HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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Agenda for a meeting of the Board of Directors held in public.
Wednesday 25th May 2016, time 13:00 – 15:45
Trust Conference Room, Warrington Hospital

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
	Staff Presentation: Radiology Learning Lessons	Akash Ganguly Consultant		13:00	-
/110	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	13:20	Verbal
/111	Minutes of the previous meeting held on 27th April 2016	Steve McGuirk, Chairman	Decision	13:22	Encl
/112	Action plan	Steve McGuirk, Chairman	Assurance	13:25	Encl
/113	Chief Executive's Report	Mel Pickup, Chief Executive	Assurance	13:30	Verbal
/114	Chairman's Report	Steve McGuirk, Chairman	Information	13:45	Verbal

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
/115	Integrated Performance Dashboard Model	Jason DaCosta, Director of IM&T	Discussion	13:55	Encl.

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
/116	Key Issues Report from the May Quality Committee	Committee Member	Assurance	14:15	Verbal
/117	Quality Dashboard M1 2016-17	Karen Dawber, Director of Nursing & Governance	Assurance	14:20	Encl.

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
/118	Workforce Dashboard M1 2016-17	Roger Wilson, Director of HR & OD	Assurance	14:30	Encl.
/119	Trust Engagement Dashboard M1 2016-17	Pat McLaren, Director of Community Engagement	Asurance	14:40	Encl.

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
/120	Key Issues Report from the May Finance & Sustainability Committee	Terry Atherton, Committee Chair	Assurance	14:50	Encl.
/121	Finance Report M1 2016-17	Andrea Chadwick, Director of Finance & Commercial Development	Assurance	15:00	Encl.
/122	Corporate Performance Report M1 2016-17	Sharon Gilligan, Chief Operating Officer	Assurance	15:10	Encl.
/123	Monitor Declaration - Systems for Compliance with Licence Conditions - in Accordance with General Condition 6 of the NHS Provider Licence	Angela Wetton, Company Secretary	Decision	15:20	Encl.
/124	Annual Senior Information Risk Officer (SIRO) Report 2015-16	Jason DaCosta, Director of IM&T	Assurance	15:25	Encl.

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.

/124	Any Other Business	Steve McGuirk, Chairman	N/A	15:35	Verbal
	Date of next meeting: Wednesday 29th June 2016				

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in public on Wednesday 27th April 2016
Trust Conference Room, Warrington Hospital

Present: **BM/16/111**

Steve McGuirk	Chairman
Mel Pickup	Chief Executive
Terry Atherton	Non-Executive Director
Andrea Chadwick	Director of Finance & Commercial Development
Simon Constable	Medical Director & Deputy Chief Executive
Karen Dawber	Director of Nursing & Governance (from item BM/16/086)
Sharon Gilligan	Chief Operating Officer
Ian Jones	Non-Executive Director
Lynne Lobley	Non-Executive Director & Deputy Chair

In Attendance:

Jason DaCosta	Director of IM&T
Lucy Gardner	Director of Transformation
Pat McLaren	Director of Community Engagement
Angela Wetton	Company Secretary
Roger Wilson	Director of Human Resources and Organisational Development

Apologies

Anita Wainwright	Non-Executive Director

Agenda Ref BM/	
16/083	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed those attending the meeting. Apologies: as above. Declarations of Interest: none declared.
16/084	**Minutes of the Previous Meeting Held on 30th March 2016** The minutes of the previous meeting were approved as a true and accurate record of the meeting.
16/085	**Action Plan** All actions were reviewed and progress was noted. The following were noted as complete: 16/16.
16/086	**Chief Executive Report** The Chief Executive updated the Board on items that had occurred or progressed since the last meeting at the end of March: • Accounts for 2015-16 had been closed off • Commissioning contracts were signed on 14.04.16 (deadline was 18th) • The clinical business unit structure was launched on 1st April – the culmination of a year long process. A workshop had been held with the leaders on 21st April.

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	• The Terms of Reference for the Mid-Mersey Local Delivery System, named the Alliance, (level 2 of the Cheshire & Merseyside Sustainability & Transformation Plan) were presented for Board agreement. The Board queried whether consideration had been given to areas of deprivation within the area and the Chief Executive confirmed that each CCG had been obliged to identify their local priorities which had then been aggregated into the Local Delivery System plan. She also confirmed that Public Health was part of the steering group. The Terms of Reference were supported. • The Concordat for the partners was presented and reference was made to the previous aspirational paper seen by Board. Following some debate around the wording of point 8, the document was noted. • Following the unprecedented 'all out' junior doctors strike on 26/27 April, the Chief Executive confirmed that consultants and non-training doctors had stepped into the gaps and helped to maintain services. Less activity was cancelled as due to having been given plenty of notice about the strike, less activity was booked in the first place. The Board acknowledged the hard work of both the Deputy Chief Operating Officer and Deputy Medical Director who had been instrumental in planning for this event. The Board noted the report.
16/087	**Chairman's Report** The Chairman gave the Board an update of events since the previous Board meeting: • He advised the Board that he had spent time speaking to junior doctors on the picket line and it would appear that an impasse had been reached with the government over the contract issues. • He updated the Board on the progress made towards refreshing some of the Council of Governors practices and confirmed a paper would be presented to the May Council meeting. The Board noted the report.
16/088	**Key Issues Report from April Quality Committee** Lynne Lobley, Chair of the Committee, reported that the Committee business had covered the following items at its April meeting: • Ratification of the Patient Experience Strategy • The quality governance framework for the new Clinical Business Unit structure and the introduction of quality bi-laterals • Draft Quality Report • The upcoming CQC safeguarding visit to the local health economy • Risk Register • How the CQC standards are monitored by the individual committees to ensure no gaps • Risk management in terms of other Board sub-committees The Board noted the report.

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16/089	**Quality Dashboard M12 2015-16** The Director of Nursing and Governance presented her report and highlighted the following: • Cardiac Arrests 89 cardiac arrests in 2015-16 • Pressure Ulcers Grade 2 pressure ulcers, 103 in 2015-2016. The reduction of grade 2 pressure ulcers would be a focus for nursing staff during 2016-17. Reduced grade 3 pressure ulcers by 50%, from 6 in 2014- 2015 to 3 in 2015-2016. The last grade 3 pressure ulcer was nine months previous. • Falls Despite a reduction in falls in the challenging months of December, January and February, we had 965 overall in 2015-2016. The hard work of the nursing staff was recognised in the quarter 4 reduction. The Board noted the report.
16/090	**Monthly Staffing Exceptions Report March 2016** The Director of Nursing & Governance presented the paper and highlighted the fact that this was the last time the Board would see the report in this format as from May 2016, this report would be merged into the Workforce Dashboard and would contain a measure for care hours per day per patient (a metric from the Lord Carter review). The Director of Nursing & Governance confirmed, following a query from the Board, that she received a daily report on staffing detailing the previous day's statistics and that the number of staff moves (to cover shortfalls elsewhere) had reduced over the last three weeks which was attributable to new staff starting in post, in particular to the cohort of Romanian nurses who have joined the Trust. The Board noted the report.
16/091	**Annual Infection Prevention and Control Report 2015-16** The Medical Director presented the report and reminded the Board that the purpose of the report was to provide information on the Trust's progress against infection prevention and control key performance indicators for financial year (FY) 2015/16. He highlighted the following points: • The Trust has reported 33 hospital apportioned cases of Clostridium difficile against the annual threshold of 27 cases. Year to date (YTD) 22 cases have been submitted to Warrington Clinical Commissioning Group and 12 removed from cases counted for contractual sanctions purposes. • YTD the Trust has reported 2 hospital acquired cases of MRSA bacteraemia against the zero tolerance threshold. The Medical Director confirmed the next steps for the team were: • Reduce the incidence of Clostridium difficile • Support work around invasive device management/bacteraemia reduction • Promote Antimicrobial Stewardship

	• Review infection control surveillance systems • Support staff training in Infection Control The Board noted the report.
16/092	**Preparation for the Goddard Inquiry** The Director of Nursing & Governance presented the paper and reminded the Board that the Annual Safeguarding Report would be presented at the June Board meeting and the refresher Safeguarding training would be provided for Board members at the same time. The paper consisted of a checklist to help Trust's prepare for the Goddard Inquiry : • Can you describe the assurance systems in place for safeguarding both internally • and externally? • How are you engaging with the LSCB? • How is that engagement reported to the organisation? • Does the organisation understand the LSCB priorities? • Has the organisation signed off and implemented recommendations from • CQC/Ofsted inspections, SCRs and safeguarding SIs and how can it demonstrate • learning? • Has the organisation received level 6 safeguarding executive leadership training as • set out in the intercollegiate guidance? • How does the organisation set out its annual audit programme relating to • safeguarding? • Does the organisation's minutes demonstrate non-executive challenge of the • safeguarding annual report? The Trust will benchmark against these key questions and the oversight of this piece of work will be at the Quality Committee. Following a query, the Director of Nursing & Governance confirmed that if a child presented regularly at the hospital with injuries then this would be flagged as would any child who was currently on a child protection plan. The Board noted the report.
16/093	**Mortality Overview Report Q4 2015-16** The Medical Director presented the report and reminded the Board that reducing the HSMR and SHMI have been identified as local quality indicators for the Trust in 2015/2016 (Quality Report 2014/2015) and Reducing Mortality is one of three commitments we have made in the national Sign up to Safety campaign 2014 - 2017. The Board noted that in terms of crude mortality (the actual, unadjusted number of deaths) the trust generally compares favourably with local trusts, as well as the North West and England averages and that this is closely monitored on a monthly basis to identify any concerning trends. The Board also noted an increase in deaths during January to March but understood this was consistent with seasonal trends and the number of deaths and death rates are lower than in the previous winter. The Board also noted the number of deaths per individual wards within the Trust.

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	The Board was pleased to hear that after 12 months of having a higher than expected SHMI (the ratio between the actual number of patients who die at the trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures), that this has now fallen into the 'as expected' range at 109. The report also highlighted that AQuA's Reducing Mortality Lead had been invited to attend the NW Mortality Review Network, created by WHH which will enable the Trust to benefit from AQuA's expertise and external assurance regarding the efficacy of its approaches. The Board noted the report.
16/094	**Trust Response to 'Better Birth Improving Outcomes of Maternity Services in England'** The Director of Nursing & Governance presented the paper and highlighted the seven key themes: 1. Personalised Care 2. Continuity of carer 3. Safer Care 4. Better postnatal and perinatal mental health 5. Multi-professional working 6. Working across boundaries 7. A fairer payment system She explained the next steps and actions and confirmed that oversight of this would be via bi-annual assurance report to the Quality Committee. Following a suggestion to have a nominated Board Champion for maternity services, the Director of Nursing & Governance agreed to look at this outside the meeting. The Board noted the report. *Action:* *The Director of Nursing & Governance to draft a role description for Maternity Services Board Champion.*
16/095	**Dementia Strategy Bi-Annual Update Report** The Director of Nursing & Governance presented the paper and highlighted the following: • The recent launch of Johns Campaign which supports the right of people with dementia to be supported by their carer's in hospital. This campaign focuses on people with dementia but there are many others who are frail or have particular needs who would benefit from the nurture of a family member or trusted friend when they are in hospital. The Trust is committed to Johns Campaign and work has commenced on supporting work streams including agreement that this will be a local CQUIN for 2016/2017 • Dementia Champions • Dementia Information - a booklet providing information about what patients and carers can expect from the staff here at the Trust. • Dementia Training - a dementia training framework to provide awareness and training

	for all staff within the Trust. • During 2015-2016 the trust celebrated one year anniversary of the opening of the Forget me Not Ward the trust's new £1 million dementia ward which is leading the way in dementia care. The unit has helped us transform how we care for patients, reducing length of stay, falls and other incidents amongst this vulnerable group of patients. Our campaign continues to spread at pace, and we are regular hosts to visitors from other trusts and organisations who are in the early stages of developing their units and strategies and wish to learn from us –*We Are What Good Looks Like* for other organisations. Reference was made to the article that appeared in The Guardian on 15th April 2016 http://www.theguardian.com/commentisfree/2016/apr/15/johns-campaign-dementia-warring-halton-nhs. The Board noted the report.
16/096	**Corporate Risk Register Q4 2015-16** The Director of Nursing & Governance presented the paper reminded the Board that the purpose of this report was to deliver assurance that all risks with a rating of 15 and above are being actively managed on a day-to-day basis, in line with the Risk Management Strategy. She highlighted: • There are 28 risks showing on the Risk Register. • The Risk Register has been aligned to the new Clinical Business Unit structure. • The April Patient Safety Sub Committee reviewed all the Clinical risk entries. There was much discussion regarding the layout of the report and the Director of Nursing & Governance reminded Board members that the report had been changed to the current extensive version at the request of the Board during 2015-16. She suggested that perhaps a small working group be set up to agree on behalf of the Board, exactly what was required in this quarterly report and to agree on the presentation format of this information. The Board noted the report. *Action:* *The Director of Nursing & Governance to establish a working group (including Non-Executive Directors) to agree the format of the quarterly risk register report.*
16/097	**Report from the April Strategic People Committee** Lynne Lobley provided an update on the April Strategic People Committee in the absence of Anita Wainwright, Chair of the Strategic People Committee. Lynne Lobley advised that completion rates for mandatory training, PDR's will be available at the May Strategic People Committee and that there is increased access to mandatory training via E-Learning and this can be accessed remotely. • Nurse vacancies continue to be managed, the Director of Nursing & Governance explained that the Trust is encouraging (growing our own nurses) and also that the nurses recruited from Romania are in place with a second cohort to start soon.

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	• Nurse Revalidation has been launched and is moving along at pace. • Turnover is high in the following areas Acute Medicine. • 7 staff are currently excluded from work and the disciplinary process is ongoing. • Recommended that the Safer Nurse Care Tool will be added to the current Allocate software • Maternity Birth Rate + Report, a number of recommendations have been implemented. The Director of Nursing advised that a gap of 10 midwife posts have been identified within the report and these are predicated on 3,150 births whereas the Trust had 2,150 births, the Trust has invested in 5 new midwife posts this year. Speak Out Safely numbers were discussed and in particular the spike in Q3 last year. The Director of Nursing & Governance explained staff had been using the SOS as the default position to report any staffing issues this has been addressed. It was noted that the largest number of staff incidents from weekend this issue to BAPM compliance and not a major safety concern. The Director of HR & OD that a discussion took place at the Strategic People Committee which reviewed the Executive attendance at the committee meetings. Forerunner Bid has been successful, and work will be undertaken to look at what a future workforce configuration will look like for the Trust. The Board noted the report.
16/098	**Workforce Dashboard M12 2015-16** The Director of HR & OD provided an update to the Board on the Workforce Dashboard: • CBU session on 21st April 2016 was very encouraging with regards to ownership on the CBU leads agenda with regards to who owns HR & OD. He was encouraged at the sense of grip and control around staff involvement, morale. • Emerging People Strategy was discussed at the 1st April 2016 Board Development session. • Agency Caps / additional spend discussed at Finance & Sustainability Committee in April 2016. Event hosted by NHS Improvements showed the best performing Trusts are those who do not have A&E departments. Colleagues around the North West were made aware to hold the line on the caps and not to breach but this was met with silence. The Director of HR & OD has been liaising with James McKay NHS Improvements who has responded positively to arranging an event called Cheshire & Merseyside Agency Cap Summit with Chief Operating Officers, Directors of Nursing and Director of HR attending. • Absence lower than last year which is progress but this will be a big focus area for CBU colleagues. Need to drive down absence and ensure return to work interviews take place immediately on return to work. The Chairman suggested that 4.8% seems reasonable attendance. The Director of HR & OD explained that the Trust is better than the NW average and he would discuss with NW Employers and refresh the policy. The Board noted the report.

DRAFT

16/099	**Engagement Dashboard M12 2015-16** The Director of Community Engagement provided the Board with a high level overview of how well the Trust is engaging and involving with key stakeholder groups, and asked for Board colleagues comments/thoughts. The Chairman commented that this is a really dashboard and very helpful and suggested that the Engagement Dashboard is linked to the Governors Dashboard. Lynne Lobley suggested including the work done with the Universities. The Good Morning WHH emails are working well. The Chief Executive asked Board colleagues to visit the Trust Just Giving page to donate to the Dragon Boat Race Event on 8th May at Manley Mere. The Board noted the report.
16/100	**Key Issues Report from the April Finance & Sustainability Committee** Terry Atherton advised the Board of the key issues arising from the April Finance & Sustainability Committee. • Early completion of 2015/16 year end negotiations with Commissioners • Subject to Audit full year deficit £17.4m (original forecast deficit agreed with Monitor £14.2m, forecast deficit predicted Feb 2016 £19.9m) • CIP full year outturn £8.2m against forecast £10.3m. Plans around 2016/17 continue to be developed and subject to NHSI oversight • Due to inability to access Sustainability & Transformation funding 2016/17 forecast deficit is £18.6m. This deficit will require in increased working capital loan. • Cash will remain tight for the foreseeable future with no margin for underperformance. • A&E performance against 4 hour target Q4 81.71% full year 88.09% Recent initiatives starting to bear fruit. Following April performance F&SC to take stock. Revised trajectory agreed with NHSI. • Lorenzo still impacting on operational matters but strong performance elsewhere especially against Cancer National Targets. • Presentation received on Agency Control Cap; not all Trusts holding the line. Potential case for us implementing a central temporary staffing arrangement. There are cross Committee issues of responsibility. • A Presentation was received around the work carried out at the FT by KPMG in 2015. The actual spend was £123k & all recommendations have either been implemented or are in progress • An update report on IM&T was considered, noting that a Business Case will come to F&SC & Board next Month around Lorenzo Phase 2 & ePMA. In the meantime Phase 1 Lorenzo remains in stabilising mode albeit improving. • Finally F&SC received a number of Sub Committee Meeting Minutes. • There were no matters which required to be escalated to the Board. The Chairman raised the issue of KPMG and the confusion with regards to the Trust spend, this has now been resolved thanks to the Director of Finance and the Director of Transformation

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	providing information on this issue. The Board noted the report.

16/101	**Key Issues Report from the April Audit Committee**
	Ian Jones advised the Board of the key issues arising from the April Audit Committee.
	
	• The draft annual reports were presented by MIAA on 13 difference aspects and all were given significant assurance.
	• 13 higher recommendations from the reports have not yet been implemented.
	• Annual Internal Audit Plan has been agreed for 2016/17.
	• The following statements were also presented to the Audit Committee
	    - Annual Governance Statement
	    - Annual Report Statement
	    - Quality Report Statement
	• The amount of tender waivers has dropped significantly since produces have been reissued.
	• Losses & Special payments £97k which is reduced against last year's figure of £120k.
	• The External Auditors contract is due for review in September 2016 and a working group of Chair of Audit, Director of Finance, Head of Procurement and one or two Governors will be set up to undertake the review process.
	
	The Board noted the report.

16/102	**Finance Report M12 2015-16** The Director Finance & Commercial Development provided the Board with an update on the Month 12 financial performance. For M12 2015-16 the Trust recorded a surplus of £0.7m and for the full year a deficit of £17.4m which is an improvement of £2.5m compared to the forecast deficit of £19.9m This excludes the impairment of £1.0m which resulted from the revaluation review of the Trust assets. The asset review has reduced capital charges by £1.9m The year-end settlement has been signed with Warrington CCG, Halton CCG and Wigan Borough CCG. The Chairman said this is great news and is a long way from the negotiations which took place last year which required the Trust going into arbitration with Warrington CCG and is an extremely positive position for the Trust to be in. The Finance paper set out a risk rating score of 2, however, the updated template removes the capital /revenue transfer which has reduced rating to 1. There are still higher levels of un-coded activity compared to pre Lorenzo. From 1st May a new Coding Manager will take up post and support the work required to reduce the gap level of un-coded activity and improve the quality of coding. The Director of Transformation explained that she had not completed a CIP paper for the Board but any issues relating to CIP would be escalated to the Board. The Chairman suggested

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	that each month a paragraph is included within the Finance paper on CIP. A more detailed update on CIP is to be presented to the Board 3 times a year. Lynne Lobley suggested that the Board have sight of the top five CIP Schemes at these quarterly updates. Terry Atherton, raised concern that any early slippage from CIP schemes would be difficult to recover. The Board noted the report.
16/103	**Corporate Performance Report M12 2015-16** The Chief Operating officer provided the Board with an update to the Board on the Corporate Report M12 2015-16. The key issues are as follows: • The Trust failed to deliver the 4 hour target in March 2016, this was in line with neighbouring Trusts. Although the Trust has improved on February's performance of 79.86% and the team is working hard to ensure deliver of improvement trajectories in all areas and has achieved 95% this week. • The Trust achieved all the other key performance targets reducing RTT despite the challenge post introduction of the new PAS • MADE – the outcomes of the workshop which took place in March will be discussed at a system wide workshop held to address the issues/actions which came out of the event. The Trust currently has actions underway to improve the 4 hour target performance and address some issues identified such as the introduction of the SAFER Bundle. • Partners are engaging with the Trust around the complex nature of the discharge process. The Board noted the report.
16/104	**Monitor Governance Declaration Q4 2015-16** The Director of Finance & Commercial Development provided the Board with an update on the Monitor Governance Declaration Q4 for 2015-16 for approval. • To maintain financial sustainability for the next 12 months with a risk rating of at least 3 the Board to respond " unconfirmed" • To the Trusts capital expenditure will not materially differ from the amended forecast the Board to respond "confirmed" • To the Governance – plans in place to ensure on-going compliance with all existing targets the Board to respond "not confirmed" • The Board confirms there are no matters arising in quarter requiring an exception report to Monitor the Board to respond "confirmed". The Board confirmed the Monitor Governance Declaration for Q4 2015-16.

