1620 ***05mins***	***Break***			

Sustainability

1625 ***10mins***	***W&HHFT/TB/15/20***	***Verbal Report from the Chair of the Finance and Sustainability Committee***	Verbal	Carol Withenshaw, Non-Executive Director
1635 ***15mins***	***W&HHFT/TB/15/21***	***Q3 Finance Report***	Paper	Director of Finance & Corporate Development
1650 ***10mins***	***W&HHFT/TB/15/22***	***i. Strategic Framework*** ***ii. Strategic Planning Process 2015***	Paper/ Presentation	Director of Finance & Corporate Development
1700 ***15mins***	***W&HHFT/TB/15/23***	***Corporate Performance Report***	Paper	Chief Operating Officer
1715 ***10mins***	***W&HHFT/TB/15/24***	***Corporate Risk Report***	Paper	Director of Nursing, Governance and OD
	W&HHFT/TB/15/25	***Board Assurance Framework***	Paper	Executive
1725 ***10mins***	***W&HHFT/TB/15/26***	***Q3 Monitor Governance Statement***	Paper	Director of Finance & Corporate Development
1735 ***10mins***	***W&HHFT/TB/15/27***	***Lorenzo project approval***	Paper	Director of IM&T
1745 ***15mins***	***W&HHFT/TB/15/28***	***Other Board Committee Reports:*** ***i. Approval of Warrington and Halton Hospitals NHS FT Charitable Fund.*** ***ii. Approval of the Finance and Sustainability Committee Terms of Reference*** ***iii. Minutes for Noting:*** ***a) Finance and Sustainability Committee held on 19 November 2014*** ***b) Quality Governance Committee held on 11 November 2014***	 Paper Paper Paper Paper	 Chair of the CFC Chair of the FSC
	W&HHFT/TB/15/29	***Any Other Business***		
1800 ***ends***		***Dates of next meeting*** *25th February 2015*		

BOARD OF DIRECTORS

WHH/B/2015/ **020**

SUBJECT:	**Verbal Report from the Chair of the Finance and Sustainability Committee**
DATE OF MEETING:	28th January 2015
DIRECTOR:	Carol Withenshaw

BOARD OF DIRECTORS

WHH/B/2015/ **021**

SUBJECT:	**Finance Report as at 31st December 2014**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO2: To be the employer of choice for healthcare we deliver SO3: To give our patients the best possible experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 31st December 2014 the Trust has recorded an actual deficit of £5,673k and a Continuity of Services Risk Rating 2.	
RECOMMENDATION:	***The Board is asked to note the contents of the report.***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	20th January 2015
	Summary of Outcome	Approved

FINANCE REPORT AS AT 31st DECEMBER 2014

1. PURPOSE

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

2. EXECUTIVE SUMMARY

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

The original 14/15 plan approved by the Board and submitted to Monitor was based on an in year deficit of £1.5m. Monitor required the Trust to produce a reforecast that was completed and approved by the Board in December that revised the deficit to £5.9m. The year to date performance is based on the original plan and the performance against the reforecast is in Section 8.

Key financial indicators

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	17.9	18.0	0.1	158.6	160.0	1.4
Operating expenses	(16.9)	(17.9)	(1.0)	(154.4)	(158.3)	(3.9)
EBITDA	1.0	0.1	(0.9)	4.2	1.7	(2.5)
Non-operating income and expenses	(0.8)	(0.7)	0.1	(7.7)	(7.4)	0.3
I&E surplus / (deficit)	0.2	(0.6)	(0.8)	(3.5)	(5.7)	(2.2)
Cash balance	-	-	-	6.5	8.3	1.8
CIP target	1.6	1.1	(0.5)	5.8	4.4	(1.4)
Capital Expenditure	0.9	0.4	0.5	6.1	3.8	2.3
Continuity of Services Risk Rating	4	2	(2)	2	2	0

3. INCOME AND EXPENDITURE

The December and year to date position is summarized in the table below.

Position = Surplus/(Deficit)	December £000	Year to date £000
Plan	173	(3,475)
Actual	(607)	(5,673)
Variance	**(780)**	**(2,198)**

The December and year to date variance by category is summarized in the table below.

Variance = Favourable/(Adverse)	December £000	Year to date £000
Operating income	62	1,438
Operating expenses	(968)	(3,891)
Non-operating income and expenses	127	254
Total	**(780)**	**(2,198)**

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

The operating performance continues to have an adverse effect on the amount of cash available to the trust and even though the cash balance is controlled through the management of working balances, a continuation of the current operating performance will mean a severe reduction in the internally funded capital programme or a significant increase in creditors to avoid the Trust running out of money next financial year.

Operating Income

Year to date operating income is £1,438k above plan due to an over recovery on other operating income (£1,616k) partially offset by an under recovery on NHS clinical income (£170k) and non NHS clinical income (£7k).

Operating Expenses

Year to date operating expenses are £3,891k above plan due to over spends on pay, clinical supplies and non clinical supplies, partially offset by under spends on drugs.

Non Operating Income and Expenses

Non operating income and expenses is £254k below plan mainly due the underspend against depreciation resulting from the slippage in the capital programme.

4. COST IMPROVEMENT PROGRAMME

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

Narrative	In Year £000	Recurrent £000
Annual Target	11,931	11,931
Value of schemes identified	11,276	13,063
Over / (Under) Achievement against target	**(655)**	**1,132**

For the period to date the planned savings for the identified schemes equate to £5,835k, with actual savings amounting to £4,419k which results in an under achievement of £1,416k. An assessment of the full year forecast has been undertaken and based on the estimated savings the in year and recurrent

shortfall is shown in the table below:

Narrative	In Year £000	Recurrent £000
Annual Target	11,931	11,931
Forecast Outturn	8,093	10,780
Over / (Under) Achievement against target	**(3,838)**	**(1,151)**

The under achievement in the current financial year is a significant contributor to the forecast deficit but the recurrent under achievement will need to be recovered, which therefore increases the cost savings required next financial year.

5. CASH FLOW

The cash balance is £8,256k which is £1,767k above the planned cash balance of £6,489k, with the monthly movements summarised in the table below.

Cash balance movement	£000
Opening balance as at 1st December	4,046
In month deficit	(607)
Non cash flows in surplus/(deficit)	731
Increase in receivables	(142)
Increase in payables	1,959
Capital expenditure	(1,134)
Other working capital movements	3,403
Closing balance as at 31st December	**8,256**

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

The current balance equates to circa 14 days operational cash, which is an improvement on the position reported last month. However the value of creditors as at 31st December stands at £8.8m, the majority of which are overdue. Under the continuity of services risk rating the liquidity metric is -9.1 days which results in a score of 2. The calculation of the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance continues to have an adverse effect on the cash position and creditor payments. This operating position, coupled with the non payment to suppliers during the upgrade of the financial systems, resulted in performance against the non NHS Better Payment Practice Code (BPPC) of 5% in the month (46% year to date). This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

A continuation of the current operating performance will mean a severe reduction in the internally funded capital programme or a significant increase in creditors to avoid the Trust running out of money next financial year.

6. STATEMENT OF FINANCIAL POSITION

Non current assets have increased by £224k in the month, as the monthly capital expenditure has exceeded the depreciation cost.

Current assets have increased by £4,589k mainly due to the increase in cash and accrued income.

Current liabilities have increased by £4,806k in the month mainly due to the increase in payables and deferred income. The increase in payables arose due to the non payment of many creditors whilst the Trust upgraded the financial system in December.

Non current liabilities have increased by £615k in the month.

7. CAPITAL

The capital programme has been increased from the original plan as a result of Halton CCG's agreement to fund the costs associated with the development of the Urgent Care Centre, although this has been partially offset by the reduction in contingency funding to cover the funding shortfall. It has also been increased by a successful economy wide Integrated Digital Care Fund bid. The amount approved over a two year period is £3.2m with £1.3m due in 14/15 and £1.9m due in 15/16.

The approved programme for the year now stands at £11.7m and to date the Trust has spent £3.8m against the budget of £6.1m, which is mainly due to delays in the commencement of various schemes.

Category	**Annual Budget £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	5.9	3.8	1.7	2.1
IM&T	4.1	1.8	1.5	0.3
Medical Equipment	1.3	0.3	0.6	(0.3)
Contingency	0.4	0.2	0.0	0.2
Total	**11.7**	**6.1**	**3.8**	**2.3**

8. FORECAST OUTTURN

The Board will be aware that all Foundation Trusts were required to submit a year end forecast and a forecast annual capital spend in December 2014. The reforecast exercise resulted in the Trust submitting a year end deficit of £5.9m which is a deterioration of £1.9m when compared to the previous forecast deficit of £4.0m. The reasons for the increase in the deficit where detailed in the presentation to the Board on 17th December.

In addition to the forecast position as at 31st March 2015 the Trust was required to submit a forecast position for period ending 31st December 2014. The December and year to date position compared to the reforecast is £65k better than plan as summarized in the table below.

Position = Surplus/(Deficit)	December £000	Year to date £000
Plan	(672)	(5,737)
Actual	(607)	(5,673)
Variance	**65**	**65**

The December and year to date variance by category is summarized in the table below.

Variance = Favourable/(Adverse)	December £000	Year to date £000
Operating income	56	56
Operating expenses	8	8
Non-operating income and expenses	1	1
Total	**64**	**64**

The revised annual capital spend was calculated at £7.2m.

A change in the year end position and reduced capital spend impacts on the Continuity of Services Risk Rating and the cash balance. The Continuity of Services Risk Rating remains unchanged at a 2 but the revised cash balance has reduced to £3.1m, which is a reduction of £3.6m compared to the original planned balance of £6.7m.

9. SUMMARY

For the period ending 31st December the Trust has recorded a deficit of £5,673k, which is £2,198k worse than the original planned deficit but £65k better than the revised reforecast. Despite a slightly improved position against the revised deficit a number of financial risks still remain that need to be managed, namely:

- Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines or penalties.
- Failure to deliver the revised income target or remain with revised expenditure forecast.
- Identified cost savings target not fully identified and delivered in in accordance with profile.
- Increase in readmissions resulting in bed blockages and payment to commissioners for exceeding current agreed threshold.
- Failure to manage escalation or partner's inability to provide services to withdraw medically fit patients from the hospital.
- Failure to appropriately reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.

The cumulative deficit includes the contractual fines or penalties associated with A&E breaches, Mixed Sex Accommodation breaches, MRSA occurrences, discharge summaries (24 hour target only), contract challenges for incomplete or invalid patient data and a contingency for 7 day discharge summaries. The total included within the current deficit is a fine / penalty of £991k.

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

Tim Barlow
Director of Finance & Commercial Development
21st January 2015

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance headlines as at 31st December 2014

Key Financial Metrics	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	17,907	17,968	62	158,586	160,024	1,438	213,746	217,113	3,367
Operating Expenditure	-16,878	-17,847	-968	-154,359	-158,249	-3,891	-204,977	-213,282	-8,305
EBITDA	**1,028**	**122**	**-907**	**4,227**	**1,775**	**-2,452**	**8,769**	**3,831**	**-4,938**
Financing Costs	-856	-729	127	-7,702	-7,448	254	-10,269	-9,706	563
Net Surplus/(Deficit)	**173**	**-607**	**-780**	**-3,475**	**-5,673**	**-2,198**	**-1,500**	**-5,875**	**-4,375**
Continuity of Services Risk Rating	4	2	-2	2	2	-1	3	2	-1
Capital Expenditure	893	400	6,123	6,123	3,825	-2,298	10,272	7,161	-3,111
Cash Balance				6,489	8,256	1,767	6,731	3,102	-3,629
Cost Savings	1,556	1,076	-480	5,835	4,419	-1,416	11,931	8,093	-3,838

Summary Position

The original 14/15 plan approved by the Board and submitted to Monitor was based on an in year deficit of £1.5m. Monitor required the Trust to produce a reforecast that was approved by the Board in December that revised the deficit to £5.9m. The in month and year to date performance is based on the original plan.

The reported position for the period is an actual deficit of £5,673k which is £2,198k worse than the planned deficit of £3,475k although this delivers a Continuity of Services Risk Rating 2 which is in line with plan. Year to date income is £1,438k above plan mainly due to overperformance on non elective activity, outpatients, training and education income and other operating income, although this is partially offset by underperformance on elective and other NHS activity. Year to date expenditure is £3,891k above plan due to overspends on pay, clinical supplies and non clinical supplies, althought this is partially offset by an underspend on drugs. Year to date non operating income and expenditure is £254k below plan due to an underspend on depreciation.

Cost savings performance is below plan by £1,416k, as schemes to achieve the annual target have not been identified and there has been slippage against a number of those identified schemes.

Forecast Outturn

The reforecast exercise completed in December revised the year end deficit of £5.9m, which represents a worsening of the forecast by £1.9m compared to the £4.0m previously reported and is

Key Variances

Operating Income - £1,438k above plan (favourable).
Operating Expenditure - £3,891k above plan (adverse).
Non operating income and expenses - £254 below plan (favourable).
Cost savings - £3,838k below plan (adverse)
Cash balances - £1,767k above plan but the inability to make routine payment to suppliers in December due to migration of the financial system from Oracle version 11 to version 12 has inflated the cash balance.
Capital expenditue - £2,298k below plan due to slippage and forecasting a shortfall against the original plan.

Key Risks

Divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in the budget setting process.
Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in commissioner levied fines and penalties.
Cost savings target not fully identified and delivered in accordance with profile.
Failure to significantly reduce bank, agency, locum, overtime and waiting list initiative expenditure.
The operating performance of the trust adversely affects the cash position and its ability to pay creditors on a timely basis and a continuation of the operating performance will result in the trust running out of money.

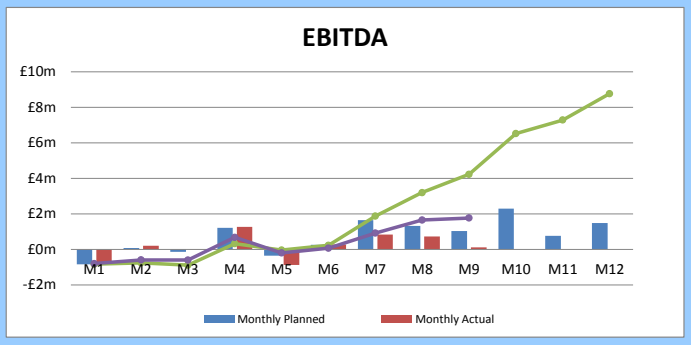
Other matters to be brought to the attention of the Board

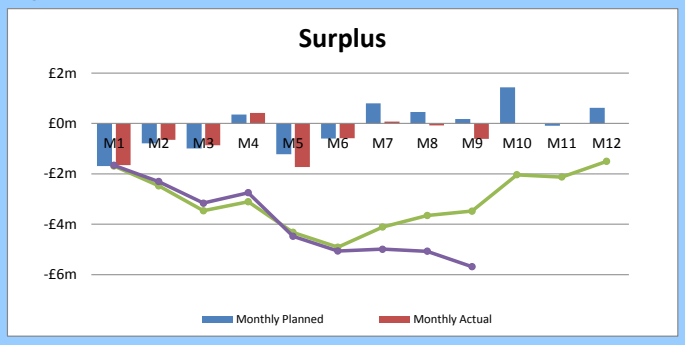
Monitor require all trusts to submit forecast revenue and capital outturns on a monthly basis.
The trust is exploring other opportunities for commercial development and is submitting tenders for a number of new services.
The trust is in discussions with CCGs and NHSE regarding financial responsisbility for specialist spinal patients as both parties are unwilling to pay for activity undertaken to 31st October 2015.
Monitor / NHSE have confirmed that trusts should receive funding equivalent to 14/15 winter monies funding.

Warrington & Halton Hospitals NHS Foundation Trust

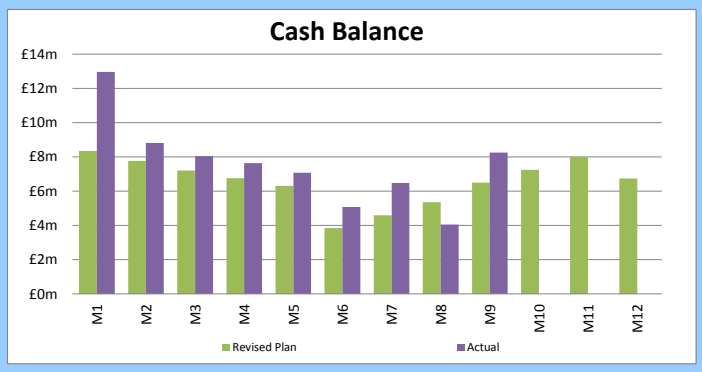
Finance Dashboard as at 31st December 2014 (Part A)

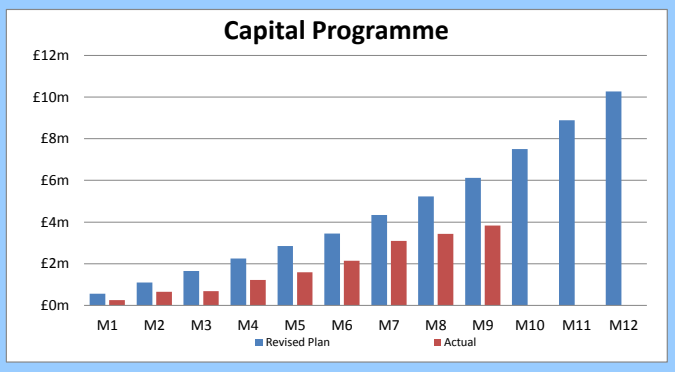
Profitability



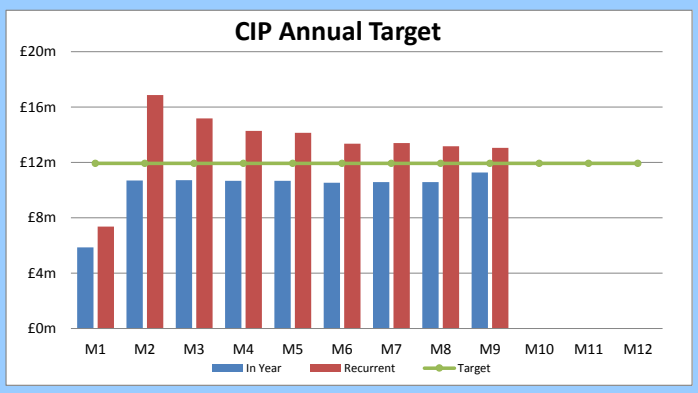


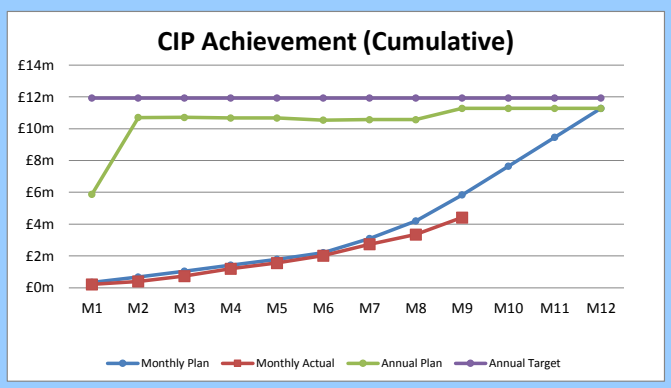
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Scheduled Care	56,162	4,720	4,784	-64	-1.4	42,385	42,779	-394	-0.9
Unscheduled Care	43,792	3,718	3,853	-135	-3.6	33,140	33,887	-747	-2.3
Womens, Children & Support Services	59,505	5,181	5,140	41	0.8	45,590	45,208	382	0.8
Corporate									
Operations - Central	523	48	40	8	16.7	454	381	73	16.1
Operations - Estates	7,551	679	658	21	3.1	5,481	5,288	193	3.5
Operations - Facilities	8,014	661	631	30	4.5	6,032	5,941	91	1.5
Commercial Development	768	87	85	2	2.3	625	553	72	11.5
Finance	9,354	782	766	16	2.0	7,008	6,984	24	0.3
Governance & Workforce	4,705	390	370	20	5.1	3,535	3,250	285	8.1
Information Technology	4,081	347	328	19	5.5	3,093	3,066	27	0.9
Nursing	1,865	156	154	2	1.3	1,398	1,396	2	0.1
Trust Executive	2,161	152	135	17	11.2	1,705	1,638	67	3.9
Total	**198,481**	**16,921**	**16,944**	**-23**	**-0.1**	**150,446**	**150,371**	**75**	**0.0**

Positive variance = underspend, negative variance = overspend.

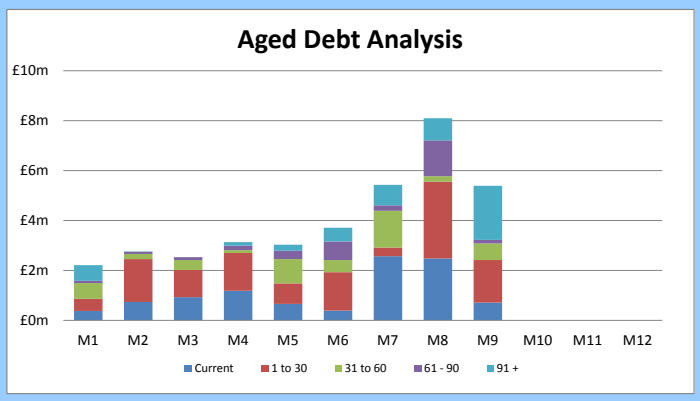
Continuity of Services Risk Rating

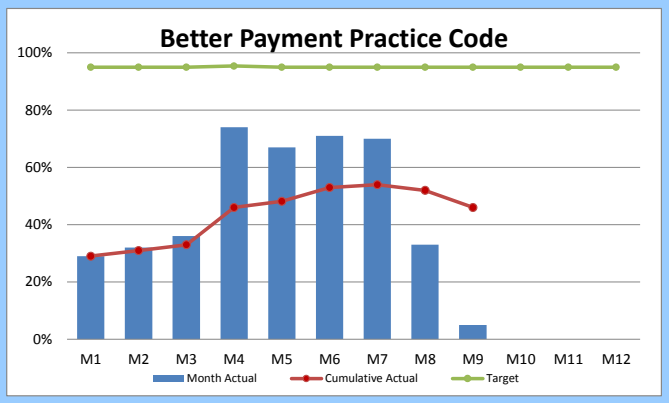
Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-9.1	2
Capital Servicing Capacity (times)	0.6	1
Overall Risk Rating		**2**

Warrington & Halton Hospitals NHS Foundation Trust

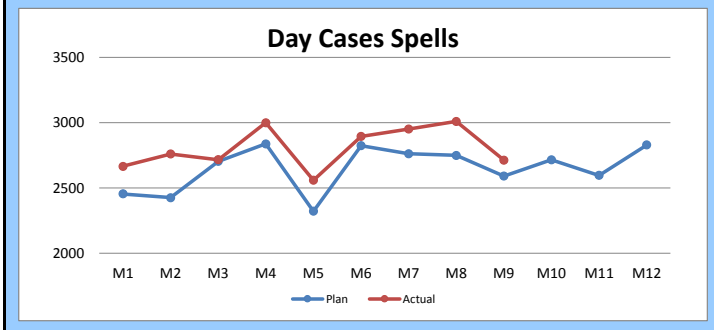
Finance Dashboard as at 31st December 2014 (Part B)

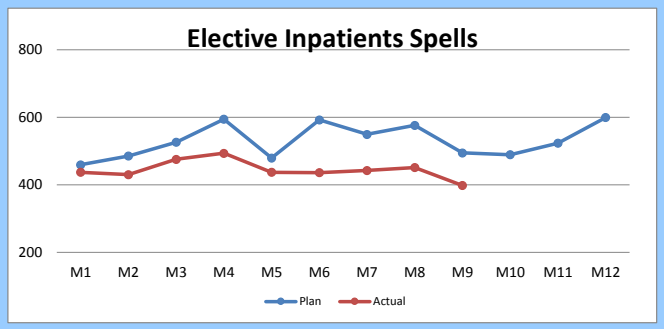
Balance Sheet and Liquidity

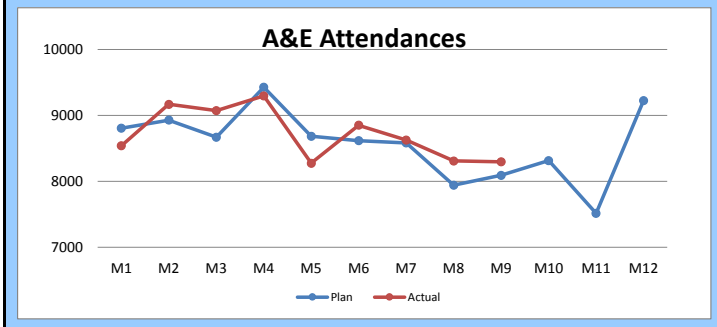


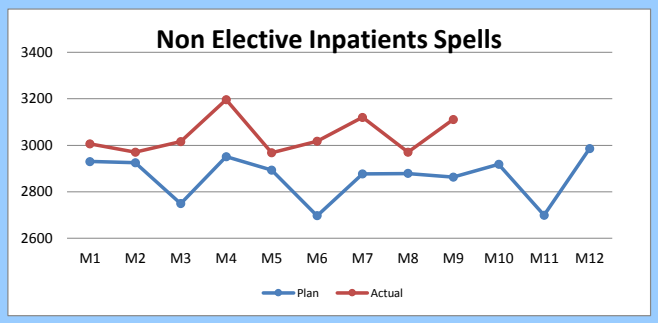


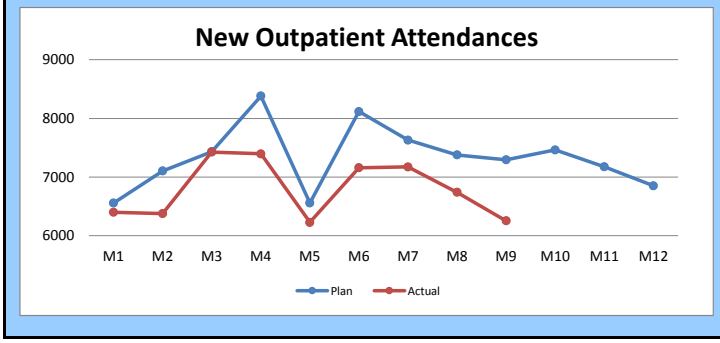
Activity Analysis

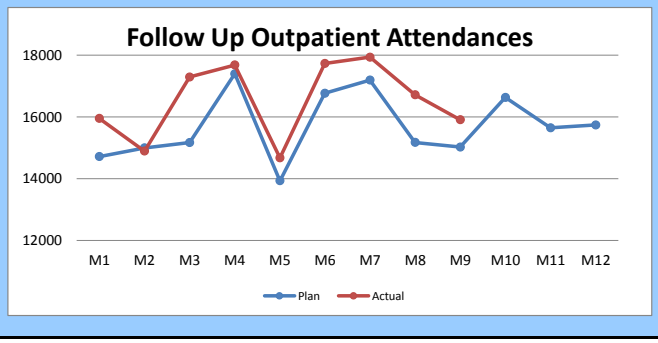












Warrington & Halton Hospitals NHS Foundation Trust **Appendix C1**

Income Statement, Activity Summary and Risk Ratings as at 31st December 2014 (Based on original plan)

