Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 28th May 2014, 1300 - 1700hrs
Trust Conference Room, Warrington Hospital

1300	***W&HHFT/TB/14/075***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/14/076	***Minutes of the previous meeting held on 30th April 2014***	Paper	
	W&HHFT/TB/14/077	***Action Plan***	Paper	Chairman
1310	***W&HHFT/TB/14/078***	***Chairman's Report***	Verbal update	Chairman
	W&HHFT/TB/14/079	***Chief Executives Report***	Verbal update	Chief Executive

Quality

1330	***W&HHFT/TB/14/080***	***Patient Story***	Presentation	Director of Nursing and Organisational Development
1350	***W&HHFT/TB/14/081***	***Quality Dashboard – Including HSMR and SHMI quarterly update.***	Paper	Director of Nursing and Organisational Development
1400	***W&HHFT/TB/14/082***	***Concerns and Complaints Annual Report 2013/14***	Paper	Director of Nursing and Organisational Development
1415	***W&HHFT/TB/14/083***	***Health and Safety Annual Report 2013/14***	Paper	Director of Nursing and Organisational Development
1420	***W&HHFT/TB/14/084***	***Risk Management Strategy***	Paper	Director of Nursing and Organisational Development

People

1425	***W&HHFT/TB/14/085***	***i) Workforce and Educational Development Key Performance Indicators*** ***ii) Transformation***	Paper Paper	Director of Nursing and Organisational Development
1435	***W&HHFT/TB/14/086***	***Ward Staffing Update***	Paper	Director of Nursing and Organisational Development
1455	***W&HHFT/TB/14/087***	***People Annual Report 2013/14***	Paper	Director of Nursing and Organisational Development
1510	***10 Minute Break***			

1520	***W&HHFT/TB/14/088***	***Approval of the Annual Report and Accounts 2013/14***	Paper	Chair of the Audit Committee
1530	***W&HHFT/TB/14/089***	***i. Finance Report to 30 April 2014*** ***ii. Service Line Reporting***	Paper Paper	Deputy Director of Finance
1600	***W&HHFT/TB/14/090***	***Corporate Performance Dashboard and Exception Report***	Paper	Chief Operating Officer
1610	***W&HHFT/TB/14/091***	***Emergency Preparedness Annual Report 2013/14***	Paper	Chief Operating Officer
1620	***W&HHFT/TB/14/092***	***Changes to the Scheme of Delegation***	Paper	Chair of Audit Committee
1625	***W&HHFT/TB/14/093***	***Monitor Provider Licence G6 and COS Compliance statements***	Paper	Chief Executive
1640	***W&HHFT/TB/14/092***	***Board Committee Reports:*** ***i. Annual Reports*** ***a) Board Committee Annual Reports: Quality Governance Committee*** ***ii. Board Committee Verbal Update*** ***a) Strategic People Committee held on 7 April 2014*** ***b) Audit Committee held on 6 May 2014 and 23 May 2014*** ***c) Charitable Funds Committee held on 6 May 2014*** ***d) Quality Governance Committee held on 13 May 2014*** ***e) Finance and Sustainability Committee held on 21 May 2014*** ***iii. Minutes for Noting:*** ***a) Quality Governance Committee – 11 March 2014*** ***b) Finance and Sustainability Committee – 16th April 2014***	Paper	Chair of Quality Governance Committee Chair of each Committee Lynne Lobley Rory Adam Clare Briegal Mike Lynch Carol Withenshaw To note To note
	W&HHFT/TB/14/093	***Any Other Business***		
1700 ends		***Dates of next meeting*** *25th June 2014*		

W&HHFT/TB/14/077

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 28th May 2014

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
26-02-2014	TB/14/026(i)	The Director of Finance and Commercial Development to report back to the Board within the next financial year, the outcomes of the business case review.	Director of Finance and Commercial Development	Due to the availability the outcomes of the business case review to be carried forward to 25th June 2014.	Action ongoing as at 28th May 2014
26-02-2014	TB/14/033	The Director of Nursing and Organisational Development to provide the Board with Quarterly Concerns and Complaints Report to coincide with the Governance Dashboard Report (see TB/14/34)	Director of Nursing and Organisational Development:	An annual Report will be produced for the year to 31 March 2013 and presented to the Board at its meeting on 28th May 2014. Future Quarterly Concerns and Complaints Reports will commence in 2014/2015 the first quarterly report will be presented to the Board at its meeting on 30th July 2014.	See Agenda item: TB/14/082 Action Complete
26-02-2014	TB/14/034	The Director of Nursing and Organisational Development to present to the April 2014 Board meeting the Governance Dashboard Report (see TB/14/33)	Director of Nursing and Organisational Development:	~~Governance Dashboard Report to be presented to the 28th May 2014 Board meeting following review at the Quality Governance Committee.~~ Due to further work on the development of the dashboard and its presentation to the Quality Governance Committee prior to Board this matter remains ongoing.	Action ongoing as at 28th May 2014

W&HHFT/TB/14/078

BOARD OF DIRECTORS

Paper Title	**Chairman's Report**
Date of Meeting	28th May 2014

W&HHFT/TB/14/079

BOARD OF DIRECTORS

Paper Title	**Chief Executive's Report**
Date of Meeting	28th May 2014


Quality

W&HHFT/TB/14/080

BOARD OF DIRECTORS

Presentation	**Patient Story** **Director of Nursing and Organisational Development**
Date of Meeting	28th May 2014

W&HHFT/TB/14/081

BOARD OF DIRECTORS

Paper Title:	Quality Dashboard May 2014 (Incorporating the mortality report)
Date of Meeting	28.05.14
Director Responsible	Karen Dawber (Director of Nursing and Organisational Development)
Author(s)	Ros Harvey (Corporate Nursing and Governance Support Manager) Hannah Gray (Clinical Effectiveness Manager)
Purpose	To monitor performance against the KPIs within the Trust's Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy (IQ Strategy)

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Executive Team	Prior to Trust Board meeting

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
The Quality Dashboard is currently under review in relation to CQUIN, contractual and improvement priority measures. These issues will be finalised by July 2014.	
○ This report contains an exception report for complaints (outlining changes to data for 2013 – 2014), mixed sex occurrences and information on incidents resulting in major and catastrophic harm.	3
○ The exceptions for VTE, Dementia and Discharge Summaries relate to the early extraction of data (21st May 2014) and are therefore provisional until final submission to UNIFY on the **28th May 2014**.	
○ The Friends and Family Net Promoter score is a composite score for inpatients and A&E. Future dashboards will include the A&E and inpatients score. The A&E score for April is included and inpatients score will be available in June.	
○ The quarterly mortality report has been incorporated within this report.	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)
The Board is asked to:

- Note progress and compliance against key performance indicators in the Improving Quality Strategy
- Approve actions planned to mitigate areas of exception

1. Key Performance Indicators

Patient Safety		Target / threshold	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
			Figures are totals or % for the month / quarter (except where stated)																
HSMR (rolling 12 months, latest data available)		See Appendix 1					2013/14 data									98			98
SHMI (rolling 12 months, latest data available)		See Appendix 1											108						108
Total deaths in hospital		None set	98																98
Regulation 28 - Prevention of future deaths report		TBC	0																0
Incidents resulting in Major or Catastrophic harm		TBC	0																0
Incidents of major or catastrophic harm under investigation		N/A	5																5
Falls (moderate, major and catastrophic harm)		<=13 per year	1																1
Falls (moderate, major and catastrophic harm) awaiting approval		N/A	0																0
Pressure Ulcers	Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	1																1
	Grade 3 and 4 Hospital Acquired (Unavoidable)	N/A	0																0
	Grade 3 and 4 Hospital Acquired (Not yet determined)	N/A	0																0
	Grade 2 Hospital Acquired	<=101 per year	3																3
	Grade 2 Hospital Acquired (under review)	N/A	0																0
MRSA		0 =Green, 1-5 =Amber, >5 =Red	0																**0**
C difficile		<=26 per year	2																**2**
Never Events		0 per year	0																**0**
VTE	% of patients risk assessed	>=95% of patients	92.51																**92.51**
	% harm free (Safety Thermometer (ST))	TBC	98.86																98.86
Medication Errors	Omitted doses (Quarterly audit)	TBC	Not yet completed																
	Insulin related errors	TBC	7																7
CA – UTI: Number of catheterised patients who developed a UTI (ST)		<=32 per year	4																4
CA – UTI % of catheterised patients who developed a UTI (ST)		TBC	0.76																0.76
Dementia Assessment (Part 1)		>=90% of patients	**94.55**																94.55
Dementia Assessment (Part 2)		>=90% of patients	**97.44**																**97.44**
Dementia Assessment (Part 3)		>=90% of patients	**100**																**100**

NB YTD results for VTE, Discharge Summaries to GPs & Dementia includes March data.

Effectiveness		2013/14	2014/15		J	F	M	Q4	YTD
Advancing Quality	Acute MI	**>=91.46%**	>=95%	2013/2014 data	**97.84**	**97.97**			97.97
	Hip and knee	**>=92.23%**	>=95%		**96.23**	**96.52**			96.52
	Heart failure	**>=86.85%**	>=90.2%		**87.35**	**87.50**			87.50
	Pneumonia	**>=75.23%**	>=73.9%		**72.95**	**72.25**			72.25
	Stroke	**>=62.57%**	>=60.4%		**55.48**	**55.82**			55.82

Discharge summaries to GPs within 24 hours	95% of patients	92.30	92.30

Patient Experience			
Complaints (number received)	None set	34	32
Concerns (number received)	None set	2	2
Complaints (% resolved within the agreed timescale)	>=94%	94.44	94.44
Mixed sex occurrences (clinical unjustified)	0	6	6
Friends and Family Test (Trust score, out of maximum 5)	TBC	4.54	4.54
Friends and Family Test – NET PROMOTER (total)	>=70	59	
Friends and Family Test – NET PROMOTER (A&E)	None set	43	

2. Exception reporting

Complaints – revision to data for 2013/2014

Q1 - April, May, June figures all correspond and are correct.
Q2 - July has one more than the Monthly KPI Report (MKR), this is because we received an out of time complaint in July and in October, due to the nature of the complaint, it was set up and investigated. As the original letter had been received in July, this was inserted into the first received date. This meant that the complaint was missed off the MKR completely because it was not counted in October's numbers and the rest of the data was not refreshed. Aug and Sept both have three additional complaints each. This is a refreshing issue as complaints have been set up in the following month and the first received date has been logged appropriately and MKR not updated.
Q3 - October has one additional complaint to the MKR figures. This is because there was a complaint which was not received in a timely manner and consequently set up in November and again the figures had not been refreshed. November and December both have two extra complaints which is again a refreshing issue where they have been set up in the following month and the MKR has not been refreshed to account for this.
Q4 - January has two extra complaints; again this is a refreshing issue. February has four fewer complaints than shown on the MKR, this is because we had two duplicate complaints that had been set up in error, these were amended for the KO41 but the MKR wasn't altered to reflect this.
There were also two concerns under a complaint code instead of concern code, this was amended for the KO41 but the MKR was not altered to reflect this.
This makes a total of 10 additional complaints for the MKR figures. The team have reviewed the systems and processes for extracting data and a new standard operating procedure will ensure the accuracy of future reporting.

Revised data for 2013/2014 for complaints received and percentage of complaints resolved.

KPI	Target	A	M	J	J	A	S	O	N	D	J	F	M	YR
Complaints (number received)	None set	39	22	26	31	37	26	32	35	34	43	47	40	412
Revised Data – complaints received 2013/2014	None set	39	22	26	32	40	29	33	37	36	45	43	40	422
Complaints (% resolved within the agreed timescale)	>=94%	47%	67%	66%	62%	70%	71%	**62%**	**80%**	**50%**	**72%**	**70%**	**94%**	68%
Revised Data for resolved complaints 2013/2014	>=94%	49%	69%	66%	58%	62%	70%	**62%**	**84%**	**52%**	**73%**	**70%**	**94%**	67%

Mixed Sex Occurrences

DSSA Breach & Sanction Reporting: There were three breaches in CDU when a male patient shared accommodation with two ladies from 22:30 hours on 1 April until 09:45 hours on 2 April 2014. There was one breach in CCU on 8 April 2014, when a patient was unable to be transferred to the cardiology ward for a period of 6 hours, 30 minutes. Two patients breached in ICU/HDU between 28 April and 29 April 2014. This led to unavoidable cross flow issues. RCA investigation reports have been completed.

Incidents: major and catastrophic harm – Improvement Priority 2013/2014

In December 2013 the trust reported 7 incidents (*all finally approved) resulting in 4 with major harm and 3 with catastrophic harm for the period 1st April 2012 until 31st March 2013. The improvement priority threshold for 2013/2014 was therefore confirmed at 6 incidents. In the Quality Report we have reported that as "at the 31st March 2014 the trust is performing well, with 6 confirmed incidents of this severity however, there are a further 11 incidents of this severity under investigation at this time". We will not know the final position until all the investigations are completed but it is unlikely that they will all close within this severity category.

Quarterly Mortality Update

Headlines

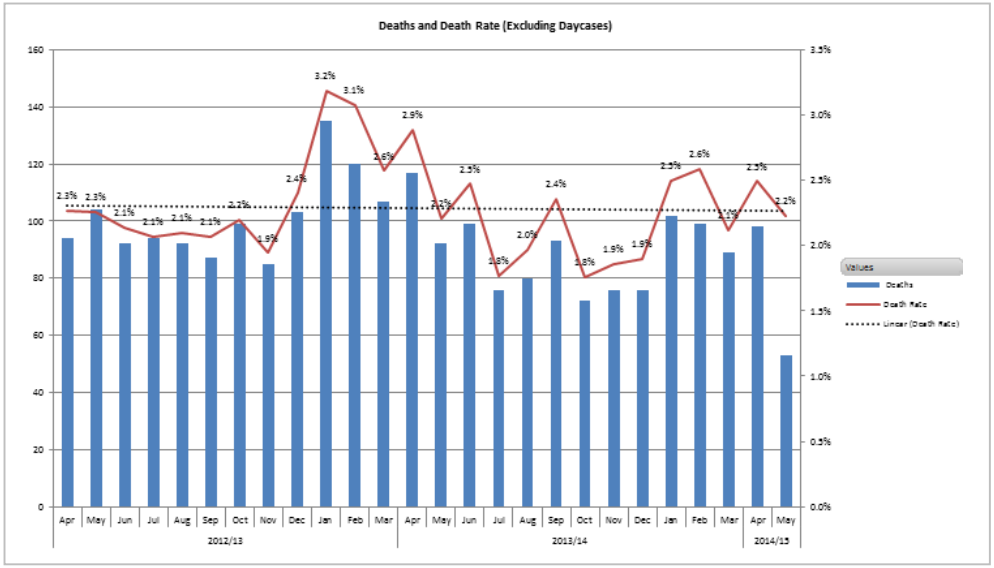
The crude death rate (excluding day cases) for 2012/13 is 2.3%, 2013/14: 2.2% and 2.4% for 2014/15 (as at 18/5/14)

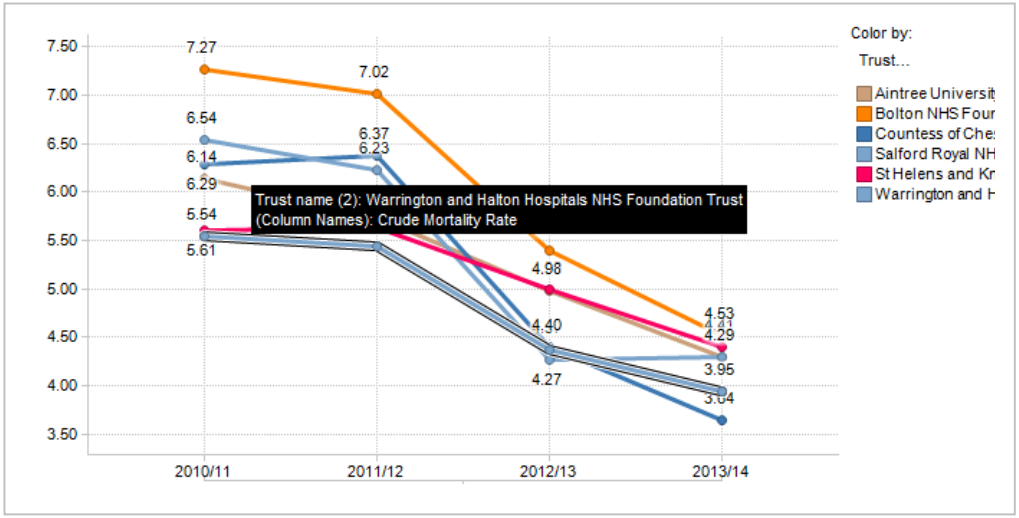
- The rolling 12 month HSMR and SHMI are 98 and 108 respectively (HSMR March 2013 – Feb 2014 and SHMI Jan 2013 – Dec 2013). The latest quarterly SHMI data published by HSCIC reveals an 'as expected' SHMI score.
- The HSMR and SHMI for the latest months available (for that month only) are 100 (Feb 2014) and 99 (Dec 2013) respectively.
- In the latest published CQC Intelligent Monitoring Report (March 2014) there were 2 mortality related risks reported. An 'elevated risk' for 'In-hospital mortality – Vascular conditions and procedures'; this is related to the aneurysm reviews the Trust conducted in 2013 which revealed no concerns about the care provided. 'In Hospital Mortality – Haematological conditions' was reported as a 'risk'. A review revealed excellent care for the four patients in question. Please see the CQC Intelligent Monitoring Report to Trust Board for further details. The next CQC Intelligent Monitoring Report will be published in June 2014.

For the latest available data at any time, click here on a tablet or smart phone to install the App: http://myapp.is/WHHMortalityData

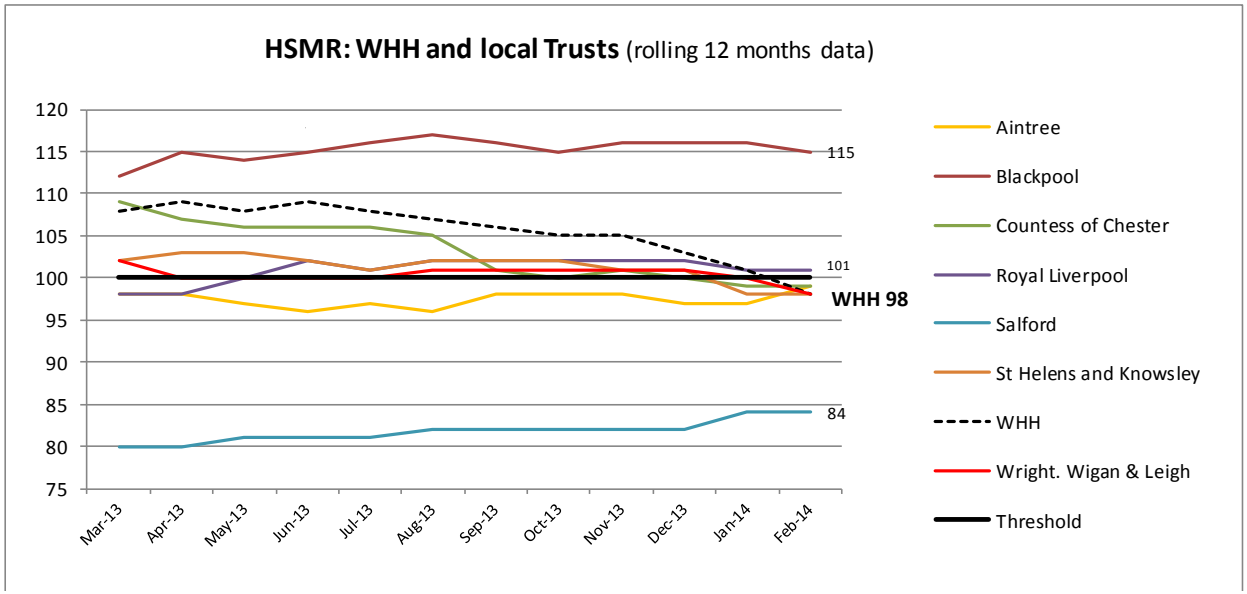
Assurance Committee: The Clinical Effectiveness Group provides assurance to the Clinical Governance, Quality and Audit Committee that mortality figures are monitored, alerts are reviewed and appropriate action is taken.

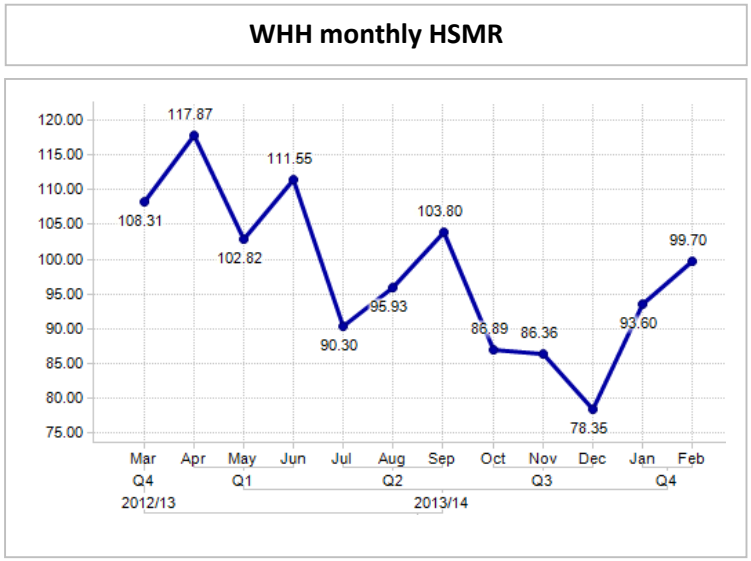
Crude Mortality (Left: WHH only per month| right: WHH (highlighted line) and local Trusts per year (HSMR diagnoses only))

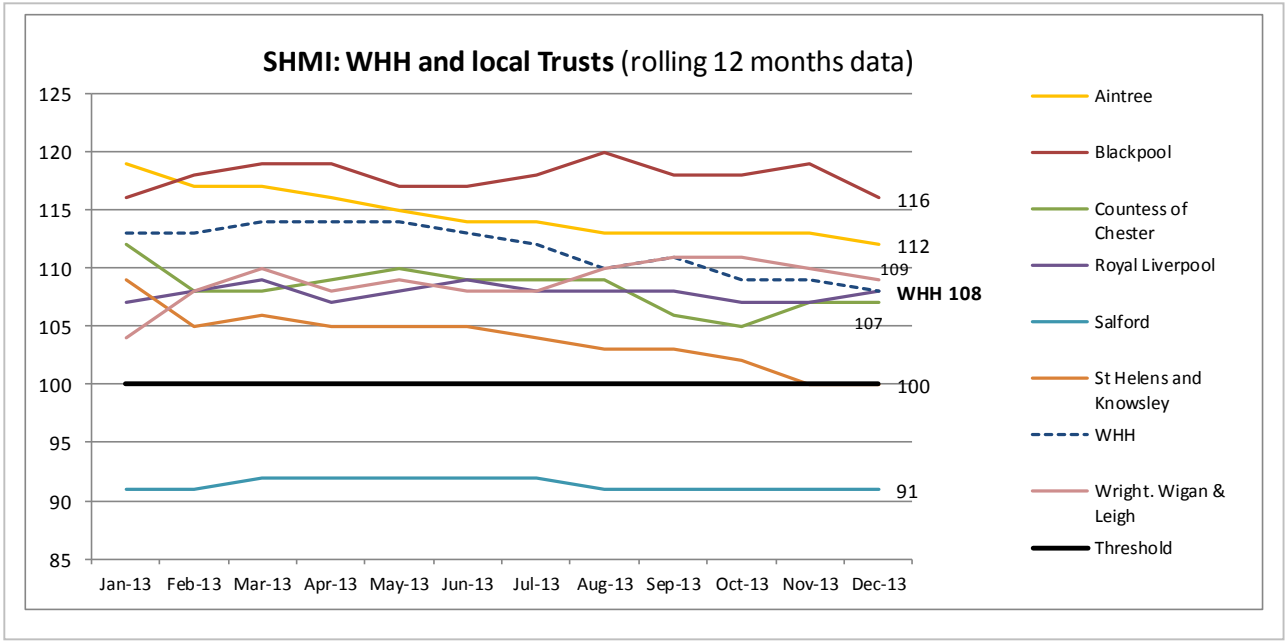


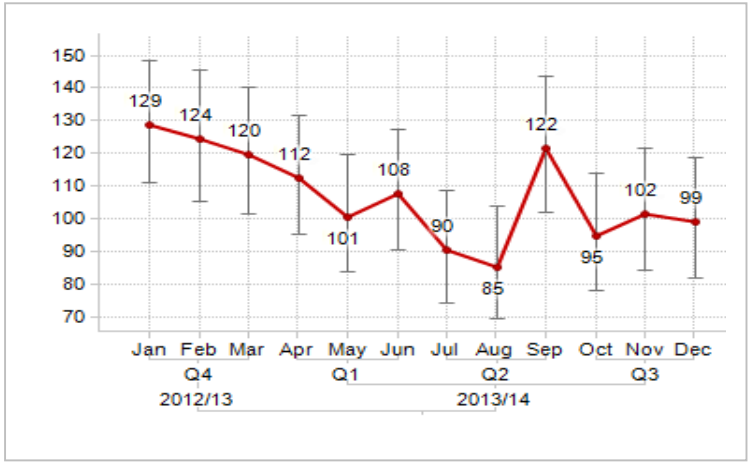


HSMR and SHMI Mortality ratios









3. Key Performance Indicators: detail (all KPIs are reported in the quarterly report, but not the monthly report)

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
Patient Safety				
HSMR	Hospital Standard Mortality Rate calculated by HED (rolling 12 months to the end of the period). RAG rating ranges are: R: in 'higher than expected' category, A: >100 but 'within expected range', G: <=100.	• Contract target • QIPSS • AQUA Reducing Mortality Collaborative (RMC)	• Commissioners •	Accessed via HED
SHMI	Standard Hospital Mortality Index calculated by HED (rolling 12 months to the end of the period) RAG rating ranges are: R: in 'higher than expected' category, A: >100 but 'within expected range', G: <=100.	• QIPSS • AQUA RMC	• Commissioners	Accessed via HED
Falls (moderate, major and catastrophic harm)	Falls which result in moderate, major or catastrophic harm to the patient (Datix finally approved incidents only)	• Contract target • QIPSS	• Commissioners • Falls Prevention Group	Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations. Falls data adheres to NRLS (National Reporting and Learning System) submission criteria. Amendments to process made following advice from PWC
Pressure Ulcers (grade 3&4 hospital acquired)	Number of hospital acquired grade 3 and 4 pressure ulcers (including patients who are admitted with a pressure ulcer (grade 1 – 2) which deteriorates after 72 hrs from admission)	• Contract target • QIPSS	• Commissioners • Pressure Ulcer Link Nurses	Mersey Internal Audit Agency report 2012: 'Significant Assurance'
Pressure Ulcers (grade 2 hospital acquired)	Number of hospital acquired grade 2 pressure ulcers (including patients who are admitted with a pressure ulcer (grade 1) which deteriorates after 72 hrs from admission)	• Contract target • QIPSS	• Commissioners • Pressure Ulcer Link Nurses	Mersey Internal Audit Agency report 2012: 'Significant Assurance'
MRSA	Number of cases of hospital acquired MRSA	• Contract target • Quality Improvement and Patient Safety Strategy 2012 – 2015 (QIPSS)	• Commissioners • Infection Control Sub Committee (ICC)	Process audited annually by PWC on behalf of Monitor.
Clostridium difficile	Number of cases of hospital acquired C difficile	• Contract target • QIPSS	• Commissioners • ICC	Data from Trust MOLIS laboratory system and Public Health England's HCAI national database is cross referenced for accuracy.
Never events	Never Events as determined by The Department of Health criteria	• Contract target • QIPSS	• Commissioners • Clinical Governance sub Committee	Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations.
VTE: % of patients risk assessed	% of inpatients who are assessed for risk of developing VTE	• Contract target • QIPSS	• Commissioners	Supplied by Information Dept. Protocol approved by the Clinical Governance Committee applying the SHA criterion. Performance monitored by Associate Director of Strategy and Business Development

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
VTE % harm free (Safety Thermometer)	% of patients who have not developed a VTE since admission to the Trust. Measured by monthly NHS Safety Thermometer point prevalence survey	• CQUIN • QIPSS	• Commissioners	Adherence to National NHS Safety Thermometer data capture and reporting procedures
Medication Errors: omitted doses	Results of a quarterly snapshot audit of the patients' current prescription chart for 8 randomly selected patients on each ward across the Trust. Only wards with 8 auditable patients for all quarters are included when measuring the reduction so that there is a consistency in patient numbers and therefore changes in numbers of omissions can be identified. For the purposes of the audit, 'omissions' = all omitted medicine doses with no documented reason or where the medication was unavailable on more than 2 occasions	• QIPSS	• Medicines Safety Committee	Consider Mersey Internal Audit Agency Review
Medication Errors: insulin related.	Number of medication errors associated with insulin. (Data source = datix incident management system)	• QIPSS	• Medicines Safety Committee	Consider Mersey Internal Audit Agency Review
Catheters and UTIs: Total (Safety Thermometer)	Number of catheterised patients who have developed a UTI since admission to the Trust. Measured by monthly NHS Safety Thermometer point prevalence survey	• QIPSS	• Patient Safety and Experience Action Group	Adherence to National NHS Safety Thermometer data capture and reporting process
Catheters and UTIs: % (Safety Thermometer)	% of catheterised patients who developed a UTI since admission to the Trust. Measured by monthly NHS Safety Thermometer point prevalence survey	• CQUIN • QIPSS	• Commissioners	Adherence to National NHS Safety Thermometer data capture and reporting process
Dementia Assessment (CQUIN)	% compliance with Dementia Assessment Part 1 as per CQUIN.	• CQUIN	• WHH Contract and Performance Group	TBC
Incidents resulting in Major or Catastrophic Harm	Incidents which result in major or catastrophic harm to the patient (Datix finally approved incidents only)	• Improvement Priority 2013/14 Quality Account)	• Commissioners	Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations.
Discharge Summaries to GPs	% of patients having a Discharge Summary sent within 24 hours (including TTO). Contract threshold 95% (penalty applies <90%)	• Contract target • QIPSS	• Commissioners	Supplied by Information Dept. Process agreed with commissioners in accordance with the contract. Independent feedback provided by GPs through the Contract Quality meetings. Compliance audits completed through the Associate Director of Nursing.
Clinical Nursing Indicators	Compliance with a range of nursing indicators relating to ward documentation and processes	• QIPSS	• NMAC • PSEAG	Audit completed by Clinical Research and Audit Nurse.
Effectiveness				
3 Clinical conditions	Focus on 3 key clinical conditions (1 per division) resulting in high patient numbers of admissions, implement best practice care bundles & production of clinical guidelines linked to evidence based pathways that support care and recovery.	• QIPSS • AQUA RMC	• TBC	See KPI detail

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
	R,A,G rating indicates level of compliance with agreed action plan targets			
Advancing Quality	Compliance with 4 AQ regional targets for patients with: AMI, heart failure, hip and knee replacement and those who have had a stroke	• CQUIN • QIPSS	• Commissioners	Process agreed with Associate Director of Strategy and Business Development and agreed with commissioners in accordance with the contract.
Critical Care Bundles, numbers of VAP and BSI	All relate to Intensive Care Unit only: Compliance with a range of critical care bundles for a sample of patients. Occurrence of Ventilator acquired pneumonia. Occurrence of line associated blood stream infections.	• QIPSS	• Acute Care Group	Mersey Internal Audit Agency has audited this KPI in 2012 and made recommendations which are being implemented
Readmissions	Emergency readmission for the same primary diagnosis group within 30 days of discharge following an elective spell (18+ only) PBR RULES	• Contract target	• Commissioners	To be confirmed – KPI newly reported following contract changes for 2013/2014
End of Life Care	Prior to April 2013 report: Compliance with End of life care action plan (incorporating best practice as defined in 'Route to success in end of life care for acute hospitals') Starting April 2013 report: Specialist Palliative care referral rates	• QIPSS • AQUA RMC	• End of Life Care Group	See KPI detail
Clinical Nursing Indicators: MEWS recorded	Compliance with a range of nursing indicators relating to ward documentation and processes: audit of MEWS being recorded	• QIPSS	• NMAC	Audit completed by Clinical Research and Audit Nurse.
Clinical Nursing Indicators: MEWS action (including use of SBAR)	Compliance with a range of nursing indicators relating to ward documentation and processes: audit of appropriate action being taken following identification of MEWS, including the use of SBAR	• QIPSS	• NMAC	Audit completed by Clinical Research and Audit Nurse.
Patient Experience				
Patient Survey	Inpatient Survey responses to 5 CQUIN related questions plus 1 other	• QIPSS	• Commissioners	Survey managed by Quality Health
Staff Survey	Staff Survey result for single question: Would you recommend this hospital to friends and relatives?	• QIPSS	• Commissioners	Survey managed by Quality Health
MSO (unjustified breeches)	Number of clinically unjustified mixed sex breaches	• Commissioning target • QIPSS	• Commissioners	Adherence to Department of Health MSO criteria for reporting Developed data capture systems relevant to each area. Datix completed. Quality Improvement Matron informed by wards and triangulates data with Datix and Extramed systems
Complaints received	Number of complaints received each month	• Related to commissioning target • QIPSS	• PSEAG	
Complaints resolved within	% of complaints closed in the month, which were resolved	• Commissioning target	• Commissioners	Process agreed with Associate Director of

	KPI detail	Rationale for inclusion	Data Circulation	Data Assurance
the agreed time	within the agreed timescales	• QIPSS		Strategy and Business Development and agreed with commissioners in accordance with the contract.

Key:
ICSC: Infection Control Sub Committee
QIPSS: Quality Improvement and Patient Safety Strategy 2012 – 2015
PSEAG: Patient Safety and Experience Action Group
WHH: Warrington and Halton Hospitals NHS Foundation Trust

W&HHFT/TB/14/082

BOARD OF DIRECTORS

Paper Title:	Complaints Annual Report 2013/14
Date of Meeting	28th May 2014
Director Responsible	Karen Dawber, Director of Nursing and Organisational Development
Author(s)	Alison Lynch, Deputy Director of Nursing, Quality and Patient Experience Michele Lord, Patient Experience Matron
Purpose	To provide the Board with an overview of complaints and feedback that the Trust has received from patients, relatives and other service users from 1 April 2013 to 31 March 2014. The report is written in accordance with the NHS Complaints Regulations (2009) and complements our Annual Governance Report where complaints data are also reported.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	none	

Relates to which Trust objectives	✓ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- 422 complaints during 2013/14, which is a 26% decrease on the previous financial year.
- 0.9% of complaints were referred by complainants to the Parliamentary and Health Service Ombudsman which is a decrease of one from 2012/13.

Recommendation(s)
The Board is asked to:
- Note progress in the management of complaints
- Approve the recommendations regarding including future Patient Experience Reports.

Executive Summary

This is our second comprehensive Patient Experience Annual Report which provides an overview of complaints and feedback the Trust has received from patients, relatives and other service users from 1 April 2013 to 31 March 2014. The report is written in accordance with the NHS Complaints Regulations (2009) and complements our Annual Governance Report where complaints data are also reported.

Delivering a quality service to our patients is central to the Trust's core strategic objectives namely:

- Ensure all our patients are safe in our care.
- Give our patients the best possible experience.

The Trust receives feedback and information about its care and services in a number of different ways, including that from formal complaints, Patient Advice and Liaison Service (PALS), NHS Choices and via our partner organisations such as Healthwatch and our Governor's Observation Visits. In the last year the Friends and Family Test has been introduced in inpatient, accident and emergency and maternity services and will be rolled out in outpatients and day surgery later this year. There are also two local surveys that are regularly administered and reported; the Patient Experience Tracker and the privacy and Dignity survey, which is a component of monthly DSSA reporting.

From 1 April 2014 patient complaints will be reported to the Board on a quarterly basis, future annual reports will provide an integrated approach to patient experience by providing additional information on national programmes used to drive improvement in patient experience including the Care Quality Commission national patient survey programme and CQUINs (Commissioning for Quality and Innovation).

This report provides information on:

- Formal complaints
- PALS contacts
- Parliamentary and Health Service Ombudsman (PHSO) investigations
- NHS Choice Website comments
- Compliments

Data from the above areas is included to provide an analysis of trends over time and illustrated with lessons learned.

We treat and care for a significant number of people every year, during 2013/2014 there were 594,817 attendances to our services. The vast majority of patients have a positive experience however, when things go wrong, we are committed to listening and seeking to understand what happened so that we can learn lessons to ensure that meaningful improvements are made.

This is reflected in the way that we seek to resolve concerns or complaints, or simply provide service users with the advice they need, as soon as these matters are brought to our attention.

Finally, we must continue to learn the lessons from the Francis Public Inquiry in to Mid Staffordshire NHS Foundation Trust and be responsive to the published review of the NHS Complaints system by Ann Clwydd, Member of Parliament and Professor Tricia Hart, particularly with regard to listening and learning from complaints. We will continue to put patients first, listen to their concerns, fears and feedback so that we can continually strive towards delivering quality care and services that they can trust and that we can be proud of. A briefing paper on the actions needed to do this was tabled at the Clinical Governance, Audit and Quality Sub-committee (CGAQSC) meeting in March 2014.

A new report from the House of Commons Public Administration Select Committee, *More Complaints Please,* was published on 26 March 2014 and discusses the principles of good complaint handling. In reference to the health service, the report lists the Parliamentary Health Service Ombudsman (PHSO) information on common failures of NHS complaints systems:

- Failure to respond to complaints within a reasonable length of time;
- Failure to provide accurate and timely information;
- Poor customer service;
- Grudging apologies;
- Failure to resolve issues;
- Poor record-keeping;
- Poor decision-making;
- Failure to learn from mistakes; and
- Providing incomplete, unhelpful or confusing responses.

A summary of this report is being prepared to be tabled at CGAQSC, along with any local recommendations for improvements.

Key Points:

- There were 422 complaints during 2013/14 which is a 26% decrease on the previous financial year.
- 26% of complaints were not upheld
- 68% of complaints were closed within agreed timescales against a target of 94%
- 0.9% of complaints were referred by complainants to the Parliamentary and Health Service Ombudsman which is a decrease of one from 2012/13.

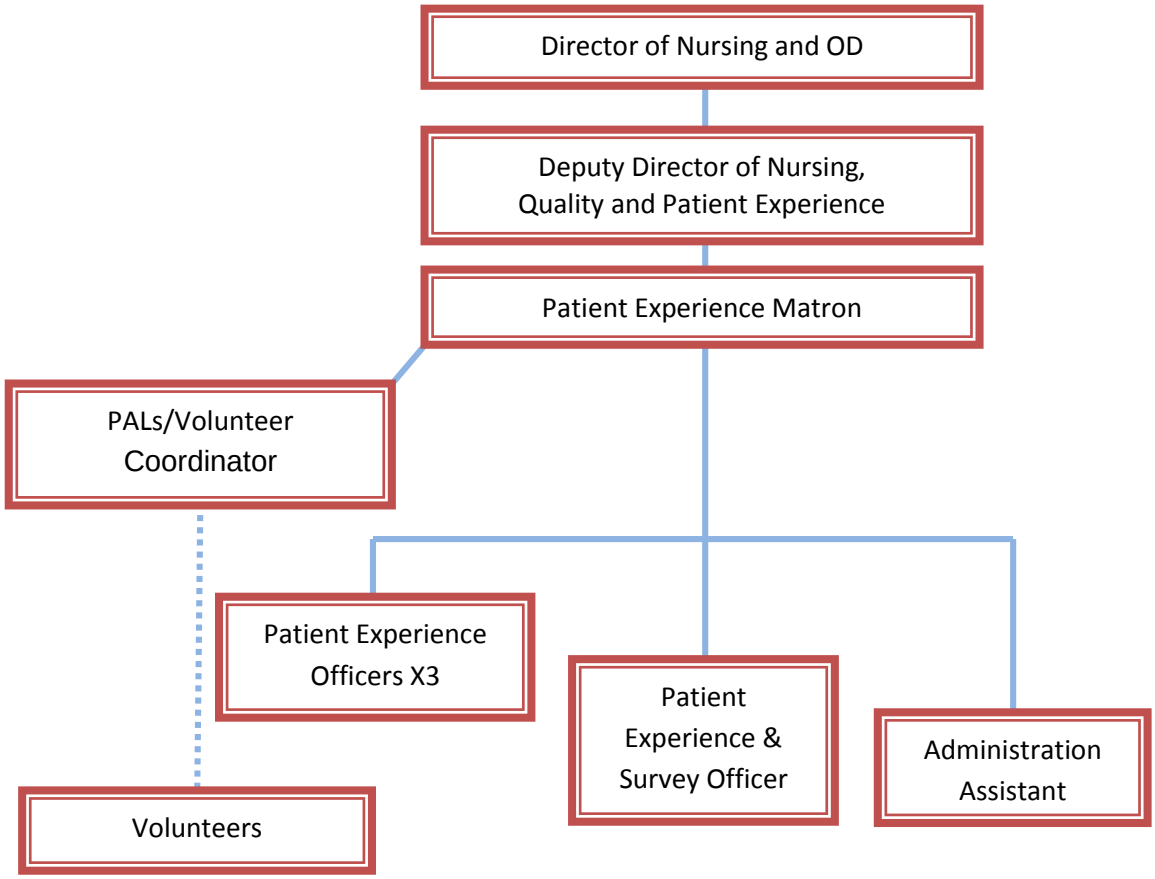
1. The Service

During the reporting period the Trust has an integrated complaints and PALS service, referred to as 'the service' throughout this report. The team manage and deal with complaints, concerns in accordance with the Trust *Complaints and Concerns Policy* and with the support of divisional teams. Other forms of feedback, i.e. surveys, are also coordinated by this team.

Since 1 May 2013 the service has developed to include all patient experience functions and is now called the Patient Experience Team. The Patient Experience Matron is responsible for leadership of the broad remit of patient experience, including complaints and PALS and for the development of both formal and informal feedback mechanism. While the Deputy Director or Nursing, Quality and Patient Experience has delegated responsibility from the

Director of Nursing and OD, working with her for the strategic development of the wider patient experience agenda. The Director of Nursing and OD has executive responsibility and is authorised by the Trust Board to oversee the Trust-wide management of complaints.

1.1 Patient Experience Structure – 2013/2014



This structure has been in place since December 2013, when the last member of the newly recruited team started in post. Complaint investigations, in the main, are the responsibility of the divisions, where the process is monitored by the senior nursing, medical and management teams.

2. Background

In accordance with *NHS Complaints Regulations* (2009), this report sets out a detailed analysis of the nature and number of formal complaints, concerns, PALS contacts, and samples from the *NHS Choices Website*. The Trust deals with complaints and concerns from patients and users, their family and carers, in accordance with local complaints policies and procedures and the Care Quality Commission's (CQC) *Essential Standards of Quality and Safety.* We declared compliance with CQC Regulation 19 - Outcome 17 during 2013/14. A recent review of the complaints systems by Mersey Internal Audit has assigned significant assurance to the improved systems for handling and investigating complaints.

2.1 *Complaints overview*

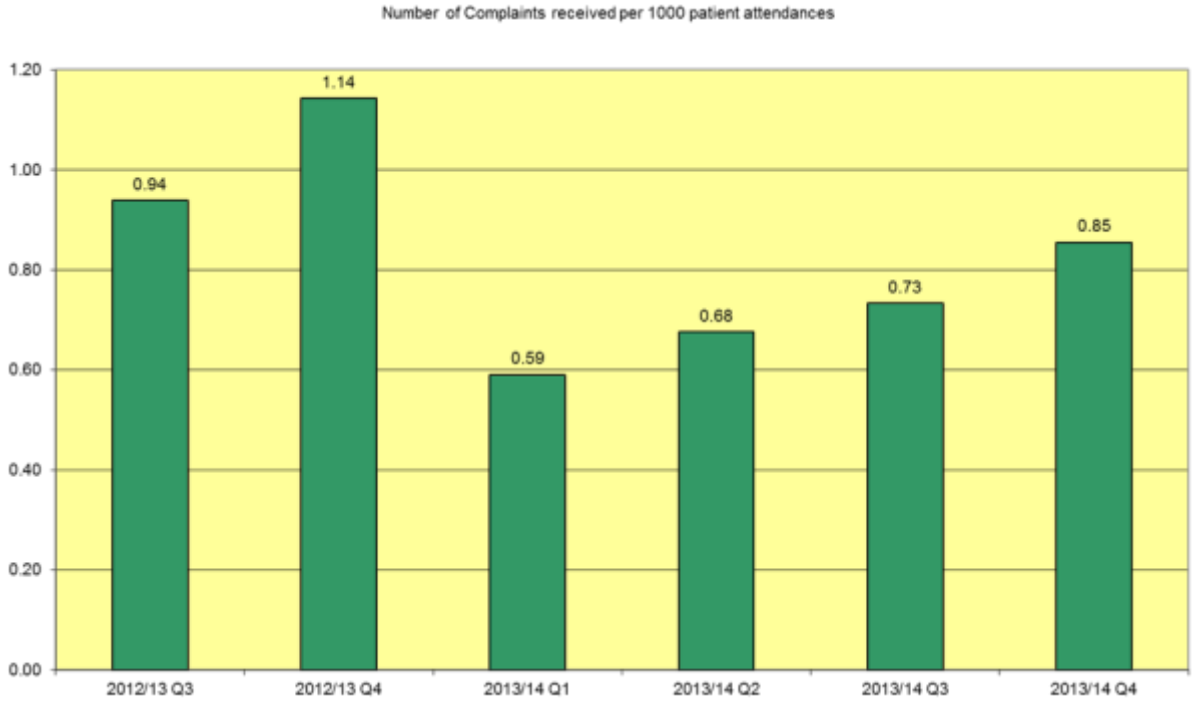
During 2013/2014 there were 594,817 attendances to our services.

Table 1 – Trust Activity 2013/2014

Activity	Type									
	Day case	Inpatient	Non-elective	New	Follow up	A&E	MIU	Ward attender	Outside clinic attend-ance	**Grand Total**
2013/ 2014	30,428	6,187	39,629	118,395	283,777	84,679	16,933	13,916	873	**594,817**

This includes 76,244 inpatients, and 101,612 attendances to the Accident and Emergency Department and Minor Injuries Unit.

Figure 1 Complaints received per 1000 patient attendances 2012/13 – 2013/14 as at 31st March 2014.



The Trust received a total of 422 formal complaints during 2013/14 which were investigated In accordance with the Trust policy, which is a 26% decrease when compared to the previous year 2012/2013.

Table 2 – Formal Complaints 2011 – 2014

Financial Year	Formal complaints received
2011/2012	505
2012/2013	571
2013/2014	422

Table 3 – Risk rating of complaints by quarter

	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	Change from last Quarter
Complaints Received	**87**	**101**	**106**	**128**	⇧
Low	12	31	35	54	⇧
Moderate	67	51	56	60	⇧
High	8	19	15	14	⇩

All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the Trust Interpreter Service. There were no formal complaints from patients who stated they had learning disabilities or from carers of patients with learning disabilities. There were three patients reporting a physical or sensory disability and two with Alzheimer's or dementia. There is an option to record disabilities on the complaints system, but this is not always known immediately, or in some cases, ever during the time the complaint is open. For the next year there is a need to better record disabilities to provide better intelligence about complainants/patients. The team do send complainants an equality and diversity form to complete, but this is voluntary and the return rate is not high; we will explore ways of improving this throughout the coming year.

All complaints are reviewed by the Director of Nursing and OD prior to letters being sent to the complainant from the Chief Executive Officer or Deputy Chief Executive Officer.

2.2 *Parliamentary Health Service Ombudsman (PHSO)*

Complainants can take their complaint to the independent PHSO if they are not satisfied with the way that the Trust has dealt with it. The PHSO will only investigate a case where it is deemed that local resolution has been sought and the complainant remains dissatisfied by the response they have received.

During 2013/2014 the Trust received 4 requests from the PHSO for complaint files and their associated medical records and these are currently with the PHSO for deliberation. 6 complaints referred to the PHSO in the previous financial year have been closed during 2013/14. Of these two were not upheld and four upheld and the Trust was required to formulate and implement action plans. 8 cases are ongoing for 2013/14.

There have been three formal complaints referred by a complainant to the Care Quality Commission (CQC) in 2013/2014. The initial complaint for one of these was made in 2011 and has been returned several times, a recent, very detailed review and meeting with the complainant was completed and we are waiting to hear if the complainant will be taking any further action. One complaint was referred after a safeguarding issue and the complainant had contacted the CQC during that process. A third complaint had been made to the CQC, but a meeting with relevant staff and assurances given was closed with no further action

2.3 *Patient Advice and Liaison Service (PALS)*

Our PALS service dealt with 1,680 people who contacted us for help/advice in 2013/2014. Of these 99 issues became formal complaints. A number of these were intending to make a complaint and approached PALS to support them in this. The HealthWatch Advocacy Service is a free and independent service to support people in making formal complaints to health service organisations. The service will refer people to this organisation if they need help to put their concerns into a formal complaint, or if they prefer independent advice, but there are still a number of people who will use the PALS service to lodge a formal complaint. The Datix module for PALS needs a similar upgrade to the one in progress with the complaints module. This is planned for 2014/2015 and will provide better intelligence on the complexities of PALS contacts.

The new team structure means that the Patient Experience Officers are expected to manage a small caseload of PALS contacts and offer some cover in the PALS office taking office drop -in and attending PALS meetings. We are also developing a small group of volunteers to support this extremely service. There are longer term plans to move the PALS office into the current membership office, utilising the front, more public part of the office as an information centre manned by volunteers.

2.4 *NHS Choices*

Patients and visitors can post comments about their experience in our hospitals on the *NHS Choices* website. They can also rate the service in terms of whether they would recommend the hospital to friends and family if they needed similar care and treatment; cleanliness; staff co-operation; dignity and respect; involvement in decisions; and same sex accommodation. *NHS Choices* calculate a star rating for each site, based on the feedback, with 5 stars being the highest.

Table 4 –Total star rating by site

Warrington Hospital	Halton Hospital	CMTC
★★★★☆	★★★★★	★★★★★

Table 5 – Number of comments posted on NHS Choices for 2013/14 by star rating

Star rating	Warrington	Halton	CMTC
★★★★★	26	33	14
★★★★	5	2	0
★★★	5	1	0
★★	7	1	0
★	12	0	1
No star rating given	0	3	2
Total for 2013/14 = **112**	**55**	**40**	**17**

Reviewers are encouraged to leave comments that are acknowledged by the communications team. If the service user expresses concerns we endeavour to address them in our response or encourage the reviewer to contact PALS for further discussions.

Comments received to the *NHS Choices* website:

Pain Clinic
After several appointments and chronic pain injections, the ward staff, theatre staff and doctors, take so much time to assure you, care for you, and ensure you're comfortable. From someone who hated hospitals, the staff at Halton are excellent, along with a brilliant pain management doctor, real gent, and professional doctor, every time.
Visited in January 2013. Posted on 11 July 2013

Halton General Hospital replied on 23 July 2013
Thanks for taking the time to leave your feedback with us - we'll make sure it is passed on to the pain management team.

Failings
I had an inpatient appointment, there was no bed, put off for hours whilst staff made excuse after another, in the end I had to come home, no phone call to apologise just left in a state of shock, the government said that staff should be truthful instead of being invisible even down to when I wheeled myself towards the nurses point they just scattered and one picked up a phone as if she was calling the bed manager, does this give confidence to a sick person?
Visited in January 2014. Posted on 19 January 2014
Warrington Hospital replied on 29 January 2014
We're sorry your inpatient appointment was cancelled at what seems like short notice from your message. When there is great demand on beds (which is usually due to a surge in emergency admissions) the staff work incredibly hard to try not to cancel patients and to make arrangements to try and avoid that happening. We would like to hear more about your experience if you are happy to discuss it so we can learn from it, please contact our patient advice and liaison service via pals@whh.nhs.uk

Was really afraid
I was really upset and nervous about my operation but all the staff were so caring and looked after me so well, all through my operation from going to sleep to being gentle woken up best treatment ever when I was back on the day ward the staff were all fantastic and I could have as many piping hot cups of tea as I wanted and the toast was hot as well
THANK YOU TO ALL THE STAFF
Visited in May 2013. Posted on 23 May 2013

Halton General Hospital replied on 27 June 2013
Thank you for your comments on the service at the hospital - we've passed them on to the team for you and are really grateful for you taking the time to contact us.

Disgraceful
An absolute disgrace to the NHS. I was ignored, verbally abused and left in excruciating pain for hours due to incompetence of staff. They need to change their attitude to patients it's appalling that the doctors seem to adopting the same attitudes too.
The care assistants think they run the show on one particular ward.
Visited in March 2013. Posted on 15 June 2013

Warrington Hospital replied on 27 June 2013
We're sorry to hear you weren't happy with the treatment you received and would like to find out more information on your experience so that we can look into it for you. Please contact our PALS officer who can take this up on your behalf. PALS can be contacted via pals@whh.nhs.uk

Staff on C20 Excellent Care
I was granted a bed on C20 (day ward) as the hospital was quite full my problem was actually surgical. The care I received was excellent praiseworthy in fact. I was treated with dignity and respect at all times by the staff nurses and auxiliaries. Particular mention to the Ward Manager and Senior Nursing staff. I am on a special diet and the staff ensured my needs were communicated to the kitchen's. There was no point at which I felt neglected in fact I felt completely safe in their care. When I requested pain relief (controlled drugs) it came quickly even though 2 staff were needed to meet my needs.

The doctor's team were amazing taking time to explain why certain decisions were made sitting by my bedside ensuring I understood what was happening with my care and listening to my concerns. Another doctor was particularly helpful and compassionate. I felt I was treated as an individual with my health and social and emotional needs taken into consideration. The auxiliary's expressed concern about my diet and endeavoured to find me something I could eat. The ward was spotlessly clean and when people had to come in to clean my room my privacy was always respected. Thank You to everyone
Visited in January 2014. Posted on 07 February 2014

Warrington Hospital replied on 10 March 2014
Thanks for taking the time to leave your feedback on C20 and we're delighted to hear your praise for the care you received. Feeling completely safe in our care is exactly what we want you feel. We'll pass on your kind message to the staff on the ward.

2.5 *Compliments*

The Trust received 43 formal compliments through letters sent directly to the Chief Executive. In the 422 formal complaints there were many occasions where even though they were raising a concern about care and treatment a compliment was made of a service or individual. In improving the Datix system, we are adding positive outcomes so that positive aspects of complaint letters can be acknowledged within subject categories.

The new Trust website will provide a new email address, Patient.ExperienceTeam@whh.nhs.uk for people wishing to make a complaint, comment or compliment. This has a less negative impression than the current "complaints" inbox. This will also assist in capturing positive feedback. As a matter of course, all compliments are forwarded to those concerned as an opportunity to celebrate positive feedback with those providing good care.