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16/105	**Modern Slavery Act 2015 Trust Statement** The Director of Finance and Commercial Development provided the Board with the proposed statutory statement and the supplier code of conduct in relation to meeting the requirements of the Act. The supplier code of conduct has been developed and the Procurement department intend to issue this to the Trust existing key suppliers and will also be included in the Trusts formal tendering process. The Board discussed the code and how this would be implemented within the Trust and the Director of Finance & Commercial Development explained that the Trust is making its ethical position known on this issue to its suppliers and also what is expected from them and the consequences of a breach of compliance with the code. The Board supported and approved the Modern Slavery Act 2015 Trust Statement and supplier code of conduct.
16/106	**Any Other Business** There being no further business to discuss, the meeting closed at 16:40 hrs **Next Meeting:** Wednesday 25th May 2016 in the Trust Conference Room

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BM/16/112

TRUST BOARD ACTION PLAN

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status
27th April 2016	16/096	The Director of Nursing & Governance to establish a working group (including Non-Executive Directors) to agree the format of the quarterly risk register report.	DoN&G End Q1	
27th April 2016	16/094	The Director of Nursing & Governance to draft a role description for Maternity Services Board Champion.	DoN&G	
30 March 2016	16/070	The Board requested the Finance & Sustainability Committee carry out a 'deep dive' into A&E at the end of April in order to see early indicators as to whether the actions identified and taken were having a positive impact.	Chief Operating Officer	A session to be held with Non-Execs and Governors during Q2.
24 February 2016	16/057	Quality Dashboard - 31 January 2016 - The (balanced scorecard) approach to the revised corporate performance dashboard to include patient experience measures from April 16.	Director of Nursing & Governance	New corporate performance dashboard to be presented to May Board
24 February 2016	16/052	Report from the Chair of the Audit Committee including draft minutes from 2 February 16 - The Board's four chairs of its assurance committees to meet informally in March to discuss their committee's respective assurance needs for the 16-17 year	Trust Secretary	Completed
27 January 2016	16/16	With regard to a Patient story, the Quality Committee to assure itself of the learning and improvement made to the service. Directors to meet with Mary's family in July 2016 to discuss the Trust's response.	DoN&G. Directors to meet family	Proposed: an informal session for NEDs with DoN&G in March to share understanding of the complaints and investigations process. Q3 complaints report in Feb 16 Board pack sets out proposed actions, including peer review.
29 July 2015	15/164	Trust Secretary to arrange a workshop with the Board and the Communications team to allow additional understanding on the Communication strategy presented	Trust Secretary	Completed

BOARD OF DIRECTORS

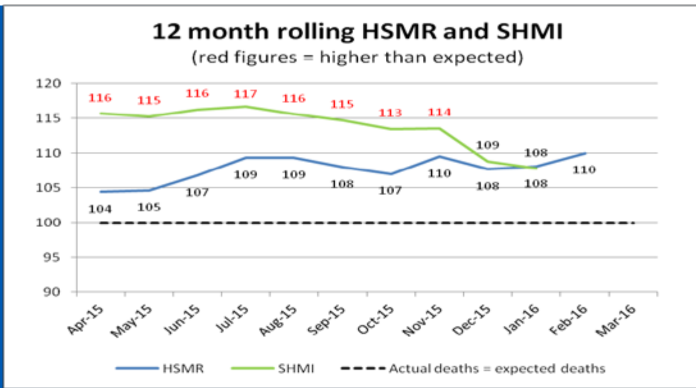
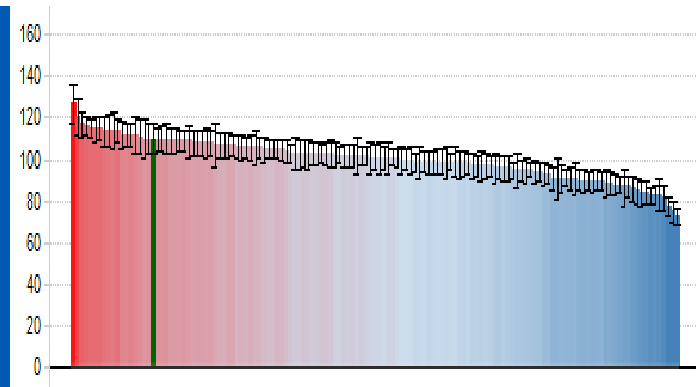
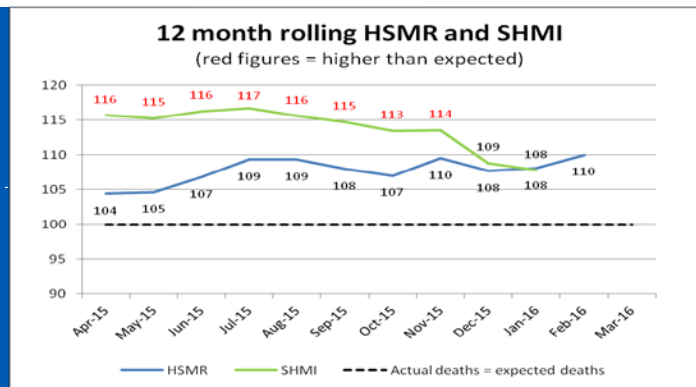
AGENDA REFERENCE:	**BM/16/115**	
SUBJECT:	**Integrated Performance Dashboard Model**	
DATE OF MEETING:	25th May 2016	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Chris White, Head of Information Services	
EXECUTIVE DIRECTOR SPONSOR:	Jason DaCosta, Director of IM&T	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.3: Clinical & Business Information Systems	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The attached model is the proposed new integrated performance dashboard that will be seen at Board. There is some further work to be done to get to the final model and this will be explained in the meeting.	
RECOMMENDATION:	The Board notes the model and next steps.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Warrington and Halton Hospitals NHS

NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

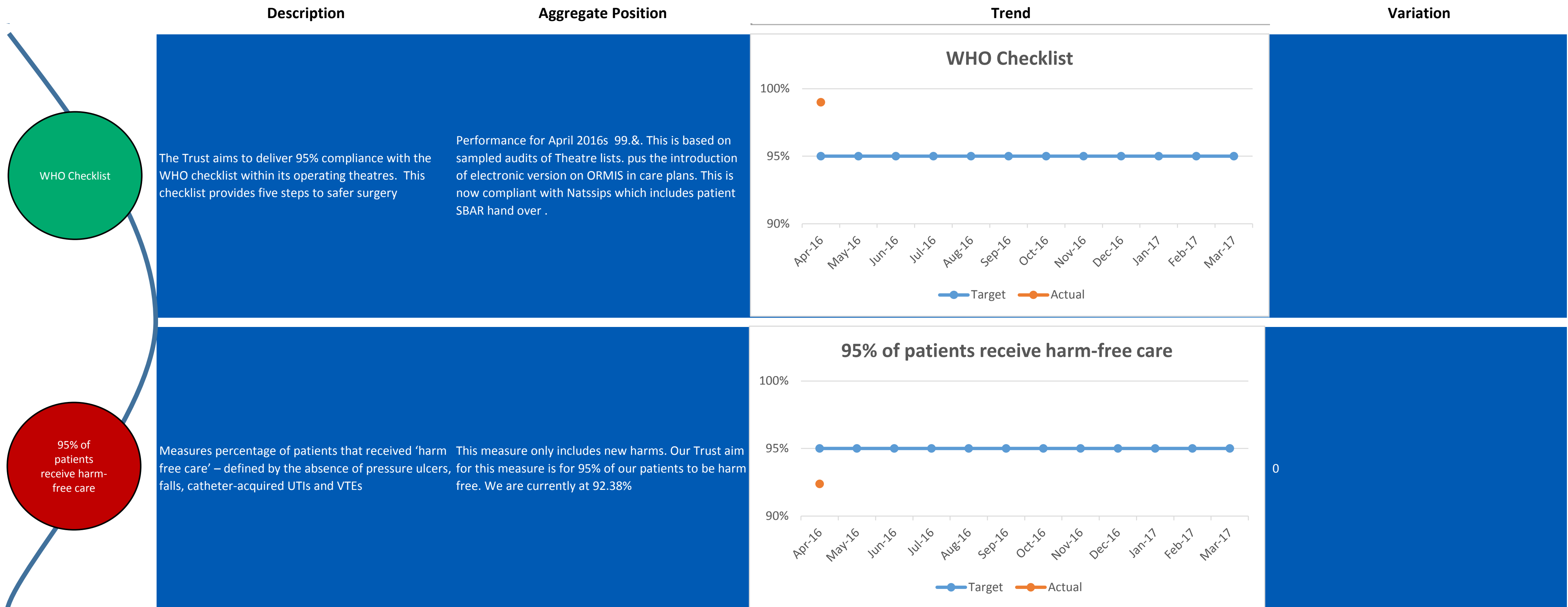
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Relative Risk HSMR	HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups	There is a CQC mortality outlier alert relating to the diagnosis of regional enteritis and ulcerative colitis, for the period January - September 2015 (6 deaths). This is being managed through the Mortality Review Group. Deaths in this diagnosis from Oct - Feb = 0		HSMR is not broken down to Divisional level.
Relative Risk HSMR - Top 10% in NHS	The Trust aims to be in the top 10% of performing NHS organisations for HSMR.	Our HSMR performance is 110, as expected, but not within the top 10% of organisations in the NHS.		HSMR is not broken down to Divisional level.
Risk Adjusted Mortality - SHMI	SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	SHMI for the latest 12 month period (December 2015 - January 2016) = 108 which is as expected		SHMI is not broken down to Divisional level.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

Quality Improvement

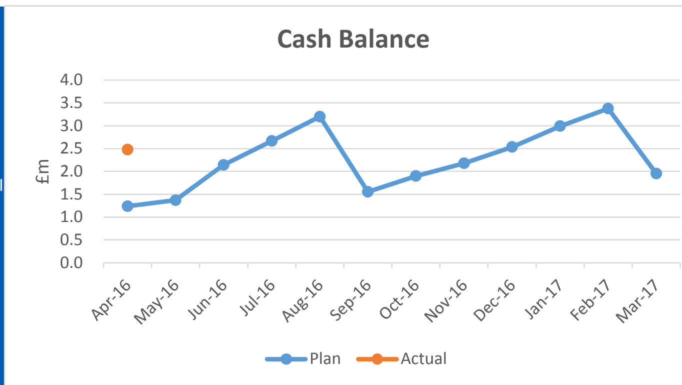
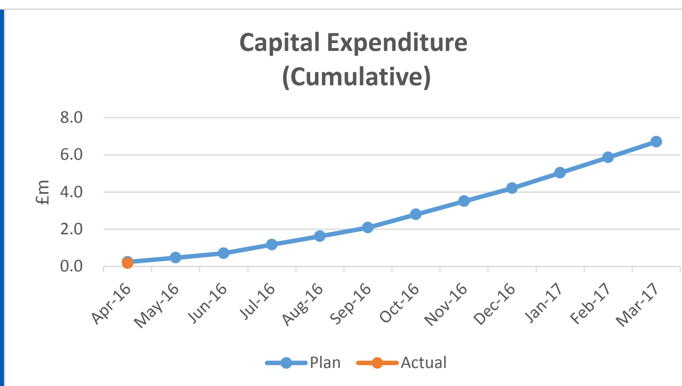
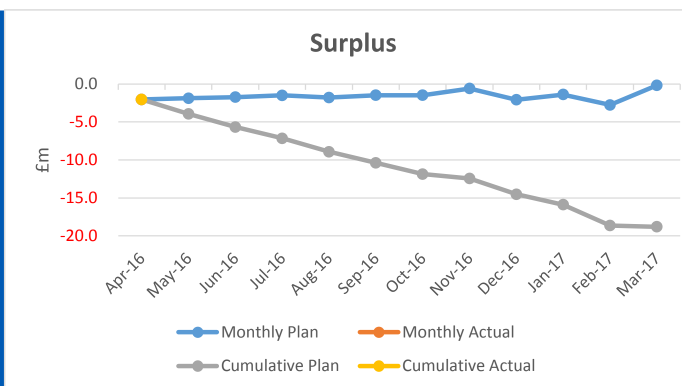


	Description	Aggregate Position	Trend	Variation
WHO Checklist	The Trust aims to deliver 95% compliance with the WHO checklist within its operating theatres. This checklist provides five steps to safer surgery	Performance for April 2016s 99.&. This is based on sampled audits of Theatre lists. pus the introduction of electronic version on ORMIS in care plans. This is now compliant with Natssips which includes patient SBAR hand over .	WHO Checklist	
95% of patients receive harm-free care	Measures percentage of patients that received 'harm free care' – defined by the absence of pressure ulcers, falls, catheter-acquired UTIs and VTEs	This measure only includes new harms. Our Trust aim for this measure is for 95% of our patients to be harm free. We are currently at 92.38%	95% of patients receive harm-free care	0

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

Safely Reducing Costs & Mandatory Standards - Finance

Description	Aggregate Position	Trend	Variation
Cash held in our Government Services Bank Account	The current cash balance of £2.5m equates to circa 4 days operational cash. Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance at the end of each month of £1.2m.		The cash balance is £2.5m which is £1.3m above the planned cash balance of £1.2m.
Year to date cumulative capital expenditure	Capital spend to date is £0.2m which is in line with plan. The annual capital programme for the year is £6.7m. The Capital planning Group is in the process of finalising the schemes that are to be included in the capital programme. This will be presented to the Finance & Sustainability Committee in June 2016.		Capital spend to date is £0.2m which is in line with plan.
Net income and expenditure position	The financial deficit at month 1 is £2.0m.		The financial position of £2.0m is £14,000 better than plan.

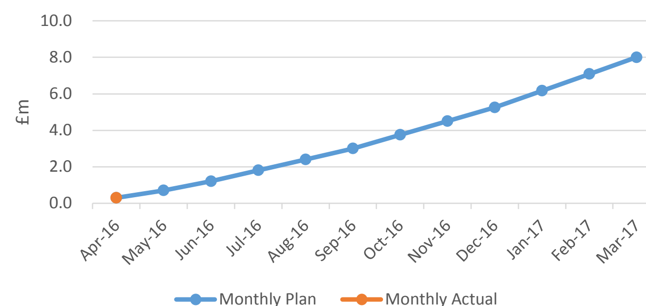
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

Safely Reducing Costs & Mandatory Standards - Finance

Description	Aggregate Position	Trend	Variation
NHSI metric of financial risk.	In month Financial Sustainability Risk Rating is 2.	(see table below)	The forecast FSRR was 1. This has improved due to delivery of a better financial position than plan.
Planned improvements in productivity and efficiency.	The Trust has a CIP target for 2016/17 of £10m, delivery of £8m is currently assumed in the financial plan. The Trust has delivered £0.353m against a plan of £0.3m in April 2016. At 12th May 2016 the Trust has developed CIP schemes for 2016/17 to the value of £7.058m pye and £8.910m fye.	(see chart below)	The Trust has delivered £0.353m against a plan of £0.3m in April 2016.

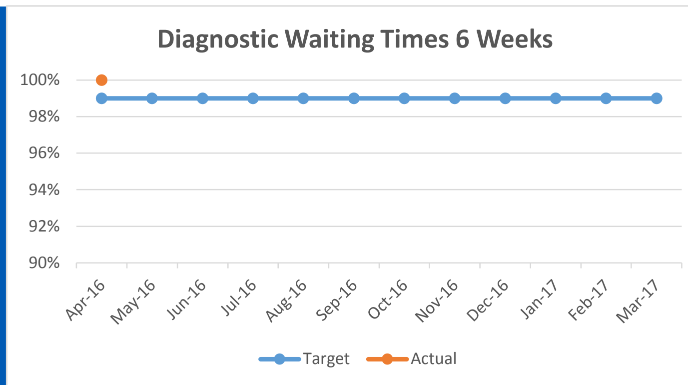
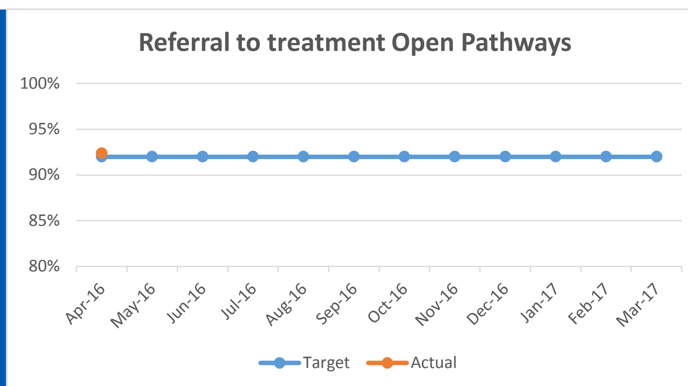
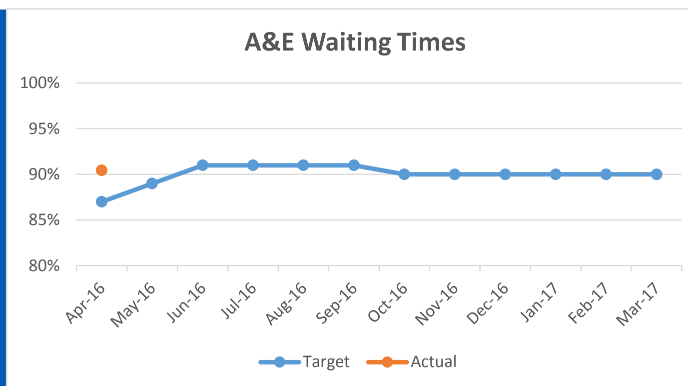
	Actual Metric	Actual Rating
Liquidity Ratio (Days)	-3.00	1
Capital Servicing Capacity (times)	-23.10	1
Income & Expenditure Margin (%)	-0.10	1
Income & Expenditure Margin (% of plan)	0.00	4
Overall Risk Rating	0.00	2



Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The target is 99% or over within 6 weeks	Diagnostic waiting times has achieved the 99% target with a performance of 100%		0 breaches of the 6 week standard
Referral to treatment Open Pathways	Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%. This is a Monitor Monthly Target and KPI.	Open pathways continue to perform above the 92% standard. There were no 52 week breaches.		The only specialties not to achieve the target where General Surgery - 78.87% Urology - 91.42% T&O - 86.60%
A&E Waiting Times	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. National Target of 95%. This is a Monitor Quarterly Target and a Monthly KI.	A&E Performance has dropped below the 95% threshold		The trust is on a improvement plan and is currently exceeding the target.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

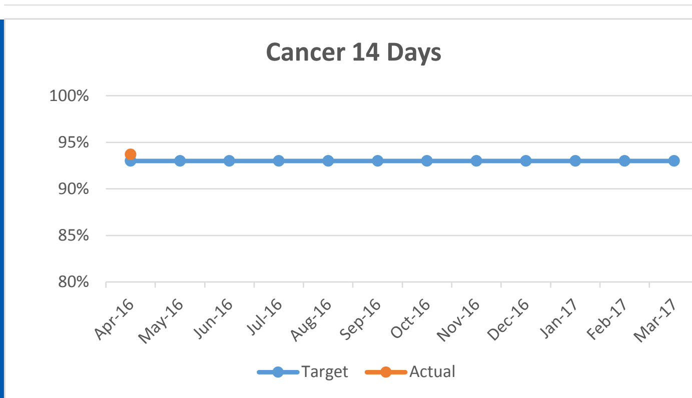
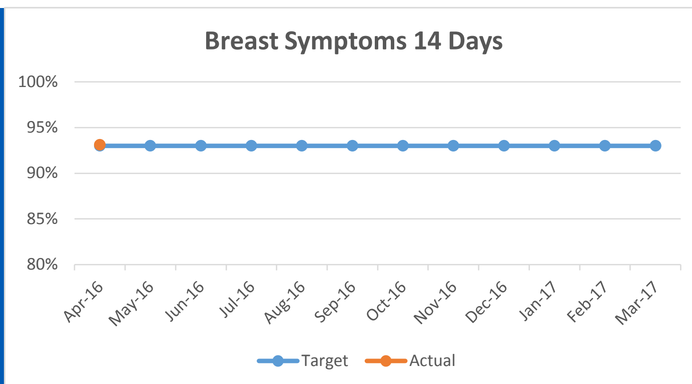
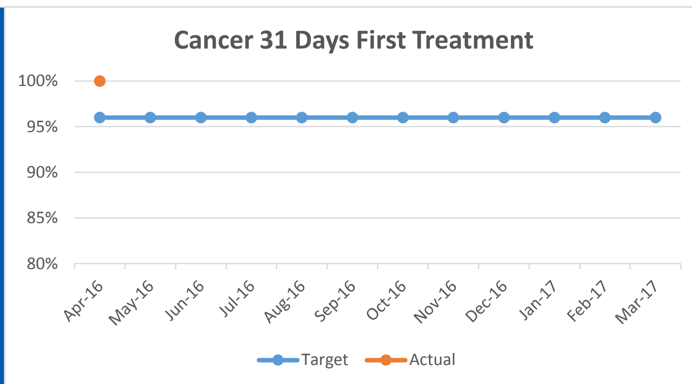
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
MRSA	There is Zero tolerance of avoidable MRSA bacteraemia. A £10,000 penalty is incurred in respect of each avoidable case.	A Nil return was submitted for April	MRSA (chart: Plan, Actual; Apr-16 to Mar-17)	In 2015/16 the Trust reported 2 post 48 hour cases
MSSA	National thresholds for MSSA bacteraemia have not been set	There were 3 post 48hr cases of MSSA bacteraemia in April 2016. The cases occurred on wards A6, A8 and ICU. Investigations are currently underway to determine root causes.	MSSA (chart: Plan, Actual; Apr-16 to Mar-17)	In 2015/16 the Trust reported 4 post 48 hour cases
C-Diff	The Trust threshold for 2016/17 is no more than 27 post 72hr cases.	There was 1 post 72hr Clostridium Difficile case in April 2016. The case occurred on STAR ward. An investigation is underway to determine the root cause.	C-Diff (chart: Plan, Actual; Apr-16 to Feb-17)	In 2015/16 the Trust reported 33 post 72 hour cases. 16 cases were deemed unavoidable by the CCG review panel.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

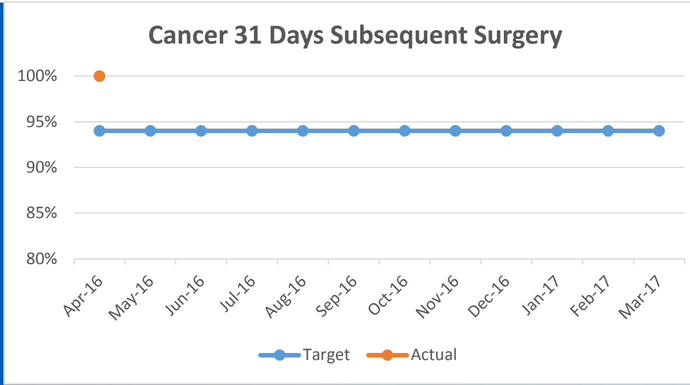
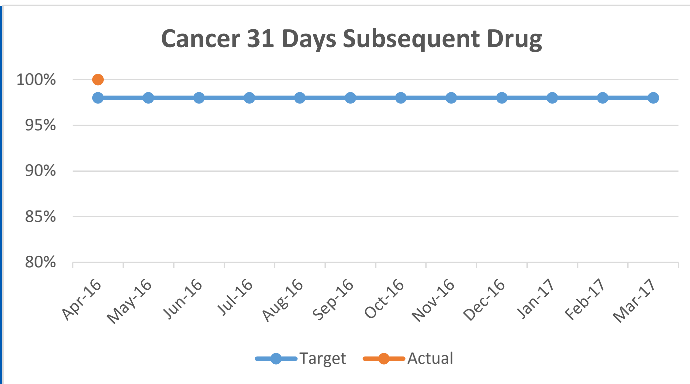
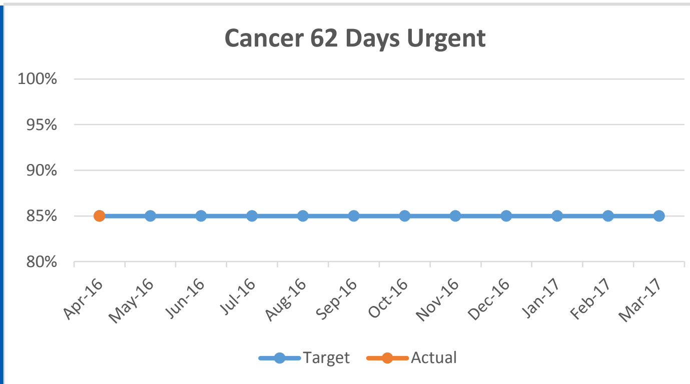
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%. This is a Monitor Monthly KPI.			
Breast Symptoms 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. Threshold of 93%. This is a Monitor Monthly KPI.			This target is becoming more and more challenging each month due to patient choice.
Cancer 31 Days First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%. This is a Monitor Monthly KPI.			

