# Warrington and Halton Hospital NHS Foundation Trust
# Board of Directors
# Agenda

Wednesday 30th April 2014, time 1300 - 1700hrs
Trust Conference Room, Warrington Hospital

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|---|---|---|---|---|
| *1300* | ***W&HHFT/TB/14/055*** | ***Welcome, Apologies & Declarations of Interest*** | | Chairman |
| | ***W&HHFT/TB/14/061*** | ***"Five Words One Action"*** | Presentation | **Alison Lynch** Deputy Director of Nursing &<br><br>**Janet Green** Acute Care Nurse Practitioner |
| *1330* | ***W&HHFT/TB/14/057*** | ***Minutes of the previous meeting held on 26th March 2014*** | Paper | |
| | ***W&HHFT/TB/14/058*** | ***Action Plan*** | Paper | Chairman |
| *1335* | ***W&HHFT/TB/14/059*** | ***Chairman's Report*** | Verbal update | Chairman |
| | ***W&HHFT/TB/14/060*** | ***Chief Executives Report*** | Verbal update | Chief Executive |

Quality

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| *1400* | ***W&HHFT/TB/14/062*** | ***Quality Dashboard*** | Paper | Director of Nursing and Organisational Development |
| *1415* | ***W&HHFT/TB/14/063*** | ***Quarterly Infection Control Report*** | Paper | Director of Nursing and Organisational Development |
| *1430* | ***W&HHFT/TB/14/064*** | ***Maternity Update Report*** | Paper/ Verbal | Director of Nursing and Organisational Development |
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People

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| *1450* | ***W&HHFT/TB/14/065*** | ***i. Workforce and Educational Development Key Performance Indicators***<br><br>***ii. Workforce Transformation Project – Trust Board Update*** | Paper<br><br>Paper | Director of Nursing and Organisational Development |

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| *1505* | ***W&HHFT/TB/14/066*** | ***Annual Equality and Diversity Report*** | Paper | Director of Nursing and Organisational Development |

Sustainability

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| *1525* | ***W&HHFT/TB/14/067*** | ***i) Finance Report***<br><br>***ii) Reference Costs*** | Paper<br><br>Paper | Director of Finance & Commercial Development |
| *1610* | ***W&HHFT/TB/14/068*** | ***Corporate Performance Dashboard and Exception Report*** | Paper | Chief Operating Officer |
| *1620* | ***W&HHFT/TB/14/069*** | ***Corporate Risk Report*** | Paper | Director of Nursing and Organisational Development |
| *1630* | ***W&HHFT/TB/14/070*** | ***Board Assurance Framework*** | Paper | Executive |
| *1640* | ***W&HHFT/TB/14/071*** | ***Monitor Quarterly Compliance Report*** | Paper | Director of Finance & Commercial Development |
| | | | | |
| *1650* | ***W&HHFT/TB/14/072*** | ***Board Committee Reports:***<br><br>***i. Annual Reports Board Committee Annual Reports:- Strategic People Committee***<br><br>***ii. Board Committee Verbal Update Finance and Sustainability Committee held on 16th April 2014***<br><br>***Minutes for Noting:***<br>***a) Audit Committee (unconfirmed) – 2nd February 2014***<br>***b) Charitable Funds Committee (unconfirmed) - 2nd February 2014***<br>***c) Quality Governance Committee – 14th January 2014***<br>***d) Strategic People Committee - 10th February 2014***<br>***e) Finance and Sustainability Committee – 20th March 2014*** | | Chair of Strategic People Committee<br><br>Chair of Finance and Sustainability Committee<br><br>For noting |
| | ***W&HHFT/TB/14/073*** | ***Any Other Business*** | | |
| *1700 ends* | | ***Dates of next meeting***<br>*28th May 2014* | | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/061**

# BOARD OF DIRECTORS

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| **Presentation** | **Five Words One Action** |
| | **Alison Lynch** Deputy Director of Nursing |
| | **Janet Green** Acute Care Nurse Practitioner |
| **Date of Meeting** | 30th April 2014 |

***W&HHFT/TB/14/058***

**TRUST BOARD**
**ACTION PLAN – Current / Outstanding Actions**
**Meeting**: Trust Board 30th April 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 of time the outcomes of the business case review to be brought to the May Board meeting. | Action ongoing as at 30th April 2014 |
| 26-02-2014 | TB/14/029 | The Chief Operating Officer and Deputy Chief Executive to review the Corporate Performance Report and present to the Board, from April 2014, a Corporate Performance Dashboard and Exception Report. | Chief Operating Officer and Deputy Chief Executive | New Corporate Performance Dashboard and Exception Report to be presented to the 30th April 2014 Board meeting | See agenda item:<br><br>***Action Complete*** |
| 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. | Action ongoing as at 30th April 2014 |
| 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. | Action ongoing as at 30th April 2014 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/059**

## BOARD OF DIRECTORS

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|---|---|
| **Paper Title** | **Chairman's Report** |
| **Date of Meeting** | 30th April 2014 |

**W&HHFT/TB/14/060**

## BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | **Chief Executive's Report** |
| **Date of Meeting** | 30th April 2014 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

***W&HHFT/TB/14/062***

**BOARD OF DIRECTORS**

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|---|---|
| **Paper Title:** | Quality Dashboard (2013/2014) April 2014 |
| **Date of Meeting** | 30 April 2014 |
| **Director Responsible** | Karen Dawber (Director of Nursing and Organisational Development) |
| **Author(s)** | Ros Harvey (Corporate Nursing Programmes Manager)<br>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

This report contains exception reports namely Mortality ratios, C difficile, AQ Pneumonia & Stroke, Dementia part 1 and Falls. 3

Discharge summaries to GP's - please note that there can be a slight variation in monthly data e.g January data reported in March was 91.09% but in April the figure had changed to 91.06%however this does not impact on compliance with targets.

VTE, Dementia and Discharge Summaries relate to early extraction of data (22nd April 2014) for this report. Data is refreshed and submitted to UNIFY on the 28th April.

**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
- Note removal of one Never Event from February – this has now been reviewed via Trust governance processes and because the patient did not suffer permanent harm this incident does not fit the criteria for a Never Event.
- Approve actions planned to mitigate areas of exception

## 1. Key Performance Indicators

| | | Target / threshold | A | M | J | Q1 | J | A | S | Q2 | O | N | D | Q3 | J | F | M | Q4 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Safety** | | | Figures are totals or % for the month / quarter (except where stated) | | | | | | | | | | | | | | | | |
| **HSMR** (rolling 12 months, latest data available) | | <=100 | 107 | 107 | 107 | | 105 | 105 | 105 | | 104 | 104 | 103 | | 101 | | | | 101 |
| **SHMI** (rolling 12 months, latest data available) | | <=100 | 113 | 113 | 112 | | 110 | 108 | 108 | | 108 | 108 | 106 | | | | | | 106 |
| **Total deaths in hospital** | | | 117 | 91 | 99 | 307 | 76 | 80 | 93 | 249 | 72 | 76 | 76 | 224 | 101 | 99 | 89 | 289 | 1069 |
| **Regulation 28 -** Prevention of future deaths report | | | | | | | | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 |
| **Incidents resulting in Major or Catastrophic harm** | | <7 (2012/13 total) | 1 | 1 | 0 | 2 | 0 | 2 | 2 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| Incidents of major or catastrophic harm under investigation | | N/A | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 3 | 1 | 3 | 3 | 7 | 11 |
| **Falls** (moderate, major and catastrophic harm) | | <=14 per year | 5 | 0 | 0 | 5 | 1 | 1 | 0 | 2 | 1 | 2 | 0 | 3 | 3 | 1 | 1 | 5 | 15 |
| **Falls** (moderate, major and catastrophic harm) awaiting approval | | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Pressure Ulcers** | Grade 3 and 4 Hospital Acquired (Avoidable) | <=16 per year | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 5 |
| | Grade 3 and 4 Hospital Acquired (Unavoidable) | N/A | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 4 |
| | Grade 3 and 4 Hospital Acquired (Not yet determined) | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 |
| | Grade 2 Hospital Acquired | <=149 per year | 16 | 6 | 11 | 33 | 7 | 7 | 18 | 32 | 3 | 5 | 9 | 17 | 8 | 6 | 15 | 29 | 111 |
| | Grade 2 Hospital Acquired (under review) | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MRSA** | | 0 per year | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 3 |
| **C difficile** | | <=19 per year | 5 | 4 | 3 | 12 | 0 | 1 | 1 | 2 | 4 | 2 | 4 | 10 | 4 | 1 | 2 | 7 | 31 |
| **Never Events** | | 0 per year | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| **VTE** | % of patients risk assessed | >=95% of patients | 95.37 | 95.05 | 95.67 | 95.36 | 95.97 | 95.84 | 95.15 | 96.26 | 96.36 | 96.74 | 95.21 | 96.6 | 95.63 | 95.14 | 95.04 | 96.29 | 96.29 |
| | % harm free (Safety Thermometer (ST) | TBC | 98 | 98 | 99 | | 98 | 98 | 99 | | 98 | 97 | 98 | | 98 | 99 | 98 | | |
| **Medication Errors** | Omitted doses (Quarterly audit) | >=10% reduction in yr | | | | 334 | | | | 371 | | | | 391 | | | | 399 | 1495 |
| | Insulin related errors | <=54 per year | 4 | 8 | 2 | 14 | 4 | 1 | 1 | 6 | 3 | 8 | 4 | 15 | 6 | 2 | 8 | 16 | 51 |
| **CA – UTI:** Number of catheterised patients who developed a UTI (ST) | | TBC | 6 | 1 | 4 | 11 | 6 | 4 | 5 | 15 | 2 | 3 | 1 | 6 | 3 | 4 | 3 | 10 | 42 |
| **CA – UTI** % of catheterised patients who developed a UTI (ST) | | TBC | 1.11 | 0.19 | 0.7 | | 1.13 | 0.73 | 0.93 | | 0.38 | 0.5 | 0.19 | | 0.53 | 0.75 | 0.55 | | |
| **Dementia Assessment** (Part 1) | | >=90% of patients | 90.43 | 93.14 | 91.35 | 91.67 | 92.87 | 95.12 | 95.12 | 94.33 | 95.2 | 95.13 | 96.11 | 95.5 | 97.67 | 97.36 | 94.57 | 96.5 | 94.44 |
| **Dementia Assessment** (Part 2) | | >=90% of patients | 96.77 | 100 | 100 | 98.78 | 100 | 100 | 93.3 | 97.4 | 100 | 96.43 | 96.88 | 98.9 | 100 | 100 | 100 | 100 | 99.72 |
| **Dementia Assessment** (Part 3) | | >=90% of patients | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| **Clinical Nursing Indicators** | | >=90% compliant | | | | 97 | | | | 95 | No data collected | | | | No data collected | | | | 96 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Effectiveness** | | | | | | | | | | | | | | | | | | | |
| **Advancing Quality** | Acute MI Threshold | >=91.46% | 97.14 | 98.65 | 97.98 | 97.98 | 98.37 | 97.97 | 98.30 | 98.30 | 98.59 | 98.77 | 98.25 | 98.25 | | | | | 98.25 |
| | Hip and knee | >=92.23% | 97.47 | 97.56 | 96.77 | 96.77 | 96.08 | 96.46 | 96.98 | 96.98 | 96.30 | 96.41 | 96.21 | 96.21 | | | | | 96.21 |
| | Heart failure | >=86.85% | 85.00 | 90.91 | 93.59 | 93.59 | 93.00 | 90.84 | 90.96 | 90.96 | 87.95 | 89.09 | 88.75 | 88.75 | | | | | 88.75 |
| | Pneumonia | >=75.23% | 64.37 | 65.36 | 68.16 | 68.16 | 68.90 | 70.00 | 70.26 | 70.26 | 70.31 | 70.93 | 71.80 | 71.80 | | | | | 71.80 |
| | Stroke | >=62.57% | 59.46 | 55.00 | 53.49 | 53.49 | 55.75 | 58.33 | 57.54 | 57.54 | 57.14 | 56.50 | 56.16 | 56.16 | | | | | 56.16 |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Critical Care:** compliance with 7 bundles in ITU | | >=90% (figure = bundles compliant) | 6 | 7 | 7 | **7** | 7 | 7 | 7 | 7 | **7** | 7 | 7 | 7 | 7 | 7 | 7 | 7 | **7** |
| **Critical Care:** total Ventilator Associated Pneumonia in ITU | | <=8 (per yr) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | **0** | **0** | 1 | 0 | 0 | 1 | **1** |
| **Critical Care:** total line associated blood stream infections in ITU | | <=1 (per yr) | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | **0** | **0** | **0** | **0** | 0 | 0 | 0 | 0 | **2** |
| **Emergency readmissions within 30days of discharge** | | | 74 | 68 | 67 | 209 | 79 | 74 | 72 | 225 | 80 | 61 | 68 | 191 | 78 | 67 | 61 | 206 | 849 |
| **End of Life Care:** Specialist Palliative Care activity | | TBC | See chart on page 4 | | | | | | | | | | | | | | | | |
| **Clinical Nursing Indicators:** | MEWS recorded | >=95% compliant | | | | 100 | | | | 100 | No data collected | | | No data collected | | | | | **100** |
| | MEWS 'action taken' | >=95% compliant | | | | 100 | | | | 100 | No data collected | | | No data collected | | | | | **100** |
| **Discharge summaries to GPs within 24 hours** | | Q3 >=92% of patients | 88.09 | 89.17 | 89.70 | 88.97 | 89.59 | 89.91 | 91.48 | 90.50 | **92.35** | **91.57** | **91.80** | **91.94** | 91.06 | 92.36 | 91.47 | 91.61 | **90.87** |

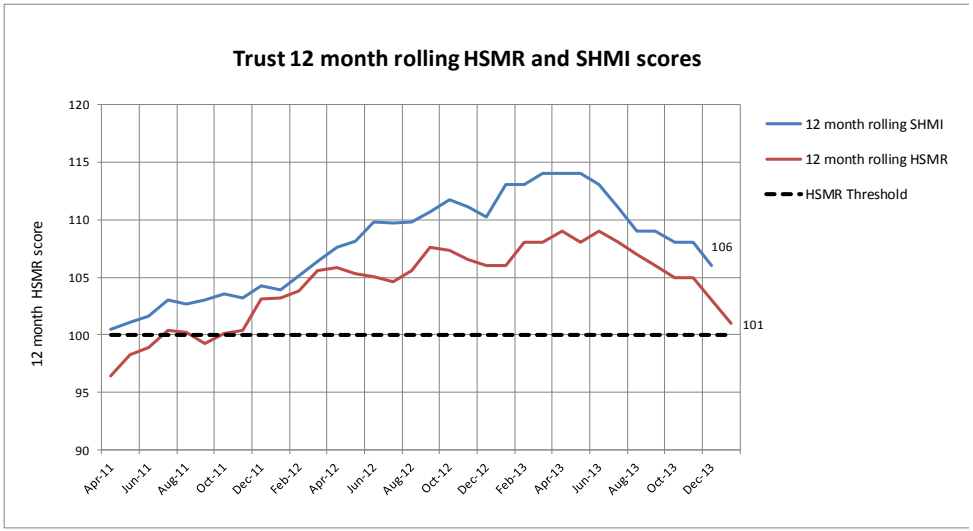
NB YTD results for Discharge Summaries to GPs includes January data (to 22/1/14).

## Patient Experience

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Survey** 5 inpatient questions – Quality Account | | >67.4% | **66.7%** (2012 survey) **2013 CQUIN REMOVED - NO DATA AVAILABLE** | | | | | | | | | | | | | | | | |
| **Staff Survey** (staff recommending the hospital) | | Yr on yr improvement | **65% 2013 survey (58%** 2012 survey) (57% in 2011 survey) | | | | | | | | | | | | | | | | |
| **Mixed sex occurrences** (clinical unjustified) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 5 | 10 | 1 | 2 | 13 | 6 | 0 | 0 | **6** | **24** |
| **Friends and Family Test** (Trust score, out of maximum 5) | | TBC | 4.7 | 4.7 | 4.7 | | 4.7 | 4.5 | 4.5 | | 4.6 | 4.6 | 4.5 | | 4.6 | 4.7 | 4.6 | | |
| **Friends and Family Test – NET PROMOTER** | | >=70 | | | 73 | | 70 | 58 | 59 | | 63 | 60 | 56 | | 61 | 69 | 65 | | |
| **Complaints** (number received) | | None set | 39 | 22 | 26 | 87 | 31 | 37 | 26 | 94 | 32 | 35 | 34 | 101 | 43 | 47 | 40 | 130 | 412 |
| **Complaints** (% resolved within the agreed timescale) | | >=94% | 47% | 67% | 66% | 58% | 62% | 70% | 71% | 69% | **62%** | **80%** | **50%** | 69% | **72%** | **70%** | 94% | 81% | 68% |

# 2. Exception reporting

## HSMR and SHMI Mortality Ratios

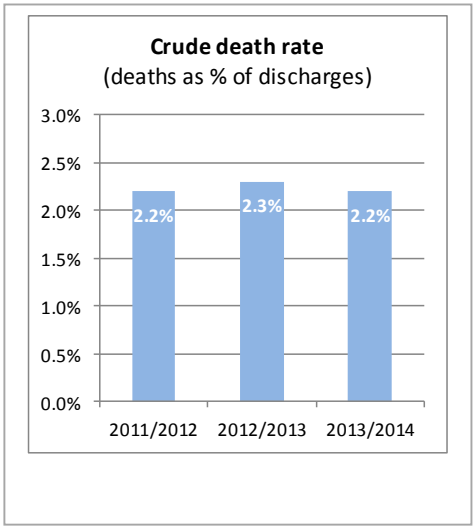



The charts to the left shows the Trust's HSMR and SHMI rolling 12 month figures, and reveal a significant reduction; from 109 (at the highest), to 101 in the HSMR, and 114 to 106 for the SHMI.

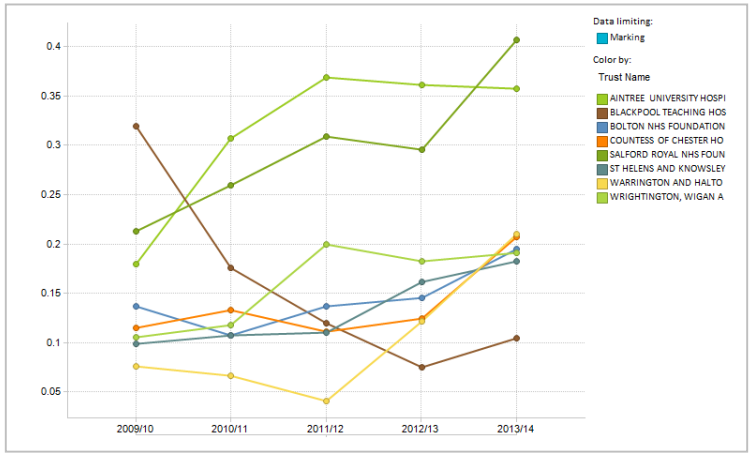
The chart to the bottom left shows the crude death rate by year which is stable at 2.2% - 2.3% over the past 3 years.

The chart to the bottom right shows what % of patients who died, were seen by the Specialist Palliative Care Team, in comparison with local acute Trusts. This has increased from an average of 4% in 2011/2012 to 21% in 2013/2014.

**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.

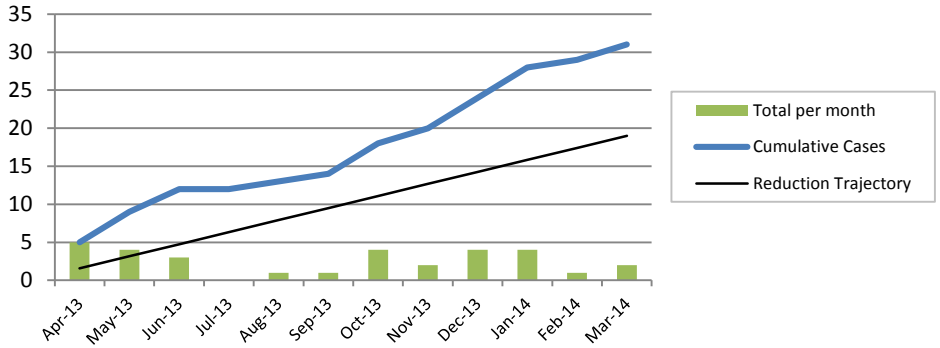



% of all patients who died, who were seen by the Specialist Palliative Care Team



## MRSA and Clostridium Difficile

**Number of hospital acquired cases of Clostridium difficile 2013-2014**
(cumulative and per month)




### MRSA & Clostridium difficile

The chart above shows the total number of C difficile cases per month and also cumulatively from 1/4/13 to 31/03/14. The Trust has had 31 hospital apportioned cases of C difficile in this period, against a threshold of 19 for the year.

**Actions**: An appeal has been lodged with the CCG. The Clostridium difficile Action Group held the first meeting in December to look at the issues across the whole health economy.

A nil return was submitted for MRSA for the March period.

**Assurance Committee:** Infection Control Sub Committee

### Discharge Summaries to GP | Dementia part 1

The data used for these KPIs was extracted on the 22nd April 2014 so this percentage may not be the final figure.

### Patient Falls

The prevention and management of falls is a high priority within the Trust. Although we haven't met our stretch target, we continue to see a reduction in the number of moderate harm falls, and up to March 31st 2013 we have seen no major or catastrophic falls. We have unfortunately had 15 falls (compared to 16 in 2012/13) where harm has occurred all of which have been subject to a Level 1 investigation and presented within clinical areas for learning. We are pleased to see that we are sustaining our improvement in reducing falls, and in the obvious improvement to patient experience. The Open and Honest Care Project continues, and we submit data relating to falls where harm occurred. We have appointed a Patient Safety & Quality Champion who will assist in the Falls work, and other quality initiatives, in our continued efforts to improve.

## Advancing Quality

**AQ Stroke (monitored via CQUIN Group)**

In order to achieve this target, the 4 hour target for direct admission needs to improve. In order to achieve the target of > 65% by the end of this financial year the target of 69.58% for direct admission needs to be achieved each month. Compliance with patients reaching the stroke unit within 4 hours of admission is one of seven factors measured for this indicator. As at December compliance against measures was as follows:-

- Stroke Unit admission 13/25
- Swallow screening 17/19
- Brain scan 21/23
- Weighed 22/23

Agreement reached to ring fence four beds for 4 hour stroke admission however this is not always assured as such the Trust may not achieve target of 62.57%, w/b 13th January shows improvement with 80% of patients admitted within 4 hours – 8/10

**AQ Pneumonia (monitored via CQUIN Group)**

There are a number of requirements that are required to achieve compliance with AQ for each patient however non-compliance does not appear to be based on one specific requirement so the team select individual issues to improve compliance. They are currently focussing attention on the issue of antibiotics being received with 6 hours of arrival as well as putting action plans are in place to ensure all doctors are trained in the requirements. As at December compliance against measures was as follows:-

- Initial antibiotic selection for CAP in immune-competent patients 32/34
- Initial antibiotic received within 6 hours of arrival 45/53
- Smoking cessation / counselling 10/11
- CURB65 Score 35/37

## 3. Key Performance Indicators: detail

| | 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) | • Quality Contract<br>• IMPROVING QUALITY STRATEGY<br>• MONITOR<br>• CQC<br>• Quality Report | • Commissioners<br>• Clinical Effectiveness Group | Accessed via HED |
| SHMI | Standard Hospital Mortality Index calculated by HED (rolling 12 months to the end of the period) | • IMPROVING QUALITY STRATEGY<br>• Quality Contract<br>• MONITOR<br>• CQC<br>• Quality Report | • Commissioners<br>• Clinical Effectiveness Group | 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) | • Quality Contract<br>• IMPROVING QUALITY STRATEGY<br>• Quality Report | • Commissioners<br>• Falls Prevention Group | Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations.<br>Falls data adheres to NRLS (National Reporting and Learning System) submission criteria.<br>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) | • Quality Contract<br>• IMPROVING QUALITY STRATEGY<br>• Quality Report | • Commissioners<br>• 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<br>• IMPROVING QUALITY STRATEGY<br>• Quality Report | • Commissioners<br>• Pressure Ulcer Link Nurses | Mersey Internal Audit Agency report 2012: 'Significant Assurance' |
| MRSA | Number of cases of hospital acquired MRSA | • Quality Contract<br>• Quality Improvement and Patient Safety Strategy 2012 – 2015<br>• MONITOR<br>• CQC<br>• Quality Report | • Commissioners<br>• Infection Control Sub Committee (ICC) | Process audited annually by PWC on behalf of Monitor. |
| Clostridium difficile | Number of cases of hospital acquired C difficile | • Quality Contract<br>• IMPROVING QUALITY STRATEGY | • Commissioners<br>• ICC | Data from Trust MOLIS laboratory system and Public Health England's HCAI national database is cross referenced for accuracy. |

| | KPI detail | Rationale for inclusion | Data Circulation | Data Assurance |
|---|---|---|---|---|
| | | • MONITOR<br>• CQC | | |
| Never events | Never Events as determined by The Department of Health criteria | • Quality Contract<br>• IMPROVING QUALITY STRATEGY<br>• Quality Report<br>• CQC | • Commissioners<br>• 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 | • CQUIN<br>• IMPROVING QUALITY STRATEGY<br>• Quality Report | • Commissioners | Supplied by Information Dept.<br>Protocol approved by the Clinical Governance Committee applying the SHA criterion.<br>Performance monitored by Associate Director of Strategy and Business Development |
| 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<br>• IMPROVING QUALITY STRATEGY<br>• Quality Report | • 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.<br><br>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 | • IMPROVING QUALITY STRATEGY | • 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) | • IMPROVING QUALITY STRATEGY<br>• Quality Report | • 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 | • IMPROVING QUALITY STRATEGY<br>• Quality Report | • 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 | • Quality Report<br>• IMPROVING QUALITY STRATEGY | • Commissioners | Adherence to National NHS Safety Thermometer data capture and reporting process |
| Dementia Assessment (CQUIN) | % compliance with Dementia Assessment Part 1 – 3 as per CQUIN. | • CQUIN<br>• Quality Report | • 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) | • Quality Report<br>• Quality Contract | • Commissioners | Adherence to Trust Policy for the Reporting and Management of Incidents and Investigations. |
| Discharge Summaries to | % of patients having a Discharge Summary sent within | • Quality Contract | • Commissioners | Supplied by Information Dept. |

| | KPI detail | Rationale for inclusion | Data Circulation | Data Assurance |
|---|---|---|---|---|
| GPs | 24 hours (including TTO).<br><br>Contract threshold 95% (penalty applies <90%) | • IMPROVING QUALITY STRATEGY | | Process agreed with commissioners in accordance with the contract.<br>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 | • IMPROVING QUALITY STRATEGY | • NMAC<br>• PSEAG | Audit completed by Clinical Research and Audit Nurse. |
| **Effectiveness** | | | | |
| 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<br>• IMPROVING QUALITY STRATEGY | • 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:<br>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. | • IMPROVING QUALITY STRATEGY | • 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 | • Quality Contract | • 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')<br>Starting April 2013 report: Specialist Palliative care referral rates | • IMPROVING QUALITY STRATEGY | • 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 | • IMPROVING QUALITY STRATEGY | • 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 | • IMPROVING QUALITY STRATEGY | • NMAC | Audit completed by Clinical Research and Audit Nurse. |
| **Patient Experience** | | | | |
| Patient Survey | Inpatient Survey | • IMPROVING QUALITY STRATEGY<br>• CQUIN | • Commissioners | Survey managed by Quality Health |
| Staff Survey | Staff Survey result for single question: Would you recommend this hospital to friends and relatives? | • IMPROVING QUALITY STRATEGY<br>• CQUIN | • Commissioners | Survey managed by Quality Health |
| MSO (unjustified breeches) | Number of clinically unjustified mixed sex breaches | • Quality Contract<br>• IMPROVING QUALITY STRATEGY | • Commissioners | Adherence to Department of Health MSO criteria for reporting<br>Developed data capture systems relevant to each area. |

| | KPI detail | Rationale for inclusion | Data Circulation | Data Assurance |
|---|---|---|---|---|
| | | | | Datix completed. Quality Improvement Matron informed by wards and triangulates data with Datix and Extramed systems |
| Complaints received | Number of complaints received each month | • Quality Contract<br>• CQC<br>• IMPROVING QUALITY STRATEGY | • PSEAG | |
| Complaints resolved within the agreed time | % of complaints closed in the month, which were resolved within the agreed timescales | • Quality Contract<br>• CQC<br>• IMPROVING QUALITY STRATEGY | • Commissioners | Process agreed with Associate Director of Strategy and Business Development and agreed with commissioners in accordance with the contract. |

**Key:**
**ICSC**: Infection Control Sub Committee
**IMPROVING QUALITY STRATEGY**: 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/14/063*

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Infection Prevention and Control Board Report |
| **Date of Meeting** | 30th April 2014 |
| **Director Responsible** | Karen Dawber Director of Nursing and Organisational Development/Director of Infection Prevention and Control |
| **Author** | Lesley McKay Matron/Associate Director Infection Prevention and Control |
| **Purpose** | To inform and update the Board on issues relating to infection prevention and control in the Trust |

| **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 |
|---|---|
| • *Clostridium difficile* update | **2** |
| • *Clostridium difficile* Objective 2014 - 2015 | **2** |
| • Carbapenemase-producing Enterobacteriaceae | **5** |

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

**The Board is asked to receive the infection control report, note the progress made and consider the recommendations to drive further improvements.**

**Infection Prevention and Control Report to the Trust Board**

## Executive Summary

This report highlights the Trust's progress for infection prevention and control against key performance indicators for April 2013 – March 2014. Recommendations are included for further actions that are required to improve the Trust's performance in relation to Clostridium difficile. Information is included on the emerging threat from Carbapenemase-producing Enterobacteriaceae and the response required by the Trust.

### *Clostridium difficile*

During the financial year, the Trust reported 56 cases of *Clostridium difficile*, 31 of which are hospital apportioned against the financial year threshold of 19 cases (appendix 1). The appeal against apportionment of 9 cases was unsuccessful. The Infection Control Team will be liaising with the Local Area Team to discuss the appealed cases.

The annual objective was challenging for the NHS as a whole and for many Trust's individually. Consequently, next year's objective sees an increase in thresholds for many organisations.

### *Clostridium difficile* Objective 2014-2015

This Trust's revised *Clostridium difficile* threshold is 26 cases, which remains one of the lowest thresholds compared to other medium-sized acute Trusts in the Cheshire and Merseyside region (appendix 2).

Several of the changes outlined in this objective have been reviewed and include:-

- closer examination of individual cases and implementation of relevant learning (appendix 3)
- Commissioner discretion in deciding whether any individual case of *Clostridium difficile* should count towards the aggregate number of cases on which contractual sanctions are calculated. Removal of the appeal process with no arbitration (appendix 3)
- Commissioner assessment that the recorded number of cases accurately reflects the *Clostridium difficile* burden. A baseline assessment on *Clostridium difficile* burden has been conducted (appendix 4)
- Reduction in contractual sanction for each *Clostridium difficile* case in excess of the Trust's objective to £10,000

Despite the continued focus of activity, progress has slowed with tackling this infection. Board members are asked to note that other interventions are required to improve the Trust's position, some of which require further resources. These include:-

- Increase in pharmacy time to support antibiotic ward rounds (from approximately 15 hours/week to full time)
- IT developments to improve access to the antibiotic formulary (i.e. via an iphone app)
- Electronic prescribing
- Extending the use of hydrogen peroxide vapour for decontamination of side rooms vacated by *Clostridium difficile* patients. This requires investment in staff training and will have an operational impact as decontamination of side rooms will take slightly longer than conventional disinfection methods
- A rolling programme for decant and deep cleaning, using hydrogen peroxide vapour across all wards. To continue after ward upgrade works are completed
- Commitment to review the cleaning requirements over the 24 hour period including task team staffing levels
- Highlight access is available to infection control advice 24/7
- Process to improve access to isolation facilities
- Ensuring compliance with policies and learning from each *Clostridium difficile* case where lapses in quality of care occurred
- Review of evidence on probiotics with a view to implementing a trial in areas with a higher incidence of *Clostridium difficile* cases

Other initiatives maintained/implemented this year include but are not limited to:-

- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort facility
- Antimicrobial steering group
- Fidaxomicin introduced for treatment of patients with recurrent *Clostridium difficile* infection
- Text alerts for *Clostridium difficile* cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Weekly multi-disciplinary team review of *Clostridium difficile* patients
- Safety alerts on management of potentially infectious diarrhoea

- Revision to hand hygiene signage
- Hand hygiene awareness raising events
- External review of governance arrangements
- Establishment of a multi-agency *Clostridium difficile* action group

## Bacteraemias

### MRSA bacteraemia

During the financial year, the Trust reported 5 MRSA bacteraemia cases, 3 of which were hospital apportioned, 1 a contaminant and 1 a community acquired case (appendix 1).

### MSSA bacteraemia

The Trust reported 45 cases of MSSA bacteraemia, 17 of which are hospital apportioned cases (appendix 1). Previously the Trust flagged as an outlier with a higher than average number of cases compared regionally and nationally. During the course of this year the Trust's rate fell from 17.87 per 100,000 bed days (April - June 2013) to 5.96 per 100,000 bed days (July - September). This rate was maintained in October to December 2013.

Despite this decrease in rate a significant number of cases are occurring in ICU. The Infection Control Team is working in partnership with ICU to identify areas for care improvement.

### E. coli bacteraemias

The Trust has reported 178 cases of E. coli bacteraemia. The Medical Microbiologists review all cases of E. coli bacteraemia. The majority of the cases are unlikely to be associated with healthcare.

For cases where there is thought to be an association with healthcare, Consultants responsible for the patient's care will be contacted and asked to examine what happened and what actions could have been taken to prevent the bacteraemia.

## Outbreaks/Incidents

### Viral Gastroenteritis

During quarter 4, a total of 10 wards were under surveillance and part or fully closed due to symptoms of viral gastroenteritis. Wards were reopened as soon as it was safe to do so.

## Emerging diseases

### Carbapenemase-producing Enterobacteriaceae

Carbapenemase-producing Enterobacteriaceae (CPEs) represent one of the most serious emerging infectious disease threats. Failure to control transmission at this point in time could have substantial human health and financial consequences. Infections caused by these bacteria are extremely difficult to treat as they are resistant to carbapenems, which are considered 'last resort' antibiotics.

The Medical Directors for NHS England and Health Protection have taken the unusual step of writing to Chief Executives to request support and action to address risks from CPEs.

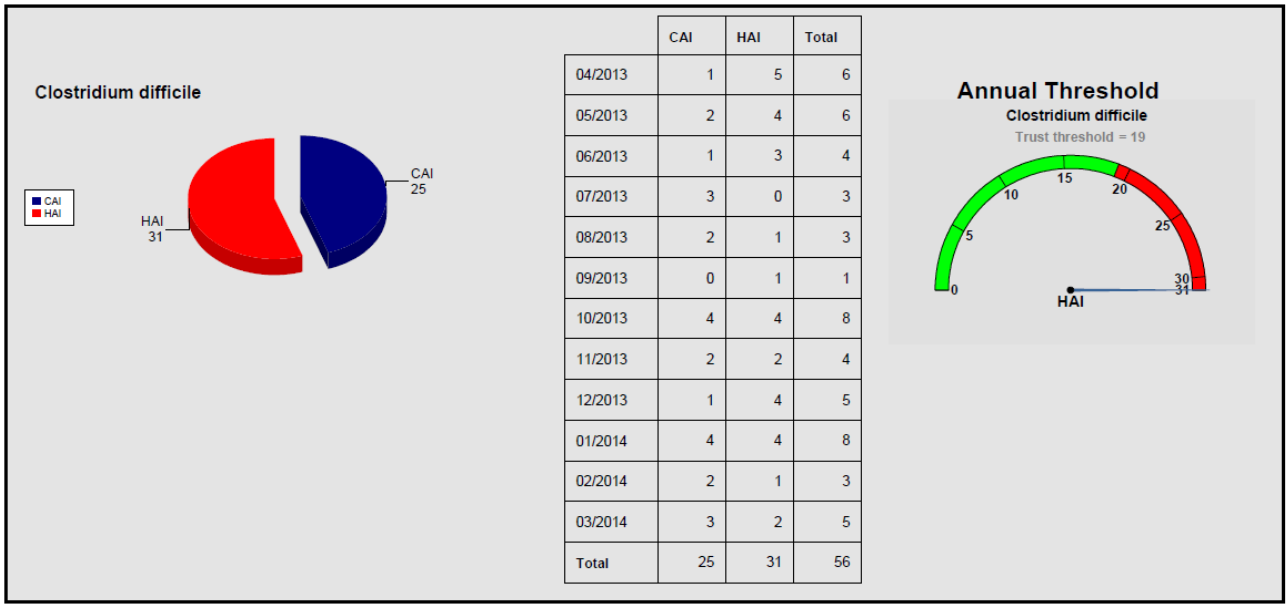
Public Health England (PHE) has published a toolkit for the early detection, management and control of CPEs. This has been reviewed by the Infection Control Team and an SOP implemented for isolating and screening patients admitted via inter hospital transfer. To date one case has been detected which was resistant to all antibiotics except one.

Further work is required in relation to contractual obligations around inter hospital transfers and ensuring patients are in the right location for optimum care. One of the most important infection control actions is isolation of patients. Due to competing priorities for side rooms, further work is required to support the CPE management agenda in line with patient pathways. Further guidance is awaited from PHE.