Table 6 – Compliments by division, 2013/2014

Division	Letters
Scheduled	17
Unscheduled	22
WCSS	3
Unknown	1
Total	43

3. Formal Complaints

3.1 *Data collection and analysis*

Complaints data are entered into the electronic database, Datix. Whilst Datix captures the main complaint issue it requires further work to facilitate sub-themes and, in the past, analysis may not always have captured all aspects of the complaint. An example would be if a complaint issue was about medications being administered late, or not at all. With the original Datix subjects, this type of complaint would have been categorised under "care". During 2013/14 we started work in this area and can report that, with the new subjects/sub-subjects, the issue can be categorised under "medications" with a sub-subject of administration problem or omission of medication. As well as adding new subjects including "referral" "nutrition" and "records", the existing subjects have been expanded to facilitate better reporting of themes, for example "privacy and dignity" now includes "breach of confidentiality" "no reasonable adjustments" and "lack of compassion". These, and other themes, reflect observational intelligence from the previous year's complaints and recognition of themes that dovetail with other forms of feedback and headlines from national inquiries.

Some anomalies in reporting of figures have been discovered. Remedial actions to ensure that all figures are consistent are to be put in place, including a standard operating procedure to ensure mapping across all reports to ensure consistency. This will be more fully explained in the Quality Dashboard to Board in May 2014.

3.2 *Formal complaints received in 2013/2014*

In line with Trust policy, a complaint becomes formal in accordance with patients' wishes. This may originate from a concern (written or verbal) that has not been possible to resolve in the clinical environment, through PALS, or directed to the service for formal investigation. A total of 422 formal complaints were received and investigated by the Trust during 2013/2014 compared to 571 received during 2012/2013. In the last year, the service has begun to process some patient enquiries as concerns, where in the past they would have been recorded as formal complaints. For the financial year 2013/2014 there were 92 concerns closed by the service.

The following graphs provide a quarterly and monthly analysis of complaints for 2013/2014:

Figure 2 - Complaints received 2010/11 – 2013/14

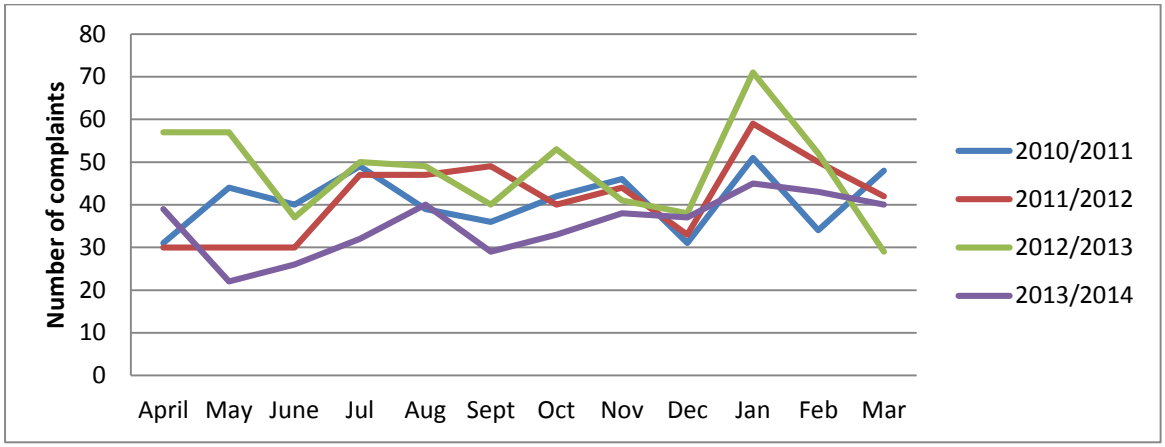


Figure 3 – Concerns by division 2013/2014

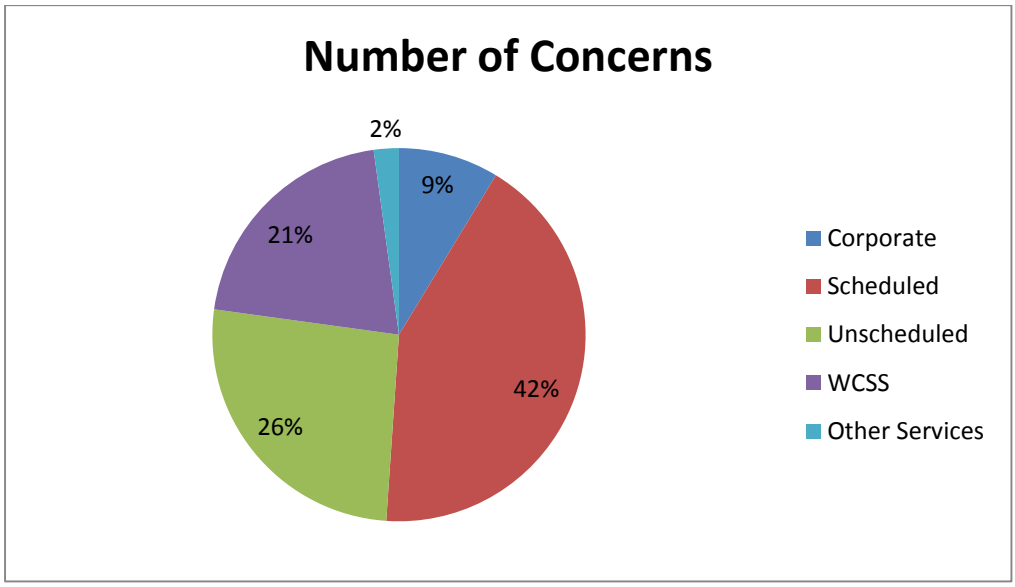


Figure 4 – Number of complaints received, by quarter 2013/2014

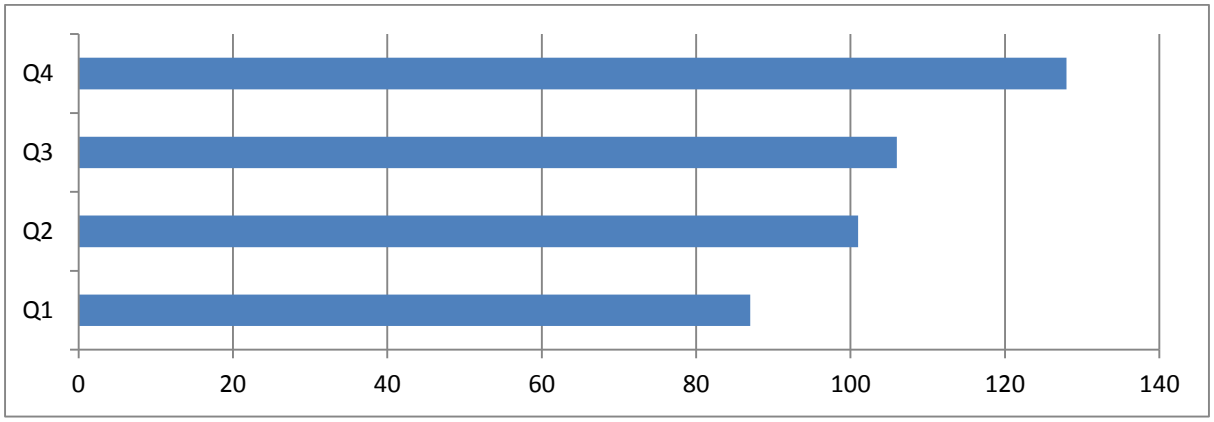
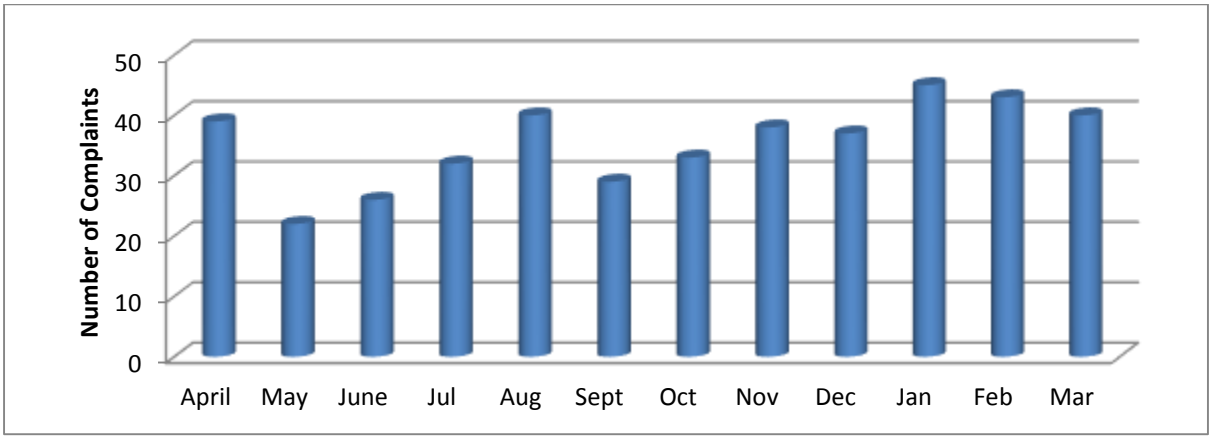


Figure 5 – Complaints, total by month 2013/2014



In 2013 /14 the top 5 reasons for complaints were as follows:-

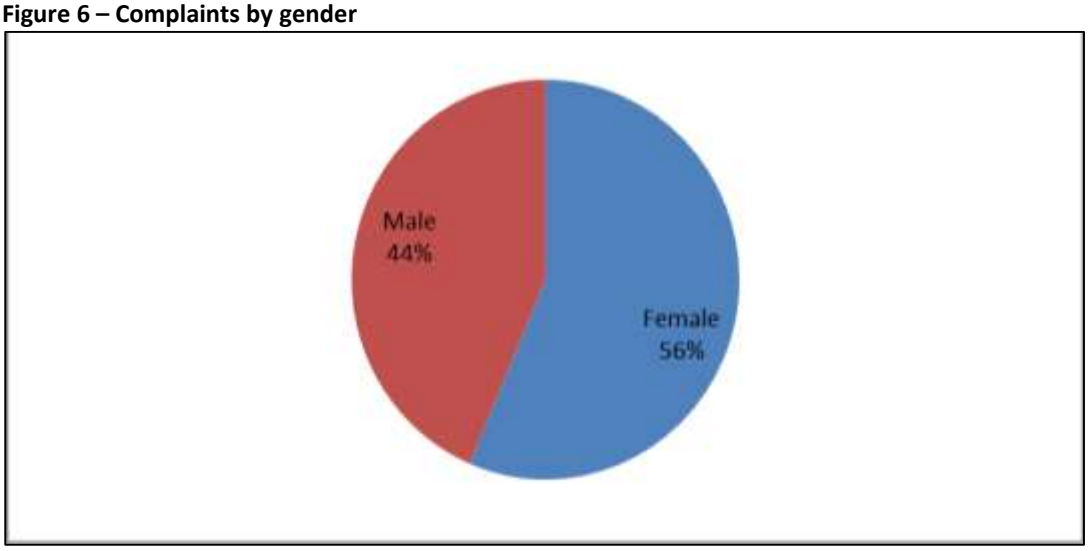
Table 7 - Complaints Categories 2013/2014 – top five, by division

Unscheduled Care	Scheduled Care	WCSS	Corporate
Attitude	Communication problems	Treatment	Attitude
Care	Waiting times	Communications problems	Communication problems
Treatment	Treatment	Attitude	Environment problems
Diagnosis	Care	Waiting times	Information
Communication problems	Diagnosis	Care	

3.3 Demographic analysis of complaints

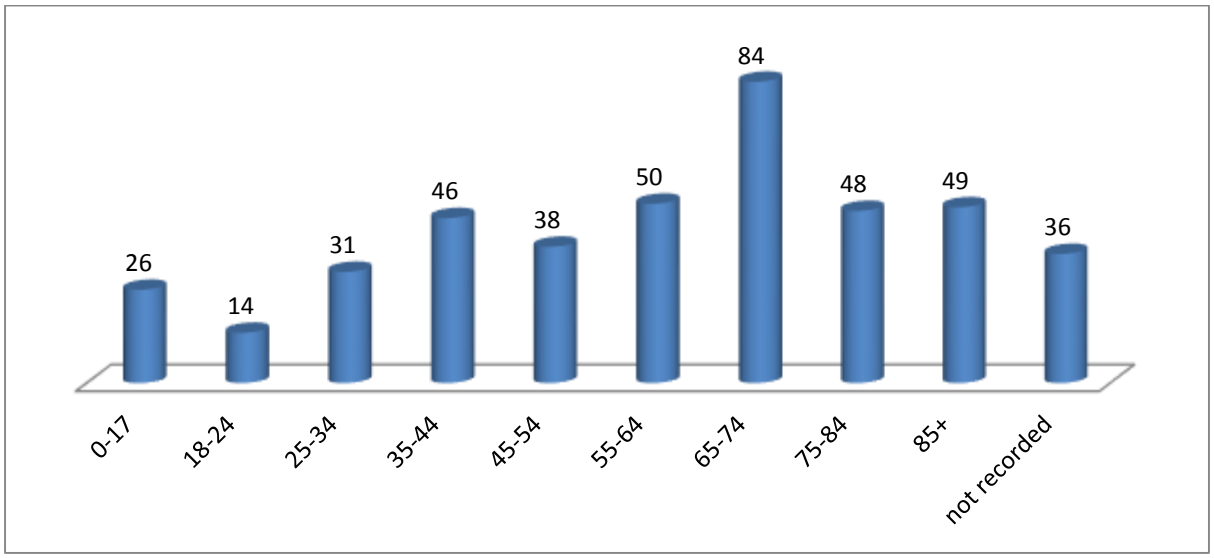
In accordance with KO41, the NHS Information Centre for Health and Social Care Survey, the Trust is also required to undertake a demographic analysis of complaints, which includes analysis by the age and gender of the person referred to in the complaint. In 2013/14 complaints made about the service related to 184 males and 238 females.

Figure 6 – Complaints by gender



If the complaint is about an individual patient, the Trust records the age of the patient however if the complaint is about a service we cannot record this information.

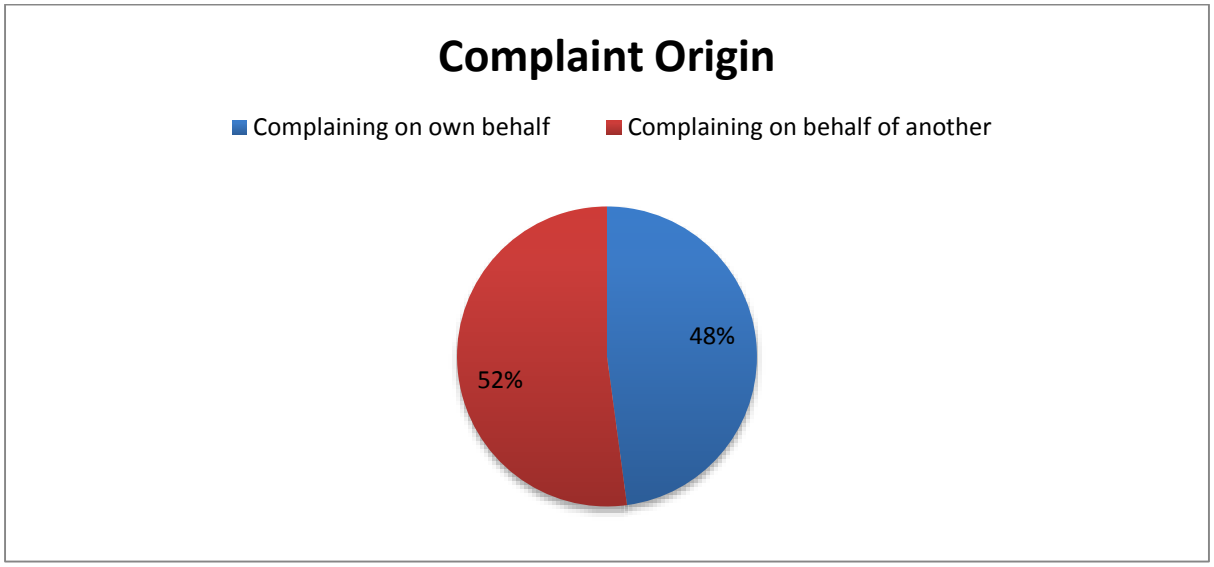
Figure 7 - Complaints by age range, 2013/2014



The highest number of complaints are within the 65 – 74 age range.

Of the 422 complaints, 48% people complained about their own care or treatment, with the remaining 52% complaints being made by someone other than the patient or service user.

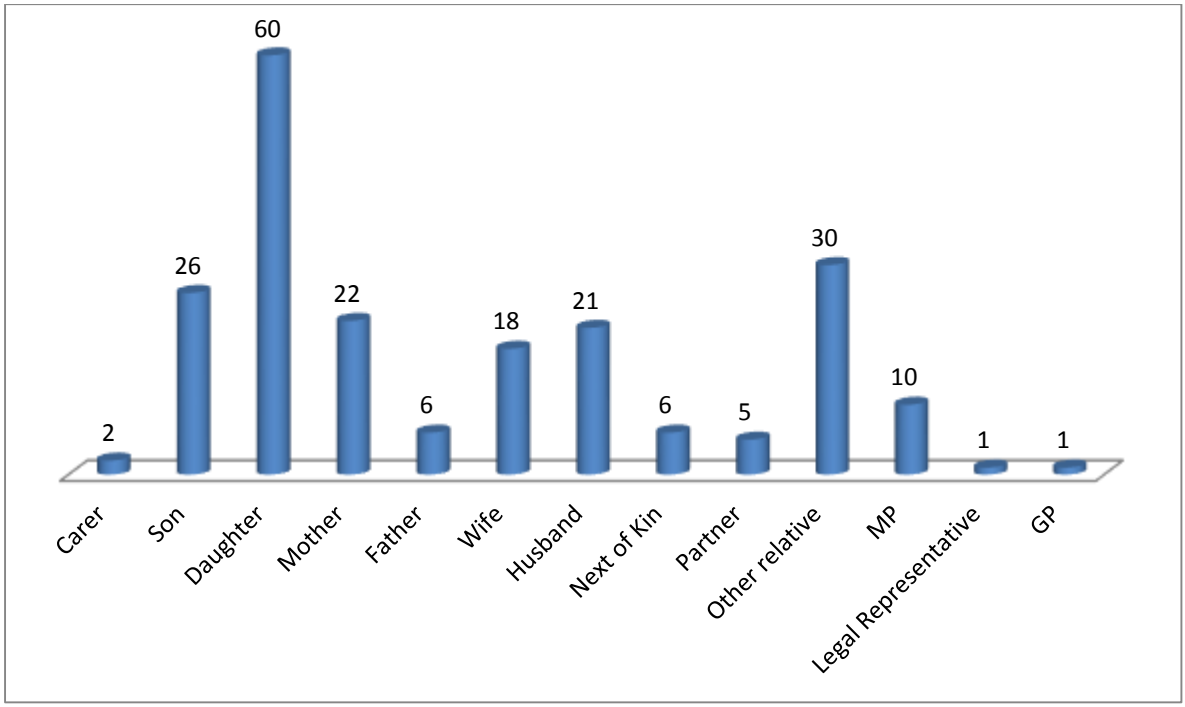
Figure 8 – Complaint origin split



For 207 of the 422 complaints, consent was required. This number does not include where a parent raises a complaint on behalf of a child. Two complaints were raised by a solicitor on behalf of a patient and the relevant consent was obtained. Three complaints were received from the constituency office of a Member of Parliament.

An emerging theme has been noted relating to increasing complexity around the question of next of kin and on several occasions the service has sought advice from the Trust Information Governance Manager to ensure that appropriate decisions are made in regard to seeking consent.

Figure 9 - Breakdown of those who complained on behalf of another person



3.4 ***Responding to people who want to tell us about their experience in a timely manner***

In 2012/2013 we responded to 75% of our complaints within agreed timescales. Provision of high quality, well investigated and thorough responses is equally important to both patients and the Trust. In 2013/2014, 68% of complaints were responded to in the agreed timescales. This is largely because of the number of late complaints that had accrued due to a combination of staff attrition and system problems in the central complaints handling team and capacity and workload pressures in the Unscheduled and Scheduled Care Divisions that left the Trust with a considerable backlog of complaints and increasingly poor relationships with complainants. A concerted effort to improve systems, to catch up with late complaints and restructuring of the team has put the system on a more even keel, though there is still room for improvement. People across all the divisions, the PET/corporate nursing team and at executive level are working very hard to improve the handling of complaints and to meet agreed timescales. In March 2014 the Trust met its key performance indicator of 94% of complaints closed within agreed timescales for the first time, an indicator that the systems have improved.

Increasingly, complaints investigations require more time to reach completion when the concerns raised are significantly more complex, and often cross-divisional. For example a patient's journey may cross diagnostic services, support services, theatres and pharmacy. The impact of investigation concerns across services and departments can build delays in completing the investigation. A major factor in this is availability of medical records.

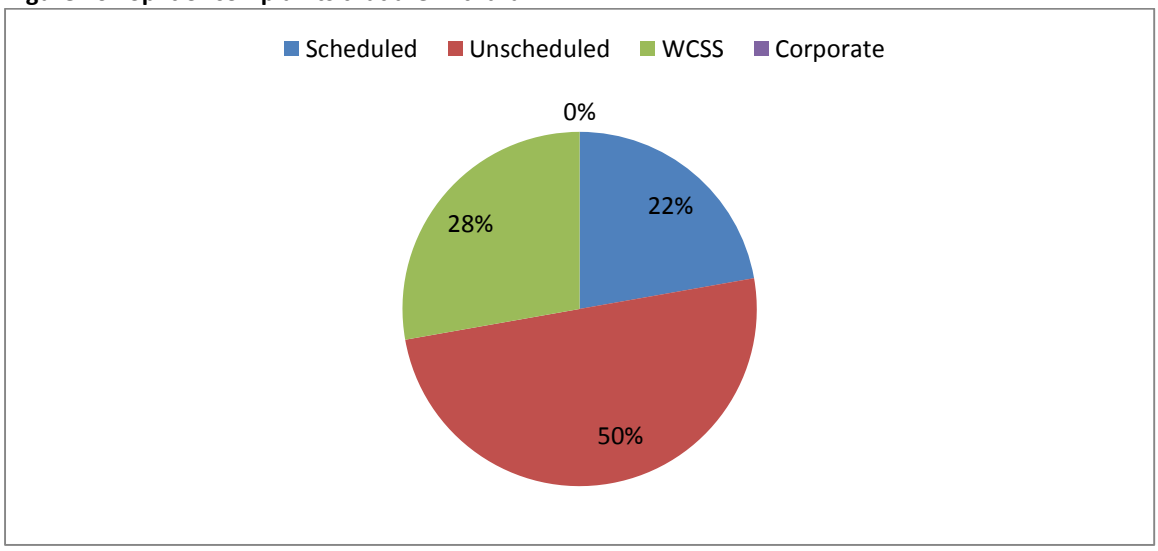
Therefore agreement for an extension for the response date needed to be negotiated with the complainant.

3.5 Complaints withdrawn

During 2013/2014 a total of 36 complaints were withdrawn. Complaints can be withdrawn for a variety of reasons, generally it is because the service user had the opportunity to discuss their issues with a member of the service or a member of staff from the divisional team had contacted them to discuss their concerns and they had been resolved, for example this could be an appointment confirmed, or clarity of information provided satisfactorily. Sometimes complainants do not return completed consent forms and the complaint may be withdrawn, after providing the complainant with a final date for sending the consent.

In past years the Trust has included withdrawn complaints in the total numbers of complaints reported. From 2014/2015, withdrawn complaints will be reassigned as concerns. In this way, we can reflect the work involved in processing and handling these up until the point they are withdrawn, whilst not inappropriately inflating the total numbers of formal complaints.

Figure 10 - Split of complaints that are withdrawn



During 2012/2013 the Patient Relations Manager assessed each complaint after its investigation, to ascertain whether or not it was upheld, not upheld or partly upheld in accordance with NHS Complaints Regulations (2009). This can be somewhat subjective and can be complex as often there are a multiplicity of concerns/allegations within an individual complaint, some of which may prove to be unfounded and not upheld and some elements which are upheld. The new Complaints and Concerns Policy (January 2014) asks that the division takes responsibility for assigning outcome to the complaint issues. These are entered on the system at the time that the response is quality checked by the Patient Experience Matron. As this is a fairly new practice the divisions are adjusting to this responsibility and the service is monitoring and offering support where required.

It is important to note that within most of the complaints, there may be several issues, some of which were/were not upheld. Any complaint involving both outcomes have been classed as partially upheld.

3.6 Returned complaints

Of those who complained, 77 people felt they were unhappy with their initial responses and they wrote to us asking for further information, to meet with us, or to provide clarification. These previously closed complaints, where the complainant has raised further questions with us we refer to as a 'return complaint'. We are going to focus on the root cause of people's reasons for dissatisfaction to try to reduce this number in 2014/2015. However, it is important to note that only 4 of the returned complaints were upheld, with 34 not upheld and the remainder partially upheld.

At the time of reporting, there are 23 outstanding return complaints from 2013/2014 and meetings are being held and further responses prepared. Table 8 provides numbers of those return complaints, by division and whether we had previously upheld their complaint. Unfortunately the system is not able to retain a record of the initial outcome without a manual trawl; something we will address during 2014/15.

Table 8 - Returned Complaints

Division	Not upheld	Partially upheld	Upheld
Unscheduled Care	13	19	2
Scheduled Care	16	14	2
WCSS	4	7	0
Corporate	0	0	0

3.7 Complaints linked to serious untoward incidents

During 2013/2014, 5 complaints had been the subject of a serious untoward incident investigation. A total of 16 complaints were linked to reported incidents that included falls, and other patient safety incidents already reported and acted upon.

3.8 Formal meetings organised

Meetings between patients and/or their families and staff in response to their complaints provide a beneficial method of sensitively addressing their concerns. The new referral form for complaints to the divisions includes a question to the division about holding an early meeting with the complainant. It has been observed that often the complainants gain a degree of satisfaction in feeling their concerns are being heard and being able to discuss what actions are to be taken.

The biggest challenge in setting up meetings is in coordinating the diaries of busy clinical and managerial staff, sometime two or three members of staff may be needed to attend the more complex complaints meetings, with additional staff from the service to support staff and complainants. Meetings are usually recorded onto CD and a copy provided to the complainant which has been very well received. An area of focus for 2013/14 is to increase the number of meetings held, and to monitor their effectiveness.

4. Lessons learned

It is essential that the Trust continues to learn from complaints, and ensures that what is learnt results in service improvements which are embedded in everyday practice. The following table provides examples of service improvements implemented in 2013/14 by the Divisions who are responsible for implementing and monitoring lessons learned through

Divisional Integrated Governance Groups. Table 6 provides a flavour of actions taken as a result of listening to our patients concerns.

Table 9 - Actions taken as a result of complaints, 2013/2014

Description of Complaint	Actions	Learning
WCSS: Complaint about father's discharge, in particular about the physiotherapy input that left father without *Zimmer* frame identified as needed. This was acknowledged as an oversight.	Alert was issued to remind all staff that patients must be discharged with appropriate aids. Also, if aids cannot be taken in homeward bound transport, therapy staff must be informed.	Improved discharge planning and update for ward staff regarding the importance of ensuring MDT input is properly noted and actioned.
WCSS: Patient complained about staff attitude in radiology reception stating that they were rude to her and her granddaughter.	Trust disciplinary process initiated for the member of staff involved, action plan monitored closely. Complaint shared with whole department as learning tool	Individual learning for member of staff named in complaint. Staff reminded they must ensure they are mindful of professional conduct when in public areas of the hospital. Asked to reflect on own performance.
Scheduled Care: Family raised their concerns around the manner and attitude of a member of nursing staff	Full investigation by Matron. Staff member dealt with through Trust disciplinary procedure. Letter of apology sent to family. Monitoring and performance management in place.	Individual learning for nurse named in complaint.
Scheduled Care: Patient was unhappy that her surgery did not take place for 6 days and that she had attended 3 times for surgery. She was also concerned that during this period she had not had her Warfarin for 6 days	Changed systems: Ward team reporting to Trauma Nurse if theatre session cancelled and patient discharged to wait at home. Trauma Nurse to be responsible for contacting patient with next available admission date and keep records of all Trauma patient management plans and calls made to patients. Audit trail in place. Review of process for Ambulatory Trauma patients being transferred for care at CMTC. New practice to discuss with Anticoagulant team if inpatients on discharge can	The need to review current systems to improve the patient experience and communication with those patients whose operations are cancelled. Opportunity to attach clear audit trail for future monitoring and improvement Review better utilisation of elective site. Improve link with anticoagulant service to safeguard patients

Description of Complaint	Actions	Learning
	receive the same service as outpatient clinic attendees (use of finger prick samples)	
Unscheduled Care: Complaint about personal care provided to late mother on Assessment Ward. Complainant waited unacceptably long time after pulling nurse call to attend to mother's soiled bed linen. Was also unhappy with attitudes of nursing staff (Agency nurse and carer) regarding the incident.	Assistant Matron had early meeting with complainant. She was able to reassure complainant of her intentions to address the care and attitude concerns raised with the ward and identified planned support by education department for carers on the ward. Meeting with ward team to highlight issues and discuss improving practice and communication. Ward manager addressed issues raised with Carer and Matron referred to NHSP to be addressed with agency nurse.	Reflection for ward nursing team on respectful and personal care. Improved communication with relatives. Improved support for carers and flagging of any individual and team issues.
Unscheduled Care: Complainant concerned that her father's Parkinson's medication had been lost twice and brother had to bring in from home. Medication not administered in a timely manner. Personal care issues, concerns re catheterisation and food. Problems with medicines pump. Concerns that staff not aware of right care for person with Parkinson's disease.	Critical Care Indicator put onto *Meditech* and development of health passport to ensure staff able to anticipate patient's needs and plan appropriate care Ward managers received training and ward resource pack regarding Parkinson's disease at Ward Managers' Day. Training for the Apo-Go Pump now part of the nurse competencies for medical devices. Feedback to ward staff regarding personal care issues and monitoring by ward manager.	Better readiness of teams for patients with Parkinson's disease. Reasonable adjustments identified and needs met. Identified learning deficits re. Parkinson's disease.

Patient stories are heard at Board, where they are welcomed by the Executive team as an opportunity step into the patient's world and to receive assurance that patient's concerns are being heard and lessons learned. On occasion a patient or family member who has made a complaint has been asked if they would like to record a patient story as part of the learning from their complaint.

5. Demonstrating compliance with legislative requirements

Complaints about the NHS, and the handling of those complaints, were described by the PHSO as a "toxic cocktail". *More Complaints Please* (2014) was prompted by failings in NHS complaints systems and the "combination of a reluctance on the part of citizens to express their concerns or complaints, and a defensiveness on the part of services to hear and address concerns". This report was prompted by the findings of the Francis report and looks at the implications for all public services. The inquiry addresses issues around good practice and concludes that while empathy and understanding are vital, systems and processes must be simple. The main conclusion is that, as with most things, leadership is fundamental to successful complaints handling and a positive attitude at the highest levels will help to instil a culture where complaints are accepted as an opportunity for learning.

6. Actions for 2014/2015

As the best performing organisations welcome complaints as an opportunity to learn and improve the services provided and involve patients, families and the public in shaping those services to be truly patient-centred. Implications of the *More Complaints Please* report and others cited elsewhere will be plotted and appropriate recommendations will be presented in the next months.

In order to meet the expectations of the Board, the commissioners and, most importantly, the public we must continue to improve the systems in place and ensure that the methods we employ to investigate and learn from complaints provide assurance and demonstrate a transparent and committed process and staff who want to acknowledge failures and learn from them.

Following on from the first complaints report (November 2013), improvements planned for 2013/2014 include:

- Developing this skills and knowledge of the new Patient Experience Team
  A competency framework has been developed for the team and first PDR will be done with each new team member in May/June 2014. The team also have regular one to one meetings with the Patient Experience Matron. A series of "Wednesday workshops" have already been presented on coroner's cases, HealthWatch advocacy, communication/building rapport and these will continue.
- Ensuring that lessons are learnt and shared throughout the Trust.
  The divisions have identified a process for ensuring that all action plans developed as a part of the investigation and response to a complaint are recorded on CIRIS and these will be reported locally within divisions, at the appropriate sub-committees and at Board.
- Developing a responsive, combined service – making it easy.
  Work will continue on improving systems. Some of the processes in the new complaints and concerns policy need more "bedding in" and can be reviewed as we progress.
- Monitoring and performance management in place.
  Twice yearly audits of the policy will be conducted to ensure that processes are working and to ensure key deadlines are met and actions are completed. A

complaints questionnaire has been in place for several years, but the information provided by complainants has only been meaningfully captured and analysed since August 2013. This will continue and the information can be shared at the Equality & Diversity Committee.

- Focus on return complaints to understand underlying root causes and better identification of outcome.
- Improved complaints monitoring through updating complaint category information collected – making data meaningful.
  All new categories have been passed to the Datix Administrator for adding to the system. As time goes on there may be more additions. In addition, the PALS module of Datix will be reviewed to provide more information.
- Updating the complaints information for patients and visitors, electronic as well as paper based.
  An audit of posters displayed around the Trust has been carried out and any gaps in provision of information will be addressed. The complaints and PALS leaflets are also being updated and will be refreshed. Changes and updates to the website have been completed.
- Develop the format of this report to encompass all aspects of Patient Experience.
  Over the next quarter we hope to coordinate the various types of patient experience feedback to offer a broader view of patient feedback and triangulation of the information provided.
- Completion and assurance for action plans developed as a result of complaints.
  The CIRIS system provides a repository for governance, risk and compliance information and it was agreed that the action plans for complaints would be recorded on the system to facilitate reporting and monitoring of action plans generated by upheld and partially upheld complaints. Divisions are embedding their systems for how this happens, but the service will monitor that this process is happening.

7. Recommendations

The Board is asked to note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented above.

W&HHFT/TB/14/083

BOARD OF DIRECTORS

Paper Title	Health and Safety Annual Report 2013/14
Date of Meeting	
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Helen Wynn, Head of Safety and Risk
Purpose	To advise the Board on the progress made with Health and Safety Management over the past 12 months.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Governance Committee	13.05.2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	RoSPA Award	**Page 2 Section3**
•	Inspections	**Page 4 Section 7**
•	Incident Reporting	**Page 6 Section 13**
•	Manual Handling	**Page 7 Section 14**
•	Needle Stick Group	**Page 9 Section 18**
•	Risk Management Framework Audit Results	**Page 10 Section 19**
•	Future Developments	**Page 13 Section 20**
•	Departmental Compliance with the Risk Management Framework	**Page 15 Appendix 1**

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

1. The Board is asked to approve the Annual Report having previously been reviewed by the Quality Governance Committee and not the progress made.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Date of Board Meeting	May 2014
Report from	Governance Team on behalf of Karen Dawber Director of Nursing and Organisational Development
Prepared by	Helen Wynn
Title	Head of Safety and Risk
Purpose	Annual Health and Safety Report April 2013 – March 2014

This report supports the Trust's Objectives

Please tick relevant box

1	Ensure all our patients are safe in our care	√
2	To be the employer of choice for health care we deliver	√
3	To give our patients the best possible experience	√
4	To provide sustainable local health care services	√

Annual Health & Safety Report
April 2013 to March 2014

Contents Page

1. Introduction

The annual report produced by the Health and Safety (H&S) Team describes Health and Safety activity at Warrington and Halton NHS Foundation Trust from January 2013 to March 2014. The management of H&S is a critical component of the overall Governance agenda, with the safety of patients and staff being a core value.

This year has seen some considerable improvements in the systems and processes for H&S, which have included a comprehensive manual handling plan to ensure risk assessments are appropriate to the needs of the organisation, implementation of audits to ensure Trust compliance with current H&S legislation, review of Stress Risk Assessments and analysis of non-clinical claims.

2013 also saw a number of Wards/Departments achieving 100% compliance with the Risk Management Framework.

The overall Trust compliance with the Risk Management Framework is 92%.

Broken down into the four categories the Trust overall compliance is:

- Health and Safety Management – 93%
- Premises Management – 92%
- People in the Workplace – 90%
- Activity in the Workplace – 93%

2. Background

There has been a significant change in H&S Management within the Trust since 2010. At this time the Trust had been issued with a number of improvement notices and there were very few processes in place for managing H&S effectively.
The Risk Management Framework was developed to provide a structured approach to the management of H&S and to ensure the standard was consistent throughout each Ward/Department. To support this process a number of policies and guidance documents were developed and placed centrally on the HUB.

3. Royal Society of the Prevention of Accidents (RoSPA) Award

RoSPA awards recognise commitment to continuous improvement in accident and ill health prevention at work.
Through the award scheme, which is open to businesses and organisations of all types and sizes from the UK and overseas, judges consider entrants' overarching occupational health and safety management systems, including practices such as leadership and workforce involvement.
Awards are judged by a number of agencies including the HSE and IOSH. Awards are Merit, Bronze, Silver and Gold.

The Trust achieved a silver award in March 2014.

4. Policies and Guidance Documents

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

- Smoking Policy
- First Aid Policy
- Inspection Guidance

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

5. Training Review

The existing mandatory Training Programme has been comprehensively assessed to ensure all staff are gaining the knowledge and skills required.

Level 2 training is now being regularly delivered to all Managers requiring risk assessment training across the Trust.

Level 3 training is currently under review to ensure it provides clear and up to date information on current legislation

A full 12 month training programme was produced for both Health and Safety and Manual Handling. However, it has proven problematic at times releasing staff from their areas of work in particularly with Clinical Manual Handling Training.

Trust compliance with Health and Safety Training –

Level 1	87.90%
Level 3	53.57%
Patient Manual Handling	66.64%
Non Patient Manual Handling	86.72%

The figures are taken as a percentage of all Trust staff, however, for Level 2 only certain staff are required to complete so the exact compliance figure is unknown.

Additional Training

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

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

6. Health and Safety Guidance, Information and Advice

The H&S Team have developed a number of pages on the Trust Hub to assist Wards and Departments in the management of H&S within their areas of work.
Information includes:

- A Health and Safety Library Page - which provides an A-Z list of all H&S guidance documents and blank templates/checklists
- Example risk assessments – this provides an example risk assessment for each standard within the Risk Management Framework
- Advice pages on specific topics which include Slips, Trips and Falls, Stress, COSHH, DSE, Housekeeping, Good Practice, Working at Height

A programme of H&S drop in sessions also took place on both sites throughout the year.

7. Inspections

A review of the Inspection Guidance and Trust Inspection template was undertaken in January 2014. The template was simplified and reduced from 26 pages to 6.
Every Department is required to have a H&S inspection each quarter. The H&S Team will complete 2 of these inspections.
Between January 2014 to March 2014 a total of 87 inspections were carried out by the H&S Team. On a whole the departments were well maintained and housekeeping of a good standard.

The common theme throughout the inspections carried out were found to be-

- Is equipment PAT tested - No
- Are any bulbs missing - Yes
- Are chairs in good repair - No
- Is equipment clean, - No
- Are heaviest items stored between knee and chest height – No

A Safety Alert has now been disseminated regarding broken chairs.

A full report of Inspections will be reviewed at the Safety Risk Leads Group.

8. SYPOL Control of Substances Hazardous to Health (COSHH)

All Departments now have a nominated person(s) who have been trained in the use of Sypol (COSHH Management System). Currently the Trust is at 60% compliance.

There are three stages to completing an assessment on Sypol which includes:

- Completion of an Assessment
- Completion of a COSHH Control Sheet
- Attachment of the Safety Data Sheet

To date there are 739 assessments completed, 490 assessments incomplete and 3 assessments pending.

Monthly updates are circulated to trained staff to ensure they have the most up to date version available and training is held once a month. There is a web community for COSHH and this is kept regularly updated by the H&S Team. Frequently Asked Questions sheets have also developed and have been well received by staff.

9. Latex Working Group

Through the Latex Working Group it was confirmed that 6 members of staff within the Trust are latex sensitive. It was confirmed that each year screening took place through questionnaires and any new starters were captured at the pre-employment stage. Furthermore over 223 Health Surveillance Questionnaires have been received by the Workplace Health and Wellbeing Department in relation to staff members using latex gloves, in areas identified by Supplies. The questionnaires have been processed, and problems have been highlighted and addressed by the Workplace Health and Wellbeing Department.
This Group last met in July 2013 and has now been incorporated into the Safety Risk Leads Group.

10. Legionella

The Water Safety Group continues to meet quarterly. This is chaired by the Associate Director of Estates and Facilities.
The Group has recently reviewed flushing regimes and will shortly be trialling the use of an electronic monitoring system (Compass).
The Group's minutes are provided to the Safety and Risk Sub Committee to provide further assurance of controls in place.

11. Smoking

The Smoking Policy was reviewed in August 2013 and a short campaign took place. This was to reinforce that the Trust is a non-smoking site and to also carry out some education on the health risks from smoking. The campaign was carried out in partnership with Live Wire and a Stop Smoking Specialist came on site for the day to offer advice and provide leaflets/stop smoking packs to staff, patients and visitors. A number of posters were also put up around the entrances of both Halton and Warrington Hospitals.

Currently the Health and Safety Team are working with Warrington Borough Council to look at smoking on the front of the Hospital. The Enforcement Team have agreed, if required, to spend some time in this area offering packs to prevent littering of cigarette stubs and to advise that littering can lead to fines of up to £70.

12. Workplace Transport

The Workplace Transport Group meets quarterly and the last meeting was held on 15th January 2014. This group is chaired by the Associate Director of Estates and Facilities and the group review issues relating to vehicle and pedestrian safety.
The main issue for discussion at present is car parking. The Local Security Management Specialist is leading on the introduction of automated number plate recognition system.

13. Incident Reporting

All non-clinical incidents are reviewed each morning by the Health and Safety Team and allocated to the appropriate manager.
All incidents reportable under RIDDOR require a level 1 investigation. An incident report is now produced every two months and reviewed at the Safety Risk Leads Group. The report shows incident data and highlights any trends or themes.
Overviews of level 1 investigations are also included in the report highlighting any learning and improvement.

Overview of all RIDDOR Incidents between the 1st April 2013 – 31st March 2014

Incident Category	Injuries Reported As a Result of the Incident(s)	No. of Incidents	Total Days Lost	Additional Information
Patient Hepatitis C Positive	Needlestick Injury	3	7	
Manual Handling of a Patient	Back Injury	4	154	Training out of date
Manual Handling with Equipment	Back Injury	2	21	
Physical Assault to Staff	Back Injury Injured Rib	3	140	
Slip on Wet Floor	Knee Injury	1	7	Successful Claim
Slip on Uneven Floor / Paving	Injury to Hip Knee Injury Fractured Cheek	3	65	2 Successful Claims
Slip on Ice	Fractured Wrist	1	42	
Visitor fell from Broken Chair	Injury to Head Stiches to Head	2	N/A	
Visitor tripped on Matting	Bruising and Fainted	1	N/A	
Visitor fell on Wet Floor	Injury to Head	1	N/A	
Visitor fell on Cracked Pavement	Injury to Head	1	N/A	Claim Received

13.1 RIDDOR Regulations

Changes to the RIDDOR Regulations were introduced in 2013. The aim was to simplify reporting arrangements, whilst ensuring that the data collected by the HSE gives an accurate picture of workplace incidents.

The main changes were in the following areas:-

- The existing schedule detailing 47 types of industrial disease has been replaced with eight categories of reportable work-related illness.
- There are fewer types of “dangerous occurrence”
- The classification of “major injuries” to workers has been replaced with a shorter list of specified injuries

14. Manual Handling

The policy was reviewed in 2013 and this can be located centrally on the CIRIS.
A full training programme was set up throughout 2013/14 and 22 Key Trainers were identified and trained to deliver Corporate Clinical Manual Handling throughout the Trust. The training presentation was reviewed and a standard presentation is used throughout the Trust.
It has been identified that there is very limited equipment to train staff with and a Business Case has been developed to secure funding for this equipment.

14.1 Manual Handling Audits

Throughout the past 12 months 75 Departments have been audited against compliance with the management of manual handling. This included:-

Compliance with the Manual Handling Policy
Risk Assessments (did not include Patient Manual Handling Risk Assessments)
Equipment
Training Records
Manual Handling Incidents

Overview of compliance within each Division/Corporate Services

Corporate Services

Areas Audited	100% Compliance	Above 90%	Below 90%
18	13	4	1

Scheduled Care

Areas Audited	100% Compliance	Above 90%	Below 90%
17	5	6	6

Unscheduled Care

Areas Audited	100% Compliance	Above 90%	Below 90%
19	7	4	8

Women, Children and Support Services

Areas Audited	100% Compliance	Above 90%	Below 90%
21	8	9	4

14.2 Findings and Learning -

There is a lack of understanding of how to complete the Manual Handling Risk Assessment Form. (Not the patient form). This has now been incorporated into Manual Handling Training with a practical exercise.
Many clinical areas found it difficult to release staff to attend the training due to staff levels and work demands.
At the end of 2013 the Manual Handling Advisor focussed on providing specific training to certain staff groups and this will continue throughout 2014/15.

15. Plus Sized Patients

Extremely heavy patients can present a number of manual handling challenges concerning their treatment and management. Failure to address these situations may lead to patients requiring increased medical or healthcare interventions.

The amount of plus sized patients treated within the Trust is increasing and it is essential that the right equipment and training is in place to support this problem. This is not currently the case and it has been identified over the past year that there is limited equipment throughout the Trust. There have been a number of incidents whereby, the admission of a plus sized patient has proved very problematic causing unnecessary stress to both staff and patients. There is also an on-going cost of hiring in equipment to treat such patients.

A Business Case has been completed and the issue is on the Part 1 Risk Register.

Currently the Plus Sized Patients Pathway and staff training needs are being reviewed.

16. External Agency Visits

An incident occurred in July on Ward A3 when the waste from a patient who had been treated with Radioactive Iodene I-131 was transferred to our waste contractor. The auditing of the waste identified levels of radioactive waste above our agreed limit.

The Environment Agency visited the site on the 10th September to review the Level 1 investigation and action plan.

A concern raised was the delay in reporting the incident to the Environment Agency which should have been immediately after being made aware the incident. The procedure for most incidents would be to gather facts before reporting.

The Environment Agency was satisfied with the action plan and requested a Safe Operating Procedure to be developed. The SOP was approved by the Safety and Risk Sub Committee in December 2013 and the incident is now closed.

17. Health and Safety Executive (HSE)

The HSE contacted Health and Safety in January 2014 regarding a defect in a passenger lift which had been reported to them by Allianz. The Estates Department confirmed the correct action had been taken and the lift was now fully repaired. The HSE were satisfied by this response.

The HSE are currently revising all Approved Code of Practice and Guidance documents. This includes COSHH, Legionella and Asbestos.

The research topics for the HSE throughout 2014 will include:

- Sharps Incidents
- Birthing Pools
- Occupational Asthma in Cleaners
- Window Restrictors
- Bed Rails

18. Needle Stick Group

The Needle stick working group established to oversee the implementation of the EU Directive 2010/32/EU "Prevention of Sharps Injuries in the Hospital and Healthcare Sector" which came into force on the 11th May 2013. This directive aims to protect healthcare workers at risk of injury from all medical sharps including needle sticks and to prevent the risk of injuries and infections caused by medical sharps.
The group established a work plan which included training, the provision of information on risk, implementation of safer procedures and the use of safety devices. The Group was active from February 2012 to August 2013.

An audit untaken between January 2013 and October 2013 found 83 needle stick injuries reported. This is a significant amount of incidents and therefore the Needle Stick Working Group was re-established in January 2014.

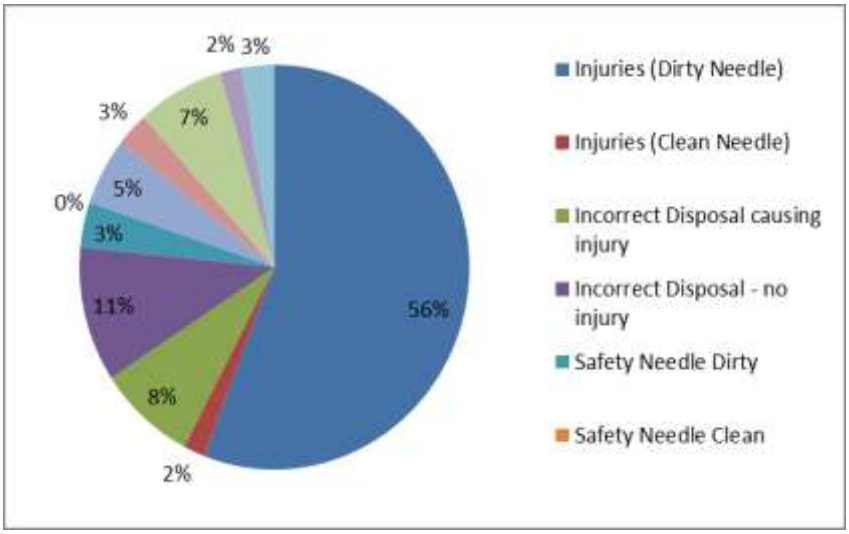
A further audit took place in February 2014 to ensure compliance with the EU Directive. All Wards/Departments were asked if they use safety needles and if not did they have a suitable risk assessment in place.
Every Ward/Department responded to the audit and the Trust is compliant with the EU Directive and therefore it was decided the Working Group no longer needed to meet.

It was found one staff group were using safety needles but breaking off the safety device before use as they were struggling to use the needle properly. This issue has now been addressed and appropriate training given.

However, there is still a concern over the amount of injuries and this will be reviewed and monitored at the Safety Risk Leads Group.

An overview of incidents reported between 1st April 2013 to 31st March 2014 –

Injuries (Dirty Needle)	62
Injuries (Clean Needle)	2
Incorrect Disposal Causing Injury	9
Incorrect Disposal – No Injury	12
Safety Needle Dirty	4
Safety Needle Clean	0
Over filled Sharps Bin causing Injury	6
Problems with Sharps Bin	3
Blood Splash	8
Near Miss	2
Cut by use Razor	3
Total -	**111**

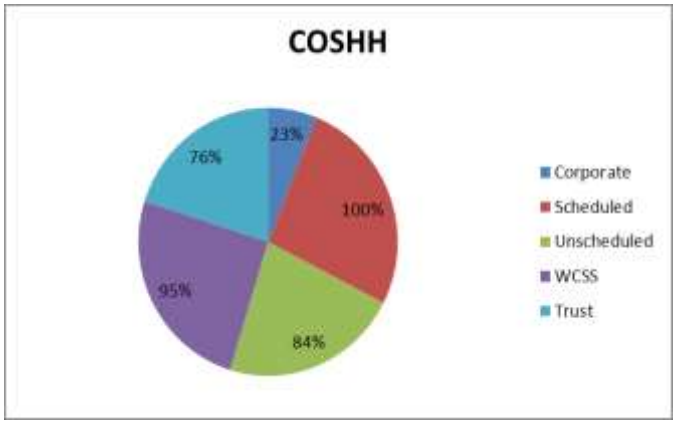


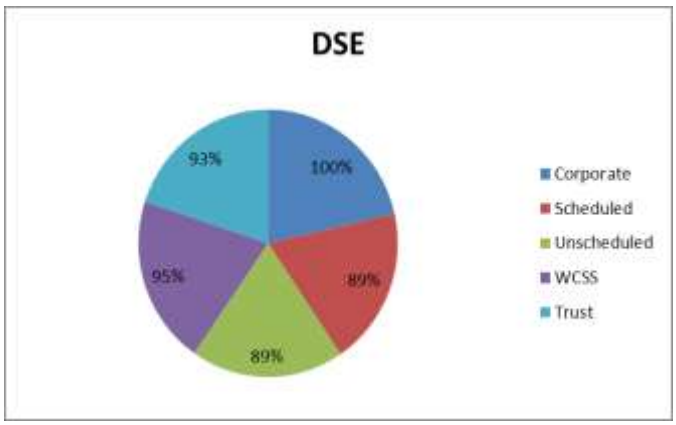
19. Risk Management Framework Audit Results (April 2013 to March 2014)

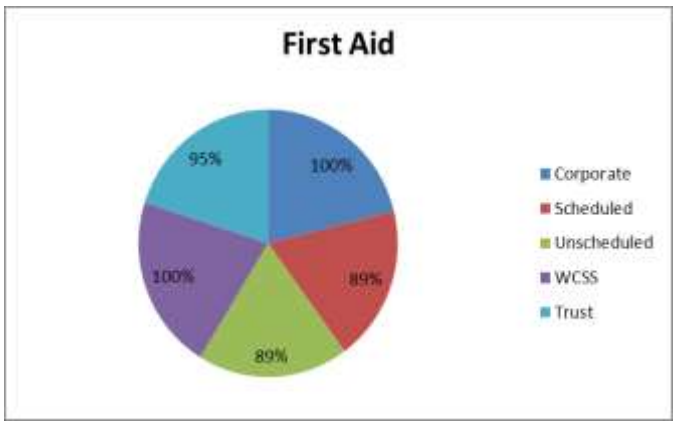
The Risk Management Framework is now fully implemented across the Trust. Over the past 12 months the Health and Safety Team have carried out audits on 76 Departments across all Divisions and Corporate Services.
If the Department did not meet 100% an action plan was developed and the Department visited at a later date.