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

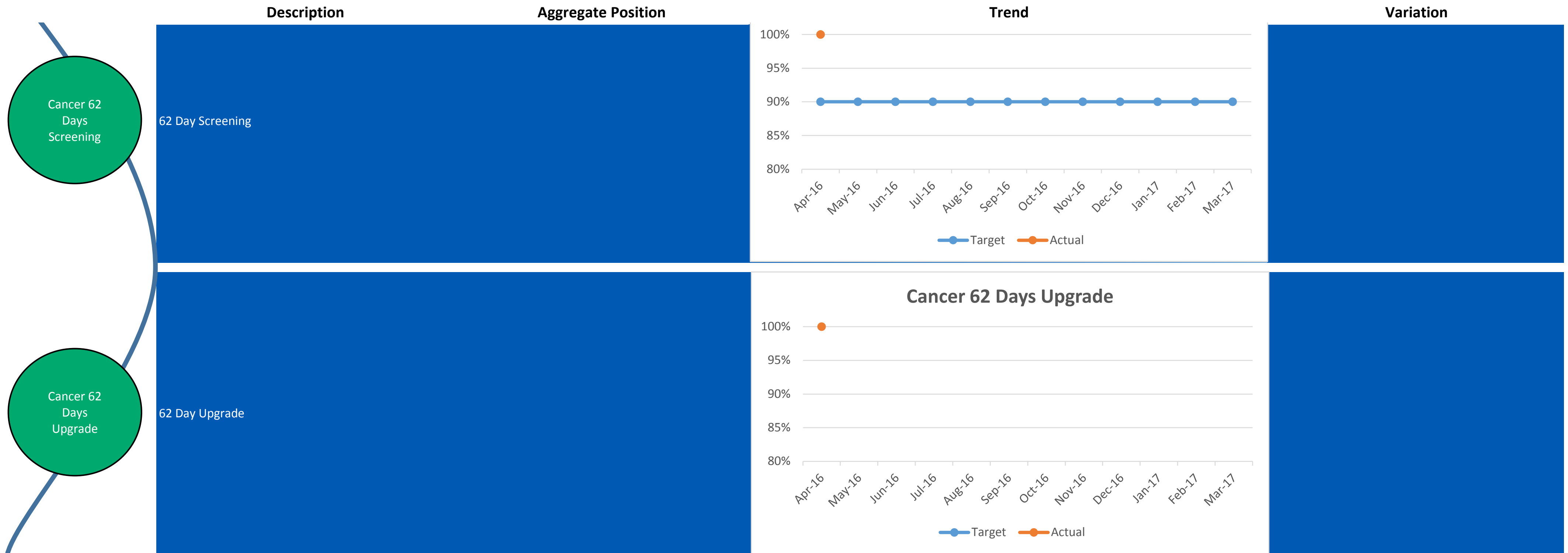
Mandatory Standards - Access & Performance

Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Surgery: All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat - Surgery Target of 94%			
Cancer 31 Days Subsequent Drug: All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat - Anti Cancer Drug Treatments Target of 98%			
Cancer 62 Days Urgent: All patients to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85%. This is a Monitor Monthly KPI.			
		Cancer 62 Days Screening	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - Apr 16

Mandatory Standards - Access & Performance



BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/117**
SUBJECT:	**Quality Dashboard M1 2016-17**
DATE OF MEETING:	25th May 2016
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
EXECUTIVE DIRECTOR SPONSOR:	Karen Dawber, Director of Nursing and Governance
LINK TO STRATEGIC OBJECTIVES:	SO1: 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
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality
	BAF1.3: National & Local Mandatory, Operational Targets
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Quality Dashboard (at Appendix 1) includes 2016/2017 quality related KPIs from the:- • CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required). • Quality Contract • Quality Account - Improvement Priorities and Quality Indicators • Sign up to Safety – national patient safety topics • Open and Honest initiative Please note that VTE, AKI and dementia are extracted for the purpose of this report in advance of submission via UNIFY at months' end and may not show compliance with the threshold. (VTE – 95% and Dementia – 90%). This will be updated in next month's Quality Dashboard.

<table>
<tr><td rowspan="1">RECOMMENDATION:</td><td colspan="2">The Board is asked to:
1. Note that the data for a number of indicators can change month on month. This applies to mortality peer review, incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased.
2. Note progress and compliance against the key performance indicators
3. Approve actions planned to mitigate areas of exception</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td>Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td></td></tr>
<tr><td>Date of meeting</td><td></td></tr>
<tr><td>Summary of Outcome</td><td></td></tr>
</table>

Please see Appendix 1 for the quality dashboard data

Patient Safety

1. Never Events

We have had 1 never event in April 2016. Wrong site surgery (as per NHS England's Never Events List 2015/16) was undertaken on an 81 year-old patient; undergoing left axillary node clearance instead of right axillary node clearance.

On a surveillance CT scan of thorax, abdomen and pelvis, undertaken as follow up for surgically treated bowel cancer, the patient was found to have a pathological looking right axillary lymph node. Biopsy examination of this right axillary node confirmed the presence of metastatic breast carcinoma. Following further investigations, which included a mammogram and MRI scan, the MDT meeting's opinion was for axillary node clearance on the side that showed metastatic breast carcinoma. The patient underwent surgery on the wrong side i.e. left axillary node clearance. The error was detected when the histology was discussed at the MDT meeting post-operatively nine days later. The patient then had the correct surgery after being offered a different surgeon but declining.

This incident is being managed in accordance with the trust's incident management policy; it will be widely circulated, have actions assigned and lessons learned.

2. VTE

VTE Prophylaxis
525 inpatients were included in April 2016's safety thermometer survey. 3 out of the 415 patients who required prophylaxis had not received it but should have done at the time of the survey.

Clinical Effectiveness

3. Advancing Quality

We are narrowly missing the cumulative target for the Pneumonia measure. The compliance for each aspect of the measure for December only is as follows:

Pneumonia 75.53% against a target of 78.1%

- Oxygen Assessment within 24 hours of arrival 61/61 100%
- Chest x-ray within four hours of arrival 46/61 75.4%
- Initial antibiotic received within 4 hours of hospital arrival 19/32 59.4%
- CURB-65 recorded 32/34 94.1%
- Appropriate antibiotic selection 20/20 100%

Patient Experience

4. Always Events

Although the target of 100% is not yet being met, we sustained an improvement throughout 2015/16 with compliance for quarter 1 at 90%, 93% for quarter 2, 95% for quarter 3 and 94% for

quarter 4. January and March compliance was 97%, February dropped to 87%, however April 2016 is again at 97%.

5. Mixed Sex Occurrences

There was 1 reported breach of same sex accommodation in April 2016, which occurred in an ITU bed. This breach has been investigated in line with policy and an RCA completed. The total number of breach days was one.

6. Complaints

91.3% (21 of 23) of complaints with a deadline in April 2016 were resolved within the agreed timescale. The target of 94% was achieved in every month of 2015/16 except March 2016, at 91.7%. These consecutive 2 months in which the target was narrowly missed relate to an unusual period of significant staffing changes within the patient experience team.

Apr-16

Quality Dashboard 2016/17

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Titles key: IC = Inclusion criteria (See key below), YTD = Year to date
Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SU2S), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)
Data key: DC = Data capture system under development, QR = Quarterly Reporting, N/A yet = Not available yet
ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
Safety																					
INCIDENTS	MODERATE, MAJOR OR CATASTROPHIC HARM: APPROVED	TBC	QC	4																4	changes monthly
	MODERATE, MAJOR OR CATASTROPHIC HARM: UNDER REVIEW	N/A		18																18	changes monthly
	SERIOUS UNTOWARD INCIDENTS (SUIs) Level 2	N/A		1																1	
NEVER EVENTS		0	QC	1																1	
HARM FREE CARE	% OF PATIENTS FREE FROM HARM (SAFETY THERMOMETER)	TBC	OH	98.48%																	
	% OF PATIENTS FREE FROM HARM (MEDICINES SAFETY THERMOMETER) Quarterly	TBC	QI	QR																	
HEALTHCARE ACQUIRED INFECTIONS	MRSA	0= green, 1-5=amber, >5 red	QC, QI	0																0	
	CLOSTRIDIUM DIFFICILE (due to lapses in care)	<=27 per year	QC, QI	0																0	
	CLOSTRIDIUM DIFFICILE (no lapse in care)	None set	N/A	0																0	
	CLOSTRIDIUM DIFFICILE (under review)	None set	N/A	1																1	
VTE	% OF PATIENTS RISK ASSESSED	>=95%	QC	88.10%																88.10%	
	% OF ELIGBLE PATIENTS HAVING PROPHYLAXIS (SAFETY THERMOMETER)	100%	QC	99.43%																99.43%	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (APPROVED)	TBC	QC	N/A yet																	
	NUMBER OF PATIENTS WHO DEVELOPED A HOSPITAL ACQUIRED VTE (UNDER REVIEW)	N/A	N/A	N/A yet																	

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
WHO Checklist	DETAILS TO BE CONFIRMED	TBC	QI	N/A yet																	
Effectiveness																					
MORTALITY	HSMR (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, QC	104	105	107		109	109	108		107	110	108		108	110				
	SHMI (12 MONTH ROLLING)	<=100 = G, As expected = A, Higher than expected = R	QI, QC	116	115	116		116	115	114		113	113	109		108					
	TOTAL DEATHS IN HOSPITAL	None set	Reporting only	93																93	
	MORTALITY PEER REVIEW (NB figures change as reviews are conducted)	95%	IP, SU2S	N/A yet																	
	REGULATION 28 - PREVENTION OF FUTURE DEATHS REPORT	None set	Reporting only	0																0	
CARDIAC ARRESTS	Annual: <75 = G, 75 – 85 = A, >85 = Red	see left	QC	N/A yet																	
ADVANCING QUALITY (2015/2016 targets and figures)	ACUTE MYOCARDIAL INFARCTION	>=95%	QI, C	93.18%	94.94%	96.83%		97.16%	97.14%	97.01%		97.31%	96.30%	95.71%						95.71%	
	HIP AND KNEE	>=95%	QI	98.51%	99.22%	98.97%		98.85%	99.01%	99.22%		99.33%	99.40%	99.08%						99.08%	
	HEART FAILURE	>=84.1%	QI, C	72.22%	73.17%	75.44%		78.85%	81.15%	82.89%		83.24%	82.32%	81.86%						81.36%	
	PNEUMONIA	>=78.1%	QI, C	80.00%	78.83%	78.65%		78.65%	78.08%	78.47%		77.11%	76.59%	75.53%						76.59%	
APPROPRIATE DISCHARGE PLANNING FOR PATIENTS WITH AKI - NO LONGER CQUIN		Sliding scale payments 50% - 90%	C	60% (validation incomplete)																	
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ACUTE INPATIENTS (* to be validated)		TBC	QI, C	N/A yet																	
SEPSIS SCREENING OF ALL ELIGIBLE PATIENTS ADMITTED TO EMERGENCY AREAS (* to be validated)		Sliding scale payments 50% - 90%	QI, C	N/A yet																	
SEPSIS ANTIBIOTICS GIVEN TO ACUTE INPATIENTS WITHIN AN APPROPRIATE TIMESCALE (* to be validated)		TBC	QI, C	N/A yet																	
SEPSIS : ANTIBIOTICS GIVEN TO EMERGENCY PATIENTS WITHIN AN APPROPRIATE TIMESCALE (* to be validated)		TBC	QI, C	N/A yet																	
INPATIENTS RECEIVED AN EMPIRIC REVIEW WITHIN THREE DAYS OF PRESCRIBING THE ANTIBIOTICS.		TBC	C	N/A yet																	
EMERGENCY PATIENTS RECEIVED AN EMPIRIC REVIEW WITHIN THREE DAYS OF PRESCRIBING THE ANTIBIOTICS.		Sliding scale payments 50% - 90%	C	N/A yet																	
Patient Experience																					
FALLS	ALL FALLS (APPROVED)	TBC	TBC	68																68	
	FALLS PER 1000 BED DAYS	<=5.6	TBC	4.16																	
	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (APPROVED)	TBC	TBC	0																0	

Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
FALLS	MODERATE, MAJOR AND CATASTROPHIC HARM FALLS (UNDER REVIEW)	N/A		1																1	
	MODERATE HARM FALLS (APPROVED)	<=12	SU2S (10% reduction)	0																0	
PRESSURE ULCERS	GRADE 3 AND 4 HOSPITAL ACQUIRED (AVOIDABLE)	<=3	IP, SU2S (10% reduction)	0																0	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNAVOIDABLE)	N/A		0																0	
	GRADE 3 AND 4 HOSPITAL ACQUIRED (UNDER REVIEW)	N/A		2																2	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	TBC	IP	1																1	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (APPROVED)	TBC	10% reduction internal stretch target	1																1	
	GRADE 2 HOSPITAL ACQUIRED, AVOIDABLE AND UNAVOIDABLE (UNDER REVIEW)	N/A		3																3	
ALWAYS EVENTS		100%	QI	97%																	
DEMENTIA	DEMENTIA ASSESSMENT % (PART 1)	>=90%	C	N/A yet																	
	DEMENTIA ASSESSMENT % (PART 2)	>=90%	C	N/A yet																	
	DEMENTIA ASSESSMENT % (PART 3)	>=90%	C	N/A yet																	
	DEMENTIA - STAFF TRAINING		C		60.86%																
CARE INDICATORS RISK ASSESSMENTS	FALLS	>=95%	QI	99%																	
	WATERLOW (PRESSURE ULCERS)	>=95%	QI	99%																	
	MUST (MALNUTRITION)	>=95%	IP	91%																	
MIXED SEX OCCURENCES		0	QC	1																1	
FRIENDS AND FAMILY (PATIENTS' VIEWS)	STAR RATING	N/A	Reporting only	N/A yet																	
	% RECOMMENDING TRUST: INPATIENTS	>=95%	IP, QI, QC	N/A yet																	
	% RECOMMENDING TRUST: A&E	>=87%	IP, QI, QC	N/A yet																	
	RESPONSE RATE: A&E WARRINGTON	Contract target to be agreed	IP, QI, QC	11.48%																11.48%	
	RESPONSE RATE: URGENT CARE CENTRE HALTON	Contract target to be agreed	IP, QI, QC	13.37%																13.37%	

		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD	Trend
FRIENDS AND FAMILY (PATIENTS' VIEWS)	RESPONSE RATE: A&E COMBINED	Contract target to be agreed	IP, QI, QC	12.17%																12.17%	
	RESPONSE RATE: INPATIENTS	Contract target to be agreed	IP, QI, QC	31.47%																31.47%	
Target or Indicator		Target	IC	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	**YTD**	Trend
COMPLAINTS AND CONCERNS	NUMBER OF COMPLAINTS RECEIVED	2015/2016 received 404 (No threshold set)	IP	36																36	
	% OF COMPLAINTS RESOLVED WITHIN THE AGREED TIMESCALE	>=94%	IP, QC	91.30%																91.30%	
	NUMBER OF RETURNED COMPLAINTS	TBC	QI	DC																	
	NUMBER OF CONCERNS RECEIVED	NOT SET	IP	2																2	

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/118**
SUBJECT:	**Workforce Dashboard M1 2016-17**
DATE OF MEETING:	25th May 2016
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Mick Curwen, Associate Director of HR
EXECUTIVE DIRECTOR SPONSOR:	Roger Wilson, Director of Human Resources & Organisational Development
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.5: Right People, Right Skills in Workforce
	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF1.3: National & Local Mandatory, Operational Targets
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None
EXECUTIVE SUMMARY (KEY ISSUES):	• Our sickness absence performance has improved in month. RTW rates largely unchanged but still lower than we require. A revised Absence Management Policy is currently in development stage. • Positive trajectory on turnover rates, the stability rate has improved. A small improvement also seen in vacancy rate. • In month, in line with the trend in the previous 12 month period, the Trust has recruited more starters than it has had people leave the organisation. • In terms of paybill, the Trust is £23k under budget in the month of April 2016, this includes contracted/non-contracted pay spend? • Trust is genuinely trying to lead in relation to compliance with capped agency rates. The Trust is discussing with NHSI, a locality summit. • Building on from the 14 Romanian nurses who commenced with the trust on 29.2.16 and 6 more will arrive on 1 June 2016, Facebook and Twitter accounts have been set up, good positive start. • Recruitment times – new stretch targets set, building on early

	successes but making a more realistic target • Employee Relations – 49 live cases, these are being managed through the appropriate governance structures	
RECOMMENDATION:	***The Board is asked to:*** Note progress on the achievement of the KPIs and the action being taken to try and address shortfalls where appropriate.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Workforce Performance Management Update

At the Strategic People Committee meeting/Operational Committee the PDR and Mandatory Training compliance rates are regularly monitored. At the bi-lateral meetings there is also a key focus on PDR and mandatory training compliance. Therefore, this report concentrates on the other workforce issues contained in the dashboard and the narrative which follows.

1. Position as at April 2016

Please see the dashboard on the next page for the trust wide position.