Lesley McKay
Matron/Associate DIPC
23rd April 2014

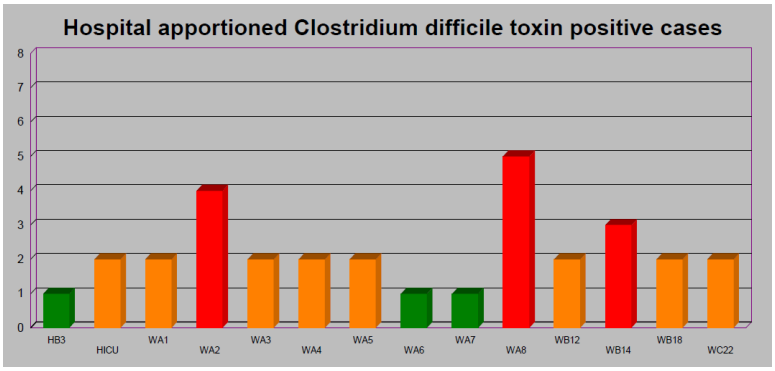
## Appendix 1 Surveillance Data April 2013 – March 2014

## CLOSTRIDIUM DIFFICILE

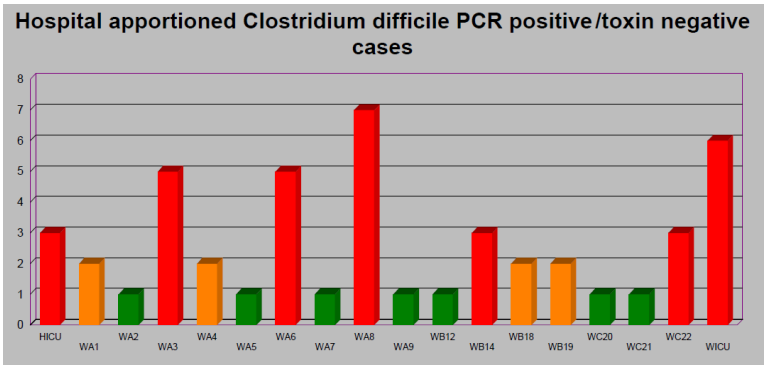



| | CAI | HAI | Total |
|---|---|---|---|
| 04/2013 | 1 | 5 | 6 |
| 05/2013 | 2 | 4 | 6 |
| 06/2013 | 1 | 3 | 4 |
| 07/2013 | 3 | 0 | 3 |
| 08/2013 | 2 | 1 | 3 |
| 09/2013 | 0 | 1 | 1 |
| 10/2013 | 4 | 4 | 8 |
| 11/2013 | 2 | 2 | 4 |
| 12/2013 | 1 | 4 | 5 |
| 01/2014 | 4 | 4 | 8 |
| 02/2014 | 2 | 1 | 3 |
| 03/2014 | 3 | 2 | 5 |
| Total | 25 | 31 | 56 |

### Clostridium difficile <u>toxin positive</u> hospital apportioned cases by location when detected

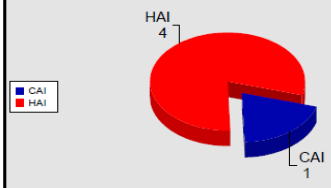



### Clostridium difficile <u>PCR positive/toxin negative</u> hospital apportioned cases by location when detected (local surveillance)



# BACTERAEMIAS

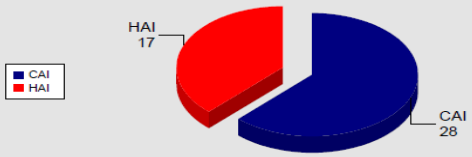
## MRSA Blood Cultures



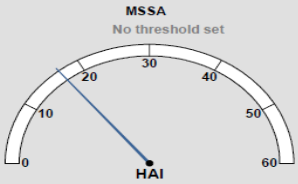

| | BLOODSTREAM | | | CONTAMINANT | | Total |
|---|---|---|---|---|---|---|
| | CAI | HAI | Total | HAI | Total | |
| 04/2013 | 0 | 1 | 1 | 0 | 0 | 1 |
| 06/2013 | 0 | 0 | 0 | 1 | 1 | 1 |
| 09/2013 | 0 | 1 | 1 | 0 | 0 | 1 |
| 10/2013 | 1 | 0 | 1 | 0 | 0 | 1 |
| 01/2014 | 0 | 1 | 1 | 0 | 0 | 1 |
| Total | 1 | 3 | 4 | 1 | 1 | 5 |

### Annual Threshold


## MSSA blood cultures

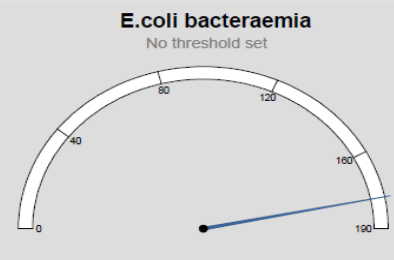



| | CAI | HAI | Total |
|---|---|---|---|
| 04/2013 | 1 | 4 | 5 |
| 05/2013 | 1 | 1 | 2 |
| 06/2013 | 2 | 4 | 6 |
| 07/2013 | 4 | 2 | 6 |
| 08/2013 | 2 | 0 | 2 |
| 09/2013 | 1 | 1 | 2 |
| 10/2013 | 3 | 0 | 3 |
| 11/2013 | 4 | 1 | 5 |
| 12/2013 | 1 | 2 | 3 |
| 01/2014 | 1 | 0 | 1 |
| 02/2014 | 5 | 2 | 7 |
| 03/2014 | 3 | 0 | 3 |
| Total | 28 | 17 | 45 |




## E Coli blood cultures

| | Total |
|---|---|
| 04/2013 | 12 |
| 05/2013 | 13 |
| 06/2013 | 8 |
| 07/2013 | 15 |
| 08/2013 | 16 |
| 09/2013 | 15 |
| 10/2013 | 17 |
| 11/2013 | 11 |
| 12/2013 | 15 |
| 01/2014 | 22 |
| 02/2014 | 18 |
| 03/2014 | 16 |
| Total | 178 |



**Appendix 2 Comparison of CDI objective/rate for medium-sized acute Trusts in Cheshire and Merseyside**

| Name | CDI case objective for 2014/15 | CDI rate objective for 2014/15 |
|---|---|---|
| Aintree University Hospitals | 81 | 33.0 |
| Countess of Chester Hospital | 30 | 15.5 |
| Southport & Ormskirk Hospital | 27 | 18.3 |
| St Helens & Knowsley Hospitals | 19 | 8.2 |
| Warrington & Halton Hospitals | 26 | 12.9 |

## Appendix 3 Learning from *Clostridium difficile* incidents

Following the external review of governance arrangements for infection prevention and control and advice from the Associate Director of Governance, hospital apportioned *Clostridium difficile* cases will be investigated as level 1 incidents.

To support the level 1 investigation, a robust assessment tool has been developed (embedded below) by the Trust's Infection Control Team with input from the Commissioning Coordinator, Deputy Director for Public Health Warrington, Medicines Management and community Infection Control Team.

This assessment tool will be used to assess individual cases. The *Clostridium difficile* Action Group, which includes the Commissioning Coordinator, will jointly review the investigation findings.

The Commissioning Coordinator can exercise discretion in deciding whether any individual case of *Clostridium difficile* should count towards the aggregate number of cases on the basis of which contractual sanctions are calculated. This includes cases where no lapses in the quality of care are identified.

There is no further arbitration/appeal process.

Toolkit for investigation of C diff

**Appendix 4 Clostridium difficile assessment tool (baseline assessment)**

| Question | Trust response | Compliance Assessment | Notes |
|---|---|---|---|
| 1. Are faecal samples sent for *C. difficile* testing from all patients who develop diarrhoea, regardless of when this occurs, who do not have a clear, non-infection, alternative explanation for its cause?<br><br>**Answer should be yes.**<br><br>If a patient has diarrhoea (Bristol Stool Chart types 5-7) that is not clearly attributable to an underlying condition (e.g. inflammatory colitis, overflow) or therapy (e.g. laxatives, enteral feeding) then it is necessary to determine if this is due to CDI. | YES | Currently assessed by quarterly audit of submitted specimens. | Guidance states:<br>Assumptions that CDI is not the cause of new diarrhoeal episodes need to be robust and documented in the patient's notes. There should be a medical assessment of cases to assure that diarrhoea is not of infective origin. |
| 2. What is the evidence that this is understood and practised consistently by all healthcare staff across the organisation? | Further work is required to assess healthcare worker knowledge | Direct questioning of healthcare workers or via audit data as above. | As this is starting point for the entire testing pathway, it is important that healthcare workers understand which patients require samples to be sent to Microbiology. |
| 3. Are all diarrhoeal samples received in the laboratory from hospital patients aged >2 years, community patients aged >65 years, and community patients aged <65 years wherever clinically indicated tested for *C. difficile*?<br>**Answer should be yes.**<br>Have laboratories audited their practice to show that appropriate samples are tested for CDI and inappropriate samples are not tested for CDI (e.g. samples from infants, | YES<br><br>None diarrhoeal specimens are rejected. An audit of laboratory practice is required.<br><br>Some patients are discussed with | There is a laboratory standard operating procedure that clearly states which samples received in the laboratory are tested for evidence of CDI. | Guidance states:<br>**Diarrhoeal samples should be tested for *C. difficile* from:**<br>• hospital patients aged >2 years,<br>• **community patients, aged >65 years,**<br>• **community patients aged <65 years wherever clinically indicated** |

| Question | Trust response | Compliance Assessment | Notes |
|---|---|---|---|
| non-diarrhoeal samples)? | clinicians | | |
| 4. Is all *C. difficile* testing consistent with the recommended two-stage algorithm?<br><br>**Answer should be yes.**<br>There should be laboratory standard operating procedure that clearly states how samples received in the laboratory are tested for evidence of CDI.<br>Have laboratories audited their practice to show that samples are tested appropriately? | YES<br><br>The trust uses 3 stage testing.<br>1) GDH<br>2) PCR<br>3) EIA | The testing kits used have high:<br><br>1) Sensitivity negative predictor value (NPV) 99.6%<br>2) -<br>3) specificity 98.6 – 98.9% | Guidance states:<br>**The first test should be either a GDH or toxin gene (PCR) test; if this is positive, the second test should be a toxin (EIA or cytotoxin) test. If the first test is negative a second test is not needed. Additional tests may be used, but not instead of the recommended approach.**<br>If samples from patients with diarrhoea are not tested appropriately for evidence of CDI then there is a risk of false-negative and/or false-positive results. |
| 5. Are all toxin positive patients reported to PHE?<br>**Answer should be yes.** | YES | The number of laboratory reported CDI positive samples should match the number of cases reported to PHE (after applying de-duplication according to 28 day rule). What is the organisation's rationale for not reporting toxin positive cases (see 6. below)? | Guidance states:<br>**All GDH EIA (or NAAT) positive, toxin positive patients/reports should be reporting to PHE.** |

| Question | Trust response | Compliance Assessment | Notes |
|---|---|---|---|
| 6. Are clinical criteria or other tests outside of the algorithm referred to in question 4 above used to determine which toxin positive results are reported to PHE? **Answer should be no.** | No<br><br>All EIA toxin positive results are reported to PHE.<br>Process is audited monthly | The number of laboratory reported CDI positive cases should match the number of cases reported to PHE (after applying de-duplication according to 28 day rule). | **See 5. above.**<br>**The results of other tests and/or clinical criteria should NOT be used to determine which positive patients are reported to PHE.** |
| 7. Are toxin positive results obtained >28 days after a previous positive result on the same patient reported to PHE. **Answer should be yes.** | YES | The number of laboratory reported CDI positive cases should match the number of cases reported to PHE (after applying de-duplication according to 28 day rule). | **See 5. above.**<br>**Patients with repeat positive results more than 28 days apart should also be reported.**<br>Such results likely indicate recurrence of CDI. Such recurrences are due to relapse or re-infection, and some may be preventable. |

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/064**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Maternity Services update to the Board |
| **Date of Meeting** | April 2014 |
| **Director Responsible** | Karen Dawber, Director of Nursing and OD |
| **Author(s)** | Millie Bradshaw, Associate Director of Governance |
| **Purpose** | To inform the Board to the on-going actions following the cluster of maternity incidents reported as part of serious incident procedures.<br><br>For the Board to review and make comment |

| **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 |
|---|---|---|
| • | Review of the incidents | 2 |
| • | Actions taken to date | 2 |
| • | Draft Letter from CEO to staff in Maternity Services | 5 |
| • | Letter from CQC received Thursday 17th April 2014 | 8 |

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

The Board is asked to:

1. to receive and comment to the contents within the Briefing paper
2. To further question to seek any further assurance from the Director of Nursing and OD to any areas of clarification

**Briefing Paper to Board of Directors re Maternity Services**

**Situation:** This briefing paper intends to provide an update relating to a cluster of incidents in maternity between May 2013 and March 2014, and contact by a whistleblower to the Care Quality Commission (CQC).

**Background:** The Board have been made aware in previous Reports submitted by the Director of Nursing of five Level 2 investigations and one Level 1 investigation relating to intrapartum events. Following these events the midwifery and medical teams have put into place a number of actions as a result. The incidents are documented below:

*March 2013*: A Level 2 Serious Untoward Incident (SUI) investigation was undertaken into a 35 week gestation intrauterine death with the involvement of an external Consultant Midwife.

*September 2013*: A Level 2 SUI investigation was undertaken into a 28 week gestation intrapartum death – with the involvement of an external Consultant Obstetrician and Consultant Midwife

*September 2013*: A Level 2 SUI investigation was undertaken into a 40+10 week gestation intrapartum death with the involvement of an external Consultant Obstetrician.

*December 2013:* A Level 2 SUI investigation was undertaken into a 40 week gestation intrapartum death with the involvement of an external Consultant Obstetrician and external Head of Midwifery.

*March 2014:* A Level 1 incident investigation has been undertaken intrapartum event and subsequent death of the baby five days post delivery. This will now be subject to an external review as part of the wider review of all the cases which took place 24th April and at the time of writing the Briefing paper are awaiting the Findings.

*March 2014*: An independent Level 2 SUI investigation is being arranged into a 37 week gestation intrapartum death

The Trust was also subject to a whistle-blower to the CQC in March 2013 which resulted in a number of meetings with midwifery staff and an increase in the midwifery staffing numbers. The Trust provided a response to the CQC and following this no additional information was requested as a result.

The Board is also aware that in March 2013 the Trust received contact from the Coroner in relation to the cluster of incidents as described above and that at the same time Warrington Clinical Commissioning Group raised concerns in relation to these incidents.

**Assessment and Actions to date:** As a result of the events described above, the Trust have taken a number of steps in a clear attempt to be open, honest and transparent in line with the Trust's values. These actions include:

- A meeting of the supervisors of midwives was held, attended by the Director of Nursing, where the untoward events were discussed. The supervisors of midwives, supported by the Director of Nursing and Consultant Obstetrician took the decision to introduce continuous monitoring in labour whilst further investigation of events is undertaken.
- Multi-disciplinary Team meetings attended by senior midwives and medical staff which led to a number of recommendations for practice as agreed by those present.
- Full investigations into all incidents using the NHS England incident framework based on the level of harm identified.
- In line with recommendations from the external review of one of the incidents described above, the Maternity Service has implemented use of the National Patient Safety Agency (NPSA) Tool for Intrapartum Fetal Death to review the care provided to women.
- Contact has been made on a number of occasions with the NHS England (North) Chief Nurse to inform her of the occurrences.
- Contact has been made with the CQC Compliance Inspectors to bring the cluster of incidents to their attention.
- As part of the external reporting of the Level 2 SUIs, known as StEIS, the main commissioning groups have been contacted which resulted in the speciality Clinical Lead and Head of Midwifery attending the CCG Serious Incident Review Group where they presented the findings of one incident investigation and answered questions relating to subsequent incidents.
- The Director of Nursing and OD has been in contact with the Coroner and has provided him with reports and copies of investigations.
- A letter and reports have been provided to Warrington CCG in response to their concerns.
- Copies of the completed investigations with the families where they have been approved in line with Trust's normal governance processes and the statutory requirement for Duty of Candour.
- A request for an full external review has been submitted to be the Royal College of Obstetricians and Gynaecologists to the following:
    - Undertake a Level 3 investigation into the case which occurred in March 2014. Usually this would be a Level 2, however due to the level 3 investigation we have requested that it would seem sensible to do these concurrently.

- Review all investigations previously undertaken as listed above
- Review the Maternity Service as a whole

The Associate Director of Governance is the key contact and support the external investigation process who with the Director of Nursing will ensure regular updates are provided to all staff throughout the Level 3 investigation process in addition to the Board, Governance Committee and Clinical Governance, Audit and Quality Sub Committee.

The Chief Executive is also writing to all maternity staff. See **Appendix 1**

On Thursday 17th April the Trust received a letter from the Care Quality Commission to a number of questions they have requested. The response deadline is Thursday 1st May, 2014.

Please see **Appendix 2.** The full response to this will be provided to the May Board

**Recommendations to the Board**

3. The Board to receive and comment to the contents within the Briefing paper
4. To further question to seek any further assurance from the Director of Nursing and OD to any areas of further clarification

**Appendix 1 Draft Letter from CEO to Maternity Staff (Trust Headings and logo to be added)**

# Taking our maternity service forward

**Mel Pickup, chief executive to all maternity staff.**

April 25th 2014.

Dear colleagues

I wanted to take time to update all of the team in maternity about the current situation following the events over the last months and to share the next steps that will take place.

I know that it has been a difficult time with the focus on the team but we are committed to moving forward and developing the service.

We also have to ensure that the service provides the very best in safety and high quality care for our women and babies which I know is an aim that we all have.

## Background

I want to offer a clear description of the actions taken and those that are planned in order to address the concerns which we all share.

As you will all be aware, although our overall stillbirth rates are below the national average, there have been an increased number of intrapartum events over the last 12 months which have been investigated or are currently investigating.

As with any case of this nature we use external review to look at these events and any learning that can be put in place.

We have also been in contact with the coroner in relation to this cluster of cases as well as responding to concerns from our commissioners Warrington Clinical Commissioning Group. Other regulators have also been informed such as NHS England, CQC and Monitor as part of our open and honest working.

Following these very sad events I appreciate that there is a real sense of concern and upset within the department. The midwifery and medical teams have put into place a number of actions as a result. I believe additional action is also required and this is explained within this paper.

## Our actions to date

As a result of the events described above, we have taken a number of steps in a clear attempt to be open, honest and transparent in line with the trust's values. These actions have included:

- A meeting of the supervisors of midwives was held, attended by the director of nursing, where the untoward events were discussed. The supervisors of midwives, supported by the director of nursing and consultant obstetrician took the decision to

introduce continuous monitoring in labour whilst further investigation of events is undertaken.

- Multi-disciplinary team meetings attended by senior midwives and medical staff which led to a number of recommendations for practice.
- Full investigations into all incidents using the NHS England incident framework.
- In line with recommendations from the external review of one of the incidents, the maternity service has implemented use of the National Patient Safety Agency (NPSA) Tool for intrapartum fetal death to review the care provided to women.
- As part of the external reporting the main commissioning groups have been contacted which resulted in the speciality clinical lead and head of midwifery attending the CCG Serious Incident Review Group where they presented the findings of one incident investigation and answered questions relating to subsequent incidents.
- We have shared copies of completed investigations with the families once they have been concluded, in line with trust's normal governance processes and the statutory requirement for Duty of Candour.

## Next steps – external review

Following on from these actions, you may be aware that we are in the process of appointing an external team from the Royal College of Obstetricians and Gynaecologists to carry out a review that will:

- Undertake an investigation into the case which occurred in March 2014.
- Review all the investigations previously undertaken as listed above
- Look at our maternity service as a whole and benchmark us against national best practice.

An internal facilitator has been identified to prepare terms of reference and support this external review process. Regular updates will be provided to all staff throughout the process.

I hope that you agree that this review is entirely the right thing to do at this point in time given the cluster of incidents. It will provide us with the evidence and expert view to ensure that our service provides the quality and service that we all strive for.

I hope you will welcome the review as a chance to showcase our services and practice and an opportunity to take stock and see what else we can do.

## Moving forward

The review will provide us with information that we can use to enhance our service and take any learning and recommendations and is an important first step in developing our services.

Our aim is to move forward from this difficult time and work with all of you to take our service forward. We have a fantastic unit, have achieved NHSLA Level 3 and developed some fantastic services and support for our women and we want to build on that.

We recently held the open evening for all staff where we have discussed our aspirations for the future delivery of services and how our current services can be strengthened and improved in the future. It is incredibly important that we continue to look forward in this way.

## Contacting me or speaking to someone about this

If any member of the team wishes to talk to someone about how they feel in relation to the cluster of incidents, review, how we move forward as a team - or indeed anything they may be worried about – I encourage you to do so. We can only move forward if there is complete honesty across the teams.

There are a number of ways that you can do this:

- You can also speak to me in confidence, please make an appointment with my PA Paula Gunner on (ext. 2299) to come and talk through any issues with myself.
- Locally you can of course talk to your ward managers, supervisors of midwives, head of midwifery or clinical lead at any time
- You can Datix (option to report anonymously) report any incidents or issues that caused you concern

Thank you for taking time to read this update. I will keep you updated throughout the process and please do not hesitate to contact me with any questions that you have.

**Mel Pickup**
Chief executive

**Appendix 2 Copy of the letter received from the CQC**

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

**www.cqc.org.uk**

Millie Bradshaw
Associate Director of Governance
Kendrick Wing
Warrington and Halton Hospitals NHS Foundation Trust RWW
Lovely Lane
Warrington
WA5 1QG

Our reference RGP1-1351070979

17 April 2014

Dear Ms Bradshaw

Re: **Warrington Hospital Maternity Unit Incident Report**
**01 April 2013 – 18 March 2014.**

Thank you for providing the commission with the Maternity Incident Report that we received on 10 April 2014.

Having reviewed the information in the report we see that between 01 April 2013 and 18 March 2014 the unit recorded 10 intra-uterine deaths. In light of these events we are requesting additional information in accordance with our powers under Section 64 of the Health and Social care Act 2008.

The information we require is as follows:

- The detailed findings of the investigation into each of the 10 intrauterine deaths.
- The actions taken to support the families following each incident.
- The lessons learnt and steps taken by the trust in relation to preventing a repeat of each type of incident.
- Information about action already taken in relation to the lessons learnt for the unit.
- Information, including timescales about progress on action plans in place to identify any changes in practice to prevent intrauterine deaths.

- The outcome of any audits already completed paying particular attention to the areas identified in the lessons learnt.
- Interim action taken as a result of the initial investigations and pending the planned fuller review of the service.

I should be pleased if you could forward this information by 5pm on Thursday 01 May 2014.

Please do not hesitate to contact me in the interim should you require any clarification of our expectations in this regard.

I look forward to hearing from you.

Yours sincerely

Rob Assall

Inspection Manager

CC

Local Supervising Authority Midwifery Officer-Lisa Bacon
lisabacon@nhs.net
Warrington Clinical Commissioning Group- Lorna Quigley
lorna.quigley@nhs.net
NHS England - Moira Dumma
moiradumma@nhs.net
Monitor-Tania Openshaw
Tania.Openshaw@monitor.gov.uk

W&HHFT/TB/14/065

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Human Resources / Education & Development Key Performance Indicators (KPIs) Report |
| **Date of Meeting** | 30 April 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 | 26 March 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 non-medical staff have increased** | **Pages 2 - 4 / Section 2.1 & 2.2** |
| **No change on revalidation** | **Page 4/Section 2.3** |
| **Sickness absence – slight decrease in month** | **Page 4 /Section 2.4** |
| **Turnover relatively stable and the number of vacancies remain at their highest level so far this year – reflecting the need to make financial savings in the latter part of the year** | **Page 5 / Section 2.5 & 2.6** |
| **Temporary staffing expenditure – overall increase in expenditure of £60k** | **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 April 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 March 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 were increases for Fire and Manual Handling. 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 February 2014):

| Division | Fire Safety | Health & Safety | Manual Handling |
|---|---|---|---|
| Scheduled Care | 72% (75%) (Amber) | 87% (87%) (Green) | 61% (64%) (Red) |
| Unscheduled Care | 76% (75%) (Amber) | 85% (85%) (Green) | 73% (72%) (Amber) |
| Women's & Children's | 76% (73%) (Amber) | 90% (89%) (Green) | 77% (75%) (Amber) |
| Estates | 67% (64%) (Red) | 98% (98%) (Green) | 95% (95%) (Green) |
| Facilities | 69% (63%) (Red) | 81% (81%) (Amber) | 83% (83%) (Amber) |
| Central Operations | 50% (50%) (Red) | 75% (75%) (Amber) | 50% (50%) (Red) |
| Corporate Areas | 81% (80%) (Amber) | 96% (95%) (Green) | 90% (88%) (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 an impressive 99% of staff attended corporate induction during March 2014.

### 2.1.1 Health & Safety (Green)

There has been no change from the previous month and the rate remains at 88% and green. This means that the target for 2013/14 has been achieved.

### 2.1.2 Fire Safety (Amber)

There has been an increase of 2% from the previous month and the rate is 75% and amber. Since April 2013 there has only been an overall net gain of 2% and the target has not been achieved. However, the rate has remained relatively stable and with more focus could be achieved in 2014/15.

A positive development is that the Fire Officer post has now been filled and Dave Wood will actually be 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 an increase of 1% from the previous month and the rate is 75% and amber. The year has finished with the highest rate yet although the target has not been achieved.

### 2.1.3.1 Manual Handling Patient Training Only (Red)

67% of staff completed Patient MH training, which is the same rate from the beginning of the year so no overall progress has been made.

### 2.1.3.2 Manual Handling Non-Patient Training Only (Green)

87% of staff completed Non-Patient MH training, which was a slight increase of 1% from February. The rate has increased steadily since August 2013 and the target has now been achieved for 3 consecutive months.

## 2.2 Staff Appraisals

The target for completed PDRs is 85%.

There has been a marked increase for non-medical staff and a slight reduction for medical staff.

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

| Division | PDR Rate |
|---|---|
| Scheduled Care | 71% (72%) (Amber) |
| Unscheduled Care | 63% (60%) (Red) |
| Women's and Children's | 74% (70%) (Amber) |
| Estates | 62% (43%) (Red) |
| Facilities | 68% (61%) (Red) |
| Central Operations | 0% (25%) (Red) |
| Corporate Areas | 62% (66%) (Red) |

NB Central Operations only has 4 members of staff

There are no areas achieving the target and almost all of the areas are showing 'red' which would suggest a trust wide problem. However, Estates did make significant progress in month with an increase of 19%.

### 2.2.1 Non-Medical Staff (Red)

For the period up to March 2014 the percentage of non-medical staff having had an appraisal increased by 3% and is 69% and the status is red. The target of 85% was therefore not achieved.

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 March 2014 has decreased by 2% to 77%. The rate for Consultants was 85% (a decrease of 2%) and other M&D 61% (a decrease of 2%).

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 has not met again since 18 March 2014, so there is no change from the previous month. 44 doctors have been approved for revalidation by the GMC with 10 doctors deferred, making the rate 81%.

The next Decision Making Group meeting will take place on 6 May 2014.

## 2.4 Sickness Absence

### 2.4.1 Sickness Absence Rates (Amber)

The new sickness absence target for 2013/14 is 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 for March 2014 showed an improvement in month from the previous month to 4.08% and the cumulative position from April – March 2014 was 4.13%. This was almost identical with the previous year of 4.12% and shows a period of stability but still short 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 either through the Short Term Absence or Long Term Absence Sections of the policy, remains at well over 300 staff.

### 2.4.2 Return to Work Interviews (RTW) (Red)

The target for this KPI is 85% and is only reported on a quarterly basis. Q1 was 30%, Q2 was 36%, Q3 was 37% and Q4 was 42%. This shows a steady increase although the rate is still 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.

## 2.5 Turnover Rate (Green)

The target for this KPI is min 7% 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 March 2014 increased to 8.7% and there is a slight upward trend developing. Nonetheless, the status remains as green and the target for the year was achieved.

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

The target for this KPI has been revised to partly take account of the 'Post Reduction' scheme and is min 6.5% or max 10% FE / SIP gap. The Trust FE FTE was 3680 and staff in post 3414 FTE. This means the vacancies FTE has remained the same 7.2% and the status is 'green' and the target has been achieved. 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 4189 which was only a reduction of 1 from the previous month. Nonetheless, there are still an additional 244 staff in post since April 2012 over and above normal turnover rates which is still significant.

**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 March 2014 increased by £60k and was £955k, which represents 7.6% of the pay bill. The cumulative expenditure for April to March was £11.3m, which is 7.52% of the pay bill. Against the agreed threshold for 2013/14 of 4.5% the status, therefore, is 'Red' and was not achieved.

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

**Nurse Bank and Agency Nursing - £401k (£382k for February)**
**Agency (exc Medical & Nursing Agency) - £181k (£159k for February)**
**Medical Locums and Medical Agency - £374k (£354k for February)**

All areas of expenditure increased almost equally with Nurse Bank /Agency increasing by £19k, Agency by £22k and Medical Locums by £20k. Total expenditure for the period April – March 2014 is as follows:

Nurse Bank and Agency Nursing - £4.2m
Agency (exc Medical and Nursing Agency) - £2.1m
Medical Locums and Medical Agency - £5m

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 22 April 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'. Feedback was received from each of the Sub Groups considering each of these issues. Various actions were agreed and will now be taken forward and implemented. This will include establishing rolling adverts for each Division for general nursing posts and recruitment days each month where Matrons/Ward Managers will interview and appoint for their whole Division. The recruitment process will also be reviewed to streamline this further. This work will complement the work undertaken by Ernst and Young on 'Cost Controls' which has a strong emphasis on reducing/controlling temporary staffing expenditure. Specifically, Ernst and Young held a meeting on 15 April 2014 to discuss a number of issues around medical productivity which

should result in a reduction in Medical Locum/Agency expenditure.

The Terms of Reference of the Temporary Staffing Group was also briefly discussed and it is expected that a paper will be brought to the next meeting.

A progress report on 'e' rostering was also received by the Temporary Staffing Group.

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 the details/options are 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)**

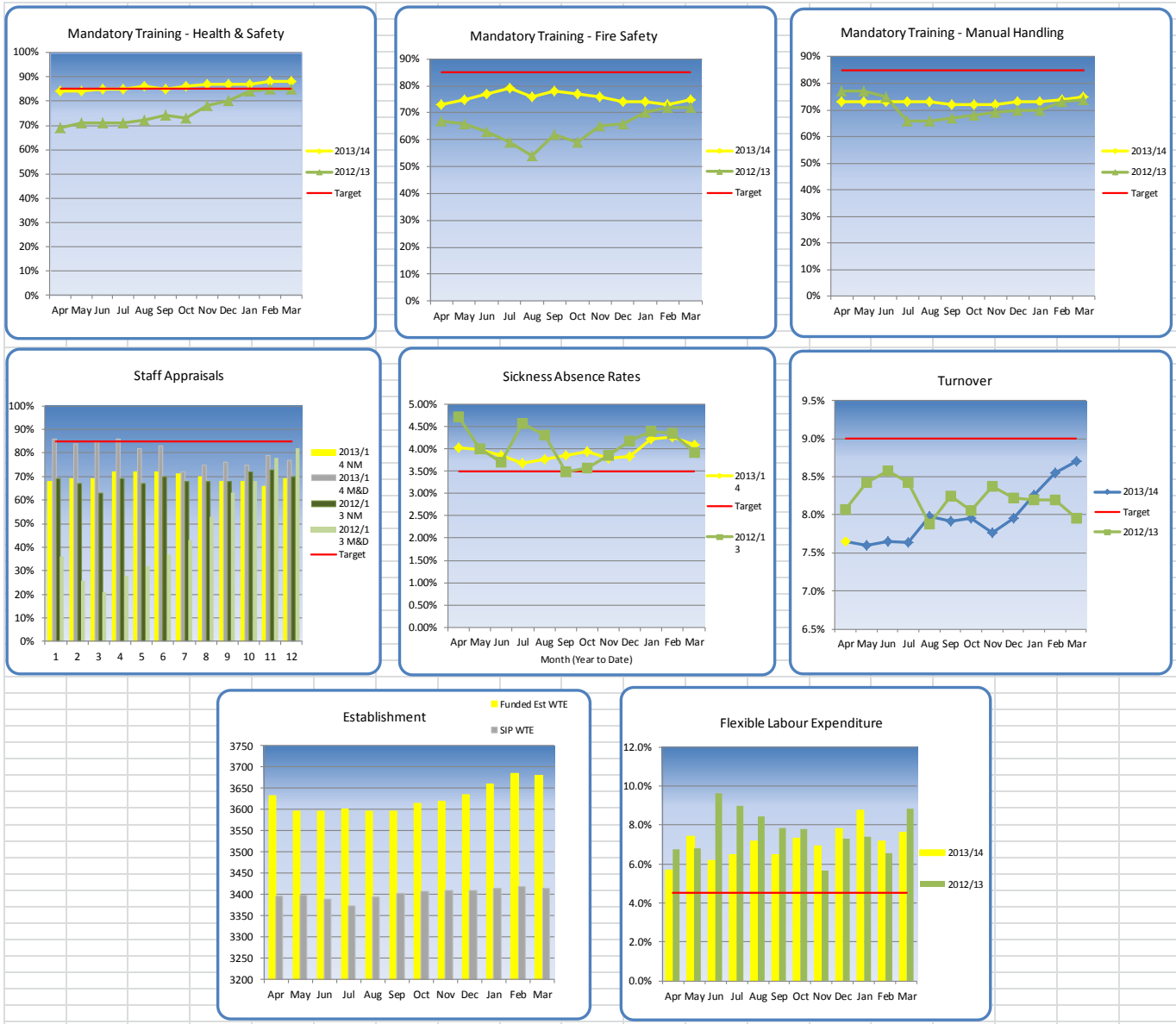
Trust staff do have access to E&D information and resources.

