WHH Board of Directors Meeting – Part 2

Wednesday 26 April 2017
1.00pm – 4:00pm
Trust Conference Room

Warrington and Halton Hospital NHS Foundation Trust
Agenda for a meeting of the Board of Directors held in public (Part 2).

Wednesday 26 April 2017, time 13:00 -4.00pm
Trust Conference Room, Warrington Hospital

REF BM/17	ITEM	PRESENTER	PURPOSE	TIME	
BM/17/ 04/37	CBU Diagnostics Presentation and Patient Story (B Palin)		Information	1.00	
BM/17/ 04/38	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	1.30	Verbal
BM/17/ 04/39	Minutes of the previous meeting held on 29.3.2107	Steve McGuirk, Chairman	Decision	1:32	Encl
BM/17/ 04/40	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	1.35	Encl
BM/17/ 04/41	Chief Executive's Report	Mel Pickup, Chief Executive	Assurance	1:40	Verbal
BM/17/ 04/42	Chairman's Report	Steve McGuirk, Chairman	Information	1.55	Verbal

Quality People Sustainability

BM/17/ 04/43	(a) Integrated Performance Dashboard March Including (b Nurse Staffing report (c) Trust Engagement Dashboard full year analysis and – Key Issues Reports for: (d) Quality Governance Committee 4.4.2017 (e) Finance & Sustainability Committee 19.4.17 and Chairs Annual Report (to follow) (f) Strategic People Committee update report	All Executive Directors Margaret Bamforth, Committee Chair Terry Atherton, Committee Chair Anita Wainwright, Committee Chair	Assurance	2.05	Encl
BM/17/ 04/44	Performance Assurance Framework 2017-18	Andrea Chadwick Director of Finance + Commercial Development	Approval	2.25	Enc
BM/17/ 04/45	Quarterly Risk Register and Board Assurance Framework	Kimberley Salmon-Jamieson Chief Nurse	Assurance	2.35	Enc

People

BM/17/ 04/46	Annual Survey Staff Results	Michelle Cloney Interm Director of HR & OD	Assurance	2.45	Enc + Presentation

Sustainability

BM/17/ 04/47	Approach to NHSI to review the Trusts Licence Conditions	Andrea Chadwick Director of Finance + Commercial Development	Assurance	3.00	Enc
CORPORATE GOVERNANCE					
BM/17/ 04/48	Board Sub-Committee ToR and Business cycles for Ratification (a) Finance & Sustainability (b) Council of Governors	Executive Leads	Ratification /Assurance	3.25	Encl

	(c) Charitable Funds Committee (d) Audit Committee (e) Quality Committee				
BM/17/ 04/49	Proposal to change the Trust Name	Pat McLaren Director of Community Engagement + Corp Affairs	Approval	3.40	Enc
BM/17/ 04/50	Quarterly Governance Declaration to Monitor	Pat McLaren Director of Community Engagement + Corp Affairs	Assurance	3.50	ENC.
BM/17/ 04/51	Any Other Business	Steve McGuirk, Chairman	N/A	4.00	Verbal
	Date of next meeting: Thursday 25 May 2017 – Year End Accounts 10.00am-10.30am, Trust Conference Room				

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 2) on Wednesday 29 March 2017
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Andrea Chadwick (AC)	Director of Finance and Commercial Development
Simon Constable (SC)	Medical Director and Deputy Chief Executive
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Michelle Clooney (MC)	Interim Director of HR + OD
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement
Jan Ross (JR)	Deputy Chief Operating Officer
Ellis Clark (presentation item only)	Clinical Informatics Matron
Wendy Johnson (presentation item)	Associate Director L&D
Becky Hossbach (presentation item only)	Matron AMC
Observing	
Norman Holding (NH)	Public Governor
Apologies	
Sharon Gilligan	Chief Operating Officer
Roger Wilson	Director of Human Resources and Organisational Development

Agenda Ref BM/17/03/	
BM 17/03	The Board Meeting opened with a presentation to the Midwifery Team to recognise their achievement in receiving a National award from the Royal College of Midwifery, recognising hard work and contribution of the Midwifery Unit to enable the change, working as a team to develop a rebranded Midwifery Unit. The significant improvements and change had also been recognised during the recent CQC inspection. All members of the Midwifery Team were awarded a Team Working award. On Behalf of the Board, the Chairman and Chief Executive extended their congratulations to the whole team. The Board received a presentation of the draft Nursing and Midwifery Strategy 2017-2020. KSJ introduced Ellis Clark, Wendy Johnson and Becky Hossbach to present key elements of the Strategy. The Strategy had been developed by 20 nurses from a variety of specialty areas, as part of a dedicated workshop, and is based on the National Nursing and Midwifery Strategy and WHH's QPS Framework. The draft will be presented formally to a future Quality Committee for approval with a work plan to support the strategy. Priorities and objectives for the nursing team will be set to support this work.

	The strategy will support a culture for nurses to work across 4 key elements of their roles, population health; patient, carers and families; nursing and midwifery care staff and improvement and innovation. Five priorities had been identified and agreed for each of these 4 areas. The Strategy will be interlinked with other Trust strategies, including the People Strategy and Patient Experience Strategy and monitored via the action plan, through the Quality Committee and Nursing and Midwifery Forum. The Strategy will be launched on National Nurses Day on 12 May, followed by the workplan with touch-points and bench-marking over the next 2-3 years to assess progress. The Board thanked colleagues for this presentation, and fully supported the Strategy which was a succinct, easy to read document for both staff and patients.
BM 17/03/25	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed those attending the meeting, Apologies: as above. Declarations of Interest: none declared in respect of agenda items.
BM 17/03/26	**Minutes of the Previous Meeting Held on 28 February 2017** First Item Mick Tighe to read Mark Tighe Item 24 AOB should read: SC confirmed that Dr Zaman Qazzafi, Consultant Microbiologist has been formally appointed as Deputy Director of Infection, Prevention & Control. With these amendments, the minutes of the meeting held 28 February 2017 were agreed as an accurate record.
BM 17/03/27	**Actions and Matters arising** All actions were reviewed and progress was noted. **Action Log** BM17/02/21 Complaints Quality Assurance Group ToR had been drafted and dates of meetings to be circulated. Action Closed. BM17/02/21 Complaints Improvement Plan- Narrative had been included on the tracker. Action Closed. **Matters Arising** Item BM17/02/21 – Complaints Quality Assurance Group. It had been agreed that SMcG will Chair this Group for the first year after which it will be reviewed.
BM 17/03/28	**Chief Executive Report** The Chief Executive updated the Board on items that had occurred or progressed since the February meeting. • The CEO of Warrington Borough Council (SB) had visited a number of departments across Warrington Hospital site with MP. He had concurred with comments made by MP at the recent Overview and Scrutiny Committee regarding the current condition of

some of the hospital estate and that it would not necessarily fit or meet the requirements for future modern health services. He agreed to support discussions when they commence regarding the potential for a new hospital site for Warrington.

- There are strong proposals across the health economy to create single health care records and the use of digitalised patient records. The volume of paper records Mr Brooomhead observed within the Medical Records Department provided a clear message of the importance to embrace new technology.
- MP and SB discussed the current vacant estate and Daresbury Ward and the option for these areas to provide an Intermediate Care facility or a wider additional social care re-ablement facility for Warrington which would relieve current pressures on the hospital. SB had proposed this recommendation at the recent Health Summit with Commissioners. Outcome of any decision is awaited.
- MP had had a positive meeting with H Jones MP last week. HJ had agreed that there is a need to look at facilities out of which health care services are provided in Warrington in the future. HJ supported the view that current facilities are not sufficient to meet the health needs of a growing population but asked that there would be an open and transparent debate, supported with a full consultation when discussing future location proposals.
- The recent CQC inspection had seen 53 inspectors on site over a 3 day period, commencing 7 March. CQC had provided initial observations and verbal feedback on Friday 10 March reporting that noticeable change had been noted since the last inspection, there had been a high level of engagement from staff, a change of culture had been evident and the inspection team had been warmly welcomed into the Trust by staff who had been honest and transparent in conversations. MP had asked if a summary of where improvements had been noted could be shared.
- The draft report is expected within 55 days but this could be received sooner. The Trust will review the report for factual accuracy before publication.
- The recent Thank you Awards had been a successful event recognising the efforts of staff over the last 12 months with a number of individual and team awards awarded. The Midwifery Unit had received the Team of the Year, recognising the transformation of the service and their achievement over the last 2 years. The Team had also received special recognition from CQC and nationally with their RCM award.
- Baroness Cumberledge had visited the Trust whilst CQC were visiting to recognise the achievements of the Midwifery Team and promote a consultation on Clinical Negligence Redress.
- Significant challenges to meet performance trajectories ahead of year end, especially A&E. The Trust improvement trajectory was set at 90% at the beginning of the year. Significant pressures experienced in December, January and February with performance at 80%. Achievement to meet the 90% trajectory is being monitored on a daily basis and is currently at 88.91%. If the A&E trajectory is achieved, WHH will be one of the best performing trusts in the north west.
- 2 radiologist trainees have been successful in securing substantive posts with the Trust reflecting the excellent training and supervision in the Trust and their desire to remain with the Trust.

	The CEO recorded thanks to all staff for their efforts in preparing for the visit, with special thanks to K Salmon-Jamieson and the Governance Team.
BM 17/03/29/	**Chairman's Report** The Chairman gave the Board an update of events since the previous Board meeting: • The Chairman echoed the CEO comments extending thanks and appreciation to all staff for their hard work ahead of and during the CQC inspection. • The Governors NARC had met on 23 March 2017 and approved a recommendation to the full Council on 6 April to appoint a new Non-Executive Director. The Chairman will report the outcome at the next Board meeting. • SMcG/MP/AC/LG/KSJ and SC had attended a positive Performance Review Meeting (PRM) with NHSI on 24 March 2017. • MP and SC are attending a STP meeting later today where future work streams will be agreed.
BM 17/03/30	**Integrated Performance Report Dashboard February)** 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 Medical Director (SC) and Chief Nurse (KSJ) took the Board through the Quality highlights of the dashboard, the Medical Director summarised: - Positive position reported with HCAI in terms of MRSA, zero tolerance maintained. Two hospital acquired CDiff cases reported February 2017. YTD position 19 hospital apportioned cases against contractual threshold of 27. - CDiff outbreak on Ward A8, 2 cases are linked, full RCA underway. - Outbreak of Norovirus also on Ward A8. An extensive deep clean will be carried out this weekend. Beds may be moved around to facilitate this clean to ensure minimal disruption for patient, being mindful of current winter pressures. - Mortality – the very latest figures should HSMR and SHMI both within expected range achieving green status. The change in both indicators from Amber to Green reflects the ongoing work. - Significant improvement in the SHMI indicator from Red to Green since the last CQC inspection 2 years ago noted which reflects all the work undertaken under the Mortality Review Group. Progress will continue to be reported to the Board on a quarterly basis as well as the monthly dashboard. - SC and MB had attended a NHSI/NHSE/CQC Mortality Event in London. There will be a national requirement for Trusts to undertake a structured review on selected deaths as a priority. Current data based on national research evidence would indicate approximately 35 - 40 avoidable deaths per year for WHH, but this has yet to be identified at this level though our current mortality reviews and this level has also not necessarily been seen at other Trusts. A policy will be developed by a working group to ensure best practice across the Trust, shared with other Alliance partners. - **Action: SC to present policy to future Board for approval by October 2017.**

	- Discharge summaries – improvements noted, trajectory of 95% not achieved, but 7 day target achieved. The Clinical Operations Board has discussed this matter and this is to be managed with individual CBUs. The Chief Nurse summarised the Quality indicators: - High risk incidents – 7 open reviews, 2 surgical never events in theatre. Immediate action had been taken following the 72 hour review. CQC and the CCG had been briefed re the Never Events and will receive the results of the review. SC added that as part of GMC regulations, this incident will be referred to the GMC. - Safety Thermometer – above 95% trajectory, increase in December due to new validation process to ensure accurate submission of data. - CQUIN – the Trust remain in negotiation with the CCG regarding Antimicrobial Resistance and Stewardship. - Falls – indicator moved to red, measure now to be changed as and 'falls per 1000 bed days' to move to number of falls and severity of harm. The Trust has identified falls prevention as a quality priority in the Quality Accounts. A deep dive will be undertaken with a Falls Cluster Analysis Report reported to Quality Committee in April. - Between April 2016-February 2017, 9 patient falls resulted in fracture neck of femur. IPR to be refreshed to ensure that falls data can be recorded correctly to provide a monthly report and action plan aligned to the risk register. A Specialist Falls Nurse has been appointed which will support this work. - Pressure Ulcers – 2 grade 3 and 1 grade 4 pressure ulcer recorded. Comprehensive action plan had been submitted to NHSI in line with national guidance. Root Case Analysis to be undertaken for all pressure ulcer grade 3 and above and action plans are monitored through the Quality Committee. - Friends and Family Inpatient + Day Cases - individual action plans with CBUs being developed and monitored to ensure that all relatives, friends, carers are supported if required to complete this documentation. - Friends and Family – A&E – action place had been put in place. In February, 298 returns received with a decrease in January, seeing the lowest number of returns received over a six month period. A number of actions now in place, new posters displayed in A&E, and a new company has been commissioned for next year to support initiatives already in place. - Complaints – 268 open complaints, 60 of which have exceeded the 6 month response target. Quality Assurance Group will take forward the Complaint Improvement Plan which is formally monitored through the Quality Committee monthly. IPR to be refreshed to include alignment of all related indicators. - Nurse staffing report – ward staffing data had been reviewed following concerns raised by the QQC. The review highlighted Ward A4 had submitted data to NHSE where night time average nursing and HCA fill rates were 50% and 43% and staffing levels were significantly higher. The review identified data anomalies for Ward A4 and other wards. Strengthened data collection and validation processes have now been put in place to ensure accurate data is collected, collated and reported from ward to Board to support accurate recording and validated of data submitted to NHSE - The Board will receive a monthly report highlighting areas were average fill rates fall

	below 90% of actual versus planned with mitigations. Actions taken to date include moving staff to meet demand in real-time on a daily basis. **Performance** The Deputy Chief Operating Officer(JR) took the Board through the Performance highlights of the dashboard: - Diagnostics – national target of 99% achieved with the Trust's actual performance achieving 100%. - RTT – 92% against national target of 92%. - 4 hour national standard - 95% target not achieved due in part to significant winter pressures still being experienced. The Trust achieved 84.50% against the NHSI improvement trajectory of 90% (at the time of the report) which moved the YTD position to 90.59%. Latest figure provided during the meeting was achievement of 89.91% with 3 days remaining to achieve improvement trajectory of 90% for March. - Cancer 31 day first treatment – Q3 achieved 95.79% against a target of 96%. The Trust is on schedule to achieve the Q4 target. - Ambulance Handover – increased pressures had resulted in a number of handover delays but the Trust continues to compare favourably across the health economy. ECIP continues to support the Trust in this work. The Director of Finance + Commercial Development presented the Finance dashboard: - additional cost pressures to meet costs of escalation wards and winter pressures of approximately £11,000k per day?? - cash balance of £1.3m, £0.2m less than the planned cash balance of £3.3m and is managed on a daily basis. - Financial position – cumulative deficit of £8.8m is £0.1m better than the planned deficit of £8.9m. - AC had attended a recent national providers DoF meeting, the key theme of which had been ways to explore/secure STF funding. - The £1 for £1 offer is still viable if the Trust can deliver above plan which could result in a potential £0.5m for the Trust. There would be no financial risk to this calculation in addition to the potential for a share of funds left for delivering the Trust planned financial positon. - Achievement of Quarter 4 STF of £2m will be dependent on 100% delivery of financial position and improvement trajectories. - Re-evaluation exercise to reduce capital charges and expenditure to be reviewed for the year, year-end negotiations with commissioners will play a key role. Cumulative capital spend of £3.9m is £1.2m below revised planned spend of £5.1m. The Capital Plan has been reduced by £1.5m. - Confirmation of share of STF funding anticipated 1.5 days before the annual accounts re to be submitted. The Director of Transformation provided an update on the CIP. - At Month 11 £8m CIP delivered and £2m in cost avoidance and income recovery. - £1m delivered over the first two quarters of the year. £11m on bottom line forecast to

	deliver £13m by the end of the financial year. - From 1 April 2017 dashboard will indicate plans for 2017-18. Schemes identified for next year indicate half of the £10.5m for next financial year which is more than identified in plans at the same time last year. Thanks were noted for the efforts of all staff. The Interim Director of HR + OD highlighted key areas for the Board to note: - Sickness absence – YTD reduction to 4.69% against a target of 4.2%. This reflects the work with Managers to ensure that the Attendance Management Policy is correctly applied and data submitted in a timely manner. The SPC will review the operationalisation of the policy in 6 months. - Agency Spend – MC to meet with Liaison to review commissioned rates as any reduction on commissioned rates could result in an overall reduction in medical agency spend. - RTW – compliance slightly reduced to 80.05% for February against target of 85%, improvement of 15% compared to 12 months ago. YTD rate increased by 7% to 80%. Further work with managers to ensure data is being recorded and submitted correctly. - Recruitment – average total days to recruit has increased to 80.3 against a target of 50 days, compared to 101.9 days 9-12 months ago. - Turnover – MC advised that the previous data received by the Board for November/December and January had been incorrect but had been corrected for this month's data. - A number of actions in place to reduce turnover including flexible working, improved induction, development opportunities, all of which will be supported by the Recruitment and Retention Plan for nursing. **The Board noted the report**
	Engagement Dashboard The Director of Community Engagement and Corporate Affairs highlighted key areas for the Board to note: - Negative media following the Warrington Health Overview + Scrutiny Committee actually had a positive result in the highest number of 'click-throughs' to the web site and other social media platforms of 42,000. - Last month had seen social media referrals double to the website. - Continued engagement with staff, February a challenging month, possibly due to added pressure and demand on staff due to the CQC inspection. - Patient Engagement/Experience – this month, in addition to NHS Choices, other platforms had been analysed which showed a higher number of positive patient experiences. - Key area of work next month to commission the new website which will be mobile enabled. - Annual Engagement Dashboard to be presented to the April Board to provide the opportunity for a trends analysis and to highlight any key themes. **The Board noted the report.**
BM 17/03/30(a)	(a) **Key Issues Report from March Quality Committee** The Key Issues Report was taken as read and Margaret Bamforth, Chair of Committee highlighted the following

	- Lessons learned newsletter had been positively received and providing useful information for staff. - Front line visits – framework and repository to be developed to triangulate soft and hard data/intelligence for this rolling programme of visits. - Complaints – escalated to the Board but the Quality Committee assured the Board that the QC continue to scrutinise and monitor the action plan which is on track for the end of March. - VTE assessment and Root Cause Analysis – the QC discussed at length. Documentation to accurately reflect that the 95% target is being achieved. The QC continue to scrutinise and monitor the action plan. - SUI – comprehensive report received and thanks extended to the Deputy of Director of Integrated Governance for the report which makes it easier to identify trends and triangulate information. - The QC had received additional assurance reports including Safeguarding Review and Mortality Review Position Paper. - The QC approved the Clinical Audit Forward Plan and approved The Pandemic Flue Plan Policy and Escalation Operation Ward Policy. **The Board noted the report.**
BM 17/03/30 (b)	(b) **Key Issues Report from March 2017 Finance and Sustainability Committee (FSC)** The Key Issues Report was taken as read and Terry Atherton, Chair of the Committee highlighted the following: - The significant effort to manage the 4 hour performance trajectory. - Achievement of £8.8m deficit, £100k better than plan. - Comprehensive IM&T update received. Lorenzo benefits reporting - template to be agreed to enable the FSC to receive detailed reports to provide onward assurance to the Board on benefits realisation from the Trust Approved Business Case. - Pay Assurance/NHSI Checklist. MC to establish a Pay Spend and Review Group which will report into the FSC and SPC in terms of assurance. - Update received on work underway to ensure compliance with IR35 guidance and identify potential implications for the Trust. - Assurance had been provided that the estimated income figure provided as a result of data omissions in Month 10 report had not been over-estimated - ToR and Cycle of Business had been reviewed and agreed subject to the amendments requested and will be presented to the April Board for formal ratification. - The 2017-18 Capital Programme and 2017-18 Budget proposals were discussed in detail and approved prior to formal ratification by the Board. **The Board noted the report.**
BM 17/03/31	**Strategic Risks** The Chief Nurse key areas for the Board to note: - No new strategic risks had been identified since the last report to the Board in February. Actions completed against strategic risks and additional actions, gaps in assurance identified against current risks were detailed within the paper. - The Board will receive a monthly update on strategic risks and the full Board Assurance Framework on a quarterly basis. The monthly updates will show the impact on risk scores when the risk is moved from Amber to Green.

	The Committee noted the report and progress made to date.
BM 17/03/32	**2017/18 Capital Plan** The Director of Finance + Commercial Development highlighted key areas for the Board to note: - The Finance and Sustainability Committee (FSC) received the Capital Programme in December and March. The FSC in March had supported a Capital Programme of £6m covering Estates, IM&T and Medical Equipment Schemes that had been risk assessed (appendix 1). - In line with the current Scheme of Reservation and Delegation (SORD) the Trust Board is requested to approve the Capital Programme for 2017-18. - Depreciation had been used to fund the Capital Programme with element of carry-forward of £0.5m. - All schemes in appendix 1 will be subject to a business case and approval through the Capital Planning Group. - Bids received from divisions for their required spend to be predominantly based on a risk assessment, however, other factors will be considered such as bids that would deliver a financial contribution. Priority to be given to projects where it is not possible to mitigate a significant risk. - IJ asked for clarity regarding the figure of £6m in the capital programme and if this was sufficient to meet potential requests for update/replacement of medical equipment due. AC commented that there could be an element of risk relating to medical equipment but a Medical Equipment Group had been established to review all medical equipment requests to ensure this was replaced or replaced / repaired ensuring that all departments could operate in a safe environment. - MB asked if E-Prescribing had been included in the capital programme as it crosses a number of areas. AC commented that significant schemes would require business cases for investment, ie, the Care Records e-Prescribing would require a business case and would not become part of the Capital Programme. **The Board reviewed and discussed the paper and approved the Capital Programme for 2017-18.**
BM 17/03/33	**2017/18 Budget Proposals** The Director of Finance + Commercial Development highlighted key areas for the Board to note: - The FSC had received, discussed and recommended approval to the Trust Board to approve the 2017-18 Budget Proposals. - The key risks are QIPP, CIP, unfunded pressures and ability to achieve all Sustainability and Transformation funding. - The Trust Board had approved the 2017-18 financial plan in December 2016. The financial plan was submitted to NHSI on 23 December accepting the control total set by NSI o £3.7m deficit. - High level of anticipated income and expenditure assumed to deliver deficit control total of £3.7m which had then been broken down across divisions. - Challenging target of £10.5m CIP delivery. FSC had discussed they key risks in the plan and leads now identified to manage cost pressures to ensure that not all cost pressures are funded.

	- It was recognised that the CIP programme for 2017-18 needs to be transformational and this will link to the Trust Strategy including, for example, delivering efficiencies through back-office reconfiguration and the high quality hospital care STP workstream. - A session to further develop the Trust Strategy will be included in Part 1 of the April Trust Board. - The proposals assume £7m STF relating to achievement of control total and performance trajectories but does not include winder pressures funding for 2017-18. **The Board reviewed and discussed the report and approved the Budget for 2017-18.**
BM/17/03/34	**Board Resolution for Deficit Support** The Director of Finance and Commercial Development highlighted key areas for the Board to note: - The Board were asked to approve the drawdown of funds from the DoH to support the planned deficit position (control total) for the year ending 31 March 2018 by way of a loan. - The Board were asked to delegate authority to obtain revenue support via loans to the value of £3.657m to the CEO and to authorise the Director of Finance and Commercial Development to despatch all documents to be signed/and or despatched by it under or in connection with the Finance Documents up to which it is a party. - A new agreement will be created each time the Trust applies for a proportion of the £3.657m control total. - As this was a Board Resolution, in line with the Constitution, a vote was required which showed support and approval by all present (8) voting members (SMcG/MP/AC/JDaC/TA/AW/IC/MB) **The Board discussed the report and supported the Board Resolution.**
BM/17/03/34	**Board Annual Cycle of Business** The Director of Community Engagement highlighted key areas for the Board to note: - Following the initial report from Deloitte as part of the Well Led Review at the Part 1 Board earlier today, it was agreed to review the Cycle of Business when the full report has been received. - Frequency of all Committees of the board will be reviewed to ensure the required attendance of 75% by NED colleagues can be achieved. - Options to be explored on other forms of meetings, ie electronically, via teleconference if IT equipment is available to support this. - The Chairman asked for a review of meetings over the last 6 months to be undertaken at a dedicated session. PMcL suggested July 2017 to review a draft calendar of meetings for 2018 and use of technology. **The Board noted the report.**

BM/17/03/35	**Changes to the Constitution:**
	The Director of Community Engagement highlighted key areas for the Board to note:
	- The Council of Governors had discussed in recent months a number of initiatives to enhance our member recruitment and public engagement. As a result, the Board were asked to approve the:
	    o Addition of the Lead Governor role, which had been supported and approved following the CoG on 19 January 2017 and
	    o Amendment to the Public Constituency at Annex 1 to change the name of area 16 to Rest of England and Wales (approved at CoG on 20 October 2016) from South Mersey.
	In line with the Constitution, a vote was required which showed support and approval by all present

	(8) voting members (SMcG/MP/AC/JDaC/TA/AW/IC/MB). **The Board discussed the report and approved the above changes to the Trust Constitution.**
BM/17/03/36	**Any Other Business** None reported **Next Meeting:** **Wednesday 26 April 2017, 1pm Trust Conference Room.**

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/17/04/40	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	26th April 2017

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
	29 March 2017		Trust Strategy to be further developed at Part 1 of the April Board	Director of Transformation	26 April 2017			
BM 17 03 30	29 March 2017	Nurse Staffing Report	The Board will receive a monthly report highlighting areas were average fill rates fall below 90% of actual versus planned with mitigations	Chief Nurse	26 april 2017			
	29 March 2017	Strategic Risks/BAF	The board will receive a monthly update on strategic risks and quarterly from April 2017	Chief Nurse	29 April 2017			

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

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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.	

RAG Key

(red)	Action overdue or no update provided
(orange)	Update provided but action incomplete
(green)	Update provided and action complete

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/43 a**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	26th April 2017
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Sharon Gilligan – Chief Operating Officer 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 Choose an item. Choose an item.
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):	Despite challenging operational pressures in March the Trust has achieved the A&E Improvement Trajectory for March and for the financial year, together with the majority of national and local operational access key performance indicators (KPIs). Whilst cancer targets remain challenging increased capacity is now in place to meet demand and the Trust is working in collaboration with GP practices to address issues relating to patient choice. The Trust had two Never Events in March which are being reviewed through the Serious Incident Reporting process.

	Recruitment, staff retention and sickness absence continues to improve. Whilst 2016/17 has been an extremely financially challenging year for the Trust, the Trust delivered its control total with a £0.7m improvement from plan. The Trust has delivered a deficit of £7.4m. The Trust anticipates £0.7m additional Sustainability and Transformation Fund (STF) for the improved position, and a further £0.1m for absorbing the impact of the change in the discount rate applied to provisions. NHS Improvement is due to confirm the final STF allocation which will include a share of the residual STF pot for delivery of the control total.	
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Integrated Performance Dashboard	AGENDA REF:	

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

- All infection prevention KPIs met for 2016/17
- New falls action plan in place
- Harm free care targets met
- Improvement in mortality rates – no longer national outlier
- 8 Serious Incidents reported in March, including 2 Never Events
- 1 grade 4 and 7 grade 3 ulcers reported – route cause analysis being carried out
- RTT 18 week aggregate and 6 week diagnostic targets achieved
- Cancer targets majority achieved with renewed focus on delays due to patient choice
- A&E 4 hour national performance target not achieved, however A&E STP Improvement trajectory achieved
- Improvement in Discharge Summaries being sent to GPs within 24 hours of discharge
- Improvement in sickness absence and return to work interviews year to date
- Staff turnover reduced for the sixth consecutive month
- Agency spend overall remains the highest element of non-contracted pay
- Financial position planned deficit of £8.1m against actual of £7.4m - £0.7m better than plan
- CIP of £8.6m delivered and cost avoidance of £2.6m achieved
- Capital spend for the year of £5.0m (£0.2m below revised plan)
- Cash balance of £1.2m which complies with loan terms and conditions
- Use of Resources Rating of 3

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:-

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

5. RECOMMENDATIONS

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

Integrated Dashboard - Board of Directors - March 17

Key Points/Actions

Quality Improvement

Feb-17: Red 2, Amber 3, Green 9, Other 5
Mar-17: Red 2, Amber 3, Green 9, Other 5

The Trust reported 8 serious incidents in March. 2 never events, 1 alleged sexual assault, 1 fractured neck of femur, 2 major falls, 1 norovirus outbreak and 1 unexpected death. RCA investigations have commenced. Falls, the Trust has put a number of actions in place being overseen by the Chief Nurse and Deputy Chief Nurse, Divisional Nurse Directors reporting to Patient Safety and Effectiveness Sub Committee. Falls reduction is also a proposed quality priority for 2017/18. The Trust has met all infection prevention control targets in relation to MRSA, MSSA and Clostridium difficile.

The Trust met its Harm Free Care targets, with an increase in performance in March due to a revised validation process. Mortality, we are no longer a national outlier, with an HSMR of 105 for the reporting period 2016/2017. This result is not significant at 95% level for the latest 12 months and the Trust is still close to the boundary for being an outlier.

The complaints position on 1/4/17 is that we have 9 active cases with the PHSO, 42 re-opened/dissatisfied cases in addition to the 226 cases that await a first response. Work is ongoing within complaints, reconciling systems and progressing the complaints improvement plan.

Access & Performance

Feb-17: Red 6, Green 10, Other 1
Mar-17: Red 9, Green 7, Other 1

The majority of Access and performance standards have been met in March with the exception of the four hour standard however although the Trust did not achieve 95% we did achieve our NHSI improvement trajectory of 90%. Cancer remains a challenging target and the teams are working on improving processes and working with GPs around patient choice.

Workforce

Feb-17: Red 4, Amber 1, Green 4, Other 3
Mar-17: Red 4, Amber 1, Green 4, Other 3

There have been no changes to the status of any of the KPIs. The sickness rate has fallen from the previous month and this has slightly reduced the rate for the YTD. RTW rates have fallen in month but it has been found that more have been recorded retrospectively so the overall position is more positive. The YTD rate has increased. Turnover rates have fallen but are still showing Red. Recruitment times have fallen, most notably for the time taken to conduct employment checks but the status remains red. Non contracted pay remains a concern. Both nurse and medical agency expenditure increased in month but the year-end position showed nurse spend less than the previous year and medical spend, more than the previous year. Mandatory Training rates have remained stable and are Green. PDR rates were maintained from the position reached the previous month and are Green. The definitions for reporting 'high cost agency workers' and 'long term agency usage' have been changed by NHSI and this has been included in the report.

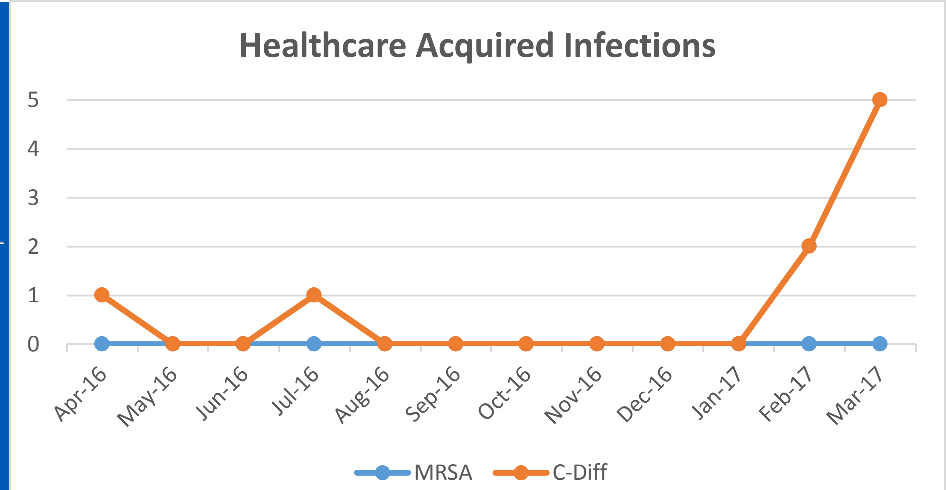
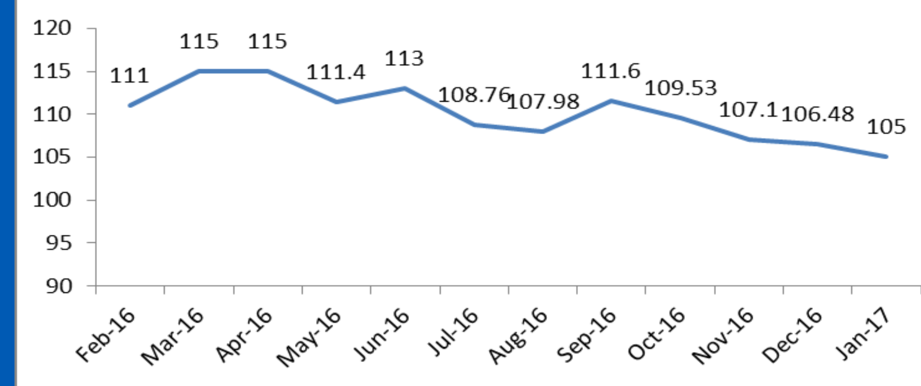
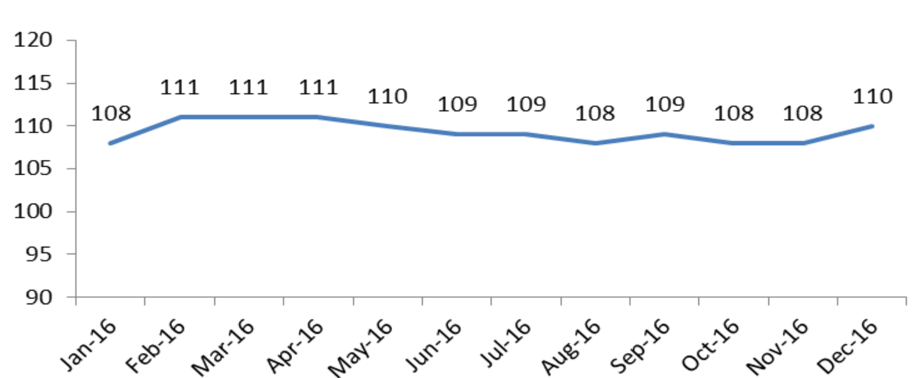
Finance

Feb-17: Red 5, Amber 3, Green 0
Mar-17: Red 4, Amber 3, Green 1

In March the Trust recorded a surplus of £1.4m (excluding impairment expenses) which decreases the year to date deficit to £7.4m which is £0.7m better than the planned deficit of £8.1m. For the year to date period income is £3.1m above plan, expenses are £4.1m above plan and non operating expenses are £1.7m below plan. The annual capital programme planned spend is £5.2m and the actual spend is £5.0m. Due to the operating position the cash balance remains low and as at 31st March the cash balance is £1.2m which is £0.6m less than the original planned cash balance of £1.8m. However under the terms and conditions of the loan the Trust is required to have a cash balance equivalent to 2 operational days which equates to £1.2m. The performance against the Better Payment Practice Code is 36% in the month and 30% to date so is significantly lower than the 95% target. For the year the Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating. The Trust's financial position is £0.7m improvement against plan. This position includes £0.1m charge for the change in discount rate on provisions. The Trust will therefore receive £0.8m additional STF (£0.7m plus £0.1m) and a share of any remaining STF monies for delivery of financial performance. The final amount will be confirmed on 24th April.

Integrated Dashboard - Board of Directors - March 17

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: t o 2 Green: 27 or less per year	MRSA - National objective is zero tolerence of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. CLOSTRIDIUM DIFFICILE (due to lapses in care) agreed threshold is <=27 cases per year. MSSA (Methicillin-sensitive Staphylococcus aureus) monitoring to commence March 2017.	The Trust has maintained its zero tolerance position for MRSA. 5 Clostridium difficile cases were reported in March 2017, they are currently under review to see if they are hospital apportioned. YTD the Trust has reported 19 hospital apportioned cases of Clostridium difficile against the annual threshold of 27 cases (this figure is subject to change following the reviews). This includes 8 cases removed from contractual sanctions following review of Q1-Q3 by the CCG. The cases from Q4 will be reviewed in May. 14 MSSA (Methicillin-sensitive Staphylococcus aureus) bacteraemia cases have been reported YTD. All cases undergo route cause analysis investigation. 2 cases are under review, 5 have been attributed to intravascular devices, 3 source unknown, 1 foetal scalp electrode and 3 related to deep seated infections identified 48 hours after admission but likely community acquired.	 	MRSA bacteraemia – a nil return was submitted for March 2017. FYTD nil case have been reported. The Trust has a period of 17 months MRSA bacteraemia free. From March onwards MSSA will be reported to Board for monitoring. Following the 5 C-Diff cases in March (currently under review) the following actions were taken ward A8 (which had 2 cases) was decanted to Daresbury and deep cleaned again. An external company were hired to hydrogen peroxide fog the ward. The Trust have now purchased their own hydrogen peroxide fog machine.
Mortality ratio - HSMR Red: Higher than expected Amber: Over 100 Green: 100 or less	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.	We are no longer a national outlier, with an HSMR of 105 for the period February 2016 – January 2017. 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. (December 2016).	 	Our HSMR shows higher weekend mortality than weekday as per the national picture, although looking at the confidence intervals, neither is statistically significant. When we look at the underlying trends, 12 month rolling HSMR weekend and weekday rates seem to be reducing slightly. The gap between weekend and weekday HSMR rates seems to be narrowing.
Mortality ratio - SHMI Red: Higher than expected Amber: Over 100 Green: 100 or less	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.	The latest SHMI is 110.170 (January 2016 to December 2016).	 	We are currently a SHMI outlier for two diagnosis groups: "urinary tract infections" and "Cancer of the rectum and anus". Case note reviews are underway for the patients within these groups and reports and learning are due to be finalised and presented at Mortality Review Group in April and May 2017 respectively. Learning and actions from these case note reviews will be diseminated throughout the appropriate channels and audited at a later date.

Integrated Dashboard - Board of Directors - March 17

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Total Deaths	Total Deaths in Hospital		Total Deaths	The Mortality Review Group is tasked with interpreting the data for the above and driving improvments including improving the percentage of completed mortality reviews. From April preventability from deaths data will be collected and therefore should enable us to RAG rate the total number of deaths.
High Risk Incidents	Serious incidents (SI's)	Year to date the Trust has reported 46 serious incident whereby the Trust has caused avoidable serious harm. A recent review showed themes to be falls, diagnostic incidents and pressure ulcers to be the top themes. Further work is ongoing to review contributory factors in these areas to ensure we have appropriate actions and learning in place. Quality Committee are overseeing this piece of work. To note the Trust has reported 2 Surgical Never Events in March. Investigations are ongoing and will be provided in the next report.	High Risk Incidents	Of the 8 Serious Incidents in March: 2 Never Events occurred in specialist surgery at the Halton site. Both incidents have had Duty of Candour applied and are being investigated. 1 Patient fall, fractured neck of femur. 1 Alleged Sexual Assault, Police Investigation underway. 1 Patient fall resulting in Subdural Haemorrhage. 1 Patient fall resulting in Intracranial Haemorrhage. 1 Unexpected Death from last year. 1 Outbreak HCAI CDT & Norovirus.
Safety Thermometer - Adult Red: Less than 90% Amber: 90% to 94% Green: 95% or more	Measures % of patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested.	This measure only includes new harms. Based on monthly snapshot audit of all inpatients, less than 1% of our patients had a fall, pressure ulcer, VTE or Catheter acquired infection in March 2017.	Safety Thermometer - Adults	The results are showing an increase since the end of December 2016, this is due to the addition of a new validation process that ensures accurate and timely data collection and submission.

Integrated Dashboard - Board of Directors - March 17

Quality Improvement

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 50% Amber: 50% to 89.9% Green: 90% or more CQUIN - Sepsis Inpatient Screening At Qtr4 Red: Less than 50% Amber: 50% to 89.9% CQUIN - Sepsis AED Antibiotics & Review Trajectory yet to be agreed with CCG CQUIN - Sepsis Inpatient Antibiotics & Review At Qtr4 Red: Less than 50% Amber: 50% to 89.9%	Screening of all eligible patients - acute inpatients (*to be validated). Screening of all eligible patients admitted to emergency areas (*to be validated). 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.	The four elements of the SEPSIS CQUIN are required to achieve the following thresholds in Q4 - AED Screening is based on the national threshold - 90% and AED Antibiotic Review - 55%; Inpatient Screening - 10% and Inpatient Antibiotic Review - 20%. Data collection for Q4 is ongoing, the Sepsis return is submitted quarterly and the validation is not yet complete, so we are unable to provide the figures for January-March at the current time.	CQUIN - Sepsis Screening (chart: AED Screening Actual, Inpatient Screening Actual, AED Screening Target, Inpatient Screening Target; Apr-16 to Qtr4) CQUIN - Sepsis Antibiotics & Empiric Review (chart: AED Antibiotic & Review Actual, Inpatient Antibiotic & Review Actual, AED Antibiotic & Review Target, Inpatient Antibiotic & Review Target; Apr-16 to Qtr4)	AED Screening achieved >=50% so deemed partially compliant, all other measures deemed compliant against Q3 thresholds.
CQUIN - Antimicrobial Resistance and Stewardship	Antimicrobial Resistance and Stewardship (AMR) National CQUIN AMR Empiric Review of antiobiotic prescriptions within 72 hours	The Trust has submitted the baseline data for antibiotic consumption as required for 2013/2014 - 2015/2016 and the 2016/2017 Q1 usage report. In Q4 the Trust has performed an empiric review at 94% in January and 92% in February of prescriptions thus achieving the required threshold that at least 75% of cases in the sample are reviewed and is therefore compliant.	CQUIN - Antimicrobial Resistance and Stewardship (chart: Empiric review of antibiotic prescriptions within 72 hours; Apr-16 to Qtr4)	The pharmacist has been contacted to request quarterly reports on antibiotic consumption so that it can be included in this dashboard to evidence antibiotic usage against baseline. Achievement of the baseline reduction in antibiotics is deemed unrealistic and a number of local Trusts have either agreed or are in the process of agreeing a contract variation with the CCG. The Trust has produced and submitted an AMR Report to CCG to negotiate contract variation around revised consumption methodology.