370 Warrington and Halton Hospitals NHS Foundation Trust

Period: 2016 04

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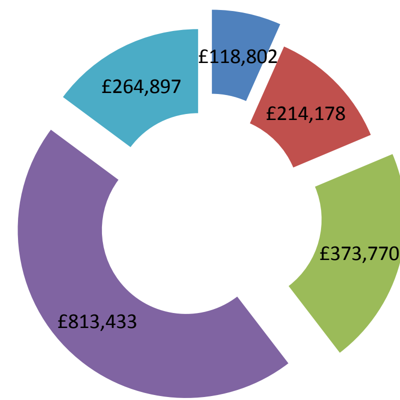
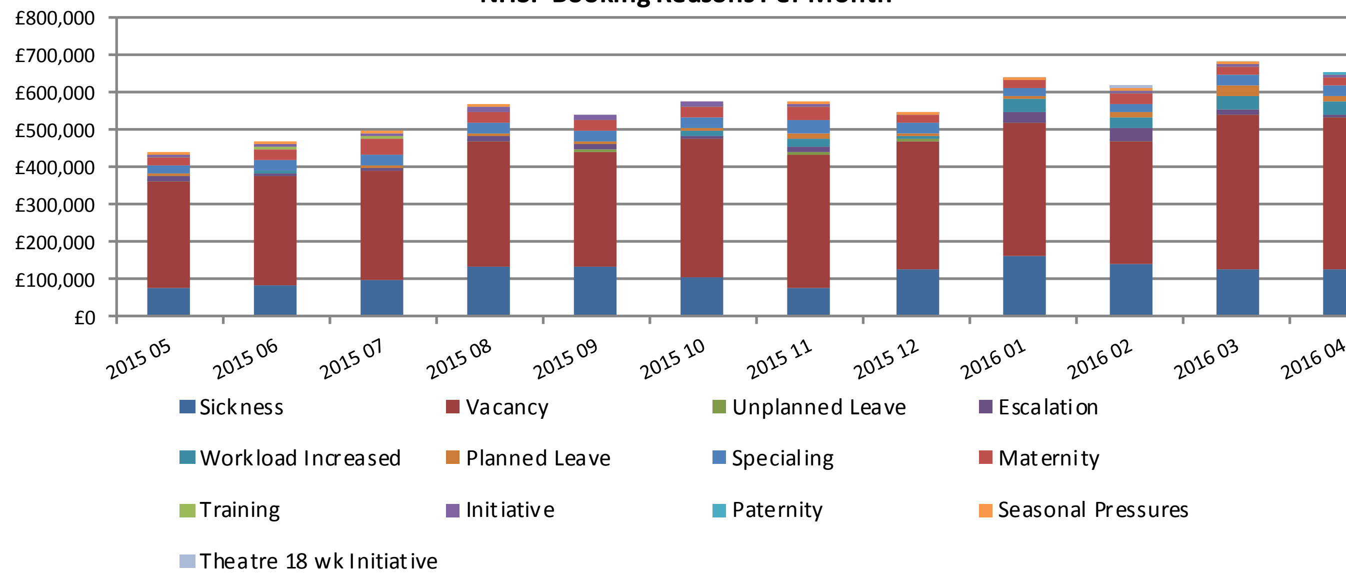
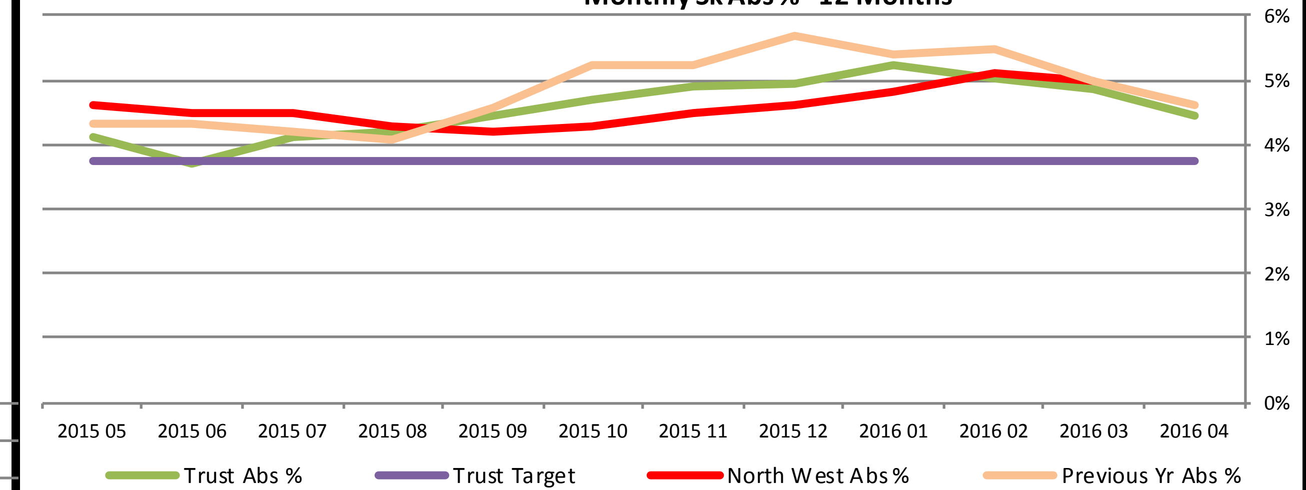
Expenditure

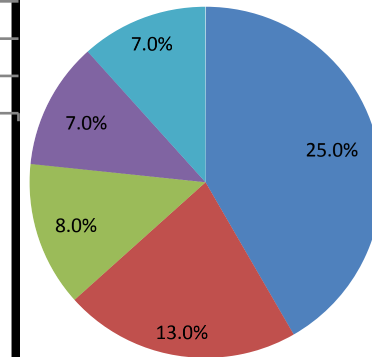
YTD Budget £	£13,735,998
YTD Contracted £	£11,927,573
YTD Non-Contracted £	£1,785,079
YTD Variance £	-£23,348
Flex Labour Reliance %	13.0%
Overpayment Balance	£69,183





Sickness Absence

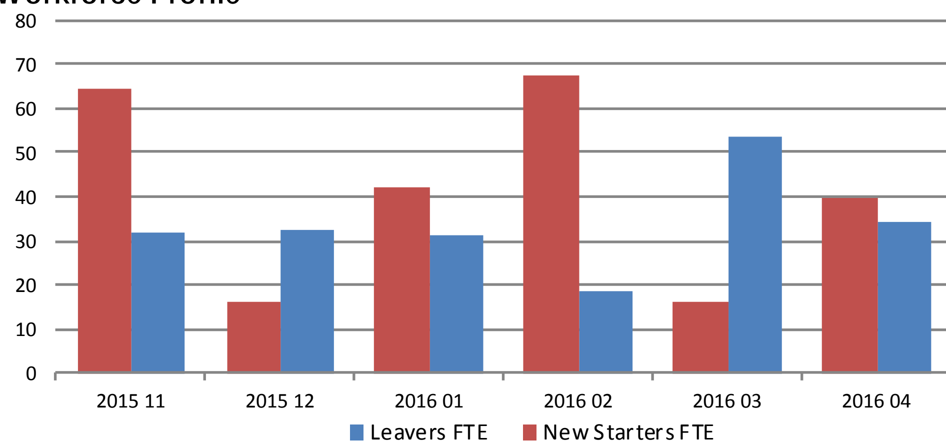


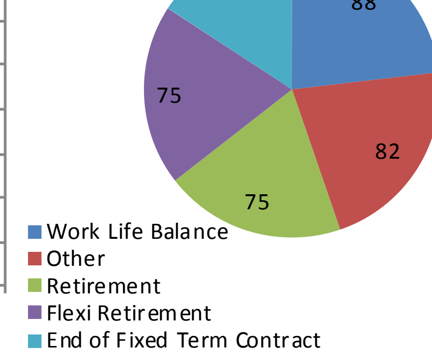


Monthly RTW %	58%	Cumulative RTW %	53%
Monthly Sk Abs %	4.5%	Trust Target	3.75%
YTD Sk Abs %	4.5%		
Long Term Sick %	2.6%	Short Term Sick %	1.9%
Calendar Days Lost	5378	No of Episodes	586
Est Monthly Cost	£357,178	Est Cumulative Cost	£4,173,945

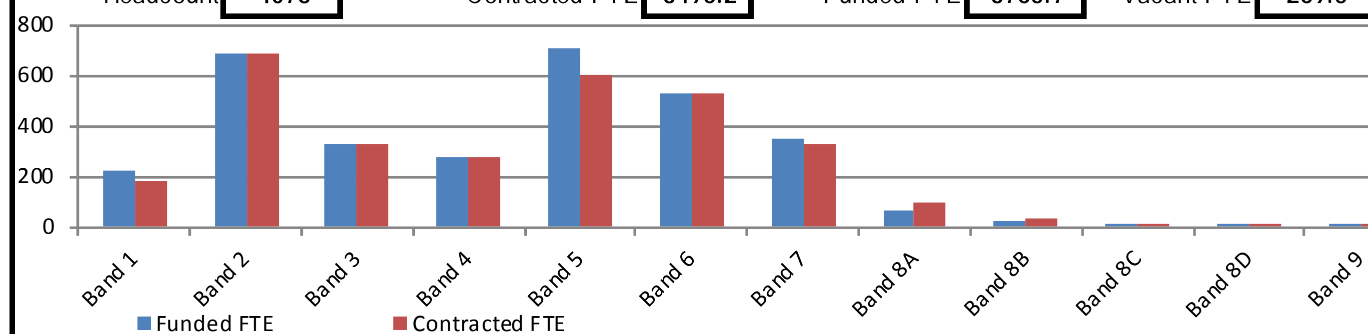
- S10 Anxiety/stress/depression/other psychiatric illnesses
- S12 Other musculoskeletal problems
- S25 Gastrointestinal problems
- S98 Other known causes - not elsewhere classified
- S13 Cold, Cough, Flu - Influenza

Workforce Profile





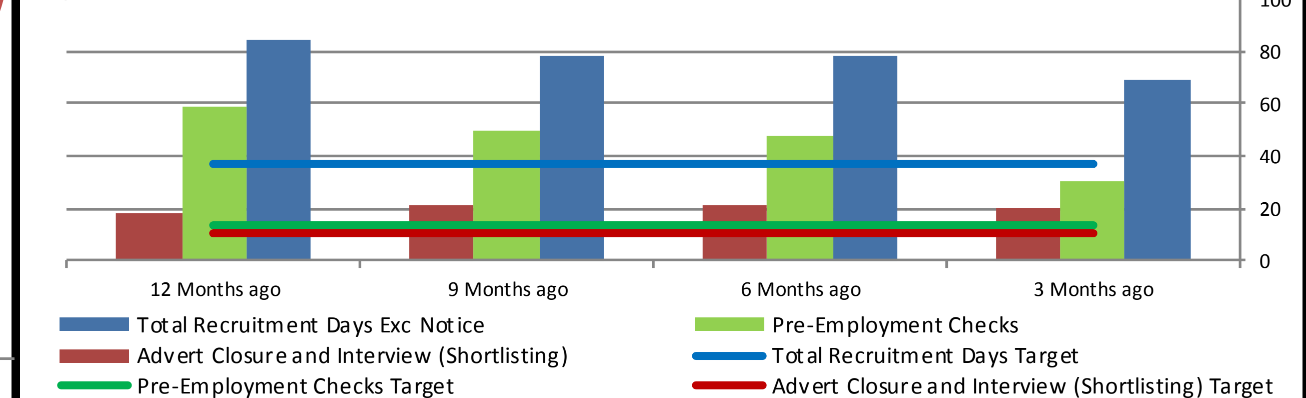
Annual Leave Hrs	156,577 : 73,328			Current Mat Leave FTE	47.6	Stability	14.3%
Headcount	4078	Contracted FTE	3496.2	Funded FTE	3765.7	Vacant FTE	269.5



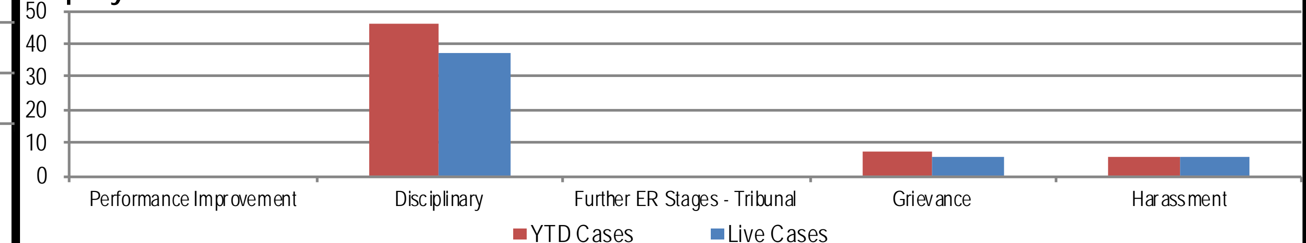
Recruitment

Overall Vacancy % & FTE	7.2%	Turnover	10.6%
Avg Monthly New Starters FTE	45.5		
Avg Monthly Leavers FTE	38.9		

Avg Recruitment Times



Employee Relations



Division/Directorate/Department Name	Period: Monthly date the data is produced
Expenditure **YTD Budget £:** Year to Date Budget from Finance **YTD Contracted £:** Year to date amount spent on contracted employees **YTD Non-Contracted £:** Year to date amount spend on non-contracted employees, such as locums, other agency, overtime, NHSP, additional hours, WLIs etc **YTD Variance £:** Difference between Budget and actual spend on the budget **YTD Non Contracted Expenditure:** Breakdown of non-Contracted expenditure **Flex Labour Reliance %:** Percentage of hours worked through non-contracted agreements compared to the contracted hours within the Division/ Directorate/Department - demonstrating reliance on non contracted hours **Overpayment Balance:** Outstanding balance of overpayments the Trust is attempting to recover **NHSP Booking Reasons:** Further breakdown of NHSP spend by reason, grade and month	Sickness Absence **RTW % :** Percentage of Return to Work interviews completed monthly and annually **Monthly Sk Abs %:** The in month sickness percentage with the graph showing the monthly sickness percentages for the last 12 months, comparing it with the Trust and the Trust Target **Trust Target:** Sickness absence percentage target set by the Trust **Cumulative Sk Abs %:** Cumulative sickness absence percentage for the last 12 months **Divisional Sk Abs %:** Divisional sickness absence monthly percentage **Long Term Sick %:** Percentage of employees absent for 28 days or more in the month **Short Term Sick %:** Percentage of employees absent of 28 days or less in the month **Calendar Days Lost:** Number of calendar days lost due to sickness in the month **No of Episodes:** Number of sickness episodes within the month **Est Monthly Cost:** Estimated monthly cost due to sickness absence, only takes into account the cost of salary **Est Cumulative Cost:** Estimated 12 month costs due to sickness absence, only takes into account the cost of salary **Top 5 Abs Reasons:** Chart showing the top 5 sickness absence reasons for the last 12 months
Workforce Profile **Leavers/Starters:** Graph showing the number of monthly leavers and new starters **Top 5 Reasons for Leavers:** Chart showing the top 5 reasons for employees leaving the Division/Directorate/Department in the last 12 months **Annual Leave:** Amount of annual leave taken compared to the target amount **Mat Leave FTE:** Current number of employees on Maternity leave in FTE **Stability %:** A percentage indication of how stable the workforce is within the selected Division/Directorate/Department, by reviewing the number of permanent leavers with less than 12 months service, 0% being very stable **Headcount:** Number of employees **Contracted FTE:** Total Employed FTE **Funded FTE:** Total FTE available **Vacant FTE:** Difference between funded and contracted FTE **Staff Profile:** Graph showing the make up of staff within the Division/Directorate by banding comparing the funded (budget) FTE and contracted (actual) FTE.	Recruitment **Overall Vacancy %:** Percentage difference between Budgeted FTE and Actual Staff in Post FTE **Avg Monthly New Starters FTE:** Average number of new starters each month (12 month period) **Avg Monthly Leavers FTE:** Average number of leavers each month (12 month period) **Turnover:** Turnover percentage, the number of leavers in the last 12 months as a percentage against the average headcount **Rec Process Start:** Average calendar days taking to start the recruitment process **Advert Closure and Interview (Shortlisting):** Average calendar days between advert closing and interview Target = 10 Days **Pre- Employment Checks:** Average calendar days between successful candidates ID checks being completed and agreeing the start date (excluding notice period) Target = 14 Days **Total Recruitment Days:** Average total number of calendar days taken to recruit from Advert to Start Date (excluding notice period) Target = 37 Days **Employee Relations:** A graph showing, by Division the number of Employee Relation Cases, both year to date and currently live

Expenditure

Whilst the flexible labour reliance (Percentage of hours worked through non-contracted agreements compared to core workforce contracted hours - demonstrating our level of reliance on non-contracted hours) remains significantly higher than we would want at 13%, April 2016 has seen a 1.5% reduction on the previous month.

In terms of actual spend, whilst the spend of £1.7m for the month, on non-contracted pay, is high, the Trust is £23k underspent on paybill for April 2016. The main areas of expenditure can be broken down as follows:

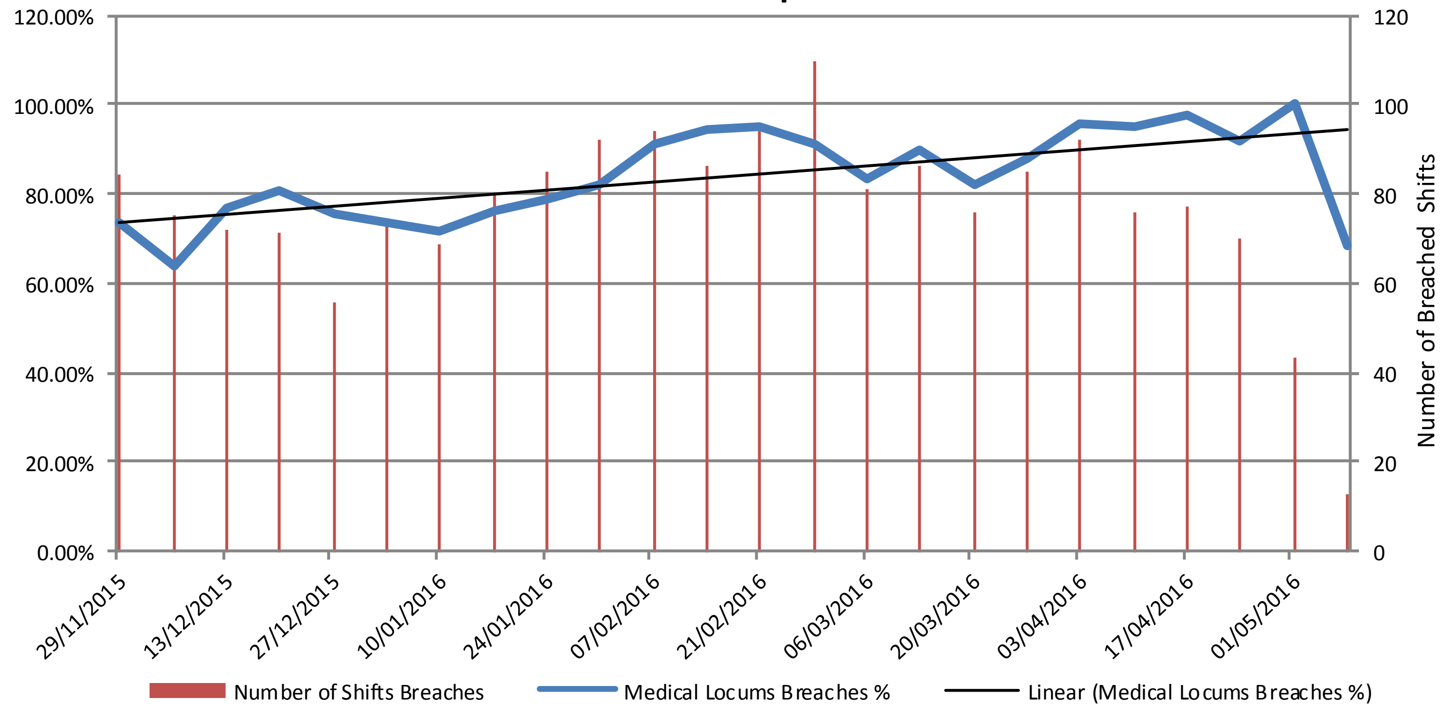
Category	**Expenditure in April**
Nurse Bank & Agency	£734k
Agency excluding Medical and Nursing	£159k
Medical Locums & Agency	£502k
TOTAL	£1.5m

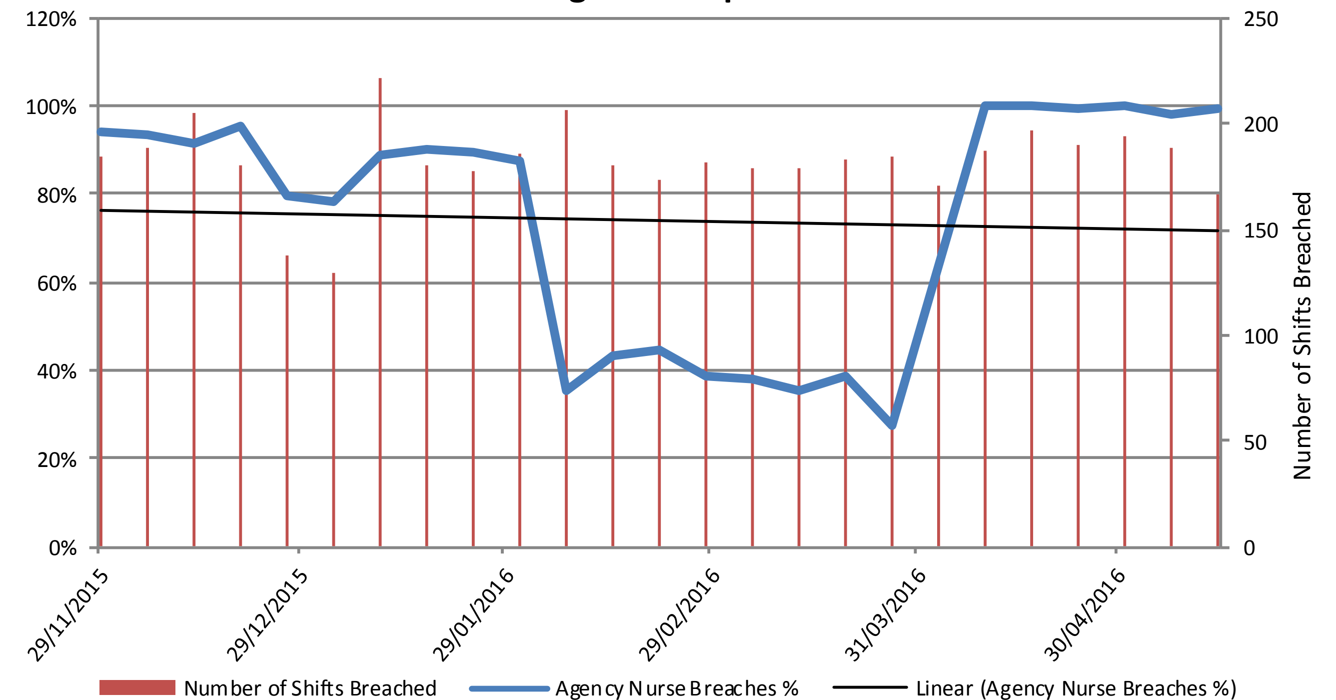
This is shown by expenditure in the former clinical Divisions and Corporate:

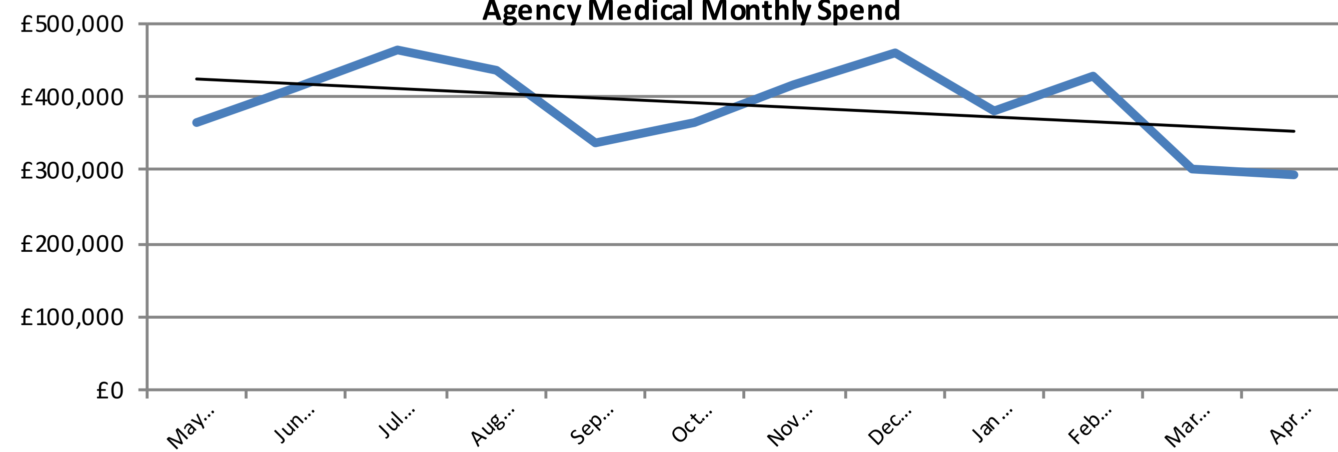
Division	**Expenditure in April**
Acute Care Services	£896k
Surgery, Women's & Children's	£342k
Outpatients	£44k
Corporate (mainly Lorenzo)	£112k

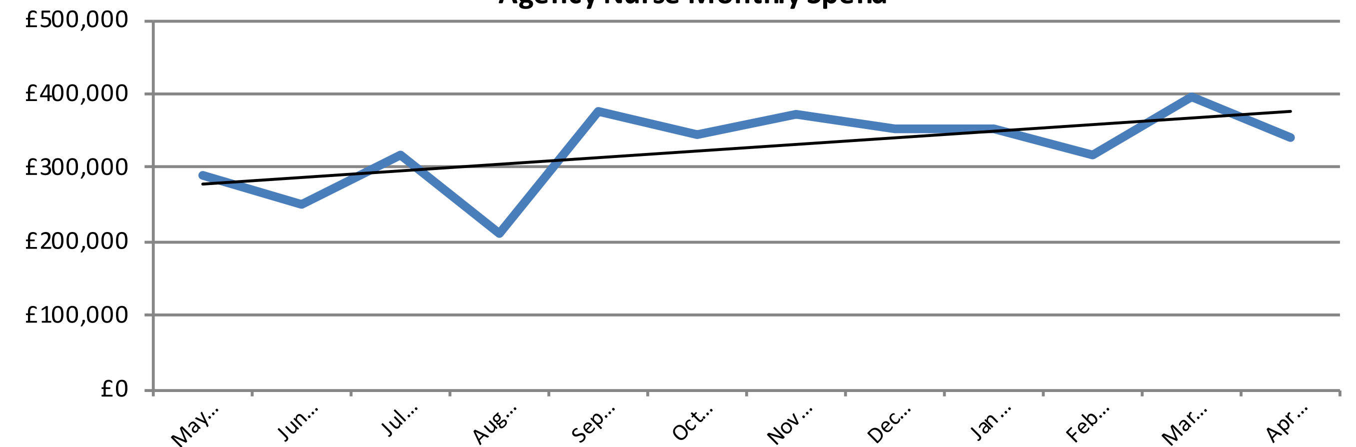
- Enhanced Grip and Control is in place within Divisions and Corporate functions to manage down our additional staff pay spend
- International recruitment continues to yield positive results, through a range of initiatives
- Exploratory conversations have taken place with Gatenby Sanderson with regard to how they could support the Trust in Consultant Recruitment
- Facebook and Twitter have been utilised to enhance our Employer Brand via Social Media, this has resulted in 31 strong expressions of interest from Nurses looking to work in the Trust. This is in line with other technological developments.