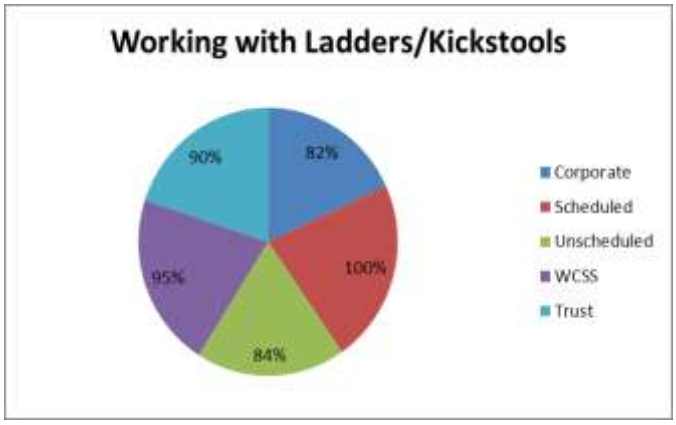
Total number of audits – 166
Total number of Departments meeting 100% compliance – 48
Total number of Departments above 90% compliance – 18

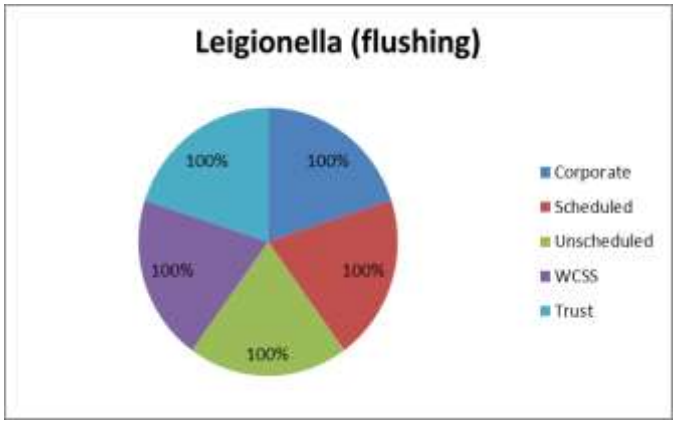
The pie charts below show an overview of compliance ratings
(Please note not all standards within the risk management framework are shown)

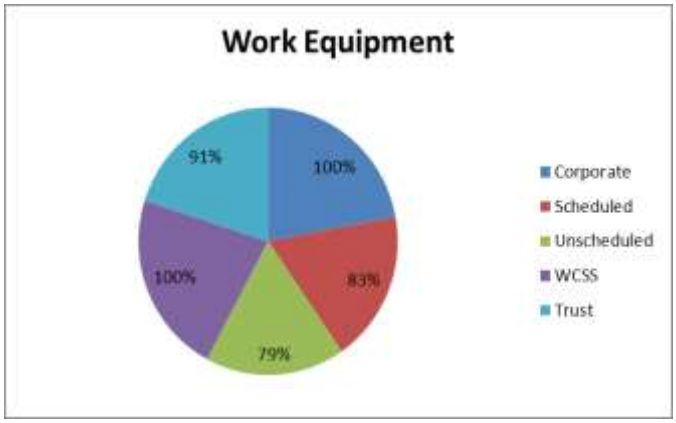


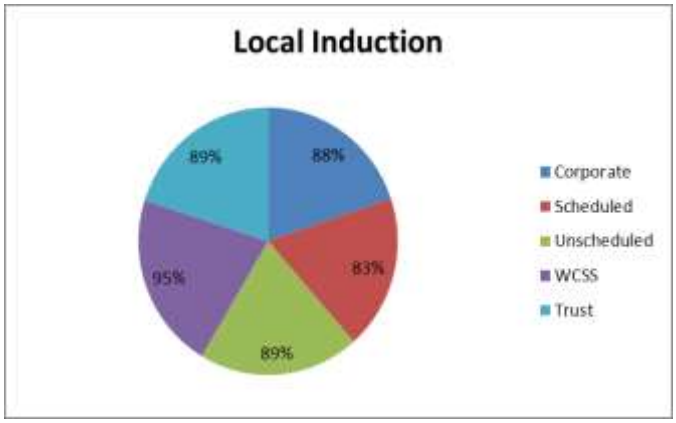


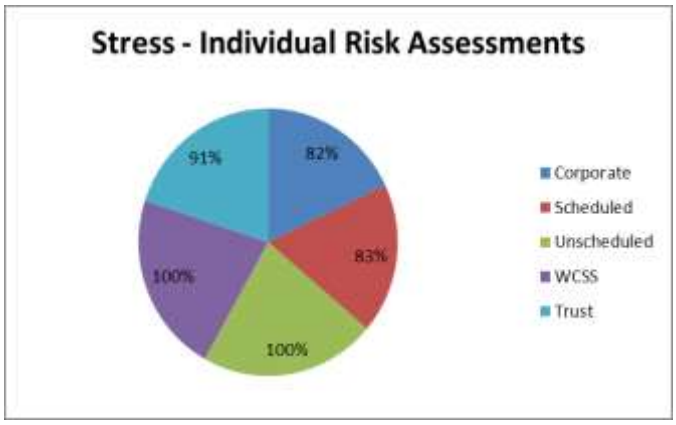


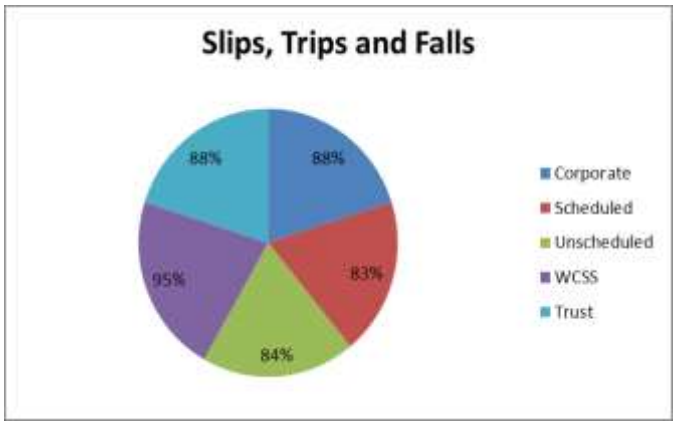


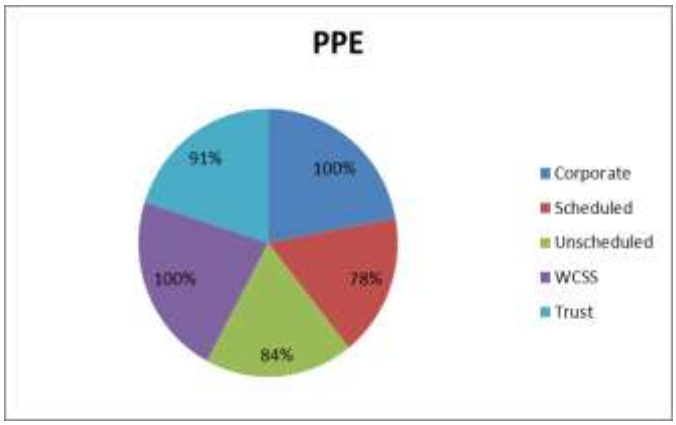


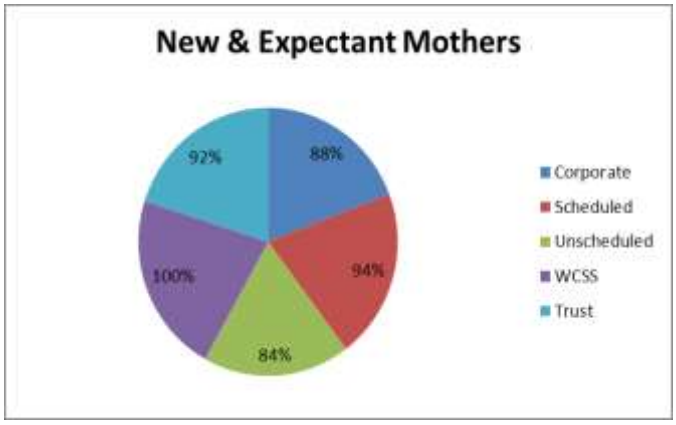


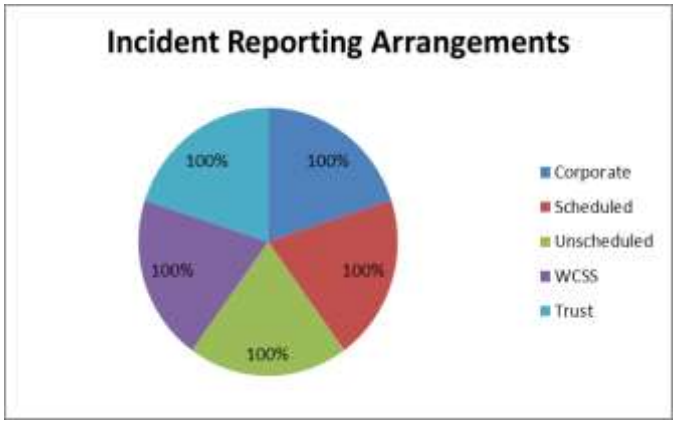












The following section of the report gives details of overall compliance within in Division/Corporate Services. Full details of Departmental compliance can be found in appendix 1.

19.1 Corporate Services - Overview of Audit Results

Total number of Departments audited – 18
Total number of audits – 41
Number of Departments at 100% compliance – 13
Number of Departments above 90% compliance – 3
Number of Departments below 90% compliance – 2

Areas of low compliance –
Executive Offices at 52%

19.2 Scheduled Care - Overview of Audit Results

Total number of Departments audited – 18
Total number of audits – 37
Number of Departments at 100% compliance – 10
Number of Departments above 90% compliance – 2
Number of Departments below 90% compliance – 6

Areas of low compliance -
Ophthalmology Administration at 45%
Ward A9 – 27%

19.3 Unscheduled Care - Overview of Audit Results

Total number of Departments audited – 19
Total number of audits – 41
Number of Departments at 100% compliance – 12
Number of Departments above 90% compliance – 5
Number of Departments below 90% compliance – 2

Areas of low compliance –
Ward A1 at 51% compliance

19.4 Women's, Children's and Support Service - Overview of Audit Results

Total number of Departments audited – 21
Total number of audits – 47
Number of Departments at 100% compliance – 13
Number of Departments above 90% compliance – 8
Number of Departments below 90% compliance – 0

Areas of low compliance –
None to report – all areas met over 90% compliance

19.5 Findings from the Risk Management Framework Audits

Reporting of Incidents
All Departments are aware of the incident reporting procedure and have access to DATIX.
Certain staff groups don't have computer access i.e. Domestic Staff. In this area, as in others, an appropriate system has been set up in order for staff to report incidents.

Management of Legionella
All Departments audited carry out flushing as required. This is documented and signed.

Health and Safety Inspections
The audits showed an improvement on the number of Departments carrying out inspections.

Gas Safety
All Departments which have gas cylinders are storing them in the correct way and cylinders are checked regularly.

Stress Management
There has been an improvement in the number of individual risk assessments carried out and a bigger improvement on the number of departmental risk assessments carried out. In some areas this is due to the online process.

First Aid
Over 90% of Departments have a suitable risk assessment and there was good evidence to show boxes are checked on a regular basis.

DSE
The majority of Departments have staff completing self- assessment forms. Staff are referred to the Health and Wellbeing Department if any problems are highlighted as a result of the task undertaken.

20. Future Development
The priorities over the next 12 months are to:-

- Use of Divisional/Departmental and Trust Risk Registers and escalation process
- Reporting and investigation of incidents at appropriate levels
- Feedback and monitoring of Serious Untoward Incident
- Development, implementation and monitoring of action plans
- Review of risk assessments to ensure significant safety hazards are identified
- Risk Management Framework Audits programme to identify shortfalls in safety management
- Manual Handling Audit to be incorporated into the Risk Management Framework to reduce the amount of visits
- Site specific inspections untaken by Safety Risk Leads and Health and Safety Team

- Estates Department review specific construction projects against legislation and approved codes of practice
- Provide Divisional reports on health and safety management data
- Continue with CIRIS risk assessment training
- Review generic risk assessments on CIRIS and the Hub to ensure they are appropriate to the needs of the Organisation and effectively implemented.
- Review of Health and Safety Training and this to be delivered in-house
- Review of Manual Handling Training to incorporate both Slips, Trips and Falls training and bed rail training. Ensure this meets NICE guidelines.
- Develop training for the management of bariatric patients
- Provide an annual report on health and safety to the Board and quarterly updates on progress with the Health and Safety Strategy.
- Ensure all RIDDOR incidents have Level 1 investigations and are affectively tracked and reduce the incidents of claims due to ensuring robust risk assessment and training is available.
- Ensure all level 1 investigations are monitored on CIRIS
- Review policies and guidance documents in line with current legislation
- Continue to develop and embed the Sypol Data base systems.
- Continue work through Safety Risk Leads meetings that address shortfalls in safety management systems.
- Continue to review needle stick injury incidents
- Produce comprehensive DSE reports for staff and managers to minimise the risk of work related upper limb disorders
- Staff initiatives
- Continue to develop guidance and advice pages on the HUB
- Continue to hold drop in sessions for all staff to attend

21. Conclusion

This has been a challenging and busy year for the H&S Team which has established a pro-active safety management system within the Trust. Documentation is now standardised and Departments are meeting compliance with the Risk Management Framework. This has been evidenced and acknowledged and has gained the Trust a silver award from RoSPA.

A culture shift is taking place where safety is seen as integral to the day to day work and not as an additional burden. The next year will see continual improvements.

The Governance Committee on behalf of the Trust Board is requested to accept the Annual Report as a means of assurance that H&S risks within Warrington and Halton Hospitals NHS Foundation Trust is being properly managed and controlled.

Helen Wynn
Head of Safety and Risk
30th April 2014

Appendix 1 – Departmental Compliance with the Risk Management Framework

Corporate Services

	Audit 1	Audit 2	Audit 3	Audit 4
Governance	98%	**100%**		
Facilities	93%	**100%**		
Supplies	92%	**100%**		
Domestics Warrington	88%	**100%**		
IT	72%	90%	**100%**	
Telecommunications	72%	**100%**		
Business Development	68%	**100%**		
Clinical Education	60%	70%	**100%**	
Domestics Halton	51%	**100%**		
Medical Engineering	43%	76%	**100%**	
Executives	29%	52%		
Security	21%	35%	81%	96%
Human Resources	66%	95%		
Catering Warrington	77%	**100%**		
Catering Halton	93%	**100%**		
Finance	95%	**100%**		
Estates Warrington	59%	80%		
Estates Halton	40%	94%		

Scheduled Care

RMF	Audit 1	Audit 2	Audit 3
Orthodontics Halton	99%	**100%**	
Ophthalmology Clinic	88%	**100%**	
Ward B19	86%	97%	**100%**
Ward A6	85%	90%	**100%**
Ward B4	78%	86%	**100%**
Orthodontics Warrington	76%	**100%**	
Medical Secretaries (Surgical)	72%	91%	

ITU	66%	**100%**	
Fracture Clinic	54%	92%	**100%**
Ward A4	50%	92%	**100%**
Ophthalmology (Admin)	45%		
Ward A5	18%	90%	92%
Ward A9	27%		
Theatres Halton	88%		
CMTC Theatres	82%		
Theatres Warrington	84%		
Day Case Unit Halton	84%	**100%**	
CMTC Ward	35%	62%	

Unscheduled Care

RMF	Audit 1	Audit 2	Audit 3
CCU	95%	**100%**	
Ward A7	93%		
Ward B1	87%	**100%**	
Cardiology	73%	**100%**	
Ward A2	71%	95%	**100%**
AED	67%	**100%**	
Ward B18	66%	**100%**	
Minor Injuries Halton	60%	83%	**100%**
Ward A8	57%	90%	
Ward A1	51%		
Diabetes	36%	45%	**100%**
Ward B14	73%	81%	
Ward C21	81%	**100%**	
Ward A3	90%	**100%**	
Med Secs and Admin	24%	76%	95%
Ward B12	55%	94%	
Cardiac Catheter Unit	69%	**100%**	
Ward C22	23%	61%	98%
Endoscopy	89%	**100%**	

WCSS

RMF	Audit 1	Audit 2	Audit 3
Pharmacy	92%	**100%**	
OPD Warrington	89%	**100%**	
B10/B11	86%	91%	96%
OPD Halton	85%	**100%**	
Labour Ward	83%	**100%**	
Antenatal Day Unit	80%	**100%**	
NNU	80%	95%	
Paed A&E	74%	81%	90%
Medical Records	73%	**100%**	
PIU - Ward A3	72%	**100%**	
Children's Outpatients	71%	83%	91%
Antenatal	69%	**100%**	
Ward C23	65%	95%	**100%**
Pathology	64%	**100%**	
Therapies	61%	**100%**	
Appointments	55%	**100%**	
Radiology	53%	81%	96%
Audiology	89%	**100%**	
Ward C20	92%		
Community Midwives	57%	96%	
GUM	82%	94%	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/084

BOARD OF DIRECTORS

Paper Title	Risk Management Strategy
Date of Meeting	May 2014
Director Responsible	Karen Dawber
Author(s)	Millie Bradshaw, Associate Director of Governance
Purpose	The Trust is required provide an revised annual risk Management Strategy and review the ToR for the Governance Committee

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Quality Governance Committee	May 2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	Title to Managers/ Clinicians from 13/14 RM Strategy.	Pages 10-14
•	Appendix 1 Organisational Governance Structure updated by Board Secretary	Page 27
•	Approved KPIs at page 21 for 14/15 following Quality Governance Committee	Page 21
•	TOR for Quality Governance Committee has not been Approved and will be subject to Approval at the July meeting following discussion to the membership and required attendance. Being taken forward by the Chief Operating Officer	Pages 34-37

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

To approve the 14/15 Risk Management Strategy

RISK MANAGEMENT STRATEGY 2014-2015

CONTENTS AND PAGE NUMBER

EXECUTIVE SUMMARY/ INTRODUCTION

The Purpose of this Strategy and underpinning operational policy is to ensure that the Trust critically examines, and effectively manages, all risks to people, structures, reputation and any other issues, which could impact upon or compromise the ability of the Trust to carry out its normal activities. The management of risk is therefore an integral component of the Trust's corporate and clinical governance agendas.

Risk is inherent in all aspects of the Trust's activities including the treatment and care we provide to our patients, the determining of our service priorities, the projects and developments we manage the equipment we purchase, the decisions we take on our future strategies, or indeed deciding when no action is to be taken.

To effectively manage the risks that are inherent in a health care setting requires a management culture that engages ALL staff, as everyone is both *a risk taker and a risk manager*. Risk management is therefore not an addition to our everyday work, but must be an integral part of all activity of the organisation.

Every member of staff has an individual responsibility for risk management as described in this strategy. The Trust recognises that for this to be achieved it requires a commitment from all staff to ensure risks are managed efficiently and effectively and to ensure the continuing development of a management culture which is seen to be just and places a high value on honesty and openness at all levels of the organisation.

When unexpected or unintended events occur, risk management is about understanding what went wrong and why, and taking action to minimise the possibility of similar incidents happening again.

This strategy and operational policy should be read in conjunction with the Trust's documented processes for Risk Management that can be found within the Appendices of the Strategy.

Mel Pickup
Chief Executive

WHAT IS RISK MANAGEMENT?

Risk Management is a framework for the systematic identification, assessment, treatment and monitoring of risks, whether the risks are clinical, organisational, business, financial or environmental. Its purpose is to minimise risks to patients, staff, visitors and the organisation as a whole by ensuring that effective risk management systems and processes are implemented in all areas of service provision, and that these are regularly reviewed

The benefits of a structured and systematic approach to the management of risk

- ❑ It supports informed management decision-making by contributing to the greater understanding of risks and their impact.

- ❑ Lessons for improvement can be learnt and disseminated, and limited resources can be targeted more effectively to address areas of highest risk.
- ❑ It can lead to a reduction in the time staff spends on fixing problems and fire fighting, by being proactive rather than reactive
- ❑ It has the potential to improve patient care by reducing the frequency and severity of adverse incidents, complaints and claims, which result from shortcomings in any of the Trust's clinical, managerial, business and operational systems and processes, by their early identification and improvement
- ❑ It can enhance the reputation of the Trust by maintaining the confidence of the stakeholders we serve, the statutory and regulatory bodies we report to, as the Trust is able to demonstrate there are effective, safe, monitored systems in place.

STATEMENT OF PURPOSE

The Board will ensure that risk is managed in a holistic way so that all risks, non clinical and clinical, business, financial, organisational and environmental are considered through the planning, decision-making and daily management of the organisation. The Warrington and Halton Hospitals NHS Foundation Trust is committed to providing an environment which minimises risk and promotes the health, safety and well being of all those who enter or use its premises within a culture of innovation in which risks are proactively managed, safeguarding the continuity of service, assets and reputation of the Trust.

The management of risk is the responsibility of all staff, the Trust will aim to support the identification of risks, incidents, and 'near misses' quickly through an open, supportive, and just culture and will use the management of risk as an opportunity for learning and improvement. It will encourage the reporting of risks, incidents and hazards and will consider disciplinary action only in cases where there is evidence of a breach of law, professional misconduct or malpractice, repetitious incidents, deliberate non-reporting of incidents or collusion with the non-reporting of incidents.

SCOPE OF THE STRATEGY AND OPERATIONAL POLICY

The procedures outlined in this strategy apply to the management of risk throughout the Warrington and Halton Hospitals NHS Foundation Trust.

SUMMARY OF KEY RISKS

Warrington and Halton Hospitals NHS Foundation Trust faces a wide range of risks associated with maintaining an acute hospital incorporating two hospital sites which lie 11 miles apart. These are documented in the Trust's Assurance Framework, which, records the potential risks to the achievement of the Trust's strategic objectives, which are; -

- ❑ Failure to deliver a high quality, safe patient experience
- ❑ Failure to ensure that all our staff are committed, equipped and supported to deliver high quality care
- ❑ Failure to generate surpluses to ensure our services are sustainable in the long term
- ❑ Failure to create a culture of excellence and mutual respect

- ❑ Failure to develop partnerships that support our business strategy and enhance our reputation

AIMS AND OBJECTIVES OF THE STRATEGY AND OPERATIONAL POLICY

This Strategy and operational policy supports an improving approach to risk management across Warrington and Halton Hospitals NHS Foundation Trust. The framework is:

- ❑ To provide a clear understanding of the roles and responsibilities of all employees of the Trust ensuring effective risk management systems are implemented and monitored
- ❑ To assist integrated risk management into the delivery planning, decision and policy making mechanisms of the Trust in order to improve the quality of care provided.
- ❑ To assist in the management of risks related to the Trust's strategic objectives and any other significant risks identified through the risk management framework
- ❑ To ensure compliance with all appropriate legislative and statutory requirements, including Care Quality Commission Essential Standards for Quality and Safety, Health & Safety Executive and to ensure that an effective integrated Assurance Framework is in place and measured.
- ❑ To foster an environment where staff are encouraged to report risks, incidents and 'near misses', capturing information and learning from adverse events.
- ❑ To create and support an organisational culture, which recognises that human errors may occur as a result of system failures, and to work to ensure that 'lessons learned' are used to bring about improvements
- ❑ To ensure that staff are trained and competent in their role and that they take account of the hazards and risks likely to be encountered in the work place.
- ❑ To assist all Trust employees to progressively undertake regular and systematic risk assessments of all activities in order to identify, and where possible, eliminate or at least minimise risk

STRUCTURES AND PROCESSES

To enable the Trust to meet these commitments it is necessary to have in place clear structures and processes for risk management at all levels of the organisation.

- ❑ Through a structured and systematic approach to the management of risk so that it becomes an integral part of all clinical, managerial, business and financial processes.
- ❑ Through the integration of effective reporting structures from within Divisions through to the Governance Committee and Trust Board.
  Through the continuing development of an integrated risk register which will support the recording and monitoring of identified risks and resulting action plans, and which provides the Trust Board with a Trust wide risk profile
- ❑ By clearly defining at every level within the organisation, individual objectives, responsibilities and accountabilities for all risk management by including them with in job descriptions and personal development plans

- By empowering all staff to report risks and register concerns about unsafe practice through an open and fair culture supported by effective Human Resources and Risk Management policies and procedures.
- By providing risk management training at all levels within the organisation and as an integral element of the Trust's training and development plans.

ORGANISATIONAL RISK MANAGEMENT STRUCTURE

The Trust manages risk proactively through a number of specific committees, groups and individuals, working together to achieve integrated risk management activity across the organisation.

Role and responsibility of the Trust Board (Board of Directors)

The Trust Board (Board of Directors) has overall responsibility for the management of risk, which it discharges through its Executive Directors.

The Trust Board is also responsible for reviewing the effectiveness of internal controls and for managing the Trust's affairs efficiently and effectively through the implementation of these controls. It gains evidence of the effectiveness of the controls in managing its risks via the Assurance Framework.

The key components of the risk management process are; -

- Allocation of risk management to individual Executive Directors with a clear performance management framework.
- Clear terms of reference for the Governance Committee which coordinates clinical and non-clinical risks through one committee.
- A single electronic data capture system which brings together complaints, PALS, incidents, litigation etc., ensuring coordinated feedback on lessons learned to staff.
- Central support for Divisions in ensuring that risk registers are live and updated.
- Clarity of expectation within line management arrangements for risk assessment and management.
- Use of root cause analysis to learn from untoward incidents/events and thus mitigate the risk of recurrence.
- Statement that the Trust will comply to the Statutory requirements relating to Duty of Candour

Duty of Candour

- All staff will be required to tell someone if they have been involved in and or observed where a patient may have been or had the potential to be harmed by something not being done
- Any actual and or potential incident to be reported on Datix (Trust integrated risk management system) as to inform others and allow for a level of investigation to take place to see what/how/why happened and to learn to ensure what occurred does not happen again
- Patients and family to be supported to deal with the consequences and have a key contact identified for the moderate/severe harm or death outcome following an Incident

- ❑ Ensure there is an appropriate level of Investigation (Level One and or Two)
- ❑ The patient/family/patient representative are informed within 10 working days
- ❑ The Initial notification should be face to face and this accompanied with an offer of a written notification
- ❑ An Apology to be provided and this must be documented in the notes
- ❑ A Step by step explanation be offered as soon as possible pending the Investigation
- ❑ Full written documentation of all meetings are kept with the patient/family and filed in Datix for future reference
- ❑ Full written documentation is kept of all staff interviews and meetings about the incident and filed in the Incident/Complaint account in Datix
- ❑ The Final Investigation will be shared with the patient/family/patient representative within 10 days of it being Approved under Governance arrangements
- ❑ The Trust will be monitored by the Commissioners as part of the monthly Quality Contract to its contractual obligations to comply with Duty of Candour

Role and responsibility of the Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the implementation of an effective risk management system across the organisation and for ensuring that; -

- ❑ The Trust's strategic objectives have been agreed.
- ❑ A sound system of internal control exists which identifies the principle risks to those objectives
- ❑ Efficient and effective management of the risks
- ❑ All statutory requirements are met
- ❑ Independent assurance is maintained
- ❑ Communication with stakeholders is maintained on problems of mutual concern.

Committees and Groups

The Governance Committee has overarching responsibility for risk.

The strategic committees are supported by a number of specific sub-committees and groups as indicated within the Trust's organisational chart **(Appendix 1)**

The Governance Committee, chaired by a Non-Executive Director, will scrutinise the management of risk, delivery of the Annual Plan and compliance with Care Quality Commission Essential Standards for Quality and Safety. Please refer to **Appendices A** for the full Terms of Reference and membership.

The Committee will also gain the necessary assurances for the compliance necessary to sign off the Statement of Internal Control; any unacceptable or high levels of risk/assurance will be reported through to the Trust Board. In order to fulfil these responsibilities it has four sub-committees reporting to it that includes:

- ❑ **The Clinical Governance, Audit and Quality Sub-Committee** approves policies under its identified schedule of approval, reviews and monitors patient safety, Quality within the Trust and ensures effective systems are in place to audit and manage these risks effectively. These include those risks relating to Acute and Critical Care of the Patient Care Group, Hospital Transfusion, Drugs and

Therapeutics, Safeguarding of Children and Vulnerable Adults, Research and Development and Clinical Policy both at corporate and Divisional level. An annual work plan is in place to the Provision to the Assurance Reports required

- **The Safety and Risk Sub-Committee** approves policies under its identified schedule of approval, reviews and monitors the management of risk and ensures that they are implemented effectively and reviewed at appropriate intervals. It reports to the Governance Committee and oversees the work of the Safety and Risk Leads Group and the Risk Register review Group. The Committee also reviews Parts 1 and the risks that require escalating from the Risk Register Part 2 group. An annual work plan is in place to the Provision to the Assurance Reports required
- **The Infection Control Committee** approves policies under its identified schedule of approval relating to the management of infection control and ensures that they are implemented effectively. An annual work plan is in place to the Provision to the Assurance Reports required
- **Information Governance and Corporate Records Committee** will approve policies under its identified schedule of approval, reviews and monitors the management of risk relating to information governance and corporate records and ensures that they are implemented effectively and reviewed at appropriate intervals. An annual work plan is in place to the Provision to the Assurance Reports required
- **Strategic Workforce Committee** will approve policies under its identified scheduled for all Human Resources policies and links to Educational Governance. An annual work plan is in place to the Provision to the Assurance Reports required

The Audit Committee, chaired by and made up of Non-Executive Director, provides an independent overview of the governance arrangements by giving assurance to the Trust Board on the working of all Board Committees. They ensure committees are working to their terms of reference and fully operating within their governance arrangements, providing a vital cross check to the Board. Along with the Governance Committee, the Finance & Performance Committee, the Patient and Workforce Experience Committee and the Strategic Planning & Development

ASSURANCE FRAMEWORK PROCESS

The Director of Nursing, Governance and Organisational Development has been delegated Executive responsibility for co-ordinating the development and implementation of the Trust's Assurance Framework and this is operationalized by the Board Secretary. This links into the Trust Strategic Objectives and any risks to achieving them. .

The overriding Assurance Framework is submitted to the Board on a quarterly basis.

DIVISIONAL GOVERNANCE STRUCTURE

The 3 clinical divisions have an Approved Risk Management Strategy. The Corporate Services (Estates and Facilities, Human Resources, Governance, IT, Finance and Corporate Nursing) provides the required assurances to the Forums.

DUTIES OF KEY INDIVIDUALS WITH DELEGATED RESPONSIBILITIES

Every member of staff has an individual responsibility for the management of risk within the organisation. Managers at all levels must understand the Trust's Risk Management Strategy and be aware that they have the authority to manage risk within their area of responsibility.

Director of Nursing and Organisational Development

The Director of Nursing and Organisational Development is accountable to the Trust Board and the Chief Executive for the Trust's clinical, organisational and environmental risk management activities. She is responsible for ensuring compliance with National Risk Management Standards and Care Quality Commission Regulated Activities within the essential Standards for Quality and Safety and for the management of risks within her/his area of responsibility.

She is responsible for ensuring the integration of Risk within the agreed reporting and monitoring arrangements including Health and Safety, litigation, Coroners Inquests. She is also responsible for workforce and organisation Strategic development activities and ensures these are integrated within all organisational risk management arrangements delegated to the Associate Director of Human Resources.

The Director of Nursing and Organisational Development is a member of the Strategic Workforce and Clinical Governance, Audit and Quality Sub Committees.

The postholder is the professional lead for Nursing and Midwifery and is responsible for the safe delivery of nursing, midwifery and allied professionals care including the Quality Account, privacy and dignity of patients which is monitored through effective Clinical Governance and audit systems via the Clinical Governance, Audit and Quality Sub Committee of which the Director of Nursing is the Vice Chair to the Sub Committee in addition Executive Lead to the Infection Control Sub Committee.

Medical Director

The Medical Director has joint responsibility with the Director of Nursing and Organisational Development for Quality, clinical risk and clinical governance.

The postholder is responsible for signing off consultant appraisal and revalidation and in addition monitors the professional standards of Consultants and Speciality Doctors within the Trust.

The Medical Director is Chair of the Clinical Governance, Audit and Quality Sub Committee

Director of Finance

The Director of Finance is accountable to the Trust Board and the Chief Executive for the Trust's financial risk management activities. He is responsible for ensuring the Trust carries out its business within sound Financial Governance arrangements that are controlled and

monitored through effective audit and accounting systems and is a member of the audit Committee.

Chief Operating Officer (Deputy Chief Executive)

The Chief Operating Officer is accountable to the Chief Executive in ensuring that the highest standards of corporate governance are adhered to operationally and to contribute to the development and further enhancement of the Trust's Risk Management Strategy relating to the operational management within the Trust activities.

In conjunction with other Executive Directors will ensure the delivery of high quality health care services are implemented and maintained and he will lead the process for the development and maintenance of the Trusts Emergency planning policies and procedures ensuring effective implementation is assured.

The Chief Operating Officer is a member of the Governance Committee.

Director of Information Management & Technology (IMT)

The Director of IMT is the accountable Executive Lead for IT, Information Governance and Records (clinical and non-clinical) and is Chair of the Information Governance and Corporate Records group. He is supported in this role by the Information Governance and Corporate Records Manager.

NON-EXECUTIVE DIRECTORS

The Non-Executive Directors have a responsibility for ensuring the systems for integrated Governance, risk management and internal control are effective and maintained across all of the organisation's activity and to ensure the strategic objectives of the organisation are achieved.

Two non-executive directors form part of the Governance Committee. One is Chair of the Committee.

DUTIES AND AUTHORITY OF ALL MANAGERS TO MANAGING RISK

Associate Director of Governance

The Associate Director of Governance is responsible for the ongoing development and implementation of the Trust's Governance arrangements at operational level. She is accountable to the Director of Governance and Organisational Development and has organisational responsibility for Governance both clinical and corporate supporting the Executive and Non-Executive Directors in carrying out their responsibilities for risk management and taking the lead for developing and implementing the Risk Management Strategy.

The Associate Director of Governance has operational and managerial responsibility for Governance, Health and Safety, Patient Safety, Coroners, Litigation and Audit. The

postholder will provide a focus for risk management at a senior level and will lead the Governance team consisting of:

- ❑ Head of Safety and Risk
- ❑ Head of Legal Services and Patient Safety
- ❑ Patient Safety Coordinator
- ❑ Health and Safety Advisor
- ❑ Manual Handling Advisor
- ❑ Head of Clinical Audit
- ❑ Staff Health and Well Being Manager

Deputy Director of Nursing

The Deputy Director of Nursing supports the Director of Nursing to ensure the safe delivery of nursing and midwifery care is underpinned within a Quality framework including privacy and dignity which is monitored for its effectiveness

Associate Director of Human Resource

The Associate Director of Human Resources is accountable to the Executive Director of Governance and Organisational Development for organisation operational development activities ensuring these are integrated within all organisational risk management arrangements.

Associate Director of Estates and Facilities

The Associate Director of Estates and Facilities is accountable to the Chief Operating Officer and is responsible for the identification of estate related risks and ensuring plans are in place to mitigate these risks linking with the Head of Safety and Risk to ensure compliance with legislation is maintained.

To be responsible for Estates related risks including fire safety in line with Department of Health Security Management Service requirements and fire code regulations.

Head of Safety and Risk

The Head of Safety and Risk is the Trust Competent Officer (expert advisor) for Health and Safety and the 31 Regulations that the Trust is required to have the underpinning policies, monitoring and assurance for non clinical incidents review and Investigation.

Head of Legal Services and Patient Safety

The Head of Legal Services and Patient Safety is responsible for managing claims against the Trust, liaising with solicitors/insurers (where appropriate), to ensure timely and cost effective claims handling. The role includes ensuring that any risk management issues/remedial action identified during the course of a claim, or during the review process on closure, is referred appropriately for action as part of the Investigation process. The post holder is a member of the monthly triangulation meeting with the Patient experience Matron, Divisional Governance Leads, Patient Safety Coordinator, Risk Midwife, Local Security Management Specialist and Head of Safety and Risk.

Patient Safety Coordinator

Is the key contact for the Coroner and Mental Health and provides help and support and Guidance. The post holder participates in Incident Investigations and is a member of the monthly triangulation meeting with the . The post holder is a member of the monthly triangulation meeting.

Patient Experience Matron

The Patient Experience and Quality Matron is responsible for the management and co-ordination of the investigation of formal complaints, ensuring that the Trust's Complaints Procedure is adhered to and investigations are completed by the Divisions and that the required follow-up actions are taken in order to prevent recurrence. The post holder is a member of the monthly triangulation meeting.

Local Security Management Specialist

The post holder ensures compliance with the strategy and directions issued by the NHS Counter Fraud and Security Management Service (CFSMS). The post holder is also responsible for review of security related incidents and investigations and to provide assurance to the Safety and Risk Committee.

Fire Safety Officer

The Fire Safety Officer is the operational lead to ensure the Trust meets its Statutory duties within the Regulatory Reform (Fire Safety). This includes any actual or potential fire incidents are investigated and recommendations actioned in addition to the trust staff adhering to Fire safety Training.

Information Governance and Corporate Records Manager

The Information Governance and Corporate Records Manager is the operational lead for Information Governance and compliance with NHS Records Guidance and is the key contact for Freedom of Information requests.

Divisional Operational Directors, Divisional Medical Directors, Divisional Governance Managers, Associate Directors of Nursing/Heads of Department, Clinical Leads and Audit and Governance Leads

- ❑ All staff are aware and effectively implement the systems documented within the Incident Reporting and Investigation Policy.
- ❑ Review, manage and monitor all risks identified through the Trust's incident reporting system and regular risk assessment process
- ❑ There are effective systems in place for the identification, assessment, control monitoring and review of risks, that risks are evaluated using the Trust Framework for the Grading of Risks and that the appropriate level of management action is initiated and completed.
- ❑ There are appropriate and effective risk management processes in place and that all staff are made aware of the risks within their work environment and of their personal responsibilities to identify report and minimise risks.
- ❑ Ensure a Divisional Assurance Framework is in place to monitor identified risks relating to the implementation of local objectives

- ❑ Divisional and Departmental risk registers are maintained and, where a risk is graded as 'Extreme', this is communicated to the appropriate Executive and the Safety and Risk Sub Committee, for consideration.
- ❑ They, and all their staff, receive the necessary information and training to enable them to work safely and to comply with appropriate Trust procedures, including incident reporting, risk assessments, fire arrangements and all health and safety and emergency procedures;
- ❑ Staff are identified and released to attend mandatory training and other appropriate training, and that adequate attendance records are maintained, with non-attendance monitored and addressed;
- ❑ They know and understand their responsibilities and duties under the Trust Health and Safety Policy and other specific health and safety related policies and have appropriate arrangements in place to ensure that these are met.
- ❑ Ensure specific Divisional/departmental policies and guidelines maintaining an archive mechanism in line with the Trust's corporate procedure
- ❑ Ensure that all contractors are given relevant Health and safety information and can demonstrate that they have received appropriate health and safety training in order to work safely.
- ❑ Provide safe systems of work and ensure that there are adequate resources made available to achieve this.
- ❑ Where risk assessments have identified the need for staff to receive health surveillance ensure that staff attends the Health and Well being department as and when required.
- ❑ Ensure compliance with the Trust's first aid policy
- ❑ Ensure adequate arrangements are in place to manage fire and other emergencies

Matrons/ Audit and Governance Leads/Service Managers

- ❑ Ensure all staff is aware and effectively implement the systems documented within the Incident Reporting and Investigation Policy.
- ❑ Report, action, review , reduce, eliminate and monitor all incidents identified through the Trust incident reporting system and regular risk assessment process
- ❑ Report unacceptable or serious risks and the effectiveness of controls to the appropriate Divisional manager and Divisional Medical Director for consideration
- ❑ Actively implement the risk assessment and risk management process within the Division/department, supporting the maintenance of the Divisional/ departmental risk register;
- ❑ Ensure that documented risk management procedures are in place and adhered to;
    - Raise risk awareness amongst staff at operational level;
    - Ensure that risk assessments are carried out appropriately in accordance with Trust guidance and the Divisional/departmental index of risk assessments;
    - Ensure that staff attend all mandatory and other appropriate training.
    - Ensure staff comply with the Trust's first aid policy
    - Ensure adequate arrangements are in place to manage fire and other emergencies

RESPONSIBILITIES OF EMPLOYEES

- ❑ Familiarise themselves and report incidents/accidents and 'near misses' in accordance the Incident Reporting and Investigation Policy.
- ❑ Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risk;
- ❑ Participate in the risk assessment process if required;
- ❑ Provide safe standards of clinical practice through compliance with the regulations of the appropriate professional bodies;
- ❑ Take reasonable care of their own health and safety and the safety of anyone else who may be affected by what they do whilst at work;
- ❑ Be familiar with, and comply with, all appropriate Trust policies and procedures, including clinical and health and safety procedures, designed to protect the health, safety and welfare of anyone affected by the Trust's business;
- ❑ Attend mandatory and other such training as required by the Trust
- ❑ Understand and comply with their responsibilities under the Trust Health and Safety Policy
- ❑ Maintain confidentiality of patient and Trust information.

IMPLEMENTATION OF THE RISK MANAGEMENT SYSTEM

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

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

It is a proactive approach, which addresses every element of the Trust's activities and provides a mechanism of assurance for all stakeholders that the trust's internal controls are effective. This includes:

- ❑ Report all incidents, accidents and 'near misses' via the trust's incident reporting System
- ❑ Identify and record all risks utilising the Trust's risk assessment process maintaining the departmental/divisional and Trust risk registers
- ❑ Develop and implement effective control measures to prevent reoccurrence
- ❑ Share lessons learned across the organisation and with all relevant stakeholders leading to learning and Improvement
- ❑ Ensure risk management is at the forefront of all Trust business
- ❑ Comply with best practice standards
- ❑ Produce annual key performance indicators

STEP ONE- RISK IDENTIFICATION

The Trust recognises that risks will be identified from a number of sources and will utilise these sources as appropriate, including:

- ❑ Risk assessments

- ❑ Incident and 'near miss' reporting and investigation including root cause analysis (RCA)
- ❑ Claims, complaints and Patient advice and Liaison (PALS) reports
- ❑ HM coroner inquests
- ❑ Central Alert System (CAS)
- ❑ External assessments e.g. Care Quality Commission, Health & Safety Executive, Environmental Health (EHO), Audit Commission, Mersey Internal Audit Agency
- ❑ Internal assessments including review of National Guidance including NICE Guidance and NCEPOD recommendations, High Level Enquiries, Inspection and Accreditation, Audit Outcomes and Audit Committee reports.
- ❑ Patient and Public Involvement Forums
- ❑ Patient and Staff surveys
- ❑ Media reports

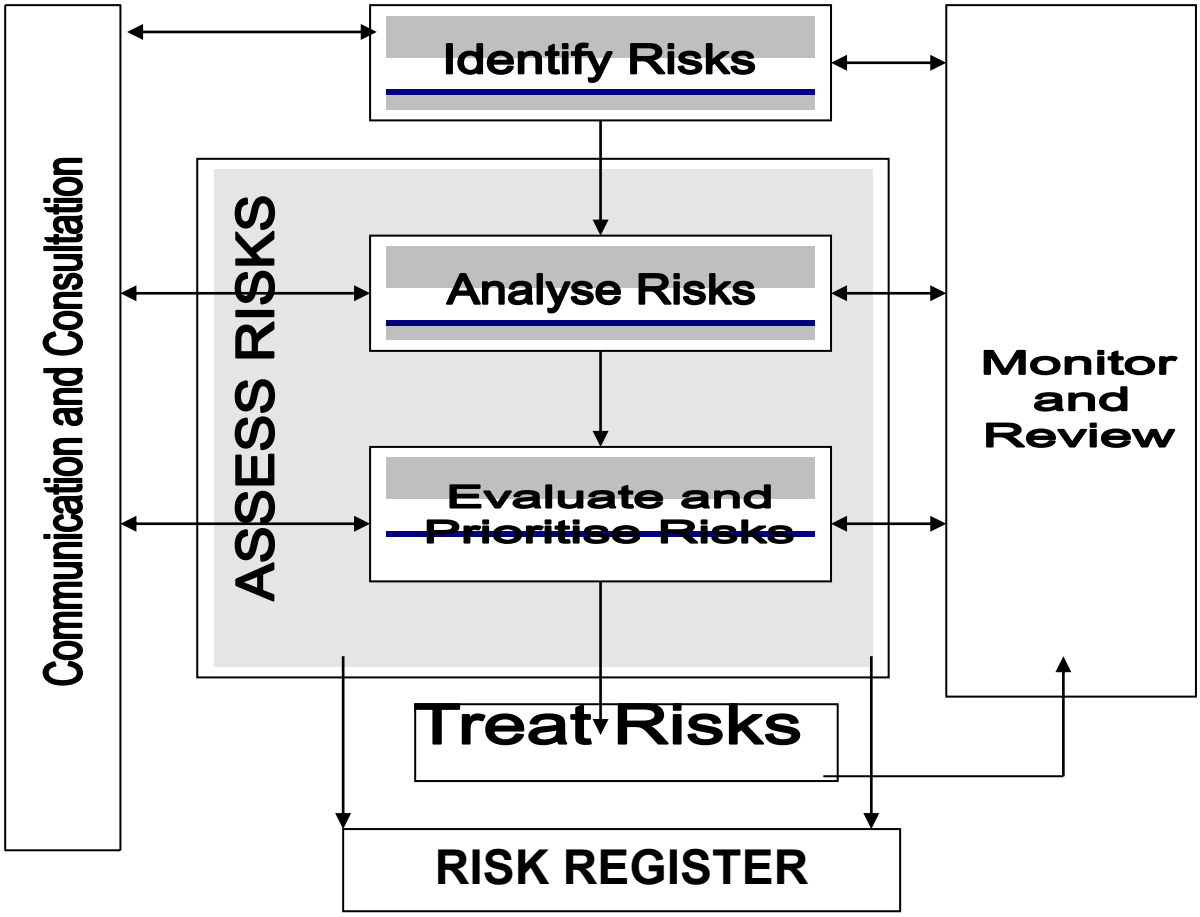
Risk assessments may be categorised as follows:

- ❑ Adverse publicity / reputation
- ❑ Business objectives / projects
- ❑ Finance including claims
- ❑ Human resources / organisational development / staffing / competence
- ❑ Impact on the safety of patients, staff or public (physical / psychological harm)
- ❑ Quality / complaints / audit
- ❑ Service / business interruption
- ❑ Environmental impact
- ❑ Statutory duty / inspections

Information from these combined sources will allow the development of a Trust-wide risk register, enabling the Trust to quantify, grade and cost its risks. The following diagram explains the process at each stage following the identification of risk.

RISK MANAGEMENT DOCUMENTED PROCESS

Source: Controls Assurance Risk Management Standard (based on the AS/NZ standard 4360:1999).



STEP 2- RISK ANALYSIS

Risks will be analysed to determine their cause, their impact on patient and staff safety, the achievement of local objectives and strategic objectives, the likelihood of them occurring or recurring and how they may be managed. Such analysis will be undertaken by the most appropriate level of management. The risk management information system (DATIX) enables data analysis and trend identification from claims, complaints, incidents and 'near misses'.

STEP 3- RISK EVALUATION AND PRIORITISATION

Risks will be evaluated and prioritised using the Trust Framework for the Grading of Risks. See Appendix 2. The Framework provides a consistent approach to the grading of risks

arising within the Trust, however, and from wherever, they are identified. It enables all risks to be graded in the same consistent manner against the same generic criteria.

STEP 4 - RISK TREATMENT AND 'ACCEPTABLE' RISK

The Framework for the Grading of Risks at **Appendix 2** will enable decisions to be taken about the level of management of each risk within the Trust. It should be used in conjunction with the Incident Reporting and Investigation Policy.

LOW (1-3) - 'Acceptable' Risk: To be managed locally by the Ward/Departmental Manager via risk assessment and/or local risk register.

MODERATE (4-6): To be managed locally by the Ward/Departmental Manager via risk assessment and/or local risk register.

HIGH (8-12: To be included on the divisional/departmental risk register and managed at local level by an appropriate manager. Risks of 8 and 10 are managed locally by Ward/Departmental Manager. Any risk that reaches 12 is escalated to the Part 2 Risk Register on CIRIS and reviewed bi-monthly at the Part 2 Review Group.

High risks should be reported to the Head of Safety and Risk where local control measures are considered by the Divisional/Departmental Manager to be inadequate or impracticable.

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

An appropriate Lead will be identified for each risk on the Risk Register to ensure regular assessment of the risk and the development and implementation of action plans.

If a risk of 15-25 is identified out of hours, this will be escalated to the relevant Director on Call who will ensure appropriate actions are taken to mitigate the risk. The Director on Call will ensure the relevant Lead places the risk on the Trust Part 1 Risk Register via CIRIS, as soon as reasonably practicable.

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

NB. Where it is not possible to treat the risk at the prescribed level, the risk must be effectively communicated up through the management structure. Where a risk is related to a serious incident it is the responsibility of the Chief Executive or delegated Executive Director to confirm reporting procedure via the STEIS system.

DOCUMENTED PROCESS FOR REVIEW OF THE RISK REGISTER AT HIGH LEVEL (TRUST BOARD) AND LOCAL MANAGEMENT OF RISK (DIVISIONAL)

Process for the Management of Risk locally via Divisional and Departmental Risk Registers

Risks below 12 are monitored at local level by the Ward/Departmental Manager. This is managed by local risk register and/or risk assessments.

All risks scoring 15-25 are collated into the Trust Risk Register Part 1 in CIRIS.

All risks scoring 12 are collated onto the Trust Risk Register Part 2 in CIRIS.

Please refer to the Trust Risk Assessment housed in Hub within Corporate Generic Community.

The Risk registers are developed from risks identified by:

- ❑ Risk assessments - organisational, clinical, business, financial, environmental
- ❑ Incident and 'near miss' reporting and investigation including root cause analysis (RCA)
- ❑ Claims, complaints and Patient advice and Liaison (PALS) reports
- ❑ HM coroner inquests
- ❑ Central Alert System (CAS)
- ❑ External assessments e.g. Care Quality Commission, risk management assessments, Health & Safety Executive, Environmental Health (EHO), Audit Commission, Mersey Internal Audit Agency
- ❑ Internal assessments including review of National Guidance including NICE Guidance and NCEPOD recommendations, High Level Enquiries, Inspection and Accreditation, Audit Outcomes and Audit Committee reports.
- ❑ Patient and Public Involvement Forums
- ❑ Patient and Staff surveys
- ❑ Media reports
- ❑ Outcomes from hearings/investigations
- ❑ Changes in legislation/strategy

These risks, dependant on their scores are then incorporated into a Trust Risk Register.

Trust Part 1 Risk Register – All risks of 15-25 are placed on CIRIS by the relevant Division/Department. Each risk has an identified Lead who will review the risk monthly and ensure any actions are implemented.

The Risk Register is reviewed by the Safety and Risk Sub Committee and the Clinical Governance Sub Committee on a monthly basis. Any amendments and/or recommendations requested by either Committee are carried out by the relevant Lead.

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

The completed risk register is reviewed by the Trust Board bi-monthly, following on from the Governance Committee.

Trust Part 2 Risk Register – All risks of 12 are placed on CIRIS by the relevant Division/Department. Each risk has an identified Lead who will review the risk to ensure any actions are implemented.

The Risk Register is reviewed at Safety and Risk Sub Committee at least 3 times a year.

Part 3 Risk Register – All risks below 12 are managed locally by each Ward/Departmental Manager. This can be managed by risk assessments and/or local risk registers. All risks must be reviewed annually and discussed/reviewed at local meetings. Including:-

- ❑ Scheduled Care Division – DIGG
- ❑ Unscheduled Care Division – Divisional Integrated Governance Group/DIGG
- ❑ WCSS Division - DIGG
- ❑ Estates Department – Estates Safety and Risk Meeting
- ❑ Corporate Nursing – Corporate Nursing Team Meeting
- ❑ Facilities – Facilities Management Team Meeting
- ❑ Finance, Supplies and Information – Review by Heads of Department and Director/Deputy Director of Finance
- ❑ IT – Departmental Health and Safety Meeting
- ❑ Governance – Governance Heads Meeting
- ❑ Human resources – HR Senior Team Meeting
- ❑ Information Governance – Information Governance and Corporate Records Sub-committee

Each risk should be reviewed to ensure that all fields listed below have been completed and that the risk score and description remains appropriate.

An update on the progress of actions must be provided and should any actions fail to meet their strategic aim risk score by the agreed target date the reasons for this must be explained and a revised target date provided.

For each risk the following information must be recorded:

- ❑ Division
- ❑ Department
- ❑ Date of Last review
- ❑ Strategic Objective Number
- ❑ Source of the Risk (e.g. Risk Assessment, Finance, incidents, complaints, claims, external reports).
- ❑ Summary of Risk Description
- ❑ Date added to the Risk Register

- ❑ Impact Rating (from Risk Grading Matrix found on page 89-90 of the Incident Reporting and Investigation Policy)
- ❑ Likelihood Rating (from Risk Grading Matrix)
- ❑ Previous Risk Score
- ❑ Managerial Lead
- ❑ Action Taken to Mitigate Risk (this should be supported by an action plan held within the division/department)
- ❑ Residual Risk Score (Risk score at the time of the most recent review taking into account any actions taken to mitigate the risk)
- ❑ Date for next review
- ❑ Strategic Aim Risk Score (the lowest possible risk score it is believed this risk can be given when all actions have been completed to mitigate the risk)
- ❑ Target Date for Completion (the target date by which all actions have been completed to mitigate the risk and the strategic aim risk score has been achieved).

External

The Trust will use the assessments of such external bodies as the Care Quality Commission, the Health and Safety Executive (HSE), Environmental Health (EHO), the Risk Management Assessment processes and the Commissioners to assist in monitoring progress and performance in the management of risk.

Progress in compliance against external standards and against any action plans developed as a result of the assessment process will be monitored via the Clinical Governance and Safety and Risk Sub Committees to the Trust Board.

The North West Strategic Health Authority will monitor the Trust's progress against its Assurance Framework through the recommendations made by Mersey Internal Audit Agency. Feedback is also provided against the STEIS reporting system

KEY PERFORMANCE INDICATORS FOR 2014/15

- ❑ To review Health and Safety Training programmes to include one stop session for Manual Handling, Health and Safety and Fire training and to include learning and Improvement as a result of any incidents reported
- ❑ Continue to provide monthly Governance Drop, Health and Safety and Audit drop in sessions to support staff
- ❑ Continue to transfer all paper risk assessments to the CIRIS electronic governance compliance system as part of the review process
- ❑ Continue with Formal Inspection Programme
- ❑ Continue with Risk Management Framework Audits and to include Manual Handling to reduce number audits on Wards
- ❑ Provide Divisional Reports on Health and Safety Data

COMMUNICATION AND CONSULTATION

The Trust will employ a variety of methods to share its Risk Management Strategy and risk management plans both internally and externally. This will include both internal and external Stakeholders including Commissioners and Monitor.

The Divisional Operational Directors /Heads of Department will ensure that staff are aware of the strategy and implement the systems included within their areas of responsibility

TRAINING AND SUPPORT

The Trust recognises that the successful implementation of its risk management strategy and system is dependent upon the provision of appropriate and sufficient training to all levels of the organisation. This is reflected into the Trust Training and Development Policy that includes the Trust Training Needs Analysis including procedures to follow up staff who fail to attend for training.

EQUALITY & DIVERSITY

The Trust aims to design and implement services, policies and procedures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. This policy has been assessed by the Policy Author using the Trust's Equality & Diversity Impact Assessment Tool and is not considered to have an adverse impact on equality issues or minority groups.

AUDIT

The Mersey Internal Audit Agency provides audit services in respect of the Trust's financial controls. In line with national guidance, their services have been extended to include assessment and validation of the Trust's risk management systems via the Audit Committee and Governance Committee. MIAA will provide assurances to the Chief Executive and to the Trust Board that the necessary systems and controls are in place and are being effectively managed in order for the Chief Executive to sign off the Statement of Internal Control .

