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Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting – Part 2

Wednesday 31 May 2017
1.00pm – 3:45pm
Trust Conference Room

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Warrington and Halton Hospital NHS Foundation Trust

Agenda for a meeting of the Board of Directors held in public.

Wednesday 31 May 2017, time **13:00 -3.45pm**

Trust Conference Room, Warrington Hospital

REF BM/17	ITEM	PRESENTER	PURPOSE	TIME	
	1. Welcome the Pilot Nurse Associates 2. Patient Story Orthoptics + Ophthalmology, Tracey Parry, Specialist Orthoptist		Information	1.00 1:10	
BM/17/05/56	Welcome, Apologies & Declarations of Interest	Terry Atherton Deputy Chair	N/A	1.30	Verbal
BM/17/05/57	Minutes of the previous meeting held on 26 April 2017 and 24 May 2017	Terry Atherton Deputy Chair	Decision		Encl
BM/17/05/58	Actions & Matters Arising	Terry Atherton Deputy Chair	Assurance		Encl
BM/17/05/59	Chief Executive's Report	Mel Pickup Chief Executive	Assurance	1.40	Verbal
BM/17/05/60	Chairman's Report	Terry Atherton Deputy Chair	Information	1.55	Verbal

Quality People Sustainability

BM/17/05/61	Integrated Performance Dashboard April 2017 Including (b) Nurse Staffing Report and Key Issues Reports for: (d) Quality Governance Committee 2.5.2017 (e) Finance & Sustainability Committee 24.5.2017 (f) Audit Committee Chairs Annual report + Key Issues report 24.4.2017 (g) Charitable Funds Committee 7.4.2017 Enc	All Executive Directors M Bamforth, Committee Chair Terry Atherton, Committee Chair Ian Jones, Committee Chair Ian Jones, Committee Chair	Assurance	2.05	Encl
BM/17/05/62	Annual Health & Safety Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	2.50	Encl
BM/17/05/63	Quarterly Mortality Report	Alex Crowe Deputy Medical Director	Assurance	3.00	Encl
BM/17/05/64	Quarterly Complaints Improvement Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	3.10	Encl
BM/17/05/65	(a) Risk Management Strategy (b) Monthly Strategic Risk Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	3.20	Encl
BM/17/05/66	Any Other Business	Terry Atherton, Deputy Chair	N/A	3.40	Verbal
	Date of next meeting: Wednesday 28 June 2017				

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Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in Public (Part 2) on Wednesday 26 April 2017 Trust Conference Room, Warrington Hospital	
Present	
Steve McGuirk (SMcG)	Chairman
Terry Atherton (TA)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Andrea Chadwick (AC)	Director of Finance and Commercial Development
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Jan Ross (JR)	Deputy Chief Operating Officer
Alex Crowe (AC)	Deputy Medical Director
Bradley Palin	Clinical Business Unit Manager – Diagnostics
Louise Harding	Clinical Tutor/Advanced Practitioner Radiographer
Alison Davis	CBU Clinical Director
Paula Evans	Clinical Lead and Advanced Practitioner Radiographer
Maureen Taylor	Clinical Lead and Advanced Practitioner Radiographer
Angela Millward	Radiology Business Support Manager
Observing	
Norman Holding	Lead Public Governor
Susan Kennedy	Public Governor
Apologies	
Mel Pickup	Chief Executive
Sharon Gilligan	Chief Operating Officer
Simon Constable	Medical Director + Deputy Chief Executive
Roger Wilson	Director of Human Resources and Organisational Development

Agenda Ref BM/17/04/	
BM 17/04	The Board Meeting opened with a presentation from Diagnostics Clinical Business Unit in which colleagues shared the significant progress and their successes over the last year. They had been voted as an excellence for Training for Junior Radiologists in the NW. Extending the roles for radiographers within the Advanced Practitioner training framework enabling staff to have access to a clear career progression with support for training and development. The team work closely with Boot out Breast Cancer Campaign and at a recent event had raised £65,000k. Plans for 2017-18 include replacement MRI scanner and new service developments to contribute to quality, safe services and enhance patient experience. As part of their 'What matters to you' campaign, 57 staff responded and results will be published and analysed against the staff survey. SMcG thanked colleagues for their comprehensive overview of their work and successes and proposed that a similar presentation is made to the Patient Experience Committee to

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	triangulate information with the Patient Experience Strategy and that the Governors as part of their Observation Ward Rounds could visit the department as a means to ensuring that feedback is fed back through the appropriate routes.
BM 17/04/38	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting, welcomed Jean-Noel Ezingeard to his first Board meeting and welcomed those in attendance. Apologies: as above. Declarations of Interest: none declared in respect of agenda items.
BM 17/04/39	**Minutes of the Previous Meeting Held on 29 March 2017** Page 9. First bullet point to read winter pressures of £8k-£11k per day. Second bullet point – to read.. cash balance of £2.0m. Penultimate point – to read.. revaluation exercise anticipated to reduce capital charges. Page 9 – CIP. Second bullet point to read £1m delivered over final quarter to date With these amendments, the minutes of the meeting held 29 March 2017 were agreed as an accurate record.
BM 17/04/40	**Actions and Matters arising** All actions were reviewed. Actions that were on today's agenda were closed.
BM 17/04/41	**Chief Executive Report** The Chief Executive will provide a written report following the meeting.
BM 17/04/42	**Chairman's Report** Due to impending General Election and the Trust being in Purdah, the Chairman will provide a comprehensive report at the next meeting
BM 17/04/43	**Integrated Performance Report Dashboard (March)** The Executive Directors each presented the performance metrics relating to their portfolios of responsibilities which included workforce and quality KPIs, and the following points were highlighted: **Quality:** The Deputy Medical Director (SC) and Chief Nurse (KSJ) took the Board through the Quality highlights of the dashboard, the Deputy Medical Director summarised: - MRSA – zero tolerance maintained, following outbreak on Ward A8 of CDT a deep-clean had taken place and weekly monitoring is taking place with Clinical Lead Nurses and Deputy Chief Nurse to reassess use of antibiotics and the work environment. - 24 Hospital apportioned cases of CDiff reported, which is below the annual threshold. 8 cases removed from contractual sanctions and Q4 cases to be reviewed in May with potential to remove a further 11 from contractual sanctions. - Mortality – the Trust is not an outlier. The Mortality Review Group taking this work forward.

The Chief Nurse summarised the Quality indicators:

- High Risk incidents – YTD 46 reported, 8 SUIs reported in March. Two surgical never events reported in March. Safer surgery had been included as a quality indicator within the Quality Accounts being chosen by the Council of Governors.
- Safety Thermometer – above 95% trajectory in March due to the addition of a new validation process to ensure accurate and timely data collection and submission.
- SEPSIS – CQUIN validation for Quarter 4 is on-going and validation of figures will be provided in next month's report. SEPSIS Nurse had commenced in post. SEPSIS Committee had been established and will be Chaired by the Deputy Chief Nurse. A key workstream will be to ensure that plans are in place to support winter screening in A&E.
- Falls - falls prevention had been included as a quality priority in the Quality Accounts. Pilot schemes underway on wards to test initiatives to reduce falls on including use of coloured slippers and blankets to easily identify patients at risk of falls. An MDT team is in place to review all falls and ensure preventative measures are put in place. These measures have seen reduction on Wards A7 and C21 and will now be replicated on other wards. Mobile PCs have been introduced on two wards for use in bays to ensure that nursing staff can remain at the bedside to complete records. An evaluation will take place, led by the Falls Nurse who will commence with the Trust in June. The Falls Action plan has oversight by the Quality Committee.
- Pressure Ulcers – improvement work continues. One Grade 4 and 7 Grade 3 pressure ulcers reported against improvement priority threshold >=3. A Tissue Viability External review had been undertaken and findings will be reported to the Quality Committee.
- Trial of beds and mattresses previously reported had been completed and business cases are being prepared for new equipment.
- Friends and Family – achieved 96% in March against trajectory of 95% due in part to renewed awareness raising and support in patient areas when completing documentation. A new company had been commissioned, Healthcare Communications, to support initiatives already in place and report on actual patient feedback providing improved data to inform future reports.
- Friends and Family A&E - Improvements reported since January. Monthly threshold of 87% exceeded for 2 months. Response rates increasing with 298 returns in February and 392 in March.
- Complaints – nine active cases with the PHSO, 42 re-opened/dissatisfied cases and 200 cases awaiting a first response. 60 complaints signed off last month. Oversight Committee established, Chaired by SMcG to oversee progress.
- Nurse Staffing – staffing resource is managed across the Trust on a shift by shift basis to ensure patient safety at all times to mitigate shift falls below 90%. Acuity and dependency review underway with Allocate and Ward teams and results will be included in the report to the Quality Committee. Staffing will be part of the ongoing Board report/ IPR.
- Discussion took place regarding the Acuity tool. KSJ added that the use of the Safer Nurse Tool Kit will allow staff to be reallocated to Wards as required in a timely manner. The Acuity Tool is being rolled out across both Divisions.
- Reference was made to the staffing figures in the report on the Neonatal Unit. KSJ

reassured the Board that NICU and ICU are staffed flexibly according to acuity and dependency/ bed and cot capacity. MB added that staff on neonatal had raised capacity issues during a Front Line visit which then impacted on opportunities for staff to undertake training away from the Ward as a result of capacity issues. KSJ commented that establishment on wards is under review to move to longer days to provide additional capacity on NICU and pathway redesign for some babies that could be cared for on maternity.

The Deputy Chief Operating Officer(JR) took the Board through the Performance highlights of the dashboard:

- 6 weeks diagnostic waiting time – Trust had achieved 100% against a trajectory of 99%, and has consistently achieved throughout the year. The deputy Chief Operating Officer made reference to the team who had presented and the hard work that goes into achieving this target.
- 18 RTT - Open pathways continued to achieve above the 92% target. Incomplete pathways target achieved of 93.01% in March against trajectory of 92% and a final year position of 93.13%. JR informed the Board that a permanent appointment of a RTT lead had been made and the centralised team is working hard to deliver this target and increase awareness across the Trust.
- Four Hour Standard national target – December, January and February challenging months due to winter pressures, but through hard work and commitment of colleagues the Trust had achieved 90.74% against NHSI improvement trajectory for March of 90% and a YTD position of 90.60%. The Board reflected on this achievement and congratulated all the staff concerned to achieve this.
- Cancer – targets remain challenging. JR reassured the Board that no patients have had extended waits. The March position is not yet closed so this is not a confirmed position the confirmed position will be in next month's report. A new reporting system had been introduced to record and collect data on one system in line with the last MIAA audit. Data is still to be validated and will be reflected in next months report. New patients will be monitored through the new system. Still issues related to changes in staff and their understanding of reporting. JR assured the committee that an audit had taken place that support this.
- Ambulance Handover – patient flow due to winter pressures and A&E pressures had resulted in a number of delays. The Trust compare favourably across C&M and had been recognised as an exemplar Trust at a recent NWAS event. The team continue to work with NWAS to further improve.
- Discussion took place regarding the Discharge Summaries target within 24 hours of discharge and if the target of 100% is negotiable. JR reassured the Board that improvements continue, especially in relation to the indicator for discharge summaries not sent within 7 days. Data is also been analysed to exclude patients who do not need a discharge summary.
- AC added that the 100% target is within the 3 year contracts signed with Commissioners and is not negotiable. Divisions continue to focus their work on this performance indicator.

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	The Director of Finance + Commercial Development presented the Finance dashboard: - Year end first draft of final accounts had been presented to FSC on 19 April. - Accounts had been completed. Lower than planned dividend payment improved financial position by £0.25m. - Confirmation had been received from NHSI that the Trust would receive a bonus payment of circa £1m for improvement against the Control Total target and the Trust will receive a bonus share of remaining STF monies of circa £800k, totalling additional funds of £1.8m for delivering the 2016-17 financial plans. This was in addition to achieving £8m STF for delivery of financial and performance targets and trajectories. - The £1.8m additional STF will support the Trust's cash position in 2017-18. - There is no longer an interim financial facility available should there be any unforeseen cash pressures. It is essential that the Trust delivers the plan. Any variance from plan will put pressure on the already challenging cash position and could lead to the Trust requiring further loans in 2017-18 in addition to the planned loan of £3.7m. Payment of creditors remains challenging for the Trust. - TA and AC had discussed the cash challenges between creditor and debtors and measures to relieve some creditor pressure. The FSC will review this as part of next month's financial report to the FSC. - Further discussion took place regarding management of cash flow and TA and JNE to meet outside of the Board to discuss further. The Director of Transformation provided an update on the CIP. - £8.6m CIP delivered, plus £2.6m in cost avoidance and income recovery and £1.8m on control measures in final quarter of 2016-17. Total impact on bottom line is £13m. - The level of achievement shows that the measures and processes in place had been effective, with oversight through the Innovation Cost Improvement Committee. - The Board recognised the achievements of the efforts of staff to achieve the final year end position and level of CIP achieved which in turn will provide additional credibility to the regulators and partners and stakeholders, recognising that a clear communication will be required across the organisation to recognise this achievement but that the transformational programme of work needs to continue. The Interim Director of HR + OD highlighted key areas for the Board to note: - <u>Sickness absence</u> overall target not achieved but improvement noted over the last 3 months, achieving 4.14% in March compared to March 2016 achievement of 4.9%. Overall improvement on YTD target of 4.66% against target of 4.2%. - <u>RTW</u> – there had been under-reporting of RTW but work with the HR team and divisions especially in relation to phased returns and occupational health assistance had seen improvements, compliance in March was 81.62% against target of 85% but this is an improvement of 15% on last year's figure. - <u>Recruitment</u> – MC and AW had met with the Head of Contracts + Performance to review the IPR Dashboard to ensure correct recording of data. Future reports will indicate constituent elements of the recruitment process. Revised dashboard will be presented to the Strategic People Committee in June for approval.

	- Turnover – continues to fall, year end position reported 13.34%. The target is 7-10% and measures put in place including improved induction, development opportunities are gradually having a positive impact on reducing turnover. This will be supported by the new Recruitment and Retention plan for nursing staff. - Pay Spend – work continues to reduce agency and temporary staff and medical and nursing spend. The Pay Spend and Review Group will have operational oversight for monitoring, with reporting and escalation to the Finance and Sustainability Committee (FSC). The FSC will continue with oversight of the NHSI Board Self Certification checklist and dashboard. Targets will be changed in year if required following the receipt of the CQC inspection report. The Trust continues to submit weekly Pay Spend reports to NHSI. **The Board noted the report**
	(c) Annual Engagement Dashboard The Director of Community Engagement and Corporate Affairs highlighted key areas for the Board to note in the annual dashboard report: - Increase in Twitter follows of 15% in year. - Website engagement increase in visitors but dwell time not increasing likely due to the templated build of the website. A mobile enabled platform to be developed to ensure that members of the public can access the Trust systems through a variety of media outlets, ie twitter, facebook and other apps. - Improved attendance at team brief noted particularly at Warrington. More open mic sessions to be arranged at Halton to provide more visibility of the Executive Team to encourage staff engagement on Halton site. - Discussion took place regarding staff survey results and patient opinion trends. - PMcL commented that the responses left on NHS Choices equated to 3 patient responses in March relating to Warrington and a total number response from Warrington patients of less than 50. Switching to Patient Choices I Want Great Care will allow patients to provide more detailed feedback across a number of themes, divisions and trust wide and allow information to be triangulated against complaint data, staff survey results and patient experience and highlight any areas for training. **The Board noted the report.**
BM 17/04/43	**(d) Key Issues Report from April Quality Committee** The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Committee highlighted the following - 3 items for escalation to the Board, SIs, Falls and DNACPR. The action plans in place for SIs and Falls and being closely monitored through the Committee. Mitigations currently do not provide full assurance to the Committee and will continue to be closely monitored. KSJ reassured the Board that the Falls Action Plan and Tissue Viability Action Plan include a time framework to ensure progress is in line with plans and that the QC would escalate to the Board if improvements are not in line with the plans. - DNACPR – the QC had received a progress report. More work required relating to decision making processes and documentation. Reporting is through the Patient Safety and Clinical Effectiveness Committee with issues escalated to the Quality Committee

	through the Acute Care high level monthly briefing report. The re-establishment of the Resuscitation Group will support action plans in place. KSJ added that the Medical Director is writing individually to all medical staff regarding their own requirements of DNACPR. **The Board noted the report and the 3 areas of escalation.**
BM17/04/43 (e)	**Key Issues Report from April 2017 Finance and Sustainability Committee (FSC) and Committee Chairs Annual Report** The Key Issues Reports were taken as read and Terry Atherton, Chair of the Committee highlighted the following: - The Committee had received its first Lorenzo Benefits Realisation report against the original business plan and will continue to have oversight, receiving quarterly reports to monitor progress and escalate any issues to the Board as appropriate. Following the AC on 24 April, it was agreed to remove the MIAA review of Lorenzo from the MIAA Audit 2017-18 plan and replace with a Pay Spend Review Audit. - The FSC received its first report from the Pay Spend Review Group to provide assurance on pay controls within the Trust. Significant work had been completed but the Committee are unable to provide full assurance to the Board that pay spend is on track The Committee is confident that the action plans now in place will mitigate further risk and MIAA will review as part of their Audit Plan. - The Committee received and approved the Committee Chairs Annual Report subject to amendments agreed. **The Board noted the report and endorsed the Committee Chairs Annual Report**
BM17/04/43 (f)	**Update Report – Strategic People Committee (SPC)** The Update report was taken as read and Anita Wainwright, Chair of the Committee highlighted the following: - AW and MC had met on 19 April and reviewed the governance and reporting structure to the SPC to ensure that appropriate structures are in place, representatives of Committee groups are correct and that Trade Unions are involved as appropriate. - A plan on a page to embed and monitor the People Strategy had been produced which will be presented to the SPC in June for approval, aligned with action plans under each element which are being developed. **The Board noted the report.**
BM/17/04/44	**Performance Assurance Framework 2017-18 (PAF)** The Director of Finance + Commercial Development highlighted key areas for the Board to note: - The PAF had been developed to establish a formal framework of accountability from Ward to Board and Board to Ward against agreed performance indicators and aligns with the NHSI Single Oversight Framework. - There had been wide consultation on the document through Executives, MIAA, Deloitte and Chairs of Sub-Committees. The PAF had been presented to the FSC in April who endorsed the framework. - The segmentation classification proposal within the PAF will run in shadow form for 6 months to ensure this can be tested. The PAF will be reviewed and refreshed annually and more frequently should any new guidance / requirement necessitate it.

	- The 2016-17 IPR dashboard had been refreshed and updated for 2017-18 with 56 indicators. The updates incorporated changes within contracts, and national and local indicators. To further enhance the IPR work is underway to consider and implement forecast indicators, kite marks/badges, a 13 month rolling review, reflect alignment to Trust strategies and improve readability with hyperlinks. - Discussion took place regarding trust wide assurance processes already in place and the indicators. Board Committees will continue to monitor their respective indicators through the current governance structure. - AC and PMcL reassured the Board that the Ward to Board reporting structure will further strengthen the Clinical Operations Board with Executive oversight against action plans. • **The Board discussed and reviewed the report.** • **The Board requested the source of each KPI to be included to distinguish between national, local in-house and mandatory indicators.** • **The Board approved the launch of the PAF and amendments to the IPR.**
BM 17/04/45	**Quarterly Risk Register and Board Assurance Framework** The Chief Nurse highlighted key points for the Board to note: - The Quality Committee receive and monitors monthly reports. - One new strategic risk had been added to the risk register since last month, VTE which had been escalated from the Quality Committee. - A number of VTE RCAs are outstanding and a backlog review improvement plan is underway lead by the medical director. - SC/KSJ/AC and UM had met and agreed an action plan will be monitored through the Patient Safety and Clinical Effectiveness Committee who will escalate any issues to the Quality Committee. A Task and Finish Group is to be established to ensure that the backlog of VTE RCAs, and risk assessments are completed by June and May respectively. - The Board were asked to note key updates relating to inclusion of additional gap in control of pay spend due to impact of IR35 but no impact on risk rating. External review of Cancer services, no impact on risk rating, KPIs agreed as part of the complaints review, no impact on risk rating. **The Board reviewed and discussed the report and noted the updates provided.**
BM 17/04/46	**Annual Survey Staff Results** The Interim Director of HR +OD highlighted key areas for the Board to note: - The Board were asked to note that staff had been asked to respond to the staff survey during the launch of the new CBU structure which is likely to have impacted on overall results. - The survey and report did provide the detail to analyse at CBU level. Work is on-going to undertake this further analysis and will be reported to the Operational People Committee with further reporting through to the Strategic People Committee of any areas for escalation. The SPC will also receive pulse check reports to provide in-year feedback from staff. - HR team are developing a process and approach to 1 key indicator, 'what would make the trust a great place to work and receive great care' - Discussion took place and the Board asked for a dedicated session to further analyse

	feedback and discuss ways to ensure all staff feedback can be triangulated and used effectively, for example feedback following the CQC inspection and from Front Line visits. **The Board reviewed and discussed the report. The presentation was not heard with a decision to discuss the Staff Survey further at a dedicated session.**
BM 17/04/47	**Approach to NHSI to review the Trust Licence Conditions** The Director of Finance + Commercial Development highlighted key areas for the Board to note: - The Trust had made significant process to deliver its services on a clinically, operationally and financially sustainable basis in 2016-17. - At the last Progress Review meeting with NHSI the Trust asked if the conditions of the licence could be reviewed. - The Trust is required to seek Board approval for the CEO to submit a formal request to NHSI to review/remove the licence conditions based on 2016-17 financial and operational performance. • **The Board reviewed and discussed the report and supported a formal approach to NHSI.** • **The Board requested that if a review or removal of the licence is not granted that reasons for their decision are confirmed in writing to the Trust.**
BM/17/04/48	**Board Sub-Committee ToR and Business Cycles 2017-18 for ratification** The Director of Community Engagement presented this report and sought formal ratification from the Board, in accordance with the Foundation Trust's Constitution SFIs, that the Board Sub Committees review their ToR and Cycle of Business annually. All had been approved at individual Board Sub Committees. • **The Board reviewed and noted the reports and ratified the Sub-Committees ToR and Cycles of Business.**
BM/17/04/49	**Proposal to change the Trust Name** Pat McLaren, Director of Community Engagement + Corporate Affairs highlighted key areas for the Board to note: - Recruitment to clinical posts remains a challenge for the Trust and the Board are asked to support to incorporate the 'teaching' element into its brand. By adopting 'Teaching Hospitals' into the name of the Foundation Trust will put WHH on a level field with neighbouring Trusts to attract staff. - It is not anticipated that this will include major re-branding costs. If any significant costs are highlighted and approval will be sought from the Board. • **The Board discussed and noted the report and approved the change of name and to proceed with the renaming process.**
BM/17/04/50	**Quarterly Governance Declaration to Monitor** The Director of Community Engagement + Corporate Affairs highlighted key areas for the Board to note: - As part of the Trust's licence conditions, the Board is required to review the Trust's Licence Conditions and the declarations of compliance and non-compliance for all conditions. - The Audit Committee had approved these declarations on 24 April 2017.

	- The Board were asked to approve a change in reporting, for the Audit Committee to review the licence declarations at each of its meetings and that the Board receive a yearly report. Cycles of Business will reflect this change. - Summary of licence conditions to be updated to reflect year end financial and performance. • **The Board discussed and reviewed the report and agreed the declarations of compliance and non-compliance for all conditions.** • **The Board approved the change in reporting.**
BM/17/04/51	**Any Other Business** None reported **Next Meeting:** Wednesday 31 May 2017, Full Trust Board Meeting, Trust conference Room.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Year End Board of Directors meeting held in Public on Tuesday 24 May 1.30pm in the Trust Conference Room, Warrington Hospital	
Present	
Steve McGuirk (SMcG)	Chairman
Terry Atherton (TA)	Non-Executive Director
Mel Pickup (MP)	Chief Executive
Margaret Bamforth (MB)	Non-Executive Director
Andrea Chadwick (AC)	Director of Finance and Commercial Development
Simon Constable (SC)	Medical Director + Deputy Chief Executive
Jean-Noel Ezingeard (JNE) *via teleconference*	Non-Executive Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
Jan Ross (JR)	Deputy Chief Operating Officer
In Attendance	
Michelle Cloney(MC)	Director of HR & OD (Interim)
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Apologies	
JasonDaCosta (JDaC)	Director of IM&T
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director

Agenda Ref BM/17/05/	
BM 17/05/52	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting, welcomed those in attendance. Apologies: as above. Declarations of Interest: none declared in respect of agenda items.
BM 17/05/53	**Recommendation to Adopt Audited Annual Report & Accounts including:** • Annual Report • Annual Governance Statement • Quality Account • Annual Accounts The Director of Finance presented a highlight of the financial accounts for the year: • Planned deficit = £8.1m. • Actual deficit = £8.3m (includes £3.0m impairments and £0.1m restructuring costs). • Actual deficit excluding exceptional items =£5.2m (£2.9m below plan). • Planned control total = £7.9m and actual control total = £5.0m (£2.9m below plan).

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	• STF monies include £8.0m core, £1.1m £ for £ incentive and £0.8m bonus = £9.9m.
	• Income – increased by £15.0m with main movements
	  o Income from activities £6.0m (Non Electives £3.6m, other activity £2.3m).
	  o Other operating income £9.0m (includes STF monies of £9.9m)
	
	• Expenditure – increased by £5.4m with main movements
	  o Staffing increased by £1.6m
	  o Impairments increased by £2.0m
	  o CNST Premium increased by £1.0m
	  o Rentals under operating leases increased by £0.7m
	  o Consultancy fees increased by £0.6m
	  o Purchase of healthcare from non NHS bodies increased by £0.4m
	  o Supplies and services (general) decreased by £0.4m
	  o Premises decreased by £0.3m
	
	• WTE numbers have also reduced by 84 from 3,720 in 2015/16 to 3,636 in 2016/17 (across all staff groups except bank and agency).
	• Cushman and Wakefield completed the review of land and buildings based on single site valuation as at 1st April 2016 and 31st March 2017.
	• This valuation resulted in a net reduction in asset value of £14.8m and reductions in capital charges.
	• The wording to be included in the annual report and notes to the accounts (accounting policies) regarding going concern needs to be finalised as discussed at Audit Committee on 23rd May.
	
	Having chaired the Audit Committee on 23rd May 2017 Anita Wainwright presented a paper (tabled - BM 17/05/55) noting the amendments made to the annual report, quality account and financial accounts since the Audit Committee
	
	She had advised that all amendments had now been accepted by the auditors and based on this the auditors had issued an unqualified opinion on the Annual Report and the Financial Accounts.
	
	She advised that the auditors had advised that they will issue a qualified opinion on the Quality Accounts with reference to the RTT indicator, which was expected.
	
	Terry Atherton raised two issues in the papers that had not been picked up at the Committee: Page 33 attendance of Board – error in SG's attendance and Page 66 – 68 MARS – clarification required around the terminology required.
	
	Jean-Noel Ezingeard asked about the 'Going Concern' statement. TA advised that while auditors are nervous around this statement, we are in fact not dissimilar to many other Trusts. AC advised that in our letter of representation we had specifically asked for an expansion on the wording as it could have been misleading. AC expanded on the board

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	resolution which is evidential that the moneys will be forthcoming on application by the CEO. **Signing of All Year End Paperwork including:** • Management Letter of Representation to Grant Thornton for the financial statements • Management Letter of Representation to Grant Thornton for the Quality Report • FTC Summarisation Schedules/Certificate
BM 17/05/54	**NHS Improvement - Self Certification Compliance with the Trust Licence** The Director of Community Engagement + Corporate Affairs presented the four items for self-declaration as required by NHS Improvement: GS6, CoS7 and NHSFT4 plus Training of Governors. The Board approved the self-certification and submission of same according to timetable.
BM/17/05/55	**Any Other Business** None reported

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BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/17/05/58	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	31st May 2017

1. ACTIONS ON AGENDA

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

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/04/50	26 April2017	Quarterly Governor Declaration	Board to receive a yearly report. Cycle of Business to be amended.	Director of Comms + Corporate Affairs	ASAP	27.4.2017		
BM/17/04/44	26 April 2017	Performance Assurance Framework 2017-18	The source of each KPI to be included to distinguish between national, local in-house and mandatory indicators.	Director of Finance + Commercial Development	ASAP	10.5.2017		
BM/17/04/50	26 April 2017	Quarterly Governance Declaration to Monitor	Cycles of Business for Audit Committee and Board to reflect change if reporting to each meeting and yearly respectively.	Director of Communications + Corporate Affairs	ASAP	3.5.2017		

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3. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/01/08	25 January 2017	Integrated Dashboard	Follow-up Mortality Board workshop to be planned.	Medical Director	7 July 2017			
BM/17/01/09	25 January 2017	DIPC Bi-Annual Report	Future report to Board on operational impact.	Medical Director	July/Aug 2017			
BM/17/01/12	25 January 2017	Charitable Funds Commission	Board to receive refreshed strategy to maximise income streams as workshop	Director of Community Engagement	7 July 2017	31 January 2017		
BM/17/01/11	25 January 2017	Lord Carter – Pharmacy Transformation Plan	Detailed plans to be presented to future Board meeting.	Medical Director	7 July 2017		28.2.2017 added to Joint Exec/NED timeout agenda Friday 7 July 2017.	
BM 17/03/30	29 March 2017	IPR Dashboard - Mortality	SC to present policy to future Board for approval.	Medical Director	25 October 2017			
BM/17/03/34	29 March 2017	Board Annual Cycle of Business	Board to review a draft calendar of meetings for 2018 and use of technology.	Director of Community Engagement +Corp Affairs	7 July 2017		31.3.2017 added to Joint Exec/NED timeout agenda Friday 7 July 2017.	

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BM/17/04/46	26 April 2017	Annual Staff Survey Results	The Board reviewed and discussed the report and will discuss further at a dedicated session.	Interim Director of HR+OD	7 July 2017		Added to Joint Exec/NED timeout agenda Friday 7 July 2017.	
BM/17/04/49	26 April 2017	Proposal to change Trust Name	Process to commence to incorporate 'teaching' element into its Brand.	Director of Communications + Corporate Affairs	ASAP		24.5.17. process has commenced.	

RAG Key

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

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/61 (a)**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	31st May 2017
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Jan Ross – Chief Operating Officer (interim) Michelle Cloney – Director of Human Resources & Organisational Development (interim) Andrea Chadwick - Director of Finance & Commercial Development
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has achieved the majority of its national and local key performance indicators (KPIs) in April including all targets relating to the STP Improvement Trajectory. At the time of producing this report Cancer KPIs are awaiting validation. The Trust is forecasting achievement of all Cancer targets with the exception of the 14 day Breast Symptomatic pathway which is experiencing issues relating to patient choice and DNAs. Workforce has seen continued improvement in staff sickness rates and medical and nurse agency spend

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	however; return to work interviews, PDRs and mandatory training have all experienced a dip in performance. The Trust's financial position is £1.8m deficit in line with plan and a Use of Resources Rating of 3.	
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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SUBJECT	Integrated Performance Dashboard	AGENDA REF:	

1. BACKGROUND/CONTEXT

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

- Quality
- Access and Performance
- Workforce
- Finance

2. KEY ELEMENTS

- There are no cases of MRSA in April and 1 case of C-Diff currently under review.
- There are 2 falls reported in April which are subject to serious incident review.
- The harm free care targets have been met.
- Mortality thresholds will be reviewed by the Quality Committee in May 2017.
- The RTT 18 week aggregate and 6 week diagnostic targets have been achieved.
- Cancer targets are forecasted to achieve with the exception of the 14 day Breast Symptomatic pathway which is experiencing patient choice and DNA related issues.
- The A&E 4 hour national performance target has not been achieved, however the A&E STP Improvement trajectory has been achieved.
- The discharge summaries target of 95% within 24 hours requires continued focus as the Trust is currently not on track to achieve Quarter 1 target, which would result in a £15k penalty.
- There has been an improvement in sickness absence rates, however compliance of return to work interviews following a period of sickness absence has dipped.
- Mandatory training and PDR performance have also dipped in April.
- There has been an improvement in nurse and medical agency spend.
- The planned financial deficit of £1.8m has been achieved.
- Capital spend for April is £0.2m below plan.
- The cash balance was £1.3m, which is £0.1m higher than plan.
- The Trust has a Use of Resources Rating of 3.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

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4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:-

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

5. RECOMMENDATIONS

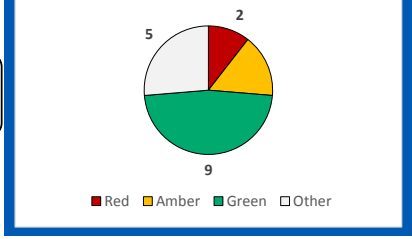
The Trust Board is asked to note the contents of this report.

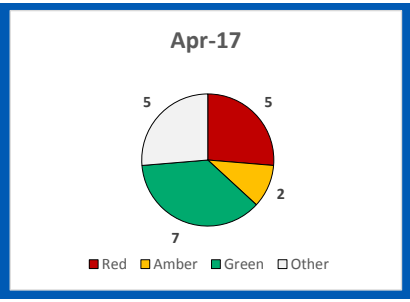
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

Key Points/Actions

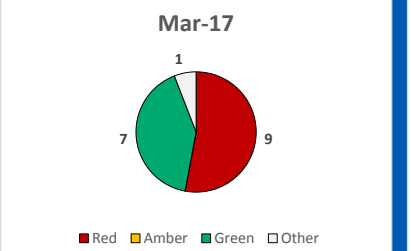
Quality Improvement

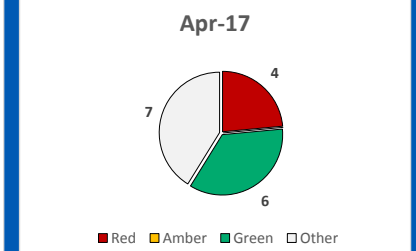




The Trust continues to have no cases of MRSA and reported 1 case of C-Diff in April, this will be reviewed by the CCG. The deep dive into UTI deaths has resulted in 1 declaration of a serious incident which is currently under review. There will be a focus on Duty of Candour (DOC) for moderate harm incidents to ensure improved compliance, following on from the increased monitoring of DOC in relation to Serious Incidents. In relation to Safety Thermometer the overall harm free care percentage is well above target. Sepsis data, whilst improving, shows continued improvement required in inpatient areas. There were 2 serious incidents reported in month related to falls. The Trust met the Friends and Family targets; work is continuing to increase response rates. The Trust continues to implement the complaints improvement plan; figures show a reduction in the number of cases in backlog and those over 6 months old. A plan is in place regarding VTE RCA completion. The percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated at appropriate.

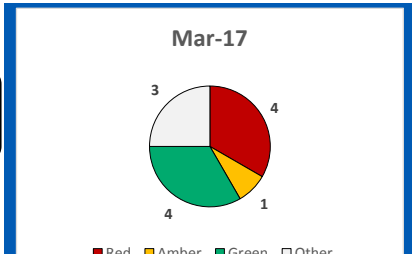
Access & Performance

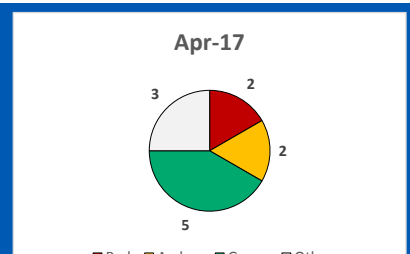




This Report highlights the Trusts position against all access and performance targets for April. The Trust did not achieve 95% against the four hour standard, although it must be noted that the NHSI improvement trajectory was over achieved. The cancer data at the time of this report cannot be validated as the position is not closed off for reporting. North West Ambulance service have been unable to provide the required information for this report due to system issues since the cyber attack. The Trust has had 22 cancelled operations in April. This number includes all patients cancelled for valid clinical reasons, others due to lists over running or equipment failure. As a Trust we are measured on those patients cancelled on the day of surgery for non-clinical reasons and not offered a date within 28 days of the cancellation of which we have had 1 patient.

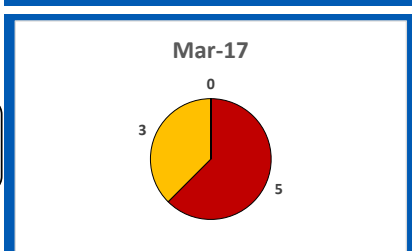
Workforce

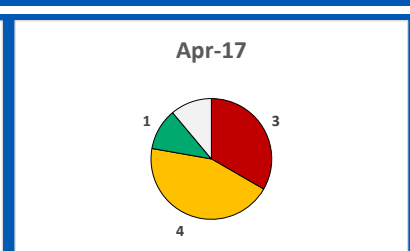




There have been changes to the status of three of the metrics. Sickness Absence and Agency Medical Spend are now green but it is difficult to predict whether these will be sustained as it is very early into the financial year. PDR rates have fallen and the status is amber. The sickness rate has fallen from the previous month and the target is just being met. Return to work (RTW) interview rates have fallen in month and are now below the target of 85%. Turnover rates have slightly increased and are still showing red. Recruitment times have slightly increased, but for the time taken to conduct employment checks, this has fallen - the status remains red. Non contracted pay remains a concern. However, both nurse and medical agency expenditure decreased in month quite significantly and is better than the same position last year and the status is green for both. Mandatory training rates have remained stable and are green. PDR rates have fallen from the position reached the position reached over the previous two months and are amber. The position of 'high cost agency workers' and 'long term agency usage' have been updated to reflect the recently changed NHSI definitions.

Finance



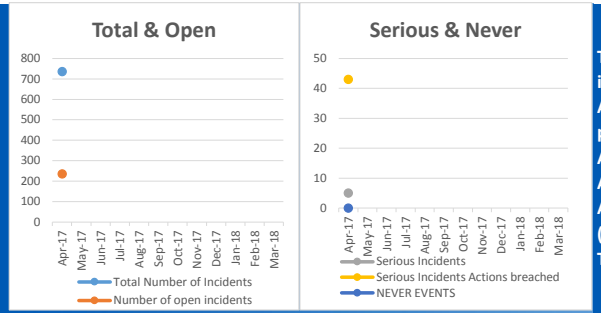
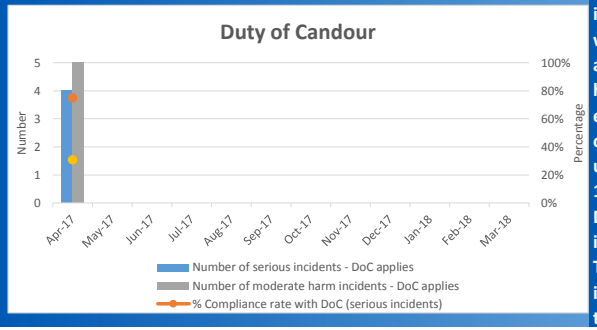
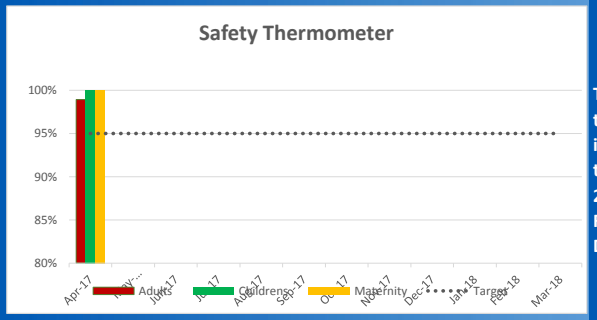


In the month the Trust recorded a deficit of £1.8m which is in line with plan. In the month income is £0.3m above plan, expenses are £0.3m above plan and non operating expenses are in line with plan. The actual capital spend is £0.3m which is £0.2m below the planned capital spend of £0.5m. Due to the historic and current operating position the cash balance remains low although as at 30th April the cash balance is £1.3m which is £0.1m above the planned cash balance of £1.2m. The terms and conditions of the loan require the Trust to have a cash balance equivalent to 2 operational days which equates to £1.2m at some point during the month. The performance against the Better Payment Practice Code is 55% in the month which is 40% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

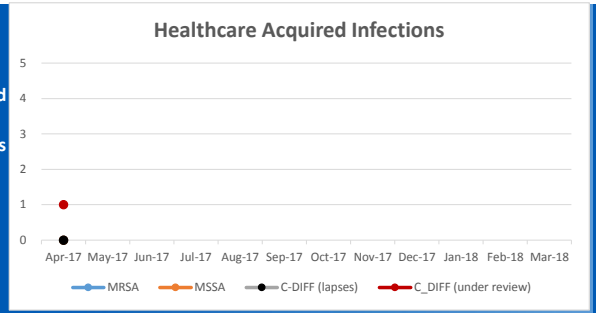
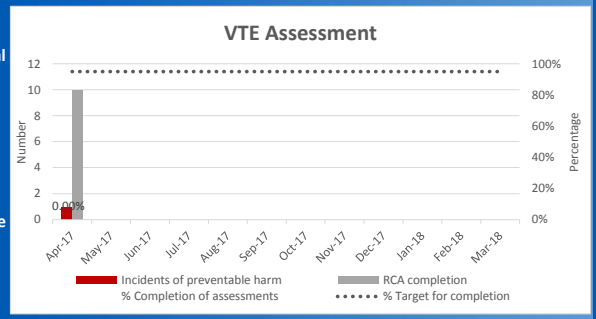
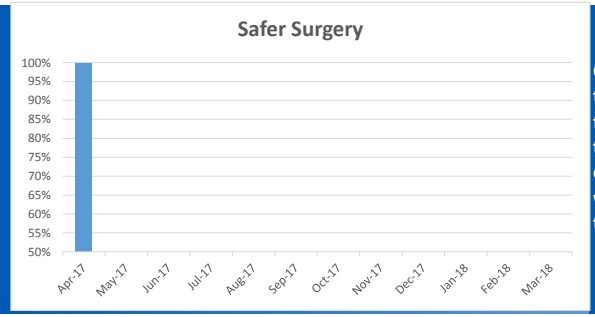
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Patient Safety				
Incidents Red: 1 or more Never Events Green: Zero Never Events	Total number of incidents received during the month. Total number of Serious Incidents (SIs) received during the month. Never Events are preventable patient safety incidents that should not occur. SI actions breached are the actions from closed serious incidents that are now overdue. Number of open incidents is the total number of incidents that we have awaiting review.	The target for Never Events is a zero tolerance.		There are currently 43 Overall Breached Actions in relation to Serious Incidents, of which; 22 Actions Outstanding linked to CBU (13 of which pertain to Urgent and Emergency Care), 11 Actions Outstanding linked to Trust Board, 7 Actions Outstanding Pre CBU - Scheduled Care, 2 Actions Outstanding linked to Acute Care Services (No Specific CBU), 1 Action Outstanding linked to Training Department.
Duty of Candour Red: <100% Green: 100%	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days.	Duty of Candour has to be completed within 10 working days.		Towards the end of 2016/17 work was completed in relation to the recording of Duty of Candour within our risk management system, Datix. We are now able to produce accurate reports which highlight the CBU's that are not performing as efftively in relation to this Duty. Following receipt of the Divisional dashboards we will request updates from each CBU that has had less than 100% compliance with the Duty. The breach in DoC for Serious incidents relates to historical incidents that have been picked up as part of Trust discrepancy meetings and therefore there is a planned approach for each of the 4 patients to fulfil Duty of Candour.
Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer mositure lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.	The target for all areas is to achieve over 95%		The overall Harm free care % is well above the target of 95%; however there were 5 patients identified within the Adult section (1.08%) within the census as acquiring new VTE (3 patients) and 2 Catheter Associated Urinary Tract Infections. Root Cause analysis is underway within the Divisions to identify any lessons for learning.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

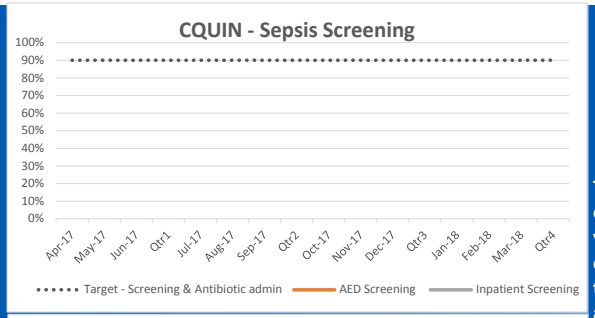
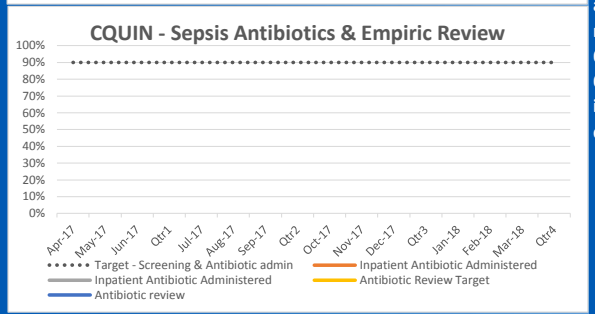
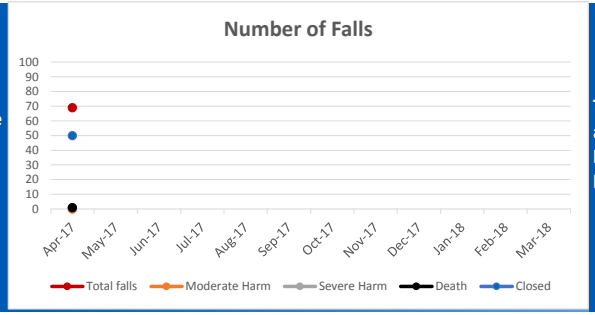
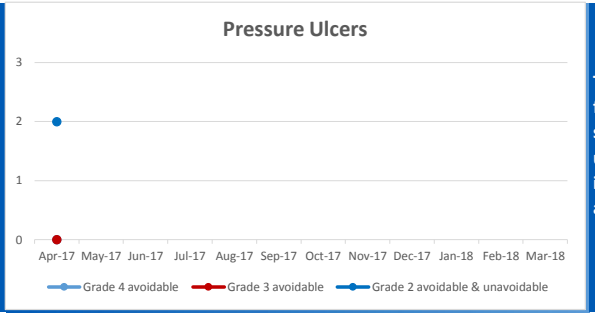
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Healthcare Acquired Infections MRSA Red: More than 5 Amber: 1 to 5 Green: 0 C-Difficile Red: More than 2 Amber: 1 to 2 Green: 0	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to meticillin are termed meticillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.	MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year.		1 hospital apportioned case reported which is being investigated. This will be reviewed by the CCG in September to determine any lapses in care.
VTE Assessment Red: <95% Green >=95%	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. The Trust achieved 95.09% in January, 95.08% in February and 95.23% in March following manual validation of patient level records and data. Technical issues with Lorenzo are being worked through with the relevant teams to ensure accurate VTE data going forward. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/15, 16/17 (risk assessed by harm and occurrence of PE). a revised process has been put in place for April 17 onwards. This will be communicated to Divisions. A revised position on VTE RCAs will be reported in May 2017.		As the full month has not been validated this KPI is incomplete
Safer Surgery Red: <100% Gene: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of Theatre Services.	The target is to achieve 100%.		Of the Safe Surgery checklists we have continued to see 100% within this area. However, recent feedback from our external auditors, as part of the Quality Account reporting, has queried this data in a small number of cases. A further update will be provided within the next dashboard as to the accuracy of these findings.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

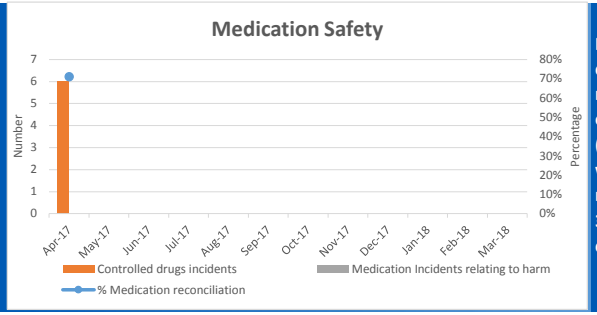
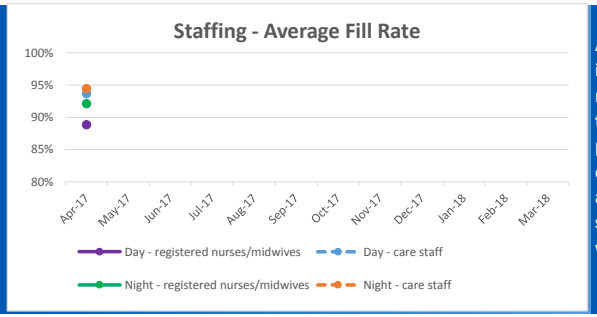
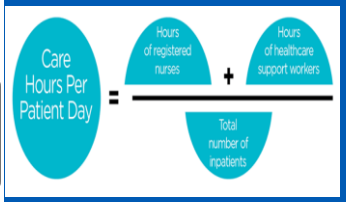
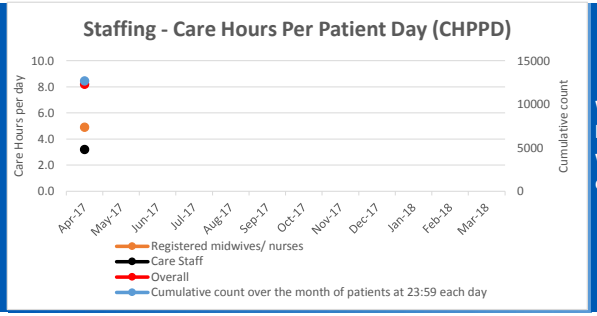
Quality Improvement

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Adminstration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Adminstration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	Targets to be agreed with Commissioners and reported to May 2017 Board which will then be reflected in the June Board IPR.	 	The data for April will not be available until the end of May. However, an update on the 16/17 year end position is available. In ED 92% of eligible patients were screened; of that 70% of those patients were administered intravenous antibiotics within 1 hour of ARRIVAL & were reviewed within 3 days. In Acute Inpatients 60.67% of eligible patients were screened; of that 60.53% of those patients who were administered intravenous antibiotics within 90 mins of diagnosis were reviewed within 3 days.
Total number of Falls & harm levels	Total number of approved falls per month and their relevant harm levels.	10% reduction in falls in 2017/18 using 2015/16 data as a baseline. Thresholds to be reviewed by the May 2017 Quality Committee with recommendation to May 2017 Board which will then be reflected in the June Board IPR.		There has been 2 falls (1 for Digestive Diseases and 1 for Specialist Medicine) which resulted in harm are both subject to Level 2 investigation and have been STEIS reported.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 82	Tissue viability is a speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration. Pressure ulcers are an injury that breaks down the skin and underlying tissue.	Grade 4 hospital acquired (avoidable). Grade 3 hospital acquired (avoidable). Grade 2 hospital acquired (avoidable and unavoidable).		There have been 2 x grade 2 Pressure Ulcers (both for Specialist Medicine) reported for April 17. It should be noted that Root Cause Analysis is underway to determine if there were any "lapses in care" in order to determine whether they were avoidable or not.