**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%. This was an improvement from the previous position reported at 30 September 2013 when the rate was 43% but is still well short of the target of 85%. The increase in the last 6 months is as a result of the E&D Specialist and the Education and Training Department exploring other means of meeting training needs and providing a number bespoke training sessions in Departments and input on courses for medical staff but it needs to be recognised that only limited resources can be devoted to this issue.

| 2013/14 | | | Target / Threshold | Frequency | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Year to Date | Green | Amber | Red |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Training & Development | Mandatory Training | Heallth & Safety | 85% staff trained in last 3 years | Monthly | 84% | 84% | 85% | 85% | 86% | 85% | 86% | 87% | 87% | 87% | 88% | 88% | **88%** | 85 - 100% | 70 - 84% | < 70% |
| | | Fire Safety | 85% staff trained in last 12 months | Monthly | 73% | 75% | 77% | 79% | 76% | 78% | 77% | 76% | 74% | 74% | 73% | 75% | **75%** | 85 - 100% | 70 - 84% | < 70% |
| | | Manual Handling - Patient | 85% staff trained in last 2 years | Monthly | 67% | 66% | 66% | 66% | 67% | 65% | 64% | 65% | 66% | 66% | 66% | 67% | **67%** | 85 - 100% | 70 - 84% | < 70% |
| | | Manual Handling - Non-Patient | | | 81% | 82% | 82% | 82% | 81% | 81% | 82% | 83% | 84% | 85% | 86% | 87% | **87%** | | | |
| | | Manual Handling - Total | | | 73% | 73% | 73% | 73% | 73% | 72% | 72% | 72% | 73% | 73% | 74% | 75% | **75%** | | | |
| | Staff Appraisals | Non Medical | 85% staff received appraisal in last 12 months | Monthly | 68% | 69% | 69% | 72% | 72% | 72% | 71% | 70% | 68% | 68% | 66% | 69% | **69%** | 85 - 100% | 70 - 84% | < 70% |
| | | Medical & Dental - consultants & career grades, (exc Jnr Drs) | | | 86% | 84% | 85% | 86% | 82% | 83% | 72% | 75% | 76% | 75% | 79% | 77% | **77%** | | | |
| | Revalidation for Medical & Dental Staff | | 85% of eligible M& D Staff revalidated | Monthly | 85% | 85% | 85% | 85% | 81% | 84% | 86% | 88% | 80% | 80% | 81% | 81% | **81%** | | | |
| Sickness Absence | Sickness Absence Rates | | 4% | Monthly | 4.03% | 3.98% | 3.85% | 3.67% | 3.76% | 3.86% | 3.94% | 3.79% | 3.82% | 4.22% | 4.27% | 4.08% | **4.13%** | 3.50% | 3.51 - 4.49 | > 4.50% |
| | Return to work interviews (wef 2013/14) | | 85% | Quarterly | | | 30% | | | 36% | | | 37% | | | 42% | **42%** | 85 - 100% | 70 - 84% | < 70% |
| Workforce | Turnover (Leavers) | | Min 7% or Max 9% | Monthly | 7.7% | 7.6% | 7.7% | 7.6% | 8.0% | 7.9% | 8.0% | 7.8% | 8.0% | 8.3% | 8.6% | 8.7% | **8.7%** | 7 - 9% | 5 - 6.9% / 9.1 - 12% | < 5% / > 12% |
| | Establishment / SIP | Funded WTE (see NB 1 below) | Min 7.5% or Max 10% FE / SIP gap | Monthly | 3632 | 3596 | 3596 | 3600 | 3597 | 3596 | 3615 | 3619 | 3636 | 3659 | 3685 | 3680 | **3680** | 6.5 - 10% | 5 - 6.4% / 10.1 - 12% | < 5% / > 12% |
| | | Staff in Post WTE (see NB 1 below) | | | 3396 | 3399 | 3390 | 3372 | 3395 | 3403 | 3408 | 3410 | 3409 | 3415 | 3419 | 3414 | **3414** | | | |
| | | Staff in Post Headcount (see NB 2 below) | | | 4136 | 4150 | 4135 | 4157 | 4155 | 4164 | 4187 | 4189 | 4195 | 4201 | 4190 | 4189 | **4189** | | | |
| | | Vacancies WTE ( see NB 1 below) | | | 236 | 197 | 206 | 228 | 202 | 193 | 207 | 209 | 227 | 244 | 266 | 266 | **266** | | | |
| | | Vacancies % | | | 6.5% | 5.5% | 5.7% | 6.3% | 5.6% | 5.4% | 5.7% | 5.8% | 6.2% | 6.6% | 7.2% | 7.2% | **7.2%** | | | |
| | Flexible Labour Expenditure (% of total paybill) | Bank / Agency / Medical Locums Total | 4.5% | Monthly | 5.7% | 7.4% | 6.2% | 6.5% | 7.2% | 6.5% | 7.3% | 7.0% | 7.8% | 8.8% | 7.2% | 7.6% | **7.5%** | 4.5% | 4.6 - 5.0% | > 5.0% |
| | Equality & Diversity | E&D Specialist in place | Achieved | 6-monthly | | | | | | Achieved | | | | | | Achieved | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Workforce Equality Analysis report published | Achieved | Annual | | | | | | | | | | | | Achieved | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Equality Duty Assurance report published | Achieved | Annual | | | | | | | | | | | | Achieved | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Equality Objectives published | Achieved | Annual | | | | | | | | | | | | Achieved | **Achieved** | Achieved | Work in progress | No progress |
| | | Annual Equality Strategy published | Achieved | Annual | | | | | | | | | | | | Achieved | **Achieved** | Achieved | Work in progress | No progress |
| | | Staff have access to E&D information and resources | Achieved | 6-monthly | | | | | | Achieved | | | | | | Achieved | **Achieved** | Achieved | Work in progress | No progress |
| | | Staff have undertaken E&D training | 85% staff trained | 6-monthly | | | | | | 43% | | | | | | 56% | **56%** | 85 - 100% | 70 - 84% | < 70% |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NB 1 Figures from Finance Ledger | | | | | **R** | **Red** | | **A** | **Amber** | | **G** | **Green** | | | | | | | | |
| NB 2 Figures from HR ESR | | | | | | | | | | | | | | | | | | | | |


Mandatory Training - Health & Safety
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2012/13
Target
Mandatory Training - Fire Safety
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2012/13
Target
Mandatory Training - Manual Handling
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2012/13
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
2013/14 NM
2013/14 M&D
2012/13 NM
2012/13 M&D
Target
Sickness Absence Rates
5.00%
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)
2013/14
Target
2012/13
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
2013/14
Target
2012/13
Establishment
Funded Est WTE
SIP WTE
3750
3700
3650
3600
3550
3500
3450
3400
3350
3300
3250
3200
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Flexible Labour Expenditure
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2012/13

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/064(ii)**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Workforce Transformation Project – Trust Board Update |
| **Date of Meeting** | 30th April 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 - This review is almost ready to commence, the scope of the review is being clarified and key elements of the review are being refined | **2. I** |
| • | Medical Productivity - A baseline audit of existing job plans has been undertaken and is currently being analysed | **2. II** |
| • | Additional Staffing Spend - Finance colleagues have provided a detailed breakdown of additional staffing spend by Division and Directorate, for the financial year 2013/2014 | **2. III** |
| • | Workforce Planning - Workshops are to be set up to allow detailed discussions with each Division about different approaches to developing a sustainable workforce for the future | **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 May Trust Board meeting

**Workforce Transformation Project**

**Trust Board Update**

**April 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

This review is almost ready to commence, the scope of the review is being clarified and key elements of the review are being refined. There have been some initial communications challenges around this work stream, but these have been ironed out in the Trust news bulletin – The Week 9th April 2014. Additional clinical engagement for this review will need to be undertaken, to establish the core areas of agreement. The outcome of the review must be an improved interface for patients with the organisation.

### II. Medical Productivity

The Medical Productivity Working Group met for the first time on 15th April 2014. There was strong representation from the Divisional Medical Directors. Several approaches to ensuring fair and equitable job plans for all Consultant colleagues were discussed. A baseline audit of existing job plans has been undertaken and is currently being analysed. At the meeting, it was agreed that this work stream would form an integral part of the Divisional Medical Directors meeting, as it was an integral part of their objectives for financial year 2014/2015.

### III. Additional Staffing Spend

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.

### 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. This has been discussed with Wendy Johnson on 16th April 2014 and these workshops will be set up with immediate effect. The aim of these workshops is to allow detailed discussions with each Division about different approaches to develop a sustainable workforce for the future and to highlight approaches made by other organisations to address recruitment difficulties. This will include a review of Advanced Practitioner roles and how they may benefit the organisation

In addition, early discussions with Divisional leads have identified the pressing need to undertake a review of the current workforce inputs and outputs. This will include an analysis of the organisation age profile and review average ages of retirement across the workforce. The review will also help us to understand turnover in certain roles and to review all "hard to fill" posts in the organisation. Discussions are due to start with colleagues in the Communications Team to explore revised approaches to recruitment using Social Media.

## 3. Summary and Recommendations

The above update report provides a summary of the initial actions undertaken as part of this project. In summary, this has involved engagement with the key stakeholders internally and a detailed analysis of current trends across the core areas of this project. This will help to establish a baseline, from which we can drive forward and progress with the project over the coming weeks and months.

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

**Roger Wilson**
**Interim Lead for Workforce Transformation**
**18th April 2014**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/066**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Annual Equality & Diversity and NHS Equality Delivery System 2 report (EDS2) |
| **Date of Meeting** | April 2014 |
| **Director Responsible** | Chief Executive |
| **Author(s)** | Joe O'Grady |
| **Purpose** | To advise the Board on equality and diversity progress and performance for year 2013 to 2014 |

| **Paper to be presented** (state Board and/or Committee and dates) | **Committee** | **Date** |
|---|---|---|
| | E&D Sub-Committee | 01/05/2014 |

| **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 |
|---|---|---|
| • | The report provides an overview of the Trust's statutory obligations to meet its public sector equality duty under the Equality Act (2010) | **Page 1** |
| | A progress report on all equality objectives and outcome evidence is outlined | **Pages 2-7** |
| | The grading results of the NHS EDS2 equality performance are provided | **Pages 8-11** |

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

1. The Board is asked to note the positive outcomes against all the equality objectives and be reassured of the continuing progress on equality performance, as measured under the improved EDS2 grades for 2013-2014.

# Annual Equality Report 2013-2014


## Summary

The Trust has met all its statutory obligation requirements under the Equality Act (2010) in the year 2013-2014. The Trust has also demonstrated significant progress with regard to its second annual equality performance under the NHS Equality Delivery System 2.


## Background

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities are adherent to the following obligations to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general duty is underpinned by a set of actions and assurances termed the ***specific duties***. These serve as guidance on how the general duty can be met, through a range of actions and the provision of evidence in varied formats. The specific duties are to:

- Publish Information outlining how they will comply with the general duty by 31/1/2012 (Annually thereafter).
- Publish details on their workforce breakdown and the local population by various equality denominations e.g. age, race etc., by 31/1/2012 (Annually thereafter).
- Undertake a revised equality screening process to replace equality impact assessments called an *Equality Analysis*, in functions, services and policies.
- Formulate one objective for each protected characteristic, by 5th of April 2012.
- Publish an equality strategy by 5th April 2013.
- All information published on how they will meet the equality duty must be presented in such a manner that it is accessible to the public.

The equality report consists of an annual progress report on the objectives of the Equality Strategy for 2013-2017 and the results of its second annual equality performance assessment under the NHS England Equality Delivery System 2.

## Equality Strategy Annual progress report 2013-2014

| Equality Objective & Outcomes: | Actions to be undertaken | Progress: | BRAG status |
|---|---|---|---|
| 1)<br><br>**Objective**:<br>Promote positive relations between people who share a protected characteristic and people who do not.<br><br>**Outcome:**<br>To demonstrate commitment to the general duty of the public sector equality duty of the Equality Act (2010). | Utilise training, communication and engagement approaches to promote the Trust's corporate values and commitment to inclusion, dignity, respect and human rights<br><br>Educate workforce as to benefit and detriment of promoting the Trust Values and its responsibility as a statutory public authority | A range of approaches has been employed in 2013-2014, in order to promote understanding and raise awareness of the statutory obligations to which the Trust and its employees are bound:<br><br>Briefings to the Equality and Diversity Sub-Committee (EDSC) and Strategic People Committee<br>Communiques through e.g. 'The Week'<br>Staff Engagement & Wellbeing event<br>Carers Strategy – Single Point learning programme<br>Promotional events e.g. – Warrington Pride, Older People's Network, Disability Awareness Day, World AIDS Day<br>A Community engagement programme with 3rd sector organisations from across the protected characteristics<br><br>Equality and Diversity training is embedded in Corporate Induction<br>Online learning modules options for Equality and Diversity training are available<br>New bespoke face-to-face E&D session within the mandatory training day for Consultants<br>Paper learning model developed and rolled out across the Trust in Quarter 4, 2014<br>. | **G** |

| Equality Objective & Outcomes: | Actions to be undertaken | Progress: | BRAG status |
|---|---|---|---|
| 2)<br><br>**Objective**:<br>Develop data collection and equality profile reports for staff to cover all protected characteristics and publicise findings<br><br>**Outcome:**<br>To publish transparently the equality profile of our workforce and how we manage employment issues in a non-discriminatory manner. | Encourage staff to update personal details on ESR equality monitoring fields via promotional and engagement events<br>Educate workforce as to benefit and detriment of undertaking equality monitoring<br><br>Formulate and publish a workforce equality analysis report for year 2013, including workforce dynamics and formal procedures | Increased 'known' status was evidenced across most of the protected characteristic fields. 'Known' status under Ethnicity was almost 100%. However, there were only minimal increases with regard to 'known' status in *Sexual orientation, Disability* and *Religion or Belief* status data capture. This is in line with evidence in many other NHS Trusts and represents an area for increased input in 2014-2015.<br>Equality monitoring is raised in E&D training, the EDSC and Disability Equality Group and in staff and wellbeing engagement events.<br><br>The Workforce Annual Equality Analysis report for calendar year ending 2013 (WEAR), was published on 30/01/2014, in order to meet public sector specific duty requirements, under the general duty of the Equality Act 2010. The WEAR 2013 was more comprehensive than its predecessor and provided more detailed and robust assurance across the range of the protected characteristics in areas such as recruitment and selection, leavers and starters and in the formal procedures section, where equality data demonstrated that no discrimination was observed in 2013-2014. The WEAR has been presented at the Equality and Diversity Sub-Committee and Strategic People Committee.<br>. | **G** |

| Equality Objective & Outcomes: | Actions to be undertaken | Progress: | BRAG status |
|---|---|---|---|
| 3)<br><br>**Objective:**<br>In conjunction with the local community organisations that support people across the protected characteristics, undertake engagement and involvement activities, to facilitate stakeholder inclusion in the review, monitoring and planning of services, functions and policies<br><br>**Outcome:**<br>To enable the Trust to engage with members of the community in order to consult on equality and diversity transparently and effectively. | Liaise with Local community groups, FT Governors, Health Watch and employees representing the protected characteristics and establish partnership working to co-facilitate engagement and inclusion options<br><br>Ensure external and internal stakeholders are involved in all phases leading to the assessment of equality performance under the Equality Delivery System (EDS) 2013-2014 grading.<br><br>Recruit internal and external stakeholders to participate in Patient Experience, Equality and Diversity and wellbeing functions, work streams and events. | A number of engagement activities were undertaken with 3rd sector organisations and in partnership with statutory partner agencies across the public sector both locally and regionally. These included events such as Disability awareness Day, Cheshire Deaf Forum, World AIDS Day and Warrington Pride. The Trust place more emphasis on engaging with Carer centres in Halton and Runcorn and Warrington, to support its Carers Strategy and action plan.<br><br>Following preparatory meetings and promotion, Health Watch Halton & Runcorn, Warrington Health Watch and local 3rd sector organisations participated in the grading phases of the EDS2 in March 2014 undertaking the role of Assessor on equality performance through 2013-2014.<br><br>Following the community engagement programme and promotional activities, there has been an increase in membership in both internal and external membership in the equality groups and as a consequence, the related work streams. This has been very significant in the Disability Equality Group, which although only formed in May 2013, has become an established function that can provide guidance and assurance in addressing inequalities faced by disabled patients, carers and staff. | **G** |

| Equality Objective & Outcomes: | Actions to be undertaken | Progress: | BRAG status |
|---|---|---|---|
| 3)<br><br>**Objective:**<br>In conjunction with the local community organisations that support people across the protected characteristics, undertake engagement and involvement activities, to facilitate stakeholder inclusion in the review, monitoring and planning of services, functions and policies | Involve stakeholders in awareness-raising, patient stories and staff training programmes | There have been a number of presentations and Patient Stories delivered to the Equality and Diversity Sub-committee and Disability Equality Group from Patients and 3rd sector organisations across the Protected Characteristics. These have helped to raise staff awareness and provide insight and guidance on how to bring about improvements to services and patient care. Presentations and Patient Stories are now standing items at equality groups | **G** |

| Equality Objective & Outcomes: | Actions to be undertaken | Progress: | BRAG status |
|---|---|---|---|
| 4)<br><br>**Objective:**<br>Progress the equality governance framework to provide assurance mechanisms for demonstrating equality duty adherence and embedding equality and human rights within mainstream functions.<br><br>**Outcome:**<br>To enable the Trust to demonstrate how it is endeavouring to pay due regard to the single equality duty and the mechanisms it has in place to provide effective equality governance in services, workforce and functions. | Support and develop internal committees and review membership whilst increasing membership across the protected groups of both internal and external stakeholders.<br><br>Ensure decisions, reports and recommendations from equality committees and sub groups fall in line with predetermined reporting mechanisms to the Board of Directors and other key committees.<br><br>Ensure the Board, Governors and senior leads are supported and updated with statutory obligations and requirements with regard to equality and human rights.<br><br>Form a new disability equality sub group to support the equality programme of the Equality & Diversity Sub-Committee and to advise on employment and Patient accessibility domains. | Following the community engagement programme and promotional activities, there has been an increase in membership in both internal and external membership in the EDSC and DEG.<br><br>All reports, publications and recommendations have been delivered to the Board and other key committees. Bespoke presentations have been delivered to the Strategic People Committee, to whom the EDSC reports. All specific duty defined time scales have been met with regard to publications by the Trust in 2013-2014.<br><br>All equality and PSED specific duties and the actions the Trust has undertaken to meet equality duty and address the potential for risk and adverse impact have been undertaken. NHS Equality Delivery System 2 outcome 4.2 which addresses this area has been rated as *Achieving* for 2013-2014, in March 2014.<br><br>The DEG was formed in May 2013. It has set out its terms of reference and comprises of a growing. representative corpus from local disability groups, internal stakeholders and key Trust personnel. | **G** |

| Equality Objective & Outcomes: | Actions to be undertaken | Progress: | BRAG status |
|---|---|---|---|
| 5)<br><br>**Objective:**<br>Services, information and resources can be accessed by all Patients and this is in evidence, across all the protected characteristics<br><br>**Outcome:**<br>To enable the Trust to demonstrate that it provides accessible services, information and resources to support the people who use its services. | Work with departments and divisions to improve data collection of patients across the range of the protected groups.<br>Provide bespoke equality analysis reports to Patient Experience and Equality and Diversity Sub-Committee (EDSC), identifying accessibility trends disaggregated across the protected characteristics.<br><br>Monitor all arrangements for interpretation and translation, involving patient experience and assessment of these services<br><br>Work within Patient experience frame work to integrate the diverse Patient's story within relevant learning and best practice arenas. | There is evidence of good Quality of data capture across the protected characteristics observed in equality monitoring mechanisms. The most accurate areas are in Inpatient Care, Maternity and unscheduled care. There are some reductions in accuracy observed with regard to Outpatients.<br>Quarterly reports are presented to the EDSC with analysis on protected groups. An inaugural annual DNA analysis report was presented to the EDSC in October 2013.<br><br>*A*n annual review of interpretation and translation is undertaken to advise the EDSC on the quality of provider support. This will be presented in May 2014. Quarterly Interpretation and translation analysis is presented to the EDSC as a standing item.<br><br>The E&D Specialist and Patient Experience Matron work on Patient Story via the PEG and EDSC. Patient stories have been incorporated into E&D training. | **G** |

## Equality Delivery System 2 (EDS2) performance results 2013-2014 **

| EDS2 Goal 1 Status – | Achieving | | | |
|---|---|---|---|---|
| EDS2 Outcome and Domain: | Undeveloped | Developing | Achieving | Excelling |
| **Health needs:** | | | | |
| 1.1 "Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities" | | | A | |
| 1.2 "Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways" | | D | | |
| 1.3 "Changes across services for individual patients are discussed with them, and transitions are made smoothly" | | D | | |
| 1.4 "The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all" | | | A | |
| 1.5 "Public health, vaccination and screening programmes reach and benefit all local communities and groups" | | | A | |

| EDS2 Goal 2 Status - | Achieving | | | |
|---|---|---|---|---|
| EDS2 Outcome and Domain: | Undeveloped | Developing | Achieving | Excelling |
| **Patient Experience:** | | | | |
| 2.1 “Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds” | | | A | |
| 2.2 “Patients are informed and supported to be as involved as they wish to be in their diagnosis and decisions about their care, and to exercise choice about treatments and places of treatment” | | D | | |
| 2.3 “Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised” | | | A | |
| 2.4 “Patients‟ and carers‟ complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently” | | | A | |

| EDS2 Goal 3 Status - | Achieving | | | |
|---|---|---|---|---|
| **EDS2 Outcome and Domain:** | **Undeveloped** | **Developing** | **Achieving** | **Excelling** |
| **Workforce:** | | | | |
| **3.1 "Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades"** | | | **A** | |
| **3.2 "Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay"** | | | **A** | |
| **3.3 "Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately"** | | | **A** | |
| **3.4 "Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all"** | | | **A** | |
| **3.5 "Flexible working options are made available to all staff, consistent with the needs of the service, and the way people lead their lives"** | | | **A** | |
| **3.6 "Staff Report positive experiences of their membership of the workforce"** | | | **A** | |

| EDS2 Goal 4 Status - | Developing | | | |
|---|---|---|---|---|
| EDS2 Outcome and Domain: | Undeveloped | Developing | Achieving | Excelling |
| **Leadership:** | | | | |
| 4.1 "Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond" | | D | | |
| 4.2 "Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed" | | | A | |
| 4.3 "Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination" | | D | | |
| | | | | |

** The EDS2 assessment was undertaken by external assessors via Halton Health Watch and Warrington Health Watch and an internal stakeholder panel of Governors and Staff.

**W&HHFT/TB/14/067(i)**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Finance Report as at 31st March 2014 |
| **Date of Meeting** | 30th April 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 31st March 2014

## 1. Purpose

The purpose of the report is to advise the Board of Directors on the financial position of the Trust as at 31st March 2014.

## 2. Executive Summary

Annual performance against key financial targets is provided in the table below further supplemented by the dashboards at **Appendix A** and **Appendices B to O** attached to this report.

### Key financial indicators

| Indicator | Plan £m | Actual £m | Variance £m |
|---|---|---|---|
| Operating income | 208.9 | 212.7 | 3.8 |
| Operating expenses | (196.8) | (205.0) | (8.1) |
| EBITDA | 12.1 | 7.7 | (4.3) |
| EBITDA % | 5.4% | 3.3% | (2.1%) |
| Non-operating income and expenses | (10.9) | (10.6) | 0.3 |
| I&E surplus / (deficit) | 1.2 | (2.8) | (4.0) |
| Surplus Margin % | 0.8% | (2.2%) | (3.0%) |
| Cash balance | 14.0 | 13.0 | (1.0) |
| CIP target | 11.0 | 8.9 | (2.1) |
| Financial Risk Rating | 3 | 2 | (1) |
| Continuity of Services Risk Rating | 4 | 3 | (1) |

## 3. Overview (Appendices B to E)

The operating financial performance in March improved due to an increase in NHS activity income and other operating income, partially offset by higher levels of pay and non pay spend. This resulted in an operating surplus of £1,390k, however after the application of non-operating income and expenditure the overall deficit for the month was £179k. The main reason for the high level of non-operating income and expenditure is due to the inclusion of £697k for asset impairments.

The year-end position is a deficit of £2,849k which is £4,001k worse than the planned surplus of £1,152k.

These results mean that the Trust achieved a Financial Risk rating of 2 against a planned rating of 3 but a Continuity of Services rating of 3 against a planned rating of 4. Members are aware that the continuity of services risk rating moved from a shadow measure to an actual target with effect from 1st October 2013.

The month 11 forecast deficit was £2,935k so the final year end deficit of £2,848k represents a reduction of £87k but it should be noted that the final deficit includes £697k of impairment costs for assets that are no longer in use. The reduction excluding the impairment funding therefore equates to £784k which is mainly due to increased levels of income secured as a result of year end settlements and increased activity in March. A further analysis is included at Appendix B2.

**Operating Income**

Operating income is £1,462k (8.2%) above plan in month and £3,842k (1.8%) above plan for the year.

| Income by category | March Variance £000 | March % | Cumulative Variance £000 | Cumulative % |
|---|---|---|---|---|
| NHS Clinical Income | 1,269 | 7.8 | 2,977 | 1.6 |
| Non NHS Clinical Income | (49) | (28.6) | (558) | (27.6) |
| Other Income | 243 | 18.4 | 1,424 | 8.5 |
| **Total** | **1,462** | **8.2** | **3,842** | **1.8** |

*Positive = over recovery against plan, negative = under recovery against plan.*

The analysis by Point of Delivery is detailed in **Appendix C** and the analysis by Specialty is detailed in **Appendix D** but the summary activity and financial performance is summarized below.

**Elective activity (excluding excess bed days)**

Elective activity is £54k (1.5%) above plan in month but £1,165k (2.8%) below plan for the year.

| Variance | March Actual | March % | Cumulative Actual | Cumulative % |
|---|---|---|---|---|
| Activity | (107) | (3.1) | (518) | (1.3) |
| Income (£000) | 54 | 1.5 | (1,165) | (2.8) |

An analysis of spells completed between April and March last financial year (37,592 spells) and April and March this financial year (37,964 spells) shows that elective activity has increased by 372 (1.0%) spells, with elective inpatients 452 (6.8%) spells less but day case 824 (2.7%) spells more than last year.

An analysis of the waiting list activity shows that it has reduced by 482 (9.7%) cases from 5,000 cases as at 31st March 2013 to 4,518 cases as at 31st March 2014.

Further analysis by specialty is attached at **Appendix E.**

**Non Elective activity (excluding excess bed days)**

Non elective activity is £33k (0.7%) below plan in month and £1,322k (2.2%) below plan for the year.

| Variance | March Actual | March % | Cumulative Actual | Cumulative % |
|---|---|---|---|---|
| Activity | (94) | (2.6) | (3,034) | (6.9%) |
| Income (£000) | (33) | (0.7) | (1,322) | (2.2) |

An analysis of spells completed between April and March last financial year (43,909 spells) and April and March this financial year (40,944 spells) shows that non elective activity has reduced by 2965 (6.8%) spells, with the main decreases in General Surgery, Accident & Emergency, General Medicine, Paediatrics, Obstetrics and Midwifery, and Gynaecology, partially offset by additional activity in Urology.

**Outpatients**

Outpatient activity is £121k (4.4%) above plan in month and £382k (1.2%) above plan for the year.

| Variance | March Actual | March % | Cumulative Actual | Cumulative % |
|---|---|---|---|---|
| Activity | 1,138 | 4.1 | 6,863 | 2.1 |
| Income (£000) | 121 | 4.4 | 382 | 1.2 |

The growth in Outpatient Activity is predominantly due to the recording and capture of Consultant to Consultant referrals related to inpatients being seen as an outpatient in a different specialty for a specialist opinion.

**Accident & Emergency**

Accident & Emergency activity is £32k (3.7%) above plan in month but £111k (1.1%) below plan for the year.

| Variance | March Actual | March % | Cumulative Actual | Cumulative % |
|---|---|---|---|---|
| Activity | 387 | 4.4 | (1,199) | (1.2) |
| Income (£000) | 32 | 3.7 | (111) | (1.1) |

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**Others**

Others contain a range of services that are contracted either on a block or cost per case basis. Income is £1,289k (36.3%) above plan in month and £6,678k (16.4%) above plan year to date mainly due to the additional income secured through final settlements with commissioners, together with over recovery on pathology direct access, radiology direct access, radiology unbundled, neo natal critical care, adult critical care, palliative care unbundled, excluded drugs, ultrasound scans (Bridgewater), spinal AQP and breast screening age extension monies as shown in the table below:

| Service | March Variance £000 | March % | Cumulative Variance £000 | Cumulative % |
|---|---|---|---|---|
| Pathology Direct Access | 62 | 15.7% | 454 | 9.9% |
| Radiology Direct Access | (2) | (1.9%) | 31 | 3.0% |
| Radiology (Unbundled) | 17 | 4.8% | 476 | 11.1% |
| Neo Natal Critical Care | (115) | (64.4%) | (165) | (7.7%) |
| Adult Critical Care | (234) | (36.8%) | (328) | (4.3%) |
| Chemotherapy (Unbundled) | (5) | (50.2%) | 60 | 48.0% |
| Palliative Care (Unbundled) | (5) | (9.1%) | 261 | 42.0% |
| Excluded Drugs | 19 | 4.3% | 1,343 | 28.0% |
| Ultrasound Scans ( note 1) | 55 | n/a | 231 | n/a |
| Spinal AQP (note 1) | 21 | n/a | 323 | n/a |
| Breast Screening (note 1) | 14 | n/a | 164 | n/a |

*Positive = over recovery against plan, negative = under recovery against plan.*

Note 1 – these services have no planned income budgeted therefore the percentage variance is not applicable.

Other income also includes £160k Winter Monies from Halton CCG (locally resourced) and £940k transitional relief from Warrington CCG (funded from the nationally resourced £1.4m Winter Monies allocated to the CCG).

**Clinical Commissioning Group Position**

The overall income performance for the period April to March across CCG's is as follows:

| CCG | Planned Contract Income £m | Actual Contract Income £m | Over / (Under) Performance £m |
|---|---|---|---|
| Warrington | 105.8 | 106.9 | 1.1 |
| Halton | 43.7 | 46.4 | 2.7 |
| St Helens | 11.8 | 10.0 | (1.8) |
| Others | 28.9 | 29.9 | 1.0 |
| **Total** | **190.2** | **193.2** | **3.0** |

Year-end settlements were agreed with Warrington, Halton and St Helens CCGs together with a number of other commissioners, with the overall position resulting in a £3.0m over recovery against the income target.

**Non Mandatory / Non Protected Income**

Private Patients and the Compensation Recovery Unit income is £49k (28.6%) below plan in month and £558k (27.6%) below plan for the year. The under recovery against the other non-protected budget is £490k to date, which is based purely on the information provided by the Compensation Recovery Unit. The level of income received for the year is £1,307k which is a significant reduction when compared to the £1,669k received for last financial year.

**Other Operating Income**

Other operating income is £243k (18.4%) above plan in month and £1,424k (1.8%) above plan for the year, mainly due to additional training and education monies and a range of services provided to other organisations, which partly offset a pay overspend. The final training and education contract values have now been published by Health Education England which have generated additional income of £636k more than planned.

**Expenditure**

Operating expenses are £713k (4.4%) above plan in month and £6,399k (3.5%) above plan for the year.

| Expenditure Category | March Variance £000 | March % | Cumulative Variance £000 | Cumulative % |
|---|---|---|---|---|
| Pay | (799) | (6.8%) | (5,988) | (4.2%) |
| Drugs | (33) | (3.5%) | (792) | (6.8%) |
| Clinical Supplies | (122) | (8.1%) | (762) | (4.2%) |
| Non Clinical Supplies | (783) | (40.5%) | (593) | (2.6%) |
| **Total** | **(1,737)** | **(10.7%)** | **(8,135)** | **(4.1%)** |

*Positive = under spend against plan, negative = over spend against plan.*

A summary of budgetary performance for both the clinical and non clinical divisions is attached at **Appendix F** and divisional dashboards for each clinical division covering budgetary position, clinical income, cost savings, referrals rates and variance analysis are attached at **Appendices G to I**.

The main areas of overspend against budget for the year are Scheduled Care (£2,914k), Unscheduled Care (£3,561k), Women's, Children and Support Services (£895k), Facilities (£134k) and Estates (£61k).

**Pay Costs**

In month pay costs are £12,578k which is £101k higher than February pay costs and £95k higher than the average for the period April to February. Pay costs are £799k (6.8%) above plan in month and £5,988k (4.2%) above plan year to date. An analysis of budgeted and actual pay costs for the last two years is in the table below:

| **Narrative** | **Budget £000** | **Actual £000** | **Variance £000** |
|---|---|---|---|
| April to March 12/13 | 140,282 | 146,003 | (5,721) |
| April to March 13/14 | 143,908 | 149,896 | (5,988) |
| **Increase / (Decrease)** | **3,626** | **(3,893)** | **(267)** |

The pay overspend to date is 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 total cost for these three areas amounts to £16,188k year to date, equivalent to circa £16.1m per annum.

The level of pay expenditure continues to significantly exceed budgets and action is underway in the divisions to ensure that expenditure is reduced especially as pay is a key feature of next year's cost savings target.

**Drugs Costs**

Drugs are £33k (3.5%) above plan in month and £792k (4.2%) above plan for the year, however the overspend relates to excluded PbR drugs which are £1,343k above plan and the additional costs are funded by commissioners, with the additional income shown against other income within NHS Activity income.

**Clinical Supplies and Services Costs**

Clinical supplies are £122k (8.1%) above plan in month and £762k (4.2%) above plan for the year, in part linked to the level of orthopaedic activity undertaken to date.

**Non Clinical Supplies**

Non clinical supplies are £783k (40.5%) above plan in month and £593k (2.6%) above plan for the year. The increase in month is mainly due to the work undertaken by Ernest & Young, the cost of a bespoke discharge service provided by North West Ambulance NHS Trust and an increase in the cost of the annual leave accrual for leave not taken as at 31st March 2014.

**Non Operating Income and Expenses**

Non Operating income and expenses are £601k (62.1%) above plan in month but £292k (2.7%) below plan year to date, mainly due to depreciation which is £521k (8.2%) below plan year to date as capital expenditure is currently less than plan and restructuring costs as no costs have been incurred. This underspend is partially offset by overspends on PDC dividends (£128k) and impairment costs (£697k).

## 4. Bank and Agency Nursing (Appendix J)

The information received from NHS Professionals indicates that there has been marginal change in the number of shifts requested and filled over the course of the year (see **Appendix J** for details). Expenditure on bank and agency nursing is £400k in month and £4,144k year to date. It is crucial that this expenditure in this area continues to decrease as a reduction in temporary staffing is a feature of next year's cost savings target and actions are in place within the divisions to place greater control over this critical area.

## 5. Cost Improvement Programme

The Trust had an annual savings target of £11.0m and by the year end schemes had been identified to achieve this target, which are included in the table below.

| **Narrative** | **Recurrent £m** | **13/14 £m** |
|---|---|---|
| Annual Target | 11.0 | 11.0 |
| Planned value of schemes identified | 11.2 | 9.7 |
| Actual value of schemes identified | 11.2 | 8.9 |
| **Over / (Under) Achievement against target (range)** | **0.2** | **(2.1)** |

For the period to date the planned savings for the identified schemes equate to £9,724k, with actual savings amounting to £8,902k which results in an under achievement of £822k (8.5%).

A verbal update from the Innovation and Cost Improvement Committee will be provided.

## 6. Financial Risk Ratings (Appendix K)

The financial metrics and the overall financial risk rating for the period are provided at **Appendix K**. The planned rating for the period is 3 but the actual rating is 2.

In accordance with Monitor's new Risk Assessment Framework published on 27th August, Financial Risk Ratings have been replaced by the Continuity of Services Risk Rating with effect from 1st October 2013.

## 7. Continuity of Services Shadow Risk Rating (Appendix L)

The financial metrics and the overall continuity of services shadow risk rating for the period are provided at **Appendix L**. The planned rating for the period is 4 but the actual rating is 3.

## 8. Statement of Financial Position (Appendix M)

### Non-Current Assets £133.9m

Non current assets have increased in the month by £3.1m due to the impact of the District Valuer revaluation exercise and capital spend.

### Current Assets £23.8m

Current assets have increased by £1.3m in the month mainly due to increases in receivables and cash, partially offset by a decrease in accrued income and prepayments.

### Current Liabilities £20.7m

Current liabilities have increased by £1.2m in the month mainly due to increases in payables and accruals, partially offset by a decrease in the PDC Dividend creditor which was paid in March.

### Non Current Liabilities £1.5m

Non current liabilities have increased by £0.1m in the month.

## 9. Cash Flow (Appendix N)

The cash balance is £13.0m which is £1.0m below the planned cash balance of £14.0m, with the monthly movement of £1.2m summarised in the table below.

| **Cash balance movement** | **£m** |
|---|---|
| Opening balance as at 1st March | 11.7 |
| Cash related EBITDA | 1.5 |
| Increase in receivables | (1.0) |
| Increase in payables | 2.3 |
| PDC Received | 0.3 |
| PDC Dividends | (2.0) |
| Other working capital movements | 0.2 |
| **Closing balance as at 31st March** | **13.0** |

The cash balance of £13.0m equates to 23 days operational cash. Under the continuity of services risk rating the liquidity metric is 0.6 days which scores at a 4, which reflects a reasonably strong liquidity position but the metric includes all current assets and liabilities excluding inventories, so masks the deteriorating 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 48% in the month and 65% for the year. 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.**

## 10. Capital

The actual spend for the year to date is £5.9m which is £2.7m below planned spend of £8.6m for the year, mainly due to delays in the commencement of various schemes. The under spend against the planned capital spend will be carried forward to next financial year.

## 11. Aged Debt (Appendix O)

The aged debt position in month has increased by £0.8m, bringing the total outstanding debt to £4.2m, although payments of £0.5m were received in early April. The increase in debt is primarily in the current debt rather than overdue debt category

The table at **Appendix O** shows that as at 31st March debt over 90 days has decreased by £0.3m in month, with the proportion of debt over 90 days now standing at 8% of the overall aged debt. The Trust continues to focus on all elements of debt to ensure full recovery of all outstanding amounts.

The dashboard shows that 10% of the debt is due to debtors over 90 days but this includes money due from the Compensation Recovery Unit which takes a long time to recover (included as other receivables in non current assets).

## 12. Income and Expenditure Bridge

A summary of the main variances between planned and actual EBITDA is provided in the table below.

| **EBITDA**<br>**Plan vs Actual Bridge Analysis (x) = adverse** | **March Variance £m** | **Cumulative Variance £m** |
|---|---|---|
| **Activity Related** | | |
| Clinical income | 1.2 | 2.4 |
| Pay – A&E | (0.1) | (1.2) |
| Pay – Medicine, Elderly Care & Stroke | (0.1) | (1.2) |
| Pay – Specialty Medicine | (0.1) | (0.7) |
| Pay – Acute Medicine | 0.0 | (0.3) |
| Pay – Critical Care | (0.1) | (1.3) |
| Pay - Surgery | (0.1) | (0.7) |
| Pay - Radiology | (0.1) | (0.7) |
| Drugs | (0.0) | (0.8) |
| Clinical Supplies and Services | (0.1) | (0.8) |
| **Sub total** | **0.5** | **(5.3)** |
| **Non Activity Related** | | |
| Non clinical income | 0.2 | 1.4 |
| Non clinical supplies | (0.8) | (0.6) |
| Net all other variances including reserves | (0.2) | 0.2 |
| **Sub total** | **(0.8)** | **1.0** |
| **EBITDA variance to plan** | **(0.3)** | **(4.3)** |

## 13. Asset Revaluation and Impairments

In accordance with accounting standards the Trust is required to undertake an annual revaluation exercise for all land and buildings so that the Trust asset base reflects the current value rather than the historic value. The District Valuer has completed the valuation exercise and as at 31st March 2014 the value of land and buildings has increased by £2.9m. This increase is reflected by an increase in the revaluation reserve, however as a result of the increase in asset value the PDC Dividends have increased by £0.1m.

The asset verification exercise has resulted in a number of assets that are no longer in use and accounting standards require that the net book value of the asset is charged to income and expenditure as an impairment expense. Therefore this results in a £0.7m impairment charge to the income and expenditure statement but is classed as a "technical adjustment" and excluded from the calculation of the Continuity of Services Risk Rating and the operating position for the year.

## 14. Conclusion

The financial performance for the year is a deficit of £2,849k which generates a Financial Risk Rating score of 2 and a Continuity of Services Risk Rating score of 3.

The draft accounts have been submitted to Monitor and to PricewaterhouseCoopers who commence the annual accounts audit on 28th April.