AUDIT OF THE DOCUMENTED PROCESS OF THE STRATEGY AND OPERATIONAL POLICY

Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
Risk Management Strategy						
Organisational risk	Review of minutes of	Governance Committee	At least Bi Monthly	Governance Committee		Governance Committee

Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
management structure detailing all those committees / subcommittees/ groups which have some responsibility for risk.	Trust Committees and Divisional Integrated Governance Groups Assurance Reports	Safety and Risk CG Sub Committee Safety and Risk Committee and CG Sub Committee Information Governance and Corporate Records Group	 At least 3 times a year At least 3 times a year	Safety and Risk CG Sub Committee Safety and Risk Committee and CG Sub Committee Information Governance and Corporate Records Group	Safety and Risk CG Sub Committee Safety and Risk Committee CG, Audit and Quality Sub Committee Information Governance and Corporate Records Group	
process for board or high level committee review of organisation wide risk register	Minutes of meetings to confirm the risk register has been reviewed by the Governance Committee and the Board Annual Report	Director of Governance and Workforce to the Governance Committee and to the Board Associate Director of Governance on behalf of the Director of Governance and Workforce	At least Bi Monthly At least 3 times a year to the Board Annual	Governance Committee and the Trust Board	Governance Committee and the Trust Board	Governance Committee and the Trust Board
process for the management of risk locally, which reflects the organisation-wide risk management strategy	Assurance Report to the Safety and Risk Sub Committee	DIGG's Departmental meetings	At least 3 times a year	Safety and Risk Committee	Divisional Integrated Governance Groups Departmental meetings	Safety and Risk Committee and Governance Committee
duties of the key individual(s) for risk management activities	Attendance at Safety and Risk Committee Review of	Director of Governance and Workforce	At least Bi-monthly	Safety and Risk Committee	Safety and Risk Committee	Governance Committee

Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
	minutes of the Safety and Risk Group DIGG minutes					
authority of all managers with regard to managing risk	Annual Report will include the attendance at Safety and Risk Sub Committee And Governance Committee	Safety and Risk CG Sub Committee	Annually	Safety and Risk Committee	Safety and Risk Committee	Governance Committee
Risk Management Committee(s)						
Duties	Annual Report Review of minutes Governance Committee, Safety and Risk Sub Committee	Governance Committee Governance Committee	Annually Bi-monthly	Governance Committee	Governance Committee	Trust Board
reporting arrangements to the Board	Minutes of Governance Committee	Trust Secretary	Bi-monthly	Trust Board	Governance Committee	Trust Board
membership, including nominated deputy where appropriate	Review of minutes Annual Report	Governance Committee	Bi-monthly Annually	Governance Committee	Governance Committee	Trust Board
Required frequency of attendance by members	Review of minutes Annual Report	Governance Committee	Bi-monthly Annually	Governance Committee	Governance Committee	Trust Board
reporting arrangements into high level Committee(s)	Review of minutes	Governance Committee	Bi-monthly	Governance Committee	Governance Committee	Trust Board
requirements for a Quorum	Review of the Terms of reference	Governance Committee	Annually	Governance Committee	Governance Committee	Trust Board

Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
	Review of minutes Risk Management Report					
Frequency of meetings	Risk Management Report	Governance Committee	Annually	Governance Committee	Governance Committee	Trust Board
Risk Management Process						
process for assessing all types of risk	Review of minutes Risk Management agreement Review of Risk Registers	Governance Committee , Safety and Risk Committee, Divisional/ Corporate Services Groups Risk Leads meeting	Bimonthly	Governance Committee/Safety and Risk, Divisional/ Corporate Services Groups	Governance Committee/ Safety and Risk, Divisional/ Corporate Services Groups	Governance Committee
process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation	Review of minutes Risk Management agreement Review of Risk Registers	Safety and Risk Committee, Divisional/ Corporate Services Groups Risk Leads meeting	Bimonthly	Safety and Risk, Divisional/ Corporate Services Groups	Safety and Risk, Divisional/ Corporate Services Groups	Governance Committee
assignment of management responsibility for different levels of risk within the organisation	Progress of the Risk Management agreement Review of Risk Registers	Safety and Risk Committee, Divisional/ Corporate Services Groups Risk Leads meeting	Bimonthly	Safety and Risk, Divisional/ Corporate Services Groups	Safety and Risk, Divisional/ Corporate Services Groups	Governance Committee

REFERENCES

Controls Assurance Risk Management Standard (AS/NZ standard 4360:1999
Care Quality Commission Essential Standards 2009.
Francis 2 High Level Inquiry into Mid Staffordshire Hospitals, February 2013

GLOSSARY OF TERMS

AS/NZ- Australia and New Zealand
CAS – Central Alert System
CQC- Care Quality Commission
EHO – Environmental Health Organisation
HSE – Health and Safety Executive
MIAA- Mersey Internal Audit Agency
NCEPOD- National Confidential Enquiries into Preoperative Outcomes and Death
NHSLA- National Health service Litigation Authority
NICE- National Institute of Clinical Excellence
OD- Organisational Development
PALS -Patient advice and Liaison Services
StEIS- Strategic Executive Incident System

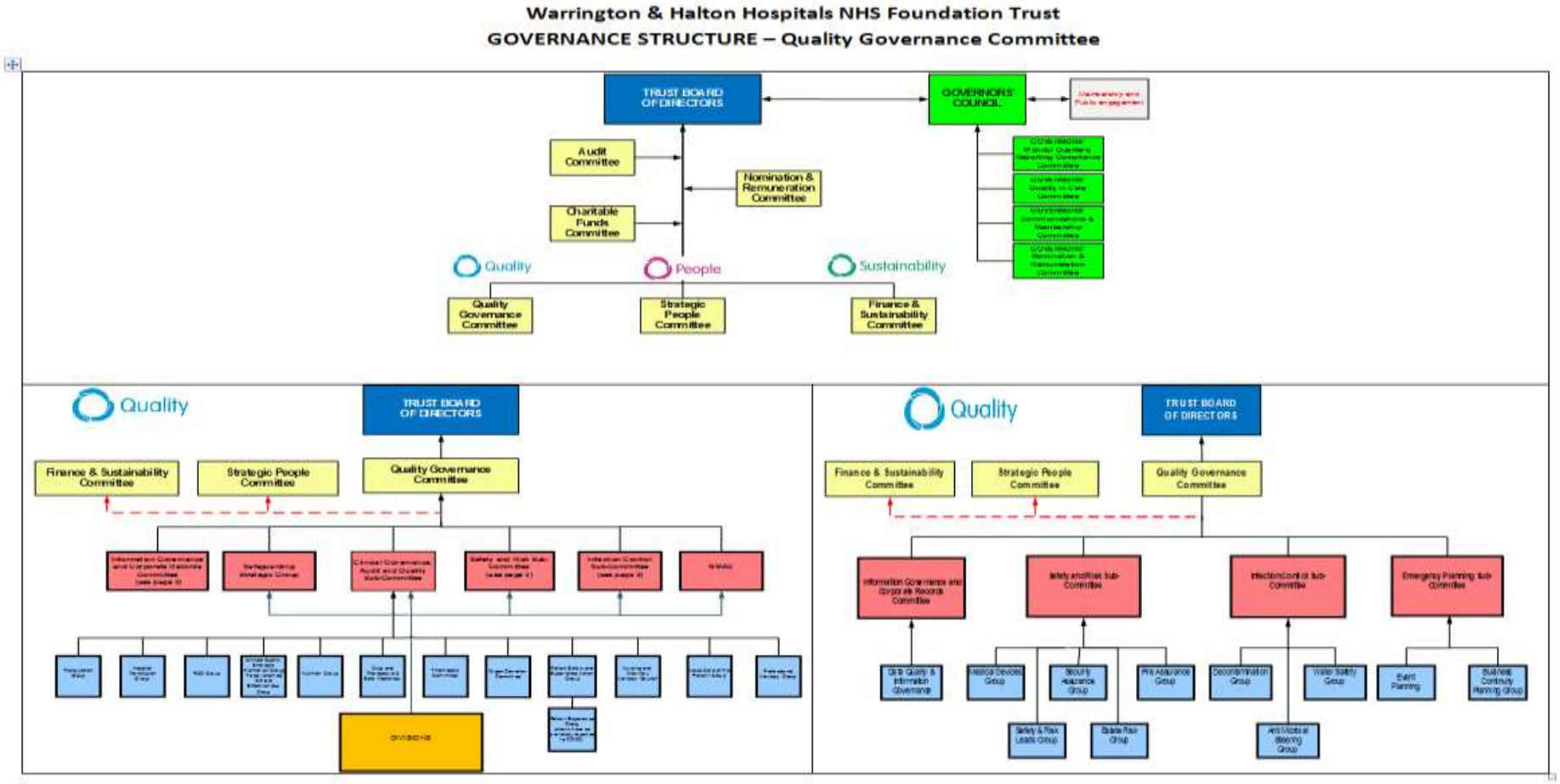
ASSOCIATED DOCUMENTS

Incident and Investigation Policy
Concerns, Compliments and Complaints Policy
Procedure for Handling Claims
Health and Safety Risk Management Agreement
Risk Assessment Policy
Health and Safety Policy
Warrington and Halton Hospitals NHS Foundation Trust Maternity Service Risk Management Strategy
Dignity at Work Policy
Safeguarding Procedures

APPENDICES

Appendix 1 Organisational Chart showing the Trust's Committee structure
Appendix 2 Framework for Grading of risks

APPENDIX 1 ORGANISATIONAL CHART



APPENDIX 2 FRAMEWORK FOR THE GRADING OF RISK

Purpose:

The purpose of the Framework is to provide a consistent approach to the grading of risks within the Trust, however and wherever, they are identified.

All risks, whether identified from a health and safety risk assessment, a clinical incident, a legal claim or a risk management standard self-assessment, should be graded in a consistent manner against the same generic criteria. The Trust Board (and its sub-committees) can then be confident that risks have been assessed using a consistent method and criteria. This will enable valid comparisons to be made between different types of risk, and for judgements and decisions to be made using a consistent methodology.

The Framework is taken from the National Patient Safety Agency document 'A Risk Matrix for Risk Managers' (January 2008).

Method:

Risk can be measured using a combination of the consequence or impact of an event and the likelihood or probability of it occurring.

The accepted formula for grading risk is*:* ***Consequence x Likelihood***

This involves making a judgement both as to the ***Consequence*** (or the severity of the impact) if the risk is realised, and the ***Likelihood*** (or probability) of the risk occurring, or recurring. To measure the risk a score is allocated from 1 to 5 for both Consequence and Likelihood with each number defining a different degree of severity or probability. Multiplying the two scores will give an overall risk score which is shown in the form of a matrix in Table 3.

A brief guide to the scores is provided below for both Consequence and Likelihood:

Consequence:	*Likelihood:*
1 = negligible	*1 = rare*
2 = minor	*2 = unlikely*
3 = moderate	*3 = possible*
4 = major	*4 = likely*
5 = catastrophic	*5 = almost certain*

RISK GRADING MATRIX

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints /audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
		Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Critical report	standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency

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

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 – 6	Moderate risk
8 – 12	High risk
15 – 25	Extreme risk

Instructions for use

- ❑ Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
- ❑ Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
- ❑ Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. Score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome.

4 Use table 3 to calculate the risk score by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score

APPENDIX A QUALITY GOVERNANCE COMMITTEE TERMS OF REFERENCE

Document Title	Quality Governance Committee Terms of Reference
Document Reference	GC
Author	Committee Chair / Associate Director of Governance
Accountable Director	Chief Executive
Trust Committee	Trust Board
Date Ratified	May 2011, May 2012,May 2013 and May 2014
Review Date	May 2015
Mandatory/ Statutory Standards or Requirements	• CQC and Monitor Compliance Framework

PURPOSE

1 The Governance Committee is accountable to the Trust Board for ensuring that the integrated governance framework is implemented throughout the organisation, so providing assurance to the Board that organisational risks are being managed appropriately and that quality and safety is adhered to in line with the Care Quality Commission Essential Standards for Quality and Safety.

ACCOUNTABILITY

2 The Committee is a formally constituted Committee of the Trust Board.

3 The Chairman of the Committee will be an independent Non Executive Director supported by the lead Executive Director.

4 The Committee will report directly to the Trust Board following each meeting providing assurance that robust governance arrangements are in place throughout the organisation.

REPORTING ARRANGEMENTS

5 The Committee will have the following reporting responsibilities:

a) To ensure that the minutes of its meetings are formally recorded and regularly submitted to the Board. Any items of specific concern, or which require Board approval, will be the subject of a separate report supplied by the Chair of the sub committee.

b) To provide an annual report to the Board setting out the progress made and future developments.

c) To bring to the Board's attention urgent risk issues.

DUTIES

6 The Committee shall have the following remit:

- ❑ To assure the Trust Board that there is a comprehensive and integrated approach to risk management throughout the organisation.
- ❑ To receive reports from the Clinical Governance, Audit and Quality Sub Committee; Infection Control Sub Committee; Safety and Risk Sub Committee; Information Governance and Corporate Records Sub Committee, Strategic Work force Sub Committee and Emergency Planning on matters and risks relating to Governance, Safety and Quality.
- ❑ To advise the Board of any areas of concern relating to the Quality of Care / Service provided to service users.
- ❑ Keep under review and revise the Trust risk management strategy to ensure relevance to the corporate agenda on an annual basis.
- ❑ Oversee the framework and governance arrangements of other Board Committees by receiving the Chairs report and any approved minutes in addition to other reports as required.
- ❑ Receive reports on risks with a current score of 15 to ensure integration into the Trust Risk Register and ensure actions are being taken to mitigate or eradicate these risks.
- ❑ Monitor and maintain the Trust Risk Register and seek assurance that appropriate actions are being taken to mitigate or eradicate risks.
- ❑ Present the Trust Risk Register to the Board for assurance.
    - ❑ Produce an annual report for the Board providing assurance on the effective operation of and compliance with the risk management framework and risk management strategy ensuring that both internal and external stakeholders are aware of the content. The annual report will also include the requirement of the Governance Committee to demonstrate compliance with these terms of reference.
    - ❑ Oversee the requirements of and the Trusts compliance with, the Statement of Internal Control, CQC registration and other legislation.
    - ❑ Receive reports and consequent action plans from reviews carried out by external agencies that have identified any areas of risk.
    - ❑ Receive reports of internal reviews and serious untoward incidents and ensure action plans are implemented.

MEMBERSHIP

7 The Governance Committee shall have the following membership:

Core Member	Nominated Deputy	Representing
Non Executive Director (Chair)	Non Executive Director	Non Executive Director
Non Executive Director	Non Executive Director	Non Executive Director
Chief Executive	Deputy Chief Executive	Lead Executive Director
Director of Nursing	Deputy Director of Nursing	Nursing Strategy
Director of Finance	Deputy Director of Finance	Finance
Director of Governance and Organisational Development	Deputy Director of Human Resources Associate Director of Governance	Human Resources Governance
Chief Operating Officer	Nominated Divisional Operational Director	Operations
Medical Director	Divisional Medical Director	Clinical Service
Director of IT	TBA	
Divisional Medical Representative	DIGG Lead Unscheduled Care	Medical Leadership
Associate Director of Governance & Risk	Head of Safety and Risk	Governance & Risk
Divisional Operational Director, WCSS	Associate Director of Nursing	Divisional Operations
Divisional Operational Director, Scheduled Care	Associate Director of Nursing	Divisional Operations
Divisional Operational Director, Scheduled Care	Associate Director of Nursing	Divisional Operations
Chief Pharmacist	Deputy Chief Pharmacist	Trust Pharmacy Service
Head of Allied Health Professionals	Senior AHP	Trust APH Representative
Nursing and Quality Lead	GP Governing Body Member	Warrington CCG
GP Governing Body Member	Nursing and Quality Lead	Warrington CCG
In Attendance	**Nominated Deputy**	**Representing**
Board Secretary	Executive Secretary	Minute Taker/Secretary to the Committee
Co-opted members as appropriate	-	-

8 When a member of the committee is unable to attend they will send their nominated deputy in their place where applicable.

9 75% attendance will be achieved by the core/nominated deputy approach.

QUORUM

10 A quorum shall be when one Non Executive Director, two Executive Directors; the Director of Nursing or deputy; and one Senior Clinician are in attendance.

11 All Core members and in their absence, their nominated Deputy shall have one vote. In the event of a tie, the Chairman of the Committee shall have the casting vote.

FREQUENCY OF MEETINGS

12 The Committee will meet every two months.

REPORTING GROUPS

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

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

14 The following groups will report directly to the Committee:

a) Safety and Risk Sub Committee
b) Information Governance and Corporate Records Sub Committee
c) Emergency Planning Sub Committee
d) Infection Control Sub Committee
e) Clinical Governance, Audit and Quality Sub Committee

ADMINISTRATIVE ARRANGEMENTS

15 The Secretary to the Committee will be responsible for:

a) attending to take minutes of the meeting;
b) keeping a record of matters arising and issues to be carried forward;
c) updating the current and archived Action Plans;
d) updating the Work Plan;
e) providing appropriate support to the Chair and Committee Members;
f) agreeing the agenda with the Chair and attendees;
g) collating papers for meetings;
h) advising the Committee on the governance arrangements of the Committee;
i) ensuring the papers of the Committee are filed in accordance with the Trust's policies and procedures.

DELEGATED POWERS

16 The Trust Board has delegated powers to the Committee to Ratify Policies relating to Control of Infection, Health and Safety, risk management and governance (including clinical).

17 The Committee will also ensure governance issues have been considered by the Clinical Governance, Audit and Quality Sub Committee, Emergency Planning Sub Committee, Safety and Risk Sub Committee, Infection Control Sub Committee, Information Governance and Corporate Records Group and Strategic Workforce for approval of policies pertaining to their terms of reference.

REVIEW / MANAGING EFFECTIVENESS

18 The Committee Chairman together with the Chief Executive and Associate Director of Governance and Board Secretary will review the years activities and produce an annual report for submission to the Trust Board on the effectiveness of the Committee, covering the following:

a) duties

b) who the members are, including nominated deputies where appropriate

c) how often members must attend

d) requirements for a quorum

e) how often meetings take place

f) reporting arrangements into the high level risk committee(s)

g) reporting arrangements into the board from the high level risk committee(s)

h) how the organisation monitors compliance with all of the above.

In compiling the report, the agenda's, papers and minutes of the meetings will be reviewed in order to report on items, a-g above. The report will include an action plan if required identifying the staff member responsible and timescale for rectifying any deficiencies in compliance for monitoring by the Trust Board or the Chief Executive on its behalf.

19 The Committee will review the Terms of Reference, Membership and Governance arrangements annually.

EQUALITY IMPACT ASSESSMENT

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

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Physical Disability	NO	
	Learning Difficulties/Disability or Cognitive Impairment	NO	
	Mental Health	NO	
	Race	NO	
	Carer	NO	
	Nationality	NO	
	Ethnic origins (including gypsies and travellers)	NO	
	Culture	NO	
	Religion or belief	NO	
	Gender (Male, Female and Transsexual)	NO	
	Sexual orientation including lesbian, gay and bisexual people	NO	
	Age	NO	
2	Is there any evidence that some groups are affected differently?	NO	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4	Is the impact of the policy/guidance likely to be negative?	NO	
5	If so can the impact be avoided?	N/A	
6	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

DOCUMENT INFORMATION BOX

Item	Value
Type of Document	Strategy
Title	Risk Management Strategy
Published Version Number	7
Publication Date	July 2013
Review Date	May 2014
Author's Name + Job Title	Millie Bradshaw, Associate Director of Governance on behalf of Karen Dawber, Executive Director
CQC Standard Measure	Outcome 1 to 28
Consultation Body/ Person	Governance Committee
Consultation Date	May 2013,July 2013, May 2014
Approval Body	Governance Committee
Approval Date	May 2013 and May 2014
Author Contact	Millie Bradshaw ext 2484
Librarian	Millie Bradshaw
Division/Corporate Services	Governance
Specialty (if local procedural document)	
Ward/Department (if local procedural document)	
Readership (Clinical Staff, all staff)	Staff
Information Governance Class (Restricted or unrestricted)	Unrestricted


People

W&HHFT/TB/14/085

BOARD OF DIRECTORS

Paper Title	Human Resources / Education & Development Key Performance Indicators (KPIs) Report
Date of Meeting	28 May 2014
Director Responsible	Karen Dawber
Author(s)	Mick Curwen
Purpose	This report focuses on the KPIs which are felt to give a good indication to the Board on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Paper previously considered	**Committee**	**Date**
HR / E&D KPIs Reports	Trust Board meetings	30 April 2014
HR / E&D KPIs Reports	Strategic People Committee	7 April 2014

Relates to which Trust objectives — **Appropriate**

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

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
Mandatory training rates are largely unchanged but appraisal rates for both non-medical and medical staff have increased	**Pages 2 - 4 / Section 2.1 & 2.2**
7 more doctors revalidated	**Page 4/Section 2.3**
Sickness absence – slight decrease in month but stable	**Page 4 /Section 2.4**
Turnover relatively stable and the number of vacancies are at their highest level for over year – reflecting the need to make financial savings in the latter part of previous year. Headcount falling.	**Page 5 / Section 2.5 & 2.6**
Temporary staffing expenditure – decrease in expenditure of £129k	**Pages 5 & 6 / Section 2.7**
All main Equality and Diversity targets achieved for 2014 and reasonable progress on training target	**Page 6 / Section 2.8**

Recommendation(s)

The Board is asked to consider the key points above and the detailed report attached (Appendix 1)

Appendix 1

Human Resources / Education & Development
Key Performance Indicators Report May 2014

1.0 Introduction

This report focuses on the KPIs which are felt to give a good indication on progress with the main workforce and governance performance areas within Human Resources and Education and Development.

Some KPIs lend themselves to monthly monitoring whilst others are bi-monthly, quarterly, bi-annually or annually and this is indicated on the 'dashboard' attached. With all of the KPIs the performance is shown under the traffic light system of Red, Amber or Green against the target and the threshold criteria. This should enable Board members to see at a glance the progress being made and to allow a greater focus on those areas which are red or amber. This 'dashboard' is part of a wider number of KPIs which are monitored at the Strategic People Committee and their links to CQC/NHSLA compliance.

The dashboard attached to this report shows the progress on KPIs, focussing on the position at April 2014, where applicable.

2.0 HR and E&D Trust Workforce Standards KPIs Overview

2.1 Mandatory Training

The target for all mandatory training is 85%.

There has been very little change to the mandatory training rates but there was an increase for Fire Safety. The trend in recent months of little change has therefore continued. However, individually, some Divisions/areas are meeting the trust target for some parts of the mandatory training.

Completion rates for the Divisions are as follows (figures in brackets denotes the month of March 2014):

Division	Fire Safety	Health & Safety	Manual Handling
Scheduled Care	73% (72%) (Amber)	88% (87%) (Green)	61% (61%) (Red)
Unscheduled Care	75% (76%) (Amber)	86% (85%) (Green)	73% (73%) (Amber)
Women's & Children's	77% (76%) (Amber)	89% (90%) (Green)	74% (77%) (Amber)
Estates	75% (67%) (Red)	98% (98%) (Green)	95% (95%) (Green)
Facilities	74% (69%) (Red)	81% (81%) (Amber)	82% (83%) (Amber)
Central Operations	50% (50%) (Red)	75% (75%) (Amber)	25% (50%) (Red)
Corporate Areas	82% (81%) (Amber)	96% (96%) (Green)	90% (90%) (Green)

NB Central Operations only has 4 members of staff

There are no areas achieving all of the targets.

At a Corporate level the arrangements introduced in September 2012 for Corporate Induction continue to work well and a very impressive 100% of staff attended corporate induction during April 2014.

2.1.1 Health & Safety (Green)

There has been no change from the previous month and the rate remains at 88% and green. The target for 2014/15 is being achieved.

2.1.2 Fire Safety (Amber)

There has been an increase of 1% from the previous month and the rate is 76% and amber.

As mentioned at the last meeting the previous Fire Officer, Dave Wood, is returning to the trust in June 2014. In the interim, Fire training is being provided from an external company.

2.1.3 Manual Handling – Patient / Non-Patient Combined (Amber)

There has been no change from the previous month and the rate is 75% and amber.

2.1.3.1 Manual Handling Patient Training Only (Red)

There has been no change from the previous month and the rate is 67% and red.

2.1.3.2 Manual Handling Non-Patient Training Only (Green)

86% of staff completed Non-Patient MH training, which was a slight reduction of 1% from March but the target is still being met.

2.2 Staff Appraisals

The target for completed PDRs is 85%.

There has been an increase for both non-medical staff and medical staff.

Completion rates for the Divisions for non-medical staff are as follows (figures in brackets denotes the month of March 2014):

Division	PDR Rate
Scheduled Care	71% (71%) (Amber)
Unscheduled Care	64% (63%) (Red)
Women's and Children's	75% (74%) (Amber)
Estates	63% (62%) (Red)
Facilities	73% (68%) (Amber)
Central Operations	0% (0%) (Red)
Corporate Areas	74% (62%) (Red)

NB Central Operations only has 4 members of staff

There are no areas achieving the target however, the Corporate areas did make significant progress in month with an increase of 12% and Facilities had a notable increase of 5%.

2.2.1 Non-Medical Staff (Amber)

For the period up to April 2014 the percentage of non-medical staff having had an appraisal increased by 1% and is 70% and the status is amber.

Divisions have been reminded at the bi-lateral meetings that priority must still be given to appraisal rates despite the financial position and there is an expectation that rates should

rise.

2.2.2 Medical & Dental Staff (Amber)

The combined rate for Consultant staff and Middle Grade doctors, up to April 2014 has increased by 2% to 79%. The rate for Consultants was 85% (no change) and other M&D 67% (a increase of 6%).

This means that the target of 85% was not achieved and the status is 'amber'.

2.3 Revalidation for Medical and Dental Staff (Green)

The Revalidation Decision Making Group met as planned on 6 May 2014. 51 doctors have been approved for revalidation by the GMC, an increase of 7 from the previous report, with 12 doctors deferred, making the rate 81%.

The next Decision Making Group meeting will take place on 3 July 2014.

2.4 Sickness Absence

2.4.1 Sickness Absence Rates (Amber)

The new sickness absence target for 2014/15 is 3.75%.

Sickness absence for April 2014 showed a slight deterioration in month from the previous month to 4.18%.

Sickness absence continues to be closely monitored and managed in all areas in the Trust in line with the Attendance at Work Policy. The number of staff being managed either through the Short Term Absence or Long Term Absence Sections of the policy, remains at well over 300 staff.

The main reason for sickness absence is 'Stress' which accounts for over a quarter of all absence. This is monitored separately and was discussed at the last Strategic People Committee. The 'Top 10' areas have been requested to ensure that stress risk assessments and action plans are in place. At this stage it is not known for certain whether the 'stress' is work related or non-work related and managers have been requested to indicate this when recording absence on ESR so that a more accurate assessment can be made.

2.4.2 Return to Work Interviews (RTW) (Red)

The target for this KPI is 85% and is only reported on a quarterly basis so the next available information will not be until July 2014. The rate shown on the dashboard is the position at the end of Q4 for 2013/14 which was 42%. At training sessions managers are reminded of the need to undertake RTW interviews and record these on ESR. It is believed that more RTW interviews are actually taking place but managers are failing to record this on ESR.

2.5 Turnover Rate (Green)

The target for this KPI is min 8% or max 9%. This is designed to reflect that both a high and a low figure could be detrimental to the interests of the trust. A high figure could indicate dissatisfaction with the trust and lead to increased recruitment and training costs. A low figure could indicate a 'stagnant' workforce with potential lack of new ideas and inspiration.

The rate for the previous 12 months up to April 2014 increased to 8.96% and there is a slight

upward trend developing. Nonetheless, the status remains as green.

2.6 Funded Establishment / Staff In Post / Vacancies (Green)

The Trust FE FTE was 3686 and staff in post 3392 FTE. This means the vacancies FTE has increased to 7.97% and the status is 'green'. The relatively high number of vacancies is mostly due to pressure on some managers to not fill vacancies to contribute to the financial position in the trust.

The headcount was 4171 which was a reduction of 18 from the previous month. From a peak of 4201 in January 2014 there have now been reductions in each of the last 3 months which is linked to the trust financial position.

2.7 Expenditure on NHSP Bank/Agency/Medical Locum (Red)

The threshold for this KPI is 4.5% of total pay bill. Total spend in April 2014 decreased by £129k and was £826k, which represents 7.58% of the pay bill. Against the agreed threshold for 2014/15 of 4.5% the status, therefore, is 'Red' and was not achieved.

Details of the main areas of expenditure for April are as follows:

Nurse Bank and Agency Nursing - £350k (£401k for March)
Agency (exc Medical & Nursing Agency) - £110k (£181k for March)
Medical Locums and Medical Agency - £366k (£374k for March)

All areas of expenditure decreased with Nurse Bank /Agency decreasing by £51k, Agency by £71k and Medical Locums by £8k.

Although it is encouraging to report a reduction in expenditure, it is therefore clear that the main focus of attention needs to remain on Nurse Bank/Agency and Medical Locum/Agency expenditure.

The Temporary Staffing Group for Nursing and Midwifery met on 20 May 2014 and as previously reported, the format of the meeting concentrated on the NHS Employers tool on 5 High Impact Actions: 'Data', 'Process', 'Workforce', 'Collaboration/Procurement' and 'Staff Engagement' and is now beginning to consider wider issues across other staff groups. Specific actions reported on included the following:

- Rolling adverts, the first of which is for A&E/AMU with interviews arranged for 4 June 2014
- Updated job descriptions and person specifications. Completed
- eDBS. Contact made with a supplier called 'Atlantic Data' but another system called TRAC being demonstrated on 22.5.14
- Nursing Home Recruitment. Joint initiative with NHSP
- Vacancy Audit. Completed for A&E/AMU.
- Recruitment Open Day. Work in progress.
- International Recruitment. Scoping work commenced for Consultant Radiologists.
- Social Media Recruitment. Progressing work with Twitter, Facebook and Linkedin. Contact made with 'WeNurses' and 'WePharmacists'.
- Recruit over Establishment. Proposals being worked up for Radiography and Pharmacy.
- Temporary Staffing Dashboard. Work in progress.

The above work complements the work undertaken by Ernst and Young on 'Cost Controls' which has a strong emphasis on reducing/controlling temporary staffing expenditure. Specific work has also been undertaken on Medical Productivity and additional resource has is to be provided by Ernst and Young from 22.5.14.

A separate report on the agenda on the Workforce Transformation Project gives more detail.

Discussions continue on all of the above issues at the bi-lateral Divisional review meetings.

2.8 Equality & Diversity

2.8.1 E&D Specialist in place (Green)

The Trust E&D Specialist Adviser commenced in June 2012 through a SLA with the Countess of Chester Hospital Trust which runs until June 2014. A meeting was held on 20.3.14 with Chester to discuss a possible extension of the SLA and agreement has now been reached and the final details are now being worked through.

2.8.2 Annual Workforce Equality Analysis Report published (Green)

This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is 'green'.

2.8.3 Annual Equality Duty Assurance report published (Green)

This was achieved for 2014 with the Report published on the Trust Website. Therefore, the status is 'green'.

2.8.4 Annual Equality Objectives published (Green)

This was achieved for 2014 and the status is 'green'.

2.8.5 Annual Equality Strategy published (Green)

This was achieved for 2014 and the status is 'green'

2.8.6 Staff have access to E&D information and resources (Green)

Trust staff do have access to E&D information and resources.

2.8.7 Staff have undertaken E&D Mandatory Training (Red)

This is only reported bi-annually and the rate for 31 March 2014 was 56%.

Warrington and Halton Hospitals NHS Foundation Trust

Governance & Workforce Division

Human Resources / Education & Development Workforce Key Performance Indicators

2014/15			Target / Threshold	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date	Criteria for RAG Status: Green	Amber	Red
Training & Development	Mandatory Training	Heallth & Safety	85% staff trained in last 3 years	Monthly	88%												**88%**	85 - 100%	70 - 84%	< 70%
		Fire Safety	85% staff trained in last 12 months	Monthly	76%												**76%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Patient	85% staff trained in last 2 years	Monthly	67%												**67%**	85 - 100%	70 - 84%	< 70%
		Manual Handling - Non-Patient			86%												**86%**			
		Manual Handling - Total			74%												**74%**			
	Staff Appraisals	Non Medical	85% staff received appraisal in last 12 months	Monthly	70%												**70%**	85 - 100%	70 - 84%	< 70%
		Medical & Dental - consultants & career grades, (exc Jnr Drs)			79%												**79%**			
	Revalidation for Medical & Dental Staff		85% of eligible M& D Staff revalidated	Monthly	81%												**81%**			
Sickness Absence	Sickness Absence Rates		4%	Monthly	4.18%												**4.18%**	3.75%	3.76-4.59%	> 4.50%
	Return to work interviews (wef 2013/14)		85%	Quarterly													**42%**	85 - 100%	70 - 84%	< 70%
Workforce	Turnover (Leavers)		Min 8% or Max 9%	Monthly	9.0%												**9.0%**	8 - 9%	5 - 7.9% / 9.1 - 12%	< 5% / > 12%
	Establishment / SIP	Funded WTE (see NB 1 below)	Min 6.5% or Max 10% FE / SIP gap	Monthly	3686												**3686**	6.5 - 10%	5 - 6.4% / 10.1 - 12%	< 5% / > 12%
		Staff in Post WTE (see NB 1 below)			3392												**3392**			
		Staff in Post Headcount (see NB 2 below)			4171												**4171**			
		Vacancies WTE (see NB 1 below)			294												**294**			
		Vacancies %			7.97%												**7.97%**			
	Flexible Labour Expenditure (% of total paybill)	Bank / Agency / Medical Locums Total	4.5%	Monthly	6.6%												**6.6%**	4.5%	4.6 - 5.0%	> 5.0%
	Equality & Diversity	E&D Specialist in place	Achieved	6-monthly													**Achieved**	Achieved	Work in progress	No progress
		Annual Workforce Equality Analysis report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Duty Assurance report published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Objectives published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Annual Equality Strategy published	Achieved	Annual													**Achieved**	Achieved	Work in progress	No progress
		Staff have access to E&D information and resources	Achieved	6-monthly													**Achieved**	Achieved	Work in progress	No progress
		Staff have undertaken E&D training	85% staff trained	6-monthly													56%	85 - 100%	70 - 84%	< 70%

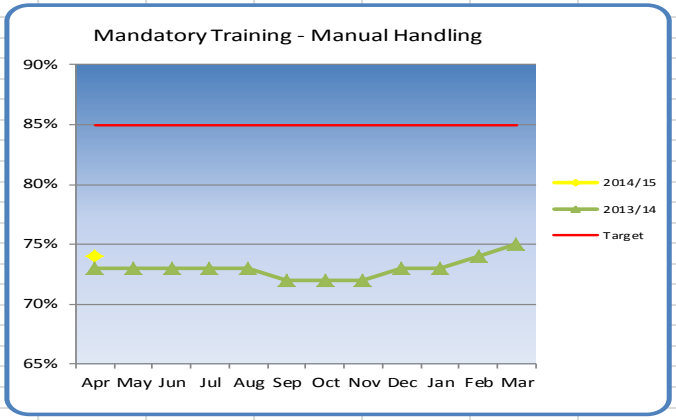
NB 1 Figures from Finance Ledger

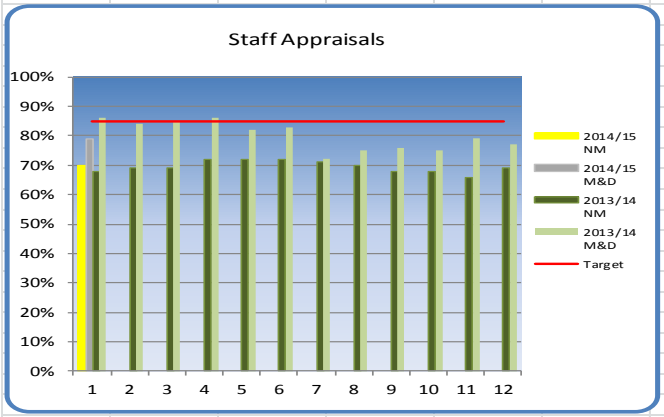
NB 2 Figures from HR ESR

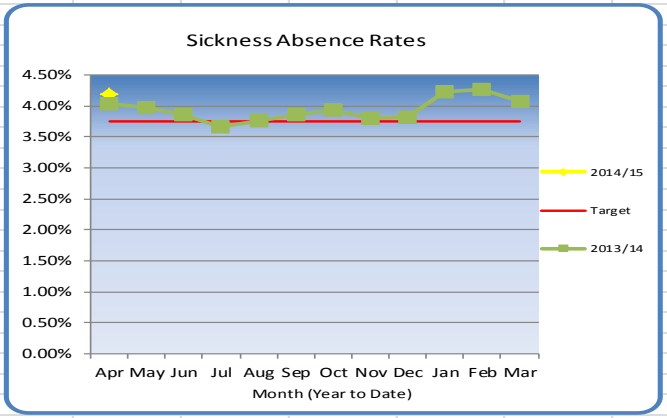
R	Red	A	Amber	G	Green

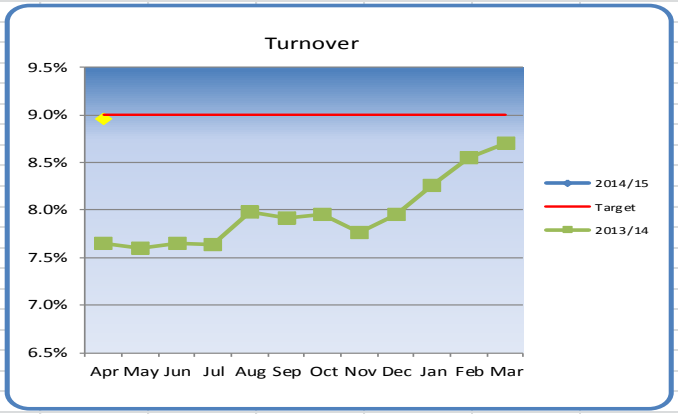

Mandatory Training - Health & Safety
89%
88%
87%
86%
85%
84%
83%
82%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target

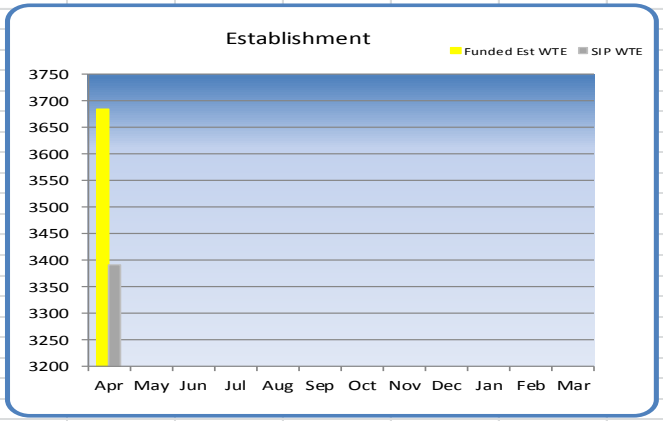

Mandatory Training - Fire Safety
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


Mandatory Training - Manual Handling
90%
85%
80%
75%
70%
65%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Target


Staff Appraisals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 2 3 4 5 6 7 8 9 10 11 12
2014/15 NM
2014/15 M&D
2013/14 NM
2013/14 M&D
Target


Sickness Absence Rates
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Month (Year to Date)
2014/15
Target
2013/14


Turnover
9.5%
9.0%
8.5%
8.0%
7.5%
7.0%
6.5%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
Target
2013/14


Establishment
Funded Est WTE
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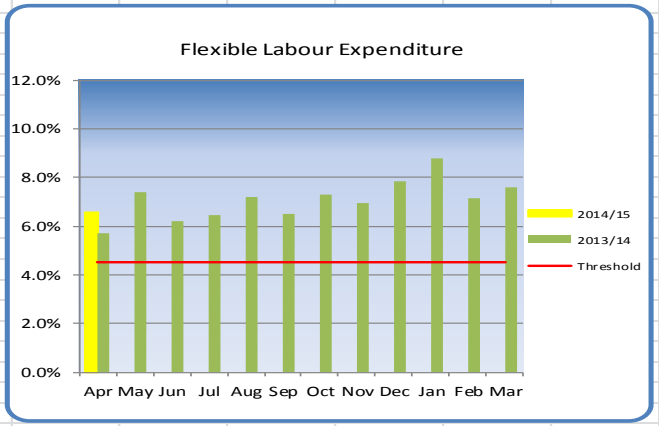
Flexible Labour Expenditure
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10.0%
8.0%
6.0%
4.0%
2.0%
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Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2013/14
Threshold

W&HHFT/TB/14/85(ii)

BOARD OF DIRECTORS

Paper Title	Workforce Transformation Project – Trust Board Update
Date of Meeting	28th May 2014
Director Responsible	Karen Dawber
Author(s)	Roger Wilson
Purpose	To update the Trust Board on the initial progress made through the Workforce Transformation Project

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	**√ appropriate**
• Ensure all our patients are safe in our care	**√**
• To be the employer of choice for healthcare we deliver	**√**
• To give our patients the best possible experience	**√**
• To provide sustainable local healthcare services	**√**

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	Administrative and Clerical Staff Review – Following Executive Team discussions, the project plan is currently being refreshed	**2. I**
•	Medical Productivity – Following the baseline audit, a reconciliation process is being undertaken to assess current job plans against payroll data	**2. II**
•	Additional Staffing Spend – Action plans are being developed to address the highest areas of spend in 2013/2014	**2. III**
•	Workforce Planning - Workshops have been set up to allow detailed discussions with each Division about different approaches to developing a sustainable workforce for the future. Work has been undertaken in Outpatients on Competency Based Workforce planning, this will be rolled out across the organisation	**2. IV**

Recommendation(s) (include what you require the Board to do; approve/**note**/ratify etc.)

The Trust Board is asked to note the content of this report. A further progress report will be presented to the June Trust Board meeting

Workforce Transformation Project
Trust Board Update
May 2014

1. Introduction

The Workforce Transformation Project effectively commenced on Monday 7th April 2014, there are three core strands to the project: -

i. Administrative and Clerical Staff Review
ii. Medical Productivity
iii. Additional Staffing Spend

There is a further strand, which is a key-underpinning element and will help to support the future sustainability of the project

iv. Revising and refreshing the Trust approach to workforce planning

2. Project Update

i. Administrative and Clerical Staff Review

Following an Executive Team discussion on Thursday 15th May 2014, the scope for the review is being refreshed and updated. The key stages of the review process are being clarified and a communication/engagement plan is being developed to support rollout.

ii. Medical Productivity

The Medical Productivity work stream continues to develop. Clinical Divisions have been refreshing the data on existing job plans and additional resource is being brought into the organisation from Ernst & Young, with effect from 22nd May 2014. The key priority at the initial stage is to audit all existing job plans and to compare with payroll data. Engagement levels with Clinical Divisions remains high.

iii. Additional Staffing Spend

From the analysis of 2013/2014 spend on Additional Staffing, 6 core areas to be addressed have been identified, these are as follows: -

a. Critical Care (20% of total net overspend figure)
b. Accident + Emergency (19%)
c. Elderly & Stroke (19%)
d. Radiology (11%)
e. Specialty Medicine (10%)
f. General Surgery (10%)

The net overspend figure for 2013/2014 was £6,379,936. Action plans are being developed to support how these areas of spend are addressed with sustainable solutions. Currently, a review of non-clinical overtime is being conducted to assess the potential for significantly reducing the spend in 2014/2015.

iv. Workforce Planning

Underpinning elements I to III above, is the need to refocus and refresh the approach to

Workforce Planning in the Trust. Health Education England will require the Trust to complete a workforce planning template document by July 2014 and this allows the Trust scope to hold workshops with all the Divisions in the Trust.

A framework for these sessions has been developed and these sessions will take place on 29th May, 2nd June and 19th June 2014. There is enthusiasm from the Divisions to have protected time to look at this issue in greater detail.

Health Education England have been invited to all of these sessions and have accepted the invitation.

In preparation for these sessions a workforce analysis has been conducted for each of the Divisions with a Trust overview too.

On a related note, the Trust has already embarked upon a roll out of Competency-Based Workforce Planning. This process started in Outpatients, the revised staffing structures are in place and went "live" on 12th May 2014. A recurrent saving of £80,000 will be realised from this revised staffing structure.

Discussions are on going with colleagues in the Communications Team to explore revised approaches to recruitment using Social Media.

3. Summary and Recommendations

The Trust Board is asked to note the content of this report. A further progress report will be presented to the June Trust Board meeting

Roger Wilson
Interim Lead for Workforce Transformation
20th May 2014

W&HHFT/TB/14/086

BOARD OF DIRECTORS

Paper Title	Publication of Ward Staffing Data
Date of Meeting	28th May 2014 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	
Purpose	The report sets out the actions required by the Board of Directors to comply with the recommendations from the 'Hard Truths' report published in November 2013

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•		

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board of Directors is asked to:

- note the progress and actions being taken
- confirm support of the proposals to publish information which will be uploaded on to the Trust website monthly
- confirm the support and give the authority to the Director of Nursing and OD to sign off the data to be submitted to UNIFY on a monthly basis.

Updated Briefing Paper on the requirements of the Trust to publish staffing

Data in line with "Hard Truths" November 2013

1.0 Introduction

1.1 The following briefing sets out the actions required by the Board of Directors to comply with the recommendations from the 'Hard Truths' report published in November 2013.

2.0 Background

2.1 This briefing builds on previous reports presented to the Board over the last twelve months. Many of the requirements set out in the report have already been actioned. However there are further requirements which will need to be put in place from April 2014 and no later than June 2014

3.0 Expectations of the Board

3.1 Boards take full responsibility for the quality of care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Responsibilities include:

- Managing staffing capacity and capability by agreeing staffing establishments
- Considering the impact of wider initiatives (such as cost improvement plans) on staffing
- Monitoring staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-by-shift basis versus planned staffing levels
- Examining trends in the context of key quality and outcome measures
- Asking about the recruitment, training, skills and experience, and management of nurses, midwives and care staff and giving authority to the Director of Nursing and OD to oversee and report on this at Board level.

4.0 How must Boards do this?

4.1 The Board should receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report page12 and reflects a realistic expectation of the impact of staffing on a range of factors.
This report:

- Draws on expert professional opinion and insight into local clinical need and context
- Makes recommendations to the Board which are considered and discussed
- Is presented to and discussed at the public Board meeting
- Prompts agreement of actions which are recorded and followed up on
- Is posted on the Trust's public website along with all the other public Board papers.

5.0 What should the Board papers look like?

Papers to the Board on establishment reviews (reported every six months as a minimum) should aim to be relevant to all wards and cover the following points:

- Demonstration of the use of evidence based tool(s)
- What allowance has been made in establishments for planned and unplanned leave
- The difference between current establishment and recommendations following the use of evidence based tool(s)
- The skill mix ratio before the review, and recommendations for after the review
- The difference between the current staff in post and current establishment and details of how this gap is being covered and resourced
- Details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent

- Evidence of triangulation between the use of tools and professional judgement and scrutiny
- Details of any plans to finance any additional staff required
- Details of workforce metrics - for example, data on vacancies (short and long-term),sickness / absence, staff turnover, use of temporary staffing solutions (split by bank /agency / extra hours and over-time)
- Information against key quality and outcome measures - for example, data on safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction.

5.1 The paper should make clear recommendations to the Board, which should be considered and discussed at a public Board meeting. Actions agreed by the Board should be detailed in the minutes of the meeting, and evidence of sustained improvements in the quality of care and staff experience should be considered periodically.

5.2 There is a requirement for our Board to receive its first report in June 2014 However, the Board has already received several reports covering elements of the requirements. The next full report will be in September 2014 ensuring compliance with the full six monthly staffing review going forward

6.0 Board and Executive responsibilities

6.1 The Board should ensure that systems, policies and procedures are in place to support decision making for staffing decisions on a shift-by-shift basis. To comply with this the following actions are in place:

- Staffing is monitored on a daily basis supported by escalation procedures and agreed staffing
- E-Roster is being implemented and the roll-out of automated bank will take place concurrently with this by use of the NHSP interface
- Any shifts that breach the minimum staffing levels are automatically flagged with senior nurse and reported on the risk management system
- We are in the process of rolling out good practice guidance and this will be updated onto the “Hub” throughout May 2014
- We are implementing a paper based system to record staffing levels throughout June. Once the E Roster has been fully rolled out we will be in a position to change to an automated process. This will include an “at a glance” dashboard on the Hub
- A full staffing review has been presented at March Trust Board that included the recommendations for:
    - Supervisory ward managers
    - Uplift in establishments - total investment £1,000,000
- The Director of Nursing and OD, through the Associate Directors of Nursing, monitors staffing shift by shift and adjustments take place as required
- Nurse Staffing levels to be a standing item at the weekly senior nurse meeting and NMAC
- Workforce data is analysed bimonthly via the strategic people committee and on a monthly basis via the HR KPI dashboard
- The quality indicators are displayed monthly via the quality dashboard at Board and throughout 2014 the revised ward assessment tool will be rolled out

7.0 Publishing and displaying data

7.1 It is now a requirement that we publish the planned and actual staffing and description of the team so that it is visible to patients and visitors at ward level, and in the future across all clinical areas. We are putting in place across all of our wards, a poster which is updated at the start of every shift that includes planned and actual staffing available. This will roll-out in June across all areas. All areas have been involved in the format of the poster via NMAC.

7.2 We are in the process of developing a report which will be uploaded on to our website and NHS Choices webpage from June, it is expected that a template will be produced for Trusts to follow.

7.3 Additionally guidance has been issued on the 17th May, form NHS England setting out how information needs to be reported on a monthly basis via UNIFY. It is expected that Trusts will upload this data no later than the 10th of June, this will then be displayed publically on NHS choices from the 24th of June along with additional quality indicators.

8.0 Governance on managing staffing capacity

8.1 The Director of Nursing and OD has reviewed the governance structure for managing safe staffing and this is set out below. This is in addition to the daily reviews.

- From June onwards the Associate Directors of nursing will be required to provide an assurance briefing on staffing levels at the monthly bilateral review
- The Director of Nursing and OD will review all staffing teams directly with ward sister/charge nurses and their management teams every six months and will provide a six monthly report to the Board.
- The Strategic People Committee will manage the risk and any exceptions and provide assurance to board.
- Weekly Executive meetings cover items of risk and the Director of Nursing and OD will brief the executive of any issues to promote prompt action and resolution
- All incidents including staffing incidents are reviewed on a weekly basis and escalated as per the risk management structures.

9.0 Recommendation

The Board of Directors is asked to:

- note the progress and actions being taken
- confirm support of the proposals to publish information which will be uploaded on to the Trust website monthly
- confirm the support and give the authority to the Director of Nursing and OD to sign off the data to be submitted to UNIFY on a monthly basis.

Karen Dawber
Director of Nursing and OD May 2014

Appendix 1 - Template

DRAFT not for use - final version to be made available via the UNIFY system

Fill rate indicator return

Staffing: Nursing, midwifery and care staff

Reporting Period: 1/5/2014 to 31/05/2014

Please provide the URL to the page on your trust website where your staffing information is available

					Day				Night				Day		Night	
Hospital Site Details		Ward name	Main two specialties on each ward		Registered nurses/ midwives		Care Staff		Registered nurses/ midwives		Care Staff					
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		S1	S2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Select from from drop down list		Select from from drop down list	Select from from drop down list									Automatic calculation	Automatic calculation	Automatic calculation	Automatic calculation

Appendix 2 - Factsheet

Nursing, Midwifery and Care Staff Staffing Fill Rate Indicator UNIFY Return

This factsheet will be updated weekly for the next four weeks to take account of additional queries
It will be posted on the NHS England website at this link http://www.england.nhs.uk/news/

Timeframes

- The first data collection period is 1 to 31 May. This data must be returned by 12 noon on Tuesday 10 June.
- The UNIFY template will be accessible on the UNIFY website on 2 June.
- The information will be subsequently be displayed on NHS Choices.

The Template Explained

Reporting Period	The calendar month.
URL Link	This link is provided to direct the NHS Choices user to more detailed information about your staffing, held on your own Trust website.
Hospital Site Code	Select your hospital site code from the drop down box. All hospital sites can be added to one overall return for each Trust.
Ward Name	Enter the ward name or number. All wards with inpatient beds need to be included, with the exception of • Day care wards • CDU • Additional capacity wards Where appropriate please ensure the ward name is in line with the names of wards used on the FFT submission to allow alignment on the NHS Choices website. Please make sure you do not use abbreviations.
First Specialty	Select the first specialty for the ward from the drop down box. The specialty list is based on the FFT specialties list with additional codes added for mental health, community and high dependency areas.
Second Specialty	If there is more than one, select the second specialty for the ward from the drop down box. Data should be entered for the whole ward. If the ward covers more than two specialties please select the two for which there are the most patients.
Night	Night is defined as the shift period within which midnight falls.
Day	Day shifts are all the periods not included in night shift.
Registered Nurse / Midwife	A member of registered nursing or midwifery staff on the duty rota dedicated to the inpatient area.

Care Staff	A member of staff on the duty rota dedicated to the inpatient area with delegated responsibility from a registered nurse/midwife. Examples could include: • Nursing Assistants • Midwifery Assistants • Health Care Assistants • Support workers • Auxiliary Nurses • Assistant Practitioners
Total monthly planned staff hours	Enter the total monthly planned hours for: • Registered Nurses / Midwives on day shifts • Registered Nurses / Midwives on night shifts • Care Staff on day shifts • Care Staff on night shifts
Total monthly actual staff hours	Enter the total monthly actual hours worked for: • Registered Nurses / Midwifes on day shifts • Registered Nurses / Midwifes on night shifts • Care Staff on day shifts • Care Staff on night shifts
Average Fill Rates	This information will be automatically calculated from the data entered on the template. The fill rate is calculated by taking actual hours as a percentage of planning hours for: • Registered Nurses / Midwives on day shifts • Registered Nurses / Midwives on night shifts • Care Staff on day shifts • Care Staff on night shifts
Hospital Site Monthly Fill Rate	This will be automatically calculated from the data entered on the template when you select your hospital site(s). The fill rate calculation is the planned versus actual staffing as a percentage variance for the hospital site.

Staff to be Included and Excluded

The following staff should be included:

All members of registered nursing/midwifery and care staff on the duty rota dedicated to the inpatient area – this includes supervisory ward/team leaders, ward co-ordinators, staff specifically booked to special a patient, staff doing additional hours on top of their booked shift should have their extra hours added.

The following staff should be excluded:

Staff not included on the staff duty rota. This would usually include specialist nurses covering a number of wards, supernumerary students, registered nurses undertaking a period of preceptorship (if not planned to be in the planned staffing and therefore supernumerary), physiotherapists, occupational therapists and hospitality staff such as hostesses.

UNIFY

The template for inputting data should be downloaded from the UNIFY system at the following address: http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx

Those Trusts who have not previously registered to use the site will be required to do so prior to data submission. If you do not have a Unify account, you can register at http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx. Click on the account request link and fill in the details. The domain you will need is Knowledge and Intelligence.

Data should be entered into the white cells. The values in green cells will be calculated automatically from the data entered.

When completed the spreadsheet should be uploaded to the UNIFY system.

Factsheet Updates

This factsheet will be updated weekly and can be found at http://www.england.nhs.uk/news/

Quarry House
Quarry Hill
Leeds
LS2 7UE

16th May 2014

Gateway Reference: 01644

To: CEOs and Directors of Nursing of Trusts and Foundation Trusts with inpatient areas
CC: NHS TDA CEO and Director of Nursing
Monitor CEO
Care Quality Commission Chief Inspector of Hospitals
Health Education England CEO and Director of Nursing
Regional Directors and Regional Chief Nurses
Area Team Directors and Area Directors of Nursing
CCG Accountable Officers

Dear Colleague

Re: Publishing Staffing Data on NHS Choices

As you are aware all Trusts with inpatient beds are required to publish their staffing fill rates (actual versus planned) in hours on the NHS Choices website in June. This letter provides you with a number of documents to enable you to deliver on this expectation. These are:

1. The template that you will need to have populated with your fill rate data from the 1st - 31st May time period, validated and submitted via UNIFY by 12 noon on 10th June
2. A factsheet including answers to queries that you might have and information on how and where to access further support with meeting this requirement

NHS Choices Website

On 24th June, data on staffing fill rates for nurses, midwives and care staff will be presented on the NHS Choices website. Patients and the public will be able to see how hospitals are performing on this indicator in an easy and accessible way. The data will sit alongside a range of other safety indicators.

As well as submitting the May staffing data via UNIFY, all Trusts are also asked to publish their actual versus planned staff fill rates on a ward by ward basis on their Trust website. You will be asked, within the template set up on UNIFY, to provide the URL to your own “safe staffing” web page (or the page where the information is published). The URL will enable the NHS Choices team to establish this link from the NHS Choices website to your Trust website. Each Trust has an NHS Choices nominated member of staff who will be able to coordinate this.

The Template

Appendix 1 sets out a mock-up of the data template. The actual template will be embedded within UNIFY, and is presented here to give you an overview of the cells and level of information required

from you. Your data for 1st to 31st May needs to be entered and uploaded by 12 noon on 10th June. Those Trusts not meeting the 10th June deadline for submission of their data via the UNIFY system will result in a red flag on their NHS Choices hospital webpage.