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	3,399	2,961	-439	29,235	28,680	-554	39,884	39,823	-61
Elective Excess Bed Days	19	9	-10	182	185	3	242	264	22
Non Elective Spells	4,277	4,906	629	39,110	40,400	1,289	52,145	53,302	1,157
Non Elective Excess Bed Days	302	265	-37	2,781	2,544	-236	3,701	3,456	-245
Outpatient Attendances	2,818	2,734	-85	24,805	25,114	309	33,480	34,018	538
Accident & Emergency Attendances	802	848	46	7,702	7,837	136	10,184	10,284	100
Other Activity	4,956	4,560	-396	42,765	41,649	-1,117	58,103	57,082	-1,021
Sub total	**16,573**	**16,281**	**-291**	**146,580**	**146,410**	**-170**	**197,738**	**198,229**	**491**
Non Mandatory / Non Protected Income									
Private Patients	13	5	-7	114	62	-52	152	86	-66
Other non protected	107	78	-29	963	1,008	45	1,284	1,397	113
Sub total	**120**	**83**	**-37**	**1,077**	**1,070**	**-7**	**1,436**	**1,483**	**47**
Other Operating Income									
Training & Education	641	827	186	5,772	6,087	315	7,696	8,327	631
Donations and Grants	0	0	0	0	0	0	0	500	500
Miscellaneous Income	573	777	204	5,156	6,458	1,301	6,876	8,574	1,698
Sub total	**1,214**	**1,604**	**390**	**10,928**	**12,544**	**1,616**	**14,572**	**17,401**	**2,829**
Total Operating Income	**17,907**	**17,968**	**62**	**158,586**	**160,024**	**1,438**	**213,746**	**217,113**	**3,367**
Operating Expenses									
Employee Benefit Expenses (Pay)	-12,065	-12,905	-839	-111,573	-114,694	-3,120	-147,753	-154,546	-6,793
Drugs	-1,204	-1,236	-32	-10,630	-10,121	509	-14,242	-13,307	935
Clinical Supplies and Services	-1,623	-1,786	-163	-14,289	-15,172	-883	-19,154	-20,189	-1,035
Non Clinical Supplies	-1,986	-1,920	66	-17,866	-18,263	-397	-23,827	-25,240	-1,413
Total Operating Expenses	**-16,878**	**-17,847**	**-968**	**-154,359**	**-158,249**	**-3,891**	**-204,977**	**-213,282**	**-8,305**
Surplus / (Deficit) from Operations (EBITDA)	**1,028**	**122**	**-907**	**4,227**	**1,775**	**-2,452**	**8,769**	**3,831**	**-4,938**
Non Operating Income and Expenses									
Interest Income	3	3	-1	30	29	-1	40	36	-4
Interest Expenses	0	-1	-1	0	-6	-6	0	-12	-12
Depreciation	-524	-429	94	-4,712	-4,485	227	-6,283	-5,770	513
PDC Dividends	-336	-302	34	-3,020	-2,986	34	-4,026	-3,960	66
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-856**	**-729**	**127**	**-7,702**	**-7,448**	**254**	**-10,269**	**-9,706**	**563**
Surplus / (Deficit)	**173**	**-607**	**-780**	**-3,475**	**-5,673**	**-2,198**	**-1,500**	**-5,875**	**-4,375**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	3,086	3,111	25	28,426	29,273	847	38,181	40,507	2,326
Elective Excess Bed Days	78	43	-35	753	811	58	1,003	1,153	150
Non Elective Spells	2,861	3,111	250	25,749	27,374	1,625	34,367	36,436	2,069
Non Elective Excess Bed Days	1,332	1,102	-230	12,287	11,264	-1,023	16,354	15,405	-949
Outpatient Attendances	26,068	27,341	1,274	240,545	253,543	12,998	320,888	343,820	22,932
Accident & Emergency Attendances	8,093	8,299	206	77,756	78,447	691	102,814	103,215	401

Continuity of Services Risk Ratings	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric
Liquidity Ratio - Metric (Days)	0.1	-0.2	-0.3	-9.8	-9.1	0.7	-9.0	-12.2	-3.2
Liquidity Ratio - Rating	4	3	-1	2	2	0	2	2	0
Capital Servicing Capacity - Metric (Times)	3.1	0.4	-2.7	1.4	0.6	-0.8	2.2	0.8	-1.3
Capital Servicing Capacity - Rating	4	1	-3	2	1	-1	3	1	-2
Continuity of Services Risk Rating	**4**	**2**	**0**	**2**	**2**	**0**	**3**	**2**	**0**

Warrington & Halton Hospitals NHS Foundation Trust **Appendix C2**

Income Statement, Activity Summary and Risk Ratings as at 31st December 2014 (Based on reforecast)

Income Statement	Month			Year to date			Forecast		
	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000	Forecast £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	3,466	2,961	-506	29,186	28,680	-506	39,823	39,823	0
Elective Excess Bed Days	22	9	-13	198	185	-13	264	264	0
Non Elective Spells	4,506	4,906	400	40,000	40,400	400	53,302	53,302	0
Non Elective Excess Bed Days	314	265	-50	2,594	2,544	-50	3,456	3,456	0
Outpatient Attendances	2,824	2,734	-91	25,205	25,114	-91	34,018	34,018	0
Accident & Emergency Attendances	787	848	61	7,776	7,837	61	10,284	10,284	0
Other Activity	4,322	4,560	238	41,411	41,649	238	57,082	57,082	0
Sub total	**16,242**	**16,281**	**40**	**146,370**	**146,410**	**40**	**198,229**	**198,229**	**0**
Non Mandatory / Non Protected Income									
Private Patients	7	5	-2	64	62	-2	86	86	0
Other non protected	116	78	-38	1,047	1,008	-39	1,397	1,397	0
Sub total	**123**	**83**	**-40**	**1,111**	**1,070**	**-41**	**1,483**	**1,483**	**0**
Other Operating Income									
Training & Education	828	827	-1	6,087	6,087	0	8,327	8,327	0
Donations and Grants	0	0	0	0	0	0	500	500	0
Miscellaneous Income	720	777	57	6,401	6,458	57	8,574	8,574	0
Sub total	**1,548**	**1,604**	**56**	**12,488**	**12,544**	**56**	**17,401**	**17,401**	**0**
Total Operating Income	**17,913**	**17,968**	**56**	**159,969**	**160,024**	**55**	**217,113**	**217,113**	**0**
Operating Expenses									
Employee Benefit Expenses (Pay)	-13,266	-12,905	361	-115,055	-114,694	361	-154,546	-154,546	0
Drugs	-902	-1,236	-334	-9,787	-10,121	-334	-13,307	-13,307	0
Clinical Supplies and Services	-1,654	-1,786	-132	-15,040	-15,172	-132	-20,189	-20,189	0
Non Clinical Supplies	-2,032	-1,920	112	-18,375	-18,263	112	-25,240	-25,240	0
Total Operating Expenses	**-17,854**	**-17,847**	**7**	**-158,257**	**-158,249**	**8**	**-213,282**	**-213,282**	**0**
Surplus / (Deficit) from Operations (EBITDA)	**59**	**122**	**63**	**1,712**	**1,775**	**63**	**3,831**	**3,831**	**0**
Non Operating Income and Expenses									
Interest Income	3	3	0	29	29	0	36	36	0
Interest Expenses	-2	-1	1	-7	-6	1	-12	-12	0
Depreciation	-430	-429	1	-4,485	-4,485	0	-5,770	-5,770	0
PDC Dividends	-302	-302	1	-2,986	-2,986	1	-3,960	-3,960	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-731**	**-729**	**2**	**-7,449**	**-7,448**	**1**	**-9,706**	**-9,706**	**0**
Surplus / (Deficit)	**-672**	**-607**	**65**	**-5,737**	**-5,673**	**64**	**-5,875**	**-5,875**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,526	3,111	-414	29,687	29,273	-414	40,507	40,507	0
Elective Excess Bed Days	97	43	-54	865	811	-54	1,153	1,153	0
Non Elective Spells	3,080	3,111	31	27,343	27,374	31	36,436	36,436	0
Non Elective Excess Bed Days	1,401	1,102	-299	11,563	11,264	-299	15,405	15,405	0
Outpatient Attendances	28,545	27,341	-1,204	254,747	253,543	-1,204	343,820	343,820	0
Accident & Emergency Attendances	7,896	8,299	403	78,044	78,447	403	103,215	103,215	0
Continuity of Services Risk Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)		-0.2		-10.3	-9.1	1.1	-8.6	-12.2	-3.6
Liquidity Ratio - Rating		3		2	2	0	2	2	0
Capital Servicing Capacity - Metric (Times)		0.4		0.6	0.6	0.0	0.8	0.8	0.0
Capital Servicing Capacity - Rating		1		1	1	0	1	1	0
Continuity of Services Risk Rating		**2**		**2**	**2**	**0**	**2**	**2**	**0**

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

Cash Flow Statement as at 31st December 2014

	Actual April £000's	Actual May £000's	Actual June £000's	Actual July £000's	Actual August £000's	Actual September £000's	Actual October £000's	Actual November £000's	Actual December £000's	Forecast January £000's	Forecast February £000's	Forecast March £000's	Annual Position March £000's
Surplus/(deficit) after tax	**(1,655)**	**(647)**	**(858)**	**414**	**(1,726)**	**(587)**	**72**	**(81)**	**(607)**	**(250)**	**(100)**	**150**	**(5,875)**
Non-cash flows in operating surplus/(deficit)													
Depreciation and amortisation	523	525	523	523	524	524	438	476	429	428	428	429	5,770
Impairment losses/(reversals)													0
(Gain)/loss on disposal of property plant and equipment													0
PDC dividend expense	336	335	336	335	336	336	336	336	302	324	324	324	3,960
Other increases/(decreases) to reconcile to profit/(loss) from operations	(16)	9	(3)	(19)	6	(16)	40	(85)	62	(26)	(26)	(25)	(99)
Non-cash flows in operating surplus/(deficit), Total	**843**	**869**	**856**	**839**	**866**	**844**	**814**	**727**	**793**	**726**	**726**	**728**	**9,631**
Operating Cash flows before movements in working capital	**(812)**	**222**	**(2)**	**1,253**	**(860)**	**257**	**886**	**646**	**186**	**476**	**626**	**878**	**3,756**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	(36)	(93)	68	52	141	(254)	(68)	(32)	(108)	80	(120)	148	(222)
(Increase)/decrease in NHS Trade Receivables	775	(332)	869	(991)	504	(618)	(346)	(3,643)	(445)	445	800	1,200	(1,782)
(Increase)/decrease in Non NHS Trade Receivables	154	(430)	(121)	203	(257)	(47)	248	(446)	471	(120)	(50)	199	(195)
(Increase)/decrease in other related party receivables	(235)	(75)	181	(237)	206	(11)	(161)	(36)	185	60	(120)	(125)	(367)
(Increase)/decrease in other receivables	(1)	303	144	(102)	137	(20)	(35)	467	(353)	(250)	300	303	892
(Increase)/decrease in accrued income	261	417	(231)	(542)	(220)	364	(647)	(175)	(668)	645	657	(134)	(274)
(Increase)/decrease in prepayments	(1,833)	507	(386)	(165)	872	(291)	253	9	463	587	171	229	416
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	(243)	612	(14)	18	344	64	1,359	1,325	1,883	(1,302)	(1,302)	(1,286)	1,459
Increase/(decrease) in Current provisions	5	(11)	12	7	8	8	0	(47)	10	(50)	30	10	(18)
Increase/(decrease) in Trade Creditors	2,508	(3,205)	(351)	(1,190)	(1,086)	1,182	2,944	(1,175)	1,939	(2,955)	(1,065)	641	(1,813)
Increase/(decrease) in Other Creditors	167	(407)	61	(27)	85	95	(63)	(93)	20	250	350	331	769
Increase/(decrease) in accruals (adj for dep'n acrrue to budget)	(189)	(568)	(645)	1,702	7	(448)	(2,162)	1,672	476	(25)	30	79	(71)
Increase/(decrease) in other Financial liabilities									734	2	2	3	741
Increase/(decrease) in Other liabilities (VAT, Social Security and Other Taxes)	(4)	94	(120)	64	(62)	15	35	2	30	60	(20)	(70)	24
Increase/(Decrease) in working capital, Total	**1,329**	**(3,188)**	**(533)**	**(1,208)**	**679**	**38**	**1,359**	**(2,171)**	**4,636**	**(2,573)**	**(337)**	**1,528**	**(441)**
Increase/(decrease) in Non-current provisions	(27)	13	14	(27)	16	15	(177)	20	41	16	20	(77)	(153)
Net cash inflow/(outflow) from operating activities	**490**	**(2,953)**	**(521)**	**18**	**(165)**	**310**	**2,068**	**(1,505)**	**4,863**	**(2,081)**	**309**	**2,329**	**3,162**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	0	0	0	0	0	0	0	0	(258)	(100)	(100)	(32)	**(490)**
Property - maintenance expenditure	(158)	(115)	(35)	(207)	(241)	(132)	(444)	(143)	(6)	(325)	(400)	(428)	**(2,634)**
Plant and equipment - Information Technology	(39)	(165)	(23)	(283)	(92)	(245)	(322)	(150)	(814)	(400)	(550)	(803)	**(3,886)**
Plant and equipment - Other	(45)	(119)	27	(61)	(23)	(179)	(194)	(37)	(56)	(50)	(70)	(78)	**(885)**
Increase/(decrease) in Capital Creditors	(171)	(865)	(171)	124	(58)	315	271	(201)	80	(75)	(75)	(54)	(880)
Net cash inflow/(outflow() from investing activities, Total	**(413)**	**(1,264)**	**(202)**	**(427)**	**(414)**	**(241)**	**(689)**	**(531)**	**(1,054)**	**(950)**	**(1,195)**	**(1,395)**	**(8,775)**
Net cash inflow/(outflow) before financing	**77**	**(4,217)**	**(723)**	**(409)**	**(579)**	**69**	**1,379**	**(2,036)**	**3,809**	**(3,031)**	**(886)**	**934**	**(5,613)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received	0												0
PDC Dividends paid	0					(2,065)						(1,895)	(3,960)
Interest (paid) on non-commercial loans	0							(5)	(1)	(2)	(2)	(2)	(12)
Interest received on cash and cash equivalents	4	2	6	3	3	3	3	3	3	2	2	2	36
Drawdown of non-commercial loans							0	0	0	0	0	0	0
Repayment of non-commercial loans	0												0
(Increase)/decrease in non-current receivables	(84)	65	(38)	(4)	9	(2)	24	(398)	399	(100)	65	(241)	(305)
Net cash inflow/(outflow) from financing activities, Total	**(80)**	**67**	**(32)**	**(1)**	**12**	**(2,064)**	**27**	**(400)**	**401**	**(100)**	**65**	**(2,136)**	**(4,241)**
Net increase/(decrease) in cash	**(3)**	**(4,150)**	**(755)**	**(410)**	**(568)**	**(1,994)**	**1,406**	**(2,436)**	**4,210**	**(3,131)**	**(821)**	**(1,202)**	**(9,854)**
Opening cash	**12,956**	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**6,482**	**4,046**	**8,256**	**5,125**	**4,304**	**12,956**
Closing cash	**12,953**	**8,803**	**8,048**	**7,638**	**7,070**	**5,076**	**6,482**	**4,046**	**8,256**	**5,125**	**4,304**	**3,102**	**3,102**

Forecast cash position as per Original Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	6,489	7,241	7,993	6,731
Actual cash position	12,953	8,803	8,048	7,638	7,070	5,076	6,482	4,046	8,256	5,125	4,304	3,102
Variance	4,611	1,031	846	887	769	1,237	1,885	-1,310	1,767	-2,116	-3,689	-3,629

Forecast cash position as per Re-Forecast Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	4,995	5,125	4,304	3,102
Actual cash position	12,953	8,803	8,048	7,638	7,070	5,076	6,482	4,046	8,256	5,125	4,304	3,102
Variance	4,611	1,031	846	887	769	1,237	1,885	-1,310	3,261	0	0	0

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

Statement of Position as at 31st December 2014

Narrative	Audited position as at 31.3.14 £000	Actual Position as at 30.11.14 £000	Actual Position as at 31.12.14 £000	Monthly Movement £000	Forecast Position as at 31.3.15 £000
ASSETS					
Non Current Assets					
Intangible Assets	316	533	490	-43	533
Property Plant & Equipment	132,588	131,799	132,466	667	133,898
Other Receivables	1,233	1,808	1,316	-492	1,808
Impairment of receivables for bad & doubtful debts	-195	-342	-249	93	-465
Total Non Current Assets	**133,942**	**133,799**	**134,023**	**224**	**135,774**
Current Assets					
Inventories	2,769	2,991	3,099	108	2,991
NHS Trade Receivables	3,052	6,834	7,279	445	4,834
Non NHS Trade Receivables	573	1,268	797	-471	768
Other Related party receivables	200	567	382	-185	567
Other Receivables	1,960	1,068	1,421	353	1,068
Impairment of receivables for bad & doubtful debts	-355	-292	-369	-77	-292
Accrued Income	884	1,658	2,326	668	1,158
Prepayments	1,727	2,761	2,298	-463	1,311
Cash held in GBS Accounts	12,937	4,026	8,236	4,210	3,082
Cash held in commercial accounts	0			0	0
Cash in hand	19	20	20	0	20
Total Current Assets	**23,766**	**20,900**	**25,489**	**4,589**	**15,507**
Total Assets	**157,708**	**154,698**	**159,512**	**4,814**	**151,281**
LIABILITIES					
Current Liabilities					
NHS Trade Payables	-1,513	-1,037	-1,710	-673	-1,597
Non NHS Trade Payables	-5,728	-5,831	-7,097	-1,266	-3,831
Other Payables	-1,755	-1,573	-1,593	-20	-2,573
Other Liabilities (VAT, Social Security and Other Taxes)	-2,678	-2,702	-2,732	-30	-2,702
Capital Payables	-1,386	-630	-710	-80	-630
Accruals	-5,986	-5,415	-5,797	-382	-5,916
Interest payable on non commercial int bearing borrowings	0	0	0	0	0
PDC Dividend creditor	-49	-668	-970	-302	0
Deferred Income	-1,353	-4,819	-6,702	-1,883	-2,078
Provisions	-282	-264	-274	-10	-264
Loans non commercial	0	0		0	0
Borrowings	0	0	-160	-160	-154
Total Current Liabilities	**-20,730**	**-22,939**	**-27,745**	**-4,806**	**-19,745**
Net Current Assets (Liabilities)	**3,036**	**-2,039**	**-2,256**	**-217**	**-4,238**
Non Current Liabilities					
Loans non commercial		0		0	0
Provisions	-1,510	-1,357	-1,398	-41	-1,357
Borrowings	0	0	-574	-574	-587
Total Non Current Liabilities	**-1,510**	**-1,357**	**-1,972**	**-615**	**-1,944**
TOTAL ASSETS EMPLOYED	**135,468**	**130,403**	**129,795**	**-608**	**129,592**
TAXPAYERS AND OTHERS EQUITY					
Taxpayers Equity					
Public Dividend Capital	90,063	90,063	90,063	0	90,063
Retained Earnings prior year	12,446	9,597	9,597	0	9,597
Retained Earnings current year	-2,849	-5,066	-5,673	-607	-5,876
Sub total	**99,660**	**94,594**	**93,987**	**-607**	**93,784**
Other Reserves					
Revaluation Reserve	35,808	35,808	35,808	0	35,808
Sub total	**35,808**	**35,808**	**35,808**	**0**	**35,808**
TOTAL TAXPAYERS AND OTHERS EQUITY	**135,468**	**130,403**	**129,795**	**-608**	**129,592**

BOARD OF DIRECTORS

WHH/B/2015/ **022(i)**

SUBJECT:	**Strategic objectives and the strategic planning framework and cycle**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Mike Barker, Deputy Director of Strategy & Commercial Development	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO4/4.1 Failure to agree and implement a focussed and robust business development strategy to achieve the strategic aims of the Trust.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This paper outlines the Trust's strategic planning framework, the planning cycle to which it should work from this point onwards and a series of refreshed strategic objectives (translated from the five year strategic plan) to guide and shape planning in the years ahead.	
RECOMMENDATION:	***The Board is asked to discuss the strategic framework and revised business planning timetable for future years and approve the proposed strategic objectives.***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/14/73
	Date of meeting	12 November 2014
	Summary of Outcome	Noted

Strategic objectives and the strategic planning framework and cycle

EXECUTIVE SUMMARY

1. Each year the Trust should agree a set of objectives for the following year which signal the start of the planning round. These objectives define what the Trust is aiming to achieve in the next year to deliver its strategy. They should be used to set the Trusts annual plan, service line plans and personal objectives for each individual within the Trust.

2. This paper outlines the Trust's strategic planning framework, the planning cycle to which it should work from this point onwards and a series of refreshed strategic objectives (translated from the five year strategic plan) to guide and shape planning in the years ahead.

CONTEXT

3. Some years ago the Board considered and agreed four key objectives as follows:

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

4. Whilst the essence of their intent remains relevant, they have organically evolved as the planning regime through Monitor has incrementally changed over time. This paper outlines a more progressive and dynamic approach and seeks to reach a Board agreed position for a formally refreshed strategic framework to guide and shape all future planning in the years ahead.

STRATEGIC PLANNING FRAMEWORK

5. The Trust has a track record of delivering high performing clinical services for the communities within the boroughs of Warrington and Halton and to visiting patients from other areas. This continued success delivered throughout six years as a Foundation Trust has been through the actions of dedicated staff and in an environment of financial stability, strategic investments and robust governance. The track record to date allowed the Board of Directors and Council of Governors to confirm the organisation's purpose as being to *"provide high quality, safe integrated healthcare to all our patients every day*".

6. Over the last 12 months work with governors and external stakeholders has led to the Trust moving that framework further by defining its long term vision in a simple statement. This simple statement seeks to describe the Trust's single vision for the sort of organisation that it wants to be. The vision is defined as follows: *"the most clinically and financially successful integrated healthcare provider in the mid-Mersey region*".

7. This year we have been reviewing our values in order to bring together values, expectations and competency into a single space. This will ultimately lead to a re-launched set of behaviours

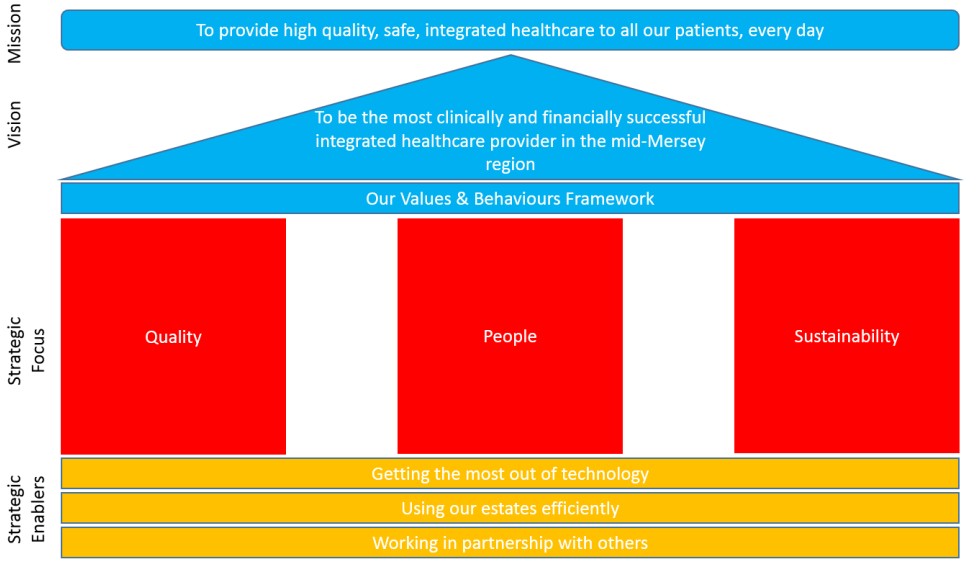
focused around our QPS triple aim, enabling us to fully link our overall strategic aims with every single individual's objectives within the organisation.

8. In order to ensure the delivery of the organisation's purpose and achieve the organisation's vision, the Board agreed a need to focus on three things: the QUALITY of our services; the PEOPLE who deliver them; and ensuring our organisation's SUSTAINABILITY within the wider local health economy in which we operate. This has internally become known as our 'QPS' framework and is the underpinning strategic framework for organising everything that we do.

9. Through the development of our five year strategic plan, approved by the Board and then submitted to Monitor last year, the Board confirmed that the 'QPS' framework will be supported and enabled by:

    - Improving our estate and physical infrastructure
    - Modernising our IM&T platforms
    - Pursuing a range of strategic collaborations and partnerships

10. This framework can be described as a simple diagram, which is as follows:



11. The elements within this proposed strategic framework chime with the changing ethos within the wider NHS which reflects the learning from a range of national work but most particularly the public inquiry into the failings at Mid-Stafford Hospital led by Sir Robert Francis QC. Moreover it is wholly consistent with the agreed strategic plan for the Trust which was launched to staff and stakeholders in October.

STRATEGIC OBJECTIVES

12. However, in order to further evolve our planning process and provide clear direction, the Board should ensure that this framework is translated into a set of tangible strategic objectives which

then lie at the heart of determining the way in which we approach the delivery of our plan over the course of the next four to five years. These tangible objectives are proposed as follows:

- **Strategic Objective 1:** To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.

- **Strategic Objective 2:** To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.

- **Strategic Objective 3:** To deliver well managed, value for money, sustainable services.

- **Strategic Objective 4:** To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.

13. Setting the strategic objectives in such a way will then enable a detailed piece of work to be undertaken to translate these strategic objectives into a set of annually reviewed corporate objectives, which will serve to then define what the Trust will do on an annual basis to deliver its strategy. Thus these proposed strategic objectives will require Board discussion and approval.

A REFRESHED PLANNING CYCLE

14. From 2015/16 it is proposed that business planning activities at the Trust are co-ordinated through a newly created Strategic and Annual Planning Steering Group which will be chaired by the Director of Finance and Commercial Development and will report to the Finance and Sustainability Committee and also the Hospital Management Board meeting. This group will become responsible for developing a comprehensive project plan which integrates all aspects of annual business planning including horizon scanning, development of corporate objectives, budget setting, agreeing the SLA, workforce planning, job planning, the development of productivity plans, reviewing plans for their quality impact, capital planning and consultation and engagement with key groups such as the Governors and our partners.

15. A new business planning programme and timetable has been developed for implementation in 2015/16m which is shown at Appendix 1 whilst Appendix 2 outlines the consequent draft reporting cycle. The Board's comments on this are welcomed.