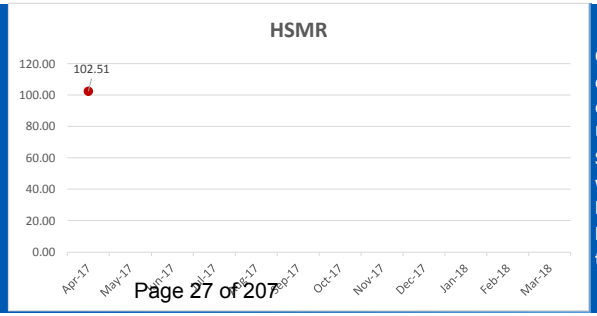
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	Targets to be set		Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking. The total number of patients requiring this in April was 1395 (excluding Paediatrics, Maternity and patients with a length of stay <1 day. Of the 1395, 948 medication reconciliations took place; of which 364 took place within 24 hours. There were 6 controlled drugs incidents for the month of April.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	Percentage of planned verses actual for registered and non registered staff by day and night	Target of >90%		Although most areas are above the 90% target it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate and a monthly safe staffing report is presented to the Trust Board which details action to mitigate.
Staffing - Care Hours Per Patient Day (CHPPD)		The data produced excludes CCU, ITU and Paediatrics		We continue to monitor CHPPD as recommended by Lord Carter to ensure daily responsive workforce plans maximise the care delivered to our patients

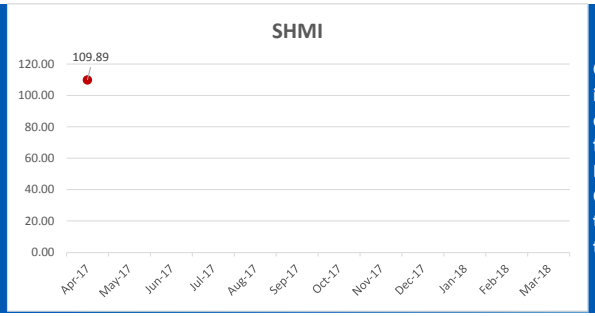
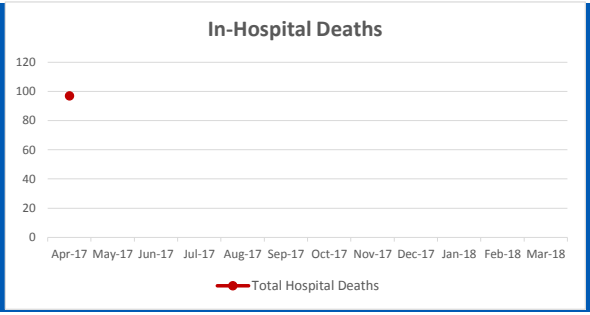
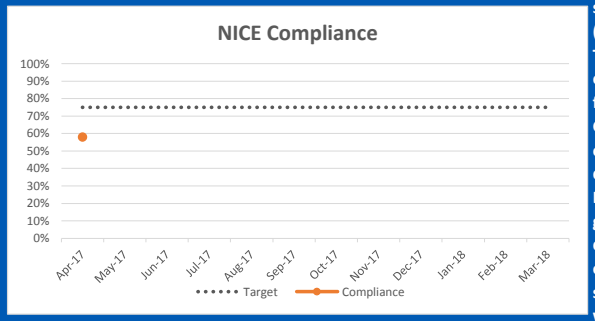
Clinical Effectiveness

Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Thresholds to be reviewed by the May 2017 Quality Committee with recommendations to May 2017 Board.		Our HSMR is continuing the downward trend as correctly coding our palliative care patients takes effect. We have completed the deep dive into UTI deaths and a report is due to go to Patient Safety & Clinical Effectiveness in May 2017. Care was good in 11 of the 12 patients and one has become an Serious Incident. A number of actions have been derived and will be implemented over the next six months.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

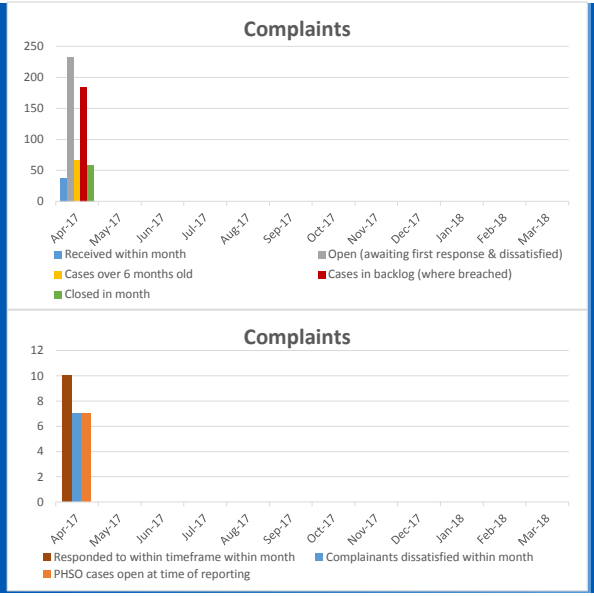
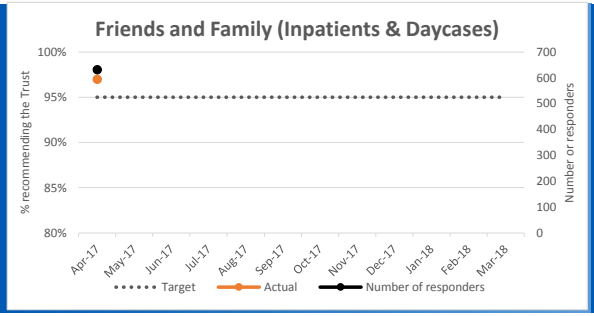
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Thresholds to be reviewed by the May 2017 Quality Committee with recommendations to May 2017 Board which will then be reflected in the June Board IPR.		Our SHMI has remained static due to an increase in the number of observed deaths over our expected. We are performing deep dives into the following areas where we have increases: Cardiac Dysrhythmias, Fractured Neck of Femur and Cancer of the Rectum & Anus. The results from these deep dives will be completed over the next three months.
Total Deaths	Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group.	Thresholds to be reviewed by the May 2017 Quality Committee with recommendations to May 2017 Board which will then be reflected in the June Board IPR.		
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.	We wish to achieve 100% compliance against all NICE guidance.		The figures included within this report are a position statement as to the current status of NICE Guidance (including Guidelines, Quality Statements and Technology Appraisals) compliance within the Trust. It encompasses NICE Guidance that has been published from 2006 to date. (The compliance date for this Guidance was 30th April 2017, therefore the outstanding guidance was not compliant before this date). It is also important to note that the figures in the graph do not include guidance which applies divisionally or Trust-wide. Where NICE Guidance is outstanding, CBU Leads are being contacted and supported to ensure we achieve 100% compliance within six-months.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

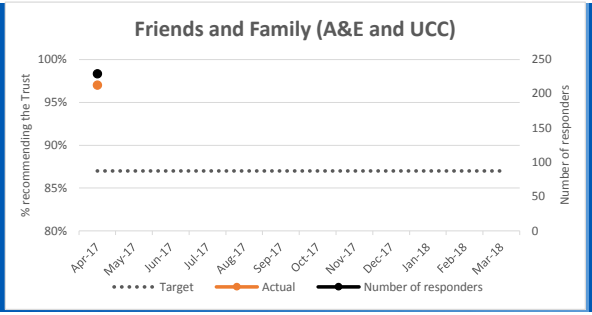
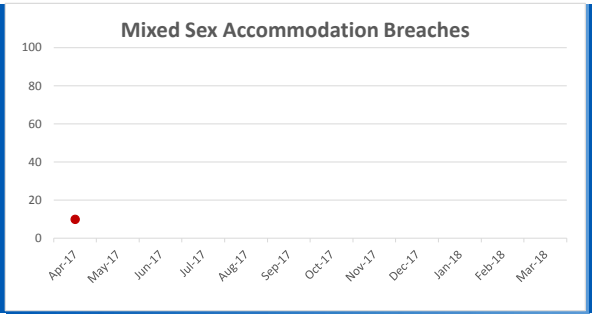
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Patient Experience				
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.	Targets to be set		The number of complaints received is based on those cases "opened" in month, and not date "first received", in order to ensure a more accurate picture given the historic issues with missed cases. In April 5 cases were opened and closed on the same day as a result of complainants confirming that they did not wish to proceed to a formal complaint, however by logging the case we have ensured that the learning is identified. The Trust wide figure will not always match the total of cases signed to ACS or SWC as there are additional complaints assigned to the Corporate Directorate. In month 6 cases were treated as "high" risk and therefore the subject of a 72hr review. Weekly performance meeting with Divisions and the Chief Nurse/Deputy Director of Governance have been reinstated.
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	The target set is to achieve over 95%.		It is pleasing to note that 97% of our patients recommend the Trust, however the number of responders is low. Transition to an alternative FFT provider is underway. The electronic SMS solution has nationally shown significant increases in response rates.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

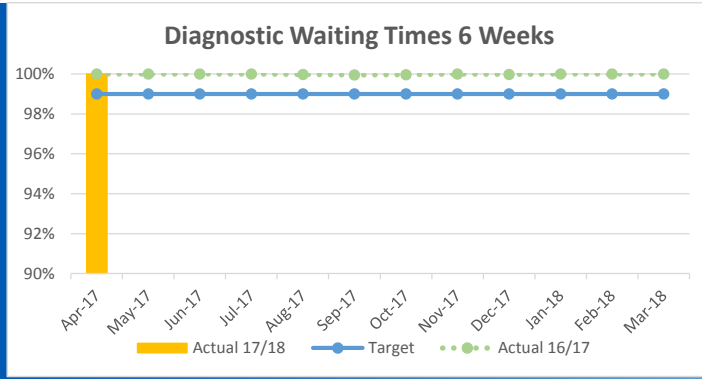
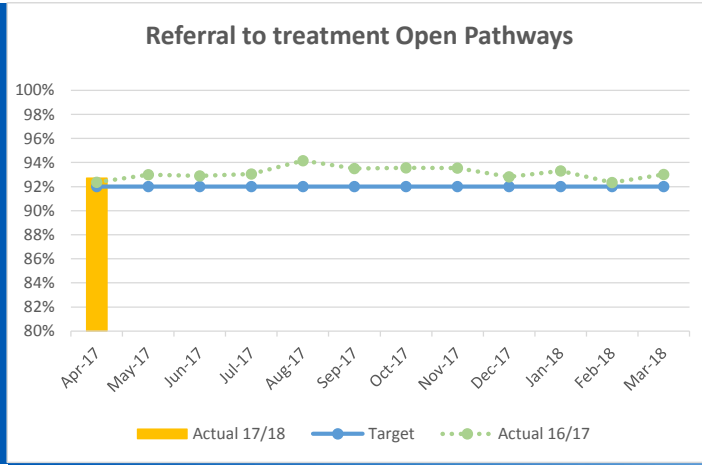
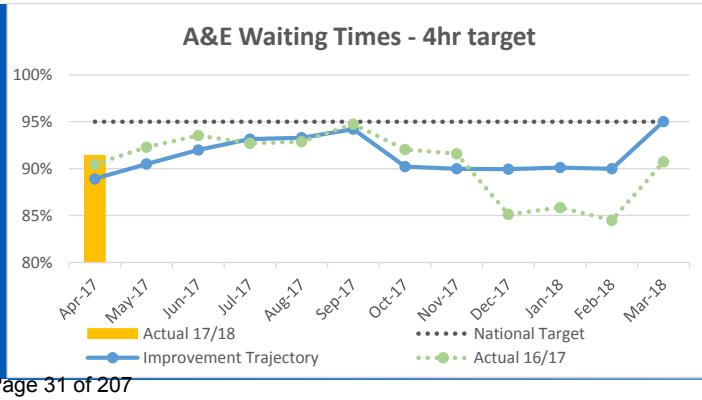
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.		The target set is to achieve over 87%. It is pleasing to note that 97% of our patients recommend the Trust, however the number of responders is low. Transition to an alternative FFT provider is underway. The electronic SMS solution has nationally shown significant increases in response rates.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.		MSA breaches continue to be monitored by the operational teams. Escalation processes are being strengthened, however it should be noted that breaches only occur from Critical Care & Coronary Care due to wider capacity challenges within the Trust. The financial penalty for MSA breaches is £250 per patient per day. The Trust is awaiting confirmation of total April 2017 fine from the CCG.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

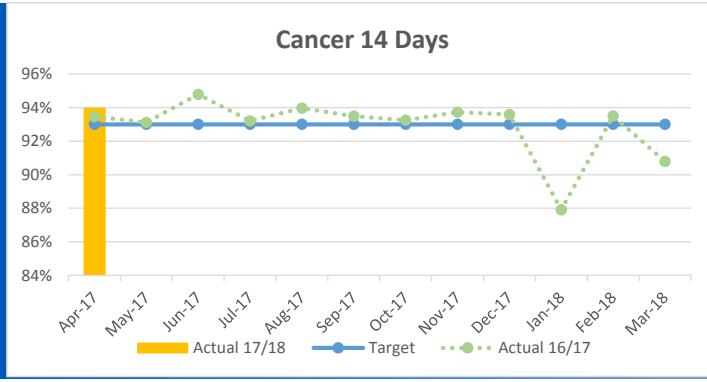
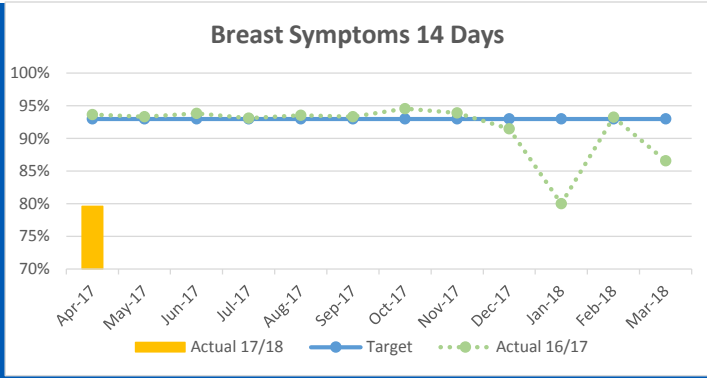
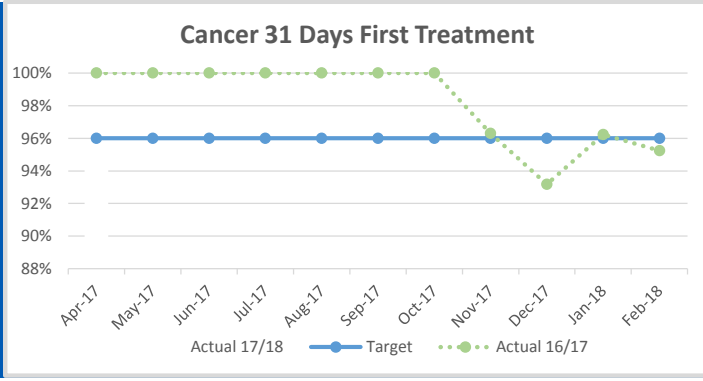
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The national target of 99% for Diagnostic waiting times has been achieved with actual performance at 100%. The Trust has also met the STP Improvement trajectory.		There are no issues with this target
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory.		Incomplete waiters: • April Submission 92.71% achieving standard for the 18th consecutive month. • Only 2 specialties not achieving standard and these are both showing improvement. • Amount of pathways requiring validation dropped again to the lowest it has been since Lorenzo Go-Live. • Over staff 750 staff completed training. • Patient Tracking/Validation now down to 15 weeks, with some specialties down to as low as 12 weeks.
A&E Waiting Times - National Target Red: Less than 95% Green: 95% or above A&E Waiting Times - STP Trajectory Red: Less than trajectory Green: Trajectory or	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust is not achieving the 95% national 4 hour target but is meeting the STP improvement trajectory.		The Trust has submited improvement trajectories to NHSI for 2017-18 these are yet to be confirmed. The Trust has over achieved this trajectory for April despite not achieving the 95% standard.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

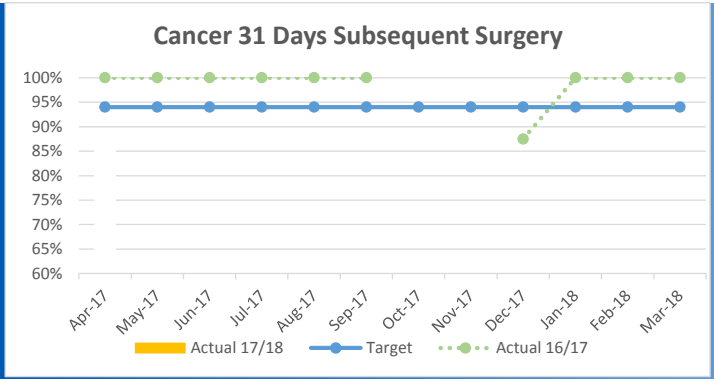
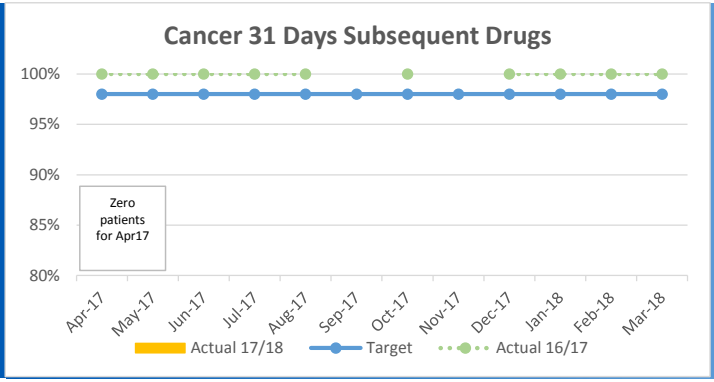
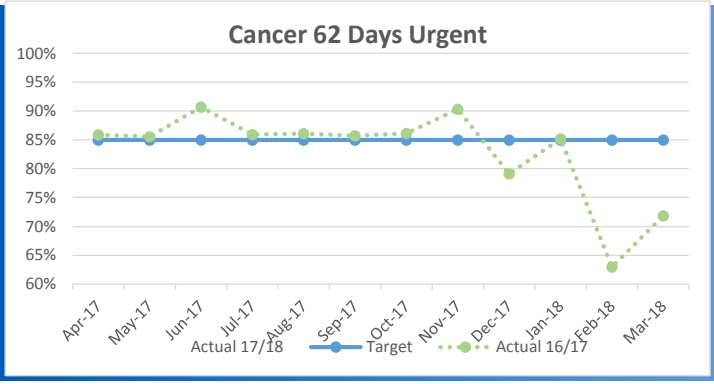
Mandatory Standards - Access & Performance

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

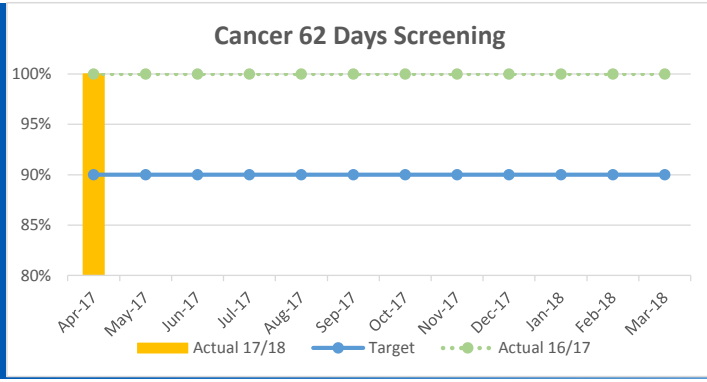
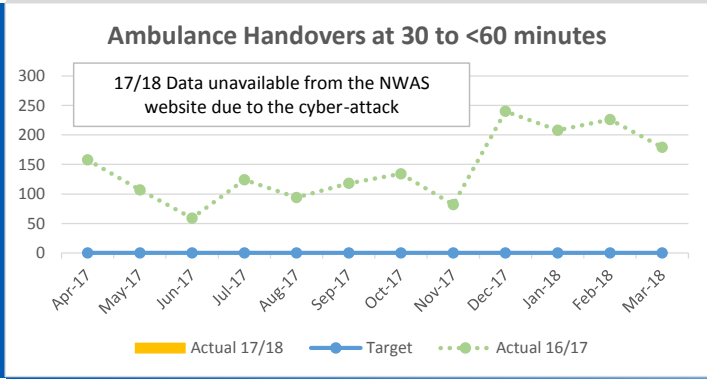
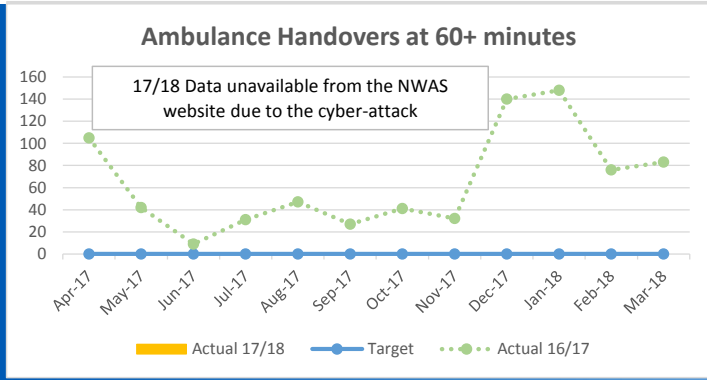
Mandatory Standards - Access & Performance

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

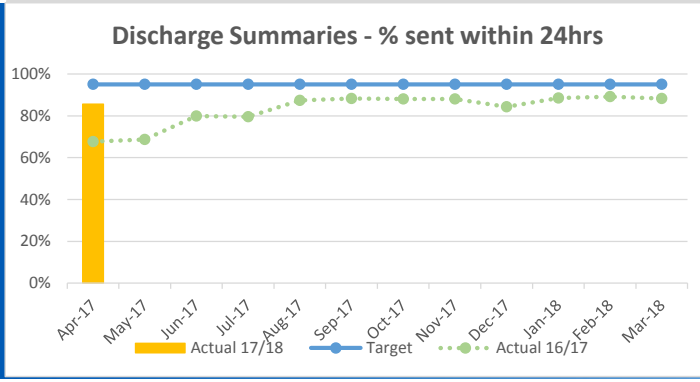
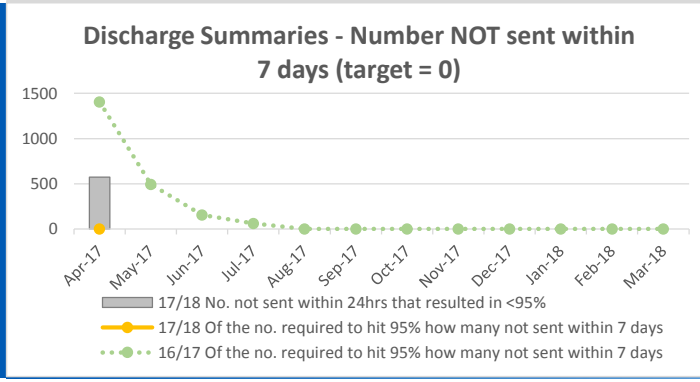
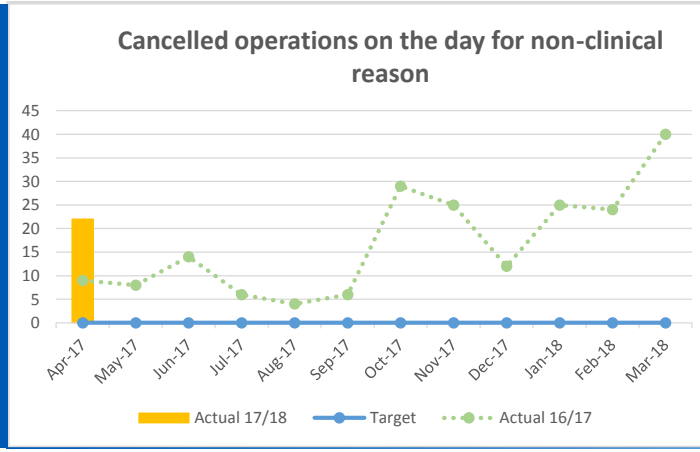
Mandatory Standards - Access & Performance

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

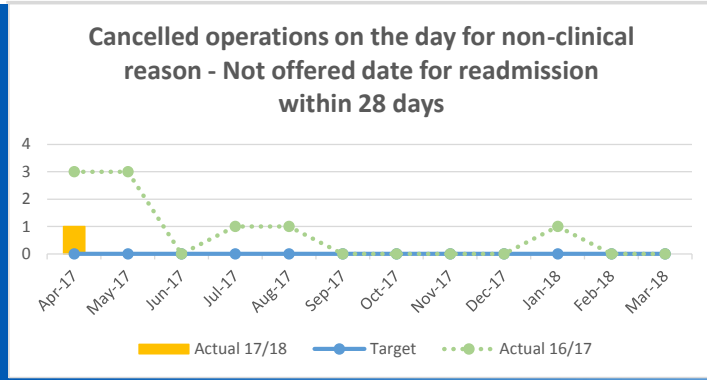
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge			The Trust has put a remedial action plan in place to improve performance against this target. Failure to achieve will result in a quarterly penalty of £15k
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge			This target has been achieved therefore no penalties for month 1
Cancelled Operations on the day for a non-clinical reason Red: Above zero	Number of operations cancelled on the day or after admission for a non-clinical reason			The Divisional Teams have introduced a weekly cancelled operations meeting which drills down into every operation cancelled the previous week and identifies trends/themes/avoidable and unavoidable reasons as to why an operation is cancelled. It is expected that this will reduce the number of non-clinical cancellations as the reasons are discussed and actions put into place to reduce this number. There are also weekly scheduling meetings that look forward to the following weeks lists to identify any issues that may come up (i.e. special equipment).

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

Mandatory Standards - Access & Performance

Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days		This is a data quality issue. This was a cardiology patient who was an in-patient in ITU in the 28 day period so therefore not fit for angiogram.

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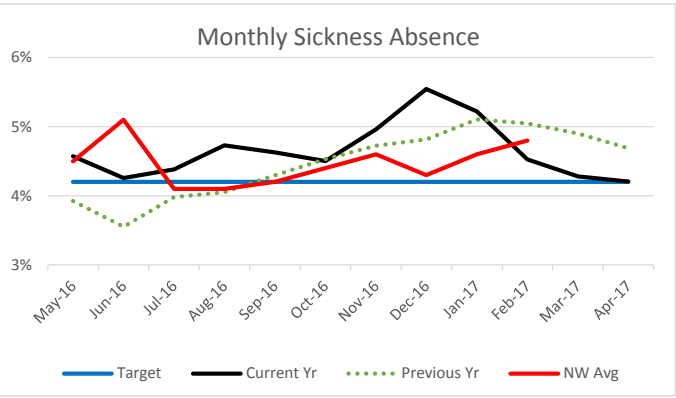
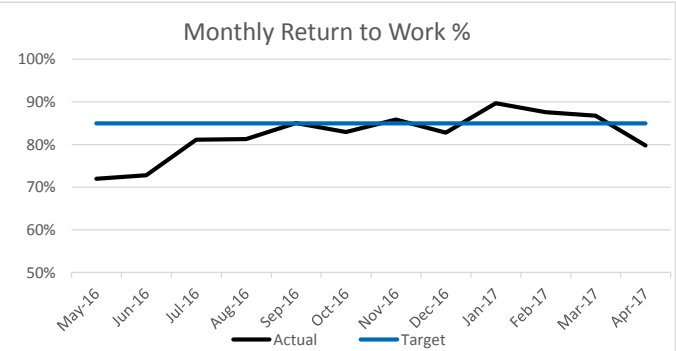
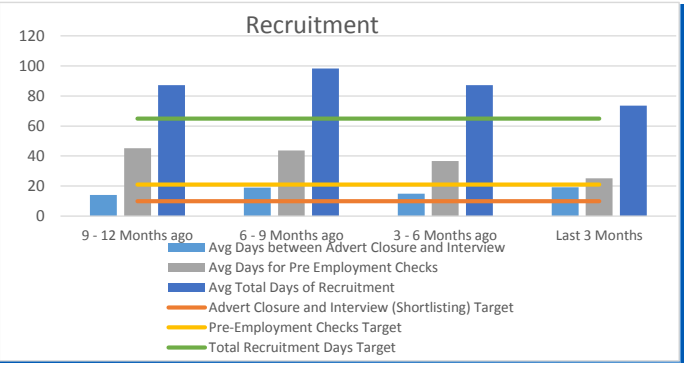
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

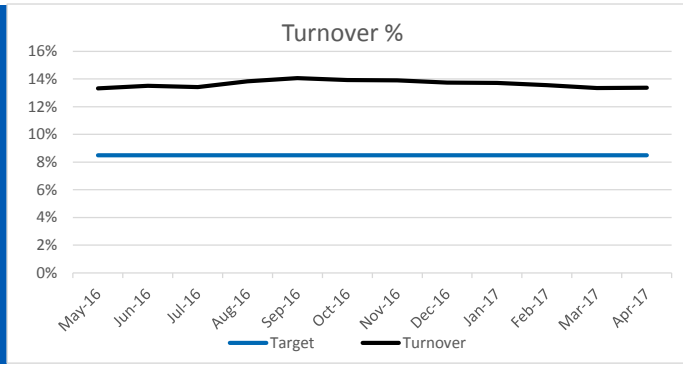
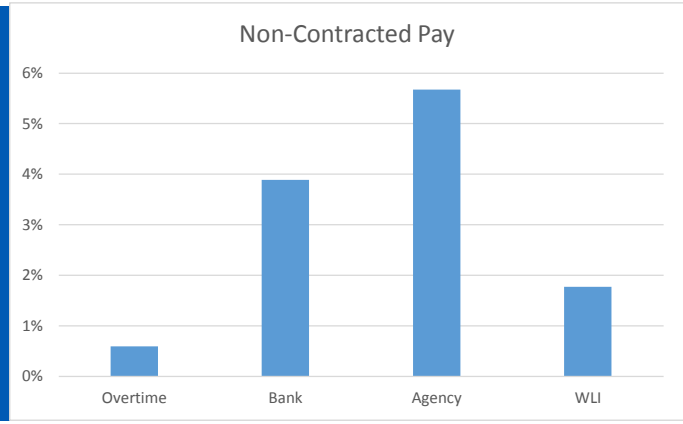
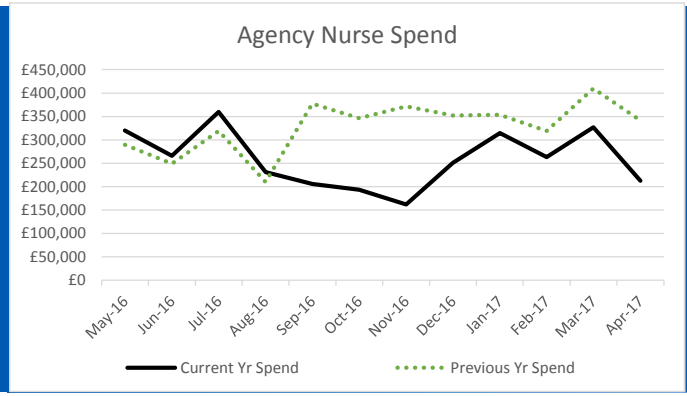
Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence for April 2017 slightly improved from the previous month and was 4.2% which was considerably better than the same month last year (4.69%). Therefore, the Trust target of 4.2% is just being met The latest figure(February 2017) for the North West absence performance was 4.8% (WHH was 4.53%)		Managers are reminded each month about the need for absence being input in a timely manner. The revised Attendance Management Policy was implemented on 1.12.16 and from January 2017 the position is much better than the same 4 month period in 2016. Furthermore, WHH has improved its position against the North West Average. Sickness for the Divisions is as follows: ACS - April-17 = 4.74% Red SWC - April-17 = 4.23% Amber Corporate - April -17 = 3.54% Green Stress remains the number one reason for absence with 24% of all sickness absence due to stress.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	RTW compliance reduced to 79.79% for April against a target of 85%.		It is disappointing to note that the RTW rate has reduced given that since January 2017 the Trust target has been met each month. There is no obvious explanation why this should be the case and monitoring at Performance Improvement meetings by HR Business Partners and the Director of HR & OD will continue in an effort to increase compliance.
Recruitment Red: Above Target Green: On or Below Target	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks	The average total days to recruit over the 3 month period ending April 2017 has slightly deteriorated from 71.6 days (March) to 73.7 days against a target of 65 days. The position 9 - 12 months ago was 87.3 days.		There is still room for improvement at each of the recruitment stages. The time taken from advert closure to interview (19.3 days) has deteriorated from the position 3-6 months ago wen it was 14.9 days. However, the time taken for employment checks has considerably improved from 36.6 days to 25.1 days over the same period but still short of the target of 21 days. Work is currently being undertaken to combine the ECF and New Starter form to improve the efficiency and the views of managers is being sought.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

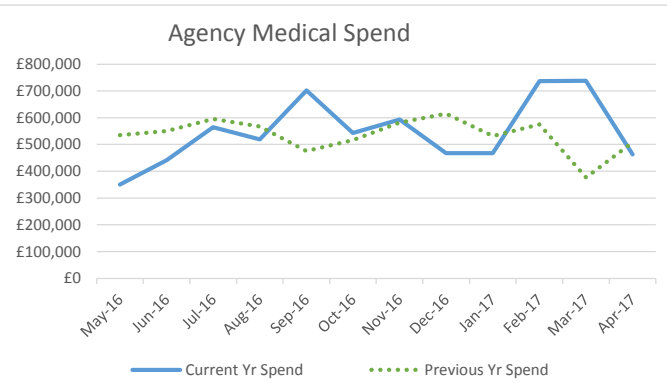
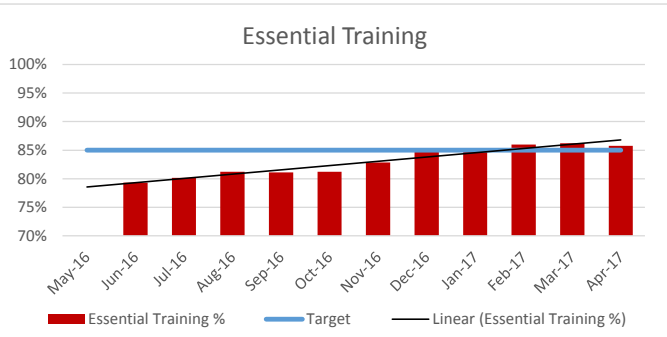
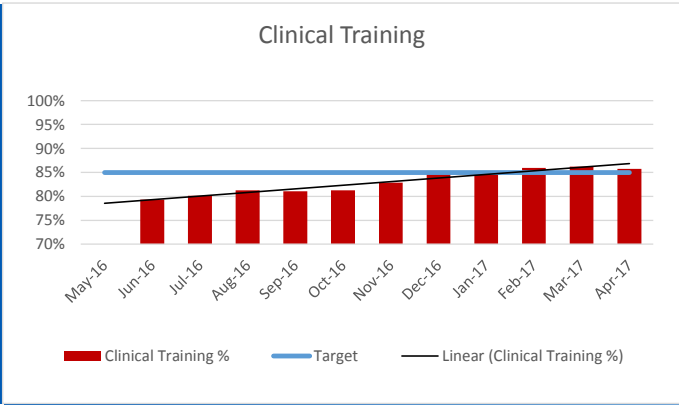
Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 12% Amber: 10% to 12% Green: Below 10%	A review of the turnover percentage over the last 12 months	Turnover marginally increased to 13.37% for the period up to April 2017. The status remains as 'red' and the target of 7 - 10% is not being met.		The various measures put in place such as exit interviews, on-boarding, improved induction, development opportunities, flexible working etc are gradually having a positive impact on reducing labour turnover but this is taking longer than expected. The new Recruitment and Retention Plan for Nursing staff will support this work. The trust continues to have more starters (40.7wte) than leavers (38.5 wte).
Non Contracted Pay	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Agency spend remains the highest element of Non-Contracted pay, accounting for 5.67% of the Trusts overall pay bill. Bank spend is 3.89% followed by WLI spend at 1.77% and then overtime at 0.59% of the pay bill. Overall Non-Contracted pay now makes up 11.93%.		Agency expenditure is reviewed at FSC and a new Pay Spend and Review Group has been established which has met on two occasions. This Group will concentrate on examining all spend within the trust including bank/agency/locum, overtime and WLIs. NHSI have issued further information during April which requires the trust to meet new targets for medical locum/agency expenditure. WLI payments as a proportionate of total spend are at their lowest level for 12 months. This reflects the reduction implemented in October 2016 and better management of lists.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on Agency Nurses	Agency Nurse spend decreased significantly in April to £212k which was an decrease of £155k from March and was also lower than the same month last year (£341k).		Whilst it is positive that there has been a reduction in agency nursing expenditure, there has been a corresponding increase in bank expenditure. This was to be expected as the trust tries to encourage agency workers to join the bank. Overall it is more cost effective to have staff working through a bank than an agency. The number of vacancies has reduced and staff in post figures have increased. The Recruitment and Retention Plan for Nursing continues to be implemented and this should assist in reducing agency expenditure further.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Locums	Agency Medical spend decreased significantly in April to £463k which was a decrease of £275k from March and was also lower than the same month last year (£508k).		Enforcing the Price Cap rules is continuing to prove difficult and the majority of shifts worked each week breach the Price Cap but these are necessary to maintain patient safety. There continues to be some progress in appointing new consultant staff and persuading some agency medical staff to work through the trust bank. The Gatenby Sanderson project went live w/c 17.4.17 with consultant vacancies being advertised in Emergency Department, Acute Medicine, Respiratory Medicine, Elderly Care and for an Intensivist.
Essential Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Essential Mandatory Training Compliance, this includes: Corporate Induction Dementia Awareness, Fire Safety Health and Safety Moving and Handling	The upward trend over the last year continues and the compliance rate for April was 89.50% which is above the trust target of 85%		The HR Business Partners are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Since June 2016 there has been an increase of over 6%. Divisional progress is as follows: ACS April = 90.01% Green SWC April = 87.12% Green Corp April = 92.14% Green
Clinical Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Clinical Mandatory Training Compliance, this includes: Infection Control Resus Safeguarding Procedures (Adults) - Level 1 Safeguarding Procedures (Adults) - Level 2 Safeguarding Procedures (Children) - Level 1 Safeguarding Procedures (Children) - Level 2 Safeguarding Procedures (Children) - Level 3 SEMA	The upward trend continues and the compliance rate for April was 85.76% which is above the trust target of 85%.		The HR Business Partners are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Since June there has been an increase of almost 7%. Divisional progress is as follows: ACS April = 85.55% Green SWC April = 84.04% Amber Corp April = 89.85% Green