Trust Board Reporting

It is an expectation set out in the National Quality Board (NQB) guidance published in November 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

Reports to your Trust Board must meet the requirements set out in the NQB guidance, with particular reference to page 12 regarding monthly publishing. The guidance states that the Board will be advised of those wards where staffing capacity and capability frequently falls short of what is planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. This could be presented as an exception report, providing the Trust website publishes ward by ward data on actual versus planned numbers of staff by registered nurse / midwifery / care staff and day duty / night duty.

Factsheet, Advice and Ongoing Support

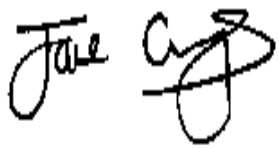
The key document underpinning this requirement is the NQB guidance. In addition, a factsheet has been prepared, and is attached as appendix 2, to provide you with additional information on data collection etc. Further support and guidance can be accessed via the Chief Nurse Offices in the four regions, your area team or the TDA:

- NHS England: North – Hazel Richards hazel.richards1@nhs.net
- NHS England: Midlands and East – Sylvia Knight sylvia.knight@nhs.net
- NHS England: London – Bronagh Scott bronagh.scott@nhs.net
- NHS England: South – Deborah Wheeler deborah.wheeler1@nhs.net
- NHS TDA: Jacqueline McKenna Jacqueline.mckenna@nhs.net

I fully appreciate the amount of work involved in enabling this significant step forward in our strive for openness and transparency and I am grateful for your support in delivering what is a first both in England and much further afield.

With thanks and best wishes

Yours sincerely,



Jane Cummings
Chief Nursing Officer
England

W&HHFT/TB/14/087

BOARD OF DIRECTORS

Paper Title	Draft People Account 2013/114
Date of Meeting	May 2014
Director Responsible	Director of Nursing and OD
Author(s)	Karen Dawber
Purpose	To advise the Board on the activity and progress of the Departments within the People Directorate during 2013/14. Final approval for the report will be at the next Strategic people Committee.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	See table setting out progress to date on the implementation of the recommendations.	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the progress made on the development of the People Account 2013/14

DRAFT PEOPLE ACCOUNT

April 2013 – March 2014

Karen, Dawber

Director of Organisational Development & Nursing

May 2014

This document details the work being done across the Director of Organisational Development and Nursing's portfolio in respect of the Trust People Agenda for 2013 / 14

DRAFT PEOPLE ACCOUNT

April 2013 – March 2014

The purpose of this report is to set out the work being done within the trust which focuses on our staff.

The greatest proportion of the Trusts annual spend is spent on staffing. Making our employees our most significant investment.

Introduction

There are many Departments within the Trust that contribute to the People Agenda. Many of the key elements of the work contributing to the People Agenda are reported within this document.

This report is not a detailed annual report of each area but an overview of the foundations which will be used to further develop the Trust People Strategy.

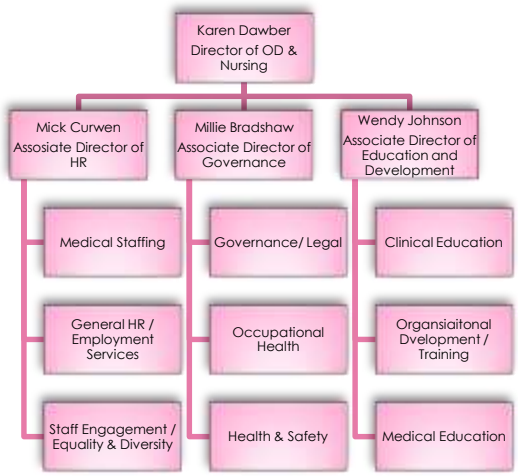
Overview of 2013 / 14

2013/2014 has been a busy and exciting year for the People Agenda. As a Trust we have taken huge steps towards embedding the People elements of QPS.

Throughout the Trust there is a genuine recognition that a sustainable organisation is only achievable with the right people in the right places. That may involve the need to attract or retain talented professional who can contribute to the overall Trust objective of achieving High Quality and Safe Patient care.

It will be essential for the success of the new 5 year strategy that the foundations that have been laid in making Warrington and Halton Hospitals an employer of choice continue and that we continue to implement an infrastructure that develops and retains our people and puts them firmly at the heart of the organisation

The People Structure



Human Resources

This year has seen a significant level of activity in the Human Resources Department with the team being heavily involved in the cost saving measures across the trust as well as the general HR responsbilities.

Policies & Procedures

Following review and full consultation the Strategic People Committee has approved the following policies during 2013/14:

- Work Experience Policy
- Disability and Equality Policy
- Equal Opportunities Policy
- Translation Policy
- Time for Trade Union Duties
- Organisational Change Policy
- Capability Procedure
- Raising Concerns (Whistleblowing) Policy
- Attendance Management Policy
- Remediation Policy for Medical and Dental Staff

Absence Management

The sickness absence target for 2013/14 was 3.5% which is challenging and requires all of the various measures put in place to be contributing to the achievement of the target.

Sickness absence continues to be closely monitored and managed in all areas in the Trust in line with the Attendance at Work Policy. The number of staff being managed at any one time thorough either the long term or short term absence sections of the policy is well over 300 individual members of staff.

The annual sickness absence figure for 2013/14 was 4.13% (up to February). The breakdown by department was as follows:

To be included when available

The Return to work KPI is 85% and reported quarterly. Although the rate is increasing the rate is still very low and well short of the 85% target. At training sessions managers are reminded of the need to undertake RTW interviews and record these on ESR. It is believed that more RTW interviews are actually taking place but managers are failing to record this on ESR.

Quarter	Return rate
Q1	30%
Q2	36%
Q3	37%
Q4	XX

Disciplinary

The Department has seen significant activity throughout 2013/14 with 62 cases. All disciplinary investigations and hearings are supported by a HR professional. Dealing appropriately with disciplinary issues is key to ensuring staff feel that a fair and just system is in place and although the Case load is significantly higher than the KPI of 24 case per year there have been no Employment Tribunal claims lodged against the trust in 2013/14.

Grievances and Dignity at Work

The KPI target set for the number of grievance cases lodged in a year is 9. There were 7 cases lodged in 2013/14.

With regard to Dignity at Work cases the KPI is 9 or less access lodged in a year. There were 17 cases lodged this is significantly higher than the KPI set. An Audit is being carried out into the reasons for the higher level of cases.

Organisational Change

The team has been involved in all consultations for organsiational change throughout the trust with effected numbers ranging from a few staff to entire departments. Some of the key projects have included:

- Outpaitents Workforce Competency Project
- Consultations with Pharmacy department regarding removal of paid breaks and changes to hours
- Migration of all staff to the Cheshire and Merseyside Treatment Centre, including Corporate, Theaters, Therapies and Radiology staff.
- Re-allocation of Domestic staffing
- Radiography working hours and Band 7 Radiology review
- GU Medicine reorganization
- Elderly Care reconfiguration
- Theatre reconfiguration

Union Relations

Following a period of unrest internally between the Unions represented at the Trust, there was a period where there was no agreed Staff Side Chair. 2013 saw the appointment by Unions of both a Staff Side Chair and Vice Staff Side Chair. This coincided with the approval of the revised Time for Trade Union Duties Policy which has increased dedicated Union time to support the Trust and its projects at this time.

The greater stability within the Union structure and the clearly identified routes for consultation has allowed a good relationship to continue. This consultative approach has been further enhanced by the introduction of a weekly meeting between the Staff Side Chair, Vice Chair, Associate Director of HR and the Director of OD and Nursing. These meetings supplement the Joint Consultative Committee and the Divisional Consultative Committees.

The new Organsaitional change policy has clearly set out the process for consultation and has also reduced some of the more common issues by laying out agreed best practice.

Workforce Planning

It is not possible to create a sustainable organisation with a competent and sustainable workforce.

As later stages of this report detail there is a significant amount of work going on to compliment the overreaching workforce plan such as the development of a Talent Management Scheme, behavioral framework and recruitment competencies.

Where we are now?

The Trust employs 4,100 individual members of staff.

A breakdown of the workforce is being produced and will be added when avalible

Plans going forward

The Trust is working closely with Heath Education North West to develop its workforce planning processes and functions in order to better support sustainability within the organisation.

Workforce planning events 2014/15

- Unscheduled Care - 29 May
- Scheduled Care – 2 June
- WCSS – 19 June

Work will be focused around the following key questions:

- What do we need to provide quality and sustainable healthcare?
- Where are the people we need?
- Where is our current Talent pool?
- What is our succession plan?

Next steps

Following completion of the Workforce Planning Events Divisional Plans will be developed and embedded.

Temporary Staffing

The levels of temporary staffing spend despite various measures remained high and a high risk to the Trust and remain unsustainable.

Finance colleagues have provided a detailed breakdown of additional staffing spend by Division and Directorate, for the financial year 2013/2014. This breakdown has been analysed in order to improve the focus of our planning for 2014/2015. We are working closely with our colleagues from Ernst & Young to identify the potential savings to be made in 2014/2015.

The Temporary Staffing Group has taken a task and finish approach to trying to resolve the current issues. A detailed dashboard is being progressed to help analysis and accuracy of assessment.

Medical Staffing

The work of the Medical Staffing team over the last 12 months has included the more regular tasks such as:

- Planning, arranging and attending the Joint Local Negotiating committee (JLNC) throughout the year
- Planning and arranging the annual Clinical Excellence award committee
- Bi-yearly monitoring of junior doctors hours of work providing the outcome analysis for each rota
- Planning, arranging and servicing the Mandatory training programme for Medical & Dental staff throughout the year
- Work related to the on-going job planning reviews
- Hosted the regional Medical Staffing Managers meeting held at the Halton site four times a year

Some more ad hoc work and new work which has required Medical Staffing involvement is detailed below.

Revalidation and Appraisal

The requirement for Medical staff to be revalidated every 5 years was introduced in December 2012. Annual strengthened medical appraisal is an essential requirement in the revalidation process. Significant work was undertaken to ensure implementation of processes related to revalidation leading up to December 2012 which included the drafting and agreeing of the Appraisal policy.

Work continues to ensure improvement upon the work already done and to implement new systems which will provide reassurance to the Trust and external regulatory bodies that clinicians at the Trust are safe to practice.

Over the last 12 months work has included:

- Monthly Appraisal and Revalidation group meetings
- Drafting and agreement of a Remediation policy
- Regular decision making panels are convened and are the forum at which the Responsible Officer will make his decision on revalidation for those individuals who are due to be re-licensed
- Issues log maintained and any highlighted issues resolved through on-going communication between the Revalidation Lead and Medical Education team
- Participation in CRMS drop in sessions which allow clinicians the opportunity to highlight and have resolved any issues they have in relation to the appraisal software
- Quality assurance is undertaken for all appraisals by the Appraisal Lead and Revalidation Lead

- An annual appraisal forum attended by those clinicians who have been allocated as an appraiser to share feedback and good practice

Locum management database

Locum bookings were previously 'managed' via the maintenance of an excel spread sheet, e-mail PST folders and a paper based documentation system. Over time this became cumbersome and was prone to error due to the vast amount of information to be retained.

Work commenced early in 2013 to introduce a Locum Management Database for which Microsoft Access was used. Points to note are as follows:

- Introduced across the Trust on 1st May 2013 (with the exception of Anaesthetics and A&E)
- Following communication with Divisional management all Anaesthetic bookings have been dealt with via the Locum management database since mid-2013.
- Communication continues with A & E

Job plan mediation

Over the last 12 months there has been only one mediation request which was heard by the Medical Director supported by the Head of Medical Employment. Agreement was reached by both parties during the mediation meeting negating the need for a formal Job plan appeal.

Medical training and education group

This group has been convened with the main aim to review current processes related to Study, Professional and Mandatory training leave for Medical & Dental staff. The outcome will be to have an agreed policy which is fair, consistent and meets with the terms and conditions of service.

Appointment of Medical Director

This year saw the appointment of a new Medical Director for which a two day process was undertaken. This was the first time this approach had been used at the Trust for this post and the arrangements and co-ordination were carried out within the Medical Staffing team.

Clinical Lead appointment process

In October 2013 a new formal process, drafted with the Medical Staffing team, was introduced at the Trust for the appointment of Clinical Leads. Previously appointments to these roles were done on an expression of interest basis and with discussions within the appropriate division. Now a formal interview is undertaken and has the involvement of the Medical Director as well as divisional staff and HR. The new process has already been used on a number of occasions and feedback has been positive.

Review of induction arrangements

Work has been on-going and will continue, to enable a more robust induction takes place for Medical and Dental staff particularly in terms of Local induction. A paper has been considered

by the Strategic People Committee and agreed in principle. Steps are now being taken to implement the recommendations.

Junior doctors action team (JDAT) training

The department arranged two sessions for rota managers, clinicians involved in rota maintenance and those who write rotas. The JDAT representative from the Deanery attended the Trust to provide a detailed understanding of the construction of rotas, rules applied to rotas, monitoring of hours etc.

Clinical Education

Information to be included when available

Staff Engagement & Well-being

In 2012 the Trust launched its Staff Engagement, Health and Well-being strategy. It is well documented that in order for Staff Health and Well-being initiatives to be successful and effective, staff need to be highly engaged with the organisation (Boorman).

NHS organisations with high levels of engagement:

- Display higher productivity and organisational performance
- Score more highly in measures of financial effectiveness
- Have higher levels of patient satisfaction
- Have lower patient mortality
- Record lower absenteeism and higher levels of retention

Staff engagement has been shown to be an essential element of successful productivity and quality improvement initiatives. In a number of organisations, is contributing to efficiency saving programmes reducing the need for staff reduction (NHS Employers).

Staff Engagement Strategy

The purpose of the staff engagement strategy was to:

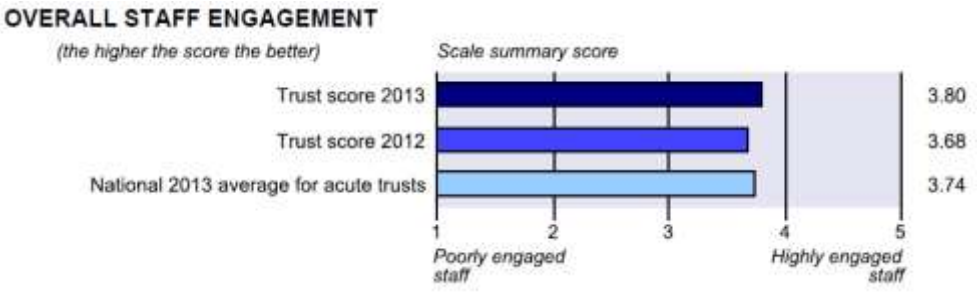
- To increase the levels of staff engagement overall within the trust over the next two years
- To increase the level of staff involvement as measured in the staff survey and staff engagement survey to meet the pledge of the NHS Constitution
- To reduce the range between scores between staff in different areas/departments
- To increase the willingness of staff to recommend the services provided by the organisation to their family and friends
- To embed the principle of Quality, People & Sustainability within the Trust
- Partnership working within the Local Health Economy and internally with our staff side representatives
- Providing an effective staff induction programme and access to learning and development opportunities at all levels in the Trust
- Defining a communication strategy to allow staff effective mechanisms for feedback and interaction

- Ensuring the annual NHS staff survey results, which is a gauge of what we are doing well and where staff feel there is room for improvement are continuously reviewed and actions identified to improve staff experiences across the Trust
- Embedding the NHS Constitution for all staff to ensure understanding, relevance and personal responsibility
- Developing a consistently applied, coordinated and effective health and well being programme for staff.
- To increase numbers of staff accessing flexible working options
- To improve the level of communication between senior managers and staff and develop leadership.

Measurement and Progress

The key measure of Staff Engagement levels within the Trust can be seen in our performance in the National NHS Staff Survey.

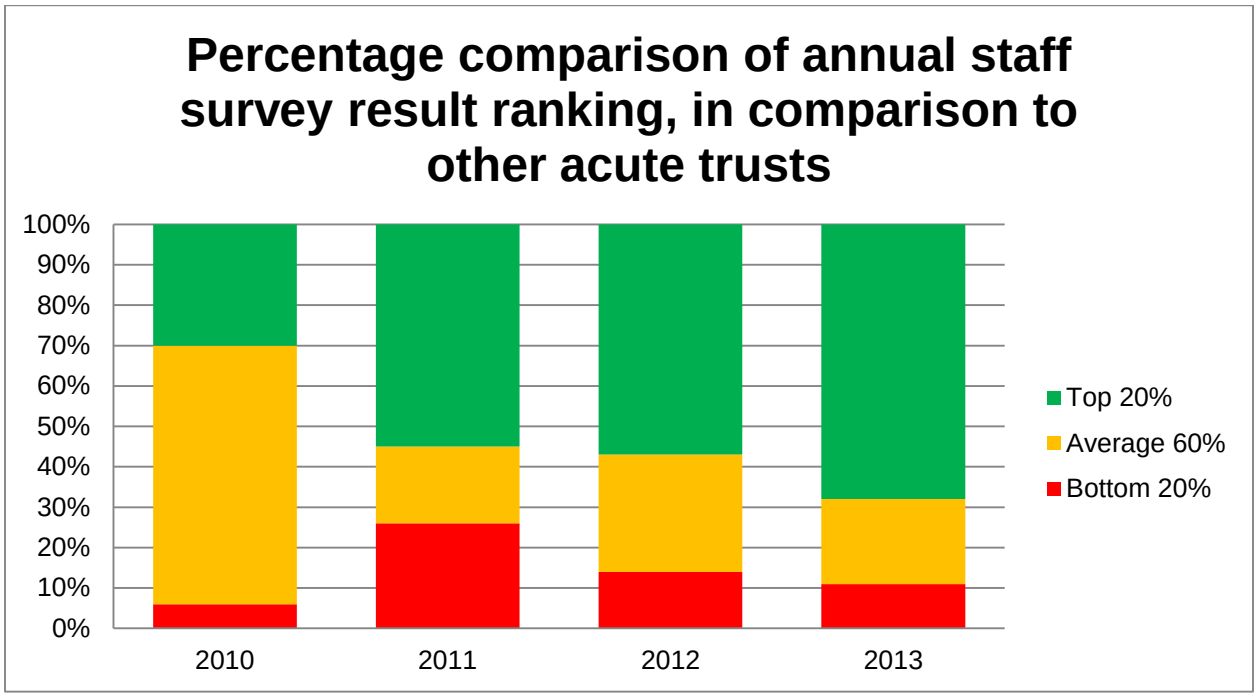
- To increase the levels of staff engagement overall within the trust over the next two years



	Change since 2012 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	✓ Increase (better than 12)	✓ Above (better than) average
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Highest (best) 20%
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	• No change	• Average
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Highest (best) 20%

- To increase the level of staff involvement as measured in the staff survey and staff engagement survey to meet the pledge of the NHS Constitution
- To reduce the range between scores between staff in different areas/departments

- Ensuring the annual NHS staff survey results, which is a gauge of what we are doing well and where staff feel there is room for improvement are continuously reviewed and actions identified to improve staff experiences across the Trust



Please see Appendix 1 for the 2013 Staff Survey Action plan.

- To increase the willingness of staff to recommend the services provided by the organisation to their family and friends

Although this remain one of our bottom 5 ranking scores and ranks us in the bottom 20% of acute Trusts the 2013 staff survey did see a statistically significant positive improvement in this score. Work need to continue to see greater and sustained improvement.

The introduction of the Family and Friends Test for Staff in 2014 may help us develop this aspect further as it requires a quarterly test detailing these questions the results of which are reported to CQC. The Questions reflect the staff survey but require the use of a free writing section to give us more detail.

- To embed the principle of Quality, People & Sustainability within the Trust

It is accepted that QPS is well established throughout the organsiation with its use through the clinical and corporate forums, trust wide communications and the corporate branding. The results of the Staff Engagement Survey in 2012 also support this.

The challenge going forward is to stop asking "Do you know what QPS is?" and start asking "How does QPS impact on your role?". The work being done to develop a behavioral framework will compliment this.

- Partnership working within the Local Health Economy and internally with our staff side representatives

Staff side representatives have been invited to the Staff engagement and Well being Committee and work is currently being done with CCG in respect of smoking cessation.

- Providing an effective staff induction programme and access to learning and development opportunities at all levels in the Trust.
- Defining a communication strategy to allow staff effective mechanisms for feedback and interaction

This work is on-going but new recognition and reward schemes and greater understanding of the need for focused communications through the Staff Survey Results will feed into this work. In addition a significant amount of work is being done on the Engagement, Health and Well-being internal and external websites.

- Embedding the NHS Constitution for all staff to ensure understanding, relevance and personal responsibility

Communication regarding the constitution were promoted through Team brief and the principles are being encompassed by the work being done on the trusts behavioral framework.

- Developing a consistently applied, coordinated and effective health and well being programme for staff.
- To increase numbers of staff accessing flexible working options

Changes in legislation will open up the right to request flexible working options to all staff. Work to review the policy is currently under way and will be taken to encompass this. The Staff Engagement Team will continue to give specialist advice and attend meetings whenever necessary in respect of these cases, looking for amicable solutions.

- To improve the level of communication between senior managers and staff and develop leadership.

The results of the Staff survey show an improvement in the level of communication between senior managers and staff ranking the Trust in the top 20% of acute trusts.

Health & Well-being

Health

During 2013/14 the following key achievements have been identified within the Workforce and Wellbeing Team (Formally Occupational Health)

- SEQOHS accredited in May 2013
- Flu results achieved this year were over the target set by the DOH (75%) at 76.1%
- Measles immunity for all staff working in the hospitals – approximately 40% of areas now have 100% immunity and results of those under 100% are reported to DIGGs every month for action.
- We have carried out work for 2 external agencies and have met the target set in our budget for income generation - we plan to develop this further in the near future and will be continuing to bid for tenders for Occupational Health provision externally.
- Inoculation injuries in 13/14 were 105 – the department has worked closely with a task and finish group chaired by Safety and Risk to introduce safer sharps devices
- Attendance at a wide range of Committee and groups across the Trust.

The following Health provisions have been provided to staff:

- Counselling provision - 145 new referrals in 2013/14
  - Leading reason for referral is work stress
  - Largest group utilizing counseling service is nurses and midwives
  - Usage is split evenly through the four divisions in relation to size of each division.
- A total of 362 Health surveillance assessments were completed in 2013/14
- Staff interactions with Workplace Health and Wellbeing:
  - New management referrals - 1047
  - Review appointments - 731
  - Pre employment assessments face to face - 148
  - Pre employment paper screens - 818
  - Self referrals - 125
  - Blood tests - 955
  - Immunisations - 1315 (this is not including the flu vaccinations)
  - Average 15 - 20 general telephone enquiries per day for health management advice

Health & Well Being Strategy

In delivering its strategic objectives and the QPS Framework the Trust recognises that health and wellbeing is an important factor in the job satisfaction of our staff. We have a clear aim to promote the positive aspects and ideas associated with health and wellbeing at work

Following the publication of the NHS Health and Wellbeing Report and in line with the NHS Constitution and strategy for improving workforce productivity, there has been a major focus on reducing sickness absence and promoting health and wellbeing improvement across the NHS.

It is important to recognise that improving health and wellbeing is about more than reducing sickness absence. A range of workforce initiatives have been utilized throughout the organsiation.

The main principles relating to promoting a healthy workplace and improved health and well being of staff are:

- Prevention of illness and promotion of wellbeing
- Early intervention for those who develop a health condition
- Everyone with the potential to work has the support to do so
- Ability for staff to access comprehensive Occupational Health Services which focus on the promotion of well being and prevention of ill health as well as the ability to provide reactive services focused on screening, treatment related to work issues and advice
- Promote health and wellbeing through Trust management policies, support services, information networks and health promotions, including alcohol awareness, diet, exercise, self management and by liaising with external agencies
- Prevent, so far as is practicable, those circumstances detrimental to mental health and wellbeing

The Healthy Worker

The Healthy Worker training course which is aimed at employees with poor attendance records and has been designed and developed to motivate and empower people to promote self-care approaches to help improve their lifestyle and lead to positive health behaviors.

The course aims to enable participants to be active self carers of their own minor ailments, acute illnesses, long term conditions, or in following a healthy lifestyle. The course was written by psychologists and has been adapted for the workplace.

A number of the Human resources and Occupational Health teams are now trained in the delivery of the course which was funded by NHS Employers North West.

There is evidence that attendance on the course shows benefits to both Employee and Trust.

- For the Employee - Improved health and wellbeing;
  Impact upon the family.

- For the Trust - Improved patient experience and outcomes;
  Sickness absence reduction – improved bottom line.

The originating Trust has estimated a reduction of sickness that they can equate to the course worth a saving of £130,000 in 12 months.

A pilot course was completed during 2013. The overall rating by participants for the course was 4 out of 5, that it had been "very beneficial". Furthermore all 22 participants also confirmed on their feedback forms that they would recommend the course to others.

A quarterly course has been set up for 2014 and staff will be able to access the course through the following routes:

- Through an action plan to improve sickness absence
- Following appraisal or managerial awareness
- Self-referral
- Sign posting through the Occupational Health Department.

We hope to be able to assess the current sickness absence for all attendees and demonstrate improvements over the next 12 months while participating in the course and show the associated drop in absenteeism and cost savings.

The Royal Society for the Prevention of Accidents Award

In April 2014 the Trust was awarded a Silver Award for continuous improvement in accident and ill health prevention at work by The Royal Society for the Prevention of Accidents (RoSPA). The judges consider entrants' overarching occupational health and safety management systems, including practices such as leadership and workforce involvement.

David Rawlins, RoSPA's awards manager, said: "*Organisations that gain recognition for their health and safety management systems such as Warrington and Halton Hospitals NHS Foundation Trust, contribute to a collective raising of the bar for other organisations to aspire to, and we offer them our congratulations.*"

The majority of the awards are non-competitive, grading achievement at merit, bronze, silver and gold levels. Organisations that maintain high standards in consecutive years can win gold medals, president's awards and orders of distinction.

This was the first year the Trust had entered the prestigious Awards lead by the Health and Safety Department an achievement we hope to build upon.

Well-being

NHS North West Games

The Trust has taken part in the NHS North West games for the last three years with participate increasing annually. Last year's event was held in June and the Trust entered Teams in Table tennis and football. For the 2014 event we have teams in half of the events with 2 teams entered for the Football.

The Team won an Award for "Improving Staff Health and Well-Being" at the event for our participation in the event and promotion of Health and Well-being throughout the Trust.

Our Table Tennis and Football Teams in action

Well-being days

For the last 3 years the Staff Engagement teams have worked very closely with the Workplace Health and Well-being team to put on a "Health and Well-Being Day". These events are open to all staff and take place across both sites.

Stall holders are invited from across the trust and the community to give staff a greater awareness of their own wellbeing. They are fun events that have received very positive feedback.

Stall holders have included:

- Fruit stall
- Smoothie on a bike
- Infection Control
- Smoking Cessation
- Exercise awareness
- Stress buster sessions

Last year we ran the Flu vaccinations at the event which was very successful. We hope to repeat the events during 2014.

Staff attending the Health and Well being days

Recruitment, Reward & Recognition

In 2013 the Employment Service Department was established. The team is made up of the Payroll, Recruitment and Workforce Information and works as a shared service for greater efficiency and based on the Halton Hospital Site. A cost efficiency saving was made through the formation of the service, through non-recruitment to posts and a redundancy.

Recruitment & Retention

Work has been continuing this year to embed the shared service principle with reviews of the recruitment processes and procedures. There has been some employee turnover and the new team members have settled in well, the team having taken on the responsibility of training with enthusiasm.

Both medical and non-medical recruitment is administered by the team and over the next 12 months we will be working towards an entirely integrated process with all the Employment Officers able to administer both processes.

There have been two significant changes within the Recruitment during the last 12 months due to outside factors. The first was the amalgamation of the Independent Safeguarding Agency (ISA) and the Criminal Records Bureau (CRB) to create the Disclosure and Barring Service (DBS). This has made little difference in practice but has improved the level of service received with the turnaround time for straightforward checks significantly reducing to around 2 weeks which has helped to speed the recruitment processes.

The second was the launch of a new and updated NHS wide national recruitment portal. The migration from NHS Jobs1 to NHS Jobs 2 occurred in March and went without issue. The system allows the team to send invite to interview, refusal and appointment emails. It also computerises the shortlisting process for the manger giving them access to all the applications both on-site and remotely. There are a few quirks of the new system and the Recruitment Officer is working with NHSJobs and the North West working group.

Recruitment Took kit

The team have worked closely with the Organisational Development Team as a member of the operational group that has designed a 'Recruitment Toolkit' which will be an interactive computerised programme which will guide managers through the recruitment process with practical guidance and tips.

The Toolkit will also be used to support managers to introduce a more competency based recruitment process. This will be supported by the implementation of the behavioral framework in 2014/15.

Recruitment data

Information being collated

Turnover rate & Stability

Turnover

The turnover rate for the Trust remains low and within the KPI target range of a min 7% or max 9% at 8.6%. The reason that the KPI has a range is as there is a recognition that either a high or low rate could be detrimental to the interests of the trust and lead to increased recruitment and training costs. A low figure could indicate a 'stagnate' workforce with potential lack of new ideas and inspiration.

Stability

The rate of stability represents the proportion of staff starters who leave the Trust within 12 months of commencement (excluding temporary staff). The rate for the previous 12 months was XX the KPI being 8% or less.

Where the stability rate has posed some concern in particular areas deep dive work has commenced and the HR Business Partners will work with the Senior Management Team to draw up any necessary action plans.

Progress for 2014

- The medical and non-medical recruitment will be fully integrated during 2014.
- The possibility of introducing an electronic DBS check is being explored and it is hoped would save further time in the number of days to fill the post as applicants would no longer need to attend the Department to complete the forms which can create an unnecessary delay depending on the individual's availability.
- If we move towards an electronic DBS we will also send out an electronic copy of the Occupational Health Questionnaire the appointed candidate can therefore choice to complete it and return us a signed copy again saving days to fill post. They will still have the option to come to the department and complete the forms if they prefer.
- An Employment Services Process group has been set up and has representatives from each team and is lead by the Head of Employment Services, the aim is to continue to examine the processes and make improvements where possible to improve greater efficiency.
- Review of the Exit interview questions and integration of the Exit interview with the ESR system.

Reward

The scope for additional reward in the NHS is fairly limited due to the national pay scales, the Staff Engagement Team work across the Trust to develop new opportunities.

Pay

2013/14 saw a pay rise of 1% across all Agenda for Change pay grades.

The creation of the Employment Services Team has allowed the integration of the Workforce information team into the team and allowed better usage and application of the ESR system.

The Team have continued to maintain the electronic SVL which has brought about efficiencies and support the e-roastering teams.

Pensions

There were no changes to the NHS Pension scheme during 2013/14. But work will start during 2014 to publicise the changes to the pension scheme that take effect in 2015.

Next steps (Total Rewards statements)

The NHS is nationally introducing the facility through the Penisons Agency for staff to access a Total Reward Statement (TRS).

A Total Reward Statement is a personalised summary that shows employees their full employment package including:

- Basic pay
- Allowances
- Pension benefits (for NHS Pension Scheme members)
- Health and wellbeing programmes
- Learning and development
- Flexible working opportunities
- Childcare vouchers
- Cycle to work schemes

Total Reward Statements will be provided annually to most employees. They will be accessible online through the Government Gateway link via the TRS portal. The Trusts statements will be available from 1 August 2014

We are currently working on ensuring staff NHS Pension records are up to date and correct

Benefits (Non pay)

The Staff Engagement team is always looking for new and imaginative ways to provide staff with additional benefits. The NHS is restricted in its pay structure by Agenda for Change and therefore to enable the Trust to stand out and attract talent it is important to ensure that we offer over and above the benefits of just a salary and a pension, every NHS trust can do that!

Salary Sacrifice Schemes

Salary Sacrifice schemes are an excellent way of offering staff benefits as they work by giving staff a pre-tax allowance to be spent on the offered items or service which reduces their overall tax bill, hence giving them a saving. But the from the Trusts perspective of the Trust this reduction in taxable pay offers National Insurance and Employer tax contribution savings also.

Childcare

The Trust has run the Childcare Voucher salary sacrifice scheme for 7 years and an estimate cost saving of £52,793 is made annually. It also enables the Trust to offering a financial benefit to staff

paying for childcare which is beneficial in attracting individuals to the Trust. XX members of staff utilise the scheme each month.

Other Salary Sacrifice Schemes

Over the last couple of years the Trust has introduced a number of additional schemes beginning with the Car Parking scheme, the Car Scheme, Cycle to Work and most recently the IT scheme. Each scheme has been fairly successful but work needs to continue to promote each scheme went the window for joining re-opens.

Scheme	Numbers of Participants	Savings made (Before administration costs and maternity)
Cycle to Work	32	£300
Car	106	£68,000
IT	305	£5000
Car Parking	XXX	XXX

It may be pertinent now staff are more used to salary sacrifice schemes and perhaps less 'skeptical' that we re-launch the Car parking scheme as this has never achieved the uptake expected.

On-site nursery

The Halty's Den Nursery situated on the Halton Hospital site offers reduced price day care to Warrington and Halton Hospital. In addition staff whose children take up places at the nursery receive the additional benefit of paying all their childcare pre-tax and therefore accumulate an even greater saving than through just the Child care voucher scheme.

There were 4 staff with children in the nursery in 2013/14 the rest of the places are taken by other NHS staff and members of the public.

Discounts and offers

The Staff Engagement Team have established a solid bank of companies that offer staff discounts. We also work with the Brindley theatre in Runcorn to offer staff discounted Pantomime tickets for them and their families during the festive season. The Trust also offers a number of NHS wide discounts through the NHS Discounts website and a website called Guava.

Some of the discounts available to our staff

Waterbabies, Topman, Urban Beauty Salon
Nando's Restaurant, Spicy Delight,
LA Bowl, Dominos Pizza,
Gullivers World, DW Gym, Costco
Frankie and Benny's Restaurant, Fit in Gym
David Lloyd, Black Diamond Garage

Recognition

The methods of recognition within the Trust have over the last 5 years greatly expanded with the introduction of the Annual Thank You Awards, team of the month and a review of the long service awards.

None pay recognition strategies are particularly important to the NHS where we are bound by a nationally agreed pay structure and are unable to award bonus like private organisations.

Recognition schemes are not only fundamental to motivation and engagement but can serve as a significant tool in attracting talented employees, by demonstrating the value and worth attached to excellence within the Trust.

The schemes run during 2013 / 14 were:

- Employee of the Month
- Team of the Month
- Thank you Awards
- 20 & 25 Year recognition
- 30, 35 & 45 Year recognition

Employee & Team of the month

To complement the successful Employee of the Month scheme during 2013 we introduced a Team of the month.

The idea for having a Team of the Month came from the Staff engagement Survey carried out in 2013. AS with the Employee of the Month the winning Team has their Award presented by the Chief Executive and instead of vouchers are given a hamper full of treats to share.

As with the Employee of the month, Team of the Month winners have come from both clinical and non-clinical areas. The photographs in figure ?? show our Pediatric team who won in September and the IT Team who won in December.

Winners for 2013/14

Month	Employee of the month	Role and Division	Team of the month	Division
April	**Gina Coldrick**	*External communications Officer - Corporate*	**Cardiac Catheter Suite**	*Unscheduled Care*
May	**Jeanette Henry**	*Clerical Assistant, Dietetic and speech. WCSS*	**critical care**	*Scheduled Care*
June	**Loraine Derbyshire**	*Hematology Nurse Specialist - WCSS*	**Cardiac Rehab**	*Unscheduled Care*
July	**Lesley Latimer**	*A&E Department Manager. Unscheduled Care*	**Theatres, Anesthetics & resus team**	*Scheduled Care*
August	**Christine Slater**	*B18 Ward Clerk. Unscheduled Care*	**Occupational Health**	*Governance and Workforce.*
September	**Michelle Beavan**	*Staff Nurse, A9. Scheduled Care, T&O.*	**Pediatric Nursing Team**	*Women's, Children's, support Services*
October	**Jennie Taylor**	*Executive Assistant. Executive Team.*	**Ward B1**	*Unscheduled Care*
November	**Hilary Porter**	*Sister/ specialist Registered Dental Nurse. Scheduled Care*	**Ward B14**	*Unscheduled Care*
December	**No award given**		**IT**	*Corporate*
January	**Michelle McQuillan**	*Ward Assistant, Domestic Services, Corporate.*	**No award given**	
February	**(Joint winners) Jane Guy and Lynda Ellison**	*Lynda Ellison, Ward Manager, Ward A6 – Scheduled Care.* *Jane Guy – Non member of staff, Multi-Disciplinary Team. Stroke Association.*	**Endoscopy**	*Unscheduled Care*
March	**Ricky Newell**	*Security Officer Corporate*	**The Orthoptic Team**	*Scheduled Care*

The makeup of the judging panel for both awards was also reviewed during 2013 with the current structure comprising of a Public Governor, Staff Side Chair, Deputy Director of Nursing, HR Business Partner, Staff Engagement Lead. In addition the scoring for the awards was redefined to make the processes easier to modify across the judges.

Long service awards

Each year a significant number of staff will reach a significant service milestone working for the Trust. Feedback from staff was that they did not feel that the awards they gained for their dedication to the Trust were a worthy representation of their loyalty and therefore the rewards were reviewed. The level of reward and the number of awards for each milestone are detailed below.

Number of years' service with Warrington & Halton Hospitals	Number of Employees recognised during 2013	Reward for service
20 Years	45	Certificate and badge presented by Manager in department
25 Years	38	Certificate and badge presented by Manager in department
30 Years	18	Invite for employee and a guest to the Thank You Awards, certificate, badge and £75
35 Years	15	Invite for employee and a guest to the Thank You Awards, certificate, badge and £150
40 Years	7	Invite for employee and a guest to the Thank You Awards, certificate, badge and £200

Thank you awards

The Thank You Awards are our annual chance to reflect on what we have done and look at how we recognise our achievements and reward staff for working in the interests of both patients and their colleagues.

Over 250 members of staff – including all the shortlisted nominees, the individuals who nominated them and staff who qualify for a long service award after 30, 35 or 40 years' service with the trust – are invited to the awards to help celebrate.

For the 2013 Awards there were over 100 individual nominations for the awards which were received from across the Trust. The numbers of nominations have grown from just 40 when we first started the awards back in 2009. Nominations have come from teams, individuals who want to recognise their colleague's achievements, managers and members of the public - nominating teams and services that they, or their families have used.

The 2013 winners were as follows:

- Patient Care – *Sue Wilde, WCSS*
- Supporting Patient Care – *Radiology Central booking Team, WCSS*
- Leadership & Learning – *Natalie Crosby, Scheduled Care*
- Innovation, Improvement & Efficiency – *Joanne Meredith, Unscheduled Care*
- Volunteer of the Year – *Warrington League of Friends*
- Team of the Year – *A7, Unscheduled Care*
- Employee of the Year – *Cheryl Holbrook & the Portering & Cleaning Team*

I just want to say a big thank you, to you and your team. The whole event was great with lovely food and music, and most of all A7 won, both my family and the community were very impressed.

Once again thanks.

Kind Regards
Rehana Hassan (Clinical Audit Manager)

Nurse of the Year

Following the celebrations for Nurses day 2013 we have decided that for 2014 we will introduce a Nurse of the Year Award. It may be that this idea can be expanded to other staff groups.

Organisational Development & Training

The service has responded well to the Trust wide challenges and has made a significant contribution to the organisation. In response to the wider financial challenge all non-essential training was postponed from January - April. This had a resulting impact on Service Line Management Development Centres, CMI First Line Management Programme, AQuA AIM programme, operational action learning sets, NLP Diploma programme. Despite this all activity is rescheduled and back on track for April 2014. The staff experience has not been impacted as open and honest communication of the situation has enabled a positive outcome.

Further work is required to drive the service forward over the next 12 months. Specific focus will be placed upon alignment of services, systems and processes.

Key achievements

- First Line Management Programme (CMI level 3) reported a 93% rate for the development of participants leadership skills and 80% application rate for transfer of new skills to the workplace.
- Partnership working with Prospect to design a bespoke Service Line Management Development Centre and supporting 360 assessment tool, based upon an SLM competency framework.
- Development and delivery of an NLP Coach Programme to a cohort of 8 NLP Practitioners.
- Design of a Senior Manager Assessment Centre and reporting structure.
- Introduction of Operational Action Learning Sets.
- Engagement with 'We need a word campaign', 2282 value words were received in total from staff, WHH members, patients and visitors.
- Induction review and subsequent reduction in the delivery time.
- Partnership working with Subject Matter Experts (SMEs).

KPI		**RAG status**
KPI 1	85% of all staff to be compliant for Health & Safety training	
KPI 2	85% of all staff to be compliant for Manual Handling training	
KPI 3	85% of all staff to be compliant for Fire training	
KPI 4	85% of staff to have received a personal development review within the last year	
KPI 5	80% of staff to have developed new knowledge and skills	
KPI 6	80% of staff to have applied new knowledge and skills within the workplace	

Training

E-Learning Activity

In addition to the instructor led sessions, all staff have access to e-learning packages for most of the topics outlined within the trust Training Needs Analysis. Over the last 12 months 4045 e-learning modules have been completed by staff throughout the Trust.

Induction Review

Following a review of Induction, the total number of days spent on induction, combined with essential training for new starters was reduced. For the period September 2013 to March 2014, 396 working days were saved.

Organisational Development

The Trusts has engaged with a number of external bodies in order to begin to develop our leadership and succession planning.

Members of the Trust have been accepted on to the following National Programmes:

- Aspirant Leadership
- National Nursing Programme – Senior Operational Leader's
- Elizabeth Garrett Anderson Programme
- Mary Seacole
- Frontline Nursing Programme

Other course provided by the North West Leadership Academy were attended by senior managers and included:

- Leadership Coaching Skills
- Creating a Resilient Culture
- Talk Culture

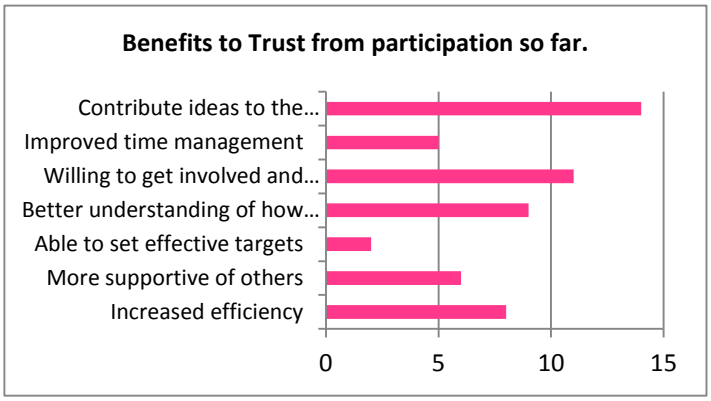
Trust Delivered Programmes – Chartered Management Institute (CMI)

Following the successful delivery of the CMI pilots, the leadership CMI courses were re-launched in 2013 under the banner "Grow your potential". Within this, two programmes will be offered, the first aimed at first line managers "Growing as a Leader" (GAL).

The first cohort commenced the GAL programme in September 2013. Due to trust financial pressures, the second part of this programme has been postponed until April 2014. Those on the course were asked to feedback on the learning to date.

- Over 93% of those who responded reported either a moderate or major development of their leadership skills since commencing the programme.
- 80% are applying new skills and knowledge at least weekly.

Benefits to the Trust of participation on the course



Feedback from previous cohorts

"The programme helped me see the bigger picture and what you actually have to take into consideration when you improve the service."

"The course was very informative and got me to think in a different way."

"At the end of the programme I was more confident in directing and supporting the team".

"There were so many aspects to the programme, the main one that transferred immediately across was the project management skills that are required to deliver a project".

Clinical Training

Information being collated

Equality & Diversity

Information being collated

What next? - 2014/15

Key themes to enable sustainability

- Retain, engage and attract outstanding employees
- Promote a workforce that is diverse and inclusive
- Develop employees to their fullest potential

Overreaching Projects

- Organisational Change Programme support
- CIP Support
- Workforce Competencies
- Behavioural framework competencies
- Talent management plan
- Leadership programme
- Additional Reward and Recognitions schemes

Progress

It is important that during 2014/15 the work within the Directorate continue and that the work being done across the directorate is tied together in the People Strategy and clear and sustainable workforce plans which mirror the intentions of the Executive and enables the achievement of the Trusts 5 year strategy.

Key finding	Focus of work	Action
% agreeing that their role makes a difference to patients	• Administrative and Clerical • Estates and Ancillary staff	• Targeted communications linking non-clinical work to the patient experience. • Patient experience or staff stories regarding the impact of non-clinical staff. • Two categories for employee of the month
% reporting good communication between senior management and staff	• Additional Professional Scientific and Technical • Allied Health Professionals • Estates and Ancillary	• Review of Senior Management communication plan and actions • Targeted communications to specific areas • Specific review of communications in The Additional Professional Scientific and Technical and Allied Health Professionals
% staff recommendation of the trust as a place to work or receive treatment	• Additional Professional Scientific • Nursing and Midwifery	• Develop Staff Family Friendly Questionnaire include space for staff to write additional information • Include additional questions to gain quarterly barometer of Staff Engagement and develop clear action plan with targeted action plan using Staff Survey and FFT results.
% feeling pressure in the last 3 months to attend work feeling unwell	• Clinical areas	• Analysis of the sickness figures and reasons for sickness. • Sickness Absence Group to focus on reasons for presenteeism and performance and reasons for sickness • Health and Wellbeing programme to be rolled out
% experiencing physical violence from patients, relatives or the public in the last 12 months	• Clinical areas	• Asses reported incidents any new patterns • Work with security to raise profile and communicate intent to staff, patients and visitors • Develop any further work with the Police
% witnessing potentially harmful errors, near misses or incidents witnessed in the last month	• Additional Professional Scientific and Technical • Allied Health Professionals	• Analysis of the reported errors, near misses or incidents • Encourage discussion at team / ward meetings and generate actions to improve • Communication of key policies and operating procedures • Use of Single Point training for repetitive issues.

Sustainability

W&HHFT/TB/14/088

Approval of the Annual Report and Accounts 2013/14

To be issued under seperate cover

W&HHFT/TB/14/089

BOARD OF DIRECTORS

Paper Title	Finance Report as at 30th April 2014
Date of Meeting	28th May 2014
Director Responsible	Tim Barlow, Director of Finance & Commercial Development
Author(s)	Steve Barrow, Deputy Director of Finance
Purpose	To provide a performance update against the annual financial plan.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	**appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- Please refer to Executive Summary.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

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

Finance Report as at 30th April 2014

1. Purpose

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 30th April 2014 and the forecast outturn as at 31st March 2015.

2. Executive Summary

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

Key financial indicators

Indicator	Plan £m	Actual £m	Variance £m
Operating income	16.5	16.5	0.0
Operating expenses	(17.3)	(17.3)	0.0
EBITDA	(0.8)	(0.8)	0.0
Non-operating income and expenses	(0.9)	(0.9)	0.0
I&E surplus / (deficit)	(1.7)	(1.7)	0.0
Cash balance	8.3	13.0	4.7
CIP target	0.3	0.2	(0.1)
Capital Expenditure	0.5	0.3	0.2
Continuity of Services Risk Rating	2	2	0

3. Income and Expenditure (Appendix B)

The reported position for the period is a deficit of £1,655k, which is £34k lower than the planned deficit of £1,689k.

This deficit position is comprised of the following variances:

- operating income is £10k above plan
- operating expenses are £22k below plan
- non operating income and expenses are £1k below plan.

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

While the in-month result is a significant deficit, this is in line with plan and reflects the expected lower levels of activity seen in April due to the impact of the Easter bank holiday period. The April results also reflect the planned profile of the cost improvement savings, the delivery of which is weighted towards later months.

4. Cost Improvement Programme

The Trust had an annual savings target of £11.9m and by the year end schemes had been identified to achieve this target, which are included in the table below.

Narrative	In Year £m	Recurrent £m
Annual Target	11.9	11.9
Value of schemes identified	5.9	7.4
Over / (Under) Achievement against target	**(6.0)**	**(4.5)**

For the period to date the planned savings for the identified schemes equate to £336k, with actual savings amounting to £207k which results in an under achievement of £129k.

5. Cash Flow (Appendix C)

The cash balance is £13.0m which is £4.6m above the planned cash balance of £8.4m, with the monthly movements summarised in the table below.

Cash balance movement	£m
Opening balance as at 1st April	13.0
Cash related EBITDA	(0.8)
Decrease in receivables	0.7
Increase in payables	2.5
Capital expenditure	(0.3)
Other working capital movements	(2.1)
Closing balance as at 30th April	**13.0**

The planned cash balances detailed in the cashflow were based on a £10.3m forecast year end cash balance but the actual cash balance was £13.0m as a number of commissioners settled outstanding invoices in March.

The cash balance of £13.0m equates to circa 23 days operational cash. Under the continuity of services risk rating the liquidity metric is -2.2 days which scores at a 3, which reflects a reasonably strong liquidity position but the metric includes all current assets and liabilities excluding inventories, so masks the challenging cash position which is managed through working balances.

The operating performance continues to have an adverse effect on the cash position and creditor payments. In order to maintain a reasonable cash balance, payments to creditors must be extended. Therefore performance against the non NHS Better Payment Practice Code (BPPC) was 46%. This low level of compliance and performance will continue until there is an improvement in the operating position and the resultant cash position.

The Board needs to be aware that until there is a significant improvement in the operating position of the Trust, the management of cash and the prompt payment of creditors will continue to be problematic. This may result in interest charges, refusal to provide goods and services by suppliers and the need to reduce the planned capital expenditure next year.

5. Statement of Financial Position (Appendix D)

Non current assets have decreased in the month by £166k, as capital expenditure is less than depreciation cost.

Current assets have increased by £922k, mainly due to the increase in prepayments relating to maintenance contracts that are paid in the early part of the year.

Current liabilities have increased by £2,438k in the month mainly due to increases in payables and the PDC Dividend creditor.

Non current liabilities have decreased by £27k in the month.

6. Capital

The Board approved the capital programme for £9.9m which has increased to £10.2 following the Capital Planning Group held in April (see Capital Programme 14/15 paper for details). To date the Trust has spent £0.3m against the budget of £0.5m, mainly due to delays in the commencement of various schemes.

Category	Annual Budget £m	Budget to date £m	Actual to date £m	Variance to date £m
Estates	6.3	0.3	0.2	(0.1)
IM&T	2.5	0.2	0.1	(0.1)
Medical Equipment	1.0	0.0	0.0	0.0
Contingency	0.4	0.0	0.0	0.0
Total	**10.2**	**0.5**	**0.3**	**(0.2)**

7. Risk and Forecast

For the period ending 30th April the Trust has recorded a deficit of £1,655k and although this is £34k better than plan, there are still a number of financial risks that need to be addressed, namely:

- Non compliance with contractual data requirements, quality standards, access targets and CQUIN targets resulting in fines or penalties.
- Divisions fail to deliver services within available resources.
- Clinical divisions unable to deliver income targets based on agreed activity plans or deliver additional activity and income identified in budget setting process eg spinal or repatriation.
- Cost savings target not fully identified and delivered in in accordance with profile.
- Increase in readmissions resulting in bed blockages and payment to commissioners for exceeding current agreed threshold.
- Failure to manage escalation or partners inability to provide services to withdraw medically fit patients from the hospital.
- Failure to continue to reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.
- Non receipt or reduced level of anticipated winter funding.

Based on the financial position as at 30th April and the processes introduced to increase financial rigor and scrutiny, the Trust is forecasting achievement of the planned deficit, continuity of services risk rating and all other key financial indicators.

Tim Barlow
Director of Finance & Commercial Development
21st May 2014

Appendix A

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Finance Headlines as at 30th April 2014

Key Financial Metrics	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income	16,537	16,547	10	16,537	16,547	10	213,746	213,746	0
Operating Expenditure	-17,370	-17,348	22	-17,370	-17,348	22	-204,977	-204,977	0
EBITDA	-833	-801	32	-833	-801	32	8,769	8,769	0
Financing Costs	-856	-855	1	-856	-855	1	-10,269	-10,269	0
Net Surplus/(Deficit)	-1,689	-1,656	33	-1,689	-1,656	33	-1,500	-1,500	0
Continuity of Services Risk Rating				2	2	0	3	3	0
Capital Expenditure	566	270	-296	566	270	-296	10,208	10,208	0
Cash				8,342	12,953	4,611	6,731	6,731	0
Cost Savings	336	207	-129	336	207	-129	11,931	11,931	0

Summary Position

The reported position for the period is a deficit of £1,655k which is £34k lower than the planned deficit of £1,689k. This delivers a Continuity of Services Risk Rating 2 which is in line with plan. Elective activity is 189 spells (£109k) above plan and outpatients are 715 attendances (£38k) above plan, although this is offset by both A&E attendances and other activity that are below plan. Pay is £51k below plan and drugs is £91k below plan, although this is partially offset by clinical and non clinical supplies which are above plan.

Cost savings performance is below plan by £129k, which is a concern as the target is backdated towards the latter part of the financial year.

Forecast Outurn

The Trust is forecasting that the planned deficit of £1.5m will be achieved based on the financial position to date, coupled with the introduction of a revised governance structure that will increase financial rigor and scrutiny.

Key Variances

Income & Expenditure - operating income £10k above plan and operating expenditure £22k below plan.
Cost savings - £129k below plan
Cash balances - £4,611k above plan but the plan was based on a forecast year end cash balance of £10.3m but the actual cash balance was £13.0m.
Capital expenditue - £296k below plan due to slippage but forecasting that all slippage is recovereed by year end.

Key Risks

Divisions unable to deliver income tragets based on agreed activity plans or deliver additional activity and income identidfied in the budget setting process.
cost savings target not fully identified and delivered in accordance with profile.
Failure to significantly reduce bank, agency, locum, overtime and waiting list initiative expenditure.

Other matters to be brought to the attention of the Board

EY continue to with operational teams to identify and maximise opportunities for cost reduction.
Monitor have approved the 14/15 forecast deficit but have given the Trust the opportunity to reconsider the £1.0m deficit in 15/16.
Corporate teams in discussions with Warrington and Halton CCGs regarding alignment of the planning assumptions for years 16/17 to 18/19 of the annual plan.