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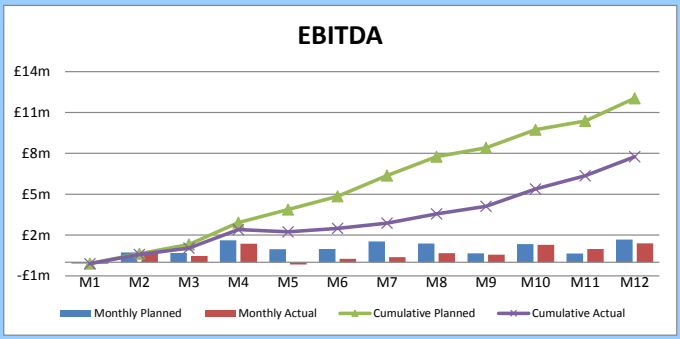
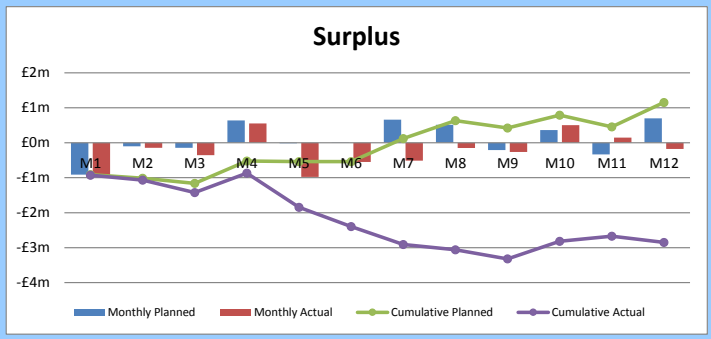
**Tim Barlow**
**Director of Finance & Commercial Development**
**22nd April 2014**

# Warrington & Halton Hospitals NHS Foundation Trust

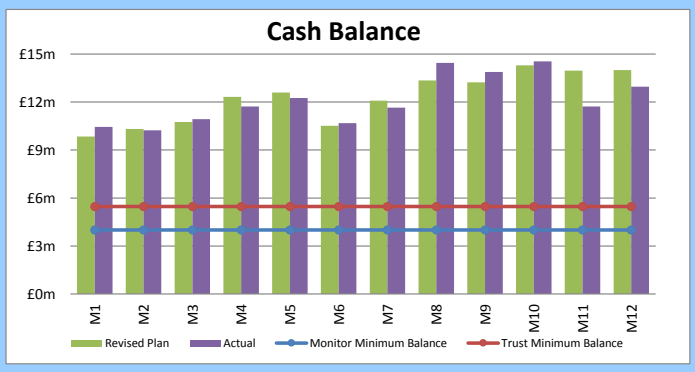
## Finance Dashboard as at 31st March 2014 (Part A)

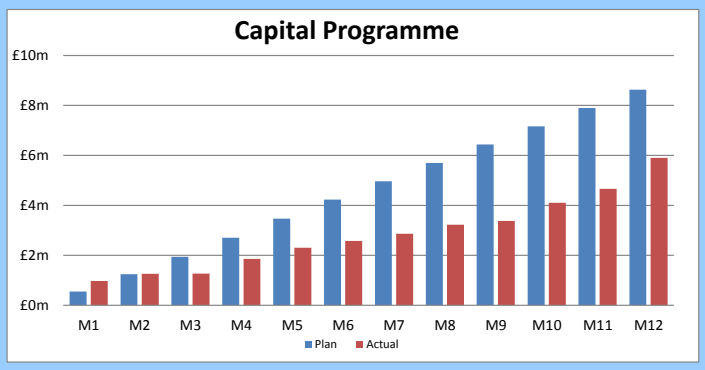
### Profitability



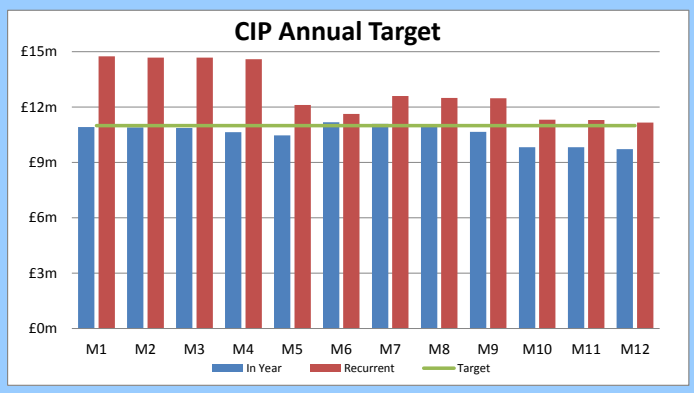



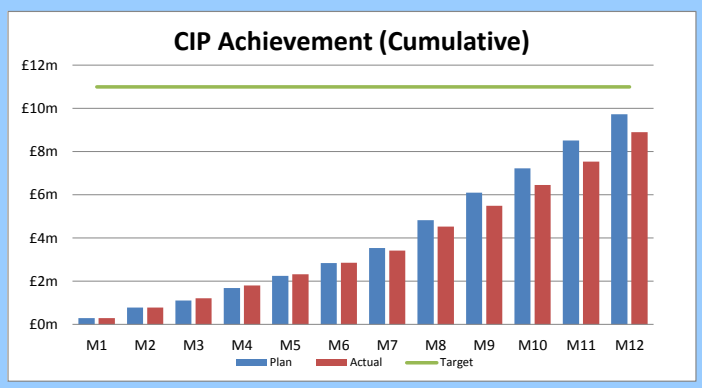

### Cash and Investment




### Cost Improvement Analysis




### Additional Metrics and Risks

| Financial Risk Rating | Actual Metric | Actual Rating |
|---|---|---|
| EBITDA margin % | 3.3% | 2 |
| EBITDA % of plan achieved | 62.2% | 2 |
| Net return after finance rating | -2.2% | 2 |
| Surplus margin | -1.0% | 2 |
| Liquidity (days) | 26.8 | 4 |
| **Overall Risk Rating** | | **2** |

| Continuity of Services Risk Rating | Actual Metric | Actual Rating |
|---|---|---|
| Liquidity Ratio (days) | 0.5 | 4 |
| Capital Servicing Capacity (times) | 1.5 | 2 |
| **Overall Risk Rating** | | **3** |

| Liquidity | |
|---|---|
| Cash Balance | 13.0 |
| Current Ratio (Current assets vs current liabilities) | 1.15 |

| Monitor Potential Financial Risk Indicators | Performance |
|---|---|
| Debtors > 90 days past due date account for no more than 5% of total debtor balances | 10% |
| Creditors > 90 days past due account for more than 5% of total creditor balances | 6% |
| Capital Expenditure < 75% of plan for year to date | 68% |

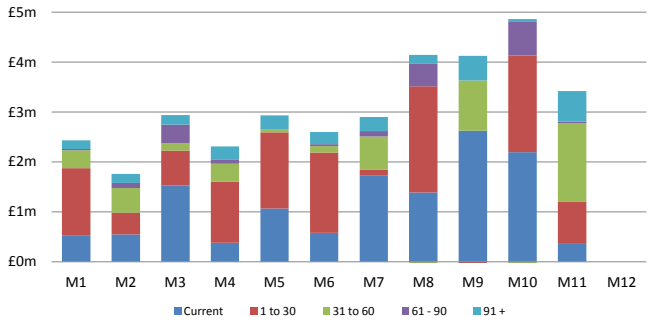
**Financial Risks 14/15**

1. Delivery of contracted activity levels resulting in income under recovery.
2. Identification and delivery both in year and recurrent cost savings target and identification of mitigation strategy to cover shortfall against target.
3. Non compliance with data requirements, quality standards, contract and CQUIN targets thereby leading to charges levied by the commissioners.
4. Increase in readmissions resulting in bed blockage and increased payment to commissioners.
5. Control over divisional pay (especially bank, agency and locum ) and non pay costs driven by bed escalation, emergency demand and sickness and absence levels.
6. Failure to increase clinical efficiency and productivity resulting in additional sessions necessary to meet demand and national waiting time targets.
7. Non receipt of centrally resourced winter monies.

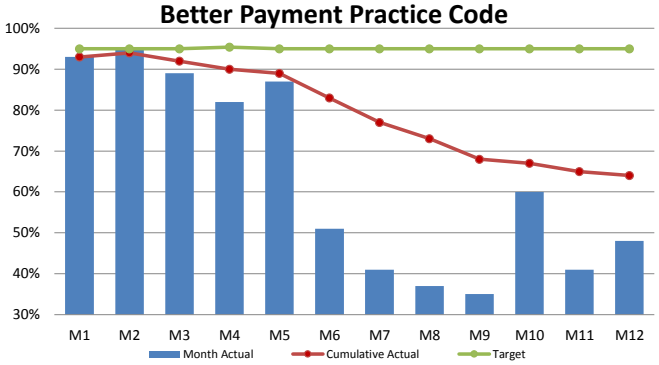
# Finance Dashboard as at 31st March 2014 (Part B)

## Balance Sheet and Liquidity

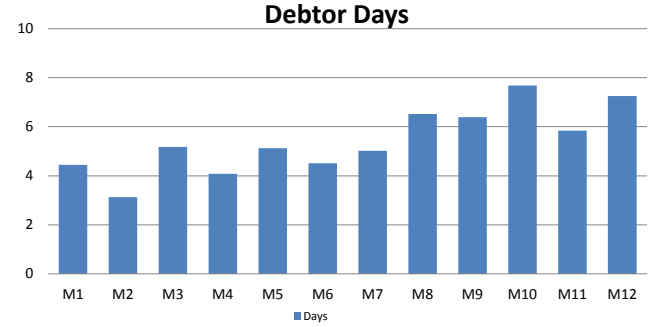
### Aged Debt Analysis



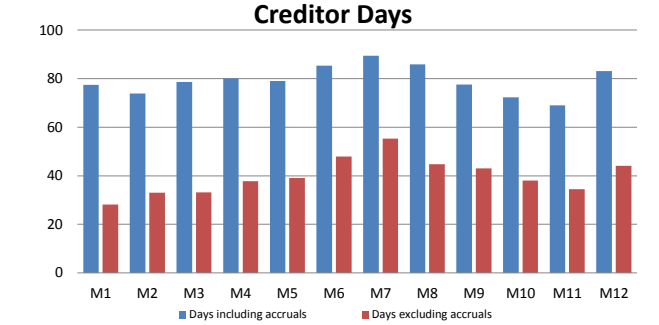

### Better Payment Practice Code




### Debtor Days

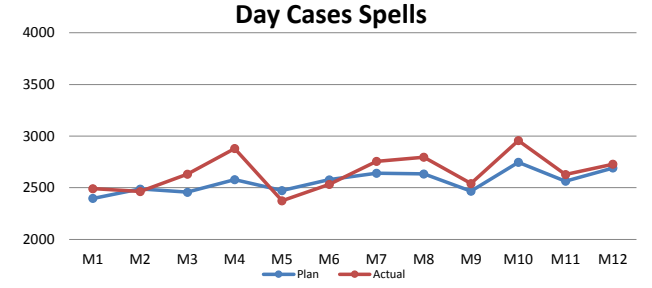



### Creditor Days

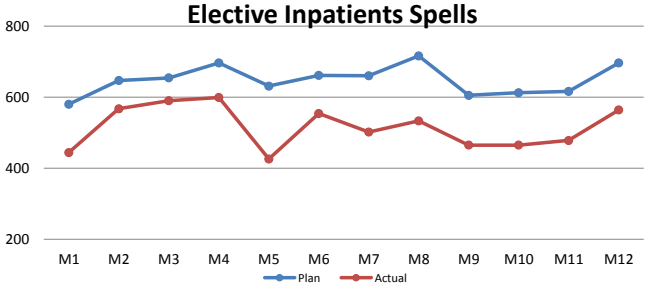



## Activity Analysis

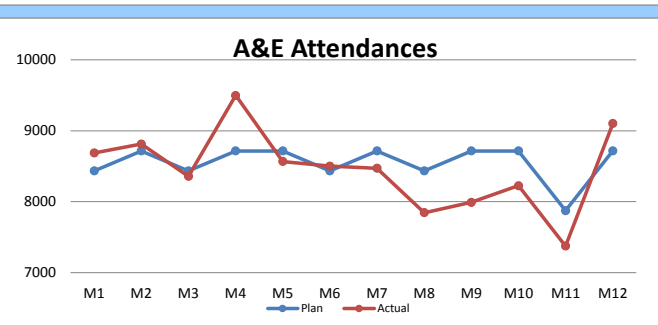
### Day Cases Spells



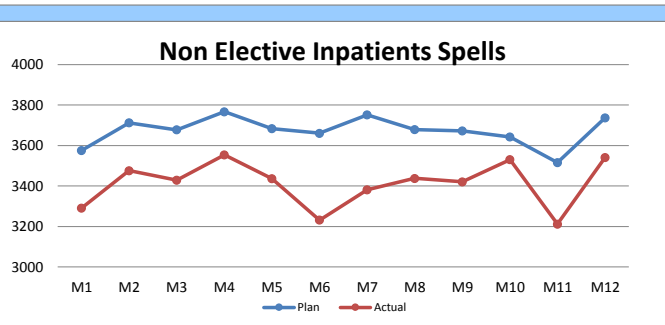

### Elective Inpatients Spells



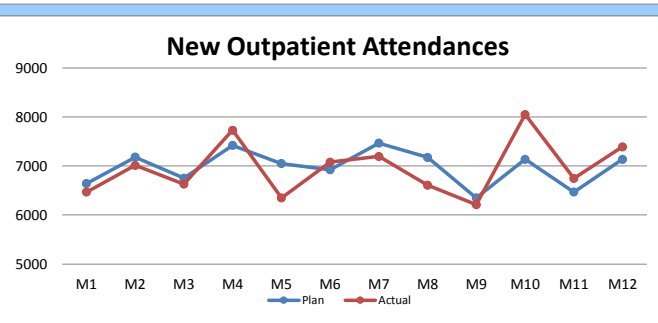

### A&E Attendances



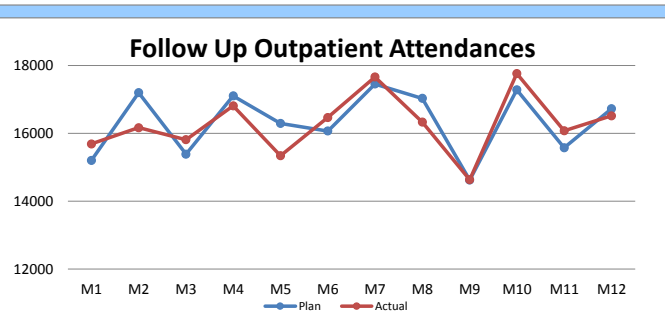

### Non Elective Inpatients Spells




### New Outpatient Attendances




### Follow Up Outpatient Attendances



## Income Statement, Activity Summary and Risk Ratings as at 31st March 2014

| Income Statement | Month | | | Year to date | | |
|---|---|---|---|---|---|---|
| | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | Variance £000 |
| **Operating Income** | | | | | | |
| **NHS Activity Income** | | | | | | |
| Elective Spells | 3,697 | 3,751 | 54 | 41,426 | 40,260 | -1,165 |
| Elective Excess Bed Days | 41 | 5 | -37 | 451 | 311 | -140 |
| Non Elective Spells | 5,049 | 5,015 | -33 | 60,049 | 58,727 | -1,322 |
| Non Elective Excess Bed Days | 397 | 240 | -157 | 4,976 | 3,630 | -1,346 |
| Outpatient Attendances | 2,762 | 2,883 | 121 | 32,320 | 32,702 | 382 |
| Accident & Emergency Attendances | 873 | 905 | 32 | 10,275 | 10,164 | -111 |
| Other Activity | 3,518 | 4,807 | 1,289 | 40,698 | 47,377 | 6,678 |
| **Sub total** | **16,338** | **17,606** | **1,269** | **190,194** | **193,171** | **2,977** |
| **Non Mandatory / Non Protected Income** | | | | | | |
| Private Patients | 22 | 4 | -18 | 213 | 145 | -69 |
| Other non protected | 151 | 119 | -31 | 1,807 | 1,317 | -490 |
| **Sub total** | **173** | **123** | **-49** | **2,020** | **1,462** | **-558** |
| **Other Operating Income** | | | | | | |
| Training & Education | 569 | 792 | 222 | 6,833 | 7,469 | 636 |
| Donations and Grants | 0 | 6 | 6 | 867 | 799 | -68 |
| Miscellaneous Income | 752 | 767 | 15 | 8,972 | 9,828 | 856 |
| **Sub total** | **1,321** | **1,564** | **243** | **16,673** | **18,097** | **1,424** |
| **Total Operating Income** | **17,831** | **19,293** | **1,462** | **208,887** | **212,730** | **3,842** |
| **Operating Expenses** | | | | | | |
| Employee Benefit Expenses (Pay) | -11,779 | -12,578 | -799 | -143,908 | -149,896 | -5,988 |
| Drugs | -950 | -984 | -33 | -11,596 | -12,387 | -792 |
| Clinical Supplies and Services | -1,504 | -1,626 | -122 | -18,231 | -18,993 | -762 |
| Non Clinical Supplies | -1,933 | -2,715 | -783 | -23,110 | -23,703 | -593 |
| **Total Operating Expenses** | **-16,167** | **-17,903** | **-1,737** | **-196,844** | **-204,979** | **-8,135** |
| **Surplus / (Deficit) from Operations (EBITDA)** | **1,665** | **1,390** | **-275** | **12,043** | **7,750** | **-4,293** |
| **Non Operating Income and Expenses** | | | | | | |
| Interest Income | 4 | 4 | 1 | 45 | 42 | -3 |
| Interest Expenses | 0 | 0 | 0 | -11 | -11 | 0 |
| Depreciation | -543 | -492 | 51 | -6,379 | -5,858 | 521 |
| PDC Dividends | -329 | -384 | -56 | -3,946 | -4,074 | -128 |
| Restructuring Costs | -100 | 0 | 100 | -600 | 0 | 600 |
| Impairments | 0 | -697 | -697 | 0 | -697 | -697 |
| **Total Non Operating Income and Expenses** | **-968** | **-1,569** | **-601** | **-10,891** | **-10,599** | **292** |
| **Surplus / (Deficit)** | **697** | **-179** | **-876** | **1,152** | **-2,849** | **-4,001** |

| Activity Summary | Planned Activity | Actual Activity | Variance Activity | Planned Activity | Actual Activity | Variance Activity |
|---|---|---|---|---|---|---|
| Elective Spells | 3,399 | 3,292 | -107 | 38,482 | 37,964 | -518 |
| Elective Excess Bed Days | 173 | 16 | -157 | 1,882 | 1,290 | -592 |
| Non Elective Spells | 3,635 | 3,541 | -94 | 43,978 | 40,944 | -3,034 |
| Non Elective Excess Bed Days | 1,719 | 1,042 | -677 | 21,547 | 15,745 | -5,802 |
| Outpatient Attendances | 27,813 | 28,951 | 1,138 | 327,547 | 334,410 | 6,863 |
| Accident & Emergency Attendances | 8,716 | 9,103 | 387 | 102,626 | 101,427 | -1,199 |

| Financial Risk Ratings | | | | Planned Metric | Actual Metric | Variance Metric |
|---|---|---|---|---|---|---|
| EBITDA margin | | | | 5.4% | 3.3% | -2.1% |
| EBITDA % of plan achieved | | | | 90.1% | 62.2% | -27.9% |
| Net return after financing | | | | 0.7% | -2.2% | -2.8% |
| Surplus margin | | | | 0.8% | -1.0% | -1.9% |
| Liquidity (days) | | | | 29.7 | 26.8 | -2.9 |
| **Financial Risk Rating** | | | | **3** | **2** | **-1** |

| Continuity of Services Risk Ratings | | | | Planned Metric | Actual Metric | Variance Metric |
|---|---|---|---|---|---|---|
| Liquidity Ratio (Days) | | | | 2.3 | 0.5 | -1.8 |
| Capital Servicing Capacity (Times) | | | | 2.5 | 1.5 | -1.0 |
| **Continuity of Services Risk Rating** | | | | **4** | **3** | **-1** |

**Warrington & Halton Hospitals NHS Foundation Trust** **Appendix B2**

**Income Statement - comparison of month 11 forecast to month 12 actual**

| Income Statement | Month 11 Forecast £000 | Month 12 Actual £000 | Monthly Variance £000 | main reasons for movements on significant variances |
|---|---|---|---|---|
| **Operating Income** | | | | |
| **NHS Activity Income** | | | | |
| Elective Spells | 39,828 | 40,260 | 432 | Increase in Month 11 forecast activity |
| Elective Excess Bed Days | 334 | 311 | -23 | Decrease in Month 11 forecast activity |
| Non Elective Spells | 58,595 | 58,727 | 132 | Increase in Month 11 forecast activity |
| Non Elective Excess Bed Days | 3,698 | 3,630 | -68 | Decrease in Month 11 forecast activity |
| Outpatient Attendances | 32,530 | 32,702 | 172 | Increase in Month 11 forecast activity |
| Accident & Emergency Attendances | 10,101 | 10,164 | 63 | Increase in Month 11 forecast activity |
| Other Activity | 46,947 | 47,377 | 430 | Additional income for cystic fibrosis, finalisation of contract settlements. |
| **Sub total** | **192,033** | **193,171** | **1,138** | |
| **Non Mandatory / Non Protected Income** | | | | |
| Private Patients | 155 | 145 | -10 | - |
| Other non protected | 1,316 | 1,317 | 1 | - |
| **Sub total** | **1,471** | **1,462** | **-9** | |
| **Other Operating Income** | | | | |
| Training & Education | 7,501 | 7,469 | -32 | Finalisation of contract values |
| Donations and Grants | 788 | 799 | 11 | - |
| Miscellaneous Income | 10,022 | 9,828 | -194 | Transfer of reablement funding from Borough Council to CCG (not shown in NHS income) |
| **Sub total** | **18,311** | **18,096** | **-215** | |
| **Total Operating Income** | **211,815** | **212,729** | **914** | |
| **Operating Expenses** | | | | |
| Employee Benefit Expenses (Pay) | -149,873 | -149,896 | -23 | - |
| Drugs | -12,449 | -12,387 | 62 | General reduction in expenditure |
| Clinical Supplies and Services | -19,078 | -18,993 | 85 | General reduction in expenditure |
| Non Clinical Supplies | -23,396 | -23,703 | -307 | EY (£228k), Annual Leave Accrual (£112k) |
| **Total Operating Expenses** | **-204,796** | **-204,979** | **-183** | |
| **Surplus / (Deficit) from Operations (EBITDA)** | **7,019** | **7,750** | **731** | |
| **Non Operating Income and Expenses** | | | | |
| Interest Income | 40 | 42 | 2 | - |
| Interest Expenses | -11 | -11 | 0 | - |
| Depreciation | -5,958 | -5,858 | 100 | Accelerated depreciation charged to revaluation reserve not Income Statement. |
| PDC Dividends | -4,025 | -4,074 | -49 | Impact due to increase in asset base following District Valuer revaluation exercise. |
| Restructuring Costs | 0 | 0 | 0 | - |
| Impairments | 0 | -697 | -697 | Finalisation of value following completion of asset verification exercise. |
| **Total Non Operating Income and Expenses** | **-9,954** | **-10,598** | **-644** | |
| **Surplus / (Deficit)** | **-2,935** | **-2,848** | **87** | |

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

**Income and Activity to 31st March 2014**

**Summary by Point of Delivery**

| | | Annual | | April-February | | | April-February | | | March | | | March | | | Year to Date | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | ACTIVITY | | | INCOME | | | ACTIVITY | | | INCOME | | | ACTIVITY | | | INCOME | | |
| | Point of Delivery Description | Planned Activity | Planned Income £ | Planned Activity | Estimated Activity | Activity Variance | Planned Income £ | Estimated Income £ | Income Variance £ | Planned Activity | Estimated Activity | Activity Variance | Planned Income £ | Estimated Income £ | Income Variance £ | Planned Activity | Estimated Activity | Activity Variance | Planned Income £ | Estimated Income £ | Income Variance £ |
| | **Elective** | | | | | | | | | | | | | | | | | | | | |
| | Elective Inpatients | 7,774 | 19,572,418 | 7,069 | 5,624 | -1,445 | 17,827,531 | 16,370,905 | -1,456,626 | 705 | 563 | -142 | 1,744,887 | 1,716,595 | -28,292 | 7,774 | 6,187 | -1,587 | 19,572,418 | 18,087,500 | -1,484,918 |
| | Elective Inpatients Excess Bed Days | | 450,514 | | | | 409,052 | 296,235 | -112,817 | | | | 41,462 | 14,606 | -26,856 | | | | 450,514 | 310,841 | -139,673 |
| | Daycase | 30,708 | 21,853,097 | 28,015 | 29,049 | 1,034 | 19,900,604 | 20,264,213 | 363,608 | 2,694 | 2,728 | 34 | 1,952,493 | 1,908,655 | -43,838 | 30,708 | 31,777 | 1,069 | 21,853,097 | 22,172,868 | 319,770 |
| | SUBTOTAL | 38,482 | 41,876,030 | 35,083 | 34,673 | -410 | 38,137,188 | 36,931,353 | -1,205,835 | 3,399 | 3,291 | -108 | 3,738,842 | 3,639,856 | -98,986 | 38,482 | 37,964 | -518 | 41,876,030 | 40,571,208 | -1,304,821 |
| | **Emergency** | | | | | | | | | | | | | | | | | | | | |
| | Non Elective Inpatients | 28,326 | 49,256,350 | 25,939 | 23,581 | -2,358 | 45,129,409 | 43,947,246 | -1,182,164 | 2,387 | 2,253 | -134 | 4,126,941 | 4,049,113 | -77,827 | 28,326 | 25,834 | -2,492 | 49,256,350 | 47,996,359 | -1,259,991 |
| | Non Elective Inpatients Excess Bed Days | | 4,976,114 | | | | 4,578,961 | 3,415,531 | -1,163,430 | | | | 397,153 | 214,646 | -182,508 | | | | 4,976,114 | 3,630,176 | -1,345,938 |
| | Non Elective Inpatients Short Stay | 15,753 | 10,792,398 | 14,403 | 13,805 | -598 | 9,870,805 | 9,792,053 | -78,752 | 1,249 | 1,305 | 56 | 921,593 | 938,579 | 16,986 | 15,652 | 15,110 | -542 | 10,792,398 | 10,730,632 | -61,766 |
| | SUBTOTAL | 44,079 | 65,024,863 | 40,342 | 37,386 | -2,956 | 59,579,176 | 57,154,830 | -2,424,346 | 3,635 | 3,558 | -77 | 5,445,687 | 5,202,338 | -243,349 | 43,978 | 40,944 | -3,034 | 65,024,863 | 62,357,168 | -2,667,695 |
| | **Outpatients** | | | | | | | | | | | | | | | | | | | | |
| | New Outpatients | 83,712 | 12,139,954 | 76,575 | 76,162 | -413 | 11,100,238 | 11,076,474 | -23,764 | 7,137 | 7,324 | 187 | 1,039,715 | 1,074,612 | 34,896 | 83,712 | 83,486 | -226 | 12,139,954 | 12,151,086 | 11,132 |
| | Follow Up Outpatients | 195,949 | 14,432,504 | 179,226 | 178,840 | -386 | 13,189,426 | 13,370,297 | 180,871 | 16,662 | 16,424 | -238 | 1,243,078 | 1,251,841 | 8,763 | 195,888 | 195,264 | -624 | 14,432,504 | 14,622,138 | 189,634 |
| | Outpatient Telephone Clinics | 11,826 | 285,578 | 10,825 | 14,138 | 3,313 | 261,404 | 341,420 | 80,016 | 1,001 | 1,364 | 363 | 24,199 | 32,942 | 8,743 | 11,826 | 15,502 | 3,676 | 285,578 | 374,361 | 88,783 |
| | Outpatient Procedures | 24,935 | 4,425,951 | 22,873 | 26,251 | 3,378 | 4,059,294 | 4,114,481 | 55,187 | 2,062 | 2,581 | 519 | 366,657 | 407,515 | 40,857 | 24,935 | 28,832 | 3,897 | 4,425,951 | 4,521,995 | 96,044 |
| | Ward Attenders | 11,187 | 1,035,673 | 10,235 | 10,437 | 202 | 947,762 | 951,646 | 3,884 | 951 | 889 | -62 | 87,911 | 80,395 | -7,516 | 11,187 | 11,326 | 139 | 1,035,673 | 1,032,041 | -3,632 |
| | SUBTOTAL | 327,608 | 32,319,660 | 299,734 | 305,828 | 6,094 | 29,558,124 | 29,854,317 | 296,193 | 27,813 | 28,582 | 769 | 2,761,560 | 2,847,304 | 85,744 | 327,547 | 334,410 | 6,863 | 32,319,660 | 32,701,622 | 381,962 |
| | **Other** | | | | | | | | | | | | | | | | | | | | |
| | A&E Attendances | 102,626 | 10,275,165 | 93,910 | 92,326 | -1,584 | 9,402,150 | 9,288,229 | -113,921 | 8,716 | 9,101 | 385 | 873,015 | 875,788 | 2,773 | 102,626 | 101,427 | -1,199 | 10,275,165 | 10,164,017 | -111,148 |
| | Pathology Direct Access | 2,251,531 | 4,576,907 | 2,057,110 | 2,256,927 | 199,817 | 4,181,688 | 4,574,359 | 392,671 | 194,421 | 225,362 | 30,941 | 395,219 | 457,411 | 62,192 | 2,251,531 | 2,482,289 | 230,758 | 4,576,907 | 5,031,770 | 454,863 |
| | Radiology Direct Access (Excluding Unbundled) | 33,392 | 1,042,331 | 30,426 | 30,395 | -31 | 950,981 | 983,876 | 32,895 | 2,966 | 2,773 | -193 | 91,350 | 89,609 | -1,741 | 33,392 | 33,168 | -224 | 1,042,331 | 1,073,485 | 31,154 |
| | Radiology Diagnostic Imaging & Echos (Unbundled) | 50,521 | 4,281,534 | 46,050 | 50,395 | 4,345 | 3,927,511 | 4,387,412 | 459,902 | 4,471 | 4,486 | 15 | 354,023 | 370,942 | 16,919 | 50,521 | 54,881 | 4,360 | 4,281,534 | 4,758,355 | 476,821 |
| | Critical Care (Neonatal) | 4,098 | 2,148,209 | 3,757 | 3,613 | -144 | 1,969,192 | 1,918,869 | -50,323 | 342 | 128 | -214 | 179,018 | 63,813 | -115,205 | 4,098 | 3,741 | -357 | 2,148,209 | 1,982,681 | -165,528 |
| | Critical Care Adult (Unbundled) | 6,189 | 7,637,978 | 5,673 | 5,923 | 250 | 7,001,479 | 6,907,442 | -94,037 | 516 | 163 | -353 | 636,498 | 402,186 | -234,313 | 6,189 | 6,086 | -103 | 7,637,978 | 7,309,628 | -328,350 |
| | Chemotherapy (Unbundled) | 398 | 124,196 | 364 | 576 | 212 | 113,846 | 178,651 | 64,804 | 33 | 17 | -16 | 10,350 | 5,158 | -5,192 | 398 | 593 | 196 | 124,196 | 183,808 | 59,613 |
| | Palliative Care (Unbundled) | 5,228 | 623,620 | 4,792 | 7,034 | 2,242 | 571,652 | 838,383 | 266,732 | 436 | 396 | -40 | 51,968 | 47,220 | -4,749 | 5,228 | 7,430 | 2,203 | 623,620 | 885,603 | 261,983 |
| | Excluded Drugs | | 4,789,256 | | | | 4,343,259 | 5,667,438 | 1,324,179 | | | | 445,998 | 465,154 | 19,156 | | | | 4,789,256 | 6,132,592 | 1,343,335 |
| | All Other Services (including CQUIN) | | 15,474,466 | | | | 14,120,452 | 17,261,660 | 3,141,208 | | | | 1,354,015 | 2,757,364 | 1,403,349 | | | | 15,474,467 | 20,019,024 | 4,544,557 |
| | SUBTOTAL | 2,453,982 | 50,973,662 | 2,242,081 | 2,447,189 | 205,108 | 46,582,209 | 52,006,319 | 5,424,110 | 211,900 | 242,426 | 30,526 | 4,391,453 | 5,534,644 | 1,143,190 | 2,453,982 | 2,689,615 | 235,633 | 50,973,662 | 57,540,962 | 6,567,300 |
| **Total** | | **2,864,151** | **190,194,214** | **2,617,241** | **2,825,076** | **207,835** | **173,856,696** | **175,946,818** | **2,090,122** | **246,748** | **277,857** | **31,109** | **16,337,543** | **17,224,142** | **886,599** | **2,863,989** | **3,102,933** | **238,944** | **190,194,215** | **193,170,960** | **2,976,745** |
| | Elective Inpatients Excess Bed Days | 1,882 | | 1,709 | 1,232 | -477 | | | | 173 | 58 | -115 | | | | 1,882 | 1,290 | -592 | | | |
| | Non Elective Inpatients Excess Bed Days | 21,547 | | 19,828 | 14,811 | -5,017 | | | | 1,719 | 934 | -785 | | | | 21,547 | 15,745 | -5,802 | | | |
| | **Total** | **2,887,580** | | **2,638,778** | **2,841,119** | **202,341** | | | | **248,640** | **278,849** | **30,209** | | | | **2,887,418** | **3,119,968** | **232,550** | | | |