Integrated Dashboard - Board of Directors - March 17

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Falls per 1000 bed days Red: More than 5.6 Green: 5.6 or less	Falls / 1000 BD. This measure relates to the number of falls per 1000 bed days. Previously the Trust used a National Benchmark from the National Patient Safety Agency of 5.6 falls per 1,000 bed days. This benchmark is no longer going to be used as per advice from the NPSA as this is data from 2010.		Falls per 1000 bed days (chart: National Average, Actual; Apr-16 to Mar-17)	The Trust has identified falls prevention as a quality priority going forward in this year's quality accounts and therefore we will measure ourselves going forward against our agreed falls reduction targets.
Total number of Falls & harm levels		Data regarding falls has been validated YTD all fractured neck of femurs and serious fractures are graded as severe harm.	Number of Falls (chart: Total falls, Moderate Harm, Severe Harm, Death; Apr-16 to Mar-17)	The Trust has reported 3 falls as serious incidents in March 2017. There are Trustwide actions being implemented with regard to training, risk assessments, SWARM and equipment. This action plan is being monitored via Patient Safety and Effectiveness Sub Committee, reporting to Quality Committee.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 82	Grade 4 hospital acquired (avoidable). Grade 3 hospital acquired (avoidable). Grade 2 hospital acquired (avoidable and unavoidable)	To date we have 1 confirmed avoidable grade 4 pressure ulcer and 7 confirmed avoidable grade 3 pressure ulcers against an improvement priority threshold of >=3. There are 42 approved grade 2 pressure ulcers. The grade 2 threshold of 82 for the year equates to 6 per month and 20.5 per quarter. Wider Service TVN review is due to commence 3rd April, an update will be provided in the next report.	Pressure Ulcers (chart: Grade 3, Grade 2; Apr-16 to Mar-17)	From March 2017 Grade 4 hospital acquired (avoidable) pressure ulcers will be reported to Board for monitoring via the narrative/aggregate position. However data will be available to view on the graph from May 2017.

NHS Foundation Trust

Integrated Dashboard - Board of Directors - March 17

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	Percentage of Inpatients 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?	Of the 1274 patients surveyed, 1223 stated that they were extremely likely or likely to recommend that ward to their friends and family.	Friends and Family (Inpatients & Daycases)	We have achieved 96% in March 2017, exceeding the 95% target for the first time since October 2016.
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 results have shown an improving situation since January. We have exceeded the monthly threshold of 87% for 2 months.	Friends and Family (A&E and UCC)	Having reviewed the data it appears that response rates are also increasing. In February we saw 298 returns this had increased to 392 returns for March.
Complaints - Number Received and Returned	Total number of complaints received and returned for further local resolution (Please be advised there is no RAG rating at present however trajectories will be set and reported on in the new financial year).	The position on 01/04/2017 is that we have 9 active cases with PHSO, and we have 42 re-opened/dissatisfied cases in addition to the 226 cases that await a first response.	Complaints - Number Received and Returned	A data cleansing of DATIX (Complaints system) is currently taking place as part of the Trust's complaints improvement plan. Given the current risk regarding complaints management within the Trust the indicators reported to the Board have been reviewed, ensuring that the Board have direct sight of the impact of the complaints improvement plan. Quality Committee receive regular assurance regarding implementation of the improvement plan.

NHS Foundation Trust

Integrated Dashboard - Board of Directors - March 17

Quality Improvement

	Description	Aggregate Position	Trend	Variation
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	Staffing resources are frequently assessed and utilised across the organisation to ensure patient safety at all times. The Trust is currently undertaking an Acuity & Dependency review working with Allocate and ward teams; the results of which will be collated, analysed and presented to the Trust Board in May 2017. A separate paper outlining the specific detail of each wards nurse staffing data is presented to the Board of Directors every month.	Staffing - Average Fill Rate 115% 110% 105% 100% 95% 90% 85% 80% Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Day - registered nurses/midwives Day - care staff Night - registered nurses/midwives Night - care staff	When numbers are greater than 100% this is usually due to specialising.
Staffing - Care Hours Per Patient Day (CHPPD)	Care Hours Per Patient Day = (Hours of registered nurses + Hours of healthcare support workers) / Total number of inpatients	We continue to monitor care hours per patient day which are nationally benchmarked and detailed within the "model hospital" dashboards.	Staffing - Care Hours Per Patient Day (CHPPD) Care Hours per day: 8.0 6.0 4.0 2.0 0.0 Cumulative count: 17000 16000 15000 14000 13000 12000 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Registered midwives/ nurses Care Staff Overall Cumulative count over the month of patients at 23:59 each day	Analysis of data from over 1,000 wards, in the pilot stage, found a wide variation in the care hours provided per patient per day - ranging from 6.33 to 15.48 hours with an average of 9.1 hours. The data produced excludes CCU, ITU and Paediatrics.

Integrated Dashboard - Board of Directors - March 17

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.	Diagnostic Waiting Times 6 Weeks 100%, 98%, 96%, 94%, 92%, 90% Apr-16, May-16, Jun-16, Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17 Target, Actual, Target with Tolerance	
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory.	Referral to treatment Open Pathways 100%, 95%, 90%, 85%, 80% Apr-16, May-16, Jun-16, Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17 Target, Actual, Target with Tolerance	The Trust has achieved the Incomplete Pathways target of 92% coming in at 93.01% for March with a final year position of 93.13%. The number of patients waiting over 18 weeks has also reduced and this is due to validation, a RTT hotline and online training backed up with specialty and role based workshops, as well as number of patients treated at the Spire hospital as a result of a successful bid to NHSI from the Trust. The specialties that sent patients to Spire were T&O and Urology.
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 or the STP improvement trajectory.	A&E Waiting Times - 4hr target 100%, 95%, 90%, 85%, 80% Apr-16, May-16, Jun-16, Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17 Improvement Trajectory, Actual, Improvement Trajectory with Tolerance	The Trust had been set and improvement trajectory for March of 90% the teams are very proud that they achieved this, achieving 90.74%, with a year end position of 90.60%. B19 remains open as a winter pressures ward and the focus for April is to close this and other escalation beds. This year's trajectories have been submitted to NHSI.

Integrated Dashboard - Board of Directors - March 17

Mandatory Standards - Access & Performance

Indicator	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.		Cancer 14 Days (chart: Target, Actual; 82%–96%; Apr-16 to Mar-17)	No issues with 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.		Breast Symptoms 14 Days (chart: Target, Actual; 70%–100%; Apr-16 to Mar-17)	As the chart shows there was an issue with capacity in December which resulted in a high number of breaches for 2 week wait patients in January. It can be clearly seen that due to robust processes now introduced there has not been any patients who have breached the 2 week wait target due to capacity issues. We still continue to see delays due to "Patient Choice" and this has been discussed with the CCG and the GP Clinical Lead for Cancer who is taking this back to the GP Focus groups. The Breast symptomatic 2 week wait continues to be challenging but this is 100% due to patient choice. There are no breaches due to capacity.
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.	The Trust narrowly missed the Q3 target, achieving 95.79% against a target of 96%. The Trust is currently on track to achieve the Q4 target.	Cancer 31 Days First Treatment (chart: Target, Actual; 88%–100%; Apr-16 to Feb-17)	The March position is not closed off and validation work is still being undertaken. There are no concerns around this target.

Integrated Dashboard - Board of Directors - March 17

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.		Cancer 31 Days Subsequent Surgery (chart: Target, Actual; Apr-16 to Mar-17)	Gap in Graph for September - November due to no data available. The March position is not closed off and validation work is still being undertaken. There are no concerns around this target.
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.		Cancer 31 Days Subsequent Drugs (chart: Target, Actual; Apr-16 to Mar-17)	Gap in Graph for August - September & November due to no data available. The March position is not closed off and validation work is still being undertaken. There are no concerns around this target. No issues to note.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.		Cancer 62 Days Urgent (chart: Target, Actual, Target with Tolerance; Apr-16 to Mar-17)	The 62 day wait for first treatment did not achieve the 85% target in February. The reasons for this are multi-factorial. The Trust made a decision to move onto one system for tracking patients (Somerset) at the recommendation of MIAA. The team are currently validating the full quarter position as the senior team are not assured that all treatments have been uploaded. March position will not be complete until 4th May 2017. The CBU Manager for Specialist Surgery has vast experience of working within the cancer team and has in the interim taken over the management of the performance side of cancer services and she has developed an action plan for the cancer team which focuses very much on the timely tracking of the cancer patients within the new system.

Integrated Dashboard - Board of Directors - March 17

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		Cancer 62 Days Screening (chart: Target, Actual; Apr-16 to Mar-17)	
Cancer 62 Days Upgrade	62 day upgrade		Cancer 62 Days Upgrade (chart: Actual; Apr-16 to Mar-17)	Gap in graph due to data avilability. No issues to note.
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)		Ambulance Handovers at 30 to <60 minutes (chart: Actual, Target; Apr-16 to Mar-17)	The increased pressure within the Trust has resulted in a number of ambulance handover delays. We continue to compare favourably compared to neighboring Trusts however strive to improve the performance to ensure our patients are handed over safely and efficiently. This continues to be a key area of focus. A Service Improvement Team has been formed by NWAS and supported by ECIP to apply focus and identify and examine improvement opportunities; propose and implement improvement measures, and discuss ways of improving quality service, systems, processes and procedures in relation to handover delays.

Integrated Dashboard - Board of Directors - March 17

Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
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)		Ambulance Handovers at 60+ minutes	The increased pressure within the Trust has resulted in a number of ambulance handover delays. We continue to compare favourably compared to neighboring trusts however strive to improve the performance to ensure our patients are handed over safely and efficiently. This continues to be a key area of focus. A Service Improvement Team has been formed by NWAS and supported by ECIP to apply focus and identify and examine improvement opportunities; propose and implement improvement measures, and discuss ways of improving quality service, systems, processes and procedures in relation to handover delays
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge		Discharge Summaries - % sent within 24hrs	The divisions continue to focus on this performance indicator. Improvements continue however the Trust is still below target.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge		Discharge Summaries - Number NOT sent within 7 days	Since the start of the year significant improvements have been seen.

Integrated Dashboard - Board of Directors - March 17

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 March 2017 improved and was 4.14% which was considerably better than the same month last year (4.9%). The latest figure(January 2017) for the North West absence performance was 4.8% (WHH was 5.16%) The YTD sickness has improved and the final position was 4.66% against a target of 4.2%. For 2015/16 the position was 4.56% so there has been very little change.	Monthly Sickness Absence (chart: 3%–6%; Apr-16 to Mar-17; Target, Current Yr, Previous Yr, NW Avg)	Managers are reminded each month about the need for absence being input in a timely manner. Historically, sickness absence is at its highest in the Winter months. The revised Attendance Management Policy was implemented on 1.12.16 and from January 2017 the position is much better than the same 3 month period in 2016. However, WHH continues to be slightly above the North West Average. Sickness for the Divisions is as follows: ACS - March-17 = 4.17%, YTD = 4.77% SWC - March-17 = 4.21%, YTD = 4.84% Corporate - March -17 = 4.11%, YTD = 4.37% 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 81.62% for March against a target of 85%. However, this is still an improvement of 15% from 12 months ago. The final YTD RTW rate has increased to 80.95%.	Monthly Return to Work % (chart: 50%–90%; Apr-16 to Mar-17; Actual, Target)	As reported at the February meeting, following the profile being raised, it has been found that in some cases the RTW interview has been undertaken but not not been recorded on ESR/'E' Rostering. This resulted in rates over the last 6 months increasing and this trend has continued with more retrospective dates recorded. This accounts for why the YTD figure is much better than first expected and is closer to the target of 85%. Monitoring at Performance Improvement meetings by HR Business Partners and the Director of HR & OD will continue.
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 March 2017 has improved from 80.3 days (February) to 71.6 days against a target of 50 days. The position 9 - 12 months ago was 93 days.	Recruitment (chart: 0–120; 9 - 12 Months ago, 6 - 9 Months ago, 3 - 6 Months ago, Last 3 Months; Avg Days between Advert Closure and Interview, Avg Days for Pre Employment Checks, Avg Total Days of Recruitment, Advert Closure and Interview (Shortlisting) Target, Pre-Employment Checks Target, Total Recruitment Days Target)	There is still room for improvement at each of the recruitment stages. The time taken from advert closure to interview (19.4 days) has deteriorated from the position 3-6 months ago wen it was 14.5 days. However, the time taken for employment checks has considerably improved from 35 days to 26.5 days over the same period but still short of the target of 21 days. Until there is further investment in staffing and/or electronic systems, there is unlikely to be any significant improvements.

Integrated Dashboard - Board of Directors - March 17

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 has fallen for the sixth consecutive month and is the final year end position is 13.34% for 2016/17. The status remains as 'red' and the target of 7 - 10% was not met.	Turnover % 16% 14% 12% 10% 8% 6% 4% 2% 0% Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Target Turnover	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 (39.9 wte) than leavers (38.2 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 5.77% of the Trusts overall pay bill. Bank spend is 2.96% followed by WLI spend at 1.84% of the pay bill. Overall Non-Contracted pay now makes up 12.73%.	Non-Contracted Pay 7% 6% 5% 4% 3% 2% 1% 0% Overtime Locum Bank Agency WLI	Work continues on implementing the action plan developed alongside E&Y with some degree of success. 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. More rigorous review and monitoring of Agency expenditure is now undertaken at FSC and a new Pay Spend and Review Group has been established which met for the first tgime on 5.4.17. NHSI have issued further guidance during March which the Trust is implementing.
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 increased in March to £327k which was an increase of £64k from February but was lower than the same month last year (£410k). Expenditure is less than in 2015/16 for the same period.	Agency Nurse Spend £450,000 £400,000 £350,000 £300,000 £250,000 £200,000 £150,000 £100,000 £50,000 £0 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Current Yr Spend Previous Yr Spend	The effect of high sickness absence levels in some areas and increased clinical activity has led to an increase in agency expenditure in month. Vacancies also remain high but it is encouraging that a large number of nurses have been appointed but they will not commence until much later in the year as many of them will be newly qualified nurses. Despite the in month increase, expenditure on agency nursing was c£600k less than in 2015/16. The Recruitment and Retention Plan for Nursing is being implemented and this should assist in reducing agency expenditure further.

Integrated Dashboard - Board of Directors - March 17

Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on Agency Locums	Agency Medical spend slightly increased in March to £738k and was considerably more than the same month last year (£377k). Expenditure is more than in 2015/16 for the same period	Agency Medical Spend £800,000 £700,000 £600,000 £500,000 £400,000 £300,000 £200,000 £100,000 £0 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Current Yr Spend, Previous Yr Spend	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 some have commenced in recent months but for others, it will be some time before these can commence. Expenditure on agency medical staff was c. £240k more than in 2015/16. The Gatenby Sanderson project is planned to go 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 continues and the final compliance rate for March and the year end was 89.20% which is above the trust target of 85%	Essential Training 100% 95% 90% 85% 80% 75% 70% Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Essential Training %, Target, Linear (Essential Training %)	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 over 6%. Divisional progress is as follows: ACS March = 90.46% Green SWC March = 87.85% Green Corp March = 89.44% 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 for the sixth consecutive month and the final compliance rate for March and the year end was 86.2% which is above the trust target of 85%.	Clinical Training 100% 95% 90% 85% 80% 75% 70% Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Clinical Training %, Target, Linear (Clinical Training %)	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 March = 85.81% Green SWC March = 84.93% Amber Corp March = 89.65% Green

Integrated Dashboard - Board of Directors - March 17

Workforce

	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	The upward trend continues and the final PDR compliance rate for March and the year end was 85.12% which is above the Trust target of 85%.	PDR chart (Target / Actual, Apr-16 to Mar-17, 40%–90%)	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. Over the last 12 months PDRs have risen by almost 13%. Divisional progress is as follows: ACS March = 82.31% Amber SWC March = 85.14% Green Corp March = 88.62% Green
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.	Highest Cost Agency Workers chart	8 of the highest earners are medical staff and there are 2 nursing agency staff in the Top 10. Earnings range from c£1500 - £5000 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.	Long term agency usage chart	6 of the staff are medical and dental; 2 are nurses.; 1 ODP and 1 pharmacist. The length of time these staff have worked at the Trust range from 5 - 18 months. In all cases they are covering vacancies and have fixed term contracts which are regularly reviewed dependent upon progress with the filling of substantive posts.

Integrated Dashboard - Board of Directors - March 17

Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	Cash balance at month end compared to plan	Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.2m equates to circa 2 days operational cash.	Cash Balance (£m; Apr-16 to Mar-17; Plan, Actual)	The current cash balance of £1.2m is £0.6m less than the planned cash balance of £1.8m but the balance of £1.2m was required to comply with the terms and conditions of the loan.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan.	The actual capital spend in the month is £1.2m which increases the annual spend to £5.0m.	Capital Programme (£m; Apr-16 to Mar-17; Plan, Revised Plan, Actual)	The annual capital spend of £5.0m is £0.2m below the revised planned spend of £5.2m (the capital plan has been reduced by 1.5m).
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	Surplus or deficit compared to plan (excluding impairment expenses).	The actual surplus in the month is £1.4m which reduces the annual deficit to £7.4m.	Financial Position (£m; Apr-16 to Mar-17; Monthly Plan, Monthly Actual, Cumulative Plan, Cumulative Actual)	The annual deficit of £7.4m is £0.7m better than the planned deficit of £8.1m. Therefore Trust anticipates £0.7m additional Sustainability and Transformation Fund (STF) for the improved position, and a further £0.1m for absorbing the impact of the change in the discount rate applied to provisions (this is not currently reflected in the position). NHS Improvement is due to confirm the final STF allocation which will include a share of the residual STF pot for delivery of the control total.

Integrated Dashboard - Board of Directors - March 17

Safely Reducing Costs & Mandatory Standards - Finance

Key	Description	Aggregate Position	Trend	Variation
Use of Resources Rating Red: Use of Resources Rating 4 Amber: Use of Resources Rating 3 Green: Use of Resources Rating 1 and 2	Use of Resources Rating compared to plan	The current Use of Resources Rating is 3. Capital Servicing Capacity and I&E margin are all scored at 4 (lowest), Liquidity is scored at a 3, Agency Ceiling is scored at 2 and Variance from plan is scored at 1 (highest).	See chart: Use of Resources Rating	The current Use of Resources Rating of 3 is in line with the planned rating of 3.
Cost Improvement Programme - Plans in Progress Red: Plan is less than 50% of annual plan Amber: Plan is between 51% and 89% of annual plan Green: Plan is over 90% of annual plan	Planned improvements in productivity and efficiency.	The Trust has a CIP target of £11m and delivery of £10.7m is currently assumed in the reforecast financial plan. For the year the Trust has developed schemes worth £8.1m in year (£8.1m recurrently).	See table: CIP by Clinical Business Unit	The value of the annual savings is £8.1m which is £2.6m below the annual target included in the reforecast annual plan.
Cost Improvement Programme - Performance to date Red: Cumulative savings less than 90% of planned savings Amber: Cumulative savings between 90% and 100% of planned savings Green: On or above plan	Cost savings delivered compared to plan.	The savings delivered in month are £0.7m which increases the annual savings delivered to £8.6m.	See table: WHH 2016/17 month by month delivery	The annual savings of £8.6m are £2.1m below the planned savings of £10.7m.

Use of Resources Rating

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Plan							3	3	3	3	3	3
Actual							3	3	3	3	3	3

Clinical Business Units / Corporate Support area	CIP Internal Target £11m	CIP costed PYE	CIP costed FYE	% of £11m target costed PYE
	£000s	£000s	£000s	%
Surgery and Women's and Children's	4,161	2,148	2,426	52%
Acute Care Services	4,516	3,538	3,691	78%
Schemes not allocated to CBUs	0	491	474	-
Controls	277	0	0	0%
Outpatients	121	121	182	100%
Corporate support areas	1,925	1,761	1,354	92%
Total Trust	**11,000**	**8,060**	**8,127**	**73%**

WHH 2016/17 month by month delivery of financial improvement from all sources

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16-17 Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
CIP schemes delivery	353	583	748	663	822	858	886	738	700	1,006	556	710	8,623
Cost Avoidance/Income Recovery schemes delivery	30	36	36	36	58	175	388	431	297	313	379	371	2,550
Enhanced expenditure control measures delivery	-	-	-	-	-	-	-	-	-	389	705	699	1,793
	383	**619**	**784**	**699**	**880**	**1,033**	**1,274**	**1,169**	**997**	**1,708**	**1,640**	**1,780**	**12,966**

Integrated Dashboard - Board of Directors - March 17

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 36% of suppliers within 30 days which results in a year to date performance of 30%.	Better Payment Practice Code (chart: Plan, Monthly Actual, Cumulative Actual; 0%–100%; Apr-16 to Mar-17)	The annual performance of 30% is 65% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £1.2m which increases the annual spend to £11.7m.	Agency Spending (chart: Monthly Planned, Monthly Actual, Cumulative Planned, Cumulative Actual; Apr-16 to Mar-17)	The annual agency spend of £11.7m is £1.7m above the annual agency ceiling of £10.0m.

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/**
SUBJECT:	**Finance Report as at 31st March 2017**
DATE OF MEETING:	19th April 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 year ending 31st March 2017 the Trust has recorded a deficit of £7.4m excluding impairments of £3.0m (resulting from the asset revaluation exercise). This impairment is charged to the income statement and is classed as a technical adjustment which is excluded from the operating position. The Trust's financial performance is £0.7m improvement against plan. The financial position includes £0.1m charge for the change in discount rate on provisions. The Trust will therefore receive £0.8m additional STF (£0.7m plus £0.1m) and a share of any remaining STF monies for delivery of financial performance. The final amount will be confirmed on 24th April. The cash balance is £1.2m and a Use of Resources Rating score is 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

FINANCE REPORT AS AT 31st MARCH 2017

1. PURPOSE

This report sets out the financial position of the Trust as at 31st March 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 J) attached to this report.

Key financial indicators:

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	20.2	21.6	1.4	227.7	230.8	3.1
Operating expenses	(18.5)	(19.5)	(1.0)	(225.0)	(229.1)	(4.1)
EBITDA	1.7	2.1	0.4	2.7	1.7	(1.0)
Non-operating income and expenses	(0.9)	(3.7)	(2.8)	(10.8)	(12.1)	(1.3)
Surplus / (deficit) inc impairments	0.8	(1.6)	(2.4)	(8.1)	(10.4)	(2.3)
Surplus/(Deficit) exc impairments	0.8	1.4	0.6	(8.1)	(7.4)	0.7
Cash balance	-	-	-	1.8	1.2	0.6
CIP target	1.2	0.7	(0.5)	10.7	8.6	(2.1)
Capital Expenditure	(0.1)	(1.2)	(1.1)	(5.2)	(5.0)	0.2

Headlines:

- The monthly position (excluding impairment costs) is a surplus of £1.4m which £0.6m better than plan. The annual position (excluding impairments costs) is a deficit of £7.4m which is £0.7m better than plan and delivers a Use of Resources Rating score of 3.
- The annual cost savings target is £11.0m of which £10.7m is included within the reforecast financial plan. For the year the planned savings target is £10.7m and £8.6m has been delivered (See agenda item Cost Improvement Report for further details).
- The actual capital expenditure for the year is £5.0m which is £0.2m below the revised planned expenditure of £5.2m (section 4).
- The cash balance is £1.2m which is £0.6m lower than the planned balance of £1.8m (section 5).

- The Better Payment Practice Code performance is 36% for the month and 30% for the year to date period (section 5).
- The value of aged debt is £4.4m (section 7).
- The value of aged creditors is £7.8m (section 8).
- The Trust has received a working capital loan totalling £9.3m in 2016/17 (£7.9m deficit and £1.4m STF) with a 1.5% interest rate replacing the interim revolving working capital facility which had an interest rate of 3.5%. Additional loans totalling £2.6m have been received in respect of the delay in STF (see section 9).
- The Trust has not applied for a capital loan in 2016/17 (section 10).
- Additional STF of £0.8m is due for improved performance against control total and a share of the remaining STF will be confirmed on 24th April (section 12).

3. INCOME AND EXPENDITURE (APPENDIX B)

In month the Trust has recorded a surplus of £1.4m which is £0.6m better than plan. This reduces the deficit to £7.4m which is £0.7m better than plan. This position excludes impairment expenses of £3.0m resulting from the asset revaluation exercise which is charged to the income statement but is classed as a technical adjustment and excluded from the underlying operating position for the year.

The main reasons for the improvement in the position include £0.2m reduced depreciation charges resulting from the revaluation exercise, £0.3m reduction in the annual leave accrual and £0.2m improvement in the operating income and expenses position.

Full and final year end settlements have been reached with NHS Warrington CCG, NHS Halton CCG and NHS Wigan Borough CCG and the impact of these settlements has been included in the reported position. The agreement with all other commissioners was not to negotiate a year end settlement but to charge based on the value of activity undertaken.

In accordance with guidance issued by NHSI the Trust is entitled to additional STF based on a £1 for £1 agreement. The additional STF due to the Trust is actually £0.8m as the Trust has managed the £0.1m financial impact of the change in discount rate on provisions within the recorded deficit. This position has been submitted to NHSI on 19th April who will confirm the £0.8m additional funding on 24th April. In addition the Trust will receive notification from NHSI of the share of any remaining STF monies which will further reduce the deficit.

Operating Income

In month operating income is £1.4m above plan which increases the annual operating income to £3.1m above plan. 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	Annual Variance £m
NHS Clinical Income	0.7	1.3
Non NHS Clinical Income	0.0	(0.1)
Other Operating Income	0.7	1.9
Total Operating Income	**1.4**	**3.1**

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

NHS Clinical income position

In month NHS clinical income is £0.7 above plan which increases the year to date position to £1.3m above plan. The clinical income plan for the month and year to date includes the share of funding relating to the Sustainability and Transformation funding which increases the monthly plan by £0.7m each month. The actual income for the month and year to date assumes that the Sustainability & Transformation funding (£0.7m in month and £8.0m year to date) 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. The variances by point of delivery is summarised in the following table.

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

Narrative	Monthly Variance Activity	Monthly Variance £m	Annual Variance Activity	Annual Variance £m
Elective Spells	(473)	(0.5)	(1,747)	(2.0)
Elective Excess Bed Days	15	0.0	(98)	0.0
Non Elective Spells	319	0.2	4,880	2.7
Non Elective Excess Bed Days	964	0.2	3,751	0.9
Outpatient Attendances	(1,699)	0.1	(16,018)	(0.8)
Accident & Emergency Attendances	467	0.0	3,313	(0.3)
Other Activity	-	0.7	-	0.8
Total NHS Clinical Income	**-**	**0.7**	**-**	**1.3**

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

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

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

Narrative	**Monthly Variance £m**	**Annual Variance £m**
Acute Care Services	0.9	4.6
Surgery, Women's and Children	0.0	(0.1)
Non divisional	(0.2)	(3.2)
Total	**0.7**	**1.3**

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:

Non NHS Clinical Income

In month Non NHS Clinical Income is on plan with the year to date position £0.1m below plan mainly due to a reduction in the values of claims submitted by the Compensation Recovery Unit.

Other Operating Income

In month other operating income is £0.7m above plan which increases the year to date position to £1.9m above plan. The main reasons for the over recovery are finalisation of the training and education target (the value of the 2016/17 Learning and Development Agreement issued by Health Education England is greater than the planned income target included in the annual plan), receipt of donations for capital assets and miscellaneous income relating to a range of service level agreements and recharges.

Operating Expenses

In month operating expenses are £1.0m above plan which has increased the annual variance to £4.1m above plan. An analysis by expense type is summarised in the following table.

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

Narrative	Monthly Variance £m	YTD Variance £m
Pay	(0.5)	(2.3)
Drugs	0.0	(0.4)
Clinical Supplies	0.0	(0.6)
Non Clinical Supplies	(0.5)	(0.8)
Total Operating Expenses	**(1.0)**	**(4.1)**

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

Pay Costs

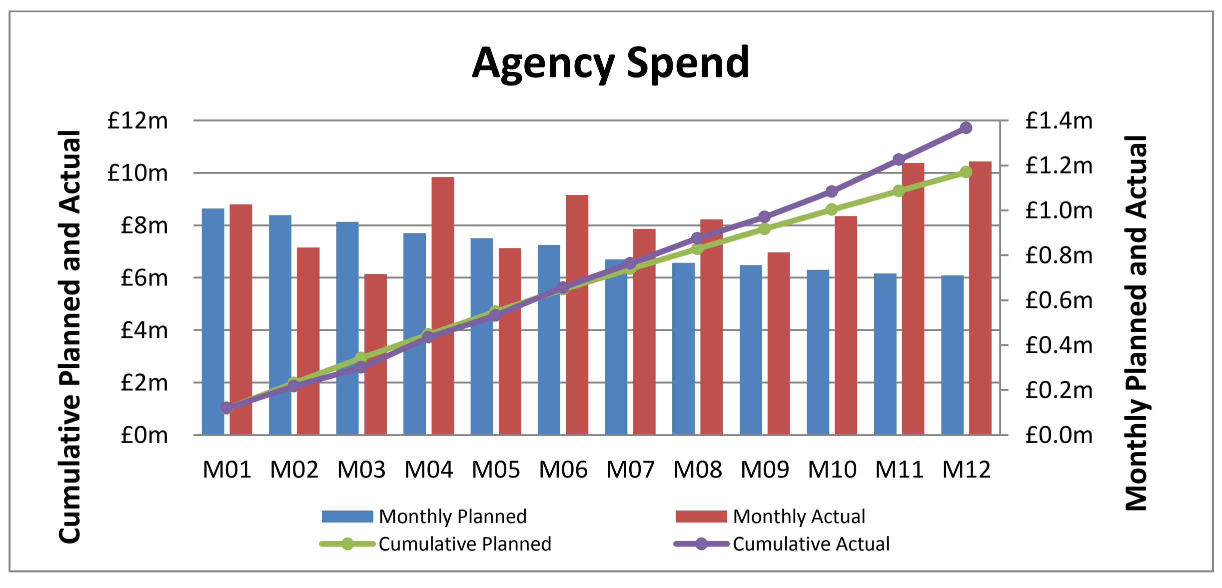
Pay costs in month are £13.8m which is £0.5m above plan. The year to date pay costs are £164.3m which is £2.3m above plan.

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. The annual cost of temporary spend is £20.7m.

Agency

The annual plan submitted to NHSI included an annual agency spend (including locums) across all staff groups of £10.0m. The annual agency expenditure amounts to £11.7m which is £1.7m above the £10.0 annual target. The monthly and annual agency spend against the planned spend is summarised in the table below.

Graph: Analysis of monthly and cumulative agency spend.



The Finance and Use of Resources Risk Rating (that replaces the Financial Sustainability 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

Drug costs in month are £1.2m which is on plan. The annual cost is £15.4m which is £0.4m above plan although this overspend relates to excluded PbR drugs which are funded by commissioners, with the additional income shown against other income within NHS clinical income.

Clinical Supplies and Services

Clinical Supplies and Services costs in month are £1.6m which is on plan. The annual cost is £20.4m which is £0.6m above plan. This mainly relates to 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

Non Clinical Supplies costs in month are £2.8m which is £0.5m above plan. The annual cost is £29.0m which is £0.8m above plan. This mainly relates to payments to Spire Healthcare for additional activity (offset by additional income), building and engineering maintenance costs, consultancy fees and the vascular risk share.

Divisional Performance

The financial position as at 31st March across all divisions is an over spend of £2.3m as summarised in the following table.

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

Division	Monthly Budget £m	Monthly Actual £m	Monthly Variance £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Acute Care	6.7	7.0	(0.3)	79.9	83.5	(3.6)
Surgery, Women's & Children's	7.0	7.4	(0.4)	84.2	83.5	0.7
Outpatients	0.3	0.3	0.0	3.6	3.8	(0.2)
Corporate	4.1	3.7	0.4	47.3	46.5	0.8
Total	**18.1**	**18.4**	**(0.3)**	**215.0**	**217.3**	**(2.3)**

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.

Non Operating Income and Expenses

Non operating income and expenses in month is £3.6m which is £2.8 above plan. The annual cost is £12.1m which is £1.3m above plan. The reason for the annual overspend results from the £3.0m impairment costs arising from the impact of the asset revaluation exercise completed in the month together with the £0.2m loss from the disposal of fixed assets, partially offset by reduced depreciation charges and PDC dividends.

Asset Revaluation Exercise

The Trust has completed the asset revaluation exercise which considered an alternative asset methodology and valued assets on a single site basis. This means should the Trust re-provide all its services on one site, if the opportunity arose, this alternative valuation methodology could be used. The revaluation exercise resulted in a reduction in asset value of £14.8m, with £11.8m taken to the Revaluation Reserve and the balance of £3.0m charged to the income statement. The impairment expense charged to the income statement is classed as a technical adjustment and excluded from the operating position and therefore the Use of Resources calculation and performance against the control total.

Use of Resources Metric

The Single Oversight Framework, effective from 1st October 2016, replaced the Financial Sustainability Risk Rating with the Use of Resources Rating to measure and assess financial performance. This builds on the metrics used in the Financial Sustainability Risk Rating by introducing metric covering agency spend.

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)	3
I&E margin	4
Distance from financial plan	1
Agency spend	2
Overall Rating	**3**

4. CAPITAL (APPENDIX F)

The annual capital programme for the year has been revised to reflect a reduction of £1.5m to £5.2m.

The capital spend for the year is £5.0m which is £0.2m less than the revised planned spend of £5.2m as summarised in the table below.

Table: Analysis of performance against the revised capital programme.

Category	Annual Budget £m	Revised Annual Budget £m	Annual Spend £m	Annual Variance £m
Estates	2.2	2.0	1.5	0.5
IM&T	1.6	1.5	1.9	(0.4)
Medical Equipment	2.8	1.7	1.6	0.1
Contingency	0.1	0.0	0.0	0.0
Total	**6.7**	**5.2**	**5.0**	**0.2**

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

5. CASH FLOW (APPENDIX G)

Based upon the original control total the Trust applied for a working capital loan of £18.6m. This was then reduced in line with the revised control total to £7.9m. The revised control total assumed receipt of the full £8.0m Sustainability & Transformation funding and the achievement in full of the additional £2.7m cost savings target.

The cash balance as at 31st March was £1.2m which is £0.6m lower than the planned balance of £1.8m. The cash balance is necessary to deliver the requirement to have a minimum cash balance of £1.2m. The cash received in March included a £2.0m loan in respect of the activity performance trajectory element of the Quarter 4 Sustainability and Transformational Funding. The monthly cash movements are summarised in the following table.

Table: Summary of the monthly cash movement.

Cash balance movement	**£m**
Balance as at 1st March	1.3
In month surplus / (deficit)	(1.6)
Non cash flows in operating surplus (including impairments)	3.4
Decrease in trade receivables (debtors)	1.8
Decrease in trade payables (creditors)	(3.1)
Capital expenditure	(1.2)
PDC Dividends Payment	(1.7)
Loan in lieu of Sustainability and Transformational Funding	2.0
Other working capital movements	0.3
Balance as at 31st March	**1.2**

The operating performance continues to have an adverse effect on the amount of cash available to the Trust. At 31st March 2017 the value of aged creditors stands at £7.8m, although this is partially covered by the value of aged debtors at £4.4m.

The current cash balance of £1.2m equates to circa 2 days operational cash. The liquidity metric is -13.7 days which results in a liquidity rating of 3 under the Use of Resources Rating. 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) remains at 36% in month and 30% year to date.

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	**April £m**	**May £m**	**June £m**
Opening balance	1.2	1.2	1.2
In month surplus/(deficit)	(1.8)	(0.4)	(0.9)
Non cash flows in surplus/(deficit)	0.8	0.8	0.8
Movement in trade receivables	0.0	0.0	0.0
Movement in trade payables	0.0	0.0	0.0
Capital expenditure	(0.5)	(0.5)	(0.5)
Sustainability & Transformation Funding	0.0	0.0	0.0
Draw down of loan	1.6	0.0	0.0
Other working capital movements	(0.1)	0.1	0.6
Closing balance	**1.2**	**1.2**	**1.2**

The challenging financial position puts considerable pressure on the cash position. A range of options to mitigate the risk and manage the cash have been considered by the Finance team. These include reducing outstanding debt, delaying creditor payments, delaying or reducing the capital programme and increasing borrowings.

6. STATEMENT OF FINANCIAL POSITION (APPENDIX H)

Non current assets have decreased by £14.2m in the month mainly due to the asset revaluation exercise, partially offset by capital spend exceeding depreciation charges.

Current assets have decreased by £1.4m in the month mainly due to a decrease in receivables and prepayments.

Current liabilities have decreased by £4.5m in the month mainly due to a decrease in payables and payment of PDC dividends.

Non current liabilities have increased by £2.0m during the month mainly due to the loan required to cover Q4 STF monies.

7. AGED DEBT (APPENDIX I)

The number of outstanding invoices has increased by 37 in the month and the value of aged debt has increased by £0.7m to £4.4m. Debt of £0.5m has been recovered in the early part of April thereby reducing overall aged debt to £3.9m.

8. AGED CREDITORS (APPENDIX J)

Aged creditors have reduced by £3.4m in the month to £7.8m (with £4.1m overdue) however as at 31st March there are 5,369 invoices outstanding for payment. 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 Depuy Synthes Ltd with £0.1m outstanding as at 31st March. 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	1,539	29	4,417	57
Others	3,830	71	3,391	43
Total	**5,369**	**100**	**7,808**	**100**

9. WORKING CAPITAL LOAN

Approval for transfer of the utilised working capital facility into a loan of £9.3m (£7.9m deficit plus £1.4m STF) at a 1.5% interest rate was approved at Trust Board on 25th January 2017. Access to a working capital facility was removed by the Department of Health upon conversion of the working capital facility into a working capital loan. By moving from a working capital facility to a loan the Trust is reducing the cost of borrowing from 3.5% to 1.5%.

Due to the delay in receipt of STF for the remainder of Q3 and for Q4, additional loans totalling £2.6m are required (£0.6m received in February and £2.0m received in March). As £1.4m STF was included in the £9.3m loan the Trust has had to take out loans of £4.0m for STF, which is 50% of the overall allocation due to delays in payment from Department of Health. This increases the total loans for the year to £11.9m.

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 will be paid twice yearly (August and February).

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

11. LOAN INTEREST

The interest resulting from the working capital facility, working capital loan and capital loan is included within the financial position as a non operating expense. The interest paid in 2016/17 from these borrowings is summarised in the table below.

Table: 2016/17 Interest Charges (forecast for the full year)

Narrative	Loan/ Facility Value £k	Interest Rate	Interest Charge £k
2015/16 Capital Loan	1,600	1.78%	27
2015/16 Working Capital Loan	14,200	1.50%	212
2016/17 Working Capital Facility (to cover deficit) *	7,900	3.50%	155
2016/17 Working Capital Facility (to cover STF) *	1,400	3.50%	1
2016/17 Working Capital Loan (to cover deficit)	7,900	1.50%	20
2016/17 Working Capital Loan (to cover STF)	1,400	1.50%	3
2016/17 Working Capital Loan (to cover STF)	2,600	1.50%	3
Total			**421**

* The working capital facility was converted to a working capital loan on 30th January 2017.

The interest charges for the year would have reduced by £0.1m had the application for the conversion from a working capital facility to a working capital loan been approved at the start of the year. The interest associated with the loans to cover the delay in STF payments amount to £7k.

12. PERFORMANCE AGAINST THE CONTROL TOTAL

For the year ending 31st March 2017 the Trust has recorded a deficit of £7.4m (excluding impairment expenses) which is £0.7m better than the planned deficit.

In accordance with guidance issued by NHSI the Trust is entitled to additional STF based on a £1 for £1 agreement. The additional STF due to the Trust is actually £0.8m as the Trust has managed the £0.1m financial impact of the change in discount rate on provisions within the recorded deficit. The table below summarises the additional STF.

Table: Summary of additional STF

Narrative	**£m**
Recorded deficit	(10.4)
Adjustments reflected in performance against control total:	
Depreciation on donated assets	0.1
Income for donated assets	(0.1)
Loss on disposal of fixed assets	0.2
Impairment expenses	3.0
Control total deficit	**(7.2)**
Planned control total	(7.9)
Variance to control total	**0.7**
Change in discount rate on provisions	0.1
Additional STF	**0.8**

This position has been submitted to NHSI on 19th April who will confirm the £0.8m additional funding on 24th April. In addition the Trust will receive notification from NHSI of the share of any remaining STF monies which will further reduce the deficit.

13. CONCLUSION

For the year ending 31st March 2017 the Trust has recorded a deficit of £7.4m excluding impairments of £3.0m (resulting from the asset revaluation exercise). This impairment is charged to the income statement and is classed as a technical adjustment which is excluded from the operating position.

The Trust's financial performance is £0.7m improvement against plan. The financial position includes £0.1m charge for the change in discount rate on provisions. The Trust will therefore receive £0.8m additional STF (£0.7m plus £0.1m) and a share of any remaining STF monies for delivery of financial performance. The final amount will be confirmed on 24th April.