RECOMMENDATIONS

16. The Board is asked to discuss the strategic framework and revised business planning timetable for future years and approve the proposed strategic objectives.

CONCLUSION

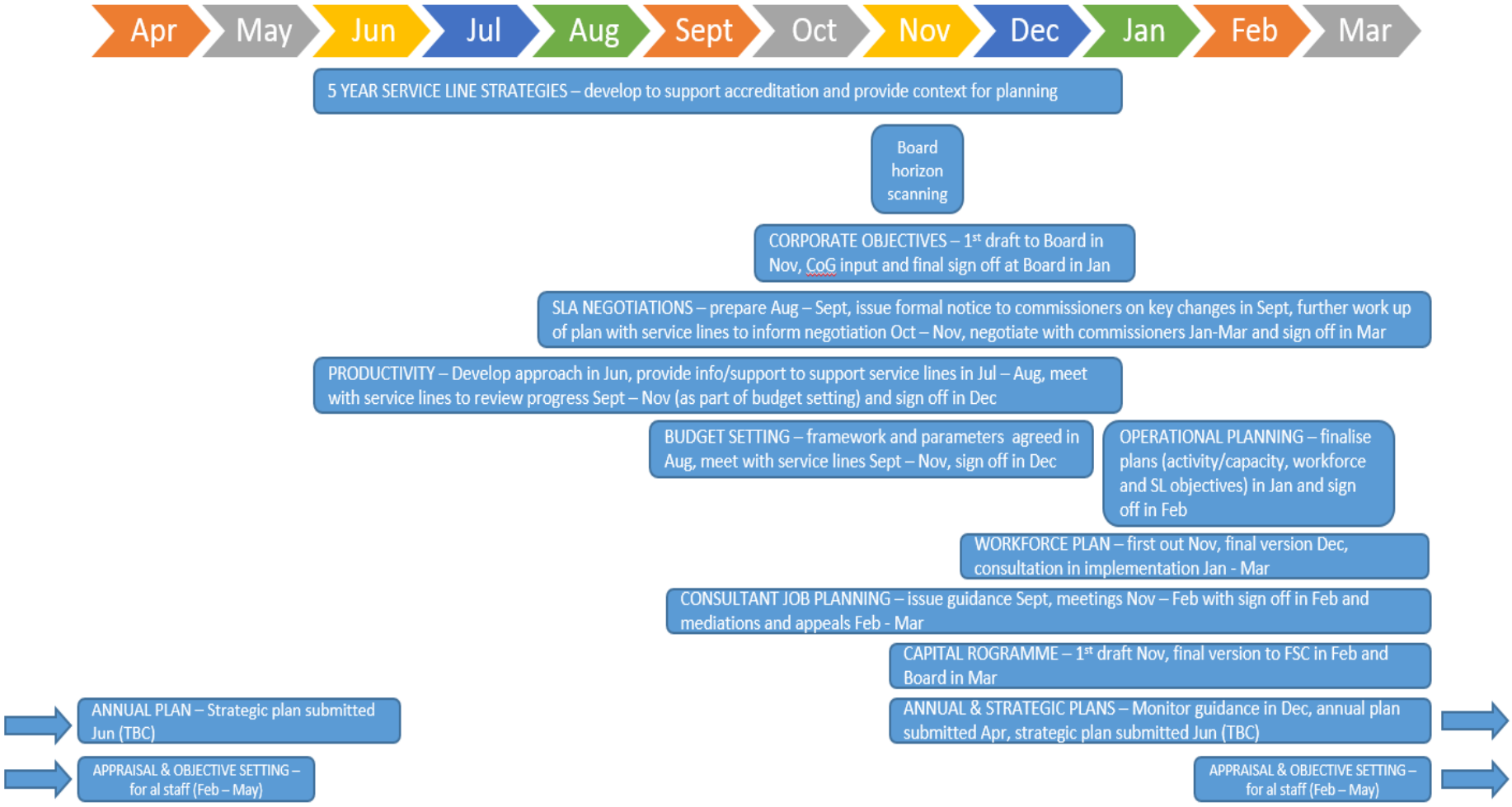
17. Pursuing our strategic objectives will enable us to further develop high quality, accessible and sustainable services that will deliver excellent outcomes and a positive experience for our patients and staff.

Appendix 1

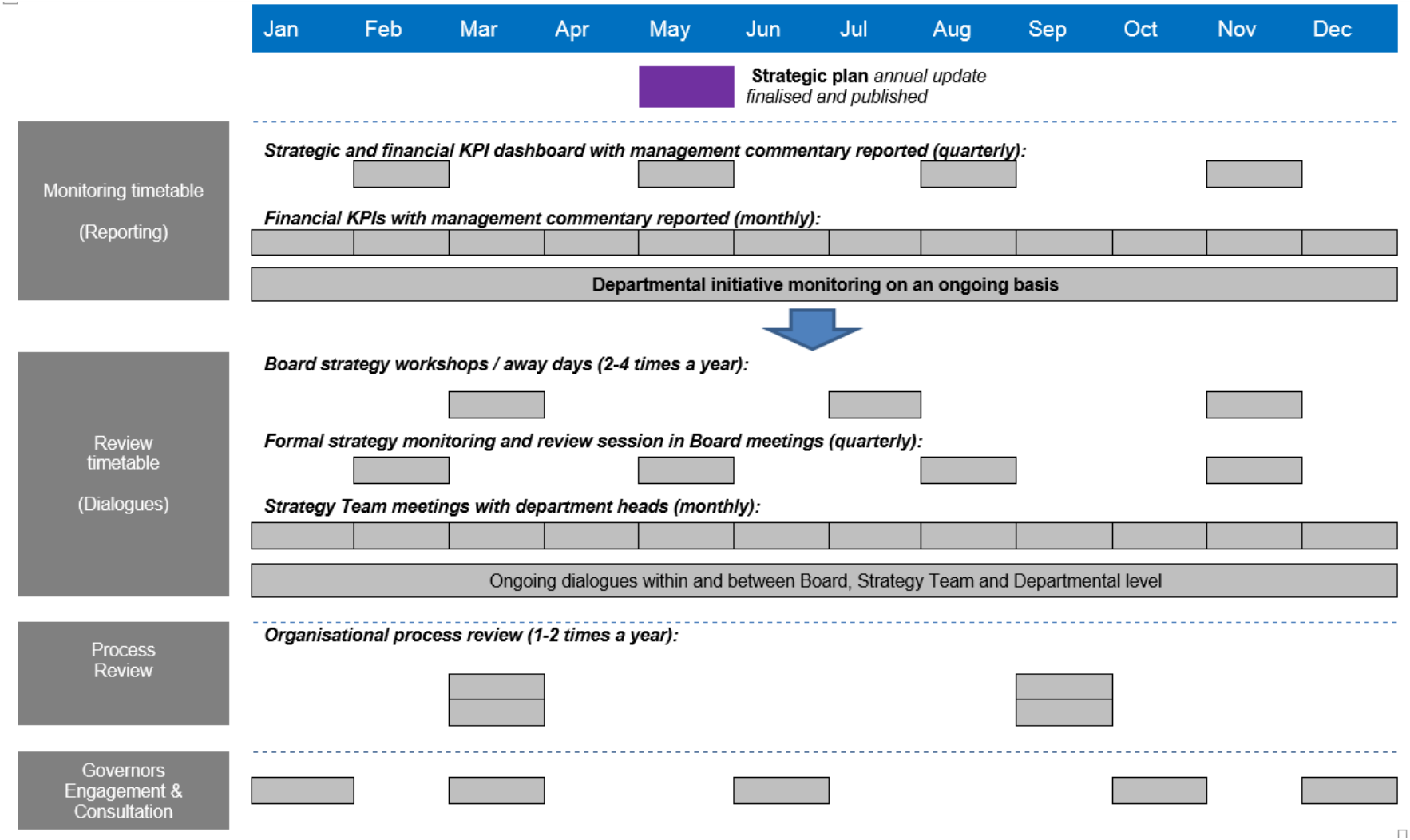
Business Planning Framework and Cycle

Programme overview

Warrington and Halton Hospitals NHS
NHS Foundation Trust



Appendix 2: Draft Board and Governors Reporting Cycle



BOARD OF DIRECTORS

WHH/B/2015/ **022(ii)**

SUBJECT:	**Planning requirements for 2015/16**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mike Barker, Deputy Director of Strategy & Commercial Development	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO4/4.1 Failure to agree and implement a focussed and robust business development strategy to achieve the strategic aims of the Trust.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The paper outlines the planning requirements issued by Monitor for foundation trusts to meeting during 2015/16. It provides the overall timetable that the Trust is following, the internal process that is being followed and an indication of the next steps that will be taken to bring about further improvements to the planning process in the coming period.	
RECOMMENDATION:	***The Board is asked to:*** note the planning requirements and timetable for 2015/16 and the process by which the Trust is meeting those requirements.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Not Applicable

Planning Requirements for 2015/16

EXECUTIVE SUMMARY

1. A sound strategy will help protect the clinical, financial and operational sustainability of the services that foundation trusts, local health economies (LHEs) and the wider NHS provide for their populations. In the NHS the 'annual plan' represents the choices and principles designed to help an organisation achieve its goals in realising its strategy. It should direct how resources are allocated and how staff prioritise their time.

2. This paper outlines the planning requirements issued by Monitor for foundation trusts to meeting during 2015/16. It provides the overall timetable that the Trust is following, the internal process that is being followed and an indication of the next steps that will be taken to bring about further improvements to the planning process in the coming period.

CONTEXT

3. To support the delivery of the ambitions set out in the five year forward view, into actions: planning for 2015/16, Monitor and the TDA have published detailed guidance for this year's annual planning review (APR).

4. For 2014/15 foundation trusts and trusts were required to develop and submit five year strategic plans, alongside their two year operational plans. This year, all foundation trusts and NHS trusts are required to submit a one year operational plan for 2015/16.

5. However, this year foundation trusts are being asked to consider two specific issues in their plans. Firstly, sustainability; how the strategic plan has been updated (recommitted to, refreshed or recreated) in light of a) the foundation trust's 2014/15 performance b) any changes to its internal/external environment. In addition, how the foundation trust plans to achieve progress against that strategy in 2015/16 with particular reference to 'The Forward View into action: partnership and planning for 2015/16'. Secondly, resilience; how quality, operational and financial requirements will be met in 2015/16. Thus plans need to be underpinned by strong supporting financial projections.

REQUIREMENTS OF FOUNDATIONS TRUSTS FOR 2015/16

6. In process terms, there has been two major changes to Monitor's requirements following the initial planning timetable published in their November 'FT bulletin': Foundation trusts are now required to submit a one year operational plan only for 2015/16 (rather than a two year plan); and foundation trusts are now required to submit a high-level draft plan at the end of February 2015 in advance of the submission of the final detailed plan in April 2015.

7. Submission of a new five year strategic plan is not required as part of this process. However, Foundation trust's may be required to submit a new five year

strategic plan later in 2015, with 2016/17 being ''year one'', as Monitor, the TDA and NHS England continue to develop a longer term planning framework for providers and commissioners based on the Five Year Forward View.

8. For 2015/16 planning the high level draft operational plan is required by midday on 27 February 2015, and should include:

    - a summarised financial template, providing high-level financial projections with relevant underlying assumptions, for 2015/16; and
    - a three page brief narrative setting out the key assumptions, the degree of confidence in these assumptions and the extent of alignment with commissioners' plans.

9. Monitor will undertake a high-level desktop review of the draft operational plans, to identify key issues or concerns that should be addressed or explained in the foundation trust's final operational plan submission. Their review will be focussed on: the key assumptions underpinning financial projections, the cohesion, plausibility and risk of the financial projections and the degree of alignment with the main commissioners' plans. Where appropriate feedback on draft operational plans will be provided to Foundation Trusts in March 2015.

10. The final, detailed operational plan is required by midday on 10 April 2015, and the key components of the detailed plan should include:

    - an operational narrative (not for external publication);
    - a redacted summary of the operational plan narrative (in a format suitable for external publication); and
    - a financial template (including the completion of one year of detailed financial forecasts).

11. Following the submission of the final operational plans Monitor will undertake a risk-based desktop review between April and May 2015, and will also incorporate the review of quarter four returns. Feedback on the final operational plan will be provided to each Foundation Trust in June 2015. In the planning guidance Monitor reiterate their focus on ensuring Foundation Trusts are capable of meeting current operational and financial requirements ('resilience') and delivering a credible strategy for achieving required performance levels into the long term ('sustainability'). Monitor state that plans will be assessed on a case-by-case basis; however Monitor will be most concerned by a lack of engagement in the planning process or by overly optimistic planning as these can indicate broader failures of governance. Regulatory action following a review of the submitted plans may include enhanced scrutiny, re-submission of plans or investigation.

12. Foundation trusts are also now required to take part in a weekly contract tracker, which will involve Monitor collecting weekly updates from foundation trust on the status of their contracts, in order to track their progress and highlight risks of misalignment. Monitor is also encouraging foundation trusts to take part in the contract dispute resolution process run by NHS England and the TDA, in order to help ensure that all commissioners and all providers have in place mutually agreed contracts prior to the start of the financial year. Please note while this is a voluntary process for foundation trusts and the arbitration stage will not be mandatory, Monitor may regard an unsigned contract as a risk in their review of plans and therefore have issued a dispute resolution process for the 2015/16 contracting process.

13. Financially distressed foundation trusts (those which currently, or expect to, require DH funding) will be subject to additional reporting requirements.

SUBMISSION AND ASSURANCE OF PLANS

14. NHS England, Monitor and TDA will still assure plans for CCGs, foundation trusts and NHS trusts respectively in line with their statutory duties. However a more joined up approach to assurance will collectively focus on:

    - finances to secure delivery and compliance with the planning guidance
    - that finance and activity projections are supported by reasonable and deliverable planning assumptions including level of assumed efficiency savings and underlying growth
    - triangulation of finance and activity
    - agreed demand and capacity plans
    - coherence with LETB work plans
    - coherence with other planning and output assumptions
    - robust local relationships which are key to ensuring delivery.

15. The following key dates are particularly useful to note:

Date	**Action**
23 December	Publication of full planning guidance *(including technical appendices from Monitor TDA)*
2015	
Early January	Publication of final tariff
13 January	submission of headline plan data *(CCGs and providers)*
From 29 January	Weekly contract tracker to be submitted *(CCGs NHS England NHS Trusts)*
20 February	National contract stocktake
27 February	Submission of full draft plans *(CCGs and providers)* followed by an assurance process by NHS England Monitor or TDA respectively *(to 30 March)*

11 March	Contracts signed post mediation
12-23 March	Contract arbitration with outcomes notified by 25 March
31 March	Plans approved by boards of CCGs foundation trusts and NHS trusts
10 April	Sign off for local plans followed by further assurance and reconciliation of operational plans.

16. The guidance states that NHS England, Monitor and TDA will consider it a 'major failing' of a local health economy if agreement is not reached (including on contracts) prior to the start of the financial year. Where this is not achieved a dispute process will apply.

INTERNAL TRUST PROCESS

17. Although the internal Trust process is designed intuitively to ensure that when Monitor Guidance is issued, the process matches the guidance requirements. Typically, Monitor guidance is issued in late December each year. It is not practicable to wait for the guidance to be issued before starting the process due to the large amount of work and tight deadlines for the annual plan submissions. This is why the Strategy and Planning Team began the planning process in early November.

18. At present the most important elements of the existing process include:

- Establishing resource requirements
- Consultations with Divisional Senior Management Teams
- Consultations with Corporate departments
- Creation of planning templates based upon planning intelligence and previous planning rounds
- Creation and delivery of Divisional Planning Sessions
- Consultation with Governors regarding strategy and planning
- Board development session for strategy and planning
- Consultation with LHE partners

NEXT STEPS

19. In terms of the Divisions they submitted first drafts of their 2015/16 business plans on 16 January. The Strategy and Planning Team, which is steering this process, have reviewed those drafts and have provided feedback, including:

- reviewing whether all key safety, quality and patient experience issues are addressed;

- providing advice on the further work expected to be completed on efficiency and capacity action plans; and
- updating income and expenditure plans, applying assumptions and improvements within activity, efficiency and capacity plans.

20. Revised Divisional plans will be reviewed at the beginning of February and Divisions will submit final plans by the end of February for consideration and sign-off in Executive Director Reviews in March. This will enable the Trust plan to be finished in time for the March Board of Directors meeting.

21. The Deputy Director of Strategy and Commercial Development is now in the final stages of a team redesign process to ensure a more comprehensive approach to annual and strategic planning. Once fully complete in Q4 of this financial year it will enable the complete redesign the planning process.

22. The intention of developing a new process is to:

    - begin planning even earlier in the calendar year, which will enable more time and resource to complete essential tasks;
    - be more engaging internally with divisions, clinicians, staff and governors as well as externally with partners and especially commissioners to better influence their intentions and plans going forward;
    - enable a much more complex analysis of capacity and demand modelling, which is also becoming incrementally more necessary each year to complete the process to a high standard; and
    - support a move toward a future service line management process.

23. The Strategy and Planning Team are currently in the midst of designing a series of key performance indicators and measurements linked to the Divisional objectives specified in the plan. Moving forward this approach will ensure the objectives are tracked and monitored in-year.

24. There is a lot to do in-year to reach a final agreed plan and the Board will continue to be updated. However, there is a lot of work to complete over the next financial year to improve our approach to planning and it will be the role of the FSC to oversee this development process throughout the next 12 months on behalf of the Board.

RECOMMENDATIONS

25. The Board is asked to note the planning requirements and timetable for 2015/16 and the process by which the Trust is meeting those requirements.

BOARD OF DIRECTORS

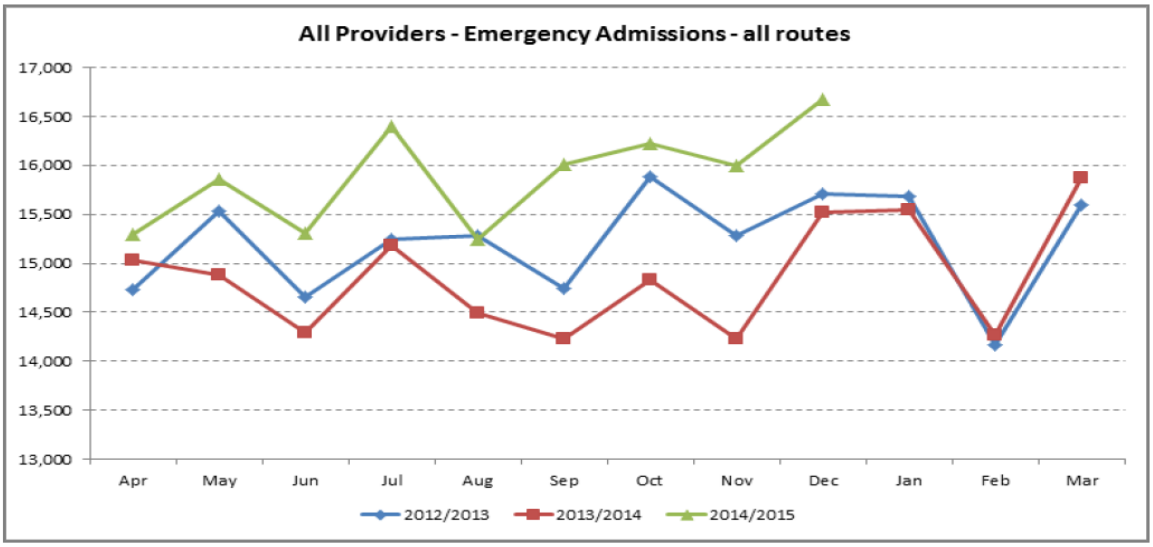
WHH/B/2015/ **023**

SUBJECT:	**CORPORATE PERFORMANCE REPORT**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Simon Wright	
EXECUTIVE DIRECTOR:	Simon Wright, Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 31st December 2014. In overall terms, based on the performance in month 9, the Trust has an Amber/Green rating, as highlighted in Appendix 1.	
RECOMMENDATION:	***The Board is asked to:*** ***Note the contents of the report***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/15/03
	Date of meeting	20th January 2015
	Summary of Outcome	Recommended for Approval

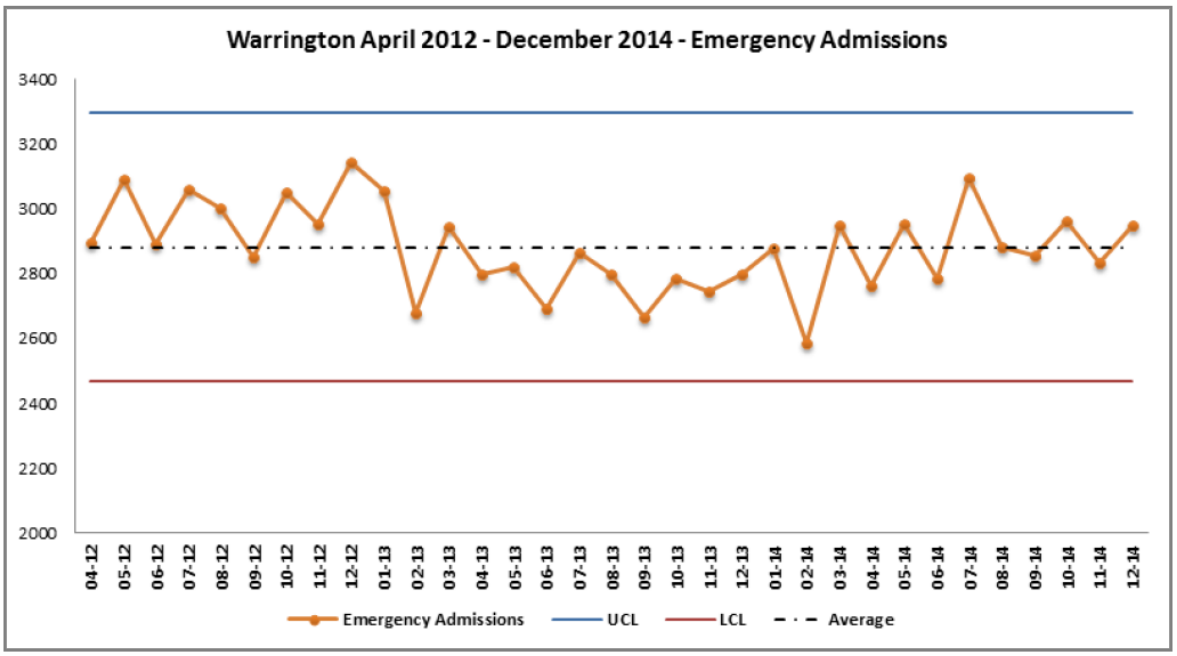
NATIONAL KEY PERFORMANCE INDICATORS

ACCIDENT AND EMERGENCY DEPARTMENT

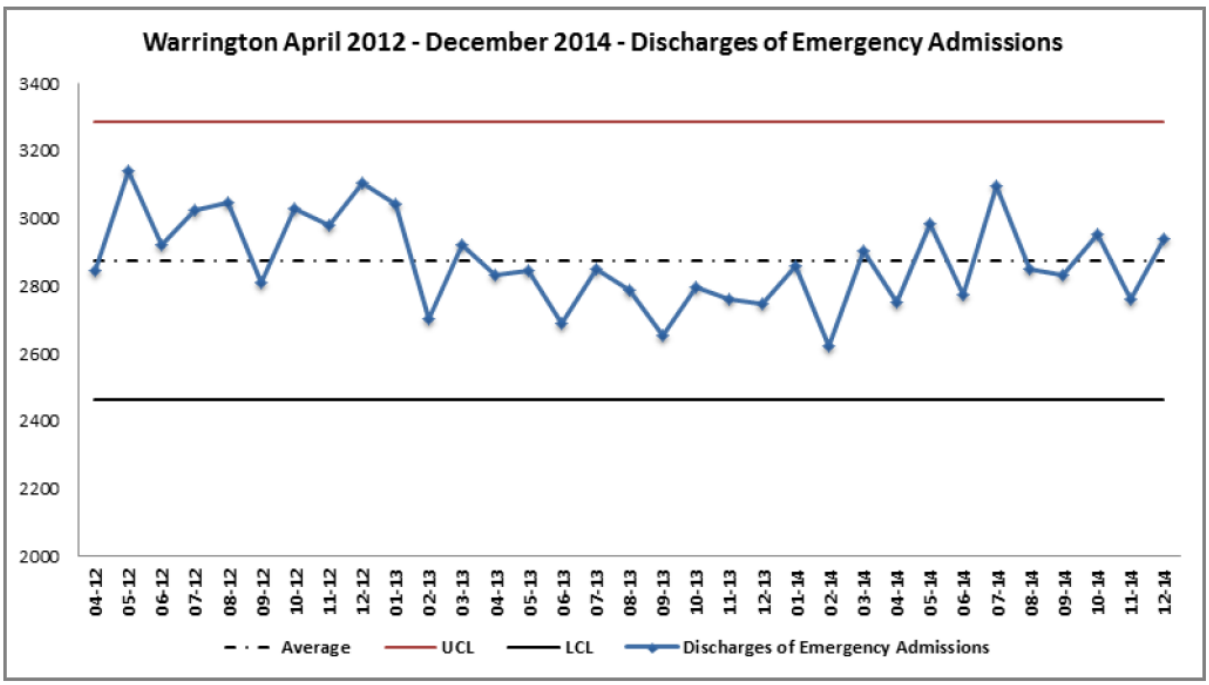
During December all of the Trusts across Merseyside came under high pressure for emergency admissions, far exceeding the planned levels of activity.



This demand resulted in bed pressure which in turn prevented the timely admission of patients resulting in AED having to 'hold' onto patients for increasingly long periods. During this time a temporary partion was in place to protect dignity, meals and drinks were provided to all patients and staff and NWAS teams. Operational teams spread the management cover across 7 days throughout the Christmas and New Year period to support the AED team.

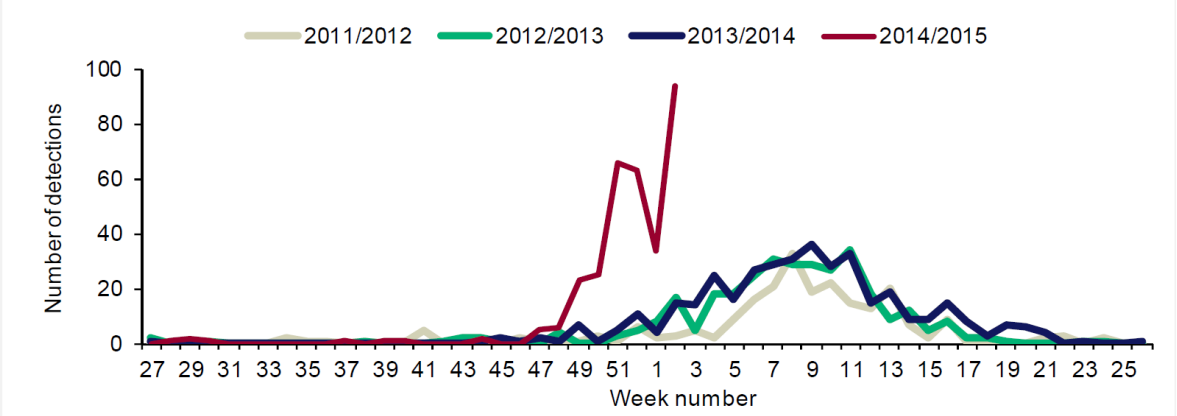


Whilst the discharge teams achieved higher than previous year performance in discharge levels this still has not been able to meet the demand (see below).



