We are
WHH

WHH Council of Governors

Thursday 16 August 2018
4:00pm – 6:00pm
Trust Conference Room
WARRINGTON HOSPITAL

COUNCIL OF GOVERNORS
THURSDAY 16 August 2018, 4.00pm-6.00pm
Trust Conference Room, Warrington Hospital

AGENDA ITEM COG/18/08/XX	TIME PER ITEM	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
			Choose an item.	Choose an item.	
COG/18/08/32	**4.00pm**	Welcome and Opening Comments • Apologies • Declarations of Interest			Chairman
COG/18/08/33 PAGE 3		Minutes of meeting held 17 May 2018	***For decision***	***Minutes***	Chairman
COG/18/08/34 PAGE 9		Matters arising/action log	***For assurance***	***Action log***	Chairman
GOVERNOR BUSINESS					
COG/18/08/35	**4.05pm**	Annual Appraisal of Trust Chairman following NARC on 3 August (Chairman to leave the room for this item)	***For approval***	***Verbal***	Lead Governor
COG/18/08/36	**4.10pm**	Lead Governor Update	***For info/update***	***Verbal***	Lead Governor
COG/18/08/37 **PAGE 10** **PAGE 13**	**4.15pm**	Items requested by Governors (Appendix A) (a) Spinal incl: Partner letter to CEOs (b) Complaints (c) Car Parking	***For info/update***	***Briefing notes +Q&A***	
COG/18/08/38	**4.30pm**	Reports from GEG	***For info/update***	***Verbal***	Chair of GEG
COG/18/08/39	**4.35pm**	Intention to review the roles, structure composition and procedures of the CoG.	***For info/update***	***Verbal***	Head of Corporate Affairs
TRUST BUSINESS					
COG/18/08/40 PAGE 14	**4.40pm**	Chief Executives Report including Integrated Performance Report	***For info/update***	***Verbal + Report***	Executive Medical Director/ Deputy Chief Executive
COG/18/08/41	**4.50pm**	Chairmans Briefing	***For info/update***	***Verbal***	Chairman
COG/18/08/42 **PAGE 50**	**4.55pm**	(i) 2018-19 Annual Report + Accounts including Quality Account Report (send separately) (ii) Auditors letter (attached)	***For assurance***	***Report***	External Auditors, Mark Heap
COG/18/08/43 **PAGE 66**	**5.05pm**	Quality Strategy	***For assurance***	***Report***	Dir Gov + Int Governance
COG/18/08/44 **PAGE 95**	**5.15pm**	Resubmission of Operational Plan	***For info/update***	***Report***	Director of Finance + Commercial Develoment
GOVERNANCE					
COG/18/08/45 **PAGE 109**	**5.20pm**	Compliance Trust Provider Licence (bi-annual report)	***For assurance***	***Report***	Head of Corporate Affairs
COG/18/08/46	**5.25pm**	WHH Trust Strategy refresh	***For info/update***	***Presentation***	Directorof Transformation
COG/18/08/47	**5.35pm**	My-Choice	***For info/update***	***Presentation***	Executive Medical Director/ Deputy Chief Executive
COG/18/08/48 **PAGE 110**	**5.45pm**	Elections Activity Bi-Annual report June 2018	***For assurance***	***Report***	Head of Corporate Affairs
COG/18/08/49 **PAGE 113**	**5.50pm**	Proposals to change the Trust's name – update	***For assurance***	***Report***	Executive Medical Director/ Deputy Chief Executive
COG/18/08/50 **PAGE 118**	5.55pm	Chairs Annual Audit Committee Report	***For assurance***	***Report***	Chair of Audit Committee
COG/18/08/51	6.00pm	CLOSE / Any Other Business		Verbal	Chair

Schedule of 2018-19 dates attached for information

Next Meeting Date will be on Thursday 15 November, 4.00pm-6.00pm
The Trust Conference Room, Warrington Hospital

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COUNCIL OF GOVERNORS

Draft Minutes of the Meeting held on Thursday 17th May 2018

3.00pm to 5.00pm, Lecture Theatre, Education Centre, Halton Hospital

Present:

Steve McGuirk (SMcG)	Chairman (Chair)
Norman Holding (NM)	Public Governor & Lead Governor
Mark Ashton (MA)	Staff Governor
Paul Bradshaw (PB)	Public Governor
Keith Bland MBE (KB)	Public Governor
Peter Lloyd Jones (PLJ)	Partner Governor, Halton Borough Council
Alison Kinross (AK)	Public Governor
Colin McKenzie (CMcK))	Public Governor
Anne Robinson (AR)	Public Governor
Louise Spence (LS)	Staff Governor
Nick Stafford (NS)	Public Governor
Pat Wright (PW)	Partner Governor, Warrington Council

In Attendance:

Terry Atherton (TA)	Non-Executive Director
Anita Wainwright (AW)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Chris Evans (CE)	Chief Operating Officer
Andrea McGee(AMG)	Director of Finance & Corporate Development
Lucy Gardner (LG)	Director of Transformation
Ian Wright (IW)	Associate Director of Estates & Facilities
John Culshaw (JC)	Head of Corporate Affairs
Liz Pritchard (LP)	Organisational Development Manager

Apologies:

Mel Pickup (MP)	Chief Executive
Simon Constable (SC)	Executive Medical Director, Deputy Chief Executive
Ian Jones (IJ)	Non-Executive Director
Jean Noel Ezingeard (JNE)	Non-Executive Director
Ryan Newman	Public Governor

COG/18/05/ 18	**Welcome, Apologies & Introductions**	
	The Chairman welcomed all Governors', Staff, and Non-Executive Directors to the meeting. Apologies - See above. **Declarations of Interest – in agenda items** There were no other interests declared in relation to the agenda items for the meeting.	
COG/18/05/ 19	**Minutes of Previous Meeting 17 May 2018**	
	The minutes of the meeting held on 15 February 2018, and the Extraordinary CoG on 8 March 2018, were approved as a true and accurate record.	
COG/18/05/ 20	**Matters arising/action log**	
	Action - COG/17/07/38 – Update to be provided at the next meeting **Progress on other actions was noted and recorded on the action log.**	
COG/18/05/ 21	**Annual Appraisal of Non-Executive Directors**	
	The Chairman confirmed to the CoG that he was currently working his way through the cycle	

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	of Non-Executive Directors (NEDS) appraisals and explained that the current process for NEDS was the same approach as the process for regular staff. The Chairman advised that he did not want the appraisal process to get in the way of the NEDs doing their jobs and the Head of Corporate Affairs would review the appraisal paperwork In relation to Executive Director Appraisals, PLJ asked NEDs ensured they were asking the correct questions and setting appropriate targets? The Chairman confirmed that NEDs met with the Chief Executive on an annual basis to oversee the objectives set for Executive Directors to ensure they aligned. **The CoG noted the update** **Head of Corporate Affairs to review NED appraisal paperwork**	
COG/18/05/22	**Lead Governor Update**	
	Norman Holding, Lead Governor advised the CoG that the response from fellow Governors to requests for CoG agenda items was pleasing and he wished to thank those who contributed. NH commented that he had recently attended the Trust's Award Night which had been very successful and several other Governors had also attended. NH gave the CoG an update on the last North West Governors Meeting that took place in February, in Bolton that covered Good Governance, the new CQC system, and collaborative working. NH advised the CoG that the next North West Governors Meeting would take place on 18th October at Wrightington, Wigan & Leigh NHS Foundation Trust. NH updated the CoG on the National Lead Governors Forum, including the election of a new Chair, the results from the Lead Governor Survey, the voting process for a Lead Governor and an incident in which an asylum seeker had been elected to the post of a Governor for the Rest of England & Wales. NH advised the CoG that of two recent MIAA training events: I. Involving Patients & Citizens in Shaping Health and Social Care II. 5th Annual Health Check on the state of the NHS and Social Care. Finally, NH confirmed to the CoG that the 2018 PLACE inspection have taken been completed at both Warrington and Halton sites **The CoG noted the update**	
COG/18/05/23	**Items requested by Governors**	
	Spinal Services Chris Evans, Chief Operating Officer advised the CoG that the Trust had received the Royal College of Surgeons final report which had been jointly commissioned by the Trust, Commissioners and NHSE. The report has not been produced and written for intended publication due to the personal identifiable information it contains of both patients and staff. Under Duty of Candour, Data Protection Regulations and the wish for transparency, the 3 organisations are seeking legal advice from their legal teams to ensure that in the event the report appears in the public domain no breaches in data protection and duty of candour occur as a result. NHSE are to produce a legal redacted version and the first priority for the Trust priority is to the families when the final report can be shared. The Chief Operating Officer explained that service provision at WHH remains suspended, with patients being repatriated to The Walton Centre; 2 consultants continue to providing consultancy advice at WHH.	

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Update on Kendrick Wing Fire
Ian Wright, Associate Director of Estates and Facilities gave a presentation to the CoG updating them on the timeline of events on the day, and the immediate actions in the aftermath.

IW further advised the CoG that of the details of the Trust's cover and that the insurance companies had accepted policy liability.

IW explained that expenditure as a result of the fire had been restricted to three categories. These were:

- health & safety and security required to ensure the safety of the building,
- prevention of further deterioration to the building – e.g. 'tin hat' over the roof,
- business continuity essentials e.g. staff & service relocation and equipment

The Chairman wished to pass his thanks on to everyone who have been involved with ensuring the continuity of business within the Trust following the fire. The Chairman commented that the investment in recent years in fir containment had proved extremely valuable. The Chairman further commented that the response to the fire form all staff had been outstanding and also wished to pass his thanks and compliments on to the Fire Service for their response.

Car Parking Fines
IW provided the CoG with an update on parking at the Trust the key points of which were:

- 7 year contract commence Jan 2017
- Capital Investment
- Income generator
- Managed service

IW explained that the contract allowed automatic number plate recognition (ANPR), provided the parking payment machines, the provision of penalty charge notices (PCN) and support of the subsequent appeals and training to WHH staff about PCNs

IW advised that there had been an issue with PCNs being erroneously assigned. IW explained that The majority of persons affected have been staff and the reasons due to either data transfer issues, staff incorrectly completing the Car Park Application forms, clerical error when inputting service users onto the Car Park database and Staff forgetting to update their vehicle registration plate when coming onto site. With regards to the Patients and visitors there has been an issue with wrong details being inputted into the Payment machines. However, IW explained that since the start of the year there had been a significant reduction in the number of incorrectly allocated PCNs

Further to this, IW advised that the Trust was doing the following to improve the service:

- IT review – data transfers
- Application process review – moving to electronic, single point of contact
- Dedicated car parking admin support
- Dedicated contactor customer service support
- Resource allocated for contract management

A review of the parking payment machines had also taken place and new machines had been recommended to include:

- Chip & Pin
- Note Readers

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- Coin accepters
- Contactless Payments
- They also given change
- Large touch screen

The Chairman commented that he recognised there had been many historical problems relating to parking at the Trust and that a poor parking experience, frames the rest of the patient experience.

Further discussion ensued about the level of the fines, which was confirmed by IW to be £60 or £30 if paid early; and how the new machines will help significantly.

PB asked from a patient experience perspective that if a machine is out of order, that a sign directing you to the nearest alternative machine would be useful.

Warrington Urgent Care Update

The Chief Operating Officer advised the CoG that the end of year performance was 88.67% including the challenging quarter 4 period in which 80 escalation beds were opened and additional staff recruited.

CE advised that good conversations with partners were being held and that the Frailty Assessment Unit would be opening in the near future.

CE reported that at the start of 2018/19 performance improved and many escalation beds closed. At the time of reporting, year to date performance was 89.87% with May being 90.43%.

CE further advised that the Ambulance handover performance was good and that the Trust was working closely with Warrington Together ahead of next winter.

Halton Healthy New Town

Lucy Gardner, Director of Transformation, updated the CoG on the Halton Healthy New Town developments and highlighted the key points of the plan.

LG explained that the latest NHS England bid for funding had been unsuccessful; however, a further bid would be submitted in in July with the result of the bid likely to be communicated in the Autumn. LG also confirmed that the Trust was looking at alternative funding options.

LG reported that all the partners had now come together and were committed to make it happen.

It was confirmed that the total cost would be a lot more than the £40m bid and that expectations must be managed and that without the funding, the timeline for the project would likely shift later.

Warrington New Hospital

Lucy Gardner, Director of Transformation explained that positives meeting had taken place in respect of a new hospital in Warrington. LG confirmed that external support would be engaged to review all potential sites against agreed criteria that partners were agreed on.

Impact on the Trust of lack of provision in Social Care Services

Chris Evans, Chief Operating Officer advised the CoG that working independently would not work and that progress would be made having agreed the Sustainability Contract with Commissioners.

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	• **The COG noted the updates**	
COG/18/05/24	**Governor Engagement Group (GEG) Chair Report**	
	K Bland, Chair of the GEG provided on update on key themes being discussed by the GEG - NHS 70th Celebrations – The group reviewed the planned timeline of events including the Dragon Boat Race on 1st July, 1940's Tea Dance at the George Llloyd Restaurant, Halton Hospital, BIG7TEA party. - What Matters to Me 2018/19 / Community Engagement Programme – The group received a report on What Matters to Me and the previous year's event and discussed potential ideas for a focused event. The group also received a briefing on the strategy for the Community Engagement programme, including promoting apprenticeships to young audiences. - Governor Elections 2018 – The group received the timetable for the Governor Elections that would take place in the next few months. - New Website – The group received a briefing on the Trust's new website and how it would work The Group also received a draft poster for 'Creating Tomorrows Health Care Today'. The group discussed the mission statement for WHH and how the changes will be more relevant to patients. **The COG noted the update**	
COG/18/05/25	**QiC Group Report Chair Report**	
	N Holding, Chair of the QiC provided an update on key themes discussed by the QiC on 1st May 2018. - CQC Action Plan – Progress against the action plan is ongoing - The following items on the Trust Dashboard were discussed, Sepsis CQUIN, Safety Thermometers, Healthcare acquired infections, falls, medication safety, ward accreditation, complaints and mixed sex accommodation. - Quality Assurance Committee update, including Serious Incident Audit, Learning From Experience Report and Mortality Review. - Governor Observation Visits – There has been two visits completed since the last meeting, one of which had caused concerns. As the matron had not been present on the day of the visit, a follow up meeting was arranged. The concerns from the visit were fed back and the response was very good - The draft Quality Account was circulated to the group and comments requested. **The CoG noted the report.**	
COG/18/05/26	**Chairman's Briefing**	
	The Chairman explained that the majority of the matters he wished to provide an update on had been covered on the agenda. However, the Chairman wanted to congratulate all the staff involved in the recent Royal visit from Princess Anne. The Chairman commented that the visit had been great for both the staff and the hospital. **CoG noted the report.**	
COG/18/05/27	**Trust Operational Plan**	
	The report was received by the CoG and Andrea McGee, Director of Finance and Corporate Development provided an overview of the Operational Plan that the Trust was required to submit on 30th April 2018. AMG advised that prior to submission; the plan was reviewed and approved by the Finance & Sustainability Committee and the Trust Board. The plan included a deficit of £24.6m which means the Trust has not accepted the control total set by NHSI of £3.3m surplus.	

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	The Chairman wished to highlight to the CoG that the Trust was not in a unique position in relation to the challenging financial position **The CoG noted the report.**	
COG/18/05/28	**Workforce Race Equality Standard (WRES) UPDATE**	
	Liz Pritchard, Organisational Development Manager explained to the CoG that Workforce Race Equality Standard (WRES) is a standard implemented to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. LP provided key updates to the CoG including: - Staffing Changes - E&D Specialist role and line management - Review of E&D portfolio - steps to ensure that patient facing elements of E&D are sat with the most appropriate service. - Actions identified from the 2017 WRES have been completed as documented in the last update provided Oct 17. Any outstanding actions to be picked up at E&D subcommittee in June 18 - Suggestions from the BME Focus Group will be considered as part of the E&D sub Committee and incorporated in to the E&D strategy delivery plan once finalised. - Work is currently underway in relation to the 2017 WRES submission - WRES Submission and associated actions to be discussed at June E&D Sub Committee, and authorised via Workforce Committee, June 18. - WRES and associated action plan to be submitted and published by 1st July 2018 The Chairman re-iterated to the CoG how important this agenda was and that it had the full support of the Trust Pat McLaren, Director of Community Engagement advised the CoG that the Trsut had recently employed a Community Engagement Officer who had presented to the Islamic Association and they were very enthusiastic about becoming involved. **The CoG noted the update**	
COG/18/05/28	**Governor Training Programme and Induction including MIAA courses**	
	Update provided in agenda item COG/18/05/22	
COG/18/05/28	**Council of Governors Terms of Reference & Cycle of Business**	
	John Culshaw, Head or Corporate Affairs presented the CoG with the Annual Cycle of Business 2018-19 and Terms of Reference for review and approval. The CoG approved the Terms of Reference and Cycle of Business	
	Date and time of next meeting **Thursday 16 August 2018, 16.00 – 18.00, Trust Conference Room, Warrington Hospital.**	

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COUNCIL OF GOVERNORS ACTION LOG

AGENDA REFERENCE	CoG/18/08/34	SUBJECT:	COUNCIL OF GOVERNORS ACTION LOG	DATE OF MEETING	16 August 2018

1. ACTIONS on Agenda

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress report	RAG Status
COG/17/07/38	**20 July 2017**	**Proposal to change the Trust's name**	MB to seek advice relating to University status for the Trust.	**Director of CE&CA**	**17.05.2018**	**Ongoing process**	19.10.2017. PMcL to raise awareness through team brief. Proposal for WHH and University Teaching Partnership to be presented to next CoG. Update next CoG. No updated on 15.02.2018 17.05.2018Discussions ongoing, update to next meeting	

3. ACTIONS CLOSED SINCE LAST MEETING

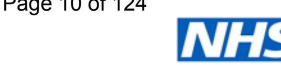
Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress report	RAG Status

4. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress report	RAG Status
COG/17/04	**6 April 2017**	**WRAG presentation**	Further session to planned for 3-6 months	**HCA**	**15.02.2018**		15.02.2018. Date TBC for further presentation. 06.08.2018 – Novemeber CoG to be extended by 30 minutes to incoroporate WRAG Update	

RAG Key

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



25th June 2018

To:

Professor Steven Broomhead, CEO Warrington Borough Council and
Mr David Parr, CEO Halton Borough Council
Mr Mike Amesbury MP Weaver Vale
Mr Derek Twigg MP Halton
Ms Helen Jones MP Warrington North
Mr Faisal Rashid MP Warrington South

Dear Colleagues,

Re: Spinal Services at Warrington and Halton Hospitals

We are writing to update you on the status of Spinal Services at Warrington and Halton Hospitals following the Royal College of Surgeons (RCS) Invited Service Review.

Summary:

You will recall that we suspended Spinal Services at the Trust in September 2017 following four serious (but unrelated) incidents; this followed an earlier voluntary, temporary suspension of complex spinal surgery. Alternative providers were sought and patients safely transferred to the Walton Centre and to Salford Royal.

Together with NHS England Specialist Commissioning we jointly commissioned an independent, expert review by the Royal College of Surgeons through the RCS Invited Review Mechanism. This took place between November 2017 and February 2018 with the report being received in February this year. The three commissioning parties undertook a joint factual accuracy check and corrections submitted to the RCS.

Cognisant of our legal responsibilities under the Data Protection Act (1998 now 2018) to protect information relating to individuals, we submitted the report for an independent DPA review by solicitors to preserve the integrity of the report. We have now shared the report with the four affected families in accordance with the Trust's commitment to openness and candour. We acknowledge that this is likely to be a very difficult report for those families to read and Family Liaison Officers have been appointed to each case. The Trust has invited each family to a follow up meeting to discuss the report and its findings and to offer any additional support where possible.

How we have responded to the RCS Invited Service Review

- As a healthcare system commissioners and the Trust fully acknowledge the findings of the RCS Invited Review and are working together to ensure that the findings are addressed; lessons are learned and shared, practice and procedures changed and that the governance of the service achieves the highest possible levels.

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- Our priority throughout has been the patients and families involved in the serious incidents that prompted the suspension and service review and the need to provide them with the answers they seek, facilitated by the Trust's investigation processes.
- The Trust has made significant progress since the suspension of its spinal service in improving its processes, learning from investigations; investing in training and development and standardising the processes for Multi-Disciplinary Team meetings. It has further worked to improve its complaints and serious incident management including a significant reduction in the complaints backlog and invested in a dedicated, specialised investigation team, with two medical leads and expertise in human factors.
- All clinical staff involved in all of the serious incident cases have reflected on their practice and subsequent HR and support processes have been put in place as appropriate.
- Together we have been working with specialised commissioners and other spinal service providers in the development of a single spinal service for Cheshire and Merseyside, overseen by NHS Improvement's Getting It Right First Time (GIRFT) team. The aim is the development of a revised specialised hub (or hubs) in Liverpool with local access preserved for the people of Cheshire through 'spoke' sites for non-complex activity - which could include the Trust. We consider that the future of the Trust's spinal service is only within such an arrangement with a senior partner organisation able to provide the support and clinical governance oversight commensurate with a specialised surgical service.
- We have begun deploying our plans to communicate our position with the Trust's spinal patients, staff, our partner organisations and other involved stakeholders.