Income Statement, Activity Summary and Risk Ratings as at 30th April 2014

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Activity Income									
Elective Spells	2,785	2,894	109	2,785	2,894	109	39,884	39,884	0
Elective Excess Bed Days	17	20	3	17	20	3	242	242	0
Non Elective Spells	4,473	4,430	-43	4,473	4,430	-43	52,145	52,145	0
Non Elective Excess Bed Days	321	307	-14	321	307	-14	3,701	3,701	0
Outpatient Attendances	2,797	2,835	38	2,797	2,835	38	36,853	36,853	0
Accident & Emergency Attendances	872	842	-30	872	842	-30	10,184	10,184	0
Other Activity	3,939	3,850	-89	3,939	3,850	-89	54,729	54,729	0
Sub total	**15,203**	**15,177**	**-26**	**15,203**	**15,177**	**-26**	**197,738**	**197,738**	**0**
Non Mandatory / Non Protected Income									
Private Patients	13	4	-9	13	4	-9	152	152	0
Other non protected	107	136	29	107	136	29	1,284	1,284	0
Sub total	**120**	**139**	**20**	**120**	**139**	**20**	**1,436**	**1,436**	**0**
Other Operating Income									
Training & Education	641	642	0	641	642	0	7,696	7,696	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Miscellaneous Income	573	589	16	573	589	16	6,876	6,876	0
Sub total	**1,214**	**1,231**	**17**	**1,214**	**1,231**	**17**	**14,572**	**14,572**	**0**
Total Operating Income	**16,537**	**16,547**	**10**	**16,537**	**16,547**	**10**	**213,746**	**213,746**	**0**
Operating Expenses									
Employee Benefit Expenses (Pay)	-12,618	-12,567	51	-12,618	-12,567	51	-147,753	-147,753	0
Drugs	-1,170	-1,079	91	-1,170	-1,079	91	-14,242	-14,242	0
Clinical Supplies and Services	-1,584	-1,688	-104	-1,584	-1,688	-104	-19,154	-19,154	0
Non Clinical Supplies	-1,998	-2,014	-16	-1,998	-2,014	-16	-23,827	-23,827	0
Total Operating Expenses	**-17,370**	**-17,348**	**22**	**-17,370**	**-17,348**	**22**	**-204,977**	**-204,977**	**0**
Surplus / (Deficit) from Operations (EBITDA)	**-833**	**-801**	**33**	**-833**	**-801**	**33**	**8,769**	**8,769**	**0**
Non Operating Income and Expenses									
Interest Income	3	4	1	3	4	1	40	40	0
Interest Expenses	0	0	0	0	0	0	0	0	0
Depreciation	-524	-523	0	-524	-523	0	-6,283	-6,283	0
PDC Dividends	-336	-336	0	-336	-336	0	-4,026	-4,026	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-856**	**-855**	**1**	**-856**	**-855**	**1**	**-10,269**	**-10,269**	**0**
Surplus / (Deficit)	**-1,689**	**-1,655**	**34**	**-1,689**	**-1,655**	**34**	**-1,500**	**-1,500**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,914	3,103	189	2,914	3,103	189	38,181	38,181	0
Elective Excess Bed Days	68	88	20	68	88	20	1,003	1,003	0
Non Elective Spells	2,930	3,006	76	2,930	3,006	76	34,367	34,367	0
Non Elective Excess Bed Days	1,417	1,359	-58	1,417	1,359	-58	16,354	16,354	0
Outpatient Attendances	28,371	29,086	715	28,371	29,086	715	358,741	358,741	0
Accident & Emergency Attendances	8,806	8,541	-265	8,806	8,541	-265	102,814	102,814	0
Continuity of Services Risk Ratings				**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Liquidity Ratio - Metric (Days)				-8.8	-2.2	6.6	-9.0	-9.0	0.0
Liquidity Ratio - Rating				2	3	1	2	2	0
Capital Servicing Capacity - Metric (Times)				-2.5	-2.4	0.1	2.2	2.2	0.0
Capital Servicing Capacity - Rating				1	1	0	3	3	0
Continuity of Services Risk Rating				**2**	**2**	**0**	**3**	**3**	**0**

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

Cash Flow Statement as at 30th April 2014

	Actual April £000's	Forecast May £000's	Forecast June £000's	Forecast July £000's	Forecast August £000's	Forecast September £000's	Forecast October £000's	Forecast November £000's	Forecast December £000's	Forecast January £000's	Forecast Febuary £000's	Forecast March £000's	Annual Position £000's
Surplus/(deficit) after tax	**(1,655)**	**(808)**	**(992)**	**(482)**	**(482)**	**(482)**	**479**	**479**	**481**	**654**	**654**	**654**	**(1,500)**
Non-cash flows in operating surplus/(deficit)													
Depreciation and amortisation	523	524	524	524	524	523	524	524	523	524	524	523	6,284
Impairment losses/(reversals)	0												0
(Gain)/loss on disposal of property plant and equipment	0												0
PDC dividend expense	336	335	335	336	335	335	336	335	335	336	335	335	4,024
Other increases/(decreases) to reconcile to profit/(loss) from operations	(3)	3	3	4	3	3	4	3	3	3	3	3	32
Non-cash flows in operating surplus/(deficit), Total	**856**	**862**	**862**	**864**	**862**	**861**	**864**	**862**	**861**	**863**	**862**	**861**	**10,340**
Operating Cash flows before movements in working capital	**(799)**	**54**	**(130)**	**382**	**380**	**379**	**1,343**	**1,341**	**1,342**	**1,517**	**1,516**	**1,515**	**8,840**
Increase/(Decrease) in working capital													
(Increase)/decrease in inventories	(36)												(36)
(Increase)/decrease in NHS Trade Receivables	775												775
(Increase)/decrease in Non NHS Trade Receivables	154												154
(Increase)/decrease in other related party receivables	(235)												(235)
(Increase)/decrease in other receivables	(1)												(1)
(Increase)/decrease in accrued income	261	656	210	(972)	605	(21)	(607)	(270)	395	(874)	657	(40)	0
(Increase)/decrease in prepayments	(1,833)	233	(100)	(100)	(100)	(100)	333	333	333	333	333	335	0
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	(243)												(243)
Increase/(decrease) in Current provisions	5	(27)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(132)
Increase/(decrease) in Trade Creditors	2,508	(5,405)	119	835	(739)	(113)	313	(22)	(310)	780	(749)	(51)	(2,834)
Increase/(decrease) in Other Creditors	163												163
Increase/(decrease) in accruals	(159)												(159)
Increase/(decrease) in Other liabilities (non charitable assets)													0
Increase/(Decrease) in working capital, Total	**1,359**	**(4,543)**	**218**	**(248)**	**(245)**	**(245)**	**28**	**30**	**407**	**228**	**230**	**233**	**(2,548)**
Increase/(decrease) in Non-current provisions	(27)												(27)
Net cash inflow/(outflow) from operating activities	**533**	**(4,489)**	**88**	**134**	**135**	**134**	**1,371**	**1,371**	**1,749**	**1,745**	**1,746**	**1,748**	**6,265**
Net cash inflow/(outflow() from investing activities													
Property - new land, buildings or dwellings	0	(244)	(245)	(38)	(38)	(38)	(323)	(323)	(323)	(342)	(342)	(343)	(2,599)
Property - maintenance expenditure	(158)	(69)	(114)	(318)	(318)	(318)	(362)	(362)	(363)	(467)	(467)	(468)	(3,784)
Plant and equipment - Information Technology	(67)	(436)	(237)	(210)	(210)	(209)	(167)	(167)	(168)	(223)	(223)	(224)	(2,541)
Plant and equipment - Other	(45)	(28)	(37)	(32)	(32)	(31)	(40)	(40)	(41)	(241)	(241)	(242)	(1,050)
Increase/(decrease) in Capital Creditors	(171)												(171)
Net cash inflow/(outflow() from investing activities, Total	**(441)**	**(814)**	**(670)**	**(598)**	**(598)**	**(596)**	**(892)**	**(892)**	**(895)**	**(1,273)**	**(1,273)**	**(1,277)**	**(10,218)**
Net cash inflow/(outflow) before financing	**92**	**(5,303)**	**(582)**	**(464)**	**(463)**	**(462)**	**479**	**479**	**854**	**472**	**473**	**471**	**(3,953)**
Net cash inflow/(outflow) from financing activities													
Public Dividend Capital received	0												0
PDC Dividends paid	0					(2,012)						(2,012)	(4,024)
Interest (paid) on non-commercial loans	0												0
Interest received on cash and cash equivalents	4	3	3	4	3	3	4	3	3	4	3	3	40
Drawdown of non-commercial loans							266	267	267	266	267	267	1,600
Repayment of non-commercial loans	0												0
(Increase)/decrease in non-current receivables	(99)	118	9	10	9	9	10	9	9	10	9	9	112
Net cash inflow/(outflow) from financing activities, Total	**(95)**	**121**	**12**	**14**	**12**	**(2,000)**	**280**	**279**	**279**	**280**	**279**	**(1,733)**	**(2,272)**
Net increase/(decrease) in cash	**(3)**	**(5,182)**	**(570)**	**(450)**	**(451)**	**(2,462)**	**759**	**758**	**1,133**	**752**	**752**	**(1,262)**	**(6,225)**
Opening cash	**12,956**	**12,953**	**7,771**	**7,202**	**6,752**	**6,301**	**3,839**	**4,598**	**5,356**	**6,489**	**7,241**	**7,993**	**12,956**
Closing cash	**12,953**	**7,771**	**7,202**	**6,752**	**6,301**	**3,839**	**4,598**	**5,356**	**6,489**	**7,241**	**7,993**	**6,731**	**6,731**

Forecast cash position as per Monitor plan	8,342	7,772	7,202	6,751	6,301	3,839	4,597	5,356	6,489	7,241	7,993	6,731
Actual cash position	12,953	7,771	7,202	6,752	6,301	3,839	4,598	5,356	6,489	7,241	7,993	6,731
Variance	4,611	0	0	0	0	0	0	0	0	0	0	0

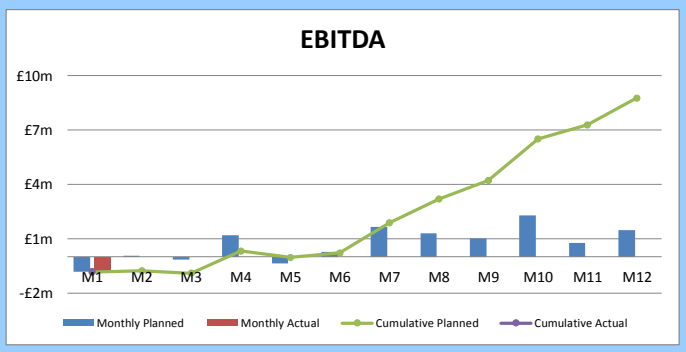
Warrington and Halton Hospitals NHS Foundation Trust **Appendix C**

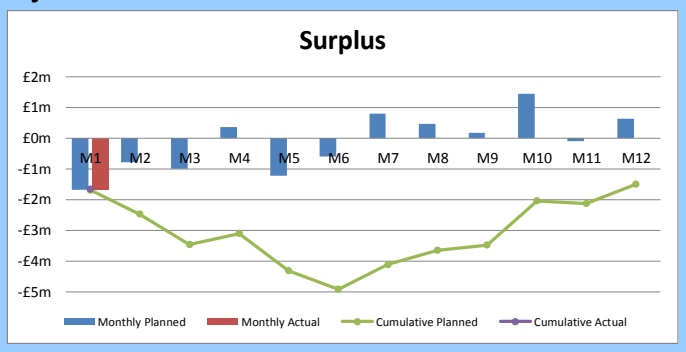
Statement of Position as at 30th April 2014

Narrative	Un-Audited Position as at 31.3.14 £000	Actual Position as at 30.04.14 £000	Monthly Movement £000	Forecast Position as at 31.3.15 £000
ASSETS				
Non Current Assets				
Intangible Assets	316	311	-5	155
Property Plant & Equipment	132,588	132,343	-245	134,972
Other Receivables	1,233	1,332	99	1,900
Impairment of receivables for bad & doubtful debts	-195	-210	-15	-465
Total Non Current Assets	**133,942**	**133,776**	**-166**	**136,562**
Current Assets				
Inventories	2,769	2,805	36	2,569
NHS Trade Receivables	3,052	2,277	-775	1,164
Non NHS Trade Receivables	573	419	-154	338
Other Related party receivables	200	435	235	606
Other Receivables	1,960	1,961	1	1,153
Impairment of receivables for bad & doubtful debts	-355	-345	10	-188
Accrued Income	884	623	-261	764
Prepayments	1,727	3,560	1,833	1,016
Cash held in GBS Accounts	12,937	12,930	-7	6,720
Cash held in commercial accounts	0	0	0	0
Cash in hand	19	23	4	11
Total Current Assets	**23,766**	**24,688**	**922**	**14,153**
Total Assets	**157,708**	**158,464**	**756**	**150,715**
LIABILITIES				
Current Liabilities				
NHS Trade Payables	-1,513	-2,123	-610	-1,732
Non NHS Trade Payables	-5,728	-7,626	-1,898	-2,694
Other Payables	-4,433	-4,596	-163	-3,478
Capital Payables	-1,386	-1,215	171	-1,124
Accruals	-5,986	-5,827	159	-6,222
Interest payable on non commercial int bearing borrowings	0	0	0	0
PDC Dividend creditor	-49	-384	-335	0
Deferred Income	-1,353	-1,110	243	-1,140
Provisions	-282	-287	-5	-317
Loans non commercial	0		0	0
Total Current Liabilities	**-20,730**	**-23,168**	**-2,438**	**-16,707**
Net Current Assets (Liabilities)	**3,036**	**1,520**	**-1,516**	**-2,554**
Non Current Liabilities				
Loans non commercial			0	-1,600
Provisions	-1,510	-1,483	27	-1,471
Total Non Current Liabilities	**-1,510**	**-1,483**	**27**	**-3,071**
TOTAL ASSETS EMPLOYED	**135,468**	**133,813**	**-1,655**	**130,937**
TAXPAYERS AND OTHERS EQUITY				
Taxpayers Equity				
Public Dividend Capital	90,063	90,063	0	90,014
Retained Earnings prior year	12,446	9,597	-2,849	8,743
Retained Earnings current year	-2,849	-1,655	1,194	-1,500
Sub total	**99,660**	**98,005**	**-1,655**	**97,257**
Other Reserves				
Revaluation Reserve	35,808	35,808	0	33,680
Sub total	**35,808**	**35,808**	**0**	**33,680**
TOTAL TAXPAYERS AND OTHERS EQUITY	**135,468**	**133,813**	**-1,655**	**130,937**

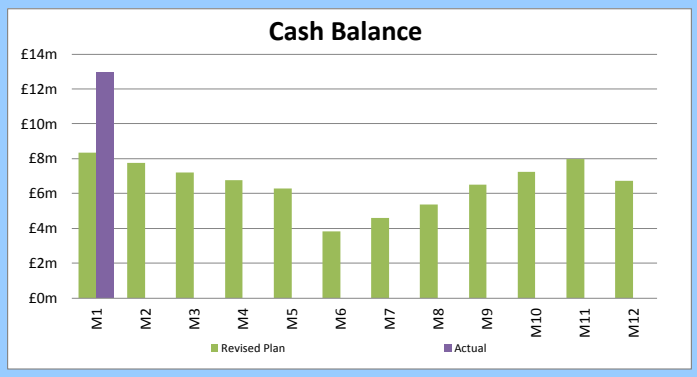
Finance Dashboard as at 30th April 2014

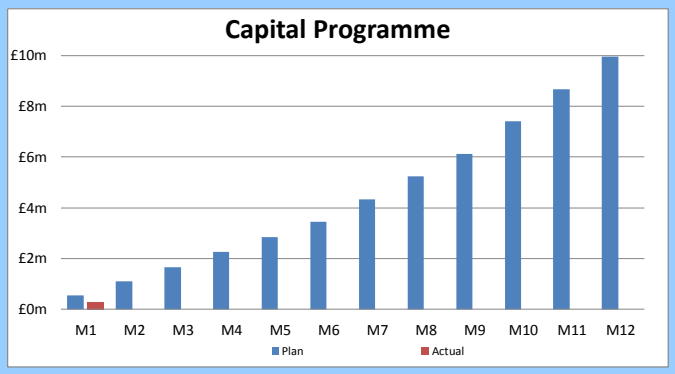
Profitability



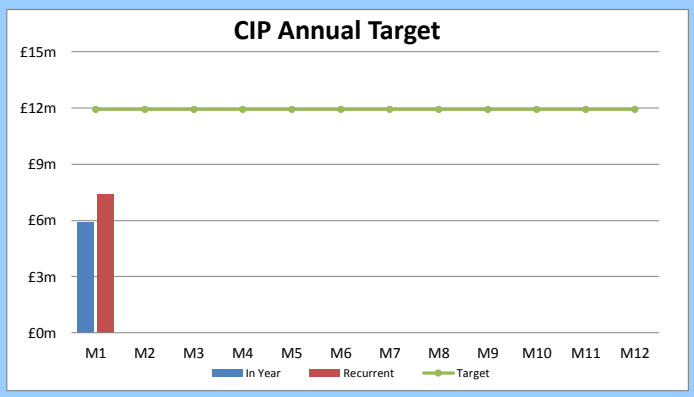


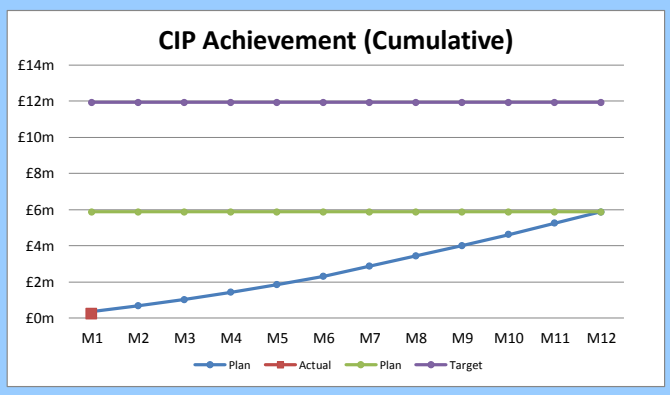
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

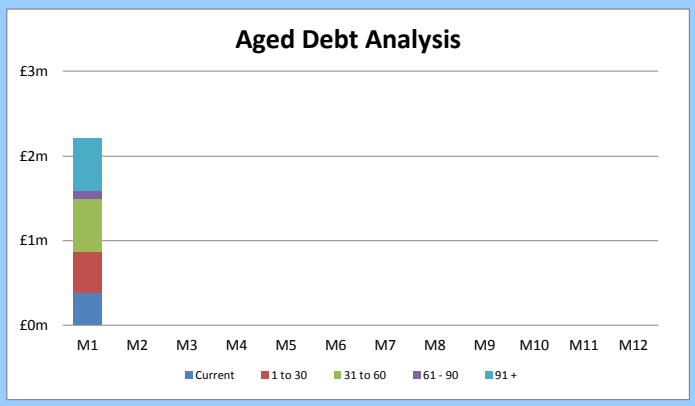
Division	Annual Budget £000	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical					
Scheduled Care	56,326	4,784	4,574	210	4.4
Unscheduled Care	42,489	3,699	3,788	-89	-2.4
Womens, Children & Support Services	55,270	5,022	4,936	86	1.7
Corporate					
Operations - Central	289	34	24	10	29.4
Operations - Estates	7,552	629	590	39	6.2
Operations - Facilities	8,069	672	692	-20	-3.0
Business Development	1,172	98	87	11	11.2
Finance	9,146	762	754	8	1.0
Governance & Workforce	3,853	321	299	22	6.9
Information Technology	1,757	146	145	1	0.7
Nursing	4,806	404	368	36	8.9
Trust Executive	1,875	261	248	13	5.0
Total	**192,604**	**16,832**	**16,505**	**327**	**1.9**

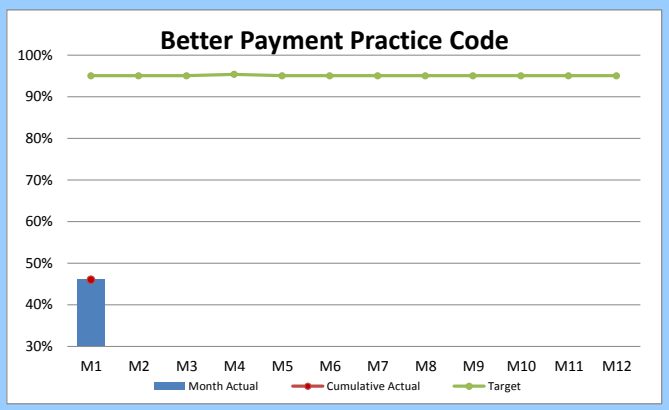
Continuity of Services Risk Rating

Continuity of Services Risk Rating	Actual Metric	Actual Rating
Liquidity Ratio (days)	-2.2	3
Capital Servicing Capacity (times)	-2.4	1
Overall Risk Rating		**2**

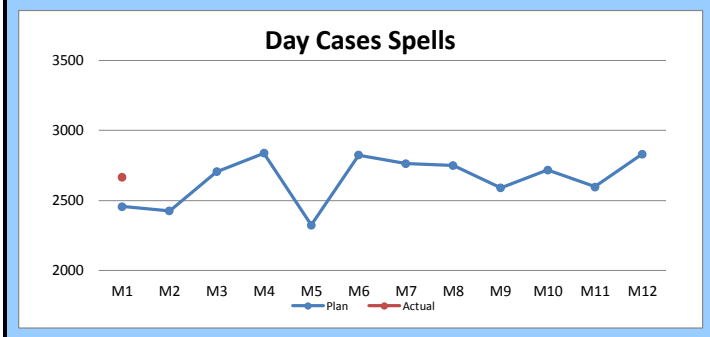
Finance Dashboard as at 30th April 2014

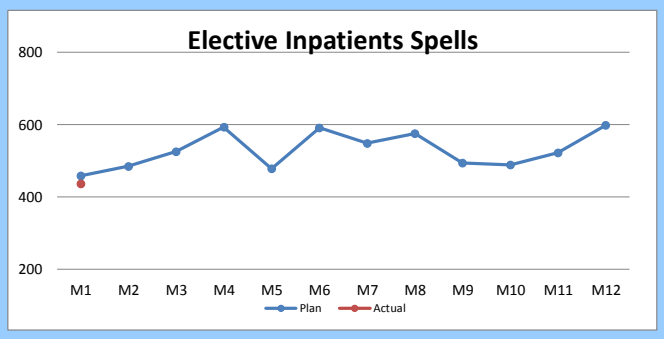
Balance Sheet and Liquidity

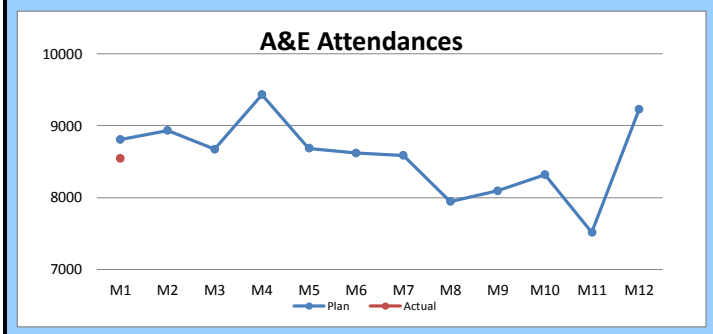


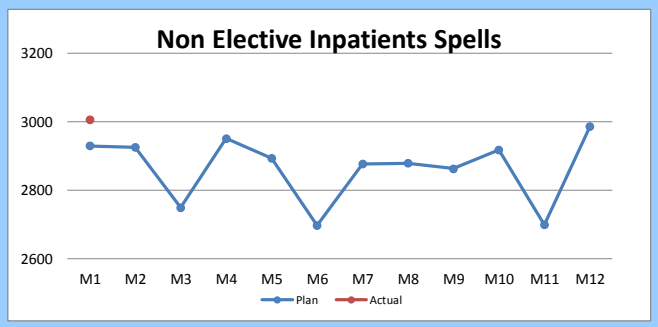


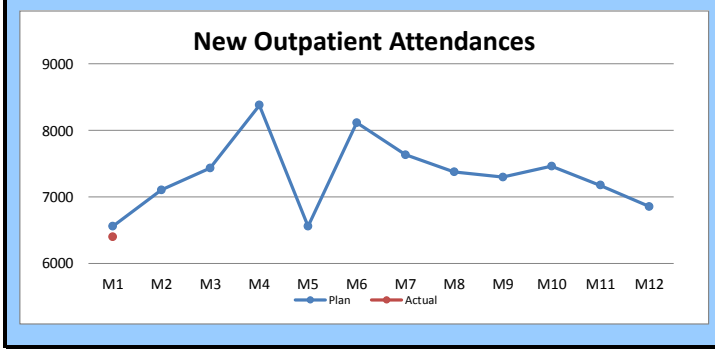
Activity Analysis

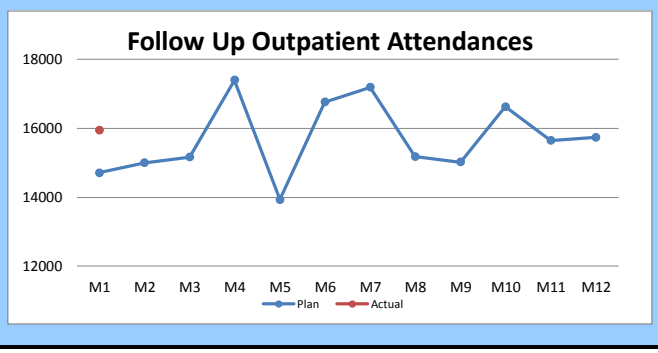












Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/089(ii)

BOARD OF DIRECTORS

Paper Title	Financial Results by Service Line, 1st April to 31st March 2014
Date of Meeting	28th May 2014
Director Responsible	Tim Barlow – Director of Finance and Commercial Development
Author(s)	Fred Pigott – Head of Strategic Financial Planning
Purpose	To provide the profitability of service lines.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	**appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper
(please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

Recommendation

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

Financial Results by Service Line for year ending 31st March 2014

1. Purpose

The purpose of the report is to advise the Board of Directors on the financial performance and profitability of the Trust by Service Line for the year ending 31st March 2014.

2. Service Line Performance

These service line results represent the profitability of the Trust's services as at 31st March 2014 for the financial year 2013/14 as reported to the Board, Divisions, Commissioners and Monitor.

The overall Trust position for the twelve month period to 31st March 2014 was a deficit of £2,849k against a planned surplus of £1,152k. This includes impairment costs of £697k, so the normalised operating deficit is £2,152k for the year.

SLR Specialty Position 2013-14

2013/14 - Income and Expenditure Detail					
Grouped Specialties	**Activity**	**Cost (£000)**	**Income (£000)**	**Margin (£000)**	**Profit / loss margin (%)**
Surgery	55,516	£27,042	£24,660	-£2,382	-10%
Critical Care	1,313	£10,207	£9,267	-£940	-10%
Urology	17,971	£6,308	£6,281	-£26	0%
Trauma & Orthopaedics	65,901	£27,035	£26,182	-£852	-3%
ENT	18,980	£3,963	£3,990	£27	1%
Anaesthetics & Pain Management	3,862	£989	£1,123	£134	12%
Ophthalmology	58,945	£8,938	£9,916	£979	10%
Scheduled Care	**222,488**	**£84,481**	**£81,419**	**-£3,062**	**-4%**
Medicine	73,929	£42,478	£37,912	-£4,566	-12%
Cardiology	19,902	£7,724	£5,965	-£1,759	-29%
Accident & Emergency	111,900	£14,474	£15,542	£1,068	7%
Unscheduled Care	**205,731**	**£64,677**	**£59,420**	**-£5,257**	**-9%**
Obstetrics	35,524	£12,762	£10,535	-£2,227	-21%
Gynaecology	27,179	£5,997	£5,825	-£172	-3%
GUM	4,283	£1,673	£1,894	£221	12%
Rheumatology	9,692	£4,127	£4,017	-£110	-3%
Haematology	57,938	£3,514	£4,408	£894	20%
Direct Access Pathology	2,482,289	£4,234	£4,839	£605	13%
Direct Access Radiology	33,168	£2,134	£2,837	£703	25%
Paediatrics	22,541	£5,955	£7,051	£1,096	16%
Womens, Childrens & Support Services	**2,672,614**	**£40,395**	**£41,406**	**£1,010**	**2%**
Other and non attributable	-	£6,101.27	£10,561.13	£4,460	42%
Trust Total including impairments	**3,100,833**	**£195,655**	**£192,806**	**-£2,849**	
Impairment costs*				**£697**	
Trust Total excluding impairments				**-£2,152**	

*Impairment costs are included within 'other and non attributable' costs and does not affect any service lines.

Appendix A provides a full specialty breakdown by activity, cost, income and contribution comparing Quarter 4 13-14 SLR against the Quarter 3 2013-14 performance.

3. Headline Summary

The individual divisional positions are:

- Scheduled Care: £3.1m loss
- Unscheduled Care: £5.3m loss
- Women's, Children's and Support Services: £1.0m surplus

- Other & Non-Attributable £4.6m
  - This includes a variety of income streams and services, for example the Halton Intermediate Care Unit, Direct Access ECG, Breast Screening and Audiology.
  - Income has increased at Quarter 4 which is in part due to an increase in non-recurrent funding; including a gain from a reduction in Non Elective Readmission penalties, Winter Pressures funding and year end settlements with Commissioners.

4. Conclusion

It is key that Divisions have an understanding and ownership of their service line's position particularly which services make money and which don't. To achieve this, there are a number of developments to progress SLR as a business tool which will be the feature of a report to a future Finance & Sustainability Committee.

5. Additional Information

The attached appendices provide further detail and examples of the outputs available from the PLICS system.

Appendix A – SLR position by grouped specialty comparing Quarter 4 2013/14 to Quarter 3 2013/14

Appendix B – SLR position by grouped specialty comparing Quarter 4 2013/14 to Quarter 4 2012/13

Appendix C – At Quarter 4, the top 10 loss making HRGs, with the average cost benchmarked against national average cost per procedure.

Tim Barlow
Director of Finance & Commercial Development
21st May 2014

Appendix A: SLR movement between Quarter 4 and Quarter 3 2013-14

Quarter 4 - Income and Expenditure Detail									
Grouped Specialties	**Activity**	**Cost (£000)**	**Income (£000)**	**Margin (£000)**	**Profit / loss margin**	**EBITDA (£000)**	**Contribution (£000)**	**Q3 Margin (£000)**	**Quarterly movement**
Surgery	55,516	£27,042	£24,660	-£2,382	-10%	-£673	£2,157	-£1,846	
Critical Care	1,313	£10,207	£9,267	-£940	-10%	-£525	£544	-£397	
Urology	17,971	£6,308	£6,281	-£26	0%	£367	£1,000	£4	
Trauma & Orthopaedics	65,901	£27,035	£26,182	-£852	-3%	£564	£2,714	-£1,187	
ENT	18,980	£3,963	£3,990	£27	1%	£312	£701	£38	
Anaesthetics & Pain Management	3,862	£989	£1,123	£134	12%	£219	£297	£107	
Ophthalmology	58,945	£8,938	£9,916	£979	10%	£1,514	£2,263	£599	
Scheduled Care	**222,488**	**£84,481**	**£81,419**	**-£3,062**	**-4%**	**£1,776**	**£9,677**	-£2,683	
Medicine	73,929	£42,478	£37,912	-£4,566	-12%	-£3,081	£1,219	-£3,156	
Cardiology	19,902	£7,724	£5,965	-£1,759	-29%	-£1,175	-£417	-£1,535	
Accident & Emergency	111,900	£14,474	£15,542	£1,068	7%	£1,821	£2,943	£1,134	
Unscheduled Care	**205,731**	**£64,677**	**£59,420**	**-£5,257**	**-9%**	**-£2,435**	**£3,745**	**-£3,557**	
Obstetrics	35,524	£12,762	£10,535	-£2,227	-21%	-£1,663	-£708	-£1,635	
Gynaecology	27,179	£5,997	£5,825	-£172	-3%	£125	£699	-£63	
GUM	4,283	£1,673	£1,894	£221	12%	£264	£377	£215	
Rheumatology	9,692	£4,127	£4,017	-£110	-3%	-£26	£134	-£71	
Haematology	57,938	£3,514	£4,408	£894	20%	£985	£1,450	£496	
Direct Access Pathology	2,482,289	£4,234	£4,839	£605	13%	£821	£1,203	£552	
Direct Access Radiology	33,168	£2,134	£2,837	£703	25%	£1,012	£1,176	£552	
Paediatrics	22,541	£5,955	£7,051	£1,096	16%	£1,458	£2,096	£790	
Womens, Childrens & Support Services	**2,672,614**	**£40,395**	**£41,406**	**£1,010**	**2%**	**£2,977**	**£6,427**	**£836**	
Other and non attributable		£6,101	£10,561	£4,460	42%	£5,432.73	£5,356	£2,081	
Trust Total including impairments	**3,100,833**	**£195,655**	**£192,806**	**-£2,849**	**-1%**	**£7,750**	**£25,205**	**-£3,323**	
impairment costs				£697					
Trust Total excluding impairments				**-£2,152**					

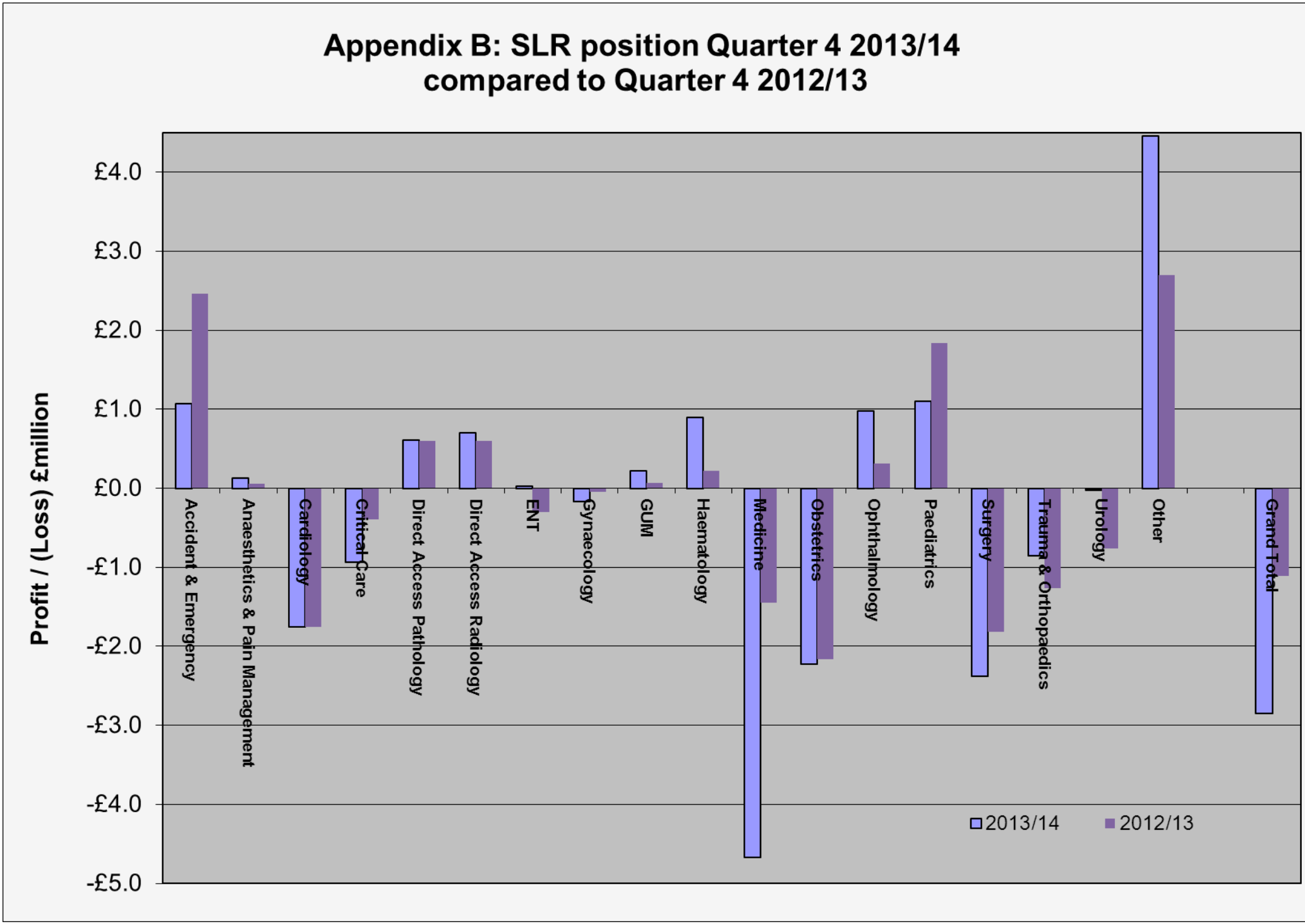
Margin – Total income less total costs

EBITDA – Earnings before Interest, Tax, Depreciation and Amortisation
Total Costs (Excluding Depreciation, Interest and PDC Dividend) less income

Contribution – Total income less Total Costs (excluding Overheads)

improvement in margin
deterioration in margin

Appendix B: SLR position Quarter 4 2013/14 compared to Quarter 4 2012/13



Appendix C: Benchmarking – Top 10 loss making HRGs.

At Quarter 4, the top 10 loss making HRGs overall have been selected and benchmarked against peer Trusts using the benchmarking tool Albatross, which compares the average cost per procedure across over 72 Trusts nationally.

Albatross also provides the ability to review peer group data, in particular length of stay and theatre time, linked back to the primary diagnosis and procedure coding.

HRG Description	WHH Episodes	WHH Margin	WHH Average Cost	Albatross average cost	Opportunity
NZ14B-Emergency Or Upper Uterine Caesarean Section Without Cc	268	-£571,437	£3,866	£3,448	£111,992
AA22A-Non-Transient Stroke Or Cerebrovascular Accident, Nervous System Infections Or Encephalopathy, With Cc	802	-£458,903	£2,856	£3,262	N/A
HA91Z-Hip Trauma Diagnosis Without Procedure	374	-£446,181	£2,585	£3,521	N/A
EA36A-Catheter 19 Years And Over	748	-£442,854	£2,180	£1,850	£247,175
WD11Z-All Patients 70 Years And Older With A Mental Health Primary Diagnosis, Treated By A Non-Specialist Mental Health Service Provider	264	-£415,592	£2,181	£2,435	N/A
LA04D-Kidney Or Urinary Tract Infections With Length Of Stay 2 Days Or More With Major Cc	707	-£379,332	£2,914	£3,206	N/A
EB01Z-Non Interventional Acquired Cardiac Conditions	1834	-£355,126	£707	£969	N/A
FZ47B-Non0malignant General Abdominal Disorders With Length Of Stay 2 Days Or More Without Major Cc	401	-£323,189	£1,641	£1,777	N/A
BZ02Z-Phacoemulsification Cataract Extraction And Lens Implant	2050	-£290,746	£920	£909	£21,563
NZ14A-Emergency Or Upper Uterine Caesarean Section With Cc	178	-£265,544	£3,975	5003	N/A

Based on the above Table, if the trusts costs were realigned to the Albatross average cost for those instances where Warrington's costs are higher, there is a potential cost saving of circa £381k.

For seven of the ten HRGs, the trust has a lower average cost than the Albatross average. Whilst this indicates that the trust is more efficient than the benchmarking average, there is still scope for investigating the reasons for these HRGs being loss making.

W&HHFT/TB/14/090

Board of Directors

Paper Title	Corporate Performance Report
Date of Meeting	28th May 2014
Director Responsible	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Author(s)	Simon Wright – Chief Operating Officer/Deputy Chief Executive
Purpose	To update the Board on the Trust's operational performance for the month of April 2014

Paper previously considered	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper

Page/Paragraph Reference

- AED performance fell under 95% for the month

Recommendation(s)

The Board is asked to note the contents of this paper

Warrington and Halton Hospitals NHS
NHS Foundation Trust

CORPORATE PERFORMANCE REPORT
April 2014

EXECUTIVE SUMMARY

1.0 Introduction

This summary corporate report updates the Board on the progress of the Trust in relation to activity and performance targets to 30th April 2014.

2.0 Performance

In overall terms, based on the performance in month 1, the Trust has an **Amber/Green** rating, as highlighted in Appendix 1.

3.0 National Key performance indicators

3.1 Accident and Emergency Department

The AED 4 hour pathway has been under severe pressure since April 1st when the reablement funding was withdrawn (see below). The entire health system has been in difficulty with all of Merseyside failing the target. The HAS screen performance is 77.81% and needs to be improved to 85% as a consequence of the department struggling to accept and transfer patients from AED due to discharge problems across our health system.

The impact has been externally validated by the Department of Health's Emergency Clinical Intervention and Support Team (ECIST) who have undertaken two point prevalence studies which have identified over 100 patients in hospital beds who are no longer receiving acute care.

Whilst additional steps including moving minor injuries into the ARC to create more space in AED for assessments and cohorting all 30 intermediate care delays onto one ward are improving the quality , dignity and experience our patients are receiving during this very difficult time, they are not impacting upon the AED performance enough as the hospital continues to be escalated at RED with no acute beds to manage emergency admissions effectively without delays occurring in AED resulting in breaches.

In May the Trust undertook the Perfect Week with ECIST to better identify what the issues were and how an alternative approach might support safer care delivery.

3.2 Delayed Discharges

Following the withdrawal of the reablement funding by the CCG and LA the trust has seen £500k of staffing and service in rapid response and discharge support removed. The delays in transfers have risen sharply since April 1st when this decision was taken resulting in a deteriation in AED performance as queues are forming as patients are now not being moved into a more appropriate part of the care pathway as quickly and some patients are having to be admitted as the services to manage them and prevent their admission have been stopped.

The SITREP delayed discharges have risen from around 1.6% (target is 0.5%) to 5.14% as a direct result of the above.

Mr Simon Wright

Chief Operating Officer

May 2014

Apr-14

Monitor Governance Risk Rating - 2014/15

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Referral to treatment waiting time	Admitted patients	90%	1.0	92.61%															
	Non-admitted patients	95%	1.0	98.03%															
	Incomplete Pathways	92%	1.0	94.55%															
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	94.54%															
All Cancers:62-day wait for First treatment	From Urgent GP Referral for Suspected Cancer **(Open Exeter Position)**	>85%	1.0 (Failure for either = failure against the overall target)	89.00%															
	From NHS Cancer Screening Service Referral	>90%		100.00%															
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	96.00%															
	Anti Cancer Drug Treatments	>98%		100.00%															
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	96.00%															
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.10%															
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.05%															
Clostridium Difficile	Hospital Acquired	26	1.0 **	2															
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No															

Cumulative
Qtr1: 6.5 Qtr2: 13
Qtr3: 19.5 Qtr4: 26

Target or Indicator	Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A		No															
CQC compliance action outstanding	N/A		No															
CQC enforcement action within last 12 months	N/A		No															
CQC enforcement action (including notices) currently in effect	N/A		No															
Moderate CQC concerns or impacts regarding the safety of healthcare provision	N/A	Report by Exception	No															
Major CQC concerns or impacts regarding the safety of healthcare provision	N/A		No															

Clostridium Difficile	Hospital Acquired	Qtr1: 6.5 Qtr2: 13 Qtr3: 19.5 Qtr4: 26	26	1.0 **	2
Failure to comply with requirements regarding access to healthcare for people with a learning disability			N/A	1.0	No

Target or Indicator	Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	Report by Exception	No															
CQC compliance action outstanding	N/A		No															
CQC enforcement action within last 12 months	N/A		No															
CQC enforcement action (including notices) currently in effect	N/A		No															
Moderate CQC concerns or impacts regarding the safety of healthcare provision	N/A		No															
Major CQC concerns or impacts regarding the safety of healthcare provision	N/A		No															
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A		No															
Score of 7 or less in standard 1 assessment at last NHSLA CNST inspection (maternity or all services)	N/A		No															
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No															
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			1.0															

Additional Notes:

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

**** Clostridium Difficile**
Monitor's annual de minimis limit for cases of C-Diff is set at 12.
Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

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

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

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Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/91

BOARD OF DIRECTORS

Paper Title	Emergency Preparedness Annual Report 2013-14
Date of Meeting	28th May 2014
Director Responsible	Simon Wright, Chief Operating Officer
Author(s)	Brian Davies, Business Continuity Manager
Purpose	To provide the Trust Board with a report on work undertaken during 2013-14.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	**appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the actions taken during 2013-14 and the work programme for 2013-14 in support of the Trust's objectives.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

EMERGENCY PREPAREDNESS ANNUAL REPORT 2013-14

CONTENTS AND PAGE NUMBER

1. INTRODUCTION

All NHS organisations are required to deliver their responsibilities for Emergency Planning via the Civil Contingencies Act 2004. As a Category 1 responder under the Act, we have a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

Like most NHS organisations, we have had our resilience tested on a number of occasions over the last few years in the form of severe weather, industrial action, outbreaks of infection and demand management pressures. Our plans and procedures, and the commitment of our staff, have enabled us to manage such incidents in a professional manner which has helped to minimise any disruption to patient care.

During the last year the NHS underwent significant structural changes which saw the introduction of new arrangements for Emergency Preparedness Response & Recovery (EPRR) both nationally and locally. We have taken the opportunity to review our systems and procedures in light of these new arrangements, and this report summarises the work which has been undertaken so far.

2. PURPOSE

The purpose of the annual report is to; -

- Provide an overview of the emergency preparedness arrangements within Warrington & Halton Hospitals NHS Foundation Trust
- Outline the work that has been undertaken in this area during the past 12 months
- Describe our responses to incidents which have occurred during 2013-14
- Summarise our planned workstreams and priorities for the year ahead.

3. EMERGENCY PREPAREDNESS STRUCTURE

The Trust has an incident response plan in place which is built on the principles of risk assessment, multi-agency co-operation, emergency planning, sharing information and communicating with the public. This plan is underpinned by a number of associated business continuity plans which demonstrate how our critical services will continue to be provided in the event of a disruptive incident.

3.1 Lead Officers:

- Simon Wright, Chief Operating Officer, is the designated Lead Executive Director with responsibility for Emergency Planning within the Trust.
- The Lead Director is supported in this role by Brian Davies, Business Continuity Manager.

3.2 Committee Structure:

In order to discharge our responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the trust's Committee structure.

The Event Planning Group, chaired by the Chief Operating Officer, is charged with the responsibility of overseeing the development of emergency preparedness arrangements within the Trust. The group meets on a monthly basis and its' membership includes senior managers from all divisions and corporate services.

The main role of the Event Planning Group is to anticipate forthcoming events which are likely to prevent a challenge to our services and resources and to develop co-ordinated plans in advance. Minutes of the Group's meetings are produced and high level briefing reports are provided to the Governance Committee and Strategic Workforce Committee. Corporate plans, approved at the Event Planning Group, are formally ratified at the Governance Committee meetings.

3.3 New EPRR Structure:

NHS Structural changes came into force on 1st April 2013 which saw changes to the Emergency Preparedness Response and Recovery (EPRR) landscape. From this date the NHS England Area Team assumed lead responsibility for co-ordinating a local health response to an emergency following the dissolution of Primary Care Trusts who previously performed this statutory duty.

Local Health Resilience Partnerships (LHRP) have been established as part of the new planning arrangements to deliver national EPRR strategy in the context of local risks. The main aim of the LHRP is to bring together the health sector organisations involved in emergency preparedness and strengthen cross-agency working. The LHRP for Cheshire, Warrington & Wirral, supported by a Practitioners Sub Group, meets on a quarterly basis and provides strategic direction to local organisations in preparing their response to emergencies and is now the main vehicle for taking forward the EPRR agenda.

3.4 Out of Hours Arrangements:

The Trust operates a three tier management on-call rota which on a 24/7/365 basis and ensures that senior managers and Executive Directors are contactable at all times and are able to respond quickly to a major or serious incident at any given time. This structure is supported by specific clinical and departmental on-call rotas which are designed to respond to local service-related operational issues.

4. ANALYSIS OF RISK

Risk assessment is seen in the Civil Contingencies Act as the first step in the Emergency Planning and Business Continuity process. It ensures that threats are identified, prioritised and assessed so that comprehensive plans can be developed

which are proportional to the risks. By anticipating what may cause a disruption to our services as accurately as possible, we can target preventative action in the areas which are more likely to make a difference.

The Trust operates a comprehensive risk management system which is designed to pro-actively manage all of the main areas of risk. The corporate risk register identifies and prioritises all of the principal risks to the Trust's strategic objectives, including risks to business continuity, and is populated via the risk assessment and evaluation process. Risks are graded and ranked using the Trust's Risk Grading Framework to establish a priority level. Action plans are drawn up for each risk in order to reduce the likelihood of occurrence. This is monitored and managed on an ongoing basis via the Trust's Governance and Safety & Risk Committees.

In addition to the corporate risk register, each division produces its own risk register to address local risks. This is updated on a monthly basis and reported in via the Safety & Risk Committee.

Externally, the LHRP maintains a register of risks which are likely to present a threat to the wider community. These risks are updated at the quarterly meetings and provide the basis for setting the planning agenda and establishing emergency preparedness work plans.

5. EXERCISES & TRAINING

The Civil Contingencies Act clearly outlines the organisational responsibility to exercise plans. Under the Act, all NHS organisations are required to undertake; -

- Live exercises every three years
- Table top exercises annually
- Communications exercises every 6 months

The Trust has organised and participated in a number of exercises and training events to test and validate our emergency plans. Details of all of these events are reported in Appendix 1 on page and demonstrate our compliance with the Civil Contingencies Act requirement.

The Trust has also developed a planned programme of simulation exercises which take place on a regular basis throughout the year. The simulation exercises are designed to examine and test the response and performance of trauma services in response to an emergency situation. The simulations are assessed and RAG rated with learning points identified for future action.

6. EXTERNAL REVIEWS & AUDITS

6.1 Cheshire & Merseyside Commissioning Support Unit Assessment

Following the re-organisation of the NHS and the publishing of the 'Health and Social Care Act 2012', the role of Emergency Preparedness, Response and Recovery (EPRR) has been re-defined to reflect the responsibilities of the new organisations.

As part of the process of providing assurance to the newly configured NHS North of England, the Cheshire & Merseyside Commissioning Support Unit undertook an on-site assessment of the Trust's Incident Response and Business Continuity plans in October 2013.

The Trust achieved 'Green' status for each of the reviews, scoring a total of 98% compliance for business continuity and 95% for incident response which provided NHS North of England with significant assurance that the Trust's systems and procedures for emergency preparedness were fit for purpose.

A small number of recommendations were made following the assessment and they have been included as actions in the work plan for 2014-15.

6.2 NWAS Decontamination Audit July 2013

On behalf of the Department of Health, the North West Ambulance Service NHS Trust undertook their annual audit of the Trust's decontamination capability in July 2013. This forms part of their role in determining the North West Hospitals Chemical, Biological, Radiological and Nuclear (CBRN) Decontamination Capability. Feedback from the audit was generally positive indicating that the Trust was capable of fully discharging its responsibility with regard to decontamination of patients in a CBRN incident. The one area of non-compliance concerned our ability to hold contaminated waste for 1 hour minimum. Two waste water containers have since been purchased to address this requirement and ensure our continued compliance.

7. REPORTS TO TRUST BOARD

Progress reports to the Trust Board with regard to EPRR arrangements were made on the following dates during 2013-14; -

1. Annual Trust Board Report for 2012-13	May 2013
2. Report on the new arrangements for EPRR	June 2013
3. Mid-Year Progress report on EPRR assurance	October 2013

8. INCIDENTS

During 2013-14 the following incidents presented a challenge to the Trust's emergency preparedness arrangements. None resulted in any significant disruption to day to services and all were managed effectively by local managers following Trust procedures.

8.1 Major Incident Standby 21st May 2013:

A major fire occurred in a recycling centre in Widnes which resulted in the declaration of a major incident standby.

8.2 Major Incident Standby 24th June 2013:

The Trust was placed on major incident standby at 22:09 on 24th June 2013 as a result of a fire in a scrapyard in Widnes. No casualties were received and stand down was received at 23:09.

8.3 Major Incident Standby declared by Cheshire Police: Risk of Flooding in the Warrington area 5th December 2013

The Environment Agency issued a flood warning for the Sankey Valley area due to forecast of heavy rainfall, strong winds coinciding with high tides. The Trust was placed on major incident standby for the duration of the day during which a number of Joint Tactical Coordinating Group meetings led by Cheshire Police took place. Minor flooding occurred in Warrington Town Centre but there was no significant impact on local health services.

8.4 Internal Major Incident 13th January 2014:

On Monday, 13th January 2014, an internal major incident was declared by the Trust in response to rising system pressures which had resulted in a potentially unsafe situation presenting a risk to patient safety.

Bed pressures had built up during the previous weekend owing to a higher than average number of A&E patients who converted to in-patients at the end of the previous week. These in-patients included a large number of poorly and elderly patients, who could not be discharged quickly.

A series of actions were undertaken to reduce pressure and increase capacity in collaboration with local partner organisations resulting in a general easing of the situation. A decision to stand down from internal major incident was taken at the 10:00 bed meeting the following day after an improvement overnight.

8.5 Major Incident Standby: Risk of Structural Damage, 12th February 2014

Major Incident Standby declared by Cheshire Police: Risk of structural damage due to storm force winds across the North West of England on 12th February 2014. JTCC meetings convened to assess the extent of the damage and to mobilise resources into the affected areas.

8.6 Internal Major Incident: Chemical Release, 19th March 2014

An incident occurred on Wednesday, 19th March 2014 when a discharge of the chemical, calcium hydroxide, occurred at the Keppel Seghers Energy Waste Plant in Runcorn. Calcium hydroxide (hydrated lime) is an odourless white powder and is used as part of the air pollution control process. It is a low risk chemical toxin which can cause irritation to eyes, skin and breathing.

23 employees self-presented to the A&E Department at Warrington Hospital causing an internal major incident to be declared in order to manage the incident as effectively as possible. The Trust's Incident Response Plan was activated enabling staff and resources to be mobilised quickly in the A&E Department. Casualties were decontaminated and treated in separate areas of the department, and all were discharged later the following day.

The incident was dealt with effectively and professionally by the A&E Department backed up by good co-operation and team working from other teams who responded. An internal debrief meeting was held within 48 hours of the incident to review our internal response. A multi-agency debrief was also conducted by the Local Resilience Forum which was used as an opportunity for organisational learning and to review at a whole system level how the various services and information flows could be improved.

9. WORK UNDERTAKEN IN 2013-14

The following workstreams were completed during the year under review; -

- Major Incident Plan and Business Continuity Plans reviewed and updated to reflect local and national developments. Both were ratified by the Governance Committee in January and March 2014.
- Provided significant assurance for core Emergency Preparedness plans to NHS North of England following external assessments by Cheshire & Merseyside Commissioning Support Unit in October 2013 (see section 6).
- Participated in 4 communications exercises to test our alerting procedures as part of our incident response procedures.
- Participated in numerous multi-agency exercises to test emergency preparedness and organisational resilience (see Appendix 1).
- Delivered training to key staff in Emergency Preparedness and Business Continuity management to relevant senior staff (see Appendix 1).
- Further development of escalation plans in response to winter pressures in 2013-14.
- Developed an induction training programme for Executive Directors who are new to the Trust's management on-call rota.
- Developed plans for bank holidays and special events which tested our resilience, e.g. Creamfields Music festival in August 2013.

- Refurbished facilities in the mortuary at Halton Hospital in collaboration with Warrington Borough Council as part of the Mass Fatalities Plan for Cheshire. This will also enable the Trust to strengthen its business continuity arrangements in this area.
- A Memorandum of Understanding (MOU) has been developed which sets out the agreed contribution to EPRR within the Cheshire, Warrington and Wirral Area Team for NHS organisations.
- Provided a High Level Assurance Report to Warrington and Halton Clinical Commissioning Groups of work undertaken during 2012-13 in compliance with the requirements of the Standard NHS contract for Emergency Preparedness.

10. WORK PROGRAMME FOR 2014-15

The following work streams have been developed using recommendations from audits and reviews including the recommendations made by the Cheshire & Merseyside Commissioning Support unit and Local Health Resilience Partnership. They will be undertaken over the next 12 months and progress will be monitored via the Event Planning Group with regular updates to the Governance Committee.