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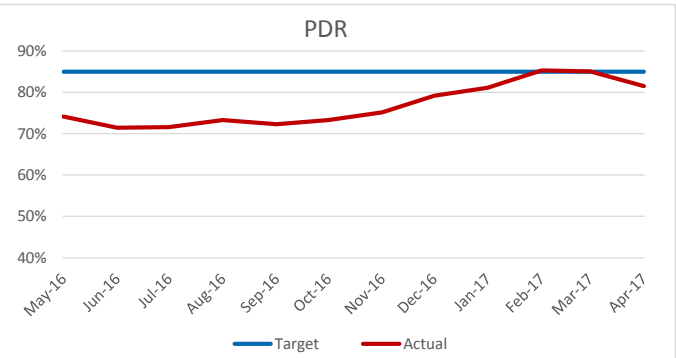
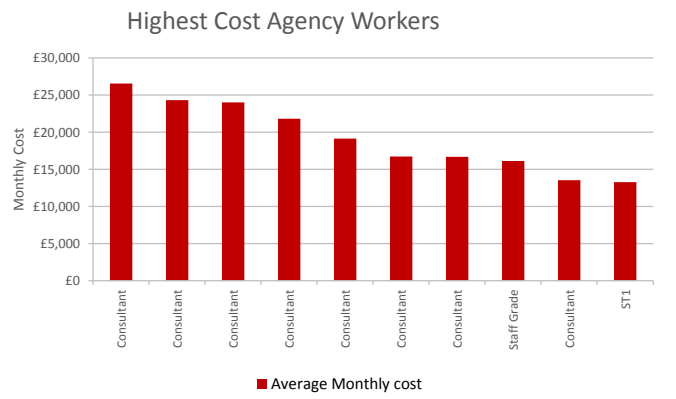
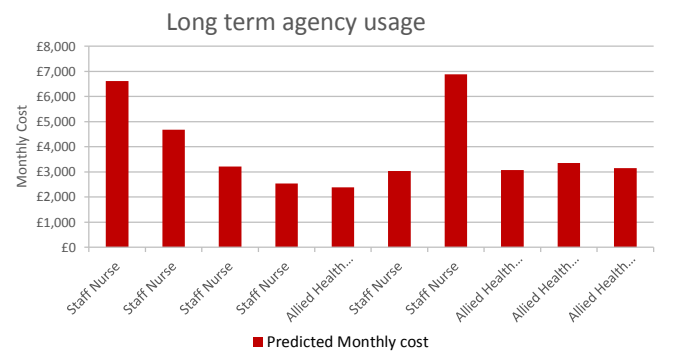
Integrated Dashboard - Board of Directors - April 2017

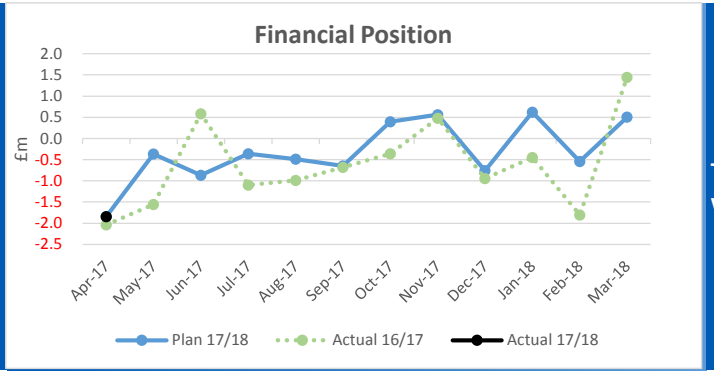
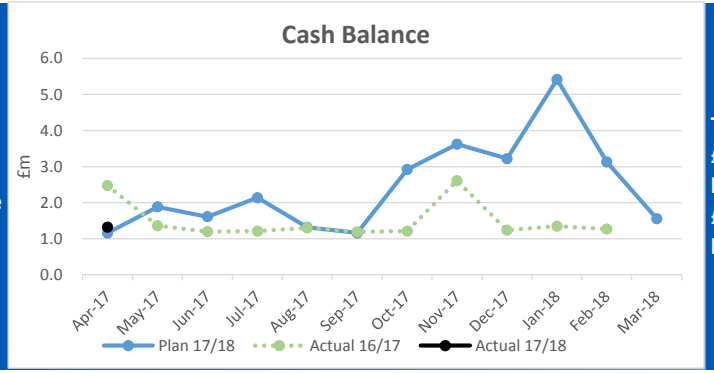
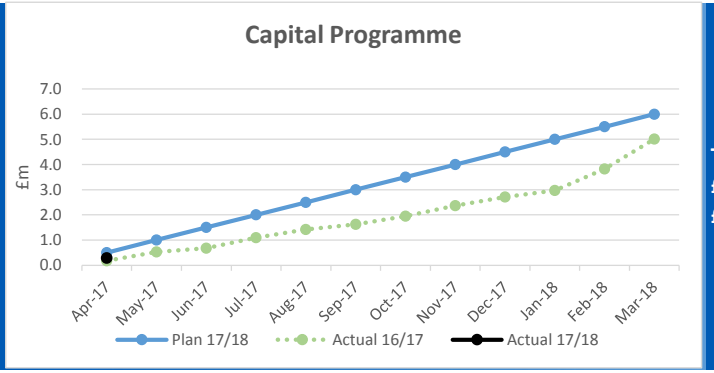
Workforce

	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	After meeting the trust target for the first time in February and maintaing this position for March, it is disappointing to report that the compliance rate for PDRs has fallen to 81.54% in April. Therefore, the Trust target of 85% is not being met.		The HR Business Partners are continuing to highlight the importance of PDRs at Divisional meetings and at Ward/Departmental meetings. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Divisional progress is as follows: ACS April = 78.84% Amber SWC April = 82.39% Amber Corp April = 83.76% Amber
Highest Cost Agency Workers	A summary of the Top 20 highest agency earners over the last 12 months	NHSI have very recently changed the reporting arrangements for the highest earning agency workers. Previously the trust was required to report the Top 20 highest earning agency workers over the last 12 months. Now trusts are required to report the Top 10 highest earning agency workers for the previous week. The Trust uses TempRe for medical/AHP staff and NHSP for nursing staff. For other staff, this is more difficult and relies on more manual systems which are being refined. The graph shows the weekly cost of the top 10 agency earners for the most recently reported position.		All of the highest earners are medical staff. Earnings range from c£2700 - £4900 per week. Efforts are continuing with NHSP and medical agencies to try and reduce the rates for the remaining agency workers or to attract them onto the trust payroll.
Long Term Agency Usage	A summary of agency workers who have been working at the trust every month for over 6 months	NHSI have very recently changed the reporting arrangements for long term agency workers. Previously long term agency workers were defined as working at the trust every month for over 6 months and all staff had to be reported. Now trusts are required to report the Top 10 agency workers who have worked at the trust for a minimum of 3 shifts per week for 6 consecutive weeks. The graph shows the Top 10 agency workers by staff group who have been working at the trust for more than 6 weeks.		5 of the staff are nurses, 3 are AHPs, 1 ODP and 1 pharmacist. The length of time these staff have worked at the trust range from 9 - 50 months. In all cases they are covering vacancies/escalation and have fixed term contracts which are regularly reviewed dependent upon progress with the filling of substantive posts.

Varrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

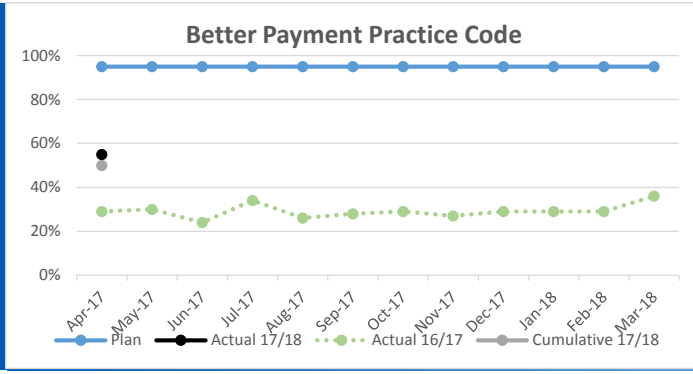
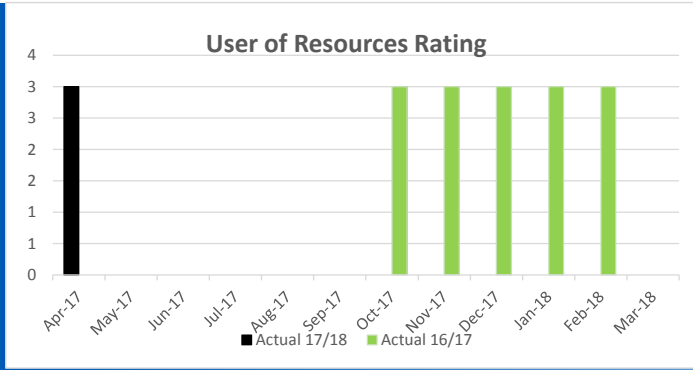
Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position	Surplus or deficit compared to plan (excluding impairment expenses).	The actual deficit in the month is £1.8m.		The monthly deficit of £1.8m is in line with plan.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	Cash balance at month end compared to plan	Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.3m equates to circa 2 days operational cash.		The current cash balance of £1.3m is £0.1m higher than the planned cash balance of £1.2m but the balance of £1.2m but the Trust requires access to borrowing.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan.	The actual capital spend in the month is £0.3m.		The monthly capital spend of £0.3m is £0.2m below the planned spend of £0.5m.

Varrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - April 2017

Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 55% of suppliers within 30 days.		The monthly performance of 55% is 40% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	Use of Resources Rating compared to plan.	The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity and I&E margin are all scored at 4 (lowest) and Variance to Control Total and Agency Ceiling is scored at 1 (highest).		The current Use of Resources Rating of 3 is in line with the planned rating of 3. The Use of Resource Rating was introduced as an indicator by NHSI in October 2016. Therefore April 2017 - September 2017 will have no comparable previous year data.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties			We have had no fines and penalties received from the Commissioners as of yet. This will be reported quarterly.

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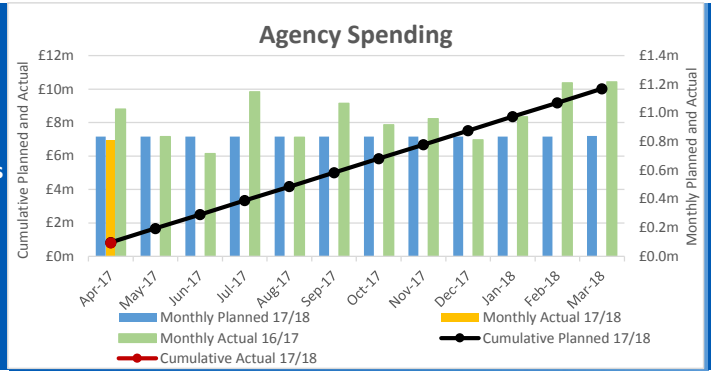
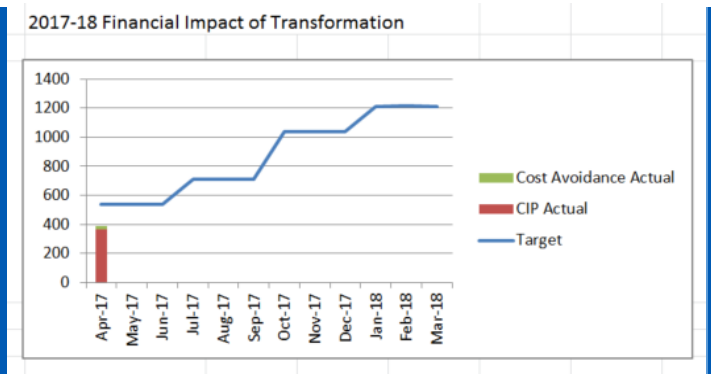
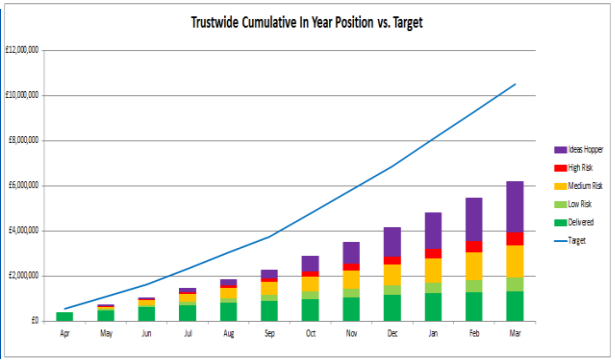
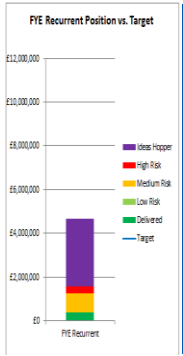
Integrated Dashboard - Board of Directors - April 2017

Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £0.8m.		The monthly agency spend of £0.8m is in line with the monthly agency ceiling of £0.8m.
Cost Improvement Programme - Performance to date Red: Cumulative CIP savings are less than 50% of planned YTD savings Amber: Cumulative CIP savings are between 50.01% and 89.99% of YTD	Cost savings delivered compared to plan.	CIP savings delivered in M1 are £0.367m against the M1 target of £0.54m a further £0.0235m was delivered in cost avoidance.		The financial impact of transformation activities was £0.390m in M1 (£0.367m CIP & £0.0235m cost avoidance) this is £0.15m below the Trust M1 CIP target of £0.54m.
Cost Improvement Programme - Plans in Progress - In Year/Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50.01% and 89.99% of the annual target Green: Forecast is more than 90% of the	Planned improvements in productivity and efficiency - In Year & Recurrent forecast vs £10.5m target	In Year -The best case forecast for Trust CIP schemes in year is around £6.2m. Best case assumes full delivery of all schemes on the tracker including all hopper ideas. The worst case forecast for CIP in year is around £2.7m. Worst case assumes the risk adjusted value of all schemes on the tracker and excludes all hopper ideas. Recurrent - The best case forecast for recurrent CIP is around £4.5m. The worst case forecast for recurrent CIP is around £0.9m.	 	The worst case current in year forecast for Trust CIP schemes is £2.7m which is £7.8m below the CIP target of £10.5m. The best case for CIP in year is £6.2m which is still £4.3m below the CIP target. Best case cost avoidance of £0.6m will help mitigate the position but would still leave a bottom line shortfall of £3.7m.

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FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/**
SUBJECT:	**Finance Report as at 30th April 2017**
DATE OF MEETING:	24th May 2017
ACTION REQUIRED	**For discussion**
AUTHOR(S):	Steve Barrow, Deputy Director of Finance
EXECUTIVE DIRECTOR	Andrea Chadwick, Director of Finance and Commercial Development
EXECUTIVE SUMMARY	For the period ending 30 April 2017 the Trust has recorded a deficit of £1.8m in line with plan, a cash balance of £1.2m and a Use of Resources Rating score of 3.
RECOMMENDATIONS	The Committee is asked to note the contents of the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

FINANCE REPORT AS AT 30 APRIL 2017

1. PURPOSE

This report sets out the financial position of the Trust as at 30 April 2017.

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	18.3	18.6	0.3
Operating expenses	(19.8)	(20.1)	(0.3)
Operating surplus/(deficit)	(1.5)	(1.5)	0.0
Non-operating expenses	(0.3)	(0.3)	0.0
Surplus/(deficit)	(1.8)	(1.8)	0.0
Control total adjustments	0.0	0.0	0.0
Control total	(1.8)	(1.8)	0.0
Cash balance	1.2	1.3	0.1
CIP target	0.5	0.4	(0.1)
Capital Expenditure	(0.5)	(0.3)	0.2

Depreciation and amortisation and restructuring costs are now included in operating expenses (see section 3).

Headlines:

- The monthly position is a deficit of £1.8m which is in line with plan and delivers a Use of Resources Rating score of 3.
- The control total is £1.8m deficit which is in line with plan.
- The annual cost savings target is £10.5m with planned savings to date of £0.5m. The savings delivered to date position is £0.4m (See agenda item Cost Improvement Report for further details).
- The actual capital expenditure for the month is £0.3m which is £0.2m below the planned expenditure of £0.5m (section 4).
- The cash balance is £1.3m which is £0.1 above the planned balance of £1.2m (section 5).
- The Better Payment Practice Code performance is 55% for the month (section 5).
- The value of aged debt is £2.9m (section 7).
- The value of aged creditors is £8.8m (section 8).

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- The Trust has requested a 2017/18 working capital loan of £3.7m to support the planned deficit. The first instalment of £1.6m has been received in April at a 1.5% interest rate (see section 9).
- The Trust has not applied for a capital loan in 2017/18 (section 10).

3. INCOME AND EXPENDITURE (APPENDIX B)

In month the Trust has recorded a deficit of £1.8m which is in line with plan.

Operating Income

In month operating income is £0.3m above 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	0.4
Non NHS Clinical Income	0.0
Other Operating Income	(0.1)
Total Operating Income	**0.3**

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

NHS Clinical Income

In month NHS clinical income is £0.4m above plan and variances by point of delivery are summarised in the table below.

Table: Analysis of monthly and year to date NHS clinical activity and income variances by category.

Narrative	Monthly Variance Activity	Monthly Variance £m
Elective Spells	(69)	0.0
Elective Excess Bed Days	0	0.0
Non Elective Spells	(61)	0.6
Non Elective Excess Bed Days	56	0.0
Outpatient Attendances	(820)	(0.2)
Accident & Emergency Attendances	775	0.0
Other Activity	-	0.0
Total NHS Clinical Income	**-**	**0.4**

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

The monthly and year to date income variance by Division is summarised in the table below.

Table: Analysis of monthly and year to date income variances by Division.

Narrative	Monthly Variance £m
Acute Care Services	0.2
Surgery, Women's and Children	0.0
Non divisional	0.2
Total	**0.4**

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

A year to date analysis of NHS clinical income by category and Division, Clinical Business Unit and specialty is available at Appendices C and D. The main headlines for each division are as follows:

Acute Care Services

The monthly position is £0.2m above plan with an over recovery in Airways, Breathing and Circulation and Specialist Medicine, partially offset by an under recovery in Diagnostics and Emergency Care.

Surgery, Women's and Children

The monthly position is on plan with an over recovery in Diagnostics offset by an under recovery in Musculoskeletal Care, Specialist Surgery and Women's and Children's Health.

The current activity plan includes £0.9m for spinal activity however NHS England is considering sending all spinal activity to The Walton Centre NHS Foundation Trust. This activity is not part of an agreed contract so there is no notice period. It is important that the cost base is reduced in line with the transfer of activity to minimise the financial loss to the Trust.

Fines and Penalties

Fines and penalties can be levied by commissioners for the non achievement of any national or local targets. However this excludes national standards relating to:

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

The Trust has agreed performance improvement trajectories for these standards and will secure Sustainability and Transformational Funding (STF) provided these trajectories are met. This approach ensures that Trusts meeting the eligibility criteria for the STF monies will not face a "double jeopardy" whereby Trusts may incur contract fines or penalties as well as losing access to funding.

The monthly financial position does not include any fines or penalties relating to the non-achievement of applicable national or local targets because at this stage the commissioners have not formally notified of any such fines or penalties. In order to minimise and ideally negate any fine or penalty, lead executive directors have been assigned to each contract target to ensure greater focus on compliance. No funding has been set aside to cover the incurrence of fines and penalties so non achievement of any target is a risk to delivery of the Trust's control total.

Commissioning for Quality and Innovation (CQUIN)

The Trust is able to earn £4.5m for the delivery of CQUIN and has assumed 100% of this income in this year's financial plan. CQUIN schemes have been agreed and assigned to a lead director to support the delivery of all schemes. In addition, investment of £0.4m has been provided to support the management and therefore delivery of the CQUIN programme. Monthly monitoring will be undertaken to identify schemes that require remedial action recovery plans to ensure compliance thereby minimising the level of financial risk. The agreed schemes are as follows:

- Improvement of health and wellbeing of NHS staff.
- Reducing the impact of serious infections (antimicrobial resistance and sepsis).
- Supporting proactive and safe discharge.
- Improving services for people with mental health needs who present to A&E.
- Offering advice and guidance.
- NHS E-Referrals.
- Preventing ill health by risky behaviours (alcohol and tobacco).
- Breast screening programme clerical staff development (health promotion role).
- Dental.
- Hospital Pharmacy Transformation and Medicines Optimisation.
- Nationally standardised dose banding for adult intravenous.

Non NHS Clinical Income

In month non NHS clinical income is on plan.

Other Operating Income

Sustainability and Transformational Funding (STF)

The value of the 2017/18 STF monies available to the Trust from the general fund is £7.0m and access to the monies will be based on the ability to meet the control total, provided Trusts have agreed the control total and ability to meet agreed access targets covering:

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

The same principles that were applied in 2016/17 will continue in 2017/18 in that the financial control totals are a binary on/off switch to secure funding. In other words if the financial control total is not achieved then no funding is allocated for the access standards.

The funding is split between financial control totals (70%) and access standards (30%) with the access standards weighted against RTT (12.5%), A&E (12.5%) and cancer days (5%). The funding is allocated after quarter end based on performance but rather than weighted equally across quarters funding is phased as follows:

- Quarter 1 (15%)
- Quarter 2 (20%)
- Quarter 3 (30%)
- Quarter 4 (35%)

Therefore the amount due in each quarter against each standard is summarised in the table below.

Table: analysis of fund by category by quarter.

Category	Quarter 1 £000	Quarter 2 £000	Quarter 3 £000	Quarter 4 £000	Total £000
Financial	738	984	1,476	1,722	4,920
A&E	132	176	263	308	879
RTT	132	176	263	308	879
Cancer	52	70	107	122	351
Total	**1,054**	**1,406**	**2,109**	**2,460**	**7,029**

There are no tolerances relating to either the delivery of financial or access standards. However there is the opportunity to recover missed payments in later quarters.

Finance – this will operate on a cumulative basis so if a Trust misses the year to date control total in a quarter it can recover the funding in a future quarter.

Access – A&E and RTT will operate on a cumulative basis so if a Trust misses the access target in a quarter it can recover the funding in a future quarter but this does not apply to cancer. The cancer access standard only applies on a non cumulative basis with each quarter measured separately.

The recovery of missed A&E and RTT funding assumes the Trust is meeting its cumulative control total under the binary on/off switch principle.

In month other operating income is £0.1m below plan mainly due to the under achievement of the income savings target.

The other operating income includes the share of funding relating to the Sustainability and Transformation funding which is £0.4m in month. The actual income for the month assumes that the Sustainability & Transformation funding will be received in full as the control total for the period has been delivered and the trajectories for the access targets have been agreed and exceeded.

Operating Expenses

In month operating expenses are £0.3m above plan and an analysis by expense type is summarised in the table below table.

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

Narrative	**Monthly Variance £m**
Pay	(0.4)
Drugs	0.0
Clinical Supplies	(0.1)
Non Clinical Supplies	0.2
Depreciation	0.0
Total Operating Expenses	**(0.3)**

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

Pay Costs

In month pay costs are £14.3m which is £0.4m above plan.

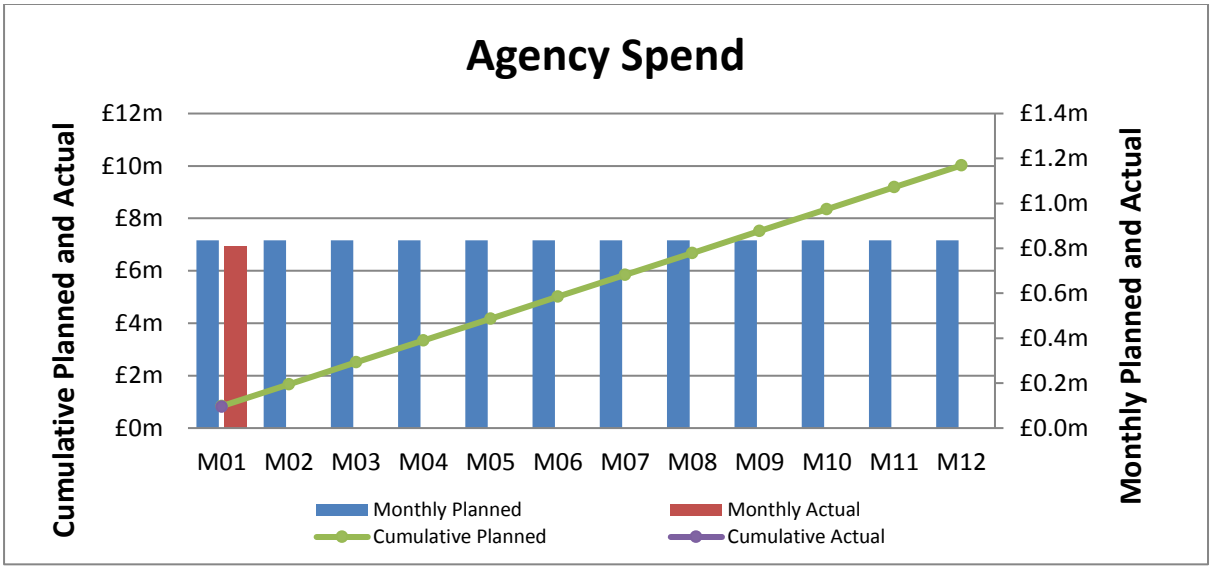
The pay spend includes the continued cost of temporary staffing including Bank, Agency and Locum costs, Waiting List Initiatives and additional hours paid at enhanced rates. To date the actual expenditure is £1.7m which equates to £20.4m per annum. Reduction in temporary spend is a key feature of the cost savings target so it is vital that these costs are minimised as much as possible.

Agency

The annual plan submitted to NHSI includes an annual locum and agency spend ceiling across all staff groups of £10.0m. A recent review of employment status has identified that some staff on zero hour and fixed term contracts have been categorised as locums. NHSI guidance indicates that the staff are not locums and therefore staff on zero hours contacts have now been categorised as bank staff and staff on fixed term contracts have now been categorised as substantive staff.

The monthly locum and agency spend amounts to £0.8m which is on plan. The monthly locum and agency spend compared to the planned spend is summarised in the table below.

Graph: Analysis of monthly and cumulative agency spend.



The Use of Resources Risk Rating includes an agency ceiling metric so agency expenditure above the annual ceiling may adversely affect the overall rating depending on performance in the other metrics.

Drugs Costs

In month drug costs are £1.4m which is on plan. The position includes excluded PbR drugs which are funded by commissioners, with the additional income shown against other income within NHS clinical income.

Clinical Supplies and Services

In month clinical supplies and services costs are £1.7m which is £0.1m above plan. This mainly relates the underachievement against the cost savings target, the over spend on pathology and radiology consumables and maintenance contracts and payments to Platform 7 for patient activity (although these costs are being offset by additional income).

Non Clinical Supplies

In month non clinical supplies costs are £2.2m which is £0.2 below plan. This mainly relates to reduced levels of expenditure on building and engineering works, utility costs and course fees.

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Depreciation and Amortisation

In order to align with the format of reporting adopted by NHSI (for planning and monitoring) and Department of Health (for annual accounts), depreciation and amortisation is now included in operating expenses and forms part of the operating surplus / deficit.

In month depreciation and amortisation costs are £0.5m which is in line with plan.

Restructuring Costs

In order to align with the format of reporting adopted by NHSI (for planning and monitoring) and Department of Health (for annual accounts), restructuring costs are now included in operating expenses and forms part of the operating surplus / deficit.

In month no restructuring costs have been incurred.

Divisional Performance

The financial position as at 30 April across all divisions is an over spend of £0.3m as summarised in the table below.

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

Division	Monthly Budget £m	Monthly Actual £m	Monthly Variance £m
Acute Care	6.6	7.0	(0.4)
Surgery, Women's & Children's	6.9	6.9	0.0
Outpatients	0.3	0.3	0.0
Corporate	4.0	3.9	0.1
Total	**17.8**	**18.1**	**(0.3)**

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

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 headlines for each division are:

Acute Care Division

In month the division is overspent by £0.4m, however clinical income is over recovered by £0.2m and therefore direct costs exceed full income by £0.2m.

All Clinical Business Units within the Division are overspent except for the Discharge / Patient Flow service. The main reasons for the overspend are £0.2m shortfall against the cost savings target, £0.1m on staffing escalation beds on Daresbury and Ward A4, £0.1m covering nurse vacancies and one to one nursing, £0.1m in Diagnostics for referred tests and WLI's partially offset by marginal underspends.

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Surgery, Women's and Children's Division

In month the division is on plan. Clinical income is on plan and therefore direct costs align with full income.

Musculoskeletal Care, Digestive Diseases and Administration are underspent although this is offset by over spends in Specialist Surgery and Women's and Children's Health. The under spend is mainly due to vacancies particularly within the Therapy Teams and nurse vacancies on A9 and in the CMTC.

Outpatients

In month the division is on plan.

Corporate Divisions

In month the corporate divisions are £0.1m under spent mainly due to underspends in Estates & Facilities, Information Technology and Pharmacy.

It is vital that all managers take corrective action where necessary to reduce costs and remain within the allocated resources.

Reserves

The Trust started the year with reserves of £24.5m including £10.8m related to high cost drugs that are funded non recurrently on a monthly basis dependent upon the spend. The remaining balance of £13.7m covers both committed reserves (£12.0m) and uncommitted reserves (£1.7m).

Committed Reserves - to date £4.9m has been transferred to divisions to fund agreed cost pressures leaving a balance of £7.1m.

Uncommitted Reserves – the balance remains at £1.7m.

The current position is summarised in the table below.

Table: Analysis of committed and uncommitted reserves (excluding high cost drugs reserve).

Narrative	Committed £m	Uncommitted £m	Total £m
Annual Position			
Balance as at 1 April	12.0	1.7	13.7
Transfer to Divisions (April)			
- Agreed pressures including Acute Care medical staffing, CQUIN compliance, vascular risk share and nurse associates	(2.6)	0.0	(2.6)
- STP costs	(0.1)	0.0	(0.1)
- NHSLA increase	(1.0)	0.0	(1.0)

- Incremental drift	(0.7)	0.0	(0.7)
- Removal of historical saving targets	(0.4)	0.0	(0.4)
- Other transfers	(0.1)	0.0	(0.1)
Total	**(4.9)**	**(0.0)**	**(4.9)**
Balance as at 30 April	7.1	1.7	8.8
Commitments	(7.1)	(1.7)	(8.8)
Reserve Balance Available	**0.0**	**0.0**	**0.0**

Non Operating Income and Expenses

Non operating income and expenses now excluded depreciation and amortisation and restructuring costs.

In month non operating income and expenses are £0.3m which is on plan.

Use of Resources Rating

The Use of Resources Rating is used to measure and assess financial performance. This is calculated on a cumulative basis and the year to date position and performance results in an overall Use of Resources Rating of 3 with the actual score against each metric summarised in the table below:

Table: Use of Resources Rating

Metric	Score
Capital Servicing Capacity	4
Liquidity (days)	4
I&E margin	4
Variance from control total	1
Agency spend	1
Overall Rating	**3**

4. CAPITAL

The annual capital programme is £6.0m. In month the actual spend is £0.3m which is £0.2m below the planned spend of £0.5m as summarised in the table below.

Table: Analysis of performance against the revised capital programme.

Category	Annual Budget £m	Budget to date £m	Spend to date £m	Variance to date £m
Estates	1.9	0.2	0.1	0.1
IM&T	1.4	0.1	0.0	0.1
Medical Equipment	2.3	0.2	0.2	0.0
Contingency	0.4	0.0	0.0	0.0

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Total	**6.0**	**0.5**	**0.3**	**0.2**

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

5. CASH FLOW (APPENDIX F)

The cash balance as at 30 April was £1.3m which is £0.1m above the planned balance of £1.2m with the monthly movements summarised in the table below.

Table: Summary of the monthly cash movement.

Cash balance movement	**£m**
Balance as at 1st April	1.2
In month surplus / (deficit)	(1.8)
Non cash flows in operating surplus	0.5
Increase / (decrease) in working capital	2.5
Increase / (decrease) in non current payables and receivables	0.1
Capital expenditure	(0.7)
Repayment of STF loan (Q3 2016/17)	(2.0)
Drawdown of 2017/18 working capital loan	1.6
Other movements	(0.1)
Balance as at 30 April	**1.3**

The operating performance continues to have an adverse effect on the amount of cash available to the Trust. At 30 April 2017 the value of aged creditors stands at £8.8m, although this is partially covered by the value of aged debtors at £2.9m.

The current cash balance of £1.3m equates to circa 2 days operational cash. Active management of the working balances continues in order to maintain a cash balance sufficient to pay creditors (see section 8 for further details). Performance against the Non NHS Better Payment Practice Code (BPPC) is 55% in the month.

The cash flow movement for the year is detailed in Appendix G. The following table summarises the short term cash flow anticipated over the next 3 months which reflects the requirement to hold a minimum cash balance of £1.2m.

Table: Short term cash flow movements.

Cash balance movement	**May £m**	**June £m**	**July £m**
Opening balance	1.3	2.0	1.8
In month surplus/(deficit)	(0.1)	(0.6)	(0.1)
Non cash flows in operating surplus	0.5	0.5	0.5
Increase / (decrease) in working capital	0.8	0.3	0.6
Capital expenditure	(0.5)	(0.5)	(0.5)

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Other working capital movements	0.0	0.1	0.0
Closing balance	**2.0**	**1.8**	**2.3**

6. STATEMENT OF FINANCIAL POSITION (APPENDIX G)

Assets employed have decreased by £1.8m in the month as a result of the monthly deficit with the movements in the month detailed below:

- Non current assets have decreased by £0.2m as depreciation charges have exceeded the capital spend.
- Current assets have increased by £0.5m mainly due to an increase in trade and other receivables.
- Current liabilities have increased by £2.7m mainly due to an increase in trade and other payables.
- Non current liabilities have decreased by £0.5m mainly due to the repayment of loans and finance leases.

The net current liabilities have improved between 31 March 2016 and 31 March 2017 by £4.8m mainly due to the improved financial performance in 2016/17 and reduced capital spend.

7. AGED DEBT (APPENDIX H)

The number of outstanding invoices has decreased by 16 in the month so the number of outstanding invoices totals 738. The value of aged debt has decreased by £1.5m to £2.9m. Debt of £0.6m has been recovered in the early part of April thereby reducing overall aged debt to £2.3m.

8. AGED CREDITORS (APPENDIX I)

The number of unpaid invoices has decreased by 1,128 in the month so the total of unpaid invoices totals 4,241. The value of aged creditors has increased by £1.0m in the month to £8.8m (with £4.4m 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. There is currently insufficient cash to pay all creditors. Priority is given to the payment of small local suppliers and then the selection criteria is based on the number, value and age of the invoices and the avoidance of potential interest charges levied by the creditors. The largest non NHS creditor by value is Spire Healthcare Ltd £0.2m outstanding as at 30 April. The volume and value of outstanding invoices is summarised in the table below (see Appendix I for further details).

Table – analysis of outstanding invoices by volume and value.

Narrative	Volume Number	Volume %	Value £000	Value %
Largest 15	1,263	30	4,934	56
Others	2,978	70	3,856	44
Total	**4,241**	**100**	**8,790**	**100**

9. WORKING CAPITAL LOAN

The Trust has requested a 2017/18 working capital loan of £3.7m to support the planned deficit. The first instalment of £1.6m has been received in April at a 1.5% interest rate.

Due to the delay in receipt of STF monies for 2016/17 Q3 and Q4, additional loans totalling £4.0m were taken out in 2016/17. The loan relating to Q3 has been repaid in April and Q4 will be repaid once the remaining monies have been received from Department of Health. No date has been provided at the time of writing.

The cumulative value of working capital loans covering the period 2015/16 to 2017/18 equates to £25.8m.

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. The loan is repayable over 15 years at an interest rate of 1.78%. Principle and interest repayments commenced in 2016/17 and are paid twice yearly (August and February).

The 2017/18 capital programme is funded by internally generated depreciation and a carry forward of the 2016/17 underspend. There is no requirement for a capital loan in year.

11. LOAN INTEREST

The interest resulting from the capital and working capital loans is included within the 2017/18 financial position as a non operating expense. The interest associated with these loans is summarised in the table below.

Table: 2017/18 Interest Charges (forecast for the full year)

Narrative	Loan/ Facility Value £000	Interest Rate	Forecast Interest Charge £000
2015/16 Capital Loan	1,600	1.78%	26
2015/16 Working Capital Loan	14,200	1.50%	208
2016/17 Working Capital Loan (to cover deficit)	7,918	1.50%	119
2016/17 Working Capital Loan (to cover Q4 STF)	2,000	1.50%	30
2017/18 Working Capital Loan (to cover deficit)	3,657	1.50%	38
Total			**421**

12. RISK AND FORECAST

For the period ending 30 April the Trust has recorded a deficit of £1.8m 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:

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- 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.
- Failure to reduce the cost base in line with the income loss for the transfer of activity to the Walton Centre NHS Foundation Trust.

13. CONCLUSION

For the period ending 30 April 2017 the Trust has recorded a deficit of £1.8m, a cash balance of £1.3m and a Use of Resources Rating score of 3.

14. RECOMMENDATION

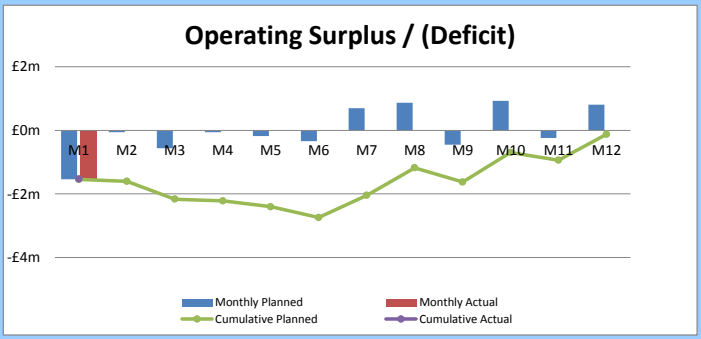
The Finance and Sustainability Committee is asked to note the content of the report.

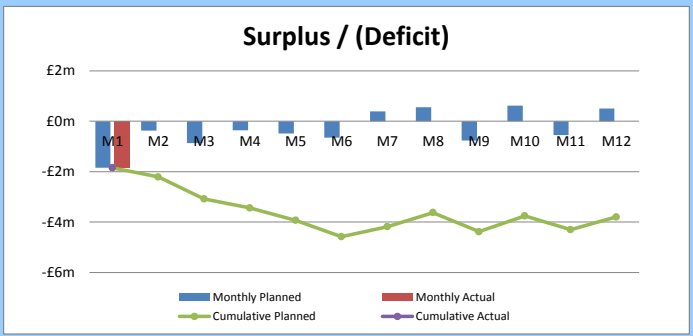
Andrea Chadwick
Director of Finance & Commercial Development

Warrington & Halton Hospitals NHS Foundation Trust

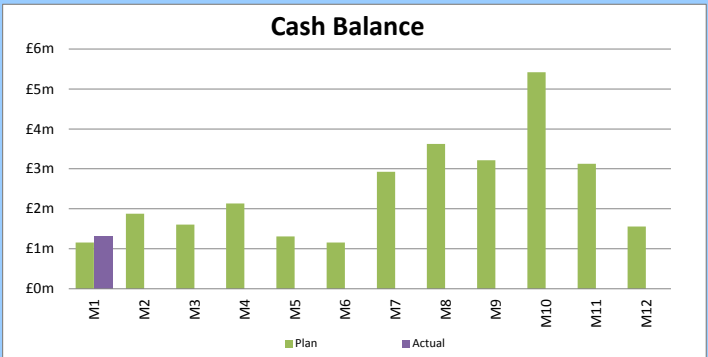
Finance Dashboard as at 30th April 2017 (Part A)

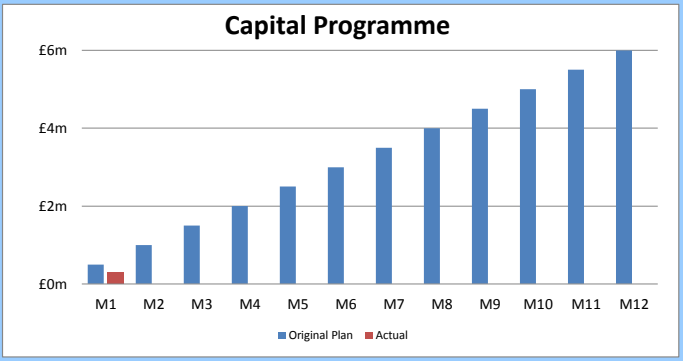
Profitability



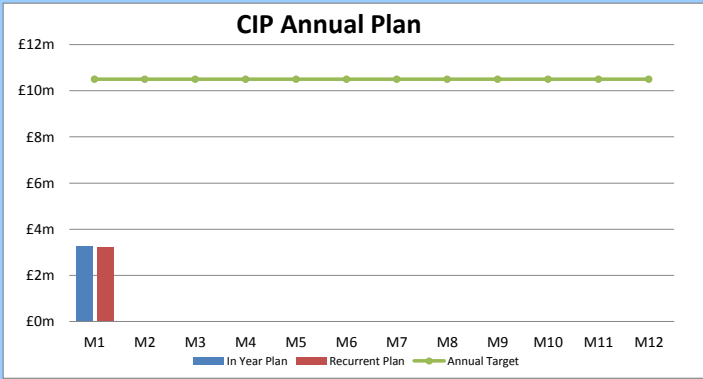


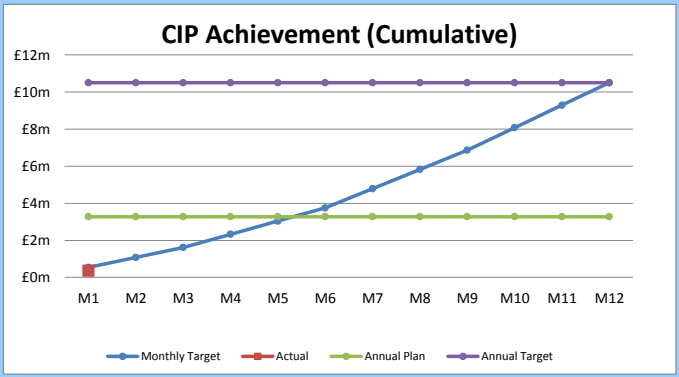
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Surgery, Women's & Children's Health	75,180	6,926	6,909	17	0.2	6,926	6,909	17	0.2
Acute Care Services	73,998	6,624	7,081	-457	-6.9	6,624	7,081	-457	-6.9
Outpatients	3,417	294	290	4	1.4	294	290	4	1.4
Corporate									
Central Operations	144	12	12	0	1.9	12	12	0	1.9
Communications & Membership	271	23	21	2	10.0	23	21	2	10.0
Estates and Facilities	14,159	1,206	1,115	91	7.5	1,206	1,115	91	7.5
Finance and Commercial Development	15,458	1,294	1,295	-1	-0.1	1,294	1,295	-1	-0.1
HR and OD	4,476	377	374	3	0.9	377	374	3	0.9
Information Technology	3,978	334	315	19	5.6	334	315	19	5.6
Nursing and Governance	1,677	142	152	-10	-6.8	142	152	-10	-6.8
Pharmacy	3,925	334	309	25	7.4	334	309	25	7.4
Transformation Team	407	34	33	1	3.6	34	33	1	3.6
Research and Development	57	5	5	0	0.0	5	5	0	0.0
Trust Executive	2,473	280	289	-9	-3.2	280	289	-9	-3.2
Total	**199,620**	**17,885**	**18,200**	**-315**	**-1.8**	**17,885**	**18,200**	**-315**	**-1.8**

Positive variance = underspend, negative variance = overspend.