The following Dashboard outlines where are with Medical and Nursing agency spend and the challenge this Trusts faces, despite encouraging signs in the reduction of Medical agency spend. This Dashboard will be reviewed on a regular basis by Finance and Sustainability Committee.









Top 10 Areas of Agency Medical Spend	Cumulative	Apr-16	Apr-15
370 ACS SM Acute Medicine and Endocrinology - 535160	£1,318,622	£84,358	£92,239
370 ACS SM Care of the Elderly - 535159	£971,340	£33,688	£99,587
370 ACS UEC A&E Medical Staff - 535002	£588,522	£34,450	£37,952
370 ACS UEC Minor Injuries - 535003	£512,482	£44,500	£0
370 SWC MC Orthopaedic Medical Staff - 535406	£481,797	£27,264	£46,633
370 SWC DD Gastroenterology - 535158	£183,304	£18,070	£7,044
370 SWC DD General Surgery Medical Staff - 535308	£172,459	£11,167	£24,264
370 ACS ABC Respiratory - 535157	£157,195	£4,747	£0
370 SWC WCH Women's Medical Staff - 535603	£121,968	£24,281	£14,800
370 SWC WCH Children's Medical Staff - 535509	£58,145	£661	£6,562

Top 10 Areas of Agency Nursing Spend	Cumulative	Apr-16	Apr-15
370 ACS UEC A&E Department - 535500	£995,624	£89,185	£93,333
370 ACS ABC Intensive Care Unit - 535212	£434,573	£41,025	£1,811
370 ACS UEC Ward A1 - 535004	£429,977	£28,500	£29,183
370 ACS SM Ward A8 - 535165	£283,864	£26,010	£3,504
370 SWC DD Ward A6 - 535325	£207,988	£19,946	£6,638
370 ACS ABC Ward A7 - 535149	£188,993	£17,456	£18,345
370 ACS SM Intermediate Care Ward - 535168	£183,608	£6,279	£16,474
370 SWC DD Ward A5 - 535324	£173,728	£15,164	£6,461
370 SWC MC Ward A9 - 535411	£169,118	£14,639	£9,856
370 ACS SM Ward A4 - 535169	£147,635	£18,363	£0

Sickness Absence

- April saw a further decrease in sickness absence from 4.8% to 4.5% and historically this is in line with trust expectations for the first quarter of the year. Over the last 5/6 months the trust rate has virtually matched the North West average percentage and the trust has shown a steady increase since August 2015 but this peaked in January 2016 and is now showing a downward trend.
- There was a slight increase with the RTW rate at 58% for April (55% March) and 53% for the last 12 months.
- The main reason for sickness absence is Stress. More work has been completed to improve the recording of whether stress is work related or not. Our initial analysis would suggest that 92% of stress is not work related stress. The top 10 areas where Stress is most prevalent is being addressed by Divisional Managers. The SPC and Staff Engagement and Wellbeing Committee regularly review stress at their meetings.

Workforce Profile

- April was another month where we can report more new starters than leavers and the overall trend over the last 12 months shows that the monthly average position remains positive with more starters (45.5 wte) than leavers (38.9 wte).
- However, the number of qualified nurse vacancies increased to 148.7 wte from 118 wte in March, this significant increase is being reviewed, early indicators suggest that this may have been a result of the realigning of budgets to the CBUs.
- The top reasons for leaving is retirement, with 150 qualified nurse leavers in the last 12 months, however, 50% of those leavers returned to the Trust to work on Flexi retirement. 88 individuals left to improve their Work Life Balance.
- The headcount has increased by 19 to 4078 and this is consistent with the higher number of starters. The number of vacancies has reduced by 14.5 wte to 269.5 wte.
- The stability rate has fallen slightly from 14.6% to 14.3%.

Recruitment

- Labour turnover has slightly improved from 10.9% to 10.6% and the vacancy rate remains stable at 7.2%.
- The average time taken to recruit has reduced significantly over the past 12 months. For 2016/2017, we have set a very ambitious recruitment target of 37 days excluding notice.

2. Recommendations

That the Board notes the contents of the report and the action being taken to improve the workforce performance indicators.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/119**	
SUBJECT:	**Trust Engagement Dashboard M1 2016-17**	
DATE OF MEETING:	25th May 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Pat McLaren, Director of Community Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This dashboard is to provide a high-level overview of how well the Trust is engaging and involving key stakeholder groups i.e. those who use, work, visit, volunteer, support, commission, partner or donate to our hospitals.	
RECOMMENDATION:	That the Board notes the content of the paper.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Trust Engagement Dashboard April 2016

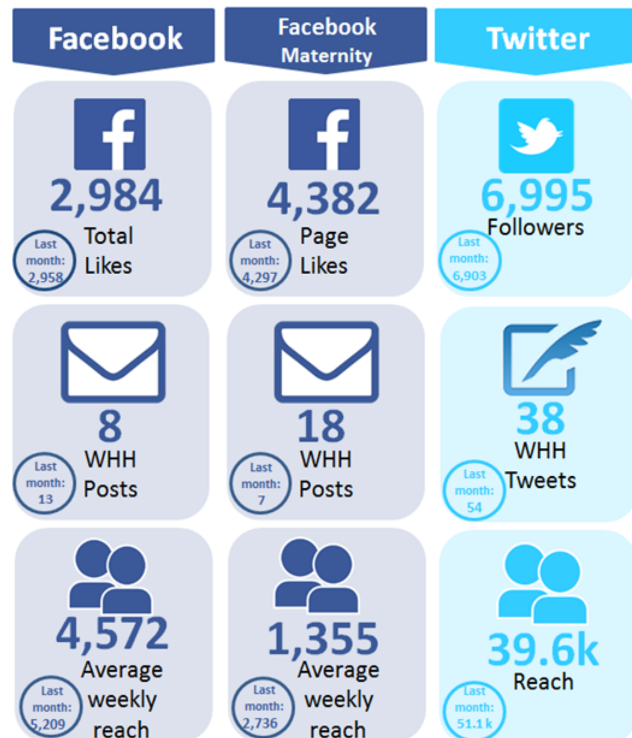
Director of Community Engagement

We are WHH

Media/wider Public Engagement

Social Media Dashboard April 2016

- Facebook likes increased in month by 26
- Maternity Facebook community continues to thrive with increase in likes by 103 and increased activity
- Twitter followers increased by 93

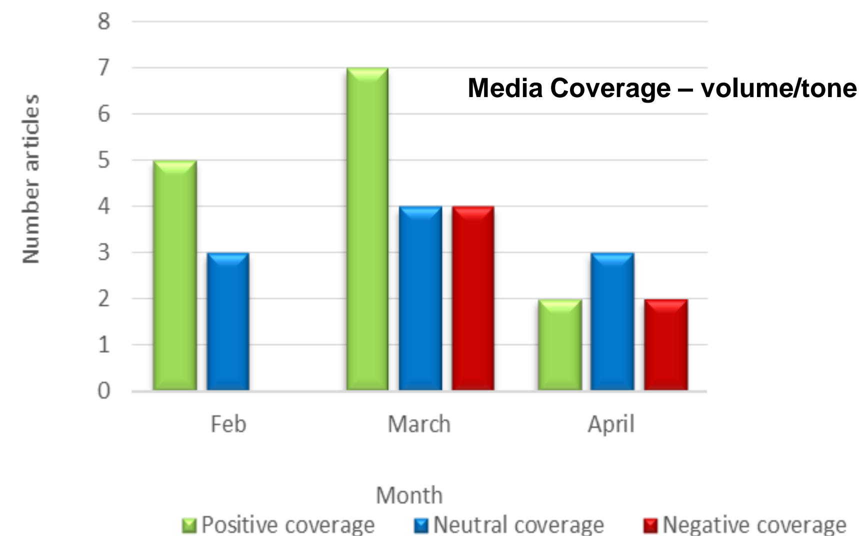


Media Dashboard April 2016

Difficult month managing reputational issues which affected output/capacity:

- Most successful PR: Children's ward mural, Queen's Nurse award
- Least successful PR: Patient treatment in ED, STAR ward closure

Publication	Date	Headline	Balance
Warrington Guardian	27/04	Children's ward mural	Positive
Warrington Guardian	25/04	Queen's nurse title	Positive
Warrington Guardian	20/04	Planning application for WH parking cameras accepted	Neutral
Warrington Guardian	26/04	Junior doctor strikes	Neutral
Warrington Guardian	13/04	Parents warned not to use ibuprofen to treat chicken pox	Negative
Warrington Guardian	14/04	STAR ward closing due to funding cuts	Negative



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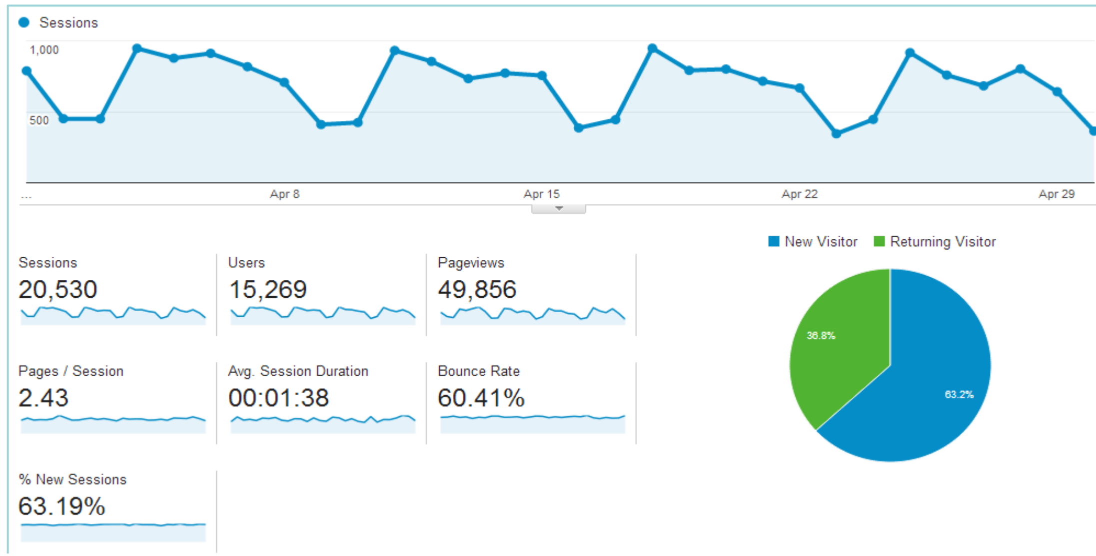
Wider Public Engagement



Website

WHH
20,530 Visits
Last month: 23,029

101 Social Media Referrals
Last month: 559

1min 38s Length of average time
Last month: 1.32s

Website Traffic April 2016

- Website traffic decreased by 2499 sessions in month
- Social media referrals decreased by 458
- Dwell time increased by 6 seconds
- 62% activity new visitors
- Most popular search terms 'Warrington' and 'Halton' Hospitals plus 'twiddle muffs'

Top Referrers	Visits
Facebook and Twitter direct referrals to site in month	101

Top Search Engines	%	Visits
Google	69.54	14,277
WHH (eg searched within site)	11.48	2,356
Direct	10.58	2,172
Rank checker	1.85	380

Top Landing Pages	%	Visits
Home page	20.76	4,263
Contact us	8.77	1,801
Hospital shuttle bus	6.13	1,258
Current vacancies	5.82	1,195
Warrington Hospital	4.22	867
Urgent care centre - Runcorn	4.16	855
What is corrective jaw surgery	2.35	482
* We have guided visitors to these pages for specific campaign/social media purposes		

	264,113 % of Total: 100.00% (264,113)	264,113 % of Total: 100.00% (264,113)
1. (not set)	115,493	43.73%
2. warrington hospital	18,282	6.92%
3. halton hospital	12,236	4.63%
4. warrington	3,664	1.39%
5. twiddle muff	3,360	1.27%
6. halton hospital runcorn	2,052	0.78%
7. whh	2,043	0.77%
8. halton general hospital	1,928	0.73%
9. warrington hospital phone number	1,821	0.69%
10. epworth sleepiness scale pdf	1,788	0.68%

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Patient Engagement

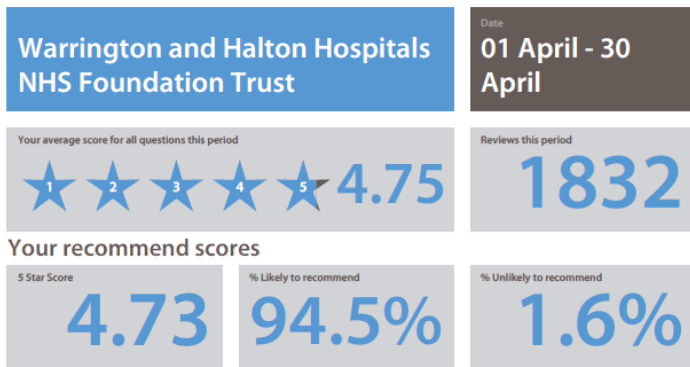
NHS Choices

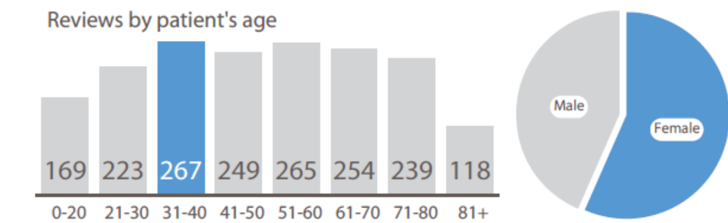
- Increase by 5 in comments posted
- Star Rating remains unchanged in month

Friends and Family Test (Adult services)

- Responses decreased by 482 in month
- Star rating increased by 0.6
- % likely to recommend increased by 2.5%
- % unlikely to recommend decreased by .08%

NHS Choices





Top three services (with 5 reviews or more)	
Coronary Care Unit	5.00
Ante Natal Day Unit	5.00
Ward Day Case Unit Halton	4.97

Bottom three services (with 5 reviews or more)	
Ward A3	4.53
Accident & Emergency Department	4.51
Ward B18	4.33

Friends and Family Test (Adult services)

Staff Engagement

Monthly data

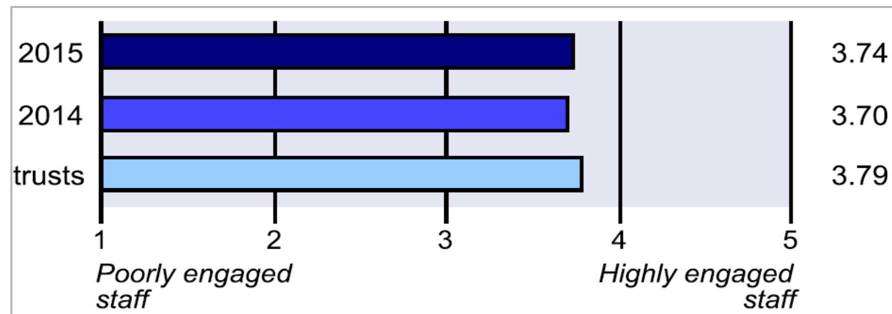
- ❑ 1,216 staff registered on the new extranet since launch 24.2.16 (increase in month of 185 new registrants)
- ❑ Staff members attending Team Brief
  - ➢ Halton 9
  - ➢ Warrington 37
- ❑ Staff nominating colleagues for :
  Employee of Month =1 (decrease of 7 in month)
  Team of Month = 2 (decrease of 4 month)

Quarterly Data

- ❑ Q4 Staff FFT – 315 responses
- ❑ **Staff FFT Recommend for Care / treatment**
  70% extremely likely or likely
  15% extremely unlikely or unlikely
  Staff FFT Recommend as Place of Work
  64% extremely likely or likely
  21% extremely unlikely or unlikely
- ❑ Q4 Staff attending 'Big Conversations' – Bright Ideas = 60

Annual Data:

- ❑ NHS Staff Survey 2015 – Engagement score 3.74 (worse than similar Trusts)



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Other Stakeholder Engagement

GPs

- **Practice visits programme in month:**
  - Stockton Heath Medical Centre
  - Brookvale Medical Centre
- ***In Practice* Newsletter**
  - New format *In Practice* newsletter in development (4 x year)
  - Contribution to weekly CCG GP bulletin
- **New directory of Services** – underway
- **Clinical and non clinical education programmes**
  - **Current trends in the management of the diabetic foot.** Conference chaired by Mr Thomas Nicholas, Consultant Vascular Surgeon and Mr Colin Chan, Consultant Vascular Surgeon Thursday 15th September
  - **Myeloma: diagnosing the difficult** Dr Steven Hawkins, Consultant Haematologist from the Royal Liverpool hospital guest speaker on 8th July 2016 at Warrington

FT Governors and Membership

- Quality in Care Governor's Sub Committee meeting
- *Your Hospitals* (via News Quest) Next issue published 22 June 2016
- Your Health events planned for members:
  - Learn more about Stroke services - Wednesday 18th May 2016
  - Respiratory Tests - Tuesday 24th May 2016
  - Diabetes awareness - Tuesday 19th July 2016
  - Take a closer look at Ophthalmology – Wed 14th September 2016

WHH Charity

- **Donor Relationships/ Management**
  - Donors total on system – 469 (Individuals 394, Corporate 75)
  - Individual donations – 63 totalling £4976.27 (ex Gift Aid)
  - Individual donations via Just Giving £2051
  - **New and Existing Corporate relationships**
    - M&S Store, Warrington - Charity of the Year 2015/16 Grand Total £2189.29
    - Water Babies, Warrington, Gifts in Kind x20 Pictures & Swimming package for Maternity unit / creating events for Children's Ward appeal
  - **Community Fundraising New contacts**
    - School & Clubs campaign – colouring competition running Sept – December raising funds for the Outdoor Play Area Appeal
    - Saughill Rotary Club – Dragon Boat organisers
  - **Staff Fundraisers**
    - Fundraising – Amber Unsworth Boot camp
    - Ward fundraising – Neonatal/Children's Ward
- **Events/Collaboration**
  - Ladies Fashion Show – The Tim Parry Jonathan Ball Peace Centre raising £1208.00
- **Campaigns**
  - Making Waves launched April total raised in month £2713.19
- **Networking**
  - North West NHS Fundraising Group, 1st meeting with regional fundraisers – Alder Hey, Christies, Manchester, Liverpool Royal plus many more (13)

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/120**	
SUBJECT:	**Key Issues Report from the May Finance & Sustainability Committee 2016-17**	
DATE OF MEETING:	25th May 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, Committee Chair	
DIRECTOR SPONSOR:	Terry Atherton, Committee Chair	
LINK TO STRATEGIC OBJECTIVES:	SO3: To deliver well managed, value for money, sustainable services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF3.3: Clinical & Business Information Systems	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	
EXECUTIVE SUMMARY (KEY ISSUES):	A summary of the key issues discussed at May's committee meeting.	
RECOMMENDATION:	The Board note the contents of the discussions and that there are no matters arising for escalation	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
MAY FINANCE AND SUSTAINABILITY COMMITTEE

Date of meeting:	**18th May 2016**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 20th April and the Extraordinary meeting held on 30th March were approved as a correct record.
Formal Business	The Finance and Sustainability Committee now meets with a smaller group of members enhancing focus and effectiveness. The Committee Work Programme has been extended to include additional FSC meetings in both August and December on a restricted agenda to enhance Grip and Control. The Annual Report of the Finance and Sustainability Committee Report 2015/16 was received and approved for onward submission to Board. The 2016/17 NHS Standard Contract with CCG Commissioners was signed on 22nd April 2016. For April, the first month of the 2016/17 financial year, performance was on track albeit a deficit of £2.0m was recorded. The Trust has applied for a working capital loan of £18.6m in 2016/17 and until this is approved the Trust has access to an interim facility. Whilst cash at month end is better than plan, this is a timing issue and cash remains tight. Capital Expenditure is on plan. Whilst no fines and penalties have been included in Month 1 results, prospective NWAS penalties of c £0.130m for the month have emerged which are being investigated and will be disputed firmly. Against a CIP plan for Month 1 of £0.3m the Trust has delivered £0.353m, 118% of plan, in actual CIP savings. At 12th May the Trust has developed 2016/17 CIP schemes to the value of £7.058m PYE and £8.910m FYE. This represents significant progress against the £8m required to be delivered within the financial plan. Against the 95% National 4 hour A&E standard, the Trust achieved 90.45% which exceeded the improvement trajectory agreed with NHSI of 87%. This was a significant improvement on the March performance of 83.70%. Whilst May to date has experienced some challenges, we expect to remain on track against the improvement trajectory for the Month of 89%. Despite

	improved performance ambulance handover times remain a concern and work is ongoing In reality, achievement of the 95% target requires a system wide response. It was agreed that a stocktake of A&E would take place once the April outturn was known and discussions with FSC have commenced. Performance beyond A&E remains credibly robust and this is worthy of note. The Committee received the customary IM&T update together with the Business Case "Lorenzo Electronic Prescribing and Medications Administration" (ePMA). This Business Case follows a clear direction of travel, with clinical and operational benefits, would attract time limited external financial support, yet would provide current financial challenges to the Trust which would not be easy to accommodate at present. Ongoing work continues around the financials and especially benefit realisation and the Board will receive an update in this respect in due course. The Committee received a number of Sub Committee meeting minutes
Local Policies and Guidance Approved:	None.
Any Learning and Improvement identified from within the meeting:	None.
Any other relevant items the Committee wishes to escalate?	None.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/120**	
SUBJECT:	**Finance Report M1 2015-16**	
DATE OF MEETING:	25th May 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea Chadwick, Director of Finance & Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 30th April 2016 the Trust has recorded a deficit of £2.0m, a cash balance of £2.5m and a Financial Sustainability Risk Rating score of 2. The Board of Directors is asked to note the contents of the report.	
RECOMMENDATION:	The Board of Directors is asked to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/16/55
	Date of meeting	18th May 2016
	Summary of Outcome	Noted

FINANCE REPORT AS AT 30th APRIL 2016

1. PURPOSE

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 30th April 2016.