The cash balance is £1.2m and a Use of Resources Rating score is 3.

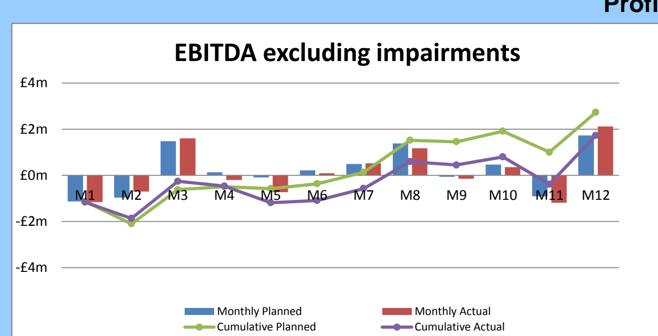
14. RECOMMENDATION

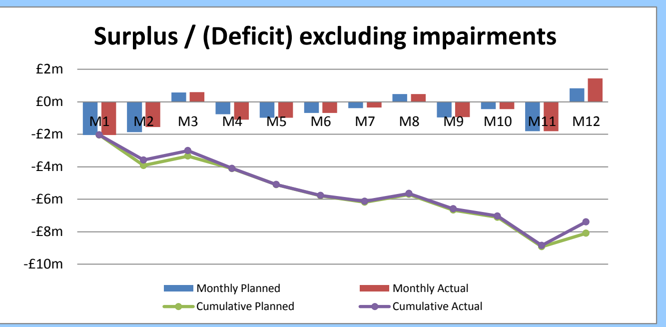
The Finance and Sustainability Committee is asked to note the content of the report.

Andrea Chadwick
Director of Finance & Commercial Development

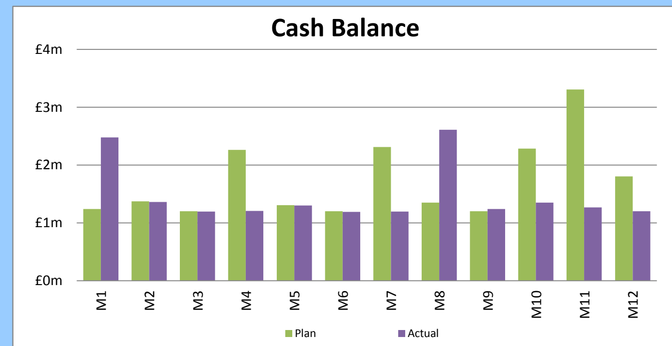
Finance Dashboard as at 31st March 2017 (Part A)

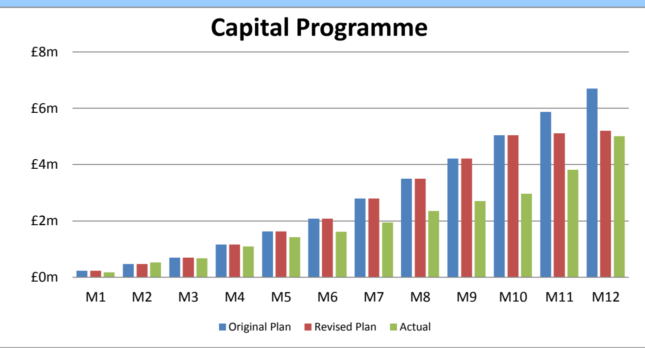
Profitability



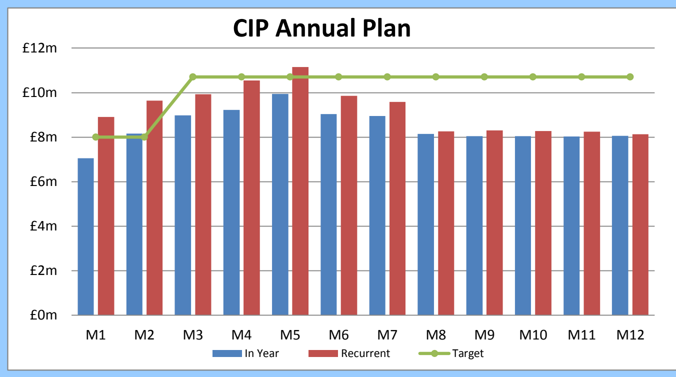


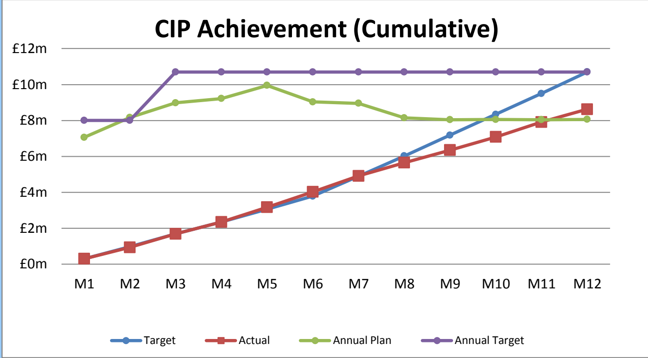
Cash and Investment





Cost Improvement Analysis





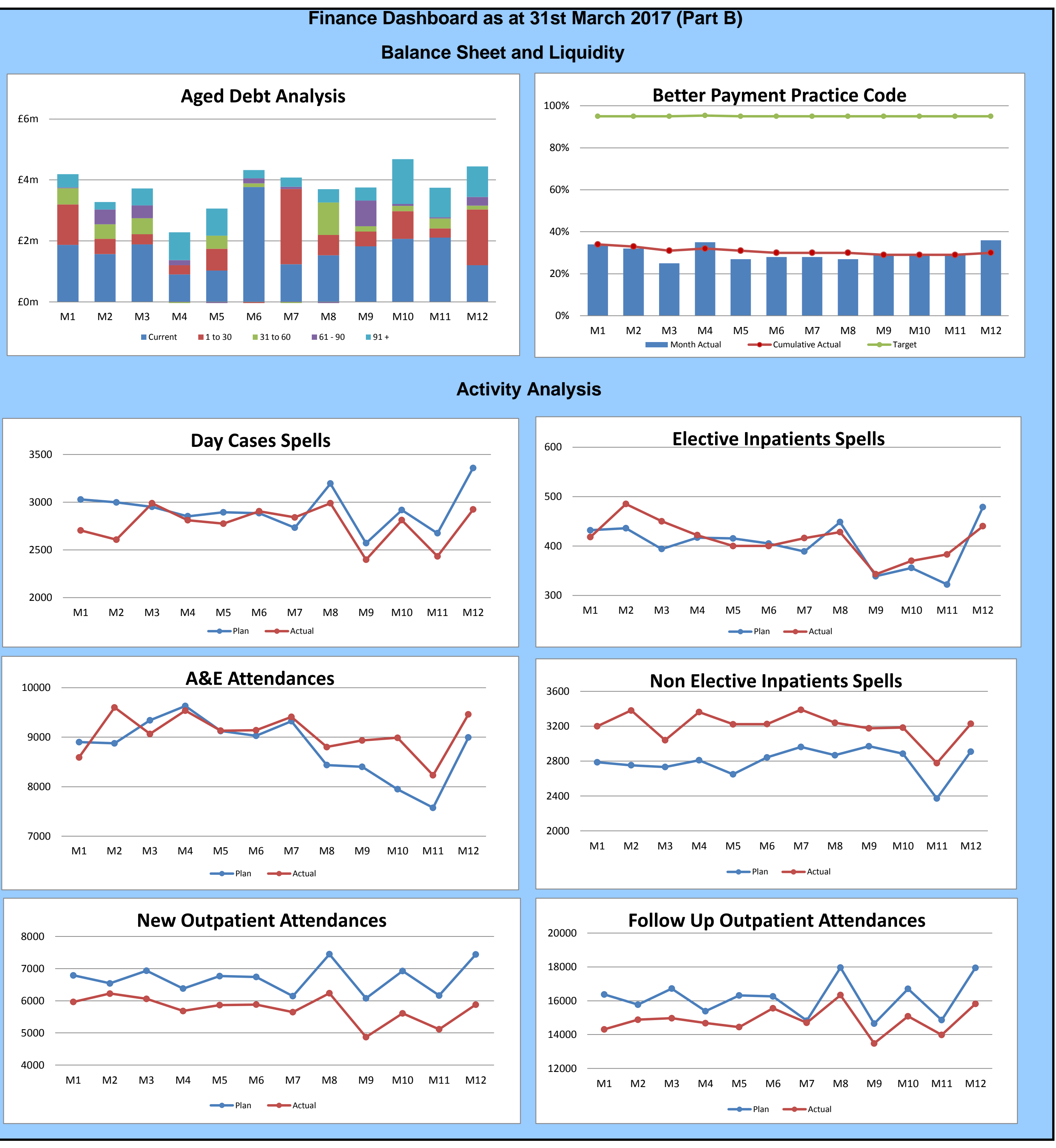
Divisional Position (net divisional income and expenditure)

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	84,171	7,013	7,383	-370	-5.3	84,171	83,465	706	0.8
Acute Care Services	79,897	6,644	7,056	-412	-6.2	79,897	83,532	-3,635	-4.5
Outpatients	3,621	300	319	-19	-6.4	3,621	3,817	-196	-5.4
Corporate									
Central Operations	150	12	13	0	-3.7	150	151	-1	-1.0
Commercial Devel & Clinical Coding	895	75	78	-3	-4.4	895	911	-16	-1.8
Communications & Membership	290	24	10	14	56.7	290	261	28	9.8
Estates and Facilities	14,828	1,281	1,214	67	5.2	14,828	14,530	299	2.0
Finance	13,513	1,127	1,100	27	2.4	13,513	13,416	97	0.7
HR and OD	4,327	381	358	23	5.9	4,327	4,560	-233	-5.4
Information Technology	4,231	443	31	412	93.1	4,231	3,705	526	12.4
Nursing and Governance	1,659	190	201	-10	-5.4	1,659	1,717	-59	-3.5
Pharmacy	4,049	348	334	14	4.1	4,049	3,759	290	7.2
Transformation Team	395	16	12	4	23.2	395	406	-11	-2.8
Research and Development	56	5	-28	33	660.1	56	23	33	59.1
Trust Executive	2,887	247	343	-96	-39.0	2,887	3,025	-138	-4.8
Total	**214,970**	**18,106**	**18,425**	**-319**	**-1.8**	**214,970**	**217,280**	**-2,310**	**-1.1**

Positive variance = underspend, negative variance = overspend.

Use of Resources Rating

Use of Resources Rating	Actual Metric	Actual Rating
Capital Servicing Capacity (times)	0.41	4
Liquidity Ratio (days)	-13.7	3
Income & Expenditure Margin (%)	-3.08%	4
Income & Expenditure Margin as a % of plan (%)	0.39%	1
Agency Ceiling (%)	16.92%	2
Overall Risk Rating		**3**


Finance Dashboard as at 31st March 2017 (Part B)
Balance Sheet and Liquidity
Aged Debt Analysis
£6m
£4m
£2m
£0m
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12
Current
1 to 30
31 to 60
61 - 90
91 +
Better Payment Practice Code
100%
80%
60%
40%
20%
0%
Month Actual
Cumulative Actual
Target
Activity Analysis
Day Cases Spells
3500
3000
2500
2000
Plan
Actual
Elective Inpatients Spells
600
500
400
300
A&E Attendances
10000
9000
8000
7000
Non Elective Inpatients Spells
3600
3200
2800
2400
2000
New Outpatient Attendances
8000
7000
6000
5000
4000
Follow Up Outpatient Attendances
20000
18000
16000
14000
12000

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/**	
SUBJECT:	**Safe Staffing Assurance Report**	
DATE OF MEETING:		
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 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	
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 nurse staffing levels falls below 90% of those that are planned.	
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**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	

FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

Safe Staffing Assurance Report

Introduction

The purpose of this paper is to transparently report the nursing and midwifery ward staffing levels across the Trust during March 2017 providing assurance that any shortfalls on each shift were addressed with mitigating actions. All Trusts have a requirement to submit staffing data to NHS England via the Unify Safe Staffing return along with providing 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.

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

Overall fill rates across the trust were:

	RN	CARE STAFF
Day	87.7%	91.5%
Night	92.7%	88.3%

Individual ward area fill rates that fell below 90% are identified by yellow highlight at appendix 1. Each area now utilises the escalation protocol previously provided to the Board of Directors to ensure mitigation of risk. Assurance is provided by the Divisional Senior Nursing teams for areas that fall below the required 90% standard with consistent daily review and support from Divisional Matrons and Lead Nurses.

During March some areas across the Trust cared for additional patients as part of our escalation processes and staffing resources were moved accordingly or additional staff requested to support these areas. Recruitment to those wards with vacancies has been on-going with a number of new recruits planned to start over the next eighteen months. In collaboration with the senior nursing teams some areas have increased head counts utilising care staff to ensure safe, quality care delivery continues.

Appendix 2 identifies mitigation where actual fell below planned.

Conclusion

This report provides evidence of the actions taken to provide adequate staffing levels across all wards.

Warrington and Halton Hospitals
NHS Foundation Trust

Appendix 1

Ward name	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	Day Average fill rate RN (%)	Day average fill rate Care Staff (%)	Night Average fill rate RN (%)	Night average fill rate Care Staff (%)
SAU	930	930	607.5	697.5	0	0	0	0	100.0%	114.8%	-	-
Ward A5	1690.5	1399	1242	1165	1069.5	1058	713	724.5	82.8%	93.8%	98.9%	101.6%
Ward A6	2047	1412	1242	1144.5	1069.5	1035	713	713	69.0%	92.1%	96.8%	100.0%
Ward C22	1069.5	985	1069.5	892.5	713	713	713	713	92.1%	83.5%	100.0%	100.0%
Ward B4 - Halton	728	705	483	354.5	256	248.5	264.5	248.5	96.8%	73.4%	97.1%	94.0%
Ward A9	1782.5	1215	1426	1110.5	1069.5	943	713	644	68.2%	77.9%	88.2%	90.3%
Ward B19	1069.5	811	1069.5	881	713	713	713	713	75.8%	82.4%	100.0%	100.0%
CMTC	1598.5	1332.5	977.5	954	713	678.5	713	651	83.4%	97.6%	95.2%	91.3%
Ward B11	2014.7	1925.7	1020	1268.5	1580.5	1529.2	124.8	52	95.6%	124.4%	96.8%	41.7%
Neonatal Unit	1782.5	1578.5	356.5	172.5	1782.5	1358	356.5	280	88.6%	48.4%	76.2%	78.5%
Ward C20	977.5	1033.5	655.5	674	644	644	0	0	105.7%	102.8%	100.0%	-
Ward C23	1288	1166	644	460	644	644	644	517.5	90.5%	71.4%	100.0%	80.4%
Delivery Suite	2495.5	2344	356.5	313.5	2495.5	2432.5	356.5	310.5	93.9%	87.9%	97.5%	87.1%
AMU	2325	2275	1550	1517.5	1953	1713	651	640.5	97.8%	97.9%	87.7%	98.4%
Ward A2	1426	1185	1269.4	1271	1069.5	1005.5	713	828	83.1%	100.1%	94.0%	116.1%
Ward A3	1448.5	1299	1621.5	1662.5	1058	1081	862.5	1058	89.7%	102.5%	102.2%	122.7%
Ward A4	1408	1145.5	1288	1129	1069.5	496.5	1426	621	81.4%	87.7%	46.4%	43.5%
Ward A8	1713.5	1381	2001	1660.5	1069.5	1081.5	1575.5	1115.5	80.6%	83.0%	101.1%	70.8%
Ward B12	1069.5	1012.5	1782.5	1967.5	713	724.5	1069.5	1269	94.7%	110.4%	101.6%	118.7%
Ward B14	1426	1267.5	1426	1239.7	713	713	713	713	88.9%	86.9%	100.0%	100.0%
Ward B18	1448.5	1299	1621.5	1662.5	1058	1081	862.5	1058	89.7%	102.5%	102.2%	122.7%
Ward A7	2081.5	1495	2047	1443	1725	1449	1690.5	1112.5	71.8%	70.5%	84.0%	65.8%
Ward C21	1069.5	1058	23	644	713	713	713	598	98.9%	90.3%	100.0%	83.9%
CCU	1782.5	1419	356.5	39.3	1069.5	1069.5	0	0	79.6%	11.0%	100.0%	-
ITU	4991	4709.3	1069.5	575	4991	4646	713	448.5	94.4%	53.8%	93.1%	62.9%

Warrington and Halton Hospitals NHS Foundation Trust

Appendix 2

	Day		Night		Mitigation
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
A5	82.8%	93.8%	98.9%	101.6%	Patient acuity and dependency frequently monitored and staffing resource moved to support and ensure patient safety
A6	69.0%	92.1%	96.8%	100%	Band 5 vacancies. On-going recruitment. 9 new starters over next 18 months. A5 supporting night duties. Acuity and dependency frequently monitored with escalation to senior clinical staff.
B4	96.8%	73.4%	97.1%	94%	Ward will flex staffing levels according to acuity of patients.
A9	68.2%	77.9%	88.2%	90.3%	Band 5 vacancies. On-going recruitment. 4 new starters over next 18 months. Ward assisted by Trauma nurse specialist.
B19	75.8%	82.4%	100%	100%	Winter Ward. Ward escalated by 2 patients throughout March 17.Staffing/acuity reviewed daily by Matron
CMTC	83.4%	97.6%	95.2%	91.3%	Higher levels of admissions during the day which reduces overnight as day case patients are discharged.
B11	95.6%	124.4%	96.8%	41.7%	Care staff utilised to support operational pressure. Low care staff at night related to operating hours of assessment area.
NICU	88.6%	48.4%	76.2%	78.5%	Unit staffed flexibly according to acuity and dependency
C23	90.5%	71.4%	100%	80.4%	Care staff moved from other areas to support shortfalls depending on acuity and occupancy
Delivery Suite	93.9%	87.9%	97.5%	87.1%	Staff moved from other areas to support shortfalls

					depending on acuity and occupancy
A1	97.8%	97.9%	87.7%	98.4%	Band 4 Assistant Practitioners support ward care
A2	83.1%	100.1%	94.0%	116.1%	High acuity on the ward requiring enhanced care, increase of Care Staff on shifts. Interviews in progress for additional RNs.
A3	89.7%	102.5%	102.2%	122.7%	Increased requirement for enhance/1:1 care
A4	81.4%	87.7%	46.4%	43.5%	Ward escalated by 8 beds. Increase in month of enhanced care.
A8	80.6%	83.0%	101.1%	70.8%	Additional staffing requested as per chief nurse plan, enhanced monitoring in place.
B14	88.9%	86.9%	100.0%	100.0%	Staffing resource reallocated to support the ward
B18	89.7%	102.5%	102.2%	122.7%	Staffing resource reallocated to support the ward
A7	71.8%	70.5%	84.0%	65.8%	Staffing resource reallocated to support the ward
C21	98.9%	90.3%	100.0%	83.9%	Staffing resource reallocated to support the ward
CCU	79.6%	11.0%	100.0%	-	Staffing resource reallocated to support the ward
ITU	94.4%	53.8%	93.1%	62.9%	ICU Occupancy 85% for March 2017. Carer recruitment pending.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/43 (b)**
SUBJECT:	**Safe Staffing Assurance Report**
DATE OF MEETING:	26 April 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 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
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 nurse staffing levels falls below 90% of those that are planned.
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**: Not Applicable **Agenda Ref.**: **Date of meeting**: **Summary of Outcome**:
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

Safe Staffing Assurance Report

Introduction

The purpose of this paper is to transparently report the nursing and midwifery ward staffing levels across the Trust during March 2017 providing assurance that any shortfalls on each shift were addressed with mitigating actions. All Trusts have a requirement to submit staffing data to NHS England via the Unify Safe Staffing return along with providing 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.

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

Overall fill rates across the trust were:

	RN	CARE STAFF
Day	87.7%	91.5%
Night	92.7%	88.3%

Individual ward area fill rates that fell below 90% are identified by yellow highlight at appendix 1. Each area now utilises the escalation protocol previously provided to the Board of Directors to ensure mitigation of risk. Assurance is provided by the Divisional Senior Nursing teams for areas that fall below the required 90% standard with consistent daily review and support from Divisional Matrons and Lead Nurses.

During March some areas across the Trust cared for additional patients as part of our escalation processes and staffing resources were moved accordingly or additional staff requested to support these areas. Recruitment to those wards with vacancies has been on-going with a number of new recruits planned to start over the next eighteen months. In collaboration with the senior nursing teams some areas have increased head counts utilising care staff to ensure safe, quality care delivery continues.

Appendix 2 identifies mitigation where actual fell below planned.

Conclusion

This report provides evidence of the actions taken to provide adequate staffing levels across all wards.

Appendix 1

Ward name	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	Day Average fill rate RN (%)	Day average fill rate Care Staff (%)	Night Average fill rate RN (%)	Night average fill rate Care Staff (%)
SAU	930	930	607.5	697.5	0	0	0	0	100.0%	114.8%	-	-
Ward A5	1690.5	1399	1242	1165	1069.5	1058	713	724.5	82.8%	93.8%	98.9%	101.6%
Ward A6	2047	1412	1242	1144.5	1069.5	1035	713	713	69.0%	92.1%	96.8%	100.0%
Ward C22	1069.5	985	1069.5	892.5	713	713	713	713	92.1%	83.5%	100.0%	100.0%
Ward B4 - Halton	728	705	483	354.5	256	248.5	264.5	248.5	96.8%	73.4%	97.1%	94.0%
Ward A9	1782.5	1215	1426	1110.5	1069.5	943	713	644	68.2%	77.9%	88.2%	90.3%
Ward B19	1069.5	811	1069.5	881	713	713	713	713	75.8%	82.4%	100.0%	100.0%
CMTC	1598.5	1332.5	977.5	954	713	678.5	713	651	83.4%	97.6%	95.2%	91.3%
Ward B11	2014.7	1925.7	1020	1268.5	1580.5	1529.2	124.8	52	95.6%	124.4%	96.8%	41.7%
Neonatal Unit	1782.5	1578.5	356.5	172.5	1782.5	1358	356.5	280	88.6%	48.4%	76.2%	78.5%
Ward C20	977.5	1033.5	655.5	674	644	644	0	0	105.7%	102.8%	100.0%	-
Ward C23	1288	1166	644	460	644	644	644	517.5	90.5%	71.4%	100.0%	80.4%
Delivery Suite	2495.5	2344	356.5	313.5	2495.5	2432.5	356.5	310.5	93.9%	87.9%	97.5%	87.1%
AMU	2325	2275	1550	1517.5	1953	1713	651	640.5	97.8%	97.9%	87.7%	98.4%
Ward A2	1426	1185	1269.4	1271	1069.5	1005.5	713	828	83.1%	100.1%	94.0%	116.1%
Ward A3	1448.5	1299	1621.5	1662.5	1058	1081	862.5	1058	89.7%	102.5%	102.2%	122.7%
Ward A4	1408	1145.5	1288	1129	1069.5	496.5	1426	621	81.4%	87.7%	46.4%	43.5%
Ward A8	1713.5	1381	2001	1660.5	1069.5	1081.5	1575.5	1115.5	80.6%	83.0%	101.1%	70.8%
Ward B12	1069.5	1012.5	1782.5	1967.5	713	724.5	1069.5	1269	94.7%	110.4%	101.6%	118.7%
Ward B14	1426	1267.5	1426	1239.7	713	713	713	713	88.9%	86.9%	100.0%	100.0%
Ward B18	1448.5	1299	1621.5	1662.5	1058	1081	862.5	1058	89.7%	102.5%	102.2%	122.7%
Ward A7	2081.5	1495	2047	1443	1725	1449	1690.5	1112.5	71.8%	70.5%	84.0%	65.8%
Ward C21	1069.5	1058	23	644	713	713	713	598	98.9%	90.3%	100.0%	83.9%
CCU	1782.5	1419	356.5	39.3	1069.5	1069.5	0	0	79.6%	11.0%	100.0%	-
ITU	4991	4709.3	1069.5	575	4991	4646	713	448.5	94.4%	53.8%	93.1%	62.9%

Appendix 2

	Day		Night		Mitigation
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
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ITU	94.4%	53.8%	93.1%	62.9%	ICU Occupancy 85% for March 2017. Carer recruitment pending.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/43c**
SUBJECT:	**Annual Engagement Dashboard 2016-17**
DATE OF MEETING:	Choose an item. 26th April 2017
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Pat McLaren
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.4: Engaging & Involving Workforce
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The Trust is required to engage with its patients, public, staff and partners and many other stakeholders as set out in the Foundation Trust's membership and engagement strategy.
EXECUTIVE SUMMARY (KEY ISSUES):	This annual report provides a high-level overview of how well the Trust is engaging and involving key stakeholder groups i.e. those who use, work, visit, volunteer, support, commission, partner or donate to our hospitals. It shows clear trends and progress against our key communication and engagement objectives. Key items to note: a. Positive media coverage outweighs negative by more than 2:1 b. The Warrington Guardian continues to be the main publisher of WHH news with online reporting being the dominant medium c. While average 'likes' remain relatively static (circa 4K) per story reach has increases sharply where sharing and re-posting has considerably exceeded expectations d. Twitter followers continue to climb and in year our Twitter community has increased by 15% e. Twitter reach is highly variable and predominately linked to traditional media reporting f. Website engagement has risen steadily in year with 172K visitors but dwell time remains static at 1.31mins. We recognise that this is due to the templated build of

<table>
<tr><td></td><td colspan="2">our existing site which is not mobile enabled and therefore visitors move on quickly
g. Almost two thirds of our website visitors arrived via mobile device (smart phone or tablet) Recognising this, a new mobile-friendly website is being commissioned for 2017-18
h. Good progress has been made in engaging staff through Team Brief, particularly at the Warrington site, where 'Core Brief' is a proven large-organisation information cascade tool.
i. Overall staff engagement score, as reported in the NHS Staff Survey, was virtually static on 2015.
j. In terms of patient engagement we continue to evaluate the NHS Choices overall 'Star' rating for the Trust recognising that the ratings are assigned on extremely small numbers. We continue to work with the Patient Experience team to boost feedback and gain deeper insight into how our patients rate their WHH experience.

This is our first year of evaluation of stakeholder engagement in this broader format but provides an excellent platform for stretch target setting and will inform the review and refreshing of our Membership and Engagement Strategy for 2017-20 in partnership with our Governors.</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="2">The Board is asked to note this first annual engagement report for 2016-17</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td>Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td></td></tr>
<tr><td>Date of meeting</td><td></td></tr>
<tr><td>Summary of Outcome</td><td></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="2">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="2">Choose an item.</td></tr>
</table>

We are
WHH

NHS
Warrington and
Halton Hospitals
NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust

Annual Engagement Report
April 2016 – March 2017

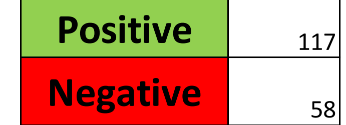
Media Dashboard 2016-2017

We are
WHH

Top Sources

0%

Source	Share
Warrington Guardian (eClips Web)	35.81%
Warrington Guardian	22.17%
Runcorn and Widnes World	10.20%
Runcorn and Widnes World (eClips Web)	8.53%
Liverpool Echo (eClips Web)	5.29%
InsideHalton.com	4.82%



Positive	117
Negative	58

Social Media Dashboard 2016-2017

FACEBOOK ENGAGEMENT 2016-17

Total Likes — Reach

Left axis: 0, 5,000, 10,000, 15,000, 20,000, 25,000, 30,000, 35,000, 40,000, 45,000

Right axis: 0, 500, 1,000, 1,500, 2,000, 2,500, 3,000, 3,500, 4,000, 4,500

APR MAY JUN JUL AUG SEPT OCT NOV DEC JAN FEB MAR

Total posts in year: 203

Social Media Dashboard 2016-2017

Twitter Engagement 2016-17

8,400
8,200
8,000
7,800
7,600
7,400
7,200
7,000
6,800
6,600
6,400
6,200

200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0

Apr May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar

Followers Reach

Warrington&Halton...
@WHHNHS

TWEETS	FOLLOWING	FOLLOWERS
4,271	303	8,196

Total Tweets in year: 742

Website Dashboard 2016-2017

We are WHH

We are WHH and together we make a difference

Warrington and Halton Hospitals NHS Foundation Trust

Home | About us | Patients & visitors | Services | Work at WHH | Contact us | Charity | GPs | Volunteer

Website Engagement 2016-17

Left axis: 30,000 25,000 20,000 15,000 10,000 5,000 0

Right axis: 2500 2000 1500 1000 500 0

Apr May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar

Visits — Social Media Referrals

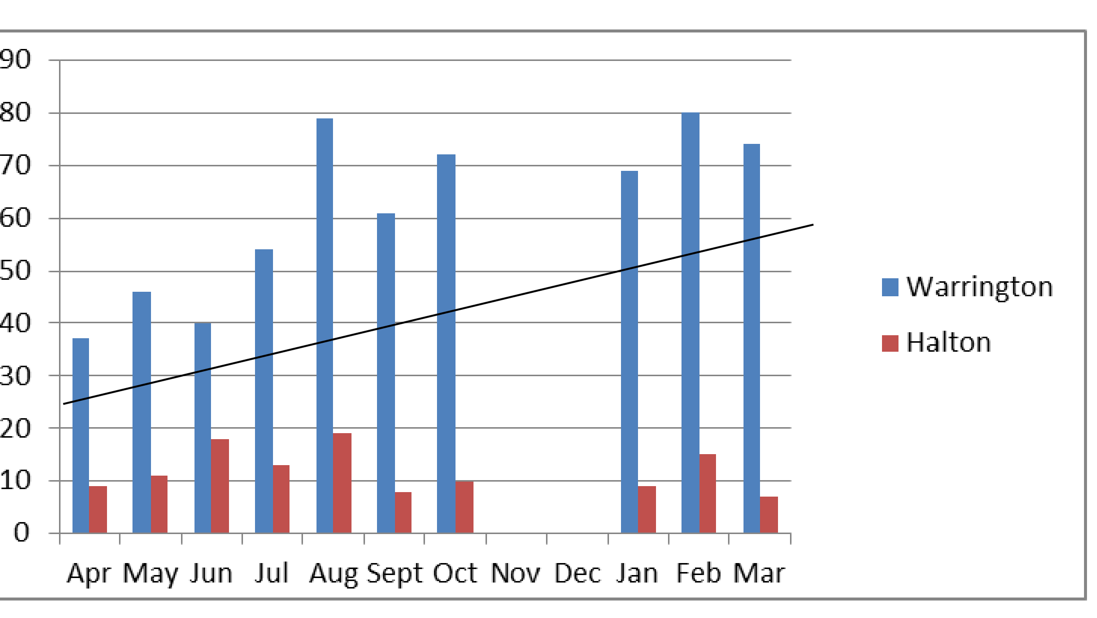
Mobile Device Info	Sessions	% New Sessions
	160,782 % of Total: 63.39% (253,648)	59.86% Avg for View: 64.77% (-7.58%)
1. Apple iPhone	67,361 (41.90%)	60.78%
2. Apple iPad	26,857 (16.70%)	60.65%
3. Samsung SM-G920F Galaxy S6	6,304 (3.92%)	54.92%
4. (not set)	5,160 (3.21%)	54.90%
5. Samsung SM-G900F Galaxy S5	3,646 (2.27%)	53.43%
6. Samsung SM-G925F Galaxy S6 Edge	2,949 (1.83%)	53.14%
7. Samsung SM-G935F Galaxy S7 Edge	2,850 (1.77%)	57.16%
8. Samsung SM-G930F Galaxy S7	2,649 (1.65%)	57.57%
9. Samsung SM-J500FN Galaxy J5	1,553 (0.97%)	59.37%
10. Samsung SM-A300FU Galaxy A3	1,492 (0.93%)	56.23%

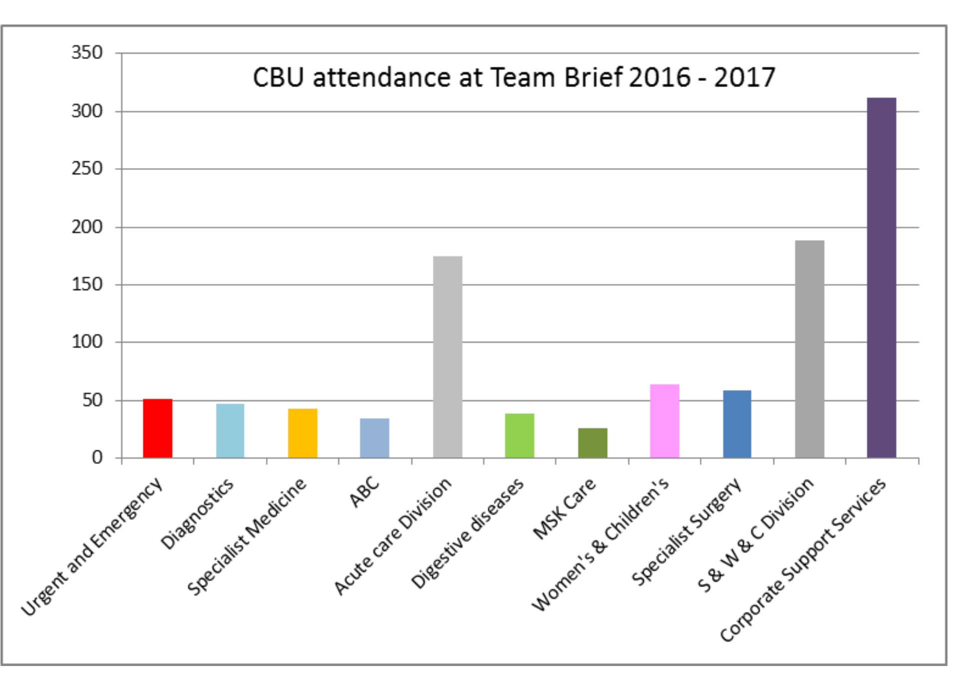
Device Category	Sessions	% New Sessions
	253,648 % of Total: 100.00% (253,648)	64.79% Avg for View: 64.77% (0.03%)
1. mobile	123,745 (48.79%)	59.89%
2. desktop	92,866 (36.61%)	73.32%
3. tablet	37,037 (14.60%)	59.76%

Total users 171,974, Total sessions in year: 258,587
Average dwell time 1.31min

Staff Engagement Dashboard 2016-2017

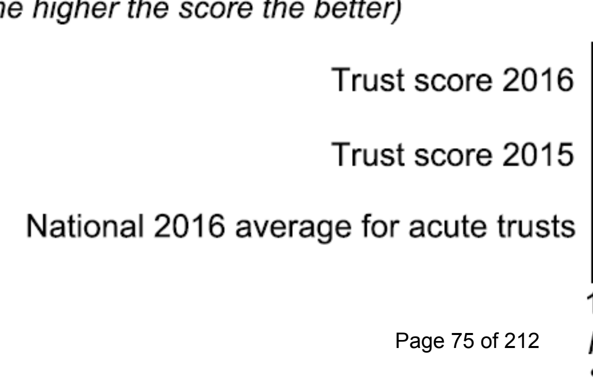
We are WHH

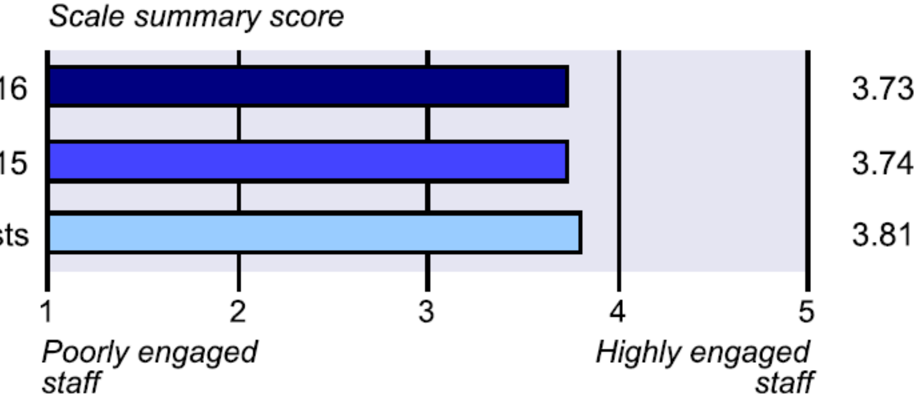




OVERALL STAFF ENGAGEMENT

(the higher the score the better)





NHS Staff Survey 2016

The trust's score of 3.73 was below (worse than) average when compared with trusts of a similar type

Patient Engagement/ Experience Dashboard 2016-2017

We are WHH

Average Rating by NHS Choices

3.5 Average rating at Warrington

Last month: 3

5 Average rating at Halton

Last month: 5

4.5 Average rating at CMTC

Last month: 4.5

Category	Stars	Ratings
Cleanliness	★★★★	19 ratings
Environment	★★★★	24 ratings
Information	★★★★	23 ratings
Involved	★★★	42 ratings
Listening	★★★★	24 ratings
Medical	★★★	19 ratings
Nursing	★★★★	17 ratings
Parking	★★★	19 ratings
Respect	★★★	42 ratings
Timeliness	★★★	42 ratings

iWantGreatCare

	Star Rating 2014/15	Star Rating 2015/16	Star Rating 2016/17
Apr	4.54	4.61	4.73
May	4.5	4.66	4.77
Jun	4.58	4.70	4.75
Jul	4.53	4.66	4.78
Aug	4.6	4.65	4.73
Sept	4.59	4.72	4.79
Oct	4.6	4.71	4.78
Nov	4.6	4.70	4.76
Dec	4.59	4.73	4.77
Jan	4.59	4.72	4.81
Feb	4.55	4.67	
Mar	4.61	4.69	

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/43 (d)**	
SUBJECT:	**Key Issues Report from the Quality Committee 4 April 2017**	
DATE OF MEETING:	26 April 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 theApril meeting.	
RECOMMENDATION:	**The Board notes the report and the issues for escalation. These include matters concerning, SI investigations, Falls and DNACPR,**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
QUALITY COMMITTEE

Date of meeting:	**4th April 2017**
Standing Agenda Items	Quality Dashboard Trust Strategic Risk Register and Board Assurance Framework
Formal Business	**Quality Account – proposed Quality Indicators** A paper was presented by Ursula Martin, Deputy Director of Integrated Governance and Quality and Kimberley Salmon-Jamieson, Chief Nurse setting out the timeframes for the 2016/17 Quality Account and proposed Quality Indicators for 2017/18. The Trust has 3 improvement priorities that are set out in the Quality Strategy and the nine proposed quality indicators have been aligned to support these. In summary, the Improvement Priorities are, to reduce harm and focus on having no avoidable deaths, to improve outcomes, and to focus on the patient and their experience. The proposed quality Indicators are: Safer Surgery, Falls and Sepsis to support Priority 1 Safe discharge, Mortality and Lessons Learned to support Priority 2 Mental Health patients in A&E, PALs and Complaints, and the roll out of the Patient Experience Strategy to support Priority 3. **The Committee approved the 9 Quality Indicators.** **Serous Incident Report and Falls Cluster Analysis** The SI Report presented the updated number of SIs to reflect the full year position. An apparent significant rise was due to the inclusion of a number of previously unreported SIs which relate to harm occurring following a fall. These had not been included previously, as they had been downgraded as unavoidable. The incident figures for falls now show 12 fractured necks of femur, three deaths and 1 fractured zygoma. In addition, 2 surgical Never Events occurred in March, 17 SI investigations are currently open and there are a significant number of outstanding actions from completed investigations, which have not been closed off. **While acknowledging the progress that has been made, full assurance was not provided and therefore the Committee is escalating to the Board.** A more detailed cluster analysis of falls was presented by John Goodenough, Deputy Nurse. The report concluded that improvement is required in a number of areas which include, improvement in falls risk assessments, the need for greater accuracy and timeliness of incident reporting, improved Root Cause Analysis and greater consistency of completion of duty of candour. A number of recommendations were made and an action plan is in place.