**Warrington & Halton Hospitals NHS Foundation Trust** **Appendix D1**

**Income and Activity to 31st March 2014**

**Summary by Division / Specialty**

| Specialty Code | Specialty Description | Annual | | April-February ACTIVITY | | | April-February INCOME | | | March ACTIVITY | | | March INCOME | | | Year to Date ACTIVITY | | | Year to Date INCOME | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned Activity | Planned Income £ | Planned Activity | Actual Activity | Activity Variance | Planned Income £ | Actual Income £ | Income Variance £ | Planned Activity | Actual Activity | Activity Variance | Planned Income £ | Actual Income £ | Income Variance £ | Planned Activity | Estimated Activity | Activity Variance | Planned Income £ | Estimated Income £ | Income Variance £ |
| | **Scheduled Care** | | | | | | | | | | | | | | | | | | | | |
| 100 | General Surgery | 42,167 | 19,788,267 | 38,663 | 34,397 | -4,266 | 18,236,366 | 16,995,502 | -1,240,864 | 3,504 | 3,235 | -269 | 1,579,995 | 1,572,806 | -7,190 | 42,167 | 37,632 | -4,535 | 19,816,361 | 18,568,308 | -1,248,053 |
| 101 | Urology | 14,173 | 4,290,560 | 12,863 | 13,246 | 383 | 3,898,082 | 4,109,766 | 211,684 | 1,316 | 1,429 | 113 | 392,478 | 405,008 | 12,530 | 14,179 | 14,675 | 496 | 4,290,560 | 4,514,774 | 224,214 |
| 110 | Trauma & Orthopaedics | 61,307 | 24,637,761 | 55,794 | 53,690 | -2,104 | 22,422,448 | 22,552,492 | 130,043 | 5,507 | 4,771 | -736 | 2,215,313 | 2,101,371 | -113,942 | 61,302 | 58,461 | -2,841 | 24,637,761 | 24,653,863 | 16,102 |
| 120 | ENT | 18,782 | 3,962,465 | 17,228 | 16,213 | -1,015 | 3,634,521 | 3,430,253 | -204,268 | 1,553 | 1,408 | -145 | 327,944 | 269,075 | -58,869 | 18,780 | 17,621 | -1,159 | 3,962,465 | 3,699,328 | -263,137 |
| 130 | Ophthalmology | 45,884 | 6,025,969 | 42,085 | 44,402 | 2,317 | 5,528,615 | 5,933,763 | 405,148 | 3,802 | 4,097 | 295 | 497,354 | 530,952 | 33,599 | 45,887 | 48,499 | 2,612 | 6,025,969 | 6,464,715 | 438,746 |
| 130 a-d & f | ARMD | 3,274 | 2,164,776 | 3,003 | 3,668 | 665 | 1,984,987 | 2,429,314 | 444,327 | 271 | 403 | 132 | 179,789 | 283,807 | 104,018 | 3,274 | 4,071 | 797 | 2,164,776 | 2,713,121 | 548,345 |
| 130e | Halton Cataracts | 784 | 192,514 | 719 | 609 | -110 | 176,512 | 146,972 | -29,540 | 65 | 62 | -3 | 16,002 | 16,196 | 193 | 784 | 671 | -113 | 192,514 | 163,168 | -29,346 |
| 140 | Oral Surgery | 6,517 | 1,412,907 | 5,974 | 5,788 | -186 | 1,294,936 | 1,230,746 | -64,190 | 543 | 521 | -22 | 117,971 | 123,108 | 5,137 | 6,517 | 6,309 | -208 | 1,412,907 | 1,353,855 | -59,053 |
| 143 | Orthodontics | 4,597 | 550,333 | 4,205 | 3,741 | -464 | 504,260 | 455,023 | -49,237 | 392 | 410 | 18 | 46,073 | 49,216 | 3,144 | 4,597 | 4,151 | -446 | 550,333 | 504,239 | -46,094 |
| 190 | Anaesthetics | 3,066 | 956,722 | 2,810 | 3,162 | 352 | 876,007 | 984,965 | 108,957 | 256 | 280 | 24 | 80,715 | 89,584 | 8,868 | 3,066 | 3,442 | 376 | 956,722 | 1,074,548 | 117,826 |
| 192 | Adult Critical Care(Unbundled) | 6,710 | 8,799,049 | 6,151 | 6,455 | 304 | 8,065,697 | 7,744,099 | -321,598 | 559 | 197 | -362 | 733,352 | 464,959 | -268,393 | 6,710 | 6,652 | -58 | 8,799,049 | 8,209,059 | -589,990 |
| | Divisional Block Income | | 265,236 | | | | 243,133 | 243,133 | 0 | | | | 22,103 | 22,103 | 0 | | | | 265,236 | 265,236 | 0 |
| | Non-Elective Fines (Readmissions & Marg Rate) | | -694,387 | | | | -636,552 | -452,421 | 184,130 | | | | -57,835 | -40,506 | 17,329 | | | | -694,387 | -492,927 | 201,459 |
| | **SubTotal** | 207,261 | 72,352,173 | 189,495 | 185,371 | -4,124 | 66,229,014 | 65,803,607 | -425,407 | 17,768 | 16,813 | -955 | 6,151,253 | 5,887,679 | -263,575 | 207,263 | 202,184 | -5,079 | 72,380,267 | 71,691,286 | -688,981 |
| | **Unscheduled Care** | | | | | | | | | | | | | | | | | | | | |
| | Endoscopy | 11,949 | 6,042,957 | 10,921 | 10,492 | -429 | 5,528,554 | 5,222,360 | -306,194 | 1,028 | 978 | -50 | 514,403 | 479,748 | -34,656 | 11,949 | 11,470 | -479 | 6,042,957 | 5,702,108 | -340,849 |
| 170 | Cardiothoracic Surgery | 468 | 89,672 | 429 | 364 | -65 | 82,258 | 68,874 | -13,385 | 39 | 39 | 0 | 7,414 | 7,394 | -20 | 468 | 403 | -65 | 89,672 | 76,268 | -13,404 |
| 180 | Accident & Emergency | 12,456 | 6,558,945 | 11,408 | 9,960 | -1,448 | 6,002,786 | 5,272,848 | -729,938 | 999 | 830 | -169 | 556,159 | 422,319 | -133,840 | 12,407 | 10,790 | -1,617 | 6,558,945 | 5,695,167 | -863,778 |
| 300 | General Medicine | 58,534 | 29,953,506 | 53,672 | 54,621 | 949 | 27,424,198 | 26,764,211 | -659,987 | 4,818 | 4,676 | -142 | 2,529,309 | 2,356,417 | -172,892 | 58,490 | 59,297 | 807 | 29,953,506 | 29,120,627 | -832,879 |
| 301 | Gastroenterology | 10,408 | 2,355,306 | 9,550 | 8,351 | -1,199 | 2,159,410 | 1,807,871 | -351,539 | 858 | 932 | 74 | 195,896 | 276,778 | 80,882 | 10,408 | 9,283 | -1,125 | 2,355,306 | 2,084,649 | -270,657 |
| 320 | Cardiology | 14,314 | 5,126,183 | 13,119 | 13,752 | 633 | 4,580,561 | 4,628,941 | 48,380 | 1,190 | 1,334 | 144 | 424,760 | 528,293 | 103,533 | 14,309 | 15,086 | 777 | 5,005,321 | 5,157,234 | 151,913 |
| 430 | Medicine For The Elderly | 1,926 | 445,477 | 1,765 | 2,333 | 568 | 410,925 | 497,769 | 86,844 | 162 | 202 | 40 | 34,552 | 37,823 | 3,271 | 1,926 | 2,535 | 609 | 445,477 | 535,592 | 90,115 |
| | A&E Attendances | 102,626 | 10,275,165 | 93,910 | 92,326 | -1,584 | 9,402,150 | 9,288,229 | -113,921 | 8,716 | 9,101 | 385 | 873,015 | 875,788 | 2,773 | 102,626 | 101,427 | -1,199 | 10,275,165 | 10,164,017 | -111,148 |
| | Unbundled Echo's | | 325,412 | 0 | 0 | 0 | 298,294 | 335,407 | 37,113 | 0 | 0 | 0 | 27,118 | 28,115 | 997 | 0 | 0 | 0 | 325,412 | 363,522 | 38,110 |
| | CPAP | | 83,138 | 0 | 0 | 0 | 76,091 | 80,650 | 4,559 | 0 | 0 | 0 | 7,047 | 7,307 | 260 | 0 | 0 | 0 | 83,138 | 87,957 | 4,819 |
| | HICU (Block) | | 1,445,397 | | | | 1,324,947 | 1,324,947 | 0 | | | | 120,450 | 120,450 | 0 | | | | 1,445,397 | 1,445,397 | 0 |
| | DA ECG (Block) | | 224,782 | | | | 206,050 | 206,050 | 0 | | | | 18,732 | 18,732 | 0 | | | | 224,782 | 224,782 | 0 |
| | Divisional Block Income | | 121,729 | | | | 111,585 | 111,585 | 0 | | | | 10,144 | 10,144 | 0 | | | | 121,729 | 121,729 | 0 |
| | Non-Elective Fines (Readmissions & Marg Rate) | | -1,371,277 | | | | -1,257,064 | -893,443 | 363,621 | | | | -114,212 | -79,991 | 34,222 | | | | -1,371,277 | -973,434 | 397,843 |
| | **SubTotal** | 212,681 | 61,676,393 | 194,773 | 192,199 | -2,574 | 56,350,746 | 54,716,298 | -1,634,448 | 17,809 | 18,092 | 283 | 5,204,785 | 5,089,317 | -115,468 | 212,581 | 210,291 | -2,290 | 61,555,531 | 59,805,615 | -1,749,916 |
| | **Women's Children's & Support Services** | | | | | | | | | | | | | | | | | | | | |
| 303 | Haematology | 51,290 | 2,649,319 | 47,005 | 50,566 | 3,561 | 2,425,867 | 2,560,082 | 134,215 | 4,286 | 4,231 | -55 | 223,452 | 206,081 | -17,371 | 51,290 | 54,797 | 3,507 | 2,649,319 | 2,766,163 | 116,844 |
| 360 | Genito-Urinary Medicine | 4,396 | 514,250 | 3,990 | 3,918 | -72 | 467,127 | 504,270 | 37,143 | 406 | 365 | -41 | 47,123 | 46,917 | -207 | 4,396 | 4,283 | -113 | 514,250 | 551,187 | 36,937 |
| 410 | Rheumatology | 7,958 | 1,181,125 | 7,270 | 7,770 | 500 | 1,074,911 | 1,081,779 | 6,868 | 688 | 891 | 203 | 106,213 | 111,377 | 5,163 | 7,958 | 8,661 | 703 | 1,181,125 | 1,193,156 | 12,031 |
| 420 | Paediatrics | 19,964 | 6,691,848 | 18,258 | 18,595 | 337 | 6,120,730 | 6,043,874 | -76,856 | 1,707 | 1,843 | 136 | 571,118 | 621,558 | 50,440 | 19,964 | 20,438 | 474 | 6,691,848 | 6,665,432 | -26,416 |
| 501 | Obstetrics | 10,853 | 6,188,958 | 9,913 | 10,158 | 245 | 5,652,635 | 5,760,644 | 108,009 | 940 | 888 | -52 | 536,322 | 513,120 | -23,202 | 10,853 | 11,046 | 193 | 6,188,958 | 6,273,764 | 84,807 |
| 502 | Gynaecology | 26,233 | 6,260,759 | 23,998 | 22,737 | -1,261 | 5,719,994 | 4,928,601 | -791,393 | 2,231 | 2,205 | -26 | 540,765 | 525,479 | -15,286 | 26,229 | 24,942 | -1,287 | 6,260,759 | 5,454,080 | -806,679 |
| 560 | Midwife Episode | 7,266 | 1,928,666 | 6,645 | 8,475 | 1,830 | 1,762,235 | 1,637,145 | -125,090 | 621 | 772 | 151 | 166,431 | 139,324 | -27,106 | 7,266 | 9,247 | 1,981 | 1,928,666 | 1,776,470 | -152,196 |
| | Critical Care ( Neo Natal ) | 4,098 | 2,148,209 | 3,757 | 3,613 | -144 | 1,969,192 | 1,918,869 | -50,323 | 342 | 128 | -214 | 179,018 | 63,813 | -115,205 | 4,098 | 3,741 | -357 | 2,148,209 | 1,982,681 | -165,528 |
| | Direct Access Pathology | 2,251,531 | 4,576,907 | 2,057,110 | 2,256,927 | 199,817 | 4,181,688 | 4,574,359 | 392,671 | 194,421 | 225,362 | 30,941 | 395,219 | 457,411 | 62,192 | 2,251,531 | 2,482,289 | 230,758 | 4,576,907 | 5,031,770 | 454,863 |
| | Direct Access Radiology(Excluding Unbundled) | 33,392 | 1,042,331 | 30,426 | 30,395 | -31 | 950,981 | 983,876 | 32,895 | 2,966 | 2,773 | -193 | 91,350 | 89,609 | -1,741 | 33,392 | 33,168 | -224 | 1,042,331 | 1,073,485 | 31,154 |
| | Radiology Diagnostic Imaging(Unbundled) | 50,521 | 4,281,534 | 46,050 | 50,395 | 4,345 | 3,927,511 | 4,227,007 | 299,496 | 4,471 | 4,486 | 15 | 354,023 | 345,717 | -8,306 | 50,521 | 54,881 | 4,360 | 4,281,534 | 4,572,724 | 291,190 |
| | Comm/DA Therapies & Audioloy (Block) | | 1,909,326 | | | | 1,750,215 | 1,750,215 | 0 | | | | 159,110 | 159,110 | 0 | | | | 1,909,326 | 1,909,326 | 0 |
| | Divisional Block Income | | 5,765,651 | | | | 5,285,180 | 5,285,180 | 0 | | | | 480,471 | 480,471 | 0 | | | | 5,765,651 | 5,765,651 | 0 |
| | Non-Elective Fines (Readmissions & Marg Rate) | | -173,186 | | | | -158,761 | -112,838 | 45,924 | | | | -14,424 | -10,102 | 4,322 | | | | -173,186 | -122,940 | 50,246 |
| | **SubTotal** | 2,467,503 | 44,965,697 | 2,254,421 | 2,463,549 | 209,128 | 41,129,506 | 41,143,065 | 13,559 | 213,078 | 243,944 | 30,866 | 3,836,191 | 3,749,884 | -86,307 | 2,467,499 | 2,707,493 | 239,994 | 44,965,697 | 44,892,949 | -72,748 |
| | **Non divisional specific services** | | | | | | | | | | | | | | | | | | | | |
| | All | 136 | 11,199,951 | 90 | | -90 | 10,147,430 | 14,283,848 | 4,136,418 | -15 | | 15 | 1,145,313 | 2,497,263 | 1,351,949 | 75 | | -75 | 11,292,719 | 16,781,110 | 5,488,391 |
| **Total** | | **2,887,580** | **190,194,214** | **2,638,778** | **2,841,119** | **202,341** | **173,856,696** | **175,946,818** | **2,090,122** | **248,640** | **278,849** | **30,209** | **16,337,543** | **17,224,142** | **886,599** | **2,887,418** | **3,119,968** | **232,550** | **190,194,215** | **193,170,960** | **2,976,745** |

**Warrington & Halton Hospitals NHS Foundation Trust** **Appendix D2**

**Income and Activity to 31st March 2014**

**Summary by Division**

| Specialty Code | Specialty Description | Annual | | April-July | | | April-July | | | August | | | August | | | Year to Date | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | ACTIVITY | | | INCOME | | | ACTIVITY | | | INCOME | | | ACTIVITY | | | INCOME | | |
| | | Planned Activity | Planned Income £ | Planned Activity | Actual Activity | Activity Variance | Planned Income £ | Actual Income £ | Income Variance £ | Planned Activity | Actual Activity | Activity Variance | Planned Income £ | Actual Income £ | Income Variance £ | Planned Activity | Actual Activity | Activity Variance | Planned Income £ | Actual Income £ | Income Variance £ |
| | **Scheduled Care** | | | | | | | | | | | | | | | | | | | | |
| | Surgery | 145,954 | 48,143,563 | 133,700 | 131,681 | -2,019 | 44,199,984 | 43,460,404 | -739,580 | 12,261 | 12,042 | -219 | 3,971,672 | 3,804,710 | -166,962 | 145,961 | 143,723 | -2,238 | 48,171,657 | 47,265,114 | -906,542 |
| | Trauma & Orthopaedics | 61,307 | 24,637,761 | 55,794 | 53,690 | -2,104 | 22,422,448 | 22,552,492 | 130,043 | 5,507 | 4,771 | -736 | 2,215,313 | 2,101,371 | -113,942 | 61,302 | 58,461 | -2,841 | 24,637,761 | 24,653,863 | 16,102 |
| | Other | | -429,151 | | | | -393,419 | -209,288 | 184,130 | | | | -35,732 | -18,403 | 17,329 | | | | -429,151 | -227,691 | 201,459 |
| | **Sub total** | **207,261** | **72,352,173** | **189,495** | **185,371** | **-4,124** | **66,229,014** | **65,803,607** | **-425,407** | **17,768** | **16,813** | **-955** | **6,151,253** | **5,887,679** | **-263,575** | **207,263** | **202,184** | **-5,079** | **72,380,267** | **71,691,286** | **-688,981** |
| | **Unscheduled Care** | | | | | | | | | | | | | | | | | | | | |
| | Accident & Emergency spells | 12,456 | 6,558,945 | 11,408 | 9,960 | -1,448 | 6,002,786 | 5,272,848 | -729,938 | 999 | 830 | -169 | 556,159 | 422,319 | -133,840 | 12,407 | 10,790 | -1,617 | 6,558,945 | 5,695,167 | -863,778 |
| | Medicine | 97,599 | 44,013,102 | 89,455 | 89,913 | 458 | 40,185,907 | 38,990,026 | -1,195,881 | 8,094 | 8,161 | 67 | 3,706,333 | 3,686,453 | -19,880 | 97,549 | 98,074 | 525 | 43,892,240 | 42,676,478 | -1,215,761 |
| | Accident & Emergency attendances | 102,626 | 10,275,165 | 93,910 | 92,326 | -1,584 | 9,402,150 | 9,288,229 | -113,921 | 8,716 | 9,101 | 385 | 873,015 | 875,788 | 2,773 | 102,626 | 101,427 | -1,199 | 10,275,165 | 10,164,017 | -111,148 |
| | Other | | 503,769 | | | | 461,609 | 829,789 | 368,180 | | | | 42,160 | 76,642 | 34,482 | | | | 503,769 | 906,431 | 402,662 |
| | **Sub total** | **212,681** | **61,676,393** | **194,773** | **192,199** | **-2,574** | **56,350,746** | **54,716,298** | **-1,634,448** | **17,809** | **18,092** | **283** | **5,204,785** | **5,089,317** | **-115,468** | **212,581** | **210,291** | **-2,290** | **61,555,531** | **59,805,615** | **-1,749,916** |
| | **Women's, Children & Support Services** | | | | | | | | | | | | | | | | | | | | |
| | Children | 19,964 | 6,691,848 | 18,258 | 18,595 | 337 | 6,120,730 | 6,043,874 | -76,856 | 1,707 | 1,843 | 136 | 571,118 | 621,558 | 50,440 | 19,964 | 20,438 | 474 | 6,691,848 | 6,665,432 | -26,416 |
| | Haematology | 51,290 | 2,649,319 | 47,005 | 50,566 | 3,561 | 2,425,867 | 2,560,082 | 134,215 | 4,286 | 4,231 | -55 | 223,452 | 206,081 | -17,371 | 51,290 | 54,797 | 3,507 | 2,649,319 | 2,766,163 | 116,844 |
| | Womens | 44,352 | 14,378,383 | 40,556 | 41,370 | 814 | 13,134,865 | 12,326,391 | -808,474 | 3,793 | 3,865 | 72 | 1,243,518 | 1,177,923 | -65,595 | 44,348 | 45,235 | 887 | 14,378,383 | 13,504,314 | -874,069 |
| | Medicine | 12,354 | 1,695,375 | 11,260 | 11,688 | 428 | 1,542,039 | 1,586,050 | 44,011 | 1,094 | 1,256 | 162 | 153,337 | 158,293 | 4,957 | 12,354 | 12,944 | 590 | 1,695,375 | 1,744,343 | 48,968 |
| | Pathology Direct Access | 2,251,531 | 4,576,907 | 2,057,110 | 2,256,927 | 199,817 | 4,181,688 | 4,574,359 | 392,671 | 194,421 | 225,362 | 30,941 | 395,219 | 457,411 | 62,192 | 2,251,531 | 2,482,289 | 230,758 | 4,576,907 | 5,031,770 | 454,863 |
| | Direct Access Radiology(Excluding Unbundled) | 33,392 | 1,042,331 | 30,426 | 30,395 | -31 | 950,981 | 983,876 | 32,895 | 2,966 | 2,773 | -193 | 91,350 | 89,609 | -1,741 | 33,392 | 33,168 | -224 | 1,042,331 | 1,073,485 | 31,154 |
| | Radiology Diagnostic Imaging(Unbundled) | 50,521 | 4,281,534 | 46,050 | 50,395 | 4,345 | 3,927,511 | 4,227,007 | 299,496 | 4,471 | 4,486 | 15 | 354,023 | 345,717 | -8,306 | 50,521 | 54,881 | 4,360 | 4,281,534 | 4,572,724 | 291,190 |
| | Neo Natal | 4,098 | 2,148,209 | 3,757 | 3,613 | -144 | 1,969,192 | 1,918,869 | -50,323 | 342 | 128 | -214 | 179,018 | 63,813 | -115,205 | 4,098 | 3,741 | -357 | 2,148,209 | 1,982,681 | -165,528 |
| | Other | | 7,501,791 | | | | 6,876,634 | 6,922,558 | 45,924 | | | | 625,157 | 629,479 | 4,322 | | | | 7,501,791 | 7,552,037 | 50,246 |
| | **Sub total** | **2,467,503** | **44,965,697** | **2,254,421** | **2,463,549** | **209,128** | **41,129,506** | **41,143,065** | **13,559** | **213,078** | **243,944** | **30,866** | **3,836,191** | **3,749,884** | **-86,307** | **2,467,499** | **2,707,493** | **239,994** | **44,965,697** | **44,892,949** | **-72,748** |
| | **Non divisional specific services** | | | | | | | | | | | | | | | | | | | | |
| | All | | 11,199,951 | | | | 10,147,430 | 14,283,848 | 4,136,418 | | | | 1,145,313 | 2,497,263 | 1,351,949 | 75 | | -75 | 11,292,719 | 16,781,110 | 5,488,391 |
| | **Sub total** | **136** | **11,199,951** | **90** | **0** | **-90** | **10,147,430** | **14,283,848** | **4,136,418** | **-15** | **0** | **15** | **1,145,313** | **2,497,263** | **1,351,949** | **75** | **0** | **-75** | **11,292,719** | **16,781,110** | **5,488,391** |
| | **Total** | **2,887,580** | **190,194,214** | **2,638,778** | **2,841,119** | **202,341** | **173,856,696** | **175,946,818** | **2,090,122** | **248,640** | **278,849** | **30,209** | **16,337,543** | **17,224,142** | **886,599** | **2,887,418** | **3,119,968** | **232,550** | **190,194,215** | **193,170,960** | **2,976,745** |

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

**Analysis of Elective Activity between April and March 12/13 and 13/14**

| Specialty | Inpatients April - March 12/13 | Inpatients April - March 13/14 | Difference | Day Cases April - March 12/13 | Day Cases April - March 13/14 | Difference | Total April - March 12/13 | Total April - March 13/14 | Difference |
|---|---|---|---|---|---|---|---|---|---|
| General Surgery | 2,275 | 1,723 | -552 | 6,275 | 1,618 | -4,657 | 8,550 | 3,341 | -5,209 |
| Urology | 1,040 | 1,050 | 10 | 3,172 | 903 | -2,269 | 4,212 | 1,953 | -2,259 |
| Trauma & Orthopaedics | 1,556 | 1,914 | 358 | 3,125 | 3,820 | 695 | 4,681 | 5,734 | 1,053 |
| ENT | 590 | 430 | -160 | 976 | 1,148 | 172 | 1,566 | 1,578 | 12 |
| Ophthalmology (see below) | 65 | 41 | -24 | 5,105 | 5,918 | 813 | 5,170 | 5,959 | 789 |
| Oral Surgery | 17 | 6 | -11 | 1,339 | 1,530 | 191 | 1,356 | 1,536 | 180 |
| Endoscopy | 0 | 202 | 202 | 0 | 8,986 | 8,986 | 0 | 9,188 | 9,188 |
| Gastroenterology | 77 | 22 | -55 | 2,954 | 18 | -2,936 | 3,031 | 40 | -2,991 |
| Haematology | 5 | 2 | -3 | 2,501 | 2,721 | 220 | 2,506 | 2,723 | 217 |
| Gynaecology | 503 | 411 | -92 | 2,320 | 2,083 | -237 | 2,823 | 2,494 | -329 |
| Others | 511 | 386 | -125 | 3,186 | 3,032 | -154 | 3,697 | 3,418 | -279 |
| **Total** | **6,639** | **6,187** | **-452** | **30,953** | **31,777** | **824** | **37,592** | **37,964** | **372** |
| **Ophthalmology Analysis** | | | | | | | | | |
| General | 65 | 41 | -24 | | | 0 | 65 | 41 | -24 |
| ARMD | | | 0 | | | 0 | 0 | 0 | 0 |
| Halton Cataracts | | | 0 | | | 0 | 0 | 0 | 0 |
| **Total** | **65** | **41** | **-24** | **0** | **0** | **0** | **65** | **41** | **-24** |

**Changes in recording between 12/13 and 13/14**

In accordance with PbR guidance diagnostic cystoscopies undertaken in Urology are now classed as outpatient procedures rather than day cases.
Inpatient & daycase endoscopy activity previously recorded under General Surgery, Urology and Gastroenterology is now recorded under Endoscopy .

**Analysis of Waiting List as at 31st March 2013 and 31st March 2014.**

| Specialty | Waiting List as at 31.03.13 | Waiting List as at 31.03.14 | Difference |
|---|---|---|---|
| General Surgery | 800 | 845 | 45 |
| Urology | 581 | 507 | -74 |
| Trauma & Orthopaedics | 1,430 | 1,047 | -383 |
| ENT | 296 | 146 | -150 |
| Ophthalmology | 877 | 810 | -67 |
| Oral Surgery | 179 | 279 | 100 |
| Pain Management | 94 | 81 | -13 |
| Gastroenterology | 296 | 329 | 33 |
| Haematology | 3 | 2 | -1 |
| Gynaecology | 198 | 254 | 56 |
| Others | 246 | 218 | -28 |
| **Total** | **5,000** | **4,518** | **-482** |

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

**Divisional Analysis**

**Net divisional income and expenditure (excludes clinical income)**

| Division | Average Monthly Variance 12/13 £000 | Variance to December 13/14 £000 | January Variance 13/14 £000 | February Variance 13/14 £000 | March Variance 13/14 £000 | Year to date Variance 13/14 £000 | Average Monthly Variance 13/14 £000 | Movement in Average Monthly Variance £000 |
|---|---|---|---|---|---|---|---|---|
| **Clinical** | | | | | | | | |
| Scheduled Care (Appendix G) | -255 | -2,440 | -265 | -49 | -160 | -2,914 | -243 | 12 |
| Unscheduled Care (Appendix H) | -400 | -2,466 | -452 | -240 | -403 | -3,561 | -297 | 104 |
| WC&SS (Appendix I) | -37 | -776 | 28 | -12 | -135 | -895 | -75 | -38 |
| **Non Clinical** | | | | | | | | |
| Operations - Central | -3 | 75 | 22 | 20 | 21 | 138 | 12 | 15 |
| Operations - Estates | -22 | -62 | 46 | -48 | 3 | -61 | -5 | 17 |
| Operations - Facilities | -2 | -174 | -8 | 38 | 10 | -134 | -11 | -9 |
| Business Development | 5 | 148 | 13 | 0 | -44 | 117 | 10 | 5 |
| Finance | 1 | 8 | -2 | -1 | 2 | 7 | 1 | 0 |
| Information Technology | 6 | -8 | 27 | 2 | 5 | 26 | 2 | -4 |
| Nursing | 0 | 37 | 1 | 4 | -2 | 40 | 3 | 3 |
| Governance & Workforce | 6 | 418 | 47 | 61 | 138 | 664 | 55 | 49 |
| Trust Executive | 9 | 59 | 7 | 3 | 8 | 77 | 6 | -2 |
| **Total** | **-692** | **-5,181** | **-536** | **-222** | **-557** | **-6,496** | **-541** | **151** |

Positive = underspent
Negative = overspent

**Warrington and Halton Hospitals NHS Foundation Trust** **Appendix G1**

**Scheduled Care Divisional Dashboard as at 31st March 2014**

**Summary Position**

| Narrative | Annual Budget £000 | Month 12 Budget £000 | Month 12 Actual £000 | Month 12 Variance £000 | Month 12 Variance % | Year to Date Budget £000 | Year to Date Actual £000 | Year to Date Variance £000 | Year to Date Variance % |
|---|---|---|---|---|---|---|---|---|---|
| **Budget Variance** | | | | | | | | | |
| Income | 475 | 45 | 45 | 1 | 1.3% | 475 | 510 | 36 | 7.5% |
| Pay | -40,547 | -3,442 | -3,549 | -107 | 3.1% | -40,547 | -42,462 | -1,916 | 4.7% |
| Non Pay | -12,610 | -1,057 | -1,110 | -54 | 5.1% | -12,610 | -13,644 | -1,034 | 8.2% |
| **Total** | **-52,682** | **-4,455** | **-4,614** | **-160** | **3.6%** | **-52,682** | **-55,596** | **-2,914** | **5.5%** |
| | | | | | | | | | |
| **Clinical Income (by specialty)** | | | | | | | | | |
| General Surgery | 19,788 | 1,580 | 1,573 | -7 | 0.5% | 19,816 | 18,568 | -1,248 | 6.3% |
| Urology | 4,291 | 392 | 405 | 13 | 3.2% | 4,291 | 4,515 | 224 | 5.2% |
| Trauma & Orthopaedics | 24,638 | 2,215 | 2,101 | -114 | 5.1% | 24,638 | 24,654 | 16 | 0.1% |
| ENT | 3,962 | 328 | 269 | -59 | 18.0% | 3,962 | 3,699 | -263 | 6.6% |
| Ophthalmology | 8,384 | 693 | 831 | 138 | 19.9% | 8,383 | 9,341 | 958 | 11.4% |
| Oral Surgery | 1,413 | 118 | 123 | 5 | 4.4% | 1,413 | 1,354 | -59 | 4.2% |
| Orthodontics | 550 | 46 | 49 | 3 | 6.8% | 550 | 504 | -46 | 8.4% |
| Anaesthetics | 957 | 81 | 90 | 9 | 11.0% | 957 | 1,075 | 118 | 12.3% |
| Adult Critical Care | 8,799 | 733 | 465 | -268 | 36.6% | 8,799 | 8,209 | -590 | 6.7% |
| Divisional Block Income | 265 | 22 | 22 | 0 | 0.0% | 265 | 265 | 0 | 0.0% |
| Non-Elective Fines | -694 | -58 | -41 | 17 | 30.0% | -694 | -493 | 201 | 29.0% |
| **Total** | **72,353** | **6,151** | **5,888** | **-264** | **4.3%** | **72,380** | **71,691** | **-689** | **1.0%** |
| | | | | | | | | | |
| **CIP** | **1,638** | **219** | **265** | **46** | **21.0%** | **1,638** | **1,625** | **-13** | **-0.8%** |

**RAG rating**

Positive variance or breakeven position = Green
Adverse variance of 0.5% or less = Amber
Adverse variance of more than 0.5% = Red

*Positive variance = overachievement on income or underspend on expenditure*
*Negative variance = underachievement on income or overspend on expenditure*

| SLR Performance (13/14 Q3) | Contribution £000 | EBITDA £000 | EBITDA % | Margin £000 | Margin % |
|---|---|---|---|---|---|
| Surgery | 1,473 | -564 | -3.1% | -1,846 | -10.0% |
| Critical Care (Adult & Neonatal) | 742 | -83 | -1.1% | -397 | -5.4% |
| Urology | 743 | 298 | 6.3% | 4 | 0.1% |
| Trauma & Orthopaedics | 1,901 | -125 | -0.6% | -1,187 | -6.1% |
| ENT | 533 | 252 | 8.3% | 38 | 1.3% |
| Anaesthetics & Pain Management | 238 | 171 | 21% | 107 | 13.1% |
| Ophthalmology | 1,592 | 1,000 | 13.7% | 599 | 8.2% |
| **Total** | **7,221** | **949** | | **-2,683** | **-4.0%** |

**RAG Rating (SLR)**

Rating based on the 13/14 planned margins:
- EBITDA margin = 5.4%
- Surplus margin = 0.8%

Red = below margin
Green = above margin

**Warrington and Halton Hospitals NHS Foundation Trust**

**Appendix G2**

**Scheduled Care Divisional Dashboard as at 31st March 2014**

**Variance Analysis**

| Category | Month 1 £000 | Month 2 £000 | Month 3 £000 | Month 4 £000 | Month 5 £000 | Month 6 £000 | Month 7 £000 | Month 8 £000 | Month 9 £000 | Month 10 £000 | Month 11 £000 | Month 12 £000 | YTD £000 | Reason for Variance | Resultant Action to be taken (including names and dates) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Budgeted Income** | | | | | | | | | | | | | | | |
| Divisional Income | 3 | 9 | 3 | 7 | 4 | 6 | -11 | -6 | 26 | -5 | -2 | 1 | 36 | M9 favourable position reported : £6.5k related to additional income from Trauma and Resus for training in theatres and £17k WLI costs recharged to other organisations.<br>Adverse variance with effect from M7 is the result of the cessation of the Vascular SLA with St Helens and Knowsley from 30.09.13.<br>Other divisional income received relates to staff secondments and sales of goods. | N/A |
| | **3** | **9** | **3** | **7** | **4** | **6** | **-11** | **-6** | **26** | **-5** | **-2** | **1** | **36** | | |
| **Budgeted Pay** | | | | | | | | | | | | | | | |
| WLIs- Critical Care | -104 | -81 | -92 | -140 | -57 | -109 | -65 | -92 | -41 | -77 | -49 | -46 | -953 | Additional Theatre and Anaesthetist WLIs necessary to meet demand and targets. Significant reduction in M9 reflective of reduction of sessions as agreed between SW & KW, WLI spend in M10 (£49.9k) is more than double that in M9 (£21.6k).<br>Significant reduction in M5 was due to the limited availability of patients able to attend and also annual leave of medical staff. | To review levels of activity and alternative arrangements for undertaking this activity. Funding identified during the budget setting process and held in reserves<br>Demand and Capacity paper now completed and necessary actions to be identified. |
| WLIs - T&O | -20 | -19 | -24 | -31 | -22 | -29 | -21 | -36 | -22 | -22 | -16 | -14 | -276 | WLIs necessary to meet demand and targets. Income target met for Month 7 for Daycases and Electives. | |
| WLIs - Surgery Medical Staff | -71 | -74 | -83 | -101 | -54 | -72 | -69 | -54 | -44 | -52 | -30 | -47 | -750 | Additional WLIs necessary to meet demand and targets - Significant reduction in M5 due to the transfer of YTD Endoscopy WLI costs to Unscheduled Care and also limited availability of patients able to attend and also annual leave of staff. | Ophthalmology - One vacancy filled wef August and second vacancy to be filled from November. Middle Grade job plans are going to be reviewed to incorporate an additional theatre session per week.<br>General Surgery - Reviewing the use of twin theatres at Halton for use by Senior SpR. Clinical lead has agreed, rotas now need to be amended to accommodate this change.<br>Demand and Capacity paper now completed and necessary actions to be identified. |
| Medical Staff pay - Urology | -52 | -11 | -7 | -3 | -7 | -20 | -16 | -12 | -7 | -9 | -12 | -19 | -175 | Cover of middle grade retirement in March. Cost of covering sickness for both on call and cover provided by locum were incurred in April & May. All other overspend relates to WLI costs, September was particularly high following annual and sick leave in August. M11 includes the use of agency to cover a vacancy at middle grade. | Sick leave has now ceased. Business case for a 4th Urologists has been completed, this would reduce the number of WLIs and deliver the service in a more sustainable way. |
| Medical Staff pay - Anaesthetics (excluding WLIs) | -22 | -23 | 21 | -4 | -42 | -34 | -55 | -45 | 18 | -19 | -32 | -17 | -253 | Anaesthetic Medical Staff M9 accrual for job planning 12/13 of £36.5k being released in month.<br>The overspend is due to additional hours at middle grade and agency costs to cover vacancies at consultant level, annual leave, sickness and 4 levels of on call, although the overspend has reduced in month following the revised job plans at middle grade which were implemented in November.<br>An agreement to pay an additional £8 per hour from August has also contributed to the overspend. | The ability to cover the rota with current numbers is not possible, this should has been incorporated into the Demand and Capacity Review and actions from the review are now awaited. |
| Ward Nursing | -31 | -79 | -51 | -14 | -18 | -18 | -95 | -6 | -5 | -28 | 18 | 34 | -291 | M11 reduction in number of beds escalated and staff returning from sick leave has resulted in reduced usage of temporary staffing.<br>M10 Increased bank use in month on ITU to a breakeven position and CMTC admin post budget transfer caused a £3k variance in month.<br>The M9 position is the most favourable position to date and includes the utilisation of CMTC staff on the Warrington site over the festive period rather than high cost agency.<br>The M7 position includes the devolvement of the YTD staff vacancy turnover factor to dept./ward level, this accounts for £68.9k of the adverse variance.<br>The M7 position excluding the vacancy staff turnover factor is £26k and is a result of NHSP nursing usage including the cover of escalation beds open on A5 (keeping SAU open overnight or later than originally funded), A6, A9 and B19 to meet demand. | |
| Pay variance | 126 | -6 | -24 | 37 | 34 | -4 | 151 | 104 | 128 | 120 | 114 | 2 | 782 | M11 £87k relates to underlying medical staff underspends in month on General Surgery, T&O and Ophthalmology.<br>M10 £74.8k relates to underlying medical staffing underspend in month on General Surgery, ENT and T&O.<br>M9 position includes the release of job plan accruals relating to Surgery and T&O of £57.8k. T&O Medical Staff vacancies and reduction in medical agency circa £20k. Theatre Staffing excluding WLI breaking even in month.<br>M8 position includes the release of job plan accruals relating to Surgery of circa £50k and a revision to additional consultant ophthalmologist sessions from Aintree following a conversation with the supplying trust of £28k.<br>£30k favourable variance has occurred in Theatres following a reduction in temporary staffing and overtime payments, back to levels comparable to August.<br>M7 includes the opposite side of the vacancy staff turnover variance shown against ward nursing and medical staff budgets. | N/A |
| | **-174** | **-293** | **-260** | **-256** | **-166** | **-286** | **-169** | **-141** | **27** | **-86** | **-7** | **-107** | **-1915** | | |
| **Budgeted Non Pay** | | | | | | | | | | | | | | | |
| Theatres prosthesis use | 77 | 14 | -60 | -120 | 1 | -15 | -75 | -100 | -100 | -115 | -15 | -53 | -560 | M11 reduction in prosthetic overspend in month includes the agreed level of funding from the Spinal Business Case. Increased activity is the driving factor in the prosthetic spend. Reduction in activity in M5 reduced the prosthesis spend in month to breakeven in month. In month 2 in T&O was offset by a credit of £51k relating to Zimmer products at CMTC. | Continue to review the prosthesis use against activity levels on a monthly basis. Discussions have taken place with Zimmer with regard to the charges to the Trust with a view to reduce costs, a review to standardise prosthesis has commenced with the support from Supplies. |
| Theatres other clinical supplies | 80 | -8 | -111 | 17 | -29 | -72 | 25 | -88 | -84 | -54 | -17 | 43 | -298 | Month 12: Year end stocktake adjustment of £132k include in month.<br>Month 11 : Position includes funding in month of £16k in relation to the approved Spinal Business Case.<br>Month 9: Position includes £31.8k Qtr. 3 stock take and £19k increased procurement CIP as per Qtr. 3 review.<br>Month 8: CMTC £24.8k overspent in month which has been deemed in relation to increased activity. Warrington Theatres are overspent by £53.8k in month which includes £339.7k on equipment hire costs, for use in trauma. Halton overspent by £14.9k in month which included a one off prosthesis, increased consumables used for laser vein procedure used for reducing the number of breaching and long waiting patients and a bulk purchase due to a manufacturing issue.<br>Month 7: Synergy contract inflation funded in month (£103k FYE funding), £51.5k favourable variance in month, which is offset by reduced credits received against contract and equipment repairs. CMTC Theatre overspends (excluding prosthesis) of £128k YTD are deemed related to activity. | Receipting of orders has be questioned at SMT and this issue will be discussed by those that receipt in theatres.<br>Quarter 3 stock take to take place last weekend in December. |
| Ward Consumables | -6 | 103 | 23 | 3 | -25 | -9 | -3 | -14 | -42 | -6 | 8 | 0 | 33 | Month 11: includes £12.6k underspend on ITU.<br>Month 9: includes £11k due to increased use of haemafiltration consumables for higher acuity patients. Following budget meetings for M9, Ward Managers confirmed the CSS increase included stocks for over the holiday period and the start of January due to leave, therefore a reduction in January is anticipated.<br>Month 7 includes £5k relating to the purchase of patient cooling kits in month on ITU.<br>Month 6 £6.6k relates to A9 and includes £2.8k due to mattress hire.<br>Month 5 £18.5k variance relates to A4 dressings and consumables.<br>Month 2 & 3 position includes credits relating to prior months and the previous financial year for Hill Rom mattress hire. | Receipting of orders has be questioned at SMT and will be communicated to budget holders. |
| Drugs | -30 | 9 | 14 | -58 | -5 | -18 | -39 | -24 | -59 | -2 | -26 | -24 | -262 | £233.8k of the year to date overspend relates to Critical Care directorate, £111.5k to CMTC Theatres due to increased activity levels and £76.2k to ITU which includes the use of haemofiltration fluid. The remaining amount is shared across theatres on both the Warrington and Halton sites. | Review by Divisional SMT of information supplied by Pharmacy in relation to CIP. Review use of drugs particularly in theatres setting. |
| Non pay variance | 53 | -15 | 10 | 0 | 8 | 45 | -30 | -10 | 0 | 3 | 8 | -20 | 52 | N/A | N/A |
| | **174** | **103** | **-123** | **-158** | **-50** | **-70** | **-122** | **-235** | **-285** | **-175** | **-41** | **-54** | **-1035** | | |
| | | | | | | | | | | | | | | | |
| **Total** | **3** | **-181** | **-380** | **-406** | **-212** | **-350** | **-302** | **-381** | **-232** | **-265** | **-50** | **-160** | **-2914** | | |

