. In May, Trust performance deteriorated to 13.29%. A number of measures have been put in place to reduce turnover which have resulted in a marginal improvement from 13.37% in April.

There are 3 Workforce indicators rated amber in month, compared to 2 in April. The 3 indicators are:

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1. Sickness Absence – performance against this indicator has deteriorated in month from green to amber. The Trust's sickness absence in May is 4.32% against a target of 4.2%.
2. Return to Work Interviews (RTW) – the Trust achieved 82.35% in month against a target of 85% this was a decrease in performance from 85% in April. The timing of recording RTW interviews on the system is under review to ensure compliance against the time frame as failure to comply will impact on actual monthly performance.
3. PDR Compliance – performance has been steadily deteriorating since March. The Trust's target of 85% has not been met this financial year and performance has dipped further in month to 78.47%.

Sustainability

Finance Sustainability KPIs

There are 4 Finance Sustainability indicators rated red, an increase of 1 in month. The 4 indicators are:

1. Financial Position - performance against this indicator has deteriorated in month from amber to red. The financial positon is showing an adverse variance from plan. The plan was a deficit of £2.2m; however the actual position is a deficit of £2.7m. This poses a significant risk to the Trust's cash position. Remedial action plans have been requested from each division to be presented at the Finance and Sustainability Committee in July.
2. Cash – continues to be a challenge and is under daily monitoring and management.
3. Better Payment Practice compliance – continues to under perform with year to date 36% against a 95% target due to the cash challenges
4. Agency Spending – has exceeded the NHS Improvement threshold of £1.7m with £1.9m year to date of which £1.1m relates to May. Plans to reduce spending on this expensive resource are required to support financial delivery.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

KPI's that are underperforming will be managed through the Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:-

- Finance and Sustainability Committee
- Audit Committee
- Quality Committee
- Strategic People Committee

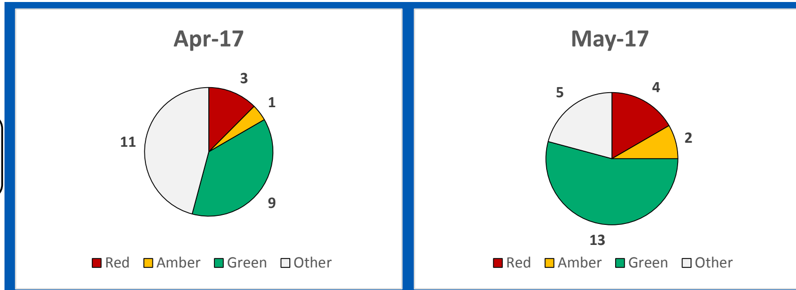
5. RECOMMENDATIONS

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

Integrated Dashboard - Board of Directors - May 2017

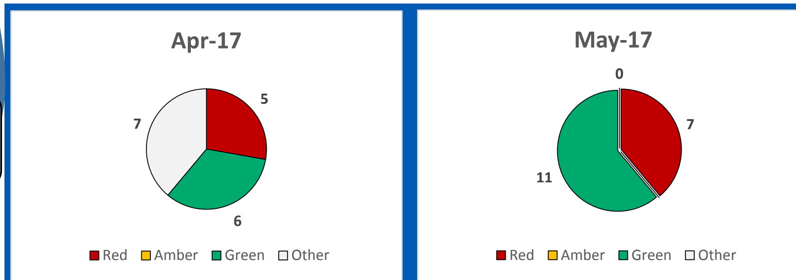
Key Points/Actions

Quality Improvement



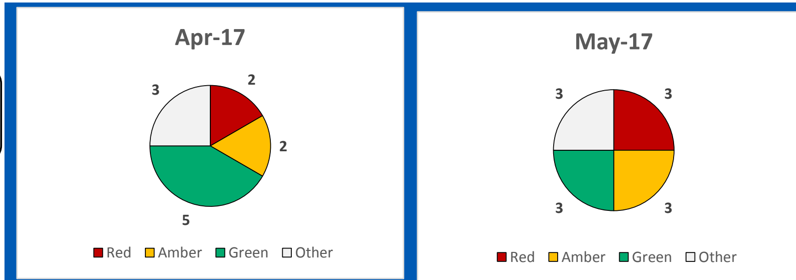
The Trust continues to have no cases of MRSA, 1 case of MSSA and reported 3 cases of C-Diff in May; this will be reviewed by the CCG. Our HSMR continues a downward trend. There continues to be a focus on DoC for moderate harm incidents. From week commencing 19/6, this will be monitored at the weekly Serious Incident Meeting. In relation to Safety Thermometer the overall harm free care percentage is well above the target percentage. Sepsis data has shown continued improvement. All areas monitored in relation to Sepsis achieved or exceeded the target of 90% for May. There was 1 grade 3 pressure ulcer and seven grade 2 pressure ulcers in month, for which a root cause analysis is underway for each one. There were 2 serious incidents reported in month related to falls. There were 12 controlled drugs incidents in month, a breakdown of which has been provided to the Divisions for comment. The Trust met the Friends and Family targets; work is continuing to increase response rates. The Trust continues to implement the complaints improvement plan; figures show a reduction in the number of cases in backlog and those over 6 months old

Access & Performance



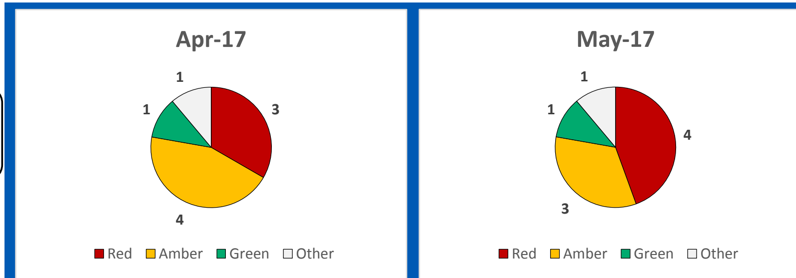
All performance indicators and targets were met for May, with the exception of Ambulance turnaround times and discharges summaries within 24 hours.
The Trust did not achieve the 95% four hour standard however did over achieve against the NHSI improvement trajectory of 90.5% by achieving 92.29%. Ambulance handover times remain a challenge we have made some improvements and the Emergency departments continue to work closely with NWAS and ECIP to support further improvements.

Workforce



There have been changes to the status of two of the metrics i.e., Sickness Absence which has changed from Green to Amber and Agency Medical Spend which has changed from Green to Red. The sickness rate has slightly increased from the previous month and is now Amber. RTW rates have fallen in month and are below the target of 85% but this could be a timing issue for recording. Turnover rates have slightly decreased and are still showing Red. Recruitment times have slightly increased, but for the time taken from shortlisting to interview, this has fallen. The status remains red. Non contracted pay remains a concern. However, nurse agency expenditure decreased in month and is Green, although medical agency expenditure increased and is now red. Mandatory Training rates have remained stable and are Green. PDR rates have fallen again and are remain at Amber. The position of 'high cost agency workers' and 'long term agency usage' has been updated.

Finance



In the month the Trust recorded a deficit of £0.9m which increases the year to date deficit to £2.7m, which is £0.5m below the planned £2.2m deficit. Year to date income is £0.1 below plan, expenses are £0.4m above plan and non operating expenses are in line with plan. The year to date capital spend is £0.9m which is £0.1m below the planned capital spend of £1.0m. Due to the historic and current operating position the cash balance remains low and as at 31st May the cash balance is £1.2m which is £0.7m below the planned cash balance of £1.9m. However under the terms and conditions of the working capital loan the Trust is required to have a cash balance equivalent to 2 operational days (which equates to £1.2m) at some point during the month. The year to date performance against the Better Payment Practice Code is 36% which is 59% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating.

Integrated Dashboard - Board of Directors - May 2017

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation

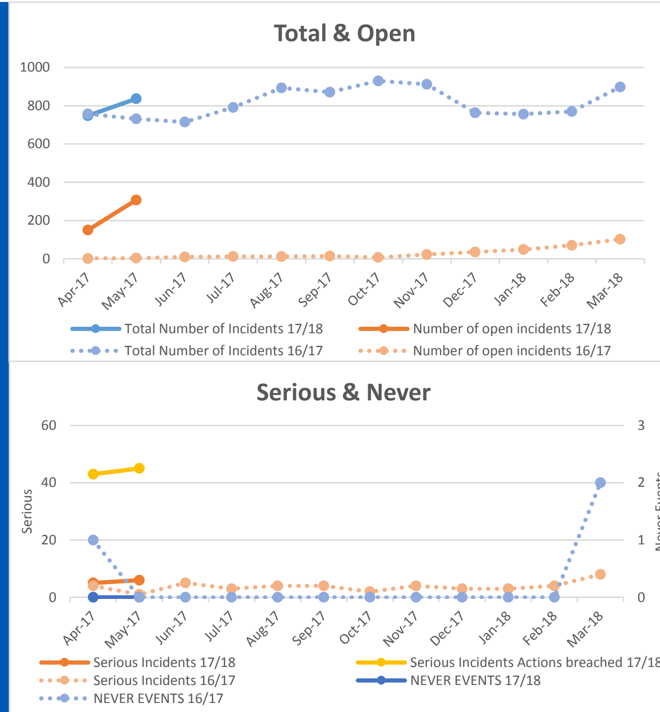
Patient Safety

Incidents

Red: 1 or more Never Events
Green: Zero Never Events

Total number of incidents received during the month. Total number of Serious Incidents (SIs) received during the month. Never Events are serious, largely preventable patient safety incidents that should not occur. SI actions breached are the actions from closed serious incidents that are now overdue. Number of open incidents is the total number of incidents that we have awaiting review.

The target for Never Events is a zero tolerance.



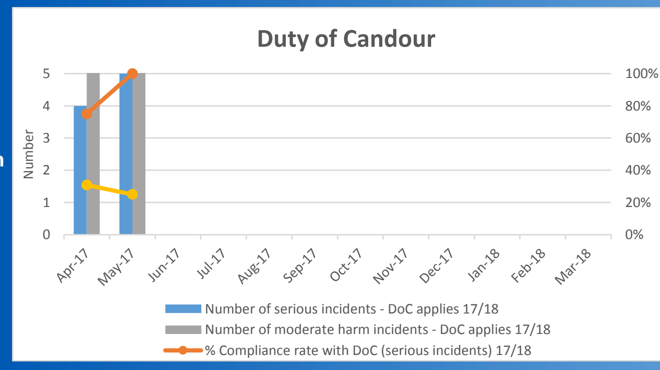
There are currently 45 overall breached actions in relation to Serious Incidents and 308 open incidents. The Divisions are asked to review this data at their Divisional Bi-lateral meetings to set improvement trajectories. Of the 837 Incidents received in May 2017 we received 464 for Acute Care Services, 309 for Surgery and Women & Children's and 64 for Corporate Services.

Duty of Candour

Red: <100%
Green: 100%

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days.

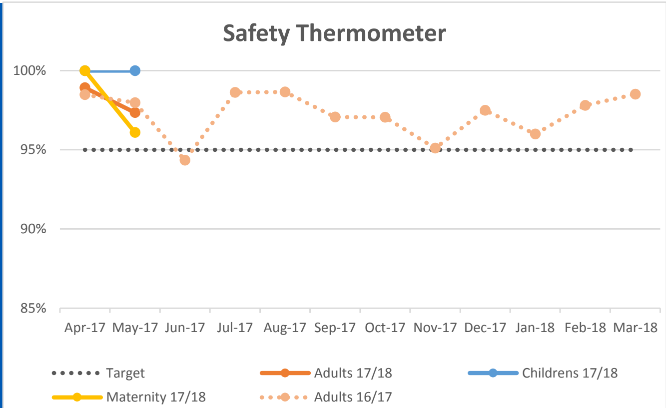
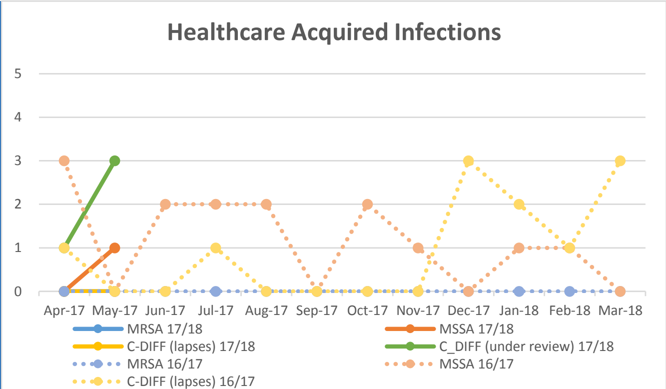
Duty of Candour has to be completed within 10 working days.



Whilst there is recognised increased performance for serious incidents relating to Duty of Candour, moderate incidents remain a focus of work and improvement. From week commencing 19/6, this will be monitored at the weekly Serious Incident Meeting. Of the 5 Serious Incidents where Duty of Candour applied May 2017; 3 for Acute Care Services, 2 for Surgery and Women & Children's and 0 for Corporate Services.

Integrated Dashboard - Board of Directors - May 2017

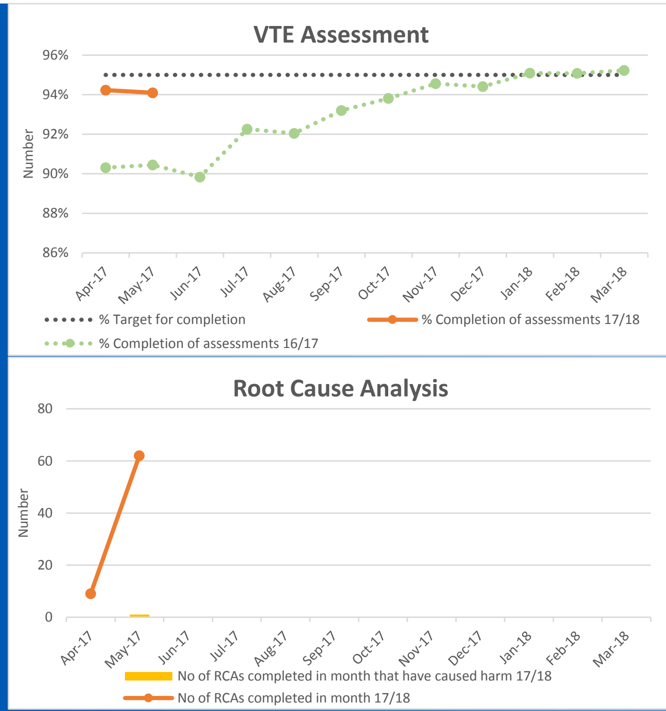
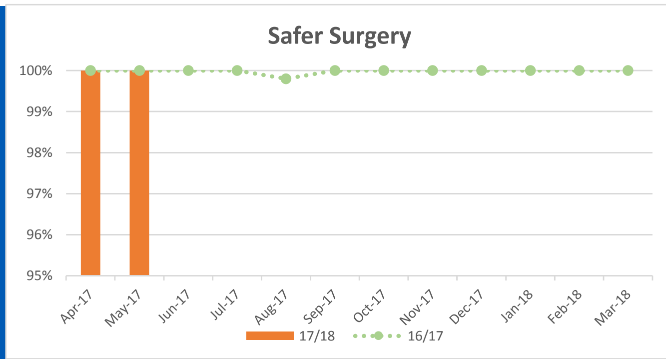
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more	**Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.**	**The target for all areas is to achieve over 95%**		**The overall Harm free care % is well above the target of 95%; areas where harm was caused in Maternity related to 1 incident in each of the following areas; Proportion of women that had a PPH of more than 1000mls, Proportion of term babies born with an Apgar of less than 6 at 5 minutes and Proportion of mother and baby separation. At the time of producing the dashboard we are awaiting further information in relation to the areas of harm caused in the Adult Thermometer.**
Healthcare Acquired Infections MRSA Red: More than 5 Amber: 1 to 5 Green: 0 C-Difficile Red: More than 2 Amber: 1 to 2 Green: 0	**Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.**	**MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficile (c-diff) due to lapses in care; agreed threshold is <=27 cases per year.**		**E-Coli will be added following confirmation of PHE improvement targets.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - May 2017