The Department of Health sent out some data on Flu prevalence (see below) which indicates the scale and unprecedented impact felt across the region.

Figure 1: Influenza A seasonal comparison of Public Health Laboratory, Manchester, data



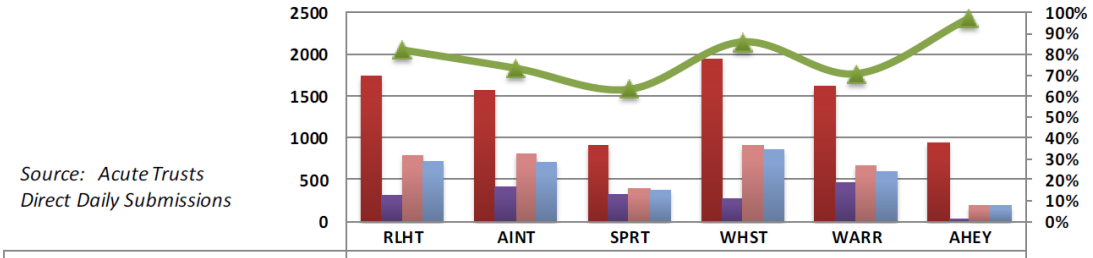
The regional performance for the month of December was 85% with our Trust delivering 83.75%.

All Providers December 2014	Mon 1st	Tue 2nd	Wed 3rd	Thu 4th	Fri 5th	Sat 6th	Sun 7th	Mon 8th	Tue 9th	Wed 10th	Thu 11th	Fri 12th	Sat 13th	Sun 14th	Mon 15th	Tue 16th	Wed 17th	Thu 18th	Fri 19th	Sat 20th	Sun 21st	Mon 22nd	Tue 23rd	Wed 24th	Thu 25th	Fri 26th	Sat 27th	Sun 28th	Mon 29th	Tue 30th	Wed 31st	Total	Avg
AED Atts *	1439	1320	1196	1329	1261	1181	1336	1416	1287	1288	1275	1242	1257	1347	1461	1335	1316	1352	1202	1242	1382	1340	1262	946	844	1217	1431	1325	1312	1201	1044	39386	1271
Breaches *	147	109	74	115	131	88	221	231	230	238	180	220	236	294	380	248	228	170	186	176	319	213	131	56	46	124	295	252	241	264	169	6012	194
AED Adms *	404	442	372	434	444	409	388	432	447	401	405	421	404	400	437	422	392	426	376	389	407	422	414	354	306	400	403	408	429	436	385	12609	407
Direct Adms *	194	169	162	119	141	60	66	172	148	142	142	157	67	50	141	185	179	172	145	70	60	169	192	164	52	94	76	68	160	156	189	4061	131
Emer Adms *	598	611	534	553	585	469	454	604	595	543	547	578	471	450	578	607	571	598	521	459	467	591	606	518	358	494	479	476	589	592	574	16670	538
Emer Dischs *	628	622	541	568	623	420	354	575	613	572	537	609	421	338	554	648	586	618	615	448	369	679	705	775	303	373	307	357	563	610	655	16586	535
% 4 Hr Wt	90%	92%	94%	91%	90%	93%	83%	84%	82%	82%	86%	82%	81%	78%	74%	81%	83%	87%	85%	86%	77%	84%	90%	94%	95%	90%	79%	81%	82%	78%	84%	85%	
>30 Mins Trnrnds *	166	137	131	162	155	140	204	242	227	209	186	217	231	241	270	233	173	201	199	177	277	226	176	164	116	202	245	246	241	276	212	6282	203
>60 Mins Trnrnds *	10	3	7	11	11	9	22	52	35	26	21	52	32	49	98	49	16	23	18	16	62	45	16	16	4	25	58	63	36	87	23	995	32
AEDs > Emer Adms	2.4	2.2	2.2	2.4	2.2	2.5	2.9	2.3	2.2	2.4	2.3	2.1	2.7	3.0	2.5	2.2	2.3	2.3	2.3	2.7	3.0	2.3	2.1	1.8	2.4	2.5	3.0	2.8	2.2	2.0	1.8	73.96	2.4
Dischs v Emer Adms	30	11	7	15	38	-49	-100	-29	18	29	-10	31	-50	-112	-24	41	15	20	94	-11	-98	88	99	257	-55	-121	-172	-119	-26	18	81	-84	-3
AED Adm Rate	28%	33%	31%	33%	35%	35%	29%	31%	35%	31%	32%	34%	32%	30%	30%	32%	30%	32%	31%	31%	29%	31%	33%	37%	36%	33%	28%	31%	33%	36%	37%	32%	

* One Standard Deviation Above the Mean (SD = average difference to the mean - for the month)
* Two Standard Deviation Above the Mean (2SD = twice average difference to the mean - for the month)

Finally the Trust performance when compared to the other large teaching hospitals is very similar in terms of demands on our capacity but we have by far the smallest levels of acute bed capacity available to us.

Urgent Care Indicators by Acute Trust: Week Ending 04-Jan-2015



Source: Acute Trusts Direct Daily Submissions

	RLHT	AINT	SPRT	WHST	WARR	AHEY
AED Type 1 Atts	1737	1558	909	1944	1607	950
4 Hour Breaches	312	416	334	274	471	26
Emergency Admissions	792	801	389	913	677	181
Discharges of Emergency admissions	730	712	370	861	600	189
4 Hour Wait Performance Type 1 (%)	82.0%	73.3%	63.3%	85.9%	70.7%	97.3%

Total G&A Accessible Bed Base*	527	651	309	631	420	179
Rate Emer. Adms > 10 Accessible Bed*	15.0	12.3	12.6	14.5	16.1	10.1
Rate AED Attendances > 10 Accessible Bed*	33.0	23.9	29.4	30.8	38.3	53.1
Rate AED Attendances > Emer. Admission	2.2	1.9	2.3	2.1	2.4	5.2
(Emergency) Discharges v Admissions	-62	-89	-19	-52	-77	+8

* Accessible Beds = Total No. of Beds to which G&A Patients can be Admitted

In response to this pressure the Trust has introduced two significant actions (of which more will be provided in February Board).

The Trust introduced a new action process with posters and focus groups across urgent and emergency care and from January 5-14th the Trust ran the ECIST recommended Perfect Week which allowed the Trust to not only recover quicker than other trusts in terms on the very challenging post New Year demands but also achieve over 95% for the first time towards the end of the programme.

Improving care for our urgent and emergency patients

Everyone is working so hard to improve the experience of our urgent and emergency patients. There are action plans with as many as 50 separate actions that if they are all to be delivered will have massive benefits to our patients. But that's part of the problem – **too** many actions, **too** many people trying to do **too** many things. So we've simplified things.

To improve our four hour target the trust has agreed that these five actions are key to our improvement.

1. **Every ward** to have at least one discharge in the discharge lounge by 10 am every day
2. **All staff groups** to listen and act upon the instruction from the A&E floor co-ordinator
3. **Triage and assessment** of all patients within 15 mins of arrival and 60 minute senior review - extending the role of ENPs to the optimum and standardised working practices
4. **Two assessment cubicles** in AED ring fenced and one assessment cubical ring fenced in SAU/MAU every day.
5. **Golden 60 minutes.** Majors patients requiring onward transfer to ITU /HDU CCU or any speciality bed to transfer within 60 minutes of arrival into AED

CLOSTRIDIUM DIFFICILE/MRSA

The trust has 23 clostridium difficile cases with reviews being undertaken against 19 of these decisions. Should the process not uphold the arguments for exclusion the Trust will be only 3 cases for the next 3 months away from breaching our trajectory target.

During Q3 the Trust also acquired another hospital acquired MRSA bringing the total to 3 for the year against a trajectory of <1.

All other national targets were fully delivered in month and quarter including all cancer and 18 wk RTT targets.

NEXT STEPS

A recovery AED meeting with the CCG is occurring every week with the System Resilience Group seeking to hold to account NWAS, Social Services, Bridgewater and our CCG for the system management changes necessary to deliver a sustainable 4 hour target.

A recovery trajectory is being supplied to monitor with a full remedial plan being undertaken and senior team leaders present till 2100 every day to support the AED team in improving our performance.

RECOMMENDATIONS

The relative performance against our peer group and the exceptional circumstances nationally effecting the Trust in terms of emergency demand and delivery of the 4 hr target. The actions taken to manage safety and demand across the Christmas period and new year and the introduction of the Perfect week to recalibrate our system following this most difficult period.

CONCLUSION

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

Mr Simon Wright

Chief Operating Officer/Deputy Chief Executive Officer

January 2015

APPENDIX 1

Dec-14

Monitor Governance Risk Rating - 2014/15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%	93.21%	93.58%	92.91%	90.70%	90.34%	92.04%	91.04%	92.07%	92.73%	92.99%	92.60%				
	Non-admitted patients	95%	1.0	98.03%	97.63%	98.54%	97.83%	97.79%	97.72%	98.14%	97.89%	97.62%	96.99%	97.51%	97.38%				
	Incomplete Pathways	92%	1.0	94.55%	94.56%	94.94%	94.55%	94.88%	95.29%	94.94%	95.03%	94.50%	94.33%	93.96%	94.27%				
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	94.54%	92.66%	95.01%	93.97%	91.74%	93.54%	93.26%	92.74%	93.00%	91.23%	83.75%	89.67%				
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0	90.00%	82.14%	85.07%	85.45%	86.81%	82.16%	88.50%	85.19%	87.00%	92.00%	86.00%	88.33%				
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%	1.0	100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	99.00%	99.00%	100.00%	100.00%	100.00%	100.00%				
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		90.00%	88.46%	85.07%	87.91%	86.52%	80.26%	85.71%	85.45%	86.00%	87.00%	87.00%	86.67%				
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	98.00%	99.33%	100.00%	98.00%	100.00%	99.00%	100.00%	98.00%	100.00%	99.00%				
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	96.00%	98.00%	97.00%	97.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	98.00%	99.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%				
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	96.00%	96.00%	98.00%	96.67%	98.00%	99.00%	100.00%	99.00%	98.00%	98.00%	97.00%	97.70%				
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.10%	92.90%	93.05%	93.00%	93.80%	92.70%	93.80%	93.50%	93.50%	95.20%	94.70%	94.80%				
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.05%	93.00%	93.10%	93.05%	93.75%	91.90%	93.90%	93.30%	92.99%	94.20%	94.20%	93.10%				
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	26 (for the Yr)	1.0 **	1	3	4	4	4	4	4	4	4	4	4	4				
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			2	5	7	7	8	15	16	16	19	20	23	23				
	Under Review			1	2	3	3	4	11	12	12	15	16	19	19				
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No				

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

APPENDIX 1

Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	Report by Exception	No	No	No	No	No	No	No	No	No	No	No	No				
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No				
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No				
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No				
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	No	No	No	No	No	No	No	Yes	No	No	No				
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No				
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A		No	No	No	No	No	No	No	No	No	No	No	No				
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A		No	No	No	No	No	No	No	No	No	No	No	No				
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No	No	No	No	No	No	No	No	No	No	No	No				
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			1.0	1.0	0.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0				

Additional Notes:

18 Weeks Referral to Treatment

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

**** Clostridium Difficile**

Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks
Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

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

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

BOARD OF DIRECTORS

WHH/B/2015/ **024**

SUBJECT:	**Part 1 Risk Register**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Millie Bradshaw, Associate Director of Governance
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance and OD
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	They are 17 risks within the Part 1 RR. The risks have been escalated up through the Governance processes of Divisional Integrated Governance Groups and sub-committees to the Governance Committee. **New Risks:** **Trust wide:** Risk 0900 re Chemotherapy Prescriptions **Unscheduled Care**: Risk 0926 The number of missing patients where the agreed SOP has not been followed which includes a patient capacity Assessment status being competed **WCSS**: Risk 0934 risk of lack of IT Systems at Bath St

PREVIOUSLY CONSIDERED BY:		
	Committee	Quality Committee
	Agenda item	W&HHFT/QGC/15/009
	Date of meeting	13th January 2015
	Summary of Outcome	Recommended for Approval

Part 1 Risk Register

EXECUTIVE SUMMARY

The primary purpose of the Risk Management System is to help staff to; -

- improve the quality of care and treatment;
- protect patients, staff and visitors from harm;
- Eliminate or reduce unnecessary costs.

PROCESS

- Source of the Risk (financial, incident, external review, national guidance) as examples
- Control measures in place to try and manage the Risk. If these do not work as the Risk continues then an ……..
- Action Plan is set up which includes a number of…….
- Actions points to clearly identify the steps in the Action Plan to mitigate the risk

CLASSIFICATION OF RISK AND PROCESS

EXTREME (15-25): In all cases, where the risk of personal injury or damage is imminent, immediate remedial action must be taken. The risk is applied to the Part 1 Risk Register on CIRIS. The risk will be reviewed at the Safety and Risk sub-Committee on a monthly basis.

An appropriate Lead is identified for each risk to ensure regular assessment of the risk and the development and implementation of action plans.

It is accepted that, in some cases, required actions will have resource implications and that this could take considerable time to achieve. It is recognised that it is neither realistic, nor practicable; to eliminate all risks and the emphasis will be upon managing and controlling significant risks. The risks of 15-25 result in the Board of Directors deciding where resources are to be allocated and which risks are to be considered acceptable.

NB. Where it is not possible to treat the risk at the prescribed level, the risk is communicated up through the management structure which includes Bilateral meetings.

REVIEW OF THE RISK REGISTER

The Risk Registers are reviewed monthly at DIGG'S and at the Safety and Risk and the Clinical Governance, Audit and Quality Sub Committees on a monthly basis. Any amendments and/or recommendations requested by either Sub Committee are carried out by the relevant Lead.

The Risk Register is reviewed at the Governance Committee bi-monthly and any amendments and/or recommendations are given to the Associate Director of Governance, who is responsible for contacting by email and phone the relevant lead to ensure these amendments are made.

ACTIONS TO ENSURE RISK REGISTERS ARE KEPT UP TO DATE

Monthly emails are sent by the Associate Director of Governance to all Leads to remind them to update their Risk Register entries, check their Control measures are in place and actions plans reviewed and updated.

NEXT STEPS

From February 2015 a Governance Dashboard has been developed and agreed for submission at the Bilateral's and the DIGG's. One indicator on the dashboard is about risk registers entries and updating them which will clearly show at Executive level where the necessary actions have not been completed.

RECOMMENDATIONS

The Board are asked to receive, review, note and comment on the escalation of the Risks within the February 2015 submission which includes:

- Part 1 Risk Register
- Controls
- Action Points not closed

CONCLUSION

The Board to be assured that all risks and being reviewed and monitored in accordance to the Risk Management Strategy.

Part 1 Risk register 17 Items

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
Group: Estates												
000134	External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 2 at Halton site (Phase 1 completed)	Estates	Risk Assessment	31/01/2009	Extreme risk 16	Patterson, Ron; Capital Projects Manager; EST	30/12/2014	4 - Major	Extreme risk 16	27/02/2015	31/03/2015	4
000170	External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing	Estates	Risk Assessment	31/01/2009	Extreme risk 16	Patterson, Ron; Capital Projects Manager; EST	30/12/2014	4 - Major	Extreme risk 16	27/02/2015	31/03/2015	4
Group: Scheduled Care												
000721	Potential risk of poor patient experience due to the increased use of escalation beds for medical outliers and associated pressures on the ward team.	Scheduled Care Division	Incident	15/07/2014	High risk 12	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	07/01/2015	3 - Moderate	Extreme risk 15	27/02/2015	01/04/2015	6
000857	Potential risk of failure to meet required contracted income plans in Surgery, ENT, T&O specialties.	Scheduled Care Division	Committee Review	07/11/2014	Extreme risk 16	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	16/01/2015	4 - Major	Extreme risk 16	27/02/2015	01/04/2015	6
Group: Trust Wide												

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
000111	Operational, financia l and potential patient safety risks associated with sustained use of escalation beds	Warrington and Halton Hospitals NHS Foundation Trust	Risk Assessment	01/08/2010	Extreme risk 15	Wood, Dawn; Assistant General Manager - Unscheduled Care; UCD	17/12/2014	4 - Major	Extreme risk 16	21/01/2015	26/02/2015	6
000681	Risk of being unable to submit AQ data as part of CQUIN requirement whilst database unavailable	Warrington and Halton Hospitals NHS Foundation Trust	Risk Assessment	27/03/2014	Extreme risk 15	Ramakrishnan, Subramaniam; Consultant; GASTRO	19/11/2014	3 - Moderate	Extreme risk 15	29/01/2015	30/01/2015	6
000900	Non-compliance with the requirement to provide full SACT data and with the requirement to have electronic chemotherapy prescriptions	Warrington and Halton Hospitals NHS Foundation Trust	External Review	02/12/2014	Extreme risk 15	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	14/01/2015	3 - Moderate	Extreme risk 15	12/02/2015	31/05/2015	3
Group: Unscheduled Care												
000165	potential risk to patient safety, performance & targets due bed capacity and patient flow through AED	Emergency Care	Risk Assessment	15/10/2012	Extreme risk 16	Garner, Chris; Senior Manager; A & E	17/12/2014	4 - Major	Extreme risk 16	21/01/2015	18/03/2015	9
000542	Lack of physical capacity of GPAMU to review patients	Acute Medicine	Risk Assessment	15/10/2013	Extreme risk 16	Wood, Dawn; Divisional Manager - Unscheduled Care; UCD	17/12/2014	4 - Major	Extreme risk 16	21/01/2015	25/05/2015	4
000898	Potential risk to Trust reputation and financial impact of not meeting AED 4 hour Targets	Emergency Care	Committee Review	28/11/2014	Extreme risk 20	Garner, Chris; Senior Manager; A & E	17/12/2014	4 - Major	Extreme risk 20	21/01/2015	31/03/2015	8
000899	Number of Consultant staff vacancies within the Division	Unscheduled Care Division	Risk Assessment	28/11/2014	Extreme risk 15	Robinson, Anne; Divisional Medical Director - Unscheduled Care; UCD	17/12/2014	3 - Moderate	Extreme risk 15	21/01/2015	31/03/2015	4

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of Last Review	Impact Rating	Residual Risk Score	Date for Review	Target Date for Completion	Strategic Aim Risk Score
000926	Potential of harm due to the number of missing patients where the agreed SOP has not being followed including assessment of patients capacity	Unscheduled Care Division	External Review	12/12/2014	Extreme risk 16	Franklin, Sue; Divisional Head of Nursing - Unscheduled Care; UCD	17/12/2014	4 - Major	Extreme risk 16	21/01/2015	31/03/2015	8
Group: WCCSS												
000089	Risk that key objectives may not be met / risk to patient safety due to ward services being reduced due to Pharmacy Staffing issues. Linked to 000347	Pharmacy	Risk Assessment	31/01/2011	Extreme risk 16	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	14/01/2015	4 - Major	Extreme risk 16	10/02/2015	30/09/2015	8
000695	CT Unit Environment : Lack of space, lack of privacy & dignity, poor ventilation & distractions which can lead to mistakes/errors, misdiagnoses.	Radiology	Risk Assessment	07/05/2014	Extreme risk 16	Holland, Neil; Principal Radiographer - MRI and CT; RAD	09/12/2014	4 - Major	Extreme risk 16	10/02/2015	31/03/2016	8
000709	Risk of reduced safe standard of care due to reduced midwifery staffing levels.	Women's Health	Risk Assessment	29/06/2014	High risk 12	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	11/01/2015	3 - Moderate	Extreme risk 15	10/02/2015	31/05/2015	6
000893	Risk of failure of Pathology's Éclair System which could result in patient's results not being available	Pathology	Risk Assessment	12/11/2014	Extreme risk 15	Davies, Wendy; Head of AHP & Technical Services; WCSS	09/12/2014	5 - Catastrophic	Extreme risk 15	10/02/2015	31/01/2015	10
000934	PART - Risk of harm to patients due to lack of access to Trust IT systems	Child Health	Risk Assessment	09/01/2015	Extreme risk 16	Scott, Jane; Matron - Child Health; SCBU & NNU	09/01/2015	4 - Major	Extreme risk 16	10/02/2015	30/01/2015	8

All Trust Risks - with controls 73 Items

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

Organisation Group equals:

Risk Score greater than or equal to:

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Organisation Group: Estates							
External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 2 at Halton site (Phase 1 completed)	000134	Estates	Patterson, Ron; Capital Projects Manager; EST	30/12/2014	Extreme risk 16	Fire Safety Training	Fire safety training will reflact that there is a loack of emergency lighting coverage in some areas.
						Install Emergency Lighting	Estates will install emergency lighting as part of the 2012 / 2013 fire precautions works
						Good Housekeeping	Estates will continue to monitor that good housekeeping and observation are in place.
						Target Completion	Target completion will be April 2013 - thereafter a review will be undertaken and additional funding sought as required.
						Local Evacuation Plans	Local evacuation plans should identify / reflect that emergency lighting is not in place.
						RRFSO Risk Assessments	Estates will list non-compliance details upon RRFSO RAs
External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing	000170	Estates	Patterson, Ron; Capital Projects Manager; EST	30/12/2014	Extreme risk 16	Current provision	Essential Lighting will be powered by hospital generator in the event of incoming (PES utility supply) mains faliure (15 second delay) - however no escape lighting would be provided in the event of local electrical failure. THIS CURRENT SITUATION IS AS PER THE ORIGINAL DESIGN - AND HAS EXISTED SINCE APPLETON WING OPENED
Organisation Group: Scheduled Care							

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Potential risk of failure to meet required contracted income plans in Surgery, ENT, T&O specialties.	000857	Scheduled Care Division	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	16/01/2015	Extreme risk 16	Monitor/review elective activities in Scheduled Care by the Executive Team.	Monitor/review weekly elective activities and associated income by the Executive Team.
Potential risk of poor patient experience due to the increased use of escalation beds for medical outliers and associated pressures on the ward team.	000721	Scheduled Care Division	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	07/01/2015	Extreme risk 15	Temporary staff are employed to fill staff shortage. Staff are redeployed in the Division after shift assessments. Unscheduled Care Matrons are allocated to review the medical patients each day	Assess shifts daily and redeploy staff to ensure patient safety. Employ temporary staff to fill staff shortage on shifts. Unscheduled Care Matrons are allocated to review the medical patients each day. There is a designated medical team responsible for review of outling patients.
						Escalation SOP, flow chart and scoring matrix have been developed to ensure optimum patient experience on outlying wards.	
						Matrons conducts daily review of skill mix on each shift to ensure that the staff can manage acuity on the wards.	
Organisation Group: Trust Wide							
Operational, financial and potential patient safety risks associated with sustained use of escalation beds	000111	Warrington and Halton Hospitals NHS Foundation Trust	Wood, Dawn; Assistant General Manager - Unscheduled Care; UCD	17/12/2014	Extreme risk 16	Medical outliers on surgical beds will be reviewed daily.	
						Weekly monitoring of the operational and financial risk associated with the sustained use of escalation beds at the Division's SMT meeting. Monthly monitoring at the BiLateral meetings.	Monitored by the Senior Management Team for the Division at daily meeting with the Operations Manager for the Trust. Monitored at the weekly meeting of the Director of Nursing and the Division's Associate Director of Nursing.
						Daily bed management meetings to monitor the escalation process and minimise the cancellation of patients.	
						Bed Meetings	Daily review of escalation and Medical patients in Scheduled Care beds.
						Medical review	All outlying patients are medical reviewed to ensure appropriate care plan is in place.
Risk of being unable to submit AQ data as part of CQUIN requirement whilst database unavailable	000681	Warrington and Halton Hospitals NHS Foundation Trust	Ramakrishnan, Subramaniam; Consultant; GASTRO	19/11/2014	Extreme risk 15	The Data Entry Clerk will collect and hold data until database situation is closed.	

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Non-compliance with the requirement to provide full SACT data and with the requirement to have electronic chemotherapy prescriptions	000900	Warrington and Halton Hospitals NHS Foundation Trust	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	14/01/2015	Extreme risk 15	SACT data entry	The Trust has staff with responsibility for collating and submitting SACT data
						Prescription safety	The Trust has pre-printed prescriptions for chemotherapy
Organisation Group: Unscheduled Care							
Potential risk to Trust reputation and financial impact of not meeting AED 4 hour Targets	000898	Emergency Care	Garner, Chris; Senior Manager; A & E	17/12/2014	Extreme risk 20	Daily staffing review	To monitor staffing and patient safety
						E Rostering system	review of staffing and skill mix in a planned
						Matron Safety Walkrounds	to monitor safety
						Rolling Staff Recruitment	to ensure ongoing recruitment
						Medical review	All outlying patients are medical reviewed to ensure appropriate care plan is in place.
						Policy of the escalation of the deteriorating patient	The Trust has a policy that ensure all patient who are found to be deteriorating as escalated to ensure appropriate review and treatment
						Weekly SMT meetings	To monitor will all the Team
						At least daily staffing review by Matrons	To ensure appropriate staffing levels to maintain patient quality and safety
						Bed Meetings	Daily review of escalation and Medical patients in Scheduled Care beds.

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
potential risk to patient safety, performance & targets due bed capacity and patient flow through AED	000165	Emergency Care	Garner, Chris; Senior Manager; A & E	17/12/2014	Extreme risk 16	Nurse co ordinator to access patient in majors A - G (as per flow chart)	To ensure patient safety and appropriate transfer.
						Progress chaser in post	AED from 1 pm - 9 pm has a progress chaser to ensure timely progress through AED.
						Close working with Patient Flow Team to enable flow of patient out.	To ensure safety and quality patient experience whilst in WHH
						Escalate to management/on - call team involvement and support via SOP and flow chart.	
						Ambulance Triage Nurse 11am - 11pm undertaking ambulance triage for initial assessment of potential deteriorating patients. To be continued at night shift handover. Patient to remain in the care of NWAS until off loaded.	To ensure patient safety and appropriate triage of ambulance patients
						Streaming Nurse to make EPUA appointments for early pregnancy as per flow chart.	To ensure patient flow through AED
						Escalate to AEDCDU as space allows and it is appropriate for the patient.	To facilitate patient flow through AED
						Streaming Nurse to refer to AED GP and Ambulatory care 10 am - 10:30 pm	to ensure patient flow through AED
						Consultant presence in AED	Consultant AED Doctor now present within AED until 1 am 7 days a week.