2. EXECUTIVE SUMMARY

Year to date performance against key financial indicators is provided in the table below and further supplemented by the dashboard (Appendix A) and schedules (Appendices B to I) attached to this report.

Key financial indicators:

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m
Operating income	17.9	17.9	0.0
Operating expenses	(19.0)	(19.1)	(0.1)
EBITDA	(1.1)	(1.2)	(0.1)
Non-operating income and expenses	(0.9)	(0.8)	0.1
Surplus / (deficit)	(2.0)	(2.0)	0.0
Cash balance	1.2	2.5	1.3
CIP target	0.3	0.3	0.0
Capital Expenditure	0.2	0.2	0.0
Financial Sustainability Risk Rating	1	2	

Headlines:

- The monthly position is a deficit of £2.0m. The position is £14,000 better than plan and this has delivered a Financial Sustainability Risk Rating score of 2.
- The annual planned cost savings target is £10.0m of which £8.0m is included within the financial plan. To date the planned savings target of £0.3m has been delivered (See agenda item Cost Improvement Report for further details).
- The planned capital expenditure to date is £0.2m and the actual spend to date is £0.2m (section 4).
- The cash balance is £2.5m, which is £1.3m above the planned balance of £1.2m (section 5).
- The Better Payment Practice Code performance for the year to date is 29% (section 5).
- The value of aged debt is £4.2m (section 7).
- The value of aged creditors is £11.6m (section 8).
- The Trust has applied for a working capital loan of £18.6m in 2016/17. Until this

application is approved the Trust has access to an interim revolving working capital facility. In April the Trust has drawn down £0.6m from this facility (section 9).
- The Trust has not applied for a capital loan in 2016/17 (section 10).
- The forecast deficit is £18.6m which is in line with plan (section 11).

3. INCOME AND EXPENDITURE (APPENDIX B)

In April the Trust has recorded a deficit of £2.0m, which is marginally better than plan. The year to date performance reflects the planned profile of the cost improvement savings.

Operating Income

In month operating income is in line with plan and an analysis by income category is summarised in the table below.

Table: Analysis of monthly and year to date income variance by category.

Narrative	Monthly Variance £m
NHS Clinical Income	0.0
Non NHS Clinical Income	(0.1)
Other Operating Income	0.1
Total Operating Income	**0.0**

Positive variance = above plan, negative variance = below plan.

Contracts Update

The Trust has experienced a positive 2016/17 contract negotiation round with Commissioners. The 2016/17 NHS Standard Contract with CCG commissioners was signed on 22nd April 2016. The Contract is for a period of 3 years. The NHS England Contract and Trust Service Level Agreements are also nearing completion and sign off.

Sustainability and Transformation Programme (STP): As part of the CCG commissioned contract the Trust has signed up to an STP performance trajectory in relation to the following key performance indicators:

- A&E 4 hour performance
- Referral to Treatment Times (RTT)
- 62 Day Cancer Waits
- 6 Weeks Diagnostics.

The KPI's contained in the above STP trajectory will not be subject to National Penalties during 2016/17. The consequence of not achieving the targets within the trajectory is the

potential inability to obtain STP funding, although precisely what amount will be retained is unknown at this time. The Trust is awaiting confirmation of this from NHS Improvement. An additional issue is at this stage the Trust is not able to access any of the Sustainability Funding (£8m) as the Trust is not able to deliver the control total required by NHS Improvement.

CQUIN Schemes: The Trust has signed up to the following CQUIN schemes:

CQUIN Description	Value Q1 £000	Value Q2 £000	Value Q3 £000	Value Q4 £000	Total Value £000
NATIONAL CQUINS					
NHS Staff Health and Wellbeing	172.1	0	0	1,118.5	1,290.6
Antimicrobial Resistance and Stewardship	21.5	21.5	21.5	365.7	430.2
Sepsis	107.6	107.6	107.6	107.6	430.4
ADVANCING QUALITY CQUINS					
AQ COPD	8.6	8.6	8.6	8.6	34.4
AQ Diabetes	8.6	8.6	8.6	8.6	34.4
AQ Pneumonia	8.6	8.6	8.6	8.6	34.4
LOCAL CQUINS					
Frailty	172.1	516.2	516.2	516.2	1,720.7
Dementia - John's Campaign	32.7	98.1	98.1	98.1	327.0
Total Value	531.8	769.2	769.2	2,231.9	**4,302.1**

The table above identifies the quarter in which delivery of the schemes will commence.

Allocation of KPI's and CQUIN Schemes to Executive Directors

The Trust's Chief Executive is in process of allocating to the Executive Directors responsibility for delivery of all KPI's and CQUIN schemes throughout 2016/17. The Head of Contracts will support the Executive Directors in achieving targets and performance managing Clinical Business Units with emphasis placed on recognising areas of excellence and understanding areas of under-performance putting in place remedial action recovery plans that will bring the Trust back in line with its contractual and statutory obligations.

Clinical Income

As at 30th April there are 3,592 uncoded elective, day case and non elective spells.

The Clinical Coding team transferred from the IM&T division to the Commercial Development division in February 2016 with an un-coded backlog of 5,400 spells. Since transfer, there have been a number of process changes to hold and improve the situation including the recruitment of a temporary runner to retrieve the clinical notes which were previously being retrieved by the Clinical Coders and staff working overtime.

The Trust has also now recruited a Head of Clinical Coding Service Development who has implemented additional processes and service improvements from 3rd May 2016. There is also a plan in place to further improve on the backlog position over the next quarter which will see the level of un-coded spells reduce to pre-Lorenzo levels (2,500) by August 2016. The plan includes a structure review to ensure that going forward, the Clinical Coding Service is appropriately resourced to replace overtime with substantive hours and facilitate clinical documentation and coding improvements to maximise income and the accuracy of clinically coded data.

NHS Clinical income is in line with plan, although there are variances across the points of delivery as demonstrated in the following table.
Table: Analysis of monthly and year to date activity and income variances.

Narrative	**Monthly Variance Activity**	**Monthly Variance £m**
Elective Spells	(332)	(0.2)
Elective Excess Bed Days	(10)	0.0
Non Elective Spells	(46)	0.2
Non Elective Excess Bed Days	(213)	0.0
Outpatient Attendances	(3,491)	(0.3)
Accident & Emergency Attendances	(309)	(0.1)
Other Activity	-	0.4
Total NHS Clinical Income	**-**	**0.0**

Positive variance = above plan, negative variance = below plan.

There are limited fines and penalties included in the financial position as no penalties can be levied for the schemes included in the Sustainability and Transformation Programme trajectory.

A full analysis of monthly and year to date NHS clinical income by category and specialty is available at Appendices C and D.

Non Mandatory / Non Protected Income

Private Patients and the Compensation Recovery Unit income is £0.1m below plan, mainly due to an under recovery against the Compensation Recovery Unit due to a reduction in the value of claims submitted.

Other Operating Income

Other operating income is £0.1m above plan year to date mainly due to an over recovery on miscellaneous income of £0.1m for a range of service level agreements and miscellaneous

recharges.

Operating Expenses

In month operating expenses are £0.1m above plan due to an over spend on clinical supplies and services of £0.1m.

Pay Costs

Pay costs are £13.7m which is in line with plan.

The pay spend includes the continued cost of temporary staffing driven by the use of Bank, Agency and Locum costs, Waiting List Initiatives and overtime. To date the total cost of temporary spend is £1.8m which equates to £21.6m per annum. Reduction in temporary spend is a key feature of the cost savings target so it is vital that these costs are minimised as much as possible.

It should be noted that there are no recurrent cost pressures resulting from the move from the old divisional structure to the new CBU structure in respect of management, nursing and AHPs. There has however been a Mutually Agreed Resignation Scheme (MARS) cost of £52k in the month. The exercise relating to the medical staff has not yet been completed but it is assumed that this will be cost neutral.

Drugs Costs

Drug costs are £1.3m which is in line with plan. The position includes an overspend of £0.1m relating to excluded PbR drugs which are funded by commissioners, with the additional income shown against other income within NHS clinical income.

Clinical Supplies and Services

Clinical supplies and services costs are £1.7m which is £0.1m above plan.

Non Clinical Supplies

Non clinical supplies are £2.4m which is in line with plan.

Divisional Performance

An analysis of the monthly and year to date income and expenditure position by each division is included in the dashboard attached at Appendix A and an analysis by each Clinical Business Unit and Corporate Division is attached at Appendix E. The summary table below shows that as at 30th April the financial position (net divisional income and expenditure) across all divisions is an over spend of £0.2m.

Table: Analysis of monthly and year to date divisional financial positions.

Division	Monthly Budget £m	Monthly Actual £m	Monthly Variance £m
Surgery, Women's & Children's	7.0	6.8	0.2
Acute Care	6.9	7.2	(0.3)
Outpatients	0.3	0.3	0.0
Corporate	3.5	3.6	(0.1)
Total	**17.7**	**17.9**	**(0.2)**

The £0.3m overspend within the Acute Care Division is due to overspends within Urgent Care, Airways, Breathing & Circulation and Specialist Medicine.

The main area of overspend in this Division in April occurred on nursing pay costs and was the result of one to one specialling for patients, staffing the escalation beds on A4, staffing the Ambulatory Care Unit and covering vacancies within the Division.

There are a number of small overspends within Corporate Services in April.

It is vital that managers take corrective action as soon as possible in order to ensure that services remain within the allocated resources.

Reserves

The Trust started the year with reserves of £19.9m and has transferred £5.9m to divisions in April, leaving a balance of £14.0m. A number of reserves transferred during the month were earmarked for divisions as part of the budget setting exercise and have therefore been allocated. The main transfers include £1.9m in respect of the 2016/17 Agenda for Change pay award and incremental uplifts, £1.2m Halton Urgent Care Centre, £1m uplift in the NHSLA premium and cost pressures agreed at budget setting of £0.8m. The drugs reserve includes the budget set aside for high cost drugs that are funded by commissioners, so the monthly budgetary transfer to divisions includes the £0.9m cost incurred by each division.

Table: Reserve movements.

Category	Opening Balance £m	Month 1 Adjustments £m	Balance Remaining £m
Income	0.1	0.0	0.1
Pay	7.0	(3.7)	3.3
Drugs	9.5	(0.9)	8.6
Clinical Supplies	1.4	(0.1)	1.3
Non Clinical Supplies	1.9	(1.2)	0.7
Total	**19.9**	**(5.9)**	**14.0**

Non Operating Income and Expenses

Non operating income and expenses is £0.9m which is in line with plan. There is an overspend on restructuring costs due to the MARS payment however this is offset by the underspend on depreciation and interest expenses.

4. CAPITAL

The annual capital programme for the year is £6.7m which is a combination of in year internally generated depreciation and a carry forward of a £0.7m underspend from 2015/16.

The Capital Planning Group is in the process of finalising the schemes that are to be included in the capital programme. These will be brought back to the Committee for approval.

The capital spend to date is £0.2m which is in line with plan as summarised in the table below.

Table: Analysis of performance against the revised capital programme.

Category	**Annual Budget £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	1.8	0.1	0.1	0.0
IM&T	1.3	0.0	0.1	(0.1)
Medical Equipment	3.6	0.1	0.0	0.1
Total	**6.7**	**0.2**	**0.2**	**0.0**

5. CASH FLOW (APPENDIX F)

The cash balance is £2.5m which is £1.3m above the planned cash balance of £1.2m, with the monthly movements summarised in the table below.

Table – Summary of monthly cash movement.

Cash balance movement	**£m**
Balance as at 1st April	2.6
In month deficit	(2.0)
Non cash flows in surplus/(deficit)	0.8
Increase in trade receivables (debtors)	(1.4)
Increase in trade payables (creditors)	2.7
Capital expenditure	(0.2)
Drawdown of interim working capital facility	0.6
Other working capital movements	(0.6)
Balance as at 30th April	**2.5**

The operating performance continues to have an adverse effect on the amount of cash available to the Trust. At 30th April 2016 the value of trade creditors stands at £11.5m, although this is partially covered by the value of trade receivables at £4.0m.

The current cash balance of £2.5m equates to circa 4 days operational cash. The liquidity metric is -23.1 days which results in a liquidity rating of 1 under the Financial Sustainability Risk Rating criteria.

Active management of the working balances continues in order to maintain a cash balance sufficient to pay creditors.

Performance against the Non NHS Better Payment Practice Code (BPPC) is 29% in the month.

The actual cash flow movements for the year to date and the forecast movements for the remainder of the year are detailed in Appendix F. The following table summarises the short term cash flow over the next 3 months.

Table: Short term cash flow movements.

Cash balance movement	**May £m**	**June £m**	**July £m**
Opening balance	2.5	1.4	2.1
In month deficit	(1.9)	(1.7)	(1.5)
Non cash flows in surplus/(deficit)	0.9	0.9	0.9
Movement in trade receivables	0.1	0.1	0.1
Movement in trade payables	(0.1)	(0.1)	(0.1)
Capital expenditure	(0.2)	(0.2)	(0.5)
Drawdown of working capital loan	1.7	1.6	1.6
Other working capital movements	(1.6)	0.1	0.1
Closing balance	**1.4**	**2.1**	**2.7**

Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance at the end of each month of £1.2m.

6. STATEMENT OF FINANCIAL POSITION (APPENDIX G)

Non current assets have decreased by £0.3m in the month as the depreciation charges exceed capital spend and there is a reduction in other receivables.

Current assets have increased by £0.1m in the month mainly due to an increase in trade receivables and prepayments partially offset by a reduction in accrued income.

Current liabilities have increased by £1.2m in the month mainly due to an increase in the trade payables partially offset by a reduction in deferred income.

Non current liabilities have increased by £0.6m in the month mainly due to the drawdown of the interim revolving working capital facility.

7. AGED DEBT (APPENDIX H)

Aged debt has increased by £0.9m in the month so as at 30th April the value of aged debt is £4.2m (with £2.3m overdue). There will be a continued focus to minimise the amount outstanding debt.

8. AGED CREDITORS (APPENDIX I)

Aged creditors have increased by £1.2m in the month. As at 30th April the value of aged creditors is £11.6m (with £6.7m overdue). The operating position reduces the amount of cash available to pay creditors in a timely manner and until the operating position improves the level of aged creditors will remain high.

9. WORKING CAPITAL LOAN

In 2015/16 the Trust secured a working capital loan of £14.2m to support the cash position resulting from the planned deficit and this loan has now been drawn down in full. The interest rate is 1.5% with interest repayments made twice yearly (May and November) and the principle repayable in full in 2018/19.

The Trust has applied for a working capital loan of £18.6m to match the planned annual deficit however until this loan application is approved the Trust has access to an interim revolving working capital facility. In April the Trust has drawn down £0.6m from this facility.

10. CAPITAL LOAN

In 2015/16 the Trust secured a capital loan of £1.6m to support the balance of the capital programme that could not be funded from internally generated depreciation or cash reserves. This loan has now been drawn down in full. The loan is repayable over 15 years at an interest rate of 1.78%. Principle and interest repayments commence in 2016/17 and will be paid twice yearly (August and February).

The 2016/17 capital programme is funded by internally generated depreciation and a carry forward of the 2015/16 underspend. There is no requirement for a capital loan in year.

11. RISK AND FORECAST

For the period ending 30th April the Trust has recorded a deficit of £2.0m, which is in line with plan. It is important that the Trust continues to focus on the mitigation of any financial risks to ensure the financial plan is delivered, namely:

- Failure to comply with all contractual data requirements, quality standards, access targets and CQUIN targets that may result in commissioner levied fines or penalties.
- Failure to deliver the income target or remain with approved budgets.
- Identified cost savings target not fully identified and delivered in accordance with profile.
- 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 Trust is on track to deliver the planned deficit of £18.6m.

12. CONCLUSION

For the period ending 30th April 2016 the Trust has recorded a deficit of 2.0m, a cash balance of £2.5m and a Financial Sustainability Risk Rating score of 2.

13. RECOMMENDATION

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

Andrea Chadwick
Director of Finance & Commercial Development
25th May 2016

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/122**	
SUBJECT:	**Corporate Performance Report M1 2016-17**	
DATE OF MEETING:	25th May 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Sharon Gilligan, Chief Operating Officer	
EXECUTIVE DIRECTOR SPONSOR:	Sharon Gilligan, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF4.1: Length of Stay; Delayed Transfers; Bed Shortages	
	BAF1.1: CQC Compliance for Quality	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This corporate report updates the Finance and Sustainability Committee on the progress of the Trust in relation to activity, performance and workforce targets to 30th April 2016.	
RECOMMENDATION:	The Board is asked to note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	Wednesday 18th May 2016
	Summary of Outcome	Noted

Corporate Performance Report

1.0 INTRODUCTION

This corporate report updates the Finance and Sustainability Committee on the progress of the Trust in relation to activity, performance and workforce targets to 30th of April 2016.

2.0 PERFORMANCE

In overall terms, based on the performance in month 1 the Trust has a Service Performance Score of 1, as highlighted in Appendix 1.

3.0 NATIONAL KEY PERFORMANCE INDICATORS

3.1 Accident and Emergency National Indicators

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
A&E & MIU	% Departed <=4hrs	>=95%	90.45%																
	Number of attendances		8818																
	Number of patients breaching 4hrs		931																

Although the Trust did not achieve the 95% four hour standard for April it did exceed the improvement trajectory of 87%. This is also a significant improvement in performance of 83.70%. Detailed breach analysis continues and actions associated with this and the revised action plan is reviewed through the four hour taskforce meeting which is chaired by the chief Operating Officer weekly. The operational teams are currently working on plans to address issues with paediatric breaches and difficulties with increased wait to be seen in the Accident and Emergency Department in the early hours of the morning. An update will be provided at the next meeting.

Ambulance Handovers

Local Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Ambulance Handovers	Number Handed over 30 to 60 mins	0	158																
	Number Handed over >60 mins	0	105																
	HAS Compliance Score		98.22%																
	Number of HAS measureable candidates		2140																
	Number handed over		1957																
	Number that needed to be handed over to hit a HAS compliance of 90%		1926																
	Variance from the number requried to hit 90%	0.00%	0																

Despite improved performance ambulance handover times are still an area for concern and work is ongoing to improve this position. HAS compliance has improved since the introduction of an ambulance liaison Officer who continues to work with both the accident and emergency staff and Ambulance crews to support more efficient handovers. The department are in the process of validating the handover data at present and a focus on handover compliance is in place.

Accident and Emergency Quality Indicators

Local Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
A&E Clinical Indicators	Total Time in A&E (95th percentile)	<=240mins																	
	Time to Initial Assessment (95th percentile)	<=15mins	69.0																
	Time to Treatment Decision (median)	<=60mins	55.0																
	Unplanned Reattendance Rate	<=5%	0.61%																
	Number of unplanned reattendances		14																
	Left Without Being Seen	<=5%	4.09%																
	Number left without being seen		351																

4hr Supporting Metrics

New metrics have been developed to support the delivery of the 4hr target, as attached in appendix 2. This is work in progress that will develop further in coming weeks to provide a dashboard covering all metrics identified in the revised recovery plan.

The AED monthly monitoring metrics which is submitted to Monitor on a monthly basis is attached as appendix 3. This is submitted on the third Friday of every month. The main area for focus is time to initial assessment to ensure that all patients are assessed within 15 minutes of arrival. This is a particular problem out of hours and something which the taskforce is working to address.