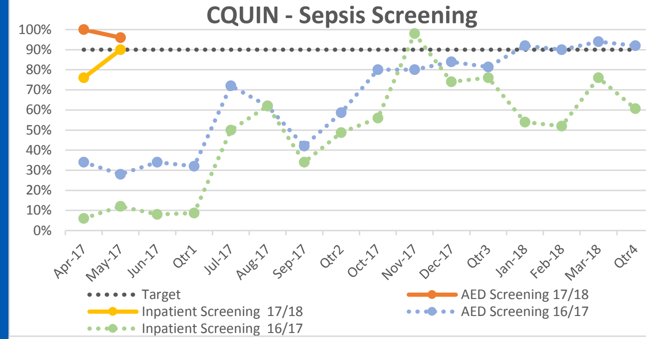
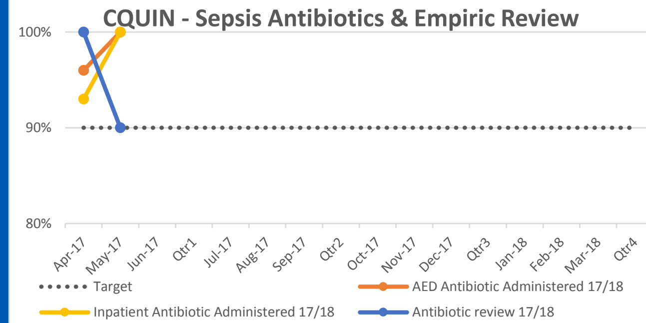
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
VTE Assessment Red: <95% Green >=95%	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. The Trust achieved 95.09% in January, 95.08% in February and 95.23% in March following manual validation of patient level records and data. Technical issues with Lorenzo are being worked through with the relevant teams to ensure accurate VTE data going forward. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/15, 16/17 (risk assessed by harm and occurrence of PE). A revised process has been put in place for April 17 onwards. This has been communicated to Divisions.		The VTE risk assessment process has been updated in April 2017. There has been a backlog of RCAs for completion with regard to patients who should have had a VTE risk assessment. There is a programme to undertake these RCAs and clear the backlog of 16/17 and 17/18. At the time of writing this report, this backlog stands at 35 cases. There has been a new process put in place going forward. For April 17 there are 9 patients who did not have a VTE assessment, which require an RCA to be completed, and for May 17 there are 7 patients identified for RCA.
Safer Surgery Red: <100% Green: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.	The target is to achieve 100%.		Of the Safe Surgery checklists we have continued to see 100% within this area. However, recent feedback from our external auditors, as part of the Quality Account reporting, has queried this data in a small number of cases. The Division need to consider increasing the overall number of cases reviewed per month. This is currently being reviewed and a further update will be provided to the next dashboard.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - May 2017

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	**Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.**	**Targets to be agreed with Commissioners and reported to May 2017 Board.**	 	**The ongoing work by the Sepsis nurse team is clearly demonstrating positive achievements. In April 17 we achieved in all areas apart from the % of patients screened for sepsis in an inpatient setting. However, in May 2017 the Sepsis Team, working closely with the Divisions, have improved this % and have now achieved the target of 90%.**

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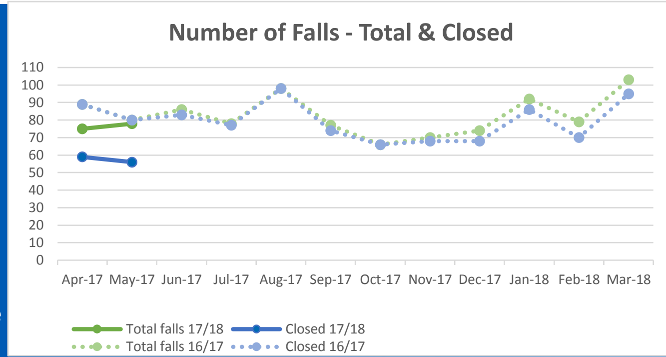
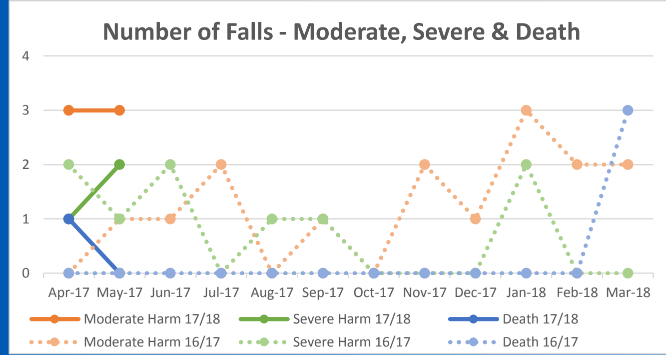
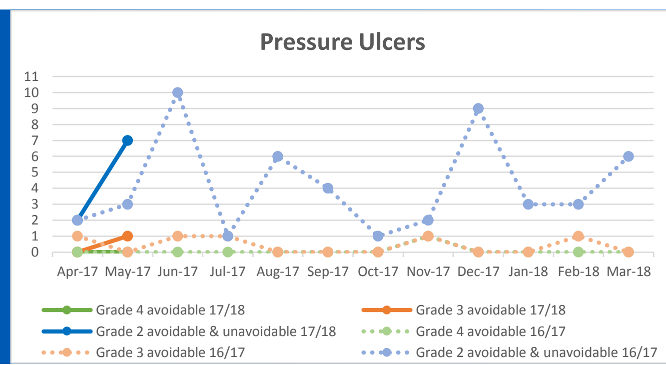
Integrated Dashboard - Board of Directors - May 2017

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels	Total number of approved falls per month and their relevant harm levels.	10% reduction in falls in 2017/18 using 2015/16 data as a baseline. Thresholds to be reviewed by the May 2017 Quality Committee with recommendation to May 2017 Board.	 	The 2 serious harm falls (severe) were both for Specialist Medicine, which resulted in harm are both subject to Level 2 investigation and have been STEIS reported.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 82	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.	Grade 4 hospital acquired (avoidable) Grade 3 hospital acquired (avoidable) Grade 2 hospital acquired (avoidable and unavoidable)		There have been 7 x grade 2 Pressure Ulcers reported for May 17 and 1 grade 3 Pressure Ulcer. It should be noted that Root Cause Analysis is underway.

Warrington and Halton Hospitals NHS
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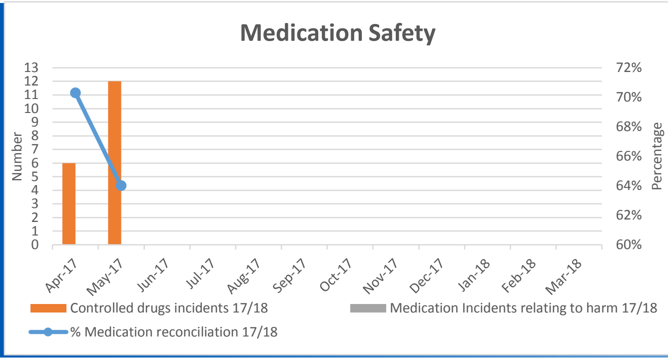
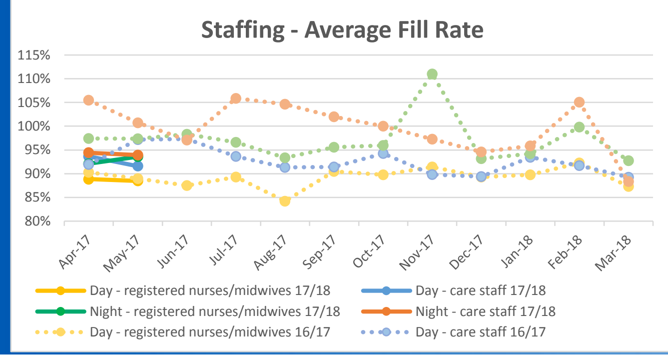
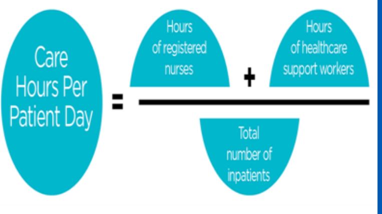
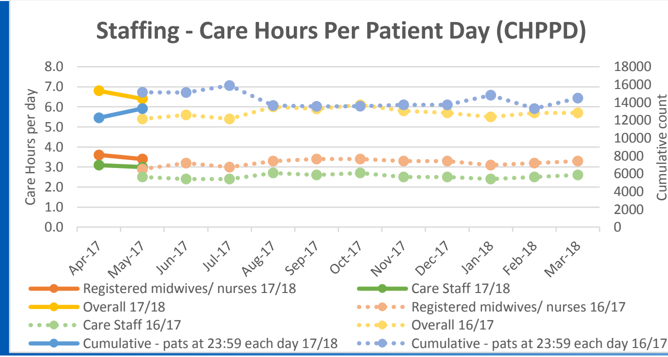
Integrated Dashboard - Board of Directors - May 2017

Quality Improvement - Trust Position

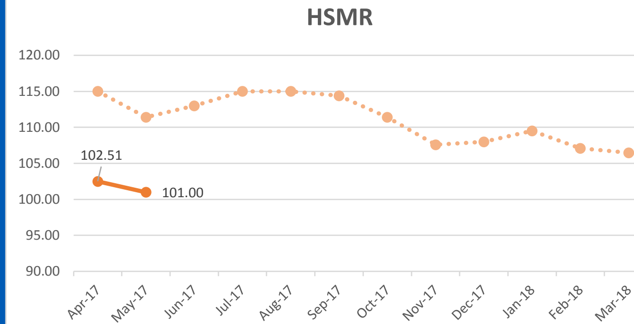
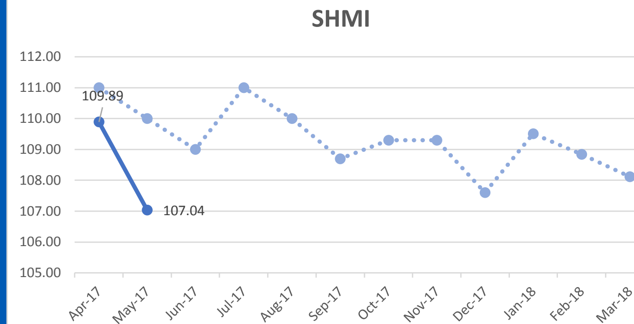
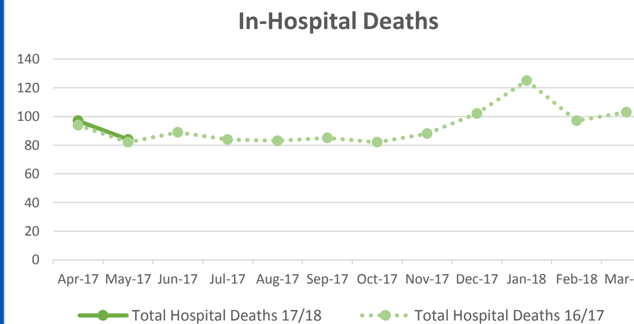
	Description	Aggregate Position	Trend	Variation
Medication Safety	**Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.**	**Targets to be set.**		**Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking. The total number of patients requiring this in May was 1467 excluding Paediatrics, Maternity and patients with a length of stay <1 day. Of the 1467, 1042 medication reconciliations took place; of which 224 took place within 24 hours. There were 12 controlled drugs incidents for the month of May.**
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	**Percentage of planned verses actual for registered and non registered staff by day and night**	**Target of >90%. The data produced excludes CCU, ITU and Paediatrics.**		**Although most areas are above the 90% target it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated at appropriate.**
Staffing - Care Hours Per Patient Day (CHPPD)		**The data produced excludes CCU, ITU and Paediatrics.**		**We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.**

Integrated Dashboard - Board of Directors - May 2017

Quality Improvement - Trust Position

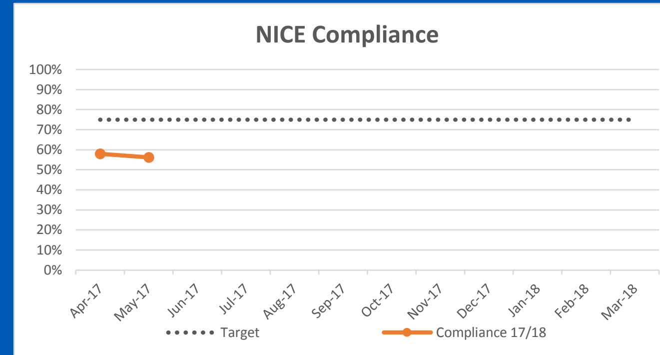
	Description	Aggregate Position	Trend	Variation

Clinical Effectiveness

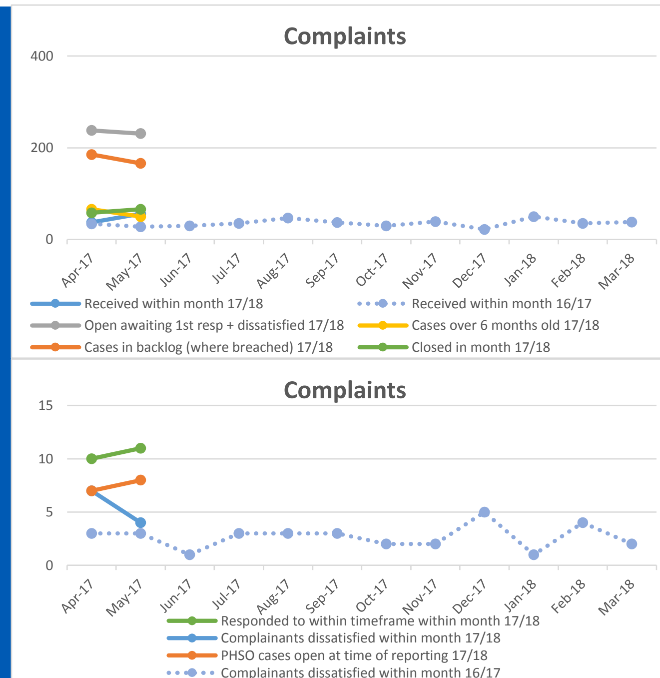
	Description	Aggregate Position	Trend	Variation
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	**Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.**	**Target for Green would be to be within expected ranges.**		**Our HSMR is continuing the downward trend as correctly coding our palliative care patients takes effect. We have completed the deep dive into UTI deaths and a report is due to go to Patient Safety & Clinical Effectiveness in May 2017. Care was good in 11 of the 12 patients and one has become an SI. A number of actions have been derived and will be implemented over the next six months.**
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	**Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.**	**Target for Green would be to be within expected ranges.**		**Our SHMI has remained static due to an increase in the number of observed deaths over our expected. We are performing deep dives into the following areas where we have increases: Cardiac Dysrhythmias, Fractured Neck of Femur and Cancer of the Rectum & Anus. The results from these deep dives will be completed over the next three months.**
Total Deaths	**Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group.**	**No threshold.**		The total deaths figure to date mirrors what we saw in 16/17, the data is further revierwed at Patient Safety and Clinical Effectiveness Sub Committee.

Integrated Dashboard - Board of Directors - May 2017

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.	We wish to achieve 100% compliance against all NICE guidance.		The figures included within this report are a position statement as to the current status of NICE Guidance (including Guidelines, Quality Statements and Technology Appraisals) compliance within the Trust. It encompasses NICE Guidance that has been published from 2006 to date (Guidance which is due to be assessed for applicability and then compliance before 30th April 2017). It is also important to note that the below figures do not include guidance which applies divisionally or Trust-wide.