- Develop and review key Emergency Plans; - Incident Response Plan, Escalation Plan, Pandemic Flu Plan, and Business Continuity Plan and ensure that they are consistent with the new EPRR guidance.
- Review the winter planning arrangements for 2013-14 to identify lessons learnt. Develop a plan for the winter of 2014-15 and bank holidays in conjunction with health partners.
- Participate in multi-agency exercises and training with partner organisations in accordance with priorities identified by the Local Health Resilience Partnership (LHRP).
- Work with partner organisations to develop an EPRR assurance framework programme on behalf of the LHRP.
- Further develop service level and corporate business continuity plans as part of the Trust's 12 month action plan as determined by the Event Planning Group.
- Participate in an audit of our pandemic influenza plans in May 2014 and also in an audit of our business continuity plans in August 2014. Both audits will be undertaken by Cheshire & Merseyside Commissioning Support Unit
- In collaboration with Warrington Borough Council, Cheshire Police and the HM Coroner for Cheshire, further develop the mortuary at Halton Hospital and participate in an exercise to validate the mass fatalities plan.
- Further develop Cheshire wide EPRR risk register in collaboration with partners and assess the impact of all risks for the Trust.
- Continue the programme of in situ simulation exercises facilitated by the Clinical Education Department and introduce a new Trauma Leader course.
- Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire LHRP.

- Develop specific plans for all bank holiday weekends, the Creamfields Music Festival, and Christmas and New Year, in order to address potential demand management pressures in the health care system.
- Develop an implementation plan for the 'Prevent' strategy by delivering the Health Workshop to Raise Awareness of Prevent to key staff.
- Produce an annual report on Emergency Preparedness for the Trust Board for 2014-15.

11. RECOMMENDATION

The Board is asked to note the work taken during 2013-14 and the planned work programme for 2014-15 in support of the Trust's objectives.

APPENDIX 1 – EXERCISES & TRAINING EVENTS IN 2013-14

Date	Event	Organiser	Staff Involved	Purpose	Outcome
2013					
May 14	Table Top Exercise 'Bandwagon'	Steve Crowder, A&E Consultant.	Steve Crowder, A&E Consultant Mark Jeffers, Emergency Planning Nurse, A&E. Registrars and Junior Doctors involved in Mersey Deanery training.	To test the major incident response plan and patient flow procedures in a simulated major incident.	Successfully achieved objectives and provided valuable learning opportunity for participants.
June 13	Communication Exercise	NHS England Cheshire Area Team	Switchboard, Director On-Call	To test the responsiveness of the Trust's communication and alerting system.	Response time 5 minutes – well inside the target time.
July 30	Trauma Exercise, A&E Department, Warrington Hospital	Sue Wilde, Trauma Co-ordinator. Steve Crowder, A&E Consultant	Orthopaedic Registrar (team lead) A/E Staff Nurse A/E Staff Nurse Anaesthetist ODP 1/ODP 2 Orthopaedic SHO Surgical Registrar Surgical SHO Clinical Attachment Radiographer Site Manager	To test the emergency response to a trauma incident.	Quick and effective response with good communication amongst teams. Debrief held to identify some lessons learned and action plan developed.

Date	Event	Organiser	Staff Involved	Purpose	Outcome
Sep 18	Communication Exercise	NHS England Cheshire Area Team	Switchboard, Director On-Call	To test the responsiveness of the Trust's communication and alerting system.	Response time 40 minutes – outside the target time.
Sep 26	Business Continuity Exercise	WHHFT	Radiology Department	To provide assurance that the Trust's PACS business continuity arrangements are effective in the event of unplanned downtime.	Failover to the back up to the Radiology Information System was successful during testing.
Oct 16	Regional Resilience Exercise	NHS North of England Regional Resilience Exercise	Assistant General Manager, WC&SS Division	Designed to test the response of senior on-call manager	Practical exercise based on a major incident scenario
Nov 20	Exercise Checkmate	Cheshire Fire & Rescue	Darren Wardley, Estates Manager. Sarah McMutrie, Acute Care Nurse.	To provide a training opportunity for managers and clinicians who are new to Emergency Planning.	Useful introduction to the roles of other emergency services in a major incident scenario.
Dec18	Communication Exercise	NHS England Cheshire Area Team	Switchboard, Director On-Call	To test the responsiveness of the Trust's communication and alerting system.	Response time 8 minutes – well inside the target time.
2014					
Jan 16	Exercise Opus Mass Fatalities Exercise	UK ACPO DVI	Brian Davies, Business continuity Manager. Amanda Williams, Chief Biomedical Scientist, Pathology Department.	To test local resilience in relation to incidents involving multiple casualties or fatalities.	Raised awareness of local and national capabilities in response to a mass fatalities incident. Clearer view of roles and responsibilities of emergency services.
Jan 29	Loggist training	Public Health England	Rebecca Mitchell, Administrator, Unscheduled Care Division and Pam	To provide a comprehensive understanding of the importance of taking notes and keeping	Provided a useful insight to the legal processes which are followed during a major

Date	Event	Organiser	Staff Involved	Purpose	Outcome
			Makin, PA, Unscheduled Care Division	evidential records in any post-incident legal proceedings.	incident and the requirement for maintaining appropriate documentation.
Feb 12	Outbreak of Infectious Diseases Exercise, Warrington.	Public Health England	Zaman Qazzafi, Consultant Microbiologist. Lesley McKay, Associate Director of Infection Control.	To test the roles, responsibilities and preparedness of local NHS organisations involved in the Multi-Agency Outbreak Control Plan.	Useful event which tested the plan and identified areas of deficiency, e.g. loss of some key functions previously provided by PCTs in the new structure.
Feb 26	Exercise Triton	Cheshire Local Resilience Forum	Brian Davies, Business Continuity Manager	To review and evaluate the response plans of local agencies that would respond to an aircraft incident occurring in the county of Cheshire, near to an airport.	Examples of good practice shared. More knowledge of planning assumptions and the capabilities of the various agencies involved.
Mar 14	Communication Exercise	NHS England Cheshire Area Team	Switchboard, Director On-Call	To test the responsiveness of the Trust's communication and alerting system.	Response time 2 minutes – excellent response, well inside the target time.
Mar 26/27	Surviving Public Inquiries	Bond Solon Training	Director of IT Assistant General Managers, Unscheduled Care & Scheduled Care	To provide delegates with an overview of how public inquiries are conducted, focussing on techniques used in evidence giving.	Very successful event. Provided participants with realistic scenarios and demonstrated a range of techniques which can be deployed. Feedback from participants was very positive.

Each exercise included a post exercise debrief of aims and objectives with agreed action points arising from the exercise.

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NHS Foundation Trust

W&HHFT/TB/14/092

BOARD OF DIRECTORS

Paper Title	Trust Scheme of Reservation and Delegation
Date of Meeting	28th May 2014
Director Responsible	Chair of the Audit Committee/ Director of Finance and Commercial Development
Author(s)	Trust Secretary and Head of Financial Services
Purpose	The purpose of this paper is to seek approval from the Board in respect of changes made to the Trust's Scheme of Reservation and Delegation (SoRD).

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Audit Committee	6 May 2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	Amendments to the SoRD previously agreed by the Committee in relation to individual delegations.	
•	Job titles have been amended to take account of changes made during the year.	
•	In accordance with the Monitors Code of Governance, the role and responsibility of the Council of Governors have been included under	section 2
•	Changes have been made to the use of the Trust's Common Seal.	Delegated matter 38, page 26

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

1. The Board is asked to approve changes to the Trust's Scheme of Reservation and Delegation (SoRD)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Scheme of Reservation and Delegation

CONTENTS

1. INTRODUCTION

1.1 General

1.1.1 The Standing Orders within the Trust's Constitution provide that the Board of Directors may delegate any of its powers to a committee of directors or to an executive director.

1.1.2 The *Code of Conduct: Code of Accountability in the NHS* issued by the Department of Health, which outlines expectations in respect of corporate conduct, requires that there should be a formal schedule of matters specifically reserved to the Foundation Trust Board. These matters are not delegated.

1.1.3 The Board of Directors remains accountable for all of its functions; even those delegated to committees, sub committees, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.2 Purpose of this document

1.2.1 The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures.

1.2.2 All staff are expected to comply with this document. If for any reason a deviation occurs, this should be alerted immediately to a manager/supervisor.

2. RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

2.1 Accountability

2.1.1 Board members share corporate responsibility for all decisions of the Board.

2.1.2 The *Code of Conduct: Code of Accountability in the NHS* (see 1.1.2) which has been adopted by the Foundation Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. These reserved matters are set out below.

2.2 Duties

It is the Board's duty to:

- act within statutory financial and other constraints;
- be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these;
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;
- establish performance and quality measures that maintain the effective use of resources and provide value for money;

- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; and
- establish Audit and Remuneration and Terms of Employment Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

2.3 Matters reserved unto the Board of Directors

2.3.1 General enabling provision

The Board of Directors may determine any matter, for which it has authority that it wishes in full session, within its statutory powers and taking account of the duties and responsibilities of the Council of Governors (see 3.8 below)

2.3.2 Regulations and control

The Board of Directors remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. The following are decisions reserved to the Board.

- Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.
- Suspension of Standing Orders.
- Variation or amendment of the Standing Orders.
- Ratification of any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with the Standing Orders.
- Approval of a Scheme of Reservation and Delegation of powers from the Board of Directors to Committees.
- Requiring and receiving the declarations of Board members' interests which may conflict with those of the Foundation Trust and determining the extent to which that director may remain involved with the matter under consideration.
- Requiring and receiving the declarations of officers' interests which may conflict with those of the Foundation Trust.
- Approval of arrangements for dealing with complaints.
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and to agree modifications thereto.
- Receiving reports from committees including those which the Foundation Trust is required by regulation to establish and taking appropriate action thereon.
- Confirmation of the recommendations of the Foundation Trust's committees where the committees do not have executive powers.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust.
- Establishing terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailee for patients' property.
- Authorising use of the seal.
- Ratification or otherwise of instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.
- Disciplining Board members or employees who are in breach of statutory requirements or Standing Orders.

2.3.3 Appointments / dismissal

- The appointment of the Vice Chairman of the Board of Directors.
- The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors.
- The appointment, appraisal, disciplining and dismissal of executive directors.
- Confirmation of the appointment of members of any committee of the Foundation Trust as representatives on outside bodies.
- The appointment, appraisal, discipline and dismissal of the ~~Board~~ Trust Secretary.
- Approval of proposals received from the ~~Appointments and Remuneration~~Nominations and Remuneration Committee regarding the Chief Executive, directors and senior employees.

2.3.4 Policy determination

The approval of Foundation Trust management policies as listed below.

- Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.
- Procedure for declaration of hospitality and sponsorship.
- Proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
- The list of employees authorised to make short term borrowings on behalf of the Foundation Trust.

2.3.5 Strategy and business plans and budgets

- Definition of the strategic aims and objectives of the Foundation Trust.
- Approval of proposals for ensuring quality and developing clinical governance in services provided by the Foundation Trust, having regard to any guidance issued by the Secretary of State or the Independent Regulator.
- Approval and monitoring of the Foundation Trust's policies and procedures for the management of risk.
- Approval of outline and final business cases for capital investment.
- Approval of income and expenditure budgets.
- Annual approval of Foundation Trust's proposed annual business plan / service development strategy.
- Ratification of proposals for acquisition, disposal or change of use of land and/or buildings.
- Approval of PFI proposals.
- Approval of proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, over £1,000,000 per annum or £2,000,000 in total, if the period of the contract is longer than 1 year.
- Approval of proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and ~~Director of Finance~~Director of Finance & Commercial Development.
- Approval of proposals for action on litigation against, or on behalf of, the Foundation Trust where the likely financial impact is expected to exceed £10,000, or is contentious or novel, or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.
- Review of the use of NHS risk pooling schemes and risk management cover.
- Approval of the opening of bank accounts.
- Approval of individual compensation payments.

2.3.6 Audit arrangements

To receive recommendations regarding the appointment (and where necessary dismissal) of the internal and external auditors. Responsibility for the appointment or removal of the auditors is held by the Council of Governors~~' Council~~.

The Board is required to

- receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee; and
- receive an annual report from the internal auditor and agree action on recommendations where appropriate of the Audit Committee.

2.3.7 Annual Reports and Accounts

- Receipt and approval of the Foundation Trust's Annual Report and Annual Accounts prior to
  - being laid before Parliament, which is prior to
  - presentation to the Council of Governors and Members ~~' Council~~ at a Members' Meeting.
- Receipt and approval of the Annual Report and Accounts for funds held on trust (charitable funds).

2.3.8 Monitoring

- Receipt of such reports as the Board of Directors sees fit from committees in respect of their exercise of delegated powers.
- Continuous appraisal of the affairs of the Foundation Trust by means of the provision to the Board of Directors as the directors may require from directors, committees, and officers of the Foundation Trust as set out in management policy statements.
- Receipt of reports from the ~~Director of Finance~~Director of Finance & Commercial Development on financial performance against the agreed annual financial plan.

2.4 Council of Governors

2.4.1 The Council of Governors have certain roles and responsibilities regarding the activity of the Trust. These are contained in statute and within the Trust's Constitution. Any matters relating to the following should be referred to the Trust Secretary for consideration on whether approval is required from the Council of Governors:

- Appointment of the Chair, Non-Executive Director and Chief Executive.
- The remuneration of the Chair and Non-Executive Directors.
- Changes to the Council of Governors Standing Orders
- The appointment or removal of the external auditor
- Any Mergers, acquisitions, separations or dissolution.
- Any significant transactions where the transaction is "significant" if its value equates to 25% of either the Foundation Trust's Gross Assets, Income or Gross Capital (inclusive of the transaction), calculated with reference to the Foundation Trust's opening Balance Sheet for the Financial Year in which approval is being sought.
- Changes to the Trust Constitution

2.4.2 Any disagreements between the Board of Directors and the Council of Governors are resolved in accordance with the requirements of the Trust's Constitution.

3. DELEGATION OF POWERS

3.1 Delegation to committees (see section 4.1)

3.1.1 The Board of Directors may determine that certain of its powers shall be exercised by standing committees or sub-committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors.

3.1.2 The Board of Directors shall determine the reporting requirements in respect of these committees.

3.1.3 In accordance with SO 6.1.5 within the Trust's Constitution, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

3.2 Delegation to officers (see section 4.1)

3.2.1 The Standing Orders of the Constitution and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the ~~Director of Finance~~Director of Finance & Commercial Development and other directors.

3.2.2 Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive.

3.3 Role of the Chief Executive

3.3.1 All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive.

3.3.2 The Chief Executive shall prepare a Scheme of Reservation and Delegation identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

3.3.3 All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

3.4 Caution over the use of delegated powers

3.4.1 Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

3.5 Absence of directors or officers to whom powers have been delegated

3.5.1 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them will automatically transfer to the Deputy Chief Executive.

3.5.2 If it becomes clear to the Board of Directors that the Accounting Officer (the Chief Executive, as designated by the National Health Service Act 2006) is incapacitated and would be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an Acting Accounting Officer, usually the ~~Director of Finance~~Director of Finance & Commercial Development, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted.

3.6 Role of the Accounting Officer

3.6.1 The Accounting Officer is the Chief Executive, as designated by the National Health Service Act 2006. The following responsibilities are defined through Monitor's Foundation Trust Accounting Officer Memorandum.

3.6.2 The Accounting Officer has responsibility for the overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that

- there is a high standard of financial management in the Foundation Trust as a whole;
- financial systems and procedures promote efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Foundation Trust; and
- financial considerations are fully taken into account in decisions on Foundation Trust policy proposals.

3.6.3 The specific personal responsibilities of the Foundation Trust Accounting Officer:

- the propriety and regularity of the public finances for which they are answerable;
- the keeping of proper accounts;
- prudent and economical administration;
- the avoidance of waste and extravagance; and
- the efficient and effective use of all the resources in their charge.

3.6.4 The Accounting Officer must:

- personally sign the accounts and, in doing so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor;
- comply with the financial requirements of the Terms of Authorisation;
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts;
- ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
- ensure that assets for which they are responsible such as land, buildings and other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate;
- ensure that any protected property (or interest in) is not disposed of without the consent of Monitor;
- ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Governors' Council or in the actions or advice of the Foundation Trust staff, including themselves; and

- ensure that, in the consideration of policy proposals relating to the expenditure for which they are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

3.6.5 The Accounting Officer should ensure that effective management systems appropriate for the achievement of the Foundation Trust's objectives, including financial monitoring and control systems have been established.

3.6.6 The Accounting Officer should ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- are assigned well defined responsibilities for making the best use of resources including a critical scrutiny of output and value for money; and
- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

3.7 Emergency Powers

3.7.1 The powers which the Board has retained to itself may, in emergencies, be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

4. SCHEDULE OF DELEGATION

4.1 General

4.1.1 The Constitution (SO 5.5) states that the Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion. Through this schedule, the Chief Executive shall determine which functions s/he will perform personally, and shall nominate Officers to undertake remaining functions, while still retaining an accountability for these to the Board.

4.1.2 The Chief Executive may periodically propose amendments to this schedule, to be considered and approved by the Board.

4.1.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the executive directors to provide information and advise the Board in accordance with any statutory requirements.

4.1.4 The arrangements made by the Board as set out in the Scheme of Delegation shall have effect as if incorporated into the Standing Orders of the Trust's Constitution.

4.1.5 Table A below details Trust-wide Delegated Authority. The 'Delegated To' authority is in accordance with the Standing Orders and Standing Financial Instructions. The 'Operational Responsibility' entries show the lowest level to which responsibility is delegated. Table B details Delegated Financial Limits.

4.1.6 Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate. If the Chief Executive is absent, powers delegated to them will automatically transfer to the Deputy Chief Executive.

4.2 Table A – Delegated Authority

If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Standing Orders/Standing Financial Instructions			
a)	Final authority in interpretation of Standing Orders.	Chairman	~~Chairman~~Trust Secretary
b)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities.	Chief Executive	All Line Managers
c)	Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial instructions and financial procedures.	Chief Executive	All Directors and Employees
d)	Suspension of Standing Orders.	Board of Directors	~~Board of Directors~~Trust Secretary
e)	Review suspension of Standing Orders.	Audit Committee	Audit Committee
f)	Variation or amendment to Standing Orders.	Board of Directors	~~Board of Directors~~Trust Secretary
g)	Emergency powers relating to the authorities retained by the Board of Directors.	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two Non-Executive Directors
h)	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors).	All staff	All staff
i)	Disclosure of non-compliance with SFIs to the ~~Director of Finance~~Director of Finance & Commercial Development (report to the Audit Committee).	All staff	All staff
j)	Advice on interpretation or application of SFIs and this Scheme of Delegation.	~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development / Internal Audit/ Trust Secretary

1.	**Audit Arrangements**		
a)	To make recommendations to the Governors' Council in respect of the appointment, re-appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor.	Audit Committee (for recommendation to the Governors' Council for approval).	~~Director of Finance~~Director of Finance & Commercial Development
b)	Monitor and review the effectiveness of the internal audit function.	Audit Committee	~~Director of Finance~~Director of Finance & Commercial Development
c)	Review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice.	Audit Committee	Head of Internal Audit
d)	Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e)	Ensure cost-effective audit service.	Audit Committee	~~Director of Finance~~Director of Finance & Commercial Development
f)	Implement recommendations.	Chief Executive	Relevant Officers
2.	**Authorisation of Clinical Trials & Research Projects**	Chief Executive	Medical Director or Director of Medical Education
3.	**Authorisation of New Drugs**	Chief Executive	Drugs and Therapeutics Committee
4.	**Bank Accounts / Cash** *(Excluding Charitable Fund (Funds Held on Trust) Accounts)*		
a)	Operation: • Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements).	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	• Opening bank accounts.	~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development
	• Authorisation of transfers between Foundation Trust bank accounts.	~~Director of Finance~~Director of Finance & Commercial Development	To be completed in accordance with bank mandate/internal procedures
	• Approve and apply arrangements for the electronic transfer of funds.	~~Director of Finance~~Director of Finance & Commercial Development	To be completed in accordance with bank mandate/internal procedures
	• Authorisation of: - GBS schedules - BACS schedules - Automated cheque schedules - Manual cheques.	~~Director of Finance~~Director of Finance & Commercial Development	To be completed in accordance with bank mandate/internal procedures
b)	Investments: • Investment of surplus funds in accordance with the Foundation Trust's Treasury policy. • Preparation of Treasury procedures.	~~Director of Finance~~Director of Finance & Commercial Development ~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services Head of Financial Services
c)	Petty Cash.	~~Director of Finance~~Director of Finance & Commercial Development	Refer To Table B - Delegated Limits
5.	**Capital Investment**		

a)	Programme:		
	• Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans / Service Development Strategy.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Preparation of Capital Investment Programme.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Preparation of a business case.	Chief Executive	Executive Director / Divisional Director of Operations / Head of Department (with advice from Divisional Accountant)
	• Financial monitoring and reporting on all capital scheme expenditure including variations to contract.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	• Authorisation of capital requisitions.	Chief Executive	Refer to Table B Delegated Limits
	• Assessing the requirements for the operation of the construction industry taxation deduction scheme.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Issue procedures to support: ○ capital investment ○ staged payments.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the Standing Orders and Standing Financial Instructions.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
b)	Private Finance:		
	• Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
c)	Leases (property and equipment):		
	• Granting and termination of leases with Annual rent < £250k.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Granting and termination of leases of > £250k should be reported to the Board of Directors.	Board of Directors	Chief Executive

6.	**Clinical Audit**	Chief Executive	Medical Director
7.	**Commercial Sponsorship**		
	• Agreement to proposal.	Chief Executive	Executive Directors / Divisional Director of Operations / Heads of Department. Approval and registration in line with Trust Standards of Business Conduct.
8.	**Complaints (Patients & Relatives)**		
a)	Overall responsibility for ensuring that all complaints are dealt with effectively.	Chief Executive	~~Director of Nursing~~Director of Nursing & Organisational Development
b)	Responsibility for ensuring complaints relating to a division / department is investigated thoroughly.	Chief Executive	Heads of Department
c)	Medico - Legal Complaints -coordination of their management.	Chief Executive	~~Director of Nursing~~Director of Nursing & Organisational Development
9.	**Confidential Information**		
	Review of the Foundation Trust's compliance with the Caldecott report on protecting patients' confidentiality in the NHS.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development / ~~Director of Governance and Workforce~~Director of Nursing and Organisational Development / ~~Director of Commercial and Corporate Development~~
	Freedom of Information Act compliance code.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development / ~~Director of Governance and Workforce~~Director of Nursing and Organisational Development
10.	**Data Protection Act**		
a)	Review of Foundation Trust's compliance.	Chief Executive	~~Director of Commercial and Corporate Development~~
11.	**Declarations of Interests**		
	• Maintaining a register of interests.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Declaring relevant and material interest.	Board of Directors	Board of Directors / Senior Managers / Consultants
12.	**Disposals and Condemnations**		
	• Items obsolete, redundant, irreparable or cannot be repaired cost effectively. • Develop arrangements for the sale of assets.	~~Director of Finance~~Director of Finance & Commercial Development	Associate Director of Estates in accordance with agreed policy Refer to Table B – Delegated Limits
	• Disposal of Protected Property (as defined in the Terms of Authorisation).	Chief Executive (with authorisation of the Independent Regulator)	Chief Executive
13.	**Environmental Regulations**		
	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal.	Chief Executive	Associate Director of Estates

14.	**External Borrowing**		
a)	Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
b)	Approve a list of employees authorised to make short term borrowings on behalf of the Foundation Trust.	Board	Chief Executive / ~~Director of Finance~~Director of Finance & Commercial Development
c)	Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Chief Executive / ~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development
d)	Preparation of procedural instructions concerning applications for loans and overdrafts.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
15.	**Financial Planning / Budgetary Responsibility**		
a)	Setting:		
	• Submit budgets to the Trust Board.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance/ ~~Director of Commercial and Corporate Development~~
	• Submit to Board financial estimates and forecasts.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	▪ Compile and submit to the Board a business plan/Service Development Strategy (SDS) which takes into account financial targets and forecast limits of available resources. The Business Plan/SDS will contain: ○ a statement of the significant assumptions on which the plan is based; ○ details of major changes in workload, delivery of services or resources required to achieve the plan.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development / ~~Director of Commercial and Corporate Development~~
b)	Monitoring:		
	○ Devise and maintain systems of budgetary control.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance & Commercial Development
	○ Monitor performance against budget.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance
	○ Delegate budgets to budget holders.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	○ Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance
	○ Submit returns in accordance with the Independent Regulator's requirements for financial monitoring.	Chief Executive	Deputy ~~Director of Finance~~Director of Finance
	○ Identify and implement cost improvements and income generation activities in line with the Business Plan.	Chief Executive	All budget holders
	Preparation of: • Annual Accounts	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance

	• Annual Report.	Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development
c)	Budget Responsibilities Ensure that • no overspend or reduction of income that cannot be met from re-designation is incurred without prior consent of Board; • approved budget is not used for any other than specified purpose subject to rules of re-designation; and • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.	~~Director of Finance~~Director of Finance & Commercial Development	Budget Holders
d)	Authorisation of Re-designation: It is not possible for any officer to re-designate from non-recurring headings to recurring budgets or from capital to revenue / revenue to capital. Re-designation between different budget holders requires the agreement of both parties.	Chief Executive	Refer To Table B - Delegated Limits
16.	**Financial Procedures and Systems**		
a)	Maintenance & update on Foundation Trust Financial Procedures.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
b)	Responsibilities:- • Implement Foundation Trust's financial policies and co-ordinate corrective action. • Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff. • Ensure that appropriate statutory records are maintained. • Designing and maintaining compliance with all financial systems.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance
17.	**Fire Precautions** • Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Associate Director of Estates
18.	**Fixed Assets**		
a)	Maintenance of asset register including asset identification and monitoring.	Chief Executive	Head of Financial Services
b)	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	~~Director of Finance~~Director of Finance & Commercial Development	Associate Director of Estates
c)	Calculate, account and pay capital charges in accordance with the requirements of the Independent Regulator.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
d)	Responsibility for security of Foundation Trust's assets including notifying discrepancies to the ~~Director of Finance~~Director of Finance &	Chief Executive	All staff

	Commercial Development and reporting losses in accordance with Foundation Trust's procedures.		

19.	**Fraud** *(see also 26, 36)*		
a)	Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive and ~~Director of Finance~~Director of Finance & Commercial Development	Local Counter Fraud Specialist.
b)	Notify Counter Fraud and Security Management Service and External Audit of all suspected Frauds.	~~Director of Finance~~Director of Finance & Commercial Development	Local Counter Fraud Specialist.
20.	**Funds Held on Trust** *(Charitable and Non Charitable Funds)*		
a)	Management: • Funds held on trust are managed appropriately.	Charitable Funds Committee	Head of Financial Services
b)	Maintenance of authorised signatory list of nominated fund holders.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
c)	Expenditure Limits.	~~Director of Finance~~Director of Finance & Commercial Development	Refer To Table B - Delegated Limits
d)	Developing systems for receiving donations.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
e)	Dealing with legacies.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
f)	Fundraising Appeals	Charitable Funds Committee	Associate Director of Communications / Head of Financial Services
	• Preparation and monitoring of budget	~~Director of Finance~~Director of Finance & Commercial Development	A nominated fund raising manager with advice from financial link.
	• Reporting progress and performance against budget.	~~Director of Finance~~Director of Finance & Commercial Development	A nominated fund raising manager with advice from financial link.
g)	Operation of Bank Accounts: • Managing banking arrangements and operation of bank accounts.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	• Opening bank accounts.	~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development
h)	Investments: • Nominating deposit taker.	Charitable Funds Committee	~~Director of Finance~~Director of Finance & Commercial Development
	• Placing transactions.	~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development / Investment Broker
i)	Regulation of funds with Charities Commission.	~~Director of Finance~~Director of Finance &	Head of Financial Services

		Commercial Development	
21.	**Health and Safety**		
	Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations.	Chief Executive	Director of Nursing & Organisational Development/ Associate Director of Governance ~~and Workforce~~
22.	**Hospitality / Gifts**		
a)	Keeping of hospitality register.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
b)	Applies to both individual and collective hospitality receipt items. See Table B for limits.		All staff declaration required in Foundation Trust's Hospitality Register
23.	**Infectious Diseases & Notifiable Outbreaks**	Chief Executive	~~Director of Nursing~~Director of Nursing & Organisational Development
24.	**Information Management & Technology**		
	Financial Systems • Developing financial systems in accordance with the Foundation Trust's IM&T Strategy. • Implementing new systems ensure they are developed in a controlled manner and thoroughly tested. • Seeking third party assurances regarding financial systems operated externally.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy Director of Finance
	• Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	~~Director of Finance~~Director of Finance & Commercial Development	~~Associate~~ Director of Information Technology
	• Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	~~Director of Finance~~ Director of IT	Associate Director of Information Technology
25.	**Legal Proceedings**		
a)	Engagement of Foundation Trust's Solicitors / Legal Advisors.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development / ~~Board~~ Trust Secretary
b)	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Executive Directors / Trust Secretary
c)	Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed.	Chief Executive	Executive Director / Trust Secretary
26.	**Losses, Write-offs & Compensation**		
	Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Counter Fraud Management Services of frauds.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development

	Losses Losses of cash due to theft, fraud, overpayment & others. Fruitless payments (including abandoned Capital Schemes). Bad debts and claims abandoned. Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson).		
	Reviewing appropriate requirement for insurance claims.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	A register of all of the payments should be maintained by the Finance Department and made available for inspection.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	A report of all of the above payments should be presented to the Audit Committee.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
	Special Payments Compensation payments by Court Order.	Chief Executive	Above Excess – NHSLA Below Excess – Chief Executive
	Ex gratia Payments:-		
	• To patients/staff for loss of personal effects.		~~Director of Finance~~Director of Finance & Commercial Development
	• For clinical negligence after legal advice.		Medical Director / ~~Director of Finance~~Director of Finance & Commercial Development
	• For personal injury after legal advice.		Medical Director / ~~Director of Finance~~Director of Finance & Commercial Development
	• Other clinical negligence and personal injury.		Medical Director / ~~Director of Finance~~Director of Finance & Commercial Development
	• Other ex-gratia payments.		~~Director of Finance~~Director of Finance & Commercial Development
27.	**Meetings**		
a)	Calling meetings of the Foundation Trust Board.	Chairman	~~Chairman~~In accordance with the Trust Constitution
b)	Chair all Foundation Trust Board meetings and associated responsibilities	Chairman	In accordance with the Trust Constitution~~Chairman~~
28.	**Medical**		
	• Clinical Governance arrangements	Medical Director / ~~Director of Nursing~~Director of Nursing & Organisational Development	Medical Director / ~~Director of Nursing~~Director of Nursing & Organisational Development
	• Medical leadership	Medical Director	Medical Director
	• Programmes of medical education	Medical Director	Medical Director
	• Medical staffing plans	Medical Director	Medical Director
	• Medical research	Medical Director	Medical Director / Director of Strategy &

			Business Development
29.	**Non Pay Expenditure**		
a)	Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B.	Chief Executive	Head of Procurement
b)	Obtain the best value for money when requisitioning goods / services.	Chief Executive	Head of Procurement / Divisional Director of Operations / Heads of Department
c)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a)).	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
d)	Develop systems for the payment of accounts.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
e)	Prompt payment of accounts.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
f)	Financial Limits for ordering / requisitioning goods and services.	~~Director of Finance~~Director of Finance & Commercial Development	Refer To Table B - Delegated Limits
g)	Approve prepayment arrangements.	~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development
30.	**Nursing**		
	▪ Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice.	~~Director of Nursing~~Director of Nursing & Organisational Development	Deputy ~~Director of Nursing~~Director of Nursing
	▪ Matters involving individual professional competence of nursing staff.	~~Director of Nursing~~Director of Nursing & Organisational Development	Deputy ~~Director of Nursing~~Director of Nursing
	▪ Compliance with professional training a development of nursing staff.	~~Director of Nursing~~Director of Nursing & Organisational Development	Deputy ~~Director of Nursing~~Director of Nursing
	▪ Quality assurance of nursing processes.	~~Director of Nursing~~Director of Nursing & Organisational Development	Deputy ~~Director of Nursing~~Director of Nursing
31.	**Patient Services Agreements**		
a)	Negotiation of Foundation Trust Contract and Non Commercial Contracts.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
b)	Quantifying and monitoring out of area treatments.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance / Head of Strategic Financial Planning
c)	Reporting actual and forecast income.	Chief Executive	Deputy ~~Director of Finance~~Director of Finance & Commercial Development / Head of Strategic Financial Planning
d)	Costing Foundation Trust Contract and Non Commercial Contracts.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance / Head of Strategic Financial Planning
e)	Reference costing / Payment by Results.	~~Director of Finance~~Director	Deputy ~~Director of Finance~~Director of

		of Finance & Commercial Development	Finance / Head of Strategic Financial Planning
f)	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance
32.	**Patients' Property** *(in conjunction with financial advice)*		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development / Divisional Director of Operations / Heads of Department
b)	Prepare detailed written instructions for the administration of patients' property.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
c)	Informing staff of their duties in respect of patients' property.	~~Director of Finance~~Director of Finance & Commercial Development	Divisional Director of Operations / Heads of Department
d)	Issuing property of deceased patients (see SFI 15.1.9 & 15.1.10) ▪ <£4,999 in accordance with agreed Foundation Trust policies. ▪ >£5,000 only on production of a probate letter of administration.	~~Director of Finance~~Director of Finance & Commercial Development	General / Cash Office Staff ~~Director of Finance~~Director of Finance & Commercial Development
33.	**Personnel & Pay**		
a)	Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts.	Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development / Divisional Director of Operations / Heads of Department
b)	Develop Human Resource policies and strategies for approval by the board including training, industrial relations.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development
c)	Authority to fill funded post on the establishment with permanent staff.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Executive Directors / Divisional Director of Operations / Heads of Department in accordance with Trust policy
d)	The granting of additional increments to staff within budget	Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development
e)	All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Associate Director of Human Resources
f)	Establishments		
	• Additional staff to the agreed establishment with specifically allocated finance.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance & Commercial Development / Head of Management Accounts
	• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Self financing changes to an establishment.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance & Commercial Development / Head of Management Accounts
g)	Pay		

• Presentation of proposals to the Foundation Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration and Terms of Employment Committee.	Chief Executive	Chief Executive
• Authority to complete standing data forms effecting pay, new starters, variations and leavers.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Divisional Director of Operations / Heads of Department
• Authority to complete and authorise positive reporting forms (SVLs).	~~Director of Finance~~Director of Finance & Commercial Development	Divisional Director of Operations / Heads of Department
• Authority to authorise overtime.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development / ~~Director of Finance~~Director of Finance & Commercial Development	Divisional Director of Operations / Heads of Department
• Authority to authorise travel & subsistence expenses.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development / ~~Director of Finance~~Director of Finance & Commercial Development	Divisional Director of Operations / Heads of Department

h) Leave *(Note entitlement may be taken in hours).* Annual Leave	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	*Refer to Annual Leave Policy*
- Approval of annual leave.		Executive Directors / Divisional Director of Operations / Heads of Department / Line Managers (as per departmental procedure)
- Annual leave - approval of carry forward (up to maximum of 5 days.	Chief Executive	Executive Directors / Divisional Director of Operations / Heads of Department
- Annual leave – approval of carry forward over 5 days (to occur in exceptional circumstances only).	Chief Executive	Non Medical Staff – Executive Directors / Divisional Director of Operations / Heads of Department Medical Staff – Medical Director
Special Leave	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	
- Compassionate leave		Executive Directors / Divisional Director of Operations / Heads of Department
• Special leave arrangements for domestic/personal/family reasons • paternity leave • carers leave • adoption leave *(to be applied in accordance with Foundation Trust Policy).*		Executive Directors / Divisional Director of Operations / Heads of Department
• Special Leave – this includes Jury Service, Armed Services, School Governor (to be applied in accordance with Foundation Trust Policy).		Executive Directors / Divisional Director of Operations / Heads of Department
• Leave without pay.		Executive Directors / Divisional Director of Operations / Heads of Department
• Medical Staff Leave of Absence – paid and unpaid.		Medical Director / Divisional Director of Operations / Divisional Medical Directors
• Time off in lieu.		Departmental / Line Managers
• Maternity Leave - paid and unpaid.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Automatic approval with guidance
Sick Leave i) Extension of sick leave on pay.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	
ii) Return to work part-time on full pay to assist recovery.		
Study Leave • Study leave outside the UK.	Chief Executive	Executive Director

	• Medical staff study leave (UK) - Consultant / Non Career Grade - Career Grade.	Medical Director	Medical Director Post Graduate Tutor
	• All other study leave (UK).	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Executive Directors / Divisional Director of Operations / Heads of Department (in accordance with agreed Foundation Trust policy)
i)	Removal Expenses, Excess Rent and House Purchases. All staff (agreed at interview) Maximum £6,000. Senior Medical Staff Maximum £8,000. Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview).	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Executive Director Refer to Table B - Delegated Limits
j)	Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Director of Organisational Development & Governance must be sought when the grievance reaches the level of Divisional Director of Operations / Heads of Department.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	As per procedure
k)	Authorised Car Users • Leased cars (Business and personal). • Regular user allowance.	Chief Executive ~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development Executive Director / Divisional Director of Operations / Heads of Department
l)	Mobile Phone / Messaging Services.	~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development / Associate Director of Facilities
m)	Renewal of Fixed Term Contract.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Heads of Department on advice from Human Resources and Management Accountant
n)	Staff Retirement Policy ▪ Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances. ▪ Authorisation of return to work in part time capacity under the flexible retirement scheme.	Chief Executive Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development ~~Director of Governance and Workforce~~Director of Nursing and Organisational Development
o)	Redundancy	Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development / ~~Director of Finance~~Director of Finance & Commercial Development
p)	Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development
q)	Disciplinary Procedure (excluding Executive Directors).	Chief Executive	To be applied in accordance with the Foundation Trust's Disciplinary Procedure

r)	Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Associate Director of Human Resources
s)	Engagement of staff not on the establishment.		
	• management consultants.		Refer to Table B
	▪ booking of bank staff		
	• nursing	~~Director of Nursing~~Director of Nursing & Organisational Development	Divisional Director of Operations / Divisional Heads of Nursing /Deputy Director of Nursing
	• other.	Executive Directors	Divisional Director of Operations / Heads of Department / Line Managers
	▪ booking of agency staff		
	• nursing	~~Director of Nursing~~Director of Nursing & Organisational Development	Divisional Director of Operations / Divisional Heads of Nursing
	• other.	Executive Directors	Divisional Director of Operations / Heads of Department / Line Managers
34.	**Quotations, Tendering & Contract Procedures**		
a)	Services:		
	• Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development / Head of Procurement / Associate Director of Estates
	• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Divisional Director of Operations /Heads of Department
b)	Competitive Tenders:		
	• Authorisation Limits	Chief Executive	Refer To Table B - Delegated Limits
	• Maintain a register to show each set of competitive tender invitations despatched.	Chief Executive	Head of Procurement
	• Receipt and custody of tenders prior to opening.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Opening tenders	Chief Executive	Two officers from the approved list as authorised by the Audit Committee or release of electronic tenders one contract management system by designated officer.
	• Decide if late tenders should be considered.	Chief Executive	~~Director of Finance~~Director of Finance & Commercial Development
	• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Executive Director / Divisional Director of Operations / Heads of Department
c)	Quotations	Chief Executive	Refer To Table B - Delegated Limits
d)	Waiving the requirement to request		
	• tenders - subject to Standing Orders (reporting to the Board).	Chief Executive	Refer To Table B - Delegated Limits
	• quotes - subject to Standing Orders.	Chief Executive or ~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development
35.	**Records**		
a)	Review Foundation Trust's compliance with the Records Management Code of Practice.	Chief Executive	Executive Directors / Divisional Director of Operations / Heads of Department
b)	Ensuring the form and adequacy of the financial records of all departments.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance
36.	**Reporting of Incidents to the Police**		

a)	Where a criminal offence is suspected • criminal offence of a violent nature • arson or theft • other	Chief Executive	Manager On-call / Heads of Department / Divisional Director of Operations
b)	Where a fraud is involved (reporting to the Directorate of Counter Fraud Services).	~~Director of Finance~~Director of Finance & Commercial Development	Head of Internal Audit / Local Counter Fraud Officer
c)	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	~~Director of Finance~~Director of Finance & Commercial Development	~~Director of Finance~~Director of Finance & Commercial Development
37.	**Risk Management**		
	• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management.	Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development
	• Developing systems for the management of risk.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Associate Director of Governance
	• Developing incident and accident reporting systems.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Associate Director of Governance
	• Compliance with the reporting of incidents and accidents.	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	All staff
38.	**Seal**		
a)	The keeping of a register of seal and safekeeping of the seal.	~~Chief Executive~~Trust Secretary	~~Board Secretary~~Trust Secretary
b)	Attestation of seal in accordance with Standing Orders.	~~Chairman / Chief Executive~~Two Directors one of which must be the Chief Executive or Deputy Chief Executive (if the Chief Executive is unavailable)	~~Chairman / Chief Executive (report to Board of Directors)~~
c)	Property transactions and any other legal requirement for the use of the seal.	Two Directors one of which must be the Chief Executive or Deputy Chief Executive (if the Chief Executive is unavailable)~~Chairman / Chief Executive~~	~~Chairman or Non Executive Director and the Chief Executive or their nominated Director~~
39.	**Security Management**		
a)	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.	Chief Executive	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development / Local Security Management Specialist.
40.	**Setting of Fees and Charges (Income)**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance & Commercial Development
b)	Non patient care income	~~Director of Finance~~Director of Finance & Commercial Development	Deputy ~~Director of Finance~~Director of Finance & Commercial Development
c)	Informing the ~~Director of Finance~~Director of Finance & Commercial Development of monies due to the Foundation Trust	~~Director of Finance~~Director of Finance & Commercial Development	All Staff
d)	Recovery of debt	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services

e)	Security of cash and other negotiable instruments	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
41.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over stores and receipt of goods, issues and returns.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Procurement / Head of Pharmacy / Associate Director of Estates and appropriate Heads of Department
b)	Stock-taking arrangements.	~~Director of Finance~~Director of Finance & Commercial Development	Head of Financial Services
c)	Responsibility for controls of pharmaceutical stock.	Designated pharmaceutical officer	

4.3 Table B - Delegated Financial Limits

All thresholds are inclusive of VAT irrespective of recovery arrangements.
Details of procurement thresholds will be provided by the Head of Procurement

If the Chief Executive is absent, powers delegated to them will automatically transfer to the Deputy Chief Executive.

	Proposed Financial Limits (Subject to funding available in budget)		**Includes:-**
1	**CHARITABLE FUNDS**		
	Charitable Funds Committee	Over £25,000	*Note: Manual system, paper based approval*
	~~Director of Finance~~Director of Finance & Commercial Development	£1,000 to £25,000	
	Head of Financial Services	Up to £1,000	
2	**GIFTS AND HOSPITALITY**	£25	
3.	**LITIGATION CLAIMS**		Clinical Negligence Claims Clinical negligence claims are handled by the NHS Litigation Authority on behalf of the Trust under the CNST and ELS Schemes. Authorisation from the NHSLA is required before admissions may be made and monetary compensation offered. All payments will be made directly by the NHSLA. (*NHSLA – Clinical Negligence Reporting Guidelines, 5th Edition, October 2008).*
	Chief Executive / ~~Director of Finance~~Director of Finance & Commercial Development	Excess payments: Over £15,000	Employers Liability and Public Liability Claims These claims are handled under the NHSLA RPST Scheme.
	~~Director of Nursing~~Director of Nursing & Organisational Development	Up to £15,000	
	Litigation & Risk Manager	PL claims: Payments within excess £3,000	
		EL claims: Payments within excess £10,000	
4.	**LOSSES AND SPECIAL PAYMENTS**		
	Losses Fruitless payments (including abandoned capital schemes)	£250,000 and above £5,000 up to £250,000	Board of Directors Chief Executive / ~~Director of Finance~~Director of Finance & Commercial Development reported to the Audit Committee
	Other Losses Losses of cash due to theft, fraud, overpayment and others	£5,000	Chief Executive / ~~Director of Finance~~Director of Finance & Commercial Development
	Bad debts and claims abandoned		
	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use		

	Proposed Financial Limits (Subject to funding available in budget)	**Includes:-**
	due to culpable causes (e.g. fraud, theft, arson etc)	

5.	**PETTY CASH DISBURSEMENTS / PATIENTS MONIES** *(authority to pay cash)*		
	~~Director of Finance~~Director of Finance & Commercial Development or Nominated Deputy	Over £50	Petty Cash/Sundry Exchequer Item
	Budget Manager	Up to £50	
	~~Director of Finance~~Director of Finance & Commercial Development	Over £5,000	Patient Monies (see Patients' Property, Table A Section 32)
	Deputy ~~Director of Finance~~Director of Finance & Commercial Development / Head of Financial Services	£101 - £5,000	
	Cash / General Office Managers	Up to £101	
6.	**REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS**		
6.1	**Non Pay Expenditure**		
	All Requisitions & Approvals: Chief Executive / Deputy Chief Executive	Over £250,000	
	Executive Directors	Up to £250,000	
	Deputy Chief Operating Officer	Up to £150,000	
	Associate Divisional Director Director of Medical Education Associate Director of Estates	Up to £50,000	
	Associate Directors *(except those listed above)* Deputy Director of Finance Head of AHP and Technical Services Assistant General Managers Divisional Nurses / Heads of Nursing Hospital Out-of-Hours Project Manager Urgent Care Lead Divisional Medical Directors Chief Pharmacist Head of Operational Estates Estates Projects Manager Medical Engineering Manager FISD Network Manager CPD & Business Support Manager Emergency Care Manager ~~Board~~ Trust Secretary	Up to £25,000	
	All Divisions: Matron *Facilities & Estates:* Estates Managers Assistant Medical Engineering Manager Head of Security & LSMS Facilities Manager Security Manager Service Manager –OPD & Medical Records *Finance:* Head of Procurement Head of Financial Services Head of Management Accounts Head of Strategic Financial Planning Head of Information Services	Up to £10,000	

	FSD Manager *Human Resources:* Head of Remuneration Head of Medical Staffing Claims & Litigation Manager Deputy Employment Services Manager Senior Executive Secretary *Scheduled Care:* Cancer Lead Manager Service Development Manager Clinical Manager Anaesthetics Decontamination Manager *Unscheduled Care:* Cardio/ Respiratory Manager Outpatients & Medical Records Support Manager Emergency and Acute Care Manager *Women's, Children's & Support Services:* Head of Microbiology Therapy Manager (Histo)/Pathology Service Manager Chief Pharmacy Technician Deputy Chief Pharmacist Principal Pharmacist Medical Laboratory Senior Officer 3 *(designated budget holder only)* Supt 3 Radiographer Radiology Service Manager Governance Compliance Manager	
	All Divisions: Ward Manager Deputy Ward Manager Clinical Nurse Specialist Divisional/Directorate Administrator *Finance:* Senior Technical Support Officer Senior Technical Support Officer (Networks) *Facilities & Estates:* Telecommunications Manager Estates/ Engineering Officer Catering Manager Domestic (and Portering) Services Manager Outpatient Access Manager Fire Safety Advisor Datix Manager / Risk Systems Analyst *Human Resources:* Senior HR Manager HR Manager HR Business Partner Manager Occupational Health Manager Medical Staffing Manager Head of Safety and Risk Health & Safety Adviser ~~Senior Executive Secretary~~ *Education & Research:*	Up to £5,000

	Post Graduate Centre Manager Team Leader Resuscitation Tissue Viability Nurse Management Development Manager Knowledge & Library Services Manager / Outreach Librarian Library Services Manager *Scheduled Care:* Sister Pre-op Sister Orthodontics Sister Day Case Unit Junior Sister T&O Macmillan Support & Information Manager Theatre Coordinator Surgical Services Manager Orthopaedics (OPD) Manager Principal Optometrist Ophthalmic Manager Department Manager ITU Nurse Practitioner Waiting List Business Manager Head Orthoptist Critical Care Coordinator Anaesthetic Coordinator Sterile Services Manager Pre-op Assessment Coordination (T&O) Orthodontics Manager *Unscheduled Care:* Sister OPD Sister A&E Assistant Matron Deputy Nurse Manager (Cardio/ Respiratory) Patient Care Facilitator Diabetes Service Manager Respiratory Nurse Senior 1 Radiographer Medical Records Manager OPD Appointments Manager Lead Nurse Minor Injuries Unit Snr Chief Cardiac Physiologist *Women's, Children's & Support Services:* Midwifery Sister Biomedical Scientist *(designated budget holder only)* Histopathology Operations Manager Microbiology Operations Manager Medical Laboratory Senior Officer 2 *(designated budget holder only)* Principal Pharmacy Technician Senior Pharmacist Senior Pharmacy Technician On-call Pharmacist *(drugs only)* Principal Sonographer Principal Radiographer Superintendent Radiographer Radiographer Senior 1 Occupational Therapist Principal Therapist Supt 3 Physiotherapist Head Occupational Therapist Antenatal Day Unit Manager

	ANC Manager Neonatal Unit Manager Manager GUM Orthotist Audiology Service Manager Chief Audiology Technician Warrington Community Cardiac Team Leader Locality Team Leader / Community Manager Office Manager PA *(to WCSS Assistant General Manager)* PA *(to Chief Pharmacist)* Team Lead Physiotherapist Pharmacy Technician Manager Principal Clinical Pharmacist Speech & Language Therapy Co-ordinator		
6.2	**Capital Expenditure (Subject to annual programme being approved by Board of Directors)**		
	Sign off by two Executive Directors following Board of Directors Approval.	Over £500,000	Initial Business case review by Executive Directors with final review and approval from Board of Directors.
	Executive Directors	£100,000-£500,000	
	Capital Planning Group	Up to £100,000	
6.3	**Removal Expenses**		
	~~Director of Governance and Workforce~~Director of Nursing and Organisational Development	Up to £8,000	
7.	**QUOTATIONS AND TENDERS**		
	Head of Procurement / Associate Director of Estates / Chief Pharmacist	£10,000 to £60,000	Quotations: *Inviting* a **minimum of 3 written quotations** for goods/services.
	Head of Procurement / Associate Director of Estates / Chief Pharmacist	Over £60,000 (in compliance with EC Directives as appropriate)	Competitive Tenders: *Inviting* **a minimum of 3 written competitive tenders** for goods/services. EU Limits and subsequent changes to be provided under separate correspondence by Head of Procurement
8.	**BUSINESS CASE APPROVAL**		**Conditions:-**
	Board of Directors	Over £500,000	Capital and Revenue costs must be approved
	Executive Team	£100,000 - £500,000	
	Operations Group	Up to £100,000	

9.	**BUDGET RE-DESIGNATION**		**Conditions:-**
	Trust Board	Over £250,000 p.a.	Trust must still meet Financial Targets
	Chief Executive	Up to £250,000 p.a.	Total Trust budget remains under spent
	~~Director of Finance~~Director of Finance & Commercial Development	Up to £100,000 p.a.	Total Trust budget remains under spent
	Deputy ~~Director of Finance~~Director of Finance	Up to £25,000 p.a.	Total Divisional / Departmental Budget remains under spent

QUALITY IMPACT ASSESSMENT

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

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Physical Disability	NO	
	• Learning Difficulties/Disability or Cognitive Impairment	NO	
	• Mental Health	NO	
	• Race	NO	
	• Carer	NO	
	• Nationality	NO	
	• Ethnic origins (including gypsies and travellers)	NO	
	• Culture	NO	
	• Religion or belief	NO	
	• Gender (Male, Female and Transsexual)	NO	
	• Sexual orientation including lesbian, gay and bisexual people	NO	
	• Age	NO	
2	Is there any evidence that some groups are affected differently?	NO	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4	Is the impact of the policy/guidance likely to be negative?	NO	
5	If so can the impact be avoided?	N/A	
6	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/093

BOARD OF DIRECTORS

Paper Title	Compliance with Provider Licence Conditions G6 and COS7
Date of Meeting	28 May 2014
Director Responsible	Chief Executive
Author(s)	Executive/Trust Secretary
Purpose	To provide compliance statements to Monitor in accordance with the Trust's Provider Licence.

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•		

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to confirm compliance with the requirements of Provider Licence Condition G6 and COS 7 as set out in the paper.

Introduction

On 1 April 2013 the Trust was issued with a Provider Licence from its regulator Monitor. The Provider Licence contains obligations for providers of NHS services that enable Monitor to fulfil its duties as the regulator of NUS Foundation Trusts and will enable Monitor to oversee the way that Foundation Trusts are governed.

The standard licence conditions are grouped in to seven sections. The first section, containing the General Conditions, sets out standard requirements and rules for all licence holders. Sections 2 to 5 of the licence are about Monitor's new functions: setting prices, enabling services to be provided in an integrated way, safeguarding choice and competition and supporting commissioners to maintain service continuity. Section 6 is about translating the well-established core of Monitor's current oversight of Foundation Trust governance in to the new provider licence. The final section, 7, contains definitions and notes.

In compliance with the Provider Licence the Trust is required to submit compliance statements during the year. Two Governance statements are required at the end of this May 2014 and further statements will be required at the end of June and submitted in conjunction with the Strategic Plan. Appendix 1 provides a screen shot of the submission document to Monitor.

Compliance Statements for submission May 2014

The two statements the Trust is required to confirm at the end of May 2014 relate to compliance with provider licence condition G6 and CoS7.

A. Provider Licence Condition G6

G6	***Systems for compliance with licence conditions and related obligations***
	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
	2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

The commentary below breaks down the compliance statement and provides supporting comments on why the Trust believes it complies with Provider Licence Condition G6.

Compliance statement (G6) and supporting comments

1. Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended [2013/14], the Licensee took all such precautions as were necessary in order to comply with

   a. the conditions of the licence;

   Response: ***Confirmed***

   Comment: During the financial year 2013/14 the conditions contained within the provider licence have been reviewed by the executive assigned to each condition to ascertain whether the trust is able to comply with its obligations and where appropriate any risks to compliance are included on the trust Board Assurance Framework (BAF). On a quarterly basis the Board reviews the BAF and also the provider licence checklist in order to assess the risk of compliance. During the year there have been no compliance issues arising from the reviews and any potential risks of compliance have been included were appropriate on the BAF. In support of compliance with the licence the Board also receives through its Governance Structure assurance that risks are managed appropriately through the Risk Management Strategy and via the Annual Governance Statement which provides additional assurances on internal control from the Chief Executive. Independent assurance on trusts processes and service provision is also provided by the Internal Auditor and External Auditor through the Audit Committee.

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

   Response: ***Confirmed***
   Comment: There were no additional requirements imposed under the NHS Acts during 2013/14

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

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

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

   Response: ***Confirmed***

   Comment: The Board continues to take into account the conditions of the provider licence in delivery of health care services.

Board Approval: With regard to Provider licence Condition G6 the Board is asked to confirm its compliance

B. Provider Licence Condition COS7

Provider Licence Condition COS7 requires

CoS7	***Availability of resources***
	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
	2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
	3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services". (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

With regard to the three certifications contained within COS7 paragraph 3, the Trust confirms sub paragraph (a).