Use of Resources Rating

Use of Resources Rating	Actual Metric	Actual Rating
Capital Servicing Capacity (times)	-3.47	4
Liquidity Ratio (days)	-14.4	4
Income & Expenditure Margin (%)	-9.84%	4
Variance from control total	-11.96%	1
Agency Ceiling (%)	-2.99%	1
Overall Risk Rating		**3**

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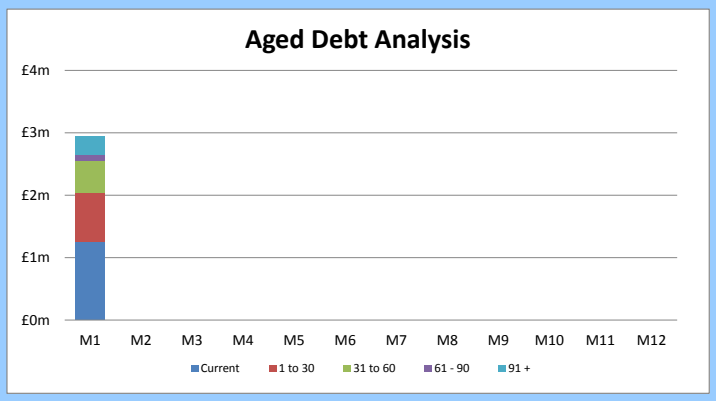
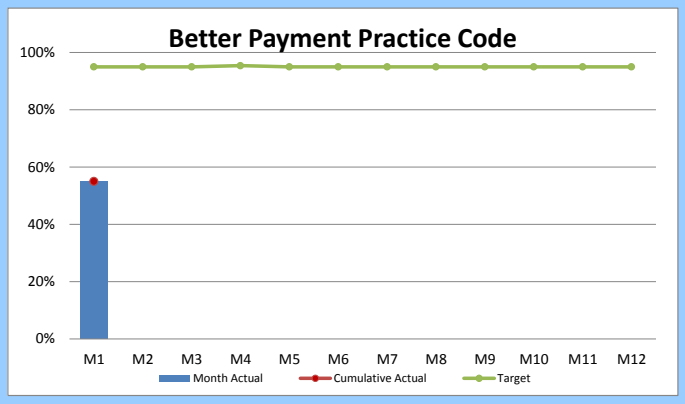
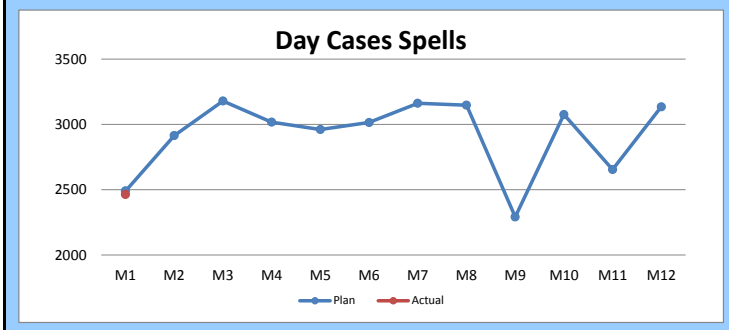
Finance Dashboard as at 30th April 2017 (Part B)

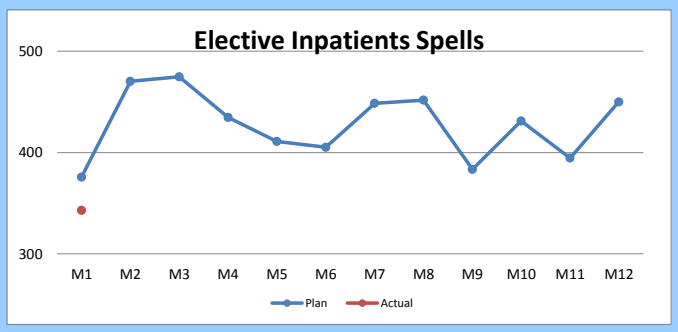
Balance Sheet and Liquidity

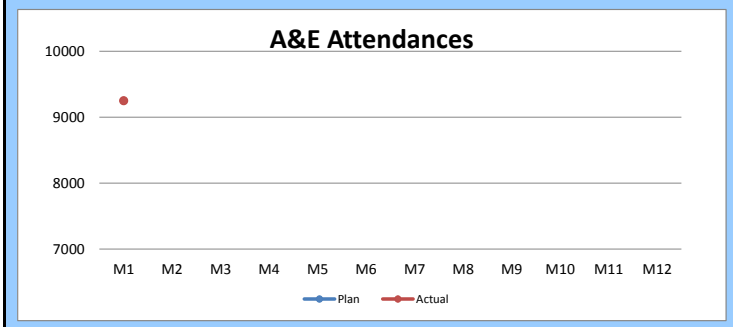


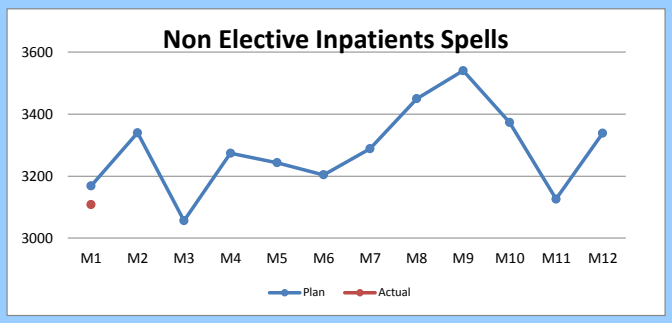


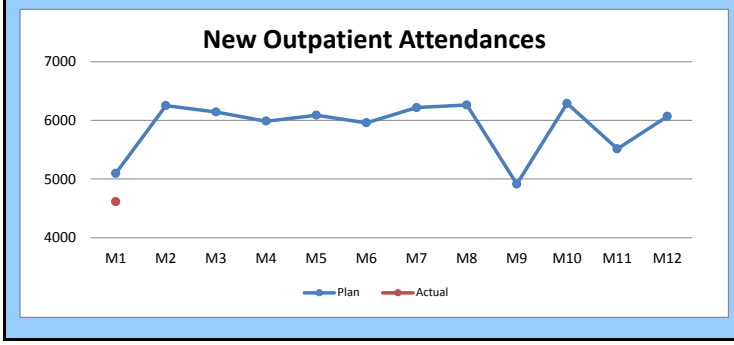
Activity Analysis

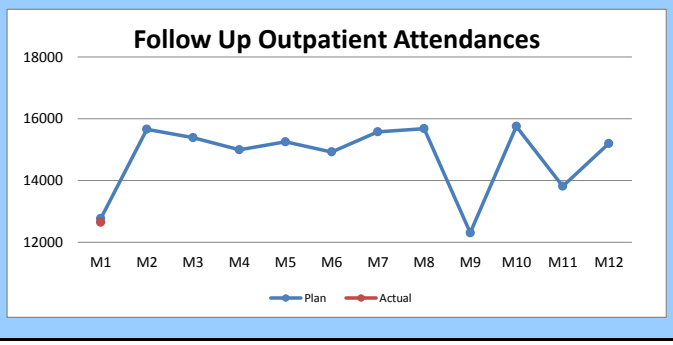












Warrington & Halton Hospitals NHS Foundation Trust **Appendix B**

Income Statement, Activity Summary and Use of Resources Ratings as at 30th April 2017

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Clinical Income									
Elective Spells	2,621	2,588	-33	2,621	2,588	-33	36,380	36,380	0
Elective Excess Bed Days	11	14	2	11	14	2	155	155	0
Non Elective Spells	4,782	5,356	574	4,782	5,356	574	59,452	59,452	0
Non Elective Excess Bed Days	177	204	27	177	204	27	2,199	2,199	0
Outpatient Attendances	2,461	2,312	-148	2,461	2,312	-148	34,174	34,174	0
Accident & Emergency Attendances	1,048	1,076	28	1,048	1,076	28	13,066	13,066	0
Other Activity	5,212	5,180	-33	5,212	5,180	-33	62,446	62,446	0
Sub total	**16,312**	**16,730**	**418**	**16,312**	**16,730**	**418**	**207,873**	**207,873**	**0**
Non NHS Clinical Income									
Private Patients	9	2	-7	9	2	-7	106	106	0
Other non protected	107	94	-13	107	94	-13	1,284	1,284	0
Sub total	**116**	**96**	**-20**	**116**	**96**	**-20**	**1,390**	**1,390**	**0**
Other Operating Income									
Training & Education	641	641	0	641	641	0	7,693	7,693	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Sustainability & Transformation Fund	351	351	0	351	351	0	7,029	7,029	0
Miscellaneous Income	827	773	-54	827	773	-54	10,081	10,081	0
Sub total	**1,819**	**1,764**	**-55**	**1,819**	**1,764**	**-55**	**24,803**	**24,803**	**0**
Total Operating Income	**18,247**	**18,590**	**343**	**18,247**	**18,590**	**343**	**234,066**	**234,066**	**0**
Operating Expenses									
Employee Benefit Expenses	-13,875	-14,292	-417	-13,875	-14,292	-417	-164,359	-164,359	0
Drugs	-1,447	-1,414	33	-1,447	-1,414	33	-17,285	-17,285	0
Clinical Supplies and Services	-1,567	-1,720	-152	-1,567	-1,720	-152	-18,264	-18,264	0
Non Clinical Supplies	-2,436	-2,236	200	-2,436	-2,236	200	-28,729	-28,729	0
Depreciation and Amortisation	-463	-463	0	-463	-463	0	-5,552	-5,552	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Total Operating Expenses	**-19,788**	**-20,125**	**-337**	**-19,788**	**-20,125**	**-337**	**-234,189**	**-234,189**	**0**
Operating Surplus / (Deficit)	**-1,541**	**-1,535**	**6**	**-1,541**	**-1,535**	**6**	**-123**	**-123**	**0**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0	0	0
Interest Income	2	1	-1	2	1	-1	26	26	0
Interest Expenses	-33	-37	-4	-33	-37	-4	-426	-426	0
PDC Dividends	-272	-272	0	-272	-272	0	-3,275	-3,275	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-303**	**-307**	**-4**	**-303**	**-307**	**-4**	**-3,675**	**-3,675**	**0**
Surplus / (Deficit)	**-1,844**	**-1,842**	**2**	**-1,844**	**-1,842**	**2**	**-3,798**	**-3,798**	**0**
Depreciation on Donated and Granted Assets	12	12	0	12	12	0	141	141	0
Control Total	**-1,832**	**-1,830**	**2**	**-1,832**	**-1,830**	**2**	**-3,657**	**-3,657**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,876	2,807	-69	2,876	2,807	-69	40,300	40,300	0
Elective Excess Bed Days	54	54	0	54	54	0	732	732	0
Non Elective Spells	3,169	3,108	-61	3,169	3,108	-61	39,402	39,402	0
Non Elective Excess Bed Days	845	901	56	845	901	56	10,512	10,512	0
Outpatient Attendances	23,667	22,847	-820	23,667	22,847	-820	328,548	328,548	0
Accident & Emergency Attendances	8,475	9,250	775	8,475	9,250	775	105,704	105,704	0
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-3.53	-3.47	0.06	1.43	1.37	-0.07
Liquidity Ratio (Days)				-27.0	-14.4	12.6	-48.9	-48.9	0.0
I&E Margin (%)				-10.04%	-9.84%	0.20%	-1.56%	-1.56%	0.00%
Variance from control total (%)				0.00%	0.24%	0.24%	0.00%	0.00%	0.00%
Agency Ceiling (%)				0.00%	-2.99%	-2.99%	0.00%	0.00%	0.00%
Ratings									
Capital Servicing Capacity (Times)				4	4	0	3	3	0
Liquidity Ratio (Days)				4	4	0	4	4	0
I&E Margin (%)				4	4	0	4	4	0
Variance from control total (%)				1	1	0	1	1	0
Agency Ceiling (%)				1	1	0	1	1	0
Use of Resources Rating				**3**	**3**	**0**	**3**	**3**	**0**

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

Income and Activity to 30th April 2017

Summary by Point of Delivery

	Point of Delivery Description	Annual		Year to Date ACTIVITY			Year to Date INCOME		
		Planned Activity	Planned Income £	Planned Activity	Estimated Activity	Activity Variance	Planned Income £	Estimated Income £	Income Variance £
	Elective								
	Elective Inpatients	5,187	16,167,219	380	343	-37	1,184,292	1,101,273	-83,019
	Elective Inpatients Excess Bed Days		155,050				11,358	13,791	2,433
	Daycase	35,112	20,212,896	2,496	2,464	-32	1,436,616	1,486,615	49,999
	SUBTOTAL	40,300	36,535,165	2,876	2,807	-69	2,632,265	2,601,680	-30,586
	Emergency								
	Non Elective Inpatients	39,402	59,451,889	3,169	3,108	-61	4,781,909	5,356,310	574,401
	Non Elective Inpatients Excess Bed Days		2,199,466				176,882	204,217	27,334
	SUBTOTAL	39,402	61,651,356	3,169	3,108	-61	4,958,791	5,560,527	601,736
	Outpatients								
	New Outpatients	72,233	11,855,193	5,201	4,612	-589	853,564	816,251	-37,313
	Follow Up Outpatients	178,884	13,941,782	12,880	12,645	-235	1,003,797	893,902	-109,895
	Outpatient Telephone Clinics	21,030	547,296	1,514	1,216	-298	39,405	29,720	-9,685
	Outpatient Procedures	51,055	7,223,209	3,687	3,903	216	520,065	525,418	5,353
	Ward Attenders	5,346	606,582	385	471	86	43,673	47,028	3,354
	SUBTOTAL	328,548	34,174,062	23,667	22,847	-820	2,460,505	2,312,320	-148,185
	Other								
	A&E Attendances	105,704	13,066,000	8,475	9,250	775	1,048,000	1,075,614	27,614
	Pathology Direct Access	2,957,046	5,248,624	246,421	246,421	0	437,385	437,385	0
	Radiology Direct Access (Excluding Unbundled)	34,359	1,149,326	2,863	2,690	-173	95,777	86,248	-9,529
	Radiology Diagnostic Imaging (Unbundled)	30,923	2,178,456	2,577	2,462	-115	181,538	183,909	2,371
	Outpatient Unbundled Radiology & Echos	47,605	4,482,230	3,428	3,818	390	395,890	324,002	-71,889
	Paediatric Diabetes		375,723				31,310	33,902	2,592
	CPAP Consumables & Maintenance		131,022				10,918	7,646	-3,272
	Critical Care (Neonatal)	4,369	2,036,443	364	336	-28	169,704	169,579	-124
	Critical Care Adult (Unbundled)	6,253	6,461,185	521	479	-42	538,432	432,542	-105,890
	Chemotherapy (Unbundled)	794	240,526	728	725	-3	220,483	217,616	-2,867
	Palliative Care (Unbundled)	12,781	1,514,969	1,065	1,233	168	126,247	146,088	19,840
	Maternity Pathway	7,768	13,082,892	650	581	-69	1,088,389	961,238	-127,152
	Excluded Drugs		10,851,767				904,314	923,268	18,955
	Sustainability & Transformation Fund		7,029,000				351,000	351,000	0
	All Other Services (including CQUIN)		14,693,123				1,012,050	1,256,338	244,287
	SUBTOTAL	3,207,602	82,541,286	267,091	267,995	903	6,611,439	6,606,375	-5,064
	Total	**3,615,852**	**214,901,868**	**296,802**	**296,757**	**-46**	**16,663,000**	**17,080,901**	**417,901**

Warrington & Halton Hospitals NHS Foundation Trust

Appendix D

Income and Activity to 30th April 2017

Summary by Division / CBU / Specialty

Division	Clinical Business Unit and Specialty	Annual		Year to Date ACTIVITY			Year to Date INCOME		
		Planned Activity	Planned Income £	Planned Activity	Estimated Activity	Activity Variance	Planned Income £	Estimated Income £	Income Variance £
Acute Care Services	**Airway, Breathing and Circulation**								
	Anaesthetics	447	32,809	32	13	-19	2,373	696	-1,677
	Cardiology	17,758	5,117,793	1,289	1,492	203	385,120	682,867	297,746
	CPAP	0	131,022	0	0	0	10,918	7,646	-3,272
	Adult Critical Care	6,253	6,461,185	521	479	-42	538,432	432,542	-105,890
	Critical Care	1,200	1,291,659	98	94	-4	103,508	105,339	1,831
	Respiratory Medicine	15,487	3,243,331	1,124	1,101	-23	242,327	542,735	300,408
	Clinical Business Unit Block Income (ABC)	0	555,211	0	0	0	46,268	46,268	0
	SubTotal	41,146	16,833,010	3,063	3,179	116	1,328,947	1,818,092	489,145
	Diagnostics								
	Haematology	51,657	2,891,601	4,367	4,379	12	404,441	402,515	-1,926
	Direct Acess Pathology	2,957,046	5,248,624	246,421	246,421	0	437,385	437,385	0
	Imaging - Direct Acess Radiology (Excl U/B)	34,359	1,149,326	2,863	2,690	-173	95,777	86,248	-9,529
	Imaging - Direct Acess Radiology Unbundled	30,923	2,178,456	2,577	2,462	-115	181,538	183,909	2,371
	Imaging - Echo's and OP U/B	47,605	4,482,230	3,428	3,818	390	395,890	324,002	-71,889
	CIP	0	0	0	0	0	0	0	0
	Clinical Business Unit Block Income (D)	0	2,116,335	0	0	0	176,361	176,361	0
	SubTotal	3,121,590	18,066,572	259,655	259,770	114	1,691,394	1,610,421	-80,973
	Specialist Medicine								
	Diabetic Medicine	10,928	868,848	787	647	-140	62,556	54,996	-7,561
	Endocrinology	2,653	438,047	191	155	-36	31,567	30,291	-1,276
	Elderly Care	1,891	679,303	144	346	202	53,121	140,377	87,256
	Palliative Care Medicine (U/B)	81	18,021	6	5	-1	1,298	603	-695
	Sexual Health	3,191	471,496	230	233	3	33,947	33,884	-63
	Stroke Medicine	1,054	161,965	76	108	32	11,723	34,161	22,437
	Clinical Business Unit Block Income (SM)	0	24,736	0	0	0	2,061	2,875	814
	SubTotal	19,799	2,662,416	1,434	1,494	60	196,274	297,187	100,913
	Urgent and Emergency Care								
	Emergency Medicine	120,142	19,357,900	9,615	10,261	646	1,551,959	1,530,805	-21,155
	General Internal Medicine	31,021	30,130,656	2,490	2,090	-400	2,420,994	2,100,785	-320,208
	Clinical Business Unit Block Income (UEC)	0	2,517,857	0	0	0	209,821	209,821	0
	SubTotal	151,163	52,006,413	12,105	12,351	246	4,182,774	3,841,411	-341,363
Surgery, Women's & Children's	**Digestive Diseases**								
	Endoscopy	11,490	4,775,392	819	871	52	340,274	359,343	19,069
	Gastroenterology	8,881	2,297,285	644	923	279	173,162	369,074	195,912
	Vascular Surgery	3,054	552,698	220	218	-2	39,841	37,179	-2,662
	General Surgery	23,662	13,852,490	1,773	1,665	-108	1,065,513	1,018,868	-46,645
	Clinical Business Unit Block Income (DD)	0	38,865	0	0	0	3,239	3,239	0
	SubTotal	47,087	21,516,730	3,455	3,677	222	1,622,029	1,787,703	165,674
	Musculoskeletal Care								
	Pain Management	3,892	1,174,743	279	174	-105	83,826	64,159	-19,667
	Rheumatology	14,151	1,710,707	1,024	843	-181	124,140	79,135	-45,005
	Trauma and Orthopaedics	57,554	24,066,760	4,170	4,176	6	1,789,116	1,832,926	43,810
	Clinical Business Unit Block Income (MC)	0	2,924,945	0	0	0	243,745	243,745	0
	SubTotal	75,596	29,877,155	5,473	5,193	-280	2,240,828	2,219,966	-20,862
	Specialist Surgery								
	ENT	17,629	3,356,464	1,279	1,027	-252	245,810	215,474	-30,337
	Maxillofacial Surgery	7,099	1,618,879	509	528	19	115,667	123,135	7,467
	Ophthalmology	46,031	7,319,073	3,310	3,270	-40	524,618	462,825	-61,793
	Ophthalmology - ARMD	6,010	2,463,353	430	465	35	176,255	190,003	13,748
	Opthalmology - Halton Cataracts Contract	509	47,388	37	32	-5	3,390	12,626	9,236
	Optometry & Orthoptics	11,683	739,895	841	879	38	53,272	52,481	-791
	Orthodontics	5,267	566,104	379	362	-17	40,759	39,956	-803
	Urology	12,544	4,201,465	926	804	-122	316,378	343,410	27,032
	Clinical Business Unit Block Income (SS)	0	1,102,816	0	0	0	91,901	110,750	18,848
	SubTotal	106,772	21,415,438	7,710	7,367	-343	1,568,051	1,550,659	-17,392
	Women's and Children's Health								
	Breast Surgery	7,630	1,826,613	550	576	26	131,932	151,773	19,841
	Maternity (Pathway)	7,777	13,103,988	650	584	-66	1,090,086	962,936	-127,150
	Obstetrics	145	107,425	12	14	2	8,499	13,089	4,590
	Gynaecology	22,567	4,901,601	1,633	1,727	94	359,677	366,134	6,458
	Paediatrics	21,316	7,388,181	1,586	1,444	-142	575,594	562,962	-12,632
	Neonatal Critical Care	4,369	2,036,443	364	336	-28	169,704	169,579	-124
	Clinical Business Unit Block Income (WCH)	0	687,473	0	0	0	57,289	46,138	-11,152
	SubTotal	63,804	30,051,723	4,795	4,681	-114	2,392,780	2,272,610	-120,170
OTHER	**OTHER Block Income**		185,468	0	0	0	15,456	15,456	0
	Non divisional specific services	139	22,472,411	11	0	-11	1,439,923	1,682,851	242,927
	SubTotal	139	22,472,411	11	0	-11	1,439,923	1,682,851	242,927
	TOTAL	**3,627,095**	**214,901,868**	**297,701**	**297,712**	**10**	**16,663,000**	**17,080,901**	**417,901**

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

Divisional Position (net divisional income and expenditure) to 30th April 2017

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Surgery, Women's & Children's Health									
Digestive Diseases	29,671	2,666	2,662	4	0.2	2,666	2,662	4	0.2
Musculoskeletal Care	17,561	1,746	1,632	114	6.5	1,746	1,632	114	6.5
Women's and Children's Health	17,620	1,506	1,578	-73	-4.8	1,506	1,578	-73	-4.8
Specialist Surgery	9,889	972	1,007	-35	-3.6	972	1,007	-35	-3.6
Divisional Administration	438	36	30	6	16.5	36	30	6	16.5
Total Surgery, Women's & Children's Health	**75,180**	**6,926**	**6,909**	**17**	**0.2**	**6,926**	**6,909**	**17**	**0.2**
Acute Care Services									
Urgent and Emergency Care	15,706	1,354	1,417	-63	-4.6	1,354	1,417	-63	-4.6
Diagnostics	22,491	2,081	2,162	-81	-3.9	2,081	2,162	-81	-3.9
Airway Breathing and Circulation	18,820	1,604	1,733	-129	-8.1	1,604	1,733	-129	-8.1
Specialist Medicine	15,169	1,436	1,614	-178	-12.4	1,436	1,614	-178	-12.4
Discharge / Patient Flow	927	77	72	5	6.1	77	72	5	6.1
Divisional Administration	885	73	83	-10	-13.8	73	83	-10	-13.8
Total Acute Care Services	**73,998**	**6,624**	**7,081**	**-457**	**-6.9**	**6,624**	**7,081**	**-457**	**-6.9**
Outpatients	3,417	294	290	4	1.4	294	290	4	1.4
Total Operational	**152,595**	**13,845**	**14,280**	**-436**	**-3.1**	**13,845**	**14,280**	**-436**	**-3.1**
Corporate									
Central Operations	144	12	12	0	1.9	12	12	0	1.9
Communications & Membership	271	23	21	2	10.0	23	21	2	10.0
Estates and Facilities	14,159	1,206	1,115	91	7.5	1,206	1,115	91	7.5
Finance and Commercial Development	15,458	1,294	1,295	-1	-0.1	1,294	1,295	-1	-0.1
HR and OD	4,476	377	374	3	0.9	377	374	3	0.9
Information Technology	3,978	334	315	19	5.6	334	315	19	5.6
Nursing and Governance	1,677	142	152	-10	-6.8	142	152	-10	-6.8
Pharmacy	3,925	334	309	25	7.4	334	309	25	7.4
Transformation Team	407	34	33	1	3.6	34	33	1	3.6
Research and Development	57	5	5	0	0.0	5	5	0	0.0
Trust Executive	2,473	280	289	-9	-3.2	280	289	-9	-3.2
Total Corporate	**47,025**	**4,041**	**3,920**	**121**	**3.0**	**4,041**	**3,920**	**121**	**3.0**
Total	**199,620**	**17,885**	**18,200**	**-315**	**-1.8**	**17,885**	**18,200**	**-315**	**-1.8**

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

Cash Flow Statement 2017/18

	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Annual
	April £000's	May £000's	June £000's	July £000's	August £000's	September £000's	October £000's	November £000's	December £000's	January £000's	February £000's	March £000's	Position £000's
CASH FLOW FROM OPERATING ACTIVITES													
Surplus/(deficit) after tax	**(1,841)**	**(61)**	**(560)**	**(57)**	**(183)**	**(341)**	**699**	**868**	**(451)**	**929**	**(237)**	**1,112**	**(123)**
Non-cash flows in operating surplus/(deficit)	**455**	**463**	**463**	**463**	**463**	**463**	**463**	**463**	**463**	**462**	**462**	**461**	**5,544**
Operating Cash flows before movements in working capital	**(1,386)**	**402**	**(97)**	**406**	**280**	**122**	**1,162**	**1,331**	**12**	**1,391**	**225**	**1,573**	**5,421**
Increase/(Decrease) in working capital	2,520	815	322	615	(553)	356	1,097	(138)	85	1,304	(1,967)	(1,849)	**2,607**
Increase/(decrease) in non-current provisions	(25)	0	0	0	0	0	0	0	0	0	0	25	**0**
(Increase)/decrease in non-current receivables	119	0	0	0	0	0	0	0	0	0	0	(119)	**0**
Net cash inflow/(outflow) from operating activities	**1,228**	**1,217**	**225**	**1,021**	**(273)**	**478**	**2,259**	**1,193**	**97**	**2,695**	**(1,742)**	**(370)**	**8,028**
CASH FLOW FROM INVESTING ACTIVITIES													
Capital expenditure (cash basis)	(680)	(463)	(463)	(463)	(463)	(463)	(463)	(463)	(463)	(462)	(462)	(244)	(5,552)
Proceeds on disposals	0	0	0	0	0	0	0	0	0	0	0	0	0
Other cash flows from investing activities	1	2	2	2	2	2	2	2	2	2	3	4	26
Net cash inflow/(outflow) from investing activities, total	**(679)**	**(461)**	**(461)**	**(461)**	**(461)**	**(461)**	**(461)**	**(461)**	**(461)**	**(460)**	**(459)**	**(240)**	**(5,526)**
Net cash inflow/(outflow) before financing	**549**	**756**	**(236)**	**560**	**(734)**	**17**	**1,798**	**732**	**(364)**	**2,235**	**(2,201)**	**(610)**	**2,502**
CASH FLOW FROM FINANCING ACTIVITIES													
Repayment of borrowings	(2,000)	0	0	0	(53)	0	0	0	0	0	(53)	0	(2,106)
Capital element of finance lease rental payments	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest element of finance lease rental payments	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(4)	(4)	(4)	(4)	(4)	(41)
Interest paid on borrowings	(30)	(32)	(33)	(31)	(32)	(33)	(31)	(32)	(33)	(31)	(33)	(32)	(383)
Other cash flows from financing activities													
PDC Dividends paid	0	0	0	0	0	(1,637)	0	0	0	0	0	(1,638)	(3,275)
Drawdown of loans, non-commercial (DH, ITFF, NLF, etc.)	1,603	0	0	0	0	1,503	0	0	0	0	0	551	3,657
Other cash flows from financing activities, total	**1,603**	**0**	**0**	**0**	**0**	**(134)**	**0**	**0**	**0**	**0**	**0**	**(1,087)**	**382**
Net cash inflow/(outflow) from financing activities, Total	**(430)**	**(35)**	**(36)**	**(34)**	**(88)**	**(170)**	**(34)**	**(36)**	**(37)**	**(35)**	**(90)**	**(1,123)**	**(2,148)**
CASH FLOW TOTALS													
Net increase/(decrease) in cash and cash equivalents	**119**	**721**	**(272)**	**526**	**(822)**	**(153)**	**1,764**	**696**	**(401)**	**2,200**	**(2,291)**	**(1,733)**	**354**
Opening Cash and Cash equivalents less bank overdraft	1,201	1,320	2,041	1,769	2,295	1,473	1,320	3,084	3,780	3,379	5,579	3,288	**1,201**
Cash and Cash equivalents changes due to transfers by absorption													
Closing Cash and Cash equivalents less bank overdraft	**1,320**	**2,041**	**1,769**	**2,295**	**1,473**	**1,320**	**3,084**	**3,780**	**3,379**	**5,579**	**3,288**	**1,555**	**1,555**
Forecast cash position as per Original Monitor plan	1,160	1,881	1,609	2,135	1,313	1,160	2,924	3,620	3,219	5,419	3,128	1,555	**1,555**
Actual cash position	1,320	2,041	1,769	2,295	1,473	1,320	3,084	3,780	3,379	5,579	3,288	1,555	**1,555**
Variance	**(160)**	**(160)**	**(160)**	**(160)**	**(160)**	**(160)**	**(160)**	**(160)**	**(160)**	**(160)**	**(160)**	**0**	**0**

Statement of Financial Position as at 30th April 2017

Narrative	Unaudited Position as at 31/03/17 £000	Actual Position as at 30/04/17 £000	Monthly Movement £000	Forecast Position as at 31/03/18 £000
NON-CURRENT ASSETS				
Intangible Assets	2,308	**2,260**	(48)	1,047
Property, Plant and Equipment	117,890	117,771	(119)	145,242
Trade and Other Receivables, non-current	991	991	0	1,205
Total Non-Current Assets	**121,189**	**121,022**	**(167)**	**147,494**
CURRENT ASSETS				
Inventories	3,437	3,525	88	3,312
Trade and Other Receivables, current	12,799	13,128	329	8,398
Cash and Cash Equivalents	1,201	1,320	119	1,555
Total Current Assets	**17,437**	**17,973**	**536**	**13,265**
Total Assets	**138,626**	**138,995**	**369**	**160,759**
CURRENT LIABILITIES				
Trade and Other Payables	(16,085)	(18,625)	(2,540)	(22,376)
Other Liabilities	(4,070)	(4,294)	(224)	(3,880)
Borrowings, current	(454)	(464)	(10)	(14,491)
Provisions	(279)	(191)	88	(256)
Total Current Liabilities	**(20,888)**	**(23,574)**	**(2,686)**	**(41,003)**
Total Assets less Current Liabilities	**117,738**	**115,421**	**(2,317)**	**119,756**
NON-CURRENT LIABILITIES				
Borrowings, non-current	(28,152)	(27,702)	450	(13,562)
Provisions	(1,377)	(1,352)	25	(1,198)
Total Non Current Liabilities	**(29,529)**	**(29,054)**	**475**	**(14,760)**
TOTAL ASSETS EMPLOYED	**88,209**	**86,367**	**(1,842)**	**104,996**
TAXPAYERS' EQUITY				
Public dividend capital	87,742	87,742	0	87,742
Income and expenditure reserve	(22,011)	(23,853)	(1,842)	(27,823)
Revaluation Reserve	22,478	22,478	0	45,077
TOTAL TAXPAYERS' EQUITY	**88,209**	**86,367**	**(1,842)**	**104,996**

Warrington and Halton Hospitals NHS Foundation Trust

Appendix H

Aged Debt Analysis as at 30 April 2017

Current month	**No. of Invoices**	**Current**	**1 - 30 Overdue**	**31 - 60 Overdue**	**61 - 90 Overdue**	**91 - 120 Overdue**	**121 - 180 Overdue**	**181 - 360 Overdue**	**361+ Overdue**	**Total Debt**
NHS		988,770	519,767	392,924	69,087	63,933	18,700	50,365	7,167	2,110,712
Non NHS		264,701	263,939	120,361	19,961	482	14,854	17,436	126,496	828,231
	738	**1,253,472**	**783,705**	**513,285**	**89,048**	**64,415**	**33,554**	**67,801**	**133,663**	**2,938,943**
Percentage debt - by age (individual)		43%	27%	17%	3%	2%	1%	2%	5%	100%
Percentage debt - by age (cumulatively)		43%	69%	87%	90%	92%	93%	95%	100%	
Previous month	754	**1,208,181**	**1,821,613**	**128,109**	**283,147**	**32,125**	**758,353**	**95,651**	**113,652**	**4,440,831**
Change on previous month (-ve is a reduction on last month)	-16	45,290	-1,037,908	385,176	-194,099	32,290	-724,798	-27,851	20,011	-1,501,888

Customer	**No. of Invoices**	**Current**	**1 - 30 Overdue**	**31 - 60 Overdue**	**61 - 90 Overdue**	**91 - 120 Overdue**	**121 - 180 Overdue**	**181 - 360 Overdue**	**361+ Overdue**	**Total Debt**	**Paid to 15.05.17**	**Revised Debt**
NHS WARRINGTON CCG	5	582,545	170	0	0	0	0	0	0	582,715		582,715
BRIDGEWATER COMM HEALTHCARE FOUNDATION TRUST	51	26,714	113,866	186,167	48,869	17,651	18,128	30,555	5,888	447,837		447,837
NHS ENGLAND	24	96,999	58,795	173,404	20,218	0	449	0	0	349,866	-174,656	175,210
ONE TO ONE (NW) LTD	46	15,676	187,402	0	0	0	0	0	29,656	232,734	-1,464	231,270
HALTON BOROUGH COUNCIL	6	207,243	1,881	0	0	0	0	0	0	209,124	-206,923	2,201
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	13	14,625	69,925	6,269	0	0	0	0	0	90,819		90,819
PUBLIC HEALTH ENGLAND	2	0	82,038	0	0	0	0	0	0	82,038		82,038
5 BOROUGHS PARTNERSHIP NHS FT	9	47,806	9,929	0	0	0	0	20,000	1,027	76,708	-49,048	27,660
WARRINGTON BOROUGH COUNCIL	7	6,280	432	6,128	217	0	0	0	46,036	59,093	-5,325	53,768
BETSI CADWALADR UNIVERSITY HB	7	0	16,446	21,735	16,759	0	0	0	0	54,940	-47,831	7,109
DEVON MEDICAL EQUIPMENT LTD	1	0	0	54,000	0	0	0	0	0	54,000	-54,000	0
NHS HALTON CCG	4	4,959	0	12,188	0	46,282	0	0	0	39,053	-39,053	0
LIVERPOOL HEART & CHEST NHS FT	3	0	10,400	18,727	0	0	0	0	0	29,127	-18,727	10,400
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2	2,050	21,763	0	0	0	0	0	0	23,812		23,812
FIRST HEALTH IMAGING	1	0	23,167	0	0	0	0	0	0	23,167	-23,167	0
Other Debtors	557	248,575	187,492	59,042	2,984	482	14,977	17,246	53,111	583,910		583,910
	738	**1,253,472**	**783,705**	**513,285**	**89,048**	**64,415**	**33,554**	**67,801**	**133,663**	**2,938,943**	**-620,193**	**2,318,750**

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

Analysis of Aged Creditors as at 30 April 2017

Current month	**No. of Invoices**	**Current**	**1-30 - Overdue**	**31-60 - Overdue**	**61-90 - Overdue**	**91+ Overdue**	**Total**
NHS	533	893,463	567,115	289,944	51,635	1,361,237	3,163,394
Non NHS Trade	3,699	3,461,386	1,370,669	281,767	74,892	433,814	5,622,528
Non NHS Other	9	539	2,598	0	-500	1,469	4,106
	4,241	**4,355,388**	**1,940,382**	**571,711**	**126,027**	**1,796,519**	**8,790,027**
Percentage Credit - by age (individual)		49.5%	22.1%	6.5%	1.4%	20.4%	100%
Percentage Credit - by age (cumulatively)		49.5%	71.6%	78.1%	79.6%	100.0%	
Previous month	**5,369**	**3,755,687**	**1,885,563**	**317,514**	**544,528**	**1,305,477**	**7,808,769**
Change on previous month (-ve is a reduction on last month)	-1,128	599,701	54,819	254,197	-418,501	491,042	981,258

Analysis of the largest 15 creditors (by value (£)) as at 30th April 2017		**Current**	**1-30 - Overdue**	**31-60 - Overdue**	**61-90 - Overdue**	**91+ Overdue**	**Total**	**Paid to 15.05.2017**	**Revised Credit**
NHS PROFESSIONALS LTD		985,890	202,825	-	-	-	1,188,714	- 615,590	573,124
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST		9,437	131,054	34,023	1,213	422,198	597,926		597,926
ST HELENS & KNOWSLEY HOSPITALS NHS TRUST		393,888	9,908	130,816	-	21,088	555,700		555,700
NHS SUPPLY CHAIN		375,255	65,448	11,442	-	-	452,145	- 8,990	443,155
COMMUNITY HEALTH PARTNERSHIPS LTD		-	-	18,890	25,285	404,771	448,946		448,946
CARE QUALITY COMMISSION		242,687	-	-	-	-	242,687		242,687
SPIRE HEALTHCARE LTD		147,455	-	47,993	-	213	195,661		195,661
AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		9,115	56,212	3,903	2,122	110,648	182,001		182,001
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST		5,375	1,267	4,222	2,956	166,760	180,579	- 164	180,415
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST		-	154,459	247	-	9,839	164,546	- 10,322	154,224
LIVERPOOL WOMENS HOSPITAL NHS FOUNDATION TRUST		5,393	17,263	6,161	8,667	122,720	160,204		160,204
ROYAL LIVERPOOL&BROADGREEN UNIVERSITY HOSPITALS NHS TRUST (THE)		2,354	34,780	41,233	9,512	63,547	151,427	- 41,049	110,378
BIOMERIEUX UK LTD		144,488	-	-	-	-	144,488		144,488
PHILIPS HEALTHCARE		136,017	400	- 903	414	83	136,011	- 135,928	83
JOHNSON & JOHNSON MEDICAL LTD		58,984	30,600	11,667	142	31,670	133,064	- 30,945	102,119
OTHER CREDITORS		1,839,050	1,236,165	262,015	75,717	442,982	3,855,930	- 1,557,401	2,298,528
Total		**4,355,388**	**1,940,382**	**571,711**	**126,027**	**1,796,519**	**8,790,027**	**- 2,400,388**	**6,389,639**

Analysis of the largest 15 creditors (by volume) as at 30th April 2017	**Current**	**1-30 - Overdue**	**31-60 - Overdue**	**61-90 - Overdue**	**91+ Overdue**	**Total****	**Paid to 15.05.2017**	**Revised Volume**
JOHNSON & JOHNSON MEDICAL LTD	92	48	1	1	14	156	- 25	131
ONE TO ONE (NORTH WEST) LTD	9	-	11	3	116	139		139
HEALTHCARE AT HOME LTD	88	19	-	-	-	107	- 84	23
DEPUY SYNTHES	41	28	2	3	31	105	- 22	83
JJR ORTHOPAEDIC SERVICES	45	41	-	-	-	86	- 17	69
OSSUR UK	37	18	14	11	1	81	- 48	33
VITESSE PLC	57	3	12	4	4	80	- 65	15
DATA SPACE	47	-	15	3	15	80	- 10	70
BLUESTONES MEDICAL	9	5	27	16	13	70	- 38	32
COMMUNITY HEALTH PARTNERSHIPS LTD	-	-	4	4	62	70		70
ALLOGA UK LTD	42	21	-	-	-	63	- 37	26
AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	3	2	1	52	60		60
PHOENIX HEALTHCARE DISTRIBUTION LTD	5	54	-	-	-	59	- 44	15
H JENKINSON & CO LTD	19	30	1	1	7	58	- 28	30
ZIMMER BIOMET UK LTD	20	23	-	-	6	49	- 16	33
OTHER CREDITORS	1,351	1,091	164	60	312	2,978	- 1,115	1,863
Total	**1,864**	**1,384**	**253**	**107**	**633**	**4,241**	**- 1,549**	**2,692**

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Warrington and Halton Hospitals NHS
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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/06/61 b**	
SUBJECT:	**Safe Staffing Assurance Report**	
DATE OF MEETING:	31st May 2017	
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**	
AUTHOR(S):	John Goodenough – Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon –Jamieson –Chief Nurse	
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):	BAF2.2: Nurse Staffing	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.1: CQC Compliance for Quality	
STRATEGIC CONTEXT	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.	
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when actual falls below 90% of planned staffing levels.	
RECOMMENDATION:	It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

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NHS Foundation Trust

Safe Staffing Assurance Report

Introduction

The purpose of this paper is to set out the nursing and midwifery ward staffing levels across the Trust during April 2017 and to provide assurance that any shortfalls on each shift were addressed with mitigating action. All Trusts are to submit staffing data to NHS England via the Unify Safe Staffing return and provide assurance to the Trust Board via the Chief Nurse.

The Safer staffing data consists of the actual numbers of hours worked by registered and care staff on a shift by shift basis measured against the numbers of planned hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill of 90% and over is considered acceptable nationally.

April Trust wide staffing data was analysed and cross referenced for validation with operational nursing staff.

Appendix 1 identifies the fill rate for staff across the trust with Care hours per day per patient (CHPPD). The table also triangulates this information by illustrating if there have been any harms reported within each area.

Appendix 2 identifies mitigation where actual fell below planned and reports if there has been any increase or decrease to CHPPD in each area

Conclusion

This report demonstrates the monthly CHPPD per ward across the Trust and provides assurance of the divisional actions taken to provide adequate staffing levels.