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Lack of physical capacity of GPAMU to review patients	000542	Acute Medicine	Wood, Dawn; Divisional Manager - Unscheduled Care; UCD	17/12/2014	Extreme risk 16	Ongoing staffing review within GPAMU	AMU co ordinator must be made aware by staff within GPAMU if patient acuity and/or number are not managable. This must be escalated within the division as required.
						GPAMU Standard Operating Procedure under review	SOP in place on the hub to ensure appropriate assessment of medical patient within A&E and GPAMU.
						Policy of the escalation of the deteriorating patient	The Trust has a policy that ensure all patient who are found to be deteriorating as escalated to ensure appropriate review and treatment
						At least daily staffing review by Matrons	To ensure appropriate staffing levels to maintain patient quality and safety
						Matron Safety Walkrounds	to monitor safety
						Weekly SMT meetings	To monitor will all the Team
						Review of staffing incidents by ADoN	To monitor themes, trends and severity within the division
						E Rostering system	review of staffing and skill mix in a planned
						Rolling Staff Recruitment	to ensure ongoing recruitment
						Daily staffing review	To monitor staffing and patient safety
Potential of harm due to the number of missing patients where the agreed SOP has not being followed including assessment of patients capacity	000926	Unscheduled Care Division	Franklin, Sue; Divisional Head of Nursing - Unscheduled Care; UCD	17/12/2014	Extreme risk 16	In house Police Constable attends AED morning Handovers	to receive and note any issues of missing patients and to help and support staff to the correct procedure to be followed.
						Safety Alerts x 2 issued	To raise awareness of the policy as part of Safety Briefings at Shift Handover
						Audit of completed Capacity Assessment formw	to monitor effectiveness
						Security Policy includes Missing Patient SOP	to show the steps to be taken to try and locate a missing patient
						Educational awareness at ward managers away days for all Divisions	To raise awareness of the procedure to be followed
						Consent to Treatment and Capacity Assessment training	held x 3 month (both sites) for staff

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
Number of Consultant staff vacancies within the Division	000899	Unscheduled Care Division	Robinson, Anne; Divisional Medical Director - Unscheduled Care; UCD	17/12/2014	Extreme risk 15	Backfill with Locums	Agency Locums
						International Consultant Recruitment	Adverts within a number of overseas and UK publications
						Weekly SMT meetings	To monitor will all the Team
Organisation Group: WCCSS							
Risk that key objectives may not be met / risk to patient safety due to ward services being reduced due to Pharmacy Staffing issues. Linked to 000347	000089	Pharmacy	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	14/01/2015	Extreme risk 16	Pharmacist clinical review of patient at discharge	Patient's medication is reviewed by a pharmacist at discharge
						Time is ring fenced for key governance activities	Time is allocated for example for antibiotics pharmacist/technician work, SOP/Policy writing and ratification, attendance at/work required for governance meetings, medicines management meetings, production of assurance reports, audit work
						Quarterly Medicines Safety Assurance Reports are prepared for the Medicines Safety Committee, shared learning from incidents is taken back into the three divisions.	Divisional Medicines assurance reports are produced quarterly for Medicines Safety Committee, they are discussed at Medicines safety and cross-divisional learning identified. Risk leads then ensure that learning is deseminated within the threee divisions.
						Review of medicines incidents and provision of support for staff who make errors	Staff encouraged to report medication incidents, and near misses onto datix. Highly graded incidents actual/potential are highlighted to Pharmacy for review/input
						Risk assess level of risk to patients from prescription issues on wards to enable prioritisation and allocation of staff resources - may be assessed on a daily basis (acute staffing problem) or for ongoing gaps in capacity-demand	Wards are assessed and categorised by potential for medication safety issues. This determines which wards do not receive a ward pharmacist visit, which wards do not receive a visit when staffing levels do not permit and which wards receive a visit on weekdays

Risk Title	Risk ID	Division / Department	Managerial Lead	Date of last review	Residual Risk Score	Control Title	Control Description
CT Unit Environment : Lack of space, lack of privacy & dignity, poor ventilation & distractions which can lead to mistakes/errors, misdiagnoses.	000695	Radiology	Holland, Neil; Principal Radiographer - MRI and CT; RAD	09/12/2014	Extreme risk 16	Utilisation of Available Space in Reporting Room	Furniture and equipment kept to a minimum. No of staff kept to a minimum - Radiollogists covering list may choose to report elsewhere. Slidings doors installed.
						Aim to Maintain Privacy as far as possible in waiting room.	OP may use US waiting area. IP have timed appts and these have been reduced to every 30mins - but it is noted that this has a detrimental effect on the capacity of the unit. Additonal IP waiting areas are available in main xray but due to the distance these are only used as a last resort.
						Measures to Enable use of Cannualtion room	As there is no drinking water plastic beakers are filled with water from the staffroom. Beakers are taken to staff room to be washed. Water cooler has been ordered.
PART - Risk of harm to patients due to lack of access to Trust IT systems	000934	Child Health	Scott, Jane; Matron - Child Health; SCBU & NNU	09/01/2015	Extreme risk 16	Access to Trust email available	Staff are able to access the email externally
Risk of reduced safe standard of care due to reduced midwifery staffing levels.	000709	Women's Health	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	11/01/2015	Extreme risk 15	Weekly meeting are held by Maternity managers to review sickness and absence and redeploy staff where staffing levels fall below the acceptable minimum	
						Midwifery Staffing Audit completed annually	Safe staffing levels are audited each year and presented at the Departmental Audit Meeting
						Midwifery Staffing Audit completed annually	Safe staffing levels are audited each year and presented at the Departmental Audit Meeting
						Commissioning of Birthrate Plus staffing assessment	Maternity service has commissioned Birthrate Plus study to assess case mix and acuity to support identification of correct midwife to birth ratio. Study to begin in January 2015
Risk of failure of Pathology's Éclair System which could result in patient's results not being available	000893	Pathology	Davies, Wendy; Head of AHP & Technical Services; WCSS	09/12/2014	Extreme risk 15	Support for the Éclair system.	Supported by one person in Pathology.
						Risk to Patient Safety - Duplicate records	Duplicate records merged or corrected reactively in response to calls generated to help desk.
						Risk to Patients Safety - Failure to transmit messages	Messages that have failed to transmit are regularly re-sent.
						Service risk - Extra staffing	

Risk Action Points - All 24 Items

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

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
Organisation Group: Estates						
Risk Score: 16						
Risk ID: 134						
Risk Title: External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 2 at Halton site (Phase 1 completed)						
001583	Install adequate Emergency Lighting	Gee, Brian; Estates Officer; EST	In progress as at 30/12/2014	31/03/2015		Extreme risk 16
Risk ID: 170						
Risk Title: External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing						
006552	Design and install appropriate emergency light fittings in line with current standards		In progress as at 30/12/2014	31/03/2015		Extreme risk 16
Organisation Group: Scheduled Care						
Risk Score: 16						
Risk ID: 857						
Risk Title: Potential risk of failure to meet required contracted income plans in Surgery, ENT, T&O specialties.						
020079	Consider other alternative model of delivering additional activities such as the Whiston model/cost per case/HBS model and review with team.	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 16/01/2015	01/04/2015	16/01/15: Other models review continues.	Extreme risk 16

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
020075	Use extended sessions to increase productivity.	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 16/01/2015	01/04/2015		Extreme risk 16
020076	Split out non pay budgets that relate to T&O from theatre budget to enable cost controls.	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 16/01/2015	01/04/2015		Extreme risk 16
020077	Secure retrospective and prospective spinal top up income and review position monthly.	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	In progress as at 16/01/2015	01/04/2015	16/01/15:Spinal top up income are reviewed monthly in the Division.	Extreme risk 16
Risk Score: 15						
Risk ID: 721						
Risk Title: Potential risk of poor patient experience due to the increased use of escalation beds for medical outliers and associated pressures on the ward team.						
022445	With the increase in medical outliers in the Division process have been implemented to ensure optimum patient experience. SOP and flow chart to be presented at the next DIGG meeting. Flow chart to be added to ward SOPs. Ensure staff record and report incidents related to medical outliers using the Trust reporting system.	Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD	In progress as at 07/01/2015	27/02/2015		Extreme risk 15
020997	Continuous recruitment against vacancies in place.	Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD	In progress as at 07/01/2015	01/04/2015	19/12/14: Some staff have been recruited to the wards.	Extreme risk 15
Organisation Group: Trust Wide						
Risk Score: 15						
Risk ID: 900						
Risk Title: Non-compliance with the requirement to provide full SACT data and with the requirement to have electronic chemotherapy prescriptions						
021646	Prepare option appraisal / outline business case	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	In progress as at 09/12/2014			Extreme risk 15
021645	Review available chemotherapy software systems	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	In progress as at 09/12/2014			Extreme risk 15
Organisation Group: Unscheduled Care						
Risk Score: 20						
Risk ID: 898						

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
	Risk Title: Potential risk to Trust reputation and financial impact of not meeting AED 4 hour Targets					
021312	AED Remedial Recovery Plan	Garner, Chris; Senior Manager; A & E	In progress as at 28/11/2014	31/03/2015		Extreme risk 20
	Risk Score: 16					
	Risk ID: 542					
	Risk Title: Lack of physical capacity of GPAMU to review patients					
021181	Review of location by new management team	Garner, Chris; Senior Manager; A & E	In progress as at 27/11/2014	06/02/2015		Extreme risk 16
	Risk ID: 926					
	Risk Title: Potential of harm due to the number of missing patients where the agreed SOP has not being followed including assessment of patients capacity					
021759	meeting with Cheshire Police	Dawber, Karen; Director of Nursing; DNU	Required as at 12/12/2014	30/01/2015		Extreme risk 16
	Risk Score: 15					
	Risk ID: 899					
	Risk Title: Number of Consultant staff vacancies within the Division					
021315	Consultant action plan in place linked to the Controls	Robinson, Anne; Divisional Medical Director - Unscheduled Care; UCD	In progress as at 28/11/2014	31/03/2015		Extreme risk 15
	Organisation Group: WCCSS					
	Risk Score: 16					
	Risk ID: 89					
	Risk Title: Risk that key objectives may not be met / risk to patient safety due to ward services being reduced due to Pharmacy Staffing issues. Linked to 000347					
020926	Recruit to new posts-Antibiotics Pharmacist, Medical Education/Safety Pharmacist	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	In progress as at 09/12/2014	31/05/2015		Extreme risk 16
020892	Recruit to vacancies	Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS	In progress as at 09/12/2014	30/09/2015		Extreme risk 16
	Risk ID: 695					
	Risk Title: CT Unit Environment : Lack of space, lack of privacy & dignity, poor ventilation & distractions which can lead to mistakes/errors, misdiagnoses.					

ID	Action Point	Action Lead	Action Status	F'cst Due Date	Last Review / Outcome	Risk Grade With Score
016421	Capital scheme to be worked up for inclusion in the Capital Porgramme 2015/2016.	Holland, Neil; Principal Radiographer - MRI and CT; RAD	In progress as at 09/12/2014	31/12/2014		Extreme risk 16
015705	Redesign and extent the CT Unit to include : Larger reporting area, Separate inpatient and outpatient waiting areas Separate male/femal IP waiting areas Patient care area Kitchen area with drinking water Sufficient storage and workspace areas	Holland, Neil; Principal Radiographer - MRI and CT; RAD	In progress as at 09/12/2014	31/03/2016		Extreme risk 16
Risk ID: 934						
Risk Title: PART - Risk of harm to patients due to lack of access to Trust IT systems						
022545	Raise at SMT risk to staff and patients due to lack of IT system access for Trust staff. Require PC with capability of windows 7.	Scott, Jane; Matron - Child Health; SCBU & NNU	In progress as at 09/01/2015	30/01/2015		Extreme risk 16
Risk Score: 15						
Risk ID: 709						
Risk Title: Risk of reduced safe standard of care due to reduced midwifery staffing levels.						
016633	All incidents involving staffing levels to be reviewed by senior managers and reported as part of incident reporting to MRMG monthly	Goodwin, Ann; Clinical Risk Midwife; WomH	In progress as at 11/01/2015	31/05/2015	11/01/2015 - Staff continue to report reduced staffing levels and increased capacity through the DATIX system. No serious incidents have occurred relating to staffing levels	Extreme risk 15
018822	HOM to produce a plan - short, medium and long term.	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	In progress as at 11/01/2015	31/05/2015	11/01/2015 - Date for Br+study commence has been agreed for March 2015. Project Team to be indentified by the end of Jan 15	Extreme risk 15
Risk ID: 893						
Risk Title: Risk of failure of Pathology's Éclair System which could result in patient's results not being available						
020937	ICE System to be deployed for viewing results following training of Trust and all external users.	DaCosta, Jason; Director of Information Technology; IT	In progress as at 09/12/2014	31/01/2015		Extreme risk 15
020938	Éclair system to be decommissioned following ICE results viewing deployment.	DaCosta, Jason; Director of Information Technology; IT	In progress as at 09/12/2014	31/01/2015		Extreme risk 15
020936	Temporary Management : Re-send the Éclair messages that have failed on a daily basis to reduce the impact.	Gaskell, Neil; Deputy Departmental Manager; BIO	In progress as at 09/12/2014			Extreme risk 15

BOARD OF DIRECTORS

WHH/B/2015/ **025**

SUBJECT:	**Board Assurance Framework – January 2015**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	
EXECUTIVE DIRECTOR:	Executive
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	N/A
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	Amendments have been made to the BAF and are highlighted on the document. The Finance and Sustainability Committee reviewed the BAF and in particular Risk 1.1: Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework has been amended as requested by the FSC in November 2014. Further amendment have been made by the Director of Nursing and Organisational Development and these are highlighted on Risk 1.3, 1.5, 2.1, 2.2 and 3.3.
RECOMMENDATION:	***The Board is asked to:*** *Review and taking into account the review of the Corporate Risk Register confirm that the BAF and the Corporate Risk Register:* i. covered the Trust's main activities and adequately identified the principal objectives the organisation was seeking to achieve; ii. adequately identified the risks to the achievement of those objectives; and

	iii. confirm that adequate assurance systems are in place to ensure the systems of control were effective and efficient in controlling the risks identified.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee For risks associated with the Committees TORS
	Agenda Ref.	
	Date of meeting	20 January 2015
	Summary of Outcome	Noted

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2014/15

Glossary of Terms

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

Likelihood and Impact Assessment

Likelihood and Impact Assessment

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

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

Quality

Strategic Objective 1
ENSURE ALL PATIENTS ARE SAFE IN OUR CARE

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
1.1 COO	**Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework**	4 x 4 (16)	Operating Framework reviewed annually, and annual plan is prepared to demonstrate ability to deliver targets effectively.	3 x 4 (12)	Board involved in the Annual Planning process and subsequent reports to monitor progress of delivery against this plan.	30 GP vacancies across Warrington with no walk in centre or UCC to divert patients away from AED
			Effective operation of Governance structure		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board.	Reduction in investment in Warrington LA has resulted in changes to criteria for care support resulting in service users having to be at the extreme of need to access support potentially resulting in a worsening in their health and independence resulting in more AED visits.
			Performance management system (eg Bi Laterals, diagnostic meetings each month)		Assurance that Performance management systems is operating effectively as designed.	Review of Intermediate care underway due to a evidenced base shortage of capacity causing delays in complex discharge
			Engagement with staff		Board confirmation that all appropriate staff are effectively engaged.	Domiciliary care contracts not resolved caused a shortfall in supply to help maintain services users independence at home
			Awareness raising programme undertaken in relation to targets.		Confirmation that Awareness raising programme has been delivered in full.	
			Corporate Performance and Quality Dashboard Reports to Board on a monthly basis, including infection control reports.		Internal Audit provide a range of independent assurances through the audit plan Other assurances from independent organisations eg data assurance.	

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
					Management assurances around the accuracy of information provided.	
			Executive and Non-Executive ward and services visits (Walkabouts)		Programme and results have been designed and reviewed effectively and outcomes feed into Trust programme.	
			3 yearly governance review		Monitor implementation of recommendations arising from the review	
			Monitor trends that are relevant to triggering a governance concern.		Results of monitoring.	
			Annual Governance Statement		Independent assurance that the annual governance statement is reliable and robust	
			Whole System Management meeting [Overall health system risk that has impact on the Trust] • Lobby for non-recurrent financial support •		Warrington wide response to emergency demand Aligning entre pathway under Trusts control Greater Control of Urgent Care Centre's (Halton) and provision of GPAU .	Reponses from external stakeholders/providers is too slow and lacks sophistication. Actions to be undertaken by the Trust to address gaps include: 1) New whole system dashboard 2) Senior leader escalation meetings 3) Measurable metrics to be available ~~daily~~weekly across health system for complex delays in discharge 4) IC service review 5) Newly reformed Transformational change board to capture issues and actions ~~4)~~6) CCG led AED recovery weekly meeting~~Finding availability impacts from external health & Social Care~~
1.2 **DON**	**Risk of harm through failure to comply with Care Quality Commission National core healthcare**	4 x 5 (20)	Executive Directors responsibility for CQC Outcomes, with identified operational leads reporting via Board Committee	2 x 5 (10)	Governance Committee assurance that accountabilities and processes have been discharged with a focus upon understanding reductions of harm.	New reporting systems & sub Committees to Quality Governance Committee have been reviewed

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
	standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust.					and require review after 12 months to assess effectiveness (Sept 2014) CQC Inspection planned for January 2015 CQC Inspection to maternity services – action required – work and action plan on going
			Clinical Effectiveness and Patient Experience Strategy		One strategy: Monitor and progress reporting against Clinical Effectiveness and Patient Experience Strategy	
			Implementation of the national CQUIN for the NHS Safety Thermometer		Targets for reducing harm have been achieved eg avoidable pressure ulcers, UTIs, VTE, medication errors and 'never events'.	
			Accountability through governance structures including Bi Lateral review at divisional level.		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.	
			Trust policies and procedures including completion of CQC Assurance Templates by leads and service managers		In house" CQC inspections MIAA audits CQC unannounced inspection report March 2013 from visit held in January 2013 Care Quality Commission rating. CQC Risk rating Governor inspections Assurance on completion of action plans Benchmarking Complaints and Patient Feedback HED data	Patient complaint service reports and review approved by Trust Board
			~~Strategy setting process eg People and Quality.~~ Quality Strategy approved by the Board in November 2014.		~~Appropriate assurance that key strategies are designed and delivered effectively.~~ Quality Strategy and score card reported to the Board	~~Quality Strategy in process of being reviewed, to be presented to November Board~~

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
1.3 DON	**Failure to achieve infection control targets in accordance with the Risk Assessment Framework**	4x4 (16)	Infection control strategy including policies and procedures.	3x4 (12)	Process in place for approval of strategy to ensure that it is robust and confirmation of subsequent delivery, taking account of the number of bed days as against threshold tolerance in the RAF Threshold higher for Cdiff for 2014/15 than 2013/14 and move in profile nationally	Process within CCG not robust to regularly review appeals or monitor as per Cdiff objective.
			Governance and Accountability arrangements		Board oversight of committee operations Quarterly infection control reports	
1.4 COO	**Failure to comply with effective business continuity plans.**	4 x 5 (20)	Emergency preparedness strategy produced annually and presented to Board	1 x 5 (5)	Board review and monitoring of delivery of strategy including formal testing, training etc	
			Business continuity plans - in all depts.		Results of annual review of all business continuity plans overseen by Business Continuity Group and reported to Board.	
			Business Continuity plans for key external agencies are received to determine any risks to the continuity of essential services		Results of review overseen by Business Continuity Group and reported to Board. • 10 Event Planning meetings held looking at continuity • External validation of Systems • Series of live exercises to test resilience	
			Civil Contingencies Act requirements monitored.		Assurance report provided to Board to confirm compliance against legislation.	
			Appropriate Governance Structure in place - including Event Planning Meetings and PRHL Regional Group meetings		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.	
1.5 DON	**Failure to comply with Health & Safety Legislation.**	4 x 5 (20)	Appropriate Governance Structure in place	2 x 5 (10)	Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.	

Ref	Principal Risk (failure = key risk)	Initial Risk Score LxI	Control systems	Residual Risk Score LxI	Assurance	Gaps in Assurance/Controls
					Results of Internal incident reporting	
			Health & Safety Strategy		Process for approval of strategy and monitoring of delivery of strategy. Health & Safety Annual Report HSE visits and inspections and associated internal progress reports	
			Mandatory training programme delivered and monitoring of attendance.		KPIs being reported regularly to the Strategic Workforces Committee.	Highlighted as outlier for H&S training on staff survey & CQCIM

People

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

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
2.1 **DON**	**Failure to engage and involve our workforce in the design and delivery of our services.**	4 x 5 (20)	Appropriate Governance Structure in place, including Strategic People Committee and Council of Governors and Members Joint working with Staff Side/JLNC Staff engagement events planned once per quarter, first session in October 14.	2 x 5 (10)	Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes including staff survey results, monthly KPIs, patient feedback. Divisional DIG and temperature checks Assurances on how duty of candour has been discharged. Staff Survey results	• Staff FFT to be embedded in 14/15 • ~~Staff not always got access to intranet – requirement to develop team briefing processes to enable to reach all staff~~ • Staff survey results due Feb 2015. •
			People Strategy		Sign off of strategy and subsequent monitoring of implementation of strategy.	Strategy is fragmented and needs to be brought together under one overarching "HR" strategy – planned by March 2015
			Cost Transformation processes		Assurance Reporting on staff and patient impact from Cost Transformation processes.	
2.2 **DON**	**Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned.**	5x5 (25)	Control systems in place to support risk: • Strategic People Committee • Education Governance • NMAC • National WFP • Medical Education Committee • OD Strategy • People Strategy • Talent Management • Recruit & Selection Policies and Procedures • ICC and Workforce Transformation	3x5 (15)	• Board Workforce KPI reports • Educational Governance Reports to SPC • Workforce analysis & Workforce Plans • External Medical Education and Nurse Education reviews • Compliance with CQC & NHSLA Standards and Audits • Staff Survey • Staff engagement & wellbeing reviews • Staff FFT • NHS top 100 employers	• Require the development of robust workforce plans linked to capacity and demand and activity profile of the changing strategic direction of the Trust • Need to strengthen the links between business planning and workforce through the FSC and SPC • ~~Additional HR professional to be brought in to lead on temporary staffing and workforce plan.~~ • HR restructure ~~to be~~ finalised in ~~Q3~~Jan 2015 to roll out in Q4.

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Gaps in Controls/Assurance
						• HRD &DNS role to split in increase capacity

Strategic Objective 3
TO GIVE OUR PATIENTS THE BEST POSSIBLE EXPERIENCE

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
3.1 **COO/ DOF**	**Failure to develop an agreed Estates Strategy to meet service priorities and Trust patient environment quality standards.**	3 x 4 (12)	Estates Strategy being developed with assistance from Keir Construction in line with Board direction. Full Business case in course of preparation for approval March 2015.	3x 3 (9)	Board approval and subsequent monitoring of delivery of strategy via updates to Board and Board workshops (including understanding of clinical and business drivers)	
			Committee Structure		Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.	
			Capital Programme including plan to address backlog maintenance		Assurance on progress of delivery of capital programme including; • Rationalisation and optimisation of non-clinical buildings • Migration of secondary care services to community services	
3.2 **DoIT**	**Failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care**	4 x 4 (16)	Overarching Strategy and implementation plan	(3 x 4) (12)	Board approval and subsequent monitoring of delivery of strategy via updates to Board with an assurance focus upon the twin national challenge of providing information to our patients by 2015 and moving to paperless by 2018.	