In conclusion

Foremost are the patients and their families whose serious incidents prompted the suspension of the spinal service and the commissioning of the RCS Invited Review. The Trust acknowledges that while nothing can change the outcome, it unreservedly apologises for failing these patients.

We further apologise to the many patients who have been inconvenienced as a result of the continued suspension and their transfer to alternative providers, the frustration that this must have caused has not been underestimated.

We are appreciative of the guidance provided by the RCS for the possible recommencement of services should we wish to do so. However it has become clear that the future of spinal surgery at the Trust is only viable through operating as part of a revised 'hub and spoke' model, similar to that operated for vascular and cancer services, and a stand-alone WHHFT spinal service is not a recommended option. We are working together with NHS Improvement's 'GIRFT' team to ensure that the report's recommendations are fully considered and incorporated as part of this wider context of spinal surgery services for Cheshire & Merseyside.

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Spinal surgery services at the Trust will therefore remain suspended pending the outcome of these discussions on the future delivery of specialist spinal services across Cheshire and Merseyside and alternative providers remain in place to take Warrington and Halton patient referrals for the foreseeable future.

The RCS Invited Service Review report is, by nature, complex and authored for a clinical readership. While we have shared the report with the four involved families the RCS did not intend for the report be published. Therefore we have produced a detailed briefing paper which will make the findings, recommendations and next steps clear and unambiguous – you can find it on the Trust's website here.

We remain available to you if you wish to discuss any element of the Spinal Service for Warrington and Halton patients in more detail; we will of course provide an update for Health Scrutiny Committees at their next meeting.

Yours sincerely,

Professor Simon Constable
Deputy Chief Executive Officer
& Executive Medical Director
Warrington & Halton Hospitals NHS Foundation Trust

Dr Andrew Davies
Clinical Chief Officer
NHS Warrington CCG

Council of Governors 16 August 2018

Briefing notes prepared by various Executive Directors in response to Agenda items.

Car Parking

Unfortunately we missed the 25th July installation due to some challenges around the change of contract numbers (£). Whilst the 3 machines have been agreed on a free trial basis, Highview, who are our contracted car parking management supplier, now want us to commit to a financial model to purchase any additional new machines **SHOULD** the trial be successful. As we fully expect and hope the trial will be successful for all the right reasons we really want to agree a financial model beyond the trial to ensure value for money. Whilst this has delayed the installation, the financial model was a late amendment to the deal imposed on us by Highview and we are doing everything we can to resolve the challenges and get the trial underway as soon as possible.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/63**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	25th July 2018
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Alex Crowe – Acting Medical Director & Chief Clinical Information Officer Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Lucy Gardner – Director of Transformation Chris Evans - Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	**Quality** There were 2 medication safety incidents relating to harm in month, these are currently under review. The Trust continues to work through the backlog of incidents and complaints. There were 5 mixed sex accommodation breaches in month; the escalation process has been reviewed. **Access & Performance** The 6 week diagnostic standard has not been met due to capacity issues with Cardiac CT and Stress Echos, there are plans to address. A&E 4 hour performance

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	continues to improve as do Ambulance handover times over 60 minutes with work continuing to improve the number of patients taking over 30 minutes to handover. There has been improvement in the number of Discharge Summaries sent within 24 hours. **Workforce** The Trust continues to reduce sickness absence and has implemented several initiatives to reduce further. Agency nurse spend remains higher than 2017/18. The Trust is working to convert agency staff to bank staff and recruit to substantive vacancies. This will also help reduce the average cost and length of service of the top 10 agency workers. **Finance** The Trust has signed up to a control total of £16.9m deficit which includes Provider Sustainability Funding (PSF) of £4.9m. The planned deficit for the quarter ending 30th June 2018 of £6.7m has been achieved. This position does not include PSF monies of £0.2m for the A&E 4 hour performance target as the requirement to achieve 90% for Quarter 1 was not delivered (89.6% was achieved).
RECOMMENDATION:	The Trust Board is asked to: **1.** 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:	BM/18/07/63

1. BACKGROUND/CONTEXT

The RAG rating for all 66 indicators from July 2017 to June 2018 is set out in Appendix 1. The Integrated Performance Dashboard (Appendix 2) has been produced to provide the Board with assurance in relation to the delivery of all KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

In month, there has been a movement in the RAG ratings as follows:

- Red - 26 in June decreased from 27 in May.
- Amber – 11 in June the same number as May.
- Green – 26 in June the same number as May.
- Not RAG rated – 3 in June an increase from 2 in May.

Due to validation timescales for Cancer, VTE and Sepsis data, the dashboard and RAG rating is based on May's validated position.

Quality

Quality KPIs

There are 10 Red indicators in June, a reduction of 1 in month.

The 8 indicators which were Red in May and remain Red in June are as follows:

- Incidents – the Trust has 108 open incidents which are over 40 days, a decrease from 114 in May.
- Safety Thermometer – The Trust achieved 96.2% for Adults, 96.6% for Children and 81.8% for Maternity against a 95% target.
- Healthcare Acquired Infections – the Trust reported 1 case of MRSA in April 2018 against a national threshold of zero tolerance; therefore this indicator will be Red for the remainder of the year.
- VTE Assessment – the Trust achieved 93.4% in May (validated position) a decrease from Aprils' performance of 95% and against a target of 95%.

- Medication Safety – there were 2 incidents of harm in June up from 1 in May, there is zero tolerance against this indicator.
- Complaints – there was 1 open case which was over 6 months old, the same number as May.
- Friends & Family Test (A&E and UCC) – The Trust achieved 83% in June, a decrease from May's performance of 86% against a target of 87%.
- Mixed Sex Accommodation Breaches (MSA) – there were 5 Mixed Sex Accommodation Breaches in June, an increase from 2 in May.

There are 2 indicators which have moved from Green to Red in month as follows:

- Sepsis Anti-biotic AED – the Trust achieved 82% (May's validated position) against a target of 90%.
- Total Falls & Harm Levels – the Trust did not achieve the 10% reduction in June, there were 83 falls against a baseline of 86. The Trust has signed up to a Falls Collaboration with NHS Improvement with the aim to prevent inpatient falls across the NHS.

There are 2 indicators which have moved from Red to Green in month as follows:

- Duty of Candour – there were no breaches in relation to DoC in month.
- Friends & Family Test (Inpatient & Daycase) – the Trust achieved 95% in June, (target 95%) an improvement from May's performance of 94%.

There is 1 Sepsis indicator which cannot be RAG rated this month.

Access and Performance

Access and Performance KPIs

There are 8 Access and Performance indicators rated Red in June, the same number as May.

The 7 indicators which were Red in May and remain Red in June are as follows:

- Diagnostic waiting times – the Trust achieved 98.2% in June, a decrease from May's performance of 98.5% (target 99%).
- A&E Waiting Times 4 hour national target – the Trust achieved 91% including walk ins and 89.5% excluding walk ins in June (target 95%), which is the same as May's performance.
- Breast Symptoms 14 days – the Trust achieved 84.75% in May (validated position) a decrease from April's performance of 88.7% (target 93%).
- Ambulance Handovers 30>60 minutes – there were 91 patients who experienced a delayed handover in June, an increase from 80 in May.

- Ambulance Handover at 60 minutes or more – the Trust seen an improvement in the number of patients experiencing a delayed handover in month from 30 in May to 12 in June.
- Discharge Summaries % sent within 24 hours – the Trust has achieved 84.4% in June (target 95%), an improvement from May's performance of 75.1%.
- Cancelled operations on the day (for non-clinical reasons) – there were 18 cancelled operations in June, an increase from 10 in May.

There is 1 additional Red indicator in month as follows:

- Cancer 62 days urgent – the Trust achieved 81.65% in May (validated position) a decrease from April's validated position of 90.4% (target 90%).

There is 1 indicator which has moved from Red to Green in month as follows:

- Discharge Summaries Sent within 7 days – all discharge summaries required to meet the 95% target were sent within 7 days in month.

PEOPLE

Workforce KPIs

There are 4 indicators rated Red in June, the same number as May.

The 3 indicators which were Red in May and remain Red in June are as follows:

- Sickness Absence – 4.65% in June (target below 4.2%) an improvement from May's performance of 4.95%.
- Agency Nurse Spend – £0.26m in June, increase from the 2017/18 baseline of £0.2m.
- Average Cost of the Top 10 Agency Workers - £0.047m in June, increased from May's baseline of £0.04m.

There is 1 additional indicator rated Red in month as follows:

- Average Length of Service for Top 10 Agency Workers – has increased from 24 months in May to 27 months in June.

There is 1 indicator which has moved from Red to Green in month as follows:

- Non Contracted Pay – was £0.13m less than budget in June, a reduction of £0.38m from May.

SUSTAINABILITY

Finance and Sustainability KPIs
There are 4 Red rated and 3 Amber rated Finance and Sustainability indicators in June, the same number as May.

The 4 indicators which were Red in May remain Red in June as follows:

- Capital Programme – the actual year to date spend is £1.7m which is £0.9m above the planned spend of £0.8m. This in part is due to £0.7m spend resulting from the Kendrick Wing fire that had been incurred earlier than anticipated.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a year to date performance of 31% which is 64% below the national standard of 95%.
- Agency Spending – the actual year to spend is £2.7m which is £0.5m above the year to date ceiling of £2.2m
- Cost Improvement Programme – the year to date savings are £0.3m which is £0.3m below the £0.6m planned savings.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in Appendix 3. The Trust is currently forecasting achievement of the planned deficit and control total.

The Trust is working with Commissioners on a shared 3 year plan to improve sustainability using CEP lite (Capped Expenditure Process) as a framework.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

KPI's that are underperforming will be managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Trust Operational Board
- KPI Sub-Committee

5. RECOMMENDATIONS

1. Note the contents of this report.

Appendix 1 – KPI RAG Rating July 2017 – June 2018

	KPI	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
	QUALITY												
1	Incidents												
2	CAS Alerts												
3	Duty of Candour												
4	Safety Thermometer												
5	Healthcare Acquired Infections												
6	VTE Assessment*												
7	Safer Surgery												
8	CQUIN Sepsis AED Screening*												
9	CQUIN Sepsis Inpatient Screening*												
10	CQUIN Sepsis AED Antibiotics*												
11	CQUIN Sepsis Inpatient Antibiotics*												
12	CQUIN Sepsis Antibiotic Review*												
13	Total Falls & Harm Levels												
14	Pressure Ulcers												
15	Medication Safety												
16	Staffing – Average Fill Rate												
17	Staffing – Care Hours Per Patient Day												
18	Mortality ratio - HSMR												
19	Mortality ratio - SHMI												
20	Total Deaths												
21	NICE Compliance												
22	Complaints												
23	Friends & Family – Inpatients & Day cases												
24	Friends & Family – A&E and UCC												
25	Mixed Sex Accommodation Breaches												
26	CQC Insight Indicator Composite Score												

Appendix 1 – KPI RAG Rating July 2017 – June 2018

	ACCESS & PERFORMANCE												
27	Diagnostic Waiting Times 6 Weeks												
28	RTT - Open Pathways												
29	RTT – Number Of Patients Waiting 52+ Weeks												
30	A&E Waiting Times – National Target												
31	A&E Waiting Times – STP Trajectory												
32	Cancer 14 Days												
33	Breast Symptoms 14 Days												
34	Cancer 31 Days First Treatment*												
35	Cancer 31 Days Subsequent Surgery*												
36	Cancer 31 Days Subsequent Drug*												
37	Cancer 62 Days Urgent*												
38	Cancer 62 Days Screening*												
39	Ambulance Handovers 30 to <60 minutes												
40	Ambulance Handovers at 60 minutes or more												
41	Discharge Summaries - % sent within 24hrs												
42	Discharge Summaries – Number NOT sent within 7 days												
43	Cancelled Operations on the day for a non-clinical reason												
44	Cancelled Operations on the day for a non-clinical reason – Not offered a date for readmission within 28 days of the cancellation												

Appendix 1 – KPI RAG Rating July 2017 – June 2018

	WORKFORCE												
45	Sickness Absence												
46	Return to Work												
47	Recruitment												
48	Turnover												
49	Non Contracted Pay												
50	Agency Nurse Spend												
51	Agency Medical Spend												
52	Agency AHP Spend												
53	Core/Mandatory Training												
54	PDR												
55	Average cost of the top 10 highest cost Agency Workers												
56	Average length of service of the top 10 longest serving agency workers												
	FINANCE												
57	Financial Position												
58	Cash Balance												
59	Capital Programme												
60	Better Payment Practice Code												
61	Use of Resources Rating												
62	Fines and Penalties												
63	Agency Spending												
64	Cost Improvement Programme – Performance to date												
65	Cost Improvement Programme – Plans in Progress (In Year)												
66	Cost Improvement Programme – Plans in Progress (Recurrent)												

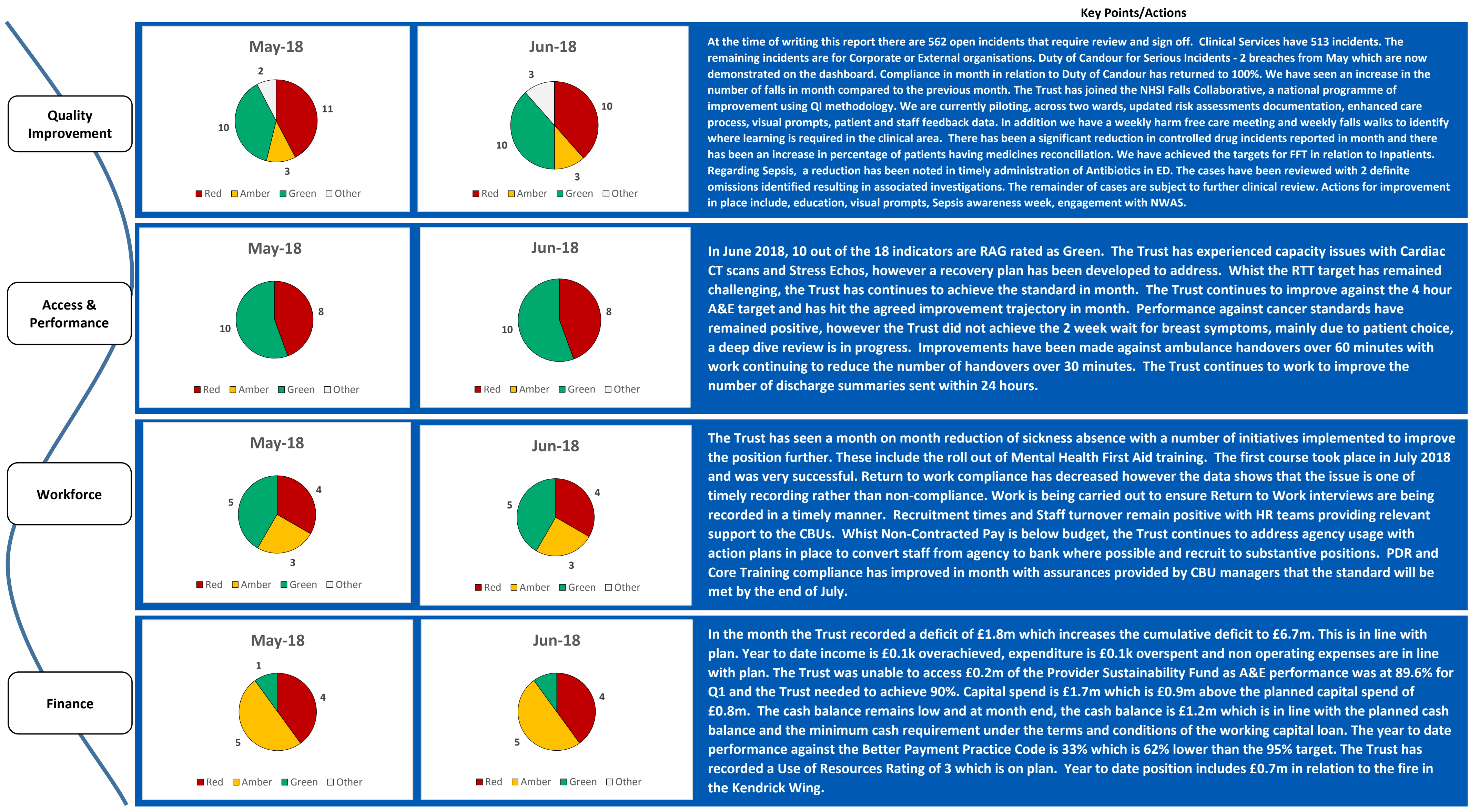
*RAG rating is based on previous month's validation position for these indicators.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - June 2018

Appendix 2

Key
Use of Resources Indicator UoR



At the time of writing this report there are 562 open incidents that require review and sign off. Clinical Services have 513 incidents. The remaining incidents are for Corporate or External organisations. Duty of Candour for Serious Incidents - 2 breaches from May which are now demonstrated on the dashboard. Compliance in month in relation to Duty of Candour has returned to 100%. We have seen an increase in the number of falls in month compared to the previous month. The Trust has joined the NHSI Falls Collaborative, a national programme of improvement using QI methodology. We are currently piloting, across two wards, updated risk assessments documentation, enhanced care process, visual prompts, patient and staff feedback data. In addition we have a weekly harm free care meeting and weekly falls walks to identify where learning is required in the clinical area. There has been a significant reduction in controlled drug incidents reported in month and there has been an increase in percentage of patients having medicines reconciliation. We have achieved the targets for FFT in relation to Inpatients. Regarding Sepsis, a reduction has been noted in timely administration of Antibiotics in ED. The cases have been reviewed with 2 definite omissions identified resulting in associated investigations. The remainder of cases are subject to further clinical review. Actions for improvement in place include, education, visual prompts, Sepsis awareness week, engagement with NWAS.

In June 2018, 10 out of the 18 indicators are RAG rated as Green. The Trust has experienced capacity issues with Cardiac CT scans and Stress Echos, however a recovery plan has been developed to address. Whist the RTT target has remained challenging, the Trust has continues to achieve the standard in month. The Trust continues to improve against the 4 hour A&E target and has hit the agreed improvement trajectory in month. Performance against cancer standards have remained positive, however the Trust did not achieve the 2 week wait for breast symptoms, mainly due to patient choice, a deep dive review is in progress. Improvements have been made against ambulance handovers over 60 minutes with work continuing to reduce the number of handovers over 30 minutes. The Trust continues to work to improve the number of discharge summaries sent within 24 hours.

The Trust has seen a month on month reduction of sickness absence with a number of initiatives implemented to improve the position further. These include the roll out of Mental Health First Aid training. The first course took place in July 2018 and was very successful. Return to work compliance has decreased however the data shows that the issue is one of timely recording rather than non-compliance. Work is being carried out to ensure Return to Work interviews are being recorded in a timely manner. Recruitment times and Staff turnover remain positive with HR teams providing relevant support to the CBUs. Whist Non-Contracted Pay is below budget, the Trust continues to address agency usage with action plans in place to convert staff from agency to bank where possible and recruit to substantive positions. PDR and Core Training compliance has improved in month with assurances provided by CBU managers that the standard will be met by the end of July.