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Appendix 1

Monthly Safe Staffing Report - April 2017

NHS Warrington and Halton Hospitals NHS Foundation Trust

Ward name	Main 2 Specialties on each ward		Day: Registered midwives/nurses		Day: Care Staff		Night: Registered midwives/nurses		Night: Care Staff		Day: Average fill rate - registered nurses/midwives (%)	Day: Average fill rate - care staff (%)	Night: Average fill rate - registered nurses/midwives (%)	Night: Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD): Cumulative count over the month of patients at 23:59 each day	Registered midwives/nurses	Care Staff	Overall	Falls (Moderate and Above)	Cdiff	MRSA	Pressure Ulcers
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
SAU	100 - General Surgery		900	900	675	675	0	0	0	0	100.0%	100.0%	-	-	0	-	-	-	0	0	0	0
W-A5 - Ward A5	100 - General Surgery		1633	1479.5	1200	1134	1035	989	690	690	90.6%	94.5%	95.6%	100.0%	960	2.6	1.9	4.5	0	1	0	0
W-A6 - Ward A6	100 - General Surgery		1978	1420.5	1200	1663	1035	954.5	690	701.5	71.8%	138.6%	92.2%	101.7%	950	2.5	2.5	5.0	1	0	0	0
W-C22 - Ward C22	301 - Gastroenterology		1035	1023.5	1035	1046.5	690	713	690	828	98.9%	101.1%	103.3%	120.0%	630	2.8	3.0	5.7	0	0	0	0
W-B4-H - Ward B4 - Halton	100 - General Surgery		666	635.5	391	379.5	195.5	188	207	195.5	95.4%	97.1%	96.2%	94.4%	45	18.3	12.8	31.1	0	0	0	0
W-A9 - Ward A9	110 - Trauma & Orthopaedics		1725	1360	1380	1285.5	1035	943	690	897	78.8%	93.2%	91.1%	130.0%	926	2.5	2.4	4.8	0	0	0	0
W-CM1-H - Ward 1 - CMTC Treatment Centre	110 - Trauma & Orthopaedics		1495	1284	920	858.5	690	667	690	644	85.9%	93.3%	96.7%	93.3%	317	6.2	4.7	10.9	0	0	0	0
AED paediatrics	180 - Accident & Emergency		720	720	360	360	720	720	360	360	100.0%	100.0%	100.0%	100.0%	0	-	-	-	0	0	0	0
W-B11B/W-B11C - Ward B11	420 - Paediatrics		1895.2	1872.5	892.3	890	1585.2	1510.4	20.8	20.8	98.8%	99.7%	95.3%	100.0%	372	9.1	2.4	11.5	0	0	0	0
W-NHDU/W-NITU/W-NSC - Neonatal Unit	420 - Paediatrics		1725	1758	345	264.5	1725	1345.5	345	161	101.9%	76.7%	78.0%	46.7%	30	103.5	14.2	117.6	0	0	0	0
W-C20 - Ward C20	502 - Gynaecology		897	839.5	636	622	644	644	0	0	93.6%	97.8%	100.0%	-	432	3.4	1.4	4.9	0	0	0	0
W-C23 - Ward C23	501 - Obstetrics	560- Midwife Led Care	1380	1299.5	690	563.5	690	690	690	575	94.2%	81.7%	100.0%	83.3%	343	5.8	3.3	9.1	0	0	0	0
Delivery Suite	501 - Obstetrics	560- Midwife Led Care	2415	2342.5	345	310.5	2415	2388	345	333.5	97.0%	90.0%	98.9%	96.7%	234	20.2	2.8	23.0	0	0	0	0
W-A1A - Ward A1 Asst	300 - General Medicine		2250	2012.5	1500	1500	1890	1512	630	630	89.4%	100.0%	80.0%	100.0%	877	4.0	2.4	6.4	0	0	0	0
W-A2A - Ward A2 Admission	300 - General Medicine		1380	1163	1194.9	1231	1035	920	690	839.5	84.3%	103.0%	88.9%	121.7%	840	2.5	2.5	4.9	0	0	0	0
W-A3OPAL - Ward A3 Opal	300 - General Medicine	430 - Geriatric Medicine	1417	1259	1380	1708	1035	931.5	690	1046	88.8%	123.8%	90.0%	151.6%	1054	2.1	2.6	4.7	0	0	0	0
W-A4 - Ward A4	300 - General Medicine		1470	1145.5	1380	1129	1035	828	1380	1322.5	77.9%	81.8%	80.0%	95.8%	960	2.1	2.6	4.6	0	0	0	1
W-A8 - Ward A8	300 - General Medicine		1656	1292.5	2070	1618.5	1035	954.5	1725	1150	78.0%	78.2%	92.2%	66.7%	666	3.4	4.2	7.5	0	0	0	1
W-B12 - Ward B12 (Forget-me-not)	430 - Geriatric Medicine		1170	1027.4	2415	2132.3	690	690	1380	1334	87.8%	88.3%	100.0%	96.7%	630	2.7	5.5	8.2	0	0	0	0
W-B14 - Ward B14	300 - General Medicine		1380	1241.5	1380	1360	690	690	690	828	90.0%	98.6%	100.0%	120.0%	720	2.7	3.0	5.7	0	0	0	0
W-B18 - Ward B18	300 - General Medicine		1382	1187.3	1380	1355	1035	908.5	1035	851	85.9%	98.2%	87.8%	82.2%	702	3.0	3.1	6.1	1	0	0	0
W-A7 - Ward A7	340 - Respiratory Medicine		2070	1534	2070	1477.5	1725	1403	1725	1115.5	74.1%	71.4%	81.3%	64.7%	990	3.0	2.6	5.6	0	0	0	0
W-C21 - Ward C21	320 - Cardiology		1035	1035	713	900	690	690	690	874	100.0%	126.2%	100.0%	126.7%					0	0	0	0
W-CCU - Coronary Care Unit	320 - Cardiology		1725	1326	345	122.8	1035	1000.5			76.9%	35.6%	96.7%						0	0	0	0
W-ICU - Intensive Care Unit	192 - Critical Care Medicine		4830	4582.8	1035	632.5	4830	4600	690	414	94.9%	61.1%	95.2%	60.0%					0	0	0	0

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Appendix 2

	Day		Night		Mitigation Actions
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
A6	71.8%	138.6%	92.2%	101.7%	Adverts out to cover vacancies. Staff transferred from A5 to cover vacancies. Day average fill rate has increased from previous month.
A9	78.8%	93.2%	91.1%	130%	Advert out for vacancies. Over the month of April there were 91 patients requiring enhanced monitoring- night staff therefore increased. Day average fill rate has increased from previous month
CMTC	85.9%	93.3%	96.7%	93.3%	The activity varies at CMTC across in-patient and day case patients over two floors. The daily staff numbers are reviewed and changed to reflect the daily demand. Day average fill rate has increased from previous month.
NICU	101.9%	76.7%	78.0%	46.7%	Unit staffed flexibly according to acuity and dependency. Fill rates have increased from previous month
A1	89.4%	100.%	80.0%	100%	Escalation beds open, staffing supported by NHSP and agency. Active recruitment in place to fill vacancies. Staff moved from within CBU to ensure safety. There is a slight decrease in RN fill rate however there is an increase in CS fill rate
A2	84.3%	103.0%	88.9%	121.7%	Staffing supported by NHSP for enhanced care in month, acuity reviewed by matron staff moved accordingly. Active recruitment in place to fill vacancies. Staff moved from within CBU to ensure.

					Day average fill rate has increased from previous month. safety.
A3	88.8%	123.8%	90.0%	151.8%	Care Staff numbers increased to support care. Daily review of staffing taken place by matron and staff moved from other areas to support care delivery. There is a slight decrease in RN fill rate however there is an increase in CS fill rate
A4	77.9%	81.8%	80.0%	95.8%	Ward escalated by 8 beds, NHSP supporting temporary cover .Matron review to ensure safety. There is a slight decrease in day fill rate % however there is an increase in night time across both RN and CS hours.
A8	78.0%	78.2%	92.2%	66.7%	Recruitment on going Increase in number of patients requiring enhanced monitoring, daily Matron review. Day fill rate are increased from the previous month
B12	87.8%	88.3%	100.0%	96.7%	Short term RN sickness, so staffing resource reallocated to support the ward. There is a slight decrease from the previous month of day fill rates
B18	85.9%	98.2%	87.8%	82.2%	Beds opened to support cohort patients. Daily Matron review and staff allocated to support. Fill rates have decreased from the previous month
A7	74.1%	71.4%	81.3.0%	64.7%	Staffing resource reallocated to support the ward. Fill rates across day and night have increased slightly from the previous month
CCU	76.9%	35.6%	96.7%	-	Staffing resource reallocated to support the ward. RN fill rates have decreased slightly however CS have significantly increased from the previous month
ITU	94.9%	61.1%	95.2%	60.0%	Carer recruitment pending. CS fill rates have increased from the previous month

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/61 (d)**	
SUBJECT:	**Key Issues Report from the Quality Committee Held 2 May 2017**	
DATE OF MEETING:	31 May 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Margaret Bamforth, Committee Chair	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	BAF2.2: Nurse Staffing	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the May Quality Committee meeting.	
RECOMMENDATION:	**The Board receives the report and notes the matters for escalation. Matters for escalation include, VTE assessments, Incident reporting and Serious Incident action plans, Complaints and the current lack of capacity with PALS. For noting is the In-patient Survey Action Plan.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
QUALITY COMMITTEE

Date of meeting:	**2nd May 2017**
Standing Agenda Items	Quality Dashboard Corporate Risk Register
Formal Business	Over the last few months, a number of concerns have been escalated from the Quality Committee to the Board. The Quality Committee continues to seek assurance on these issues and monthly and bimonthly reports are being received which relate to those high-risk areas. There is also monitoring through the risk register. Current areas of risk include, VTE, Complaints, Falls, Pressure Ulcers and Safeguarding. Action plans are in place and are managed through the Patient Safety and Clinical Effectiveness Sub-committee with oversight from the Quality Committee. The key issues paper to Board will continue to up-date on progress relating to these areas. In May, a report was received on progress with VTE and the Annual Complaints Report was presented and discussed. An update on **Venous Thromboembolism (VTE) Risk Assessment** was provided by Simon Constable, Medical Director. The current electronic dashboard performance does not credit a significant number of VTE risk assessments, for example, day-case cohorts. It is therefore not possible to be confident in the data and, even though it would appear that the target of 95% is being met, the proof is lacking. There remains a backlog of Root Cause Analysis investigations for 34 Hospital Acquired VTEs. An executive and medically led VTE steering group has been established to manage the action plan and to strengthen governance. The Thrombosis Group has been re-established and the processes around, recording, reporting, incident reporting and harm assessment have been reviewed to ensure they are fit for purpose. However, full assurance cannot be provided currently. **The Committee is escalating to Board because of the continuing lack of assurance. Monthly reporting on progress will continue through the Patient Safety and Clinical Effectiveness Group and the Quality Committee will continue to provide oversight.** **The Serious Incident Monthly Report** provides an update on the status of all open Serious Incidents. The paper provides the details of the number of new SIs reported, the total number of current SIs that have been

	reported externally which are open or breached, an update on actions to be taken as a result of SI investigations and a summary of feedback from inquests. 7 new SIs have been reported since the last report, which include 4 radiological incidents. The Committee received assurance that duty of candour had been applied in all as appropriate. 20 SIs are open as of 25th April. The Committee discussed the backlog of open actions and it was proposed that the Divisions convene meetings to address these outstanding actions and offer support to individuals as appropriate. **The Committee continues to lack assurance regarding the open actions and it was agreed to escalate to Board. The backlog will be managed by the Divisions, which will report to the PSCE Sub-Committee and through the Quality Bi-laterals.** The good news is that following the implementation of the Pilot Falls Prevention Action Plan in February, there has been a reduction in falls on C21 of 72%, on A8 of 81% and of 84% on B12. This project is to be rolled out to Surgery, Women's and Children's. **The Complaints Annual Report was received.** 430 formal complaints have been received for the year, an increase of 6.7%. At 1st April 2017, 234 complaints were open and under investigation. There has been a decrease in the number of PALS enquiries, down from 2558 to 1694. The Committee discussed the possible impact of capacity within the PALS team on the number of enquiries. At the moment, the Team is being supported with resource from the Complaints Team and going forward the PALS function will be reviewed as a key component of the Patient Experience Strategy. Complaints have been identified as a priority within the Quality Accounts for 2017/18. The on-going work to clear the backlog of complaints will continue to be closely monitored by the Quality Committee. **The concern relating to the capacity of the PALS function is escalated to the Board.** **The Health and Safety Annual Report** was received and discussed by the Committee. 409 H&S inspections had been undertaken in the year and 299 had topics identified, which is an improvement on the previous year. 24 incidents have been reported under RIDDOR. Of particular note is the number of sharps incidents, 117. The Needle Stick Working Group has been reinstated to address increasing education and raising awareness. **Approved for endorsement at Board.**

	The Patient Experience Strategy was presented by John Goodenough, Deputy Chief Nurse. The strategy is ambitious and sets out the approach to improving patient experience. The central ambition is to create a culture that truly puts the patient first in everything we do as an organisation. A workshop, which included staff and Governors, was held to support the development of the strategy and the programme of work to implement the strategy includes 5 work streams based on belief and promise statements developed through the workshop. There is an implementation sub-group for each of the statements and each group will have a work plan with clearly defined objectives. The implementation of the strategy will be monitored through the PSCE Committee with oversight from the Quality Committee. This is an important initiative designed to build on the Trust values and align with the Trust and Nursing and Midwifery strategies. It is particularly important to engage staff in delivering the strategy as the **National In-patient Survey** results**,** reported in last month's key issues paper, were disappointing. There is clearly a lot of work that can be done to support the improvement of patient experience. Following the feedback from the in-patient survey, an action plan has been developed and was presented to the Quality Committee. This includes three priority areas one of which is the Patient Experience Strategy. Other priorities include improving patient diet, customer care communication and improving information given at discharge. The action plan and implementation of the Strategy will be managed through the Patient Experience Sub-Committee. The Committee spent some time focussing on Pharmacy services. Papers received included, the **Hospital Pharmacy Transformation Plan** and the **Medicines Management/Controlled Drugs Annual Report**, which were approved for presentation to the Board. The transformation programme will be a 3-4 year programme of work and will be driven by the medicines optimisation CQUIN. The plan includes a self-assessment against the parameters set out in Lord Carter's review. The plan involves using resources more effectively and a significant shift in the utilisation of staff into the ward areas. Pharmacy technicians are already supporting staff on A1 and A6 and this has proved to be a popular initiative. Other significant areas for possible development outlined in the transformation plan include the use of ward automated cabinets, electronic prescribing, 7 day working and collaborative working within the LDS. The **Learning from Experience Report** was presented and discussed. This is a detailed report that brings together the learning from incidents, complaints and claims. This was the first report in the new integrated format. The Trust is an outlier in the reporting of low harm, although, at

	an incident reporting rate of 37.78 per 1000 bed days, it is within the middle 50% of reporting Trusts. There is an issue to do with categorisation of harm and a review is underway to look at how reporting can be improved to ensure the correct reporting fields are used. The aim is to continue to develop the reporting so that the breakdown of incidents, complaints and claims can be identified at CBU level. The Committee also received the Mortality Review Quarterly Report, the CQUIN Quarter 4 and update on CQUINs for 2017/18 and the following High Level Briefing Papers: Quarterly Bi-lateral Meeting 12th April – Surgery, Women's and Children's Medicines Governance Sub-committee The following were also approved/endorsed: Risk Management Strategy (to come to Board) Nursing and Midwifery Strategy
Local Policies and Guidance Approved:	
Any Learning and Improvement identified from within the meeting:	None.
Any other relevant items the Committee wishes to escalate?	None.

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 17/05/61 (e)**	
SUBJECT:	**Key Issues Report from the Finance and Sustainability Committee held 24 May 2017**	
DATE OF MEETING:	31 May 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, Committee Chair	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF3.3: Clinical & Business Information 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):	This report provides a high level summary of business at the May 2017 meeting.	
RECOMMENDATION:	**The Board note the report and the matters identified for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

HIGH QUALITY, SAFE HEALTHCARE
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Warrington and Halton Hospitals NHS
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KEY ISSUES REPORT - FINANCE and SUSTAINABILITY COMMITTEE

Date of meeting:	**24 May 2017**
Standing Agenda Items	The Meeting was quorate The Minutes of the F&SC Meeting held on 19 April were accepted as a true record, subject to a small number of amendments.
Formal Business	• At the request of the Committee a presentation was received in respect of the recent Cyber attack against the Trust (as part of a wider attack on the NHS). • The sequencing and development of the attack were described from the initial events on Friday 12 May alongside the decisions taken by the Trust, the most significant being to switch off our e-mail system at 6.00pm. • NHS England announced the attack as a Major Incident; unfortunately they were still communicating by e-mail (a key learning for them as part of a wider debrief). • Our own emergency planning was brought into play and "Battle Boxes" were employed at CBU level. • A "Whats app" group was established for appropriate members of our team (but no patients) as a secure means of communication. • Various members of our team were present over that weekend and a great team spirit was evident. There were some key learning's around members of the IM&T team. • Paper records were readied for patient clinics etc over the coming days to minimise the impact on patients. • To summarise, of 2960 devices, 2958 were patched, 2 required 3rd party support to patch (and the ability to achieve this in good time was an issue) and as a consequence none were infected. • Where Medical devices were still vulnerable, port 445 is blocked as the being associated with the Cyber attack. • The Trusts response to the attack was outstanding as was the commitment of those members of our team who stood up and dealt with the situation. Clearly there are key learning's locally as well as for nationally and as further attacks are expected, we all need to remain vigilant. • The deployment of Lorenzo stood us well in response to the attack. • The Medical Director along with the Chief Nurse presented the Pay Assurance Dashboard alongside the NHSI Checklist. • The Committee was updated in respect of Agency Spend overall, Doctors, Nurses and other categories. • There remains considerable focus both internally and at NHSI level around Agency spend, IR35 issues and the use of PSCs. • In respect of Medical and Dental staff the trend remains upward for expenditure, April showed a downward trend albeit unclear if this can be sustained. There are initiatives in train to mitigate the position if at all possible. • In respect of Nursing and Midwifery staff, cap breaches are showing a downward trend and good progress is being made in recruitment. Again there are various indicatives in place. • In respect of Other Staff, increased focus will now be brought. • An update was received in respect of the work of the Pay Spend and Review Group alongside of the Minutes of the Meeting of 3 May 2017. • The Chair of the F&SC reported on a recent discussion with the Acting Chief Operating Officer around Waiting List Initiatives. • The Acting Chief Operating Officer presented the first performance report for 2017/18. In respect of the A&E 4 hour performance for the Month of April the Trust achieved 91.41%, above trajectory albeit that has yet to be "approved"

	• In view of the Trust performance, ECIP support is now being withdrawn. Our 4 Hour Steering Group has now been replaced with a patient flow board. • Due to the Cyber attack, NWAS have been unable to supply data around Ambulance Handovers. • RTT for April was achieved. • In February Cancer Services moved to using just one system to track patients – Somerset – which is used Nationally. It is fair to say that the implications of this change were not fully realised and it became difficult to obtain a clear picture of performance of the Service and indeed patient tracking. • Concern was evident internally as well as by the CCG who commissioned an Audit Report on 6 April which looked back at 3 Months of data. The findings of the Report were detailed to F&SC alongside the recommendations which are currently being developed into an action plan. • It was clear from the Report that patients were being treated and tracked and no evidence of harm due to these tracking processes. • Progress was detailed since the CCG Report in recovering and addressing the position but clearly both F&SC and the Quality Committee will need to track progress of the action plan. • In terms of performance in April against the various Cancer Targets, the data had not been closed off at the time of the Meeting. • The Outpatient DNA rate remains above the national average and the Director of IM&T is compiling a Business Case for a reminder service to reduce. • The Committee received the Draft Minutes of the Outpatients Turnaround Board Meeting of 19 April 2017. • The Director of Finance & Commercial Development presented the Finance report for the Month of April. The Trust has recorded a loss of £1.8m which is on plan (clearly losses of this magnitude cannot be sustained!) • Capex for the Month was £0.3m, some £0.2m behind plan. In considering the Minutes of the Capital Planning Group of 28 April, the Committee were concerned to learn of priorities not identified by CBUs as part of the planning process. • The Committee considered the variances in income, costs and activity. • Disappointingly pay costs for the Month were £14.3m, some £0.4m above plan. • Activity is respect of Outpatients was behind plan supporting the case for a reminder service. • Whilst this was the first Month of our new financial year, the Report highlighted the risks facing the Trust in reaching its` Control Total, including those around CIP achievement, the ability to reduce our cost base in the event of loss of spinal activity, the assumptions around CQUIN achievement together with planned reductions in bank, agency, locum, overtime and waiting list initiatives. • The Committee received the report in respect of the Financial Transformation Programme.For 2017/18, the Trust has a CIP Target of £10.5m. At the end of Month 1 the Trust has delivered £0.367m CIP £0.0235m of cost avoidance and income recovery to a total of £0.390m. The target for the Month was £0.540m, so this is a disappointing outcome. Analysis of the current schemes indicates best case CIP of £5.96m and worst case £2.65m, so there remains much to be done. • The Key Priorities going forward were detailed which highlight as we well know that to achieve our CIP Target and indeed our Control Total for 2017/18 that this year will need to be transformational in its` widest sense. • The Draft Minutes of the ICIC Meeting of 12 April were received. • The IM&T Report for the Month was presented by the Deputy Director of IM&T together with the various Minutes of the Committees reporting into the ePR Programme Board. F&SC Members digested the considerable detail supporting the Report receiving appropriate highlights. The Committee had already focussed on

	the Trusts response to the Cyber attack as detailed earlier. • A Presentation was received in respect of The new General Data Protection Regulations which come into force in May 2018. The Committee will need sight of an Implementation Plan and it was agreed that Internal Audit should join the Group that will need to be established to oversee the implementation. • F&SC will need to track progress through specific update and Group Minutes as part of the IM&T Monthly Report. • The Director of Finance & Commercial Development updated the Committee on the Bid Opportunities that had presented themselves at STP level.
Local Policies and Guidance Approved:	
Any Learning and Improvement identified from within the meeting:	
Any other relevant items the Committee wishes to escalate?	

Terry Atherton
25 May 2017

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/61 (f)**	
SUBJECT:	**Key Issues Report from the Audit Committee January 2017**	
DATE OF MEETING	**24th April 2017**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Ian Jones, Committee Chair**	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	**ALL**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):		
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**This report provides a high level summary of business at the January meeting.**	
RECOMMENDATION:	**The Board note the report and the matters arising for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
AUDIT COMMITTEE

Date of meeting:	**24th April 2017**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 16th January 2017 were approved as a correct record.
Formal Business	• At the Audit Committee of 16th January 2017, further assurance was requested in respect of the Tenders & Waivers for Medical Staff. Although some information had subsequently been provided it was felt that it fell short of providing full assurance. As Finance & Sustainability Committee has recently put in place a Pay Spend Review Group, Terry Atherton, as Chair of that Committee, will included the assurance follow up work within the Review Group's remit, to avoid duplication of effort. • The Committee agreed the Internal Audit Plan for the year 2017/18 • Internal Audit (MIAA) presented four reports: (1) Significant Assurance was given in respect of Combined Financial Systems (2) the use of the IG Toolkit. (3) Limited Assurance was given in respect of the processes surrounding the use of Bank & Agency – Medical Locums. The Pay Spend Review Group (FSC) and the Strategic People Committee are both closely involved in the improvement of these processes and the respective Chairs, who both sit on Audit Committee, will inform AC of progress at the next meeting. (4) Some recommendations were put forward as improvements to the use of the Assurance Framework and will be considered in conjunction with the ongoing strengthening of the AF following the appointment of the Director of Integrated Assurance & Quality. • The Annual Internal Audit Opinion was provided by the Head of Internal Audit, who reported Significant Assurance. • The External Auditors provide an update on the progress of their work and also gave some detailed and useful benchmarking information on the presentation of Corporate Governance information nationwide. • MIAA's Annual Counter Fraud workplan was received and noted • The Draft Unaudited Accounts were presented to Committee by the Deputy Director Finance and some minor changes were made after the figures and notes were scrutinised.

	• A discussion took place in respect of the Going Concern Statement which was approved by Committee, after some clarification in respect of the agreed Control Total. • Routine business completed at Committee included reviews of (1) Special Payments and Losses (2) Quotations and Tender Waivers, (3) Bad Debt Write-offs (4) Progress on Internal Audit Follow-ups and (5) small amendments to the Scheme of Reservation and Delegation • Annual Statutory Reports were reviewed and supported: (1) The Trust Annual Report, (2) The Annual Governance Statement (draft), (3) Trust Quality Account, (4) Code of Governance Compliance Declaration. These reports were at various stages of completion and will be finalised within the prescribed timeframe. • The NHS England Conflict of Interest Policy and Registration Progress was presented to the Committee and will be adopted by the Trust. Some enhancements and clarifications were suggested by the Chair of the Strategic People Committee and these will be built into the final policy • An update on the Board Assurance Framework and Risk Management System was provided by the Director of Communications & Corporate Affairs. Audit Committee was satisfied that an integrated approach is being adopted, with appropriate and aligned oversight by Committees. In future, the BAF will be reviewed by Audit Committee 3 times annually.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/61 (f)**	
SUBJECT:	**Chairs Audit Committee Annual report**	
DATE OF MEETING:	31 May 2017	
ACTION REQUIRED	**To note**	
AUTHOR(S):	Pat McLaren, Director of Communications + Corp Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT		
EXECUTIVE SUMMARY (KEY ISSUES):	This report seeks to deliver assurance to the Board and Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.	
RECOMMENDATION:	**The Board is asked to review the document and ensure it meets its purpose.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee
	Agenda Ref.	AC/17/04/43
	Date of meeting	24 April 2017
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Chairs Audit Committee Annual report	AGENDA REF:	BM/17/05/61 (f)

AUDIT COMMITTEE REPORT 2016-17

The Committee

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

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

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

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

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

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

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

Terms of Reference

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

Frequency of Meetings & Summary of Activity

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

Governance & Risk Management

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

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

Internal Audit Activities

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

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

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

Specific attention has been focused during the year on:

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

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

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

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

External Audit

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

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

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

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

Anti-Fraud Activity

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

Issues Carried Forward

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

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

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

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

Summary

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

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

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

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

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

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

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

Ian Jones
Chair of Audit Committee
April 2017

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/61(g)**	
SUBJECT:	**Key Issues Report from the Charitable Funds Committee 7 April 2017**	
DATE OF MEETING:	**31 May 2017**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Ian Jones, Committee Chair**	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	**ALL**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):		
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**This report provides a high level summary of business at the Quarterly meeting.**	
RECOMMENDATION:	**The Board note the report and the matters arising for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
CHARITABLE FUNDS COMMITTEE

Date of meeting:	**7th April 2017**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 5th December 2016 were approved as a correct record.
Formal Business	• The Finance Report was received showing Total Fund Balances at end of March 2017 of £524k, of which £99k Unrestricted (net of overheads and commitments) £127k in Designated funds and £298k in Restricted Funds. This represents a reduction of £48k over a 12 months period. • Total income in 12 months: £156k, of which £39k came from legacies. • Total expenditure 12 months: £204k. of which Administration and Governance costs amounted to £77k. • The Committee approved a specific campaign to be launched by the Maternity Services Team to raise money to improve the environment on the maternity ward and neo-natal unit to make it more welcoming for patients and visitors. The objective is to raise £10k in the next 2 months. • On the wider front, the Committee received and approved the 5 year Strategic Plan, a comprehensive document which includes challenging but achievable targets for fundraising. Net income is projected to build by approximately £100k over each of the next 5 years to reach an annual income in excess of £500k by 2022. A key driver will be much greater focus on Corporate fundraising. • As previously advised the temporary position of Fundraising Manager has now been upgraded to a permanent position and the formal recruitment process will be completed shortly. • Other business included the finalisation of the Terms of Reference and the bid application process. The Terms of Reference will be ratified by the Board at its' April meeting.

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/62**
SUBJECT:	**Health & Safety Annual Report**
DATE OF MEETING:	31 May 2017
ACTION REQUIRED	**Review, Discuss and note**
AUTHOR(S):	Ursula Martin, Deputy Director of Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
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
STRATEGIC CONTEXT	The Health & Safety Annual Report to the Board is a statutory requirement to ensure the Trust is discharging its legal responsibilities under Health & safety at Work Act, and other associated legislation aligned to the strategic health & safety agenda.
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: Training has continued for staff in year in relation to Health & Safety and, following a review of training, the following training is now delivered. • Health and Safety Awareness Training for all Staff and Managers • Health and Safety Awareness Training for Senior Managers and Doctors • Risk Assessment Tutorials • A full 12 month training programme was produced for Non-Clinical Manual Handling Training. The Trust has reviewed a number of policies in relation to Health & Safety in year. The Trust is managing Control of Substances Hazardous to Health (COSHH) appropriately: • The Trust has in place Sypol for the management of COSHH throughout the Organisation.

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	• All staff who are responsible for the management of COSHH within their areas have had the necessary training. • There are 1,407 individual COSHH assessments available with new assessments being added on a regular basis and there are 1,276 different materials used within the Trust. There have been a number of inspections undertaken through the year – recurrent themes PAT testing, sharps bins left open, estates issues (walls, lighting, flooring) A new contractor is in place regarding PAT testing. From a review of incidents, sharps incidents and staff assault (verbal and physical) are the highest reporting. Focused work on both these areas will be part of forthcoming 17/18 priorities. 24 incidents were reported to Health & safety Executive under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Priorities for the forthcoming year are: 1. Communication – promoting health and safety to staff with newsletters, learning from incidents etc. 2. Increase in inspections 3. Safer Sharps 4. Ensuring Trust risk assessment process is robust 5. Reviewing non clinical claims- ensuring robust investigations and learning	
RECOMMENDATION:	Review, Discuss and note the Trust Annual Health & Safety Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	April 2017
	Summary of Outcome	Approved for receipt by Board of Directors
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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BOARD OF DIRECTORS

SUBJECT	Health & Safety Annual Report	AGENDA REF:	BM/17/05/62

1. BACKGROUND/CONTEXT

The annual report describes health and safety (H&S) activity within the Trust from April 16 to March 17. The management of Health and Safety is a critical component of the overall Governance agenda, with the safety of patients and staff being a core value.

This year has seen improvement in the systems and processes for H&S, which have included simplified documentation for the completion of incident investigations, analysis of non-clinical claims and recording of lost time incidents.

2. KEY ELEMENTS

The report covers findings from audits carried out throughout the past year. This includes the risk management framework audit. The risk management framework is the core of the health and safety management system and measures compliance on relevant legislation within each department.

3. ASSURANCE COMMITTEE

This report was received by the Trust Quality Committee in April 2017.

4. RECOMMENDATIONS

The Board are asked to review, discuss and note the Health & Safety Annual Report.

Annual Health & Safety Report
April 2016 to March 2017

1. Introduction

The annual report describes Health and Safety (H&S) activity within the Trust from April 16 to March 17. The management of H&S is a critical component of the overall governance agenda, with the safety of patients and staff being a core value.

This year has seen improvement in the systems and processes for H&S, which have included simplified documentation for the completion of incident investigations, analysis of non-clinical claims and recording of lost time incidents.

2. Background

There has been a significant change in H&S Management within the Trust since 2010; at this time the Trust had been issued with a number of improvement notices.

The Trust now has a level of compliance within all relevant H&S legislation. This is supported by a robust and structured H&S Management System. To support the management system a wide range of policies and guidance documents have been developed and implemented throughout the Trust. The system supports the organisation in ensuring a safe and healthy environment for patients, visitors, staff and contractors.

3. Policies and Guidance Documents

The following policies have been reviewed and approved by the Health and Safety Sub Committee over the past 12 months:

- Smoke Free Policy
- First Aid Policy
- DSE Policy
- Stress Policy
- Risk Assessment Policy
- Welfare at Work Guidance
- Inspection Template
- Needlestick Injury Template (NSI1)

All the above policies and procedures are accessible to staff via the Hub. These can be found on the H&S pages, where there is also a large range of other guidance documents on a number of health and safety topics, all of which support the Risk Management Framework.

4. Training Review

The existing mandatory training programme has been comprehensively assessed to ensure all staff are gaining the knowledge and skills required. And to ensure training is easily accessible to all staff.

The new training programme consists of:-

- Health and Safety Awareness Training for all Staff and Managers - This is a general awareness of health and safety law and how it is managed throughout the Trust. The training can be accessed via a classroom based session or e-learning.

- Health and Safety Awareness Training for Senior Managers and Doctors - This is a training booklet which provides up to date information on current legislation and corporate manslaughter.

- CIRIS Risk Assessment Tutorials – This training provides guidance and support for all staff who are required to complete risk assessments. This also provides training on how to complete risk assessments on CIRIS.

- A full 12 month training programme was produced for Non-Clinical Manual Handling Training.

Additional Training
There have been specific courses run throughout the year which include:

- Health and Safety Awareness for Trust Volunteers
- Health and Safety Awareness for Junior Doctors
- Working at Height (Ladder Training)
- Hazard Awareness Training
- Smoking Awareness Campaign
- CIRIS Risk Assessment Training
- SYPOL/COSHH

5. Health and Safety Guidance, Information and Advice

The H&S Team, over the past two years, have developed a number of pages on the Trust Hub to assist Wards and Departments in the management of H&S within their areas of work.

Information includes:

- A Health and Safety Library Page - which provides an A-Z list of all H&S guidance documents and blank templates/checklists
- Example risk assessments – this provides an example risk assessment for each standard within the Risk Management Framework
- Advice pages on specific topics which include Slips, Trips and Falls, Stress, COSHH, DSE, Housekeeping, Good Practice, Working at Height
- A programme of H&S drop in sessions took place on both sites throughout the year
- Safety Alerts are also provided on any particular issues that may need immediate attention.

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6. Control of Substances Hazardous to Health (COSHH)

- The Trust has in place Sypol for the management of COSHH throughout the Organisation.
- All staff who are responsible for the management of COSHH within their areas have had the necessary training.
- Ad hoc training sessions take place on a 1:1 basis at the request of the service manager.

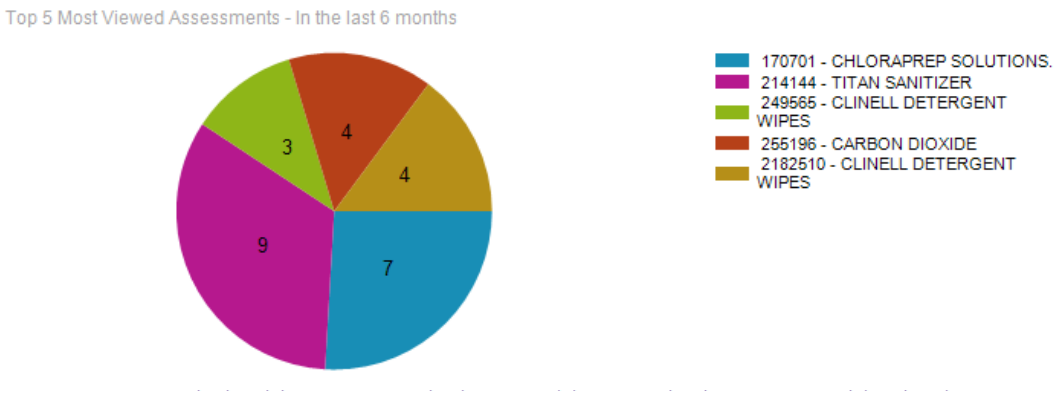
There are 1,407 individual COSHH assessments available with new assessments being added on a regular basis and there are 1,276 different materials used within the Trust.

The graph below shows the number of assessments completed by staff during the last 12 months

All substances used throughout the Trust are risk rated. The graphs below show the ratings of all substances.

Any substances used with a high risk rating are managed with a robust safe operating procedure following advice from the safety data sheet and/or manufacturer.

The database also identifies the top 5 most used assessments in the last 6 months within the Trust which are detailed below:



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7. Smoking

Smoking on site remains problematic. Visitors and patients are still smoking at the hospital entrances despite the voice boxes and signage in place.

A smoking campaign was carried out in June 2016 in conjunction with Live Wire (Smoking Cessation Service), to prevent awareness on the health risks from smoking. The campaign took place on both hospital sites with a successful 55 referrals to smoking cessation services. 22 of those referrals were made by Trust employees.

Posters and leaflets have been revamped and can now been seen in waiting areas and the hospital entrances.

There is still ongoing work within this area and this will move forward with Health and Safety, Occupational Health and Communications.

8. Inspections

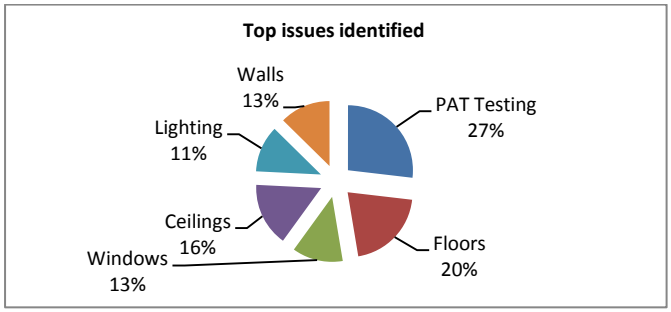
It is Trust policy that the Health and Safety Inspections are carried out by H&S every quarter. This includes all Wards and Departments on both hospital sites.

From April 2016 to March 2017, 409 inspections where carried out.
The following gives an overview of the findings:

Corporate Services

A total of 136 inspections were carried out.

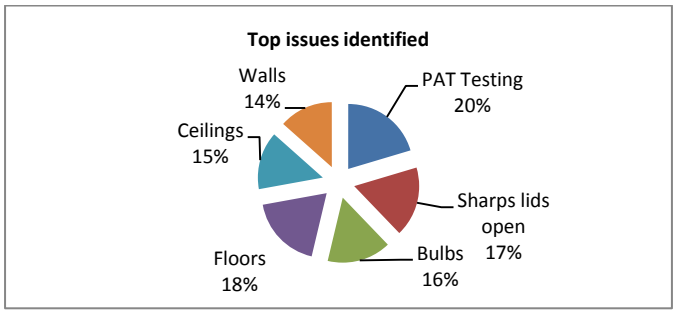
The top issues identified were:



Acute Care Services

A total of 127 inspections were carried out within Acute Care Services.

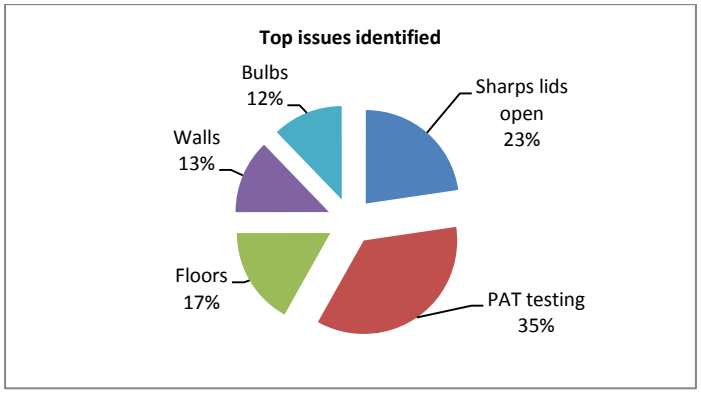
The top issues identified were:



Surgery, Women and Child Health Services

A total of 146 inspections were carried out.

The top issues identified were:



Out of the 409 inspections carried out, 299 areas had few topics identified which is an improvement from the previous year.

Overall Findings–

- **Walls in a poor condition –** Mainly due to the age of some of the buildings such as Kendrick Wing and Thelwall House, however some walls had been damaged by equipment.
- **Expired PAT Testing –** A new Contractor has been used to carry out PAT testing throughout the whole site. The next inspections should expect to see a huge improvement in this area.
- **Poor lighting** – due to bulbs being missing or not working
- **Sharps Bins –** A number of inspections highlighted concerns relating to sharps bins being left open.
- **Flooring –** A number of areas were identified as poor. Some of these areas have since had new flooring so the next inspection report should see an improvement within this area. Work will continue to replace or mend defective flooring.

Recommendations -
Inspections need to increase and more actions need to be taken to ensure all areas are safe, healthy, clean and tidy.

The H&S Team will carry out joint inspections with the Union Representation and the frequency of inspections will increase to every 6 weeks.

There will be a programme of inspection dates but staff will carry out the inspection unannounced.

9. Inspections of Internal Corridors

Inspections of internal corridors on both sites are carried out 3 times per week. 56 at

Halton Hospital
There are very few issues identified on the Halton site. The house keeping on the main corridor is very good and it is very rare that any items are found stored on this corridor.

Warrington Hospital
There are a number of issues within Warrington hospital main corridors. The main issues to address were the storage of beds, patient trolleys, mattresses and items of equipment.
Clinical waste bins were found to be open on a daily basis at one point within the year.

Environmental and building issues were also raised which have since been resolved such as new flooring re-laid, several metal barriers erected, structural damage repaired and the décor improved.

Recommendations -
A revised SOP for the removal of items and equipment from Wards and Departments was circulated to all areas.

A H&S newsletter is going to be produced with pictures of the worst areas being published and highlighting the most improved areas.

10. Sharps

During the past 18 months a lot of education and awareness has been raised around sharps, in particularly safety devices.
A full Trust audit was carried out by the Health and Safety Department in August 2016. The findings were:

- 19 areas were 100% compliant,
- 20 areas were above 90% compliant
- 17 areas were above 80% compliant
- 2 areas were below 80% compliant

From these findings the Needle Stick Working Group has been reinstated. And will work towards ensuring the Trust is using safer sharps and the equipment is fit for purpose. Ensuring that further education and awareness is provided and that reports on sharps incidents are discussed and reviewed at the Health and Safety Sub Committee.

A review of the sharps investigation form (NRI1) form was carried out. This was to identify any training issues and ensure the correct equipment is in use on Wards.

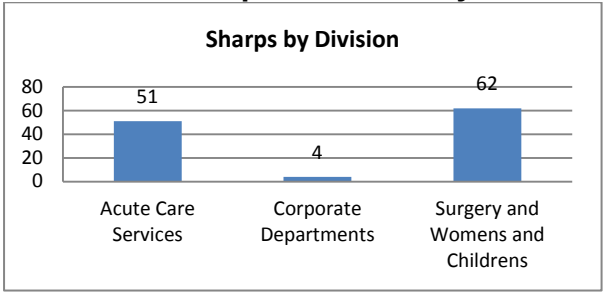
10.1 Sharps incidents

From April 2016 to March 2017 there were 117 sharps incidents reported. Of these, 3 were high risk incidents and were reported to the HSE under the RIDDOR Regulations.

- Member of staff from C22 sustained an injury from a patient with Hep C.
- Agency staff on A1 sustained an injury from a patient who was HIV positive.
- Member of staff from AED sustained an injury from a patient with Hep C.

All incidents had a full investigation which found Trust process were followed, correct PPE was worn and staff had gained advice and ongoing support from Occupational Health.

Number of sharps incidents by Division



All 4 incidents occurring within Corporate Departments involved Catering staff sustaining injuries when removing patient food trays. Investigation found that patients using their own insulin pens wrapped this up in a tissue after use and placed on the food tray.

Overview of Sharps Incidents Reported	
Incorrect disposal of sharps	17
Needle Stick Injury – Clean needle	5
Needle Stick Injury – Dirty needle	80
Sharps box overflowing	2
Sharps box not sealed	4
Sharps box inappropriately stored	1
Blood Splash	8

A further audit of compliance will be undertaken later in the year in conjunction with Infection Control.

11. Non – Clinical Manual Handling

Manual Handling audits are now incorporated into the Risk Management Framework. To date all Wards/Departments are compliant with non-clinical manual handling. All have suitable and sufficient risk assessments in date and training figures are high. A full programme of training dates is now in place for 2017/18.

A number of guidance pages have been developed on the extranet and a back care booklet is currently being produced by the Trust Manual Handling Co-ordinator.

12. Incident Reporting

All non-clinical incidents are reviewed each morning by the Health and Safety Team and allocated to the appropriate manager.

Last year a new incident investigation form was developed and implemented, throughout the Trust, for non-clinical level one investigation. The form was simplified and tick boxes added against certain criteria to ensure all the detail needed is captured.

All incidents reportable under RIDDOR require a level 1 investigation. A dashboard report of incident data is produced monthly and reviewed by the Health and Safety Sub Committee.

The Table below shows an overview of all RIDDOR Incidents between 1st April 16 – 31st March 17

Division	Brief Description	Injuries Reported	Days Lost
Corporate Services	Trip in Car Park	Fracture to hand	0
Corporate Services	Manual Handling Incident	Back Pain	53
Corporate Services	Trip in Car Park	Bruised Hip	0
Corporate Services	Trip over box	Injury to wrist	44+
Corporate Services	Slip on wet floor	Injury to head and knee	10
Corporate Services	Fall in Car Park	Injury to head	0
Corporate Services	Collision with cart	Fracture to leg	0
Corporate Services	Fall in Car Park	Injury to head/arm	0
Acute Care Services	High Risk Needlestick Injury	Needlestick Injury	0
Acute Care Services	Collision with staff member	Fracture to ribs	27
Acute Care Services	High Risk Needlestick Injury	Needlestick Injury	0
Acute Care Services	Manual Handling Incident	Pain in thigh	16
Acute Care Services	Assault to staff	Sprained Hand	20
Acute Care Services	Manual Handling Incident	Back Pain	58

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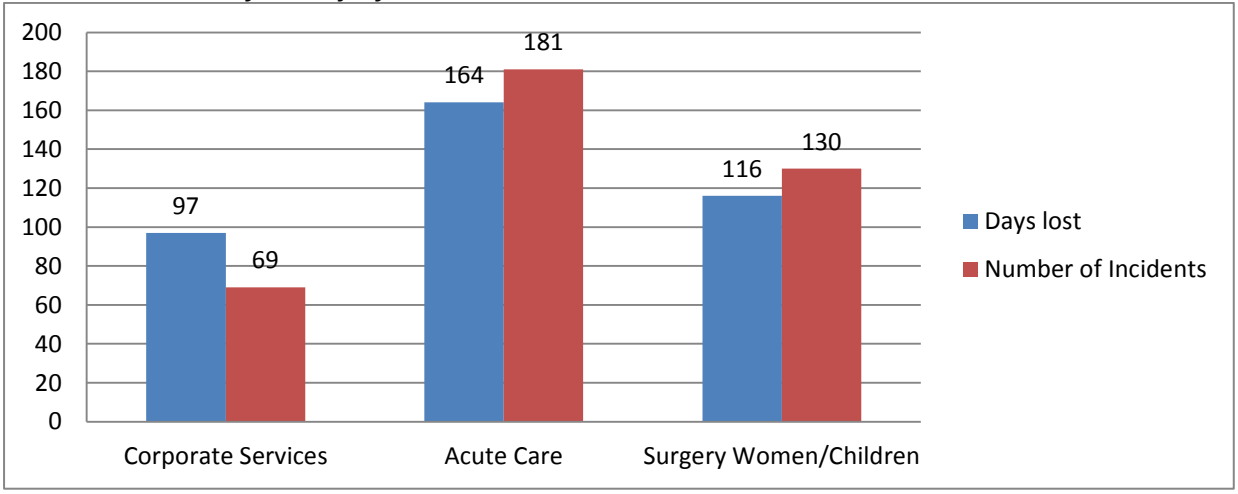
Division	Brief Description	Injuries Reported	Days Lost
Acute Care Services	Hit by object	Injury to head	0
Acute Care Services	High Risk Needlestick Injury	Needlestick Injury	0
Acute Care Services	Slip on wet floor	Injury to back	25
Acute Care Services	Trip on loose hazard tape	Fracture to foot	7
Acute Care Services	Manual Handling Incident	Back Pain	11
Surgery, Women and Children	Manual Handling Incident	Fracture to hand	17
Surgery, Women and Children	Manual Handling Incident	Back Pain	3
Surgery, Women and Children	Manual Handling Incident	Back Pain	17
Surgery, Women and Children	Manual Handling Incident	Back Pain	58
Surgery, Women and Children	Manual Handling Incident	Back Pain	21

13. Lost Time Incidents

The table below shows the information collated from April 2016 to March 2017 with regards to lost time data due to incidents/injuries at work against the number of incidents whereby an injury was received



Lessons Learnt:

A number of people were taking shorts cuts at the front of the hospital and walking on a gravelled areas instead of the designated footpath - A metal fence has now been erected along the perimeter of the grounds to prevent short cuts being taken through a car park

A safety alert was sent out to all staff to raise awareness of the timely reporting of identified defects or contaminates to prevent and avoid unnecessary injuries to staff, visitors and patients.