	The Committee remain unassured regarding the mitigations currently in place while acknowledging the work in progress. **This concern is escalated to the Board and will be continue to be closely monitored by the Quality Committee.** **DNACPR – action plan update** Dr James Wallace and Louise Simpson presented the update on the recommendations and actions following the MIAA audit on DNACPR. There were 5 key recommendations that included education and training, in particular, mandatory training, and the recording of discussions and decision-making. Although progress has clearly been made, especially regarding governance arrangements, an audit of DNACPR decision-making and documentation did not provide full assurance. The Resuscitation Group has met and the terms of reference for the Group have been reviewed and updated. The line of accountability is via the Acute Care Group to the Patent Safety and Clinical Effectiveness Committee. There is clearly work still to be done and because of the **lack of assurance around the decision-making processes and documentation the issue is escalated to the Board.** **National In-patient Survey** The results for 2016 were disappointing when compared to 2015. The Trust's response rate was 40% compared to 44% in 2015. Improvement was shown on 8 questions. On 18 questions the Trust has worsened by 5% or more. The Trust was significantly better than the national average on the question about leaving hospital but was within the lowest 20% of Trusts for a further 32 questions. The new Patient Experience Strategy will align work streams that will address the main themes highlighted in the survey. An update report will be presented to the Quality Committee in 6 months. The Patient Experience Committee will provide oversight. The Committee received the **Infection Control Sub Committee High Level Briefing Paper** and an exception report reviewing the outbreak of C. Difficile on ward A8. The Committee was assured that that an action plan is in place and is being monitored via the Infection Control Committee and Specialist Medicine. **An update on the Lorenzo Patient Letter incident** was provided by Jan Ross, Deputy Chief Operating Officer. This is issue is now largely resolved. It has not been possible to make contact with 12 patients and communication in writing has been sent both to them and to their GPs. 42 out of 119 deceased patients were identified as not having received an appointment letter and these cases are being reviewed to identify if any harm has been caused. The incident is being investigated as a SUI and the CCG are being kept informed. The Committee was assured that actions are in place to mitigate further risk. **The Committee received the quarterly Quality Impact Assessment**

	Monitoring Report. This report provides a more formal process for updating the Quality Committee on quality risks associated with the organisation's transformation programme. The report for this quarter included a post-implementation review of the Trauma and Orthopaedics Redesign Scheme. The first formal update to the Committee will be presented in July with the summary of quality risks in relation to quarter 1 of the financial year and the 2017/18 transformation programme. **Complaints Review Status Report** The Committee received the report and the update on the on-going status of all complaints in progress. The Committee supported the proposal to use Datix for recording and the close down of the stand-alone dashboards. The Committee approved the ToR for the Complaints Quality Assurance Group and noted that the Chairman of the Trust will chair the Group for the initial 12 months. The Committee noted the significant amount of work that had taken place to review the backlog and develop SOPs to support the on-going work to clear the backlog. The Committee received the **Bilateral Briefing Papers from the Acute Care and the Surgery, Women's and Children Divisions**. This is a new addition to the Committee papers and was welcomed as providing oversight of the quality agenda from Board to Ward. **Trust Strategic Risk Register and Board Assurance Framework** The Committee considered the addition of a new risk to the strategic risk register regarding the failure to comply with thromboprophylaxis risk assessments and follow-up investigations. Residual risk rating is assessed as 12. The Committee supported the addition of VTE to the Risk Register. Updates were received on, A&E, Cancer, Falls, Complaints Handling, Safeguarding and Corporate Governance (Duty of Candour). The Committee will continue to receive monthly reports with a quarterly report which will go to Board.
Local Policies and Guidance Approved:	**Maternity Strategy received and endorsed**
Any Learning and Improvement identified from within the meeting:	None.
Any other relevant items the Committee wishes to escalate?	None.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 17/04/43 (e)**
SUBJECT:	**Key Issues Report from the Finance and Sustainability Committee held 19 April 2017**
DATE OF MEETING:	26 April 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 April 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	

KEY ISSUES REPORT - FINANCE and SUSTAINABILITY COMMITTEE

Date of meeting:	19 April 2017
Standing Agenda Items	The Meeting was quorate The Minutes of the F&SC Meeting held on 22 March were accepted as a true record, subject to a small number of amendments.
Formal Business	• The Medical Director together with the Deputy Chief Nurse attended the Meeting to assist the Interim Director of HR & OD with the presentation of the Agenda Item *"Pay Assurance together with the NHSI Checklist, Agency Spend". • Pay, the use of Agency Staff and Interims continues to be subject to increasing oversight by NHSI. Added to this there is the impact of IR35, which has been driving some evidence of change in behaviour. As far as we are concerned, the impact is still being assessed, be there have been some exits most notably in IT. • F&SC continues to receive a Pay Assurance Dashboard. For Medical and Dental staff the trajectory continues to show an upward trend for expenditure but a reduction for cap breaches. The increase in expenditure is concerning but the overwhelming reason is directly related to vacancies. • In respect of Nursing and Midwifery staff, whilst the cap breaches are showing a downward trend, expenditure is showing an upward trend; the scale of vacancies together with staff sickness levels are the two main contributory factors. There are a whole series of actions in place including retention and recruitment, albeit that some of the impacts will not all be felt until later this year. In respect of "Other Staff" there is a flatter trend. • Total Agency spend (including locums) for 2016/17 was £11.7m against the Agency Cap of £10m. • The Pay Spend and Review Group held its` inaugural Meeting on 5 April. As the Minutes of that Meeting highlight, there is much to do across the Trust, which will be subject to the joint oversight of both F&SC and SPC. • The Finance Report at Month 12 & hence the year end was received. There are elements of the Report that remain "Draft" due to year end issues, but the team are confident that there should not be any material adjustments necessary. Year end settlements have been agreed with our main local Commissioners. • The outcome at this stage is very positive for the Trust albeit tempered by the fact we are still in a lossmaking situation (as indeed are the bulk of Acute Providers) • The M12 outturn was crucial to our year end position and we brought in a performance that was needed & together with a number of year end adjustments, the deficit has been reduced to £7.4m which after adjustments is £700k better than plan. • We have an agreement with NHSI that we will be entitled to further STF (we have assumed receipt of the full £8m due for 2016/17) which subject to a technical adjustment should produce the sum of £800k, to reduce our deficit plus a further share of any residual STF that might be available. We expect to receive advise of our position on 24 April. These funds are not available for "Spending" though we

	will need to reflect on our best application of this additional STF funds. • Capital Expenditure has come in at £5.0m against the original Plan of £6.7m & the amended Plan of £5.2m. • Turning to the Transformation Programme, against the revised CIP Target of £10.7m, the Trust has delivered £8.623m CIP, £2.550m cost avoidance & income recovery and £1.793m cost improvement through enhanced controls, giving a total impact on the bottom line of £12.996m. • For 2017/18 the plan shared with NHSI assumes delivery of £10.5m CIP. There are 543 individual saving ideas recorded on the tracker. 408 of these ideas have an estimated benefit recorded against them to a total of £3.97m. New year, new immediate challenges................. • F&SC received the monthly IM&T update & a presentation around the Warrington Care Record Project. • A further presentation was received on the Benefits realised in 2016/17 against the Lorenzo Business Case together with those forecast to be achieved in 2017/18 & beyond. • The Deputy COO presented the Corporate Performance Report for Month 12 and hence the year end. After what can only be described as a mammoth effort, the Trust was to report that against the 4 hour A&E trajectory of 90% agreed with NHSI, a performance for the year of 90.60% has been achieved. • The Committee paused to reflect on this achievement given that the trajectory had not been met for the Months of December, January and February. • The team are working on more sustainable schemes to secure this years` trajectories given all Trusts have been given a target rising over Summer and Autumn and culminating in a Target for March 2018 of 95%. • F&SC debated NHSE interventions in respect of GP/Primary care streaming, co-located within EDs. Whilst in Warrington this is off site, we have submitted a bid to secure capital investment to support co-location. • The Winter Months have seen a deterioration in Ambulance Handover times. • Subject to validation 18 week RTT target has been achieved as has the Diagnostic target for March. • The 62 day wait for first cancer treatment was not met in February due to a number of reasons; the March position will not be confirmed until 4 May; clearly the position needs appropriate oversight of the action plan. Further year end positions will also not be validated until May. • Delayed Transfers of Care continue to feature. • The Committee received the Minutes of the Meeting of the Outpatients Turnround Board of 22 March & following the April Meeting prior to this F&SC received an update in respect the delayed Appointments following the Lorenzo Outpatients Letters issue.

	• The Deputy Director of Finance presented the Performance Assurance Framework which has been established which sets out Board to Ward accountability. F&SC was pleased to review the Framework & its` launch. • Finally the Committee received the Annual 2016/17 F&SC Report to the Board. • There are very clear strong performances across the Trust as highlighted above which a very worthy of celebration (albeit, we have started all over again)
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
20 April 2017

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/43 f**
SUBJECT:	**Update Report from Chair of Strategic People Committee**
DATE OF MEETING:	Strategic People Committee was cancelled 18 April 2017 to enable the NED Chair of the committee and the Director of HR & OD (Interim) to review the workplan for the committee and agree actions to take this work forward. A non-quorate Scrutiny meeting was held on 19 April 2017 between Chair of Committee and Director of HR & OD (Interim)
ACTION REQUIRED:	For Assurance
AUTHOR(S):	Anita Wainwright, Committee Chair
DIRECTOR SPONSOR:	
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMWORK(BAFf):	BAF 1.1: 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.
	BAF 2.1: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
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (*if relevant*)	None
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an update on issues raised at an non-quorate Scrutiny meeting held between the Committee Chair and the Director of HR & OD (Interim) on 19 April 2017
RECOMMENDATIONS:	To note the report content.
PREVIOUSLY CONSIDERED BY:	Committee: Not Applicable Agenda Ref.: Date of meeting: Summary of Outcome:

UPDATE REPORT FROM CHAIR OF STRATEGIC PEOPLE COMMITTEE

1. Introduction

1.1 The Strategic People Committee meets bi-monthly to provide assurance to the Board on the people agenda for the Trust.

1.2 During March 2017, an interim Director of HR & OD was appointed.

1.3 The Chair of Committee cancelled the meeting in order to have a dedicated meeting with the Interim Director of HR & OD in order to discuss the workplan for the committee and agree priority areas of action.

1.4 The purpose of this update report is to provide assurance to the Board that the Strategic People Committee has a 2017/18 work plan agreed with a number of actions to strengthen the Trusts response to the People Strategy and the recently published Five Year Forward Review – Strengthening Our Workforce.

2. Update Issues

2.1 Our People Strategy

The People Strategy was endorsed by the Strategic People Committee in December 2016. A draft People Strategy – Plan on a Page (appendix 1) has now been developed. The intention is to align the People Key Performance Indicators to the Plan on a Page and report this through the Committee.
Five workplans will be developed from the Plan on a Page to be managed and reported on through the Operational People Committee.

A revised Key Performance Indicators (KPI) Dashboard will be tabled at the Strategic People Committee in June 2017 for sign off. This will report on Trust and Divisional performance.

A revised Key Performance Indicators (KPI) Dashboard will also be developed for the Operational People Committee and will be tabled for sign off. This will report on Trust, Divisional and CBU performance.

2.2 Terms of Reference

The Terms of Reference for the Strategic People Committee and Operational People Committee will be reviewed, including purpose of the groups and how they relate to each other and membership.

2.3 Staff Opinion Survey

The results of the Staff Opinion Survey were discussed. These have previously been presented to the Executive Team Meeting. The results to be presented to Trust Board (April 2017).

2.4 Trade Union Act 2016

Trade Union Act 2016 (came into force on 1 March 2017).

A series of modernising reforms are being introduced to ensure strikes can only go ahead as a result of a clear and positive democratic mandate from union members. It will ensure industrial action only ever goes ahead when there has been a ballot turnout of at least 50 per cent.

The main provisions of the act are:

- Increasing to 50 per cent the voting threshold for union ballots turnouts (while retaining the requirement for there to be a simple majority of votes in favour of industrial action).

- Introducing an additional requirement that 40 per cent of all those entitled to vote in the ballot must vote in favour of industrial action in certain public services such as health, education, fire and transport. The following health services are deemed to be important public services:
    - Ambulance service.
    - Accident and emergency in a hospital.
    - Services which are provided in high-dependency units and intensive care in a hospital.
    - Psychiatric services provided in a hospital for conditions which require immediate attention in order to prevent serious injury, serious illness or loss of life.
    - Obstetric and midwifery services provided in a hospital for conditions which require immediate attention in order to prevent serious injury, serious illness or loss of life.

- Requiring a description of the trade dispute on the voting paper and providing information to union members about the results of the ballot.
- Introducing measures for unions supervision of picketing.

- Introducing changes to the role of the certification officer allowing enforcement powers in relation to reporting requirements on and industrial action and political fund expenditure.
- Introducing a 12 month transition period for the new members to opt into the political fund element of trade unions subscriptions.

- Increase the amount of notice of a strike to be given to an employer to 14 days (two weeks).
- Restricting the mandate for industrial action post ballot to 6 months.

The government has decided to retain the check-off arrangements and agreed in principle to amend this proposal to allow the check-off system to remain where there is agreement with the employer to provide check-off and the union meets the administrative cost.

2.5 Facility Time Publication Requirements Regulations 2017 (came into force 1 April 2017)

Public sector employers who are caught by the Regulations are listed in Schedule 1 and include NHS bodies. In addition, employers must have at least one employee who is a relevant union official, namely a trade union official, a trade union learning representative or a safety representative in accordance with the Health and Safety at Work Act 1974.

If the “employee number condition” is met for the relevant period, the employer must provide the information set out in Schedule 2 of the Regulations. The relevant period will run for 12 months from 1 April each year, with the first relevant period commencing 1 April 2017.

The employee number condition is met if the employer has more than 49 full-time equivalent employees for any seven months in the relevant period.

What information must be published? The information must be set out in tables as laid down in Schedule 2 of the Regulations, and published before **31 July** following the end of the relevant period.

The tables must include the following information:

- Table 1: The number of employees who were relevant union officials during the relevant period, and the number of full-time equivalent employees.
- Table 2: Percentage of time spent on facility time for each relevant union official.
- Table 3: Percentage of pay bill spent on facility time.
- Table 4: Number of hours spent by relevant union officials on paid trade union activities as a percentage of total paid facility time hours.

For these purposes, facility time is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

The Associate Director of HR has been tasked with pulling together the 2016/17 time off for union activities for all union and professional groups – medical and non-medical. An email was sent to the BMA full time office and the WHH Staff Side chair on 13 April 2017 providing an overview of the publishing requirements and indicating that they will be contacted in due course to confirm and validate information prior to publishing.

What next? The Regulations also grant the power for the Government to make further regulations exercising “reserve powers”, after a three year lead-in period and where it is appropriate to do so. Such further regulations would enable employers to cap the paid time off taken for facility time as a percentage of the employer’s total pay bill. It is anticipated that the cap will only be used as a last resort if publication of the figures does not lead to the required efficiency savings and deliver value for money for the taxpayer.

3. Recommendations

3.1 Trust Board are asked to note the content of the report.

Appendix 1:

WHH People Strategy 2016 – 2019
Plan on a page (DRAFT V5)

Our People Pledge	**To have in place a workforce which is fit for the future and is able to meet the challenges of a changing health and social care landscape**

Our commitment and expectations of WHH workforce

W E A R E

Our leaders will;

Support the delivery of our services efficiently and always aim to give our staff the resources they need to do a good job

Care for and support colleagues to maintain their health, wellbeing and safety

Ensure our colleagues feel listened to and act on feedback

Listen to our colleague's concerns and value their ideas

Ensure visible, accessible leadership

Recognise our colleagues hard work and performance

Listen, engage and involve our colleagues in decisions affecting their role

Our workforce will;

Provide honest feedback on how WHH can improve

Take care of your own health, wellbeing and safety

Raise issues, concerns regularly

Always act in the patient/service user's best interest

Engage with learning and development opportunities to ensure you learn and grow

Be efficient, flexible and professional

Believe in yourself

Our Strategic Principles
Our Aims
Our Key Priorities

Engage

Creating a progressive, collaborative and healthy working environment, that is conducive and beneficial to both staff and patient experience

Promote and support the development of a healthy workplace where staff feel valued

Empower our colleagues to realise their full potential. Promote collaborative working to enable a culture of shared, compassionate collective leadership

Create opportunities for working together across internal and external boundaries

Create a culture where we are supportive of innovative roles

Adopt a strength based approach to support our colleagues to grow and build resilience

Respond to internal and external feedback to ensure that our workforce would recommend WHH as a place to work and receive care

Embed equality, inclusion and diversity as fundamental principles in all activities effecting current and future workforce

Communicate, involve, participate and engage with our workforce using appropriate methods

Work in partnership with our colleagues, staff side, professional organisations, regulatory bodies and key stakeholders to enable a workforce fit for the future.

Embed and develop the Trusts 'We Are' behaviours and the People Pledges across the organisation

Attract	Retain	Develop
Attracting and recruiting the best staff is crucial to the future sustainability and success of our organisation. We must recruit the highest quality employees that align to our culture and workforce plans.	We want to create an environment in which our staff can see (and are rewarded for) an alignment between their overall contribution and the quality of patient care delivered.	WHH is committed to developing a culture of lifelong learning to support patient safety and quality care delivery
• Become an employer of choice. • Develop a unique, flexible WHH offer, utilising multiple platforms to attract the best talent to the organisation • Ensure our offer reflects and is responsive to 'difficult to recruit' (DTR) posts • Utilise multiple platforms to attract the best talent to the organisation using innovative recruitment and retention initiatives for all staff groups • Maximise our workforce intelligence to fully understand our workforce profile to inform workforce planning • Promote 'Grow your Own' initiatives with the local community to understand the potential future workforce • Maximise utilisation of the apprenticeship levy to support the development of our workforce • Realise the added value of our volunteers, third sector organisations and the armed forces • Develop our onboarding approach to enhance the induction and support of new staff • Work in partnership with our managers to strengthen and streamline our recruitment processes	• Further develop the WHH Reward, Recognition and Retention Package that is flexible and equitable for all colleagues • Ensure flexible working opportunities for staff including flexible retirement • Empower our colleagues to access opportunities and ensure they have the right competence, the right skills and knowledge to deliver the best service • Capture and share our success stories, recognising our WHH role models and sharing this learning through promoting achievements and awards • Enhance and develop our 'Fit to Care' programme ensuring it is reviewed annually to best meet the needs of the organisation • Build our talent management processes to provide opportunities for staff who demonstrate the aptitude to progress • Develop a planned and systemic approach to succession planning and capacity building • Promote integrated and inclusive approaches to personal and professional development through a structured PRD / Appraisal process • Create opportunities for our workforce to gain experience of the wider health economy	• Support a culture of workforce transformation • Establish a workforce planning framework by utilising WRaPT (Workforce Repository and Planning Tool) and population centric approaches • Develop and evaluate the impact of new roles and new ways of working • Source funding streams and collaborative working opportunities across the Local Delivery System (LDS) • Understand regulatory framework and the potential impact on our workforce/services • Provide assurance of our Educational activity through the Education Governance framework • Proactively identify training needs to respond to changes in the local health and social care economy • Realise the potential of our volunteers to enhance service delivery • Upskill our workforce to support them to work in a digitally enabled environment • Support evidence based decision making • Promote sharing of best practice across CBUs • Enrich and strengthen our workforce through 'Grow your Own' initiatives • Support the introduction and development of a Quality Academy

Perform

Enable the delivery of high quality and safe healthcare

- Ensure timely, appropriate resolution of employee relations issues mirroring our 'WE ARE' behaviours
- Measure our organisational health through our People Measures
  -
- Realise our people measures in order to measure the Operational People Plan and implement the people strategy
- Review any fundamental changes made to our workforce with Quality Impact Assessments (QIA) to ensure the care we deliver is not effected
- Maximising the potential of ESR to develop an inclusive, in depth understanding of our workforce
- Ensure appropriate utilisation of temporary workforce within local and national guidance
- Deliver cost effective services which can demonstrate added value across the Local Delivery System (LDS)
- Maximise our medical workforce, improve productivity and modernise medical careers
- Support and monitor the transition of junior doctors on to the new contract
- Preparation for and implementation as appropriate the new consultant contract when published
- Embed systems that support revalidation across professional groups

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/44**
SUBJECT:	**Amendments to Integrated Performance Report (IPR) and the launch of the Performance Assurance Framework (PAF)**
DATE OF MEETING:	26 April 2017
ACTION REQUIRED	**Approval**
AUTHOR(S):	Jane Hurst, Deputy Director of Finance (Strategy)
EXECUTIVE DIRECTOR SPONSOR:	Andrea Chadwick, Director of Finance & Commercial Development Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO3: To deliver well managed, value for money, sustainable services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management
	BAF1.3: National & Local Mandatory, Operational Targets
	Choose an item.
STRATEGIC CONTEXT	Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	This paper is being presented to the Trust Board to seek approval for the amendments to Integrated Performance Report (IPR). Outlining the removal of 10, amendment of 10 and the addition of 11.
RECOMMENDATION:	The Trust Board is asked to approve the amendments to Integrated Performance Report (IPR) and note the launch of the Performance Assurance Framework (PAF)
PREVIOUSLY CONSIDERED BY:	**Committee**: Not Applicable **Agenda Ref.**: **Date of meeting**: **Summary of Outcome**:
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

BOARD OF DIRECTORS

SUBJECT	Amendments to Integrated Performance Report (IPR) and the launch of the Performance Assurance Framework (PAF)	AGENDA REF:	BM/17/04/44

1. BACKGROUND/CONTEXT

This paper is being presented to the Trust Board to note the launch of the Performance Assurance Framework (PAF) and to seek approval for the amendments to the Integrated Performance Report (IPR).

The current Integrated Performance Report includes 56 indicators across 4 main areas of Quality (19), Access and Performance (17), Workforce (12) and Finance (8).

2. KEY ELEMENTS

The Trust has have established a Performance Assurance Framework which sets out Ward to Board accountability (see Appendix A). It has been developed to provide clarity of accountability and responsibilities from Ward to Board, and to effectively manage and improve performance.

The framework has been reviewed by Internal Audit, Deloittes, Trust senior leaders, Board Committee chairs and the Executive Team.

Alongside the Performance Assurance Framework, the current Key Performance Indicators (KPIs) within the Integrated Performance Report have been reviewed with Non Executive and Executive Directors. This has resulted in:

The removal of some KPIs which no longer need to be monitored (Appendix B)
The amendment of some KPIs (Appendix C)
Additional KPI's for 2017/18 (Appendix D)

The Trust Board currently receives information on 56 KPIs each month. It is suggested that 10 are removed, 9 are amended and 11 are added.

The updated Integrated Performance Report KPI's provide 57 indicators for 2017/18 across 4 main areas of Quality 19, Access and Performance 17, Workforce 12 and Finance 9 (see Appendix E).

The KPIs have been checked against the Single Oversight Framework to ensure all metrics that should be reported are captured.

3. NEXT STEPS

The Performance Assurance Framework will be reviewed and refreshed at least annually and more frequently should new guidance / requirement necessitate it.

Further enhancement to the Integrated Performance Report will include:

- Forecast indicators
- Badges / Kite Marks
- 13 month rolling review
- Indicate alignment to Trust strategies
- Improve readability with hyperlinks

4. RECOMMENDATIONS

The Trust Board is asked to approve the amendments to the Integrated Performance Report and note the launch of the Performance Assurance Framework.

Appendix A – Performance Assurance Framework

Warrington and Halton Hospitals NHS Foundation Trust

Performance Assurance Framework

Performance Assurance Framework

1. Introduction

1.1. Background

This Performance Assurance Framework has been developed to provide clarity of accountability and responsibilities from Ward to Board, and to effectively manage and improve performance.

The Performance Assurance Framework will ensure that an integrated approach to managing performance is embedded throughout the Trust and there are clear lines of accountability from Board to Ward/all departments. The Board and other key stakeholders need to understand, monitor and assess the Trust's performance, and to identify appropriate action to be taken when performance deteriorates. Information must be timely, accurate and complete and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

1.2. Scope

The Performance Assurance Framework covers all performance requirements set out in the Trust's Operational Plan, NHS Improvement Single Oversight Framework, NHS Standard Contract and Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff makes to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust Performance Management Policy/Incremental Pay Progression Policy.

1.3. Dependencies

To continually develop the performance culture of the organisation through an increased use of broader business intelligence, including outcome measures which provide a wider insight beyond headline KPI's, delivery against the Performance Assurance Framework will be dependent upon the production of information dashboards and reports by the Trust's Information Team.

1.4 Associated Polices and Strategies

Whilst the Performance Assurance Framework incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures that will contribute to the delivery of this Performance Assurance Framework. The Performance Assurance Framework will support achievement of the Trust's vision, mission, objectives and values (see **Appendix 1**).

2. Role and Function of the Performance Assurance Framework

2.1. Main Purpose

This Performance Assurance Framework sets out the approach the Trust will take in ensuring there are effective systems in place to track and monitor performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate remedial actions put in place to bring performance back to an acceptable level. The Performance Assurance Framework will:

- Set out clear lines of accountability and responsibility for delivery of KPI's from Board to Ward/all departments.
- Provide assurance to the Board, governors, stakeholders and the public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Support the achievement of the Trust's objectives.
- Support the delivery of the requirements of the Trust's Foundation Trust Licence, NHS Improvement Single Oversight Framework and the NHS Standard Contract.
- Support the delivery of high quality patient care.
- Provide focus on and assurance of best value for money ensuring that services provided meet the needs of the local population and local health economy.
- Support the delivery of an engaged, motivated workforce with the right skills and numbers to provide consistent good quality care.

3. Approach to Performance Management in the Trust

3.1 Ward to Board Accountability Structure

The accountability structure provides a line of sight from ward to Board and Board to ward, as set out in **Appendix 2** and detailed as follows:

1) **CBUs/Wards/Departmental Meetings**
The CBUs/Wards/Departments will receive monthly performance information to enable them to monitor performance and ensure the required levels of performance are being delivered. The CBUs/departments are required to take corrective action to improve areas of underperformance.

2) **Divisional/CBU KPI Meetings**
The Divisional leaders will meet with the CBU leaders on a monthly basis, and review the CBU performance that sits within their Division, holding the CBU leadership to account for performance delivery. The Division will request Remedial Action Plans from the CBUs to address areas of concern.

3) **Clinical Operational Board (COB)**
The Divisional, CBU and Corporate leaders will meet monthly with the Executive Team in the COB. Monthly performance reports at Divisional level will be presented. The Executive Team will request Remedial Action Plans where there are any performance concerns. The COB will undertake a detailed performance review of each CBU at least annually.

4) **Executive Team Meeting**
Should performance not improve as agreed and expected, escalation to the Executive Team meeting may be requested in the form of deep dives. The Divisional leaders will be required to present a 10 minute deep dive setting out the issue and the actions being taken to improve performance at the Executive Team meeting. This will continue on a weekly basis

until the Executive Team is assured that the actions will return performance to acceptable levels within an agreed timeframe.

5) **Board Committees**
The frequency of Board Committee meetings is currently under review. At these meetings, Executive directors and senior leaders of the Trust will present updates on performance. The Committees can request deep dives from the Executives and senior leaders where there are any performance concerns. Any concerns are escalated to the Trust Board via the committee Chair reports.

6) **Trust Board**
The Trust Board meets monthly and receives the Integrated Performance Report IPR) which is presented with explanation by the Executive Directors. The report highlights reasons for any under performance and/or performance deterioration, and assurance that investigations are taking place together with the implementation of appropriate remedial action plans for recovery of underperformance.

3.2 The Performance Team will provide training to the Divisions so that all staff has sight and understanding of the performance KPI's they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.3 All actions and interventions relating to adverse performance will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support recognising any organisation wide resource needs.

3.4 A standardised remedial action planning process will be utilised for all KPI's that are underperforming to ensure there are clear remedial action plans.

4. Performance Reports.

4.1 **Trust Board**
The production of quality, meaningful and timely performance information is fundamental to the delivery of the Performance Assurance Framework. The Trust has developed and produces a monthly integrated performance report (IPR) for the Board. Each Committee sets out a selection of KPI have to go in to the Board IPR. The Board IPR will be reviewed on at least an annual basis. Each Committee, Executives Directors and senior leaders of the Trust will review the Board IPR and make recommendations for amendments. The Board will receive the proposed amendments for approval. **Only once Board has approved and minuted a change to its KPIs will it be included, amended or removed from the Board IPR.** The KPI's will be reviewed and refreshed at least annually prior to reporting on the new financial year.

4.2 **Board Committees**
Each Committee receives regular performance reports as part of its agenda. The KPI's contained in the Committee reports can be changed by approval of Committee members as there may be occasions where the Committee wants to report at a more granular level. Any changes to KPIs need to triangulate to the Board IPR. All changes must be minuted to include the rationale for the change

4.3 **Clinical Operational Board (COB)**

The KPI's contained in the COB dashboard will be informed by the relevant Committee, e.g. Quality KPI's set by the Quality Committee, and must triangulate to the Board IPR and any Committee reports and dashboards. However, unlike the Board IPR, changes can be made to the KPI's in the COB dashboard without Board approval. All changes must be minuted to include the rationale for the change.

4.4 **Divisional/CBU KPI Meetings**

The Divisional/CBU KPI meeting receives a regular performance dashboard. Where available, the dashboard contains granular CBU performance data.

When any change has been approved as set out above the respective Executive Lead will liaise with the Performance Team to action in partnership with the Information Team.

5. Structure and Governance to ensure Delivery.

5.1. **Appendix 2** sets out the proposed Trust Accountability, Responsibility, and Information Reporting structure. Each meeting will have a Terms of Reference setting out clear roles, responsibilities, objectives and membership and the devolved responsibilities from Board to Ward.

5.2. It is proposed that that the Trust uses the proportion of KPI's that are Red/Green to enable allocation to segmentation. This will be initially trialled for a period of 6 months. The four segmentation classifications are as follows:

Segmentation Classification

Classification	Criteria
1. Maximum autonomy	• **90% of KPIs are RAG rated green**
2. Clinical or Corporate area offered targeted support	• **30% of KPIs are RAG rated red**
3. Clinical or Corporate area receiving mandated support for Signiant concerns	• **40% of KPIs are RAG rated red**
4. Special measures	• **50% or more KPIs are RAG rated red**

5.3 Support will be offered to assist in bringing performance back to an acceptable level. The support offers are:

Support Offers

Support level	Support offered
1.Universal Support (Classification 1)	• **Business as usual**
2. Targeted Support (Classification 2 & 3)	• **Clinical or Corporate area to produce remedial action plan with support from Performance Team and submit to COB** • **Clinical or Corporate area to be held to account on delivery of remedial action plan at COB and relevant Committee** • **Assurance to Trust Board on delivery of remedial action plan from relevant Committee**
3. Mandated Support (Classification 4)	• **Clinical or Corporate area to produce remedial action plan with support from Performance Team and submit to COB** • **Clinical or Corporate Lead to attend fortnightly meetings with Executive Team (supported by Head of Performance) to provide update on progress** • **Clinical or Corporate area to be held to account on delivery of remedial action plan at monthly COB meeting** • **Assurance to Trust Board on delivery of remedial action plan from relevant Committee**

5.3. There is a vision to further enhance the Performance Assurance Framework by developing a culture where good performance is recognised and rewarded. One way of achieving this is by introducing an Earned Autonomy Framework across the Trust. Earned autonomy focuses on empowered leadership and devolving levels of decision making to Divisions and the Clinical Business Units in recognition of sustained good performance. The possibility of a Trust Earned Autonomy Framework that is aligned to the performance segmentation classifications will be explored further with a recommendation being presented to Trust Board for approval.

6.0 Next Steps

This Performance Assurance Framework will be presented to the Trust Board in April 2017 along with the proposed dashboard in April each year. The framework will be reviewed on at least an annual basis. The Performance Assurance Framework will also be presented to the Board Committees and COB and will be cascaded to the CBU and Trust leaders.

Appendix 1

Our Vision: 'To be the most clinically and financially successful healthcare provider in the Mid-Mersey region'

Our Mission: 'To provide high quality, safe integrated healthcare to all our patients'

Our Strategic Objectives - (*What we need to do):*

a. 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.

b. To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.

c. To deliver well managed value for money, sustainable services.

d. To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.

Our Core Values - (*How we need to do it):*

Working Together: 'We promise an environment where patient care is paramount and our staff matter'

Excellence: 'We ensure excellence across our teams in providing the best care for our patients'

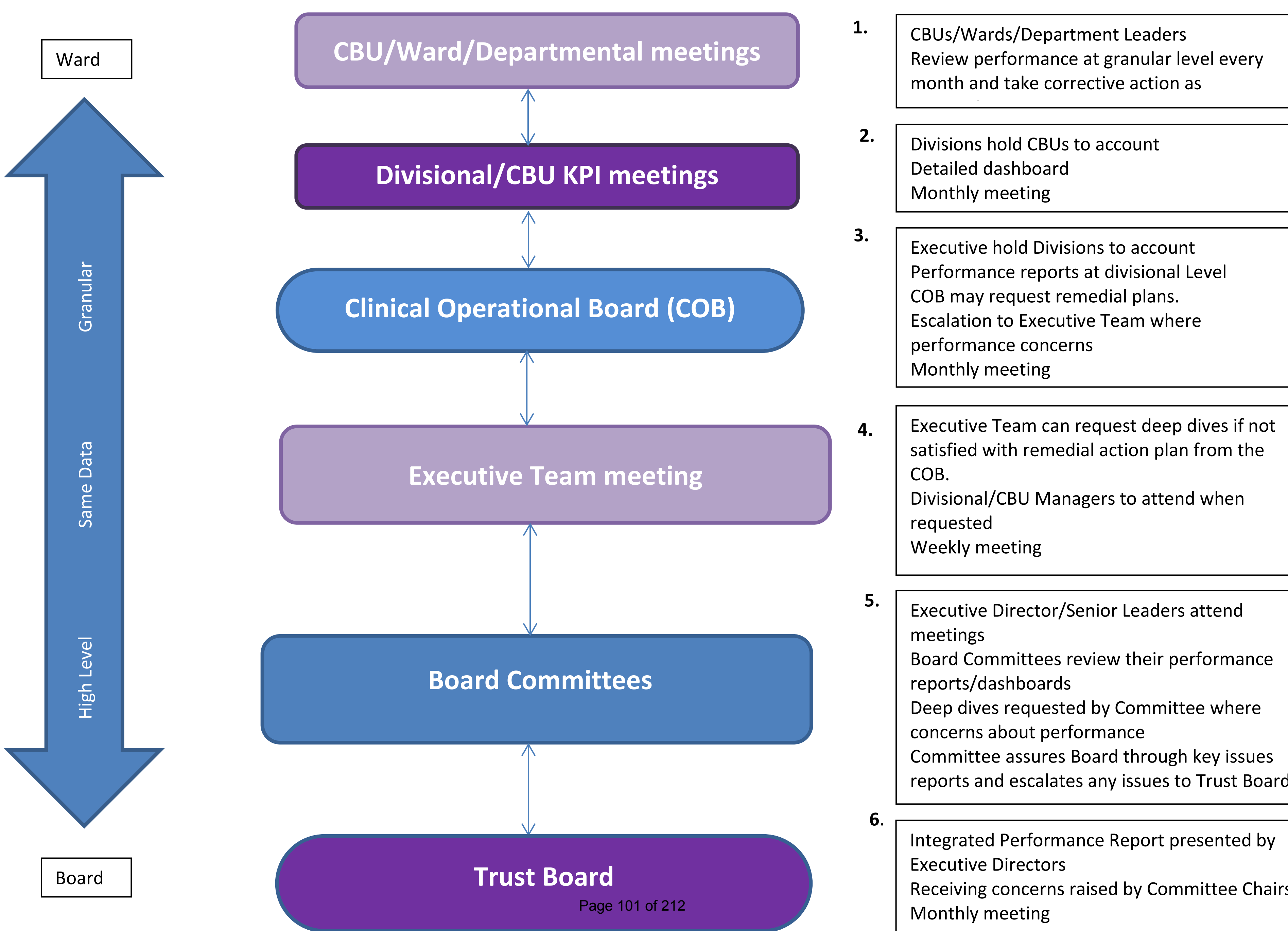
Accountable: 'We make sure that everyone is involved in making decisions'

Role Models: 'We inspire and innovate through great leadership to provide excellent care for our patients'

Embracing Change: 'We are open to new ideas from patients, the public and everyone in our team'

Our QPS Aims and Objectives:

Appendix 2 **Trust Accountability, Responsibility and Information Reporting Structure – Ward to Board**



Appendix B – Removed KPIs

KPI	Proposed Changed	Rationale
Access & Performance		
Cancer 62 Day upgrade	Remove KPI from Integrated Performance Report (IPR)	Not a standalone measure and not recognised nationally as it is measured as part of the 62 day cancer urgent and screening KPI's that we already report against in the IPR.
Quality Improvement		
CQUIN	Remove 5 CQUIN KPIs from the IPR: • Sepsis AED Screening • Sepsis Inpatient Screening • Sepsis AED Antibiotics and Review • Sepsis Inpatient Antibiotics and Review • Antimicrobial Resilience and Stewardship The financial implications of not achieving a CQUIN will be reported in the Finance section of IPR	CQUIN performance will be performance managed as part of the Quality Committee agenda and a standalone CQUIN performance report will go to Board at the end of each quarter.
Nurse Staffing Average Fill	Remove KPI from IPR	Each month the Board will receive a paper covering this topic. The paper will be appended to the IPR.
Staffing Care Hours Per Patient Day	Remove KPI from IPR	Each month the Board will receive a detailed paper covering this topic. The paper will be appended to the IPR.
Falls per 1000 Bed Days	Remove KPI from IPR	No longer a national valid measure.
Finance		
CIP Plans in progress	Remove KPI from IPR	This KPI is being replaced by a forecast CIP to include PYE and recurrent FYE.

Appendix C – Amended KPIs

KPI	Proposed Changed	Rationale
Quality Improvement		
Falls	Total number of falls KPI will monitor levels of harm, with the priority of reduction by 10% of moderate/severe harm falls being reduced over time using 2015/16 as a baseline to develop trajectories and baselines.	The 2016/17 indicator was from National Patient Safety Agency data in 2010 and is no longer valid. Reduction of falls by 10% is a 2017/18. This is a quality priority for the Trust.
Healthcare Acquired Infections	Addition of MSSA (Methicillin sensitive Staphylococcus Aureus) infections. There is currently no national target – Public Health England is reviewing this. In the absence of a national target and by way of good practice/lessons learnt the Trust will carry out a Route Cause Analysis on any reported cases and develop a local threshold.	This is a good measure of infection prevention in addition to CDiff/MRSA.
Pressure Ulcers	Addition of hospital acquired grade 4 pressures ulcers to existing indicator. Zero tolerance - one or more grade 3 or 4 hospital acquired pressure ulcers in month = RAG rating Red. The May 2017 Quality Committee will review the grade 2 hospital acquired threshold by reviewing averages from 2016/17 to calculate new thresholds for RAG status in 2017/18. The Quality Committee will make a recommendation to the May 2017 Board.	Ensure the Board is aware of hospital acquired pressure ulcers and harm.
Complaints	In addition to "Received" and "Dissatisfied" the Trust will report on: • Total cases open • Total cases over 6 Months Old RAG rating parameters for all complaints measures will be reviewed and agreed at the Complaints Working Meeting scheduled for the 5th May 2017. The Quality Committee with make a recommendation to the May 2017 Board.	Requirement to have increased information due to ensure the Trust complies with the Department of Health complaint regulations on timeliness.
Mortality	Amend total deaths KPI to preventable deaths. In the absence of a national threshold the Quality Committee will baseline, benchmark and review locally with a recommendation made to the May 2017 Board.	Monitoring of this KPI is a national requirement and forms part of the Trust's 2017/18 quality priorities.
Safety Thermometer	Amend KPI to also measure Children and Maternity in addition to Adults.	To ensure the Trust has the entire scope of harm free care measures across all our services, which is clearly visible to the Board.

<table>
<tr><th>Workforce</th><th></th><th></th></tr>
<tr><td>Recruitment</td><td>Change “Average Total Days To Recruit” target from 50 to 65.</td><td>To benchmark against neighbouring Trusts who use a target of 65.</td></tr>
<tr><td>Non Contracted Pay</td><td>The graph will be renamed “Premium Spend Analysis”
The 2016/17 graph shows the Trust percentage of non-contracted pay by the following headings:
• Overtime
• Locum
• Bank
• Agency
• Waiting List Initiatives (WLI)
The 2017/18 graph will:
• Report at CBU Level
• Show the CBU’s percentage of non-contracted pay against budget for the following:
o Overtime
o Locum
o Bank
o Agency
o Waiting List Initiatives (WLI)</td><td>To provide oversight by CBU.</td></tr>
<tr><td>Finance</td><td></td><td></td></tr>
<tr><td>CIP</td><td>2016/17 CIP KPI reported CIP programme performance to date. For 2017/18 the KPI will be amended to show YTD performance, CIP cost avoidance and income recovery.</td><td>To show full picture of impact of schemes.</td></tr>
</table>

Appendix D – New KPIs in 2017/18

KPI	Proposed change	Rationale
Access & Performance		
Cancelled operations on or after the day	Addition of national KPI - Cancelled operations on or after the day of admission for non-clinical reasons. Zero Tolerance – 1 or more = RAG rating Red.	National KPI - All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days.
Quality Improvement		
Duty of Candour	Addition of monitoring at Board Level of Duty of Candour. The Trust will be RAG rated Red if not compliant with the indictor of informing patients/families by letter within 10 days if they have been involved in an incident where the outcome is moderate, severe harm or death.	Board oversight of Duty of Candour
VTE	Addition of completion of assessments, incidents of preventable harm and Root Cause Analysis (RCA) completion – with a proposed RAG rating of 95% compliance for VTE assessments. • Performance below 95% = RAG rating red • 95% and above = RAG rating Green • There is no Amber RAG rating for this KPI	Currently been identified as a risk due to compliance and lack of completion of Root Cause Analysis.
Safer Surgery	Addition of indicator re completion of World Health Organisation checklist- target 95%. • Below 95% = RAG rating Red. • 95% and above = RAG rating Green. • There is no Amber RAG rating for this KPI.	Ensuring oversight of safer surgery – 2017/18 quality indicator.
Medication safety	Addition of reconciliation KPI. Thresholds and RAG rating parameters to be agreed at the May 2017 Quality Committee with a recommendation to the May 2017 Board.	Ensuring oversight of medication safety by the Board. This is a national contractual requirement.

Medication Safety	Addition of controlled drug incidents KPI. Thresholds and RAG rating parameters to be agreed at the May 2017 Quality Committee with a recommendation to the May 2017 Board.	Ensuring oversight of medication safety by the Board. This is a national contractual requirement.
Medication Safety	Addition of Incidents relating to harm KPI. Thresholds and RAG rating parameters to be agreed at the May 2017 Quality Committee with a recommendation to the May 2017 Board.	Ensuring oversight of medication safety by the Board. Local requirement.
Mixed Sex Accommodation	Addition of this KPI. Zero Tolerance – 1 or more breach = RAG rating Red	To ensure the Board has oversight of breaches. This is a national contractual requirement.
Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	Addition of this KPI. Target will be agreed with Commissioners to reflect 2017/18 national CQUIN target.	Whilst all CQUINs will be performance managed and reported via the Quality Committee, assessment of clinical antibiotic review is also a Trust quality priority and will be included in the IPR as a KPI.
Finance		
CIP	Addition of forecast CIP data including PYE and recurrent FYE	To enable Board to see anticipated year end forecast.
Finance	Addition of CQUIN penalties and contractual fines.	To identify where failures are causing financial penalties.