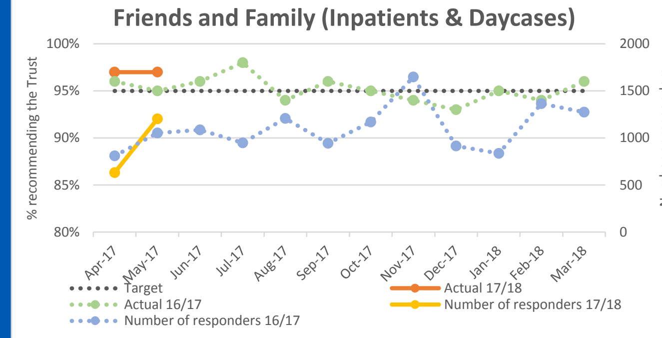
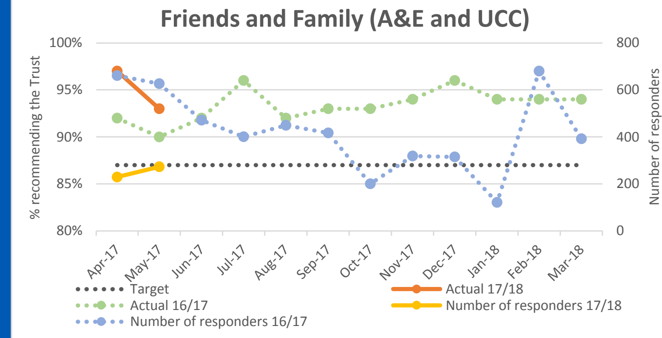
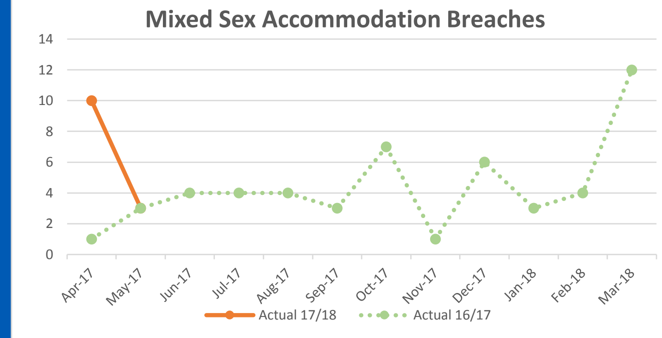
Patient Experience

	Description	Aggregate Position	Trend	Variation
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.	Targets to be set.		The number of complaints received is based on those cases "opened" in month, and not date "first received", in order to ensure a more accurate picture given the historic issues with missed cases. The Trust wide figure will not always match the total cases assigned to ACS or SWC as there are additional complainants assigned to the Corporate Directorate. In month 6 cases were treated as "high" risk and therefore the subject of a 72hr review. Weekly performance meeting with Divisions and the Chief Nurse / Deputy Director of Governance have been reinstated to monitor complaints performance and to focus areas for improvement. There are currently 231 open complaints, of which; 100 relate to Acute Care Services, 115 relate to Surgery and Women & Children's and 16 relate to Corporate Services.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - May 2017

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	Percentage of Inpatients and daycase patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	The target set is to achieve over 95%.		It is pleasing to note that we have continued to achieve 97% of our patients recommending the Trust. Another area that has shown a vast improvement is in relation to the number od responders which have nearly doubled in the last month.
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.		The target set is to achieve over 87%. It is pleasing to note that 93% of our patients recommend the Trust. Although we have seen a slight increase in the number of responders, the figure remains low.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.		MSA breaches continue to be closely monitored by the operational teams. It should be noted that only Critical Care & Coronary Care step down breaches occur due to capacity challenges within the Trust. The CCG's have now agreed that an RCA is not required for each MSA breach, they have requested the breach information in the form of a spreadsheet each month.

Warrington and Halton Hospitals NHS
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Integrated Dashboard - Board of Directors - May 2017

Mandatory Standards - Access & Performance - Trust Position

Indicator	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The national target of 99% for Diagnostic waiting times has been achieved with actual performance at 100%. The Trust has also met the STP Improvement trajectory.	Diagnostic Waiting Times 6 Weeks (chart: Actual 17/18, Target, Actual 16/17; Apr-17 to Mar-18; 90%–100%)	There are no issues with this target
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory.	Referral to treatment Open Pathways (chart: Actual 17/18, Target, Actual 16/17; Apr-17 to Mar-18; 80%–100%)	Incomplete waiters: • May Submission 93.07% achieving standard for the 19th consecutive month with further improvement on position from April to May. • Only 2 specialties not achieving standard (T&O and Urology) and these are both showing improvement with actions being put in place to address route cause.
A&E Waiting Times - National Target Red: Less than 95% Green: 95% or above A&E Waiting Times - STP Trajectory Red: Less than trajectory Green: Trajectory or	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust is not achieving the 95% national 4 hour target but is meeting the STP improvement trajectory.	A&E Waiting Times - 4hr target (chart: Actual 17/18, National Target, Improvement Trajectory, Actual 16/17; Apr-17 to Mar-18; 80%–100%)	The Trust has submitted improvement trajectories to NHSI for 2017-18 these are yet to be confirmed. The Trust has over achieved this trajectory for May despite not achieving the 95% standard.

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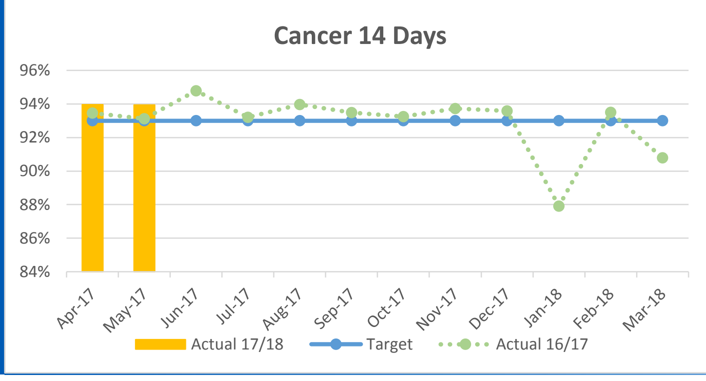
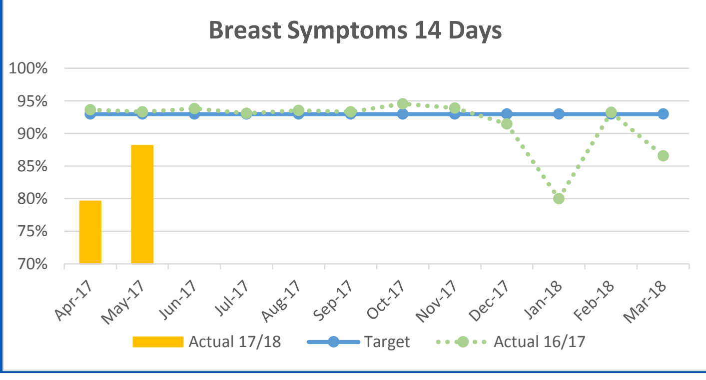
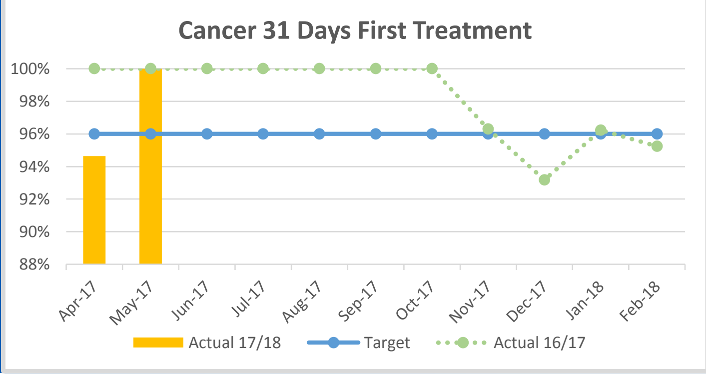
Integrated Dashboard - Board of Directors - May 2017

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	**All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.**			**Since the introduction of the robust process introduced by the Cancer Management team in January 2017 there have been no breaches of this target.**
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	**All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.**			**All of the breaches within this target are due to patient choice (patients refusing to attend within 14 days despite appointment offered). This has been raised with the CCG and the GP Cancer lead who is reporting back to the GP forums. In addition an audit is being undertaken to provide evidence to GPs and to establish if there is a trend within certain GP Practices.**
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	**All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.**			**The Trust is forecasting achievement of this quarterly national target.**

Integrated Dashboard - Board of Directors - May 2017

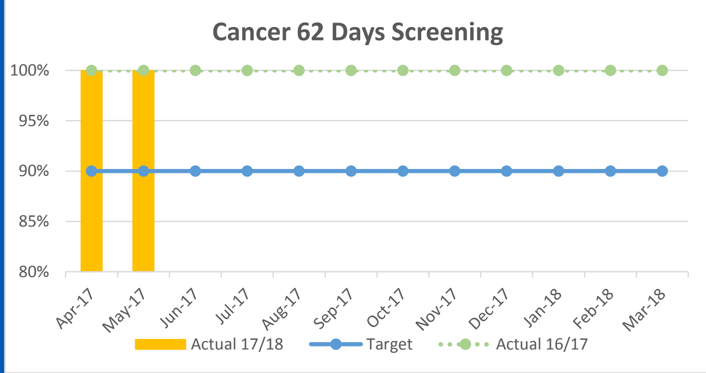
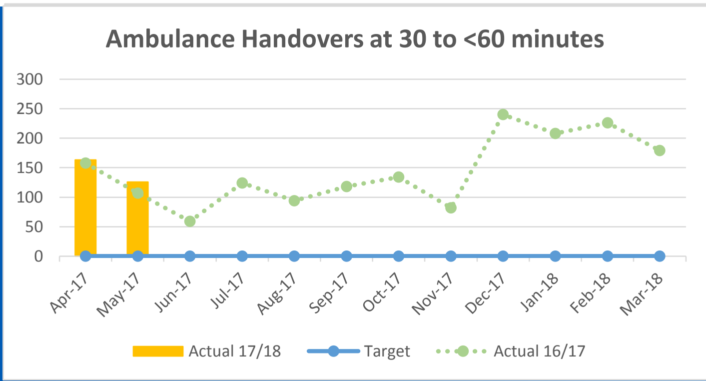
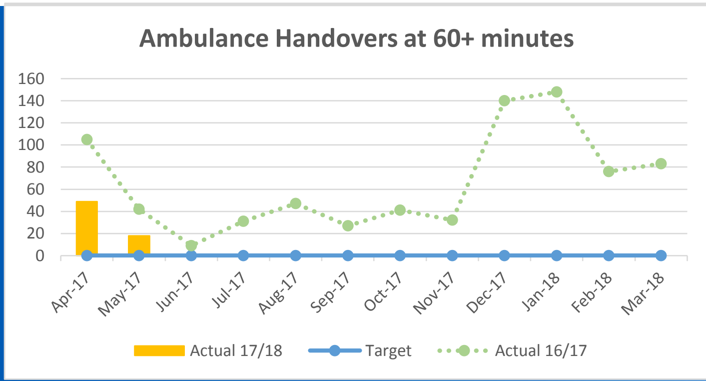
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	**All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.**		Cancer 31 Days Subsequent Surgery	**The Trust is forecasting achievement of this quarterly national target.**
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	**All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.**		Cancer 31 Days Subsequent Drugs	**The Trust is forecasting achievement of this quarterly national target.**
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	**All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%.** **This metric also forms part of the Trust's STP Improvement trajectory.** **The proposed tolerance levels applied to the improvement trajectories are also illustrated.**		Cancer 62 Days Urgent	**The Trust is forecasting achievement of this quarterly national target.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - May 2017

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis			The Trust is forecasting achievement of this quarterly national target.
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system)			The Trust are supported by ECIP and presented at an ECIP improvement event in April. Although we struggle to achieve the target we remain one of the better performing Trusts regionally.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system)			The Trust are supported by ECIP and presented at an ECIP improvement event in April. Although we struggle to achieve the target we remain one of the better performing Trusts regionally.

Integrated Dashboard - Board of Directors - May 2017

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge		Discharge Summaries - % sent within 24hrs (chart: Actual 17/18, Target, Actual 16/17; Apr-17 to Mar-18; 0%–100%)	The Trust has put a remedial action plan in place to improve performance against this target which has resulted in a 2% improvement April to May. However failure to achieve the 95% target at Trust level for quarter 1 will result in a penalty of £15k.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge		Discharge Summaries - Number NOT sent within 7 days (target = 0) (chart: 17/18 No. not sent within 24hrs that resulted in <95%; 17/18 Of the no. required to hit 95% how many not sent within 7 days; 16/17 Of the no. required to hit 95% how many not sent within 7 days; Apr-17 to Mar-18; 0–1500)	There are no issues with this target
Cancelled Operations on the day for a non-clinical reason Red: Above zero	Number of operations cancelled on the day or after admission for a non-clinical reason		Cancelled operations on the day for non-clinical reason (chart: Actual 17/18, Target, Actual 16/17; Apr-17 to Mar-18; 0–45)	The divisional teams have introduced a weekly cancelled operations meeting which drills down into every operation cancelled the previous week and identifies trends/themes/avoidable and unavoidable reasons as to why an operation is cancelled. It is expected that this will reduce the number of non-clinical cancellations as the reasons are discussed and actions put into place to reduce this number. There are also weekly scheduling meetings that look forward to the following weeks lists to identify any issues that may come up (i.e. special equipment).

Warrington and Halton Hospitals NHS
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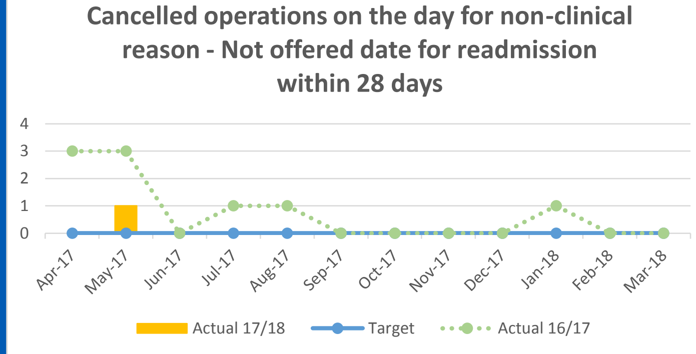
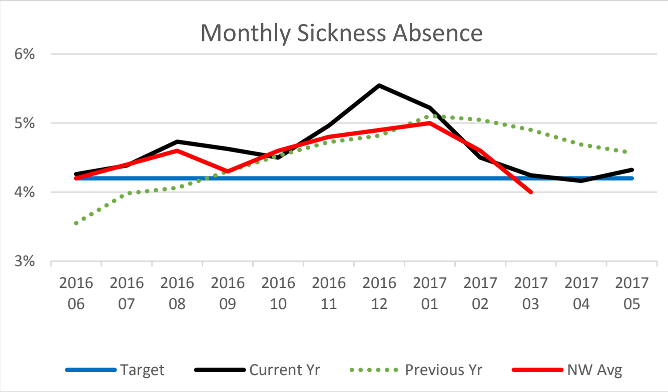
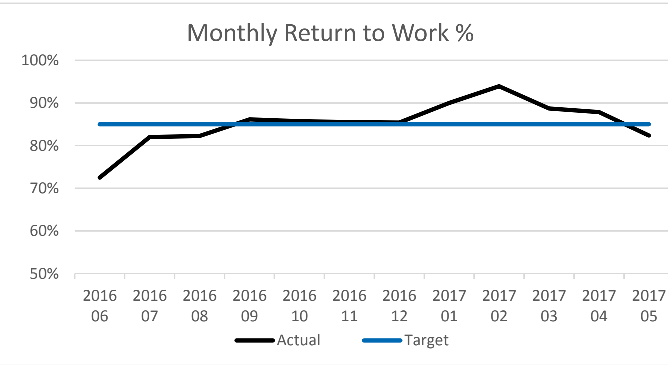
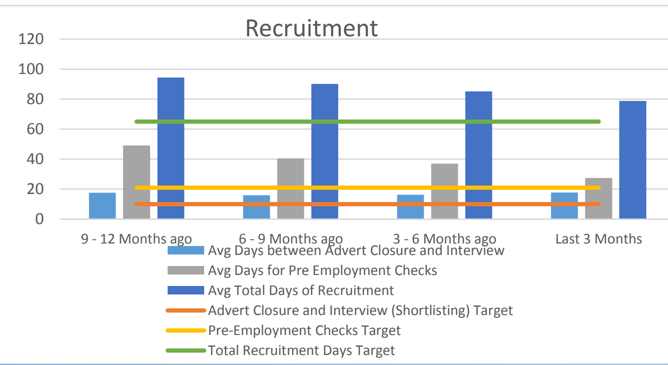
Integrated Dashboard - Board of Directors - May 2017

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days			There has been 1 breach in May. The Division is investigating the reason and will provide a verbal update to the COB meeting. The Trust will be fined the total cost of the procedure for this breach. The finanical impact of this breach is currently unknown and will be reported in the July COB performance report and to the FSC.