3.2 18 Week Referral to Treatment

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
RTT - 18 Weeks	Incomplete Pathways % <18 Weeks	>=90%	92.37%																
	Number of incomplete pathways		22511																
	Number of patients waiting 18+ weeks		1718																

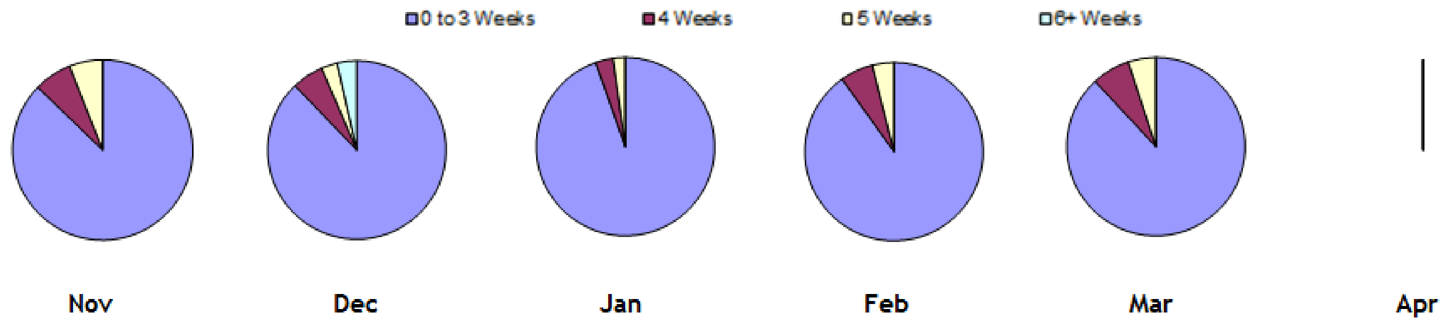
The Trust has consistently achieved the RTT targets since Lorenzo go live, but increased validation has been necessary in line with expectation. The number of patients on an incomplete pathway has increased significantly and this is being closely monitored to ensure that it is entirely a data issue. The team are working on understanding an accurate picture and then a robust plan can be put in place for a more sustainable approach to delivery for the future. The junior doctor's industrial action and associated clinic cancellations has placed additional pressure on this target. Although the April final figure has not been confirmed there is no concern that the Trust will not achieve 92% and therefore the improvement trajectory.

3.3 Diagnostics

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Diagnostics - 6+ Week Waiters	% of Patients Waiting 6+ Weeks	<1%	0.00%																
	Number of watients waiting		5025																
	No of patients waiting 6+ weeks		0																

The April position for Diagnostics is not yet available the submission date is the 18th May although there are no concerns about achieving this indicator and therefore achieving the improvement trajectory.

Diagnostic Waiters at Month End



3.4 Cancer

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
	2 Week Wait	>=93%	93.70%																
	Breast Symptom 2 Week Wait	>=93%	93.10%																
	31 Day First Treatment	>=96%	100.00%																
	31 Day Subsequent Treatment : Surgery	>=94%	100.00%																
Cancer	31 Day Subsequent Treatment : Drugs	>=98%	100.00%																
	62 Day First Treat - Urgent GP - Open Exeter	>=85%	85.00%																
	62 Day First Treat - Urgent GP - Reallocation	>=85%	85.00%																
	62 Day First Treatment - Screening	>=90%	100.00%																
	CRS 62 Day Consultant Upgrade	>=90%	100.00%																

The overall indicators for cancer have been achieved and therefore the improvement trajectory for the 62 day target has also been achieved. Appendix 4 provides a summary by month and by tumour group.

3.4 Cancelled Operations

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Non-Clinical Cancelled Operations On the Day	Number of Cancellations not offered a date for readmission within 28 days	0	3																

The CBUs have revised the standard Operating Procedure for cancelled operations to try and address some of the communication issues when operations are cancelled and need rescheduling; there have been a number of issues with medical outliers within the surgical bed base throughout April and individual CBU managers are looking at different approaches to reduce this number to support the elective program.

Local Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Non-Clinical Cancelled Operations	% of Cancelled Operations on the Day	<=2%	0.40%																
	Elective FFCEs		2978																
	Number of cancelled operations on the day		12																
	% of Cancellations Readmitted within 28 days	>=95%	86.36%																
	Number of cancellations due to be readmitted with 28 days		22																
	Number of breaches of the 28 day rule		3																

4.0 LOCAL TARGETS

4.1 Delayed Discharge

Local Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Delayed Transfers of Care	% of Delayed Transfers of Care	<=0.5%	4.95%																
	Number of delayed transfers of care (on last Thursday of the month)		27																
	Average number of occupied beds per day (exc. ITU but including Maternity)		545																
	Number of days delay in the month		444																

There continues to be delays with partner agencies in the transfer of patients out to community beds or IMCH. The main reason is that there is limited capacity in the community beds, and delays in assessments, which is escalated daily in the teleconference call. Daresbury is now operating as discharge ward and new process implemented to improve internal discharge.

21 day length of stay audit continues and compliance has remained at 100%.

4.2 DNA Management

Local Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Outpatient DNA Rate	New DNA Rate		13.44%			13.44%													13.44%
	Number of new attendances + new DNAs		8447			8447													8447
	Number of new DNAs		1135			1135													1135
	Follow-up DNA Rate		13.26%			13.26%													13.26%
	Number of follow-up attendances + follow-up DNAs		23231			23231													23231
	Number of follow-up DNAs		3081			3081													3081
	Paediatric (<18) New DNA Rate		14.59%			14.59%													14.59%
	Number of new attendances + new DNAs		1131			1131													1131
	Number of new DNAs		165			165													165
	Paediatric (<18) Follow-up DNA Rate		23.90%			23.90%													23.90%
	Number of follow-up attendances + follow-up DNAs		2000			2000													2000
	Number of follow-up DNAs		478			478													478

There has been an increase in DNAs since the introduction of Lorenzo. There have also been some issues around the patient reminder service which ceased at the end of January. A new outpatient manager is now in post and discussions are taking place around a number of options to introduce an enhanced patient reminder service.

4.3 Activity Profile

Local Indicators		Cumulative Plan	Cumulative Actual	Variance
PBR Activity	Daycase Spells	3028	2704	-10.70%
	Inpatient Spells	432	424	-1.85%
	Non-Elective Spells	2787	2741	-1.65%
	New OP Attendances (exc. Phone contacts)	6789	6026	-11.24%
	Follow-up OP Attendances (ex. Phone contacts)	16373	14280	-12.78%
	Outpatient Telephone Contacts	1527	1116	-26.92%
	Ouitpatient Procedures	3119	2873	-7.89%
	Ward Attenders	559	581	3.94%
	A&E/MIU Attendances	8901	8592	-3.47%

Work is underway to validate activity post Lorenzo implementation to ensure that all activity has been recorded and coded appropriately. Some activity was lost due to the industrial action, but this does not account for the entire variance. The Chief Operating is exploring with the management teams.

APPENDIX 1

Apr-16

Monitor Access Targets & Outcomes - 2016/17

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Threshold	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%	N/A	85.20%															
	Non-admitted patients	95%	N/A	94.41%															
	Incomplete Pathways	92%	1.0	92.19%															
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	90.45%															
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	85.00%															
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%		100.00%															
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		85.00%															
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%															
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	100.00%															
	Anti Cancer Drug Treatments	>98%		100.00%															
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	100.00%															
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.70%															
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.10%															
Clostridium Difficile - Hospital acquired (**CUMULATIVE**)	Due to lapses in care	27 (for the Yr)	1.0 **	0															
	Not due to lapses in care			0															
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			1															
	Under Review			1															
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No															

This is not the final RTT position for April, the validation process is ongoing and is due to be completed early week commencing 16/05/2016. The return is not due for submission to the DH until 19/05/2016.

Cumulative
Qtr1: 7 Qtr2: 14
Qtr3: 21 Qtr4: 27

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		No															
Date of last CQC inspection	N/A		Jan-15															
CQC compliance action outstanding (as at time of submission)	N/A		No															
CQC enforcement action within last 12 months (as at time of submission)	N/A		No															
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No															
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A	Report by Exception	Requires Improvement															
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No															
Overall rating from CQC inspection (as at time of submission)	N/A		No															
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		No															
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No															
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A																	
Service Performance Score			1.0															

We are in breach to a number of regulated activities as a result of the CQC Inspection in January 2015 and the subsequent report to which the Trust reviewed and agreed.

An action plan is in place that is being monitored at Trust, Commissioner, NHS England (North West) and Monitor level.

Until such time that the CQC revisit the Trust and re-inspect our services and provide a subsequent report to say that we are now compliant with the Regulations (or not) the red/amber rating is this section will remain in place.

NHS foundation trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action

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 Risk Assessment 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.

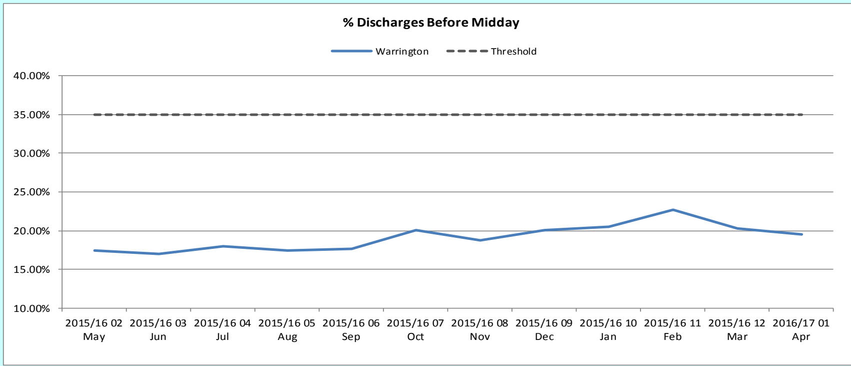
Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit	No
If a trust exceeds the de minimis limit, but remains within the in-year trajectory# for the national objective	No
If a trust exceeds both the de minimis limit and the in-year trajectory for the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

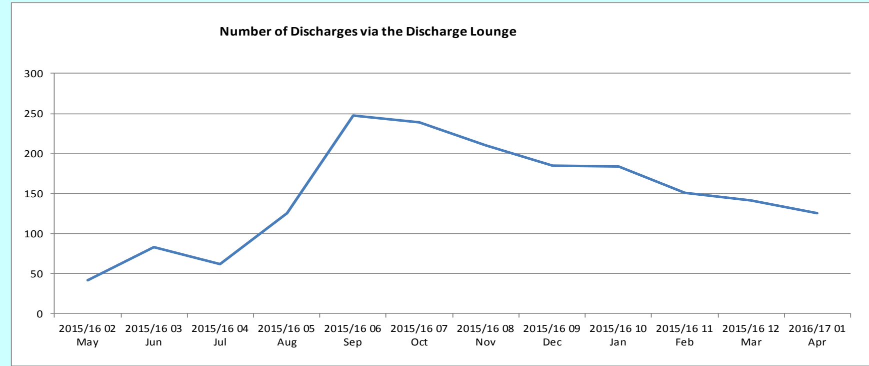
Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).
Monitor will not accept a trust's own internal phasing of their annual objective or that agreed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

APPENDIX 2

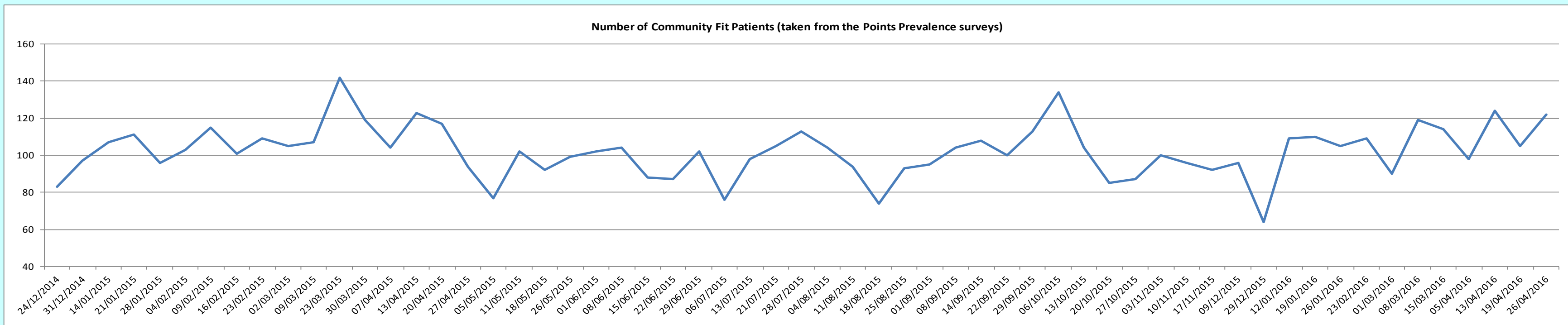
4hr Supporting Metrics

Increase Discharges Before Midday

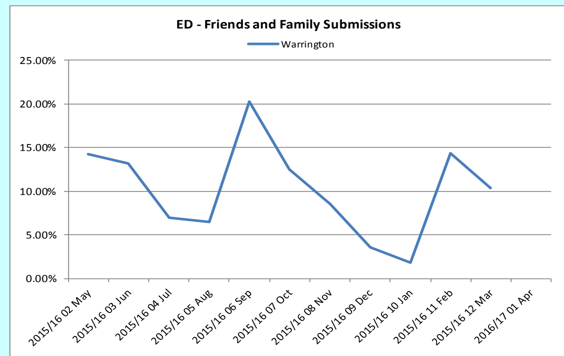


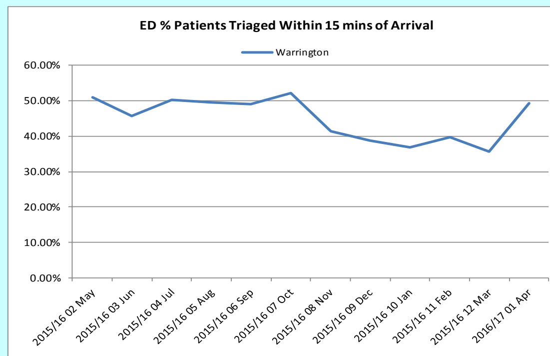


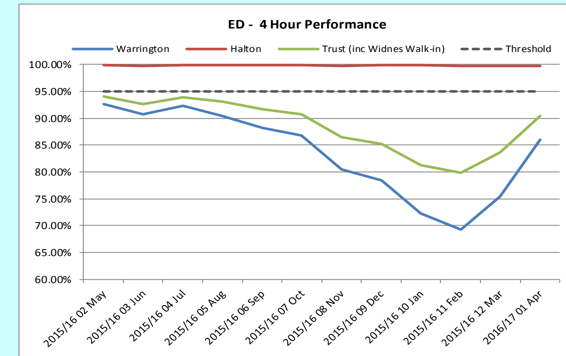
Reduce the Number of Community Fit Patients



Reduce the Overall Waiting Time for Patients in ED

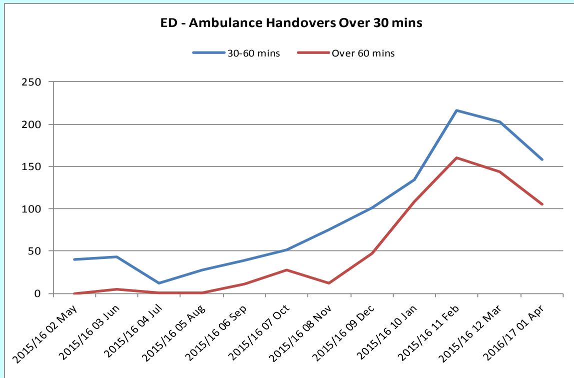


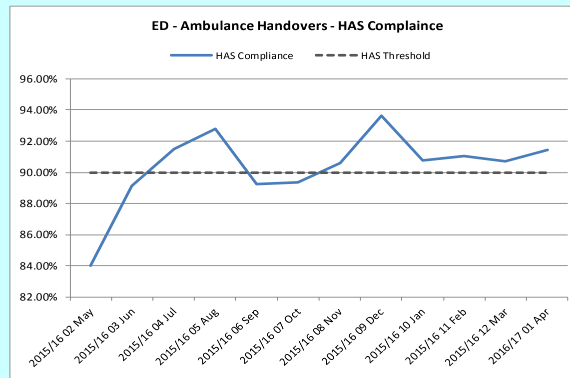


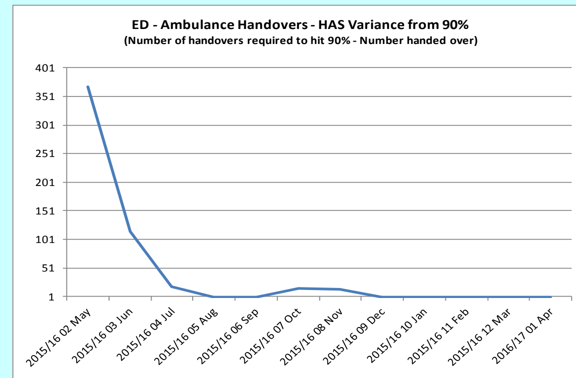


APPENDIX 2

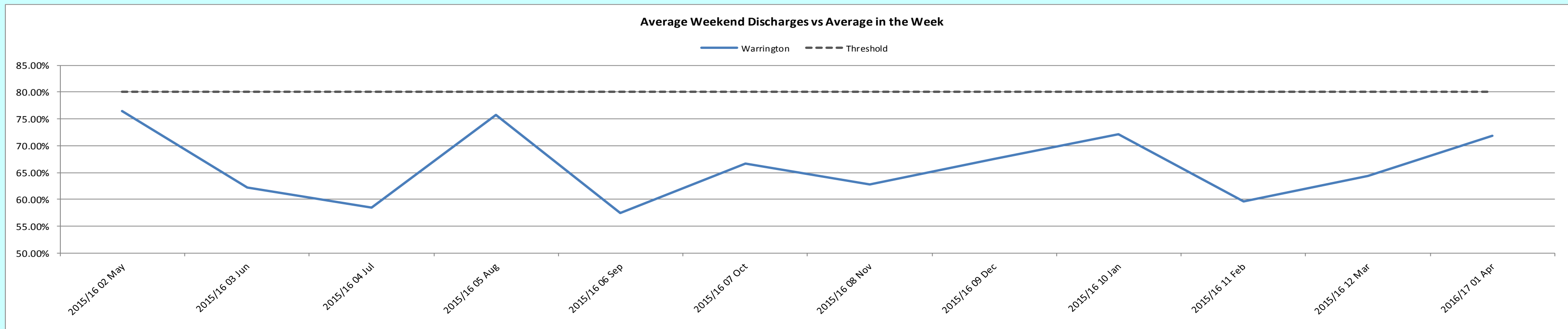
Reduce the Ambulance Handover Time



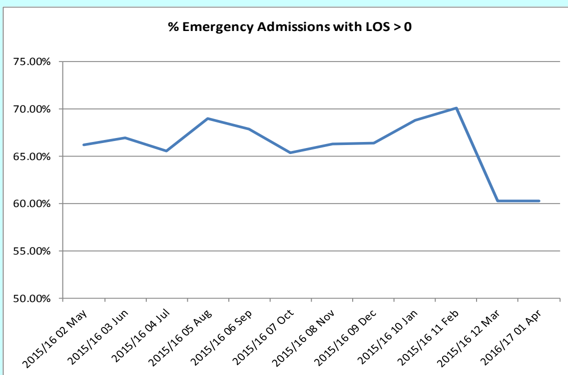


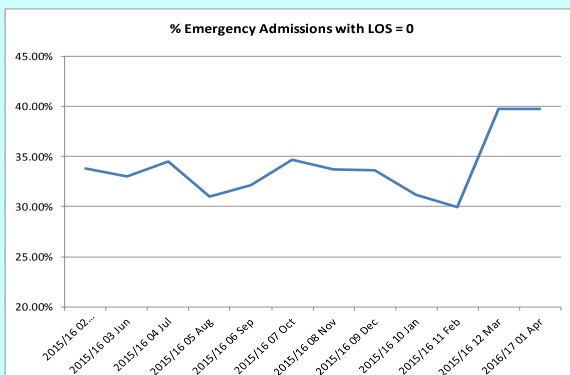


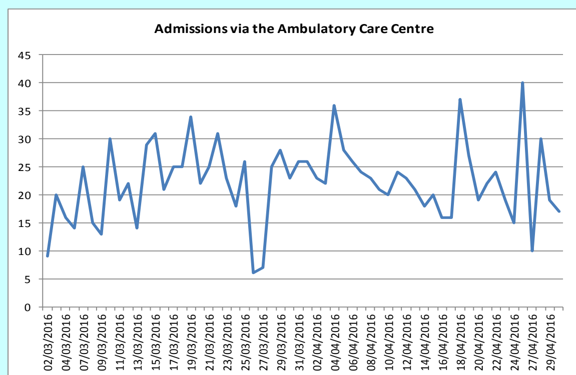
Increase the Number of Discharges at the Weekend



Increase the Use of Ambulatory Care







APPENDIX 3

Warrington and Halton NHS Foundation Trust - 2016/17

AED monthly monitoring metrics for Monitor

#	Metric	Target trajectory	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4
1	A&E 4 hour wait target (including walk-in activity from Widnes from August)	95% by end of Sept 2015	90.45%															
2a	Median time to initial assessment in AED	Q2 <70mins Q3 <65mins Q4 <60mins	13.0															
2b	95th percentile time to initial assessment in AED	Q2 <120mins Q3 <110mins Q4 <100mins	69.0															
3	Median time to treatment in AED	Q2 <200mins Q3 <190mins Q4 <180mins	55.0															
4	Medical outliers on last day of the month / quarter	<10 patients by end of Sept 2015	11															
5	% discharges taking place before midday (average for month / quarter)	Q2 20% Q3 28% Q4 35%	18.34%															
6a	NHS attributable DToC (patients)	Q2 15 patients Q3 10 patients Q4 5 patients	25															
6b	NHS attributable DToC (days)	Q2 45 days Q3 30 days Q4 15 days	397															
6c	External partner attributable DToC (patients)	Q2 50 patients Q3 40 patients Q4 30 patients	2															
6d	External partner attributable DToC (days)	Q2 150 days Q3 120 days Q4 90 days	47															
7	% of patients in hospital for 21 days who receive an MDT case note review	Q2 40% Q3 60% Q4 80%	88.13%															

APPENDIX 4

2016/17 Cancer Performance

Trust

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
All Cancers:31-day wait for second or subsequent treatment	Surgery	94%	100.00%																
	Anti Cancer Drug Treatments	98%	100.00%																
	Radiotherapy	94%																	
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	85.00%																
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%	100.00%																
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%	85.00%																
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%	100.00%																
All Cancers: 31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
Cancer: Two Week Wait From Referral To Date First Seen	All Cancers	93%	93.70%																
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	93%	93.10%																
All Cancers: 62-day wait for First treatment - Consultant Upgrade			100.00%																

APPENDIX 4

Breast

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	96.50%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	100.00%																
	Screening Service referral	90%	100.00%																
	Consultant Upgrade		0.00%																

Breast Symptomatic

National Targets and Minimum Standards	Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	Jun	YTD
2 Week Wait	93%	92.80%																
31-Day Wait From Diagnosis To First Treatment	96%	100.00%																

Dermatology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	0.00%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	0.00%																
	Consultant Upgrade		0.00%																

Gynaecology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	95.60%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	100.00%																
	Screening Service referral	90%	100.00%																
	Consultant Upgrade		100.00%																

Haematology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	100.00%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	100.00%																
	Consultant Upgrade		0.00%																

APPENDIX 4

Head & Neck

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	90.00%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%																	
	Consultant Upgrade		0.00%																

Lower GI

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	91.40%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	88.90%																
	Screening Service referral	90%	100.00%																
	Consultant Upgrade		0.00%																

Upper GI

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	92.60%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	80.00%																
	Consultant Upgrade		0.00%																

Respiratory

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	90.90%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	85.00%																
	Consultant Upgrade		100.00%																

APPENDIX 4

Sarcomas

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	0.00%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	0.00%																
	Consultant Upgrade		0.00%																

Urology

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	92.00%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	94.70%																
	Consultant Upgrade		100.00%																

Other

National Targets and Minimum Standards		Target	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4	YTD
2 Week Wait		93%	100.00%																
31-Day Wait From Diagnosis To First Treatment		96%	100.00%																
62-day wait for First treatment	From urgent GP referral	85%	0.00%																
	Consultant Upgrade		0.00%																

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/123**
SUBJECT:	**Monitor Declaration - Systems for Compliance with Licence Conditions - in Accordance with General Condition 6 of the NHS Provider Licence**
DATE OF MEETING:	25th May 2016
ACTION REQUIRED	**For Decision**
AUTHOR(S):	Angela Wetton, Company Secretary
EXECUTIVE SPONSOR:	Angela Wetton, Company Secretary
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None
EXECUTIVE SUMMARY (KEY ISSUES):	NHS Foundation Trusts are required to make the following declarations to Monitor relating to Systems for compliance with licence conditions – in accordance with General Condition 6 of the NHS provider licence
RECOMMENDATION:	

PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

BACKGROUND

NHS Foundation Trusts are required to make the following declarations to Monitor:

1&2	Systems for compliance with licence conditions – in accordance with General Condition 6 of the NHS provider licence
3	Availability of resources and accompanying statement – in accordance with Continuity of Services condition 7 of the NHS provider licence
4	Corporate governance statement – in accordance with the Risk Assessment Framework
5	Certification on AHSCs and governance – in accordance with Appendix E of the Risk Assessment Framework
6	Certification on training of Governors – in accordance with S151(5) of the Health and Social Care Act

WHEN

Declaration 3 was included in the Annual Plan 2016/17 Financial Template which was submitted to Monitor during April 2016.