**Warrington and Halton Hospitals NHS Foundation Trust** **Appendix H1**

**Unscheduled Care Divisional Dashboard as at 31st March 2014**

**Summary Position**

| Narrative | Annual Budget £000 | Month 12 Budget £000 | Month 12 Actual £000 | Month 12 Variance £000 | Month 12 Variance % | Year to Date Budget £000 | Year to Date Actual £000 | Year to Date Variance £000 | Year to Date Variance % |
|---|---|---|---|---|---|---|---|---|---|
| **Budget Variance** | | | | | | | | | |
| Income | 987 | -135 | -114 | 21 | 15.4% | 987 | 1,171 | 184 | 18.6% |
| Pay | -34,824 | -3,015 | -3,334 | -319 | 10.6% | -34,824 | -38,352 | -3,528 | 10.1% |
| Non Pay | -6,236 | -506 | -611 | -105 | 20.7% | -6,236 | -6,451 | -215 | 3.5% |
| **Total** | **-40,073** | **-3,655** | **-4,058** | **-403** | **11.0%** | **-40,073** | **-43,633** | **-3,560** | **8.9%** |
| | | | | | | | | | |
| **Clinical Income (by specialty)** | | | | | | | | | |
| Accident & Emergency | 6,559 | 556 | 422 | -134 | 24.1% | 6,559 | 5,695 | -864 | 13.2% |
| Cardiothoracic Surgery | 90 | 7 | 7 | 0 | 0.3% | 90 | 76 | -13 | 14.9% |
| Gastroenterology | 2,355 | 196 | 277 | 81 | 41.3% | 2,355 | 2,085 | -271 | 11.5% |
| General Medicine | 29,954 | 2,529 | 2,356 | -173 | 6.8% | 29,954 | 29,121 | -833 | 2.8% |
| Endoscopy | 6,043 | 514 | 480 | -35 | 6.7% | 6,043 | 5,702 | -341 | 5.6% |
| Cardiology | 5,126 | 425 | 528 | 104 | 24.4% | 5,005 | 5,157 | 152 | 3.0% |
| Medicine For The Elderly | 445 | 35 | 38 | 3 | 9.5% | 445 | 536 | 90 | 20.2% |
| A&E Attendances | 10,275 | 873 | 876 | 3 | 0.3% | 10,275 | 10,164 | -111 | 1.1% |
| OP Echo Unbundled | 325 | 27 | 28 | 1 | 3.7% | 325 | 364 | 38 | 11.7% |
| CPAP | 83 | 7 | 7 | 0 | 3.7% | 83 | 88 | 5 | 5.8% |
| Block Income | 1,792 | 149 | 149 | 0 | 0.0% | 1,792 | 1,792 | 0 | 0.0% |
| Non Elective Marginal/Readmissions | -1,371 | -114 | -80 | 34 | 30.0% | -1,371 | -973 | 398 | 29.0% |
| **Total** | **61,676** | **5,205** | **5,089** | **-115** | **2.2%** | **61,556** | **59,806** | **-1,750** | **2.8%** |
| | | | | | | | | | |
| **CIP** | **1,937** | **234** | **229** | **-5** | **2.1%** | **1,937** | **1,925** | **-12** | **0.6%** |

**RAG rating**

Positive variance or breakeven position = Green

Adverse variance of 0.5% or less = Amber

Adverse variance of more than 0.5% = Red

*Positive variance = overachievement on income or underspend on expenditure*

*Negative variance = underachievement on income or overspend on expenditure*

| SLR Performance (13/14 Q3) | Contribution £000 | EBITDA £000 | EBITDA % | Margin £000 | Margin % |
|---|---|---|---|---|---|
| Medicine | 1,086 | -2,041 | -7.3% | -3,156 | -11.3% |
| Cardiology | -494 | -1,096 | -26.2% | -1,535 | -36.7% |
| Accident & Emergency | 2,569 | 1,699 | 14.3% | 1,134 | 9.5% |
| **Total** | **3,161** | **-1,438** | **3.2%** | **-3,557** | **-1.1%** |

**RAG Rating (SLR)**

Rating based on the 13/14 planned margins:

- EBITDA margin = 5.4%
- Surplus margin = 0.8%

Red = below margin

Green = above margin

**Warrington and Halton Hospitals NHS Foundation Trust** **Appendix H2**

**Unscheduled Care Divisional Dashboard as at 31st March 2014**

**Variance Analysis**

| Category | Month 1 £000 | Month 2 £000 | Month 3 £000 | Month 4 £000 | Month 5 £000 | Month 6 £000 | Month 7 £000 | Month 8 £000 | Month 9 £000 | Month 10 £000 | Month 11 £001 | Month 12 £002 | YTD £000 | Reason for Variance | Resultant Action to be taken (including names and dates) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Budgeted Income** | | | | | | | | | | | | | | | |
| Divisional Income | 13 | 16 | 15 | 27 | 21 | 13 | 19 | -13 | 9 | 33 | 10 | 21 | 184 | N/A | N/A |
| | **13** | **16** | **15** | **27** | **21** | **13** | **19** | **-13** | **9** | **33** | **10** | **21** | **184** | | |
| **Budgeted Pay** | | | | | | | | | | | | | | | |
| Nursing - Escalation | -71 | -179 | -72 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -321 | NHSP nursing covering escalation beds open on UCC and A&E/medicine nursing supporting other areas in trust, backfill via NHSP. | UCC closed and escalation stopped at the end of June 13. |
| Nursing - Winter pressures | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -65 | -8 | -74 | Winter pressures Bank and Agency costs in excess of funding received. | Winter escalation areas were due to close March 13. Some beds have remained open in April due to beds closures on wards with D&V. |
| Nursing - Specialing | 25 | -48 | -21 | -40 | -48 | -31 | -42 | -36 | 10 | -21 | 15 | -21 | -257 | Patient specialing (predominantly on B12; C22; A7). | K Edge has reviewed nursing levels and has produced a paper that has gone to Execs for discussion/approval. |
| Nursing - Acute Medicine | 4 | 1 | -32 | -25 | -42 | -19 | -16 | -15 | -21 | -28 | -23 | -22 | -236 | Bank and agency usage on AMU due to GPAU escalation, sickness and vacancies. A2 location on Daresbury imapcting on staffing levels. | K Edge has reviewed nursing levels and has produced a paper that has gone to Execs for discussion/approval. |
| Nursing - A&E | -6 | -32 | -31 | -53 | -47 | -54 | -52 | -53 | -36 | -36 | -49 | -56 | -505 | Over-establishment of A&E qualified nurses to meet activity levels and waiting time targets and cover for sickness, as agreed with KD and SW meeting 14/2/13. | A&E establishment agreed at exec meeting 5/9/13. Recruitment now in progress. |
| WLIs | -30 | -67 | -39 | -58 | -151 | -57 | -59 | -56 | -47 | -44 | -45 | -54 | -706 | Predominantly WLIs in Endoscopy. This has already started reducing. | AGM working on Endo efficiency as per PID. WLIs already reducing. |
| Medical Staffing - A&E | -11 | -58 | -4 | -42 | -62 | -65 | -60 | -68 | -50 | -56 | -28 | -36 | -540 | Agency cover for vacancies and workload. Reduction in agency Mth 11 but increase in WLI payments. | Vacant consultant posts out to recruitment. DMD has produced a paper that was discussed at execs meeting 17/10/13. |
| Medical Staffing - AMU/Medicine | -5 | -11 | 6 | 29 | -34 | -70 | -92 | -52 | -97 | -190 | -26 | -34 | -576 | Locum and agency staffing covering vacancies and gaps on rota. £179k in month 10 relates to prior periods due to data errors in medical staffing database. | Changes to on call rota for juniors in place and appointment of 10 clinical fellowes to cover rota gaps and avoid agency costs. AMU consultant posts now recruited to substantively. |
| Pay variance | 19 | -35 | -44 | -51 | -56 | -43 | 117 | -2 | -33 | -62 | -37 | -87 | -314 | N/A | N/A |
| | **-74** | **-428** | **-236** | **-240** | **-439** | **-339** | **-204** | **-281** | **-275** | **-437** | **-257** | **-319** | **-3528** | | |
| **Budgeted Non Pay** | | | | | | | | | | | | | | | |
| Clinical Non Pay | 31 | 98 | 47 | -22 | -31 | -45 | 51 | -54 | -146 | -48 | 7 | -105 | -215 | N/A | N/A |
| | **31** | **98** | **47** | **-22** | **-31** | **-45** | **51** | **-54** | **-146** | **-48** | **7** | **-105** | **-215** | | |
| **Total** | **-29** | **-314** | **-174** | **-234** | **-449** | **-371** | **-134** | **-348** | **-412** | **-451** | **-240** | **-403** | **-3560** | | |
| **Clinical Income** | | | | | | | | | | | | | | | |
| Accident & Emergency | -77 | -27 | -25 | -64 | -15 | -33 | -48 | -44 | -122 | -124 | -151 | -134 | -864 | In March, A&E attednances recovered compared to previous months. Generally will need to see what happens early 14/15 | Audit of activity recording, as reported activity seems to have tailed off with the introuduction of Symphpony IT system |

**Warrington and Halton Hospitals NHS Foundation Trust** **Appendix I1**

**Womens, Childrens and Support Services Divisional Dashboard as at 31st March 2014**

**Summary Position**

| Narrative | Annual Budget £000 | Month 12 Budget £000 | Month 12 Actual £000 | Month 12 Variance £000 | Month 12 Variance % | Year to Date Budget £000 | Year to Date Actual £000 | Year to Date Variance £000 | Year to Date Variance % |
|---|---|---|---|---|---|---|---|---|---|
| **Budget Variance** | | | | | | | | | |
| Income | 4,512 | 216 | 195 | -21 | 9.7% | 4,512 | 4,672 | 160 | 3.5% |
| Pay | -48,959 | -4,180 | -4,118 | 62 | 1.5% | -48,959 | -48,817 | 142 | 0.3% |
| Non Pay | -12,729 | -1,068 | -1,241 | -173 | 16.2% | -12,729 | -13,806 | -1,077 | 8.5% |
| **Total** | **-57,176** | **-5,032** | **-5,164** | **-132** | 2.6% | **-57,176** | **-57,951** | **-775** | **1.4%** |
| | | | | | | | | | |
| **Clinical Income (by specialty)** | | | | | | | | | |
| Paediatrics | 6,692 | 571 | 622 | 50 | 8.8% | 6,692 | 6,665 | -26 | 0.4% |
| Maternity (Obs & Midwife Episodes) | 8,118 | 703 | 652 | -50 | 7.2% | 8,118 | 8,050 | -67 | 0.8% |
| Gynaecology | 6,261 | 541 | 525 | -15 | 2.8% | 6,261 | 5,454 | -807 | 12.9% |
| Haematology | 2,649 | 223 | 206 | -17 | 7.8% | 2,649 | 2,766 | 117 | 4.4% |
| Critical Care (neonatal) | 2,148 | 179 | 64 | -115 | 64.4% | 2,148 | 1,983 | -166 | 7.7% |
| DA Pathology | 4,577 | 395 | 457 | 62 | 15.7% | 4,577 | 5,032 | 455 | 9.9% |
| DA/OP Radiology | 5,324 | 445 | 435 | -10 | 2.3% | 5,324 | 5,646 | 322 | 6.1% |
| Genito-Urinary Medicine | 514 | 47 | 47 | 0 | 0.4% | 514 | 551 | 37 | 7.2% |
| Rheumatology | 1,181 | 106 | 111 | 5 | 4.9% | 1,181 | 1,193 | 12 | 1.0% |
| Block Income | 7,675 | 640 | 640 | 0 | 0.0% | 7,675 | 7,675 | 0 | 0.0% |
| Non-Elective Marginal Rate/Readmissions | -173 | -14 | -10 | 4 | 30.0% | -173 | -123 | 50 | 29.0% |
| **Total** | **44,966** | **3,836** | **3,750** | **-86** | **2.2%** | **44,966** | **44,893** | **-73** | **0.2%** |
| | | | | | | | | | |
| **CIP** | **2,250** | **253** | **282** | **29** | **11.5%** | **2,250** | **2,197** | **-53** | **-2.4%** |

**RAG rating**

Positive variance or breakeven position = Green
Adverse variance of 0.5% or less = Amber
Adverse variance of more than 0.5% = Red

*Positive variance = overachievement on income or underspend on expenditure*
*Negative variance = underachievement on income or overspend on expenditure*

| SLR Performance (13/14 Q3) | Contribution £000 | EBITDA £000 | EBITDA % | Margin £000 | Margin % |
|---|---|---|---|---|---|
| Obstetrics | -465 | -1,212 | -15.5% | -1,635 | -20.9% |
| Gynaecology | 550 | 160 | 3.7% | -63 | -1.5% |
| GUM | 299 | 247 | 17.2% | 215 | 15.0% |
| Rheumatology | 116 | -7 | -0.2% | -71 | -2.4% |
| Haematology | 775 | 576 | 17.5% | 496 | 15.0% |
| Direct Access Pathology | 953 | 703 | 19.9% | 552 | 15.6% |
| Direct Access Radiology | 905 | 783 | 36.7% | 552 | 25.8% |
| Paediatrics | 1,565 | 1,062 | 20.6% | 790 | 15.4% |
| **Total** | **4,699** | **2,311** | | **836** | |

**RAG Rating (SLR)**

Rating based on the 13/14 planned margins:
- EBITDA margin = 5.4%
- Surplus margin = 0.8%

Red = below margin

Green = above margin

**Warrington and Halton Hospitals NHS Foundation Trust** **Appendix I2**

**Womens, Childrens and Support Services Divisional Dashboard as at 31st March 2014**

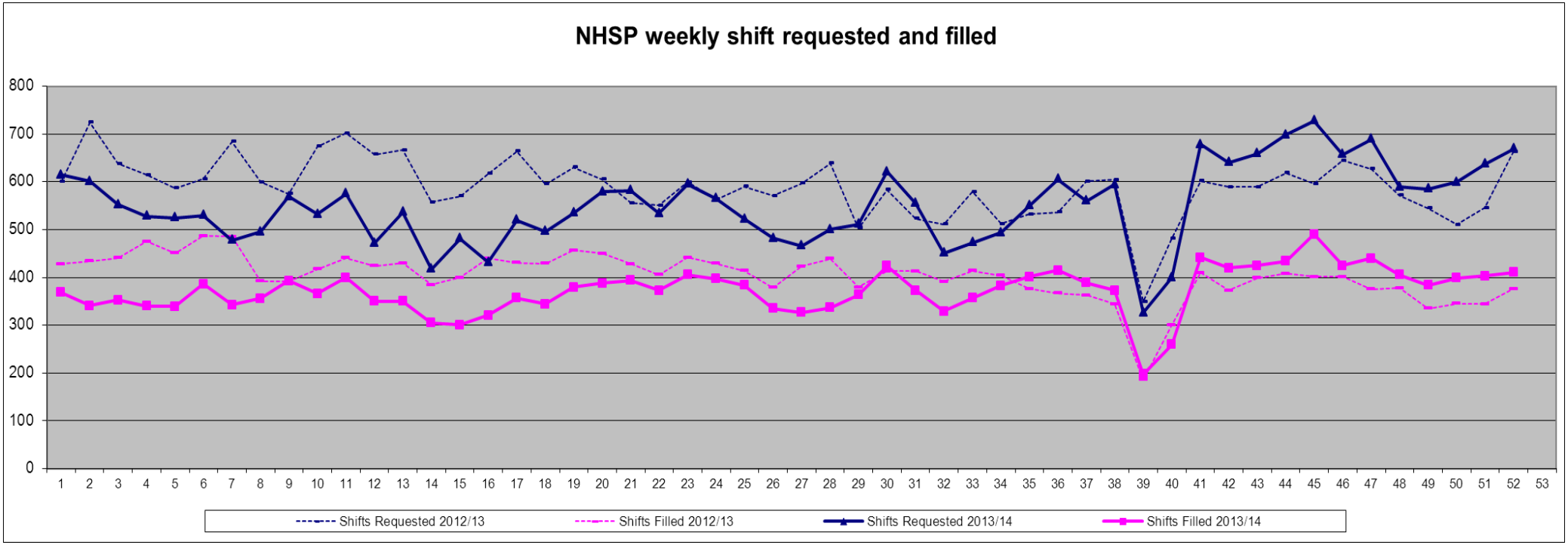
**Variance Analysis**

| Category | Month 1 £000's | Month 2 £000's | Month 3 £000's | Month 4 £000's | Month 5 £000's | Month 6 £000's | Month 7 £000's | Month 8 £000's | Month 9 £000's | Month 10 £000's | Month 11 £000's | Month 12 £000's | YTD £000's | Reason for Variance | Resultant Action to be taken (including names and dates) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Budgeted Income** | | | | | | | | | | | | | | | |
| Therapies- MSK | -18 | -18 | -18 | -18 | 65 | -1 | -1 | 1 | 0 | 0 | -16 | -35 | -61 | Review of SLA and accounting for deferred income. | Change in income stream now confirmed |
| Radiology | | 7 | 3 | -10 | 8 | 2 | 3 | 3 | 5 | -2 | 3 | 1 | 24 | Walton Centre Scans accruals invoiced. | N/A |
| Pharmacy | 14 | 7 | 14 | 7 | -19 | -4 | 16 | 27 | 16 | 17 | 2 | 1 | 97 | Review of SLA previous month included fve £9k dispensing services to St&K | N/A |
| Income variance | 4 | 24 | -5 | -1 | 22 | 77 | -24 | 0 | -8 | 8 | -10 | 12 | 98 | Recharge for external tests, over achieved previous month. | N/A |
| | **-1** | **19** | **-6** | **-22** | **76** | **74** | **-6** | **31** | **13** | **23** | **-22** | **-21** | **158** | | |
| **Budgeted Pay** | | | | | | | | | | | | | | | |
| Pathology | -40 | -2 | -6 | 6 | 6 | -36 | 0 | 5 | 52 | 22 | 14 | 32 | 52 | Cytology Contract previously overspending has been funded & Vacant Pots | Finance to liaise with HR on final job planning contracts and calculations |
| Radiology | -27 | -10 | -63 | -58 | -55 | -94 | -56 | -69 | -66 | -37 | -19 | -72 | -626 | WLI's & Agency staffing-reduction in agency staffing / reduction in month due to review of planned lists and improved throughput of WLI. | WLI's continuing until the new posts which were agreed in the business case are in post. Consultant posts are being advertised. 2 Agency staff have been released with some of the new radiographers commencing |
| Divisional Management | -10 | -8 | -8 | -8 | -7 | -6 | -6 | -19 | -8 | -9 | -14 | -12 | -114 | Unfunded Modern Matron post and vacancy turnover target | Division looking to identify funding to Matron post. |
| Pay variance | 57 | 40 | 54 | 47 | 21 | 28 | 82 | 154 | 52 | 104 | 79 | 114 | 832 | Unfilled posts in Therapies | N/A |
| | **-20** | **21** | **-24** | **-13** | **-35** | **-108** | **20** | **70** | **30** | **80** | **61** | **62** | **144** | | |
| **Budgeted Non Pay** | | | | | | | | | | | | | | | |
| Pathology | 32 | -40 | -30 | -32 | -44 | 21 | -68 | -32 | -82 | -7 | -57 | -61 | -400 | Purchase of laboratory consumables & External tests- New annual Premium for Siemens contract- increase due to increased Direct access requests | Monitor stock levels- External tests are a possible upcoming CIP scheme to reduce unnecessary tests |
| Radiology | 29 | 47 | 18 | 16 | -132 | -65 | -53 | -3 | -5 | -53 | 13 | -82 | -270 | Increase in External Tests being investigated. | Prepayment Schedule re worked from April 13 |
| Drugs | -13 | -28 | 31 | -17 | -14 | -19 | 15 | 8 | 22 | 37 | 49 | 39 | 110 | Blood Contract under performance masking the drug over spend on the wards. Increased expenditure on Medical Gases | Pharmacy and finance to outline cause for these overspends and identify corrective actions to be taken |
| Non pay variance | 17 | -29 | -43 | -35 | 5 | -84 | -56 | -52 | -86 | -38 | -46 | -69 | -516 | N/A | N/A |
| | **64** | **-50** | **-24** | **-68** | **-185** | **-147** | **-162** | **-78** | **-151** | **-60** | **-42** | **-173** | **-1,076** | | |
| **Total** | **43** | **-10** | **-53** | **-103** | **-144** | **-181** | **-149** | **23** | **-108** | **43** | **-3** | **-132** | **-775** | | Dan Grimes to benchmark WHH maternity costs |
| **Clinical Income** | | | | | | | | | | | | | | | |
| Paediatrics | 21 | 0 | -101 | 1 | -76 | -59 | -50 | 27 | 76 | 62 | 23 | 50 | -26 | Above plan for last 5 months of 13/14, profiling issue identified earlier in the year reflects this | Ensure profiling in 2014/2015 plans reflected more accurately |
| Gynaecology | -70 | -73 | -95 | -92 | -85 | -68 | -60 | -88 | -73 | -34 | -54 | -15 | -807 | Continued under-performance against plan in line with previous trends. Catch up of activity and income from additional Junior Doctors being in post has not returned activity levels to plan. | Finance and Division working togther on 14/15 plan and opportunity. |
| Haematology | 42 | -1 | 8 | 3 | -2 | 16 | 28 | 8 | 12 | 14 | 6 | -17 | 117 | Specialty well above plan - OP and unbundled Chemotherapy activity the drivers behind this | N/A |
| Critical Care (neonatal) | 5 | -40 | 37 | 5 | -7 | -55 | 99 | 37 | -26 | -58 | -48 | -115 | -166 | Does not include patients not discharged (was included in previous months so will have negative impact on Month 12 position). Overall position for year reflective of performance against plan directly. | 14/15 plans to be based on Month 8 figure, underperformance since will mean potential underperformance in new year - needs to be discussed |
| DA Pathology | 74 | 93 | -69 | 37 | 20 | 22 | 59 | 25 | 33 | 65 | 34 | 62 | 455 | Inclusion of activity for HPV at increased tariff, both of which were not included within plans, part of the reason - also activity levels well above plan in other areas | Activity plans for 14/15 will be rebased on the higher level of activity seen. |
| DA Radiology | 114 | -23 | -147 | -19 | 160 | 120 | 57 | 30 | 25 | 37 | -22 | -10 | 322 | Activity continues to perform significantly above plan. | Activity plans for 14/15 will be rebased on the higher level of activity seen. |
| Balance | -33 | 114 | -139 | 12 | 82 | -18 | 4 | -44 | 40 | 48 | 7 | -41 | 32 | Various non-major variances not included above including Maternity activity | N/A |
| | **153** | **70** | **-506** | **-53** | **92** | **-42** | **137** | **-5** | **87** | **134** | **-54** | **-86** | **-73** | | |
| **CIP** | | | | | | | | | | | | | | | |
| Pharmacy-medicine procurement | 2 | 1 | -4 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | N/A | N/A |
| WCSS sustainability | - | - | 35 | -32 | -33 | -33 | -89 | 135 | -7 | -8 | -7 | -8 | -47 | YTD actual achieved £1,276k against target £1,323k. Over performance on direct access pathology and recharges for ultrasound scans helps offset the underperformance on this scheme. | N/A |
| Bright ideas | 0 | 0 | 0 | 0 | 0 | 0 | -8 | 0 | -1 | 0 | 0 | -1 | -10 | YTD actual achieved £40k against target £50k. | N/A |
| 1% WCSS non recurrent | - | - | - | - | - | - | - | -16 | -40 | -40 | -40 | -31 | -167 | YTD actual achieved £59k against target £226k. Over performance on direct access pathology and recharges for ultrasound scans helps offset the underperformance on this scheme. | N/A |
| Direct Access Pathology income | 0 | 0 | 0 | 0 | 0 | 0 | -7 | 71 | 15 | 48 | -10 | 45 | 162 | Income over-achievement offsets the below plan performance on the 1% non-recurrent and sustainability schemes | N/A |
| Reducing DNAs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -12 | -13 | -25 | Scheme commenced February 2014 | N/A |
| Additional Income from ultrasound scans recharged to Bridgewater Community Trust | - | - | - | - | - | - | - | 0 | 0 | 0 | 0 | 35 | 35 | Income over-achieved offets the below plan performance on the 1% non-recurrent and sustainability schemes. | |
| Other divisional CIP schemes | 0 | 0 | 0 | 0 | 0 | 0 | -5 | 1 | 3 | -1 | 0 | 1 | -1 | N/A | N/A |
| | **2** | **1** | **31** | **-31** | **-33** | **-33** | **-109** | **191** | **-30** | **-1** | **-69** | **28** | **-53** | | |

*Positive variance = overachievement on income or underspend on expenditure*
*Negative variance = underachievement on income or overspend on expenditure*

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

**Analysis of NHS Professionals Shifts 2012/13 and 13/14**



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

**Financial Risk Rating as at 31st March 2014**

**Indicators**

| Financial Criteria | Metric | Metric Weighting | Rating Category | | | | |
|---|---|---|---|---|---|---|---|
| | | | 5 | 4 | 3 | 2 | 1 |
| | | | Best | | | | Worst |
| Underlying performance | EBITDA margin | 25% | 11% | 9% | 5% | 1% | <1% |
| Achievement of plan | EBITDA % of plan achieved | 10% | 100% | 85% | 70% | 50% | <50% |
| Financial efficiency | Net return after finance rating | 20% | 3% | 2% | -0.5% | -5% | <-5% |
| | Surplus margin | 20% | 3% | 2% | 1% | -2% | <-2% |
| Liquidity | Liquidity (days) | 25% | 60 | 25 | 15 | 10 | <10 |

Overall rating = weighted average of financial criteria scores

**Financial Risk Rating Metrics**

| Financial Criteria | Metric | Year to Date | |
|---|---|---|---|
| | | Plan | Actual |
| Underlying performance | EBITDA margin % | 3 | 2 |
| Achievement of plan | EBITDA % of plan achieved | 4 | 2 |
| Financial efficiency | Net return after finance rating | 3 | 2 |
| | Surplus margin | 2 | 2 |
| | **Overall financial efficiency rating** | **3** | **2** |
| Liquidity | Liquidity (days) | 4 | 4 |
| **Calculated rating** | | **3.15** | **2.50** |
| **Allocated rating** | | **3** | **2** |

| Risk Ratings Overriding Rules | Rating |
|---|---|
| One financial criterion scored at 1 | 2 |
| One financial criterion scored at 2 | 3 |
| Two financial criteria scored at 2 | 2 |
| Two financial criteria scored at 1 | 1 |
| PBC Breached | 2 |
| Less than 1 year as a Foundation Trust | 4 |

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

**Continuity of Services Rating as at 31st March 2014**

**Indicators**

| Metric | Metric Weighting | Rating Category | | | |
|---|---|---|---|---|---|
| | | 4 | 3 | 2 | 1 |
| | | Best | | | Worst |
| Liquidity Ratio (days) | 50% | 0 | -7 | -14 | < -14 |
| Capital Servicing Capacity (times) | 50% | 2.5 x | 1.75 x | 1.25 x | < 1.25 x |

Overall rating = weighted average of financial criteria scores

**Continuity of Services Risk Rating Metrics**

| Metrics | Definition / Workings | Year to date | |
|---|---|---|---|
| | | Plan £000 | Actual £000 |
| **Liquidity Ratio** | | | |
| Working Capital Balance | Fully committed Working Capital Facility | 0 | 0 |
| | Plus Current Assets | 21,424 | 23,786 |
| | Less Current Liabilities | -17,605 | -20,750 |
| | Less Inventories | -2,569 | -2,769 |
| | | 1,250 | 267 |
| Operating Expenses within EBITDA | | 196,844 | 204,979 |
| Days in period | | 360 | 360 |
| **Liquidity (days)** | | **2.3** | **0.5** |
| **Rating** | | **4** | **4** |
| **Capital Servicing Capacity** | | | |
| Revenue available for capital service | Surplus | 1,152 | -2,849 |
| | Donations and Grants | -867 | -799 |
| | Impairments / Losses or reversals on non PFI | 0 | 697 |
| | Restructuring Costs | 600 | 0 |
| | Depreciation & Amortisation | 6,379 | 5,858 |
| | PDC Dividends | 3,946 | 4,074 |
| | Interest Expense | 11 | 11 |
| | | 11,221 | 6,993 |
| Annual Debt Service | PDC Dividend Expense | 3,946 | 4,074 |
| | Interest Expense | 11 | 11 |
| | Loan Repayments | 450 | 450 |
| | | 4,407 | 4,535 |
| **Capital Servicing Capacity** | | **2.55** | **1.54** |
| **Rating** | | **4** | **2** |
| **Calculated Continuity of Services Ratio** | | **4.0** | **3.0** |
| **Allocated Continuity of Services Ratio** | | **4** | **3** |

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

**Statement of Position as at 31st March 2014**

| Narrative | Audited position as at 31.3.13 £000 | Actual Position as at 28.02.14 £000 | Actual Position as at 31.03.14 £000 | Monthly Movement £000 |
|---|---|---|---|---|
| **ASSETS** | | | | |
| **Non Current Assets** | | | | |
| Intangible Assets | 259 | 299 | 316 | 17 |
| Property Plant & Equipment | 130,252 | 129,504 | 132,580 | 3,076 |
| Other Receivables | 1,900 | 1,264 | 1,233 | -31 |
| Impairment of receivables for bad & doubtful debts | -239 | -200 | -195 | 5 |
| **Total Non Current Assets** | **132,172** | **130,867** | **133,934** | **3,067** |
| **Current Assets** | | | | |
| Inventories | 2,569 | 2,641 | 2,769 | 128 |
| NHS Trade Receivables | 1,164 | 2,113 | 2,988 | 875 |
| Non NHS Trade Receivables | 338 | 1,308 | 1,294 | -14 |
| Other Related party receivables | 606 | 372 | 200 | -172 |
| Other Receivables | 1,153 | 1,640 | 1,960 | 320 |
| Impairment of receivables for bad & doubtful debts | -188 | -280 | -355 | -75 |
| Accrued Income | 764 | 978 | 247 | -731 |
| Prepayments | 1,016 | 2,012 | 1,727 | -285 |
| Cash held in GBS Accounts | 13,139 | 11,710 | 12,950 | 1,240 |
| Cash held in commercial accounts | 1 | | | 0 |
| Cash in hand | 10 | 10 | 6 | -4 |
| **Total Current Assets** | **20,572** | **22,504** | **23,786** | **1,282** |
| **Total Assets** | **152,744** | **153,371** | **157,720** | **4,349** |
| **LIABILITIES** | | | | |
| **Current Liabilities** | | | | |
| NHS Trade Payables | -115 | -941 | -1,010 | -69 |
| Non NHS Trade Payables | -2,576 | -4,254 | -5,728 | -1,474 |
| Other Payables | -4,411 | -4,485 | -4,433 | 52 |
| Capital Payables | -1,124 | -573 | -1,386 | -813 |
| Accruals | -7,922 | -5,214 | -5,986 | -772 |
| Interest payable on non commercial int bearing borrowings | 0 | 0 | 0 | 0 |
| PDC Dividend creditor | -22 | -1,644 | -49 | 1,595 |
| Deferred Income | -1,140 | -2,139 | -1,877 | 262 |
| Provisions | -317 | -283 | -281 | 2 |
| Loans non commercial | -450 | 0 | 0 | 0 |
| **Total Current Liabilities** | **-18,077** | **-19,533** | **-20,750** | **-1,217** |
| **Net Current Assets ( Liabilities )** | **2,495** | **2,971** | **3,036** | **65** |
| **Non Current Liabilities** | | | | |
| Loans non commercial | 0 | 0 | 0 | 0 |
| Provisions | -1,358 | -1,369 | -1,510 | -141 |
| **Total Non Current Liabilities** | **-1,358** | **-1,369** | **-1,510** | **-141** |
| **TOTAL ASSETS EMPLOYED** | **133,309** | **132,469** | **135,460** | **2,991** |
| **TAXPAYERS AND OTHERS EQUITY** | | | | |
| **Taxpayers Equity** | | | | |
| Public Dividend Capital | 87,950 | 89,780 | 90,063 | 283 |
| Retained Earnings prior year | 11,679 | 11,679 | 12,438 | 759 |
| Retained Earnings current year | 0 | -2,670 | -2,849 | -179 |
| **Sub total** | **99,629** | **98,789** | **99,652** | **863** |
| **Other Reserves** | | | | |
| Revaluation Reserve | 33,680 | 33,680 | 35,808 | 2,128 |
| **Sub total** | **33,680** | **33,680** | **35,808** | **2,128** |
| **TOTAL TAXPAYERS AND OTHERS EQUITY** | **133,309** | **132,469** | **135,460** | **2,991** |