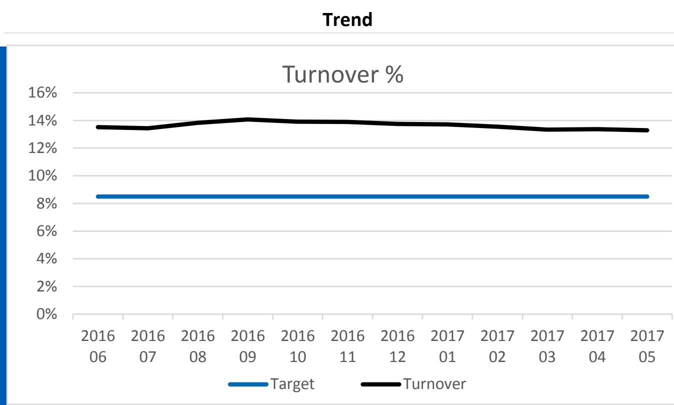
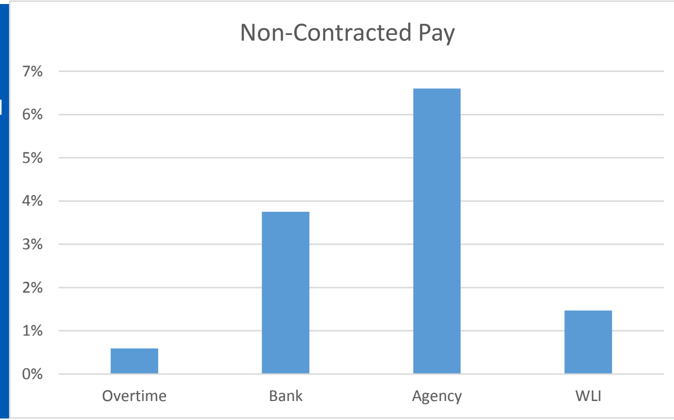
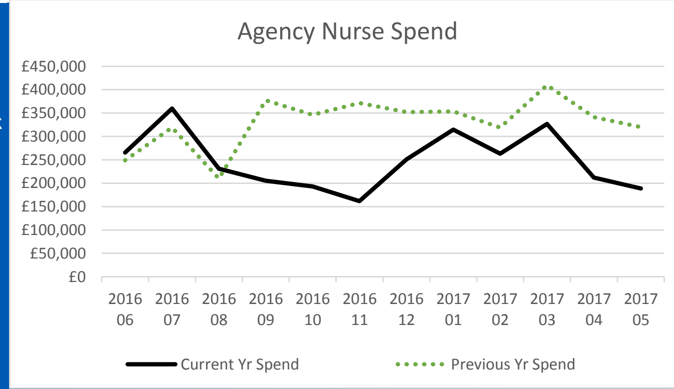
Integrated Dashboard - Board of Directors - May 2017

Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence for May 2017 increased from the previous month and was 4.32% but this was better than the same month last year (4.57%). The cumulative position from April - May is 4.24%. Therefore the trust target of 4.2% is not quite being met. The latest figure(March 2017) for the North West absence performance was 4% (WHH was 4.25%)		Managers are reminded each month about the need for absence being input in a timely manner. The revised Attendance Management Policy was implemented on 1.12.16 and from January 2017 the position is much better than the same 5 month period in 2016. Over the same period 8 staff have had their contracts terminated for long term and short term absence. Sickness for the Divisions is as follows: ACS - May-17 = 4.9% Red SWC - May-17 = 4.35% Amber Corporate - May -17 = 3.54% Green Stress remains the number one reason for absence with 25% of all sickness absence due to stress.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	RTW compliance reduced to 82.35% for May against a target of 85%.		Although the trust target has apparently not been met, a pattern seems to be emerging that some RTW interview dates seem to be being input after the cut off date for running this report. In previous Board reports it has been reported that the RTW rate has not met the target but when the report has been run again, it is clear that further information is being input, to the extent that the target has been met for the last 8 months. Monitoring at Performance Improvement meetings held by HRBPs and the Director of HR & OD will continue in an effort to increase compliance and improve timely recording.
Recruitment Red: Above Target Green: On or Below Target	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks	The average total days to recruit over the 3 month period ending April 2017 has slightly deteriorated from 73.7 days (April) to 78.8 days against a target of 65 days. The position 9 - 12 months ago was 94.4 days.		There is still room for improvement at each of the recruitment stages. The time taken from advert closure to interview (17.8 days) has slightly improved from the previously reported position of 19.3 days. However, the time taken for employment checks has slightly increased from 25.2 days to 27.5 days over the same period. Work is currently being undertaken to combine the ECF and New Starter form to improve the efficiency. The views of managers has been sought and it has ben demonstrated.

Integrated Dashboard - Board of Directors - May 2017

Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 12% Amber: 10% to 12% Green: Below 10%	A review of the turnover percentage over the last 12 months	Turnover marginally improved to 13.29% for the period up to May 2017. The status remains as 'red' and the target of 7 - 10% is not being met.		The various measures put in place such as exit/aspiration interviews, on-boarding, improved induction, development opportunities, flexible working etc are gradually having a positive impact on reducing labour turnover. The new Recruitment and Retention Plan for Nursing staff is supporting this work. The trust continues to have more starters (40.6wte) than leavers (37.9 wte) which means that there are 32 more staff working at the trust than 12 months ago.
Non Contracted Pay	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Agency spend remains the highest element of Non-Contracted pay, accounting for 6.6% of the Trusts overall pay bill. Bank spend is 3.75% followed by WLI spend at 1.47% and then overtime at 0.60% of the pay bill. Overall Non-Contracted pay now makes up 12.42%.		The Trust still has a high reliance on non-contracted pay and increasingly so for therapy staff. Agency expenditure is reviewed at FSC and at the Pay Spend and Review Group. This Group is concentrating on examining all spend within the trust including bank/agency/locum, overtime and WLIs. NHSI have set the trust new targets for medical locum/agency expenditure. WLI payments as a proportionate of total spend are at their lowest level for more 12 months.This reflects the reduction implemented in October 2016 and better management of lists.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on Agency Nurses	Agency Nurse spend decreased in May to £189k which was an decrease of £23k from April and was also lower than the same month last year (£320k). Overall agency nurse spend is less than the same period in 2016/17		Whilst it is positive that there has been a reduction in agency nursing expenditure, there has been a corresponding increase in bank expenditure. This was to be expected as the trust tries to encourage agency workers to join the bank. Overall it is more cost effective to have staff working through a bank than an agency. It is worth highlighting that the Emergency Department have recruited to all of their vacancies although some staff have yet to commence. This will enable the Department to make savings of c£200k this year anf £232k FYE. The Recruitment and Retention Plan for Nursing continues to be implemented and this resulted in an Open Day held on 15.6.17. c60 nurses attended and offers of employment were made to virtually all of these.

Warrington and Halton Hospitals NHS
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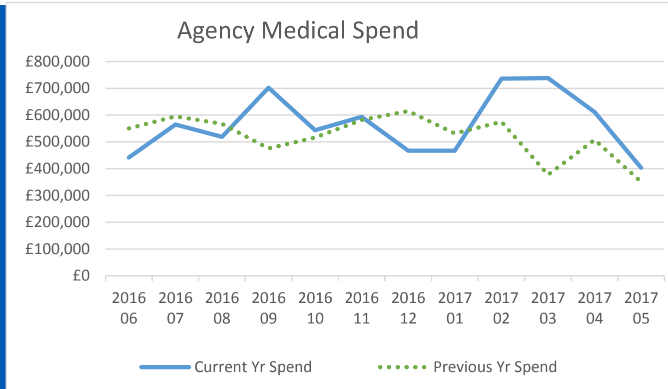
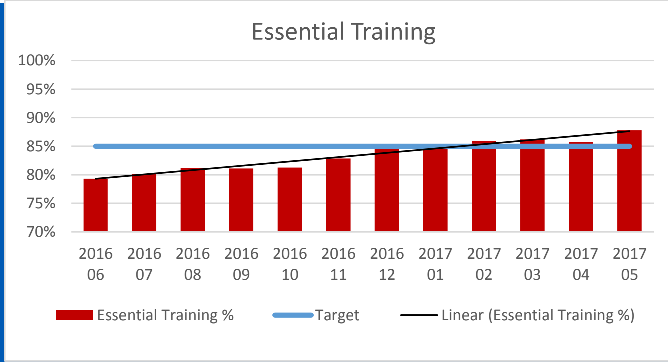
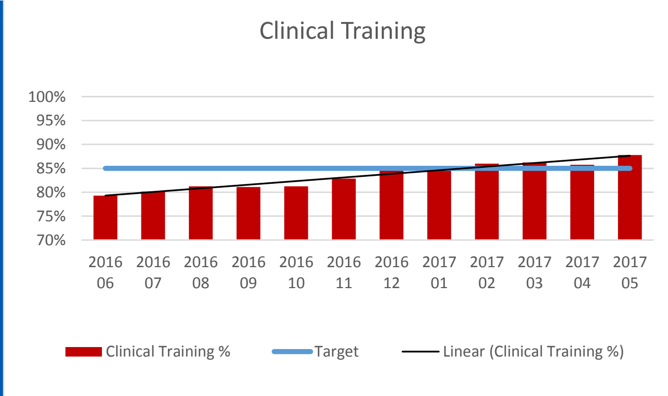
Integrated Dashboard - Board of Directors - May 2017

Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Locums	Agency Medical spend decreased significantly in May to £403k which was a decrease of £208k from April but was still higher than the same month last year (£351k). Overall agency medical spend is more than the same period in 2016/17		Enforcing the Price Cap rules is continuing to prove difficult and the majority of shifts worked each week breach the Price Cap but these are necessary to maintain patient safety. There continues to be some progress in appointing new consultant staff and persuading some agency medical staff to work through the trust bank. The Gatenby Sanderson project went live w/c 17.4.17. Two responses were received in relation to the vacancy for Consultant in Respiratory Medicine, one of whom was interviewed on 13.6.17 and was appointed. The other is being interviewed on 27.6.17. Adverts have appeared for Haematology and an Intensivist and one is planned for Acute Medicine.
Essential Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Essential Mandatory Training Compliance, this includes: Corporate Induction Dementia Awareness, Fire Safety Health and Safety Moving and Handling	The upward trend over the last year continues and the compliance rate for May was 89.57% which is above the trust target of 85%		The HR Business Partners are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. The trust target has now been met for 10 consecutive months. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Divisional progress is as follows: ACS May = 90.07% Green SWC May = 87.33% Green Corp May = 92.02% Green
Clinical Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Clinical Mandatory Training Compliance, this includes: Infection Control Resus Safeguarding Procedures (Adults) - Level 1 Safeguarding Procedures (Adults) - Level 2 Safeguarding Procedures (Children) - Level 1 Safeguarding Procedures (Children) - Level 2 Safeguarding Procedures (Children) - Level 3 SEMA	The upward trend continues and the compliance rate for April was 85.76% which is above the trust target of 85%.		The HRBPs are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. The trust target has now been met for 5 consecutive months. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Divisional progress is as follows: ACS May = 87.27% Green SWC May = 86.19% Green Corp May = 92.16% Green

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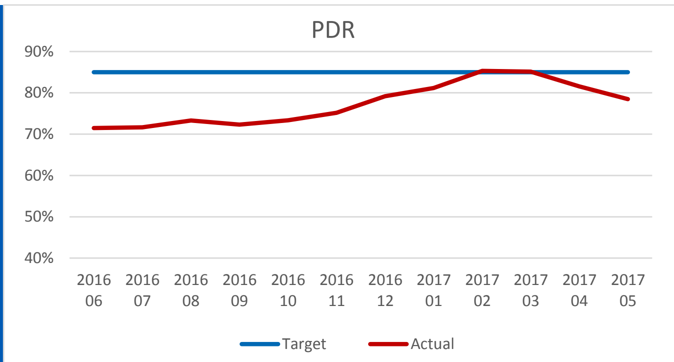
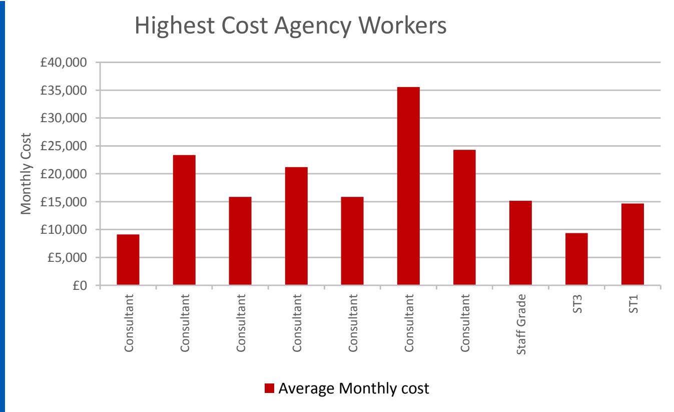
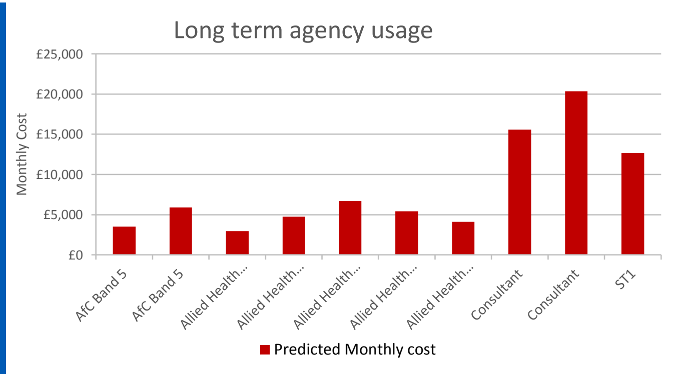
Integrated Dashboard - Board of Directors - May 2017