In the month the Trust recorded a deficit of £1.8m which increases the cumulative deficit to £6.7m. This is in line with plan. Year to date income is £0.1k overachieved, expenditure is £0.1k overspent and non operating expenses are in line with plan. The Trust was unable to access £0.2m of the Provider Sustainability Fund as A&E performance was at 89.6% for Q1 and the Trust needed to achieve 90%. Capital spend is £1.7m which is £0.9m above the planned capital spend of £0.8m. The cash balance remains low and at month end, the cash balance is £1.2m which is in line with the planned cash balance and the minimum cash requirement under the terms and conditions of the working capital loan. The year to date performance against the Better Payment Practice Code is 33% which is 62% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is on plan. Year to date position includes £0.7m in relation to the fire in the Kendrick Wing.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

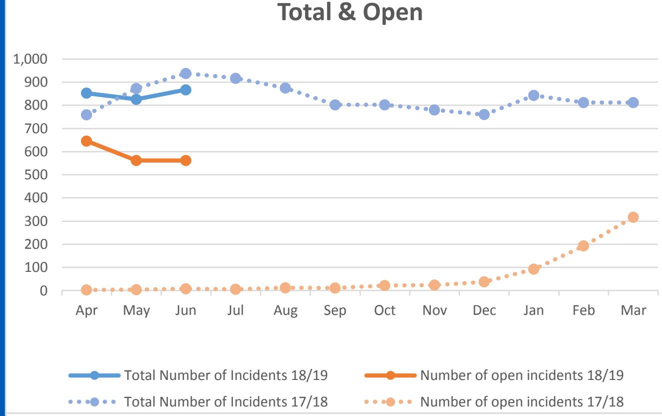
Patient Safety

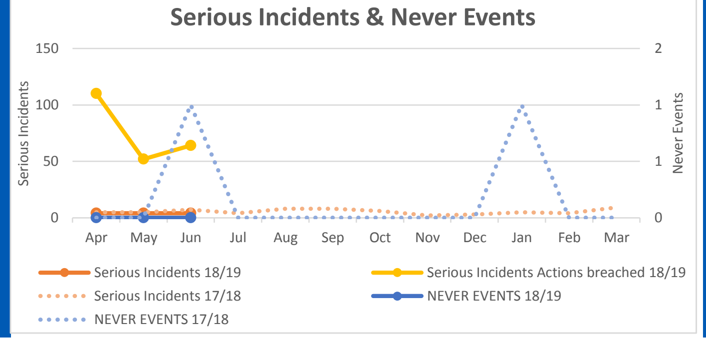
Incidents

Red: 1 or more Never Events or open incidents outside 40 day timeframe .
Amber: Zero Never Events and open incidents between 20 - 40 days old.
Green: Zero Never Events and open incident within timeframe of 20 days.

Number of Never Events (Never Events are serious patient safety incidents that should not occur).
Number of Serious Incidents and actions breached.
Number of open incidents is the total number of incidents that we have awaiting review.

The target for Never Events is a zero tolerance.
Green: open incidents within timeframe (within 20 working days)
Amber: open incidents outside of timeframe (within 40 working days)
Red: open incidents outside of timeframe (over 40 working days old).





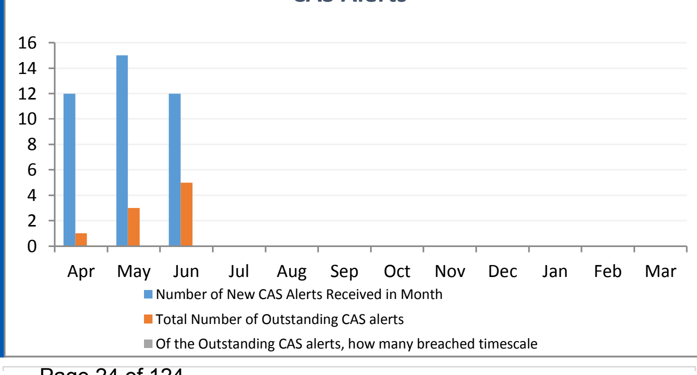
There are 562 open incidents which require review and sign off. This represents a downward trajectory in line with the CQC action to close all backlog incidents. The indicator is rated red as we still have a number of incidents (n=108) over 40 days old.

CAS Alerts -

Green - All relevant CAS Alerts actioned within timescales
Red - Applicable CAS Alert not actioned within the timescale.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependant upon the specific CAS alerts.

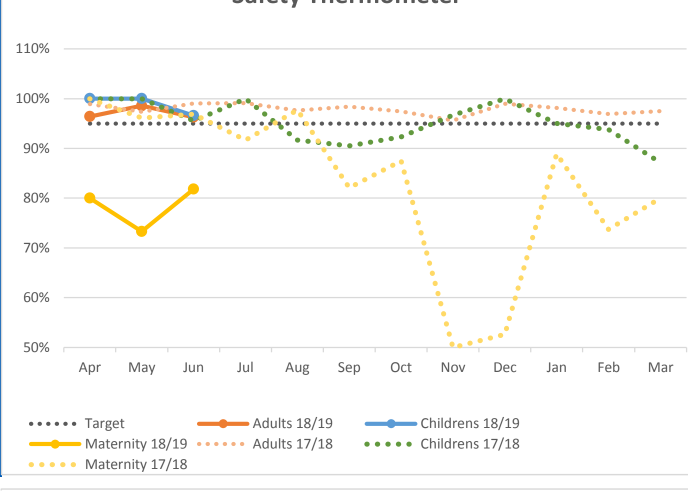
All CAS alerts should be reviewed and actioned within their individual timeframes.



We received 12 alerts in June, of which 7 have been closed.
There are 5 open alerts within the CAS system for the Trust.
We have no alerts past the close by date.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Duty of Candour Red: <100% Green: 100%	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days.	Duty of Candour has to be completed within 10 working days.	Duty of Candour (chart: Number of serious incidents - DoC applies 18/19; Number of moderate harm incidents - DoC applies 18/19; % Compliance rate with DoC (serious incidents) 18/19; % Compliance rate with DoC (moderate incidents) 18/19; Apr–Mar)	There have been 2 breaches in relation to DoC. Both patients/families have been subsequently contacted but this was outside of the 10 working day timeframe and therefore have been declared as breaches. These happened in May and are retrospectively being reported to the Board. June's performance is 100% of duty of candour delivered for those incidents confirmed as being moderate harm or above.
Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.	The target for all areas is to achieve over 95%.		In June the Adult Classic Safety Thermometer shows 6 pressure ulcers, 6 CAUTIs & 6 VTEs with no individual ward being of concern. The matrons have a process in place to validate the data from their areas to ensure correct recording of harm. Overall this meant a harm free percentage of 96.25%. The Maternity ST showed 81.8% harm free. Following a review of the data this was found to be as a result of babies being admitted to the Neonatal Unit. The team are making improvements in Transitional Care facilities to ensure that as many babies as possible remain on the ward during the post natal period. The mothers' perception of their safety was 100% positive. The Children's ST was 96.6% harm free, this was due to 1 baby in Neo-Natal Unit with an extravasation incident.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

Healthcare Acquired Infections

MRSA
Red: 1 or more

Green: 0

C-Difficile
Red: More than 2
Amber: 1 to 2
Green: 0

Description	Aggregate Position	Trend	Variation
Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.	MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.	Healthcare Acquired Infections - MRSA, MSSA, E-Coli Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar MRSA 18/19, MSSA 18/19, E-Coli 18/19, MRSA 17/18, MSSA 17/18, E-Coli 17/18 Healthcare Acquired Infections - C-Difficile Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar C-DIFF (lapses) 18/19, C_DIFF (under review) 18/19, C-DIFF (lapses) 17/18	MRSA bacteraemia - 1 hospital onset case reported by ward A7 in April 2018 this was considered avoidable. Work is in progress with AED to promote timely blood culture sampling. Clostridium difficile - 3 hospital onset cases reported in June 2018. Root cause analysis investigations are in progress. Ward A8 has had an increased incidence in cases. Ribotyping results to date indicate these cases are different. This is a cluster of cases not an outbreak. Review of antibiotic prescribing is in place. MSSA - 5 hospital onset case reported in June 2018. Investigations are in progress. 2 of the 7 cases FYTD are peripheral cannula related and additional training has been organised. Gram negative bloodstream infections in June: E. coli - 5 hospital onset case; Klebsiella - 0 hospital onset case and Pseudomonas aeruginosa 1 hospital onset case reported. A GNBSI action group is being established to review key themes from surveillance data and identify preventative action. Use of investigation toolkits has been implemented from start of Q2.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/16, 16/17, 17/18 (risk assessed by harm and occurrence of PE).	VTE Assessment (chart: Number 91%–97%, Mar–Mar; % Target for completion; % Completion of assessments 18/19; % Completion of assessments 17/18) Root Cause Analysis (chart: Number 0–60, Apr–Mar; No of RCAs completed in month that have caused harm 18/19; No of RCAs completed in month 18/19; No of RCAs completed in month 17/18)	Compliance with VTE standards for assessment in May for the Trust is 95.45%. Daily reminders are sent to ward areas to ensure assessment is completed within the required timeframe, and the Trust has a action plan in place for further improvement. There are currently a number of outstanding moderately graded RCA cases being reviewed through MDT workshops, the first workshop highlighted the requirement for further clinical assessment, a second workshop has been arranged to complete the reviews and identify any harm caused.
Safer Surgery Red: <100% Green: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.	The target is to achieve 100%.	Safer Surgery (chart: 95%–100%, Apr–Mar; 18/19; 17/18)	Total number of operations 1220, total number of WHO checklist started 1220, this gives a percentage of 100%.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	The target is to achieve 90%	CQUIN - Sepsis Screening 100% 90% 80% 70% 60% Apr May Jun Qtr1 Jul Aug Sep Qtr2 Oct Nov Dec Qtr3 Jan Feb Mar Qtr4 Target; AED Screening 18/19; Inpatient Screening 18/19; AED Screening 17/18; Inpatient Screening 17/18 CQUIN - Sepsis Antibiotics & Empiric Review 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% Apr May Jun Qtr1 Jul Aug Sep Qtr2 Oct Nov Dec Qtr3 Jan Feb Mar Qtr4 Target; AED Antibiotic Administered 18/19; Inpatient Antibiotic Administered 18/19; Antibiotic review 18/19	A reduction is noted in timely administration of Antibiotics in ED. The cases have been reviewed with 2 definite omissions identified resulting in associated investigations. The remainder of cases are subject to further clinical review. Actions for improvement in place include; education, visual prompts, Sepsis awareness week and engagement with NWAS.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels	Total number of falls per month and their relevant harm levels.	10% reduction in falls in 2018/19 using 2017/18 data as a baseline.	Number of Falls (Total falls 18/19; Total falls 17/18; Apr-17 to Mar-18). Number of Falls - Moderate, Severe & Death (Moderate Harm 18/19; Severe Harm & Death 18/19; Moderate Harm 17/18; Severe Harm & Death 17/18)	An increase in falls across the Trust was noted in June, with 2 noted to be severe resulting in hip fractures, those falls occurred on ward A8 and A4. A further 2 falls were recorded as moderate with a further 19 graded as minor and the remaining with no harm. The areas with the highest number of falls were Specialist Medicine, Digestive Diseases and Urgent and Emergency Care. The Trust has joined the NHSI Falls Collaborative, a national programme of improvement using Quality Improvement methodology. We are currently piloting, across two wards, updated risk assessments documentation, enhanced care processes, visual prompts, and patient and staff feedback data, as part of this work. In addition we have a weekly harm free care meeting and weekly falls prevention walks to identify where learning is required in the clinical area.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 7 Green: 7	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.	Grade 4 hospital acquired (avoidable and unavoidable) Grade 3 hospital acquired(avoidable and unavoidable) Grade 2 hospital acquired (avoidable and unavoidable)	Pressure Ulcers (Grade 4 un-avoidable 18/19; Grade 4 avoidable 18/19; Grade 3 un-avoidable 18/19; Grade avoidable 18/19; Grade 2 unavoidable 18/19; Grade 2 avoidable 18/19; Grade 4 avoidable 17/18; Grade 3 avoidable 17/18; Grade 2 avoidable & unavoidable 17/18; Apr to Mar)	The number of grade 2 pressure ulcers noted to have acquired in hospital in June is 4, following the RCA review panel 2 were recorded as avoidable. Themes noted were lack of communication, assessment and timely provision of preventative kit. The Trust has joined a TV collaborative through NHSI using ward C21 as a pilot area for improvement, focussing on the avoidance of heel pressure ulcers utilising QI methodology.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Medication Safety Red - any incidents of harm. Green - no incidents of harm.	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	The target for Medication Safety is a zero tolerance for incidents of harm.	Medication Safety (chart)	The June medicines reconciliation position includes maternity and children. June is showing an increase in total and % MRs completed when compared with the previous 2 months. 27.9% of MRs were completed within 24 hours of admission and 48% within 48 hours of admission. There has been a reduction in CD incidents comparing non-audit months (16->8). There was 1 incident re-categorised as a harm incident in May and 2 have been reported in June. These are undergoing review to enable learning to be identified and disseminated.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	Percentage of planned verses actual for registered and non registered staff by day and night	Target of >90%. The data produced excludes CCU, ITU and Paediatrics.	Staffing - Average Fill Rate (chart)	The majority of areas are above the 90% target YTD and it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates have decreased, due to seasonal trend. Bank incentives and escalated rates for critical areas have been put in place to improve the shift fill rate.

Medication Safety

Number axis: 0, 5, 10, 15, 20, 25; Percentage axis: 60%, 65%, 70%, 75%, 80%
Months: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar
Legend: Controlled drugs incidents 18/19; Medication Incidents relating to harm 18/19; Controlled drugs incidents 17/18; Medication Incidents relating to harm 17/18; % Medication reconciliation 18/19; % Medication reconciliation 17/18

Staffing - Average Fill Rate

Axis: 80%, 85%, 90%, 95%, 100%, 105%, 110%
Months: Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar
Legend: Day - registered nurses/midwives 18/19; Night - registered nurses/midwives 18/19; Day - registered nurses/midwives 17/18; Night - registered nurses/midwives 17/18; Day - care staff 18/19; Night - care staff 18/19; Day - care staff 17/18; Night - care staff 17/18

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
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	The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.	Staffing - Care Hours Per Patient Day (CHPPD)	We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Target for Green would be to be within expected ranges.	HSMR: HSMR 18/19 Apr 97.28, May 99.71, Jun 99.44	We are as expected for HSMR. Our HSMR is below 100, work continues regarding implementation of our Learning from Deaths Policy via our Mortality Review Group.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Target for Green would be to be within expected ranges.	SHMI: SHMI 18/19 Apr 104.70, May 104.70, Jun 104.70	SHMI source data is not currently available. NHS Digital has not been able to provide HED with the normal raw data used to produce SHMI related modules. They have also not been able to provide HED with any further information regarding when this data will become available so we continue to use the last known position of 104.70 which is within the expected range.

Staffing chart legend: Registered midwives/ nurses 18/19; Care Staff 18/19; Overall 18/19; Registered midwives/ nurses 17/18; Care Staff 17/18; Overall 17/18; Cumulative - pats at 23:59 each day 18/19; Cumulative - pats at 23:59 each day 17/18. Axes: Care Hours per day (0.0–8.0); Cumulative count (10000–16000); Apr–Mar.

HSMR chart legend: HSMR 18/19; HSMR 17/18. SHMI chart legend: SHMI 18/19; SHMI 17/18.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total Deaths	Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group.	There is no target against this indicator.	In-Hospital Deaths (chart: Total Hospital Deaths 18/19; Total Hospital Deaths 17/18; Apr–Mar; 0–140)	All the Standard Judgment Reviews (SJRs) are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub Committee. The Trust will be reporting avoidable mortality in the Quality Accounts, which are currently being prepared. Any review conducted where they may be potentially avoidable mortality, is reported as a Serious Incident and subject to a full Root Cause Analysis before avoidability is confirmed.
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.	The target is to achieve 100% compliance against all NICE guidance.	NICE Compliance (chart: Target; Compliance 18/19; Compliance 17/18; Apr–Mar; 0%–100%)	There are currently 3 pieces of NICE Guidance which are outside the 90 day assessment period: Hypothermia, Asthma and the Quality Standard for Patient Experience. The next stage of our NICE improvement work has started looking at guidance where we are partially compliant and assessing action plans for full compliance.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

Patient Experience

Complaints

Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.

Red - Trust not meeting improvement trajectories or complaints open over 6 months old.
Amber - No complaints over 6 months old, Trust meeting backlog improvement targets
Green - No backlog, complaints responded to within agreed timescales.
Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan.

In June, there was one case over 6 months which was a complex case and involved several areas. The amount of breached complaints has been halved within the month with cases being responded to on time more frequently. There has been an increase in the number of dissatisfied complainants. This is mainly due to the amount of responses that were sent out in the month, as this was much higher than previous months. The Trust has opened significantly less new complaints within the month.

Friends and Family (Inpatients & Day cases)

Red: Less than 95%
Green: 95% or

Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

The target set is to achieve over 95%.

The Trust has achieved the target of 95% of patients who would recommend the Trust which is an increase from 94% last month. The response rate has also continued to improve with a significant 35.8%.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.	Friends and Family (A&E and UCC)	The target for the Trust is 87%, in June both the recommendation and response rates reduced to 83% and 17.6% respectively. An urgent review of the process in ED has been undertaken and improvement measures include adding FFT to care and comfort rounds and the daily nursing huddle. The co-ordinator will oversee progress with this and address any lapses on a daily basis, with an associated action plan to be developed by ED.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.	Mixed Sex Accommodation Breaches	There have been 5 MSA breaches in June 2018, an increase from 2 in May 2018. The escalation process has been reviewed, to ensure there are robust measures in place that potential breaches in ICU & CCU are escalated and patients are prioritised and moved to the most appropriate ward. Mini RCAs are completed after each breach and a summary sent to the CCG as per national requirements. Themes from MSA breaches are to be discussed at critical care and patient flow governance meetings to ensure there is learning.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQC				
CQC Insight Composite Score Red (inadequate): <-3 Amber (req improvement): >-2.9 - 1.5 Green (good/outstanding): >1.5	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.	The RAG rating is based on the thresholds within the CQC Insight Report. Scores Below -3 are rated as "Inadequate", between -2.9 and 1.5 scores are rated as "Requires Improvement", scores between 1.5 - 4.9 are rated "Good" , scores of above 5 are rated "Outstanding"	CQC Insight Composite Score (chart)	The Trust is currently rated as -1.3 by the CQC which means that we currently score in the spectrum of those Trusts that "Requires Improvement". It is important to note that a lot of the data in this report is out of date and is being constantly refreshed.

CQC Insight Composite Score

2.0
1.5
1.0
0.5
0.0
-0.5
-1.0
-1.5
-2.0

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

Target
Actual 17/18
Actual 18/19

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

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 Trust achieved 98.18% in June 2018.	Diagnostic Waiting Times 6 Weeks (No. of Patients 18/19; No. of Patients 17/18; Target; % 18/19; % 17/18)	The diagnostic target deteriorated further in month and therefore was not achieved. The failure is associated with the lack of capacity for CT scans and stress echo's which represents the majority of the breeches recorded. The new Diagnostic CBU manager has developed a recovery plan to bring performance back in line by the end of August 2018 and this remains on track. The business case for additional support and equipment has been agreed.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or; **RTT - Number of patients waiting 52+ weeks** Green = 0, otherwise Red — Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 92.13% in June 2018.	Referral to treatment Open Pathways (No. of Patients 18/19; No. of Patients 17/18; Target; % 18/19; % 17/18)	The Trust achieved the 18 week referral to treatment target, achieving 92.13% against a target of 92%; this is a difficult target which remains challenging given the continued pressure experienced by the Trust and cancellations. Additional validation support is continuing to assist the central team and all specialities not achieving this standard have individual recovery plans in place for the remainder of the year. These are already showing improvement especially in those challenged areas such as MSK.
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above; **Four Hour Standard 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 achieved 91.00% (including walk in) and 89.53% (excluding walk in) in June 2018.	A&E Waiting Times - 4hr target (No. of Patients 18/19 (Including Walk-In); No. of Patients 18/19 (Excluding Walk-In); No. of Patients 17/18 (Including Walk-In); No. of Patients 17/18 (Excluding Walk-In); Improvement Trajectory; % 18/19 (Including Walk-In); % 18/19 (Excluding Walk-In); % 17/18 (Including Walk-In); % 17/18 (Excluding Walk-In); National Target)	The Trust has seen a progressive improvement in 4 hour performance since April 2018 in line with our internal NHSI trajectories. Unfortunately, the Provider Sustainability Fund (PSF) criteria was not met for Q1. Notification was received on the 27th June 2018 that the threshold was to achieve outturn of 17/18 performance or 90% for this period. This has been challenged with NHSI. Escalated beds have continued to decrease with the further reduction of beds on C20 to allow for the development of GAU. There remain circa 42 additional beds still open and being utilised, although plans are now in place to reduce this to 8 in the coming months. A silver command rota remains in place which provides senior management presence in the patient flow office to ensure that there challenges are actioned in a timely manner. There is a zero tolerance on non-admitted breeches for 18/19 and these are reviewed on a daily basis.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.	The Trust achieved 93.51% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 14 Days	The Trust achieved the Cancer 14 Day target in May. The June data is in draft format and will only be released once fully validated and uploaded in July.
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.	The Trust achieved 84.75% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Breast Symptoms 14 Days	The 2 week wait for breast symptomatic failed in May and this was mainly attributed to breeches associated with patient choice. As a consequence of this, it is likely that Q1 overall will fail. The Womens & Childrens CBU has undertaken a deep dive review and action has been taken with additional capacity has been made available.
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 achieved 97.62% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days First Treatment	The Trust achieved this target in May 2018.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days Subsequent Surgery	The Trust achieved this target in May 2018.