Declaration 5 is not applicable as the Trust is not/does not host an AHSC (Academic Health Science Centre).

Declarations 1&2 are set out in this report for the Board to consider and Sections 4&6 will be considered at the June Board Meeting.

FOR CONSIDERATION

Declaration 1 states

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended 2015/16, the Licensee took all such precautions as were necessary in order to comply with

a. the conditions of the licence;

Response: Not confirmed

Comment: During the financial year 2015/16 the Trust was subject to an enforcement notice under S106 of the Health and Social Care Act 2012.

b. any requirements imposed on it under the NHS Acts; and

Response: Confirmed
Comment: There were no additional requirements imposed under the NHS Acts during 2015/16

c. have had regard to the NHS Constitution in providing health care services for the purposes of the NHS

Response: Confirmed

Comment: The Trust continues to have regard to the provisions contained within the NHS Constitution through the formulation and adoption of trust policies and procedures. The NHS constitution is in line with the Trust's overall vision of high quality care for all using the QPS framework. The Trust governance structure reflects the needs of the NHS constitution and the rights of patients, service users and staff. Assurance on this is via the CQC monitoring that we have in place.

Declaration 2 states

The board declares that the Licensee continues to meet the criteria for holding a licence.

The two criteria for holding a Licence are:
1. the Trust must be registered with the Care Quality Commission (CQC); and
2. the directors or governors of the Trust must meet Monitor's fit and proper test.

For the purposes of the Monitor Licence someone who is not a fit and proper person would fall within the following categories:

- be an undischarged bankrupt;
- have undischarged arrangements with creditors;
- be subject to a moratorium period under a debt relief order;
- have received a prison sentence of three months or longer during the previous five years;
- be subject to a disqualification order or undertaking

Response: Confirmed

Comment: During the financial year 2015/16 the Trust remained registered with the CQC and all the directors and governors met Monitor's fit and proper persons test.

NEXT STEPS
Once the declarations have been agreed by the board, the document will be signed on the Board's behalf by the Chairman and Chief Executive and electronically submitted to Monitor by the 31st May 2016.

RECOMMENDATION

- **The Board agrees the suggested declarations and responses and requests that the Company Secretary ensures the document is completed and uploaded to Monitor by the 31st May 2016.**

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/123**	
SUBJECT:	**Senior Information Risk Owner (SIRO) Report 2015-16**	
DATE OF MEETING:	25th May 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Mark Ashton, Information Governance & Corporate Records Manager	
EXECUTIVE DIRECTOR SPONSOR:	Jason DaCosta, Director of IM&T	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.3: Clinical & Business Information Systems	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report summarises the key themes of the work undertaken by the Information Governance and Corporate Records Sub-Committee during 2015/16.	
RECOMMENDATION:	It is also designed to provide the IG and Corporate Records Sub-Committee (IGCRSC) members with an overview on the organisational compliance with legislative and regulatory requirements relating to the handling of information, and the management of information, risk including compliance with the Data Protection Act 1998 and the Freedom of Information Act 2000.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

EXECUTIVE SUMMARY

This assurance report is provided by the Senior Information Risk Owner who has executive responsibility for information risk and information assets. In order to demonstrate compliance with IG Toolkit standards and to ensure the Board is adequately briefed on information risks it is necessary to provide a report detailing identified information risks and progress against the IG Toolkit standards more generally. The Senior Information Risk Owner is required to act as an advocate for information risk on the Trust Board and is responsible for providing appropriate content for inclusion in the Statement of Internal Control (SIC).

INFORMATION GOVERNANCE MANAGEMENT

The Information Governance and Corporate Records Sub-Committee (IGCRSC), which is chaired by the Director of IT (SIRO) and is attended by the Caldicott and Deputy Caldicott Guardians respectively, makes recommendations, produces policy and procedural documentation and agrees the annual IG work programme.

The IGCRSC terms of reference and the Trust's Information Governance Framework were re-drafted and submitted for ratification in May 2016. The terms of reference was re-drafted to include membership changes within the group which include the addition of the Information Asset Owners for key systems. The IG framework was modified to include changes to the key governance bodies and IG policies. The IG and Corporate Records Sub-Committee reports to the Finance and Sustainability Committee.

2016 MIAA IG TOOLKIT REVIEW

The Trust is audited annually by the Mersey Internal Audit Agency on its management of the Information Governance agenda. In 2016 MIAA awarded the Trust a significant assurance rating against the attainment levels submitted against version 12 of the Information Governance Toolkit in March 2016. During the March 2016 audit the Trust was audited on 15 sample requirements of the intended March 2016 IG Toolkit submission. The audit sample used in this year's audit constitutes an audit of 33% of the total IG Toolkit requirements for Acute Trusts.

The results of the 2016 audit are summarised in the table below.

Self-Assessment Score	Our Opinion		
	Agreed	Unsubstantiated	Overstated
Not Relevant	-	-	-
0	-	-	-
1	2	-	-
2	13		-
3	-	-	-

Conclusion

The Trust is scoring below minimum required compliance in two requirements. It is recognised that senior management have been informed and plans have been put in place to mitigate the risk.

In light of the findings the level of assurance provided is:

Significant

IG AND ISMS POLICIES STATUS

The Trust's Information Governance policies (listed below) have been reviewed and the content changed as necessary. The policies were approved by the Information Governance and Corporate Records Sub-Committee in 2015.

- The Information Governance and Corporate Records Strategy and Policy
- Data Protection and Confidentiality Policy
- Mobile Communication Policy
- Policy for the Management of Corporate (non-clinical) Records
- Freedom of Information Policy
- IT Acceptable Use Policy
- Information Security Management Policy

In addition to the above corporate policies the Trust's IT department maintains an Information Security Management System (ISMS). The ISMS is a detailed suite of operating procedures and standards used to ensure good practice in the secure management of:

- Networks
- Remote Access
- Access and Authentication to Networks
- Anti-Virus and Housekeeping
- Business Continuity
- Incident Response (Incl Legal and Forensics)
- System Risk Assessment
- Mobile Devices Security

- Encryption
- IT Procurement
- IT Asset Management

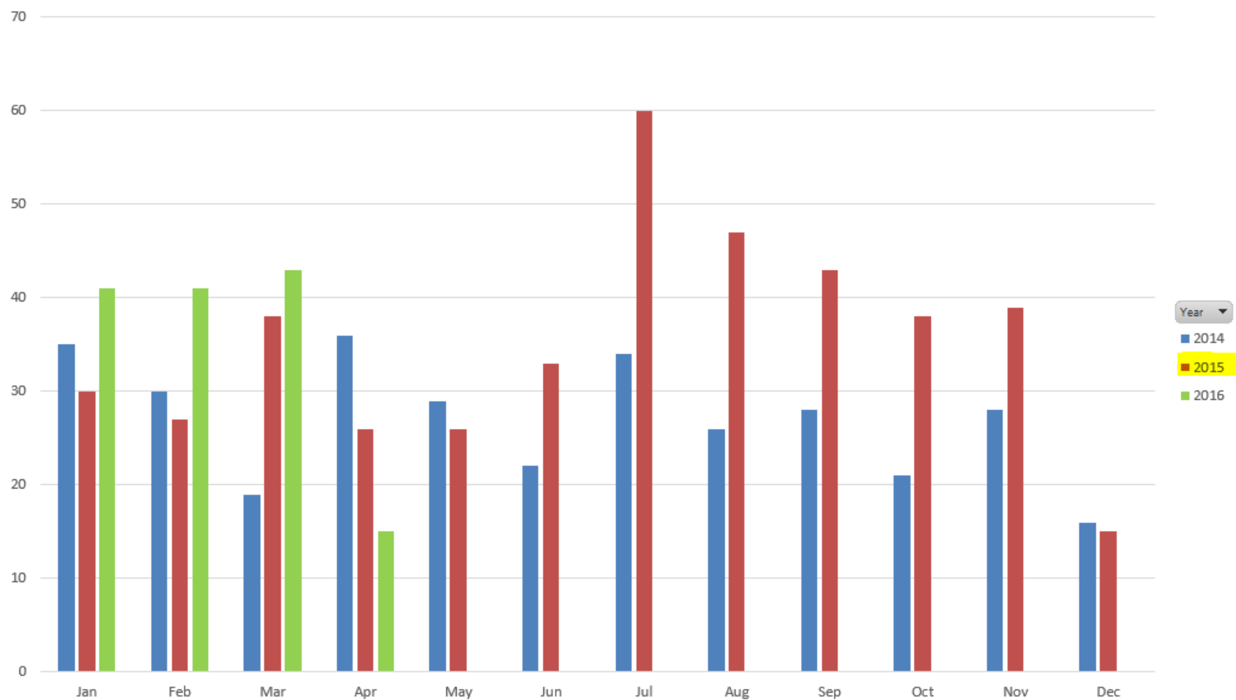
ISMS audits and progress on the maintenance of the Information Security Management System were reported on during 2015 at the IGCRSC. 8 of a total of 37 pieces of ISMS documentation and associated processes require review.

A report on the effectiveness of the Information Security arrangements within IT will be presented at the July 2016 meeting of the IGCRSC.

2015 FREEDOM OF INFORMATION PERFORMANCE

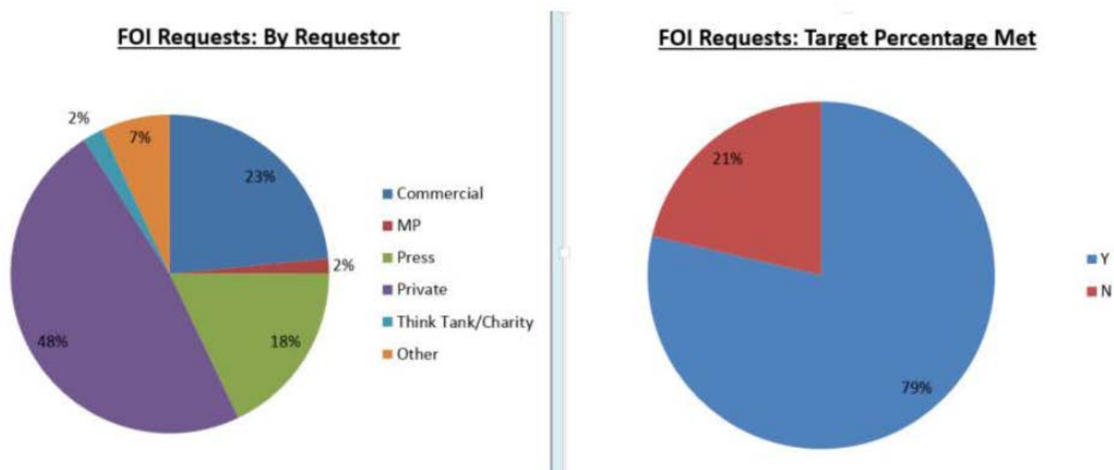
The Trust received 538 Freedom of Information requests in 2015 as opposed to the 481 requests handled under the 2000 Act in 2014. This represents the highest total of requests received by the Trust since the introduction of the legislation in 2005. 79% of Freedom of Information requests were answered within the statutory timeframe of 20 working days. The volume of requests handled in 2015 when compared with 2014 represents an 11.8% increase.

FOI REQUESTS YEARLY COMPARISON



Since 2010 the Trust has seen a 121% increase in Freedom of Information requests handled when compared with the quantity of requests received in 2015. In 2015 admin support to deal with the burgeoning FoIA 2000 agenda was appointed. This appointment contributed to an increase in the quantity of requests answered within the 20 working day statutory timescale which increased from 67% in 2014 to 79% in 2015.

2015 FoIA 2000 REQUESTS STATISTICS



The Trust should endeavour to improve upon the FoIA compliance levels achieved in 2015 and as a minimum should maintain compliance with the 20 day statutory timescales for final responses in 75% of cases.

2015 SUBJECT ACCESS PERFORMANCE

Subject Access Requests are handled by the Trust's Medico-Legal Team based in the Medical Records department. During 2015 the Trust received 2,011 requests for access to personal information made under the Data Protection Act 1998 and the Access to Health Records Act 1990.

The Trust's Outpatients and Health Records staff and Business Change teams within the IT Department are currently working with CSC in reviewing the end-to-end Subject Access Request functionality within the Lorenzo system. The Trust's Medico-legal team are using legacy systems to meet the legal requirements of the Data Protection Act 1998 in relation to the subject access process.

EXTERNALLY REPORTABLE DATA LOSS INCIDENTS

In the period January 2015 to date the Trust has reported 8 incidents of data loss to the Health and Social Care Information Centre. One of the incidents was categorised as a level 2 SIRI (serious incident requiring investigation) by the HSCIC and as a result this incident was reported to the Information Commissioner's Office. In April 2016 the ICO issued a decision in relation to this incident which stated that the incident did not necessitate further action.

SUMMARY OF DATA LOSS INCIDENTS JANUARY 2015 TO DATE

Date of Incident	ID	IG SIRI Level	Status	Summary of Incident	
03-Mar-16	IGI/5228	2	Closed	ward handover sheets found in former home of carer employed at the Trust.	Edit
11-Jan-16	IGI/4986	1	Closed	GP letter enclosed in letter to patient	Edit
08-Nov-15	IGI/4724	1	Closed	adoptive parents given details of previous foster parents of adopted child	Edit
15-Sep-15	IGI/4531	1	Closed	faxed referral from screening team sent to wrong service	Edit
19-Aug-15	IGI/4157	1	Closed	A Clinical Assessment and Treatment Service letter relating to patient A was sent to patient B in error. The letter contained the name, NHS number and address of patient A. The patient whose details were disclosed in error has been informed.	Edit
07-Aug-15	IGI/4155	1	Closed	alphabetical list of patients found by member of the public. 12 patients details were contained within the list incl name, dob and local hospital identifier. No clinical details were included.	Edit
17-Feb-15	IGI/3183	1	Closed	one statement last in transit between minor injuries team and police liaison	Edit
14-Jan-15	IGI/3113	1	Closed	Letter (medical history) sent to incorrect recipient which was a health clinic that was not the patients correct practice.	Edit

INFORMATION RISK MANAGEMENT AND ASSURANCE

The Trust's IT Team maintains a register of Information Assets and Information Asset Owners for key systems have been identified. The key IT systems supported by the Trust's IT Department and the respective Information Asset Owners are shown in the below table.

Key System	Department	Information Asset Owner
CIRIS	Governance	James Manders
Datix	Governance	James Manders
Data Warehouse (DWARF)	IT	Chris White
DAWN AC	Pharmacy	Maria Keeley
ESR/ESVL	HR	Steve Evison

E Rostering	Corporate Nursing	Angela Madigan
Ensemble Interface Engine	IT	Chris White
IT Infrastructure Server/Storage/SAN	IT	Stephen Deacon
I Bleep	Corporate Nursing	Tracey Mason
JAC	Pharmacy	Maria Keeley
Lorenzo	IT	Sue Caisley
Lorenzo Extensions (ePR Extensions)	IT	Sue Caisley
MiCheckin	IT	*yet to go-live
N3 Network	IT	Stephen Deacon
ORMIS	Theatres	Mark Rigby
PACS	Radiology	Gareth James
RIS	Radiology	Gareth James
Savience ED Kiosks	ED	Roy Bhati
Sunquest ICE	Pathology	Deborah Egerton
Sysmex MOLIS	Pathology	Neil Gaskell
SBS	Finance/Supplies	Katie Armstrong
Unisoft GI Reporting	Endoscopy	Tom Liversedge/Karen Smith
Virtual Desktop Integration	IT	Stephen Deacon
WHH Network	IT	Stephen Deacon

Information Asset Owners are responsible for risk assessing business critical systems and completing the role specific training NHS Information Risk Management for SIROs and IAOs on an annual basis. The list of key systems and Information Asset Owners was agreed at the IGCRSC in March 2016.

Information risks for both Information Technology and Information Governance are managed via the CIRIS Governance compliance system. Information risks are reviewed on a monthly basis and actions are updated and reviewed as necessary.

SECURITY OF PAPER CORPORATE RECORDS

In order to comply with the Corporate Information Assurance initiative within the Information Governance Toolkit the Trust must audit corporate records in at least 4 areas of the organisation.

Audits of records in corporate areas and the arrangements for secure storage and disposal are reported routinely to the Information Governance and Corporate Records Sub-Committee

Corporate records assurance will continue to be submitted to the Information Governance and Corporate Records Sub-Committee in 2016 as part of the IG annual workplan. Action plans to address areas of weakness are included in the corporate records documentation submitted to the IGCRSC.

The Trust's off-site corporate records are managed via the FileLive system which is a web-based product supplied by DataSpace, the Trust's contracted off-site records management partner. DataSpace are accredited to the BS27001 standard for Information Security Management Systems.

The Trust has 23 users of the FileLive system. These users are able to arrange for collection and return of documents to and from the secure off-site storage facility. They are also required to add retention and destruction dates for corporate records they are responsible for. Reports indicating the destruction dates of corporate records have been distributed to the following departments in 2015 with a request that destruction dates are enforced in line with *Records Management: NHS Code of Practice 2009.*

- Finance
- Corporate Nursing
- Governance
- HR (incl Medical Staffing)
- Occupational Health
- Payroll
- Research and Development
- Catering

A non-compliance action plan was distributed to staff in late 2015 in relation to the corporate records they are responsible for. The audit undertaken highlighted some areas of weakness which are included in the table below.

Area Reviewed	Recommended Action	Review Date
Estates	• Department reminded to maintain up-to-date records schedule	Corporate Records Report IGCRSC July 2016
Facilities	• Facilities to review storage and retention arrangements for contracts held by the department • Review of Halton site storage arrangements to be conducted	Corporate Records Report IGCRSC July 2016
Finance	• Comprehensive destruction register to be kept for all	Corporate Records Report

	future records destruction	IGCRSC July 2016
HR/Medical Staffing	• Storage of Medical Staffing information in Block 10 Halton site to be reviewed • Medical Staffing Manager asked to update records destruction schedule	Corporate Records Report IGCRSC July 2016

IG TRAINING

76.32% of the Trust's staff received Information Governance training in 2015/16. Training is delivered as part of the mandatory training programme, in departmental sessions and the option to complete electronic training via the NLMS is provided. It is a requirement of the IG Toolkit training standard that all new starters receive IG training.

The following subject areas have been covered in IG mandatory sessions to support level 1 compliance with the IG Toolkit training standard.

- Data Protection and Caldicott principles
- Person identifiable data items
- Access to Health Records and Subject Access Requests
- Keeping patients informed of use of PID
- Freedom of Information Act 2000
- Password Management
- NHS mail/Secure Email use
- Secure disposal of person identifiable data
- Key IT Systems and Risk Assessments
- Identity of Caldicott Guardian/SIRO
- Safe Haven FAXs/Encrypted Trust-issued media
- IG/IT Policies
- Availability of IG guidance on the intranet (HUB)
- Reporting DP incidents via Datix

LEARNING AND IMPROVEMENT FOR 2016/17

- Address the findings of the 2015/16 IG audit performed by Mersey Internal Audit
- Attain level 2 status for remaining IG Toolkit standards which are currently rated at level 1
- Further raise the profile of IG across the organisation to drive compliance and embed good practice across the organisation
- Consolidate work completed in managing off-site corporate records electronically by purging on-site corporate records
- Increase engagement with Information Asset Owners and provide content for IAO job descriptions to reflect their responsibilities to document information risks

- Expand asset list of key information assets and report regularly on risks to key assets identified

CONCLUSION

The Trust is currently not compliant with all standards contained within version 13 of the HSCIC Information Governance Toolkit. It should be a priority to attain the level 2 standard across all IG Toolkit standards during 2016/17.