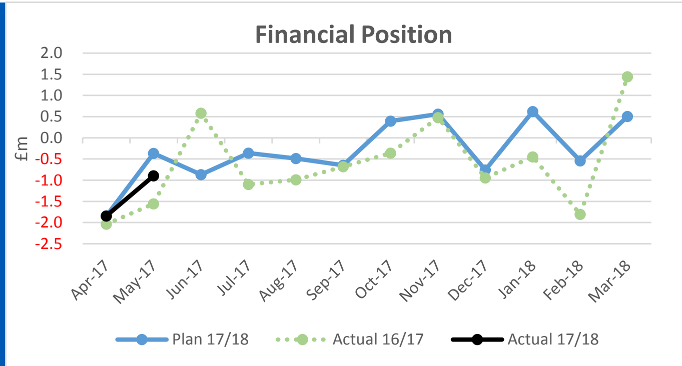
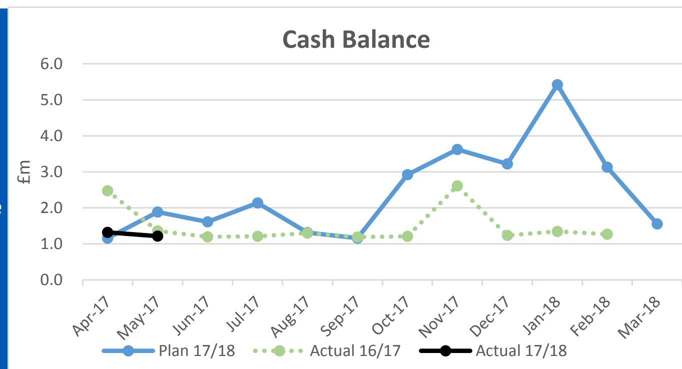
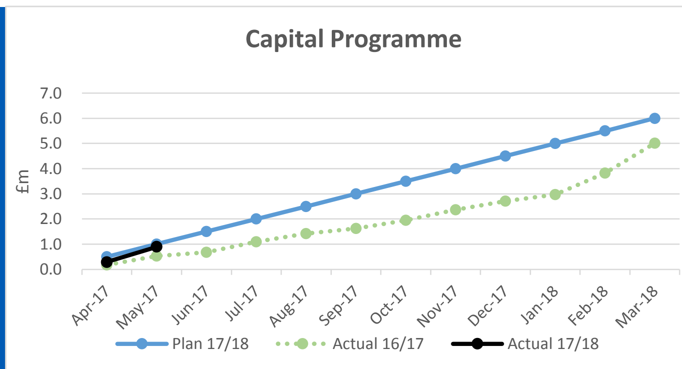
Workforce

Description		Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	After meeting the trust target for the first time in February and maintaing this position for March, it is disappointing to report that the compliance rate for PDRs has fallen to 81.54% in April. Therefore, the Trust target of 85% is not being met.		From reaching the trust target in February and sustaining this for March, it is disappointing that this progres has not been maintained for April and May. Operational pressures are likely to be suggested as the reason for this but the Divisions are keen to reverse this situation and have put plans in place to retrieve the situation. At the Performance Improvement meetings, the Director of HR & OD reviews will re-iterate this message and continue to monitor progress as part of the People Measures pilot. Divisional progress is as follows: ACS May = 76.24% Amber SWC May = 82.70% Amber Corp May = 75.53% Amber
Highest Cost Agency Workers	A summary of the Top 20 highest agency earners over the last 12 months	NHSI have very recently changed the reporting arrangements for the highest earning agency workers. Previously the trust was required to report the Top 20 highest earning agency workers over the last 12 months. Now trusts are required to report the Top 10 highest earning agency workers for the previous week. The Trust uses TempRe for medical/AHP staff and NHSP for nursing staff. For other staff, this is more difficult and relies on more manual systems which are being refined. The graph shows the weekly cost of the top 10 agency earners for the most recently reported position.		All of the highest earners are medical staff. Earnings range from c£3300 - £4900 per week. Efforts are continuing with the medical agencies to try and reduce the rates for the remaining agency workers or to attract them onto the trust payroll.
Long Term Agency Usage	A summary of agency workers who have been working at the trust every month for over 6 months	NHSI have very recently changed the reporting arrangements for long term agency workers. Previously long term agency workers were defined as working at the trust every month for over 6 months and all staff had to be reported. Now trusts are required to report the Top 10 agency workers who have worked at the trust for a minimum of 3 shifts per week for 6 consecutive weeks.The graph shows the Top 10 agency workers by staff group who have been working at the trust for more than 6 weeks.		5 of the staff are AHPs, 3 are doctors and 2 are nurses. The length of time these staff have worked at the trust range from 9 - 32 months. In all cases they are covering vacancies/escalation and have fixed term contracts which are regularly reviewed dependent upon progress with the filling of substantive posts. Efforts continue to try and persuade these staff to work directly for the trust.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - May 2017

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position	Surplus or deficit compared to plan	The actual deficit in the month is £0.9m which increases the cumulative deficit to £2.7m.		The cumulative deficit of £2.7m is £0.5m below plan.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	Cash balance at month end compared to plan	Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.2m equates to circa 2 days operational cash.		The current cash balance of £1.2m is £0.7 below the planned cash balance of £1.9m but the balance of £1.2 at month end is required to comply with the terms and conditions of the working capital loan.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan. The capital plan has been increased to by £1.0m to £7.0m in respect of the Department of Health funding for the implementation of primary care streaming in A&E.	The actual capital spend in the month is £0.6m which increases the cumulative spend to £0.9m.		The monthly capital spend of £0.9m is £0.1m below the planned spend of £1.0m.

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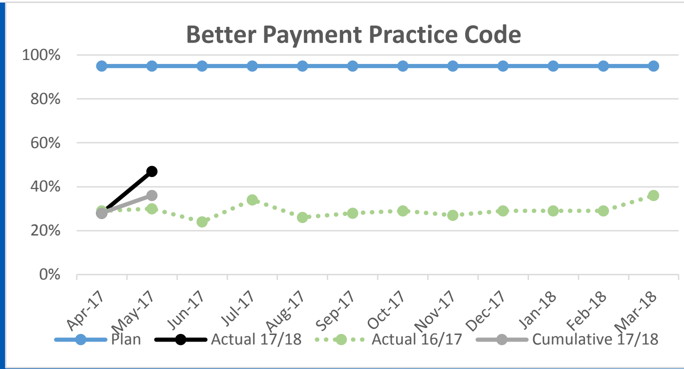
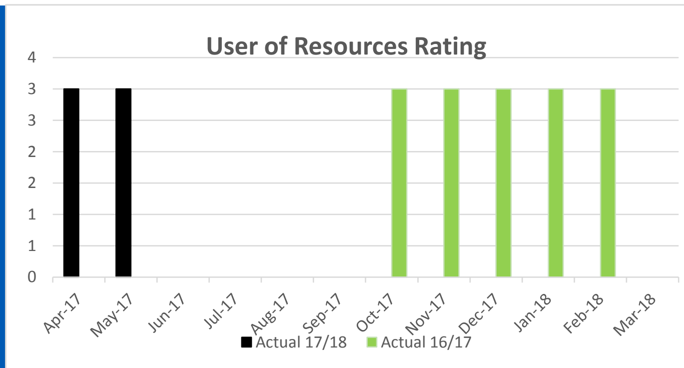
Integrated Dashboard - Board of Directors - May 2017

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 47% of suppliers within 30 days which results in a year to date performance of 36%.		The cumulative performance of 36% is 59% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	Use of Resources Rating compared to plan.	The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity and I&E margin are all scored at 4 (lowest) and Variance to Control Total and Agency Ceiling is scored at 1 (highest).		The current Use of Resources Rating of 3 is in line with the planned rating of 3. The Use of Resource Rating was introduced as an indicator by NHSI in October 2016. Therefore April 2017 - September 2017 will have no comparable previous year data.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties			The Trust has not received notification from the Commissioners of any fines & penalities.

Warrington and Halton Hospitals NHS

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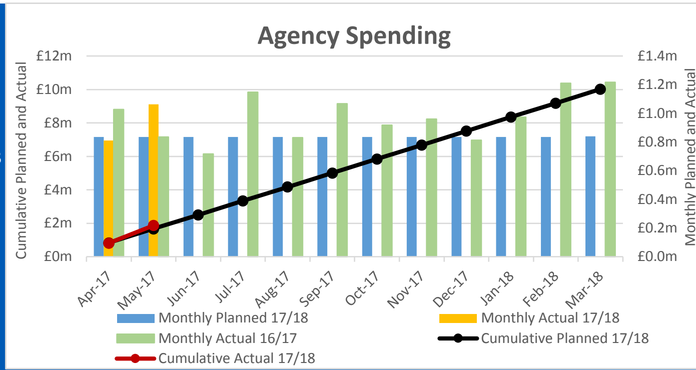
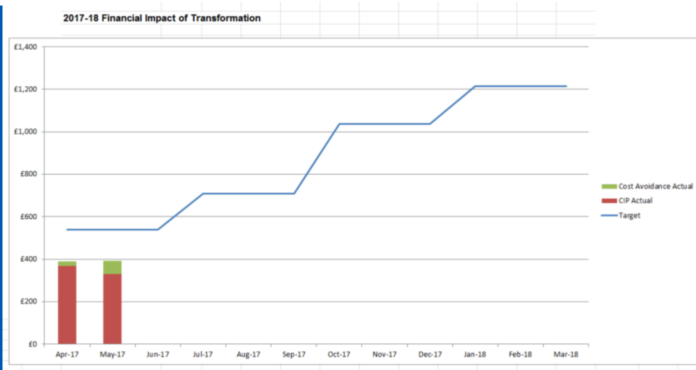
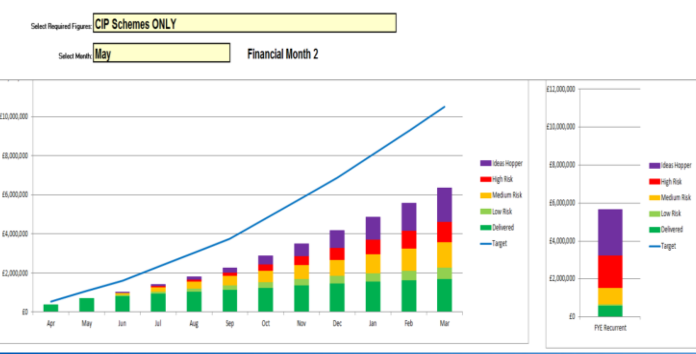
Integrated Dashboard - Board of Directors - May 2017

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £1.1m which increases the cumalative spend to £1.9m.		The cumulative agency spend of £1.9m is £0.2m (12%) above the cumulative agency ceiling of £1.7m.
Cost Improvement Programme - Performance to date Red: Cumulative CIP savings are less than 50% of planned YTD savings Amber: Cumulative CIP savings are between 50% and 90% of YTD planned savings	Cost savings delivered compared to plan.	CIP savings delivered M2 YTD are £0.696m against the M2 target of £1.080m. A further £0.087m M2 YTD has been delivered in cost avoidance/income recovery.		The YTD M2 financial impact of transformation activities is £0.783m (£0.696m CIP & £0.087m cost avoidance). This is £0.297m below the Trust M2 CIP target of £1.08m.
Cost Improvement Programme - Plans in Progress - In Year/Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	Planned improvements in productivity and efficiency - In Year & Recurrent forecast vs £10.5m target	In Year - The best case forecast for Trust CIP schemes in year is £6.361m. Best case assumes full delivery of all schemes on the tracker including all hopper ideas. The worst case forecast for CIP in year is around £3.298m. Worst case assumes the risk adjusted value of all schemes on the tracker and excludes all hopper ideas. Recurrent - The best case forecast for recurrent CIP is around £5.654m. The worst case forecast for recurrent CIP is around £1.614m.		The worst case current in year forecast for Trust CIP schemes is £3.298m which is £7.202m below the CIP target of £10.5m. The best case for CIP in year is £6.361m which is still £4.139m below the CIP target. Best case cost avoidance of £0.954m will help mitigate the position but would still leave a bottom line shortfall of £3.185m.

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COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/17/07/34**	
SUBJECT:	**Annual Report & Accounts 2016-17** **Including:** **Auditors Letter and Report on Quality Report**	
DATE OF MEETING:	**20th July 2017**	
ACTION REQUIRED	**Annual Report & Accounts for Information** **Auditors Letter and Report on the Quality Report for Assurance**	
AUTHOR(S):	**Various**	
RESPONSIBLE DIRECTOR:	**Mel Pickup** **Chief Executive**	
SUMMARY (KEY ISSUES):		
RECOMMENDATION:	The COG is asked to receive the Annual Report & Accounts for the reporting period April 2015 – March 2016 and the Auditors Letter and Report on Quality Report.	
PREVIOUSLY CONSIDERED BY:	Committee	Audit Committee Trust Board
	Agenda Ref.	
	Date of meeting	May 2017
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	

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COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/17/07/35**
SUBJECT:	**Election Activity, Vacancies and Governor Terms of Office**
DATE OF MEETING:	20th July 2017
ACTION REQUIRED	**For assurance**
AUTHOR(S):	Pat McLaren, Director of Community Engagement and Corporate Affairs
EXECUTIVE DIRECTOR	Pat McLaren, Director of Community Engagement and Corporate Affairs
EXECUTIVE SUMMARY	For Assurance this report on election activity, vacancies and Governor Terms of Office is brought to the Council bi-annually.
RECOMMENDATIONS	Governors are asked to note the report and the planned election timetable.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	None

Warrington and Halton Hospitals NHS
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SUBJECT	Election Activity, Vacancies and Governor Terms of Office 2017

The Foundation Trust is required to hold elections at the end of 2017 due to a number of terms of office concluding.

Election support is currently being procured to ensure that the process is delivered in the most effective and efficient manner via a competitive quotation process. The appointed supplier will act as the Returning Officer. Elections will be held according to the following DRAFT timetable:

Timetable for 2017 Elections

Event	Date
Publication of Notice of Election	Thursday,14 September 2017
Deadline for Receipt of Nominations	Tuesday, 17 October 2017
Publication of Statement of Nominations	Wednesday, 18 October 2017
Deadline for Candidate Withdrawals	Friday, 20 October2017
Notice of Poll / Issue of Ballot Packs	Wednesday, 1 November 2017
Close of Poll – 5pm	Friday, 24 November 2017
Declaration of Result	Monday, 27 November 2017

Constituencies eligible for election are:

Constituency
Norton South, Halton Brook, Halton Lea
Lymm, Grappenhall, Thelwall
Appleton, Stockton Heath, Hatton, Stretton and Walton
Penketh and Cuerdley, Great Sankey North, Great Sankey South
Poplars and Hulme, Orford
North Mersey
Rest of England and Wales (formerly South Mersey)
Staff - Support
Staff - Estates, Administration, Managerial

Vacancy or first term coming to end (governor may stand for re-election)
Second term coming to end

The current Council and tenure is attached for reference.

- There are two vacancies; Norton South, Halton Brook, Halton Lea (Vacant since Jan 2017) and Rest of England and Wales (formerly South Mersey) vacant since October 2016.
- Four Governors have first terms coming to an end and are eligible for re-election: Jeanette Scott, Sue Kennedy, Jim Henderson and Mark Ashton

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- We will sadly lose three governors that have concluded two terms and will stand down: Alf Clemo, Peter Harvey and staff governor Sue Bennett.

Promotion

Planning is already underway to promote the role of the Governor which is being overseen by the Governors Engagement Group.

The formal announcement of the 2017 elections will be made at the Annual Members Meeting 2017

Conclusion

Procurement of an election partner is underway using a competitive process. Work is underway to ensure that a successful election is launched and concluded in 2017 with promotional work planned to ensure that we fill all nine vacancies.