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
					Programme board established to monitor progress reporting into FSC. Lorenzo Board established to deliver PAS replacement programme reporting into FSC. Capital programme in place to deliver the strategy. External funding being sourced to secure addition investment. Additional resources secured and new structure being put in place aligned to delivery programme.	
			Governance Structure; IM&T Programme Board Data Quality and Management Steering Group Information Governance and Corporate Records Group. OPD User Group. Diagnostic Users Group Benchmarking Review Group Finance and Sustainability Committee.		KPI meeting held fortnightly Medical Records Strategy Group reports and minutes. Internal audit review and reports and management action plans IT systems project implementation progress reports to Board. Reporting through committee structure (new Finance and Sustainability Committee)	
3.3 **DON**	**Failure to provide staff, public and regulators with assurances post Francis and Keogh review**	5 x 5 (25)		2 x 5 (10)	Board approval and monitoring of implementation of strategy. (particularly focusing assurance of patient experience and outcomes, rather than performance management)	
					Assurance over delivery and impact on the patient experience and outcomes.	
			• High level briefing papers and action plans • Board Development Review • Governance Structure • Internal/External Audit • Shine programme		• Effective operation of Assurance Committees. • Outcomes from work of Assurance Committees are reported to Board eg Quality Dashboard reporting to the Board • Quality Improvement Committee exception reporting to the Board • Patient Survey results • Patient Reported Outcome Measures (PROMS) reporting	~~New process for CQC inspections still to be fully understood~~

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ assurance
					• CQUIN progress reports to Board • Mortality Outlier Reports • Governor ward visits • Impact of new nursing structure changes • Patient Advisory Group. • LINKs feedback • Membership feedback • Compliance reporting on; • Reduced admissions, compliance with end of life care and Advancing Quality Targets • Quality Account/Report • Board workshop presentation on CQC inspections • Processes in place through Governance Department on Keogh Review inspections including across trust drop in sessions and training. The Sessions are to raise awareness amongst staff to the new Care Quality Commission Inspection Framework and what the impact of this for staff and the Trust	
			Quality Improvement themes		Board oversight of delivery of quality improvements	
			Communications and marketing		Board is assured on how effective the Trust has been in understanding their communities.	
			Whistle blowing arrangements		Effective learning on whistle blowing case studies	
			Friends and Family Test		Board & Governor overview of results of friends and family test.	
			Duty of Candor		• Briefing paper to the Board. Attached. • A Staff information was produced and distributed to all wards and depts.(attached) in addition to Trust induction for all new starters • Educational sessions arranged within all DIGGs/Specialties, Governance Committee, CG, Audit and Quality and Safety and Risk SC • The Incident and Investigations Policy was revised to include DoC and Approved under Governance arrangements (can be found on the Hub) • All Level One and Two Investigations has a DoC Checklist and is QC for audit purposes	

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

Strategic Objective 4
TO PROVIDE SUSTAINABLE LOCAL HEALTHCARE SERVICES

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ Gaps in Assurance
4.1 DOF	**Failure to agree and implement a focussed and robust business development strategy to achieve the strategic aims of the Trust.**	4 x 4 (16)	• Finance and Sustainability Committee to take forward and develop the recommendations of our external Strategic Review and determine our future strategy. • Monthly Divisional Bilateral Meetings. • Finance and Sustainability Committee (FSC) in place from February 2014.	3 x 4 (12)	Board approved 'Business Development Strategy' that describes the Trust objectives and approach to collaboration, service reconfiguration and partnership working. Quarterly reports to the FSC evidencing actions and approach support the delivery of the strategy and its expected outcomes. Monthly meetings of the FSC Committee to agree and oversee the implementation of the annual business development work plans. 5 Year Strategic Plan 2014-19 Strategic Plan toolkit to be utilised to develop Board awareness.	To refresh the Trust's Business Development Strategy in light of the Ernst and Young Strategic Study and develop robust annual work plans to support implementation and delivery. Establishment of Commercial Development Team to develop and support implementation of the Trusts Strategic Plan/Strategy
4.2 **DOF**	**Failure to:** ▪ **Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis.** ▪ **Remain a going concern at all times / remain solvent.**	4 x 5 (20)	▪ Monthly detailed and dash board report to the Board: I&E, activity, Balance Sheet performance metrics and 2 year cash profile. ▪ CoS risk rating assessment current and forecast ▪ Reporting other compliance metrics ▪ PMO arrangements ▪ Detailed discussion and papers to the FSC	3 x 5 (15)	▪ Financial and Sustainability Committee reviews all relevant financial and strategic reports ▪ Strategy Roll out to staff and stakeholders undertaken (Oct 2014) ▪ Audit Committee reporting to the Board ▪ Internal audit reports ▪ Annual Head of Internal Audit opinion ▪ SIC ▪ Statutory External Audit of accounts ▪ Audit Commission PbR audits ▪ Monitor risk assessment and level of involvement ▪ Internal Audit Programme	Updated risk Realigned controls and assurances

Ref	Risk (failure = key risk)	Risk Score LxI	Control systems	Residual Score LxI	Assurance	Action Plan Gaps in Control/ Gaps in Assurance
	▪ **Comply with section G6 of the provider licence.**		▪ Executive Meeting Monthly Review ▪ Divisional management and governance accountability structures ▪ Standing financial instructions and scheme of delegations ▪ Legal contracts agreed with CCG.		▪ ▪ Monthly Board reporting ▪ Budget and Annual Plan 14/15 and 15/16	
4.3 **DOF**	**Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards (provision and receipt of services); and failure of operational processes to deliver service to agreed contract targets, outputs or standards.**	5x 5 (25)	Monthly Divisional Bilateral Meetings and KPI meetings. Quality Group meetings with Warrington CCG Contract Risk Report Monthly Contract meetings with Warrington CCG and monthly correspondence with CCG. Finance and Sustainability Committee monthly Reviews	4 x 5 (20)	FSC to receive contract risk reports and actions outstanding issues to provide Board assurance. Contract Team in place – Robust challenge of all penalties and service delivery queries Evidence of contract performance (provision of service) and contract management (receipt of service) provided through Divisional Bilateral Reports. Operational review process through Bi-lateral; Quality and FSC meetings	Establishment of a contract (including SLA) register with identified responsible leads for each contract. Proactive management of contracts for receipt of services between operational teams, finance, procurement and business development. Proactive management of operational performance and delivery for provision of services between operational teams, finance, procurement and business development.
4.4 **DOF**	**Failure to conclude/reach agreement on year end contract or future year value and enter into Arbitration process; and in year disputes regarding contract that require a entering into Arbitration.**	4x5 (20)	National guidance Contract meeting with CCG Executive Directors Review of contract position Monthly monitoring and reporting of contract through FSC.	3x5 (15)	Contract team and Finance team review with Executive Director Approach adopted by other trusts and central guidance Reports to Board and Board Committees	Trust has limited control over whole system and no control over how Commissioners allocate resources

BOARD OF DIRECTORS

WHH/B/2015/ **026**

SUBJECT:	**Governance Statement Quarter 3 14/15**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	Please see paper.	
RECOMMENDATION:	***The Board is asked to discuss and agree the governance statement for submission to Monitor as set out in the paper.***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST

MONITOR GOVERNANCE STATEMENT

QUARTER 3 2014/15 (1st APRIL 2014 – 31st DECEMBER 2014)

1. BACKGROUND

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

2. STATEMENTS

2.1 FINANCE STATEMENT

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

2.2 GOVERNANCE STATEMENT

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

2.3 OTHERWISE

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

3. RECOMMENDATIONS

Finance

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

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

The actual continuity of services risk rating as at 31st December 2014 is 2, which is in accordance with the plan for the period.

The Board will recall that the 14/15 reforecast exercise approved by the Board and submitted to Monitor in December revised the forecast year end deficit to £5.9m, which resulted in a forecast continuity of services risk rating of 2 which is below the plan for the period.

The finance statement requires the Board to confirm that it anticipates it will maintain a continuity of services risk rating of 3 for "at least over the next 12 months" which therefore runs to Quarter 3 15/16. The December reforecast exercise and the annual plan submission shows that the Trust will not achieve and is not planning to achieve a risk rating of 3 over the next 12 months.

Therefore based on current and planned performance it is recommended that the Board states that it cannot confirm that it anticipates maintaining a risk rating of at least 3 over the next 12 months.

Governance

In Quarter 3 all targets and indicators were achieved with the exception of A&E Clinical Quality – total time in A&E under 4hours. This target scores 1 point against the governance risk rating.

To date the trust has had 23 cases of C Diff. It has been confirmed that 4 cases are due to lapses in care and 19 cases are under review. The reason for the delay in confirmation of status of the cases is the delay in the appeals process arranged by the commissioner. The latest position is summarized in the table below:

Narrative	Q1	Q2	Q3	Total
Cases due to lapses in care	4	0	0	4
Cases not due to lapses in care	0	0	0	0
Cases under review	3	9	7	19
Total	**7**	**9**	**7**	**23**

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

Otherwise / Exception Reporting

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

Tim Barlow
Director of Finance & Commercial Development
21st January 2015

Worksheet "Targets and Indicators"

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

These targets and indicators are set out in the Risk Assessment Framework

Definitions can be found in Appendix A of the Risk Assessment Framework

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Scoring under Risk Assessment Framework	Quarter 1 Actual Performance	Quarter 1 Achieved/Not Met	Scoring under Risk Assessment Framework	Quarter 2 Actual Performance	Quarter 2 Achieved/Not Met	Scoring under Risk Assessment Framework	Quarter 3 Actual Performance	Quarter 3 Achieved/Not Met	Any comments or explanations	Scoring under Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	No		92.9%	Achieved		91.0%	Achieved		92.6%	Achieved		
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	No		97.8%	Achieved		97.9%	Achieved		97.4%	Achieved		
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	0	94.6%	Achieved	0	95.0%	Achieved	0	94.3%	Achieved		0
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	No	0	94.0%	Not met	1	92.7%	Not met	1	89.7%	Not met		1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	No		85.5%	Achieved		85.1%	Achieved		88.3%	Achieved		
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No	0	99.3%	Achieved	0	99.0%	Achieved	0	100.0%	Achieved		0
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					87.9%			86.5%			86.7%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					99.3%			99.0%			99.0%			
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		97.0%	Achieved		100.0%	Achieved		100.0%	Achieved		
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		99.3%	Achieved		100.0%	Achieved		100.0%	Achieved		
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	0	96.7%	Achieved	0	99.0%	Achieved	0	97.7%	Achieved		0
Cancer 2 week (all cancers)	93%	1.0	No		93.0%	Achieved		93.5%	Achieved		94.8%	Achieved		
Cancer 2 week (breast symptoms)	93%	1.0	No	0	93.1%	Achieved	0	93.3%	Achieved	0	93.1%	Achieved		0
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	1.0	No		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		
Care Programme Approach (CPA) formal review within 12 months	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Admissions had access to crisis resolution / home treatment teams	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Meeting commitment to serve new psychosis cases by early intervention teams	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Ambulance Category A 19 Minute Transportation Time	95%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
C.Diff due to lapses in care	20	1.0	No	0	0	Achieved	0	3	Achieved	0	4	Achieved		0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					7			16			23			
C.Diff cases under review					7			13			19			
Minimising MH delayed transfers of care	<=7.5%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Data completeness, MH: identifiers	97%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Data completeness, MH: outcomes	50%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	N/A	Not relevant		0
Community care - referral to treatment information completeness	50%	1.0	No		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		
Community care - referral information completeness	50%	1.0	No		0.0%	Not relevant		0.0%	Not relevant		0.0%	Not relevant		
Community care - activity information completeness	50%	1.0	No	0	0.0%	Not relevant	0	0.0%	Not relevant	0	0.0%	Not relevant		0
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No			No			No			No		
CQC compliance action outstanding (as at time of submission)	N/A		No			No			No			No		
CQC enforcement action within last 12 months (as at time of submission)	N/A		No			No			No			No		
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No			No			No			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No			No			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No			No			No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No			No			No			No		
Results left to complete			0			0		0	0			0		
Total Score			0			1			1			1		

Worksheet "Governance Statement"

Click to go to index

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

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

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

Signed on behalf of the board of directors

Signature		Signature	
Name	Mel Pickup	**Name**	Tim Barlow
Capacity	Chief Executive	**Capacity**	Director of Finance
Date	28.01.15	**Date**	28.01.15

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

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

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

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

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

A

B

C

Attachment 3

RISK ASSESSMENT FRAMEWORK (PAGE 21, DIAGRAM 6)

EXAMPLES OF EXCEPTION REPORTS

CONTINUITY OF SERVICES (ALL LICENSEES)

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

FINANCIAL GOVERNANCE (NHS FOUNDATION TRUSTS)

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

GOVERNANCE (NHS FOUNDATION TRUSTS)

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

OTHER RISKS

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

BOARD OF DIRECTORS

WHH/B/2015/ **028(i)**

SUBJECT:	**Charitable Fund – Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2014.**	
DATE OF MEETING:	28th January 2015	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Karen Spencer – Head of Financial Services	
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	N/A	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	To present the Charitable Fund Annual Report and Accounts for approval by the Trust Board acting as the Corporate Trustee of the Charitable Fund.	
RECOMMENDATION:	***The Board is asked to:*** Approve the Charitable Fund Annual Report and Accounts for 2013/14	
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee
	Agenda Ref.	
	Date of meeting	10th December 2014
	Summary of Outcome	Recommended for Approval

Charitable Fund – Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2014

EXECUTIVE SUMMARY

The purpose of this paper is to present the Charitable Fund Annual Report and Accounts for 2013/14 for approval prior to submission on Friday 30th January 2015.

CONTEXT

The Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2014 have been prepared in accordance with both the Charities Statement of Recommended Practice 2005 (SoRP), and the Charities (Accounts & Reports) Regulations 2008, in addition to the Charities Act 2011.

BACKGROUND

The Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2014 have been examined by Voisey & Co, and no errors were found.

The document was presented at the Charitable Funds Committee meeting held on 10th December 2014, during which the Committee provided the recommendation that the Board should approve the Warrington and Halton Hospitals Charitable Fund – Trustee's Annual Report and Independently Examined Financial Statements for the Year to 31st March 2014.

NEXT STEPS

The Charitable Fund Annual Report and Accounts are required to be submitted to the Charity Commission on or before 31st January 2015.

RECOMMENDATIONS

Approval of the Charitable Fund Annual Report and Accounts for 2013/14.

CONCLUSION

The Board is asked to approve the Charitable Fund Annual Report and Accounts for 2013/14.

Warrington and Halton Hospitals Charitable Fund

Trustee's Annual Report & Independently Examined Financial Statements

For the Year to 31st March 2014

Registered Charity No 1051858

Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund

Trustee's Annual Report and Accounts

Year Ended 31st March 2014

CONTENTS

Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund

Trustee's Annual Report and Accounts

Year Ended 31st March 2014

Reference and administrative details

Address of Charity:	Lovely Lane Warrington Cheshire WA5 1QG Tel: 01925 662835
Registered Charity no:	1051858
Bankers:	Government Banking Service 7th Floor, Southern House Wellesley Grove Croydon CR9 1TR
Independent examiners:	Voisey & Co 8 Winmarleigh Street Warrington Cheshire WA1 1JW

Report of the Trustee for the year ended 31st March 2014

Foreword

Warrington and Halton Hospitals NHS Foundation Trust (the "Corporate Trustee") presents the Charitable Funds Annual Report together with the independently examined financial statements for the year ended 31st March 2014 of Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund ("the Charity"). Under Part 8 section 145 of the Charities Act 2011, the Corporate Trustee has exercised the Charity's exemption from audit. External scrutiny through *independent examination* is permitted and deemed appropriate for the Charity as its gross income is below a statutory threshold.

The Charity's Annual Report and Accounts for the year ended 31st March 2014 have been prepared by the Corporate Trustee in accordance with Part 8 of the Charities Act 2011 and the Charities (Accounts & Reports) Regulations 2008. The Charity's report and accounts include all of the separately established funds for which the Warrington and Halton Hospitals NHS Foundation Trust is sole beneficiary.

Structure, governance and management

Corporate Trustee

The sole corporate trustee of the Charity is the Warrington and Halton Hospitals NHS Foundation Trust. The Charity was established in accordance with paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Corporate Trustee is managed by its Board of Directors which consists of executive and non-executive directors. It has responsibility for ensuring that the NHS body fulfils its duties in managing the charitable funds. The members of the Board of Directors of the Corporate Trustee who served during the financial year and up to the date of compilation of this Report were as follows.

Name	Title	
Allan Massey	Chairman	
Allan Mackie	Non-Executive Director / Deputy Chair	Resigned 30th June 2013
Clare Briegal	Non-Executive Director / Deputy Chair(5)	Resigned 30th June 2014
Mike Lynch	Non-Executive Director	Commenced 22nd July 2013
Rory Adam	Non-Executive Director / Deputy Chair (6)	
Lynne Lobley	Non-Executive Director(7)	
Carol Withenshaw	Non-Executive Director	
Ian Jones	Non-Executive Director	Commenced 1st July 2014
Terry Atherton	Non-Executive Director	Commenced 1st July 2014
Mel Pickup	Chief Executive	
Jonathan Stephens	Director of Finance/Deputy Chief Executive	Resigned 31st May 2013
Steve Barrow	Acting Director of Finance	Interim period from 1st June 2013 to 10th September 2013
Tim Barlow	Director of Finance and Commercial Development	Commenced 11th September 2013
Karen Dawber	Director of Nursing and Organisational Development(1)	
Simon Wright	Chief Operating Officer / Deputy Chief Executive(2)	
Phil Cantrell	Medical Director	Resigned 12th May 2013(4)
Jason DaCosta	Director of Information Technology(3)	
Caroline Salden	Interim Director of Commercial and Corporate Development(3)	Commenced 1st April 2013 Resigned 11th October 2013
Paul Hughes	Medical Director	Commenced 1ST February 2014
Mark Halliwell	Interim Medical Director	Commenced 13th May 2013 Resigned 31st January 2014 (4)

(1) Karen Dawber was appointed to the temporary post of Interim Director of Nursing on 14th January 2013 in addition to her role as Director of Governance and Workforce. On the 16th May 2013 the Board Nominations and Remuneration Committee approved the creation of the position of Director of Nursing and Organisational Development which combined the roles of Director of Nursing and Director of Governance and Workforce, and Karen Dawber was appointed to that position.

(2) Simon Wright was appointed Deputy Chief Executive from 1st June 2013.
(3) Jason DaCosta and Caroline Salden were non-voting Executive Directors.
(4) Refers to their position as a director of the Corporate Trustee.
(5) Deputy Chair from 1st July 2013.
(6) Deputy Chair from 1st July 2014 - 30th November 2014.
(7) Deputy Chair from 1st December 2014.

The Charity is established as an umbrella charity, registered with the Charity Commission (no. 1051858). The umbrella charity covers the existence of a single unrestricted general fund containing 6 (2013: 36) designated funds as at 31st March 2014, and, currently, 4 restricted funds (2013: 1). The Charity was first registered as both Halton General Hospital NHS Trust Charity and Warrington Hospital NHS Trust Charity in April 1996 under the Charities Act 1993, which is now been incorporated into the Charities Act 2011.

In April 2001, supplemental deeds were executed to amalgamate the administration, trustees, objects and powers of the two charities following merger of the two organisations, creating the single body known as North Cheshire Hospitals NHS Trust Charitable Fund. On 1st December 2008, the Trust changed its name to Warrington and Halton Hospitals NHS Foundation Trust, following its transition to Foundation Trust status. The name of the Charity was changed accordingly by way of a supplemental deed and registered with the Charity Commission on 16th March 2010.

Charitable Funds Committee

The Board of Directors (the Board) established a committee on 5th April 2001, known as the Charitable Funds Committee, (the Committee) reporting to the Board, in accordance with standing order 6 for the practice and procedure of the Board of Directors (annex 7 of the Trust's Constitution). The role of the Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee. The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

Aside from any restricted funds held, the Charity holds a single general fund, within which designated funds have been created to acknowledge expressions of wish from donors about the particular department or ward which should ideally benefit from their generosity. The Trustee has an intention to use the income of designated funds in the areas indicated by donors. However the Committee may choose to apply the funds to general purpose in any area of the Trust's hospitals in accordance with the Health Service Act 1977 and the Charity's dormant funds policy. During the period under review the structure of the funds was reviewed. As a result 28 of the designated funds were re-designated within unrestricted funds to the general purposes of the charity. A further 3 were restricted following a review of historical legacies.

Membership of the Committee

The Committee comprises:

- at least two non-executive directors of the Board*;
- the Director of Finance and Commercial Development or his delegated deputy;
- the Director of Nursing;
- the Director of Commercial and Corporate Development;
- Head of Financial Services;
- Associate Director of Communications; and
- One public governor

* All non-executive directors of the Trust are members of the Charitable Funds Committee and are entitled to attend and vote at any meeting of the Committee.

During the year under review and up to the date of compilation of this Report, the members of the Charitable Funds Committee were as follows.

Name	Position held	
Allan Massey	Chairman	
Allan Mackie	Non-Executive Director (Deputy Chair of Charitable Funds Committee)	Resigned 30th June 2013
Clare Briegal	Non-Executive Director (Chair of Charitable Funds Committee)	Resigned 30th June 2014
Mike Lynch	Non-Executive Director	Commenced 22nd July 2013
Rory Adam	Non-Executive Director	
Lynne Lobley	Non-Executive Director (Deputy Chair of Charitable Funds Committee)	
Carol Withenshaw	Non-Executive Director	
Ian Jones	Non-Executive Director (Chair of Charitable Funds Committee)	Commenced 1st July 2014
Terry Atherton	Non-Executive Director	Commenced 1st July 2014
Caroline Salden	Interim Director of Commercial and Corporate Development)	Commenced 1st April 2013 Resigned 11th October 2013
David Ellis	Public Governor of Warrington and Halton Hospitals NHS Foundation Trust	
Jonathan Stephens	Director of Finance / Deputy Chief Executive	Resigned 31st May 2013
Steve Barrow	Acting Director of Finance	Interim period from 1st June 2013 to 10th September 2013 (1)(2)
Tim Barlow	Director of Finance and Commercial Development	Commenced 11th September 2013
Shirley Martland	Head of Financial Services	Resigned 27th September 2013
Karen Spencer	Head of Financial Services	Commenced 2nd December
Chris Horner	Associate Director of Communications	
Karen Dawber	Director of Nursing and Organisational Development	Commenced 14th January 2013(1)

(1) Refers to membership
(2) During the period 12th September 2013 and 1st December 2013, in his capacity as Deputy Director of Finance Steve Barrow attended meetings on behalf of the Interim Head of Financial Services.

The Director of Finance and Commercial Development is responsible for day to day control of the administration of the charitable funds, and, in conjunction with the Chief Executive, approves expenditure on behalf of the Corporate Trustee with an upper limit of £25,000. Expenditure in excess of £25,000 is referred to the Charitable Funds Committee for approval.

Members of the Trust Board and the Charitable Funds Committee are not individual Trustees under Charity Law, but act as agents on behalf of the Corporate Trustee.

Corporate Trustee's appointments

The methods of appointment to the key governance roles within the Board of Directors and Council of Governors of the Corporate Trustee are reported in the Corporate Trustee's Annual Report and Accounts 2013/14 and contained within the Corporate Trustee's Constitution. Copies of these documents can be obtained from the Corporate Trustee's website or from its Membership Office, located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

All appointments to the Committee are made in accordance with the Committee's approved Terms of Reference.

Trust staff, including executive and non-executive directors, are required to complete the Trust's corporate induction programme, and are encouraged towards continuous professional development through the Trust's on-going performance management arrangements. Directors are able to seek individual professional advice or training at the Trust's expense in the furtherance of their duties.

Governors' knowledge is refreshed through a range of briefing sessions and workshops. The Board of Directors, Committee and governors all have direct access to advice from the Board Secretary who is responsible for ensuring that the Corporate Trustee's procedures are followed and that applicable regulations are complied with.

Administration

The accounting records and day to day financial administration of the funds are dealt with by the Finance Department. Fund raising and promotion of the charity is administered by the Trust's Communication team located within the Membership office, both are located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

Risk management

The major risks to which the Charity is exposed have been identified and considered. A risk register has been compiled which is reviewed by the Committee on a biannual basis. Income and expenditure is monitored as part of the risk management process, to avoid unforeseen calls on reserves.

Objectives and strategy

The objective of the Charity is to provide for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Warrington and Halton Hospitals NHS Foundation Trust.

In its widest context this can mean the provision of medical equipment and training for any hospital employee or group of employees, and the provision of facilities for the direct benefit of our patients. The Corporate Trustee attempts to balance the purchasing of essential equipment for essential services against expenditure which improves the general environment and facilities of the hospitals for its patients. In achieving this balance, the Corporate Trustee always has in mind the wishes of the donors to the Charity.

Public interest benefit

The Corporate Trustee ensures that the *public interest benefit* criteria, as detailed in the Charities Act 2011, are met by critically assessing each funding application from sub-fund holders. Applications for funding can be made by any department within the hospitals, and applications are only restricted by the availability of funds and the quality of the application.

Where possible, funds are used to provide benefit to a wide range of patients, and funds used for staff enablement are allocated to projects that will directly benefit patients. A summary of major purchases made by the Charity during the year under review is contained in the Annual Review of Income and Expenditure Activities [page 9].

On 1st January 2014 following a review of the Charity's Public Interest Benefit the balance of the Hospitals' staff lottery of £30,848 was paid to Warrington and Halton Hospitals NHS Foundation Trust. The Trust now holds the monies on behalf of its staff lottery.

Reserve policy

Requirement

In accordance with Charity Commission guidance, the Corporate Trustee acknowledges that there is a requirement to hold reserves. This is to allow freedom to initiate expenditure when required, in advance of donations. This can be particularly useful when considering educational courses and training. In some instances, the Corporate Trustee may wish to acquire expensive equipment, which may necessitate the building up of resources. In these cases, a variation to this policy will be issued.

Level of reserves

- In order to meet expenditure in any financial year, the Corporate Trustee considers that a minimum reserve of £200,000 in the unrestricted general purpose fund should be permanently maintained. It is the duty of the Director of Finance and Commercial Development to monitor and advise the Charitable Funds Committee of the balance of reserves.

- The Charitable Funds Committee has authority to vary the minimum level of reserves.

Monitoring

The Director of Finance and Commercial Development will report on the progress of the reserves and make recommendations in order to comply with the policy on reserves.

Investment policy

Introduction

Where NHS charitable funds have surplus monies not needed to fund immediate charitable activities, Trustees may elect to invest some or this entire surplus in order to generate additional income to fund future activities.

Investment criteria

The investment policy of the Corporate Trustee is to deposit the entire value of the fund with the Government Banking Service in an interest-bearing account. This decision is based upon the intention in the short term to spend the funds, such that long-term investment would not be appropriate.

Interest receivable, interest payable and bank charges

It is the policy of the Corporate Trustee to charge all interest payable and bank charges to the General Fund, and to credit the General Fund with the proceeds of the Charity's investments.

Annual review of income and expenditure

During 2013/14, the Charity continued to support a wide range of charitable and health-related activities, by purchasing supplementary and complementary equipment or services which may not ordinarily have been provided from NHS sources.

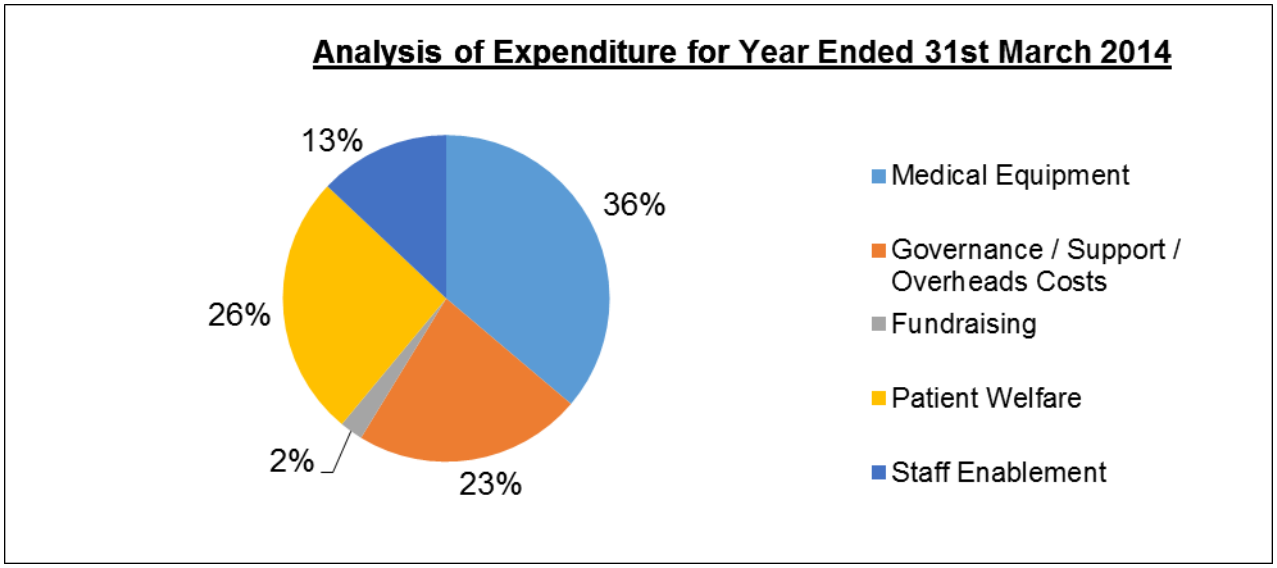
The main source of income received this year by the Charity has been voluntary donations from members of the public totalling £192,873 (2012/13: £95,133). The Charity also received legacy income of £92,113 (2012/13: £30,925). Legacy income where subject to a legal trust is held as restricted funds.

The Charity's unrestricted general fund contains a number of designated funds in order to assist the donors in matching their donation with a particular department. All donations are accepted taking into account the donors' intentions and are held in the general fund unless a restriction has been applied; in this case, a separate restricted fund may be created.

This year, volunteers and staff at the MacMillan Delamere Unit spent £2,800 (2012/13: £2,915) to generate income of £6,300 (2012/13: £6,000). The surplus is to be spent on cancer patient services.

The Corporate Trustee is committed to ensuring that all funds are directed to patient benefit as soon as possible. Expenditure on charitable activities for the year ended 31st March 2014 was £258,307 (2012/13: £150,850).