Chart legend (all charts): No. of Patients 18/19; No. of Patients 17/18; Target; % 18/19; % 17/18. Axes: % Performance; Number of patients; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days Subsequent Drugs	The Trust achieved this target in May 2018.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 81.65% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 62 Days Urgent	The Trust did not hit the threshold in May 2018 for the reallocated position. The Open Exeter position is 85.58% for May 2018 which is the reportable position and this did achieve the standard. From Q3 the Trust will be monitored against the reallocated position.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 62 Days Screening	The Trust achieved this target in May 2018.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
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).	There were 91 patients where the ambulance handover was between 30 and 60 minutes in June 2018.	Ambulance Handovers at 30 to <60 minutes	Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, however the number of handovers greater than 60 minitues has improved again in June. Work continues to focus on reducing number waiting over 30 minitues. A successful pilot with a handover practitioner is to be made substantive to ensure continued high performance in this area. The compliance score has decreased in June and a deep dive will be undertaken to improve the number of handovers to ensure a return to 90%. June was the first month this occurred however Q1 was achieved.
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).	There were 12 patients where the ambulance handover was more 60 minutes in June 2018.	Ambulance Handovers at 60+ minutes	Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, however the number of handovers greater than 60 minutes has improved again in June. Work continues to focus on reducing number waiting over 30 minutes. A successful pilot with a handover practitioner is to be made substantive to ensure continued high performance in this area. The compliance score has decreased in June and a deep dive will be undertaken to improve the number of handovers to ensure a return to 90%. June was the first month this occurred however Q1 was achieved.
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge.	The Trust achieved 84.44% in June 2018.	Discharge Summaries	The Trust continues to drive compliance improvement across all CBUs. This is monitored via the weekly & monthly KPI meetings.
Discharge Summaries - Number NOT sent within 7 days Red: Above 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.	All discharge summaries were sent within 7 days in June 2018.	Discharge Summaries - Number NOT sent within 7 days (target = 0)	The Trust achieved this target in June 2018.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason Red: Above zero	Number of operations cancelled on the day or after admission for a non-clinical reason.	There were 18 operations cancelled on the day due to non-clinical reasons in June 2018.	Cancelled operations on the day for non-clinical reason Legend: No. of Patients 18/19; Target; No. of Patients 17/18	This has remained a challenge in June with bed pressures at peak times continuing.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.	There was no patients whose operation was cancelled on the day for non-clinical reasons whom was not readmitted within 28 days in June 2018.	Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days Legend: No. of Patients 18/19; Target; No. of Patients 17/18	There were no breeches of the 28 day target recorded this month. This is a significant improvement from previous months.

Integrated Dashboard - June 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	UoR Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence has decreased again slightly in June 2018. Sickness absence remains above target at 4.65%.	Monthly Sickness Absence (chart: 3%–6%; Jul-17 to Jun-18; Target, Current Yr, Previous Yr, NW Avg)	Key actions to address continue from last month: > Review of current policy continues. > Benchmarking against similar neighbouring Trust is taking place to understand and implement best practice in relation to stress. Ideas from other Trust sare now being reviewed and considered for implementation > HR team delivering bespoke actions and coaching with hotspot areas. > Mental Health First Aider Training - first training course has been a huge success.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	The RTW Interview compliance for June is currently reported at 81.10%.	Monthly Return to Work % (chart: 50%–100%; Jul-17 to Jun-18; Actual, Target)	To be noted is the increase in the May position (now at 87.46% compared to the reported position of 76.83%). This is due to retrospective inputting of RTW data since the last report. This data highlights the need for more timely completion of the RTW interview and inputting of the data on to either E-Rostering or ESR. The HRBP team continue to work with the CBUs to raise this importance of this aspect of the attendance policy. In addition, the Nursing Workforce Improvement Lead has undertaken a deep dive into the nursing figures, has verified the accuracy of the data and has confirmed that the issue is the timeliness of recording.
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or	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	Average time to hire has increased slightly to 73 days (up from 70.1).	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)	Although there has been a slight increase in time to hire, the trend of achieving around 71-74 days is maintained.

Integrated Dashboard - June 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	UoR A review of the turnover percentage over the last 12 months	Trust Turnover remains below target at 11.95%.	Turnover % (chart: Target, Turnover; Jul-17 to Jun-18)	The HR team continue to provide tailored support to areas with high turnover and work is on-going across the Trust in relation to specific staff groups, including Nursing and Midwifery staff and AHPs. The Trust now has access to Peer average turnover data and the Trust's current turnover rate is above average. This data will be monitored over the next quarter to establish trends.
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	UoR A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Expenditure on pay in June was less than the previous month by £381k and was less than the budget by £133k.	Non Contracted Spend vs Budget (chart: Contracted, Overtime, Bank, Agency, WLI, Budget; Jul-17 to Jun-18)	There were reductions in all 4 pay elements as follows: contracted (£108k), bank (£134k), agency £110k and WLIs (£28k). FSC continue to monitor all elements of expenditure.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Nurses	Agency Nurse Spend was £263k and Bank Nurse Spend was £333k in June 2018.	Agency & Bank Nurse Spend (chart: Current Yr Bank Spend, Current Yr Agency Spend, Previous Yr Agency Spend; Jul-17 to Jun-18)	Agency Nurse Spend remained stable in month whist Bank Nurse Spend has reduced slightly in month.

Integrated Dashboard - June 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Locums	Medical Agency Spend was £476k and Bank Medical Spend was £207k in June 2018.	Agency & Bank Medical Spend £1,000,000 £800,000 £600,000 £400,000 £200,000 £0 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Current Yr Bank Spend Current Yr Agency Spend	Medical and Bank Agency Spend have both reduced slightly in month.
Agency AHP Spend Red: Greater than Previous Yr Green: Less then Previous Yr	UoR A review of the monthly spend on AHP Locums	AHP Agency Spend was £75k in month.	Agency & Bank AHP Spend £250,000 £200,000 £150,000 £100,000 £50,000 £0 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Current Yr Bank Spend Current Yr Agency Spend Previous Yr Agency Spend	AHP Agency Spend has reduced in month and remains lower than the same period last year.
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safegarding.	Core Skills Mandatory Training Compliance was 84.86% in June 2018.	Core/Mandatory Training 100% 95% 90% 85% 80% 75% 70% Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Core/Mandatory Training % Target Linear (Core/Mandatory Training %)	CBU triumvirates have given assurance to Trust Operational Board that 85% compliance will be achieved by 31/07/2018.

Integrated Dashboard - June 2018

Workforce

	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	**A summary of the PDR Compliance rate**	**PDR Compliance was 83.2% in June 2018.**	PDR (chart: Target, Actual; 90%–40%; Jul-17 to Jun-18)	**CBU triumvirates have given assurance to Trust Operational Board that 85% compliance will be achieved by 31/07/2018.**
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than	UoR **Monthly costs for the top 10 highest cost Agency Workers**	**The monthly cost for the top earning agency workers ranged from £72k to £31k. The average cost was £47k.**	Average cost of the top 10 highest cost agency workers (chart: Monthly Cost £0–£50,000; Sep-17 to Jun-18)	**The high cost agency workers data is scrutinised monthly and work is on-going to produce exit plans for each worker, as well as short term mitigation plans such as renegotiating rates. This work is reported through to the Premium Pay Spend Review Group.**
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month	**The length of service (months) of the Top 10 agency workers who have been working at the trust for a minimum of 3 shifts per week for a consecutive period of 6 weeks.**	**The length of service for the longest serving agency workers ranged from 50 months to 17 months. The average length of service was 27 months.**	Average length of service of the top 10 longest serving agency workers (chart: Length of service (months) 0–30; Sep-17 to Jun-18)	**The length of service for agency workers is reported on a weekly basis to NHSI. The current length of service poses low risk to the organisation.**

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

Key	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	UoR Surplus or deficit compared to plan	The actual deficit in the month is £1.8m which increases the cumulative deficit to £6.7m.	Financial Position (chart)	The cumulative deficit of £6.7m is in line with plan.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	UoR Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).	The current cash balance of £1.2m equates to circa 2 days operational cash.	Cash Balance (chart)	The current cash balance of £1.2m is in line with the plan. Due to the operating position additional working capital loans are required to maintain liquidity and meet financial obligations. The value of working capital loans drawn down to 30th June 2018 is £40.9m.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR Capital expenditure compared to plan (The capital plan has been increased to £7.3m as a result of additional funding from the Department of Health for A&E Primary Care Streaming and WiFi infrastructure upgrade and capital donations from Can treat, Health Education England and Charitable Funds.	The actual capital spend in the month is £1.0m which increases the cumulative spend to £1.7m.	Capital Programme (chart)	The cumulative capital spend of £1.7m is £0.9m above the planned capital spend of £0.8m.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or	UoR Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month, the Trust has paid 28% of suppliers within 30 days which results in a year to date performance of 31%.	Better Payment Practice Code	The cumulative performance of 31% is 64% below the national standard of 95%, this is due to a challenging cash position. Cash is managed closely on a daily basis.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	UoR Use of Resources Rating compared to plan.	The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity, I&E margin are scored at 4 whilst Agency Ceiling is scored at 2 and performance against control total is scored at 1.	Use of Resources Rating	The current Use of Resources Rating of 3 is in line with the planned rating.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties	Fines and Penalties are levied by commissioners as outlined in the contracts.	Fines and Penalties	The Trust is awaiting notification of any fines or penalties levied by commissioners during Q1. The Trust has agreed with commissioners in Warrington & Halton to reinvest any fines and penalties as part of the sustainability contract.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	UoR Agency spend compared to agency ceiling	The actual agency spend in the month is £0.9m which increases the cumulative spend to £2.7m.	Agency Spending (chart)	The cumulative agency spend of £2.7m is £0.5m (22%) above the cumulative agency ceiling of £2.2m.
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	Cost savings delivered compared to plan.	CIP savings delivered in M3 are £0.15m which is below the M3 target of £0.24m. YTD £0.34m has been delivered against the target of £0.60m. In addition, £0.03m of cost avoidance has been delivered YTD.	CIP chart	The Trust is reporting on CIP delivery to NHSI every 2 weeks. The Executive Team has reviewed existing CIP schemes and is assessing the viability of potential schemes to address the shortfall.
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	Planned improvements in productivity and efficiency - In Year forecast vs £7m target.	An assessment of existing ideas/schemes has been undertaken. The latest forecast delivery in year has been assessed at between £4.6m and £2m.	Trustwide Cumulative In Year Position vs. Plan submitted to NHSI (chart)	Delivery of £7m CIP programme presents a significant challenge and is under constant review and assessment by the Executive Team.

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	**Planned improvements in productivity and efficiency - Full Year Forecast vs. £7m target.**	**The latest forecast delivery of recurrent CIP is between £6.2m and £1.7m.**	FYE Recurrent Position vs. Plan submitted to NHSI £8,000,000 £7,000,000 £6,000,000 £5,000,000 £4,000,000 £3,000,000 £2,000,000 £1,000,000 £0 FYE Recurrent Ideas Hopper High Risk Medium Risk Low Risk Delivered Plan submitted to NHSI	**The recurrent nature of the CIP programme falls under the review and mitigation of the Executive Team.**

Appendix 3

Income Statement, Activity Summary and Use of Resources Ratings as at 30th June 2018

	Month			Year to date			Forecast		
Income Statement	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**
Operating Income									
NHS Clinical Income									
Elective Spells	2,813	2,664	-149	8,306	7,858	-448	33,894	33,894	0
Elective Excess Bed Days	8	44	36	25	73	48	101	101	0
Non Elective Spells	4,820	5,366	546	14,770	15,621	851	59,030	59,030	0
Non Elective Excess Bed Days	164	238	73	504	613	110	2,013	2,013	0
Outpatient Attendances	2,782	2,830	47	8,215	8,279	64	33,522	33,522	0
Accident & Emergency Attendances	1,133	1,248	115	3,371	3,661	290	13,451	13,451	0
Other Activity	5,573	4,956	-616	16,731	15,799	-931	69,120	69,120	0
Sub total	**17,294**	**17,346**	**52**	**51,921**	**51,905**	**-17**	**211,131**	**211,131**	**0**
Non NHS Clinical Income									
Private Patients	5	5	-1	15	67	52	152	152	0
Non NHS Overseas Patients	4	13	9	11	25	14	44	44	
Other non protected	95	62	-33	285	187	-98	1,135	1,135	0
Sub total	**104**	**80**	**-24**	**311**	**279**	**-32**	**1,331**	**1,331**	**0**
Other Operating Income									
Training & Education	641	641	0	1,923	1,923	0	7,693	7,693	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Provider Sustainability Fund	741	519	-222	741	519	-222	4,942	4,942	0
Miscellaneous Income	1,575	1,850	275	4,724	5,123	399	20,503	20,503	0
Sub total	**2,957**	**3,010**	**53**	**7,388**	**7,565**	**177**	**33,138**	**33,138**	**0**
Total Operating Income	**20,355**	**20,435**	**81**	**59,621**	**59,749**	**128**	**245,600**	**245,600**	**0**
Operating Expenses									
Employee Benefit Expenses	-15,060	-15,037	23	-45,245	-45,636	-390	-179,196	-179,196	0
Drugs	-1,419	-1,260	160	-4,278	-3,786	492	-17,026	-17,026	0
Clinical Supplies and Services	-1,744	-1,790	-45	-5,243	-5,285	-42	-20,582	-20,582	0
Non Clinical Supplies	-3,101	-3,314	-213	-9,303	-9,529	-226	-36,874	-36,874	0
Depreciation and Amortisation	-501	-486	15	-1,502	-1,458	44	-6,007	-6,007	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Total Operating Expenses	**-21,825**	**-21,886**	**-61**	**-65,571**	**-65,693**	**-122**	**-259,686**	**-259,686**	**0**
Operating Surplus / (Deficit)	**-1,470**	**-1,451**	**19**	**-5,950**	**-5,944**	**6**	**-14,086**	**-14,086**	**0**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0	0	0
Interest Income	3	5	2	9	14	5	36	36	0
Interest Expenses	-136	-154	-18	-244	-244	0	-813	-813	0
PDC Dividends	-203	-203	0	-544	-544	0	-2,174	-2,174	0
Net Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-337**	**-352**	**-15**	**-779**	**-773**	**5**	**-2,951**	**-2,951**	**0**
Surplus / (Deficit)	**-1,807**	**-1,803**	**4**	**-6,729**	**-6,718**	**11**	**-17,037**	**-17,037**	**0**
Less Donations & Grants Income	0	0	0	0	0	0	0	0	0
Less Depreciation on Donated & Granted Assets	13	14	1	39	40	1	156	156	0
Control Total	**-1,794**	**-1,789**	**5**	**-6,690**	**-6,677**	**13**	**-16,881**	**-16,881**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,999	2,834	-165	8,855	8,183	-672	36,135	36,135	0
Elective Excess Bed Days	34	182	147	102	297	195	415	415	0
Non Elective Spells	3,029	2,908	-121	9,280	8,510	-770	37,091	37,091	0
Non Elective Excess Bed Days	676	1,019	343	2,072	2,556	484	8,283	8,283	0
Outpatient Attendances	25,938	25,761	-177	76,579	76,434	-145	312,490	312,490	0
Accident & Emergency Attendances	9,678	9,973	295	28,792	29,511	719	114,866	114,866	0
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-5.64	-5.17	0.47	-2.69	-2.69	0.00
Liquidity Ratio (Days)				-16.4	-38.1	-21.7	-14.3	-14.3	0.0
I&E Margin (%)				-11.22%	-11.18%	0.05%	-6.87%	-6.87%	0.00%
Performance against control total (%)				0.00%	-0.07%	-0.07%	0.00%	0.00%	0.00%
Agency Ceiling (%)				0.00%	21.98%	21.98%	0.00%	0.00%	0.00%
Ratings									
Capital Servicing Capacity (Times)				4	4	0	4	4	0
Liquidity Ratio (Days)				4	4	0	4	4	0
I&E Margin (%)				4	4	0	4	4	0
Performance against control total (%)				1	1	0	1	1	0
Agency Ceiling (%)				1	2	1	1	1	0
Use of Resources Rating				**3**	**3**	**0**	**3**	**3**	**0**

Annual Audit Letter

Year ending 31 March 2018

Warrington and Halton Hospitals NHS Foundation Trust

8 June 2018

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A Reports issued and fees

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Executive Summary

Purpose

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Warrington and Halton Hospitals NHS Foundation Trust (the Trust) for the year ended 31 March 2018.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this Letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit Committee as those charged with governance in our Audit Findings Report on 22 May 2018.

Respective responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the National Health Service Act 2006 (the Act). Our key responsibilities are to:

- give an opinion on the Trust financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust financial statements, we comply with International Standards on Auditing (UK) (ISAs) and other guidance issued by the NAO.

Our work

Materiality	We determined materiality for the audit of the Trust's accounts to be £4,164,000, which is 1.75% of the Trust's 2016/17 gross operating expenses.
Financial Statements opinion	We gave an unqualified opinion on the Trusts financial statements on 25 May 2018. We included a material uncertainty paragraph in our report on the Trust's financial statements to draw attention to the note which explains the basis on which the Trust has determined that it is still a going concern. This does not affect our opinion that the statements give a true and fair view of the Trust's financial position and its income and expenditure for the year.
NHS Group consolidation template (WGA)	We also reported on the consistency of the accounts consolidation template provided to NHS England with the audited financial statements. We concluded that these were consistent.
Use of statutory powers	We did not identify any matters which required us to exercise our additional statutory powers.

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Executive Summary

Value for Money arrangements	We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for the £10.9m adverse variance in the year end financial position which indicates weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. We therefore qualified our value for money conclusion in our audit report to the Directors of the Trust on 25 May 2018.
Quality Report	We completed a review of the Trust's Quality Report and issued our report on this on 25 May 2018. We concluded that the Quality Report was prepared in line with the NHS foundation trust annual reporting manual and supporting guidance. However our report was qualified due to the underlying data quality issues in 2017/18 associated with the mandated indicator; 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' (RTT).
Certificate	We certify that we have completed the audit of the accounts of Warrington and Halton Hospitals NHS Foundation Trust in accordance with the requirements of the Code of Audit Practice.

Working with the Trust

During the year we have delivered a number of successful outcomes with you:

- An efficient audit – we delivered an efficient audit with you in May, delivering the accounts four days before the deadline, releasing your finance team for other work.
- Understanding your operational health – through the value for money conclusion we provided you with assurance on your operational effectiveness.
- Sharing our insight – we provided regular audit committee updates covering best practice. We also shared our thought leadership reports
- Providing training – we provided your teams with training on financial accounts and annual reporting

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

Grant Thornton UK LLP
June 2018

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Audit of the Accounts

Our audit approach

Materiality
In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for the audit of the Trust's accounts to be £4,164,000, which is 1.75**%** of the Trust's 2016/17 gross revenue expenditure. We used this benchmark as, in our view, users of the Trust]'s financial statements are most interested in where the Trust has spent its revenue in the year.

We also set a lower level of specific materiality for senior officer remuneration and related party transactions.

We set a lower threshold of £208,000, above which we reported errors to the Audit Committee in our Audit Findings Report.

The scope of our audit
Our audit involves obtaining sufficient evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:

- the accounting policies are appropriate, have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the accounts included in the Annual Report on which we gave our opinion.

We carry out our audit in accordance with ISAs (UK) and the NAO Code of Audit Practice. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

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Audit of the Accounts

Key Audit Risks

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Improper revenue recognition Under ISA (UK) 240 there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. Approximately 89% of the Trust's income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities - provided that they are additional to those incorporated in these contracts (contract variations) - are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. We identified the occurrence and accuracy of income from contract variations as a risk requiring special audit consideration and a key matter for the audit.	As part of our audit work we: • gained an understanding of the Trust's system for accounting for income from contract variations and evaluated the design of the associated controls; • evaluated the appropriateness of the Trust's accounting policy for recognition of income from patient care activities and assessing its compliance with the Department of Health and Social Care Group Accounting Manual 2017/18; • on a sample basis agreed amounts recognised as income in the financial statements to signed contracts, and agreed contract variations to supporting documentation.	Our audit work did not identify any issues in respect of revenue recognition.