Appendix E – 2017/18 KPIs that will be measured and reported via the Board Integrated Performance Report (IPR)

	2017/18 KPIs	**Target/Threshold/Tolerance**
	Access & Performance	
1.	Diagnostic Waiting Times 6 Weeks	99% target
2.	RTT Open Pathways	92% target
3.	RTT Number of Patients Waiting 52 Weeks +	Zero tolerance
4.	A&E Waiting Times – National Target	95% target
5.	A&E Waiting Times – STP Trajectory	To be agreed by NHS Improvement
6.	Cancer 14 Days	93% target
7.	Breast Symptoms 14 Days	93% target
8.	Cancer 31 Days First Treatment	96% target
9.	Cancer 31 Days Subsequent Surgery	94% target
10.	Cancer 31 Days Urgent	98% target
11.	Cancer 62 Days Urgent	85% target
12.	Cancer 62 Days Screening	85% target
13.	Ambulance Handovers 30 – 60 Minutes	Zero tolerance
14.	Ambulance Handovers – 60 Minutes or more	Zero tolerance
15.	Discharge Summaries percentage sent within 24 Hours	95% target
16.	Discharge Summaries not sent within 7 Days	5% tolerance
17.	Cancelled Operations on or after the day	Zero tolerance
	Quality Improvement	
18.	Health Care Acquired Infections: • MRSA • MSSA • CDIFF	 Zero tolerance Zero tolerance 27

19.	Mortality Ratio - HSMR	Thresholds to be reviewed by the May 2017 Quality Committee with recommendation to May 2017 Board.
20.	Mortality Ratio - SHMI	Thresholds to be reviewed by the May 2017 Quality Committee with recommendation to May 2017 Board.
21.	Mortality - Preventable Deaths	Thresholds to be reviewed by the May 2017 Quality Committee with recommendation to May 2017 Board.
22.	High Risk Incidents	Zero tolerance
23.	Safety Thermometer – Adult, Children and Maternity	95% target
24.	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	Target to be agreed with Commissioners and reported to the May 2017 Board.
25.	Falls – total number of falls and harm levels	Target – 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.
26.	Pressure Ulcers – Grade 2,3 &4	Zero tolerance - grade 3 or 4 hospital acquired pressure ulcers. The May 2017 Quality Committee will review the grade 2 hospital acquired threshold by reviewing averages from 2016/17 to calculate new thresholds for RAG status in 2017/18. The Quality Committee will make a recommendation to the May 2017 Board.
27.	Friends and Family – Wards	Target 95%
28.	Friends and Family – A&E	Target 87%

29.	Complaints: • Received • Dissatisfied • Total cases open • Total cases over 6 months old	Thresholds to be reviewed by the May 2017 Quality Committee with a recommendation to the May 2017 Board.
30.	VTE	Target 95%
31.	Duty of Candour	Zero tolerance
32.	Safer Surgery	Target 95%
33.	Medication Safety - Reconciliation	Thresholds and RAG rating parameters to be agreed at the May 2017 Quality Committee with a recommendation to the May 2017 Board.
34.	Medication Safety – Controlled drugs Incidents	Thresholds and RAG rating parameters to be agreed at the May 2017 Quality Committee with a recommendation to the May 2017 Board.
35.	Medication Safety – Incidents relating to harm	Thresholds and RAG rating parameters to be agreed at the May 2017 Quality Committee with a recommendation to the May 2017 Board.
36.	Mixed Sex Accommodation	Zero tolerance
	Workforce	
37.	Sickness Absence	Target 4.2% or below
38.	Return to Work	Target 85%
39.	Recruitment	Target 65 days
40.	Turnover	Target 10% or below
41.	Premium Spend Analysis	Target – CBU remains in budget
42.	Agency Nurse Spend	Target – Less than 2016/17
43.	Agency Medical Spend	Target – Less than 2016/17

44.	Essential Training	Target 85%
45.	Clinical Training	Target 85%
46.	PDR	Target 85%
47.	High Cost Agency Workers	Thresholds and RAG rating parameters to be reviewed at the June 2017 Strategic Peoples Committee with a recommendation to the June 2017 Board.
48.	Long Term Agency Usage	Thresholds and RAG rating parameters to be reviewed at the June 2017 Strategic Peoples Committee with a recommendation to the June 2017 Board.
	Finance	
49.	Cash Balance	Target on or greater than plan
50.	Capital Programme	Target on plan 90 – 100%
51.	Financial Position	Target - Surplus
52.	Use of Resources Rating	Target – Use or Resources Rating 1 and 2
53.	Cost improvement Programme – Forecast CIP data including PYE and recurrent FYE	Target – on or above plan
54.	Cost Improvement Programme – YTD performance, Cost avoidance and income recovery	Target – on or above plan
55.	Better Payment Practice Code	Target – Cumulative performance 95% or above
56.	Agency Spending	Target – Equal to or less than agency ceiling
57.	CQUIN Penalties and Contractual Fines	Zero Tolerance

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/45**
SUBJECT:	**Update on Strategic Risks**
DATE OF MEETING:	26 April 2017
ACTION REQUIRED	**Discuss and note the update to strategic risks**
AUTHOR(S):	Ursula Martin, Deputy Director of Integrated Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The Board Assurance Framework outlines risks against delivery of strategic objectives.
EXECUTIVE SUMMARY (KEY ISSUES):	There has been one new strategic risk agreed since the Board last received the Strategic Risk Register Update. There have been actions completed against strategic risks, and additional actions, gaps in assurances identified against current risks, and these have been summarised in the paper. The Board of Directors will receive a monthly update report of strategic risks and the full Board Assurance Framework on a quarterly basis. The Trust's Risk management Strategy is currently under review, being presented to Quality Committee May 2017.
RECOMMENDATION:	The Board of Directors are asked to discuss and note the updates to strategic risks.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.

BOARD OF DIRECTORS

SUBJECT	Update on Strategic Risks	AGENDA REF:	BM/17/04/45

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.

2. KEY ELEMENTS

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).

2.1 New Risks – A new risk was agreed to be escalated to Strategic Risk Register from Quality Committee following concerns regarding poor completion of risk assessments in some clinical areas and also poor completion of RCA for Hospital Acquired VTE.

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.	
Gaps in Control	• 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
Initial Risk rating	**16 (4x4)**
Controls/Assurances	• Monitor of progress by Patient Safety and Clinical Effectiveness committee, Quality Committee; monthly assessment of progress with number of RCAs • Harm free care figures
Residual Risk rating	**12 (4x3)**
Actions	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 By end May 2017 Review Terms of Reference for Thrombosis Group Lead Clinicians VTE By end May 2017
Target Risk Rating	**8 (4x2)**

2.2 Existing Risks

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 and impact on Trust access and financial targets.	An additional gap in control has been added regarding the impact of IR35.	No impact on risk rating
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 raying
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	Mapping of complaints spreadsheets into Datix has completed New KPIs have been agreed regarding complaints so that there is greater transparency regarding the backlog. Trajectories are to be agreed for the divisions and CBUs, which will be performance managed by the Chief Nurse and Deputy Director of Governance at the weekly complaints performance meeting. The Chair of the Trust will chair a Complaints Quality Assurance Group – terms of reverence being agreed by Quality Committee March 2017 and the first meeting is in May 2017.	No impact on risk rating
Lack of assurance regarding the Trust's safeguarding agenda being implemented	An audit of Mental Capacity has been undertaken and is being presented to the Patient Safety & Effectiveness	No impact on risk rating

Strategic Risk	Update since last Risk review	Impact of update on risk rating
across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.	Committee in April.	
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.	No impact on risk score
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.	Actions have been completed regarding commencement of a information and IT restructure. An additional diagnostic team member has been recruited. 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.	Recommendation from Director of IT to reduce the risk from 20 (5x4) to 16 (4x4)

3. RECOMMENDATIONS

The Board are asked to note the changes to the strategic risks. A review of this will be undertaken at March Quality Committee, and any further updates to this will be provided to the Board.

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) March 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)
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)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	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)
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)
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)	16 (4x4)	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)	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	16 (4x4)	16 (4x4)	16 (4x4)

Risk	Residual Risk Rating (Impact x Likelihood) Feb 2017	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) March 2017
on patient safety and cause the Trust to breach regulations.			
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)
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)
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)
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)
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)	12 (4x3)	12 (4x3)
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)
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)

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/46**
SUBJECT:	**2016 NHS Staff Survey results**
DATE OF MEETING:	26 April 2017
ACTION REQUIRED	Briefing and approval of key recommendations
AUTHOR(S):	Candice Ryan, Head of Workforce Strategy & Engagement and Georgia Stokes, HR Project Manager
EXECUTIVE DIRECTOR SPONSOR:	Choose an item. Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	Choose an item.
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The purpose of this report is to provide the Board with a summary of the 2016 NHS Staff Survey results and how they align with the Trust's values and vision. It will also outline key recommendations for the Trust to focus on in the next 12 months.
EXECUTIVE SUMMARY (KEY ISSUES):	The overall results in comparison to 2015 show that the Trust has made progress in the majority of areas however, most of these changes have not been statistically significant and it is stressed that there is still a need to improve in all areas and accelerate progress.
RECOMMENDATION:	The Trust Board are asked to review the findings and support the future action to work in partnership with our managers and teams to ensure we act appropriately on the feedback we have been provided.

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	

BOARD OF DIRECTORS

SUBJECT	2016 NHS Staff Survey	AGENDA REF:	BM/17/04/46

1. BACKGROUND/CONTEXT

1. Introduction

The purpose of this report is to provide the Board with a summary of the 2016 NHS Staff Survey results and key recommendations for the Trust to focus on over the next 12 months.

In comparison to the 2015 NHS Staff Survey, this year rather than a statistically representative sample, the survey was sent to all full-time and part-time directly employed members of WHH Staff. This gave us the opportunity to ask all our staff to tell us their views. 1465 responses were received a response rate of 38% compared to the national average for acute trusts of 44% and a 5% improvement on the 2015 WHH response rate. The questionnaire was unchanged from 2015.

For WHH the survey captures the first feedback following the introduction of the Clinical Business Unit (CBU) structure and the 'WE ARE' behaviours in April 2016. It is acknowledged that there is still work to embed the behaviours and ongoing work to support CBU structure and these results represent a 'work in progress'.

In addition, the survey results are such that they, for the first time, align with the new divisions and clinical business unit (CBU) structure which will allow the organisation to fully analyse the results by department and build bespoke action plans to target key areas. Following the sharing of this paper, there will be meetings with the CBU triumvirates and Deputy Heads to undertake a more detailed analysis of the results to establish robust action plans to make improvements. This process will be in partnership with the teams, HR Business Partners and the Head of Workforce Strategy and Engagement.

This report will provide an assessment of the overall results, staff engagement levels for the organisation and report on progress within the nine key themes as shown below, with a focus on the trusts bottom 5 results:

- Appraisals and support for development
- Equality and Diversity
- Errors and incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experiences
- Violence, harassment and bullying

2. Summary of results

The overall results in comparison to 2015 show that the Trust has made progress in the majority of areas however, most of these changes have not been statistically significant and it is clear that there is still a need to improve in all areas and accelerate progress.

The results show has had two statistically significant, positive changes in 2016 those being, 'Quality of non-mandatory training, leaning or development' (4.07 compared to 3.92 in 2015) and 'Effective use of patient/service user feedback' (3.63 compared to 3.46 in 2015), see figure 1. The positive results reflect the action taken over the last 12 months; in 2015 both of the scores were in the Trusts bottom five results. It should be noted that although the result for 'Effective use of patient/service user feedback' shows improvement it remains below the national average and there is stil scope for further improvement. There have been no statistically significant, negative changes in comparison to 2015.

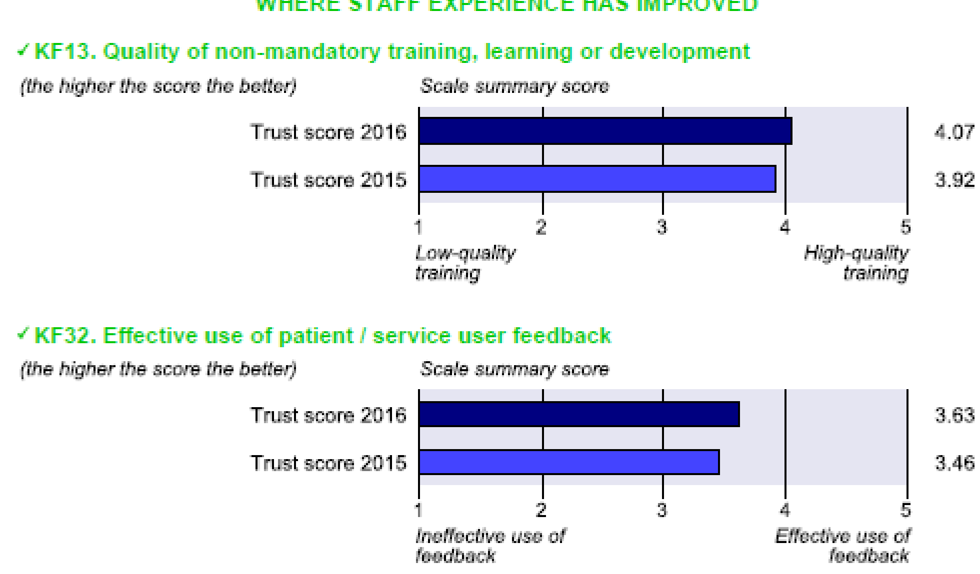


Figure 1. Positive statistically significant changes compared with 2015 NHS Staff Survey

Following the changes that have been implemented across the organisation over the last 12 months to improve our services, including the new division/CBU structure, it may have been anticipated that there would be a more significant improvement in the organisations results. However, the structure was only been in place for 6 months when the 2016 survey data was gathered. It will take time to embed and realise the benefits of these changes although progress can be seen. For instance, one respondent commented "changes in senior management/nursing roles have caused an immense sense of instability within the organisation" with another commenting "There is a lot of positive work going on such as the CBUs. When they are embedded and allowed to be more autonomous this will be better. Engagement from CBU team is better than the old system".

The 2016 results show that the Trust is in the best 20% nationally across acute trusts for 7 areas including equal opportunities for career progression, staff reporting experience of violence, staff experiencing discrimination at work, reporting of errors/incidents, staff working extra hours, action on health and wellbeing and support from immediate line managers. There were only 2 key findings in the bottom 20% of acute trusts compared to 7 in 2015.

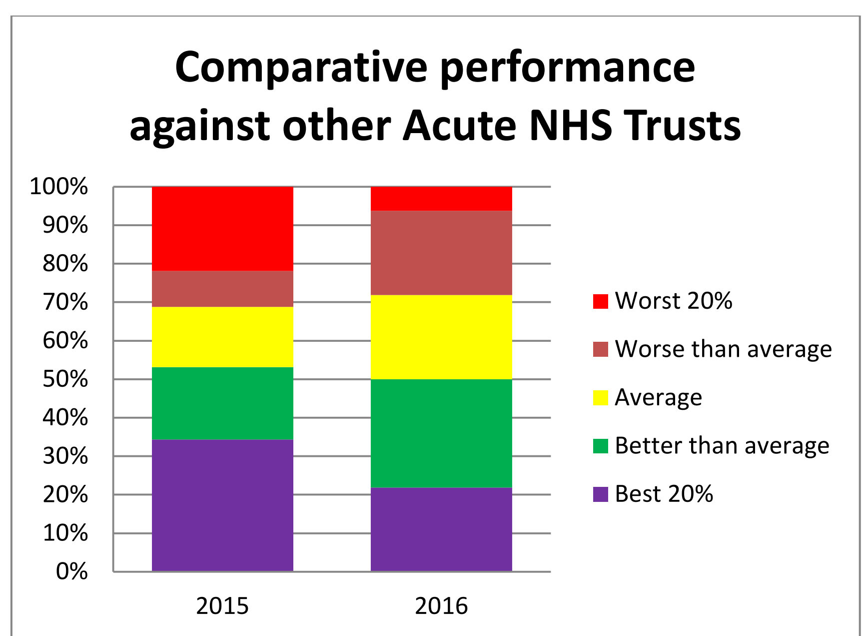


Figure 2. 2016 NHS Staff Survey results compared with 2015.

For a table of comparison of all the 2016 key findings performance compared to 2015 please see Appendix 1.

The results highlight 5 key areas where WHH compares least favourably and where we need to work together and focus our attention;

1. Staff recommendation of the organisation as a place to work or receive treatment
2. Effective team working
3. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
4. Percentage of staff agreeing that their role makes a difference to patients/service users
5. Effective use of patient/service user feedback

3. Overall Staff Engagement

The overall staff engagement score represents staff members perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place of work or receive treatment, and the extent to which they feel motivate and engaged with their work.

The staff engagement score for the Trust is 3.73, which is below the national average for acute trusts (3.81). However, the trust has improved in all of the areas that contribute to the engagement score in comparison since 2015 although the results rank in the bottom 20%, see figure 2. One of the respondents stating “Engagement from CBU team is better than the old system”.

		Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	69%	76%	63%
Q21b	"My organisation acts on concerns raised by patients / service users"	69%	74%	62%
Q21c	"I would recommend my organisation as a place to work"	54%	62%	49%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	57%	70%	54%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.59	3.77	3.51

Figure 3. WHH organisation 2016 in comparison to 2015 and the average for acute trusts

This demonstrates that, although we have made some progress, there is a need to accelerate the action taken since 2015 and establish new approaches to improve the working lives of our colleagues. The Trusts People Strategy has engagement at the core of its model and all of its actions are founded on these principles.

4. Analysis of results by key finding

The staff survey contains 9 key themes our results have been summarised against each theme with specific focus given where the findings rank in our bottom 5 results.

4.1 Appraisals and support for development

Of the staff that completed the survey 89% stated that they had had a Personal Development Review (PDR) in the last 12 months. A slight increase on last year and higher than the national average. The staff assessment of the quality of the PDR has also increased slightly this year (3.09) but remains slightly below the national average (3.11). A new PDR document which is less cumbersome and aligned to the trusts ‘WE ARE’ behaviours is about to be launched trust wide and should help to improve the quality of the PDRs.

The quality of non-mandatory training, learning or development was our lowest ranked score in 2015. A significant amount of work has been on going to develop the Essential Mangers courses, Growing as a Leader and the induction and mandatory training across the organisation. This has seen a statistically significant increase in these results (see section 2 of this report), work will continue to develop the trust training offer in line with the People Strategy.

4.2 Equality and Diversity

The proportion of staff reporting that they have experienced discrimination at work in the last 12 months remains very low at 8% putting the trust in the best 20% of acute trusts. Along with 91% of staff believing that the organisation provides equal opportunities for career progression or promotion again putting the trust in the top 20% of acute trusts. This is triangulated by our employee relation cases.

Specific actions may be incorporate in to the Workforce Race Equality Standard action plan depending on the further analysis. Actions will be reported to Strategic People Committee and the Equality & Diversity Sub Committee.

4.3 Errors and incidents

The Trusts QPS framework emphasises the trust's focus on Quality, specifically "managing and reducing clinical and operational risk" and as such, reducing and learning from incidents and errors. In comparison to the 2015 Staff Survey results, while there have been no significant changes in the Errors and Incidents scores, the trust has made improvements.

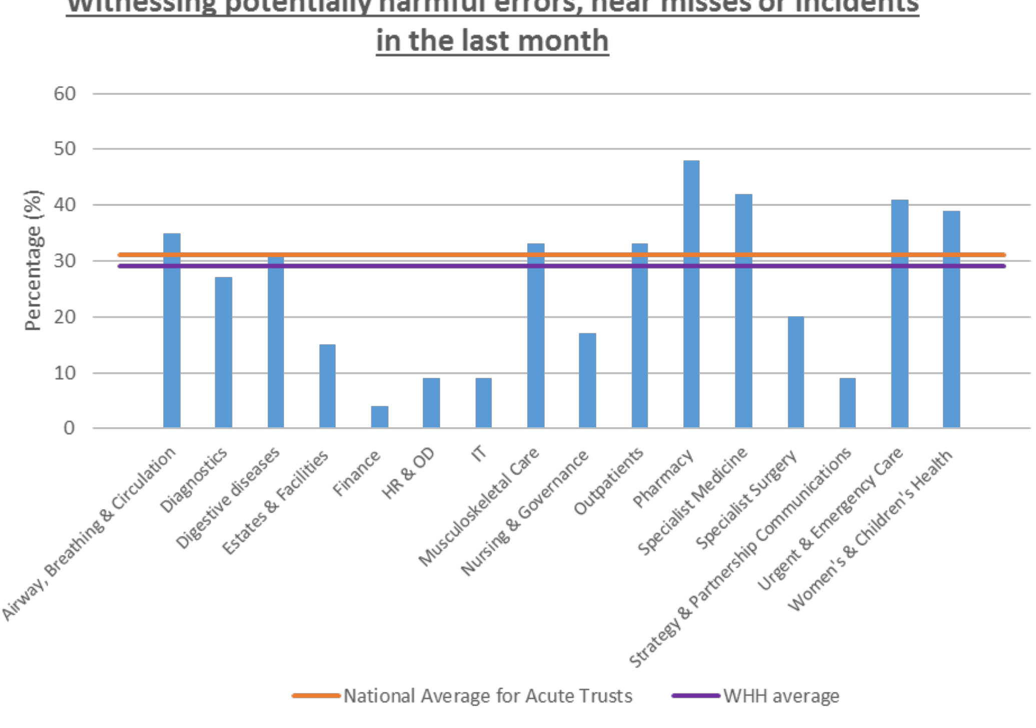


Figure 4. Witnessing potentially harmful errors, near misses or incidents in the last month in comparison to the national and WHH average

Overall with regards to our colleagues witnessing potentially harmful errors, near misses or incidents, the Trust compared better than the national average. However, when broken down to CBU level, there are 7 areas whose score compared with the worst 20% nationally including ABC, MSK and Pharmacy (see figure 4).

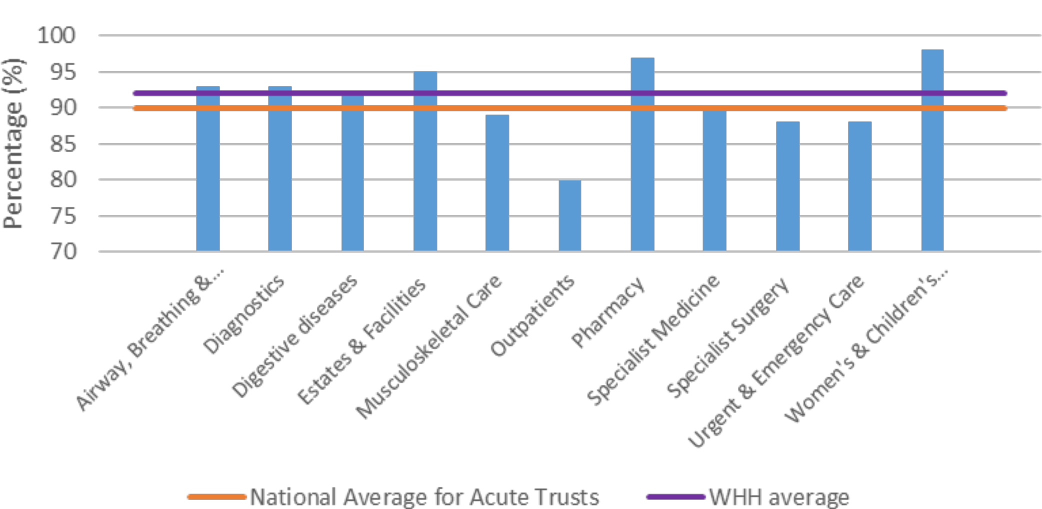


Figure 5. Reporting potentially harmful errors, near misses or incidents in the last month in comparison to the national and WHH average

To ensure the safety of our colleagues and patients, it is important to learn from potentially harmful events however, this can only be done if our colleagues are reporting incidents and there are robust process in place to capture and act on this reporting. Positively, the Trust scored in the top 20% nationally for the percentage of staff reporting errors, near misses or incidents witnessed. Furthermore, in CBUs such as, ABC, Pharmacy and Women's and Children's Health, although colleagues witnessed more than average potential errors or near misses, they scored in the top 20% for reporting errors when compared to the national average. However, MSK, Outpatients, Specialist Surgery and Urgent and Emergency Care scored in the lowest 20%. Work to share best practise across all CBUs will help to drive improvements.

It is important to understand from areas which scored less favourably in this area why our colleagues are not reporting events, to ensure that errors and incidents are being rectified and learned from.

Unfortunately, ten areas across the Trust scored below the national average for the "Fairness and effectiveness of procedures for reporting errors, near misses and incidents" including ABC, Specialist Surgery and Outpatients. Furthermore, overall the Trust scored below average for "Staff confidence and security in reporting unsafe clinical practice". Five areas across the Trust scored in the worst 20% compared to the national average for acute trusts for confidence in reporting. This included Diagnostics, HR & OD, IT, Pharmacy and Women's and Children's Health. These results demonstrate a lack of confidence in reporting procedures across the Trust, which may explain why some areas have highlighted that they do not raise issues/errors. This finding is not limited to our clinical areas but Finance and Nursing and

Governance scored positively in all aspects of this area with Nursing and Governance's scores comparing with the top 20% of acute trusts. This demonstrates an area of good practise where lessons could be learned and shared with the rest of the organisation.

The Trusts QPS framework aligns with the future vision of the organisation and states "We will communicate openly with our teams and expect the same from them in return. We expect our staff to take accountability for their actions and will support them to do so". The results from the 2016 Staff Survey suggest that while the majority of our colleagues are speaking up and raising incidents, they are not confident in the fairness or security and support of the procedures. This highlights the need for the organisation to concentrate attention in this area to enable to QPS framework and ensure our staff are able to take accountability, in line with the 'WE ARE' behaviours and the People Strategy, for their actions in a safe and supportive environment, where we can share lessons learned and best practise from errors and incidents.

4.4 Health and wellbeing

The survey asks staff about a number of aspects that contribute to the overall theme of Health and wellbeing, including managerial and organisational interest in staff health, musculoskeletal problems and stress.

The majority of staff reported that both the organisation and management take a positive interest in their health and wellbeing (3.72) with the trust score being in the top 20% of acute trusts.

The percentage of staff reporting feeling unwell due to stress was 34%, slightly below the national average (better than). This score has remained stable within the organisation for a number of years and it is hoped that over the next 12 months we can further utilise the staff counsellor in order to continue to work in a more proactive way and help to reduce this figure. For example April is stress awareness month at WHH with information stalls, drop-in sessions and the introduction of relaxation classes.

Over the last 12 – 18 months a significant amount of work has been ongoing around this agenda we have introduced our 'Fit to Care' programme, changed our counselling services and introduced a number of initiatives across the trust including Ward Manager stress training session, Essential Manager training on health and wellbeing, our fruit and vegetable man, monthly health focus events and exercise classes the impact of which can be seen in the score. The academic link between an organisation that cares about its staffs health and wellbeing and staff engagement level is well established and therefore will remain a key area of focus for the next 12 months. This work is also critical to achieving the 2017 – 2019 CQUIN for Health and Wellbeing.

4.5 Working patterns

Staff were asked if they were satisfied with the flexible working opportunities provided by WHH 51% of staff were satisfied which is line with the national average. Although not an

outlier, as a whole this finding is particularly important to analysis by staff group and CBU in order to see if there is any correlation to the retention and recruitment issue faced by the organisation.

Further the Trust scored well with only 67% of staff working extra hours paid and unpaid compared to 72% nationally, putting the trust in the best 20% of acute trusts.

4.6 Job satisfaction

In order to achieve the Trust's vision it is essential that we, not only attract the best people to work at WHH, but we retain the talent we already have. A key driver for employee retention is job satisfaction and the NHS Staff Survey allows us to review our colleague's opinion on their role and their motivation in work.

As in 2015, the Trust scored in the lowest 20% of acute trusts for 'Staff recommendation of the organisation as a place to work or receive treatment' however, the Trust did improve slightly on year (figure 6). The scores for ten areas in the Trust were comparable with the lowest 20% for acute trusts (see figure 7). The score achieved in Finance compared with the top 20% of acute trusts nationally and presents an opportunity to work with this department as an area where best practise could be learned and shared. It would interesting to understand why some corporate services would recommend our organisation and others are less likely to. It may be argued that due to the nature of these teams, they are more aware in their roles of the Trust's achievements and concerns.

The Trust has seen an improvement in areas such as effective team working and satisfaction with resourcing and support in comparison to 2015 but unfortunately, the improvements have not made a significant difference to the score. The trust scored in the lowest 20% comparative to the average score for acute trusts nationally for effective team working. The introduction of the new 'WE ARE' behaviours, the emphasis on team of the month and the implementation of the new management/CBU structure has seen the trust score improve from 3.68 to 3.70 however, moving forwards improving this remains a key priority for the organisation.

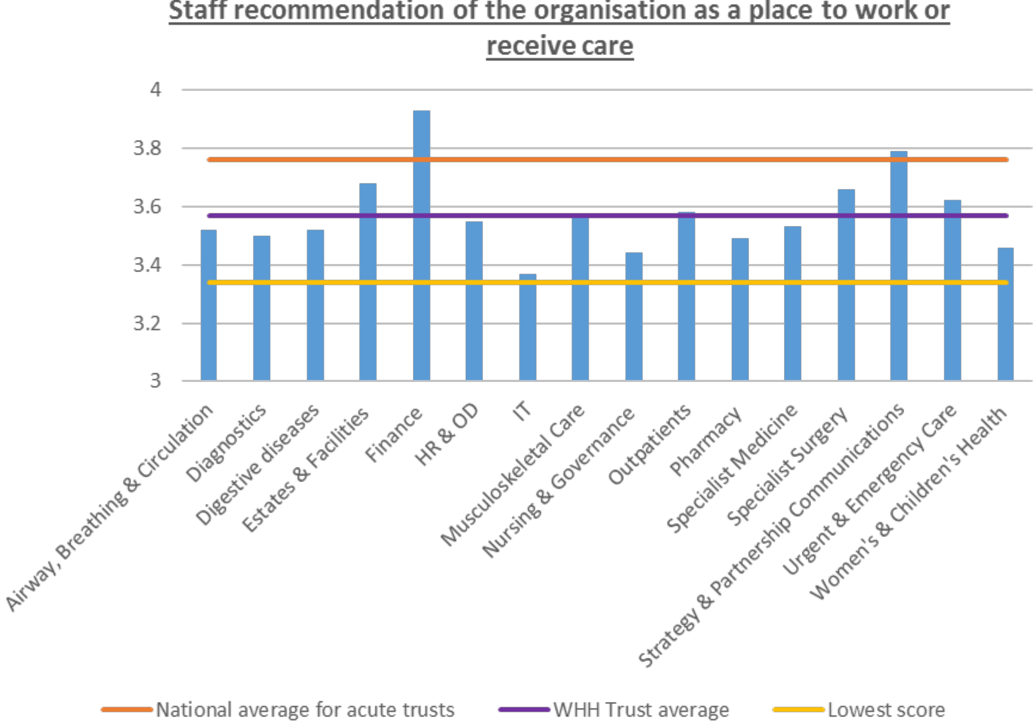


Figure 6. Recommendation of the trust as a place to work or receive treatment.

Key areas to concentrate on with regards to job satisfaction are Outpatients, Pharmacy, Urgent and Emergency Care and Women's and Children's as their scores compared with the lowest 20% of acute trusts. It is essential that all our departments have a sense of job satisfaction, especially these areas which are responsible and potentially directly influence patient care.

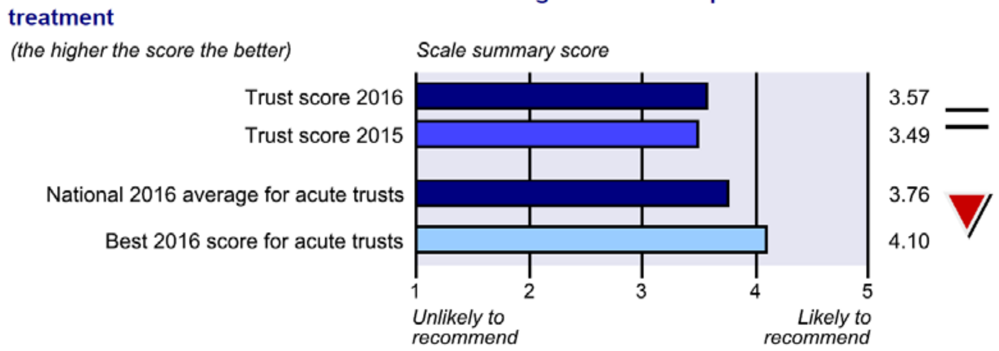


Figure 7. Staff recommendation of the Trust as a place to work or receive treatment.

Furthermore, the Trust scored below average when compared with the national average for acute trusts in the "ability to contribute towards improvements at work" with a score of 69% (av 70%). Eight areas across the Trust scored in the lowest 20% including Diagnostics, Digestive Diseases and MSK, figure 8. The development of multiple transformation initiatives would be expected to increase this score however this has not been realised in all areas. Figure 8 shows that Corporate services including Finance, HR & OD, Strategy and Partnership Communications feel they are able to influence improvements in their areas, it is important to understand why this is. It could be argued that it is more practical in corporate areas when compared to clinical areas but this does not need to be the case as highlighted in the scores for ABC and Specialist Surgery.

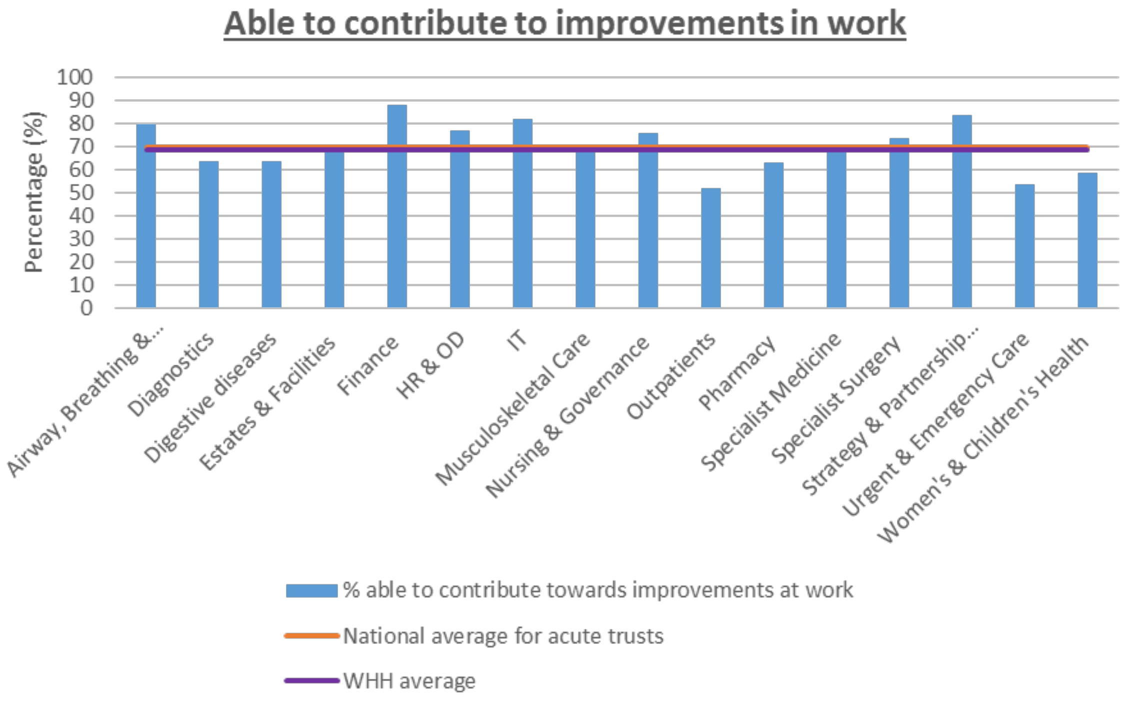


Figure 8. % able to contribute to improvements at work.

One of the Trust values is Embracing Change; it is essential for colleagues to embrace and support change to ensure we are developing and adapting our services/processes to provide the best possible patient care. In particularly, future work for the organisation is currently being shaped with the development of our strategic plans with the Alliance and the Cheshire and Mersey STP and it is essential that our teams are embracing this. For our colleagues to truly embrace and champion change, it is important to communicate and involve them in changes; explaining the reasons for change and, where possible, involvement in decision making. One survey respondent stated that "I enjoy working at the Trust… the future is uncertain with the new Alliance"; this demonstrates that there is a need to ensure our colleagues understand what the Alliance aims and objectives are and promote the benefits of the changes.

The 2016 results demonstrate that there is a need to work with our teams with a view to increasing their awareness of ongoing changes and where possible, maximising the

opportunity to involve people in our change journey. It has been shown that job satisfaction and employee engagement are linked to increased patient experience therefore this is a key area of focus for the next 12 months.

4.7 Managers

The survey included questions about the extent to which staff feel valued for their work and the recognition their individual contribution receives. Although the Trust score was above the national average (3.49) when broken down into its component questions it is clear that improvement is needed in staff recognition with just over half of staff saying they were satisfied with the recognition they received for their contribution at work. The changes to Thank You Awards and the introduction of Behaviours Badges will have helped to improve this however there is a gap at a local, line manager level and this will be discussed with the departments and CBUs.

The staff continue to feel that the support from their immediate line managers is very high putting the trust in the top 20% of acute trusts. But, although showing an improvement from 2015 the percentage of staff who feel that there is good communication between senior management and staff is still below the national average at 29% and work will need to continue to address this disparity.

4.8 Patient care and experiences

Our patients are at the centre of the Trusts aims, objectives and vision; WHH want to create tomorrow's healthcare today. However, two of the least favourable results for the trust are colleagues "agreeing their role makes a difference to patients/service users" and "effective use of patient/service user feedback".

It is important to highlight that the results for "effective use of patient/service user feedback" have significantly increased since 2015 from 3.46 to 3.63. This demonstrates that the action taken in the last 12 months including the incorporation of Patient FFT comments into the Good Morning WHH and Team Brief performance dashboard, have made big improvements for our colleagues. Moving forwards, utilisation of feedback remains a key area of focus for the Trust to ensure that our services are effective, efficient and patient centred.

The 2016 Staff Survey results highlighted that the corporate services including Estates and Facilities, Finance and IT did not agree that their role made a difference to patient/service users and disappointingly, these areas compared with the lowest 20% of acute trusts nationally. Furthermore, five clinical areas also disagreed with this statement, comparing with the lowest 20% (figure 9). Five areas also compared with the lowest 20% for "Staff satisfaction with the quality of work and care they are able to deliver" including HR & OD, IT, Urgent and Emergency Care and Women's and Children's Health. The results from the 2016 Staff Survey demonstrate that some of our colleagues are not satisfied with the care they can provided and furthermore, they do not feel able to contribute to improvements at work. As an organisation we need to actively listen and enable our colleagues to provided excellent

care. As leaders of the organisation we need to be removing boundaries and barriers to ensure our teams are proud of the service they provide and are able to make improvements.

The scores for patient care and experience are disappointing for the Trust as all of our colleagues are responsible for enabling and delivering patient care; these results show that we need to promote the importance of our whole workforce and how they impact on patient care.

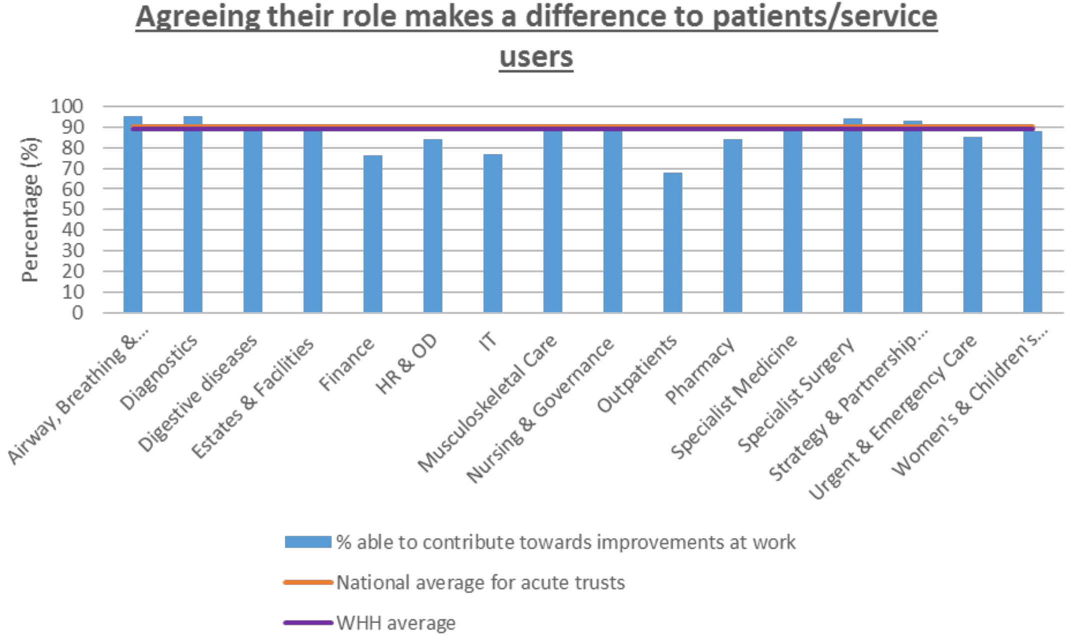


Figure 9. Colleagues agreeing that their role made a difference to patients/service users.

4.9 Violence, harassment and bullying

In 2016, 15% of staff reported that they have experience physical violence from patients, relatives or members of the public in the last 12 months, this is in line with the national average and has remained static for a number of years. However the proportion who have experienced harassment on at least one occasion from these groups was higher at 27%. Although this is a slight decrease on the 2015 survey it is essential that work continue to raise awareness for both our patients and visitors and our staff. This section links directly to the reporting on incidents and staff need to feel that the Trust will take their concerns seriously and those actions will be taken and we can see from the results that progress has been made (See section 4.3).