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14. Display Screen Equipment Assessments

Staff suffering with problems whilst sitting at their work stations can asked their manager to request a formal DSE assessment from the Health and Safety Department.

In the last 12 months, 14 DSE assessments have been requested and carried out. The aim of all assessments is to ensure there is no risk of injury or ill health to staff and to ensure any existing medical conditions are not exacerbated by work equipment.

By conducting a risk assessment and gathering necessary details it can avoid the member of staff going off sick for any given time. 7 members of staff had identified medical conditions and 5 members of staff had been involved in a previous incident and the workstation was having an impact on their health. All work stations were adjusted accordingly and staffs were satisfied by the actions taken to support them.

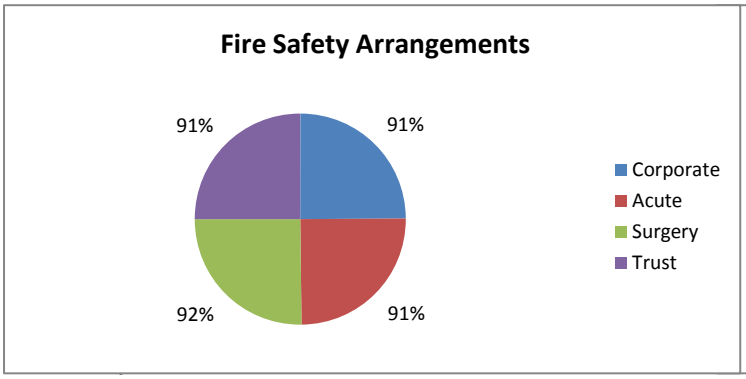
15. Risk Management Framework Audit Results (April 2014 to March 2015)

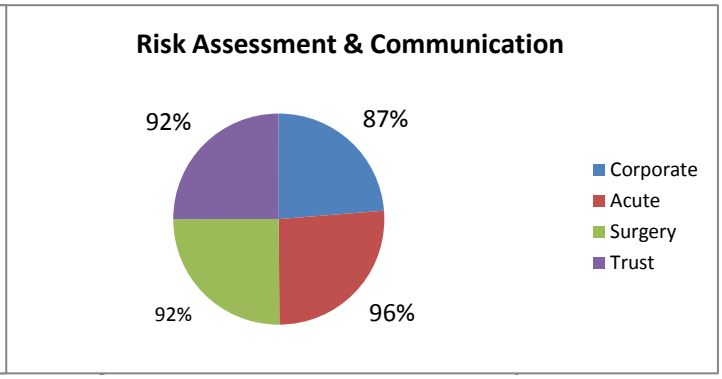
The Risk Management Framework is the basis of the Health and Safety Management System for WHH. This provides a structure for Managers to follow to ensure compliance with legislation within their areas of work.

Over the past 12 months the Health and Safety Team have carried out audits on 79 Departments across all Divisions and Corporate Services. If the Department did not meet 100%, an action plan was developed and the Department re-visited at a later date.

Total number of audits – 135
Total number of Departments meeting 100% compliance – 12
Total number of Departments above 90% compliance – 29

The pie charts below show an overview of compliance ratings





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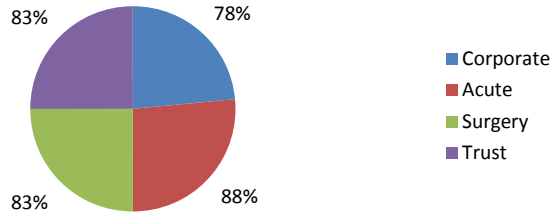
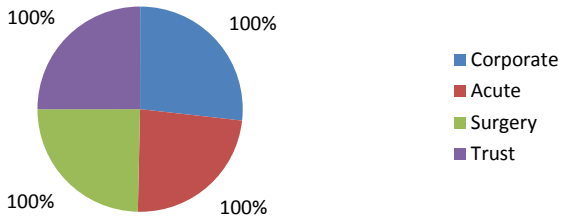
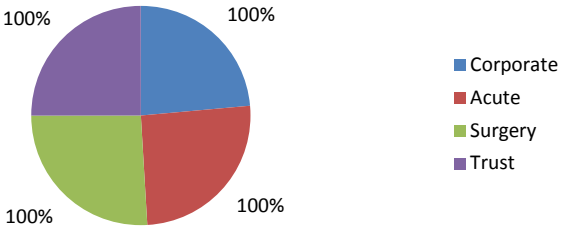
Display Screen Equipment



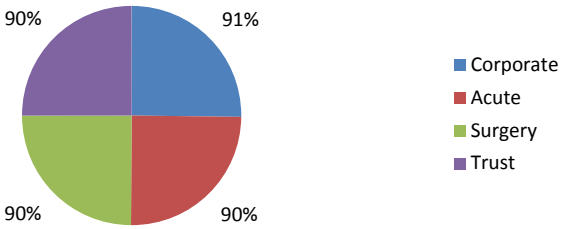
Incident Reporting



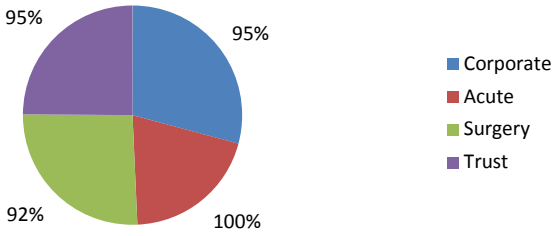
Legionella



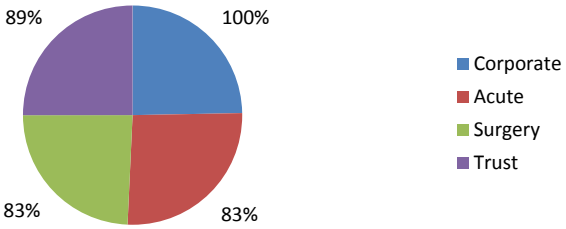
H&S Local Induction



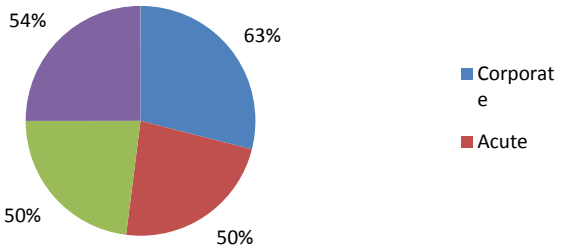
Slips, Trips and Falls



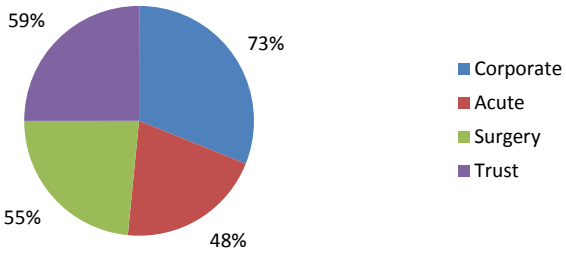
Work at Height



Work Equipment



Personal Protective Equipment



There are a few standards shown with lower than average percentage. The reason for this is the Health and Safety Sub Committee agreed that all H&S risk assessments should be transferred onto CIRIS, as per Trust policy at the time. A number of Wards/Departments struggled with the system and consequently the compliance rating dropped. This has now been taken out of the RMF audit tool and should see a rise in compliance throughout 2017/18.

A full detailed annual RMF audit report will be presented at the Health and Safety Sub Committee.

16. Future Development

The priorities over the next 12 months are to:-

- Development of a Health and Safety Newsletter every 2 months.
- Increase in the number of inspections for Wards and Departments by collaborative working with the Union Representatives
- Review of the inspection template
- Introduction of the Operational Health and Safety Group to discuss matters arising from inspections and all operational concerns
- Development of an external inspection template
- Reinstated Needle Stick Working Group to ensure compliance and reduce injuries
- Reports on non-clinical claims to the Health and Safety Sub Committee each quarter
- Sharing feedback and learning on non-clinical incidents
- Provide good practice links in Communications to highlight areas of excellent housekeeping or other areas of outstanding performance in health and safety
- Review of the RMF audit tool to include a Welfare standard
- Continue to analysis of lost time incidents looking at trends and themes.
- Ensure level ones have appropriate detail and are completed in time
- Ensure all RIDDOR incidents have Level 1 investigations and are affectively tracked and reduce the incidents of claims due to ensuring robust risk assessment and training is available.
- Review of incident reports
- Provide Divisional reports on health and safety management data
- Promote a topic of the month to ensure outstanding compliance with the legislation
- Review generic risk assessments to ensure they are appropriate to the needs of the Organisation and effectively implemented.
- Provide quarterly reports on compliance with the Risk Management Framework and Inspection findings
- Review policies and guidance documents in line with current legislation
- Produce comprehensive DSE reports for staff and managers to minimise the risk of work related upper limb disorders
- Continue to develop the extranet pages
- Provide tool box talks on various topics at the Safety Risk Leads Group
- Develop risk assessment training for all levels of staff across the Trust

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17. Conclusion

There is an established pro-active safety management system within the Trust in particularly with audits and inspections. Further development to further strengthen this system is required to ensure full compliance with the risk management framework. This will take place during the next 12 months.

The Governance Committee on behalf of the Trust Board is requested to discuss, and note the information within the Health and Safety Report.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/63**	
SUBJECT:	Mortality Review Findings Report	
DATE OF MEETING:	31 May 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Dr P. Cantrell, Lead Clinician for Mortality G. Sutton, Clinical Effectiveness Manager	
EXECUTIVE DIRECTOR SPONSOR:	Professor Simon Constable, Medical Director & Deputy CEO	
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):	Choose an item.	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT	This briefing paper overviews Trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce Trust mortality rates and the Trust mortality ratio figures.	
EXECUTIVE SUMMARY (KEY ISSUES):		
RECOMMENDATION:	The Board is asked to discuss and endorse the recommended options.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Agenda Ref.	QC/17/05/107
	Date of meeting	2 May 2016
	Summary of Outcome	Endorsed
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Mortality Review Findings Report	AGENDA REF:	BM/17/05/63

1. BACKGROUND/CONTEXT

The importance of reporting mortality statistics at Board level was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010) to which Warrington and Halton Hospitals NHS Foundation Trust provided a full position response reported at Board in September 2010.

The CQC is looking at how NHS Acute, Community Health and Mental Health Trusts investigate deaths and learn from their investigations. This was following a report commissioned by NHS England which looked at the deaths of people using Mental Health and Learning Disability services run by Southern Health Foundation Trust.

The Government has asked the CQC to look at how NHS Trusts across the country investigate deaths to find out whether similar problems can be found elsewhere.

3. KEY ELEMENTS

We use the HED (Healthcare Evaluation Data) system to asses our overall mortality data. This allows us to produce graphs and assess our position against other Trusts nationally. We evaluate areas for concern or trends which points us towards focused reviews in these particular areas.

2.1 Screening Reviews

All deaths have a 'screening review' by a consultant (not the consultant in charge of the patient) for an over view on the quality of care received by that patient. This review assesses whether a more in-depth review by a member of the Mortality Review Group (MRG) is required.

2.2 Secondary Reviews

Particular groups of patients are reviewed at the MRG :

1. All deaths of patients on DoLs (Deprivation of Liberty)
2. All deaths of patients with learning disabilities
3. All deaths following admission under the Mental Health Act
4. All deaths of patients admitted for an elective surgical procedure
5. All deaths occurring in theatre

Any member of staff can flag a patient to the MRG if there are concerns regarding a patient death for a secondary review. Secondary reviews are presented to the MRG and any actions or lessons to be learned are sent to the appropriate fora.

2.3 Focused Reviews

We conduct focused reviews where the HED system indicates we are an outlier in a particular diagnosis group, for example Pneumonia. It is important to note that the diagnosis group relates to the condition the patient was being treated for during their stay in hospital and not their cause of death.

Where we are above our expected number of deaths in a diagnosis group for over three months we will work alongside specialists within the appropriate specialty to perform case note reviews of the patient's stay.

This deep dive provides us with valuable learning as to what is needed to be implemented to ensure we have no further triggers within diagnosis groups. Some aspects of learning are applicable to reduce the likelihood of triggering in the future, such as improved documentation and coding, whereas others are specifically of relevance to that treatment, such as using a dip stick before diagnosing a patient as having a urinary tract infection.

2.4 Mortality Data Analysis

There are three main types of overall data used:

2.4.1 Crude Mortality Rates

This is the percentage/number of deaths against the total number of discharges in a particular timeframe. It needs to be used with caution as it does not take into account complexity of patients.

2.4.2 HSMR (Hospital Standardised Mortality Ratio)

All spells culminating in death at the end of a patient pathway defined by the primary diagnosis for the spell. It uses 56 diagnosis groups which account for about 80% of in-hospital deaths; therefore it does not included 'all' deaths.

Adjustments are made for:

• sex • age • admission method • comorbidities (based on Charlston score) • number of previous emergency admissions • history of previous emergency admissions in the last 12 months	• month of admission • socio economic deprivation quintile (using Carstairs) • primary diagnosis sub-group • palliative care • year of discharge

2.4.3 SHMI (Summary Hospital Mortality Indicator)

All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities.

Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we still look at HSMR and the crude mortality rates, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

4. MEASUREMENTS/EVALUATIONS

3.1 Screening Reviews

Month	Good Practice	Room for Improvement	Further Review Required	Screening Review Return
2016 Backlog	56	14	3	77% (n=56)
January	61	8	1	76% (*n*=93)
February	63	10	0	75% (*n*=97)
March	21	3	0	36% (n=67)*

*Please note: March reviews have not reached the 30 day threshold to date; therefore it is too early to accurately report.

- The **4** reviews marked as "*Further Review Required*" are subject to a secondary review by a member of MRG. The findings from these reviews will be discussed at MRG and the appropriate action taken. Please see section for the learning derived from secondary reviews.
- The **36** reviews marked as "*Room for Improvement*" have been reviewed by the Lead Clinician for Mortality and a further **4** reviews have been put forward for secondary review by a member of MRG. The remaining **32** reviews relate to:

Improvement Identified	Number	Actions
DNACPR and earlier end of life care	19	Discuss with Palliative Care Consultant
Death certification accuracy	6	Improvement project currently underway with Foundation Year doctors and Senior Clinicians.
Documentation	5	Discuss with Deputy Director of Nursing and Medical Education for a project to improve documentation and record keeping.

Delayed discharge	1	After discussion with the Reviewer, it was felt that this was an isolated incident and due to factors out of control of the Trust.
Delayed diagnosis	1	Although the care provided was good, the patient was clinically difficult to manage due to multiple comorbidities and the Reviewer felt that the investigations conducted were correct.

3.2 Secondary Reviews

There have been **18** secondary reviews conducted between October 2016 and March 2017. **8** of these reviews were identified via a screening review. The remaining **10** were triggered as a result of them being elective deaths (*n*=6) or specifically requested due to an investigation or complaint (*n*=2).

3.3 Focused Reviews

The below table sets out the focused reviews that have been conducted over the past six to twelve months:

Diagnosis Group	Trigger	Observed deaths versus expected deaths	Date completed/ due for completion	Learning Identified
Regional Enteritis	HSMR		October 2016	See Section 3.6
Pneumonia	HSMR	237/218	March 2017	
Urinary tract Infections	HSMR & SHMI	71/46	April 2017	Report due 4/4/17
Diabetes with Complications	SHMI	8/4	February 2017	See Section 3.6
Cancer of the Rectum & Anus	HSMR & SHMI	7/2.78	May 2017	Report due 4/4/17
Cardiac Dysrhythmias	HSMR	14/7	June 2017	Report due 4/4/17
Fractured Neck of Femur	SHMI	41/30	July 2017	

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3.4 Crude Mortality

- Crude mortality should be viewed with caution, as it does not take into account the complexities of the patients, but it is useful to monitor numbers of observed deaths.
- Because of the relative consistency of the relationship between in hospital crude mortality and crude mortality including deaths with 30 days out of hospital, it can give an 'early warning' with regards to mortality including deaths within 30 days out of hospital.
- This month, if this trend continues, it suggests a rise in mortality rates including out of hospital deaths may be expected for December 2016, when data is available next month, and this may also be true for the SHMI.

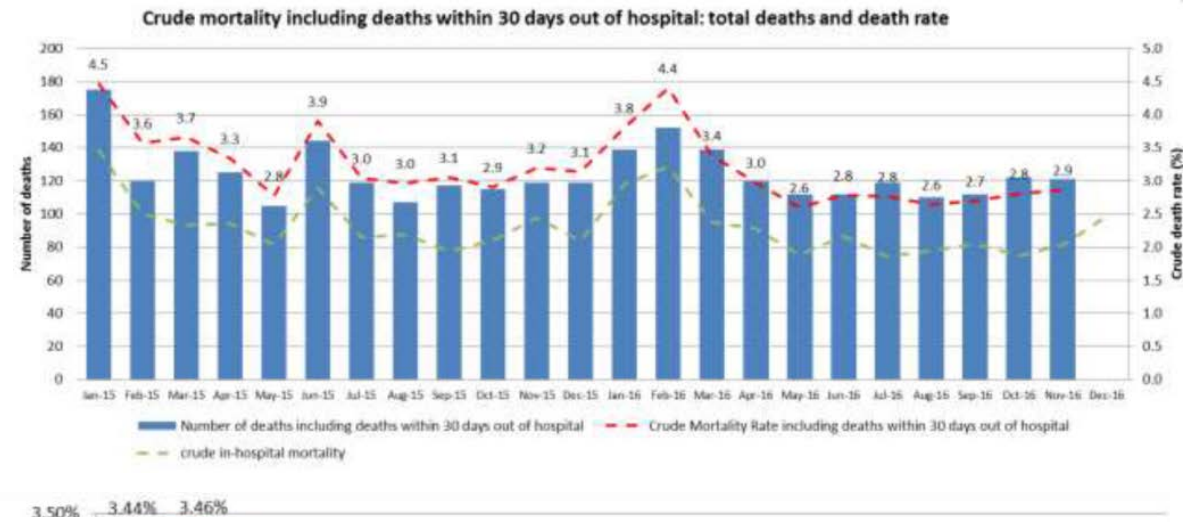

Figure 1: Crude Mortality January 16 to December 16

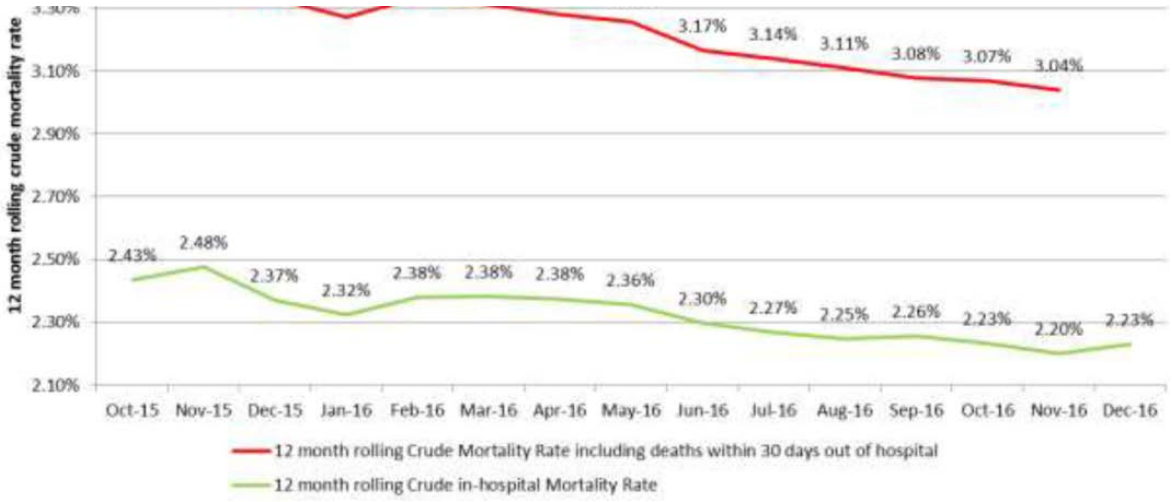

Figure 2: Crude mortality 12 month rolling figures

- Using 12 month rolling rates removes the effect of seasonal variation.
- With this adjustment it is clear to see an improvement in crude mortality.

3.5 HSMR

- **We are not a national outlier, with a HSMR of 106.48 for January 2016 – December 2016.**

- This result is not significant at 95% level for the latest 12 months. However it is still very close to the boundary for being an outlier.

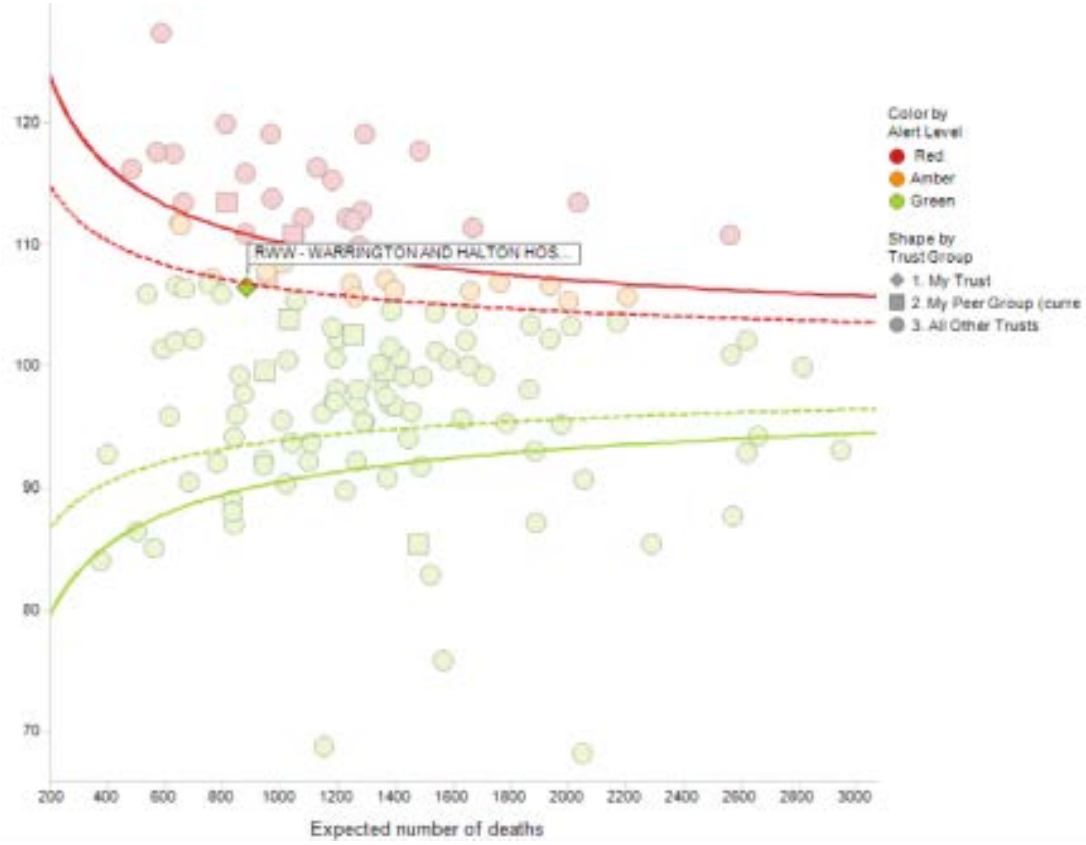

Figure 3: HSMR January 16 to December 2016

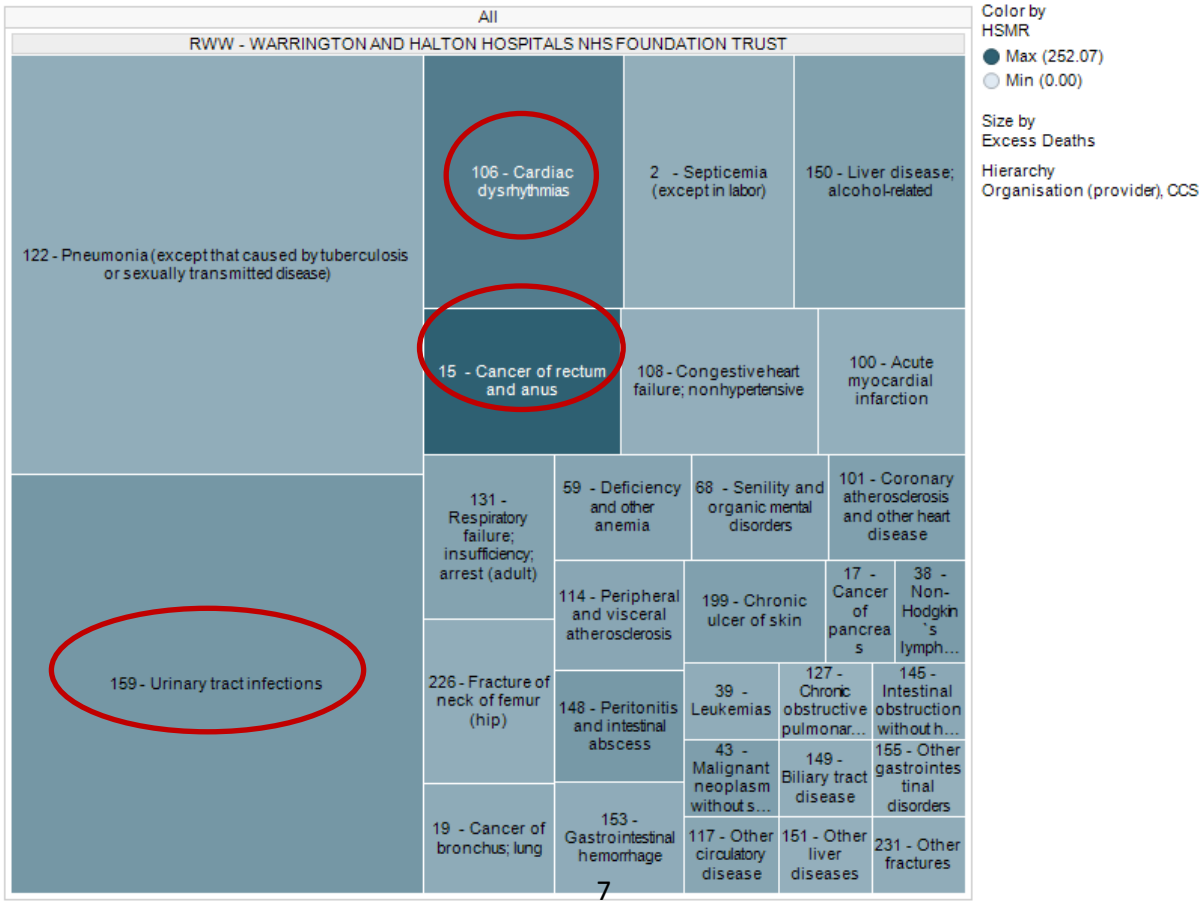

Figure 4: HSMR excess mortality by diagnostic groupings

- Statistical significant CCS groups are ringed red and are currently under investigation.
- Note: You can see by the size of the blocks that Pneumonia also makes a high volume contribution to excess deaths without being statistically significant. (pneumonia: 237 observed deaths, 213 expected, 1,458 discharges, HSMR: 111.34, not an outlier)

3.5.1 Weekend/Weekday HSMR

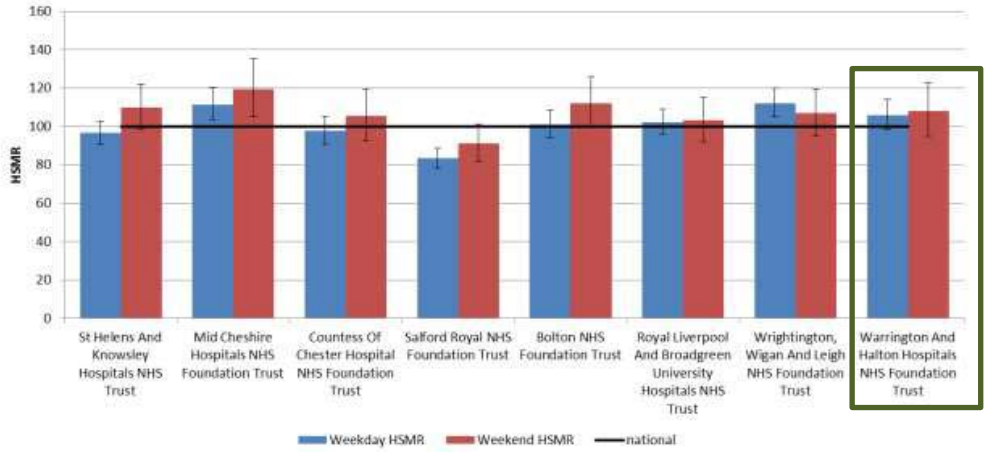

Figure 5: Weekend / weekday HSMR compared to peers

- This graph shows Warrington has only a slightly higher weekend HSMR than weekday, and neither score is statistically significantly high.
- Most peer trusts show a greater variation between weekend and weekday than Warrington has for the last 12 months, except Wrightington, Wigan and Leigh, which had the opposite trend.
- Error bars denote 95% confidence intervals.

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3.5 SHMI

We are a 'green alert' for this indicator, with a SHMI of 108.12 for the period December 2015 to November 2016.

Figure 6: SHMI Funnel Plot (December 2015 - November 2016)

St Helens & Knowsley	Mid Cheshire	Countess of Chester	Salford Royal	Bolton	Royal Liverpool	Wrightington, Wigan & Leigh	Warrington & Halton

Figure 7: 12 month rolling SHMI over last 3 years for Warrington compared to peers

- Our continuing improvement can be seen

- Salford shows the greatest improvement although their SHMI may be starting to rise slightly.

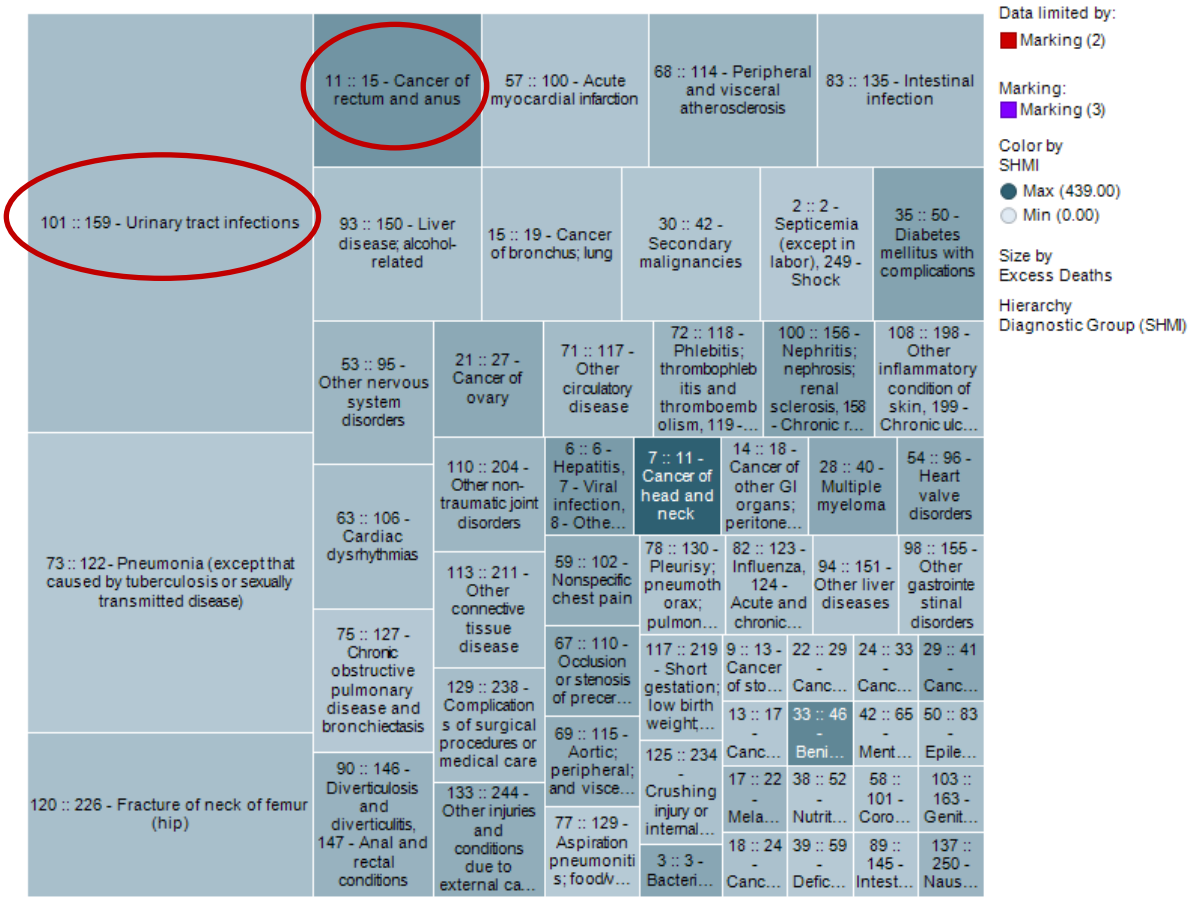

Figure 8: SHMI excess deaths by diagnostic grouping; tree diagram

- CCS groups which are statistically significantly high are ringed red and subject to focused reviews.

3.5.1 Weekend/Weekday SHMI

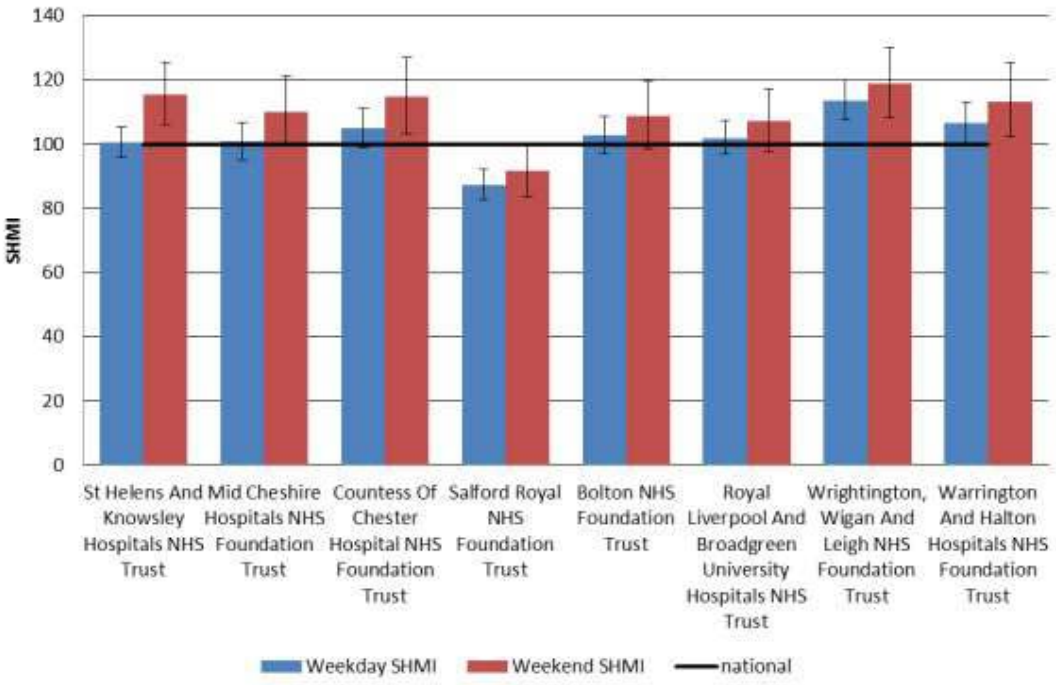

Figure 9: Weekend / weekday SHMI compared to peers

- Weekend SHMI is higher than the weekday SHMI for our Trust and all of peers.
- Both weekend and weekday SHMI is statistically significantly high for our Trust; the same is true for Wrightington, Wigan and Leigh.
- St Helens and Knowsley, and Countess of Chester both have a statistically significantly high weekend SHMI.
- SHMI is statistically significantly low for Salford for weekdays and weekends.

3.6 Learning Identified from Mortality Reviews

Issue	How Identified	Outcome
Medical patients admitted who have possible surgical diagnosis (bowel ischaemia/obstruction.	Focused review into Regional Enteritis and Ulcerative Colitis.	• Review undertaken by the Digestive Diseases CBU Lead. • Guidelines and timelines agreed for a number of diagnoses presented at the surgical and medical Governance and Audit meetings for dissemination.
Identification and recognition of patients with possible adrenal insufficiency.		• Guidance to be produced into general management of patients on steroids (short and long term). • Being undertaken by Dr Paula Chattington.
Patient with renal failure and a high potassium waiting for dialysis and a bed at the Royal Liverpool University Hospital (RLUH).	Secondary reviews	• Referral and Transfer Pathway drawn up by the RLUH visiting nephrologist to Warrington & Halton Hospitals (WHH).
Patients admitted as a day case who require stay in as an inpatient as a result of a complication of a procedure not known to out-of-hours/weekend on-call team. Gastroenterology and respiratory patients involved.		• All such patients to be handed over directly to the medical registrar on-call to ensure managed as an acute admission and reviewed by the on-call team.
Poor/inadequate management of patients who have been stepped-down from ITU due to inadequate handover (medical).		• Paper discharge form detailing ceilings of care provided to be available immediately in notes (there is a 2-3 day delay in transferring information to Lorenzo).
Pneumoperitoneum on chest x-ray missed by reviewing medical staff.		• Case presented at the medical Audit and Governance forum to highlight the case and refresh knowledge of pneumoperitoneum on chest x-ray.
Poor/delayed recognition and treatment of sepsis.		• Trust Sepsis Lead invited to Mortality Review Group to present the work now being done on sepsis, the new Sepsis Pathway and the plans for dissemination and training.
Very poor correlation between the death certificate cause of death and the cause of death identified by a consultant undertaking a secondary review. This is a recurring theme.	Identified on numerous secondary reviews and focused reviews.	• Work Group set up to look at best practice guidance and bringing recommended guidance and training plans to the Medical Cabinet.
Trauma patient with fall and head injury – thoracic injuries not	Identified as part of the Trauma reviews for trauma	• Reinforced the importance of following the Thoracic Injury Pathway at the

recognised.	patients.	surgical/orthopaedic/A&E Audit meetings.
Patients under an Oncology consultant who present as an acute admission to the Trust. Teams unaware patient is receiving therapy or indeed unaware in some cases that the patient has a known malignancy. Not managed appropriately as a result.	Regional Enteritis & Ulcerative Colitis and Pneumonia focused reviews	• Taken to the Patient Safety and Clinical Effectiveness Sub Committee. • Also to be taken to the Lead Manager for Cancer Services and Lead Clinician for Cancer for action.
• Review by HED into the Trust's high SHMI/HSMR since July 2016 suggested depth of coding issues. • High number of R codes identified by AQUA • Inadequate co-morbidity documentation.	• Identified as part of MRG review of HMSR/SHMI even though we are aware that there is a month-on-month reduction in the levels. • Also noted that all of the patients reviewed as part of the focused pneumonia deaths were patients who should have all been 'expected to die'.	• We have invited AQUA to help us identify areas where we should target for changes. • First meeting scheduled for 14 March 2017.

2. ASSURANCE COMMITTEE

Quality Committee

3. RECOMMENDATIONS

The Board is asked to discuss and endorse the recommended options.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/64**
SUBJECT:	**Complaints Improvement Report**
DATE OF MEETING:	31 May 2017
ACTION REQUIRED	**Review, Discuss and note**
AUTHOR(S):	Ursula Martin, Deputy Director of Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
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
STRATEGIC CONTEXT	Complaints Handling is a statutory and regulatory requirement.
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • A full data cleanse of complaints has now been completed – all inboxes have been reviewed, all additional systems recording complaints have been decommissioned – there is now one system in the Trust recording complaints – Datix • Standard Operating Procedures have been developed for administrative staff using Datix • The Trust is working with Datix to improve the functionality even further • The complaints team and function within the Trust have been reviewed and additional substantive resource has been put in place, as well as temporary resource • Performance has improved over the last few months • Performance meetings with divisions reinstated weekly • PALS service has been reviewed and a business case is in development. • A new complaints process has been developed and will be piloted in a number of CBUs in early June.

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	• Training will be delivered in June 2017 re complaints handling and rolling programme out in place.	
RECOMMENDATION:	Review, Discuss and note the Trust Annual Health & Safety Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	April 2017
	Summary of Outcome	Approved for receipt by Board of Directors
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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BOARD OF DIRECTORS

SUBJECT	Complaints Improvement Report	AGENDA REF:	BM/17/05/64

1. BACKGROUND/CONTEXT

The Board of Directors and Quality Committee received a report in February 2017, outlining an improvement plan, following a review of the Trust's complaint handling function. A high level review identified deficiencies in performance against the 2 national targets (time taken to acknowledge and time taken to respond) and a significant accumulated backlog of historic complaints. In addition the review identified a need to review systems and processes in managing complaints within the Trust.

This paper notes progress against a series of comprehensive indicators, outlines the current position and actions completed to improve complaints handling at Warrington and Halton Hospitals (WHH) NHS Foundation Trust.

2. KEY ELEMENTS

The complaints improvement plan update is given in Appendix 1.

Since the last report, the following additional actions have been taken

- The complaints data cleanse has resulted in the DATIX database now being fit for use as a reporting system for the complaints function, allowing for weekly reports to all CBUs.
- This data has now been sent to the triumvirate of each CBU. The triumvirate is being supported by the Divisional Complaints Managers to scrutinise and improve the data recorded.
- Standard Operation Procedures for key elements of the complaints process have been drafted and are being operationalised and a training plan is in place.
- The 72hour review process for red rated complaints is now fully implemented, with a process in place to identify and declare Serious Incidents as an early stage in the process, and ensure Duty of Candour is in place.
- All emails (from the Patient Experience inbox, where there had been c3,000 emails) have been scrutinised and actioned, this means that this inbox is now only being used for current email correspondence.
- Historical e-mails (in the Complaints inbox) have been audited. All e-mails with scanned attachments have been reviewed and actioned. Based on the audit findings of the remainder of e-mails in this inbox, this is now being left

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dormant, as there is a very low risk of un-actioned correspondence being identified.

- The complaints monthly dashboard data has been developed, with a review of KPIs having been undertaken, the emphasis being on the provision of relevant and useable data.
- A substantive administrative assistant has been appointed, subject to standard HR checks.
- The substantive Complaints Improvement Lead has been appointed, and is due to commence in post mid-June.
- As a result of staff absence, Patient Experience Officers are covering the PALS service. Whilst this impacts on the service it is also identifying key areas for improvement in the PALS service. A business case is in development for PALS
- The Trust's Complaints Annual Report has been drafted and will be presented to Trust Board in June 2017 for approval.
- A draft of the revised complaints management process has been created and pilots will commence in early June in Urgent Care, MSK and Outpatients services. This process is shown in Appendix 2. This focuses on more clinical and managerial ownership and more contact with the complainant from the outset.