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Audit of the Accounts

Key Audit Risks - continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Going concern material uncertainty disclosures As auditors, we are required to "obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern" (ISA (UK) 570). The Trust incurred a £14.7m financial deficit in delivering its services in 2017/18 and requested financial revenue support via working capital loans of £17.3 million during the year. Management anticipates that it may take a number of years before the Trust's income equals or exceeds its expenditure. The Trust will therefore require further cash support via revenue loans to pay its expenses in 2018/19. The source and value of the loans has yet to be confirmed. We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk requiring special audit consideration. Given the sensitive nature of these disclosures, we identified this a key audit matter for the audit.	We obtained sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements in order to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern.	The Trust's projection for 2018/19 is a deficit position of £24.6m based on an increased efficiency savings target of £7m. The forecast assumes no receipt of Sustainability and Transformation Funding in 2018/19, as the Trust does not expect to achieve its 2018/19 control total of a surplus of £3.3m and will need an additional £24.4m revenue support in 2018/19 to meet the on-going deficit position. Overall the level of loans required to ensure liquidity continues to rise, and is expected to be approximately £63.8m by 31/3/19. This will only start to reduce once the Trust achieves a surplus, which is not predicted in the foreseeable future. Given the continued increased reliance on DH support with little prospect of this reducing in the short term our audit report includes reference to a material uncertainty relating to going concern. The Trust has also included within the going concern section of accounting policy Note 1 a disclosure that there is a material uncertainty as the Department of Health has not yet confirmed support of the required loan support for 2018/19.

Audit of the Accounts

Key Audit Risks - continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Valuation of property, plant and equipment The Trust revalues its land and buildings on an annual basis to ensure that carrying value is not materially different from fair value. This represents a significant estimate by management in the accounts. We identified the valuation of land and buildings revaluations and impairments as a risk.	As part of our audit we: • reviewed management's assessment of the valuation of property, plant and equipment and gained an understanding of the valuation process, including the key controls and assumptions used by management; • assessed the competence, objectivity and expertise of management's valuer (Cushman and Wakefield); • assessed the appropriateness of the instructions issued to the valuer and the scope of their work, including the completeness of the data provided to the valuer; • for a sample of assets revalued in the year, agreed the valuation included in the valuer's report to the asset register and the financial statements; • challenged and obtained evidence for the assumptions made by management in relation to the valuation of land and building; and • assessed the impact of the fire at the Trust on 23 March 2018 and ensured that this had been accounted for correctly	Our audit work did not identify any significant issues in relation to the risk identified.

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Audit of the Accounts

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 25 May 2018, in advance of the national deadline.

Preparation of the accounts

The Trust presented us with draft accounts in accordance with the national deadline, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the accounts

We reported the key issues from our audit to the Trust's Audit Committee on 22 May 2018.

Annual Report, including the Annual Governance Statement

We are also required to review the Trust's Annual Report, including the Annual Governance Statement. A number of changes were made to the Annual Report and the Annual Governance Statement.

The Annual Report as submitted for audit was incomplete in several key respects, with further information added during the audit. In particular, the Remuneration Report was not made available for audit until 11 May 2018. In future, the Trust should prepare early plans to enable it to submit all necessary information for audit by the due date, as agreed in our audit plan. Failure to do so can affect our ability to complete the audit in the most efficient and effective way.

Changes were made to the Annual Governance Statement following our audit. These related mainly to the need to include consideration of the Trust’s financial performance in the context of the Trust’s governance arrangements, and also to the need to reflect the results of other external inspections.

Whole of Government Accounts (WGA)

We issued a group return to the National Audit Office in respect of Whole of Government Accounts, which did not identify any issues for the group auditor to consider.

Other statutory powers

We are also required to refer certain matters to the Secretary of State under schedule 10 (6) of the NHS Act 2006. We did not make any such referrals.

Certificate of closure of the audit

We are also required to certify that we have completed the audit of the accounts of Warrington and Halton Hospitals NHS Foundation Trust in accordance with the requirements of the Code of Audit Practice.

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Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2017 which specified the criterion for auditors to evaluate:

In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key findings

Our first step in carrying out our work was to perform a risk assessment and identify the key risks where we concentrated our work.

The key risks we identified and the work we performed are set out overleaf.

Overall Value for Money conclusion

We are satisfied that, in all significant respects, except for the matter we identified below, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2018.

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

The Trust incurred a deficit of £14.7 million in 2017/18, compared to a planned deficit of £3.8m. Unprecedented levels of activity, the suspension of the spinal service, and the premium cost of winter had an adverse effect on the Trust's financial position. This had an impact on the Trust's ability to deliver its planned level of cost savings and its expected access to income of £4.6 million from the Sustainability and Transformation Fund. The Trust also requested revenue support from the Department of Health during the year of £17.3m. As at 30 April 2018 the Trust forecasts that it will need to continue to rely on revenue support in 2018/19 and will have a working capital loan requirement of £63.8 million.

This matter identifies weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. This issue is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

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Value for Money conclusion

Significant Value for Money Risks

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Financial reporting and outturn The Trust is operating within an extremely challenging financial environment with structural deficit within the local health economy. The Trust has a financial plan aimed at delivering a planned deficit for 2017/18 of £3.8m (an improved financial position of £4.5m since last year), which is subject to full receipt of £7m Sustainability and Transformation Fund support. This funding is conditional on meeting milestones for achievement of the financial control total and for achievement of A&E target and for primary care streaming. The Trust has also to achieve CIPs of £10.5m. The overall risk for the Trust is around the ability to monitor regularly the financial and operational performance of the Trust, keeping management and Non-Executive Directors informed of the financial and operational performance against plan and targets, and where necessary to respond appropriately	As part of our work we have: • Reviewed key documents and reports • Reviewed the minutes of key meetings • Held detailed discussions with senior management	The Trust had a planned deficit of £3.8m for 2017/18 and delivered an actual year end deficit of £14.7m. The Trust received a “bonus” Sustainability and Transformation Fund payment on 20 April 2018 of £1.8m, which helped improve the overall reported financial position at year end. Unprecedented levels of activity, the suspension of the spinal service, and the premium cost of winter, had an adverse effect on the financial position and on the Trust’s ability to deliver the planned level of CIP. This meant that the Trust has not been able to access £4.6m of Sustainability and Transformation Funding. The Trust also sought revenue support from the Department of Health during the year of £17.3m. The Trust forecasts that for 2018/19 it will continue to rely on revenue support and will have a working capital loan requirement of £63.8m. These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. This issue is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions. The in year financial position is reported to management and Non-Executive Directors through the monthly Finance and Sustainability Committee and also to each Board meeting as part of the Integrated Performance Dashboard Reports. Review of the finance reports to the Finance and Sustainability Committee showed that the financial information is comprehensive and is being reporting only one month in arrears, demonstrating that the reports produced are timely and up to date.

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Value for Money conclusion

Significant Value for Money Risks

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Financial reporting and outturn (continued)		The level of detail allows members of the committee to be fully briefed on the current financial position of the Trust. There is a useful financial summary at the start of the reports which includes an analysis of year to date performance against a series of key financial indicators. The report also provides further granular detail of income and expenditure at divisional level, as well as information on the Trust's cash management position (including aged debtor and creditor profiles and cash flow statements) and progress on the delivery of the Trust's challenging Cost Improvement Programme (CIPs). The financial information provided to Board members is in a similar format and provides a good summary of the financial position compared to the plan, the cash management position and CIP performance. Again information provided to the Board is timely. There is an absence in the Board papers of some of the divisional breakdown of financial performance that is available in the Finance and Sustainability reports. Whilst some Board members may have seen this information, if they are members of the Finance and Sustainability Committee, it might be helpful for all Board members to see the same level of detail. Review of the minutes of both the Board meetings and that of the Finance and Sustainability Committee did not appear to indicate any examples where management, other than the usual committee members, were called to account to justify the significant variances from plan. This may occur at other forums but may be something the Board wishes to consider in the future. The £10.9m adverse variance in the year end financial position indicates weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, we gave a qualified 'except for' conclusion on your arrangements for securing economy, efficiency and effectiveness in your use of resources.

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Quality Report

The Quality Report

The Quality Report is an annual report to the public from an NHS Foundation Trust about the quality of services it delivers. It allows Foundation Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

Scope of work

We carry out an independent assurance engagement on the Trust's Quality Report, following NHS Improvement (NHSI) guidance issued in February 2018. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Report is not prepared in line with the criteria specified in the NHS foundation trust annual reporting manual and supporting guidance;
- the Quality Report is not consistent with other information, as specified in the NHSI guidance; and
- the indicators in the Quality Report where we have carried out testing are not compiled in line with the NHS foundation trust annual reporting manual and supporting guidance and do not meet expected dimensions of data quality.

Quality Report Indicator testing

We tested the following indicators:

- A&E Waiting Times (% of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge): selected due to issues raised in 2016/17.
- RTT Patient Pathways (% of incomplete pathways within 18 weeks for patients on incomplete pathways): selected as indicator was qualified in 2016/17
- VTE Risk Assessment (% of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period) – selected due to concerns held by the Governors over the reliability of the data.

For each indicator tested, we considered the processes used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to underlying Trust data. We then tested a sample of cases included in the indicator to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the defined indicator definition.

Key messages

- We confirm that, aside from the issues arising from our detailed testing of the Performance Indicators, the Quality Report has been prepared in all material respects in line with the requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.
- We confirm that the Quality Report is not materially inconsistent with the sources specified in NHS Improvement's Guidance.
- Our testing of the A&E waiting times indicator included in the Quality Report identified that the performance data relating to the Widnes walk-in centre, which is managed by Bridgewater Community Healthcare NHS Foundation Trust was included within the Trust's figures. Recent guidance suggests this should not be included and the Trust has amended the indicator for this.
- Our testing of RTT 18 week pathways data, included in the Quality Report, did find evidence that the indicator was not reasonably stated, in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.
- Our testing of the VTE (venous thromboembolism) indicator selected by the governors found evidence that this indicator was reasonably stated, in all material respects except for two cases out of the 25 tested. In line with NHS Improvement's Guidance, we do not express any assurance in respect of this indicator.

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Quality Report

Conclusion

As a result of this we issued a qualified conclusion on the Trust's Quality Report on 25 May 2018.

Our audit opinion is qualified due to the underlying data quality issues in 2017/18 associated with the mandated indicator; 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' (RTT).

It should be noted that data quality issues associated with RTT and qualifications of this indicator are not uncommon across the NHS. The indicator did not meet the six dimensions of data quality in relation to accuracy, validity and timeliness. We found that there were five errors identified from the 25 cases. Of these, two cases were found to have been created inappropriately and should not have been included and for three cases the clock recording the time of the pathway had not been stopped correctly. Due to these errors we could not conclude that the indicator is reasonably stated in all material respects

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A. Reports issued and fees

We confirm below our final reports issued. We also list the fees amounts we have billed in respect of the statutory audit and non-audit related services respectively for 2017/18.

Reports issued

Report	Date issued
Audit Plan	March 2018
Audit Findings Report	May 2018
Annual Audit Letter	June 2018

Fees

	Planned £	Actual fees £	2016/17 fees £
Statutory audit	52,200	52,200	52,200
Total fees	**52,200**	**52,200**	**52,200**

Amounts billed for non-audit services

Service	Amount billed £
Audit related services - None	Nil
Non-Audit related services - Review of legacy utility costs	21,256 (excluding VAT)

Non- audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified.
- We have considered whether non-audit services might be perceived as a threat to our independence as the Trust's auditor and have ensured that appropriate safeguards are put in place.

The above non-audit services are consistent with the Trust's policy on the allotment of non-audit work to your auditor.

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WHH Quality Strategy 2018-2021

Quality begins with Me

Everyone in Healthcare has two jobs when they come to work; to do their work and to improve it. This is the essence of Quality Improvement Paul B. Batalden

Page 66 of 124

Welcome

Welcome to Our Quality Strategy

We would like to welcome our staff, patients, carers and stakeholders to our Quality Strategy. This Strategy sets out our firm commitment to improving the quality of care for our patients and how we will make this a reality, in terms of equipping our staff with the right policies, processes skills and environment to deliver quality patient care, every day.

It is important to recognise we have made many improvements to the safety and quality of patient care. However, there is recognition that we have further to go on our journey of continuous improvement.

In the words of Paul B. Batalden:

"Everyone in Healthcare has two jobs when they come to work; to do their work and to improve it. This is the essence of Quality Improvement."

Our aim is to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

The objectives and commitments set out in this strategy will be reviewed on an annual basis to ensure our plans and key projects support the delivery of this strategy in practice.

We look forward to working with staff to support the implementation of this strategy. Together we will report measurable success in our Trust Annual Quality Account and commit to celebrating your achievements year on year.

Thank you for all your hard work.

Prof Simon Constable and Kimberley Salmon-Jamieson
Executive Medical Director and Chief Nurse

Foreword

Quality

We will... **Always put our patients first** through high quality, safe care and an excellent patient experience

We are proud to present our Quality Strategy which is built on the foundations of our Quality, People and Sustainability Framework (QPS).

Recognising that our patients and staff deserve nothing less than the very best, we have embarked on an organisation-wide change journey called '*Getting to Good, Moving to Outstanding*'. We have updated our strategy to reflect our 'Outstanding' ambitions and our mission has changed to '*We will be OUTSTANDING for our patients, our communities and each other'.*

We are remedying our shortcomings, we are investing (where appropriate) in our aging estate to ensure it is an acceptable environment to treat patients; we will launch our Quality Academy, we are embedding the highest quality and safety of care at every level and throughout every staff group - so that everyone knows how and is empowered to make a difference for our patients – every time.

We believe this is the single most important thing we can do for our patients and I have every confidence in our amazing Team WHH to embrace this task so that together we can take the Trust to where it deserves to be – *Moving to Outstanding*.

Mel Pickup
Chief Executive

You must be the change you wish to see in the world.
Mahatma Gandhi

Our Quality Pledges

Perfection is not attainable. But if we chase perfection, we can catch excellence.

Vince Lombardi

This strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be.

With this care model in mind we use the following three priority domains:

- Patient safety
- Clinical effectiveness
- Patient experience

Our Quality Pledges

Our Quality Pledges

We are committed to developing and enhancing our patients' safety and learning culture where quality and safety is everyone's top priority

Our Patient Safety Pledge

We will have **safe systems** of work in place – all staff will work with robust clinical policies, procedures, safe equipment, have training to enable them to competently their job and work within appropriate Health & Safety processes;

We will ensure that we **minimise harm for patients**, specifically pledging to deliver:

- A 20% reduction in falls for our patients who stay in hospital.
- 100% medicines reconciliation when patients come into hospital and promotion of safe prescribing and administration of medicines.
- A 10% reduction in Hospital Acquired Infections – particularly focusing on safe catheter care and implementation of the Trust's Urinary Tract Infection (UTI) pathway.
- 100% of patients having sepsis screening and being treated appropriately.
- 100% patients to have a Venous Thromboembolism (VTE) assessment and to have appropriate treatment.

*We will have systems in place to ensure that we are a **learning organisation** and we will foster a culture of continuous learning and Quality Improvement.*

Clinical effectiveness is about ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients

- Reduce DTOCs to no greater than 3%
- Reduce readmissions within 30 days for patients >65 to no greater than 12.5%
- Understand variance in clinical outcome measures across all specialities, measure and agree improvements
- Number of Quality Improvement projects successfully completed
- Increase number of staff with quality improvement training via Quality Academy

Our Clinical Effectiveness Pledge

We will ensure that we providing care that is **evidence based** and that we adopt a culture of innovative and research and development within the Trust, to always look to provide the best for our patients.

We will ensure that we are focused on **outcome**s for patients and that are benchmarking/peer reviewing ourselves against the 'best in class'.

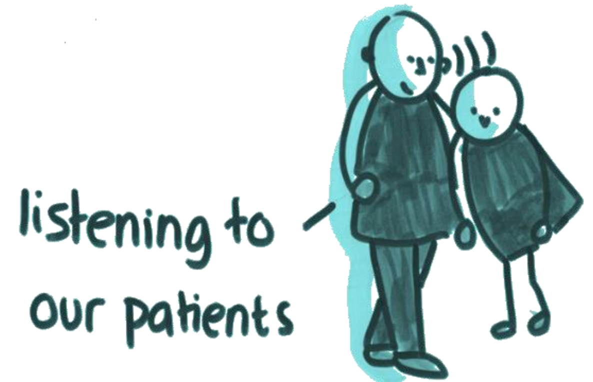
We will ensure that we foster a culture of **Quality Improvement** and we provide our staff with the information, training, systems and empowerment to make changes to our services to benefit our patients and public that we serve.

Our Quality Pledges

By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is the norm.

Our Patient Experience Pledge

- Increase in Friends and Family Test scores to ensure all specialities meet or exceed national benchmarks
- Improve across all indicators in the inpatients survey
- 10% reduction in formal complaints



Listening, learning and leading change
We believe every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services

Communicating in line with our values
We believe our patients should be first in everything we do and we promise to communicate based on what matters most to you

Partnership Working and needs based care
We believe every patient should experience care and treatment in the right environment and we promise to continuously improve what you can see, do, hear and feel during your stay

Simplifying patient focused processes
We believe that our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.

How we will deliver our Ambitions and Pledges

Our WHH values

In line with our Trust values, we will **Work Together** in **Excellence**, commit to being **Accountable and Responsible** as **Role Models** and **Embrace Change** for each of the quality priorities.

Achieving our ambitions

We agree that to achieve this Quality Strategy, we need to focus on areas for priority every year.

Our Quality Pledges

Board Commitment

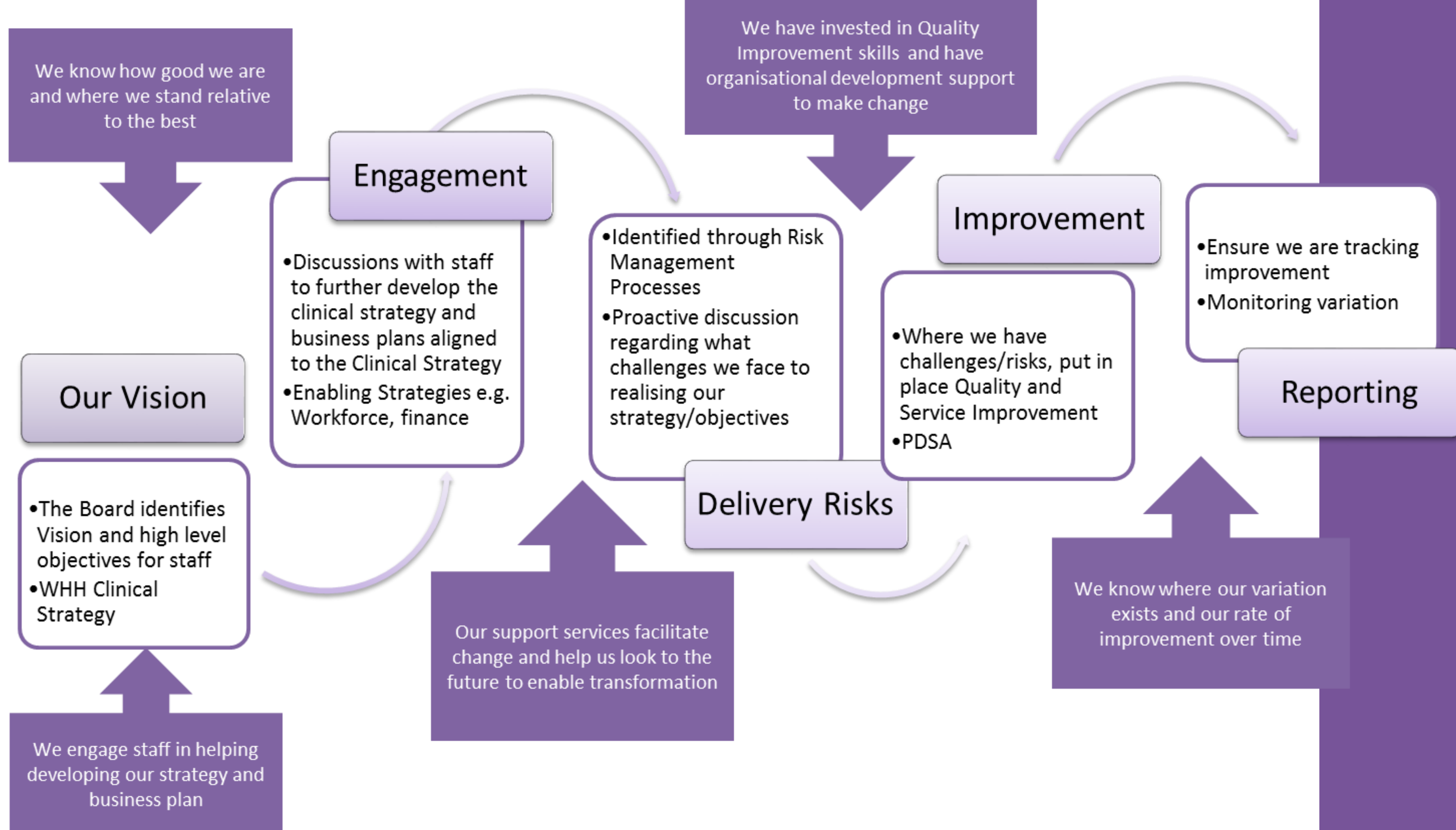
The Trust's Board of Directors

Pledges

- The Board are committed to delivering this Quality Strategy and the aim is to ensure that, like all the best organisations that focus on constant improvement, innovation and adaptation, the Board pledge to:
- Set out the Vision for staff and patients regarding Quality within the Trust;
- Ensure that the Leadership and Culture of the Trust focuses on Quality of care for patients;
- Invest in developing capability for staff in Systems and Quality Improvement;
- Help support a system where staff know what the direction of the Trust is, so that leaders can develop their business planning and delivery;
- Put in place a system within the Trust where Service and Quality Improvement will be facilitated and enabled by support services.