Although not a statistically significant increase it is noteworthy that a higher percentage of staff have reported experiencing harassment, bullying or abuse from staff in the last 12 months, although still below the national average (better than). There have been changes to the policy over the last 12 months with mechanisms for resolution being clarified for staff, it is hoped that ongoing work around the 'WE ARE' behaviours will also help to improve these finding. It is encouraging that almost half of those experiencing harassment bullying or abuse had reported their most recent experience and work will continue to encourage reporting.

Specific actions may be incorporate in to the Workforce Race Equality Standard action plan depending on the further analysis. Actions will be reported to Strategic People Committee and the Equality & Diversity Sub Committee.

5. Conclusions

The Trust has seen improvements in the 2016 Staff Survey results when compared to 2015 however, there is still work to be done and always room for improvement.

The improvements seen in the 2016 scores are encouraging, they show there is progress being made across the organisation and we are heading in the right direction. We need to celebrate where the staff survey results show we are working well and work together to make improvements in other areas. The results provide an insight into how our colleagues feel about the Trust but they do not tell us everything. A key focus in response to these results will be to analyse them in line with the People Strategy to ensure our People Plan is fully aligned to the responses from our colleagues. Furthermore, the results will be analysed within the local context of CBUs and departments, understand the reasoning behind the responses and create bespoke action plans for our teams to improve their working lives and ultimately patient experience.

To conclude, the Staff Survey compares the Trust to the national average, at WHH we want to be better than the average acute trust, we want to be the most clinically and financially successful healthcare provider in the mid-Mersey region. The results are an effective method to review our progress as an organisation and ensure that we are focusing our attention in the right areas. The action to follow the publication of these results will be to work in partnership with our managers and teams to ensure we act appropriately on the feedback we have been provided.

6. Key Recommendations

1. CBU/Department level action plans to be developed in response to the area specific feedback gathered
2. Departmental review of reporting procedures and a benchmarking exercise across the Trust
3. Engagement with areas where best practise and lessons learnt could be shared through focus groups and surveys
4. Increased communication and promotion of the link between job satisfaction and patient care/experience in team brief, team meetings
5. Review the appraisal process to ensure it captures key drivers which motivate our colleagues, their ambitions and how they achieve job satisfaction
6. Promote the importance of our whole workforce including Corporate Services, clearly demonstrating the link between their role and patient care

2. KEY ELEMENTS

The 2016 NHS Staff Survey results highlight 5 key areas where WHH compares least favourably and where we need to work together and focus our attention;

1. Staff recommendation of the organisation as a place to work or receive treatment
2. Effective team working
3. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
4. Percentage of staff agreeing that their role makes a difference to patients/service users
5. Effective use of patient/service user feedback

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Trust Board are asked to review the 2016 NHS Staff Survey results as outlined in this report. Furthermore, the Trust Board are asked to support and champion the recommendations set out to ensure that the organisation is responding appropriately to the feedback received.

4. IMPACT ON QPS?

The Staff Survey results reflect areas that require attention in order to enable the QPS Framework. This is highlighted in section 1. Background/Context of the report.

5. MEASUREMENTS/EVALUATIONS

The aim of the work to follow the 2016 NHS Staff Survey results will be to continue improving our scores as a Trust. Although we will endeavour to collect ongoing feedback from our colleagues, the overall evaluation of the work that will be done over the next 12 months will be reflected in the 2017 NHS Staff Survey results.

6. TRAJECTORIES/OBJECTIVES AGREED

The CBU/Department level action plans will be confirmed following the publication of this report. The action plans will be formulated with robust feedback arrangements in place.

7. MONITORING/REPORTING ROUTES

The Staff Survey CBU action plans and progress will be approved and monitored by the Strategic People Committee.

8. TIMELINES

The Trust's response to the 2016 NHS Staff Survey results will be ongoing however, our action plans will be continually reviewed over the next 12 months prior to the 2017 NHS Staff Survey.

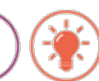
9. ASSURANCE COMMITTEE

Strategic People Committee

10. RECOMMENDATIONS

The key recommendations for the Board to approve are;

1. CBU/Department level action plans to be developed in response to the area specific feedback gathered
2. Departmental review of reporting procedures and a benchmarking exercise across the Trust
3. Engagement with areas where best practise and lessons learnt could be shared through focus groups and surveys
4. Increased communication and promotion of the link between job satisfaction and patient care/experience in team brief, team meetings
5. Review the appraisal process to ensure it captures key drivers which motivate our colleagues, their ambitions and how they achieve job satisfaction
6. Promote the importance of our whole workforce including Corporate Services, clearly demonstrating the link between their role and patient care



APPENDIX 1 – 2016 Key Findings in comparison to 2015 results

3.3. Summary of all Key Findings for Warrington and Halton Hospitals NHS Foundation Trust (cont)

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	! Lowest (worst) 20%
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	! Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	✓ Above (better than) average
KF9. Effective team working	• No change	! Lowest (worst) 20%
KF14. Staff satisfaction with resourcing and support	• No change	✓ Above (better than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	✓ Above (better than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	✓ Highest (best) 20%
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	• Average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	! Below (worse than) average
KF32. Effective use of patient / service user feedback	✓ Increase (better than 15)	! Below (worse than) average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	• Average
KF24. % reporting most recent experience of violence	• No change	✓ Highest (best) 20%
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Below (better than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Above (better than) average

2016 National NHS staff survey

Brief summary of results from Warrington and Halton Hospitals NHS Foundation Trust

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1. Introduction to this report

This report presents the findings of the 2016 national NHS staff survey conducted in Warrington and Halton Hospitals NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2016 survey results for Warrington and Halton Hospitals NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who "Agree" and "Strongly Agree" compared to the total number of staff that responded to the question.

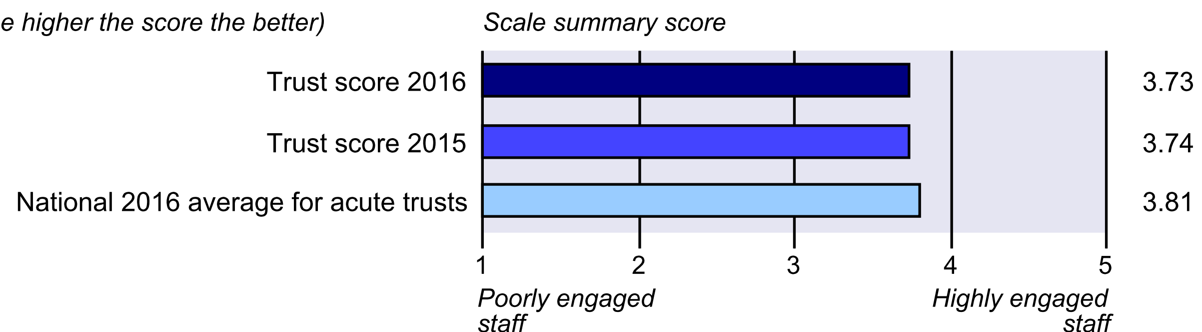
Q21a, Q21c and Q21d feed into Key Finding 1 "Staff recommendation of the organisation as a place to work or receive treatment".

		Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	69%	76%	63%
Q21b	"My organisation acts on concerns raised by patients / service users"	69%	74%	62%
Q21c	"I would recommend my organisation as a place to work"	54%	62%	49%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	57%	70%	54%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.59	3.77	3.51

2. Overall indicator of staff engagement for Warrington and Halton Hospitals NHS Foundation Trust

The figure below shows how Warrington and Halton Hospitals NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.73 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Warrington and Halton Hospitals NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2015 survey.

	Change since 2015 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	! Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	! Lowest (worst) 20%
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Below (worse than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Below (worse than) average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

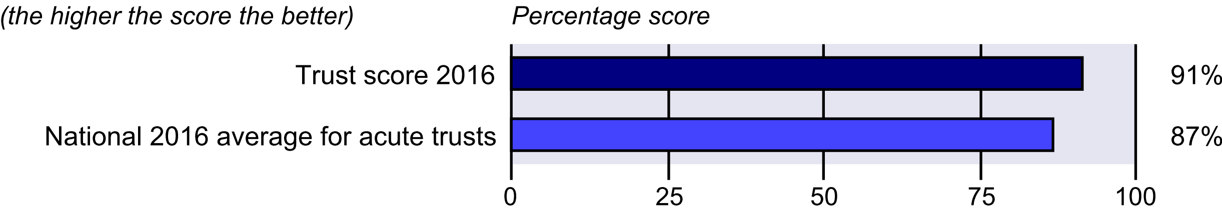
3. Summary of 2016 Key Findings for Warrington and Halton Hospitals NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

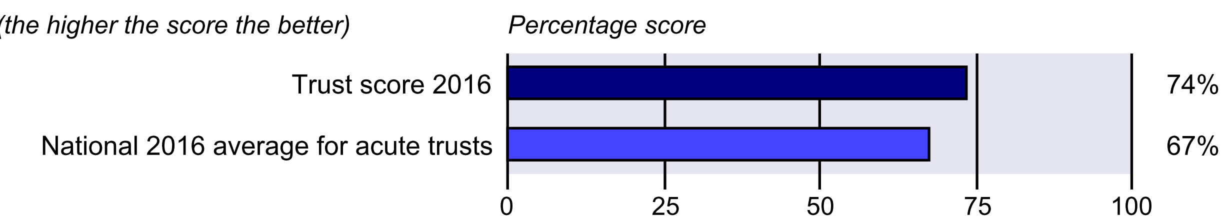
This page highlights the five Key Findings for which Warrington and Halton Hospitals NHS Foundation Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

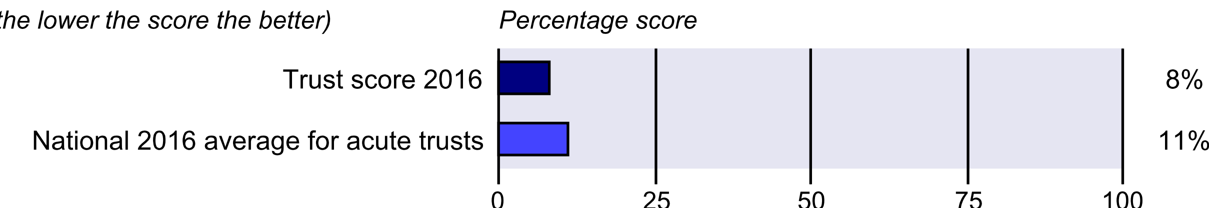
✓KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



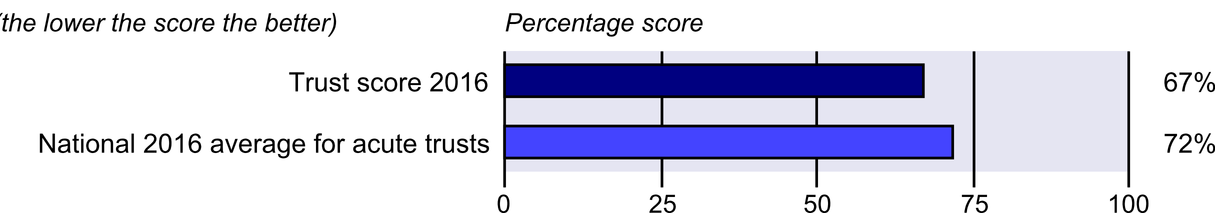
✓KF24. Percentage of staff / colleagues reporting most recent experience of violence



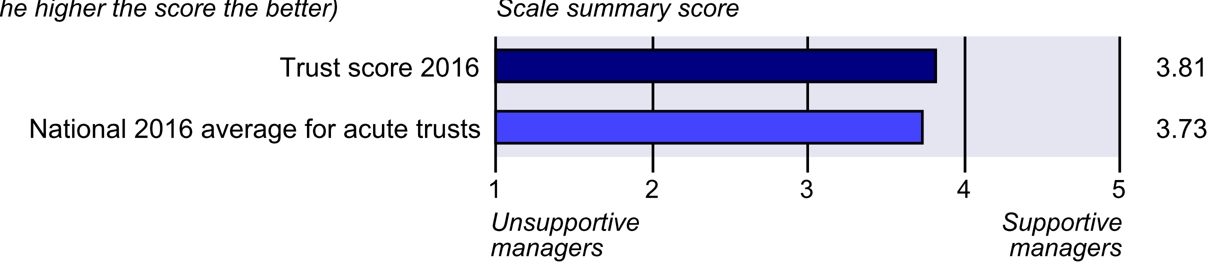
✓KF20. Percentage of staff experiencing discrimination at work in the last 12 months



✓KF16. Percentage of staff working extra hours



✓KF10. Support from immediate managers

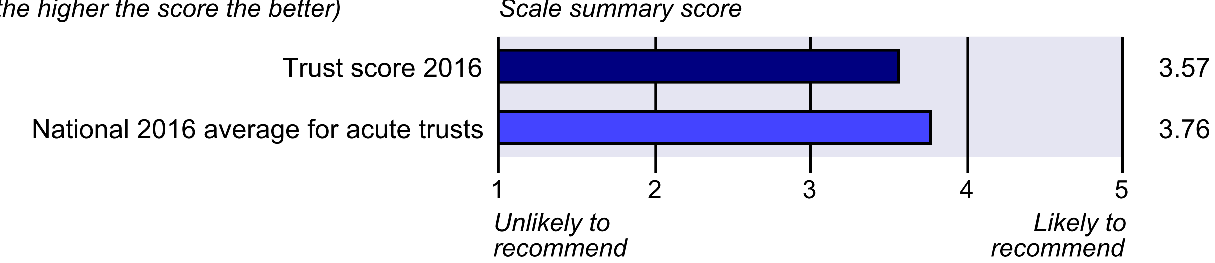


For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 98 (the bottom ranking score). Warrington and Halton Hospitals NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

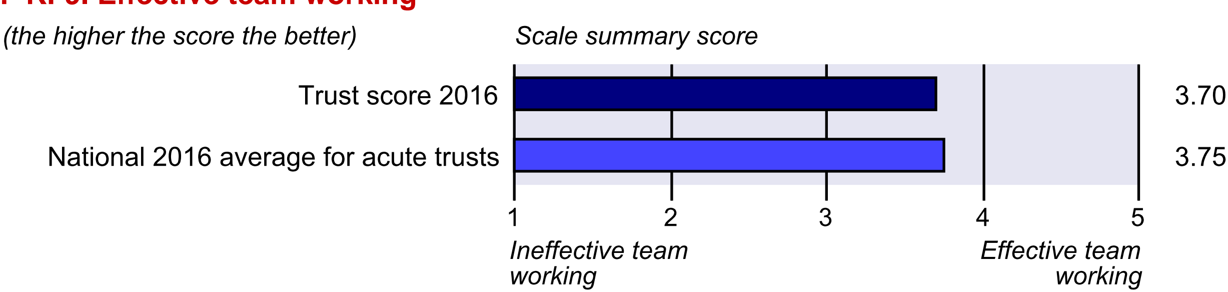
This page highlights the five Key Findings for which Warrington and Halton Hospitals NHS Foundation Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

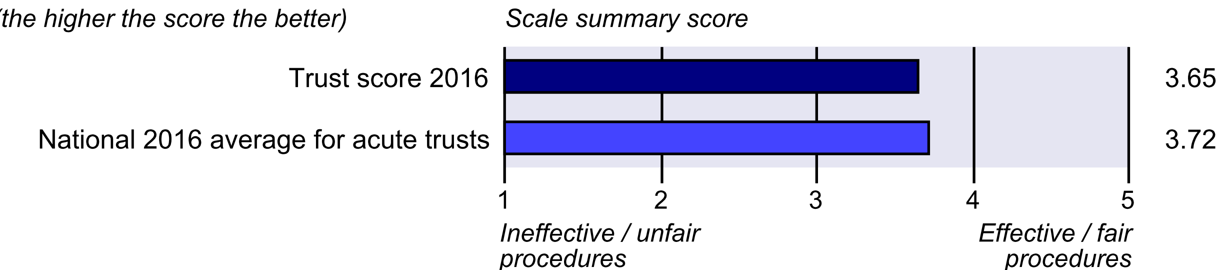
! KF1. Staff recommendation of the organisation as a place to work or receive treatment



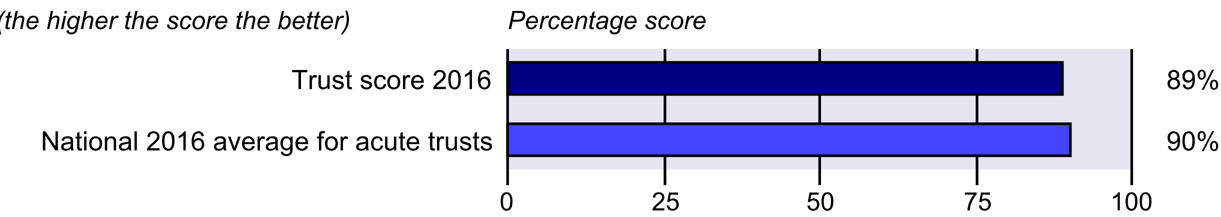
! KF9. Effective team working



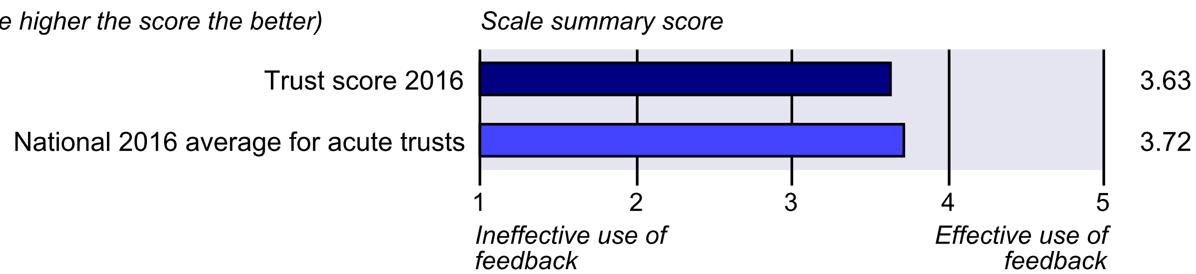
! KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents



! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users



! KF32. Effective use of patient / service user feedback



For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 98 (the bottom ranking score). Warrington and Halton Hospitals NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 98. Further details about this can be found in the document ***Making sense of your staff survey data***.

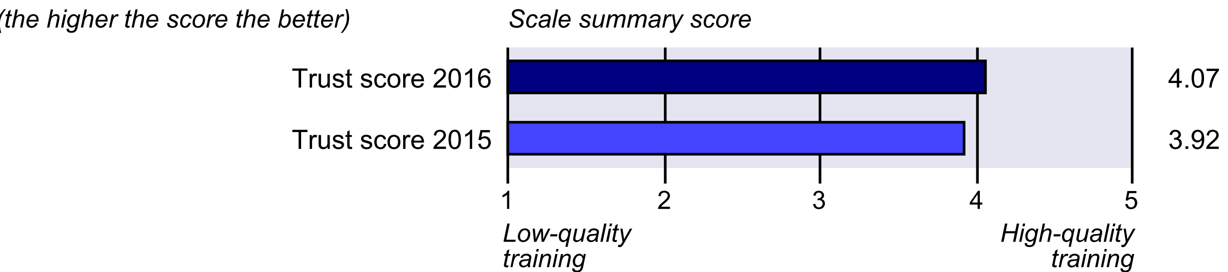
3.2 Largest Local Changes since the 2015 Survey

This page highlights the two Key Findings where staff experiences have improved at Warrington and Halton Hospitals NHS Foundation Trust since the 2015 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other acute trusts in England, the score for Key finding KF32 is worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

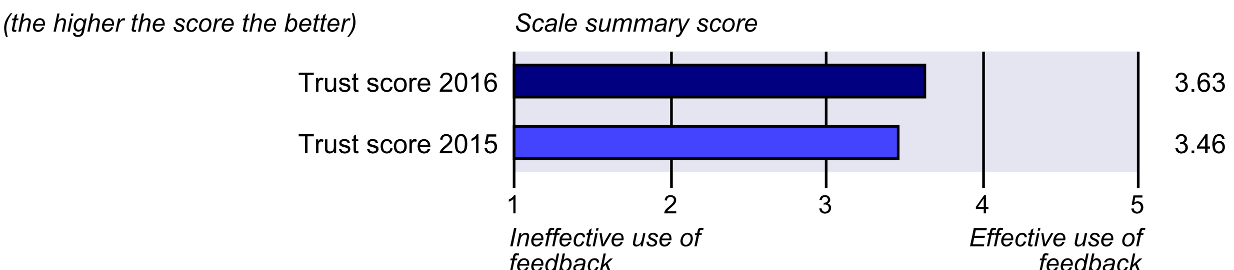
✓ KF13. Quality of non-mandatory training, learning or development

(the higher the score the better)



✓ KF32. Effective use of patient / service user feedback

(the higher the score the better)



3.2. Summary of all Key Findings for Warrington and Halton Hospitals NHS Foundation Trust

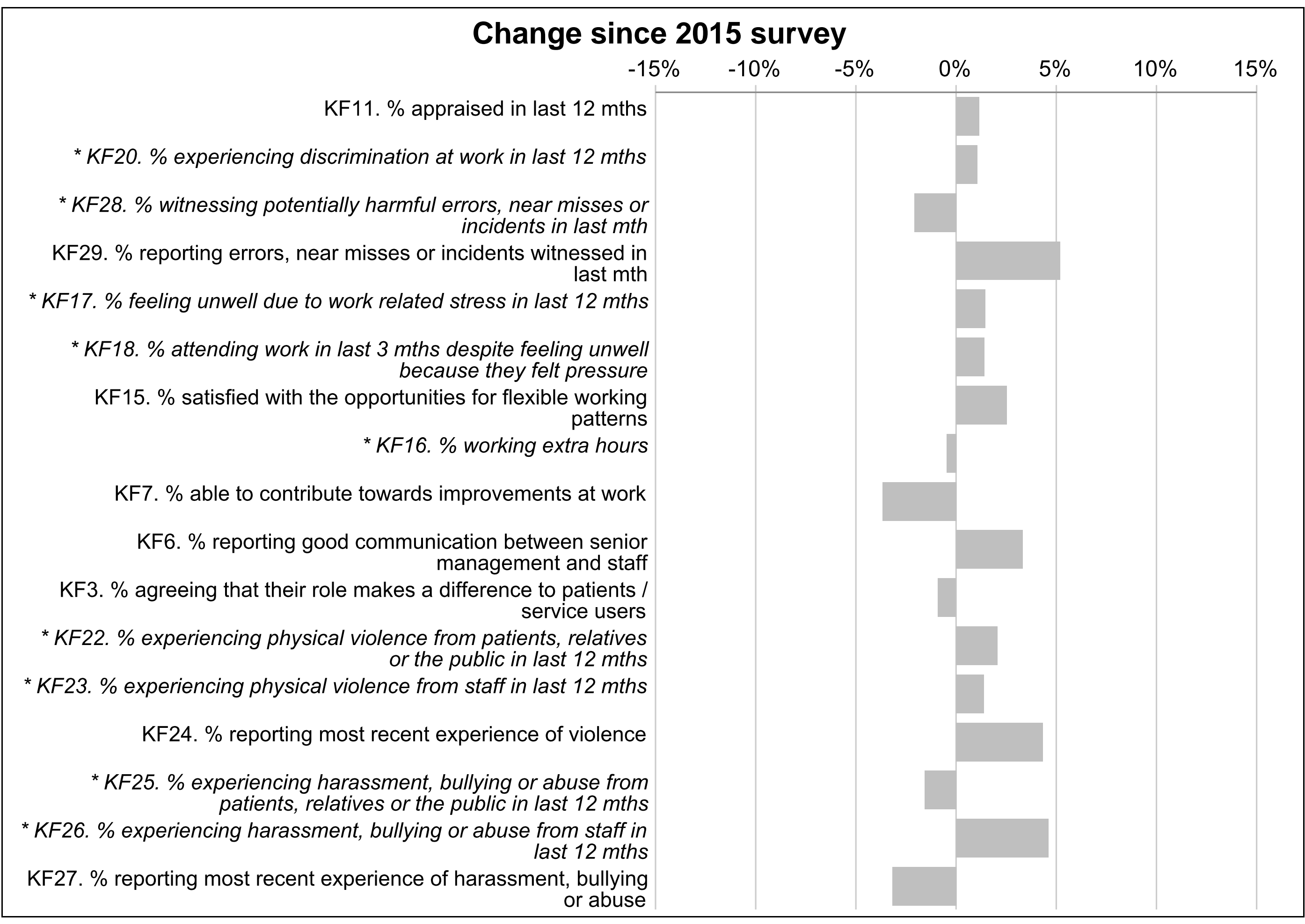
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for Warrington and Halton Hospitals NHS Foundation Trust

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Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

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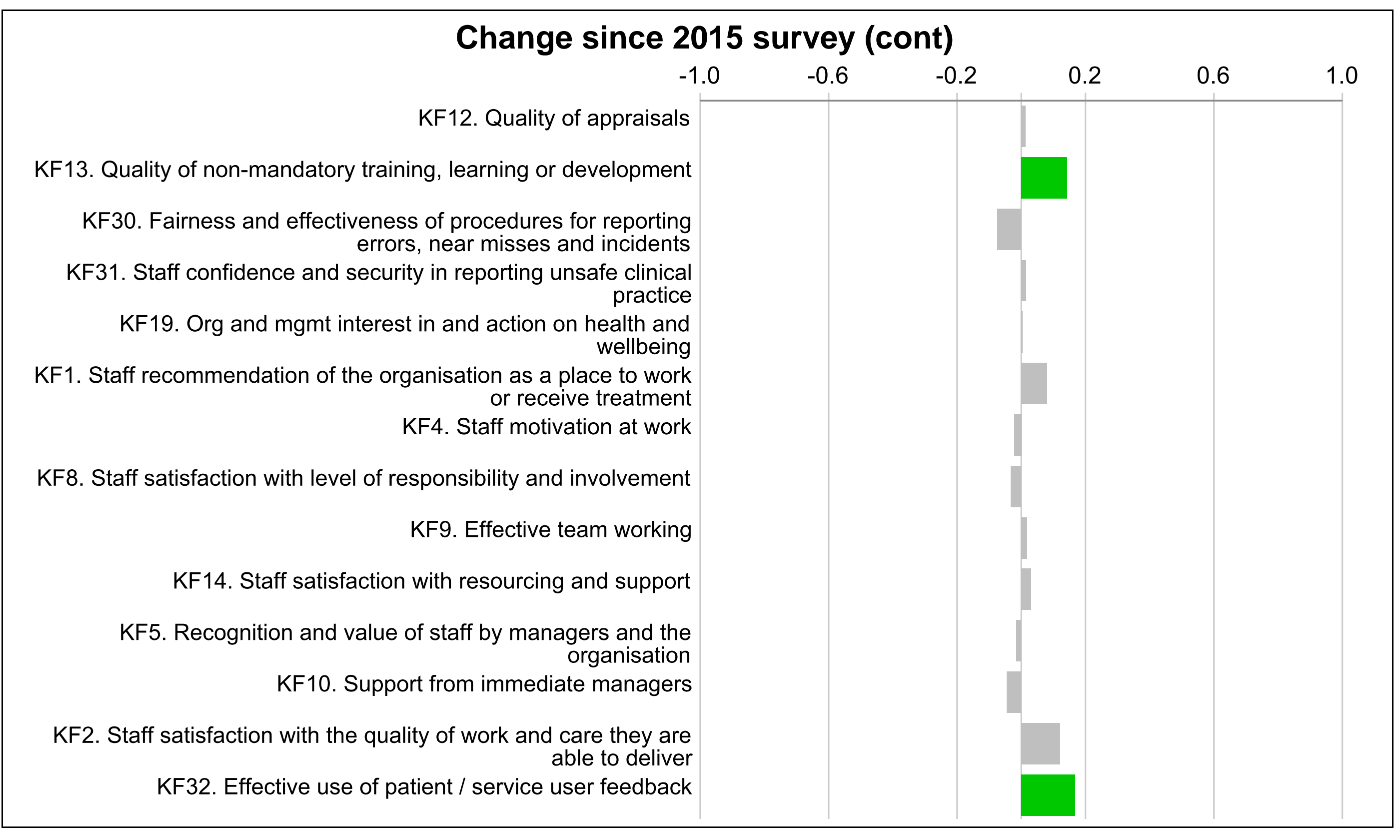


3.2. Summary of all Key Findings for Warrington and Halton Hospitals NHS Foundation Trust

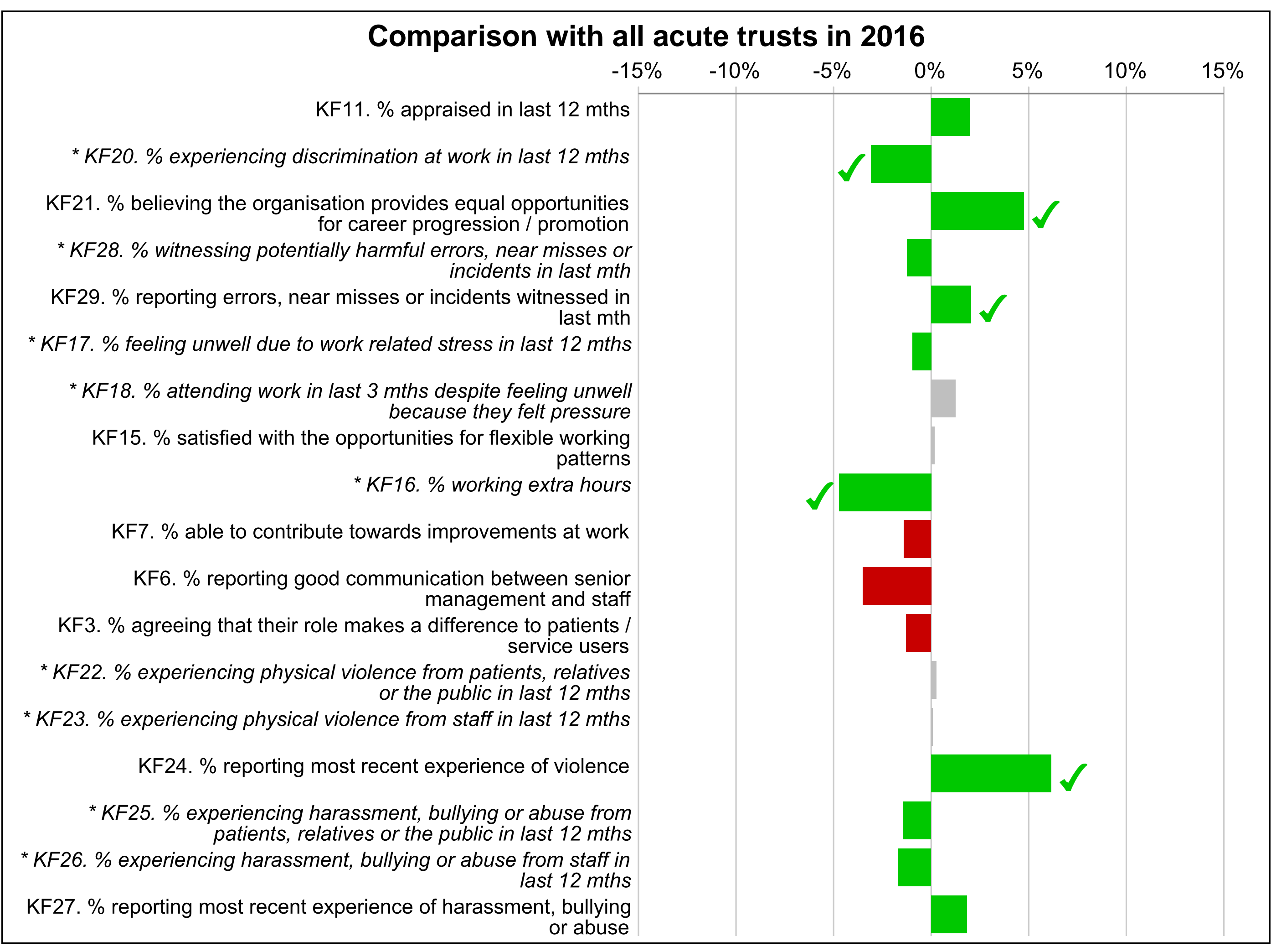
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for Warrington and Halton Hospitals NHS Foundation Trust

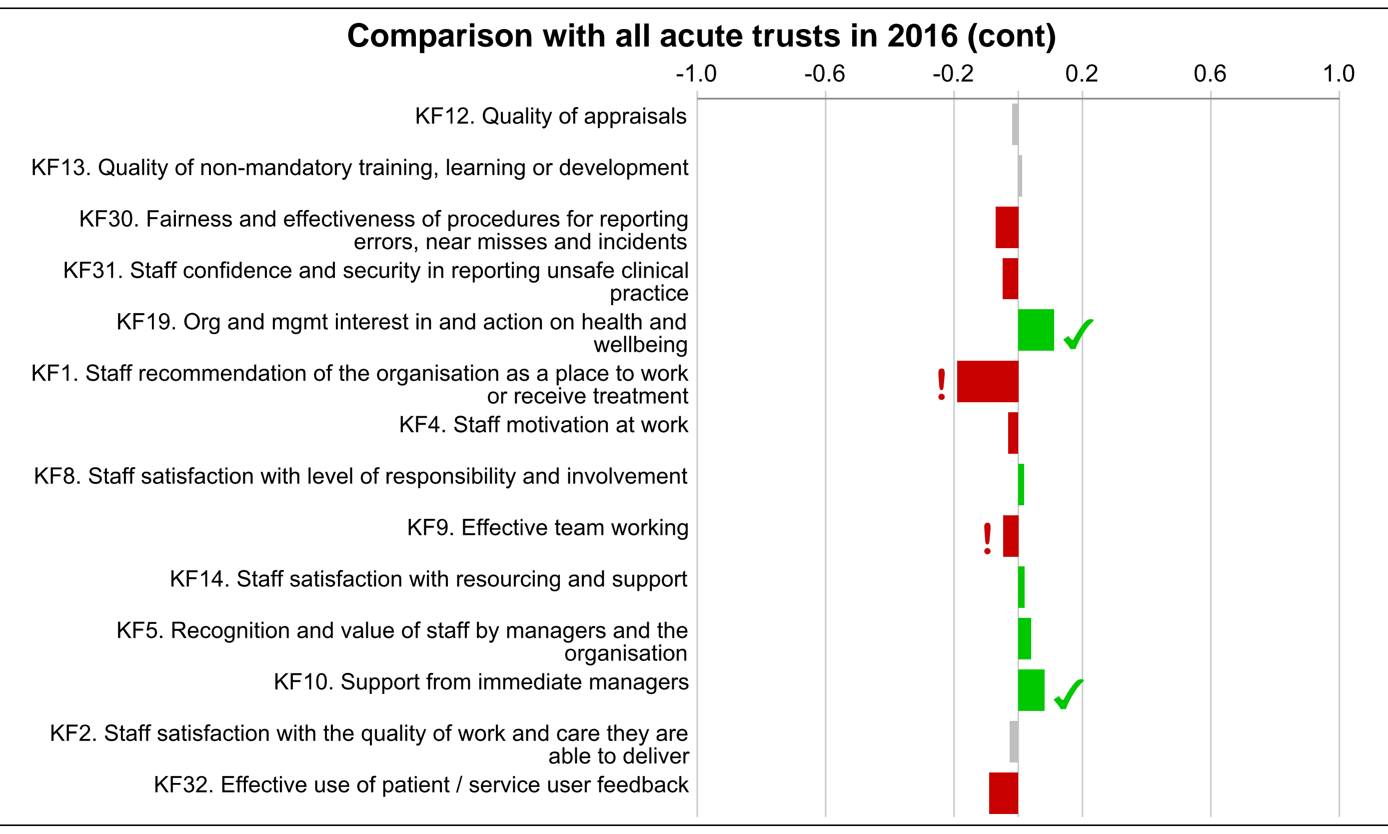
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Warrington and Halton Hospitals NHS Foundation Trust

KEY

- ✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2015.
- ! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2015.
- 'Change since 2015 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2015 survey.
- -- Because of changes to the format of the survey questions this year, comparisons with the 2015 score are not possible.
- * For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	✓ Above (better than) average
KF12. Quality of appraisals	• No change	• Average
KF13. Quality of non-mandatory training, learning or development	✓ Increase (better than 15)	• Average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Lowest (best) 20%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	--	✓ Highest (best) 20%
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	✓ Below (better than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Highest (best) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	• Average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	✓ Highest (best) 20%
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	• Average
* *KF16. % working extra hours*	• No change	✓ Lowest (best) 20%

3.3. Summary of all Key Findings for Warrington and Halton Hospitals NHS Foundation Trust (cont)

	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	! Lowest (worst) 20%
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	! Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	✓ Above (better than) average
KF9. Effective team working	• No change	! Lowest (worst) 20%
KF14. Staff satisfaction with resourcing and support	• No change	✓ Above (better than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	✓ Above (better than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	✓ Highest (best) 20%
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	• Average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	! Below (worse than) average
KF32. Effective use of patient / service user feedback	✓ Increase (better than 15)	! Below (worse than) average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	• Average
KF24. % reporting most recent experience of violence	• No change	✓ Highest (best) 20%
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Below (better than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Above (better than) average

4. Key Findings for Warrington and Halton Hospitals NHS Foundation Trust

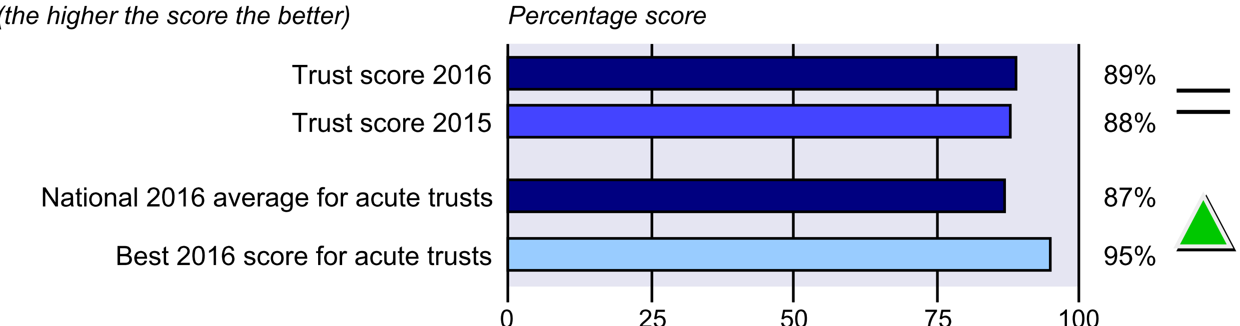
Warrington and Halton Hospitals NHS Foundation Trust had 1475 staff take part in this survey. This is a response rate of 38%[1] which is below average for acute trusts in England, and compares with a response rate of 33% in this trust in the 2015 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2016 survey, and compares these to other acute trusts in England and to the trust's performance in the 2015 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

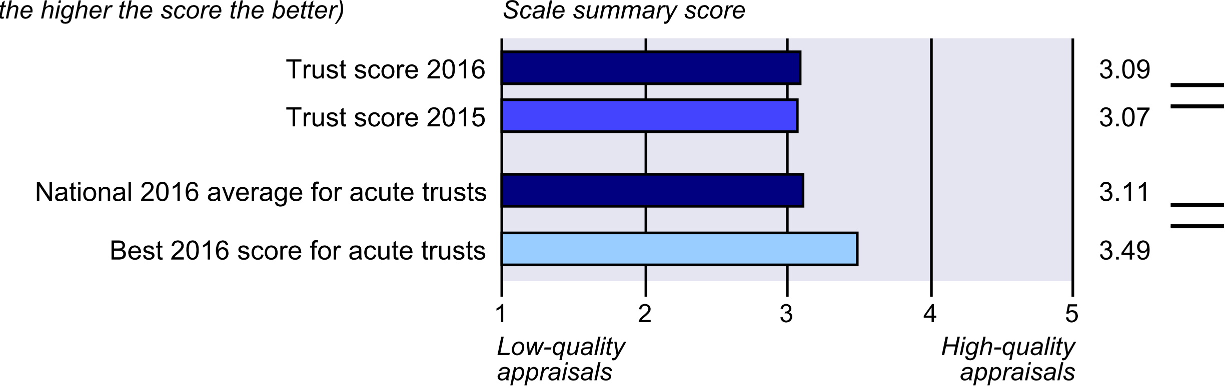
Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2015). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2015). An equals sign indicates that there has been no change.