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

**Cash Flow Statement as at 31st March 2014**

| | Actual April £000's | Actual May £000's | Actual June £000's | Actual July £000's | Actual August £000's | Actual September £000's | Actual October £000's | Actual November £000's | Actual December £000's | Actual January £000's | Actual Febuary £000's | Actual March £000's | Annual Position £000's |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Surplus/(deficit) after tax** | **(925)** | **(144)** | **(353)** | **553** | **(978)** | **(551)** | **(513)** | **(151)** | **(264)** | **504** | **149** | **(179)** | **(2,849)** |
| **Non-cash flows in operating surplus/(deficit)** | | | | | | | | | | | | | |
| Depreciation and amortisation | 495 | 495 | 493 | 479 | 480 | 478 | 488 | 488 | 488 | 492 | 492 | 492 | 5,858 |
| Impairment losses/(reversals) | | | | 0 | 0 | 0 | 0 | 0 | | | | 548 | 548 |
| PDC dividend expense | 329 | 329 | 328 | 329 | 329 | 329 | 414 | 341 | 341 | 285 | 335 | 384 | 4,074 |
| Other increases/(decreases) to reconcile to profit/(loss) from operations | 7 | 54 | (11) | (5) | 6 | (4) | 46 | (2) | (15) | (5) | (4) | 65 | 132 |
| **Non-cash flows in operating surplus/(deficit), Total** | **831** | **878** | **810** | **803** | **815** | **803** | **948** | **827** | **814** | **772** | **823** | **1,489** | **10,613** |
| **Operating Cash flows before movements in working capital** | **(94)** | **734** | **457** | **1,356** | **(163)** | **252** | **435** | **676** | **550** | **1,276** | **972** | **1,310** | **7,761** |
| **Increase/(Decrease) in working capital** | | | | | | | | | | | | | |
| (Increase)/decrease in inventories | (36) | 19 | (1) | (118) | 311 | (141) | (192) | 61 | (79) | 66 | 38 | (128) | (200) |
| (Increase)/decrease in NHS Trade Receivables | (578) | 817 | (1,060) | 198 | 465 | (249) | (570) | (596) | 388 | (438) | 674 | (875) | (1,824) |
| (Increase)/decrease in Non NHS Trade Receivables | (345) | (154) | (115) | 387 | (1,037) | 580 | 261 | (286) | (321) | (339) | 399 | 14 | (956) |
| (Increase)/decrease in other related party receivables | 142 | 265 | (302) | (10) | 62 | (91) | (41) | 201 | 102 | (36) | (58) | 172 | 406 |
| (Increase)/decrease in other receivables | (22) | (524) | 51 | 5 | (28) | 11 | 16 | (36) | 81 | (47) | 6 | (320) | (807) |
| (Increase)/decrease in accrued income | (418) | (750) | (180) | (171) | 640 | (299) | 587 | 223 | 322 | 96 | (264) | 731 | 517 |
| (Increase)/decrease in prepayments | (1,617) | 421 | (419) | (143) | (223) | 24 | 331 | (149) | (184) | 17 | 947 | 285 | (710) |
| Increase/(decrease) in Deferred Income (excl. Govt Grants.) | 1,333 | (476) | 1,663 | (1,316) | 1,199 | (27) | (377) | 3,254 | 283 | 345 | (4,882) | (262) | 737 |
| Increase/(decrease) in Current provisions | (27) | 1 | 17 | (9) | 3 | 0 | 0 | | (8) | 8 | (22) | (2) | (39) |
| Increase/(decrease) in Trade Creditors | 1,206 | 689 | 69 | 716 | 246 | 1,350 | 1,218 | (1,491) | (213) | (732) | (555) | 1,543 | 4,046 |
| Increase/(decrease) in Other Creditors | 141 | (21) | (75) | 35 | (15) | 28 | 79 | (78) | (22) | 11 | (1) | (52) | 30 |
| Increase/(decrease) in accruals | (1,098) | (1,144) | 703 | (346) | (299) | (297) | (375) | 1,093 | (937) | (23) | 19 | 772 | (1,932) |
| Increase/(decrease) in Other liabilities (non charitable assets) | 0 | 0 | 0 | (8) | 0 | 0 | 0 | | | 0 | 0 | 0 | (8) |
| **Increase/(Decrease) in working capital, Total** | **(1,319)** | **(857)** | **351** | **(780)** | **1,324** | **889** | **937** | **2,196** | **(588)** | **(1,072)** | **(3,699)** | **1,878** | **(740)** |
| Increase/(decrease) in Non-current provisions | (33) | 12 | 13 | (21) | 13 | 9 | (16) | 14 | 13 | (21) | 31 | 141 | 155 |
| **Net cash inflow/(outflow) from operating activities** | **(1,446)** | **(111)** | **821** | **555** | **1,174** | **1,150** | **1,356** | **2,886** | **(25)** | **183** | **(2,696)** | **3,329** | **7,176** |
| **Net cash inflow/(outflow() from investing activities** | | | | | | | | | | | | | |
| Property - maintenance expenditure | (555) | (267) | (12) | (440) | (342) | (161) | (97) | (228) | (84) | (157) | (559) | (1,245) | (4,147) |
| Plant and equipment - Information Technology | (26) | (10) | 0 | (139) | (24) | (62) | (22) | (98) | (68) | (434) | 0 | 0 | (883) |
| Plant and equipment - Other | (396) | (4) | 0 | (9) | (83) | (45) | (169) | (34) | | (135) | 0 | 0 | (875) |
| Increase/(decrease) in Capital Creditors | (347) | (297) | (57) | 338 | (241) | (35) | (68) | 217 | (301) | 329 | (89) | 813 | 262 |
| **Net cash inflow/(outflow() from investing activities, Total** | **(1,324)** | **(578)** | **(69)** | **(250)** | **(690)** | **(303)** | **(356)** | **(143)** | **(453)** | **(397)** | **(648)** | **(432)** | **(5,643)** |
| **Net cash inflow/(outflow) before financing** | **(2,770)** | **(689)** | **752** | **305** | **484** | **847** | **1,000** | **2,743** | **(478)** | **(214)** | **(3,344)** | **2,897** | **1,533** |
| **Net cash inflow/(outflow) from financing activities** | | | | | | | | | | | | | |
| Public Dividend Capital received | | | | 444 | | | | | | 860 | 526 | 283 | 2,113 |
| PDC Dividends paid | | | | | | (1,995) | (73) | | | 0 | 0 | (1,979) | (4,047) |
| Interest (paid) on non-commercial loans | (1) | (2) | (2) | (2) | (2) | (2) | | | | 0 | 0 | 0 | (11) |
| Interest received on cash and cash equivalents | 3 | 3 | 4 | 3 | 4 | 2 | 4 | 5 | 3 | 4 | 2 | 4 | 42 |
| Repayment of non-commercial loans | | | | | | (450) | | | | 0 | 0 | 0 | (450) |
| (Increase)/decrease in non-current receivables | 68 | 471 | (57) | 36 | 45 | 32 | 40 | 42 | (81) | 6 | (6) | 31 | 627 |
| **Net cash inflow/(outflow) from financing activities, Total** | **70** | **472** | **(55)** | **481** | **47** | **(2,413)** | **(29)** | **47** | **(78)** | **870** | **522** | **(1,661)** | **(1,727)** |
| **Net increase/(decrease) in cash** | **(2,700)** | **(217)** | **697** | **786** | **531** | **(1,566)** | **971** | **2,790** | **(556)** | **656** | **(2,822)** | **1,236** | **(194)** |
| **Opening cash** | **13,150** | **10,450** | **10,233** | **10,930** | **11,716** | **12,247** | **10,681** | **11,652** | **14,442** | **13,886** | **14,542** | **11,720** | **13,150** |
| **Closing cash** | **10,450** | **10,233** | **10,930** | **11,716** | **12,247** | **10,681** | **11,652** | **14,442** | **13,886** | **14,542** | **11,720** | **12,956** | **12,956** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Forecast cash position as per Monitor plan | 9,840 | 10,317 | 10,750 | 12,323 | 12,597 | 10,518 | 12,083 | 13,354 | 13,236 | 14,294 | 13,963 | 14,002 |
| Actual cash position | 10,450 | 10,233 | 10,930 | 11,716 | 12,247 | 10,681 | 11,652 | 14,442 | 13,886 | 14,542 | 11,720 | 12,956 |
| Variance | 610 | -84 | 180 | -607 | -350 | 163 | -431 | 1,088 | 650 | 248 | -2,243 | -1,046 |

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

**Aged Debt Analysis as at 31st March 2014**

| ***Current month*** | | Current | 1-30 | 31-60 | 61-90 | 91-180 | 181-360 | 361+ | Total Debt |
|---|---|---|---|---|---|---|---|---|---|
| | NHS | 1,353,629.11 | 794,378.74 | 198,909.39 | 424,707.51 | 236,283.59 | -16,007.21 | -5,358.60 | 2,986,542.53 |
| | Non NHS | 134,756.75 | 141,417.97 | 67,296.51 | 794,441.43 | 68,319.10 | 23,142.91 | 31,364.94 | 1,260,739.61 |
| | | 1,488,385.86 | 935,796.71 | 266,205.90 | 1,219,148.94 | 304,602.69 | 7,135.70 | 26,006.34 | 4,247,282.14 |
| Percentage debt - by age ( individual) | | 35.0% | 22.0% | 6.3% | 28.7% | 7.2% | 0.2% | 0.6% | 100.0% |
| Percentage debt - by age (cumulatively) | | 35.0% | 57.1% | 63.3% | 92.0% | 99.2% | 99.4% | 100.0% | |
| ***Previous month*** | | 376,975.48 | 831,122.90 | 1,570,302.60 | 35,353.12 | 533,146.33 | 45,835.10 | 28,593.58 | 3,421,329.11 |
| **Change on previous month (-ve is a reduction on last month)** | | 1,111,410.38 | 104,673.81 | -1,304,096.70 | 1,183,795.82 | -228,543.64 | -38,699.40 | -2,587.24 | 825,953.03 |

| Top 15 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Customer | No. of Invoices | Current | 1 - 30 | 31 - 60 | 61 - 90 | 91 - 180 | 181 - 360 | 361+ | Total Debt | Paid up to 15.04.14 | Revised Debt |
| NHS WARRINGTON CCG | 11 | 53,792.49 | 495,402.00 | 0.00 | 229,800.00 | 285,286.00 | 0.00 | 0.00 | 1,064,280.49 | 50.00 | 1,064,230.49 |
| NHS ENGLAND | 9 | 879,343.00 | 6,039.94 | 75,900.98 | 0.00 | 78,572.00 | 0.00 | 0.00 | 882,711.92 | 16.00 | 882,695.92 |
| WARRINGTON BOROUGH COUNCIL | 5 | 772.44 | 742.80 | 45,000.00 | 721,571.00 | 0.00 | 325.00 | 0.00 | 768,411.24 | 23,412.07 | 744,999.17 |
| BRIDGEWATER COMM HEALTHCARE | 17 | 56,755.51 | 14,019.79 | 106,551.07 | 86,337.00 | 102,252.25 | 320.75 | 0.00 | 366,236.37 | 268,263.51 | 97,972.86 |
| HALTON BOROUGH COUNCIL | 6 | 115.20 | 141,395.14 | 1,516.42 | 31,011.00 | 0.00 | 0.00 | 0.00 | 174,037.76 | 110,384.14 | 63,653.62 |
| ALDER HEY CHILDREN'S NHS FOUNDATION TRUST | 5 | 110,580.00 | 21,404.72 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 131,984.72 | 0.00 | 131,984.72 |
| NHS HALTON CCG | 8 | 28,840.50 | 112,422.19 | 0.00 | 3,880.50 | 0.00 | 35,491.30 | 0.00 | 109,651.89 | 0.00 | 109,651.89 |
| COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST | 3 | 0.00 | 600.00 | 0.00 | 52,099.00 | 0.00 | 0.00 | 0.00 | 52,699.00 | 0.00 | 52,699.00 |
| BETSI CADWALADR UNIV HB | 7 | 10,925.14 | 8,078.06 | 2,148.41 | 13,136.56 | 17,329.38 | 0.00 | 173.62 | 51,791.17 | 0.00 | 51,791.17 |
| THE CLATTERBRIDGE CANCER CENTRE NHS FT | 6 | 26,759.17 | 18,984.21 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 45,743.38 | 45,743.38 | 0.00 |
| SIEMENS FINANCIAL SERVICES LTD | 1 | 0.00 | 41,763.78 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 41,763.78 | 0.00 | 41,763.78 |
| NHS STAFFORD AND SURROUNDS CCG | 4 | 39,189.50 | 306.61 | 162.33 | 0.00 | 218.41 | 0.00 | 0.00 | 39,876.85 | 0.00 | 39,876.85 |
| NHS VALE ROYAL CCG | 5 | 0.00 | 0.00 | 671.25 | 25,377.00 | 11,025.25 | 265.00 | 0.00 | 37,338.50 | 0.00 | 37,338.50 |
| FIRST HEALTH IMAGING | 9 | 1,548.04 | 2,048.87 | 7,028.40 | 8,129.57 | 10,836.70 | 6,062.58 | 0.00 | 35,654.16 | 0.00 | 35,654.16 |
| NHS SOUTH MANCHESTER CCG | 5 | 14,017.22 | 4,157.08 | 7,515.72 | 0.00 | 2,471.76 | 2,030.01 | 0.00 | 30,191.79 | 5,224.59 | 24,967.20 |
| | 101 | 1,222,638.21 | 867,365.19 | 246,494.58 | 1,171,341.63 | 350,847.75 | -26,487.96 | 173.62 | 3,832,373.02 | 453,093.69 | 3,379,279.33 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/067(ii)**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Reference Cost Submission 2013/14 |
| **Date of Meeting** | **TBC** |
| **Director Responsible** | Tim Barlow, Director of Finance & Commercial Development |
| **Author(s)** | Jody Penney, Strategic Financial Planning Accountant |
| **Purpose** | To inform the Board on the reference cost submission process and seek approval for methodology and approach of costing |

| **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

- Methodology in line with Monitor Costing guidance.

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

The Board is asked to approve the costing process that generates the reference cost submission.

## 1. Introduction

All NHS providers are required to submit the annual reference costs for 2013/14 to the Department of Health in July 2014. The reference cost collection is the process by which the Department of Health collates information from all NHS providers on the cost of delivering healthcare and will be used by Monitor and NHS England to calculate future national payment tariffs.

## 2. Board Approval & Sign Off

For the 2013-14 collection, the Board are required to approve four conditions of the costing process which generates the reference cost submission. In addition to the requirement for the Director of Finance to sign off the return, Trust Board approval should be obtained in April/May in advance of the 2013/14 submission.

The reference costs guidance states that the Board of each Trust are satisfied by the processes and systems in place. They will be required to confirm the following conditions:

(a) Costs will be prepared with due regard to the principles and standards set out in Monitor's Approved Costing Guidance.
(b) Appropriate costing and information capture systems are in operation.
(c) Costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference cost guidance.
(d) Procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs.

The Director of Finance is required to sign off the reference costs return for 2013/14 in Unify2 (Reference Cost Data Collection System), confirming that:

(a) The Board or its appropriate sub-committee has approved the costing process ahead of the collection.
(b) The self-assessment quality checklist has been completed and used to improve quality and to provide assurance to the Department about the accuracy of the return.
(c) Finance teams have actively engaged clinicians and other relevant non-finance stakeholders in the costing process.

Appendix A provides an extract from the reference costs guidance in relation to Board approval and Finance Director sign off.

## 3. Conditions

a) **Costs will be prepared with due regard to the principles and standards set out in Monitor's Approved Costing Guidance**.

The responsibility of issuing the costing guidance has been transferred to Monitor from the Department of Health as outlined in the "Approved Costing Guidance" issued in February 2014. The costing principles and standards specific to reference costs are identified below and reflect how Warrington & Halton Hospitals comply.

i. **Are services costs calculated on full absorption basis to identify full cost?**
YES: Reference cost return is based on a full absorption costing methodology with reconciliation to the annual accounts.

ii. **Are costs allocated and apportioned accurately by maximising direct charging, where this isn't possible using standard methods of apportionment?**

YES: A patient level costing system (PLICS) was introduced in 2010 and allowed the Trust to share the first results in December that year. The patient level costing system is used to produce the annual reference cost return by aggregating patient level information up to an average cost by Health Resource Group (HRG) level. Direct matching of costs to patients is used where information is available i.e. theatre session costs matched to individual theatre lists and then by theatre time for each patient within a list. Where direct matching isn't possible, the Trust apportions cost based on costing guidance approved by Monitor.

iii. **Are costs matched to services that generate them to avoid cross subsidisation?**

YES: The following services costs are matched to patients who have had diagnostics/clinical services e.g. Radiology, Echocardiogram Tests, Pathology, Theatres, High Cost Drugs, Non Ward Drugs, Bloods.

iv. **Are costs retrospective and costs used in reference cost production reconciled to annual accounts?**

YES: The return is retrospective and a full reconciliation to audited accounts is undertaken prior to submission.

v. **Are average unit costs produced, irrespective of underlying data supporting their calculation?**

YES: Average unit costs are produced by Health Resource Group(HRG) at both spell and episode level and reported as part of the collection. The units costs are derived from the PLICS system, which assigns costs based on actual patient level activity where available (70% of total costs excluding overheads) as opposed to average apportionment methodology.

**b) Appropriate costing and information capture systems are in operation**

Activity information is taken from the Trust's patient administration system "Meditech". In addition data is collected electronically from other departments such as radiology and pathology and matched to the relevant patient record. The costs of these services are then allocated at patient level. With the ability of PLICS we have been able to refine the accuracy of the costing model and this has led to a number of developments and better use of the information systems available. Theatre costs are now be allocated based on theatre utilisation and patient time, specialist nursing resource ordered via Meditech can now be used to allocate cost more appropriate.

**c) Costing team adequately resourced**

The financial planning team is staffed by 1.75wte and this is a sufficient resource to carry out the reference cost exercise.

**d) Procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs.**

The Department of Health expects that mandatory, non-mandatory and self-assessment checks are undertaken as part of the reference cost exercise.

The mandatory validations are designed to provide assurance on the basic integrity of the data. These checks are embedded in the collection workbooks and trusts are unable to sign off returns until the data passes each of the validations. As in previous years the organisation will undertake the necessary checks as prescribed in both the mandatory and non mandatory validations. The costing team has procedures in place to reconcile both activity and costs as directed in the self-assessment quality checklist as well as any other checks to ensure the collection is as accurate as possible.

## 4. Audit

Internal audit carried out a review of PLICS and the costing system which was approved by the Audit Committee in 2011/12. The review was given significant assurance on control, design and operation controls. The overall objective of the review was to undertake an assessment of the progress made to date with regard to the implementation of PLICS.

## 5. Materiality and Quality Score(MAQS)

Although not mandated, organisations should measure and document the materiality and quality of their costing systems. This should be evidenced by a materiality and quality score (MAQS) a template developed jointly by Monitor and HFMA which assesses the accuracy and quality of the trusts costing data.

The score structure is:
Gold 75% - 100%
Silver 60% - 75%
Bronze 45 – 59%
Baseline below 45%

WHHFT completed a self-assessment in 2012 and using the MAQS rules came out with a bronze classification overall, however there were a number of areas in which Silver was achieved such as theatres as we felt this was among others an important area to develop our cost classification. It's unlikely that any organisation could achieve gold standard given the specification and level of information capture systems needed to progress to this level. We felt that this should be the organisations aspiration and devised a plan of information and resource needed to deliver further improvements to the costing model and progress to the next step(silver).

## 6. Conclusion

The above sections and appendices have provided information and assurance that Warrington and Halton Hospitals does meet the requirements set out by the Department of Health prior to reference cost submission.

## 7. Recommendation

The Board is asked to note this report approve the costing process that generates the reference cost submission

**Tim Barlow**
**Director of Finance & Commercial Development**
**April 2014**

**Appendix A**

**Extract from Reference Costs Guidance**

## Board approval and Finance Director sign off

79. The Board of each NHS trust and NHS foundation trust, or its Audit Committee or other appropriate sub-committee, is required to confirm in advance of the reference costs submission (for example at the April or May Board meeting) that it is satisfied with the trust's costing processes and systems, and that the trust will submit its reference cost return in accordance with guidance. In providing this confirmation, Boards or their appropriate sub-committees may wish to satisfy themselves that procedures are in place to ensure that the self-assessment quality checklist can be completed at the time of the reference cost submission. Trusts that are unable to provide this confirmation should provide details of non-compliance. Specifically, Boards or their appropriate sub-committees are required to confirm that:

(a) costs will be prepared with due regard to the principles and standards set out in Monitor's *Approved Costing Guidance*
(b) appropriate costing and information capture systems are in operation
(c) costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance
(d) procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return.

80. The Finance Director is required to sign off the reference costs return in Unify2, confirming that:

(a) the Board or its appropriate sub-committee has approved the costing process ahead of the collection
(b) the self-assessment quality checklist has been completed and used to improve quality and to provide assurance to the Department about the accuracy of the return
(c) finance teams have actively engaged clinicians and other relevant non-finance stakeholders in the costing process.

81. A Trust's reference costs submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the Trust. As the designated lead nominated to submit the reference costs submission, the Director of Finance is the senior professional responsible for the data used to inform tariff, and as a result ensuring that the National Tariff functions in a manner that benefits the service overall. Material errors in reference costs submissions will not only impact on the accuracy of any resultant tariff, but may also have an impact on the provider licence for foundation trusts, and applications for FT-status at aspiring trusts.

82. In submitting a Trust's reference costs return, the Director of Finance is stating that they have discharged their responsibility to scrutinise and challenge the organisations costing information, and has satisfied themselves that the submission is correct.

83. Evidence from the PbR Data Assurance Framework Review of 2013 reference costs submissions has shown that good arrangements for senior sign-off leads to improved accuracy of costing information. Where submissions were found to be accurate overall, and at individual unit cost level, the following characteristics were usually found:

(a) The production of reference costs at a Trust was subject to senior management scrutiny on an on-going basis. This was either from the Director of Finance, or a deputy with operational responsibility for costing. There were formal checkpoints leading up to the submission.

(b) The checks outlined in the self-assessment quality checklist completed by the Trust were reviewed as part of this on-going scrutiny, focusing on areas of materiality for the trust. These checks and the actions to address issues identified were clearly documented. Excluded services and the overall quantum were also checked as part of this process.

(c) The final sign-off of the reference costs submission was via a minuted meeting, with evidence of challenge and scrutiny. This meeting focused on:

(i) areas of material impact, both to the Trust and to national tariff, either because the trust was a specialist centre, or because benchmarking or validations identified a high market share;
(ii) areas of risk identified through the checks outlined in the self-assessment checklist;
(iii) highlights of the senior scrutiny of the process where the Director of Finance delegated this responsibility; and
(iv) a formal sign-off of the workbooks, including the information submitted in the self-assessment checklist, and the reconciliation statement.

## External assurance

84. Some trusts will be subject to external review as part of a wider external assurance programme.

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/068**

# Board of Directors

| | |
|---|---|
| **Paper Title** | Corporate Performance Report |
| **Date of Meeting** | |
| **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 March 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

- 
- 
- 
- 

**Recommendation(s)**

***The Board is asked to note the contents of this paper***

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# CORPORATE PERFORMANCE REPORT
# March 2014

## EXECUTIVE SUMMARY

## 1.0 Introduction

This corporate report updates the Board on the progress of the Trust in relation to activity, performance and workforce targets to 31st March 2014.

## 2.0 Performance

In overall terms, based on the performance in month 12, the Trust has an **Amber/Green** rating, as highlighted in Appendix 1. Every National Target from the Operating Framework has been fully delivered.

## 3.0 National Key performance indicators

### 3.1 Accident and Emergency Department

The Quarter 4 AED performance achieved 95.68% and ended the rolling 12 months over 95%. There have been no 12 hour trolley waits in this 12 month period.

The success of the performance against a backdrop of very view Trusts delivering consistent four quarter performance is in part down the following:

- Changes in the complex pathways and the discharge delays that such patients can received causing delays in AED for admission
- Introducing trolley triage to deliver a year to date performance of 24minutes for the average handover time for ambulance patients this year, one of the very best in the North West.
- The transfer of minor injuries out of AED creating 5 additional assessment cubicles and on occasion during the winter a second clinical decision making unit.
- The creation of a dedicated sub-acute environment throughout the winter period on UCC to speed up transfers of care
- The external analysis and support of ECIST, UM and the delivery of point prevalence exercises, and a multiagency winter summit in September.
- Investment of £330k in additional nurses to improve quality, care and experience of our AED patients and their carers.
- Support of our whole system at times of duress in targeting extra resource and help to the hospital team

In addition we have secured funding for the psychiatric liaison service in AED and now to reach into the wards as well for 2014, we trial the perfect week on May 7th to better understand the system and process delays in discharging patients and transferring care in complex models.

Finally this has been achieved against a backdrop of a new IT system (Symphony) being introduced, changes across the emergency platform with UCC models and reablement new clinical lead and divisional medical director appointments and whilst moving the acute medical unit into Daresbury and closing 42 beds across B2/3.

The final and most important mention goes to our wonderful staff who have worked incredibly hard and with continued compassion and determination improving all of our quality metrics whilst ensuring our AED was able to see, assess, diagnose, treat and in the lowest levels in the north west for an AED (24%) admit patients under 95%.

**3.2 18 week Referral To Treatment**

The trust has for the 6th year in a row delivered its commitment for access from GP referral to treatment for the people of Warrington and Halton in under 18wks for over 90% of all referrals. In addition we have 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. This has successfully seen our Trust achieving 18wks 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.

This has not been achieved without considerable hard work from our call centres, OPD, Diagnostic, waiting list teams, secretaries, Nurses, therapists, surgeons, anaesthetists and managers who have all worked in a unified way to deliver the best outcomes and service for all of our elective patients.

**3.3 Cancer**

This year saw the introduction of a new local rule on allocation of breaches at day 42 on a pathway. This has seen most hospital trusts failing at least one of the national access targets. Our trust has worked incredibly hard to manage, amend, support and seek changes at other hospitals to continue to deliver this commitment and target. We remain one of a very small group who has achieved this throughout 2013.

Final points in summary, this has been a difficult year for operations, we continue to innovate, challenge, motivate, improve and work tirelessly to ensure the Trust and the patients we support get the right care, when they need it at the right time on the most suitable site. The team have delivered another huge success in achieving every single national target from the operating framework and I would like the Board to extend its thanks to all of the team for this successful year.

**Mr Simon Wright**

**Chief Operating Officer**

**April 2014**

**Mar-14**

# Governance Risk Rating - (Monitor) 2013/14

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

| Level One - National Targets | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clostridium Difficile | Hospital Acquired (Cumulative Qtr1: 5 Qtr2: 10 Qtr3: 14 Qtr4: 19) | 19 | 1.0 ** | 5 | 4 | 3 | 12 | 0 | 1 | 1 | 2 | 4 | 2 | 4 | 10 | 4 | 1 | 2 | 7 |
| | Total | | | 6 | 6 | 4 | 16 | 3 | 4 | 1 | 7 | 8 | 4 | 5 | 17 | 8 | 3 | 5 | 16 |
| MRSA Bacteraemia - (Hospital Acquired Target) | | 0 | 1.0 ** | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | | | | | | | | |
| All Cancers:31-day wait for second or subsequent treatment | Surgery | >94% | 1.0 (Failure for any of the 3 = failure against the overall target) | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 98.00% | 99.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| | Anti Cancer Drug Treatments | >98% | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| | Radiotherapy (not performed at this Trust) | >94% | | | | | | | | | | | | | | | | | |
| 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) | 87.95% | 88.12% | 86.89% | 88.29% | 85.00% | 86.89% | 86.00% | 85.96% | 92.00% | 85.10% | 90.90% | 89.80% | 85.71% | 89.61% | 93.06% | 89.74% |
| | From NHS Cancer Screening Service Referral | >90% | | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Referral to treatment waiting time | Admitted patients | 90% | 1.0 | 90.93% | 91.01% | 91.41% | 91.03% | 91.19% | 91.02% | 90.52% | 90.92% | 91.70% | 91.34% | 93.29% | 92.06% | 92.44% | 92.81% | 93.37% | 92.62% |
| | Non-admitted patients | 95% | 1.0 | 98.04% | 97.76% | 98.17% | 97.99% | 97.69% | 97.96% | 97.77% | 97.80% | 98.07% | 97.78% | 97.28% | 97.72% | 97.26% | 98.06% | 97.97% | 97.65% |
| | Incomplete Pathways | 92% | 1.0 | 92.13% | 92.11% | 92.46% | 92.23% | 92.81% | 92.41% | 92.94% | 92.71% | 93.31% | 93.45% | 93.72% | 93.49% | 94.09% | 94.40% | 94.66% | 94.25% |

| Level Two - Minimum Standards | | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| All Cancers: 31-Day Wait From Diagnosis To First Treatment | | >96% | 0.5 | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 98.00% | 100.00% | 100.00% | 97.00% | 98.00% | 98.50% | 99.00% | 98.50% | 98.50% | 98.67% |
| 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) | 96.40% | 95.60% | 95.58% | 95.00% | 95.81% | 95.20% | 94.52% | 95.18% | 93.00% | 95.40% | 94.40% | 94.20% | 93.15% | 94.02% | 96.31% | 94.49% |
| | Symptomatic Breast Patients (Cancer Not Initially Suspected) | >93% | | 97.70% | 96.30% | 95.60% | 96.00% | 94.62% | 93.00% | 93.98% | 94.00% | 93.85% | 95.54% | 97.99% | 96.50% | 93.55% | 93.00% | 93.4% | 93.32% |
| A&E Clinical Quality | A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge | >=95% | 1.0 | 93.65% | 96.34% | 98.03% | 96.03% | 95.09% | 95.29% | 95.64% | 95.33% | 95.23% | 94.77% | 95.61% | 95.20% | 94.09% | 96.21% | 96.96% | 95.68% |
| Failure to comply with requirements regarding access to healthcare for people with a learning disability | | N/A | 1.0 | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |

| Other Indicators | 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 | 4.0 | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| CQC compliance action outstanding | N/A | Special | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| CQC enforcement action within last 12 months | N/A | Special | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Symptomatic Breast Patients (Cancer Not Initially Suspected) | >93% | target) | 97.70% | 96.30% | 95.60% | 96.00% | 94.62% | 93.00% | 93.98% | 94.00% | 93.85% | 95.54% | 97.99% | 96.50% | 93.55% | 93.00% | 93.4% | 93.32% |
| A&E Clinical Quality | A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge | >=95% | 1.0 | 93.65% | 96.34% | 98.03% | 96.03% | 95.09% | 95.29% | 95.64% | 95.33% | 95.23% | 94.77% | 95.61% | 95.20% | 94.09% | 96.21% | 96.96% | 95.68% |
| Failure to comply with requirements regarding access to healthcare for people with a learning disability | | N/A | 1.0 | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |

| Other Indicators | 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 | 4.0 | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| CQC compliance action outstanding | N/A | Special | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| CQC enforcement action within last 12 months | N/A | Special | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| CQC enforcement notice currently in effect | N/A | 4.0 | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| Moderate CQC concerns or impacts regarding the safety of healthcare provision | N/A | Special | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| Major CQC concerns or impacts regarding the safety of healthcare provision | N/A | 2.0 | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| Trust unable to declare ongoing compliance with minimum standards of CQC registration | N/A | Special | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No | No |
| **Overall Governance Risk Rating**<br>**Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)** | | | 2.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 2.0 | 1.0 | 1.0 | 2.0 | 1.0 | 1.0 | 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 & MRSA Bacteraemia**
Monitor's annual de minimis limit for cases of MRSA reflecting a governance concern is set at 6. the de minimis for C-Diff is set at 12.
See table below for the circumstances in which we will score NHS foundation trusts for breaches of the MRSA objective.
Monitor will assess NHS foundation trusts for breaches of the C. difficile and MRSA objectives against their objectives 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.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/069**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Part 1 Risk Register with Action Points within the Action Plan still open |
| **Date of Meeting** | April 2014 |
| **Director Responsible** | Karen Dawber, Director of Nursing and OD |
| **Author(s)** | Millie Bradshaw, Associate Director of Governance |
| **Purpose** | To inform the Board to the latest Part I Risk Register and Action points within the relevant actions plans which are still open |

| **Paper previously considered** (state Board and/or Committee and dates) | **Committee** | **Date** |
|---|---|---|
| | Safety and Risk Sub Committee<br>Acute and Critical Care of the Patient Group | 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 |
|---|---|---|
| • | Monthly emails are sent by the Associate Director of Governance to all Leads to remind them to update their Risk Register entries and actions plans ready for review at Safety and Risk Sub Committee & Governance Committee | |
| • | Deteriorating patient safety risk transferred to Part 2 Risk Register following the Acute and Critical Care of the Patient Group meeting in April 2014 | |

**Recommendation(s)** (include what you require the Board to do; approve/note/ratify etc.)
To review and accept the Part I Risk Register with the Action Points still Open

# Part 1 Risk register 34 Items

| Risk ID | Risk Title | Division / Department | Source of the Risk | Date Identified | Initial Risk Score | Managerial Lead | Date of Last Review | Impact Rating | Residual Risk Score | Date for Review | Target Date for Completion | Strategic Aim Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Group: Corporate Nursing** | | | | | | | | | | | | |
| 000074 | Risk of adverse impact on patient safety and quality due to hospital acquired infection (MRSA Bacteraemia) | Infection Control | Incident | 30/04/2010 | Extreme risk 16 | Dawber, Karen; Director of Nursing; DNU | 27/03/2014 | 4 - Major | Extreme risk 16 | 06/05/2014 | 31/03/2014 | 8 |
| 000281 | Risk of adverse impact on patient safety and quality due to hospital acquired Clostridium difficile. | Infection Control | Risk Assessment | 01/05/2013 | Extreme risk 16 | Dawber, Karen; Director of Nursing; DNU | 27/03/2014 | 4 - Major | Extreme risk 16 | 06/05/2014 | 31/03/2014 | 8 |
| 000536 | The Clostridium difficile threshold of 19 cases or less has not been met for the Financial year 2013 - 2014 | Infection Control | Committee Review | 26/11/2013 | Extreme risk 20 | Dawber, Karen; Director of Nursing; DNU | 27/03/2014 | 5 - Catastrophic | Extreme risk 20 | 06/05/2014 | 31/03/2014 | 10 |
| **Group: Estates** | | | | | | | | | | | | |
| 000025 | Risk Due to Ageing & Failing Windows - Warrington - Appleton Wing | Estates | Risk Assessment | 29/02/2012 | Extreme risk 20 | Patterson, Ron; Capital Projects Manager; EST | 26/02/2014 | 5 - Catastrophic | Extreme risk 15 | 30/04/2014 | 30/11/2014 | 5 |
| 000134 | External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 1 & Phase 2 at Halton site | Estates | Risk Assessment | 31/01/2009 | Extreme risk 16 | Patterson, Ron; Capital Projects Manager; EST | 26/02/2014 | 4 - Major | Extreme risk 16 | 30/04/2014 | 30/09/2014 | 4 |
| 000170 | External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing | Estates | Risk Assessment | 31/01/2009 | Extreme risk 16 | Patterson, Ron; Capital Projects Manager; EST | 26/02/2014 | 4 - Major | Extreme risk 16 | 30/04/2014 | 30/09/2014 | 4 |

| Risk ID ▲ | Risk Title | Division / Department | Source of the Risk | Date Identified | Initial Risk Score | Managerial Lead | Date of Last Review | Impact Rating | Residual Risk Score | Date for Review | Target Date for Completion | Strategic Aim Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Group: HR** | | | | | | | | | | | | |
| 000269 | Risk of expenditure on temporary staffing significantly exceeding budget and affecting the future viability of the trust with reports to Monitor | Human Resources and Organisational Development | Committee Review | 01/04/2012 | Extreme risk 20 | Dawber, Karen; Director of Governance and Workforce; DODG | 14/04/2014 | 4 - Major | Extreme risk 20 | 12/05/2014 | 31/03/2015 | 8 |
| **Group: Information Governance** | | | | | | | | | | | | |
| 000139 | Risk to compliance with FOI legislation due to late responses to Freedom of Information requests. | Information Governance | Incident | 01/02/2012 | Moderate risk 6 | Ashton, Mark; Information Governance and Corporate Records Manager; TBA | 12/03/2014 | 3 - Moderate | Extreme risk 15 | 21/04/2014 | 31/03/2014 | 6 |
| 000304 | Risk to Information Governance agenda due to over reliance on a single-handed Information Governance lead | Information Governance | Risk Assessment | 24/06/2013 | High risk 12 | ; Information Governance and Corportae Records Manager; IT | 12/03/2014 | 4 - Major | Extreme risk 16 | 21/04/2014 | 31/03/2014 | 4 |
| **Group: Information Technology** | | | | | | | | | | | | |
| 000037 | Insufficient IT Storage-Server Team | Server Team | Risk Assessment | 15/05/2013 | High risk 12 | Garnett, Joe; IT Systems Manager; IT | 12/03/2014 | 4 - Major | Extreme risk 16 | 21/04/2014 | 31/01/2014 | 4 |
| 000482 | Risk of unsupported, ageing IT infrastructure which is technically unable to support the Trust's IT requirements | Information Technology | Incident | 04/10/2013 | Extreme risk 16 | Garnett, Joe; IT Systems Manager; IT | 12/03/2014 | 5 - Catastrophic | Extreme risk 20 | 21/04/2014 | 14/10/2013 | 4 |
| 000593 | Risk of funding not being secured in time for new PAS procurement | Information Technology | Committee Review | 13/01/2014 | Extreme risk 20 | DaCosta, Jason; Director of Information Technology; IT | 12/03/2014 | 5 - Catastrophic | Extreme risk 20 | 21/04/2014 | 31/03/2014 | 4 |

| Risk ID ▲ | Risk Title | Division / Department | Source of the Risk | Date Identified | Initial Risk Score | Managerial Lead | Date of Last Review | Impact Rating | Residual Risk Score | Date for Review | Target Date for Completion | Strategic Aim Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 000594 | Insufficient IT staff resources to meet external requests for data capture | Information Technology | Incident | 13/01/2014 | Extreme risk 15 | DaCosta, Jason; Director of Information Technology; IT | 12/03/2014 | 3 - Moderate | Extreme risk 15 | 21/04/2014 | 31/03/2014 | 6 |
| **Group: Scheduled Care** | | | | | | | | | | | | |
| 000111 | Operational and financial risks associated with sustained use of escalation beds in the Division | Wards (SCD) | Risk Assessment | 01/08/2010 | Extreme risk 15 | Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD | 27/02/2014 | 4 - Major | Extreme risk 16 | 30/04/2014 | 30/04/2014 | 6 |
| **Group: Trust Wide** | | | | | | | | | | | | |
| 000027 | There are a number of Pathology Test results to which it cannot be demonstrated have been seen and actioned by Clinicians | Warrington and Halton Hospitals NHS Foundation Trust | Risk Assessment | 30/04/2012 | Extreme risk 16 | Bradshaw, Millie; Associate Director of Governance; GOV | 27/03/2014 | 4 - Major | Extreme risk 16 | 08/05/2014 | 04/08/2014 | 8 |
| 000035 | Risk to the care and safety of plus size patients due to limited bariatric equipment. | Warrington and Halton Hospitals NHS Foundation Trust | Incident | 14/06/2012 | Extreme risk 16 | Wynn, Helen; Health and Safety Manager; HS | 09/04/2014 | 4 - Major | Extreme risk 16 | 30/06/2014 | 30/04/2014 | 8 |
| 000144 | Potential risk to Patient Safety due to poor management of patient casenotes & reputational risk following NHSLA/CQC Inspection & Assessment | Warrington and Halton Hospitals NHS Foundation Trust | Risk Assessment | 01/02/2012 | High risk 12 | Brown, Richard; Divisional Manager - WCSS; WCSS | 27/03/2014 | 4 - Major | Extreme risk 16 | 24/04/2014 | 02/06/2014 | 12 |
| 000216 | Defibrillators available in the Trust from different manufacturers | Warrington and Halton Hospitals NHS Foundation Trust | Risk Assessment | 29/11/2012 | Extreme risk 15 | Kelsey, Sallie; CPD and Business Support Manager; ED | 05/03/2014 | 5 - Catastrophic | Extreme risk 15 | 30/04/2014 | 30/04/2014 | 10 |
| **Group: Unscheduled Care** | | | | | | | | | | | | |