Direction Setting

- We want to ensure that we know how good we are and where we stand relative to the best and that we outline for staff our vision.
- We ensure then we engage staff so that in order to deliver our vision, we engage them to develop our Clinical Strategy for the Trust.
- Our enabling strategies are in place to support delivery of that Clinical Strategy e.g. workforce, finance and this Quality Strategy.
- We ensure that due to our governance systems, we know where our risks are and that we have plans to ensure we manage and reduce our risks.
- We ensure that we have Quality Improvement skills in the Trust so that when we need to make improvements, we have the people who know how to do this and who are empowered
- We have robust data and information that can show tests of change and the effectiveness of improvement.



'Transforming the NHS depends much less on bold strokes and big gestures by politicians than on engaging doctors, nurses and other staff in improvement programmes'. (Ham, 2014)

Quality Improvement

Quality Improvement Training

In order to enable delivery of this Quality Strategy the Trust is launching a **Quality Academy.**

The key objectives for the Quality Academy are to help foster a culture of learning and continuous improvement by:

- Ensuring staff are trained in Quality Improvement methodology, for example 'Plan, Do, Study, Act' (PDSA) methodology;
- Encourage innovation and increase Research & Development profile within and outside the Trust;
- Support us to use knowledge management to move toward best practice in all of our services

Quality is not an act, it is a habit." Aristotle

Practice the philosophy of continuous improvement. Get a little bit better every single day. *Brian Tracy*

Quality Improvement Methodology

The Trust will use a variety of methodologies dependent on the need. For example:

Example	Suggested QI method
A capacity and demand study reviewing elective sections within the Trust and ensuring productivity	LEAN/Failure Modes and Effects Analysis
Outlier for outcomes in a national audit	Cause and Effect Plan Do Study Act to influence change
Understanding whether we are an outlier for anything	Information shown on a control chart to understand variance and monitor improvement.

There will also be a training programme developed within the Trust based on the model shown, whereby there will be differing levels of Quality Improvement training given to individuals within the Trust. All staff will receive Foundation Level training, as part of induction.

Quality Improvement

Engagement

Key to ensuring that we are addressing the right issues with regard to the service we provide is to actively seek, listen and act on feedback received from our patients, the public, our staff and groups such as Governors, HealthWatch and Health Scrutiny Committees.

The Quality Academy therefore will link to work being undertake with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement.

Also the Quality Academy will work with Workforce & Organisational Development, to ensure that staff can engage in the agenda and are given the empowerment and support to make improvements in their work.

Our Quality Priorities 2018-19

These quality priorities have been developed from information from our patients, public, our clinical governance systems and from our partners and regulators.

Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures

E-Prescribing – Improving patient safety by decreasing prescribing errors and saving time and resource

Increase Incident Reporting – Ensure that we don't miss opportunities to learn from mistakes and make changes to protect patients from harm

Diagnostics – Review policies and roll out training

Ward Accreditation – To engage staff and empower leadership

Discharge – Improve the quality and timeliness of discharge summaries

Child friendly - Making adult areas within the hospital more children friendly to increase the overall experience for patients/relatives/public

Rapid Discharge Process - Improve the Rapid Discharge Process for End of Life Care patients

Bereavement Service - Ensure that Bereavement Services are equipped to provide a caring and compassionate service, offering *support* and reassurance, information and guidance

What will delivery of this strategy look like?

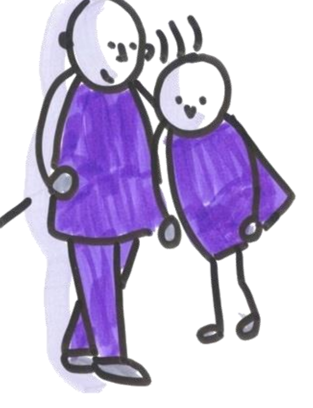
This strategy will be monitored by our Board and Quality Assurance Committee and by our public and partners by publication of our Quality Accounts, but here are examples of what success will look like

#WHHQuality

MAKE EVERY CONTACT COUNT for patients and families!

Positive Friends and Family ratings

listening to our patients



Safe Policies and Processes that are being audited to provide assurance

An increase in the number of no/low harm incidents as we foster an open culture of learning

A decrease in the number of patients falls by 20%

What will delivery of this strategy look like?

NO Never Events

STAFF
Keeping motivated + informed
Looking After
Involving from start
Skills + training gap
Standards: normalising the abnormal

All wards accredited in the new Ward Accreditation Scheme

End of Life patients being able to be rapidly discharged to ensure they pass away in a place of their choosing

Safe prescribing and administration of medicines whilst in hospital with a reduction in avoidable harm

Great things are done by a series of small things brought together.

Vincent Van Gough

With thanks

To our Patients and their Families, our Council of Governors, our Health and Social Care Partners and our amazing WHH Staff for coming together to help us develop and test this Quality Strategy.

With special thanks to artist Caroline Chappel for helping us bring it to life with her illustrations.

We are guests in our patients' lives

Don Berwick

For more information about our Quality Strategy and programmes please contact:

Clinical Governance & Quality Department Tel: 01925 662789
Warrington and Halton Hospitals NHS Foundation Trust
Lovely Lane, Warrington WA5 1QG
www.whh.nhs.uk

Warrington and Halton Hospitals NHS
NHS Foundation Trust

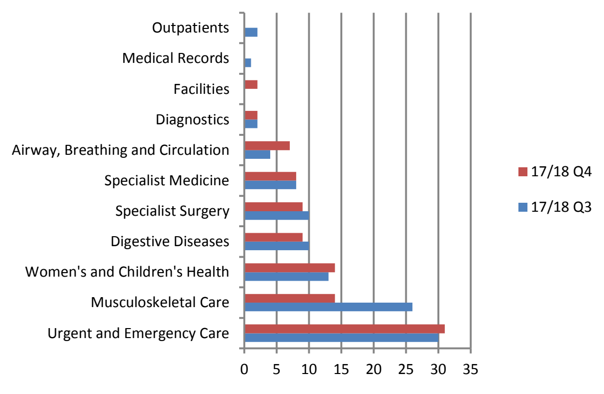
And together we

make a difference

Complaints Headlines Q3 vs Q4

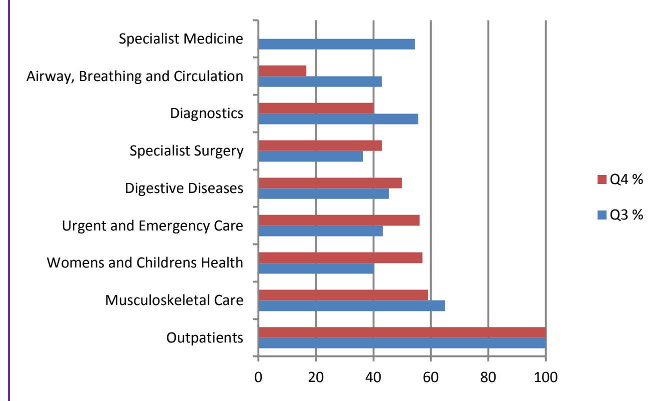
How many people are raising complaints Q3 vs Q4?

- There was a **decrease** in complaints opened Trust wide in Q4 (106 in Q3 vs 96 in Q4).
- All areas had a decrease in complaints or stayed the same as the pervious quarter; except Urgent and Emergency Care, ABC and Woman's and Children's Health. This is partially due to the effect of full capacity and Winter Pressures (A&E). MSK opened significantly less complaints as there were less complaints regarding spinal care.



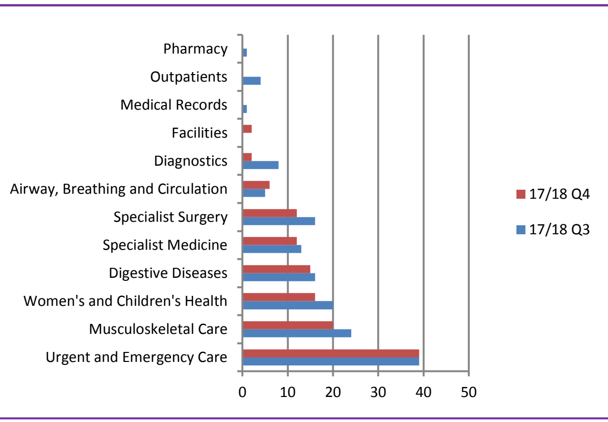
Are we Responsive Q3 vs Q4?

- The majority of areas managed to increase or maintain their performance for responding to complaints on time; however, there was a slight decrease overall from Q3 (51.3% in Q3 vs 50.4% in Q4).
- The Trust continues to reduce the amount of backlogged complaints it holds and now holds the lowest to date.



How many complaints has the Trust closed Q3 vs Q4?

- There was a **decrease** in complaints closed in the Trust in Q4 (147 in Q3 vs 124 in Q3).
- Every area, with the exception of Facilities and Urgent and Emergency Care, has decreased the amount of complaints they have closed. This needs to be taken in context as due to a reduction in the backlog of complaints, there are less to close.



Complaints Analysis Q4

The information shows the top subjects in complaints in Q4. As the subjects have been revised a direct comparison cannot be made with other quarters. Note: Complaints can have more than one subject.

Subject	Approx. count
Patient property / expenses	
Cleanliness / laundry	
Failure to follow agreed procedures	
Personal records	
Date for appointment	
Date of admission / attendance	
Admissions / transfers / discharge procedure	
Communication (oral)	
Attitude and behavior	
Clinical treatment	

Axis: 0, 20, 40, 60, 80, 100, 120, 140

Discharge Problems & Waiting Times:

- A lack of communication in relation to discharge procedures and what the next steps of care are for the patients.
- Lack of communication of discharges to carer's / families.
- Inadequate follow up care.
- This issue can also be linked to when the Trust is on full capacity.
- Long waits to be seen in A&E. This is a theme that can be seen when the Trust is under high pressure.
- Waiting time in other areas and wards is also a theme due to high pressure.
- This has been a continual theme from October 2017 forwards which is in line with winter pressures.

Discharge Problems & Waiting Times:

- There is a lack of clear communication both to patients and their relatives around the treatment they are receiving or their follow-up.
- Test results not being communicated properly to the patients is an emerging theme in complaints and this will be monitored in Q1 of the next financial year.

Attitude:

- This is an emerging theme from Q4. This correlates with the Winter Pressures being at their peak.
- There is a perception that staff sound abrupt or as if they are not listening to the patients concerns. This often occurs during peak of high demand on services.

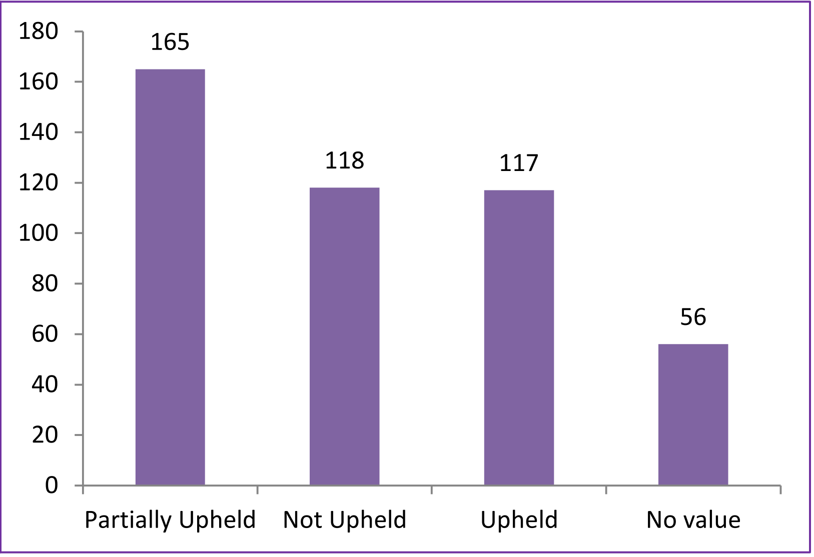
Care:

- Lack of communication and co-ordination between speciality areas regarding patient treatment often leads to a perception of inadequate care. This is linked closely to the lack of communication.
- Poor nursing care is a theme that has emerged during Q4 with Winter Pressures being at their peak.
- No provision of care or appropriate follow up.

We are WHH

Closed Complaints

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation. A complaint will be "upheld", "upheld in part" or "not upheld". Those not yet concluded or those to which we have not yet received consent at the time of writing this report, are categorised as "No value".



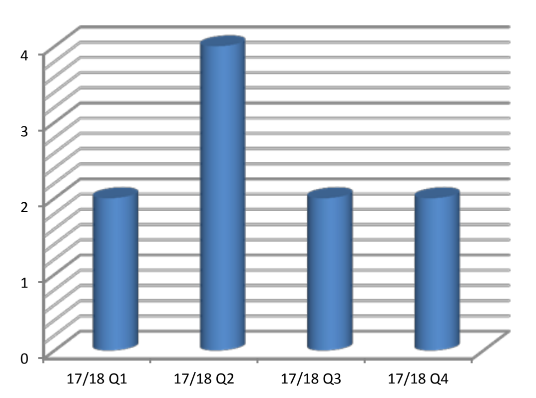
We are WHH

PHSO

Warrington and Halton Hospitals NHS
NHS Foundation Trust

So how many complaints do they investigate?

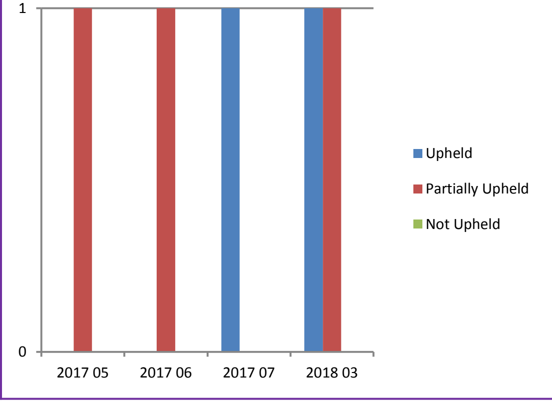
The PHSO has commenced 10 investigations into the Trust over the past financial year.



Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

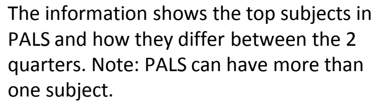
And what are the outcomes?

The PHSO has fully upheld 2 complaints and partially upheld 3 complaints. All complaints upheld or partially upheld have actions plans in place to prevent reoccurrence. There have also been financial penalties with some of the complaints that have been investigated.



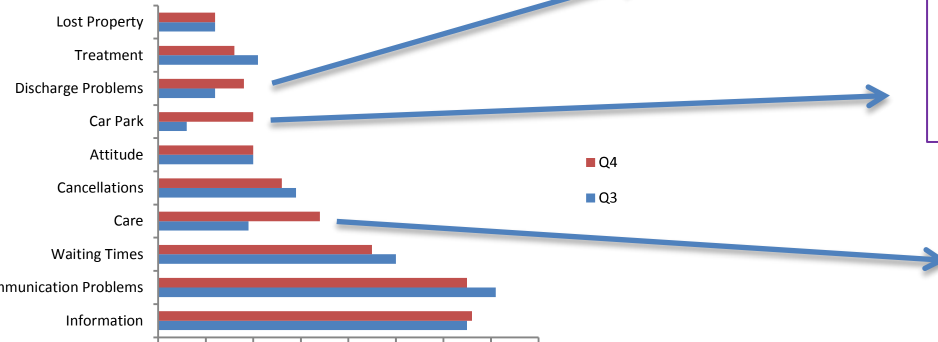
PALS Analysis Q3 vs Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust



The information shows the top subjects in PALS and how they differ between the 2 quarters. Note: PALS can have more than one subject.

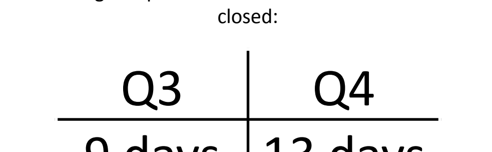
Discharge Problems:
- A lack of communication in relation to discharge procedures and what the next steps of care are for the patients.
- Lack of communication of discharges to carer's / families.
- Inadequate follow up care.



Car Parking:
- Incorrect notices being given to patients and their relatives.
- Confusing system about how to pay and use the parking meters.
- This issue is now emerging in formal complaints.

Care:
- Issues with pathways or treatment plans.
- Communication with the relatives and families of patients on the ward in relation to their ongoing treatment and pathways.
- Poor nursing care and lack of nursing care.
- Lack of letters i.e. discharge summaries or appointment letters being sent to patients.

The average response time for a PALS concern of those closed:



Q3	Q4
9 days	13 days

PALS to complaints referrals:

Q3	Q4
5	12

We are WHH

Learning from Complaints and PALS

You Said….	We Did….
The complainant felt that the bedside tables on the wards were dirty.	The Matron has introduced bedside table audits and will monitor the standards of cleanliness to ensure that the results meet the required criteria.
The patient's family's request for the patient's ears to be cleaned were not followed up.	The Ward Sister has highlighted the importance of this with staff and has arranged for information leaflets regarding hearing loss and the build up of wax to be printed on the ward for staff and patients.
The patient's fracture was missed during two visits to the Trust.	Feedback has been given to the members of staff involved and the learning has also been shared with the entire department via a governance update to increase awareness of these types of injury.
The patient had several issues in relation to their PEG tube when they attended the Trust.	The Endoscopy team are going to review and update the SOP on the insertion and care of PEGs.

Annual Headlines of Complaints and PALS

- Increased quality of complaints responses
- Increased timeliness of responses
- No complaints over 6 months
- The least amount of breached complaints held by the Trust
- A new policy and a new process was developed on how the Trust deals with complaints, to ensure it was more person centred
- Training was provided to staff to ensure they were trained on the Trust's new complainants policies and processes and on good complaints handling
- A Quality Assurance Group led by the Trust Chairman was developed to review the quality of our complaints responses and to promote accountability of leading the complaints agenda at senior management level within the clinical services
- An improvement in how the Trust responds to PALS concerns
- Fully resourced the complaints and PALS teams so that the service can run effectively
- Revision of the governance structures this learning can now be shared through the End of Life Steering Group and the Speciality M&M meetings. This allows for learning to be shared through these speciality meetings and also through to the wards and staff involved. This is turn allows for greater learning from complaints
- Smart actions from complaints are being developed

What Next?

- Patient Focus Group to be held to obtain feedback from patients and families on the Trusts complaints process so we can make it more patient focused
- Continued improvement in the Trust culture to resolve complaints locally and rapidly
- Reporting on action from complaints to ensure compliance
- Auditing the actions from complaints to ensure that they have made the desired change

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/18/08/44**
SUBJECT:	**Revised Operational Plan 2018/19**
DATE OF MEETING:	16 August 2018
ACTION REQUIRED	**Paper for noting**
AUTHOR(S):	Jane Hurst, Deputy Director of Finance (Strategy)
EXECUTIVE DIRECTOR	Andrea McGee, Director of Finance and Commercial Development
EXECUTIVE SUMMARY	The Trust submitted the 2018/19 Operational Plan to NHSI on 30 April 2018. NHSI provided feedback on the plan and gave the Trust the opportunity to resubmit the plan on 20 June 2018. The feedback required the Trust to consider all points raised with the Trust Board which were incorporated within the June Trust Board agenda. This paper sets out the changes made to the Operational Plan 2018/19.
RECOMMENDATIONS	The Council of Governors is asked to note the paper.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	None

SUBJECT	Trust Operational Plan 2018/19

1. BACKGROUND/CONTEXT

The Trust submitted the 2018/19 Operational Plan to NHSI on 30 April 2018. NHSI provided feedback on the plan and gave the Trust the opportunity to resubmit the plan on 20 June 2018. The feedback required the Trust to consider all points raised with the Trust Board which were incorporated within the June Trust Board agenda. This paper sets out the changes made to the Operational Plan 2018/19.