Appraisals & support for development

KEY FINDING 11. Percentage of staff appraised in last 12 months

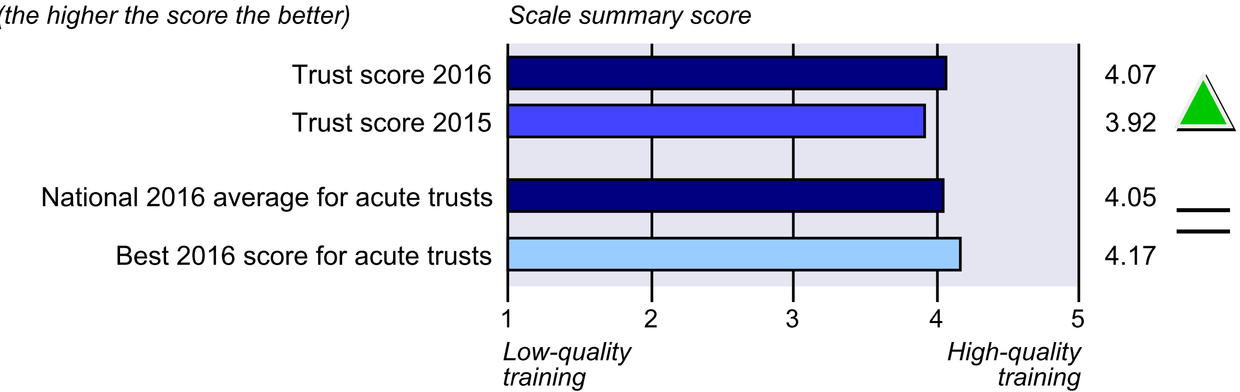


KEY FINDING 12. Quality of appraisals



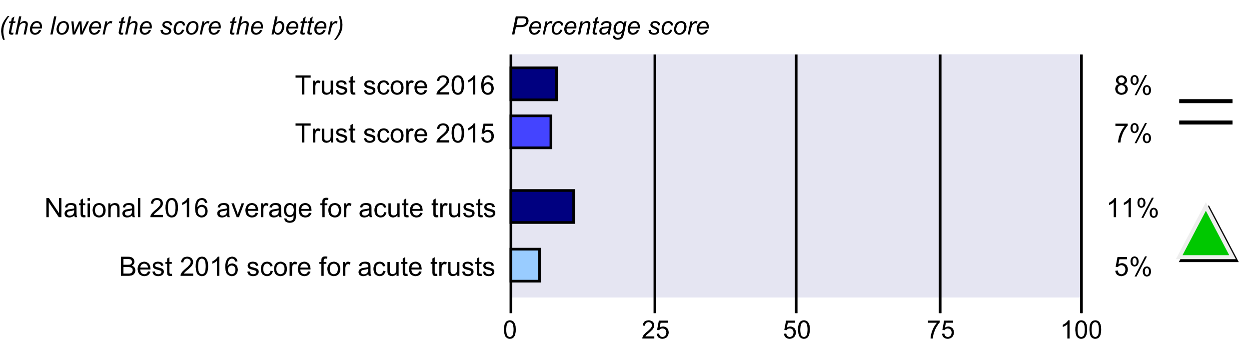
[1]Questionnaires were sent to all 3855 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

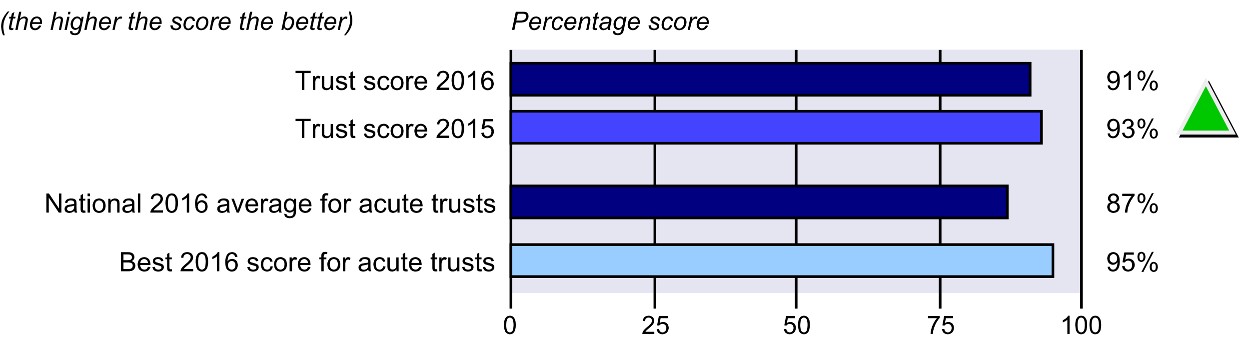


Equality & diversity

KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

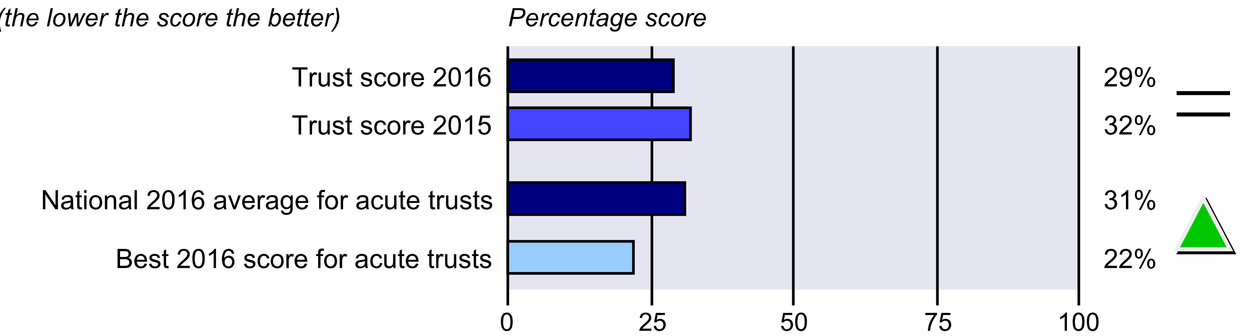


KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

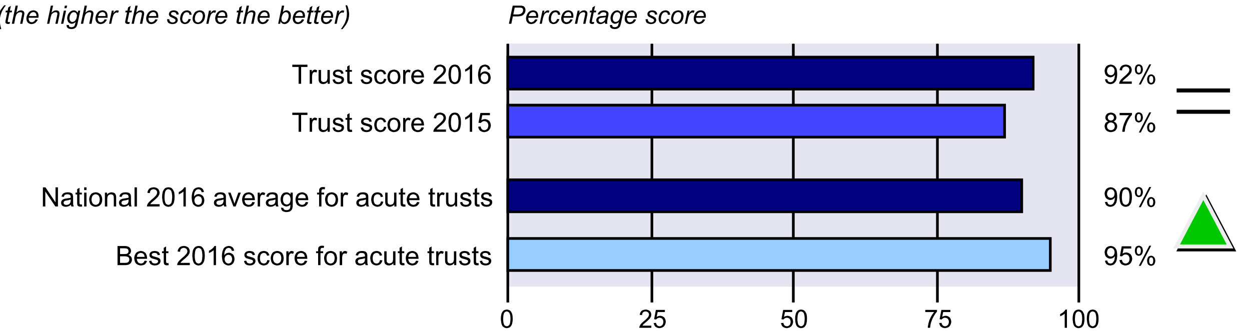


Errors & incidents

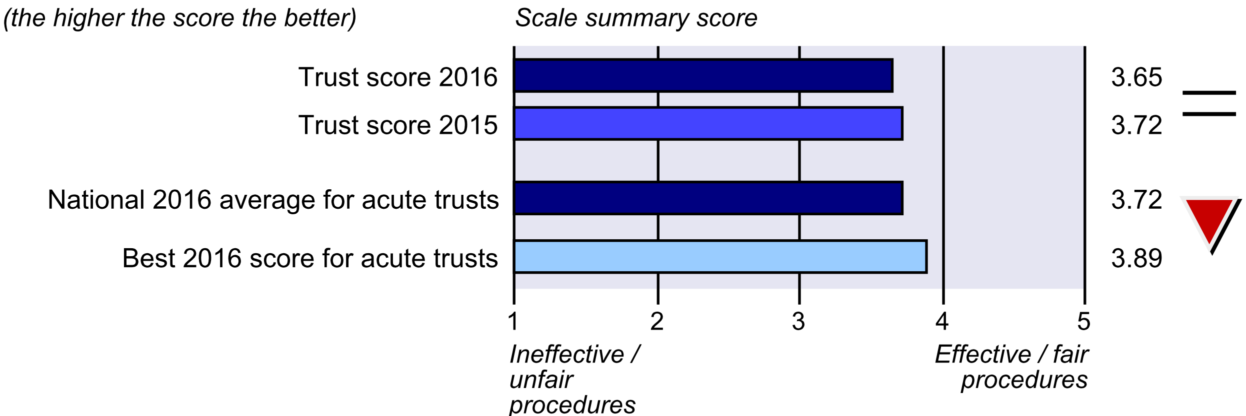
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



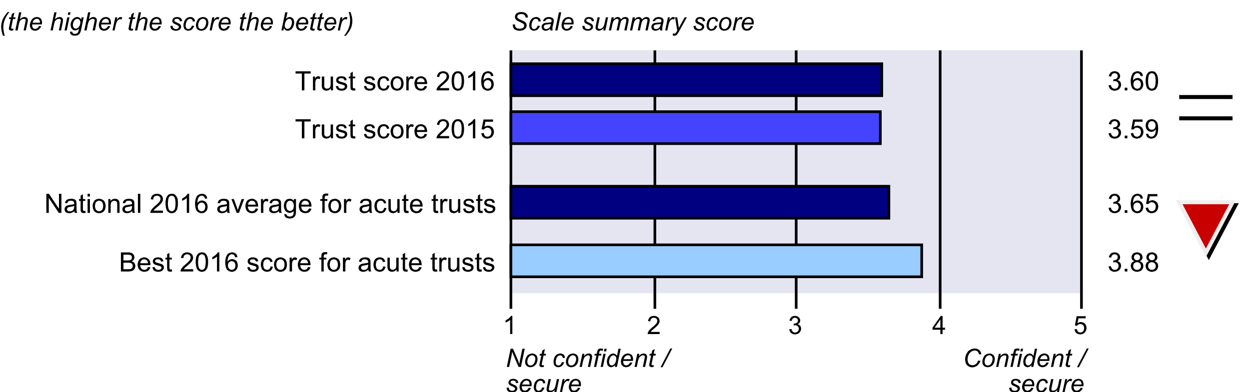
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

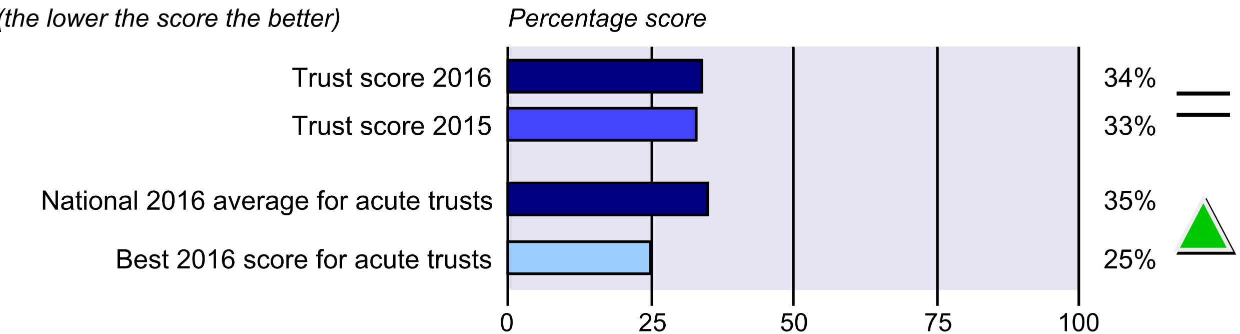


KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

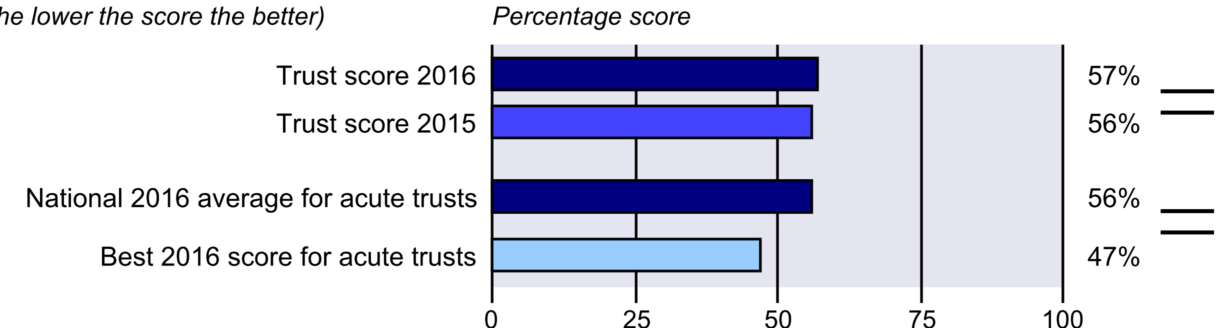


Health and wellbeing

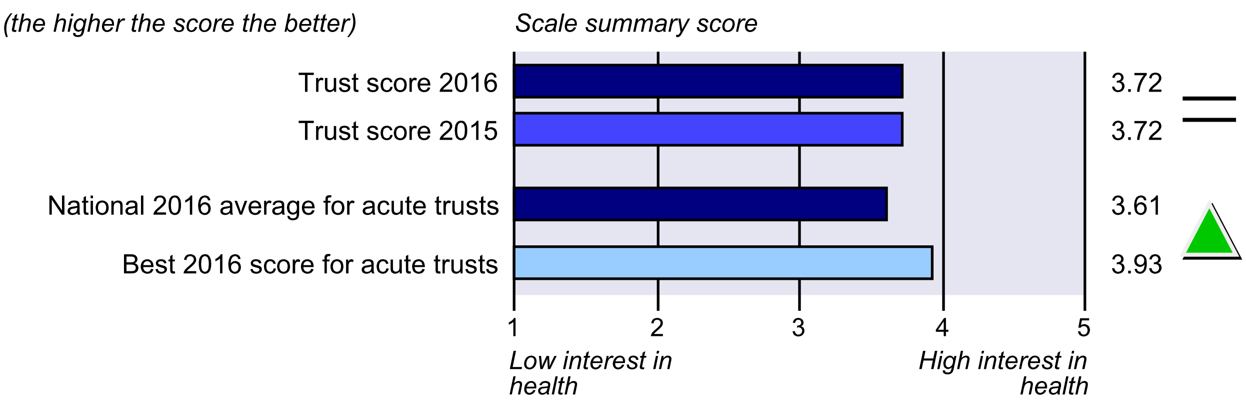
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months



KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

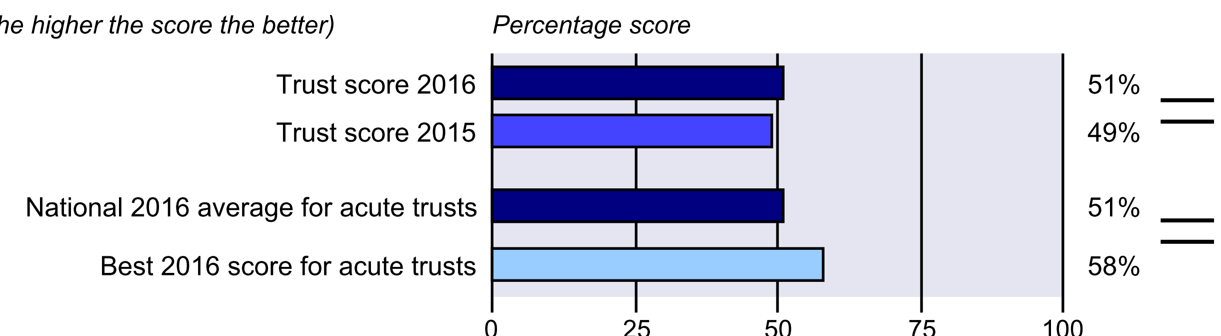


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

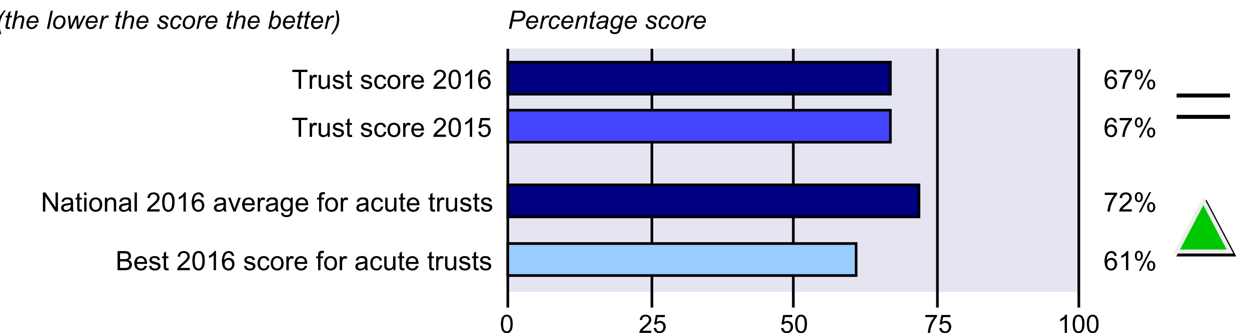


Working patterns

KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns



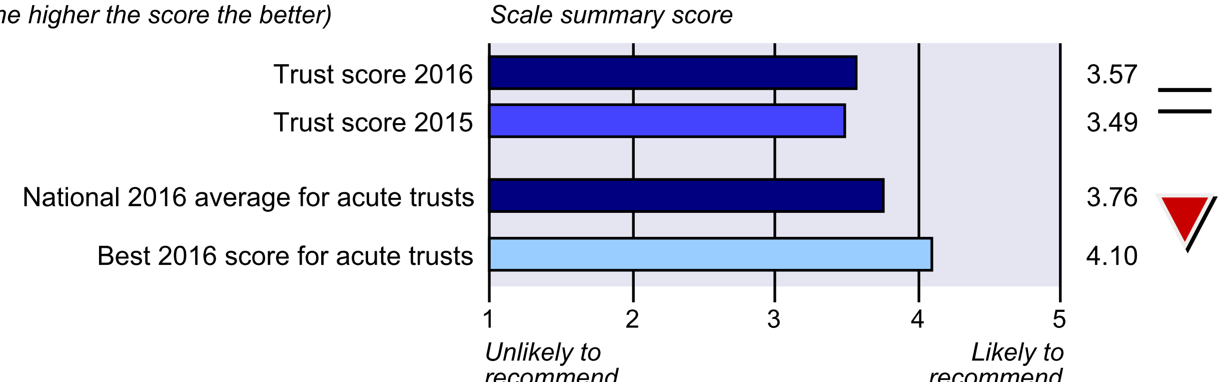
KEY FINDING 16. Percentage of staff working extra hours



Job satisfaction

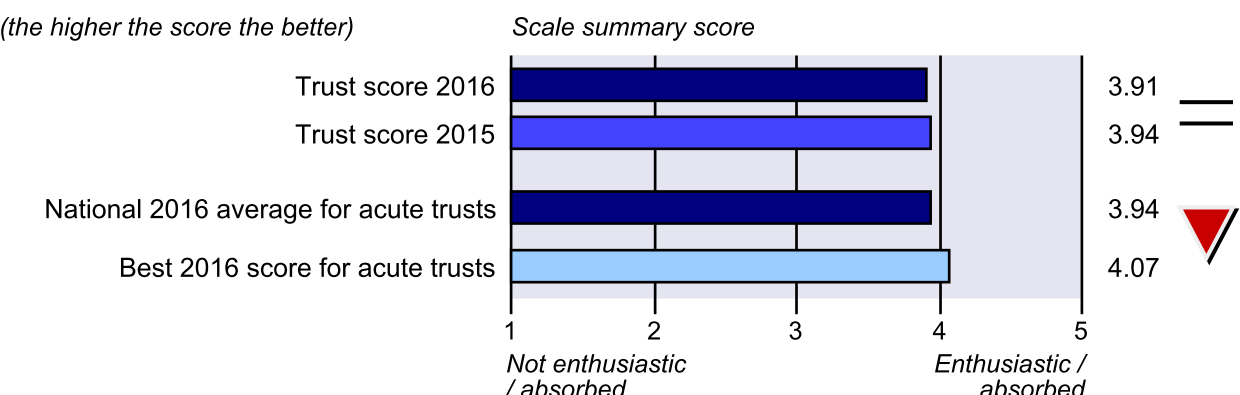
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



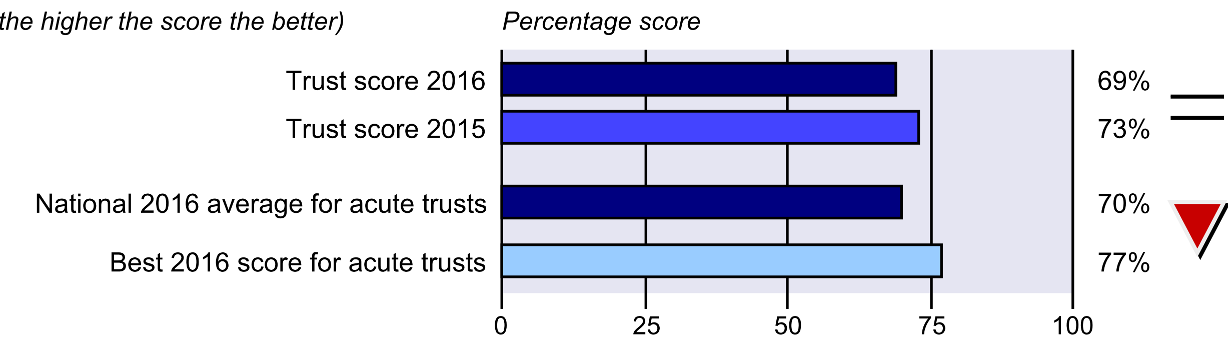
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



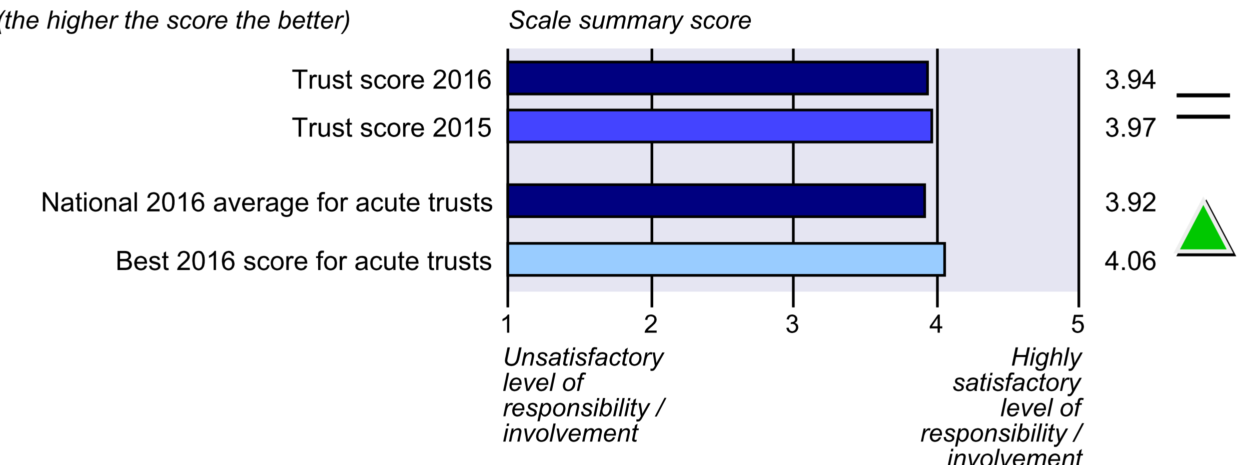
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)

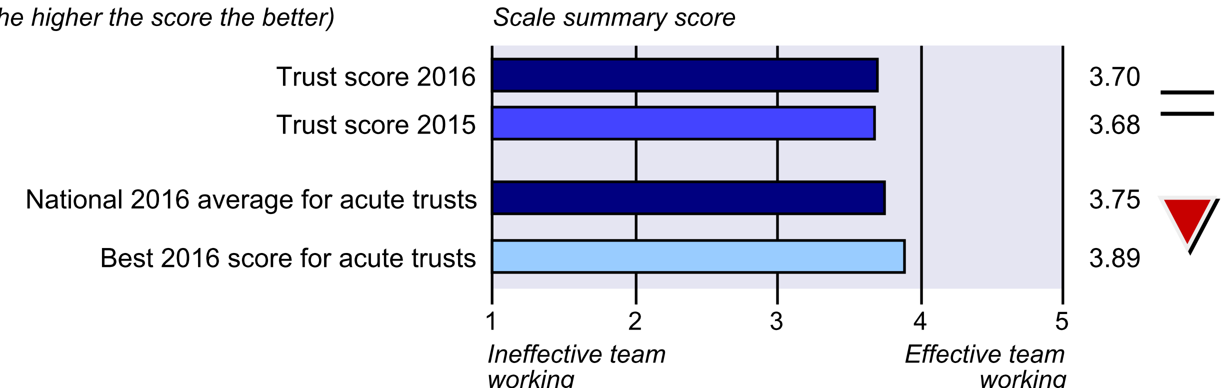


KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

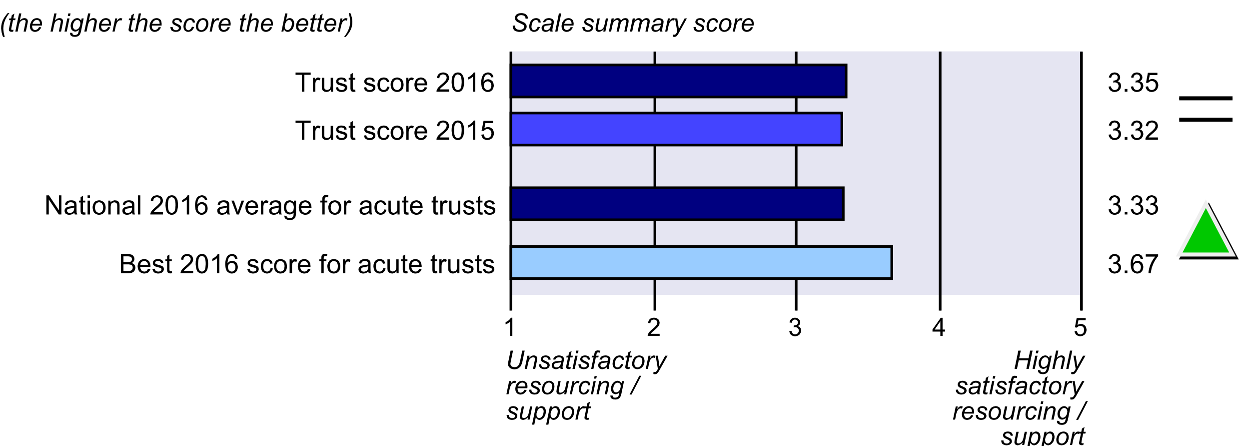
(the higher the score the better)



KEY FINDING 9. Effective team working

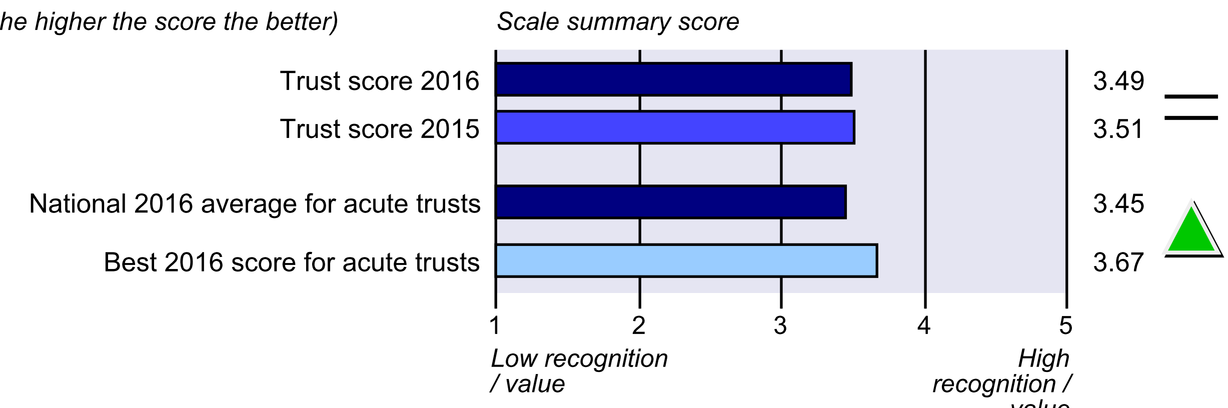


KEY FINDING 14. Staff satisfaction with resourcing and support

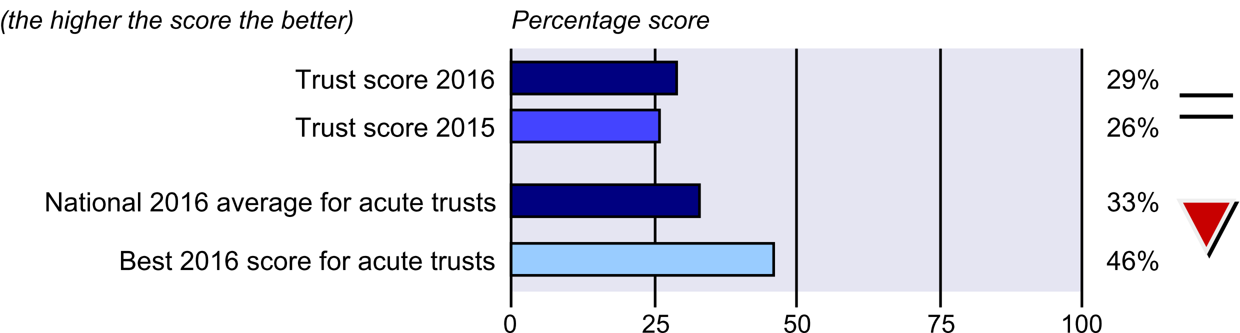


Managers

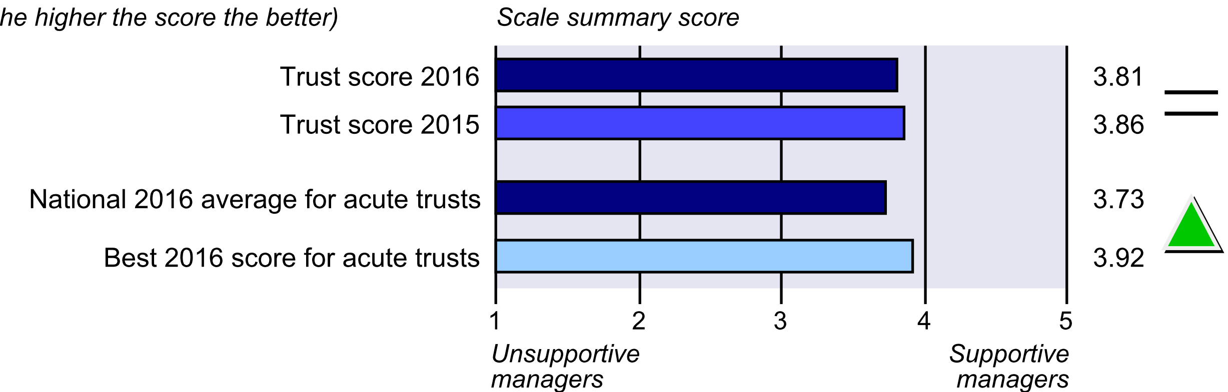
KEY FINDING 5. Recognition and value of staff by managers and the organisation



KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

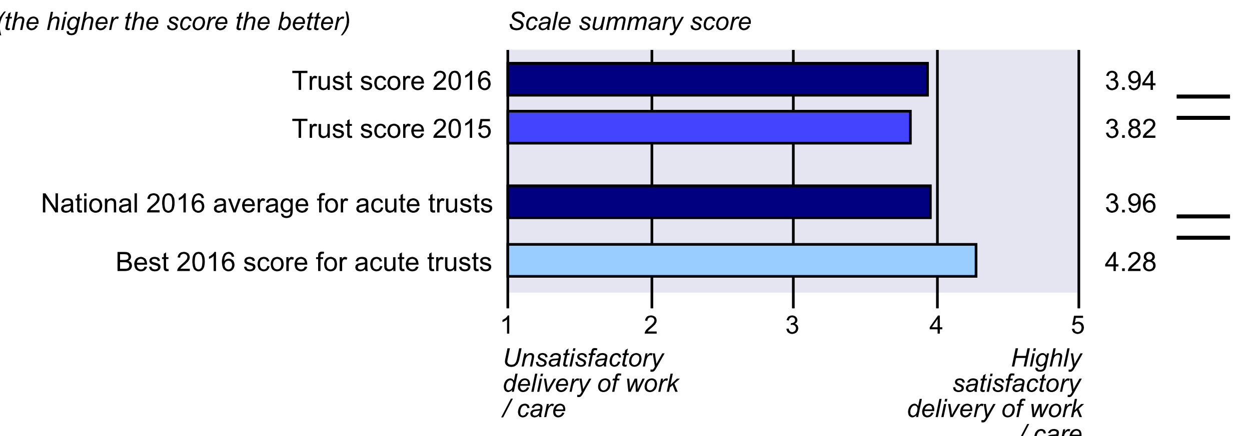


KEY FINDING 10. Support from immediate managers

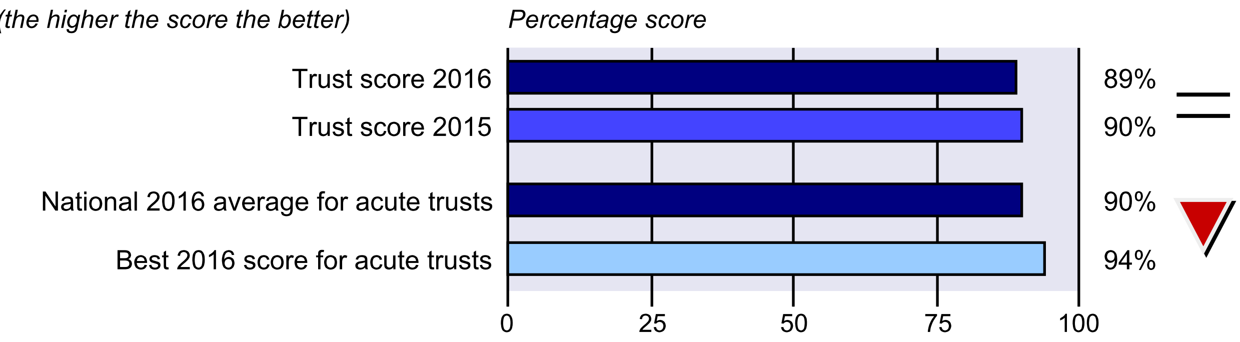


Patient care & experience

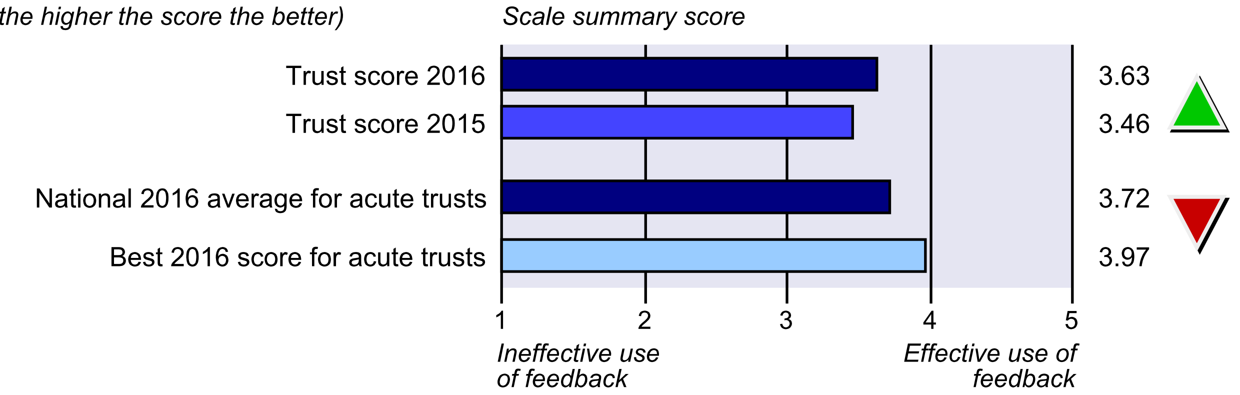
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver



KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

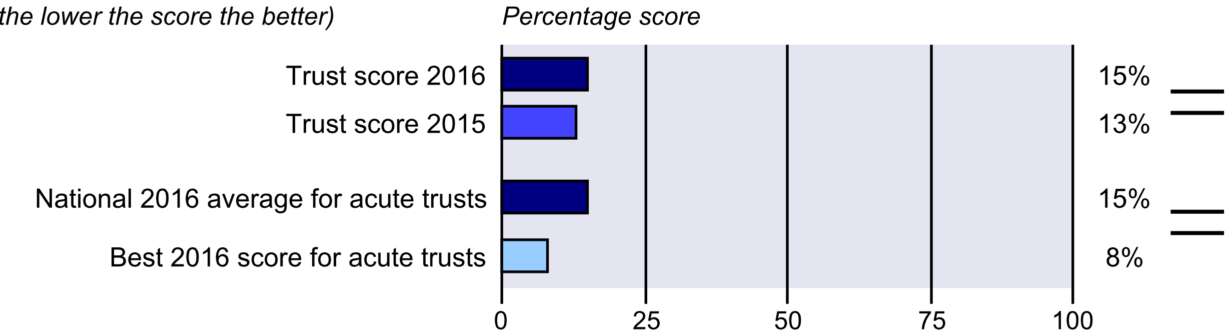


KEY FINDING 32. Effective use of patient / service user feedback

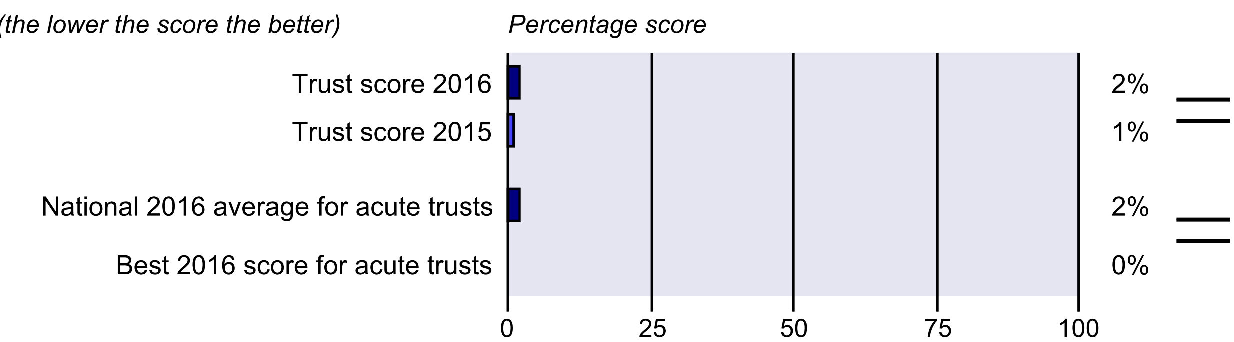


Violence, harassment & bullying

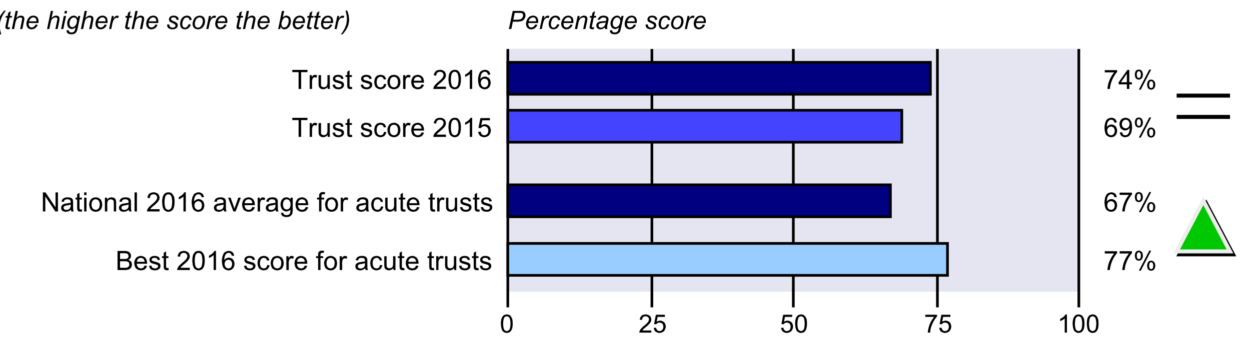
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



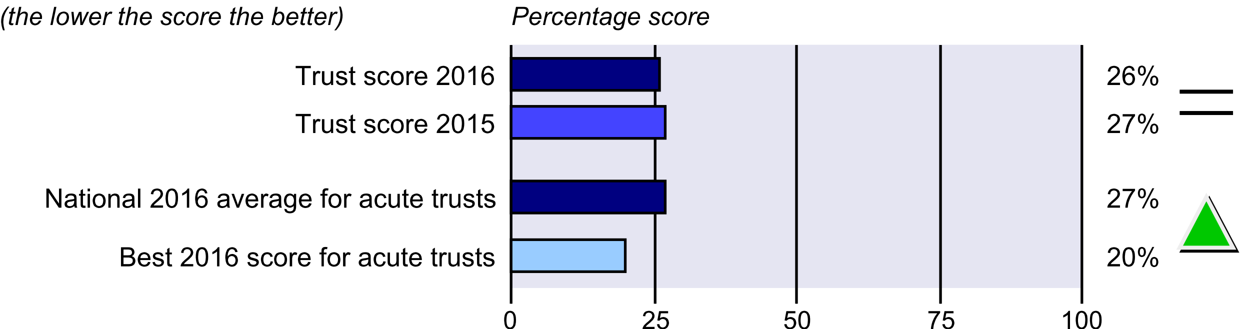
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months



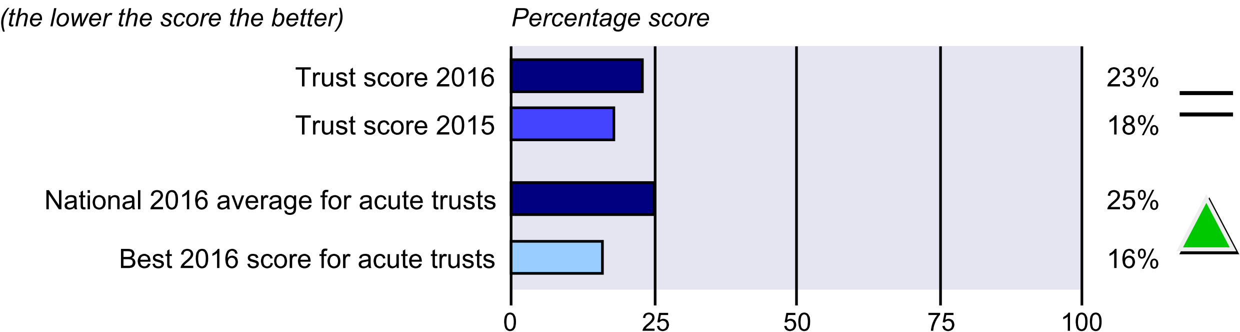
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence



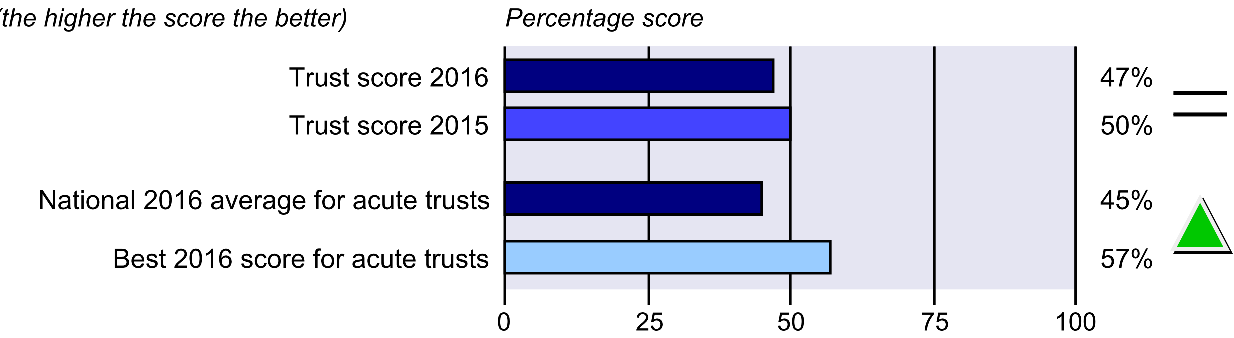
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/47**
SUBJECT:	**Approach to NHSI to review the Trusts Licence Conditions**
DATE OF MEETING:	Choose an item. 26th April 2017
ACTION REQUIRED	**For Decision**
AUTHOR(S):	Pat McLaren
EXECUTIVE DIRECTOR SPONSOR:	Andrea Chadwick, Director of Finance & Commercial Development Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	Monitor authorises Foundation Trusts to operate within the terms of their license
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust remains under Enforcement from Monitor pursuant to its powers under s106 of the Health & Social Care Act 2012 for the following: • 2014/15 financial position and 2015/16 financial forecast which resulted in a forecast Continuity of Services Risk Rating of 1 • Absence of a recovery plan to return the Trust to a Continuity of Services Risk Rating of 3 or greater and reliance upon external support to develop a turnaround plan • Historic and current performance re: delivery of the cost savings programme In 2016-17 the Trust has made significant progress to deliver its services on a clinically, operationally and financially sustainable basis including: • An action plan to reduce the financial deficit and improve the 2016-17 year financial position beyond that submitted as part of the Annual Planning process. • An action plan to minimise the 2016-17 deficit and seek to move to a position of breakeven. • Acceptance of NHSI's control total for 2017-18 and 2018-19

<table>
<tr><td rowspan="1"></td><td colspan="2">The development of a longer term strategic plan to move a position of breakeven whilst remaining clinically and operationally over the longer term period.</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="2">The Board is asked to support a formal approach to NHS Improvement to review/remove the licence conditions.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td>Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td></td></tr>
<tr><td>Date of meeting</td><td></td></tr>
<tr><td>Summary of Outcome</td><td></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="2">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="2">Choose an item.</td></tr>
</table>

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/48**	
SUBJECT:	**Terms of Reference and Cycle Of Business 2017-18– formal Sub Committees of the Trust Board**	
DATE OF MEETING:	26 April 2017	
ACTION REQUIRED	**Approval**	
AUTHOR(S):	Various executive directors	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Corp Affairs Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	 All Choose an item.	
STRATEGIC CONTEXT	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis.	
EXECUTIVE SUMMARY (KEY ISSUES):	Each ToR and CoB has been reviewed and approved by the relevant committee.	
RECOMMENDATION:	The Trust Board is required to ratify the Terms of Reference and Cycles of Business of its committees for 2017-18	
PREVIOUSLY CONSIDERED BY:	**Committee /date**	• Quality Committee – approved by the QC 7 February 2017. • Financial and Sustainability Committee – approved by the FSC 22 March 2017 • Audit Committee – approved by the AC 16 January 2017. • Charitable Funds Committee – approved by the CFC 7 April 2017 • Council of Governors – approved by the CoG 19 January 2017
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

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

2. AUTHORITY

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

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

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

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

The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

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

Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the Monitor Provider Licence (under the auspices of NHS Improvement).
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- To provide overview and scrutiny to the development of the medium and long term financial models (MTFM and LTFM).
- To ensure the MTFM and LTFM is designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the MTFM and LTFM is

provided.