The current position is as follows (as at 22 May 2017):

	Total No of Complaints in Division	**No Over 6 months**	**No between 35days and 6 months**	**Under 35 days = within timescales for internal target**	**Complaints where the complainant is dissatisfied and has requested a further response**
ACS	89	18	44	27	8
SWC	100	25	47	28	15
CORP	16	1	8	7	1
Total (May)	205	44	99	62	24
Total (March)	238	63	130	45	42
% Change	-14%	-30%	-24%	+ 38%	-43%

The above chart shows a significant improvement in the total number of cases across each of the areas.

There has been a reduction of 30% in the number of cases over 6 months old and the additional temporary resource, which was allocated to the Patient Experience Team, continues to prioritise these often complex cases. There has also been a reduction of 43% in the number of cases awaiting a further response due to the complainant's dissatisfaction with the original response.

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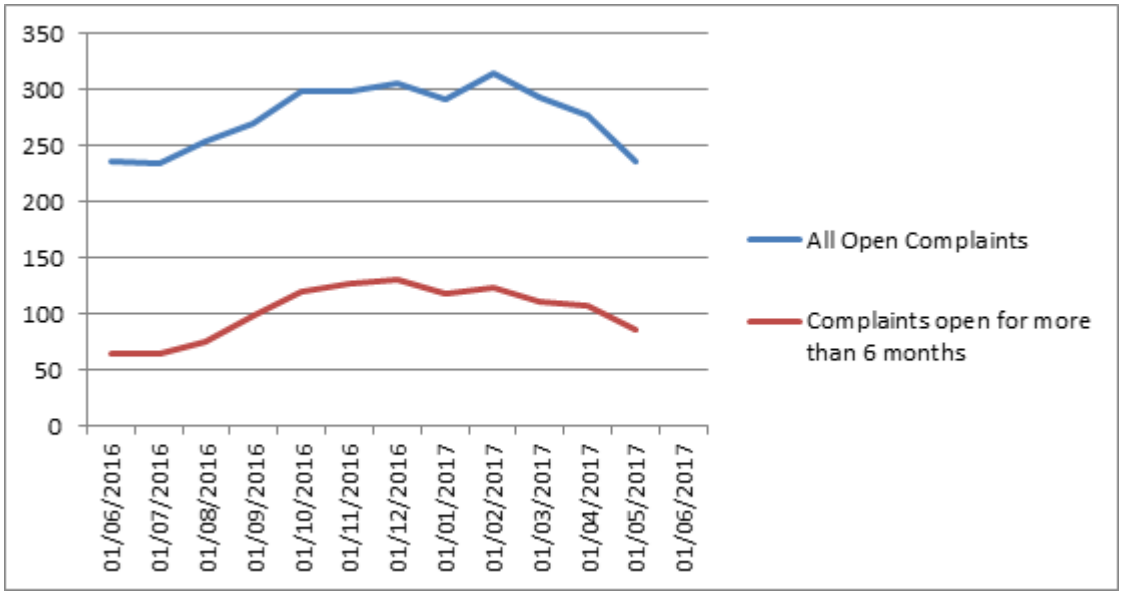
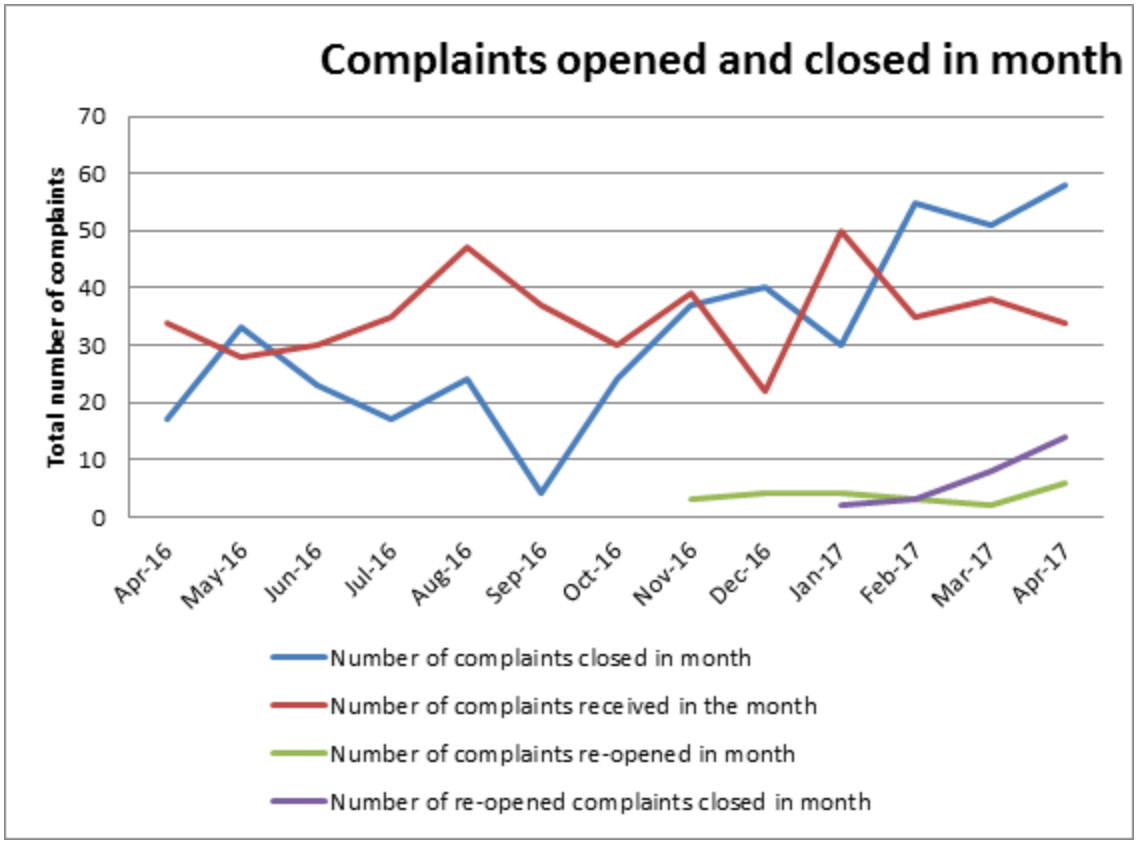
Graph 1 – graph showing trend of open complaints and those over 6 months



Graph 2 – graph showing numbers of complaints received versus closed by month



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Key actions going forward:

- The new process in Appendix 2 is to be piloted and then implemented.
- The first Complaints Quality Assurance Group will meet in June 2017.
- Training in complaints handling will be delivered in June 2017 and a rolling programme put in place.
- There will be an appropriate system for capturing and monitoring lessons learned from complaints and concerns so we can identify patient experience and quality improvement priorities, so that we can systematically show that we have made improvements and listened to our patients and public.

3. RECOMMENDATIONS

Whilst significant work has been undertaken regarding complaints handling, further work and review is required.

The Board of Directors are therefore asked to:

- Note the position in terms of complaints handling and the actions taken to date;
- Note the update with regard to the complaints improvement plan;
- Note the revised process, which will be piloted in the next few weeks.

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Review of the Complaints Management Department and Function

Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
Ensure the Complaints Handling Processes are in line with Complaints Regulations and best practice	Review the Trust Complaints Policy	This policy has been reviewed and is being considered for approval at the Trust Quality Committee in February	End February 2017	**COMPLETED**	Deputy Chief Nurse
	Review of operational processes to ensure compliance against NHS Complaints Procedure (2009)	This review has been undertaken The PET department and staff are aware of the requirements of the NHS Complaints Procedure (2009) and its targets. However, the department does not comply with the target for the resolution of complaints and actions are required (outlined below) for actions regarding this.	End November 2016	**COMPLETED**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
	Review compliance with National complaints handing recommendations as set out in *'A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture' and My Expectations for raising concerns and complaints'*. And update this action plan accordingly	The process has been fully reviewed in line with best practice.	End March 2017	**COMPLETED**	Complaints Programme Consultant
	Introduce a Complaints Quality Assurance Group (recommended that this is chaired by a Non Executive Director).	Terms of Reference have been developed	End March 2017	**SLIGHTLY OFF TRACK** **Terms of Reference have been approved - The first meeting is in June**	Deputy Director of Governance & Quality
	Write the Trust Complaints Annual Report and ensure it is in line with statutory and regulatory requirements.	The report has been completed – will be presented to the Board in June 2017.	End April 2017	**COMPLETED**	Deputy Director of Governance & Quality

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Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
Ensure that the complaints team establishment and structure is reviewed	Review the departmental staffing establishment and skill mix and take any action as required	This has been completed. An administrative member of staff employed, a substantive Complaints Improvement Manager and the divisional complaints function has been integrated into corporate team.	End March 2017	**COMPLETED – A new Complaints improvement Manager has been appointed and a review undertaken**	Deputy Director of Governance & Quality/Complaints Programme Consultant
Review how complainants are engaged in the resolution of their complaint	Identify how informal complaints are handled and managed; Review the PALS function, resource and accessibility;	The review of PALS has been completed – the requirement for additional resource has been flagged to the executive team and a business case is underway.	End March 2017	**COMPLETED – a business case is in development**	Deputy Director of Governance & Quality/Complaints Programme Consultant
	Ensure all complainants have a point of contact in the Trust	The complainant will be contacted by telephone to provide a name of the case handler and to establish the exact issues that require investigation. This encourages a relationship with the	End February 2017	**COMPLETED**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
		complainant at the outset. Case Handlers will keep complainant informed of progression in the investigation. Due to the backlog and interim staff requirements, this has taken some time to implement, but by the end of February 2017 all complainants (new and old) will have a point of contact in the Trust.			
Ensure training in the complaints handling process is in place within the Trust	Undertake a review of the complaints handling training within the Trust , ensuring it is in line with the revised policy.	A review of the training has been undertaken.	End February 2017	**COMPLETED – training review undertaken**	Complaints Programme Consultant
	Develop a Complaints Handling Toolkit for staff for all investigating officers	This has been completed.	End March 2017	**COMPLETED**	Complaints Programme Consultant
	Review the training requirements for the complaints cases officers within the Trust and put in place a	SOPs have been developed and a competency framework also developed – to be	End March 2017	**SLIGHTLY OFF TRACK SOPs and a**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	training programme	implemented in full by Complaints Improvement Manager		**training programme developed - to be implemented**	
	Review the quality of complaint responses, to examine language used, grammar, style and empathy demonstrated in tone;	This is ongoing	Ongoing Improvements will be incremental	**ONGOING**	Complaints Programme Consultant
Ensure that data quality in complaints handling improves	Develop a live spread sheet of all cases which will provide ' a single version of current position' This report will have the ability to be 'filtered' to enable various staff group to effectively use the data	Live spread sheet populated with all cases. Relevant dates added for each case. Systematic review of each case ongoing with Divisional Complaints Managers to establish the current status of each complaint. Weekly meetings with Divisional Governance/Complaints leads and PET officers to take place to update current progress with	End December 2016	**COMPLETED**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
		every case. Following DATIX data cleanse this spreadsheet has been decommissioned and all live data is available direct from DATIX.	End April 2016	**COMPLETED**	
	Undertake a full data cleanse of the Datix Software package, examining every open case. Rectify and ensure: • Develop Standard Operating procedures for all staff regarding complaints management on the Datix system • That all current cases have the correct data fields completed. (a number of file have crucial data missing) • That all current cases have the	This has been commenced and significant progress has been made	End March 2017	**COMPLETED** **In Draft- to be implemented** **Completed**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	relevant documentation uploaded to the case file to ensure this is always up to date with the current status.(a number of cases have documentation gaps on the case files) • In liaison with the CBUs and Divisional Complaints Managers, ensure high risk profile cases have been downgraded (if required) following the 72 hour review. • Ensure that cases which are actually closed are marked as such on Datix. • Highlight cases which have had no action which should be progressed. • Take appropriate action to progress the case.			**Completed** **Completed / ongoing** **Completed** Completed Ongoing	

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	• Identify and action cases where they have stalled. e.g. Draft letter on file but not followed up (sometimes for a number of weeks) (action being taken to rectify this) • Keep contemporaneous records of all actions taken to complete a comprehensive data cleanse, this will enable production of a report noting all anomalies corrected			Ongoing ongoing	
	• Undertake a full review of the functionality of the Datix Risk Management Software – Complaints Module to ensure it is fit for purpose. • Work with the Datix organisation to develop the software package as appropriate.	DATIX have planned site visit to work with teams to improve data accessibility	End June 2017	**COMPLETED** **On track – Datix coming into the Trust June 2017**	Complaints Programme Consultant/ Complaints Manager

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	• Liaise with internal colleagues and Datix Administrator to make any changes necessary.			ongoing	
Ensure that performance in complaints handling improves	Calculate a trajectory to ensure the backlog of complaints is resolved	This has progressed and improvements are being made with regard to performance.	End February 2017	SLIGHTLY OFF TRACK Reviewing this with divisions with new reports	Complaints Programme Consultant
	Review reporting arrangements to Clinical Business Units and within the Trusts' Clinical Governance Framework to performance manage complaints within the Trust	This has progressed and a weekly meeting is in place chaired by the Chief Nurse with reporting into the Executive Team meeting weekly.	End February 2017	COMPLETED	Complaints Programme Consultant
	Develop a monthly report on complaints handling mapping progress against action timeframes and trajectories, as well as monitoring KPIs in the revised complaints policy.	Monthly KPIs have been reviewed and are in new quality dashboard	End February 2017	COMPLETED	Deputy Director of Governance & Quality Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
Ensure that lessons are learned as a result of informal and formal concerns raised	Ensure there is an appropriate system for capturing and monitoring lessons learned from complaints and concerns	Any learning identified during an investigation is captured within Datix to assist in ongoing audit	End March 2017	**ONGOING**	Deputy Director of Governance & Quality Complaints Programme Consultant
	Ensure that there is triangulation of complaints data at a ward level with incidents, staffing etc.	To commence	End July 2017	**ON TRACK**	Deputy Director of Governance & Quality Deputy Chief Nurse
	Ensure there is an aggregate learning report developed for incidents, Serious Incidents, complaints, concerns and claims	There is currently a report in place produced on a quarterly basis – Learning from Experience Report	End June 2017	**COMPLETED**	Deputy Director of Governance & Quality Complaints Programme Consultant
	Ensure there is a lessons learned framework developed, which sets out how to learn lessons across the	To commence	End June 2017	**ON TRACK**	Deputy Director of Governance &

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
	Trust				Quality
	Ensure there is a lesson learned audit put in place within the Trust, as part of the Trust's annual clinical audit cycle	To commence	End June 2017	**TO COMMENCE**	Deputy Director of Governance & Quality

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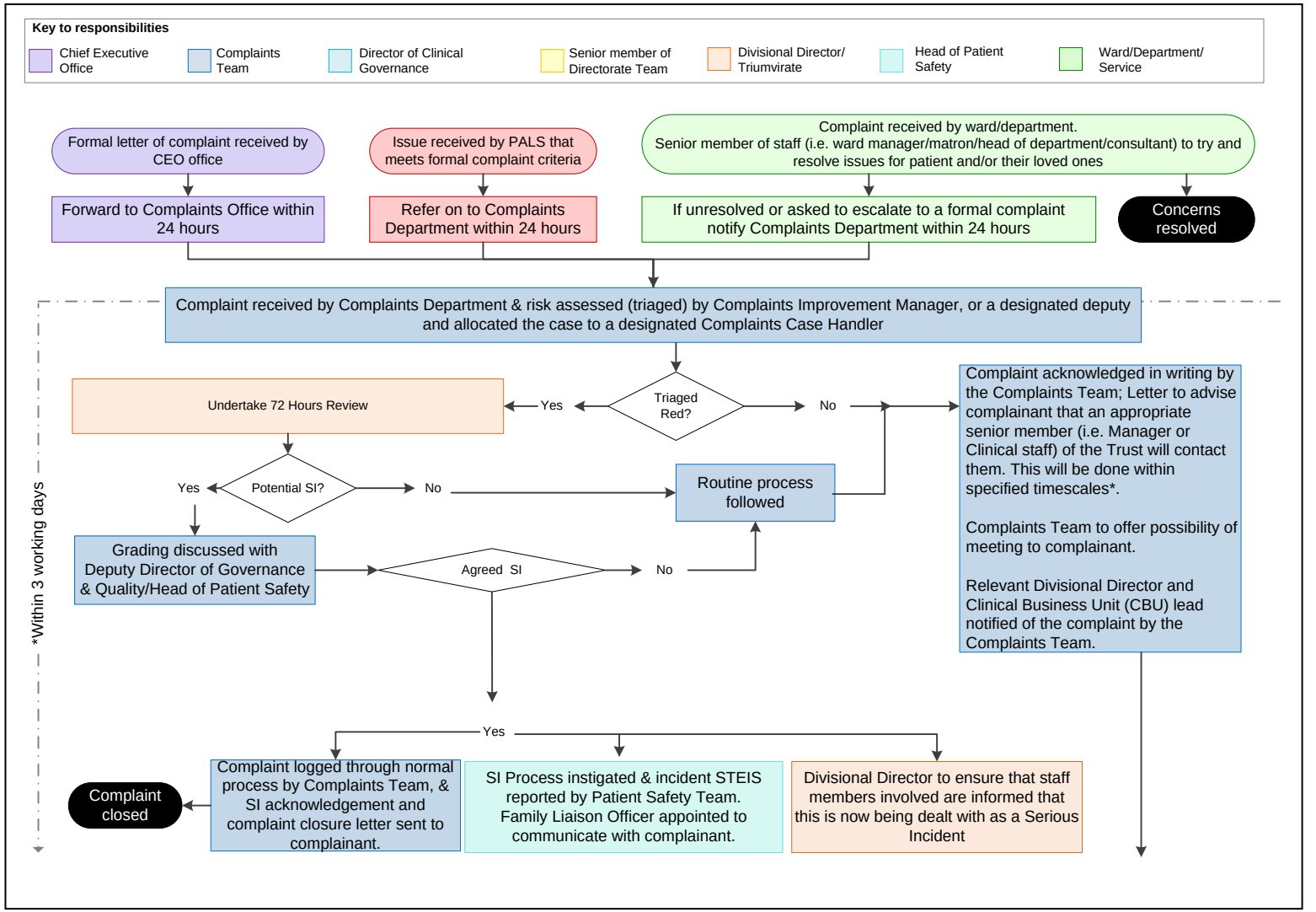
NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 2 – revised complaints process being piloted



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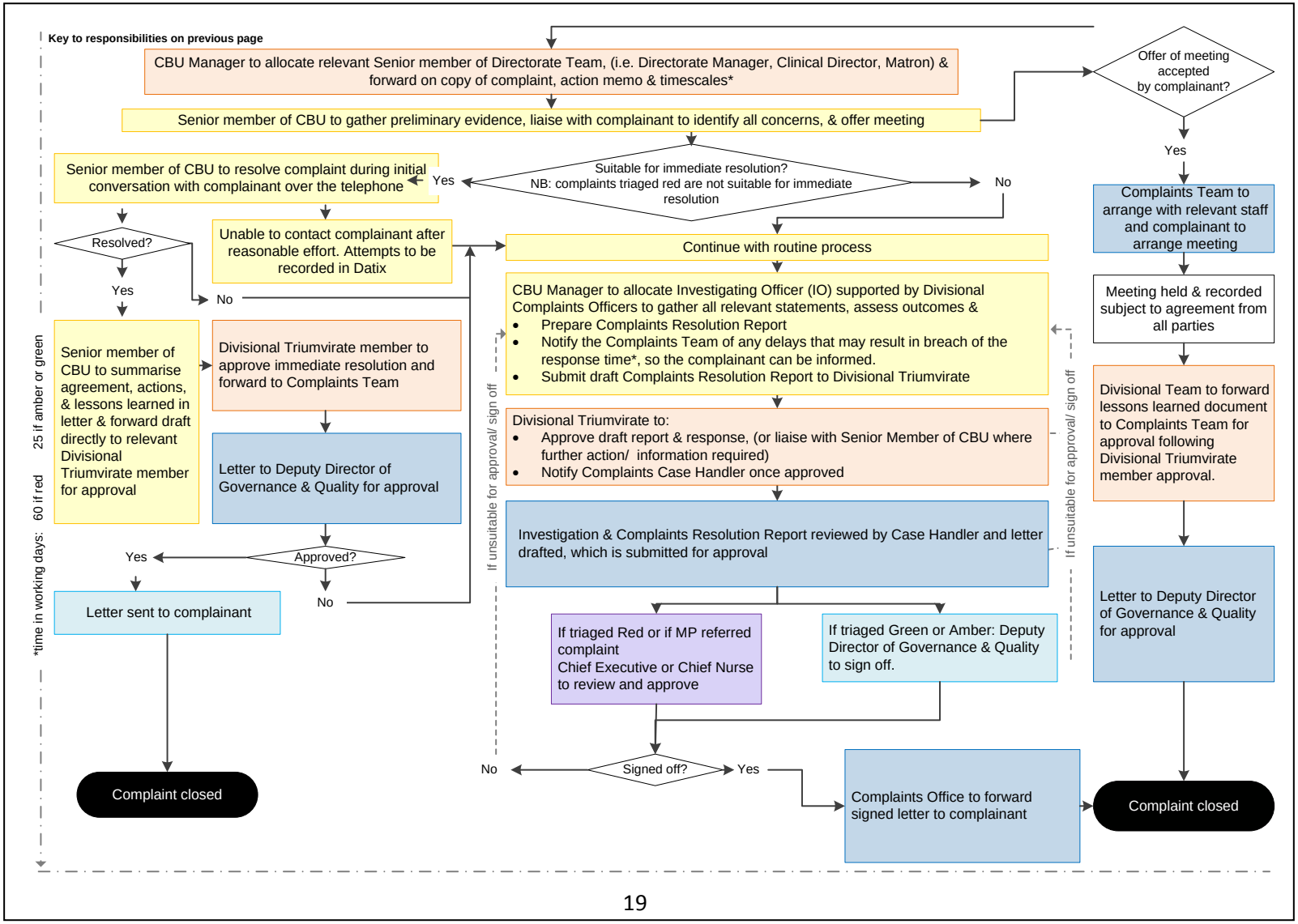


BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/65 (a)**
SUBJECT:	**Risk Management Strategy and Policy**
DATE OF MEETING:	31 May 2017
ACTION REQUIRED	**Review, Discuss and approve**
AUTHOR(S):	Ursula Martin, Deputy Director of Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
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
STRATEGIC CONTEXT	Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures.
EXECUTIVE SUMMARY (KEY ISSUES):	The proposed changes to the risk management strategy: 1. Review of process to manage risk, with clear lines of escalation 2. A review of governing management of risk within the Trust- there will be a review of meetings within the Trust, which has commenced- this may impact on the corporate governance arrangements going forward. 3. Transferring the risk assessments and risk registers from CIRIS to the DATIX Risk Management Module – this will provide an efficient and simplistic tool for all managers to report, monitor and review their risks. 4. Development of an integrated self-assessment tool to manage all risks i.e. clinical risk, financial, health and safety, staffing. 5. Introduction of a Risk Review Group to monitor

	and review all strategic risks. The group will review all high level risks and give recommendations to the Quality Committee for inclusion on the strategic risk register. The Group will review all Divisional risk registers on a rolling 6 month programme. 6. Development of a training programme for identified staff and managers. This will be included in the Trust TNA	
RECOMMENDATION:	Review, Discuss and approve the Trust Risk Management Strategy	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	April 2017
	Summary of Outcome	Approved for ratification by Board of Directors
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

BOARD OF DIRECTORS

SUBJECT	Risk Management Strategy	AGENDA REF:	BM/17/05/65 (a)

1. BACKGROUND/CONTEXT

Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss.

The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures.

Currently there are processes in place to manage risk within the Trust but these could be further strengthened with the implementation of the revised risk management strategy.

2. KEY ELEMENTS

The proposed changes to the risk management strategy:

- Review of process to manage risk, with clear lines of escalation
- A review of governing management of risk within the Trust- there will be a review of meetings within the Trust, which has commenced- this may impact on the corporate governance arrangements going forward.
- Transferring the risk assessments and risk registers from CIRIS to the DATIX Risk Management Module – this will provide an efficient and simplistic tool for all managers to report, monitor and review their risks.
- Development of an integrated self-assessment tool to manage all risks i.e. clinical risk, financial, health and safety, staffing.
- Introduction of a Risk Review Group to monitor and review all strategic risks. The group will review all high level risks and give recommendations to the Quality Committee for inclusion on the strategic risk register. The Group will review all Divisional risk registers on a rolling 6 month programme.
- Development of a training programme for identified staff and managers. This will be included in the Trust TNA

Benefits:

- To provide assurance that all levels of risk are monitored appropriately, have sufficient controls in place and are up to date
- Ensure that risk scores are accurate for the level of risk and this is consistent throughout the Trust
- Well Led is part of the CQC fundamental standards and an effective, robust risk management process reflects on well led throughout the Trust
- Proactive risk management ensures a safe environment for patients, staff and visitors by reducing and, where possible, eliminating the risk of loss/harm

3. ASSURANCE COMMITTEE

This Strategy was received by the Trust Quality Committee in April 2017.

4. RECOMMENDATIONS

The Board are asked to review, discuss and approve the Trust Risk Management Strategy.

Risk Management

Strategy and Policy

2017 - 2019

Contents

1. Introduction

Having a robust Risk Management system means having a planned and systematic approach to the identification, evaluation and control of the risks facing Warrington and Halton NHS Foundation Trust (WHH) and is a means of preventing harm to patients and staff, minimising costs and disruption to the Trust, caused by undesired events.

The aim of this Risk Management Strategy is to ensure the Trust has an effective process to support better decision making through good understanding of risks and their likely impact by:

- Raising awareness of the need for risk management;
- Ensuring there are systems and processes to enable staff to implement the requirements of this strategy;
- Ensuring there is adequate training in place for staff within the Trust in relation to risk management;
- Ensuring that there are clear governance processes in place, to ensure policy and decision making are informed by identifying risks and their likely impact.

2. Why is Risk Management Important?

Risk management is the process of identifying possible risks or problems before they happen. This allows the Trust to set up procedures to avoid the risk, minimise its impact, or at the very least help cope with its impact. The Trust should make a realistic evaluation of all potential risks and put controls in place to minimise any harm or loss. It is important that we have this in place, as it is a measure of how well led an organisation is, and risks that are left unchecked can escalate into serious issues, which put patients, staff, the public and the organisation in danger.

3. What are our Strategic Objectives regarding Risk Management

For Risk Management to be successful, it is vital that there is a single approach adopted for the management of all risks throughout all levels of the Trust.

The new strategy aims to simplify the current process by providing a clear framework for managers to follow. The key changes will be to:

- Develop a clear and understandable process for all staff to assess, score and escalate risk;
- Develop an integrated self-assessment tool which will include all Trust risks e.g. clinical risks, and health and safety, which will be aligned to the Care Quality Commission regulatory framework;

- Develop a easy to use IT system regarding Risk Management; system of choice will be Datix;
- Development of training and guidance to support and implement and embed the process throughout the Trust;
- Review our monitoring and governance systems relating to risk management within the Trust.

The changes will ensure the effective identification, assessment and control of risk throughout the organisation. (see appendix 4 and 5 for strategic implementation).

4. Benefits to the Trust

The benefits gained from effectively managing risk include:

- Keeping our patients, our staff and the public safe from harm;
- Greater ability to deliver against objectives and targets;
- Improved decision making;
- Reduction in time spent dealing with the consequences of a risk event having occurred;
- Improved service delivery;
- Better informed financial decision making;
- Greater financial control;
- Minimising waste and poor value for money;
- Reduction in claims against the Trust.

5. Roles and Responsibilities

Board of Directors

Responsible for approval of this strategy and policy and for the review of the strategic risk register and board assurance framework.

The Chief Executive

Is the overall accountable officer for the delivery of integrated governance and is therefore responsible for all aspects of quality governance, risk management and performance management. This responsibility is delegated to the executive team, outlined within designated executive portfolios, as below.

The Chief Nurse

Has executive responsibilities, which include delegated executive director responsible for risk management and clinical governance. In addition patient safety, nursing, midwifery, Allied Health Professionals practice and associated quality and safety initiatives and child and adult safeguarding, all come under the Chief Nurse portfolio. The Chief Nurse is accountable to the Chief Executive for risks arising from these areas.

The Medical Director

Has executive responsibilities, which include, education & research and medical practice (including professional lead for pharmacists). He is accountable to the Chief Executive for risks arising from these areas. Infection prevention comes under the role of Medical Director. The Medical Director is accountable to the Chief Executive for risks arising from these areas.

The Director of Operations

Has executive responsibilities, which include effective and safe delivery of clinical services. The Director of Operations is accountable to the Chief Executive for risks arising from these areas.

The Director of Finance

Has executive responsibilities, which include overseeing financial risks and the performance management framework at corporate and operational levels.

The Director of Human Resources & Organisational Development

Has executive responsibilities, which include ensuring the development of a workforce and organisational development strategy within the Trust and that any risks associated with this are identified and actions put in place.

Deputy Director of Governance and Quality

Has delegated responsibility from the Chief Nurse and Chief Executive to ensure that there are effective risk management systems in place throughout the Trust.

Chief of Service / Associate Director of Operations / Associate Director of Nursing

Accountable for the effective management of risk and the implementation of this policy within their Clinical Business Units

Clinical Business Unit Managers / Corporate Services Managers

Accountable for the effective management of risk with their services and the implementation of this strategy.

Matron, Lead Nurse, Heads of Service, Ward Managers

Are responsible for identifying, assessing, responding, reporting and reviewing risks within their wards/departments. They must ensure risks are reviewed and updated at least annually, and that the risk entries are kept updated to reflect current position and activity.

Head of Safety and Risk

Has responsibility for maintaining the Strategic Risk Register and reporting to Trust Board and Quality Committee on strategic risk.

Ensure risk management training is provided as per the Trust training needs analysis (TNA)

Review health and safety risk assessments

Divisional Governance Managers

Has the responsibility for providing support and advice on the risk management strategy ensuring that risk registers are up to date, controls are in place and are reviewed and the risks are monitored monthly via the Divisional committee structure.

All Staff and Contractors

Have a responsibility to:

- Observe and comply with the policies and procedures of the Trust;
- Take reasonable care for the health, safety and welfare of themselves and others;
- Co-operate on matters of risk management and health and safety;
- Participate in induction and all relevant mandatory training as defined by the Induction and Mandatory Training Policy (as amended);
- Comply with the requirements of WHH policy, procedure and approved guidance;
- Report all identified hazards and adverse incidents;
- Undertake reasonable actions as required to reduce or eliminate risks associated identified hazards or adverse incidents.

6. Governing Risk in the Trust

The Quality Committee is the delegated committee of the Board of Directors to oversee the strategic risk register. Strategic risks are discussed at each meeting. It approves amendments to the strategic risk register / board assurance framework for ratification by the Board of Directors.
The Finance and Sustainability Committee will oversee financial risk on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register.
The Strategic People Committee will oversee workforce risk on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register

The Risk Review Group will report to Trust Quality Committee and oversee divisional risk registers and make recommendations to Quality Committee regarding risks for inclusion on the Trust Strategic Risk Register.
The Clinical Operations Board (COB) oversees the Trust's operations and any risks associated with delivery of this and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register. Any operational risks are monitored at Quality Committee and items relating to risks may be referred to COB from the Quality Committee and vice versa.
The Audit Committee oversees the entire risk management system. It commissions an annual audit of the board assurance framework and strategic risk register, as part of the internal audit plan, to satisfy itself that the system of internal control is effective. It examines the assurances on the effectiveness of controls for all strategic risks received from the chair of the Quality Committee, and from internal and external auditors.

Divisional Bilateral Meeting will review and discuss all their service risks, and risks scoring ≥ 10 escalated from their wards, departments and directorates, on a monthly basis. Any changes agreed must be recorded on the risk register and communicated to relevant managers and staff. As part of a rolling programme, the committee also reviews the risks scoring ≥ 8 for each directorate at least annually.
Clinical Business Unit Meetings / Corporate Services Meetings will review and discuss all their service risks, and risks scoring ≥ 8 escalated from their wards and departments, at least two-monthly. Any changes agreed must be recorded on the risk register and communicated to relevant managers and staff.

Ward Managers Meeting and Corporate Manager Meetings will discuss all the department's active risks, at least two-monthly, in order to raise awareness amongst the staff and to highlight specific difficulties or the introduction of new control measures. Any changes agreed must be recorded on the risk register and communicated to relevant managers and staff.

7. Glossary of Terms

Risk: the possibility of harm/damage occurring

Risk Assessment: a systematic process of evaluating the potential risks that may be involved in a projected activity or undertaking

Target risk score: is the score that can be reasonably achieved if additional controls were implemented or further assurance available.

Residual risk score: the residual risk left after putting controls in place to avoid harm/loss as far as is reasonably practicable

Open risk: A risk assessment that has demonstrated a gap between the residual risk score and the target risk score. In WHH, this will have an action plan to reduce the risk to the target score.

Significant risk: a risk scoring ≥ 15 (5 x 5 severity / likelihood matrix)

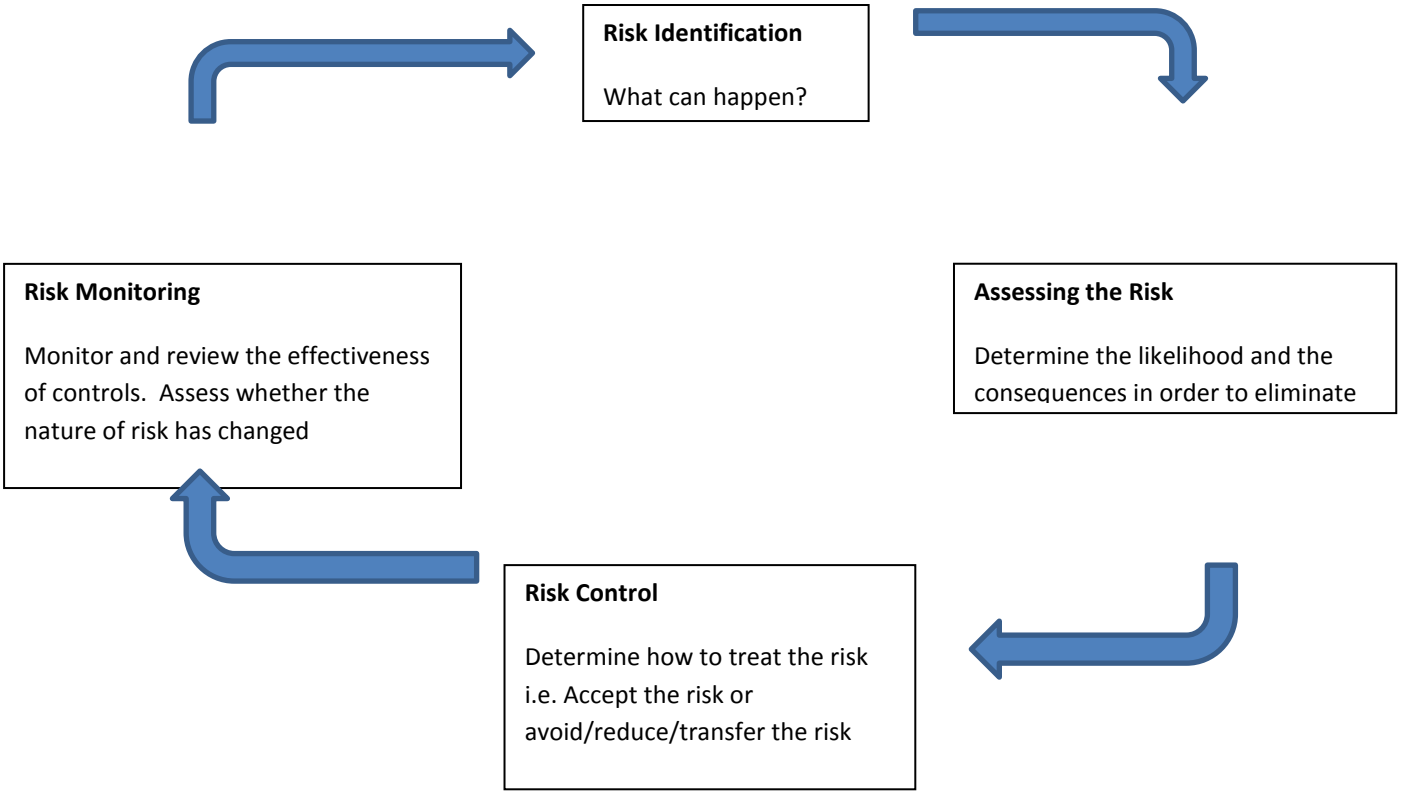
Strategic risk: a risk that may affect achievement of the Trust's objectives (and is therefore included on the strategic risk register). The ownership and accountability for strategic risks is assigned to the relevant executive director, though responsibility for managing a risk may be delegated. Many, but not all, strategic risks will be Trust-wide.

Risk appetite: the level of a risk that an organisation is prepared to seek, accept or tolerate. The appropriate level will depend on the nature of the work undertaken and the objectives pursued. For example, where patient safety is critical the appetite will be lower than for an innovative project - where it might be accepted that short-term failure could pave the way to longer-term success.

Risk tolerance: an organisation's readiness to bear risks in order to achieve its objectives. Sometimes risk tolerance is limited by legal or regulatory requirements.

8. Risk Process

The risk management process within the Trust is summarised in Appendix 1 of this strategy and policy document.



8.1 Risk Identification

Risks can be identified proactively, or reactively – see examples in the table below:

Proactive risk identification	Reactive risk identification
Annual planning / objective setting	Review of cases where failure of controls has resulted in avoidable harm: incidents, complaints, claims
Self-assessment against Risk Management Framework	External health economy decisions / impact of commissioners' or other trusts' decisions
Impact assessments of proposed service developments and CIP measures	Response to external recommendations
Risk assessments conducted within the Trust	Audits; either clinical or internal/external audits

8.2 Assessing the Risk

A risk matrix is used to evaluate the risks so that there is an understanding of the risk exposure faced, which in turn influences the level of risk treatment that should be applied to manage/reduce/prevent that risk from occurring.

Risk scores are assessed using a 5 x 5 matrix (appendix 2 and 3). Three scores are assessed:

- **Initial risk score** – where we are at now without any controls in place
- **Residual risk score** – the score once controls are in place
- **Target risk score –** the score that could be achieved if additional controls were implemented or further assurance available

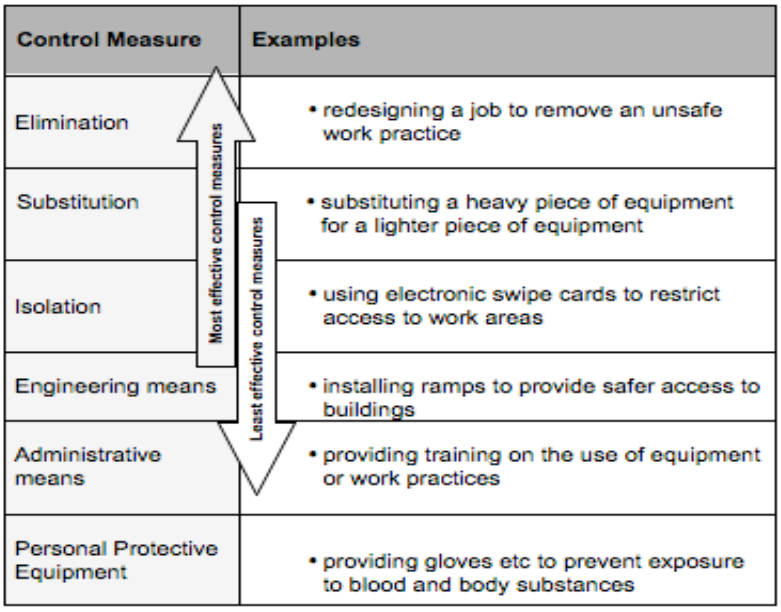
8.3 Who should assess the Risk?

Risks should be scored by the competent person undertaking the risk assessment and validated by a manager according to the residual risk score:

- 6 or below (low, and very low) are verified by the ward or department manager.
- 8-10 (moderate) are verified by CBU Managers, Corporate Heads of Service, Lead Nurse, Matron
- 12 (high) are verified by the Clinical Directors, Associate Director of Nursing and Associate Director of Operations
- ≥15 (significant) are verified at Executive level. They are reviewed at the Risk Review Group by the Chief Nurse, Deputy Director of Governance and Quality, Deputy Director of Operations, Deputy Medical Director, Head of Safety and Risk and the Divisional Governance Managers. The risk review group will review the risk for inclusion onto the Trust Strategic Risk Register and Board Assurance Framework. This recommendation will be reviewed and ratified by the Trust Quality Committee.

8.4 Risk Controls

Having identified and analysed the risks, it is necessary to decide what to do and who will do it.



8.5 Risk Review

	Level of Risk	Monitored by:	Frequency of review
Local Risks	Below 8	Ward/Departmental Manager- managed locally	At least annually
Moderate Risks	Above 8	CBU Managers, Corporate Heads of Service, Lead Nurse, Matron	Reviewed every month at CBU Governance Meetings
High Risks	Above 12	Clinical Directors, Associate Director of Nursing, Associate Director of Operations, Associate Director of a Corporate Service	Reviewed every month at the Divisional Bilateral Meeting
Significant Risks	15 and above	Verified at Executive Level.	Reviewed at the Risk Review Group monthly.

Although ownership of an action related to a risk may be assigned to a manager outside of the department or directorate, the overall responsibility for management of the risk remains with the risk owner.

8.6 Recording of Risks

Currently all risks are recorded onto CIRIS. This is a complex system and can be problematic for staff to use. From July 2017 the Trust will use the risk management module of DATIX. There is a plan in place for this transformation to take place.

Every Clinical Business Unit / Corporate Department will be expected to have a risk register in place on DATIX.

8.7 Risk Reporting / Oversight

The Board of Directors will receive, at each formal meeting, a summary report of significant strategic risks i.e. those risks >15, which will include a description of the risk, the residual and target risk and progress of actions. The Board also receives the full strategic risk register / assurance framework document four times yearly for review.

If a new significant risk arises, it will be assessed by the Risk Review Group, and a recommendation will be made for inclusion on the Strategic Risk register if appropriate.

8.8 Risk Management Training

This strategy recognises that training will be required to manage risks effectively.

Training will be detailed in the Trust Training Needs Analysis (TNA)

Reference Documents

Associated Trust Documents:

- Risk Assessment Policy
- Incident Reporting Policy
- Complaints Handling Policy

This is not an exhaustive list, please check on the ‘Documents’ pages of the Trust extranet.