Total expenditure, which includes overheads and costs of generating income, for the year ended 31st March 2014, was £310,361 (2012/13: £169,536). This is split across the Charity's different categories of expenditure below.



Analysis of significant purchases (exceeding £1,000) made in 2013/2014

ECG machine and automatic ECG arrhythmia detection system for the Heart Unit	£26,596
Bladder scanners for Maternity, A&E and Elderly Care	£20,864
Monitors and guardrails for vulnerable patients	£15,452
Expenditure on behalf of the Staff Lottery	£6,581
Portable monitors for Intensive Care	£8,800
Cardio pulmonary testing system	£7,660
Maternity department information video for mums and their partners	£6,744
Bathing Trolley, Vapotherm and Neopuff devices for Neonatal	£6,345
Powered hoist	£5,733
Saturation monitors	£5,001
Donation to Warrington Disability Awareness Day 2013 and 2014	£4,800
Equipment and literature for use in Education and Training	£4,139
Equipment for Cancer Patient Support at the Macmillan Delamere Unit	£3,764
Volunteer expenses for Cancer Patient Support at the Macmillan Delamere Unit	£9,415
Drug cabinet, linen trolley and pulse oximeters for Children's unit	£3,250
Specialist chairs for patient use	£2,957
Videoconferencing equipment for the CMTC	£2,893
Paintings in hospitals	£2,400
Pregnancy and postnatal yoga teacher training course	£1,900
Spirometer reporting tool	£1,640
Licences for Hospital Radio	£1,600
Portering chairs for Urgent Care Centre	£1,580
Specialist camera for use in patient care	£1,555
Chronic pain relief booklets for patients	£1,250
Medical training equipment for Orthopaedics	£1,232
Replacement seating in main entrance at Warrington Hospital	£1,210
Midwifery and obstetric training simulators	£1,198
Pressure-relieving cushions to improve patient comfort	£1,088
Diploma in palliative care	£1,000
Subtotal of expenditure classes over £1,000	£158,647
Other Charitable purchases (under £1,000)	£40,012
Total Charitable purchases	£198,659

Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund

Trustee's Annual Report and Accounts Year Ended 31st March 2014

How your donations make a difference to patients.

Portable bladder scanning equipment improves fast access to tests

New equipment is a key element of our fundraising work. Thanks to funding of **£20,864** our maternity, accident and emergency and elderly care departments have been able to buy the latest in ward based bladder-scanning equipment. These scanners allow clinical teams to assess if patients are retaining urine and can significantly reduce the need for uncomfortable catheter use that carries a relatively high risk of infection.

"Bladder scanning is seen as the gold standard for patients now," says **Wendy Cox**, urology nurse specialist, "It prevents the need for unnecessary use of a catheter so provides a better service for our patients. Being able to provide these portable scanners in key areas of the trust so they are available 24 hours a day makes a huge difference to hundreds of patients."

Helping detect heart defects and improve coronary care

The Charitable Fund provided **£26,596** to buy an ECG (electro cardio graph) machine and automatic ECG arrhythmia detection system for the Heart Unit. The unit allows for potential screening for heart defects of the type that affected premier league footballer Fabrice Muamba in younger patients.

"We weren't able to provide these tests locally before fundraising took place," explains **Carol Over**, cardiac rehabilitation lead, "Patients had to travel to Liverpool or Manchester to access them. The detection system is really important as it allows us to rule out potentially serious problems in younger patients where the symptoms can easily be confused for things like asthma. It's a really important piece of kit for us to have here at the trust."

Improving support and care for our cancer patients

Over at Halton General Hospital, the Charitable Fund has continued to provide some key enhancements for our cancer services. **£9,415** was received by the Macmillan Delamere Cancer Centre at the hospital this year to invest in their award winning volunteer scheme that provides support and services to patients and their families with cancer.

The donation has again funded the complementary therapy service that provides relaxation, stress management and coping techniques for people with cancer and those undergoing treatment. It also funds special training for the team of volunteers (pictured right) so that their knowledge and advice is as up to date as possible. The volunteers provide services ranging from meeting and greeting patients coming in for chemotherapy, through to providing lifestyle and benefits advice.

Supporting new parents with video.

The fund isn't just about new equipment and hands on services, it's also about working in new ways to provide information and support to patients and visitors. **£6,744** allowed the trust's maternity unit to create an education video to let first time parents know about the maternity service, promote low risk births and create a virtual tour of the department that has freed up staff time spent on tours. It's also improved patient satisfaction.

Over 3,200 people viewed the video in just over six months since it launched and it's the kind of development that wouldn't have been possible from existing NHS funds.

Future plans

The Corporate Trustee does not expect significant changes in the objectives of the Charity in the forthcoming year and intends to significantly reduce reserves where suitable projects or programmes can be identified.

The Corporate Trustee is committed to utilising funds in the next financial year to ensure that funds expended are directed to patient benefit as soon as is practical. At the date of compilation of the financial statements, the following schemes, each involving commitments in excess of £1,000, have been approved.

Fibro scanner - purchased with monies from the Brian Mercer fund	£94,450
Additional therapy staff for Forget Me Not Unit	£76,224
Provision of "capture stroke service" for patients with suspected TIA	£49,836
Upgrade to mortuary waiting area for bereaved visitors	£38,976
Cataract software	£17,748
Wireless foetal monitor	£16,532
Bed, hoist and slings for clinical education	£16,080
Additional therapies for inpatients to improve recovery	£13,904
Specialist chairs for stroke patients	£10,314
Testing Kit, tonometer and examination couches to support the glaucoma service	£7,987
Nesting wheelchairs for disabled patients	£6,891
TC70 Cardiograph and trolley	£6,617
Ultrasound Machine for Intensive Care	£6,323
iPads and specialist computer programs for stroke patients	£5,509
Electronic bed and dialysis scale	£4,199
Educational equipment for cancer survivors	£3,389
Fitness courses to benefit cancer patients recovery	£3,240
Wall mounted thermometers for Children's Unit	£2,320
Spirometer and calibration syringe	£2,258
Blood pressure monitors	£1,812
Specialist bed	£1,385
Vital signs monitor	£1,086

Statement on future strategy

Our strategy for 2014-2015 builds on our work in 2013-2014 that has seen the charity brand begin to be established in a more high profile way with distribution of collection tins, a strengthened community profile, professional database management, donation tracking and administration functions – along with increased support for teams fundraising.

Our aim now is to increase the amount of active fundraising and thus income to the fund in the future. It is an exciting time for the charity and one where there is a strong belief that foundations have been laid that can now be built on over the next 12 months and beyond.

Our outline strategy for 2014-2015 sets the following objectives, with the ultimate objective of significantly increasing income to the charity from community sources:

- Raise the profile of the Warrington and Halton Hospitals' Charity across the local community and across the hospitals' internal communities;
- Be clearer about why the trust is fundraising, and more transparent about how donations are invested for the benefit of patients (including the difference Gift Aid makes);
- Engage supporters and local communities in ways they can fundraise or volunteer for the new charity, with an emphasis on fundraising activities which do not require extensive management or investment by the trust;
- Build long-term relationships with supporters through effective donor communications and stewardship;
- Internally, engage all wards and departments in thinking of their area as being part of one charity, with fundraising benefitting all areas equally.

In order to meet the above objectives, 6 priority areas have been identified and were agreed by the Charitable Funds Committee in July 2014.

This outline strategy does consider the current resources of the Charity, in order to set realistic and achievable delivery aims, and as such focuses on a smaller number of areas to make a bigger impact.

Our six priority areas:

1. **Launch of giving campaigns to ask people to fundraise for clearly identified projects**. These projects have been selected to move us towards the aim of identifying clear fundraising campaigns for periods of the year with clear outcomes that allow us to and to create a strong call for support, and a single focus for community and corporate fundraising across all charity and trust communications. Six campaigns have been chosen for further exploration as there is a specific need in this area, or they have previously had a popular standalone fund. Some of the campaigns will last for several months, others for shorter or longer specific periods of time.

The initial six identified projects are:

- **Above and Beyond Fund -** new branding for the fund currently known as the General Fund to create an ongoing theme for general fundraising
- **Forget Me Not Fund** – funds specific for the dementia care projects, looking at rempods and extras for the ward
- **Children's ward** – developing the playground and play area development project
- **Halton MR Scanner Fund -** supporting costs for the new MR scanner for Halton Hospital
- **Neonates –** supporting purchase of new equipment on the unit
- **Stroke** - emergency care project and ongoing support for the ward.

Each of these projects will be provided with specific support by the charity team.

2. **Increase of 'In Memory' thank you fundraising promotion, and begin promoting Tribute Funds**
   The charity already attracts a good level of In Memory fundraising with the majority of Just Giving pages being set up in memory of a person who had received care by the trust. However, the charity currently misses an opportunity to increase income to this area, and particularly through utilising the Just Giving In Memory function which enables donors to set up a specific page about their loved one and ask their friends and family to donate. Further promotion of this function will be developed with the outcome being an increase in In Memory fundraising during the early part of 2015.

3. **Increasing the number of Fundraising Committees**
   We are targeting securing two new fundraising committees during the year. Fundraising Committees are often groups of friends or family members who come together to raise money in their spare time. In the case of hospital charities, this is often because one of the group, or a loved one, has received care at the hospital.

   The charity's role is to offer some basic guidance where needed, and to attend Committee fundraising events where appropriate to give thanks; sometimes the Committee may ask for help in sourcing an item for a raffle or auction, or they may require a letter from the charity to confirm that they are aware that the committee is fundraising for their benefit.

   The Delamere Centre already has a Fundraising Committee which the charity will support, and other groups such as dementia and child heath are being encouraged to formally form as a committee using the support of service users in these areas.

4. **Launch of the charity newsletter**
   Communicating the work of the charity is seen as a key priority and we will launch our first newsletter, and distribute to all donors, widely across the hospital sites and across community venues. This will support a number of our aims.

5. **Increase recognition of our charity 'tree' logo**
   We will hold a number of highly visible fundraising events across the hospital sites, such as our 'silly socks' day, charity abseil and taking the charity to community and social events across the trust's communities.

   We will continue positioning collection tins across the local community, organising town centre 'bucket collections', and through potential partnerships with businesses and other organisations.

   While retail is not included within this outline strategy, the Charity will develop potential income to be gained from Christmas card sales, as well as the opportunity to increase recognition of the tree logo through the distribution of the cards across the local community.

   We will also make better use of our own hospital environment with static collection units and greater poster and graphic use in the hospital sites.

6. **Charity volunteer recruitment**
   A key element as our work grows is a focus on recruiting volunteers to assist us with events and community growth. We will focus on promoting a 'Charity Champions' type scheme where staff members can nominate themselves to this role, and they agree to keep up to date with the charity, help spread the word and help at events, and attend a 6 monthly update session. Members of the local community who wish to volunteer their time will also be actively encouraged to do so.

Developing the charity function in the trust

We have set out some challenging objectives for the charity. At present support for the charity development is provided from external resource using a consultancy service. However, it is considered to be more beneficial and cost effective if this model is changed going forward.

The trust is committed to moving to a 'fixed term' employment model where the support provided by the consultancy would be adjusted to internal resources. The aim is to recruit to a community fundraiser post to take forward our strategy in early 2015. This post would take a lead on delivering this strategy working closely with the trust communications team.

Acknowledgement

The Corporate Trustee would like to extend its sincere thanks on behalf of the patients and staff who have felt the impact of this year's donations and legacies, received in person at our Cash Offices, by post or through the Just Giving website. Many of our donors have contributed in times of personal difficulty.

Gratitude is also extended to the Leagues of Friends at the Trust's Warrington and Halton sites. These independent charities operate alongside the Charity, sharing similar objectives, and the Charity occasionally co-purchases items with them.

The Corporate Trustee would also like to acknowledge the increasing fundraising activities of our donors, who have been holding events and undertaking a variety of sponsored feats to generate awareness and funds for the Charity. Their contributions, imagination and enthusiasm are greatly appreciated.

Information regarding the independently examined accounts can be obtained from the Finance Department on 01925 662835.

Approved on behalf of the Corporate Trustee.

TIM BARLOW…….Date: 28th January 2015
Director of Finance and Commercial Development

Statement of Trustee's responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements;
- prepare the financial statements on the *going concern* basis unless it is inappropriate to presume that the Charity will continue in operation;
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed; and
- Safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 19 to 29 attached have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

Approved by the Corporate Trustee on 28th January 2015 and signed on its behalf by:

ALLAN MASSEY ……..
Chairman

TIM BARLOW ……
Director of Finance and Commercial Development

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEE OF WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST CHARITABLE FUND

I report on the accounts for the year ended 31 March 2014 set out on pages 20 to 29.

Respective responsibilities of trustee and examiner
The charity's trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year (under Section 144(2) of the Charities Act 2011 (the 2011 Act)) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under Section 145 of the 2011 Act;
- follow the procedures laid down in the General Directions given by the Charity Commission (under Section 145(5) (b) of the 2011 Act); and
- state whether particular matters have come to my attention.

Basis of the independent examiner's report
My examination was carried out in accordance with the General Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statements below.

Independent examiner's statement
In connection with my examination, no matter has come to my attention:

(1) which gives me reasonable cause to believe that, in any material respect, the requirements
  - to keep accounting records in accordance with Section 130 of the 2011 Act; and
  - to prepare accounts which accord with the accounting records and to comply with the accounting requirements of the 2011 Act have not been met; or

(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Philip Urmston BSc FCA.
Voisey & Co
Chartered Accountants
8 Winmarleigh Street
Warrington
Cheshire
WA1 1JW

29th January 2015

Statement of Financial Activities

	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	2013/14 £'000 Total Funds	2012/13 £'000 Prior Year Total Funds
Incoming resources						
Incoming resources from generated funds						
Voluntary income	2	285	0	0	**285**	126
Activities for generating funds		6	0	0	**6**	6
Investment income	3	1	0	0	**1**	2
Total incoming resources		292	0	0	**292**	134
Resources expended						
Costs of generating funds						
Fundraising: costs of goods sold and other costs		6	0	0	**6**	3
Charitable activities	4	258	0	0	**258**	151
Governance costs	6	15	0	0	**15**	16
Transfers		31	0	0	**31**	0
Total resources expended		310	0	0	**310**	170
Net outgoing resources before transfers		(18)	0	0	(18)	(36)
Gross transfers between funds		(110)	110	0	0	0
Net movement in funds		(128)	110	0	**(18)**	0
Reconciliation of funds						
Total funds brought forward		619	31	0	650	686
Total funds carried forward		**491**	**141**	**0**	**632**	**650**

Balance Sheet as at 31st March 2014

	Note	2013/14 £'000	2012/13 £'000
Fixed assets		0	0
Current assets			
Cash at bank and in hand	7	667	665
Debtors	8	9	4
Total current assets		676	669
Current liabilities			
Creditors: amounts falling due within one year	9	44	19
Net current assets		632	650
Total assets less current liabilities		632	650
Net assets		**632**	**650**
The funds of the Charity:			
Restricted income funds	13	141	31
Unrestricted income funds	13	491	619
Total Charity funds		**632**	**650**

The notes on pages 22 to 29 form part of these accounts.

Signed:

Chairman……Date 28th January 2015

Director of Finance and Commercial Development……Date 28th January 2015

Notes to the accounts

Note 1 Accounting policies

1.1 The financial statements have been prepared under the historical cost convention and in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2005) issued in March 2005, applicable UK Accounting Standards and the Charities Act 2011.

1.2 Funds structure

Restricted funds are to be used in accordance with the specific restrictions imposed by the donor. The Charity held 4 restricted funds at the end of the year under review.

The Charity did not hold any endowments, expendable or otherwise, during the year under review.

Unrestricted funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of the Charity's charitable objects. The Charity has a single unrestricted general fund containing several designated funds. These unrestricted designated funds are created to honour donors' expressions, or are created by the Trustee, at its discretion, to designate monies for specific future purposes. Any funds held within a designated fund can be merged or transferred within the general fund at any time, at the discretion of the Trustee, in accordance with the Health Service Act 1977 and the Charity's dormant funds policy.

No future transfers between restricted and unrestricted funds are anticipated.

1.3 Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is certain that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

There were no *gifts in kind* or *intangible income* in the year under review.

1.4 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt, or where the receipt of the legacy is virtually certain. This would require that confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred, and that all of the conditions attached to the legacy have been fulfilled.

Material legacies which have been notified, but not recognised as incoming resources in the Statement of Financial Activities, are disclosed in Note 12 to the accounts, with an estimate of the amount receivable.

1.5 Resources expended

All expenditure is accounted for on an accruals basis, and has been classified under the headings that aggregate all costs related to that category. All expenditure is recognised once there is a legal or constructive obligation committing the Charity to the expenditure.

The Charity does not make grants to third parties.

Contractual arrangements are recognised as goods or services are supplied.

1.6 Costs of generating funds

These are costs associated with generating incoming resources, and are recognised as per the Charity's other expenditure. The Charity does not currently incur material costs in generating incoming resources.

1.7 Charitable activities

The costs of charitable activities include all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise the direct costs of charitable purchases, and overhead and support costs as shown in Note 4.

1.8 Governance costs

Governance costs comprise all costs incurred in the governance of the Charity. These costs include fees pertaining to the provision of governance and financial papers to the Charitable Funds Committee, the creation of this Annual Report and Accounts, the audit or independent examination of the accounts, and any associated support costs.

Expenditure on strategic advice and consultancy services are also classed as governance costs.

1.9 Fixed asset investments

There were no fixed asset investments as at the Balance Sheet date.

1.10 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

Note 2. Analysis of voluntary income

	Unrestricted Funds £'000	Restricted Funds £'000	**2013/14 Funds £'000**	2012/13 Funds £'000
Donations	193	0	**193**	95
Legacies	92	0	**92**	31
Total	285	0	**285**	126

Note 3. Analysis of investment income

	Unrestricted Funds £'000	Restricted Funds £'000	**2013/14 Funds £'000**	2012/13 Funds £'000
Bank interest	1	0	**1**	2
Total	1	0	**1**	2

Note 4. Analysis of charitable activities

	Unrestricted Funds £'000	Restricted Funds £'000	**2013/14 Funds £'000**	2012/13 Funds £'000
Patient welfare	69	0	**69**	30
Staff enablement	34	0	**34**	41
Medical equipment	95	0	**95**	61
Support costs and overheads	60	0	**60**	19
Total	258	0	**258**	151

Support costs and overheads comprises an apportionment from the Trust's administration charge (Note 5) of £18,085 (2012/13: £18,089); it also includes licences and fees paid to third parties. During the year the Charity employed the services of Plum Marketing to assist in the development and implementation of the Charity's future strategy at a cost of £38,000. This fee is included within support costs and overheads.

Note 5. Allocation of administration charge

The Charity employs one part-time member of staff to assist with fundraising and the general administration of the charity. An administration charge is also raised to cover the governance, financial and procurement resources of Warrington and Halton Hospitals NHS Foundation Trust. The charge for the year ended 31 March 2014 was £32,000 (2012/13:£32,000).

The costs of administering the Charity have then been apportioned between governance costs (Note 6) and support costs and overheads (Note 4), and charged to the General Fund. The element of the administration charge that is attributed to governance costs pertains to the costs associated with the preparation of Committee papers and this Annual Report and Accounts.

Note 6. Governance costs, including costs of independent examination and audit

	2013/14 Total £'000	2012/13 Total £'000
Independent examination / audit fees	**1**	1
Administration charge	**14**	14
Consultancy and advice	**0**	1
Total	**15**	16

Independent examination / audit fees consists of an accrual for the independent examination fee of £1,470 (2012/13: £1,440) for the period of this review.

Note 7. Analysis of cash at bank and in hand

	2013/14 £'000	2012/13 £'000
Bank current account	**667**	665
Total	**667**	665

Note 8. Analysis of debtors

	2013/14 £'000	2012/13 £'000
Prepayments and accrued income	**1**	1
Other debtors	**8**	3
Total	**9**	4

Other debtors represents the balance owed to the Charity by Warrington and Halton Hospitals NHS Foundation Trust. This is because of income received by the Trust on behalf of the Charity at the end of the financial year and purchases made on behalf of the Hospital's Staff Lottery.

Note 9. Analysis of current liabilities and long term creditors

	2013/14 £'000	2012/13 £'000
Accruals and purchases made on behalf of the Charity	**44**	19
Total	**44**	19

Note 10. Related party transactions

The Charity is a subsidiary of the Trust and is therefore a related party. Warrington and Halton Hospitals NHS Foundation Trust is the sole beneficiary of the Charity. The Charity provides funding to the Trust for approved expenditure made on behalf of the Charity. During the year the Charity made payments to Warrington and Halton Hospitals NHS Foundation Trust totalling £245,023 (2012/13: £176,883) for purchases made by the Trust on behalf of the Charity. At 31st March 2014 the Charity owed Warrington and Halton Hospitals NHS Foundation Trust £15,739 (2012/13:£11,524) for purchases made on behalf of the Charity.

At 31st March 2014, Warrington and Halton Hospitals NHS Foundation Trust owed the Charity £7,722 (2012/13:£3,778) for purchases made on behalf of the Hospitals' Staff Lottery and for income due to the Charity which had been paid into the Trust's bank account in the first instance, and which were held there at the Balance Sheet date. All debts were settled after the Balance Sheet date through a reduction of £7,722 in the monthly payment from the Charity to the Trust for its charitable purchases. All transactions entered into during the year were conducted on an arm's length basis.

Transfers totalling £30,848 represent the balance of the Hospitals' staff lottery which was paid to Warrington and Halton Hospitals NHS Foundation Trust during the year. The Trust now holds the monies on behalf of its staff lottery.

During the year, none of the members of the Trust Board or senior Trust staff, or parties related to them, were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the Trust Board has received honoraria, emoluments or expenses in the year. The Corporate Trustee has not used the funds of the Charity to purchase trustee indemnity insurance.

Board members, and other senior staff, take decisions on both Charity and exchequer matters, but endeavour to keep the interests of each discrete, and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public in the Corporate Information section of the Trust's website.

From 1st April 2013 NHS charitable funds considered to be subsidiaries are to be consolidated within the Trust accounts in accordance with an accounting direction issued by Monitor. For 2013/14 the Trust has opted not to consolidate charitable funds with the main Trust Accounts because they are immaterial. This will be reviewed each year for appropriateness.

Note 11. Post Balance Sheet events

There have been no events since the Balance Sheet date that would indicate that any revision to the accounts is necessary.

Note 12. Legacies

During the period following the Balance Sheet date, the Charity was advised of future legacy income of £230,308 all of which had been received by the date of compilation of this Annual Report and Accounts.

Note 13. Fund structure and summary of movements

Charitable funds

The Charity has 5 funds. These are the (unrestricted) General Fund, and 4 Restricted Funds. The restriction has arisen due to the legacy donor's stipulation that the monies be spent within a particular Department.

It is anticipated that there will be no future transfers between the funds. A summary of fund movements is given below.

FUND	Balance as at 1st April 2013	Outgoing resources	Incoming resources	Transfers	Balance as at 31st March 2014
	£	£	£	£	£
General Unrestricted	619,345	(279,543)	292,464	(141,363)	490,903
Ophthalmology Restricted	30,925			-	30,925
Cancer Patient Support Restricted	-			20,748	20,748
Heart Unit Restricted	-			37,512	37,512
Stroke Unit Restricted	-			52,255	52,255
Total Funds	**650,270**	**(279,543)**	**292,464**	**(30,848)**	**632,343**

Unrestricted general fund: sub-fund balances

A summary of the sub-funds held within the unrestricted general fund is given overleaf. The *Transfers* column quantifies the effects of a number of mergers and transfers undertaken within the financial year ending 31st March 2014 as a result of the Committee's on-going review and application of the Charity's dormant funds policy and reassignment of funds within the general unrestricted fund. The Charity Development Fund represents monies set aside to pay for the Charity's re-launch in 2013/14, ongoing development and costs associated with the Charity Administrator role.

FUND	Balance as at 1st April 2013	Outgoing resources	Incoming resources	Transfers	Balance as at 31st March 2014
	£	£	£	£	£
General Unrestricted	**25,993**	**(85,771)**	**208,999**	**240,656**	**389,877**
Charity Development	**60,000**	**(41,901)**	**-**	**-**	**18,099**
Children's Unit	**11,174**	**(7,933)**	**3,176**	**2,130**	**8,547**
Heartbeat Halton	**9,296**	**(7,214)**	**310**	**-**	**2,392**
Intensive Care	**36,156**	**(8,800)**	**18,478**	**-**	**45,834**
Neonatal	**21,440**	**(16,446)**	**15,619**	**-**	**20,613**
Ophthalmology	**-**	**-**	**-**	**5,541**	**5,541**
Adult Medicine Fund	3,479	-	-	(3,479)	-
Cancer Patient Support Fund	23,699	(25,287)	22,336	(20,748)	-
Cardiac Research	17,538	-	25	(17,563)	-
Chaplains' Fund	677	-	-	(677)	-
Chaplains' Fund [WGH]	451	(484)	-	33	-
Diabetes and Endocrinology Fund	33,235	(2,484)	-	(30,751)	-
Education and Training	15,083	(6,877)	-	(8,206)	-
Elderly Care Unit	18,376	(7,485)	300	(11,191)	-
General Surgical	7,799	(700)	20	(7,119)	-
Geriatric Research	1,311	-	-	(1,311)	-
Haematology / Leukaemia Fund	2,018	(333)	1,155	(2,840)	-
Halton Pain Relief	4,979	(2,079)	-	(2,900)	-
Heart Unit	61,498	(26,636)	2,651	(37,513)	-
Lung Cancer & Palliative Care	6,585	(1,368)	3,342	(8,559)	-
Medical Miscellaneous	5,361	-	1,255	(6,616)	-

Contd.