Comments to support compliance with 3a:

- *The 13/14 annual accounts were prepared on a going concern basis (external audit will confirm this approach as part of their review).*
- *The Trust planned for a £1.5m deficit in 14/15 and a continuity of services risk rating 3.*
- *There is sufficient cash available during the year and the cash balance at year end based on the planned deficit and the approved capital programme is £6.7m.*
- *The sensitivity analysis presented and agreed at the F&S committee showed that the Trust would need to record a deficit of £8.3m before running out of cash (and this is still based on full completion of the £9.9m capital programme).*

- *Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the cost saving targets are achieved.*

- *The trust has revised the governance structure to monitor financial performance including the introduction of the F&S committee, a more robust role for the ICIC and the introduction of transformational workstreams. These changes will provide greater scrutiny and support in the achievement of the cost savings target.*

Board Approval: With regard to Provider licence Condition COS7 the Board is asked to confirm its compliance paragraph 3a.

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 **General condition 6 - Systems for compliance with license conditions**

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed:**
	AND	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	**Confirmed**

3 **Continuity of services condition 7 - Availability of Resources**

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**
	OR	
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	
	OR	
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

BOARD OF DIRECTORS

Paper Title	Risk Management Annual Report to the Effectiveness of the Governance Committee 1st April 2013 to 31st March 2014
Date of Meeting	May 2014
Director Responsible	Karen Dawber Mike Lynch
Author(s)	Millie Bradshaw, Associate Director of Governance
Purpose	The Trust is required provide an annual report based to the effectiveness of the Governance Committee as identified within the ToR

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Governance Committee	May 2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	Attendance at Governance Committee of members	Page 3
•	Attendance of Safety and Risk Sub Committee of members	Pages 3 & 4
•	Attendance of Clinical Governance, Audit and Quality Sub Committee	Pages 5 & 6
•	Chair of the Governance Committee to review the meeting scheduled for the Information Governance and Corporate Records Group with the Director of IM&T	Page 7
•	Mandatory training of members of the Governance Committee	Pages 7-9
•	Number of Policies Approved under Governance arrangements	Pages 9 & 10
•	Risk KPIs for 13/14	Pages 11
•	Additional Achievements and overview to annual reports submitted and risk register review	Page 11
•		

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)
To receive, review and Note the Report

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Risk Management Annual Report for the period 1st April 2013 to 31st March 2014 to the Governance Committee

Introduction

Risk Management in Warrington and Halton Hospitals NHS Foundation Trust aims to ensure it critically examines, and effectively manages, all risks to people, structures, reputation and any other issues, which could impact upon or compromise the ability of the Trust to carry out its normal activities. Having identified these risks it then becomes necessary to manage them through the implementation of measures to either prevent them happening, reduce the likelihood of them happening, or the impact if they do occur.

The management of risk is therefore an integral component of the Trust's corporate and clinical governance agendas. This Annual Report from 1st April 2013 to 31st March 2014 describes the monitoring of the effectiveness of the agreed processes within the Trust as agreed within the Risk Management Strategy.

Background

To enable the Trust to meet these commitments it is necessary to have in place clear structures and processes for risk management at all levels of the organisation:

- a structured and systematic approach to the management of risk so that it becomes an integral part of all clinical, managerial, business and financial processes.
- effective reporting structures from within Divisions through to the Governance Committee and Trust Board.
- continuing development of an integrated risk register to support the recording and monitoring of identified risks and resulting action plans, and which provides the Trust Board with a Trust wide risk profile.
- individual objectives, responsibilities and accountabilities for all risk management by including them within job descriptions and personal development plans.
- empowering all staff to report risks and register concerns about unsafe practice through an open and fair culture supported by effective Human Resources and Risk Management policies and procedures.
- providing risk management training at all levels within the organisation and as an integral element of the Trust's training and development plans.

Risk Management Effectiveness

The Governance Committee is chaired by a Non- Executive Director. The Committee has the overarching responsibility for risk within the Trust and is supported by a number of sub-committees and groups. In order to fulfil these responsibilities it has three sub-committee reporting to it that includes:

- **The Clinical Governance, Audit and Quality Sub-Committee** reviews and monitors patient quality, safety and Effectiveness within the agreed assurance systems agreed as part of an annual work plan which includes the management of any risks. The Sub Committee also approves policies under its identified schedule. The Group met on 11 occasions during the Report period.
- **The Safety and Risk Sub-Committee** reports to the Governance Committee and oversees the work of the health and Safety, Fire, Estates, Divisions and corporate services including Medical Devices management which occurred during 13/14. The Sub Committee reviews Parts 1 and 2 of the Risk Register as part of the timetable within the annual work plan and approves policies. The Group met on 12 occasions during the Report period.
- **Information Governance and Corporate Records Committee** approve policies under its identified schedule of approval, reviews and monitors the management of risk relating to

information governance toolkit & Standards in addition to corporate records and ensures that they are implemented effectively and reviewed at appropriate intervals. The Group has not met to the times within its Terms of Reference. This is being reviewed by the Director of IM&T.

Delegated Responsibilities

The Director of Nursing and OD is accountable to the Trust Board on behalf of the Chief Executive for the Trust's organisational Governance and risk management activities. She is responsible for ensuring compliance with Care Quality Commission Regulated Activities within the essential Standards for Quality and Safety.

As Executive Lead she is supported in this role by the Associate Director of Governance and for workforce and organisation by the associate Director of Human Resources.

The Director of Nursing is responsible for Patient Experience, Safeguarding procedures and Infection Control.

The Medical Director is the Executive Lead for Clinical Governance and Effectiveness. The present postholder has been in post just over 3 months.

Monitoring Effectiveness of the Risk Management Strategy and Processes

The Report and contents are based on the NHSLA Risk Management Standards criteria and focuses on the Governance Committee, Safety and Risk, and Clinical Governance Sub Committees as the key forums for risk monitoring and effectiveness.

Board Level Review of the Risk Register

The Trust Board received and reviewed the risk register on 29 May 2013, 31 July, 2 Oct 27 Nov and the 29 Jan 2014 and is therefore compliant with the current Risk Management Strategy.

Action: None required

Attendance and monitoring to Committees and Sub Committees

Governance Committee. The Governance met on six occasions within the 12 month **Figure 1** and over the page provides the attendance at the Governance Committee. The bold font denotes below 75% attendance.

Member	Number of meetings attended	Apologies recorded	Deputy	Comments
Chair (Non-Executive Director)	6			
Chief Executive	4		2	
Chief Operating Officer	5		1	
Chief Pharmacist	6			
Director of Finance	6			3 by interim DoF 3 by new DoF
Director of Nursing and OD	6			
Medical Director	2		1	Interim in place July '13
Director of IM&T	**0**		**1**	
Associate Director of Governance	6			
Assistant Divisional Manager, Therapies and Pathology	5		1	

Member	Number of meetings attended	Apologies recorded	Deputy	Comments
Deputy Director of Nursing	6			
Associate Director of Nursing Scheduled Care	5	1		Not on ToR
Associate Director of Nursing WCSS	5	0	1	Not on ToR
Associate Director of Nursing Unscheduled Care	**3**	**2**	**1**	Not on ToR
Associate Operational Director WCSS	4	0	2	
Associate Operational Director Unscheduled Care	**3**	**2**	**1**	
Associate Operational Director Scheduled Care	4		2	
DIGG Lead representative	**1**	**5**		
Non- executive Director	6			

Action: Chair to review and discuss attendance to the Committee as part of this submitted Report.

Safety and Risk Sub Committee

The Safety and Risk Sub Committee met bi monthly. A revised work plan being introduced during this period.. **Figure 2** below and over the page provides the attendance. The bold font denotes below 75% attendance.

Member	Number of meetings attended	Apologies recorded	Deputy	Comments
Associate Director Estates and Facilities	10	2	1	
Associate Director of Governance(Chair)	11	1	0	
Information Governance and Corporate Records Manager	7	1	0	
Chief Pharmacy Technician	10	2	0	
Deputy Director of Finance (covers for Supplies_)	**1**	**3**	**6**	
Deputy Director of HR	8	4	0	
Deputy Director of Nursing	7	3	0	
Associate Director Infection Prevention and Control	2	1	0	Membership commenced in January 2014

Member	Number of meetings attended	Apologies recorded	Deputy	Comments
Associate Operational Director Scheduled Care	9	3	0	
Associate Operational Director WCSS	8	4	0	
Associate Operational Director Unscheduled Care	**5**	**7**	**0**	
Divisional Clinical Governance Coordinator WC&SS	11	1	0	
Head of Safety and Risk	11	1	1	
LSMS	6	5	1	
Health and Well Being Manager	**3**	**5**	**1**	
Governance Manager unscheduled Care	6	3	0	
Governance Manager Scheduled Care	**4**	**0**	**1**	
Head of Legal Services and Patient Safety	9	3	0	
Medical Engineering Manager	5	0	0	Membership commenced in November 2013
Medical Devices Training Co-Ordinator	5	1	0	Membership commenced in November 2013

Action: Chair to review and discuss attendance to the Committee of the Unscheduled Care Divisional Director and Deputy Director of Finance

Clinical Governance, Audit and Quality Sub Committee

The Clinical Governance Sub Committee met on 11 occasions. There are no meetings in August due to this being peak annual leave period. **Figure 3** over the page provides the attendance. The bold font denotes below 75% attendance.

Member	Number of meetings attended	Apologies recorded	Deputy	Comments
Medical Director (Chair)	**4**	**4**		Interim Chair stood down for th present postholder in Feb 2014
Director of Nursing	8	2		

Member	Number of meetings attended	Apologies recorded	Deputy	Comments
and OD				
Associate Director of Governance	10	0		
Deputy Director of Nursing	8	2		
Associate Operational Director Scheduled Care	9	1		
Associate Operational Director WCSS	7	3		
Associate Operational Director Unscheduled Care	**4**	**6**		
Associate Director of Education and Development	**3**	**6**		
Deputy Chief Pharmacist	10	0		
Medical Clinical Effectiveness Lead	10	0		
Clinical Effectiveness Manager	**2**	**0**		Became member January 2014
Head of Legal Services and Patient Safety	7	3		
Governance Manager, Scheduled Care	6	1		
Governance Manager, Unscheduled Care	8	2		
Clinical Governance Coordinator WCSS	9	1		
Associate Director of Nursing, Scheduled Care	8	2		
Associate Director of Nursing , Unscheduled Care	**0**	**2**		
Associate Director of Nursing , WCSS	8	2		
DIGG Lead for Unscheduled Care	**4**	**6**		
Quality Improvement Matron	**4**	**0**		

Action: Chair to review attendance as part of this Report to those below 75% attendance.

Management of risk locally

The Divisional Integrated Governance Groups and Corporate Services Groups review their risk registers and communicate information from the Safety and Risk and Clinical Governance Sub Committees.

Action: In 2013/14 a revised work plan was submitted to DIGGs to ensure consistency throughout the Divisions.

Duties of Key Individuals for risk management activities

The delegated executive directors submit to the Governance Committee and summary of the outcome of meetings within an agreed template in order to focus the Reader to the key outcomes of the meeting and risks identified and action taken. The following Reports were submitted:

- ❑ Director of Nursing and OD – Infection Control Committee
- ❑ Medical Director Clinical Governance, Audit and Quality Sub Committee
- ❑ Director of Nursing and OD - Safety and Risk Committee, Strategic Workforce Sub Committee
- ❑ Director of IM&T - Information Governance and Corporate Records Group
- ❑ Chief Operating Officer – Event Planning

Action: Chair of the Governance Committee to review the meeting scheduled for the Information Governance and Corporate Records Group with the Director of IM&T

Authority of Managers with regard to managing Risk

The Governance Team continues to work closely with Divisional and Corporate Services management teams to ensure they understand their accountabilities and responsibilities for managing risks in their areas. This is formalised through the bi-monthly meetings Safety and Risk meetings, attendance when requested at Divisional Integrated Governance Groups and submission of Reports to the Bilateral Reviews with the Executive Directors. Informal monthly Governance, Health and safety and Audit drop in sessions continue.

Governance reviews have taken place in Unscheduled Care, Theatres, Trauma and Orthopaedic, Anaesthetics and WCSS. An external review is due to take place for Maternity Services. AED and Scheduled Care is planned at the time of the production of writing the Report

Risk Management training

Patient Safety and Risk Management is now integral to the educational programme for all staff which is reflected in the Training and Development Policy, Training Needs Analysis. A review of members compliance with mandatory training for the Governance Committee can be seen below.

Position Title	Equality and Diversity	Fire Safety	Governance, Safety and Protection	Harassment and Bullying	Health and Safety Level 1	Health and Safety Level 3	Health Records Management
Associate Director of Governance	12/02/2014		24/11/2010	24/11/2010	31/01/2012	20/09/2011	24/11/2010
Associate Director of Nursing			17/08/2009	17/08/2009	29/02/2012		17/08/2009
Divisional General Manager - Scheduled Care	12/02/2014		01/01/2006	01/01/2006	01/10/2012	01/10/2012	01/01/2006
Non Executive Director			31/12/2007	31/12/2007	28/08/2013	28/08/2013	31/12/2007
Director of Finance	07/10/2013	07/10/2013	07/10/2013	07/10/2013	07/10/2013		07/10/2013
Non Executive Director			27/04/2009	27/04/2009	28/08/2013	28/08/2013	27/04/2009
Director of Information Technology	04/02/2013		04/02/2013	04/02/2013	28/08/2013	28/08/2013	05/02/2013
Director of Governance and Workforce	08/03/2012	05/09/2013	08/03/2012	08/03/2012	11/01/2012		08/03/2012
Non Executive Director	30/04/2013		03/02/2010	03/02/2010	28/08/2013	28/08/2013	03/02/2010
Non Executive Director	30/11/2012		30/11/2012	30/11/2012	28/08/2013	28/08/2013	30/11/2012
Chief Executive	08/03/2012		08/03/2012	08/03/2012	28/08/2013	28/08/2013	08/03/2012
Non Executive Director			03/07/2006	03/07/2006	28/08/2013	28/08/2013	03/07/2006
Chief Operating Officer/Deputy Chief Executive			07/01/2008	07/01/2008	28/08/2013	28/08/2013	07/01/2008
Divisional Head of Nursing	10/03/2014	06/08/2013	05/08/2013	05/08/2013	06/08/2013		06/08/2013
Associate Divisional Director - Unscheduled Care	10/10/2012		10/10/2012	10/10/2012	08/11/2012		08/11/2012
Consultant - Acute Medicine	21/01/2014	21/01/2014	07/10/2008	07/10/2008	28/11/2012	28/11/2012	07/10/2008
Divisional General Manager - WCSS	10/02/2014	20/02/2014	01/01/2006	01/01/2006	08/11/2012	08/11/2012	01/01/2006
Head of AHP & Technical Services		15/01/2014	01/01/2006	01/01/2006	31/01/2012		01/01/2006
Associate Director of Nursing			01/01/2006	01/01/2006			01/01/2006
Chief Pharmacist	10/02/2014		31/01/2006	31/05/2012	08/11/2012	08/11/2012	31/01/2006

Position Title	Infection Control (Clinical)	Infection Control (Non-Clinical)	Information Governance	Medicines Management	Moving and Handling - Non-Patient	Moving and Handling - Patient	PDR
Associate Director of Governance					16/01/2014		07/10/2013
Associate Director of Nursing						01/02/2013	04/09/2013
Divisional General Manager - Scheduled Care					31/07/2011		23/07/2013
Non Executive Director		27/08/2013			29/06/2011		13/08/2013
Director of Finance					07/10/2013		
Non Executive Director		27/08/2013			29/06/2011		29/07/2013
Director of Information Technology		05/02/2013			05/02/2013		20/09/2013
Director of Governance and Workforce		08/03/2012	25/11/2013		11/01/2012		15/08/2013
Non Executive Director		27/08/2013			03/10/2011		06/08/2013
Non Executive Director		27/08/2013					19/08/2013
Chief Executive		27/08/2013			07/03/2012		07/08/2013
Non Executive Director		27/08/2013			29/06/2011		
Chief Operating Officer/Deputy Chief Executive		27/08/2013			29/06/2011		30/08/2013
Divisional Head of Nursing		06/08/2013	05/08/2013		06/08/2013		06/02/2014
Associate Divisional Director - Unscheduled Care		11/10/2012			08/11/2012		31/05/2013
Consultant - Acute Medicine	21/01/2014		21/01/2014	06/09/2011	06/09/2011		07/10/2008
Divisional General Manager - WCSS			20/02/2014		29/07/2011		06/03/2014
Head of AHP & Technical Services							11/06/2013
Associate Director of Nursing						22/10/2012	23/07/2013
Chief Pharmacist		16/10/2012	11/02/2014	30/09/2009	11/02/2014		

Position Title	Safeguarding Procedures (Adults) - Level 1	Safeguarding Procedures (Children) - Level 1	Safeguarding Procedures (Children) - Level 3	Slips, Trips and Falls - Non-Clinical
Associate Director of Governance				31/01/2012
Associate Director of Nursing				29/02/2012
Divisional General Manager - Scheduled Care				01/10/2012
Non Executive Director				28/08/2013
Director of Finance	07/10/2013	07/10/2013		07/10/2013
Non Executive Director				28/08/2013
Director of Information Technology	05/02/2013	05/02/2013		28/08/2013
Director of Governance and Workforce	08/03/2012	27/12/2012		28/12/2012
Non Executive Director				28/08/2013
Non Executive Director	30/11/2012	30/11/2012		28/08/2013
Chief Executive	08/03/2012	08/03/2012		28/08/2013
Non Executive Director				28/08/2013
Chief Operating Officer/Deputy Chief Executive				28/08/2013
Divisional Head of Nursing	06/08/2013	06/08/2013		06/08/2013
Associate Divisional Director - Unscheduled Care	08/11/2012	08/11/2012		08/11/2012
Consultant - Acute Medicine	03/05/2012		21/01/2014	21/01/2014
Divisional General Manager - WCSS				08/11/2012
Head of AHP & Technical Services				31/01/2012
Associate Director of Nursing	03/06/2013			
Chief Pharmacist				08/11/2012

Action: The report identifies a number of members require to undertake their mandatory training requirements.

Policies Ratified by the Governance Committee via the Sub Committees

Committee	Approved	Ratified	Total (Some may count in both columns)
Acute & Critical Care Group	1	0	1
Clinical Governance, Audit and Quality Sub-Committee	12	16	25
Divisional Integrated Governance Group - Scheduled Care	14	2	15
Divisional Integrated Governance Group - Unscheduled Care	9	3	9
Divisional Integrated Governance Group - WCCSS	16	5	16
Drugs & Therapeutics Committee	5	0	5
Estates and Facilities Water Safety Group	1	0	1
Estates Risk Group	1	0	1
Fire Assurance Group	1	0	1
Governance Committee	6	11	12
Hospital Transfusion Group	8	0	8

Committee	Approved	Ratified	Total (Some may count in both columns)
Infection Control Sub Committee	10	8	10
Information Governance & Corporate Records Sub-Committee	2	2	2
Maternity Risk Management Group	14	8	14
Medical Devices Group	1	0	1
Nursing and Midwifery Advisory Council	1	0	1
Operations Group	1	1	1
Radiology	0	1	1
Safety & Risk Sub-Committee	1	3	4
Therapies Risk Group	3	0	3
Other / Not Stated	3	2	4
Total	**110**	**62**	**135**

Compliance with alerts issued via the central alert system (CAS)

In 2013/14 there were **224 CAS** Alerts received centrally by the Governance Department and cascaded to relevant staff trust-wide via Datix.

There were **5 breaches by 1-3** days out of the **224** issued to which none impacted on the CQC intelligent monitoring as the criteria focus for these were not NPSA (now NHS England) Alerts.

Risk Management KPIs for 2013/14

Below were the agreed Risk Management KPIs. All bar one as identified in the bold font were met. The introduction of electronic risk assessments are aimed to be introduced by July 2013 and will form the 2013/14 KPIs

KPI	Comments
❑ To fully comply with Duty of Candour Regulatory requirements	Achieved
❑ Achievement of NHSLA Risk Management Standards at Level 3 Accreditation	Aborted
❑ All risk assessments to be electronically housed in CIRIS	On-going as a result of actions being taken at the stage when risk assessments require review to reduce additional work to staff
❑ All Level One Incident and actions plans managed within Divisions to be housed in CIRIS	Achieved
❑ All CQC Outcomes to be integrated into CIRIS	Achieved
❑ Education and Training surrounding Francis 2 Recommendations including Duty of Candour-	Achieved
❑ Revision of incident and investigations, claims and complaints, being Open and Supporting staff	Achieved

	polices aligned to Francis 2 Recommendations -	
❑	Continue with monthly Governance Drop in sessions	Achieved
❑	Patient Safety, Claims Handling and Coroner to merge to form integrated Patient Safety and Legal Services Department	Achieved
❑	Complaints action plans to be integrated into CIRIS	On-going to house and monitor as new complaints actions

Additional Achievements

- ❑ Review of non-clinical claims now takes place led by the Head of safety and Risk
- ❑ Level One Investigation for non- clinical incident now in place
- ❑ Health and Safety Formal Inspection Programme in place

Risk Management Framework: The audits of the 31 Health and Safety Regulations continues to increase with some areas reaching 100%.

165 audits carried out for the Risk Management Framework to support Departments/Wards to achieve 100%. 47 areas are now at 100%. 17 areas are now over 90% compliant.

118 Manual Handling Audits carried out. 36 areas are not at 100%. 21 areas are now over 90% compliant.

Health and Safety: The Governance Committee will receive a Health and Safety Annual Report and in addition receive Health and Safety updates at meetings.

Manual Handling including management of the Bariatric patient: There is one full time clinical manual handling trainer and 2 days per week non patient handling.

A review of all manual handling training has taken place by the new Clinical Manual Handling Trainer. Key Trainers have been identified and trained up working to agreed competencies but release of these staff to support the training is proving very difficult.

Lack of a training location at the Halton site and not having the necessary training equipment has been escalated via business cases and 1-1 meeting with the Executives including the Directors of Nursing and Finance. The risk is in the Part 2 Risk Register since January 2012

Records have been kept to audit the number of Bariatric patients who have been admitted to the trust since October 2013. To date there have been **25 patients**. These patients prove difficult to manage as staff are not trained to the specialist techniques required and location of equipment is not owned or tracked to specific locations. The risk is in Part 1 Risk Register since June 2012

2014/15 Key Performance Indicators as submitted within the revised 14/14 Risk Management Strategy

- ❑ To review Health and Safety Training programmes to include one stop session for Manual Handling, Health and Safety and Fire training and to include learning and Improvement as a result of any incidents reported
- ❑ Continue to provide monthly Governance Drop, Health and Safety and Audit drop in sessions to support staff
- ❑ Continue to transfer all paper risk assessments to the CIRIS electronic governance compliance system as part of the review process
- ❑ Continue with Formal Inspection Programme
- ❑ Continue with Risk Management Framework Audits and to include Manual Handling to reduce number audits on Wards
- ❑ Provide Divisional Reports on Health and Safety Data

Conclusion

Governance is one of the new CQC Keogh Inspection criteria and hence is paramount to ensuring all staff knows of their responsibilities to the systems and processes in place.

The Governance Committee on behalf of the Trust Board is requested to accept this third risk management annual report as a means of Assurance that risk within Warrington and Halton Hospitals NHS Foundation Trust is being properly managed and controlled.

Millie Bradshaw
Associate Director of Governance on behalf of Karen Dawber
Director of Governance and Workforce

W&HHFT/TB/14/094(ii)

BOARD OF DIRECTORS

Paper Title	Verbal update on activity of Board Committees
Date of Meeting	28th May 2014

Board Committee Verbal Update

a) Strategic People Committee held on 7 April 2014 – Lynne Lobley

b) Audit Committee held on 6 May 2014 and 23 May 2014 – Rory Adam

c) Charitable Funds Committee held on 6 May 2014 – Clare Briegal

d) Quality Governance Committee held on 13 May 2014 – Mike Lynch

e) Finance and Sustainability Committee held on 21 May 2014 – Rory Adam

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/094(iii)

BOARD OF DIRECTORS

Paper Title	Board Committee Minutes for noting only
Date of Meeting	28th May 2014
Director Responsible	Chair of Board Committees
Author(s)	
Purpose	The Board had received verbal updates from the Chair of each Committee regarding the meetings held. The minutes are for noting only

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	None	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the Board Committee minutes:

a) Quality Governance Committee – 11 March 2014

b) Finance and Sustainability Committee – 16th April 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

QUALITY GOVERNANCE COMMITTEE

Minutes of the Meeting held on Tuesday 11th March 2014 at 9:00 am
Trust Conference Room, 1st Floor, Burtonwood Wing, Warrington Hospital

Present:

Mike Lynch	Non-Executive Director (Chair)
Tim Barlow	Finance Director
Alison Lynch	Deputy Director of Nursing
Amanda Risino	Associate Director of Operations, Unscheduled Care
Ann Robinson	Associate Medical Director, Unscheduled Care
Diane Matthew	Chief Pharmacist
Jason DaCosta	Director of IT
Karen Dawber	Director of Nursing & Organisational Development
Kate Warbrick	Associate Director of Operations, Scheduled Care
Lynne Lobley	Non Executive Director
Mel Pickup	Chief Executive
Millie Bradshaw	Associate Director of Governance and Risk
Paul Hughes	Medical Director
Rachael Browning	Associate Director of Nursing, Scheduled Care
Richard Brown	Associate Director of Operations, WCSS
Simon Wright	Chief Operating Officer/Deputy Chief Executive
Wendy Davies	Represented by S. D Walker for AHP, WC&SS
Clare Fozard	FY2 Doctor, Paediatrics (Aug-Dec 2013)

In Attendance:

Jennie Taylor	Executive PA (minutes)
Margaret Kendall	Consultant Nurse

	WHHFT/GC/14/013 - Apologies for Absence and Introductions	Responsibility and Target date
1	Apologies received from: John Wharton, Nurse Quality Lead, CCG, Jan Snoddon, Chief Nurse, Halton CCG, Paula Chattington, Consultant, Richard Denton CE Lead, Mel Hudson, Associate Director of Nursing, WC&SS/Head of Midwifery, Emma Buckley, Governance Compliance Manager.	
	WHHFT/GC/14/014 – Declarations of Interest	
2	There were no declarations of interest made in relation to the agenda items for the Governance Committee meeting.	
	WHHFT/GC/14/015 – Minutes of the previous meeting held on 14th January 2014	**Members**
3	The minutes of the meeting held on 14th January 2014 were agreed as an accurate record with the following amendments: Paragraph 25 – The Associate Director of Operations, Scheduled Care	

	advised that this relates only to the WHO checklist and not the SUI.	
	WHHFT/GC/14/16 Action Plan	
4	WHHFT/GC/14/006 – Risk 00027 Pathology The Associate Director of Governance and Risk advised that the risk aassociated with this has been on the Risk Register for approximately 18 months, a piece of work has been undertaken by IT and a more formal response will be provided at the May meeting. The Director of IT explained that the roll out of ICE system will consolidate this into one system.	**Director of IT May 2014**
5	The Chief Executive advised that when she attended the Junior Doctor forum this was not raised as an issue.	
6	**Risk 00139 and 00304 Information Governance** Action Complete and can be removed.	
7	**Risk 00482 – Information Technology** Action complete and can be removed.	
8	**Risk Register Discussion** Action complete and can be removed.	
9	**WHHFT/GC/14/013 – ITU Matron** Action Complete and can be removed.	
10	**WHHFT/CG/14/147 – loss of ED cards** Item complete and can be removed.	
	WHHFT/GC/14/017 – Quality Improvement Stakeholder Workshop	
11	The Deputy Director of Nursing explained that this exercise forms part of the Quality Account, the event was very well attended with nice triangulation with our own principles.	
	WHHFT/GC/14/018 - Joint Statement by the Leadership Alliance for the Care of Dying People – Margaret Kendall	
12	M. Kendall explained that the Liverpool Care Pathway is to be withdrawn later this year. Interim guidance has been delayed and will not be available until May 2014. She explained that WHHFT are still supporting End of Life Care with Liverpool Care Pathway and is proposing along with Dr Marley to develop our own guidance. The Liverpool Care Pathway will not be replaced by an alternative pathway so an aide memoire and checklist will be produced and circulated in due course but expects that this will be before June 2014. M. Kendall explained that patients who are dying and their families are well supported here and this is supported by there being practically no complaints. The key is consent, engagement and flexibility on a daily basis. M. Lynch, Non-Executive Director/Chair considered this approach to be relevant given the national problem. M. Kendall was thanked for providing this assurance.	

13	**WHHFT/GC/14/019 – Summary of Changes/Corporate Risk Register (15+) Review and Update**	
14	M. Lynch, Non Executive Director/Chair complemented the improvement in the appearance of the Risk Register commenting that it was much easier to read and understand.	
15	The Associate Director of Governance and Risk made reference to appeal that has been submitted in support of risk relating to Cdiff.	
16	**000111 – HR Staffing Costs relating to Escalation Beds** The Director of Nursing explained that the Temporary Staffing Group meet monthly, the next meeting has temporary staffing as the only agenda item.	
17	**Estates** The Chief Operating Officer advised that work relating to fire audit has received an extension and work is continuing as per programme.	
18	Appleton Wing window replacement work is continuing in partnership with decamp programme.	
19	**Information Governance** Director of IT informed the Committee that support is being considered for the Information Governance Manager.	
20	**Information Technology** Director of IT confirmed that progress is on track, council and CCG integrated solutions to maximise savings are being encouraged. He advised that the risk will not reduce until the equipment is operational.	
21	**Scheduled Care** Associate Director of Nursing, Scheduled Care explained that escalation is still being used, temporary staff is expensive although some trained nurses are at risk due to the vascular move so these will be redeployed but are not available yet.	
22	Associate Director of Operations, Scheduled Care informed the Committee that a new risk has been added to the Risk Register which relates to the lens master which has failed in Ophthamology resulting in patients having to be sent elsewhere for diagnosis although the patients affected is very small.	
23	**Unscheduled Care** Associate Director of Operations, Unscheduled Care advised that there has been very little change, the telemetry business case requires some change before it is submitted to the Board.	
24	Discussion took place around undetected deteriorating patients, making sure GPAMU staffing levels are effective is a budgetary pressure. M. Lynch, Non- Executive Director/Chair asked whether Associate Director of Operations, Unscheduled Care believes we have the staffing levels right in assessment unit, she confirmed that we do but if ambulatory care is opened then staffing will need to be reviewed.	

25	**Trustwide** Chief Operating Officer explained that the risk relating to GI bleed rota will be resolved by the appointment of two additional gastro consultants. The remainder of the Risk Register was noted with none raising exceptional concern.	
26	**WC&SS** Associate Director of Operations, WC&SS confirmed that the MRI scanner replacement has achieved approval for capital funding.	
27	Managing the number of patients requiring Anticoagulation service is being reviewed and moving to Bath Street is being considered as it involves high numbers being in outpatient department, this service is already offered in community.	
28	Director of Nursing and OD informed the Committee of an inter partum event on Friday. An emergency meeting took place including clinicians and the past 18 months of activity was reviewed. It has been agreed that all ladies now coming into maternity will receive a CTG with continuous CTG while in labour. Although guidance does say that CTG is not necessary on low risk pregnancies it has been agreed to trial this procedure. Advice to mums at 28 weeks is also being given relating to foetal movement this is instead of being provided to mothers at 30 weeks and the pink pre-assessment form has been reintroduced.	
29	An external review has commenced with another one due at end of April. M. Lynch, Non-Executive Director/Chair asked when would assurance be received, Director of Nursing and OD responded that this would be in time for the May Board meeting. M. Lynch, Non-Executive Director/Chair commented that this has been a solid resilient response to this very sad episode.	
30	Associate Director of Nursing, Scheduled Care asked what process is in place for assessing very small babies. Director of Nursing and OD responded that we are introducing the growth chart which should identify about 60% of small babies also any babies born under 2.2kg will be put onto Datix so we can monitor the numbers.	
31	L.Lobley, Non-Executive Director asked about the situation around case notes. The Associate Director of Governance and Risk explained that changes have been agreed but the cost of £26k has not been approved yet. An Implementation Team is in place as introduction of the new records system will be a challenge.	
32	The Chief Pharmacist raised the shortage of coagulation staff as a risk which needs mitigating by looking into the service we provide. M. Lynch, Non-Executive Director/Chair explained that we have described the pressure due to the volume of patients and an additional pressure now is the expected shortage of staff. It was agreed that Director of Nursing and OD would look into this with HR before the problem escalates. The Chief Pharmacist wondered if it was a viable option to reduce or cease this service for in-patients	Director of Nursing and OD/Associate Director of HR May 2014
33	C. Fozard explained that is not something that the junior doctors would undertake but if this service is removed from Pharmacy then it will end up being something F1 and F2 doctors will need to be trained in.	

34	Deputy Director of Nursing explained that anti coagulation specialist nurses were introduced and that this is a very serious issue as patients need anti coagulation control.	
35	Associate Director of Governance and Risk agreed that a full risk assessment is needed, good practice is described and we need to be aware if we are not going to be able to provide this level of service of 'fit for service outcomes for patients'.	
36	The Medical Director agreed to head up a review.	Medical Director May 2014
37	Chief Pharmacist agreed to approach potential retiree to see if they would defer retirement.	Chief Pharmacist May 2014
38	It was agreed that a comprehensive feedback on the risk and workforce planning element is at May Governance Committee.	Associate Director of Governance and Risk May 2014
	WHHFT/14/021 – Quality Report	
39	Deputy Director of Nursing explained that this report is not complete yet and the format is also being improved. M. Lynch, Non-Executive Director / Chair praised it for being a comprehensive report but queried where National Targets are explained. Deputy Director of Nursing confirmed that these will form part of Section 3, Core Quality Indicators.	
40	L. .Lobley, Non-Executive Director asked if the report will contain more about the workforce. Director of Nursing confirmed that she has asked HR to produce a similar report (Workforce Quality Report) and this will go to the May Board meeting after the Strategic People Committee has had chance to review it in April.	**Associate Director of HR May 2014**
	WHHFT/14/022 – Serious Incident completed Level Two Investigations (annonomised version)	
41	Associate Director of Governance and Risk reviewed the report and explained that she has introduced a presentation for all divisions and the Director of Medical Education to show what has been learned.	
42	M. Lynch, Non-Executive Director/Chair confirmed that this is an area that this Trust does very well in and confirmation on our open and transparent reporting has been received.	
	WHHFT/CG/14/024 – Business Continuity Policy	
43	Policy ratified by Governance Committee	
	WHHFT/GC/14/025 – Escalation Policy	
44	Policy ratified by Governance Committee	

	WHHFT/CG/14/026– Preparing for CQC Inspection (Keogh Framework)	
45	The Associate Director of Governance and Risk explained that the Director of Nursing and OD is the Lead and she is the Operational Lead on this proposal to interpret the Keogh report into radical changes to hospital inspections which was introduced in October 2013.	
46	The CQC will spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas. The presentation is attached for information.	
47	There will be three phases to the inspection model: • Preparing for an inspection • Inspecting the services • Reporting the findings	
48	Phase 1 will help the CQC make a decision on who needs to be on the inspection team, which areas they need to focus on and the concerns to look at.	
49	Phase two will include setting up focus groups, watching and discussions. Some visits will be outside of normal hours therefore a plan needs to be in place allowing for smooth response when CQC arrive.	
50	Phase 4 will result in quality summits as a platform for sharing the information following an inspection.	
51	Divisions and Specialties will be briefed on what they need to be familiar with if an inspection team arrives.	
52	M. Lynch, Non-Executive Director/Chair explained that at least two of the inspectors will have the power to arrest which confirms the seriousness these inspections have.	
53	The most important theme of CQC inspections appears to be “what does good look like”, do we have pathways or do we have evidence based documentation. M. Lynch, Non-Executive Director/Chair advised that he has undertaken two of these inspections and confirmed they are very challenging and reflect not only on the Board but every individual that is involved in patient care and safety. The CQC has had a troubled history and now has a desire to show it has improved although they can be challenged.	
54	Associate Director of Operations, Scheduled Care recommended that pertinent question being added to the Safety Walkabout. This was agreed as a very good suggestion.	
55	Associate Director of Operations, Unscheduled Care asked if it was possible to find out how many of our staff are inspectors. Associate Director of Governance and Risk responded that over 30k applied but not all have been processed yet.	

56	L. Lobley, Non-Executive Director agreed that governors and key personnel in the Trust need to be fully versed, the recent CQC visit we had did highlight some weaknesses and she believes it is vital that we act in advance of any future visits. It is a theory that if an organisation doesn't handle complaints well then it doesn't handle patients well either.	
57	The Associate Director of Governance and Risk explained that a Task and Finish Group has been set up with key stakeholders working to an action plan to review and progress within the Trust. The Action Plan includes such things as: • Visiting sites already inspected to learn from their experience • Process of raising awareness with staff including training programmes already in place. • Review of Governance systems in the Divisions • Action card for In Hours and Out of Hours visit • Inclusion into Team Brief • Internal Keogh ward/department inspections • Development of Keogh Dashboard for monitoring by the Board • Ensuring all support evidence is readily available in CIRIS aligned to the Essential Standards • Production of Staff Information Leaflet • CQC Information Community on the Hub.	
	HIGH LEVEL BRIEFING AND MINUTES FROM REPORTING COMMITTEE CHAIRS	
	WHHFT/CG/14/027 – Information Governance and Corporate Records	
58	There was no report as no meeting has taken place since last Governance Committee meeting.	
	WHHFT/CG/14/028 – Safety and Risk Sub Committee	
59	The notes of the meeting from 16th January were noted by the Governance Committee.	
	WHHFT/CG/14/029– Workforce, Education and Organisational Development	
60	The High Level Report was noted by the Governance Committee.	
	WHHFT/CG/14/030 – Event Planning Group and Local Health Resiliance Group	
61	The High Level Report was noted by the Governance Committee.	
	WHHFT/CG/14/031 – Clinical Governance, Audit and Quality Sub Committee	
62	Director of Nursing and OD advised that the meeting produced some good discussion and that there were no issues to report.	
	WHHFT/CG/13/032 – Infection Control Sub Committee	
63	The High Level Report was noted by the Governance Committee	

64	The Director of Nursing and OD explained that appeals have been submitted in relation to CDiff and advised that a new resistant organism CPE and the detection of which will involve rectal swabs, or stool samples, if patients refuse, routinely on transfers only. Awaiting guidance from Public Health England, started the work against the toolkit provided.	
	W&HHFT/GC/14/033 - Any Other business	
65	Clare Fozard reviewed a report she had produced following the Junior Doctors Forum which had been well attended, Chief Executive, Medical Director and Divisional Medical Director, Unscheduled Care had also attended.	
66	Main topics of the meeting were:	
67	**Keeping patients in longer than they should be** – Divisional Medical Director Unscheduled Care confirmed she took these issues to the Consultant Meeting	
68	**Discharge Summaries** – the forum wondered whether including pharmacy on ward rounds at weekends would speed up the process. Medical Director explained that there is an exercise called "Perfect Week" planned and that he and the Divisional Medical Director, Unscheduled Care will be fundamental at leading on this.	
69	**E-Prescribing** – the Junior Doctors are keen on this being introduced. The Chief Pharmacist confirmed that she and the IT Director are trying to achieve this being introduced.	
70	L. Lobley, Non-Executive Director asked about whether I-Bleep has improved the situation for on-call. C. Fozard responded that F1 doctors are happy with it but it would appear that some are not switching the bleep on, it has been running for a month now and everyone is still learning. The nurse coordinator can see all responses. It was agreed that C. Fozard undertakes a review and provide feedback at the next meeting.	**C. Fozzard May 2014**
71	L. Lobley, Non-Executive Director advised that following a Deanery visit the GMC have said explicitly that SHO grade must not be used.	
72	Discussion took place around not having a standard discharge form. Director of IT explained that care coordination checklist and medical content needs to be agreed on before a standard discharge form can be agreed..	
73	Deputy Director of Nursing advised the pledge made to patients which is "Hello, my name is ….." Director of Nursing wanted this to be extended to "Hello, my name is ….. would you like a drink?" It is essential to keep patients hydrated and this is an ideal and simple way to ensure patients are offered refreshments regularly.	
74	M. Lynch, Non-Executive Director/Chair wanted to include a pledge of	

	"do the now jobs now"	
59	**Date and time of next meeting:** 13th May at 9am in the Trust Conference Room	

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

FSC/14/024

FINANCE AND SUSTAINABILITY COMMITTEE

Draft Minutes of Meeting of the Committee held on 16th April 2014

Present

Carol Withenshaw	Non-Executive Chair
Rory Adam	Non-Executive Director
Tim Barlow	Director of Finance and Commercial Development
Simon Wright	Chief Operating Officer/ Deputy Chief Executive (delayed - attended from 1425hrs)
Alison Lynch	Deputy Director of Nursing

In attendance

Colin Reid	Trust Secretary

Apologies:

Mel Pickup	Chief Executive
Jason DaCosta	Director of IT
Karen Dawber	Director of Nursing and Organisational Development
Paul Hughes	Medical Director

Apologies and Declarations of Interest – FSC/14/13

1 Apologies: As stated above
Declarations: None

Minutes of meeting & Actions – FSC/14/14

2 The minutes of the meeting held on 20th March 2014 were amended and approved.

The action on the Medical Director to consider the re-establishment of the Medical Devices Group remained ongoing.

Year End Financial Position – FSC/14/15

The Director of Finance and Commercial Development presented the Trust year-end financial position and reported that he was pleased that the trust had achieved below the agreed deficit with Monitor of £2.9m at £2.8m (£2.849m), this equated to a year-end position of £4,001k worse than the planned surplus of £1,152k. The Director of Finance and Commercial Development advised that the results meant that the Trust achieved a Financial Risk rating of 2 against a planned rating of 3 and a Continuity of Services rating of 3 against a planned rating of 4.

The Director of Finance and Commercial Development advised that NHS activity was £1.3m better in month whilst other income activity also increased following receipt of extra income from Alder Hey, pathology and Bridgwater community services.

The Director of Finance and Commercial Development advised that the year-end settlements had been agreed with Warrington, Halton and St Helens CCGs together with a number of other commissioners, with the overall position of a £3.0m over recovery against the income target. He advised that with regard to Warrington CCG, the trust had reached an agreement that at year end certain elements of patient costs would be paid to the trust which was accounted for in a similar to work in progress.

The Director of Finance and Commercial Development advised that as with previous months pay costs continued to be higher primarily driven by the continued use of Bank, Agency and Locum costs (£11,297k), overtime (£1,176k) and Waiting List Initiatives (£3,715k) in the clinical divisions.

The Director of Finance and Commercial Development advised that cash flow was below plan and as at 31 March 2014 cash stood at £13m against a planned cash balance of £14m. The £13m equated to 23 days operational cash.

With regard to the balance sheet the Director of Finance and Commercial Development advised that as at 31st March 2014 the value of land and buildings had increased by £2.9m. This increase has been reflected by an increase in the revaluation reserve, however as a result of the increase in asset value the PDC Dividends had increased by £0.1m. The Director of Finance and Commercial Development advised that there was a £0.7m impairment charge to the income and expenditure statement due to a number of assets that were no longer in use and accounting standards required that the net book value of the asset is charged to income and expenditure as an impairment expense.

The Director of Finance and Commercial Development thanked the staff for all their hard work and diligence in delivering the £2.9 deficit. The Chair thanked the Director of Finance and Commercial Development for his report noting that although this was not a successful year for the trust it had delivered against a target agreed with Monitor and echoed the Director of Finance and Commercial Development thanks to the staff at the trust who had made this possible.

Update on Budget 2014/15 and Annual Plan Submission 2014/16 – FSC/14/16

Budget 2014/15 & 2015/16

The Director of Finance and Commercial Development provide the committee with a presentation that set out the changes made to the budget submitted to Monitor for 2014/15. In particular the Director of Finance and Commercial Development referred to income and expenditure quarterly plan which showed the trust delivering a £1.5m deficit for the year. Contracted income on page 5, provided details of the agreed positions with all the commissioners. In response to a question from Rory Adam, the Director of Finance and Commercial Development advised that the trust has one contract with the commissioners, with Warrington CCG being the primary commissioner.

With regard to non-contracted income, this had been left out of the contract, however it was recognised by the commissioners that this would require payment. The trust however had a duty to inform the commissioners if activity levels exceeded plan. Referring to clinical coding and consultant to consultant referrals, the Director of Finance and Commercial Development advised that the commissioners had agreed to pay for these from 1 April 2014 subject to a review that the changes and referrals were above board.

The Director of Finance and Commercial Development referred the committee to the Continuity of Services (CoS) risk rating slide and reported that the trust was planning to deliver CoS rating of 2 for Q1-Q3 and 3 for Q4 which he felt was not out of kilter with other DGH's.

With regard to financial year 2015/16, the Director of Finance and Commercial Development advised that the trust was showing delivery of a £1m deficit. He advised that having considered the risks, he felt that it would not be prudent to try and deliver a break even budget. This would deliver a CoS rating of 2 for Q1-Q3 and 3 for Q4 and an end of year cash position of £6.9m.

The committee recognised that this budget was stretching for the trust and that to achieve the planned deficit's the trust had to deliver against cost improvement plans in 2014/15 and 2015/16 and keep expenditure under control whilst delivering greater activity.

The committee noted the 2014/15 and 2015/16 budget.

Operational [Annual] Plan Submission 2014/16

The Director of Finance and Commercial Development presented the Operation Plan submission advising that as with the budget the Operational Plan had been submitted to Monitor prior to the submission date of 4 April 2014.

The Operational Plan was noted with the following comments:

- The front page required changing as the picture was out of date regarding the hair policy implemented by the trust.
- Page 17 refers to the development of specialist 'centre of excellence', the Chair supported the view and felt that the CMTC provided the vehicle to support centre of excellence.
- The Chief Operating Officer felt that the CMTC needed a change of name to link it to the trust. He felt that the name did not convey what services were provided within the facility. The Chief Operating Officer advised that the facility was state of the art and should be sold as such. He also felt that once Halton received JAG accreditation this would provide a bigger opportunity to market the services.

Commissioner Contract 2014/15 and future reporting on performance– FSC/14/17

The Director of Finance and Commercial Development reported on the contract that had been signed with the Commissioners for 2014/15 and referred to the penalty risks in the contract the majority of which were nationally mandated.

The Chief Operating Officer referred to the A&E breaches and advised that the trust would be penalised for monthly breaches, whereas Monitor requirements for delivery of the 4 hour target remained quarterly. This was being addressed.

The Committee recognised the zero threshold for MRSA and in particular the financial penalty of £10,000 each incidence over the threshold. C.diff threshold had increased from 19 to 26 and any cases over the new threshold amounted to circa £10,000 per case.

Rory Adam referred to page 8 of the report and the requirement to ensure patients had a minimum supply of 2 weeks newly prescribed (initiated) medication on discharge and asked whether two weeks was appropriate. In response the Director of Finance and Commercial Development advised that this requirement was being investigated further and was hopeful that the number of days could be reduced to 7. It was recognised that 2 weeks medication added an extra cost burden to both the CCG and the trust.

The Director of Finance and Commercial Development advised that he hoped to have a quarterly paper that would come to the committee setting out the trust performance against the contract and any potential risks.

The Committee noted the status of the Commissioner Contract 2014/15.

Corporate Performance Report (Board paper of 26 March 2014)– FSC/14/18

The Chief Operating Officer presented the corporate performance report that went to the Board in March 2014. He advised that at the Board he was asked to present the performance by exception, however he felt that in doing this the Board did not receive the full details on how certain services were continuing to outperform national and local targets in the provision of quality healthcare and felt that staff should be recognised for the work they were doing in supporting the delivery of the targets.

The Chief Operating Officer ran through the report highlighting each services performance.

With regard to A&E the Chief Operating Officer advised that there was only a very small group of acute trusts delivering the 4 hour target. He advised that staff had been looking at different ways of delivering the service which had supported the delivery of AED's performance. The Chief Operating Officer reported that from 7th to 13th May the trust would be undertaking the Perfect Week initiative and advised that the aim of the week was a focus on achieving the best possible operational performance in order to provide the best possible outcomes for the trusts patients through the transition from admission to discharge. This initiative was being supported by all stakeholders and community providers and a full presentation on what was being envisaged would be presented to the Board at its April meeting.

The Chair, referring to A&E asked for an update on workforce moral. In response the Chief Operating Officer reported that generally this was improving although there was a need to improve on quality and the emphasis surrounding it. He advised that security of staff issues were being addressed which was sometimes seen as a moral issue which included better such things as closer staff parking for night shift staff. One area that has impacted on the staff moral had been the implementation of the Symphony system. The Chief Operating Officer advised that when the system went down due to technical problems, staff had to revert back to a paper system until it was back up again. Once the system was up and running there was an added complication and resource issue as the paper data had to be entered onto the system.

Rory Adam asked why the trust was performing against the 4 hour A&E target when other trusts weren't. In response the Chief Operating Officer advised that there was an argument that consistency was a factor. The staff in A&E have been in place for a long period of time and this would almost certainly support better delivery of service. He also felt that there was a culture and ownership within the department that seeks to manage patients' pathway and this only comes with having a stable workforce.

With regard to 18 week referral to treatment, the Chief Operating Officer reported that the trust had for the 6th year in a row delivered its commitment for access from GP referral to treatment for over 90% of all referrals. He further advised that the trust had seen the second and third phase of the planned transfer of activity across to Halton with Orthopaedics and spines in phase II and the remaining general surgery, Urology, Breast and Gynae in phase III. The Chief Operating Officer advised that this had seen the trust achieving 18 weeks for orthopaedics in January and continuing to receive the highest patient's ratings for quality and service at the Halton site of any hospital across the North West. The Chief Operating Officer advised that this had been achieved with the considerable hard work from all the trust's staff who had worked in a unified way to deliver the best outcomes and service for all of the trust's elective patients.

The Chief Operating Officer reported on the continued high performance within the trust's cancer services, which was one of the highest performing serve in the north west. He advised that this year saw the introduction of a new local rule on allocation of breaches at day 42 on a pathway. This had seen most hospital trusts failing at least one of the national access targets. Staff within the trust's cancer services had worked incredibly hard to manage, amend, support and seek changes at other hospitals in order to continue to deliver the commitment and target.

The Committee reviewed the remainder of the Corporate Performance Report which was noted.

Business and Commercial Development Update – FSC/14/19

The Director of Finance and Commercial Development presented the Business & Commercial Development Report which was taken as read.

With regard to the development of the trust strategy the Director of Finance and Commercial Development reported that this was on target to be completed in time for submission at the end of June 2014. He advised that as part of the development of the strategy the Board would be undertaking Monitors strategy toolkit at the next Board workshop which would help to develop the Board's effectiveness in delivering a 5 year strategic plan. The Director of Finance and Commercial Development advised that developing the 5 year plan would be a challenge given the Commissioners plan to develop 8 hubs in Warrington that would, if successful impact on a number of services provided by the trust. The Chief operating Officer supported this view and advised that the trust did not feature in the higher levels within the local health economy referring to the Health and Well Being Board at which the trust was not a member and felt this had a bearing on the Commissioners views regarding the impact of services provided by the trust. The Committee noted that if the implementation of hubs were successful there would have to be a resultant downsizing in trust services. The Committee further noted that the Commissioners were looking to have them in place with the next 18months which did not seem feasible given the scale of the project. Given the concerns regarding the impact to the trust the Committee recognised the importance of putting in place Board to Board workshops with the Commissioners so that the concerns of the trust can be aired.

The Director of Finance and Commercial Development referred the Committee to the section 'Developing' and reported that the team was reviewing all possible tenders and AQP's to

ensure that due diligence is applied to each bid process to support the development of sustainable commercial opportunities for the trust. The Director of Finance and Commercial Development advised that the team was supporting both Orthopaedics and Children's Surgery in developing business plans to attract new business from within existing and emerging markets. These business plans, once developed, would be presented at Divisional Bi-lateral meetings for approval and reported to the committee for ratification.

The Director of Finance and Commercial Development advised that the trust was actively pursuing a formal partnership with Widnes based GP Consortium *Platform 7*. The partnership would provide community based ENT services in Widnes with a view to submitting a joint bid for a Halton-wide community ENT service that was being put to AQP by Halton commissioners. The Director of Finance and Commercial Development reported that *Platform 7* represented seven of the eight GP practices in Widnes and as such was a highly influential consortium. He felt that by entering into partnership with *Platform 7* on services where they have aspirations to develop local service provision the Trust would be able to generate reciprocal benefit in other areas and thereby improve market share in Widnes.

With regard to the section on 'Delivery', the Director of Finance and Commercial Development advised that a suite of commercial reports are being developed that would support a Commercial Development dashboard. He reported that the dashboard would be an integral part of the Commercial functions reporting to the Committee in the future and would provide at a glance, an indication of the impact of Commercial Development schemes on the trust's financial position.

The Chair asked whether the Board would have opportunity to discuss in detail the longer terms plans, recognising that it had not had as much opportunity to do so when with the 2 year operational plan. In response the Director of Finance and Commercial Development felt that it would be appropriate that this was the case and felt that when the Board undertook the Strategy Toolkit workshop this would be identified in the outcomes. The Trust Secretary was asked to note that it would be appropriate to hold a workshop on the development of a 5-10 year plan.

The Committee noted the contents of the Business & Commercial Development Report. The Committee felt that it was important that the a Board to Board workshop with the Commissioners was put in place before the Board was required to approve the 5 year strategic plan.

External Auditor Appointment – FSC/14/20

The Director of Finance and Commercial Development reported that the term of office of PwC the external auditor was due to expire on 1 October 2014. He explained that under the terms of their appointment in 2011, they were appointed by the Council of Governors for three years with an option to extend the term for up to an addition period of two years, subject to the approval of the Council of Governors.

Rory Adam advised that this matter would be brought up at the Audit Committee in May to seek approval to extend. Subject to getting that approval the matter would be raised with the

Council of Governors through the Monitor Quarterly Reporting Compliance Committee and thereafter the full Council.

Review of Minutes of Reporting Committees/Groups – FSC/14/21

i. Innovation and Cost Improvement Committee: the Committee received and noted the minutes of the ICIC of 21 March 2014.
ii. Capital Planning Group: the Committee received and noted the minutes of the Capital Planning Group of 5 March 2014.
iii. KPI Group: The Chief Operating Officer and Deputy Chief Executive presented the notes of the meeting of the KPI Group which were noted. It was recognised that the KPI Group was not a constituted committee and was to provide the Chief Operating Officer with updates on the operation aspects of the KPIs. Consideration would be given on whether the KPI Group should be a fully constituted group or remain an operational group.
iv. IM&T Steering Committee: the Chair noted that the minutes were not available and that the Director of IM&T was not present to provide an update. She asked that for the next meeting the Director of IM&T provide an update on the current status of the IM&T Strategy.
v. Estates Strategy Group: The Director of Finance and Commercial Development reported that this committee had not met for some time. He advised that now that the Board was in the process of approving the estates strategy it would be resurrected with improved terms of reference that would be fit for purpose in moving the estates strategy forward. The Director of Finance and Commercial Development advised that he would present new terms of reference of the group at the May meeting.

Any Other Business – FSC/14/22

24 There being no further business the Chair closed the meeting.

Action List

Finance and Sustainability Committee

May 2014

Minute Reference	Action	Responsibility & Target Dates
FSC/14/11	Medical Director to consider whether it was appropriate to re-instate the Medical Devises Group.	Medical Director