Appendix 1 – Risk Management Process

<table>
<tr><td>Identification</td><td>Identification
Using incidents, complaints, claims, patient feedback, safety inspections, external review, objectives or ad hoc assessments</td><td>Board assesses risks to objectives

Risk identification to be aligned to annual/business planning process</td></tr>
<tr><td>Quantification</td><td colspan="2">Risks Scored
Using a matrix of 1 to 5 in likelihood & severity giving a maximum score of 25; this affects how the risk is escalated. Support for risk assessment can be given by the Governance Department.</td></tr>
<tr><td>Risk Registers</td><td>Strategic Risk Register
Those risks mapped against delivery of corporate objectives
Those operational risks either 15 and below deemed to be strategic
Those operational risks deemed to be strategic following cross sectional analysis of impact and likelihood</td><td>Operational Risk Registers
Risk Registers in place at Ward/Department level – any risks below 8
CBU Risk Registers developed with risks to delivery of divisional business plans & those directorate /departmental risks below 10
Divisional Risks 15 or above will be escalated & considered for inclusion on the Strategic Risk Register at the Risk Review Group
Cross sectional analysis of risks undertaken across divisional risk registers to assess strategic impact</td></tr>
<tr><td colspan="2">Audit Committee
Annual Governance statement – reviewing systems of internal control
Internal audits of issues linked to strategic risks & monitoring of these action plans</td><td>Quality Committee
Delegated Committee responsible for overseeing risk on behalf of the Board
Monthly review of strategic risk register
Assurance regarding review of divisional risks via Divisional Quality Dashboard reports</td><td>Finance & Sustainability Committee
Oversees financial risk on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register</td></tr>
<tr><td colspan="2">Strategic People Committee
Oversees all workforce risks on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register</td><td>Clinical Operations Board
Monthly review of strategic operational risks
Identification of operational risks and escalation of risk to be recorded on the appropriate risk register</td><td>Risk Review Group
Monthly report to Quality Committee highlighting exceptions, recommendations for new strategic risks, review of existing strategic risks and an assurance review of a divisional risk register
Rolling review of Divisional Risk Register at the Risk Review Group – at least six monthly review for each CBU</td></tr>
<tr><td colspan="2">Bilateral Meetings
Review and discuss all risks at a score of 12 or above
As part of a rolling programme, the Group will review all risk for each Ward/Department annually</td><td>CBU Meetings
Review and discuss all risks at a score of 8 or above
Review and discuss all their services risks from Wards, Departments on a monthly basis.
Any changes must be recorded on the risk register and communicated to all relevant staff</td><td>Ward and Departmental Meetings
Discuss all the Department's active risks
Risks scored less than 8 managed locally
Any changes agreed must be recorded on the risk register and communicated to all staff</td></tr>
</table>

Appendix 2 – Risk Scoring

Each risk is assessed by multiplying the scores for severity of harm and the likelihood of that level of harm occurring. This calculation will produce the **Risk Score.**

	Severity	Likelihood
5	Death or multiple permanent injuries or irreversible health effects; or totally unacceptable level or quality of treatment / service; *or* gross failure of patient safety; or de-authorisation *or* suspension of registration / prosecution; *or* prolonged national adverse media coverage*; or* total loss of public confidence; or loss of >1% of budget; or permanent loss of service or facility.	Almost Certain Poor control Daily
4	Major injury or harm leading to long-term or permanent incapacity / disability requiring extensive rehabilitation / increase in length of hospital stay by >15 days; or non-compliance with national standards with significant risk to patients if unresolved; or red formal complaint or multiple complaints; or uncertain delivery of key objective / service due to lack of staff; or unsafe staffing level or competence (5-14 days); or multiple breeches in statutory duty; or national media coverage with <3 days service well below reasonable public expectation; *or* loss of 0.5 to 1% of budget;	Likely Weak control Weekly
3	**Moderate harm** – Short-term harm e.g.# wrist, ankle / un-expected return to theatre / increase in length of hospital stay by approx 4-14 day; or RIDDOR / agency reportable incident - 8 days or more off work; or treatment or service has significantly reduced effectiveness; or amber formal complaint; or repeated failure to meet internal standards; or unsafe staffing level or competence (1-5 days); or single breech in statutory duty; or local media coverage/ medium-term reduction in public confidence; or loss / interruption of service >1 day or *or* loss of 0.25 to 0.5% of budget;	Possible Adequate control Monthly
2	**Minor harm** – required extra observation or minor intervention; increase in length of stay approx 1-3 days; *or* loss of 0.1 to 0.25% of budget; *or* overall treatment or service sub-optimal; *or* green formal complaint; or ongoing low staffing levels: or local media coverage; or loss / interruption of up to 24 hours	Unlikely Good control Annually
1	**Negligible / no harm:** 0 - £50K loss; *or* peripheral element of treatment or service suboptimal; *or* short-term staffing level (< 1 day); *or* minimal impact / breach of guidance; *or* service disruption up to 8 hours; *or* potential for public concern; *or* schedule slippage; *or* loss of service < 8 hours	Extremely rare Strong control < annually

X	LIKELIHOOD					
SEVERITY		1	2	3	4	5
	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Severity score: 1 represents negligible harm; 5 represents catastrophic harm / loss. Each level of severity looks at the extent of injury to persons, the level of financial loss or the damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting levels.

Likelihood score: 1 represents an extremely rare probability of occurrence; 5 represents an almost certain likelihood of [re]occurrence.

Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur.

E.g. death from a medication error is extremely rare, but minor or moderate harm is more common and may therefore have a higher residual risk. Whichever way the residual risk score is determined; it is the **highest residual risk score** that must be recorded on the risk register.

Appendix 3 detailed risk grading table

Severity (consequence)					
Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Patient / staff / public harm	No harm, requiring no or only minimal intervention or treatment. No time off work	Minor injury or illness, patient required extra observation or minor intervention. (E.g. bruising skin tear, psychological harm due to delayed surgery) Increase in length of hospital stay by approx 1-3 days Staff first aid / minor treatment. Requiring time off work for 0-7 days	Short-term harm e.g.# wrist, ankle, symphysis pubis or un-expected return to theatre. Increase in length of hospital stay by approx 4-14 days RIDDOR / agency reportable incident Requiring time off work for 8 days or more An event which impacts on a small number of patients	Major injury or harm leading to long-term or permanent incapacity / disability requiring extensive rehabilitation Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Requiring time off work for >6 months / permanently unable to work	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint / inquiry	Overall treatment or service suboptimal Green formal complaint Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Amber formal complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if not acted on	Non-compliance with national standards with significant risk to patients if unresolved Red formal complaint or multiple complaints / independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff / capacity Unsafe staffing level or competence (1-5 days) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (5-14 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice	Multiple breeches in statutory duty Enforcement action Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Severity (consequence)					
Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity / reputation	Adverse rumours Potential for public concern	Local media coverage: short-term reduction in public confidence Elements of public expectation not being met	Local media coverage: medium-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation Prolonged loss of public confidence	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5 – 9.9% over project budget Moderate schedule slippage	10 – 25 % over project budget Major schedule slippage Key objectives not met	>25 % over project budget Severe schedule slippage / abandonment Key objectives not met
Finance	Negligible loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective / Loss of 0.5–1.0 per cent of budget Purchasers failing to pay on time	Non-delivery of key objective / Loss of >1 per cent of budget Failure to meet specification / slippage Loss of contract / payment by results
Litigation	No risk / minor, out-of-court settlement	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Claim(s) >£1 million
Service / business interruption	Loss / interruption of < 8 hour s	Loss / interruption of up to 24 hours	Loss / interruption of >1 day	Loss / interruption of >1 week	Permanent loss of service or facility
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

Appendix 4

What are we working on to achieve?

The map below sets out the projects we will be working to deliver over the next 2 years.

Theme	2017 / 2019
Framework	Approval & Implementation of RM Strategy & Policy
Profile and Visibility	Communications plan to be developed and implemented to raise the profile of risk Extranet improvements on risk
Tools and Guidance	Development of new tools and guidance Advanced tools and techniques developed for “Super Users”
Systems	Development and roll out Development of reporting and system enhancements Fit for purpose review of system
Training and Education	New training programme designed and delivered for all key functions Risk system training
Governance and Reporting	Development of monthly reports Integrated risk reports Divisional and CBU reports

Appendix 5

Project Plan 2017

Actions	Action Lead	Planned Completion Date	April	May	June	July	Aug	Sep	Nov	Dec	Jan	Feb	Mar
Policies and Guidance													
Review of Risk Management Strategy	HW	April 2017											
Review of Risk Assessment Policy	HW	May 2017											
Approval of Risk Management Strategy	HW	May 2017											
Approval of Risk Assessment Policy	HW	May 2017											
Risk Management Framework Audit (RMF)													
Develop an integrated framework to incorporate CQC standards	HW / JM	May 2017											
Implementation of the framework	HW	June 2017											
Development new guidance in line with the new process	HW	May 2017											
Create audit page on the Extranet site	JM	June 2017											
Systems													
Purchase of Risk Management module in DATIX	JM	April 17											
Identify super users to attend training on DATIX	HW/JM	June 17											
Attend training for Risk Management module	HW / JM	June 17											
Development of user guides and training manuals for all staff	JM	May/June 17											
Develop roll out plan for Risk Management Module	JM	May 17											
Information to go out in Comms re new strategy	HW / JM	May/June 17											
Training sessions to be arranged and advertised	JM	May/June 17											
Review of existing risk register on CIRIS	HW / JM	May/June 17											
Review of risk assessments on CIRIS	HW / JM	May/June 17											
Pilot of new system in IT	HW / JM	May / June 17											
Deliver training session to staff	HW / JM	July / August 17											
Roll out of the risk management system across the Trust	HW / JM	July / August 17											

Communications													
Update Comms on the new system	HW / JM	June / July 17											
Advertise training dates	JM	June 17											
Provide updates to staff re the transformation	HW / JM	July / August 17											
Meetings													
Set up the Risk Review Group	JM	May 17											
Terms of Reference for the Risk Review Group	HW	April 17											
Attendance at local meetings to discuss new process	HW	June / July 17											
Reports													
Provide monthly reports to the Risk Review Group	JM	July 17											
Set up CBU reports in DATIX	JM	July 17											
Set up Corporate Services reports in DATIX	JM	July 17											
Audits													
Monthly audits of the system	JM	July /August 17											
Data quality checks monthly	JM / HW	July / August 17											
Working Groups													
Set up a monthly super user group	JM	May 17											
Attend super user group and discuss any technical problems	JM	May 17											

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Appendix 6 – Equality Impact Assessment

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

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Physical Disability	NO	
	Learning Difficulties/Disability or Cognitive Impairment	NO	
	Mental Health	NO	
	Race	NO	
	Carer	NO	
	Nationality	NO	
	Ethnic origins (including gypsies and travellers)	NO	
	Culture	NO	
	Religion or belief	NO	
	Gender (Male, Female and Transsexual)	NO	
	Sexual orientation including lesbian, gay and bisexual people	NO	
	Age	NO	
2	Is there any evidence that some groups are affected differently?	NO	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4	Is the impact of the policy/guidance likely to be negative?	NO	

5	If so can the impact be avoided?	N/A	
6	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

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

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Document Information Box

Item	Value
Type of Document	Policy
Title	Risk Management Strategy
Published Version Number	2
Publication Date	April 2017
Review Date	June 2019
Author's Name + Job Title	Helen Wynn, Head of Safety and Risk
Consultation Body/ Person	
Consultation Date	
Approval Body	Quality Committee
Approval Date	
Ratified by	Quality Committee
Ratification Date	
Author Contact	01925 662047
Librarian	Debbie Weeks
Division	Corporate Services
Specialty (if local procedural document)	
Ward/Department (if local procedural document)	
Readership (Clinical Staff, all staff)	All staff
Information Governance Class (Restricted or unrestricted)	Unrestricted

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/05/65 (b)**	
SUBJECT:	**Board Assurance Framework and Strategic Risk Register**	
DATE OF MEETING:	31 May 2017	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Deputy Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
STRATEGIC CONTEXT	Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures.	
EXECUTIVE SUMMARY (KEY ISSUES):	There are key updates to strategic risks. There is a escalated risk, which is currently being assessed with controls and actions- which will be reported to the Quality Committee June 2017.	
RECOMMENDATION:	Review, Discuss and approve the Trust Risk Management Strategy	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	April 2017
	Summary of Outcome	Approved for ratification by Board of Directors
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/17/05/65 (b)

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Board Assurance Framework. It has been agreed that the Board receives a monthly update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Committee. The Board Assurance Framework and full strategic risk register will be presented on a quarterly basis.

The strategic risk register is outlined in Appendix 1. The following gives notable updates since the strategic risks were last presented to the Board of Directors. These updates have been mapped into the Board Assurance Framework (BAF) (Appendix 2).

2. KEY ELEMENTS

2.1 **New Risks** – A current risk is being assessed for inclusion on the Trust strategic risk register. This was discussed at Patient Safety & Effectiveness Committee and relates to lack of assurance in some areas regarding training and competency assessment for staff on blood transfusion standards and competencies. This risk assessment with controls and actions will be presented to Quality Committee in June 2016. Immediate actions have been put in place to scope the areas of non compliance and develop a plan for staff to be trained.

2.2 Existing Risks – updates

Strategic Risk	Update since last Risk review	Impact of update on risk rating
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care	An additional gap in control has been added regarding the impact of IR35. Managers have completed an action to risk assess the impact of IR35 in each of their areas – reporting through to HR.	No impact on risk rating

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Strategic Risk	Update since last Risk review	Impact of update on risk rating
and impact on Trust access and financial targets.		
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	A review of cancer services has been commissioned from CCGs reviewing clinical cases and internal audit reviewing processes - this is due to report by end June 2017.	No Impact on risk rating
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	The tender process is underway for the bed replacement programme. Trial of various beds has been undertaken by operational staff.	No Impact on risk rating
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	A plan has been put in place regarding VTE RCA backlog- the outstanding list has been sent out to divisions. There is a revised process of investigating VTE incidents from April onwards. This will be overseen by Thrombysis Group and Patient Safety & Effectiveness Sub Committee.	
Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements	Assurance has been received following the Well Led review commissioned by the Trust from Deloitte. Actions from this review will be monitored by the Board. The Trust Risk Management Strategy was approved by Quality Committee for ratification by the Board May 2017.	No impact on risk rating
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	A review of health and safety risks was undertaken at the May 2017 Health & Safety Committee – a further review will be undertaken following this meeting to ensure all appropriate risks are escalated through the strategic risk	No impact on risk rating

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Strategic Risk	Update since last Risk review	Impact of update on risk rating
	processes.	
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	A review of the Trust's policy on management of NICE guidance has commenced as there is a lack of assurance regarding how NICE is managed in the Trust and	No impact on risk rating
Risk: Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	It was agreed that the 2016/17 SIRO report will be an agenda item at the next Information Governance and Corporate Records Sub-Committee which takes place on 10/07/2017. A Cyber security element will be included with a summary of recent national events and the impact at WHH. The results of our recent submission to gauge our readiness against the Cyber Essentials standard and the results of a remote security scan on our network will also be included in the report. The remote scan will be carried out by NCC Group PLC prior to the next meeting of the IGCRSC on 10/07/17. After completion of the scan the results will be reviewed by a cyber security expert and a debrief with the Trust's IT Team will take place. After the debrief is completed a Cyber essentials pass/fail report and (if appropriate) certificate will be issued.	No impact on risk rating
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	Development of a Market analysis of Trust competitors to understand imminent and future risk to income Director of Finance – end May 2017- this action timeframe has been revised until end July 2017 Progress update : An analysis of the market is underway down to specialty level, led by the Commercial Development Team. This will for	No impact on risk rating

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Strategic Risk	Update since last Risk review	Impact of update on risk rating
	example enable the Trust to understand which GP / Patients from the Warrington and Halton postcodes (and surrounding areas) attend other providers. The reporting tool is being tested with senior managers and the Transformation team. This work will be incorporated within the updated Financial Strategy.	

2.3 Other updates

The Trust Risk Management Strategy has been reviewed and is being presented to this Board meeting for ratification, following approval at Quality Committee.

As part of the implementation plan regarding implementing and embedding the strategy, the strategic risk register will be managed going forward using the Datix system. Work has commenced looking at the Datix module and pilots will be taking place in June 2017. Following this, full training will be given to Executive Officers and delegated individuals so that strategic risks can be managed in real time, as currently the Board Assurance Framework is administered by the Deputy Director of Governance. Use of the Datix system will also enable reports to oversight committees/sub committees of strategic risks.

3. RECOMMENDATIONS

The Board of Directors are asked to note the updates to the strategic risks and the Board Assurance Framework.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1- Strategic Risk Register

Risk	Residual Risk Rating (Impact x Likelihood) Feb 2017	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (4x5)	20 (4x5)	20 (4x5)	20 (4x5)
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	20 (5x4)	20 (5x4)	16 (4x4)	16 (4x4)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

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Risk	Residual Risk Rating (Impact x Likelihood) Feb 2017	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017
claims against the trust.				
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	N/A	N/A	12 (4x3)	12 (4x3)
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

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Risk	Residual Risk Rating (Impact x Likelihood) Feb 2017	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017
and delivery of the Trust's strategic objectives				
Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)
Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

Appendix 2 - Strategic Risk Register and Board Assurance Framework – May 2017

Risk	Residual Risk Rating (Impact xLIkelihood)
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	20 (5x4)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (4x5)
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	16 (4x4)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	16 (4x4)
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	16 (4x4)
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)
Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.	16 (4x4)
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	15 (5x3)
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15 (5x3)
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact**.**	12 (4x3)
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	12 ($x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)
Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care	12 (3x4)
Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements	12 (4x3)

Strategic Objective 1	Risk: Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Nurse/ Medical Director**
	Operational Lead **Divisional Nurse Directors/Chiefs of Staff**
	Assurance Committee: **Strategic People Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Recruitment and Retention strategy has been developed for nursing and is being operationalised • Nursing Recruitment and Retention meetings held 3 weekly • Nursing Recruitment Leads x 2 Matrons in place • Business case developed to support Nursing recruitment and retention • Senior staffing meeting put in place and processes at an operational level to ensure safe nurse staffing along with staffing checks at every capacity meeting • Reporting on safe staffing monthly to Board and staffing will be reported on all wards in line with national requirements. • Risk Management Systems allow for reporting of incidents re staffing and escalation of risk, when required • Individual staffing action plans for high risk areas • Review of skill mix and creating roles in teams e.g. pharmacy technicians to support medication administration • With regards to Consultant Recruitment – an external company has been appointed to recruit at Consultant Level with a review of JD's/Marketing of our posts; supported by EXIT Interviews for Leavers.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • 6 monthly nursing acuity & dependency review undertaken, Results being collated • Recruitment and Retention Strategy developed December 2016 and in being operationalised and implemented • The Trust has had concerns raised by Health Education North West/Deanery regarding supervision and education of junior doctors in some medical specialities (acute medicine and geriatric care) • There is a gap in control regarding implementation of IR35 across the Trust

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Staffing rates monitored on a shift by shift basis (actual versus planned numbers) and reported to the Board • 6 monthly acuity & Dependency review undertaken across all areas – Adults, Paediatric, Maternity & NICU. Results to be reported to Board. • Incident data regarding staffing reviewed by Chief Nurse • Escalation protocols in place – evidence of these being activated by nursing team • We have recently been successful in appointing 4 Cardiology Consultants and are attending ES Training in due course and will be allocated Trainees as required. • The Trust is ensuring safe medical staffing via use of long term locums in some specialities and also by breaking the cap, when required. • There is an action plan in place following concerns raised by HENW/Deanery	Undertake the Allocate Safer Nursing Care Acuity review to understand establishments with regard to acuity Acuity / Dependency review undertaken in May 2017. Results being collated. **Deputy Chief Nurse/Divisional Associate Director of Nursing – end June 2017** Develop a risk assessment process for opening/closing beds/ward **Deputy Chief Nurse – end March 2017** **COMPLETED** Monthly reporting of Recruitment and Retention Strategy to Strategic People Committee and Nursing and Midwifery Board. **Chief Nurse – monthly** **ON-GOING** Ensure a report is given to the Board of Directors regarding medical staffing in medical specialities, including a progress update of the action plan **Medical Director – end March 2017** **COMPLETED** Ensure a report is given to the Board on nurse staffing assurance processes **Chief Nurse – end March 2017** **COMPLETED** All areas to have risk assessed implications of IR35 **CBU Managers – end April 2017** **COMPLETED**
Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	**Risk: Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.**
Risk Source: Performance Reporting	**Exec Lead:** **Chief Operating Officer**
	Operational Lead Associate Directors of Operations
	Assurance Committee: **Finance and Sustainability**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Weekly monitoring of all performance indicators • KPI meeting attended by all CBU managers • IT support to develop accurate data reports • Business case approved to have a centralised RTT function with a lead manager • Business case approved to increase outpatient call centre and reception staff to locally manage issues • Four hour performance meeting in place weekly to monitor performance and required actions • Reporting on all key performance metrics to FSC on a monthly basis • Risk Management Systems allow for reporting of incidents • Individual action plans for high risk areas including outpatients • ECIP support to establish key areas for improvement	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Electronic solution to data reporting including e outcomes • Further validation of migrated patients from meditec to Lorenzo • Further capacity and demand work required • A review of cancer has been commissioned regarding data processes and breach management

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Outpatients is on the Trust Internal Audit Plan for 2017 • An outpatients steering group takes place monthly and feeds into the outpatient board chaired by the CEO there are 8 identified work streams all with individual KPIs and dashboards • All performance metrics are reported monthly externally • ECIP dashboard benchmarks against other trusts • Daily performance metrics circulated • FSC and board papers • CCG contract review meeting	Development of an OPD dashboard **Outpatient and Medical records Service Manager – end June 2017** Live accurate data – business intelligence review to be undertaken **Head of Information – end September 2017** Capacity and demand work to be undertaken across the trust **Director of Operations – end September 2017** Review of WLI payments to be undertaken **Director of Operations – end June 2017** Ensure a review of cancer processes is undertaken **Director of Operations – end June 2017**

Residual Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	**Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.**
Risk Source: Incident Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Falls Policy in place. • The Trust participates in NHS Safety Thermometer, which gives benchmarking data. • Risk Management systems and incident policy require staff to report incidents regarding falls so that any incidents can be appropriately investigated and learning can be cascaded.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • There have been a number of falls within the Trust causing Serious Harm • There is a requirement to review falls prevention equipment • There is a requirement to have a bed replacement programme in place • Falls training is not mandated for staff • Lack of senior specialist input for falls prevention

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Audits undertaken of falls policy on at least an annual basis • All patients have falls Positive risk factor and bed-rails assessments completed on admission, and are reassessed in accordance with policy. • Trust is meeting the required performance in NHS Safety Thermometer- • Projects are being piloted in the Trust for falls prevention e.g. slippers socks and yellow blankets for patients etc. • Falls RCAs in place with Senior Nurses reviewing this post fall. Quarterly reporting of falls analysed within the Trust Governance Report.	Recruit Falls Nurse Specialist **Chief Nurse – end February 2017** **COMPLETED** Develop a business case for bed replacement programme **Chief Nurse – end February 2017 rescheduled to end April 2017** **Tender process underway. Trial of various beds has been undertaken by operational staff.** Ensure Falls Prevention training is mandated for staff **Chief Nurse – end March 2017** **COMPLETED** Ensure a review of falls equipment is undertaken across the Trust to assess requirements **Deputy Chief Nurse- end March 2017** **COMPLETED**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	**Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints**
Risk Source: Performance Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Director of Governance & Quality**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • An external review has been undertaken of the complaints function in the Trust • Complaints Policy been updated • Central and divisional complaints teams in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • The Trust is not meeting performance targets with regard to complaints – a significant number of complaints are greater than 6 months old • Data quality issues with regard t complaints – multiple databases and systems to record complaints • There are a lack of standardised processes for complaints handling centrally and divisionally/CBU level • There is a lack of training in the Trust with regard to complaints management and handling • Lack of being able to evidence lessons learned and action plan monitoring as a result of complaints • A review of PALS and complaints function needs to be undertaken • Lack of patient experience strategy in the Trust to promote local resolution

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Additional capacity has been put into the complaints team – including integration of the divisional and corporate complaints teams • Process mapping of complaints has been undertaken, to ensure the process is streamlined and everyone understands their roles and responsibility- Standard Operating procedures have started to be developed • Mapping of complaints spreadsheets into Datix has started and will complete by end March 2017 • The Chair of the Trust will chair a Complaints Quality Assurance Group – terms of reverence being agreed by Quality Committee March 2017	Develop a complaints improvement plan following the external review **Deputy Director of Governance & Quality – end February 2017** **COMPLETED** Put in place additional capacity in the complaints team to improve performance **Deputy Director of Governance & Quality – w/c 1st February 2017** **COMPLETED** Ensure the complaints process in the Trust is process mapped, to ensure we are meeting best practice and that the process is as streamlined as possible **Deputy Director of Governance & Quality – end March 2017** **COMPLETED** Ensure a review is undertaken of complaints data, all complaints spreadsheets are mapped over to Datix, and new KPIs are developed for Board/Quality Committee and Divisions/CBUs **Interim Complaints Improvement Lead – end March 2017** **COMPLETED** Convene a Complaints Quality Assurance Group **Deputy Director of Governance & Quality – end March 2017 – first meeting scheduled June 2017** **Ensure a new complaints training programme is developed** **Interim Complaints Improvement Lead – end April 2017** **COMPLETED** Ensure KPIs are developed to monitor effectiveness of complaints improvement plan and report to Quality Committee **Deputy Director of Governance & Quality – end March 2017** **COMPLETED** Development of a Lessons Learned Framework for the Trust **Deputy Director of Governance & Quality – end July 2017**

Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 1	**Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.**
Risk Source: External review	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • External review conducted • Safeguarding teams in place • Training in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Review of safeguarding governance structure required • Review of the safeguarding team and functions • Requirement to review practices of chemical restraint • A review of safeguarding training required • A policy review • Representation at Local Safeguarding Boards to be reviewed • A review of policies to be undertaken • Development of an electronic system for use by the safeguarding team • Lack of LD specialist support • CQC raised issues regarding mental capacity assessments and DOLS

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• External support put in place re safeguarding with newly appointed Deputy Chief Nurse • Supervision put in place for named nurses • Commissioning of level 3 safeguarding training	Development of an action plan following on from external review Deputy Chief Nurse – end February 2017 **COMPLETED** Progress update on action plan bi-monthly to Quality Committee **Deputy Chief Nurse – March 2017 onwards** **COMPLETED** Ensure an audit of Mental Capacity is undertaken **Safeguarding Adults lead – end March 2017** **COMPLETED**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 1	**Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Operating Officer**
	Operational Lead **Associate Director of Estates**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Estates strategy • PLACE assessment action plan • Risk Management systems and incident reporting • General capital investment • Compass reporting re: water flushing • Matron and estates walkabouts • Reporting structure for maintenance • On call service for OOH issues • Maintenance log	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Maintenance improvement program • Medical equipment maintenance is managed by a risk assessed approach whereby equipment is identified as: High Medium Medium/Low Low All high and medium is fully maintained. Medium/low and low is operator assessed and reported to medical equipment engineering as required.

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Water quality group • Fire safety group • Medical gasses group • Estates safety • Medical Equipment group • Capital Planning group • Six Facet survey – condition appraisal of estate (annually) 5 Year program 20% each year • Asbestos survey annually • Premises Assurance model (PAM) Self-assessment tool estate compliance • Good Corporate Citizen self-assessment (review of sustainability)	Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy **Associate Director of Estates – end September 2017** Participate in Halton Healthy Hospitals strategy **Director of Transformation/Associate Director of Estates – ongoing**

Residual Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	Risk: Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.
Risk Source: Performance Reporting	**Exec Lead:** **Medical Director**
	Operational Lead **Divisional Chiefs of Staff**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* •	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Performance report shows numbers of VTE RCAs outstanding and poor compliance in some areas with risk assessments • Lack of assurance that that numbers of hospital associated VTEs are being monitored within clinical governance processes within Divisions/CBUs and being fed back to individuals • Thrombysis Committee terms of reference need to be reviewed

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Monitor of progress by Patient Safety and Clinical Effectiveness committee, Quality Committee; monthly assessment of progress with number of RCAs • Harm free care figures • Mortality/coroners data does not suggest that the Trust is an outlier in terms of harm being caused to patients	Develop a revised process for VTE RCAs **Lead Clinicians VTE/Deputy Director of Governance/Deputy Medical Director** **End April 2017** **COMPLETED** Develop a plan for VTE RCA backlog to be delivered **Lead Clinicians VTE** **End June 2017** Ensure information regarding VTE assessments and RCAs are circulated to individuals/CBUs and Divisions **Lead Clinicians VTE** **COMPLETED** Review Terms of Reference for Thrombosis Group **Lead Clinicians VTE** **COMPLETED – to be ratified by Patient Safety & Effectiveness Sub Committee**

Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	**Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Medical Director**
	Operational Lead **Associate Medical Director Quality**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Policies and procedures in place across the Trust governing systems and processes to minimise potential for service failure. • Incident reporting regime enables issues to be raised and lessons learnt. • Governance structure– Quality Committee and Patient Safety & Effectiveness Committee and high level reporting from Divisional Bi-lateral Committees • Integrated Performance Report in place. • Dashboards to assess against standards • Mortality review processes • Mortality action group strengthened focusing on reducing mortality with detailed action plan developed. • Independent mortality review process • Associate Medical Director overseeing Mortality Review process	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Clinical Governance systems within the Trust need to be reviewed e.g. Lack of integrated effectiveness agenda corporately • Clinical/CBU leadership model still embedding • Further work to develop integrated performance report, dashboards and cross referencing / escalation of issues • The Trust is reporting higher than expected mortality rates in HSMR, although SHMI showing a significant downward trend. • UTI outlier in term of mortality • Lack of co-ordinated learning framework within the Trust • Lack of assurance regarding NICE guidance compliance within the Trust

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Risk based internal audit programme linked to potential identified gaps in controls with Trust policies. • External audit process • Incident analysis completed monthly and weekly updates on SI/red incidents given to Senior Management Team. • Review of Quality Committee terms of reference and workplan been undertaken • Integrated Performance Report reported at monthly Board, prior to this scrutiny given at Trust and Divisional Quality & Governance meetings • Good Clinical audit participation in the national programme • A recent JAG visit described our endoscopy services as an 'excellent service', demonstrating cohesive leadership, exceptional governance standards and robust processes both clinically and administratively. • The Trust has been named as the best performing Trust in the region for providing hip and knee replacement surgery by AQUA. • Excellent feedback received in the Cheshire and Merseyside Critical Care Network report.	Ensure a governance review is undertaken, including a review of integrated effectiveness agenda **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality – end June 2017** Ensure a review of quality indicators reporting on dashboard undertaken **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality/Deputy Chief Nurse – end June 2017** Ensure there is a review of Patient Safety and Effectiveness Sub Committee terms of reference and reporting groups **Director of Integrated Governance & Quality Improvement- end May 2017 COMPLETED** Ensure that there is a UTI deep dive on mortality **Associate Medical Director Mortality/Clinical Effectiveness Manager – end July 2017** Development of a Lessons Learned Framework **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality/Deputy Chief Nurse – end July 2017** Ensure the Trust's NICE policy is reviewed **Head of Clinical Effectiveness – end June 2017**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care
Risk Source: Incident Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**12**
Impact (1-5)	**3**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Increased staff at night and robust escalation process in place • Review of paediatric service in A&E underway via an external consultant from Alderhey. • Review of paediatric A&E staffing (nursing and medical) to be considered and pathways of care.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Staffing and skill mix • Pathway of care to be reviewed
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Increased staff at night to ensure service is safe • A review of incidents and complaints undertaken to seek assurance that service is safe	**Mitigating Actions** *(What more should we do?)* Commission a review of Paediatric care in A&E **Director of Transformation – end March 2017** **COMPLETED** Development of an action plan following on from external review **Service leads – by end April 2017** **COMPLETED** **Ensure the action plan us presented to Quality Committee for approval** **Head of Midwifery – end June 2017**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**3**

Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 2	Risk: . Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives
Risk Source: Performance Reporting	**Exec Lead:** **Director of HR/Director of Communications**
	Operational Lead **Head of HR/Head of Communications**
	Assurance Committee: Strategic People Committee
	Date to be reviewed: Monthly
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Communications: We have developed a Communications and Engagement Work plan 2016-17 which is being delivered across the WHH workforce • There is a revised leadership model in place within the Trust • Priorities for the Trust are promoting learning and development, driving clinical leadership, having efficient job plans, celebrating success through staff awards and supporting innovation and working with partner organisations • There is an established Strategic People Committee of the Board • Investment in training and Support for staff • Open Mic sessions/Team Talk in place to engage staff and offer them a voice	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • CBU leadership structure still embedding • Gaps in information/data due to lack of service line reporting in place enable it difficult to analyse significance of staffing impact on productivity e.g. staff sickness levels due to work related stress etc. • Periodic staff survey (added to Staff FFT Qs) to include communications awareness/engagement • Establishment of evaluation parameters linked to 'communication tools' ie google analytics
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Engagement Dashboard reported to Trust Board (includes monitoring of Team Brief attendance) • Staff FFT and Annual NHS Staff Survey (published March each year) both reported to SPC	**Mitigating Actions** *(What more should we do?)* Further diversification of communication tools – greater use of social media and developing site-specific communications **Director of Communications – end July 2017** Further opportunities for staff to engage with senior managers/executive Team – Open Mic **Director of Communications – ongoing**

	Following development of Trust Strategy, ensure staff engagement events/communications are developed **Director of Communications – end September 2017** Creation of 'People Champions' network **Director of Communications – end July 2017**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 3	**Risk: Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.**
Risk Source: Performance Reporting	**Exec Lead:** **Director of Finance**
	Operational Lead **Deputy Director of Finance**
	Assurance Committee: **Finance and Sustainability Committee**
	Date to be reviewed: **Monthly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Core financial policies controls in place across the Trust • Revised governance structure within the Trust to enable strengthened accountability • Finance and Sustainability Committee (FSC) established overseeing financial planning • CIP programme in place aligned to the Transformation agenda • Monthly financial monitoring with NHSI • Regular review at Executive team meeting and development sessions • Attendance at the STP boards and Committee • Annual plan development process • Health economy commissioning meetings to identify any financial performance issues/demand management etc. • Support agreed to help achieve CQUIN monies • Performance monitoring of financial governance within the Trust. • Negotiations with Commissioners on Contract income on going • Monitor SLAs and contracts to enable extension of contracts or tenders to be managed • Charitable funds strategy in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Failure to achieve Financial control total may result in loss of STF and worsening cash position. • The Trust was found in breach of its licence in August 2015 and was subject to enforcement. Significant improvements have been made. However, the Trust continues to be financially challenged and is forecasting a year end deficit of £7.9m. • Failure to manage fines and penalties and CQUIN which may result in loss of STF and worsening cash position • Risk to financial stability due to loss of income relating to STP changes • Inability to develop a strategic plan to deliver a breakeven position over the next 5 to 10 years • Loss of contracts due to competitive market which may result in Trust no longer being sustainable. There is a gap in Market analysis and Knowledge of our competitors • Loss of income through the failure of WHH Charity

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• New Director of Finance appointed 2016, with a Deputy Director of Finance also appointed and a reconfiguration of the finance function • Robust financial controls introduced • Director of Transformation appointed as a new post in the Trust • Increased focus on delivering CIPs, via the Trust Transformation agenda • Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board • Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports • Annual external audit and reporting to Charities Commission • Trust achieved better than planned for deficit 2016/17	Continue to seek support from Commissioners **Director of Finance – ongoing** Continue to seek support from NHSI on Winter pressures and Capital to Revenue **Director of Finance – ongoing** Development of a Market analysis of Trust competitors to understand imminent and future risk to income **Director of Finance – end May 2017- revised date end July 2017** *An analysis of the market is underway down to specialty level, led by the Commercial Development Team. This will for example enable the Trust to understand which GP / Patients from the Warrington and Halton postcodes (and surrounding areas) attend other providers. The reporting tool is being tested with senior managers and the Transformation team. This work will be incorporated within the updated Financial Strategy.* Development of a Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery **Director of Finance – end June 2017** Greater involvement of the Corporate Trustee in Charitable Funds strategy development (planned for Board Workshop in 2017) **Director of Communications – end December 2017**

Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**10**
Target Impact (1-5)	**5**
Target Likelihood (1-25)	**2**

Strategic Objective 3	Risk: Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT**
	Operational Lead **IT Leads/CIO**
	Assurance Committee: **Finance and Sustainability Committee** **Digital Optimisation Group** **e PR Programme Board**
	Date to be reviewed: 15/03/2017
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**

Controls: *(What are we doing about the risk?)*	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)*
• IT Strategy in place • Routine RAG reporting of IM&T projects to ePR Programme Board and upwards to Finance and Sustainability Committee • Reviewing EPR system upgrade plans with suppliers and agreeing revised dates based around resource contention • Working with CBUs to involve more admin and clinical staff for testing upgrades • Reviewing contingency plans • Cross training staff to increase leveraging of resources and minimise single points of failures • Cross skilling help desk to strengthen first line support • IG sub-group reviews contingency plans with Information Asset Owners from the CBUs • Anti-virus has been added to IM&T Capital Shortlist for 17/18 and will be agreed at the next Capital Planning Group • IT Seniors routinely act upon CareCERT information security bulletins released by NHS Digital's Data Security Centre. Actions performed in response to bulletins are documented. • Information Security Management System reports to Information Governance and Corporate Records Sub-Committee to provide assurance on the effectiveness of controls • Inspection by Trust's auditors on IT infrastructure security • Capital paper submitted to secure funding for hardware to improve infrastructure in time for requisite Windows 10 migration	• Failure to provide IMT system support caused by lack of staff or single points of expertise in the structure; resulting in systems being unavailable for longer periods of time in the event of a failure. Impact on trust access, quality of care and financial targets with potential for reputational damage. • Failure to secure trust's IMT systems from cyber-attacks due to poor end user training and awareness, limited and out of date security systems and increasing complexity of attacks. Impact is loss of patient data resulting in fines, organisational reputational damage or extended downtime of systems, resulting in loss of financial information and loss of ability to treat patients. • Failure of IMT infrastructure to be available 24*7 due to increasing demands requiring additional hardware which cannot be purchased due to funding restraints. • Assurance that DQ reports available within the BIS are being accessed and acted upon by operational staff • Sufficient time for engagement from CBUs around system management • Certification to the Cyber Essentials standard in quarter 1 Financial year 2017/18 is required. This was recommended in the National Data Guardian/CQC report of 2016

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Monitoring of Data Quality in systems implemented and reporting of DQ metrics via Data Quality and Management Steering Group • Monitoring of external data quality reports such as the NHS Digital Data Quality Maturity index and benchmarking with other organisations • Clear communications of upgrades changes • Good user engagement for testing • Monitoring of helpdesk tickets to understand trends after upgrades • Assess hot stops from IMT Helpdesk calls • Critical systems continuity plans identify key staff who will work to ensure systems return to normal as quickly as possible • Capital programme spend reviewed by Capital group and F&S, hardware inventory maintained to ensure end user equipment remains fit for purpose. • ePR programme Board reviews each project progress against Programme Plan expectations • Internal IMT department progress recorded at Seniors meetings • New diagnostic post being recruited linking to identifying single points of failure • The Director of IT has undertaken a review regarding IT infrastructure risks, which may impact upon 24/7 availability of key services and systems and the capital programme has been updated to reflect these risks. • Actions have been completed regarding commencement of a information and IT restructure. An additional diagnostic team member has been recruited.	Work with other Trusts to share testing resources **Director of IT – ongoing** Invest in additional IMT staffing as workload increases, restructures based on work being reviewed with IMT management **Director of IT – ongoing** Comprehensively identify all single points of failure and assess risks surrounding each **Director of IT – end June 2017** Test contingency plans regularly- development of a plan **Director of IT – end May 2017** Routinely report all Cyber-attacks via Datix incident reporting system to ensure SIRO and Caldicott Guardian are sighted on the issues **Director of IT – end June 2017** Include Cyber Security element in annual SIRO report **Director of IT – end April 2017** It was agreed that the 2016/17 SIRO report will be an agenda item at the next Information Governance and Corporate Records Sub-Committee which takes place on 10/07/2017. IT Manager to produce a report detailing IT infrastructure risks which may impact upon 24/7 availability of key services and systems **Director of IT- end April 2017** **COMPLETED** Continuous audit of IMT infrastructure- development of a plan **Director of IT – end May 2017**

Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**10**
Impact (1-5)	**5**
Likelihood (1-5)	**2**

Strategic Objective 3	**Risk: Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.**
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT** **Operational Lead** **CCIO** **Head of Information** **Assurance Committee: ePR Programme Board** **Date to be reviewed: 15/03/2017**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Prioritising work around BAU i.e. statutory and contractual dataset returns such as daily/weekly Sitreps, monthly Board reporting, FOI's, Ad-hoc information requests and CQC inspection. • Providing regular updates to the project board and current plans, progress and risks/issues • Recruited one temporary staff to cover Maternity datasets as replacement for one of the Band 6 staff that has left. • Re-planned and allocated work to the team for other Band 6 staff that has now left. • Recruiting for a Band 5 replacement that leaves end of March. • Taking on the NVQ data quality staff from Lorenzo team. He will initially work 2/3 days per week from 27th Feb and permanently then once a DQ backfill has been recruited. • Appointed new Head of Information that starts at the beginning of April • Interim Head of Information re-developing plans and prioritising work	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • The new Head of Information will be joining end of March who will review the overall strategy for delivering information services, she has already started to look at this following a meeting on 15/02/17 – on going • New interactive tools to allow users to manually 'data mine' the reports is in pilot.

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • The key objective is to ensure all BAU work is being maintained i.e. statutory returns, adhocs and FOI's and support CQC inspection. Escalate to Exec level if any delays are likely • Continue to Access reports via the BIS application, new reports are being made available all the time • Continue to report progress, risks and issues through finance and project board meetings	**Mitigating Actions** *(What more should we do?)* Continue to work with the Business and clinical teams to help manage expectations and ensure work is prioritised around key objectives (BAU, CQC, etc) and then by the high priority datasets **Head of Information – ongoing** Establish new information reporting structure lead by the new Head of Information starts **Head of Information – End September 2017** Develop interactive Business Intelligence system for end users for self-service to reduce demand for routine information enquiries **Head of Information – End September 2017**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 3	**Risk: Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Director of Communications**
	Operational Lead **Board Secretary**
	Assurance Committee: **Audit Committee**
	Date to be reviewed: Ongoing
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Compliance with license conditions – reportable quarterly via Audit Committee • Appointment of Advisor to Board • Re-establishment of Foundation Trust Office • Recruitment of Secretary to Board and support	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Need to relaunch the Board Assurance Framework and align to the Strategic Risk Register • Lack of ongoing regular review of Well Led standards • Lack of assurance regarding a centralised system to monitor Duty of Candour compliance

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Well Led Review and CQC inspection 2017 • NHS Improvement Assessment • Board Evaluation Surveys • Well-led Self-Assessment • Assurance has been received following the Well Led review commissioned by the Trust from Deloitte. Actions from this review will be monitored by the Board.	Complete the Well-led Self-assessment and develop an action plan **Chief Executive/Director of Communications – end May 2017** **COMPLETED – action plan underway** Ensure there is an annual review of Well –led assessment mapped into the Audit Committee and Board business cycles **Chief Executive/Director of Communications – end May 2017** **COMPLETED** Review the Trust Risk Management Strategy **Chief Nurse/Deputy Director of Integrated Governance & Quality – end May 2017** **COMPLETED** Ensure a Duty of Candour protocol and centralised system is developed, which is reported monthly to the Board of Directors **Deputy Director of Integrated Governance & Quality – end March 2017** **COMPLETED**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**10**
Impact (1-5)	**5**
Likelihood (1-5)	**2**

Strategic Objective 4	Risk: Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Executive** **Operational Lead: Divisional triumvirates** **Assurance Committee: Finance and Sustainability Committee, Strategic People Committee, Quality Committee** **Date to be reviewed: Quarterly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Members of the board have secured lead roles on a range of programmes within the LDS and STP, most notably High Quality Hospital Care, which is led by our Chief Executive and Medical Director for the STP. • The board is further developing the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • We are developing plans, with partners, to establish Accountable Care Organisations in both Halton and Warrington. • We have developed an engagement strategy in partnership with our Governing Council • We have developed a Communications and Engagement Work plan 2016-17 • We are delivering a programme of 'Your Health' Events across all of our services to which public, partners, members and governors are invited/involved • We have established a community-wide newsletter Your Hospitals • We have a programme of visiting GP practices on a 'customer care' platform	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Our CQC rating will likely impact our ability to influence and at this stage is not known. • Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. • Failure to successfully engage with all of our stakeholders across our catchment population • Measurement of GP engagement

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Evidenced by lead roles in STP and LDS. • No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the STP. • The Trust has developed effective clinical networking and integrated partnership arrangements: • The Trust is successfully leading and co-ordinating the delivery of new integrated care pathways for the frail elderly with partners from primary and social care, the voluntary sector, 5 Boroughs NHSFT and Bridgewater Community NHSFT. • The Trauma and Orthopaedic service has developed excellent links with the Walton Centre for all complex spinal patients. • The Musculoskeletal team are undertaking collaborative work with Warrington CCG and Walton Neuro Vanguard developing a CPMS service meeting patients' needs. • Monitoring engagement by stakeholders (attendance at events, membership survey) • Well Led Review and CQC inspection 2017 • Reports and Feedback from Healthwatch	Continue to hold lead roles. **Chief Executive – ongoing** Ensure evidence is provided to support decision making. Development of Trust Strategy document aligned to Trust planning priorities and external agenda **Director of Transformation – end June 2017** Ensure robust communications, engagement and consultation. Review the internal/external communications strategy for staff and partners **Director of Communications – end June 2017** Re-establish 'Board Talk' stakeholder newsletter **Director of Communications – end May 2017** **COMPLETED** Create more opportunities for stakeholder engagement at our hospitals **Director of Communications – end June 2017** Revisit the Your Hospitals newsletter/membership communications to ensure optimised **Director of Communications – end May 2017** **COMPLETED** Establish clinician-led GP engagement opportunities **Director of Communications – end June 2017**

Residual Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

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