PMc
11.7.17

Warrington and Halton Hospitals NHS
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Appendix 1

WHH Council of Governors – Elections 2017

Public No:	Constituency (16 public)	Governor	Term (of 2)	Term Ends
1	Daresbury, Windmill Hill, Norton North, Castlefields	Alison Kinross	1	30/06/2018
2	Beechwood, Mersey, Heath, Grange	Joe Whyte	1	30/06/2018
3	Norton South, Halton Brook, Halton Lea	Vacant since Jan 17		VACANT
4	Appleton, Farnworth, Hough Green, Halton View, Birchfield	Colin McKenzie	1	23/12/2019
5	Broadheath, Ditton, Hale, Kingsway, Riverside	Kenneth Dow	1	30/06/2018
6	Lymm, Grappenhall, Thelwall	Jeanette Scott	1	30/11/2017
7	Appleton, Stockton Heath, Hatton, Stretton and Walton	Sue Kennedy	1	30/11/2017
8	Penketh and Cuerdley, Great Sankey North, Great Sankey South	Peter Harvey	2	30/11/2017
9	Culcheth, Glazebury and Croft, Poulton North	Keith Bland MBE	1	23/12/2019
10	Latchford East, Latchford West, Poulton South	Carol Astley	2	30/06/2018
11	Bewsey and Whitecross, Fairfield and Howley	Phil Chadwick	1	30/06/2018
12	Poplars and Hulme, Orford	Alf Clemo	2	30/11/2017
13	Birchwood, Rixton and Woolston	Anne M Robinson	1	23/12/2019
14	Burtonwood and Winwick, Whittle Hall, Westbrook	Norman Holding	1	30/06/2018
15	North Mersey	Jim Henderson	1	30/11/2017
16	Rest of England and Wales (formerly South Mersey)	Vacant since Oct 2016		VACANT
	Constituency (5 Staff)	Governor	Term (of 2)	Term Ends
Staff A	Medical and Dental	Dr Helen Bowers	1	23/12/2019
Staff B	Nursing and Midwifery	Jo Meek	1	23/12/2019
Staff C	Staff - Support	Sue Bennett	2	30/11/2017
Staff D	Clinical Scientist or Allied Health Professionals	Louise Spence	1	23/12/2019
Staff E	Estates, Administration, Managerial	Mark Ashton	1	30/11/2017
	Constituency (6 Partners)		Appointed	N/A
	Halton Borough Council	Cllr P Lloyd Jones	24/6/2014	
	Warrington Borough Council	Cllr Pat Wright	17/10/2011	
	Wolves Foundation	Neil Kelly	1/9/2013	
	University of Chester	Dr Mike Brownsell	01/01/2017	
	VACANT – to be appointed			VACANT
	VACANT – to be appointed			VACANT

◯ First term ending, eligible to stand for second term

◯ Vacancy

◯ Second term ending, governor standing down.

We are WHH

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COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**CoG/17/07/36**
SUBJECT:	**Review the Trust's Compliance with its Licence Q4 2016-17**
DATE OF MEETING:	20 July 2017
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Pat McLaren, Director of Community Engagement and Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR	Pat McLaren, Director of Community Engagement and Corporate Affairs
EXECUTIVE SUMMARY	The Trust is required to declare that: 1. it has taken all precautions necessary to comply with its licence, NHS Acts and the NHS Constitution – condition G6 2. it has complied with the required governance arrangements – condition FT4 3. it has reasonable expectation that required resources will be available to deliver the designated service – condition CoS7 The Audit Committee received the Annual Code of Governance Declaration at its meeting on 24th April 2017 where it noted progress in 2016-17 to address non-compliance in three areas:A.5.6; A.5.7 and C.3.8 and therefore the Trust was able to declare full compliance with provisions of the Code in the Annual Report 2016-17.
RECOMMENDATIONS	The Self Certification for the items is attached and the Council of Governors is asked to: 1. Note compliance with G6, FT4 and CoS7 2. Request that the Governors review the three licence declarations and seek their input and 3. Approve the self-certification submission to NHS Improvement by the 31st May 2017 deadline. The Self Certification has been reviewed and approved by: Audit Committee on 24 April 2017 and Trust Board on 24 May 2017
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.

Warrington and Halton Hospitals NHS
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Summary of Licence Conditions

General Licence Conditions (G)

Ref	Condition	Summary
G1	Provision of Information	Obligation for licences to provide Monitor/NHSI /NHSI with any information required for licensing functions
G2	Publication of Information	Obligation to publish such information as Monitor/NHSI /NHSI may require
G3	Payment of fees to Monitor/NHSI /NHSI	Gives Monitor/NHSI /NHSI the ability to charge fees and obliges licence holders to pay fees to Monitor/NHSI /NHSI as requested
G4	Fit and Proper Persons	Prevents licensees from allowing unfit persons to become or continue as Governors or Directors (or those performing similar or equivalent functions). In exceptional circumstances and at Monitor/NHSI's discretion a license may be issued without the licensee having met the requirement.
G5	Monitor/NHSI Guidance	Licensees must have regard to guidance issued by Monitor/NHSI
G6	Systems for compliance with licence conditions and related obligations	Requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements
G7	Registration with the Care Quality Commission	Requires providers to be registered with the CQC (if required to do so by law) and notify Monitor/NHSI if their registration is cancelled.
G8	Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner
G9	Application of Section 5 (Continuity of Services)	This applies to all licence holders. It sets out the conditions under which a service will be designated as a Commissioner Requested Service. If a licensee provides any Commissioner Requested Services, all of the Continuity of Services Conditions apply to the licence holder

Pricing Conditions (P)

Ref	Condition	Summary
P1	Recording of Information	Monitor/NHSI may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by Monitor/NHSI
P2	Provision of Information	Having recorded the information in line with P1, licensees can then be required to submit this information to Monitor/NHSI
P3	Assurance report on submissions to Monitor/NHSI	When collecting information for price setting, it will be important that the information submitted is accurate. This condition allows Monitor/NHSI to oblige licensees to submit an assurance report confirming that the information they have provided is accurate
P4	Compliance with national tariff	The Health and Social care Act 2012 requires commissioners to pay providers a price that complies with, or is determined in accordance with, the national tariff for NHS Healthcare services. This licence condition imposes a similar obligation on licensees, i.e the obligation to charge for NHS Healthcare services in line with National Tariff
P5	Constructive engagement concerning local tariff modifications	The Health and Social care Act 2012 allows for local modifications to process. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to Monitor/NHSI for a modification

Choice and Competition (CC)

Ref	Condition	Summary
CC1	The rights of patients to make choices	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice of provider under the NHS Constitution or where a choice has been conferred locally by commissioners

CC2	Competition oversight	Prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of healthcare users

Integrated care (IC)

Ref	Condition	Summary
IC1	The Integrated Care condition applies to all licence holders. It is a broadly defined condition	The licensee shall not do anything that could be reasonably regarded as detrimental to enabling integrated care. It also includes a patient interest test, meaning that the obligations only apply to the extent that they are in the best interests of people who use healthcare services.

Continuity of Services (CoS)

Ref	Condition	Summary
GENERAL CONDITION 9	Application of Section 5 (Continuity of Services)	This applies to all licence holders. It sets out the conditions under which a service will be designated as a Commissioner Requested Service. If a licensee provides any Commissioner Requested Services, all of the Continuity of Services Conditions apply to the licence holder
CoS1	Continuing provision of Commissioner Requested Services	Prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provide Commissioner Requested Services, without the agreement of relevant commissioners
CoS2	Restriction on the disposal of assets	Ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain Monitor/NHSI’s consent before disposing of these assets when Monitor/NHSI is concerned about the ability of the licensee to carry on as a going concern

CoS3	Monitor/NHSI Risk rating	Requires licensees to have due regard to adequate standards of governance and financial management
CoS4	Undertaking from the Ultimate Controller	Requires licensees to put in place a legally enforceable agreement with their ultimate controller to stop ultimate controllers from taking any action that would cause licensees to breach the licence conditions. This condition specifies who is considered to be the ultimate controller. **To note: this condition does not apply to the Trust**
CoS5	Risk Pool Levy	Obliges Licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an insurance mechanism to pay for vital services if a provider fails.
CoS6	Cooperation in the event of financial stress	This applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with Monitor/NHSI in these circumstances
CoS7	Availability of Resources	Requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services

NHS Foundation Trust Conditions (NHSFT)

Ref	Condition	Summary
NHSFT1	Information to update the register of NHS Foundation Trusts	Ensures that Trusts provide required d ocumentation to Monitor/NHSI
NHSFT2	Payment to Monitor/NHSI in respect of registration and related costs	If Monitor/NHSI moves to funding by collecting fees, it may need this condition to charge additional fees to NHS Foundation trusts to cover the costs of registration. Stakeholders would be consulted prior to introducing such a fee.
NHSFT3	Provision of information to an advisory panel	This gives Monitor/NHSI the ability to establish an advisory panel that will consider questions brought by Governors. The condition requires NHS Foundation trusts to provide the information requested by an advisory panel.
NHSFT4	NHS Foundation trust governance arrangements	Enables Monitor/NHSI to continue oversight of governance of NHS Foundation Trusts.

SELF ASSESSMENT OF COMPLIANCE WITH MONITOR/NHSI PROVIDER LICENCE CONDITIONS Q2 2016-17 This document should be read in conjunction with the Summary of Licence Conditions to provide further detail on the conditions listed.						
	Licence Condition	**Executive Lead**	**Compliance Y/N**	**Narrative**	**Evidence of Assurance**	**Identified Further Actions**
GENERAL CONDITIONS (G)	**G1: Provision of Information**	Director of Finance and Commercial Development	Y	The Trust is compliant with this condition. There are three established contacts with Monitor/NHSI -Chief Executive; Director of Finance and Company Secretary. All information requested by Monitor/NHSI is supplied within deadlines in the format requested. Copies of all information supplied are either held by the Company Secretary or are available within the Monitor/NHSI portal if supplied via this system.	• Quarterly submissions to Monitor/NHSI and accompanying commentary. • Additional information provided on CIP and finance • Annual Plan and further information provided	None
	G2: Publication of Information	Director of Community Engagement and Corporate Affairs	Y	The Trust is compliant with this condition. Information is published as required with the Monitor/NHSI Code of Governance; Annual Reporting Manual or regulatory requirements.	• Code of Governance declaration to the Audit Committee and in Annual Report following self-assessment • Annual Report • Remuneration Report • Safe Staffing data • CQC ratings • Non-confidential information published on Trust website and discussed at Public Board	None
	G3: Payment of fees to Monitor/NHSI	Director of Finance and Commercial Development	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A
	G4: Fit & Proper	Director of	Y	The Trust is compliant with this condition. The	• Enhanced DBS checks on Directors	Confirmation

	Persons	Community Engagement and Corporate Affairs		Board also complies with this requirement in accordance with additional CQC requirements post November 2014.	• Pre-employment recruitment processes/reference checks • Declaration of F&PP made by Board members and those acting in interim positions, countersigned by Chairman and held by the Foundation Trust Office	received from HR that Exec and NED engagement letters contain the F&PP clause.
	G5: Monitor/NHSI Guidance	Chief Executive	Y	The Trust is compliant with this condition. Part of the role of the Company Secretary is to horizon scan ensuring Execs are aware of any revised/new Monitor/NHSI guidance and the implications for the Trust and an Exec Lead is assigned dependent upon subject matter. Briefing notes are disseminated to as required. Self-assessments are carried out against guidance that requires compliance e.g. Code of Governance	• Annual Reporting Manual • Risk Assessment Framework • Quality Governance framework • Code of Governance Report to Board and Audit Committee • Transaction Guidance	None
	G6: Systems for Compliance with Licence Related Conditions and Related Obligations	Chief Executive	Y	The Trust is now compliant with this condition (previously not compliant as per the declaration the Board signed at the end of May 2016.) This compliance report is now submitted on a quarterly basis to the Audit Committee and on a bi-annual basis to the Council of Governors.	• Signed declaration • Factored into business cycles	
	G7: Registration with the Care Quality Commission	Chief Nurse	Y	The Trust is compliant with this condition. WHH is fully registered with the CQC. All sites are registered. An inspection took place in 2015 and a rating of 'Requires Improvement' was received. All recommendations have been progressed via the Quality Committee (Board Assurance Committee).	• CQC registration documents • CQC Report	None
	G9: Application	Director of Finance	Y	The Trust is compliant with this condition.	• Signed contract listing	None

	of Section 5 (Continuity of Services)			Commissioner requested services are agreed on an annual basis. It continues to deliver all commissioner requested services. There are no disputes in relation to which services are commissioner requested. This is reviewed annually as part of the annual planning and contract negotiation process.	commissioner requested services	
PRICING CONDITIONS (P)	**P1: Recording of Information**	Director of Finance and Commercial Development	Y	The Trust is compliant with this condition. Its implementation is in line with current financial procedures of the Trust, including following HFMA guidance.	• Reference costs reported to FSC/Board annually • Audit reports relating to costs	None
	P2: Provision of Information	Director of Finance and Commercial Development	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A
	P3: Assurance on submissions to Monitor/NHSI	Director of Finance and Commercial Development	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A
CHOICE & COMPETITION (CC)	**CC1: The rights of patients to make choices.**	Chief Executive	Y	The Trust is compliant with this condition. The Trust does not give any benefits or inducements to refer patients or commission services.	• Standards of Business Conduct • Gifts & Hospitality Register • Declarations of Interests	These policies will be retired and replaced with an overarching Managing Conflicts of Interest Policy by 1st June 2017
	CC2: Competition Oversight	Chief Executive	Y	The Trust is compliant with this condition. Given the STP and LDS work, the Board is mindful of this condition and will engage with relevant parties should this become necessary.	N/A	None

INTEGRATED CARE (IC)	**IC1: Provision of Integrated Care**	Chief Operating Officer	Y	The Trust is compliant with this condition. The Trust is fully supportive of the delivery of integrated care pathways and has extensive engagement with commissioners and other local providers to ensure services are as joined up as possible.	• Regular meetings with commissioners and external partners.	None
CONTINUITY OF SERVICES (COS)	**CoS1: Continuing provision of Commissioner Requested Services**	Director of Finance and Commercial Development	Y	The Trust is compliant with this condition. The Trust delivers a list of services that meet the requirements of the CQC. These are delivered in accordance with a signed contract.	• List of commissioner requested services • Signed Commissioner Contracts • Activity information in monthly report to the Board	None
	CoS2: Restriction on the disposal of assets	Director of Finance and Commercial Development	Y	The Trust is compliant with this condition. The Trust maintains an asset register and would comply with the terms of this condition regarding disposal as required.	• Asset Register • External Audits	None
	CoS3: Standards of corporate governance and financial management	Director of Finance and Commercial Development & Director of Community Engagement and Corporate Affairs	N	The Trust is not compliant with this condition. The Trust has sound systems of corporate governance; however, the financial management standards were not as robust as they should have been during 2015-16 and consequently the Trust was found to be in breach of its provider licence for reasons of financial governance. It currently has a FSRR of 2. The Trust is rated Red for Governance. The financial management controls and reporting have been strengthened since Q4 2015-16 which should ensure the Trust delivers its control target	• Head of Internal Audit Opinion • Internal & External Audit reports • Standing Financial Instructions / Scheme of Delegation • Operational Plan • Board Assurance Framework & Significant Risk Register • Risk Management Strategy & Procedure	Independent Well Led Review Jan-Mar 2017

					• Annual Governance Statement • Self-assessment against Monitor/NHSI 's Code of Governance • Monitor/NHSI Governance declarations	
	CoS5: Risk Pool Levy	Director of Finance and Commercial Development	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A
	CoS6: Co-operation in the event of financial stress	Director of Finance and Commercial Development	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A
	CoS7: Availability of Resources	Director of Finance and Commercial Development	Y	The Trust is compliant with this condition. Following discussion with NHSI, the plans, originally submitted in April 2016, now reflect the agreed control total.	• Board self-assessment certificate • Minutes of Board meetings • Quarterly governance declaration to Monitor/NHSI • Operational Plan	None
NHS FOUNDATION TRUST CONDITIONS (NHSFT)	**NHSFT1: Information to update the Register of NHS Foundation Trusts**	Director of Community Engagement and Corporate Affairs	Y	The Trust is compliant with this condition. The Trust has supplied and will continue to supply all required information in order to keep the register up to date e.g. Constitution; Report & Accounts; Director details	• Monitor/NHSI 's Foundation Trust Register	None
	NHSFT2: Payment to Monitor/NHSI in	Director of Finance and Commercial Development	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A

	respect of registration and related costs					
	NHSFT3: Provision of information to an advisory panel	Chief Executive	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A
	NHSFT4: Foundation Trust Governance	Director of Finance and Commercial Development	**N**	The Trust is not compliant with this condition as it is in breach of its provider licence and subject to an enforcement notice resulting in being red rated for Governance. However, the Head of Internal Audit opinion; Annual Governance Statement and the self-assessment against the Code of Governance suggest that the overall system of control is sufficient and the tightening of the financial governance aspects have resulted in improvements during 2016-17.	• Annual Governance Statement • Code of Governance self-assessment evidence • Head of Internal Audit Opinion	Independent Well Led Review Jan-Mar 2017 CQC inspection (well led domain) Mar 2017

Warrington and Halton Hospitals NHS
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Summary of Licence Conditions

General Licence Conditions (G)

Ref	Condition	Summary
G6	Systems for compliance with licence conditions and related obligations	Requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements

Self-certification response to condition G6: Confirmed

Continuity of Services (CoS)

Ref	Condition	Summary
CoS7	Availability of Resources	Requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services

Self-certification response to condition CoS7: Confirmed with the following note:

In 2015/16 the Trust was subject to an enforcement notice under section 106 of the Health and Social Care Act 2012 as it was in breach of certain licence conditions relating to its financial position. The Trust subsequently agreed to a series of Undertakings with a commitment to take all reasonable steps to deliver its services on a clinically, operationally and financially sustainable basis.