2. KEY ELEMENTS

In April the Trust submitted the 2018/19 Operational Plan with a control total deficit of £24.6m. In May NHSI contacted the Trust to discuss improving the position by £2.6m and in doing so gaining the ability to access £4.9m PSF (50% of the original value available). This proposal was presented to the Board and approval was given to accept the new offer of a £16.9m deficit control total.

NHSI feedback on the operational plan was minimal. The one significant issue being the change to the control total, requiring the Trust to resubmit the plan. The revised plan is attached as Appendix 1. The feedback has been reviewed and the following key changes have been made.

- Change in control total to £16.9m deficit including PSF of £4.9m
- Change in A&E Trajectory as asked to consider revising the trajectory to show winter dip in performance as seen in 2017/18 (see page 3, Appendix 1)
- Included reference to the plans in place for patients with length of stay longer than 21 days (see page 4, Appendix 1)
- An explanation of any reduction in income from 2017/18

Discussion on the above points took place at the June Trust Board.

3. RECOMMENDATIONS

The Council of Governors is asked to note the revised 2018/19 Operational Plan as submitted to NHS Improvement in June 2018.

Warrington & Halton Hospitals NHS Foundation Trust
Narrative to update 2018/19 Plan

Status: Draft
Version: 3
Date of Submission – 20 June 2018

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Activity Planning

The Trust's activity and income assumptions underpinning the 2018/19 revised plan are based on the 2017/18 forecast outturn, adjusted for tariff deflation, demand changes, and service changes. The demand and capacity modelling is being undertaken and the plans have been shared to make sure that they are aligned with the Commissioners planning assumptions. This will ensure the activity plans are sufficient to deliver key operational standards, in particular accident and emergency (A&E), referral to treatment (RTT), incomplete, cancer, and diagnostics.

The plan includes growth assumptions in line with the national assumptions with exception of outpatients as highlighted in the following table.

POD	Activity				£				
	17/18	18/19 Plan	Variance	Variance %	17/18	18/19 Plan	Variance	Variance £	National %
A & E	112,929	114,866	1,937	**1.72%**	13,370,518	13,450,720	80,202	**0.60%**	**1.10%**
Elective	35,747	36,135	388	**1.09%**	33,476,563	33,994,456	517,893	**1.55%**	**3.60%**
Non Elective	35,393	37,091	1,698	**4.80%**	62,154,357	61,042,980	-1,111,377	**-1.79%**	**2.30%**
OP	315,985	312,490	-3,495	**-1.11%**	33,082,229	33,522,239	440,010	**1.33%**	**4.90%**

2017/18 A&E trajectory was as follows:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	91%	92%	92%	92%	92%	92%	91%	91%	91%	91%	91%	91%
Actual	91.4%	92.8%	90.4%	92.8%	94.4%	90.9%	89.5%	87.8%	83.8%	85.6%	83.8%	82.0%

Current plans set a proposed A&E trajectory for 2018/19 as follows:

Performance	**Y1 M01**	**Y1 M02**	**Y1 M03**	**Y1 M04**	**Y1 M05**	**Y1 M06**	**Y1 M07**	**Y1 M08**	**Y1 M09**	**Y1 M10**	**Y1 M11**	**Y1 M12**
	Plan	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**
*Revised A&E %**	**85.0%**	**85.9%**	**86.9%**	**87.8%**	**88.8%**	**89.7%**	**90.0%**	**85%**	**85%**	**85%**	**83%**	**83%**

*The above plan assumes inclusion of walk in centre data in line with previous years. Month 8 to month 12 has been revised in line with the feedback from NHSI.

The contract discussions with the Lead Commissioners have led to agreeing a block contract for 2018/19. The revised financial control total and PSF allocation has led to a review of the operational plan and acceptance of the new control total of £16.881m deficit. The Trust is working with local Commissioners to produce a three year plan to improve the financial position of the local health economy.

In the spirit of working together the Lead Commissioners have not included QIPP and the Trust has not included any income CIP in the 2018/19 plan. The Trust and Commissioners have agreed to progress working within the Capped Expenditure Process (CEP) and are investigating how a block contract might work for the health economy.

The Trusts CIP will continue to focus on productivity in theatres and outpatient clinics; this will be linked to demand and capacity modelling and shared with the Commissioners. The Trust and CCG's continue to work together along with other partners across the Accountable Care Partnership (ACP) to provide quality sustainable care.

Capacity planning includes focus on length of stay this includes weekly focus and escalation through Length of Stay Meeting and all wards maintain a delays action plan for patients over 21 days LOS. The Trust is working to reduce over 21 days LOS in line with recent guidance.

Quality Planning

Section 1: Approach to Quality Governance

Kimberley Salmon-Jamieson (Chief Nurse) -named executive lead for quality improvement

The Trust reviewed its Quality Strategy in 17/18, focusing on key improvements against Lord Darzi's domains of quality; patient safety, clinical effectiveness and patient experience. The strategy was developed in partnership with staff, and partner organisations, and takes into account feedback from the Trust's regulators. The quality priorities defined for the Trust include reduction in avoidable harm, commitment to learning, commitment to ensuring positive outcomes for patients by delivering evidence based practice and ensuring that the patient's voice is heard in everything we do. The Quality Account describes the programme of quality and safety improvement for 2017/2018 and sets out the quality indicators and priorities for 2018/19.

The Trust has reviewed and strengthened its quality governance structure and reporting lines. Each speciality has a clinical governance and quality assurance meeting, reporting through to the Clinical Business Unit (CBU) Clinical Governance Quality Assurance meeting. Each CBU reports its governance updates to the Trust Quality Assurance Committee. The Trust Quality Assurance Committee reports to the Board of Directors and is responsible for overseeing quality governance processes in the Trust, and is also the designated Committee responsible for risk. The reporting Sub Committee of the Trust Quality Assurance Committee are outlined below.

The Trust's processes relating to Quality Governance is aligned to the CQC Fundamental Standards, which is integral to the development of a Quality Performance Assessment Framework. The revised governance arrangements described above have further strengthened ward to Board reporting. In order to discharge its responsibilities, the Quality Assurance Committee has the following Sub Committees reporting to it

- Patient Safety & Clinical Effectiveness Sub Committee
- Patient Experience Sub Committee
- Health & safety Sub Committee
- Safeguarding Sub Committee
- Risk Review Sub Committee

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- Complaints Quality Assurance Group
- Information Governance Sub Committee
- CBU Governance & Assurance meetings

The Trust appointed a Director of Governance and Quality, reporting to the Chief Nurse and matrix working across the Medical Director/Deputy Chief Executive to drive strategic quality governance issues and lead the development of a new Quality Academy to align quality with organisational development and transformation.

Below is the model which is being adopted to promote continuous improvement within the Trust.

This model is one which there is more effective use of shared resources, matrix working across portfolios, to ensure continuous improvement this needed to be articulated, in order to move forward.
The Quality Academy has been approved and will launch in April 2018, the priorities being:

- Key enabling arm to deliver support the delivery of the Trust Clinical and Quality Strategies.
- Training people in QI methodology to give staff the empowerment, tools and training to improve the care they give to patients.
- Encouraging innovation and increasing R&D profile within and outside the Trust.
- Supporting WHH to move toward best practice- benchmarking ourselves against best in class – therefore using effective knowledge management.

The Trust continues to be involved in a collaborative patient safety project with Stanford University (US). This is using design theory as a vehicle for quality improvement in medicines management. The Trust continues to work to

ensure evidence based practice and benchmarking itself against best practice. A learning framework was developed in 2017/28 and this has been implemented throughout the year and will be further developed in 2018/19. This has involved delivery of training, development of lessons learned forums, learning debriefs and conducting learning audits.

The current 'Ward to Board' quality reporting occurs via the Quality Dashboard, Divisional Dashboard (COB) and the Trust Board Integrated Dashboard. Further work is being progressed on ward based quality metrics, ward accreditation and rolling out revised risk management processes.

Section 2: Summary of the quality improvement plan

Over the next two years the Trust will further strengthen quality improvement in line with the Trust's Quality Strategy, supporting an effective sustainable transformation plan.

National clinical audits - The Trust has robust processes in place for managing National Audits and Confidential Enquiries, which are included in the work plan for the Patient Safety and Clinical Effectiveness Sub Committees. A monthly update on clinical audit is given to Patient Safety & Effectiveness Sub Committee, reporting performance against national audits, tracking progress with internal clinical audit plans and monitoring improvements required. The Trust also complies with the mandatory reporting of this within the Quality Account.

The four priority standards for seven-day services - The Trust actively participate in the national audit of 7 day services and compliance with the standards. The Medical Director is the executive lead. The Trust takes a continuous improvement approach to the four main priorities identified as having the most impact on reducing weekend mortality – time to consultant review, on-going review, access to diagnostics and access to consultant-delivered interventions. All WHH clinical teams are asked to define their internal professional standards with reference to these priorities. It is recognised there is a need to consolidate existing improvements in provision through projects including rota redesign, the expansion of consultant shift working and the appointment of more substantive consultant physicians.

Working within the Cheshire and Merseyside STP, the three acute providers within the Alliance LDS are developing the vehicle for further improvements in quality and reducing variation through service redesign which includes further increase to the provision of seven day acute services. This is being led by the three Medical Directors.

Safe staffing - The Trust has developed a Recruitment and Retention Strategy. Patient safety is maintained at all times by senior nursing teams monitoring staffing levels daily. The staffing reports are shared with NHS Improvement (NHSI) and published online. There is an active "Freedom to Speak Up" Campaign within the Trust which offers further reassurance around staffing. Following a recent ward establishment review, the Board of Directors have recently approved a substantial business case to improve staffing on a cohort of wards.

Care hours per patient day - In line with Lord Carter's recommendations the Trust has, since April 2016, collected Care Hours per Patient Day (CHPPD). The Trust uses an electronic rostering system for effective staff utilisation, which includes a systematic evidence based acuity tool, Safe Care, to determine the number and skill mix of staff required. A 6 monthly strategic staffing review is undertaken by the Chief Nurse to monitor staffing levels in the Trust.

Better Births Review - The Trust has reviewed the report and undertaken a gap analysis to identify priorities and benchmark current performance against the recommendations. This response which identified continuity of care in the community as a key action was submitted to the Clinical Commissioning Group (CCG) in June 2016.

Improving the quality of mortality review and Serious Incident investigation and subsequent learning and action - The Trust has appointed a lead consultant with PA allocation for mortality review. The Mortality Review

Group (MRG) which includes multidisciplinary representation from across the Trust and the CCG, ensure all deaths are reviewed as per the Trust's new Learning from Deaths Policy, and lessons learned are disseminated and lead to change/quality improvement in patient care. Appropriate action plans are developed identifying areas for improvement which are reviewed by the MRG and reported to the Patient Safety and Clinical Effectiveness Sub-Committee. This learning is communicated to pertinent staff to ensure the appropriate level of care is provided in the future. Consultants involved in the peer-review process will provide feedback to the quality of their reviews ensuring the learning loop is closed.

The Trust uses the Healthcare Evaluation Data (HED) System to assess mortality data. We then compare our position nationally with regards to SHMI (Summary Hospital Mortality Indicator) and HMSR (Hospital Standardised Mortality Ratio). We evaluate areas for concern or trends which point us towards focused reviews in these particular areas.

Antimicrobial resistance - The Trust is committed to supporting this programme of work by increasing funding to provide additional hours to the role of Antibiotics Pharmacist. Work is progressing to meet the national CQUIN in terms of timely empirical treatment reviews and overall consumption reduction. The Trust has a proactive Antimicrobial Stewardship Group, undertakes quarterly point prevalence audits and conducts eight Antimicrobial Ward Rounds each week. The Trust participates in national awareness raising events e.g. Antibiotic Awareness Week. Changes to the Antibiotic Formulary will be made according to local microorganism resistance patterns.

Infection prevention and control - An overarching strategy has been developed which brings together assessment of compliance with the Code of Practice on prevention of HCAIs and more recently antimicrobial resistance. The strategy includes driving further quality improvements by implementing surgical site infection surveillance and compliance with NICE quality standards. Our robust system ensures compliance with mandatory surveillance. Infection Control is embedded across the organisation and the Trust participates in national/global awareness raising events to keep this on the agenda.

Falls- The prevention of inpatient falls is a quality improvement priority for the Trust. A trajectory of a 10% reduction is in place for 17/18 using 16/17 data as a baseline. A Trust wide falls action plan has been developed with progress monitored through the Patient Safety and Clinical Effectiveness sub-committee. A number of initiatives have commenced including weekly Harm Free Care meetings to review low and no harm falls and falls walks within clinical areas. To support the educational needs of the clinical staff, Trust wide training is available and when required focussed local training is also delivered. Any falls resulting in moderate harm or above are investigated through the Trust wide RCA process with actions plans for improvement developed.

Pressure Ulcers- The Trust is represented on the Pressure Ulcer Steering Group which assist the Cheshire and Merseyside Quality and Safety Forum in developing a consistent approach to pressure ulcer reduction across the region. The aim is to align practice across Cheshire and Merseyside, share best practice and reduce the number of grade 3 and 4 pressure ulcers by 2017. A reduction in incidence of grade 3 and 4 pressure ulcers was achieved across the region and mirrored within the Trust. Other aims of the group are to standardise practice and treatment of suspected Deep Tissue injuries (DTI). The Trust continues to be part of the regional pilot for standardised RCA documentation and collaborates actively with Edge Hill University and other Trusts in relation to this. Local initiatives for the Trust include trialling new pressure reliving mattresses, reviewing and updating documentation and improving access to pressure relieving equipment for ward and departmental staff. To support the educational needs of the staff an e-learning package for the prevention of pressure ulcers is now in place.

End of life care - The Palliative Care Team participates in national audits e.g. The Royal College of Physicians End of Life Care Audit – Dying in Hospital and will be participating in the 2017 audit. National Audit results evidenced WHH are not an outlier within our region and that we performed within the expected range.

The team is involved in regional audits within the Cheshire and Mersey Strategic Clinical Network which are presented to audit meetings and Grand Rounds. The Trust participates in a Warrington-wide Integrated Multidisciplinary Team Meeting where patients with complex palliative care needs across the hospital, hospice and community are discussed. A local Advance Care Planning Document is in development to further support patient

care in their location of choice. The use of the Individual Plan of Care continues and the Trust provides training including an Intermediate Skills Course for staff to support the needs of individuals and those close to them who are dying within the hospital. Palliative Care now features on induction training for new nursing staff and it is likely that the mandatory annual updates for senior medical personnel will reflect this. The End of Life Steering Group continues to meet bimonthly and the team continues to provide a 7 day face to face service.

Patient Experience - Patient experience is an improvement priority for the Trust. An Experience of Care Strategy has been developed through involvement with patients, relatives, carers and the public to ensure high quality services are delivered to our patients. This Strategy is structured into work streams with the Patient Experience Sub Committee monitoring progress. Identified work streams include effective management of high risk complaints by introducing 72 hour review and production of a Friends and Family scorecard which indicates a positive performance by the Trust against the national average.

National CQUINs - The Trust is required to respond to a range of national and local CQUINs. For 2017/18, the CQUINS are all nationally agreed, and are two year programmes working in partnership across systems. The Trust is committed to ensuring delivery of these CQUINs to improve care across systems for patients.

Section 3: Summary of quality impact assessment (QIA) process

The Trust has an effective QIA process for service developments and efficiency plans and the governance structure surrounding scheme creation, acceptance and monitoring of implementation. The Transformation team works with staff to support the generation of new savings and improvement.

Risks are captured via the Project Initiation Document process, and sign off is required by 2 of the 3 Clinical Business Unit Triumvirate (CBU manager, Clinical Director and Lead Nurse) or the Corporate Lead for the corporate directorates. Any schemes over £100k in financial value or which have any potential impact on patients or nurse staffing are also reviewed and signed off by the Chief Nurse and the Medical Director. Schemes are assessed against their qualitative impact on patients and staff and the impact on local and national targets.

All Senior Responsible Officers (SRO) are required to identify measurable key performance indicators (KPIs) to ensure delivery of the scheme without a detrimental impact on safety or quality. Performance against KPIs is managed through a fortnightly Grip and Control meeting. Risks are identified and high risk schemes are reported to the Quality Committee. A monthly overview of all schemes is provided to the Finance and Sustainability Committee (F&SC). Schemes that impact outside of CBUs or corporate areas are reviewed at Innovation and Cost Improvement Committee (ICIC), which reports to the F&SC.

Section 4: Summary of triangulation of quality with workforce and finance

Three dashboards relating to quality, finance and workforce have been integrated into a key metrics high level Integrated Dashboard. This dashboard includes metrics for quality, access and performance, workforce and finance and is reviewed by the Trust Board. The quality metrics focus on high risk issues including HCAI; fall and pressure ulcers; CQUINs including SEPSIS and Antimicrobial Resistance in addition to key patient experience metrics namely complaints and friends and family.

Integrated monitoring of performance is undertaken at CBU and divisional level via monthly review meetings, and with the Executive Team and Division at a monthly Clinical Operational Board. The performance dashboards in the Trust have been reviewed to ensure compliance and alignment with the standards expected within the Single Oversight Framework which went live in October 2016.

Workforce Planning

The Trust continues to work towards all elements of the Workforce Plan included in the Operational Plan. With regards to the People Strategy, the key elements have been updated to include attraction, retention, engagement, development and performance. The People Strategy will be refreshed in 2018/2019 in line with the internal and external context, and in consultation with the organisation. Performance against the Strategy will continue to be monitored at the Trust Workforce Committee.

The Trust remains committed to Workforce Transformation and has adopted a Population Centric Workforce Planning Model, as opposed to utilising the Calderdale Framework. Exciting and innovative work is on-going through the vanguard approach.

In relation to Safer Staffing, the Trust has adopted the approach taken with Nursing Staff for both Medical and Therapies staff and is now working to share that learning across the workforce and produce a Trust wide approach to attraction and retention.

The plan to reduce agency spend relates to the Trust plans to increase our nursing workforce by 93 wte in line with a recent business case to invest £3m in nursing following a review. The HR and OD Directorate are working closely with the Nursing Leadership Team to recruit into these posts and to develop plans to retain staff.

The Trust is introducing a number of new roles across the organisation as part of a programme of workforce redesign. The HR Business Partnering Team support Clinical Business Units with the workforce element of budget setting and are integrated into the development of business cases and service developments ensuring the workforce provision is adequate for quality and performance. The reduction in agency and increase in bank reflects the continuation from 2017/18 where we saw the schemes in place to reduce agency start to have an impact.

Financial Planning

Section 1: Financial Forecasts and Modelling

The Trust has had a challenging financial year in 2017/18 which has led to significant changes in year 2 of the two year plan. The original plan signed up to the control total for 2017/18 (£3.7m deficit) and 2018/19 (£3.6m deficit). The Trust has not been able to achieve this target in 2017/18 and this will impact on the 2018/19 plan. The main reasons have been loss of spinal work, loss of Provider Sustainability Fund (PSF) and shortfall in achieving recurrent CIP. The continued need for premium rate staff, the number of escalation beds, increased non elective activity and elective reduction for winter have also impacted on the financial performance.

The financial forecast for 2018/19 has been developed across the organisation with input from Executive Directors, CBU Managers, the Contract and Commissioning Team and Commissioners. The budget setting process has identified anticipated cost pressures and the Trust has been working with the Commissioners to finalise contract income. The draft financial plan reflects changes in national pay and non-pay inflationary pressures, operational pressures and investments necessary to ensure compliance with quality standards and performance targets.

The original control total has been revised to £16.9m deficit. The revised control total reflects CNST reduction and tariff inflation, the Trust has accepted this control total.

This plan represents a realistic assessment of anticipated performance whilst accepting the need to meet patient demand and expectation, commissioner changes, efficiency requirements and maintain and enhance patient quality and safety.

The plan sets a significant financial challenge for the Trust and local health economy. The Trust‘s main commissioners, Warrington CCG and Halton CCG along with the Trust have formally committed to the CEP lite process, with papers setting out the commitment agreed at the respective finance committees. The process has included a review of the current contracting methodology and block contract have been agreed. A three year plan is being developed to improve the overall financial performance of the local health economy.

This plan includes cost pressures of £21.9m which have been reviewed with the Executive team and reflects investment in nursing, medical and quality issues. The plan reflects the sustainability contract agreed with the main

Commissioners but doesn't assume any activity or costs above plan. Other areas of income are based on known contracts. The Trust will continue to bid for additional income which has been achieved in previous years but not assumed. The following table shows the movement in income.