- To review and monitor the in-year delivery of annual efficiency savings programmes.
- To review the performance indicators relevant to the remit of the Committee .
- Consider any relevant risks within the Board Assurance Framework and corporate level Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Key Issues Report.

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £500k or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- Oversee the development of the Trust's Estates' Strategy for approval by the Board and oversee implementation of that strategy.
- Receive a monthly IM&T report on implementation of the Trust IM&T Strategy, Information Governance and project management.

5. MEMBERSHIP

The Committee shall be composed of not less than two (2) independent Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

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

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

6. CORE ATTENDEES

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Director of Finance & Commercial Development
- Chief Operating Officer
- Director of Transformation
- Director of IM&T
- Chief Nurse

- Medical Director/Deputy Chief Executive
- Director of HR and Organisational Development
- Deputy Director of Finance

Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items, however, there is no requirement to attend the whole meeting.

7. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non Executives Directors who are not members of the Committee may attend in substitution and be counted in the quorum.

8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

9. REPORTING GROUPS

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

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

The following groups will report directly to the Committee:

- Innovation and Cost Improvement Committee ICIC
- Information Management & Technology Steering Committee including reports from
  - Lorenzo Project Group
  - Information Governance and Corporate Records Committee (including the Data Quality & Information Governance Group)
- Capital Planning Group
- Out-Patient Turnaround Board
- Pay Spend and Review Committee minutes to reporting groups.

10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

11. REVIEW / EFFECTIVENESS

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

Date: March 2017

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	V1
Implementation Date:	April 2017
Review Date:	March 2018
Approved by:	Finance + Sustainability Committee
Approval Date:	22 March 2017

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
22 March 2017	**3 – Reporting arrangements**	- There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum.	
22nd March 2017	**4. Duties and Responsibilities**	- To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement	
22 March 2017	**6 - Attendance**	- Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy. - Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance	
22 March 2017	**9. Reporting Groups**	Two groups removed: - The Business Planning sub Committee (strategic). - Strategic & Annual Planning Steering Group. One Group added: - Pay Spend and Review Committee minutes to reporting groups.	
22 March 2017	**10 Administrative Arrangements**	- Due to change in administrative support to the Committee - Agreement with the Chair and Director of Finance to amend the timescale for circulating papers	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

			2017								2018		
	Exec Lead	**19.4.17**	**24.5.17**	**21.6.17**	**19.7.17**	**23.8.17**	**20.9.17**	**18.10.17**	**22.11.17**	**19.12.17**	**Jan**	**Feb**	**Mar**
INTRODUCTION & ADMINISTRATION													
Apologies for Absence	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of the Last Meeting	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Matters Arising+ Action Log	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Rolling attendance log	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
GOVERNANCE & COMPLIANCE													
Committee Terms of Reference	**DoCE&CA**												X
Committee Cycle of Business	**DoCE&CA**												X
Annual Report of the FSC to the Board	**Chair**	X											
Pay Assurance (inc NHSI checklist) + Pay Spend and Review Group Notes/Mins	**Dir HR+OD**	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register	**DoF&CD**	X	X	X	X	X	X	X	X	X	X	X	X
FINANCIAL ASSURANCE													
Monthly Finance report, forecast overview+ actions including cash +funding, risks + management; capital expenditure	**DoF&CD**	X	X	X	X	X	X	X	X	X	X	X	X
Contracts & Income (CQUIN etc)	**DoF&CD**	X	X	X	X	X	X	X	X	X	X	X	X
CIP Update + ICIC mins	**DoT**	X	X	X	X	X	X	X	X	X	X	X	X
Draft Capital Planning Group Action Notes	**DoF&CD**	X	X	X	X	X	X	X	X	X	X	X	X
INVESTMENT													
Annual Capital Programme	**DoF&CD**											X	
Estates Strategy Update	**DoF&CD**	X						X			X		
PLANNING													
Operational Plan & Budgets	**DoF&CD**									X			
IM&T Update	**DoIM&T**	X	X	X	X	X	X	X	X	X	X	X	X
Lorenzo Benefits Report	**DoIM&T**	X			X			X			X		
Performance Report (incl efficiency, productivity, utilisation, LOS, DNAs) + Outpatient Board Mins	**COO**	X	X	X	X	X	X	X	X	X	X	X	X
Service Line Reporting – 6 month report	**DoF&CD**				X						X		
Sustainability and Transformation Plan	**DoF&CD /DoT**				X							X	
CLOSING													
Key issues to the Board	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Any Other Business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Next Meeting Date & Time	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X

	13th April (moved to 6.4.17)	20th July 2017	19th October 2017	TBCJanuary 2018	TBC April 2018
STANDING ITEMS					
Chairman's Opening Remarks & Welcome	X	X	X	X	X
Apologies & Declarations of Interest	X	X	X	X	X
Minutes of Previous Meeting	X	X	X	X	X
Action Log	X	X	X	X	X
Chairman's Briefing (report from work of NEDS)	X	X	X	X	X
Chief Executives Report	X	X	X	X	X
FORMAL BUSINESS					
Integrated Performance Report	X	X	X	X	X
Presentation on current topic	X	X	X	X	X
Reports from Governor Sub-Committees	X	X	X	X	X
Ratification of NED Appointment (as required)	X				
Trust Operational Plan	X				X
Annual Appraisal of Trust Chairman		X			
Governor Engagement Group Terms of Reference & Cycle of Business		X			X
Governor Quality in Care Group Terms of Reference & Cycle of Business		X		X	
Annual Appraisal of Non-Executive Directors	X				X

Annual Report & Accounts		**X**			
Annual Audit Committee Report		**X**			
Auditors Letter and Report on Quality Account		**X**			
Elections Activity Bi-Annual Report : Vacancies & Governors Terms of Office		**X**		**X (Nov elections)**	
Compliance Trust Provider Licence (bi-annually)		**X**		**X**	
Governor Training & Development Programme 1. New Governor Induction				**X**	
Governor Training & Development Programme 2. MIAA courses – as available	**X**	**X**	**X**	**X**	**X**
Lead Governor role (every two years – next due January 2019)					
Appointment of External Auditors (every three years next due October 2019)					
OTHER BUSINESS					
Annual Members Day – date tbc					
Annual Members Meeting – annually (date tbc but must be no later than December each year)					

2017 TERMS OF REFERENCE OF THE COUNCIL OF GOVERNORS

COUNCIL OF GOVERNORS (COG)

Approved by the Council of Governors on (19 January 2017)

1. PURPOSE

The role of the Council of Governors is derived from Schedule 7 and other sections of the National Health Service Act 2006 as amended by the Health & Social Care Act 2012. This document should be read in conjunction with the act.

2. GENERAL DUTIES

The general duties of the Council of Governors are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Trust as a whole and the interests of the public

3. STANDING

The full meeting of the Council of Governors and its Nomination & Remuneration Committee are the bodies in which Governors have official standing. All other forums are advisory.

4. MEMBERSHIP

The composition of the membership of the Council of Governors is set out in the Constitution. The Chair of the Board of Directors is the Chair of the Council of Governors and presides over meetings of the Council of Governors. In the absence of the Chair, the Senior Independent Director will take the Chair.

5. QUORUM

The quorum for the Council of Governors is set out in the Constitution.

6. COUNCIL OF GOVERNORS COMMITTEES

The Council of Governors will establish the following committees:

- Nomination & Remuneration Committee
- Such other committees as may be required from time to time
- Task & Finish Working Groups as necessary

7. THE ROLE OF THE COUNCIL OF GOVERNORS

Non-Executive Directors; Chief Executive and the Auditors

- Approve the policies and procedures for the appointment and where necessary for the removal of the Chair of the Board of Directors and non-executive directors of the Trust Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve the appointment or removal of a Chair of the Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve the appointment or removal of a non-executive director on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve the policies and procedures for the annual appraisal of the Chair of the Board of Directors and non-executive directors of the Trust Board on the

recommendation of the Council of Governor's Nomination & Remuneration Committee

- Approve changes to the remuneration, allowances and other terms of office for the Chair of the Board and other non-executive directors on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve or where appropriate, decline to approve the appointment of a proposed candidate as Chief Executive recommended by the non-executive directors
- Approve the criteria for appointing, re-appointing or removing the Auditor
- Approve the appointment or re-appointment and the terms of engagement of the Auditor on the recommendation of the Audit Committee

Constitution and Compliance

- Jointly approve with the Board of Directors amendments to the Constitution, subject to any changes in respect of the powers, duties or role of the Council of Governors being ratified at the next general meeting of members (at which a member of the Council of Governors needs to present the change.)
- Notify Monitor, via the Lead Governor, if the Council of Governors is concerned that the Trust is breaching its Licence if these concerns cannot be resolved at the local level.

Governors

- Approve the allocation of Governors to sub-groups of the Council of Governors, working groups and any joint working groups set up by the Board of Directors.
- Approve the appointment and the role of the Lead Governor.
- Receive quarterly reports from the Chairs of the Council of Governors sub-groups in the discharge of the sub-groups' duties
- Approve the removal from office of a Governor in accordance with procedure set out in the Constitution.
- Approve jointly with the Board of Directors the procedure for the resolution of disputes and concerns between the Board of Directors and the Council of Governors.

Strategy, Planning, Reorganisations

- Provide feedback on the development of the strategic direction of the Trust to the Board of Directors as appropriate.
- Contribute to the development of stakeholder strategies, including member engagement strategies.
- Act as a critical partner to the Board of Directors in the development of the forward plan.
- Where the forward plan contains a proposal that the Trust will carry on an activity other than the provision of goods and services for the purposes of the NHS in England, determine whether the proposal will interfere or not in the fulfilment by the Trust of its principal purpose (the provision of goods and services for the purposes of the health service in England). Notify the board of its determination.
  Approve or not approve increases to the proposed amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the trust.

- Approve or not approve proposals from the Board of Directors for mergers, acquisitions, separations and dissolutions. More than half of the total number of Governors needs to approve such a proposal.
- Approve or not approve proposals for significant transactions where defined in the Constitution or such other transactions as the Board may submit for the approval of Governors from time to time. Such transactions require the approval of more than half of Governors voting at a quorate meeting of the Council of Governors.

Representing Members and the Public

- Approve the membership engagement strategy.
- Contribute to members' and other stakeholders' understanding of the work of the trust in line with engagement and communication strategies.
- Seek the views of stakeholders, including members and the public and feedback relevant information to the Board of Directors or to individual managers within the Trust as appropriate.
- Act as ambassadors in order to raise the profile of the Trust's work with the public and other stakeholders.
- Promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy.
- Attend events during the year that facilitate contact between members, the public and Governors to promote Governor accountability
- Report to members each year on the performance of the Council of Governors.

Holding the Non-Executive Directors to Account

- The Council of Governors must hold the non-executive directors individually and collectively to account for the performance of the board. It must agree a process and dialogue with the board that will enable them to fulfil this duty.
- As part of this a good working relationship between the Board of Directors and Council of Governors is critical; it can be fostered by meeting regularly and with sufficient frequency to establish appropriate channels of communication and constructive challenge.

Some of the following may support this process and dialogue:

- Receive the agenda of the meetings of the Board of Directors before the meeting takes place.
- Be equipped by the trust with the skills and knowledge they require in their capacity as governors.
- Receive the annual report of the audit committee on the work, fees and performance of the auditor.
- Receive the annual report and accounts (including quality accounts).
- Receive the quarterly report of the board of directors on the performance of the foundation trust against agreed key financial, operational, quality and regulatory compliance indicators and stated objectives.
- Participate in opportunities to review services and environments such as PLACE inspections/quality reviews/ local activities and evaluation of user/carer experience.

- Receive and review quarterly assurance reports.
- Receive reports from the board on important sectoral or strategic issues.
- Use information obtained through the above sources to monitor performance and progress against the key milestones in the strategic and annual plans and to hold the non-executive directors to account for the performance of the board of directors.
- If considered necessary (as a last resort), in the fulfilment of this duty, obtain information about the Trust's performance or the directors' performance by requiring one or more directors to attend a Council of Governor meeting

8. COLLECTIVE EVALUATION OF PERFORMANCE

The Council of Governors will carry out an annual review of its effectiveness and efficiency in the discharge of its responsibilities and achievement of its objectives.

9. FREQUENCY OF MEETINGS

The Council of Governors will meet at 4 times per year.

10. MINUTES

The Council of Governors will be supported by the Secretary to The Trust Board who will agree the agenda with the Chair and produce all necessary papers. Minutes will be circulated promptly to all members as soon as reasonably practical.

11. REVIEW

The Council of Governors will review these Terms of Reference annually.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Council of Governors
Version	V2
Implementation Date	
Review Date	19 January 2017
Approved By	

REVISION			
Date	**Section**	**Reason for Change**	**Approved By**
19.1.17	10	The Council of Governors will be supported by the Secretary to the Trust Board.	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**

CHARITABLE FUNDS CYCLE OF BUSINESS 2017-18

	Exec Lead	7 April 2017	7 July 2017	13 October 2017	January 2018	April 2018
INTRODUCTION & ADMINISTRATION						
Apologies for Absence	Chair	X	X	X	X	X
Declarations of Interest	Chair	X	X	X	X	X
Minutes of the Last Meeting	Chair	X	X	X	X	X
Matters Arising+ Action Log	Chair	X	X	X	X	X
Rolling attendance	Chair	X	X	X	X	X
GOVERNANCE & COMPLIANCE						
Terms of Reference and Cycle of Business	Chair/Director of Community Engagement/Corporate Affairs	X				X
Charities Commission Checklist	Director of Community Engagement/Corporate Affairs		X			
Finance Report	Director of Finance + Commercial Development	X	X	X	X	X
Fundraising Report	Fund Raising Manager	X	X	X	X	X
Annual Report and Accounts	Director of Finance + Commercial Development/Financial Accountant			X		
Charitable Funds Strategy	Director of Community Engagement/Corporate Affairs	X				X
Annual Work Plan	Director of Community Engagement/Corporate Affairs		X			
Committees annual report to Board	Chair		X			
CLOSING						
Key issues to the Board	Chair	X	X	X	X	X
Any Other Business	Chair	X	X	X	X	X
Next Meeting Date & Time	Chair	X	X	X	X	X

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The Board of Directors, acting as Corporate Trustee for the Charitable Funds, hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. AUTHORITY

The Committee is authorised to:

- perform any of the activities within its terms of reference;
- obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- make recommendations to the Board for actions it deems necessary.

The Trust is Trustee of charitable funds registered together under charity registration 1051858 and the Committee is appointed as the Trust's agent in accordance with s16 of the NHS Trusts (Membership and Procedures) Regulations 1990.

The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

- The Committee will be accountable to the Board of Directors. A report of the meeting will be submitted and presented to the Board by the Chair who shall draw to the attention of the Board issues that require disclosure to the full Board, or require executive action. The minutes of the Committee meetings will be formally recorded and circulated to the Board.
- The Committee will report to the Board annually on its work and performance in the preceding year.
- The Trust standing orders and standing financial instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

The Committee’s responsibilities fall broadly into the following areas:

- Ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.
- Obtain plans for all individual funds and approve if/when appropriate.
- Ensure that donations and investment income or losses are attributed to individual funds appropriately.

- Ensure the sources of income and the terms on which donations are received are acceptable to the Trustees.
- Ensure that all funds are correctly allocated as restricted, unrestricted or designated, and accounted for accordingly. This analysis will differentiate between restricted, specific and the General charitable fund.
- Recommend an investment advisor to the Trustees following appropriate tendering procedures and regularly monitor and review their performance.
- Ensure that the investment policy for Charitable Funds set by the Trustees is implemented and that sufficient funds are kept readily available to meet planned requirements.
- Ensure (through the NHS Foundation Trust's Finance Department and accounting systems*)* that there is an appropriate system of control over income and expenditure, and that there are robust governance arrangements in place.
- Ensure that the NHS Foundation Trust's Constitution Standing Financial Instructions and the Scheme of Reservation and Delegation are appropriately interpreted for charitable funds.
- Receive and discuss all audit reports on charitable funds and recommend action to the Trustees.
- Review the Charitable Funds annual accounts and comment/ recommend approval to the Trustees as appropriate.
- Respond to requests from the Board of Trustees for review or investigation on relating to charitable funds.
- Receive WHH Charity Strategy and annual strategic review
- Receive the WHH Charity Annual Operational Plan

5. MEMBERSHIP

The Committee shall be composed of all independent Non-Executive Directors (excluding the Chairman), one of whom will be appointed as Chair of the Committee.

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

6. ATTENDANCE

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Director of Finance & Commercial Development
- Chief Nurse or nominated deputy
- Director of Community Engagement and Corporate Affairs
- Fundraising Manager
- Head of Financial Services
- Publicly elected Governor

Other Directors or staff members may also be invited to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

7. QUORUM

A quorum shall be two (2) members. In the event that a Non-Executive Directors cannot attend a meeting of the Committee, one of the Non Executives Directors who are not members of the Committee may attend in substitution and be counted in the quorum.

8. FREQUENCY OF MEETINGS

The Committee will meet on a quarterly basis.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent 5 days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties. This review will inform the Committee's annual report to the Board.

DATE: April 2017

NEXT REVIEW: April 2018

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	**CHARITABLE FUNDS COMMITTEE**
Version:	Issue No 7
Implementation Date:	April 2017
Review Date:	April 2018
Approved by:	Charitable Funds Committee
Approval Date:	7 April 2017

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
7 April 2017	**4 – Duties and Responsibilities**	Add the following - Receive WHH Charity Strategy and annual strategic review - Receive the WHH Charity Annual Operational Plan	
7 April 2017	**6 – Attendance**	Amend titles to read: - Chief Nurse or nominated deputy - Director of Community Engagement and Corporate Affairs	
7 April 2017	**10 – Administrative Arrangements**	Replace with the following: Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent 5 days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.	
7 April 2017	**5 – Membership**	The Committee shall be composed of ~~three (3~~) **All** Non-Executive Directors ….	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

AUDIT COMMITTEE – CYCLE OF BUSINESS APRIL 2017-MAY 2018

		2017					2018				
		January	April	23 May Year End	July	October	January	April	May Year End	July	October
INTERNAL AUDIT	**LEAD**										
Internal Audit Plan & Fees	MIAA		X					X			
Internal Audit Progress Report	MIAA	X	X		X	X	X	X		X	X
Head of Internal Audit Opinion	MIAA		X					X			
Insight Report	MIAA		X	X	X	X	X	X	X	X	X
EXTERNAL AUDIT											
External Audit Plan & Fees	External Audit		X					X			
Report and Updates from External Audit	External Audit	X	X		X	X	X	X		X	X
Renewal/Refresh of External Audit Contract (at term)	External Audit				X					X	X
COUNTER FRAUD											
Annual Counter Fraud Plan	Counter Fraud		X					X			
Counter Fraud Progress Updates	Counter Fraud	X	X		X	X	X	X		X	X
Annual Counter Fraud Annual Report	Counter Fraud		X					X			
FINANCE											
Final Accounts Timetable	DoF+CD	X					X				
DRAFT Unaudited Accounts & Financial Statements	DoF+CD		X					X			
FINAL Audited Accounts & Financial Statements	DoF+CD			X					X		X
Losses & Special Payments	DoF+CD	X	X		X	X	X	X		X	X
Review of Quotation + Tender Waivers	DoF+CD	X	X		X	X	X	X		X	X
Debtors & Creditors	DoF+CD	X	X		X	X	X	X		X	X
Going Concern Report	DoF+CD				X					X	
GOVERNANCE											
DRAFT Annual Report	DoCE+CA		X					X		X	

		2017					2018				
		January	**April**	**23 May Year End**	**July**	**October**	**January**	**April**	**May Year End**	**July**	**October**
FINAL Annual Report	DoCE+CA			X					X		
DRAFT Annual Governance Statement	DoCE+CA		X					X			
FINAL Annual Governance Statement	DoCE+CA			X					X	X	
Code of Governance Compliance Declaration	DoCE+CA		X					X			
Compliance Trust Provider Licence	DoCE+CA	X	X		X	X	X	X		X	X
Corporate Registers	DoCE+CA		X					X			
Standing Financial Instructions and Scheme of Delegation	DoCE+CA	X									
Board Assurance Framework and Risk Management System	DoCE+CA		X			X		X			X
Chairs report on Audit Committee for Board & Council of Governors	Chair		X					X			
Terms of Reference & Cycle of Business	DoCE+CA	X					X				
Audit Committee Effectiveness	Chair		X						X		

TERMS OF REFERENCE

AUDIT COMMITTEE

1. PURPOSE

The Audit Committee has primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Audit Committee shall provide the Board of Directors with a means of independent and objective review of assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical), both generally and in support of the Annual Governance Statement. In addition the Audit Committee shall:

- provide assurance of independence for external and internal audit;
- ensure that appropriate standards are set and compliance with them monitored in all areas that fall within the remit of the Audit Committee ; and
- monitor compliance with corporate governance requirements (e.g. compliance with the terms of the Licence; Constitution; codes of conduct; standing financial instructions; maintenance of registers of interest).

2. AUTHORITY

The Audit Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit Committee shall not have any executive powers in addition to those delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice on any matter within its Terms of Reference to the total of £10,000 per annum, and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3. REPORTING

The Committee shall report to the Board of Directors and Council of Governors annually on how it discharges its responsibilities; specifically on its work in support of the annual governance statement, commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements

- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements
- The robustness of the processes behind the quality account

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The minutes of the Committee's meetings shall be formally recorded and submitted to the Board. The Chair of the Audit Committee shall draw to the attention of the Board any issues that require disclosure or require executive action via a Key Issues Report.

4. DUTIES & RESPONSIBILITIES

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

Integrated Governance, Risk Management and Internal Control

The Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the governing body.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality Committee) so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2013* and provides appropriate independent assurance

to the Committee, Accountable (or Accounting) Officer and governing body. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- Considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the governing body when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the governing body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation.

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the governing body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference to the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances.

Raising Concerns (Whistleblowing)
The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

5. MEMBERSHIP

The Committee shall be composed of not less than three (3) independent non-executive directors, at least one of whom should have recent and relevant financial experience (Monitor Code C.3.1), as follows:

- at least one member of the Trust's Quality Committee will be a member of the Trust's Audit Committee
- the Chair of the Trust shall not be a member

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

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

6. ATTENDANCE

Only members of the Audit Committee have the right to attend meetings, but the following individuals shall normally be in attendance:

- Director of Finance & Commercial Development
- Director Community Engagement and CORPORATE AFFAIRS
- Representative(s) of the external audit service provider
- Representative(s) of internal audit service provider
- Representative(s) of counter fraud service provider

The Chief Executive may also be invited to attend and should in any case, attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Other Trust Directors and/or staff shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

7. QUORUM

The quorum necessary for the transaction of business shall be two members.

8. FREQUENCY OF MEETINGS

Meetings shall be held at least five times per year with additional meetings where necessary.

The internal auditor and external auditor shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent out 5 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

10. REVIEW / EFFECTIVENESS

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

DATE: JANUARY 2017
Approved: 16 January 2017
REVIEW DATE: JANUARY 2018

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Audit Committee
Version	V2
Implementation Date	Immediate
Review Date	16 January 2017
Approved By	Audit Committee

DRAFT

REVISION			
Date	Section	Reason for Change	Approved By
16.1.2017	10	- Review date amended from at least annually to every 2 years - Committee to be supported by the Secretary to the Trust Board.	Audit Committee

TERMS OF REFERENCE OBSOLETE		
Date	Reason	Approved By

QUALITY COMMITTEE- TERMS OF REFERENCE

1. PURPOSE

The Quality Committee (the Committee) is accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety.

The Quality Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks are managed appropriately in line with the CQC Essential Standards of Quality and Safety.

2. AUTHORITY

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

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

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.
- The Chair of the Committee will provide a written key issues report to the Board monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented at the May Board meeting on its work and performance in the preceding year.

4. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Oversee the development and implementation of the Trust's strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance

and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;

- Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring that there is scrutiny and oversight of the strategic risk register and Board Assurance Framework, prior to approval at the Board of Directors and that there is appropriate liaison with the Audit Committee, to ensure internal audit resources within the Trust are aligned appropriately to risk;
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory and contractual requirements;
- Ensure there is a process in place regarding assessing and monitoring the impact on quality from Trust transformation and efficiency plans;
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated;
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations;
- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust;
- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately and escalated when off track;
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit and assessments are communicated appropriately and changes in practice are facilitated;
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.
- Ensure that the Trust has effective communication channels in place for ward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) and risk management (Annual Governance Statement) reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;
- To inform the Board where it has significant concerns about:
  - Standards of care in the Trust
  - Or where it considers any service (or part of) to be unsafe

5. MEMBERSHIP

The Committee shall be composed of three Non-Executive Directors, one of whom shall be appointed by the Board to be Chair of the Committee.

Core Members

Chief Nurse
Medical Director
Chief Operating Officer
Deputy Director of Integrated Governance and Quality
Deputy Chief Nurse
Deputy Medical Director
Deputy Director of IM&T
Director of Transformation
Chief Pharmacist,
Chiefs of Service, Surgery, Women's & Children's and Acute Care Services
Associate Directors of Nursing
Associate Medical Director, Quality Improvement
Lead AHP
Head of Midwifery
Associate Director of Infection Control

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

6. ATTENDANCE

Members

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

Core Attendees

Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Committee may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Committee if they are unable to attend and who will attend as their deputy.

7. QUORUM

A quorum shall be 7 members, to include 1 Executive Director, 2 Non-Executive Director and 1 representative from each Division. In the event that a Non-Executive Director member cannot attend a meeting of the Committee, one of the Non Executives Directors who are not members of th Committee may attend in substitution and be counted in the quorum of the Committee.

8. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

9. REPORTING GROUPS

The sub committees listed below are required to submit high level briefing papers to the Committee:

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience Sub-Committee
- Health & Safety Sub-Committee
- Infection Control Sub-Committee
- Information Governance and Corporate Records (on aspects relating to quality and safety)
- Medicines Governance Committee

The Quality Committee is to receive minutes from the Workforce Sub Group and Strategic People Committee, and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters.

10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee the Agenda and Papers will be sent out 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

11. REVIEW / EFFECTIVENESS

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

January 2017

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality Committee
Version:	Draft V1 and V2
Implementation Date:	
Review Date:	6 December 2016, 0 January 2017, 7 February 2017
Approved by:	Quality Committee 7 February2017
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
6 December 2016	5 - Membership	Revised to include Non-Executive Directors to be amended to read **two** Core Attendees – to read **Core Members** Delete Divisional Operational Directors from the Core Membership **ADD Transformation Director** **ADD - Co-Opted Members from the Workforce Sub Group.** The Quality Committee to receive minutes from the WSG and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters in relation to staffing, quality and safety. Quorum – change from 10 **to maximum of 7, to include 1 Executive Director, 1 Non-Executive Director and 1 representative from each Division.**	
	10 – Administrative Arrangements	The Committee will be supported by the Secretary to the Trust Board.	7.2.17
10 January 2017	5 - Membership	Membership further reviewed to include Head of Midwifery and Associate Director Infection Control + Prevention.	7.2.17
7 February 2017	5 – Membership	Delete Director of IM&T	7.2.17

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

Quality Committee Cycle of Business 2017

Criteria for review in Work programme	Lead	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Quality Dashboard	Chief Nurse/Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality End of Year Report	Deputy Chief Nurse, Associate Med Director, Deputy Dir Integrated Governance+Quality	✓			✓								
Review the controls and assurance relevant quality risks on the Board Assurance Framework	Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complaints Reports bi-mthly	Deputy Dir Integrated Governance and Quality	✓	✓	✓		✓		✓		✓		✓	
SIs Reports	Deputy Dir Integrated Governance and Quality	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SI Lessons Learning Audit – quarterly report	Deputy Dir Integrated Governance and Quality			✓			✓			✓			✓
Quarterly Incident, Complaints, Claims, Coroners Report	Deputy Dir Integrated Governance and Quality	✓			✓	✓		✓			✓		
Health and Safety Annual Report	Head of Safety + Risk					✓							
Clinical Audit Annual Report	Chief Nurse Deputy Dir Integrated Governance and Quality					✓							
Medicines Management/Controlled Drugs Annual Report	Medical Director					✓							
Risk Management Annual Report	Deputy Dir Integrated Governance and Quality					✓							
Dementia Strategy Annual Review + 6mth	Deputy Dir Integ Governance and Quality		✓ Annual Review						✓ 6mth update				
NICE and Clinical Audit (Annual Report)	Chief Nurse Deputy Dir Integrated Governance and Quality					✓				✓			✓
Safeguarding Review Action plan update	Deputy Dir Integrated Governance and Quality			✓		✓		✓		✓		✓	
Medicines Management (quarterly)	Chief Pharmacist			✓			✓			✓			✓
Quality Impact Assessment monitoring (quarterly report)	Director of Transformation				✓				✓				✓
DIPC Infection Control (1/4 ly)	Chief Nurse			✓			✓			✓			✓
Mortality Review (quarterly report)	Medical Director				✓			✓			✓		✓
Safeguarding (bi-annual report)	Deputy Dir Integrated Governance and Quality					✓						✓	
Clinical Forward Audit Plan	Deputy Dir Integrated Governance and Quality			✓									
Clinical Audit Quarterly report	Deputy Dir Integrated Governance and Quality			✓			✓			✓			✓
Front Line Visits Quarterly report	Deputy Chief Nurse			✓			✓			✓			✓

Criteria for review in Work programme	Lead	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
High Level Enquires (when notified)	Deputy Dir Integrated Governance and Quality	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Monitoring of Ctte Attendance	Chair												✓
High Level Briefing Paper and Approved Action Notes from Chair of the Sub Committees reporting to Quality Committee													
		Jan	**Feb**	**Mar**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Quality Bi-Lateral Meetings				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Safety and Clinical Effectiveness Sub Committee			✓	✓	✓	✓		✓			✓		✓
Patient Experience Sub Committee			✓		✓		✓		✓		✓		✓
Health and Safety Sub Committee			✓		✓		✓		✓		✓		✓
Infection Control Committee			✓		✓		✓		✓		✓		✓
Safeguarding Steering Group				✓		✓		✓		✓	✓		✓
Medicines Governance Sub Cttee			✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Strategic People Committee		✓		✓		✓		✓		✓		✓	
Information Governance and Corporate Records Group **TBC**		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/49**
SUBJECT:	**Proposal to Change the Trust's Name**
DATE OF MEETING:	26th April 2017
ACTION REQUIRED	**For Decision**
AUTHOR(S):	Pat McLaren
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement 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
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	Recruitment of clinical staff continues to be challenging for Trusts but is particularly difficult for those Trusts perceived to be 'district general hospitals'. As a medium sized acute trust, with three hospitals over two sites and increasingly notable performance it is appropriate and timely that the Trust seeks a name change to incorporate the 'teaching' element into its brand. More prominent advertising of its teaching capabilities make the Trust a significantly more desirable employer when candidates have more than one choice in the region.
EXECUTIVE SUMMARY (KEY ISSUES):	In March 2017 all NHS Organisations in England were contacted by the NHS Identity team to receive and begin to implement their new logo. Our logo change detail in this paper has prompted us to consider, once again, the adoption of 'Teaching Hospitals' in the name of our Foundation Trust for the purposes of competing for medical, nursing and other staff on a 'level playing field'.
RECOMMENDATION:	The Board is asked to approve the change of name and to grant approval to the Director of Community Engagement to proceed with the renaming process.

PREVIOUSLY CONSIDERED BY:	**Committee**	Executive Team
	Agenda Ref.	
	Date of meeting	6th April 2017

	Summary of Outcome	Seek approval from Board to proceed.
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Changing the Trust's Name

1. BACKGROUND/CONTEXT

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

Old logo

Warrington and Halton Hospitals NHS
NHS Foundation Trust

New logo

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

Proposed logo

2. KEY ELEMENTS

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

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

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

Teaching Trusts' Employment Offer:

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

1. Although as an NHS Foundation Trust WHH has an independent status within the NHS our proposed name must follow NHS naming principles ie organizational descriptor (NHS FT), be clear, logical and descriptive and contain a geographic reference – the proposed name will comply with this.

2. Our proposed new name of *Warrington and Halton Teaching Hospitals NHS Foundation Trust* does not conflict with the names of neighbouring NHS organisations or services and there is no local, regional or national conflict
3. We are required to engage with our Foundation Trust members and wider patients and the public to check our proposed new NHS name is clear and understandable – this will be done by the Communications and Engagement Team
4. An amendment to the Foundation Trust's constitution will be required and will need to be approved by our Council of Governors with the Board of Directors' recommendation.
5. On completion, we are required to inform our key stakeholders as soon as possible of our new name so they can update their records including:

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

Considerations

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

4. ASSURANCE COMMITTEE (IF RELEVANT)

Executive Team approval to proceed granted on 6th April 2017, a recommendation to be presented to Trust Board for views/approval and then to Council of Governors in July 2017 for ratification.

5. RECOMMENDATIONS

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

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/04/50**
SUBJECT:	**Review the Trust's Compliance with its Licence Q4 2016-17**
DATE OF MEETING:	26th April 2017
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Pat McLaren
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management Choose an item. Choose an item.
STRATEGIC CONTEXT	The NHS Foundation Trust Code of Governance (the Code) last updated by Monitor in in July 2014 is issued under the principle of 'comply or explain'. This review details the evidence supporting the various declarations. Compliance is declared with all conditions except CoS3 and NHSFT4.
EXECUTIVE SUMMARY (KEY ISSUES):	There are a number of updates to this declaration for Q4: **G4: Fit & Proper Persons -** further assurance provided by separate F&PP declaration being signed by the appointee and countersigned by the Chairman. This has also extended to those in interim or acting positions. Register held at the Foundation Trust Office **G6: Systems for Compliance with Licence Related Conditions and Related Obligations -** The Trust is now compliant with this condition (previously not compliant as per the declaration the Board signed at the end of May 2016.) as this compliance with license declaration is factored into both Audit Committee and Council of Governors Business Cycles and is reviewed accordingly.

<table>
<tr><td rowspan="1"></td><td colspan="2">CC1: The rights of patients to make choices. The policies listed will be retired and replaced with an overarching Managing Conflicts of Interest Policy by 1st June 2017

CoS3: Standards of corporate governance and financial management The Trust remains non-compliant at this time however an independent Well Led Review was carried out between Jan-Mar 2017 which may influence our levels of compliance with this standard.

NHSFT4: Foundation Trust Governance The Trust remains non-compliant at this time however an independent Well Led Review was carried out between Jan-Mar 2017 as well as a CQC inspection (Well Led Domain) the outcomes of which may influence our levels of compliance with this standard.

(Updates have been highlighted in the assessment in yellow)</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="2">The Board is asked to note and agree the declarations of compliance and non-compliance for all conditions.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td>Audit Committee</td></tr>
<tr><td>Agenda Ref.</td><td>AC/17 01 14</td></tr>
<tr><td>Date of meeting</td><td>24/4/17</td></tr>
<tr><td>Summary of Outcome</td><td></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="2">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="2">Choose an item.</td></tr>
</table>

Summary of Licence Conditions

General Licence Conditions (G)

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

Pricing Conditions (P)

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

Choice and Competition (CC)

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

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

Integrated care (IC)

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

Continuity of Services (CoS)

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

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

NHS Foundation Trust Conditions (NHSFT)

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

SELF ASSESSMENT OF COMPLIANCE WITH MONITOR/NHSI PROVIDER LICENCE CONDITIONS Q4 2016-17 This document should be read in conjunction with the Summary of Licence Conditions to provide further detail on the conditions listed.						
	Licence Condition	**Executive Lead**	**Compliance Y/N**	**Narrative**	**Evidence of Assurance**	**Identified Further Actions**
GENERAL CONDITIONS (G)	**G1: Provision of Information**	Director of Finance and Commercial Development	Y	The Trust is compliant with this condition. There are three established contacts with Monitor/NHSI -Chief Executive; Director of Finance and Company Secretary. All information requested by Monitor/NHSI is supplied within deadlines in the format requested. Copies of all information supplied are either held by the Company Secretary or are available within the Monitor/NHSI portal if supplied via this system.	• Quarterly submissions to Monitor/NHSI and accompanying commentary. • Additional information provided on CIP and finance • Annual Plan and further information provided	None
	G2: Publication of Information	Director of Community Engagement and Corporate Affairs	Y	The Trust is compliant with this condition. Information is published as required with the Monitor/NHSI Code of Governance; Annual Reporting Manual or regulatory requirements.	• Code of Governance declaration to the Audit Committee and in Annual Report following self-assessment • Annual Report • Remuneration Report • Safe Staffing data • CQC ratings • Non-confidential information published on Trust website and discussed at Public Board	None
	G3: Payment of fees to Monitor/NHSI	Director of Finance and Commercial Development	N/A	The Trust would comply with this condition as the requirement arose.	N/A	N/A
	G4: Fit & Proper	Director of	Y	The Trust is compliant with this condition. The	• Enhanced DBS checks on Directors	Confirmation

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

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

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

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

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