The Trust ended financial year 2015/16 with a deficit of £17.3m (excluding impairment costs) but has improved its financial performance and ended financial year 2016/17 with a deficit of £5.3m (excluding impairments). This improvement was brought about by Sustainability and Transformation Funding of £9.9m but also by the continued focus on increased financial governance achieved through:

- Introduction of a new clinical management structure resulting in divisions supported by a range of service specific clinical business units. Each clinical business unit has a clinical, nursing and managerial lead supported by finance, procurement and Human Resources.

- Introduction of a clinical operational board to facilitate discussions, review and support between Executive Directors and clinical divisions.

Warrington and Halton Hospitals NHS Foundation Trust

• Grip and control meetings led by the Transformation Team.

• Cost saving target meetings with each clinical and corporate division.

• Continued review of non-catalogue spend by Executive Directors and/or the procurement team.

• Daily review of cash balances and a rolling 13 week cashflow forecast.

• Increased monitoring and focus on temporary spend (bank, agency, locum and premium payments) to understand trends, performance and actions necessary to reduce spend.

• Active monitoring of agency spend against both agency caps and the agency ceiling.

The above actions are supplemented by a monthly meeting of the Innovative and Cost Improvement Committee to review, monitor and manage performance against the annual cost savings target to ensure maximisation of any income generation and cost reduction opportunities. This committee reports directly to the Finance and Sustainability Committee that meets monthly to review and monitor all aspects of the Trusts financial performance including income and expenditure, cash flow, capital, cost savings, treasury management together with forecast projections. This committee reports directly to the Board of Directors.

NHS Foundation Trust Conditions (NHSFT)

Ref	Condition	Summary
NHSFT4	NHS Foundation trust governance arrangements	Enables Monitor/NHSI to continue oversight of governance of NHS Foundation Trusts.

Self-certification response to condition NHSFT: Confirmed

SELF ASSESSMENT OF COMPLIANCE WITH MONITOR/NHSI PROVIDER LICENCE CONDITIONS 2016-17 This document should be read in conjunction with the Summary of Licence Conditions to provide further detail on the conditions listed.						
	Licence Condition	**Executive Lead**	**Compliance Y/N**	**Narrative**	**Evidence of Assurance**	**Identified Further Actions**
	G6: Systems for Compliance with Licence Related Conditions and Related Obligations	Chief Executive	Y	The Trust is now compliant with this condition (previously not compliant as per the declaration the Board signed at the end of May 2016.) This compliance report is now submitted on a quarterly basis to the Audit Committee and on a bi-annual basis to the Council of Governors.	• Signed declaration • Factored into business cycles	
	CoS7: Availability of Resources	Director of Finance and Commercial Development	Y	The Trust is compliant with this condition. Following discussion with NHSI, the plans, originally submitted in April 2016, now reflect the agreed control total.	• Board self-assessment certificate • Minutes of Board meetings • Quarterly governance declaration to Monitor/NHSI • Operational Plan	None
	NHSFT4: Foundation Trust Governance	Director of Finance and Commercial Development	**Y**	The Trust was not compliant with this condition as it is in breach of its provider licence and subject to an enforcement notice resulting in being red rated for Governance. However, the Head of Internal Audit opinion; Annual Governance Statement and the self-assessment against the Code of Governance suggest that the overall system of control is sufficient and the tightening of the financial governance aspects have resulted in significant improvements during 2016-17.	• Annual Governance Statement • Code of Governance self-assessment evidence • Head of Internal Audit Opinion	Independent Well Led Review Jan-Mar 2017 CQC inspection (well led domain) Mar 2017

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve McGuirk	**Name**	Mel Pickup
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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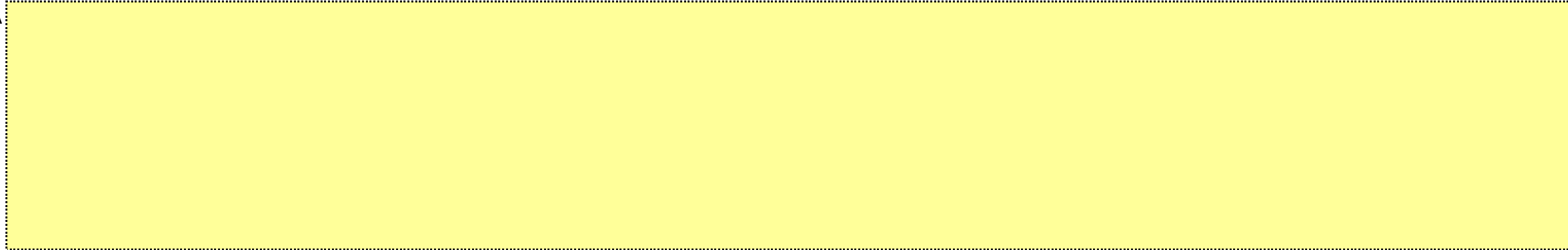

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is satisfied. Failure to achieve the highest level of corporate governance is recognised and recorded on the Trust's Board Assurance Framework at risk rating 12 and is reviewed quarterly. Mitigating actions include • Compliance with license conditions – reportable quarterly via Audit Committee and to Trust Board
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board reviews/discusses this at the part 1 (private) section of the Board and at planned Board development (time out) sessions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	A robust governance structure is in place and this is reviewed regularly. Board Committees are guided by Terms of Reference reviewed annually, together with Cycles of Business updated to reflect the changing needs of the organisation. Issues of concern are escalated through Chair key issues reports. 'Ward to Board' governance is via escalation/reporting by exception with CBUs accountable to the Clinical Operations Board
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board is satisfied. Where risks to the organisation are identified these are featured on the risk register and mitigations are identifed. The Board receives a current, integrated performance dashboard monthly which is RAG rated and trends-focused, this is supported by key issues reports from the various assurance committees. A process of business planning is established and a two-year operational plan is in place with the Trust working at least one year in advance. Quarterly review of the Trust's compliance with it's license is in place via the Audit Committee and Trust Board. The Trust's Disclosures relating to the Foundation Trust Code of Governance are received annually by the Audit Committee and are reported in the Annual Report and Accounts. A system of internal audit is in place reporting to the Audit Committee on a quarterly basis.

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board includes a clinical non-executive director, a Medical Director and Chief Nurse who are accountable for assurance of and delivery of the quality agenda. Quality metrics are scrutinised at the Quality Committee and assurance provided, or not, to the Board via the Chair's key issues report. Quality is further prioritised by the involvement of the Foundation Trust Governors via Quality in Care governor committees which report to the Council of Governors quarterly. The Quality dashboard is reviewed at a number of levels before being presented for assurance to the subcommittee of the Board.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is satisfied. It has sought further assurance in 2016-17 through a commissioned 'Well Led Review' (Deloitte Jan-Mar 2017) across 4 domains: Strategy and planning, Capability and culture, Structure and processes, Measurement for which it received an Amber/Green rating.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name Steve McGuirk, Chairman

Name Mel Pickup, Chief Executive

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

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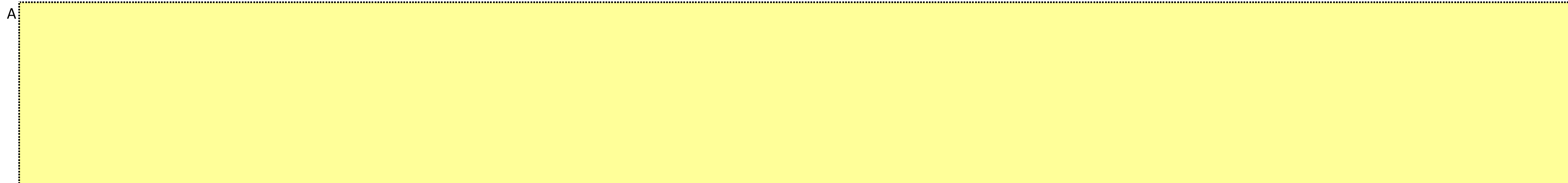

Self-Certification Template - Conditions G6 and CoS7

Warrington and Halton Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These Declarations are set out in this template.

Templates should be returned via the Trust portal.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — **Confirmed** — **OK**

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — **Confirmed** — Please fill details in cell E22

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

In 2015/16 the Trust was subject to an enforcement notice under section 106 of the Health and Social Care Act 2012 as it was in breach of certain licence conditions relating to its financial position. The Trust subsequently agreed to a series of Undertakings with a commitment to take all reasonable steps to deliver its services on a clinically, operationally and financially sustainable basis.

The Trust ended financial year 2015/16 with a deficit of £17.3m (excluding impairment costs) but has improved its financial performance and ended financial year 2016/17 with a deficit of £5.3m (excluding impairments). This improvement was brought about by Sustainability and Transformation Funding of £9.9m but also by the continued focus on increased financial governance achieved through:

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve McGuirk	**Name**	Mel Pickup
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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We are WHH

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/17/07/37**
SUBJECT:	**Proposed Amendments to the Foundation Trust's Constitution**
DATE OF MEETING:	20 July 2017
ACTION REQUIRED	**For approval of the described amendments**
AUTHOR(S):	Pat McLaren, Director of Community Engagement and Corporate Affairs
EXECUTIVE DIRECTOR	Pat McLaren, Director of Community Engagement Choose an item.
EXECUTIVE SUMMARY	The Trust conducts its business according to the terms set out in its Constitution. As per Article 45 'Amendment to the Constitution' within the Constitution document, the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the amendments. The Council of Governors has been engaged over recent months in a number of initiatives to enhance our member recruitment and public engagement. As a result of two positive developments, and with the approval of the Council of Governors, the Board approved the two amendments to our FT Constitution. There are three amendments required at this time: 1. Creation of the role of Lead Governor (new) to item 10 'Council of Governors – composition' with the Lead Governor role description included at Annex 3a 2. Amendment to the Public Constituency at Annex 1 to change the name of area 16. **These amendments were approved by the Trust Board 29 March 2017.** 3. Changes to Register of Members The General Data Protection Regulation (GDPR) becomes effective in May 2018 and will replace current data protection legislation. As a Foundation Trust we are required to have a membership and the processing of members' data will be affected by the new regulations. This paper explains the required changes to our Foundation Trust Constitution in order for us to proceed in advance of May 2018. The required changes to the constitution involve how we: 1. Communicate privacy information 2. Observe Individual's rights 3. Describe our lawful basis for processing personal data 4. Gain Consent 5. Treat Children

	These amendments were approved by the Trust Board 28 June 2017. **The amendments/additions are contained within the report.** Following approval, the changes to the constitution will be enacted - in liaison with and with support from the Information Governance Manager.
RECOMMENDATIONS	The Council of Governors is asked to consider the requested amendments to the constitution and to approve, **by recorded vote**, these amendments which will be entered to create v3.2 and approve the amendments.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	None

We are
WHH

NHS
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Halton Hospitals
NHS Foundation Trust

SUBJECT	Amendment of the Foundation Trust Constitution

1. BACKGROUND/CONTEXT

The Council of Governors has been engaged over recent months in resolving a number of initiatives to enhance our member and public engagement which now require amendments to our FT Constitution.

As per Article 45 'Amendment to the Constitution' the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the request.

2. KEY ELEMENTS

There are three amendments required at this time:

1. **Creation of the role of Lead Governor (new) to item 10 'Council of Governors – composition' with the Lead Governor role description included at Annex 1**

   In its Code of Governance Monitor asks that all foundation trusts have a 'lead governor' who can be a point of contact for Monitor/NHSI and can liaise with Monitor/NHSI, on behalf of the governors, in circumstances where it would be inappropriate for Monitor/NHSI to contact the chair, or vice versa.

   Such contact is likely to be a rare event and would be seen, for example, should NHSI wish to understand the view of the Governors about the capability of the chair, or be investigating some aspect of an appointment process of decision which may not have complied with the constitution.

   It is important to note that it is the Council of Governors *as a whole* (and no individual governor) that has the responsibilities and powers in statute.

   While a public governor has informally undertaken this role on behalf of the Council of Governors, the role is not included in our FT Constitution and needs to be formalised, along with description of duties, eligibility, term and selection process (see appendix 1).

   This role and the nomination/selection process was approved by the Council of Governors at its meeting on 19th January 2017 (minute ref **COG 17/01/09)** and a Lead Governor selected and appointed on 16th February 2017. **This role and appointment was approved at the Trust Board on 29 March 217.**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

2. Amendment to the Public Constituency

The Council of Governors resolved at its meeting on 20th October 2016 to change the name of Area 16 'South Mersey' to 'Rest of England and Wales' (**minute ref 16/53 Governor Recruitment)** The rationale for this is:

1. That due to Governor (constituency) vacancies there are many constituents which are not represented or supported across the WHH geographical footprint
2. That in the changing healthcare landscape and as greater collaboration and sharing is implemented across the Alliance LDS, it is very likely that WHH will be providing services across a much wider population. As the only Foundation Trust in the LDS it is incumbent on WHH to ensure that the wider constituencies have the opportunity to be represented by a Governor.
3. That by not having a 'rest of England and Wales' constituency that candidates for future NED roles are excluded from the process if they do not live in one of the existing constituencies.

The Constitution requires amendment at Annex 1 The Public Constituency to reflect this name change.

This amendment was approved at the Trust Board on 29 March 217.

3 Membership and Constituencies (page 6)

4.2 The names of members shall be entered in the register of members *and the member shall be asked to give their consent at time of registration for their personal data to be entered onto this register.*

The Trust is a Foundation Trust, the Constitution of which specifies that the Trust must have a membership. Warrington and Halton Hospitals NHS Foundation Trust has a membership that comprises two constituencies: the Public constituency and the Staff constituency. The Trust will enter your information into a secure database and will only use your data for the following purposes:

To conduct elections to our Council of Governors, which are elected by either public or staff members

To produce and annual membership report as prescribed by Monitor, our Regulator, under the Annual Reporting Manual. This report describes the membership database in its entirety and does not identify individuals.