Ophthalmology Fund	46,000	-	3,822	(49,822)	-
Orthopaedic Fund	1,493	(2,579)	200	886	-
Outpatients	1,846	-	-	(1,846)	-
Paediatric Respiratory Fund	2,687	(836)	280	(2,131)	-
Radiology General	2,256	139	-	(2,395)	-
Respiratory Care	13,607	-	141	(13,748)	-
Rheumatology	9,962	(99)	-	(9,863)	-
Staff Lottery	33,976	(6,581)	3,453	(30,848)	-
Stroke Fund	71,842	(20,324)	737	(52,255)	-
Surgical Unit	16,839	-	310	(17,149)	-
Surgical Ward A5	1,431	-	-	(1,431)	-
Therapies	1,230	(1,034)	-	(196)	-
Ultrasound	40,899	(38)	-	(40,861)	-
Urological Fund	455	(260)	-	(195)	-
Vascular Fund	4,105	-	-	(4,105)	-
Maternity	4,569	(6,133)	5,855	(4,291)	-
Unrestricted Fund Total	**619,345**	**(279,543)**	**292,464**	**(141,363)**	**490,903**

BOARD OF DIRECTORS

WHH/B/2015/ **028(ii)**

SUBJECT:	**Terms of Reference of the Finance and Sustainability Committee**
DATE OF MEETING:	28th January 2015
ACTION REQUIRED	**For Decision**
AUTHOR(S):	Trust Secretary
EXECUTIVE DIRECTOR:	Tim Barlow, Director of Finance and Commercial Development and Chair of the FSC, Carol Withenshaw
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO4/4.4 Failure to conclude/reach agreement on year end contract or future year value and enter into Arbitration process; and in year disputes regarding contract that require a entering into Arbitration. SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard SO4/4.1 Failure to agree and implement a focussed and robust business development strategy to achieve the strategic aims of the Trust. SO4/4.2 Failure to: Maintain a liquidity ratio and capital servicing capacity necessary to deliver a continuity of services risk rating of at least 3 on a quarterly basis; remain a going concern at all times remain solvent; and Comply with section G6 of th SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Finance and Sustainability Committee reviewed its terms of reference in light of changes to the Governance Structure arising from the approval of the Quality Strategy and having regard to the remit of the Committee approved by the Board and an effectiveness review undertaken by the Chair of the Committee.
RECOMMENDATION:	***The Board is asked to:*** Approved the amendments to the Terms of Reference of the Finance and Sustainability Committee.

PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/15/09
	Date of meeting	20 January 2015
	Summary of Outcome	Recommended for Approval

FINANCE AND SUSTAINABILITY COMMITTEE

TERMS OF REFERENCE

Document Title	Finance and Sustainability Committee - Terms of Reference
Document Reference	FSC/TOR/0002(version 1 Draft)
Author	Lead Executive Director / Trust Secretary
Intranet Location	TBC
Lead Executive Director	Director of Finance and Commercial Development
Reporting to	Board of Directors
Date Ratified	Board Approval: TBC
Review Date	January 2016
Mandatory/ Statutory Standards or Requirements	Provider Licence Board Assurance Framework

1. PURPOSE

The Finance and Sustainability Committee (the Committee) is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

2. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded and circulated to the Board. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Committee will report to the Board annually on its work and performance in the preceding year.

The Trust standing orders and standing financial instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

The Committee will:

a) Receive and consider the ~~annual~~ financial and operational plans and make recommendations as appropriate to the Board.

~~b) Review progress against key financial and performance targets~~

~~c) Review and monitor progress, on behalf of the Board, the Trust's temporary staffing levels~~

~~d) Review, on behalf of the Board, Monitor quarterly and annual returns.~~

~~e)~~b) Review the service line reports for the Trust and ~~advise~~ seek assurance that~~on~~ service improvements are being implemented.

~~f)~~c) Review the productivity metrics for the Trust and oversee performance against these metrics

~~g)~~d) Review the treasury management procedures and make recommendations of any amendments to the Board of Directors.

~~h)~~e) Oversee the development and implementation of the estate strategy

~~i)~~f) Oversee the development and implementation of the information management and technology strategy

~~j)~~g) Consider any matters that are escalated to it by the Board of Directors, Board Committees or Operational Committees or groups (such as the Bi-lateral Divisional Meetings)

h) Examine specific areas of financial and operational risk and highlight these to the Board as appropriate

~~k)~~

Strategy, planning and development

The Committee will:

a) Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management

b) Advise the Board and maintain an oversight on all major investments and business developments.

c) Advise the Board on all proposals for major capital expenditure over £500k or such capital expenditure of lower levels that have a material impact on the Trust's operation.

d) Develop the Trust's Commercial strategy for approval by the Board and oversee implementation of that strategy

e) Review the Risks identified in the Trust's Board Assurance Framework within the scope of the Committees areas of responsibility.

~~d)~~f) Receive a monthly IM&T report on implementation of the Trust IM&T Strategy, Information Governance and project management.

Policies

The Committee will receive and approve any Trust policies that relate to the areas contained within these terms of reference.

Overall

~~h)~~i) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.

5. MEMBERSHIP

The Committee membership will be appointed by the Board and will consist of:

- Non-Executive Director (Chair)
- One additional Non-Executive Director
- Director of Finance & Commercial Development
- Chief Executive
- Chief Operating Officer
- Director of Nursing and ~~Organisational Development~~Governance (job title change from 1 February 2015)
- Director of IM&T~~T~~
- Medical Director
- Director of Human Resources and Organisational Development (from 1 February 2015)

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

6. ATTENDANCE

a. Members

Members will be required to attend a minimum of 75% of all meetings.

b. Officers

The chair of each of the committee or groups reporting to the Committee will be expected to attend each meeting of the Committee.

Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

7. QUORUM

A quorum shall be ~~three~~ five members including ~~one~~ two Non-Executive Director, and ~~two~~ three Executive Directors. The Chair of the Trust may be included in the quorum if present at a meeting. In the event that a Non-Executive Director member cannot attend a meeting of the Committee, one of the Non Executives Directors who are not members of the Committee may attend in substitution and be counted in the quorum of the Committee.

8. FREQUENCY OF MEETINGS

Meetings shall be held at least 6 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

9. REPORTING GROUPS

The groups listed in the next paragraph are required to submit the following information to the Committee:

a) the formally recorded minutes of their meeting;
b) separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have;
c) an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

a) Innovation and Cost Improvement Committee
b) Information Management & Technology Steering Committee including reports from
    a. Lorenzo Project Group
    ~~a.~~b. Information Governance and Corporate Records Committee (including the Data Quality & Information Governance Group)
~~b)~~c) Capital Planning Group
~~c) Commercial and Business Development Committee~~
~~d) Temporary Staffing Group~~
~~e)~~d) The Business Planning sub Committee (strategic).

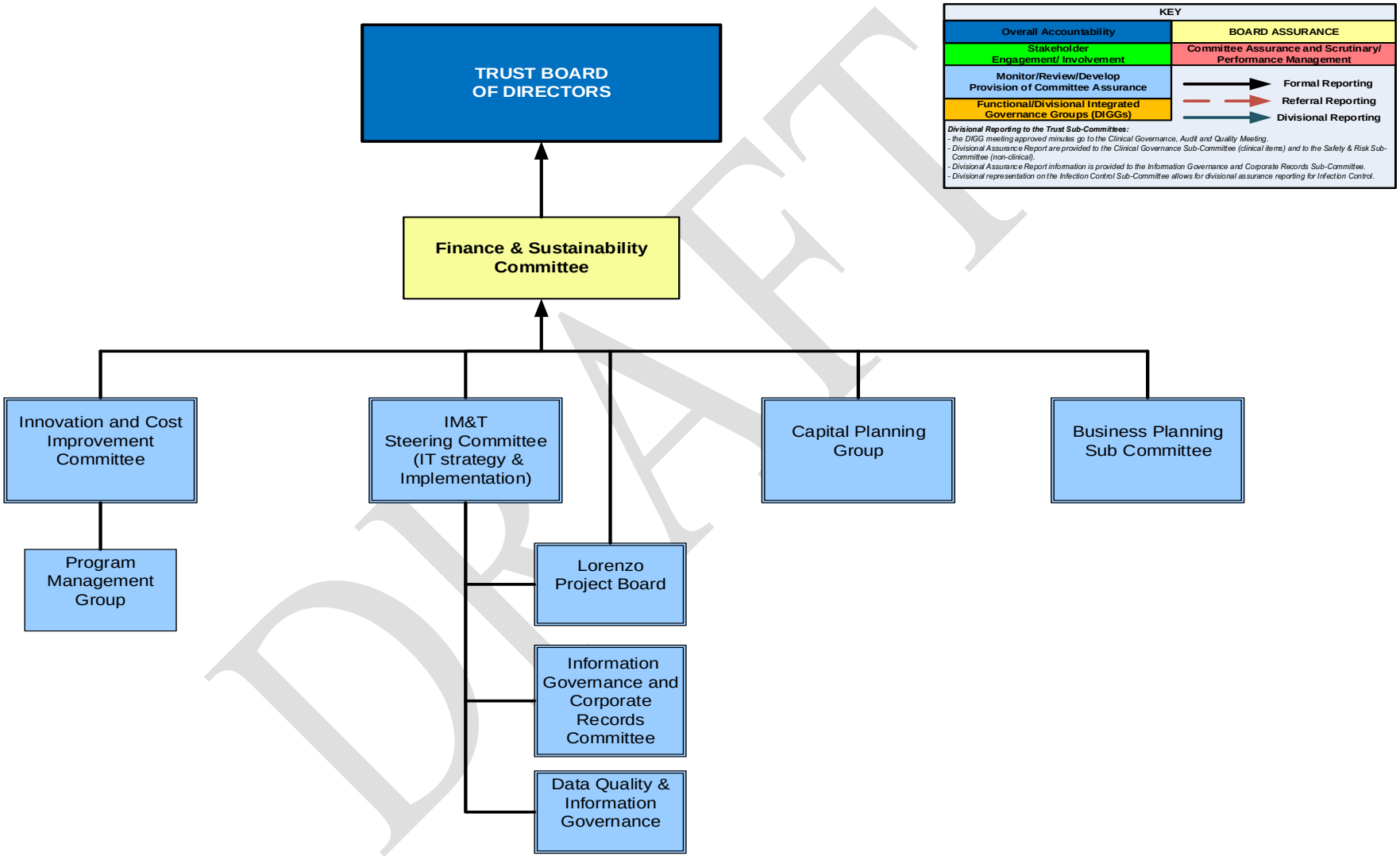
10. ADMINISTRATIVE ARRANGEMENTS

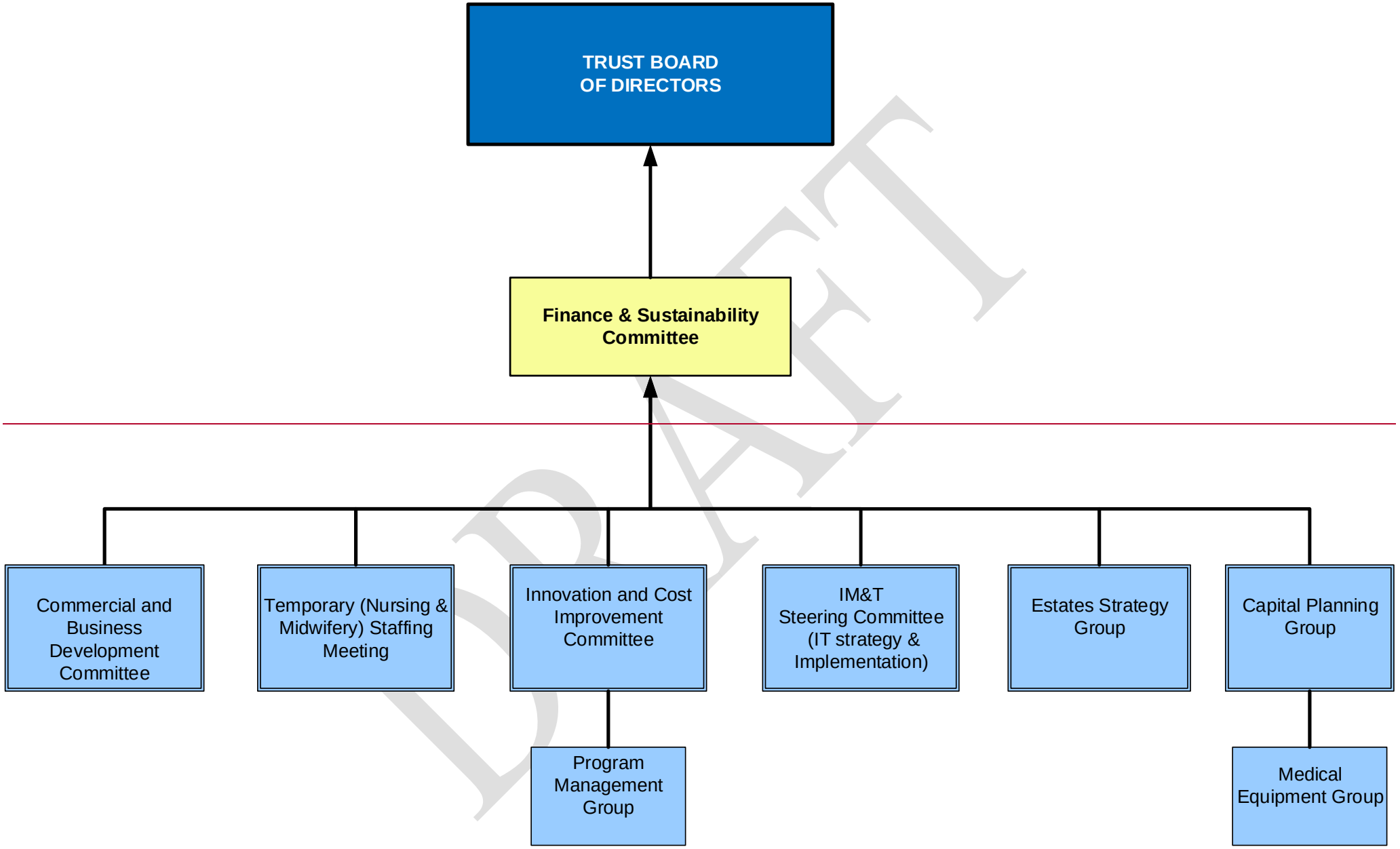
The Trust Secretary or his delegate will be secretary of the Committee

11. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed at least annually by the Committee

Sustainability




TRUST BOARD
OF DIRECTORS
Finance & Sustainability Committee
Commercial and Business Development Committee
Temporary (Nursing & Midwifery) Staffing Meeting
Innovation and Cost Improvement Committee
IM&T Steering Committee (IT strategy & Implementation)
Estates Strategy Group
Capital Planning Group
Program Management Group
Medical Equipment Group

Warrington and Halton Hospitals NHS
NHS Foundation Trust

QUALITY GOVERNANCE COMMITTEE

Minutes of the Meeting held on Tuesday 11th November 2014 at 9:00 am
Trust Conference Room, Warrington Hospital

Present:

Mike Lynch	Non-Executive Director (Chair)
Alison Lynch	Deputy Director of Nursing
Dawn Wood	Associate Director of Operations, Unscheduled Care
Diane Matthew	Chief Pharmacist
Karen Dawber	Director of Nursing and OD
Kate Warbrick	Associate Director of Operations, Scheduled Care
Mel Hudson	Associate Director of Nursing, WC&SS Head of Midwifery
Mel Pickup	Chief Executive
Millie Bradshaw	Associate Director of Governance and Risk
Paul Hughes	Medical Director
Richard Brown	Associate Director of Operations, WC&SS
Simon Wright	Chief Operating Officer/Deputy CEO
Tim Barlow	Finance Director
Wendy Davies	Assistant General Manager, WC&SS, AHP lead

In Attendance:

Jennie Taylor	Executive PA (minutes)

	WHHFT/GC/14/97 - Apologies for Absence and Introductions	**Responsibility and Target date**
1	Apologies received from: Jason DaCosta, Director of IT Rachael Browning, Associate Director of Nursing, Scheduled Care Lynne Lobley, Non-Executive Director, represented by C. Withenshaw John Wharton, Nurse Quality Lead, CCG, Jan Snoddon, Chief Nurse, Halton CCG,	
	WHHFT/GC/14/098– Declarations of Interest	
2	There were no declarations of interest made in relation to the agenda items for the Governance Committee meeting.	
	WHHFT/GC/14/099– Minutes of the previous meeting held on 9th September 2014	**Members**
3 4	The minutes of the meeting held on 9th September were agreed as an accurate record with the following amendment. Page 5, paragraph 32 Minor Harm not ‘hard’.	
	WHHFT/GC/14/100 - Action Plan	
5	<u>WHHFT/GC/14/074 Risk Register – Information Governance</u> Associate Director of Governance reported that a meeting had taken place on 10th November, the Terms of Reference have been revised and Approved.	

6	Director of IT is the Chair of the meeting but ToR now show that the Associate Director of Governance can Chair as Deputy Caldicott Guardian.	
7	M. Lynch, Non-Executive Director/Chair asked about Medical Records and Associate Director of Governance explained that Gordon Robinson had given details of case note tracking. A revised Policy was also agreed relating to audit of casenotes. <u>WHHFT/GC/14/085 - Risk Register</u>	
8	Extensive discussion took place around the Risk Register. Assurance was provided to members for their review as to the details for controls, Action plan and actions points still open. The Associate Director of Governance said that she continues to provide educational sessions and in addition 1:1 sessions with Governance Leads on maintenance of the Risk Register are taking place and also attending SMT meetings. This is in addition to the monthly review at the Safety and Risk Sub Committee and Clinical Governance, Audit and Quality Sub Committees. <u>WHHFT/GC/14/096 – Clinical Governance Audit and Quality Sub Committee</u>	
9	M Lynch, informed the members of 9 MET calls in one night and where was the assurance and review received in addition to the review of returns to theatre especially at night.	
10	The Chief Executive asked which groups examine these sorts of activity? The Associate Director of Governance said MET calls formed part of the work plan of the Acute and Critical Care of the Patient Group (ACCPG). The Medical Director explained that this was a further reason for sub-dividing groups reporting to the Clinical Governance, Audit and Quality Sub Committee to allow information to be scrutinised. P Hughes said these appear on the agenda currently but at times there is not enough time to cover the whole agenda each month.	
11	M. Lynch, Non-Executive Director/Chair asked about progress made to date on the reporting metric for the Sub Committees reporting into Quality Governance Committee. He recommended the data reflecting Safety and Patient Experience in particular should be evident in these dashboards. The Deputy Director of Nursing, advised that the new Quality Framework will be reviewed by the Trust Board at the November meeting and that these dashboards and reporting formats will be discussed.	
12	The Chair of QGC asked that the MET calls be analysed and reported to next Quality Governance Committee meeting. The request was fully supported by the CEO	**Medical Director January 2015**

	WHHFT/GC/14/101 – Revised Annual Work Plan	
13	The Quality Account has changed.	
14	The Revised Work Plan was accepted by the members.	
	WHHFT/GC/14/102 – Complaints Summary Report	
15	The Deputy Director of Nursing explained that this report was submitted to Board in October. The Chief Executive commented that as compliments received by e-mail or by card to the ward are not logged would be useful to include in further Reports.	
16	The Deputy Director of Nursing advised that KPI's are at 97% but as yet have not captured all the lessons learnt as this sits with the Divisions. The Ward Managers have been made aware to the importance to be able to relate to all complaints received, actions taken and lessons learnt for the report to be truly effective and an exercise around this is planned.	
17	M. Lynch, Non-Executive Director/Chair considered this report reflects a lot of the work undertaken and positive progress being made.	
	WHHFT/GC/14103 – Corporate Risk Register	
18	The Corporate Risk Register was reviewed in detail. M. Lynch, Non-Executive Director/Chair requested that further clarity was required on the monitoring arrangements for outstanding risks. The Associate Director of Governance which included Safety and Risk Sub Committee, and DIGGs as reflected into the Risk Management Startegy.	
19	Specific Risks were discussed as follows:	
20	Estates - the window replacement programme is expected to be completed by 31.12.14 and a discussion took place around the risk of windows falling likelihood should reduce as the windows are replaced.	
21	IT Risks were reviewed yesterday at Information Governance Meeting but have not yet been updated.	
22	Scheduled Care – discussion took place around the financial risk. It was agreed Associate Director of Operations, Scheduled Care would review T&O aspect. The CT Scanner replacement is first on the Capital Plan.	
23	Trust Wide – Bariatric funding for hoists and scales has been approved. There will be a future bid for wheelchairs and commodes. There is no specialist training programme in place for the use of the equipment.	
24	Chief Executive asked that as some equipment has been approved should that now reduce the risk score together with the low number of patients who require such equipment, she also asked if there was a policy for the treatment of bariatric patients. It was agreed there is a process in place.	

25	Risk to be reviewed at next Safety and Risk Sub Committee.	**Associate Director of Governance and Risk January 2015**
26	Resuscitation Equipment - this is nearing end of life and no parts are available. Business cases have been produced. Discussion took place about where the funding for this type of equipment can be addressed. It was agreed Director of Nursing and OD will discuss this with Associate Director of Education and Development. The Committee agreed that this item is of high priority until further discussion take place.	**Director of Nursing and OD January 2015**
27	Sharps Incidents – review date at the next Safety and Risk Sub-Committee, risk is likely to be reduced due to controls measure now in place which includes the Task and Finish Group.	
28	CQUIN – Deputy Director of Nursing advised that mitigation is being undertaken to reduce all risks associated with under performance.	
29	Consultant Radiologist – Associate Director of Operations, WC&SS explained that there is difficulty recruiting to post, the risk relates to delay in patients getting results.	
30	Unscheduled Care – Risk 542 Delay in clinical assessment – Associate Director of Operations, Unscheduled Care reported that she is chairing a meeting this week to review all risks as she is new in post. Chief Executive reported that a workshop is being established to really examine the Risk Register with key lines of enquiry being discussed with all divisions.	
31	Pharmacy – staffing issues is being mitigated by interviews and appointments made.	
32	MR Scanner – business case is being produced	
33	Pharmacy JAC computer system- goes live on 12th November	
34	CT Unit Environment – capital submission intended for new financial year.	
35	The Finance Director queried the column on the right of the Risk Register, Strategic Aim Risk Score. This was clarified as the score to reduce the risk as a result of the Controls and action plan proving successful and the level of accepted risk.	
	WHHFT/14/104– Quarter 2 Governance Report	
36	M. Lynch, Non-Associate Director/Chair sought assurance that the report is shared widely especially with the Consultant Workforce. The Associate Director of Governance and Risk explained that from this report Divisional Managers will take relevant sections to DIGGs and consultants will also receive a copy.	
37	Associate Director of Operations, Scheduled Care described activities at her DIGG meetings and agreed that the report is also to be distributed to all staff.	
38	It is important to know what the top 5 areas which need to improve in each division and what the key messages are.	

39	Deputy Director of Nursing will be supplying each ward/department with detailed information on what is relevant and what can and is being done to address these.	**Deputy Director of Nursing January 2015**
40	The members were asked to provide back for the next meeting any questions as a result of the Report for the next meeting.	**Members January 2015**
	WHHFT/14/105 – Serious Incident Completed Level Two Investigations	
41	Associate Director of Governance reported that there have been no SUIs in July, August or September although two grade 3 pressure ulcers were reported in October.	
42	Associate Director of Governance explained the report she is compiling for the next Board and is gathering information on lessons learnt in divisions from the action plans on completed SUIs.	
43	M. Lynch, Non-Executive Director/Chair advised that all divisions need to be able to demonstrate their contributions to the Action Plan and subsequent audit of consequences.	
44	The Committee agreed that extensive audit activity occurs although positive activity is not reported or circulated. It was agreed the Chief Executive will make enquiries around branding for examples of outstanding practices.	**Chief Executive January 2015**
45	Associate Director of Governance expressed the importance of ensuring any audits undertaken are recorded as a result of SUI's managed in the Divisions.	
	WHHFT/CG/14/106 – Update on New Quality Report	
46	Deputy Director of Nursing explained that the first draft will be available in January, the risks are known and the stakeholder meeting will also be in January.	
	WHHFT/CG/14/107 –CQC inspection Report	
47	Director of Nursing and OD explained that this is the final report following inspections in June and July 2014. The report provides a clean bill on theatres but identified a few issues with maternity.	
48	Associate Director of Nursing, WC&SS/Head of Midwifery explained that issues are restricted to low risk mums and that actions have all been drawn up.	
49	M. Lynch, Non-Executive Director/Chair advised that high levels of confidence are needed that concerns have been addressed.	
50	Associate Director of Nursing, WC&SS/Head of Midwifery advised that morale in the unit is improving and an audit of low risk care is being undertaken and expects the findings of this audit will also improve staff morale.	

	WHHFT/CG/14/108 – Trust Updated CQC Statement of Purpose as at November 2014	
51	Chief Operating Officer/Deputy CEO said that the Statement of purpose required updating in order for the Associate Director of Governance to send with the CQC submission for the Halton UCC. He had asked M Barker to assist in order to provide a detailed document.	
	WHHFT/CG/14/109 – Trust Safety Walkrounds Report	
52	Associate Director of Governance reported that 38 have been completed resulting in 74 actions.	
53	M. Lynch, Non-Executive Director/Chair agreed that this is good practice but could result in excellent as it shows that senior managers are interested in getting out into the Trust. It was suggested that mapping completed actions to key areas such as safety and quality is important.	
54	Chief Operating Officer/Deputy CEO advised taking feedback to DIGG meetings and discussed there.	
55	Associate Director of Governance said that for 2015 the walkrounds will provide the lead with the actions from 2014 so they are fully informed.	
56	Director of Nursing and OD also recommended the lead is provided with details of compliments and complaints in the area beforehand so that these can be discussed with staff.	
	HIGH LEVEL BRIEFING AND MINUTES FROM REPORTING COMMITTEE CHAIRS	
	WHHFT/CG/14/110 – Information Governance and Corporate Records	
57	There was no report as meeting only took place on 10th November.	
	WHHFT/CG/14/111 – Safety and Risk Sub Committee	
58	Items of note include Medical Devices report to be submitted by Estates. M. Lynch, Non-Executive Director/Chair asked about the policy on medical devices/equipment. Associate Director of Governance and Risk responded that this is under review. Agreed that Chief Operating Officer would discuss with Associate Director of Estates and Facilities. MIAA review has been undertaken.	
59	The notes of the meetings on 10th July and 11th September were noted by the Quality Governance Committee.	
	WHHFT/CG/14/112 - Strategic People Committee	
60	Items of note include Industrial Action Risk was managed, NICE Staffing Guidance and Workforce Technology are new standing item and was discussed at meeting of 10th November. The HLPB was noted by the Quality Governance Committee.	

	WHHFT/CG/14/113 – Event Planning Group and Local Health Resilience Group	
61	The Chief Operating Officer explained that the HLBP does a statement of readiness which is green, external audit of areas for business continuity received initial positive feedback although full report not received yet. Winter Plans will be submitted to Board shortly The HLBP and minutes of meeting of 26th September were noted by the Quality Governance Committee.	
	WHHFT/CG/14/114 – Clinical Governance, Audit and Quality Sub Committee	
62	The minutes of the Clinical Governance, Audit and Quality Sub Committee meeting held on 25th September were noted by the Quality Governance Committee. It was noted that there were no Executives present at the meeting.	
	WHHFT/CG/13/115– Infection Control Sub Committee	
63 64 65	The minutes of the Infection Control Sub Committee meeting of 21st October and the HLBP was noted by the Quality Governance Committee. Discussion took place around medical staff representation at the meetings which has been requested. Medical Director to see if job description of Divisional Medical Directors makes allowance for attendance. Leadership is needed and a clear commitment around the importance of Trust infection control needs to be reiterated. Discussion took place around taking doctors through disciplinary process if failing to comply with Trust policy on infection control measures.	**Medical Director January 2015**
	W&HHFT/GC/14/116 - Any Other business	
66	There was no further business	
	Date and time of next meeting: 13th January 2015 at 9am in the Trust Conference Room	

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