	2017/18 Plan £000's	2017/18 Actual £000's	2018/19 Plan £000's
Overseas Visitors	0	58	44
Local Authorities	1,843	2,451	1,933
Education & Training	7,693	9,511	7,693
Research & Development	0	0	0
Private Patients	106	50	152
ICR	1,287	1,074	1,135
Other NHS Income	206,002	205,157	207,805
Other Non NHS Income	24	445	592

The plan does not budget for fines and penalties under the sustainability (block) contract with Lead commissioners which agrees reinvestment of any financial penalties levied. Based on 2017/18 without sign up to the control total national penalties would have been c £3m. The Trust is working with Commissioners under the CEP lite framework working together to achieve a sustainable health economy.

The original forecast position included the following key assumptions which did not materialise in 2017/18:-

- The Trust delivers the control total in 2017/18
- The Trust receives all income relating to activity forecast in 2017/18
- The 2017/18 unfunded cost pressures are managed
- The Trust can deliver £10.5m CIP schemes
- The Trust receives all PSF in 2017/18

Liquidity

In 2017/18 the Trust has an audited year end position of £15m deficit with a closing cash balance of £1.2m. On this basis the Trust will owe £41.2m in revenue loans at the end of 2017/18 (£14.2m borrowed 2015/16 and £7.9m borrowed 2016/17, £19.1m borrowed 2017/18). Current Better Payment Practice Code performance based on volume is 19% for the month and 31% for the year. NHS Debtors are £4.3m and creditors £12.8m which are similar to previous years. The Trust has therefore very restricted flexibility for the management of cash or for making any improvement to the cash position.

Based on the assumptions being delivered, the Trust will require an additional working capital loan equal to the forecast deficit in 2018/19 (£16.9m). The Trust is due to pay back the 2015/16 loan of £14.2m in 2018/19 and will need to borrow to repay this loan; this has been discussed with NHSI. The total value of loans by 31 March 2019 based on existing and forecast borrowing is £58.1m. A system solution will be required to address this level of borrowing, which places an absolute requirement to work with the local health economy as per the CEP process.

Section 2: Efficiency Savings for 2017/18 – 2018/19

Productivity and Efficiency Programme

The Trust has a reference cost of 98. The Trust has incorporated £2m income into baseline plans and the block contract which will be delivered through the financial improvement and efficiency programme, predominantly

through improved utilisation of theatre and outpatient services, enabling the Trust to meet RTT targets. In addition to this the Trust has a £7m CIP target and as such is targeting delivery of a total of £9m financial improvement. The £7m CIP target for 2018/19 will be stretching and require the beginnings of true system change as part of a collaborative 3 year programme. The CIP themes are structured around tactical and transformational schemes and have been allocated across categories as follows:

Scheme	Target 2017/18	Original Target 2018/19	Revised Target 2018/19
Clinical Income	£0.5m	£0.5m	£1.4m*
Non clinical Income	£0.5m	£0.5m	£0 m
Pay	£6.5m	£6.0m	£4.6m
Non Pay	£3.0m	£2.5m	£1.0m
Total	**£10.5m**	**£9.5m**	**£7.0m**

*Note – per CEP lite the Trust and Commissioners are working as agreement that QIPP / CIP schemes that will only be pursued if they improve the performance of the Local Health Economy. The clinical income we are looking to generate will not be from Warrington CCG and Halton CCG unless it is linked to repatriation of local patients.

Tactical

The Trust is planning to continue to deliver an element of savings this financial year through tighter cost control and cost reduction measures by focusing on procurement (reduced prices, product rationalisation and standardisation, collaboration and partnership working), drugs (reduced usage and prices, increased use of bio-similars), reduction in premium rates for additional clinical sessions, reduction in agency usage (to contain the spending within the ceiling and ultimately reduce it further) and income generation opportunities. 247 schemes for 2018/19 have been identified to date and progress in validating, costing and delivery planning for these schemes is being tracked on our CIP tracker.

Transformational

The Trust has committed to putting more emphasis and resource into the delivery of larger, transformational programmes of work to deliver the majority of its financial sustainability challenge for 2018/19 and beyond. These programmes are aligned to the Sustainability and Transformation Plan (STP), to our Healthy New Town programme (supported by NHSE) and to Lord Carter's priorities. All schemes will be reviewed and prioritised jointly with Commissioners as part of the CEP lite process.

Section 3: Capital Planning

The capital programme comprises site maintenance, facilities improvement, new medical equipment and technology development. Together these enable and support the delivery of the operational services. Capital resources are constrained and require prioritisation, so schemes that are essential to the provision of safe, sustainable services that offer value for money are prioritised. The process to prioritise the schemes is led initially by the Clinical Business Units informed by assessment of risk. The case for funds is then assessed and prioritised using a framework by a multi-professional team before consideration at the Finance and Sustainability Committee and approval at the Trust Board. The capital programme is funded by internally generated depreciation (£5.5m) and an element of carry forward (£1.6m) from the 2017/18 programme. The capital programme is £7.1m for 2018/19.

Summary

Given the significant financial pressure, and in setting a stretching CIP the ability to deliver the control total set will be challenging. The Trust endeavours to balance investment in quality and in delivery of performance while at the same time supporting financial sustainability. Under current contracting arrangements with pressures funded the deficit control total is £16.9m, which moves the organisation into further debt.

The Trust will continue to work with the local commissioners on a three year plan and to move to a stronger more viable position locally.

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/18/08/45**
SUBJECT:	**Review the Trust's Compliance with its Licence 2017-18**
DATE OF MEETING:	16 August 2018
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR	Simon Constable, Deputy Chief Executive & Executive Medical Director
EXECUTIVE SUMMARY	This update details any changes to the various declarations of compliance with the Trust's Provider License. Following review of the Trust's compliance with its License, the Trust continues to declare full compliance with all conditions.
RECOMMENDATIONS	The Council of Governors is asked to note full compliance with all license conditions.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/18/08/48**
SUBJECT:	**Election Activity 2018**
DATE OF MEETING:	16th August 2018
ACTION REQUIRED	**For assurance**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR	Simon Constable, Deputy Chief Executive & Executive Medical Director
EXECUTIVE SUMMARY	For Assurance this report on election activity and outcomes, vacancies and Governor Terms of Office is brought to the Council bi-annually.
RECOMMENDATIONS	Governors are asked to note the Activity report, the outcomes of the 2018 elections.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	None

SUBJECT	Election Activity 2018

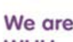
The Foundation Trust held a Public Governor election between 25th April and 25th June 2018 due to a number of terms of office concluding. Election support was procured through competitive process and the successful Returning Officer was *UK Engage*, the incumbent. Elections were held according to this timetable:

Timetable for 2018 Elections

Event	Date
Publication of Notice of Election	Wednesday, 25 April 2018
Deadline for Receipt of Nominations	Monday, 14 May 2018
Publication of Statement of Nominations	Tuesday, 15 May 2018
Deadline for Candidate Withdrawals	Thursday, 17 May 2018
Notice of Poll / Issue of Ballot Packs	Wednesday, 30 May 2018
Close of Poll – 5pm	Friday, 22 June 2018
Declaration of Result	Monday, 25 June 2018

Constituencies eligible for election were:

Constituency and Class	Number of Seats
Public - Daresbury, Windmill Hill, Norton North, Castlefields	1
Public - Beechwood, Mersey, Heath, Grange	1
Public - Norton South, Halton Brook, Halton Lea	1
Public - Broadheath, Ditton, Hale, Kingsway, Riverside	1
Public - Latchford East, Latchford West, Poulton South	1
Public - Bewsey and Whitecross, Fairfield and Howley	1
Public - Burtonwood and Winwick, Whittle Hall, Westbrook	1
Public - Rest of England and Wales	2



Promotion of Election

The promotion of the election was supported by the sending of voting papers (both electronically and postal depending on preference) to all the members of the relevant constituencies. The sum total amounted to 6,679 communications (5,317 post, 1,362 email)

Election Outcomes

Two constituencies were elected to with unopposed candidates:

- Beechwood, Mersey, Heath, Grange
- Rest of England & Wales

Three constituencies were contested:

- Latchford East, Latchford West, Poulton South
- Daresbury, Windmill Hill, Norton North, Castlefields
- Burtonwood and Winwick, Whittle Hall, Westbrook
-

Vacancies:
There were no candidates for the

- Norton South, Halton Brook, Halton Lea;
- Broadheath, Ditton, Hale, Kingsway, Riverside
- Bewsey & Whitecross, Fairfiedl and Howley

Conclusion

The election was conducted according to the terms set out in the Foundation Trust's Constitution working with Returning Officer *UK Engage*.

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/18/08/49**
SUBJECT:	**Changing the Trust's Name - Update**
DATE OF MEETING:	16 August 2018
ACTION REQUIRED	**For Information**
AUTHOR(S):	Pat McLaren, Director Community Engagement
EXECUTIVE DIRECTOR	Prof Simon Constable, Executive Medical Director/ Deputy Chief Executive
EXECUTIVE SUMMARY	The Trust is planning to change its name to **University Hospitals of Warrington and Halton NHS Foundation Trust** and has commenced this journey. This paper provides an update to the Council and outlines timeline and next steps.
RECOMMENDATIONS	1. That the Council of Governors' note the progress and action plan as outlined. 2. That the Council notes the Trust's obligation to consult with the Membership and agrees to lead this exercise (with the Foundation Trust Office support) on behalf of the Trust.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	Choose an item.

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

SUBJECT	Changing the Trust's Name

1. BACKGROUND/CONTEXT

In July 2017 the Council of Governors approved a proposal to change the Trust's name and to commence the engagement process as described by NHS England's brand identity team. The name change is proposed because:

- Recruitment of clinical staff continues to be challenging but is particularly difficult for those Trusts perceived to be 'district general' hospitals
- More prominent promotion of our teaching capabilities will make the Trust a significantly more desirable employer when candidates have more than one choice in the region.
- We have wide university and college affiliations and have formal teaching programmes for a wide range of staff groups – Medical, Nursing, AHPs, nurse associates and many more.

Warrington and Halton Hospitals is a Teaching Trust. We train countless healthcare professionals each year, in partnership with a number of Universities including the University of Chester and others, as well as running a very successful apprenticeship programme.

As we were about to commence the engagement process we learned that the University of Chester – our university partner - had made a £40m bid to the Department of Health to establish a state-of-the-art medical school and we therefore paused our work to see the outcome of the bid, preferring to rename the Trust University Hospitals of Warrington and Halton NHS FT. We have now learned that their bid was unsuccessful in this round although the University already has an established Medical School, albeit Post-Graduate. It has an established track record in Post-Graduate Medical Education and has recently been designated as a provider of Physician Associate training.

2. KEY ELEMENTS

The University of Chester trains nurses, midwives, biomedical scientists, pharmacists, dieticians at its various campuses including Warrington. It has newly been accredited to provide Physician Associate training (post grad) as well as a raft of other health sciences to which healthcare professionals can study to MSc Level at its Medical Faculty:

- MSc Biomedical Science
- MSc Cardiovascular Disease
- MSc Clinical Bariatric Practice
- MSc Diabetes
- MSc Gastroenterology
- MSc Haematology
- MSc Infection and Immunity
- MSc Medical Genetics
- MSc Oncology
- MSc Orthopaedics*
- MSc Physician Associate
- MSc Psychiatric Medicine*
- MSc Respiratory Medicine*
- MSc Exercise Medicine (University Centre Shrewsbury)

Prof John Williams, the Director Chester Medical School and Associate Dean Faculty of Medicine Dentistry & Life Science is very supportive and a letter of support is being secured from the Vice

Chancellor. In addition, we have asked Prof Williams to replace former governor Dr Mike Brownsell who has had to step down due to overseas commitments.

On a wider level, our staff study the following at the University of Chester:

- Clinical Consultation Skills in Minor Injury and Minor Illness
- Clinical Supervision
- Evidence Based Practice in Health and Social Care
- Examination of New born
- Foundations in Leadership
- Multi Professional Support for Learning and Assessment in Practice
- Non-medical Prescribing
- Advanced Practice in Healthcare
- Clinical Examination Skills
- Diagnostics and Health Assessment
- Professional Education – theory and practice
- Principles of Critical Care Nursing
- Chartered manager Degree Apprenticeship
- Healthcare Assistant Practitioner – level 5 apprenticeship
- Nursing Associate – level 5 apprenticeship

3. ACTIONS REQUIRED

As a Foundation Trust we have considerably more freedom than NHS Trusts and to achieve a name change the following steps are required:

1. Check with our regional NHS England communications team that our proposed name follows NHS naming principles
2. Check with NHS stakeholders that our proposed new name won't conflict or be confused with the names of neighbouring NHS organisations or services
3. Engage with our Foundation Trust members and wider patients and the public to check our proposed new NHS name is clear and understandable
4. Changes to our NHS Foundation Trust name require an amendment to our NHS Foundation Trust's constitution which needs to be approved by our Council of Governors and our Board of Directors.
5. Inform our key stakeholders as soon as possible of our new name so they can update their records.

For reference, the NHS identity guidelines state: *The name of your NHS organisation, service or partnership should adhere to the following principles:*

- ***The position of the word 'University' in an NHS organisation's name should be carefully considered. 'University' should be placed at the start of the name or within it. When it is placed at the end of the name, the prominence of the word could give the impression of the title of a university rather than an NHS Foundation Trust or NHS Trust.***
- *be clear, logical and descriptive*
- *consider, and be able to demonstrate, that the benefits of changing your NHS organisation's name justify the use of public money*
- *The name should be written out in full, without the use of acronyms, abbreviations or symbols such as '&' – except St for 'Saint' and NHS for 'National Health Service'*
- *include the letters 'NHS' within the written version of the name*
- *contain a geographic reference, unless it is a national NHS organisation, service or partnership (e.g. NHS Improvement)*

- *if it is an NHS service, start with a geographic reference, then a descriptor for the service (e.g. Mental Health) and typically end with the word 'Service', unless it is a national service (e.g. NHS 111)*

Our proposed name is: University Hospitals of Warrington and Halton NHS Foundation Trust

4. EVALUATIONS/TIMELINES

Actions	Materials/Communications format	Timeline	Status
Proposal to change Trust's name	• Trust Board approval • CoG approval	April 17 July 17	Complete
Branding	• Draft design for engagement • Application to NHS Identity team for new branding • Rebrand all digital platforms • Rebrand print items only as due for renewal/re-order • New signage main entrances	April 17 On completion	
Support from the UoC	Letter from CEO MP requesting letter of support from Vice Chancellor (SAC hand deliver w/c 13 August 18)	Aug 18	
Stakeholder engagement	• Trust staff – Team Brief/all staff comms survey consultation • Governors and Members • University of Chester • Other academic partners • Commissioners • MPs • Warrington Together partners • One Halton partners • Healthwatch • NHSI regional team • Media	Sept 18	
Formal notification of name change	• NHS Improvement national team • NHS England • NHS Digital • Care Quality Commission		

5. NEXT STEPS

1. Draft letter to the Vice Chancellor of University of Chester seeking support.
2. Commence engagement once received
3. Change name and branding and notify regulators/key stakeholders as above

6. RECOMMENDATIONS

3. That the Council of Governors' note the progress and action plan as outlined.
4. That the Council notes the Trust's obligation to consult with the Membership and agrees to lead this exercise (with the Foundation Trust Office support) on behalf of the Trust.

PMc

COUNCIL OF GOVERNORS

AGENDA REFERENCE:	**COG/18/08/50**
SUBJECT:	**Audit Committee Chairs Annual Report**
DATE OF MEETING:	16 August 2018
ACTION REQUIRED	**To note**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
SPONSOR	Ian Jones, Chair of Audit Committee
EXECUTIVE SUMMARY	This report seeks to deliver assurance to the Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls. The Report was approved at Audit Committee on 22 May 2018 and Trust Board on 24 May 2018
RECOMMENDATIONS	**The Committee reviews the document, ensure it meets its purpose and approve.**
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	Choose an item.

SUBJECT	Audit Committee Chairs Annual Report

AUDIT COMMITTEE REPORT 2017-18

The Committee

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and, where necessary, highlighting any areas of concern. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2017 -31 March 2018.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda, and are in support of the achievement of the Trust's objectives.

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

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

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by myself, the Chair of the Committee and the details of my biography can be found on page 22 (*of the Annual Report and Accounts*).

Member	Attendance (Actual v Max)
Ian Jones, Non-Executive Director & Chair	4/5
Terry Atherton, Non-Executive Director	5/5
Margaret Bamforth , Non-Executive Director	4/5
Anita Wainwright, Non-Executive Director	3/5
Jean-Noel Ezingeard, Non-Executive Director	1/3

Regular attendees at the Committee Meetings were Grant Thornton (External Auditors), Mersey Internal Audit Agency ("MIAA") (Internal Audit & Anti-Fraud Services), the Director of Finance & Commercial Development and the Director of Community Engagement & Corporate Affairs (Company Secretary Designate).

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in February 2018 to ensure they continue to remain fit-for-purpose.

Frequency of Meetings & Summary of Activity

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

Governance & Risk Management

During the year the Trust approved its Risk Management Strategy and refined its Board Assurance Framework to provide more detail around the Trust's key strategic risks and any movement on the underlying risk scores through regular Board updates. The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a Moderate Assurance rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Committee and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

During the year reports were received for the following audits:

Significant Assurance -

- Capital Assets
- Combined Financial
- Systems
- Outpatients
- Payroll
- IG Toolkit
- Mortality

Moderate Assurance –

- Multidisciplinary Team Meetings
- Medical Devices
- Patient Falls
- Incident Reporting and Duty of Candour
- Cancer Data
- Junior Doctors Contract
- Consent

Advisory Support and Guidance Provided to –

- Cyber Security
- General Data Protection Regulations
- Conflict of Interest review

The Internal Audit reports include detailed recommendations to improve systems and address weaknesses identified. Based on these recommendations, actions are agreed with Line Management and the Audit Committee tracks the implementation of the agreed actions to ensure implementation within an appropriate timeframe.

An Assurance Framework opinion test against NHS best practice was undertaken and the standards were met.

External Audit

Grant Thornton commenced its 3-year term as Auditors to the Trust in January 2017 following a competitive procurement exercise and review and recommendation by the Council of Governors.

During the year the Auditors reported on the 2016-17 Financial Statements and Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Counter Fraud Service (CFS) working to a programme agreed with the Audit Committee. The role of CFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-

Fraud, Bribery and Corruption Policy. The Audit Committee received regular progress reports from the CFS and also received an annual report.

No significant cases or issues of Anti-Fraud took place or were identified during the year.

Issues Carried Forward

The Audit Committee will continue its work to ensure the overall system of internal controls and the assurance processes remain robust.

In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.

Whilst the outcomes of the Clinical Audit programme falls under the remit of the Quality Committee and are reported and challenged in that forum, this Committee will review its approach purely from an audit perspective and to obtain assurance of methodology and approach as well as its contribution to improving quality.

With respect to the Internal Audit plan for 2017-18, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the 2018-19 Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

During 2017-18, alongside the Audit Committee, three main Board assurance committees were in place: (1) Quality, (2) Finance & Sustainability and (3) Strategic People. All of these committees were chaired by Non-Executive Directors and each committee included at least two Non-Executive Directors. This structure gave strong visibility and focus at Non-Executive level on the key issues facing the Trust. The NEDs meet several times a year to assess a wide range of Trust issues including the appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

As an example of cross-Committee liaison, the Chair of the Finance and Sustainability Committee and the Chair of Audit Committee are addressing Board concerns about the Trust's pay bill and, as part of that process, Audit Committee has requested that a quarterly report be added to its annual work plan relating to recruitment of senior posts at Band 8C and above and appointment and term of contract for all interim posts.

Summary

In year, the Committee has considered a wide range of issues in relation to financial statements, operations and compliance and has sought to gain assurance on each element by working closely with Internal Audit, the other Board committees and key individuals across the Trust.

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

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in August 2018.

The Committee has also assessed its own performance during the year and will report to the Board of Directors in April 2018.

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

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

Ian Jones
Chair of Audit Committee
May 2018

Council of Governors

DATES 2018-2019

Meetings in theTCR, Warrington to be held 4.00pm-6.00pm

Meetings at Halton Hospital to be held 3.00pm-5.00pm

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
		2018	
Thursday 15th February **(TCR Warrington)**	Tuesday 23rd January	Tuesday 6th February	Thursday 8th February
Thursday 17th May **(Lecture Theatre, Halton Hospital)**	Tuesday 24th April	Tuesday 8th May	Thursday 10th May
Thursday 16th August **(TCR Warrington)**	Tuesday 24th July	Tuesday 7th August	Thursday 9th August
Thursday 15th November **(TCR Warrington)**	Tuesday 23rd October	Tuesday 6th November	Thursday 8th November
		2019	
Thursday 14th February **(TCR Warrington)**	Tuesday 22nd January	Tuesday 5th February	Thursday 7th February