We will not share your data with any person or organisation beyond secure transfer to our independent database provider which will, in turn, not share any data without specific authority from the Foundation Trust.

Members Individual Rights

The Foundation Trust commits that members:

- *Have the right to be informed*
- *Have the right of access to their information*
- *Have the right to rectify any personal data held in the membership database*
- *Have the right to request that their record is deleted from the membership database*
- *Has the right to request exclusion from processing, such as for the election of governors, the receipt of correspondence or the production of the annual membership report*
- *Has the right to object to any element of how we hold and process individual data*
- *Has the right not to be subject to automated decision-making including profiling.*

Lawful basis for processing personal data

The Foundation Trust is required, under its Constitution, to have a membership. Members will be recruited through multiple means and will be advised during recruitment about the processing of their data. Members' data will be processed securely and only for the purposes described above.

Consent

Upon membership application members will be asked to give their consent to have their data processed as described. If members do not give their consent then their application will be processed for subscription as requested but their data will not be further accessed for elections, correspondence or for membership reports.

Children

To become a Foundation Trust member the minimum age is 12. Young people aged between 12 and 16 applying for membership will be required to indicate that they have the consent of their parent or guardian to join the membership and provide the parent/guardian contact details. The young person's membership will not be processed until written consent has been received by the parent/guardian giving consent.

Item 34 Registers (page 20)

34.1.1 *Where the member gives consent, upon registration,* a register of members showing, in respect of each member, the Constituency to which he belongs and where there are Classes within it, the Class to which he belongs

35.1 The Trust shall *NOT* make the registers specified in paragraph 34 above, available for inspection by members of the public except in the circumstances set out below or as otherwise prescribed by regulations:

The production of the annual membership report where the data to be published will be arranged by constituency population and the demographic diversity of the membership as an entirety.

~~35.2 The Trust shall not make any of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.~~
~~34.3 So far as the registers are required to be made available:~~
~~35.3.1 They are to be available for inspection free of charge at all reasonable times; and~~
~~35.3.2 A person who requests a copy of, or extract from, the registers is to be provided with a copy or extract.~~
~~35.4 If the person requesting a copy or extract is not a member of the Trust,~~
~~The Trust may impose a reasonable charge for doing so.~~

This amendment was approved at the Trust Board on 28 June 217.

3. ACTIONS REQUIRED

Foundation Trust Constitution amendments made and **published to website –** Company Secretary (Director of Community Engagement and Corporate Affairs)

4. EVALUATIONS/TIMELINES

Within one week of Council of Governors approval being granted.

5. RECOMMENDATIONS

The Council of Governors note the amendments and approve accordingly.

We are WHH

Warrington and Halton Hospitals
NHS Foundation Trust

Appendix 1

The Role of the Lead Governor

Duties

- Leading the Council of Governors in exceptional circumstances when it is not appropriate for the chair or another non-executive to do so)
- Collating the input of Governors for the senior independent director or chair regarding annual performance appraisals of the chair and non-executive directors;
- Leading Governors on the Governors nominations and remuneration committee (GNARC) in the process for appointing a chair and non-executive directors;
- Acting as a point of contact and liaison for the chair and senior independent director;
- Acting as a co-ordinator of governor responses to consultations;
- Chairing informal governor-only meetings;
- Trouble-shooting and problem solving by raising issues with the chair and chief executive;
- Leading Governors in holding the non-executive directors to account;
- Contribute to the induction of new Governors;
- Work with individual Governors who need advice or support to fulfil their role as a Governor;
- Acting as a point of contact for the CQC and Monitor/NHSI

Term

The 'term of office' will be for a two year period or until their term ends, whichever is the sooner. The Lead Governor role is subject to two-yearly election

Eligibility

To be eligible to stand governors:
1. Must have served at least one year with the WHH Council of Governors
2. Must have achieved reasonable attendance at the CoG (min attendance is 75%)

Nomination/Selection Process

Declarations of Intent will be sought by the Company Secretary from the Governors' Council at their formal meeting. Interested parties will be required to respond in writing setting out rationale for standing for the role. The deadline for Governor declarations of interest will be set at not less than two weeks from the commencement of the process.

Nomination forms will then be circulated to the Governors (electronically unless specified otherwise) for selection by the Company Secretary and the successful candidate (by number of votes) advised to the Council by the Chairman on completion on completion of the process. If a nominee is uncontested then the Chairman will approve the appointment on behalf of the Council.

We are WHH

Warrington and Halton Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/17/07/38**
SUBJECT:	**Proposal to Change the Trust's Name**
DATE OF MEETING:	20 July 2017
ACTION REQUIRED	**For Decision**
AUTHOR(S):	Pat McLaren, Director of Community Engagement
EXECUTIVE DIRECTOR	Pat McLaren, Director of Community Engagement Choose an item.
EXECUTIVE SUMMARY	Recruitment of clinical staff continues to be challenging for Trusts but is particularly difficult for those Trusts perceived to be 'district general hospitals'. As a medium sized acute trust, with three hospitals over two sites and increasingly notable performance it is appropriate and timely that the Trust seeks a name change to incorporate the 'teaching' element into its brand. More prominent advertising of its teaching capabilities make the Trust a significantly more desirable employer when candidates have more than one choice in the region. In March 2017 all NHS Organisations in England were contacted by the NHS Identity team to receive and begin to implement their new logo. Our logo change detail in this paper has prompted us to consider, once again, the adoption of 'Teaching Hospitals' in the name of our Foundation Trust for the purposes of competing for medical, nursing and other staff on a 'level playing field'.
RECOMMENDATIONS	The Council of Governors is asked to ratify the Board's decision to approve the change of name and to grant approval to the Director of Community Engagement to proceed with the renaming process. **Executive Team approval to proceed granted on 6th April 2017, and a recommendation presented and approved at Trust Board 26 April 2017.**
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	None

SUBJECT	Proposal to Change the Trust's Name

1. BACKGROUND/CONTEXT

In March 2017 all NHS Organisations in England were contacted by the NHS Identity team to receive and begin to implement their new logo. Our logo change detail is as below, this has prompted us to consider, once again, the adoption of 'Teaching Hospitals' in the name of our Foundation Trust.

Old logo

New logo

Proposed logo

2. KEY ELEMENTS

The core reason for change is to attract and retain staff who have a large choice of organisations in the North West, many of whom identify themselves as 'teaching' organisations. We are aware of the many lost opportunities where candidates have withdrawn after accepting an offer citing the fact that their preferred teaching hospitals choice had made an offer. While there is no clear guidance from NHS England on the specifics required to use the 'teaching' or 'university' trust, they have provided clear guidance to us relating to changing our Trust name.

Neighbouring Trusts (within a 25mile radius of WHH) that identify themselves as 'teaching' organisations and with whom we compete in recruiting staff, particularly medical and nursing staff, are:

Acute Trust
Aintree University Hospital NHS Foundation Trust
Bolton NHS Foundation Trust
Countess of Chester Hospital NHS FT
East Cheshire NHS Trust
East Lancashire Hospitals NHS Trust
Manchester Royal Infirmary
Mid Cheshire Hospitals NHS Foundation Trust
Pennine Acute Hospitals NHS Trust
Pennine Care NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Salford Royal NHS Foundation Trust
Southport and Ormskirk Hospitals NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Stockport NHS Foundation Trust
Tameside Hospital NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
Warrington and Halton Hospital NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust

Teaching Trusts' Employment Offer:

Teaching Trust Offer	WHH
Close affiliation with partner Universities	√
Research opportunities	?
An end to end Trainee employment life cycle	?
Continuous management and support	√
Equitable treatment of Trainees	√
Reduced risk	√
Improved Governance	√
Economies of scale savings for the local health economy	?
Overview of region good/bad practice	√
Development of expertise	√
Including for non-core services i.e. safeguarding	√
Regional 'employment support and expertise' for the Professional Support Unit/Doctors and Dentists Review Groups	?
Supporting Medical Revalidation	√
Regional Training	√
Regional Reporting	√
Greater ability to deliver change across the local health economy	√
Regional/national influence	√
Continuous review of regional services	√
Centralised recruitment	X
Leading to streamline function with pro-active/preventative service	?
GMC enforced	√
Working closely with GMC/BMA/NCAS/JDAT/NHS Employers and other professional bodies	√
Named in the HSJ 100 top employers	√
X	Multi-Award winning
X	Foundation Trust
X	Chief Registrar Role
X	Values-led

We are WHH

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3. ACTIONS REQUIRED

We have sought advice from NHS Identity regarding changing our NHS Foundation Trust's name and advise the following:

1. Although as an NHS Foundation Trust WHH has an independent status within the NHS our proposed name must follow NHS naming principles ie organizational descriptor (NHS FT), be clear, logical and descriptive and contain a geographic reference – the proposed name will comply with this.
2. Our proposed new name of *Warrington and Halton Teaching Hospitals NHS Foundation Trust* does not conflict with the names of neighbouring NHS organisations or services and there is no local, regional or national conflict
3. We are required to engage with our Foundation Trust members and wider patients and the public to check our proposed new NHS name is clear and understandable – this will be done by the Communications and Engagement Team
4. An amendment to the Foundation Trust's constitution will be required and will need to be approved by our Council of Governors with the Board of Directors' recommendation.
5. On completion, we are required to inform our key stakeholders as soon as possible of our new name so they can update their records including:

   - Care Quality Commission
   - Our regional team contact at NHS Improvement (in addition to updating its records, NHS Improvement would also update the NHS Foundation Trust directory)
   - NHS England
   - NHS Digital
   - Our local MP(s)
   - Local authority and local Healthwatch organisation(s).

Considerations

Cost implications will be negligible, only newly commissioned signage and print work will carry the new logo. All electronic templates, digital media platforms can be amended simply by our in-house team.

4. RECOMMENDATIONS

The Council of Governors is asked to consider the change of name for the purposes of competing for medical, nursing and other staff on a 'level playing field' and to grant approval to the Director of Community Engagement to proceed with the renaming process.

We are WHH

Warrington and Halton Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/17/07/39**
SUBJECT:	**Chairs Audit Committee Annual report**
DATE OF MEETING:	20 July 2017
ACTION REQUIRED	**To note**
AUTHOR(S):	Pat McLaren, Director of Communications + Corp Affairs
EXECUTIVE DIRECTOR	Pat McLaren, Director of Community Engagement Choose an item.
EXECUTIVE SUMMARY	This report is to provide assurance to the Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period on the Trust's performance. The report was approved at the Audit Committee on 24 April 2017 and the Trust Board on 31 May 2017.
RECOMMENDATIONS	**The Council of Governors is asked to review the document and ensure it meets its purpose.**
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	None

We are WHH

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS

SUBJECT	Chairs Audit Committee Annual report	AGENDA REF:	COG/17/07/39

AUDIT COMMITTEE REPORT 2016-17

The Committee

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2016 -31 March 2017.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda, not just the finances, and is in support of the achievement of the Trust's objectives.

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

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

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by myself, the Chair of the Committee and the details of my biography can be found within the Annual Report

Member	Attendance (Actual v Max)
Ian Jones, Non-Executive Director & Chair	5/5
Lynne Lobley, Non-Executive Director (until October 2016)	2/4
Margaret Bamforth (from May 2016) Non-Executive Director	0/3
Terry Atherton, Non-Executive Director	4/5
Anita Wainwright, Non-Executive Director	1/5

Regular attendees at the Committee Meetings were PriceWaterhouseCooper (External Auditors to December 2016) and Grant Thornton (External Auditors from January 2017), Mersey Internal Audit Agency ("MIAA") (Internal Audit & Anti-Fraud Services), the Director of Finance & Commercial Development and the Company Secretary to October 2016.

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in January 2017 to ensure they continue to remain fit-for-purpose.

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Frequency of Meetings & Summary of Activity

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

Governance & Risk Management

During the year the Trust has sought to build on the significant work undertaken in the previous year in this area to embed an integrated Governance & Risk system and approach to comply fully with Monitor's Foundation Trust Code of Governance.

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

Internal Audit Activities

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval.

A detailed programme of work is agreed with the Executive Team via the Director of Finance and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.
Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

Specific attention has been focused during the year on:

- Exit Payments
- E – Rostering
- On call, call out and overtime arrangements
- Do Not Attempt Cardiopulmonary Resuscitation
- Lorenzo Phase 2
- Payroll
- Complaints
- Bank & Agency and + Combined Financial Systems Review
- Follow up of previous audits where issues were identified

During the year significant assurance reports were received for the following audits:

- Lorenzo Phase 2
- Clinical Quality Dawes
- Performance Compliance – PDR training + mandatory training
- Payroll

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The aim of the Committee is to ensure best practice is shared within the wider Trust where high assurance levels are received.
The Head of Internal Audit overall opinion for 2016-17 is Significant Assurance.

External Audit

The three year contract for the supply for external audit services by PriceWaterhouseCooper (PWC) expired at the end of September 2016. In accordance with Monitor's guidance, the Trust undertook a full market testing exercise during 2016. Following this process, the award for the supply of External Audit Service was granted to Grant Thornton who attended their first Audit Committee meeting in January 2017.

PWC attended a Council of Governors meeting following the production of the Annual Report and Financial Statements to ensure Governors are assured by the process undertaken to audit the accounts. In addition, they also presented their opinion on the Quality Account to the Council of Governors and to the Annual Members Meeting.

PriceWaterhouseCooper (PWC) continued its role as Auditors to the Trust to October 2016 and during the year reported on the 2015-16 Financial Statements & Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of PWC attended each Audit Committee.

During 2016-17, the Trust remained red for governance under Monitor's Risk Assessment Framework and consequently the Value For Money (VFM) conclusion will be limited.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Counter Fraud Service (CFS) working to a programme agreed with the Audit Committee.
The role of CFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.
Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy.
The Audit Committee received regular progress reports from the CFS and also received an annual report.
No significant cases or issues of Anti-Fraud took place or were identified during the year.

Issues Carried Forward

The Audit Committee will continue its work to ensure the overall system of internal controls and the assurance processes remain robust.
In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.
Whilst the outcomes of the Clinical Audit programme falls under the remit of the Quality Committee and are reported and challenged in that forum; this Committee will review its approach purely from

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an audit perspective and to obtain assurance of methodology and approach as well as its contribution to improving quality.

With respect to the Internal Audit plan for 2017-18, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

Alongside the Audit Committee, there are three main Board assurance committees: (1) Quality; (2) Finance & Sustainability and (3) Strategic People. This structure ensures there is greater visibility and focus at Non-Executive level on the key issues facing the Trust. Arrangements are being made for the Board assurance Committee Chairs to meet formally on an annual basis going forward to ensure appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

Summary

During the year the Audit Committee has been involved in reviewing the new governance arrangements for the Trust and it is pleasing to report that the Trust has established and embedded for Q4 a refreshed Board Assurance Framework and Risk Register which is operating to support the Chief Executive's Annual Governance Statement. This provides reasonable assurance that there is an effective system of internal control to manage the principle risks identified by the Trust.

The Committee encourages frank, open and regular dialogue with the Trust's internal and external audit teams and regular attendees to the meetings.

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

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in July 2017.

The Committee has also assessed its own performance during the year and will report to the Board of Directors in May 2017. The Board received confirmation that all aspects of the Committee's terms of reference have been fulfilled, that the review has informed the Committee's work programme for 2017-18 and the refreshed terms of reference will be presented to the Board for approval in April 2017.

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

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

Ian Jones
Chair of Audit Committee
April 2017