| Risk ID ▲ | Risk Title | Division / Department | Source of the Risk | Date Identified | Initial Risk Score | Managerial Lead | Date of Last Review | Impact Rating | Residual Risk Score | Date for Review | Target Date for Completion | Strategic Aim Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 000365 | Increased pt dependency on A7& financial pressures due to ALL patients who have a tracheostomy are admitted to the ward in addtion to NIV pts | Respiratory | Committee Review | 19/04/2013 | Extreme risk 15 | Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD | 19/03/2014 | 3 - Moderate | Extreme risk 15 | 23/04/2014 | 31/03/2014 | 4 |
| 000520 | Risk to patients waiting for a Telemetry unit as an inpatient following an Acute Event | Cardiology | Incident | 25/10/2013 | Extreme risk 16 | Seddon, Helen; Service Manager - ECG; ECG | 19/03/2014 | 5 - Catastrophic | Extreme risk 15 | 23/04/2014 | 31/03/2014 | 4 |
| 000540 | Risk of sub - optimal care due to staffing levels and pt dependancy on Wds GPAMU/B18/A8/B12/ B14/A3/C22 | Unscheduled Care Division | Risk Assessment | 26/11/2013 | Extreme risk 16 | Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD | 19/03/2014 | 4 - Major | Extreme risk 16 | 23/04/2014 | 31/03/2014 | 6 |
| 000542 | Delay in clincial Assessment due to unpredictable volume and acuity of the Patients in the GPAMU; Potential for undetected deteriorating Patient | Acute Medicine | Risk Assessment | 15/10/2013 | Extreme risk 16 | Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD | 19/03/2014 | 4 - Major | Extreme risk 16 | 23/04/2014 | 09/08/2013 | 4 |
| 000545 | Cardiac rhythm abnormalities may not always be captured and observed at the time of occurrence due to lack of designated Telemetry Nurse | Cardiology | Incident | 26/11/2013 | Extreme risk 20 | Seddon, Helen; Service Manager - ECG; ECG | 19/03/2014 | 5 - Catastrophic | Extreme risk 15 | 23/04/2014 | 31/03/2014 | 4 |
| 000618 | Risk of business continuity. Scopes maybe recalled at short notice by 4G leaving Endoscopy Service severely compromised | Gastroenterology | Committee Review | 22/01/2014 | Extreme risk 16 | Khalid, Salahudin; Clinical Lead Medicine, Lead Investigating Officer; TBA | 26/02/2014 | 4 - Major | Extreme risk 16 | 23/04/2014 | 30/05/2014 | 6 |
| **Group: WCCSS** | | | | | | | | | | | | |

| Risk ID | Risk Title | Division / Department | Source of the Risk | Date Identified | Initial Risk Score | Managerial Lead | Date of Last Review | Impact Rating | Residual Risk Score | Date for Review | Target Date for Completion | Strategic Aim Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 000266 | MOLIS : Laboratory Information System (Vision4Health) Current software unable to embrace new technologies which could affect future requirements | Pathology | Risk Assessment | 21/03/2013 | High risk 12 | Davies, Wendy; Head of AHP & Technical Services; WCSS | 14/04/2014 | 3 - Moderate | Extreme risk 15 | 12/05/2014 | 31/07/2014 | 3 |
| 000347 | Anticoagulation Service : The continuing rise in the numbers of patients needing anticoagulation cannot be managed safely within existing services. | Pharmacy | Risk Assessment | 17/06/2013 | Extreme risk 16 | Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS | 10/03/2014 | 4 - Major | Extreme risk 16 | 14/04/2014 | 30/06/2014 | 8 |
| 000373 | Due to potential for harming patients, the MRI Scanner in the CMTC is working at reduced capacity.. | Radiology | Risk Assessment | 17/07/2013 | Extreme risk 16 | Grimes, Dan; Assistant Divisional General Manager (Radiology, Women's & Children's Health) - WCSS; WCSS | 14/04/2014 | 4 - Major | Extreme risk 16 | 12/05/2014 | 31/01/2015 | 8 |
| 000380 | Anaerobic atmosphere for isolation of medically significant organisms. Risk of cabinet failing due to certain parts becoming obsolete & irreplacable | Pathology | Risk Assessment | 01/08/2013 | Extreme risk 15 | Davies, Wendy; Head of AHP & Technical Services; WCSS | 15/04/2014 | 3 - Moderate | Extreme risk 15 | 12/05/2014 | 30/07/2014 | 6 |
| 000381 | Risk of poor patient experience due to ward C20 being escalated with medical & surgical pts. Elective cases are being cancelled at short notice | Women’s Health | Risk Assessment | 06/08/2013 | Extreme risk 16 | Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS | 14/04/2014 | 4 - Major | Extreme risk 16 | 12/05/2014 | 30/04/2014 | 8 |

| Risk ID ▲ | Risk Title | Division / Department | Source of the Risk | Date Identified | Initial Risk Score | Managerial Lead | Date of Last Review | Impact Rating | Residual Risk Score | Date for Review | Target Date for Completion | Strategic Aim Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 000604 | Impact on business continuity from system failure - withdrawal of support for Windows XP & for the current version of the Pharmacy JAC System (v4.47) | Pharmacy | Risk Assessment | 13/01/2014 | Extreme risk 25 | Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS | 15/04/2014 | 5 - Catastrophic | Extreme risk 15 | 12/05/2014 | 31/05/2014 | 6 |
| 000641 | Inability to programme hearing aids for adults/ children leaving them vulnerable due to equipment failure. Unable to access AQP reports. | Audiology | Risk Assessment | 12/02/2014 | Extreme risk 15 | Atherton, Paula; Audiology Service Manager; TBA | 14/04/2014 | 3 - Moderate | Extreme risk 15 | 12/05/2014 | 31/05/2014 | 3 |
| 000643 | Failure to meet turn around times for samples sent to Reference Laboratories resulting in reduction in quality of service. | Microbiology | Risk Assessment | 11/02/2014 | Extreme risk 16 | Marshall, Graham; Microbiology Manager - Microbiology; TBA | 14/04/2014 | 4 - Major | Extreme risk 16 | 12/05/2014 | 30/04/2015 | 8 |
| 000645 | Replacment of MR Scanner on the Warrington site due to age. Risk of missing CFT targets, breaching National wtg list targets. | Women's, Children's and Support Services Division | Risk Assessment | 23/11/2013 | Extreme risk 16 | Holland, Neil; Principal Radiographer - MRI and CT; TBA | 05/03/2014 | 4 - Major | Extreme risk 16 | 14/04/2014 | 01/12/2015 | 8 |
| 000671 | Damage to Reputation of Trust due to Poor Condition of Flooring on B10 and B11. Risk of slips, trips and falls. | Child Health | Risk Assessment | 25/03/2014 | Extreme risk 15 | Scott, Jane; Matron - Child Health; SCBU & NNU | 25/03/2014 | 3 - Moderate | Extreme risk 15 | 12/05/2014 | 31/08/2014 | 6 |

# Action Points for Risks 50 Items

Risk Status equals: "Open"
Organisation Group equals:
Risk Monitoring Committee equals: "Safety & Risk Sub-Committee"
Action Status equals:
Action Status not equal to: "Completed"

| Risk ID | Risk Title | Residual Risk Score | Description | Action Lead | Cost (£) | Action Status | Target date for action to be completed |
|---|---|---|---|---|---|---|---|
| **Name: Corporate Nursing** | | | | | | | |
| 000536 | The Clostridium difficile threshold of 19 cases or less has not been met for the Financial year 2013 - 2014 | Extreme risk 20 | An appeal is being lodged against apportionment of 9 of the cases | | | In progress as at 03/03/2014 | 31/03/2014 |
| | | | Negotiations in place with CCG | | | In progress as at 03/03/2014 | |
| 000281 | Risk of adverse impact on patient safety and quality due to hospital acquired Clostridium difficile. | Extreme risk 16 | CDT action plan in place. | McKay, Lesley; Matron - Infection Control; INFCON | | In progress as at 13/06/2013 | 31/03/2014 |
| 000074 | Risk of adverse impact on patient safety and quality due to hospital acquired infection (MRSA Bacteraemia) | Extreme risk 16 | Improve compliance with use of urinary catheter documentation forms | Cox, Rachel; Nurse Specialist; TBA | | Created as at 04/10/2013 | 31/03/2014 |
| **Name: Estates** | | | | | | | |
| 000134 | External Fire Audit has identified a risk due to Inadequate Emergency (Escape) Lighting within Phase 1 & Phase 2 at Halton site | Extreme risk 16 | Install adequate Emergency Lighting | Gee, Brian; Estates Officer; EST | | In progress as at 26/02/2014 | 30/09/2014 |
| 000170 | External Fire Audit has identified a Risk due to Inadequate Emergency (Escape) Lighting - Warrington Appleton Wing | Extreme risk 16 | Design and install appropriate emergency light fittings in line with current standards | | | In progress as at 26/02/2014 | 30/09/2014 |
| 000025 | Risk Due to Ageing & Failing Windows - Warrington - Appleton Wing | Extreme risk 15 | Ideally the existing Appleton Wing windows require replacement. Capital scheme to replace windows is currently in progress. | Patterson, Ron; Capital Projects Manager; EST | | In progress as at 26/02/2014 | 30/11/2014 |

| Risk ID | Risk Title | Residual Risk Score | Description | Action Lead | Cost (£) | Action Status | Target date for action to be completed |
|---|---|---|---|---|---|---|---|
| **Name: HR** | | | | | | | |

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For HR points see next page

| Risk ID | Risk Title | Residual Risk Score | Description | Action Lead | Cost (£) | Action Status | Target date for action to be completed |
|---|---|---|---|---|---|---|---|
| 000269 | Risk of expenditure on temporary staffing significantly exceeding budget and affecting the future | Extreme | With regard to the Elderly Care Consultant posts the Division need to decide how they wish these posts to progress. | Risino, Amanda; Divisional Manager - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | Plans should be put in place, if not already, to decide how the department will move forward in relation to the Consultant in Emergency Medicine vacancy. | Risino, Amanda; Divisional Manager - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | Escalation beds within the Division either need to be closed or for the new financial year if the beds are deemed necessary within the Division then a business case for additional staffing is required. | Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | A&E needs to mirror the work undertaken in ITU to move staff from agency to NHSP; in addition the division needs to demonstrate the clinical model for AED and how this should be staffed | Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | Regular contact with the agency must happen to ensure the Consultant locum in place within Diabetes and Endocrinology is given appropriate notice for their placement to cease. | Risino, Amanda; Divisional Manager - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | There are two new Gastroenterology posts and one Palliative Care post which the Trust is in the process of gaining Royal College approval. This should be expedited if appropriate to avoid the need for continued Locum cover. | Risino, Amanda; Divisional Manager - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | The Division needs to agree safe staffing levels and draw up a business case for a planned increase in nurse staffing where appropriate. NB - This has been done initially within the 12 hour shift scheme | Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | The division has already taken steps to try to reduce locum and agency spending. They have amended a trainee on-call rota to reduce the need for locums. LAS appointments have been made where this has been possible. Clinical Fellow posts have been introduced and are being utilised to fill some of the junior specialty trainee gaps. Wherever possible they use internal locums to reduce, but not eradicate, the need for agency locums. DRS Realtime has been purchased and is being utilised for rota management within the Medicine specialties. Although decisions have not been reached on all posts it is evident that recruitment to gaps is an on-going process within the division. | Risino, Amanda; Divisional Manager - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | A decision needs to be made as to the requirement for the Surgical Assessment Unit to be used for bedding down at night and if this is the case then again a business case for additional staffing is required. | Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | Arrangements must be made for the re-advertising of the 4th Consultant in | Risino, Amanda; | | In progress | 31/03/2014 |

| Risk ID | Risk Title | Residual Risk Score | Description | Action Lead | Cost (£) | Action Status | Target date for action to be completed |
|---|---|---|---|---|---|---|---|
| | viability of the trust with reports to Monitor | risk 20 | Acute Medicine post. | Divisional Manager - Unscheduled Care; UCD | | as at 12/02/2014 | |
| | | | Interviews are scheduled to take place on 12th March 2014 for the Consultant in Stroke Medicine post. The Trust must ensure this date is kept to and shortlisting undertaken in a timely manner. Regular contact should take place with the agency to ensure the cover arrangements cease at the appropriate time and with the relevant notice. | Risino, Amanda; Divisional Manager - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | A close eye should be kept on the outstanding permit to work for the Trust appointment covering the Senior Specialty Trainee post. This must be chased at regular intervals. | Risino, Amanda; Divisional Manager - Unscheduled Care; UCD | | In progress as at 12/02/2014 | 31/03/2014 |
| | | | Clinical lead to be appointed to review medical staffing expenditure | | | In progress as at 02/09/2013 | 30/09/2013 |
| | | | Executive Team to review expenditure with Divisions at monthly bi-lateral review meetings | | | Created as at 02/09/2013 | 31/03/2014 |
| | | | Consider RRP for staff working in A&E and Theatres to attract staff to work through NHSP rather than agencies and thereby reduce temporary staffing expenditure | | | In progress as at 02/09/2013 | 17/09/2013 |
| | | | Managers to account for temporary staffing expenditure at Temporary Staffing Group.<br>Top 5 overspending areas to be targeted | Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS | | In progress as at 02/09/2013 | 31/03/2014 |
| **Name: Information Governance** | | | | | | | |
| 000304 | Risk to Information Governance agenda due to over reliance on a single-handed Information Governance lead | Extreme risk 16 | IG admin included in new IT Structure | DaCosta, Jason; Director of Information Technology; IT | | In progress as at 10/02/2014 | 10/02/2014 |
| **Name: Information Technology** | | | | | | | |
| 000593 | Risk of funding not being secured in time for new PAS procurement | Extreme risk 20 | System specification to be written in February 2014 | DaCosta, Jason; Director of Information Technology; IT | | In progress as at 10/02/2014 | 28/02/2014 |
| | | | PAS Procurement advertisement to be placed in March 2014 | DaCosta, Jason; Director of Information Technology; IT | | Created as at 13/01/2014 | 31/03/2014 |

| Risk ID | Risk Title | Residual Risk Score | Description | Action Lead | Cost (£) | Action Status | Target date for action to be completed |
|---|---|---|---|---|---|---|---|
| 000482 | Risk of unsupported, ageing IT infrastructure which is technically unable to support the Trust's IT requirements | Extreme risk 20 | Produce a capital business case to finance infrastructure costs. | Garnett, Joe; IT Systems Manager; IT | | In progress as at 10/02/2014 | 20/01/2014 |
| 000037 | Insufficient IT Storage-Server Team | Extreme risk 16 | Tender for a new SAN. Server Team are scoping products and associated costs | Garnett, Joe; IT Systems Manager; IT | | In progress as at 08/01/2014 | 31/01/2014 |
| 000594 | Insufficient IT staff resources to meet external requests for data capture | Extreme risk 15 | IT Department structure to be re-written and funding options for more staff to be sought | DaCosta, Jason; Director of Information Technology; IT | | In progress as at 10/02/2014 | 31/03/2014 |
| **Name: Scheduled Care** | | | | | | | |
| 000111 | Operational and financial risks associated with sustained use of escalation beds in the Division | Extreme risk 16 | Trust has agreed to fund escalation bed staffing over the winter months. Recruitment process is under way. | Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD | | In progress as at 27/02/2014 | 30/04/2014 |
| | | | Consideration being given to more elective work being undertaken at Halton to mitigate impact | Warbrick, Kate; Divisional Manager - Scheduled Care; SCD | | In progress as at 27/02/2014 | 28/02/2014 |
| **Name: Trust Wide** | | | | | | | |
| 000035 | Risk to the care and safety of plus size patients due to limited bariatric equipment. | Extreme risk 16 | | | | | |
| 000027 | There are a number of Pathology Test results to which it cannot be demonstrated have been seen and actioned by Clinicians | Extreme risk 16 | SBAR Report to IT Programme Board to consider ICE roll out. This was agreed and to form an Implementation Plan and roll out of ICE for Diagnostic Testing and management of Results. This will include stopping sending paper results to the ward and only critical abnormal results will be phone through via Blood Sciences | DaCosta, Jason; Director of Information Technology; IT | | Created as at 02/06/2014 | 31/05/2013 |
| 000144 | Potential risk to Patient Safety due to poor management of patient casenotes & reputational risk following NHSLA/CQC Inspection & Assessment | Extreme risk 16 | Implementation Group for casenote roll out | Bradshaw, Millie; Associate Director of Governance; GOV | | Scheduled as at 18/02/2014 | 30/04/2014 |
| 000216 | Defibrillators available in the Trust from different manufacturers | Extreme risk 15 | Acquire funding to standardise defibrillators and have a rolling replacement programme, through business case development. | Kelsey, Sallie; CPD and Business Support Manager; ED | | In progress as at 12/03/2014 | 30/04/2014 |
| **Name: Unscheduled Care** | | | | | | | |

| Risk ID | Risk Title | Residual Risk Score | Description | Action Lead | Cost (£) | Action Status | Target date for action to be completed |
|---|---|---|---|---|---|---|---|
| 000540 | Risk of sub - optimal care due to staffing levels and pt dependancy on Wds GPAMU/B18/A8/B12/B14/ A3/C22 | Extreme risk 16 | Assess patient put out 1-1 if required for patient clinical behaviour and treatment | Hatton, Deborah; Matron - C21; C21 | | In progress as at 25/03/2014 | 30/04/2014 |
| 000542 | Delay in clincial Assessment due to unpredictable volume and acuity of the Patients in the GPAMU; Potential for undetected deteriorating Patient | Extreme risk 16 | Daily review of staffing and patient depedency | Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD | | In progress as at 15/01/2014 | 31/03/2014 |
| **Name: WCCSS** | | | | | | | |
| 000643 | Failure to meet turn around times for samples sent to Reference Laboratories resulting in reduction in quality of service. | Extreme risk 16 | | | | | |
| 000645 | Replacment of MR Scanner on the Warrington site due to age. Risk of missing CFT targets, breaching National wtg list targets. | Extreme risk 16 | Provide imaging using a mobile unit as an addition to using the CMTC | Holland, Neil; Principal Radiographer - MRI and CT; TBA | | In progress as at 05/03/2014 | 31/07/2014 |
| | | | Seek capital funding for equipment replacement for 2014/15. | Holland, Neil; Principal Radiographer - MRI and CT; TBA | | In progress as at 05/03/2014 | 31/03/2015 |
| 000381 | Risk of poor patient experience due to ward C20 being escalated with medical & surgical pts. Elective cases are being cancelled at short notice | Extreme risk 16 | Bed availability - Alternative beds to be identified when elective patients cannot be accommodated. | Goodwin, Ann; Clinical Risk Midwife; WomH | | In progress as at 14/04/2014 | 30/04/2014 |
| 000373 | Due to potential for harming patients, the MRI Scanner in the CMTC is working at reduced capacity.. | Extreme risk 16 | Provide imagings using a mobile unit either as an alternative to the CMTC scanner or in addition to. | Grimes, Dan; Assistant Divisional General Manager (Radiology, Women's & Children's Health) - WCSS; WCSS | | In progress as at 14/04/2014 | 31/01/2015 |
| | | | Purchase new MRI scanner for CMTC in Q4 2014/15 | Holland, Neil; Principal Radiographer - MRI and CT; TBA | | In progress as at 14/04/2014 | 31/01/2015 |
| 000347 | Anticoagulation Service : The continuing rise in the numbers of patients needing anticoagulation cannot be managed safely within existing services. | Extreme risk 16 | Assess potential to move clinics from outpatients into the Community or find a suitable alternative location within the Hospital(s) | Farrimond, Amanda; Anticoagulation Service manager; WCSS | | In progress as at 14/04/2014 | 30/06/2014 |
| | | | Prepare business case for additional staffing requirements | Matthew, Diane; Chief Pharmacist - Pharmacy; WCSS | | In progress as at 14/04/2014 | 30/06/2014 |

| Risk ID | Risk Title | Residual Risk Score | Description | Action Lead | Cost (£) | Action Status | Target date for action to be completed |
|---|---|---|---|---|---|---|---|
| 000671 | Damage to Reputation of Trust due to Poor Condition of Flooring on B10 and B11. Risk of slips, trips and falls. | Extreme risk 15 | Secure funding to replace flooring. | Blackhurst, Yvonne; Paediatric Risk Lead - Child Health; TBA | | In progress as at 14/04/2014 | 31/08/2014 |
| 000641 | Inability to programme hearing aids for adults/children leaving them vulnerable due to equipment failure. Unable to access AQP reports. | Extreme risk 15 | Replace old equipment - funded from Oticon hearing aid rebate system. | | | In progress as at 14/04/2014 | 31/05/2014 |
| 000604 | Impact on business continuity from system failure - withdrawal of support for Windows XP & for the current version of the Pharmacy JAC System (v4.47) | Extreme risk 15 | Place order for upgrade of JAC system. | Matthew, Diane; Lead Investigating Officer; WHH | | In progress as at 15/04/2014 | 31/05/2014 |
| 000380 | Anaerobic atmosphere for isolation of medically significant organisms. Risk of cabinet failing due to certain parts becoming obsolete & irreplacable | Extreme risk 15 | To procure a replacement facility. | Marshall, Graham; Microbiology Manager - Microbiology; TBA | | In progress as at 15/04/2014 | 30/07/2014 |
| 000266 | MOLIS : Laboratory Information System (Vision4Health) Current software unable to embrace new technologies which could affect future requirements | Extreme risk 15 | Tender for new LIS as soon as possible.<br>Bid to Capital Group completed. Await funding confirmation for 2014/15.<br>Prepare specificationfor tender and project plan for implementation April 2014.<br>Update 10-.3.14 : Funding agreed at Capital Planning meeting on 5 3 14 to replace MOLIS. | Gaskell, Neil; Deputy Departmental Manager; TBA | | In progress as at 14/04/2014 | 30/04/2014 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/070**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Board Assurance Framework (BAF) and Provider Licence Checklist Q4 |
| **Date of Meeting** | 30 April 2014 |
| **Director Responsible** | Executive |
| **Author(s)** | Trust Secretary/Executive |
| **Purpose** | To review and note the Trust's Board Assurance Framework and Provider Licence Checklist. |

| **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

- The BAF and compliance against the Provider Licence will be reviewed by the Audit Committee in line with its terms of reference.
- The Provider Licence checklist C1(3) - The Trust is revisiting its patient access policy to comply with the requirements - 'offering the choice options' and applying the rules when breached.
- The BAF is updated to take into account gaps in controls and assurance and also take into account the requirements of the Provider License.

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

***The Board is asked to Review and taking into account the review of the Corporate Risk Register confirm that the BAF and the Corporate Risk Register:***

i. **covered the Trust's main activities and adequately identified the principal objectives the organisation was seeking to achieve;**
ii. **adequately identified the risks to the achievement of those objectives;**
iii. **confirm adequate assurance systems were in place to ensure the systems of control were effective and efficient in controlling the risks identified.**

***The Board is asked to note the status of the Provider Licence Checklist as at Q4.***

# ASSURANCE FRAMEWORK 2013 - 2014

~~January~~ April 2014


# Strategic Objective 1
# ENSURE ALL PATIENTS ARE SAFE IN OUR CARE

| Ref | Risk (failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Gaps in Assurance/Controls |
|---|---|---|---|---|---|---|
| **1.1**<br><br>**COO** | **Risk of failure to achieve agreed thresholds of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework** | 3 x 4<br>(12) | Operating Framework reviewed annually, and annual plan is prepared to demonstrate ability to deliver targets effectively. | 3 x 4<br>(12) | Board involved in the Annual Planning process and subsequent reports to monitor progress of delivery against this plan. | |
| | | | Governance structure | | Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board. | |
| | | | Performance management system (eg Bi Laterals, diagnostic meetings each month) | | Assurance that Performance management systems is operating effectively as designed. | |
| | | | Engagement with staff | | Board confirmation that all appropriate staff are effectively engaged. | |
| | | | Awareness raising programme undertaken in relation to targets. | | Confirmation that Awareness raising programme has been delivered in full. | |
| | | | Corporate Performance and Quality Dashboard Reports to Board on a monthly basis, including infection control reports. | | Internal Audit provide a range of independent assurances through the audit plan<br>Other assurances from independent organisations eg data assurance.<br>Management assurances around the accuracy of information provided. | |
| | | | Executive and Non Executive Walkabouts | | Programme and results have been designed and reviewed effectively and outcomes feed into Trust programme. | |
| | | | 3 yearly governance review | | Monitor implementation of recommendations arising from the review | |
| | | | Monitor trends that are relevant to triggering a governance concern. | | Results of monitoring. | |

| Ref | Risk<br>(failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Gaps in Assurance/Controls |
|---|---|---|---|---|---|---|
| | | | Annual Governance Statement | | Independent assurance that the annual governance statement is reliable and robust | |
| **1.2**<br><br>**DON** | **Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust.** | 4 x 5<br>(20) | Executive Directors responsibility for CQC Outcomes, with identified operational leads reporting via Board Committee | 2 x 5<br>(10)<br><br>(Previous 3x4) | Governance Committee assurance that accountabilities and processes have been discharged with a focus upon understanding reductions of harm. | New reporting systems & sub Committees to Quality Governance Committee have been reviewed and require review after 12 months to assess effectiveness (Sept 2014) |
| | | | Clinical Effectiveness and Patient Experience Strategy | | One strategy: Monitor and progress reporting against Clinical Effectiveness and Patient Experience Strategy | |
| | | | Implementation of the national CQUIN for the NHS Safety Thermometer | | Targets for reducing harm have been achieved eg avoidable pressure ulcers, UTIs, VTE, medication errors and 'never events'. | |
| | | | Accountability through governance structures including Bi Lateral review at divisional level. | | Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes. | |
| | | | Trust policies and procedures including completion of CQC Assurance Templates by leads and service managers | | In house" CQC inspections<br>MIAA audits<br>CQC unannounced inspection report March 2013 from visit held in January 2013<br>Care Quality Commission rating.<br>CQC Risk rating<br>Governor inspections<br>Assurance on completion of action plans<br>Benchmarking<br>Complaints and Patient Feedback<br>HED data | Patient Complaints service reviewed June 2013. Assess effectiveness in 12 months. |
| | | | Strategy setting process eg People and Quality. | | Appropriate assurance that key strategies are designed and delivered effectively. | |

| Ref | Risk<br>(failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Gaps in Assurance/Controls |
|---|---|---|---|---|---|---|
| **1.3 DON** | **Failure to achieve infection control targets in accordance with the Risk Assessment Framework** | 4x4 (16) | Infection control strategy including policies and procedures. | 2x4 (8) | Process in place for approval of strategy to ensure that it is robust and confirmation of subsequent delivery, taking account of the number of bed days as against threshold tolerance in the RAF.<br><br>Threshold higher for Cdiff for 2014/15 than 2013/14 and move in profile nationally | |
| | | | Governance and Accountability arrangements | | Board oversight of committee operations<br>Quarterly infection control reports | |
| **1.4 COO** | **Failure to have appropriate and effective business continuity plans.** | 4 x 5 (20) | Emergency preparedness strategy produced annually and presented to Board | 2 x 5 (10) | Board review and monitoring of delivery of strategy including formal testing, training etc | |
| | | | Business continuity plans - in all depts. | | Results of annual review of all business continuity plans overseen by Business Continuity Group and reported to Board. | |
| | | | Business Continuity plans for key external agencies are received to determine any risks to the continuity of essential services | | Results of review overseen by Business Continuity Group and reported to Board.<br>• 10 Event Planning meetings held looking at continuity<br>• External validation of Systems<br>• Series of live exercises to test resilience | |
| | | | Civil Contingencies Act requirements monitored. | | Assurance report provided to Board to confirm compliance against legislation. | |
| | | | Appropriate Governance Structure in place | | Effective operation of Assurance Committees.<br>Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes. | |
| **1.6. DON** | **Failure to comply with Health & Safety Legislation.** | 4 x 5 (20) | Appropriate Governance Structure in place | 2 x 5 (10) | Effective operation of Assurance Committees.<br>Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes.<br>Results of Internal incident reporting | |
| | | | Health & Safety Strategy | | Process for approval of strategy and monitoring of delivery of strategy.<br>Health & Safety Annual Report | |

| Ref | Risk<br>(failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Gaps in Assurance/Controls |
|---|---|---|---|---|---|---|
| | | | | | HSE visits and inspections and associated internal progress reports | |
| | | | Mandatory training programme delivered and monitoring of attendance. | | KPIs being reported regularly to the Strategic Workforces Committee. | |

People

# Strategic Objective 2
# TO BE THE EMPLOYER OF CHOICE FOR HEALTHCARE WE PROVIDE

| Ref | Risk (failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Gaps in Controls/Assurance |
|---|---|---|---|---|---|---|
| **2.1**<br><br>**DON** | **Failure to engage and involve our workforce in the design and delivery of our services.** | 4 x 5<br>(20) | Appropriate Governance Structure in place, including Strategic People Committee and Council of Governors and Members<br>Joint working with Staff Side/JLNC | 2 x 5<br>(10) | Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes including staff survey results, monthly KPIs, patient feedback.<br>Divisional DIG and temperature checks<br>Assurances on how duty of candour has been discharged.<br>Staff Survey results | • Staff FFT to be embedded in 14/15<br>• Staff not always got access to intranet – requirement to develop team briefing processes to enable to reach all staff |
| | | | People Strategy | | Sign off of strategy and subsequent monitoring of implementation of strategy. | |
| | | | Cost Transformation processes | | Assurance Reporting on staff and patient impact from Cost Transformation processes. | |
| ~~**2.2**~~<br><br>~~**DON**~~ | ~~**Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned.**~~ | ~~4 x 4~~<br>~~(16)~~ | ~~People Strategy and annual business planning framework. (Strategy informed from our understanding of commissioner intentions).~~ | ~~3 x 4~~<br>~~(12)~~ | ~~Process for approval of strategy and monitoring of delivery of strategy.~~ | ~~Need to understand further relationship between pay and income to ensure affordability~~ |
| | | | ~~Reporting Arrangements via Strategic People Committee~~<br><br>~~Roll out of CBW planning~~ | | ~~Assurance and exception reporting of Workforce Planning Sub Committee, Workforce Committee, JNCC / JLNC~~<br>~~Board dashboard~~<br>~~Stress and staff surveys~~<br>~~Review of attendance rates~~<br>~~EWTD Compliance~~<br>~~Assurances cost efficiencies have been achieved and standards maintained through Competency Based Workforce Planning (CBWP)~~<br>~~Assurance provided to Board that Trust is delivering thresholds and tracking trends~~ | ~~Turnover of staff in workforce planning, opportunity to firm up OD and WFP for coherent Service~~ |
| **2.2**<br><br>**DON** | **Risk that the Trust does not have the right people with the right skills ie workforce is** | 5x5<br>(25) | Control systems in place to support risk:<br>• Strategic People Committee<br>• Education Governance | 3x5<br>(15) | • Board Workforce KPI reports<br>• Educational Governance Reports to SPC<br>• Workforce analysis & Workforce Plans | • Require the development of robust workforce plans linked to capacity and demand and |

| Ref | Risk<br>(failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Gaps in Controls/Assurance |
|---|---|---|---|---|---|---|
| | **not competent and cannot deliver as commissioned.** | | • NMAC<br>• National WFP<br>• Medical Education Committee<br>• OD Strategy<br>• People Strategy<br>• Talent Management<br>• Recruit & Selection Policies and Procedures<br>• ICC and Workforce Transformation | | • External Medical Education and Nurse Education reviews<br>• Compliance with CQC & NHSLA Standards and Audits<br>• Staff Survey<br>• Staff engagement & wellbeing reviews | activity profile of the changing strategic direction of the Trust<br>• Need to strengthen the links between business planning and workforce through the FSC and SPC<br>• Vacancy freeze to be enabled<br>• Additional HR professional to be brought in to lead on temporary staffing and workforce plan. |


# Strategic Objective 3
# TO GIVE OUR PATIENTS THE BEST POSSIBLE EXPERIENCE

| Ref | Risk (failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Action Plan Gaps in Control/ assurance |
|---|---|---|---|---|---|---|
| **3.1**<br><br>**COO /DOF** | **Failure to develop an effective Estates Strategy to meet service priorities and Trust patient environment quality standards.** | 3 x 4<br>(12) | Estates Strategy being developed by Keir Construction in line with Board direction. | 3x 3<br>(9) | Board approval and subsequent monitoring of delivery of strategy via updates to Board and Board workshops (including understanding of clinical and business drivers) | Understanding future provision ~~of clinical~~of clinical services and the footprint for hospital services from (1) Commissioners perspective and (2) political position – May 2015 elections. |
| | | | Committee Structure | | Effective operation of Assurance Committees. Outcomes from work of Assurance Committees are reported to Board eg exceptions and assurances through minutes. | |
| | | | Capital Programme including plan to address backlog maintenance | | Assurance on progress of delivery of capital programme including;<br>• Rationalisation and optimisation of non-clinical buildings<br>• Migration of secondary care services to community services | |
| **3.2**<br><br>**DoIT** | **Failure to develop a fit for purpose clinical and business information systems to support delivery of high quality patient care** | 4 x 4<br>(16) | Overarching Strategy and implementation plan | (3 x 4)<br>(12) | Board approval and subsequent monitoring of delivery of strategy via updates to Board with an assurance focus upon the twin national challenge of providing information to our patients by 2015 and moving to paperless by 2018. | Inability to provide funding and resources to enable fit for purpose systems and implementation of strategy |
| | | | Governance Structure;<br>IM&T Programme Board<br>Data Quality and Management Steering Group<br>Information Governance and Corporate Records Group.<br>OPD User Group.<br>Diagnostic Users Group<br>Benchmarking Review Group | | KPI meeting held fortnightly<br>Medical Records Strategy Group reports and minutes.<br>Internal audit review and reports and management action plans<br>IT systems project implementation progress reports to Board.<br>Reporting through committee structure (new Finance and Sustainability Committee) | |

| Ref | Risk<br>(failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Action Plan<br>Gaps in Control/ assurance |
|---|---|---|---|---|---|---|
| | | | Finance and Sustainability Committee. | | | |
| **3.3**<br><br>**DON** | **Failure to provide staff, public and regulators with assurances post Francis and Keogh review** | 5 x 5<br>(25) | | 2 x 5<br>(10) | Board approval and monitoring of implementation of strategy. (particularly focusing assurance of patient experience and outcomes, rather than performance management) | |
| | | | | | Assurance over delivery and impact on the patient experience and outcomes. | |
| | | | • High level briefing papers and action plans<br>• Board Development Review<br>• Governance Structure<br>• Internal/External Audit | | • Effective operation of Assurance Committees.<br>• Outcomes from work of Assurance Committees are reported to Board eg Quality Dashboard reporting to the Board<br>• Quality Improvement Committee exception reporting to the Board<br>• Patient Survey results<br>• Patient Reported Outcome Measures (PROMS) reporting<br>• CQUIN progress reports to Board<br>• Mortality Outlier Reports<br>• Governor ward visits<br>• Impact of new nursing structure changes<br>• Patient Advisory Group.<br>• LINKs feedback<br>• Membership feedback<br>• Compliance reporting on;<br>• Reduced admissions, compliance with end of life care and Advancing Quality Targets<br>• Quality Account/Report<br>• Board workshop presentation on CQC inspections<br>• Processes in place through Governance Department on Keogh Review inspections including across trust drop in sessions and training. The Sessions are to raise awareness amongst staff to the new Care Quality Commission Inspection Framework and what the impact of this for staff and the Trust | New process for CQC inspections still to be fully understood |
| | | | Quality Improvement themes | | Board oversight of delivery of quality improvements | |

| Ref | Risk<br>(failure = key risk) | Risk Score LxI | Control systems | Residual Score LxI | Assurance | Action Plan<br>Gaps in Control/ assurance |
|---|---|---|---|---|---|---|
| | | | Communications and marketing | | Board is assured on how effective the Trust has been in understanding their communities. | |
| | | | Whistle blowing arrangements | | Effective learning on whistle blowing case studies | |
| | | | Friends and Family Test | | Board & Governor overview of results of friends and family test. | |
| | | | Duty of Candor | | • Briefing paper to the Board. Attached.<br>• A Staff information was produced and distributed to all wards and depts.( attached) in addition to Trust induction for all new starters<br>• Educational sessions arranged within all DIGGs/Specialties, Governance Committee, CG, Audit and Quality and Safety and Risk SC<br>• The Incident and Investigations Policy was revised to include DoC and Approved under Governance arrangements ( can be found on the Hub)<br>• All Level One and Two Investigations has a DoC Checklist and is QC for audit purposes<br>• Commissioners monitor level 2 Investigations as part of the Quality Contract | |


# Strategic Objective 4
# TO PROVIDE SUSTAINABLE LOCAL HEALTHCARE SERVICES

| Ref | Risk<br>(failure = key risk) | Risk Score Lxl | Control systems | Residual Score Lxl | Assurance | Action Plan<br>Gaps in Control/ Gaps in Assurance |
|---|---|---|---|---|---|---|
| **4.1 DOF** | **Failure to agree and implement a focussed and robust business development strategy to achieve the strategic aims of the Trust.** | 4 x 4 (16) | • Strategy Committee ~~Group~~ to take forward and develop the recommendations of our external Strategic Review and determine our future strategy.<br><br>• Monthly Divisional Bilateral Meetings.<br><br>• Strategy Committee replaced by the Finance and Sustainability Committee (FSC) in February 2014. | 3 x 4 (12) | Board approved 'Business Development Strategy' that describes the Trust objectives and approach to collaboration, service reconfiguration and partnership working.<br><br>Quarterly reports to the ~~Board~~ FSC evidencing actions and approach support the delivery of the strategy and its expected outcomes.<br><br>Monthly meetings of the ~~Strategy~~ FSC Committee to agree and oversee the implementation of the annual business development workplans.<br><br>5 Year Strategic Plan 2014-19<br><br>Strategic Plan toolkit to be utilised to develop Board awareness. | To refresh the Trust's Business Development Strategy in light of the Ernst and Young Strategic Study and develop robust annual workplans to support implementation and delivery.<br><br>Establishment of Commercial Development Team to develop and support implementation of the Trusts Strategic Plan/Strategy |
| **4.2**<br><br>**DOF** | **Failure to:**<br>▪ **CoS rating of at least 3**<br>▪ **remain at all times a going concern**<br>▪ **maintain a sufficient liquidity ratio or capital servicing capacity**<br>▪ **ensure the ~~3~~ 5 year financial projection adequately reflect the Trust's financial stability** | 4 x 5 (20) | ▪ Monthly detailed and dash board report to the Board: I&E, activity, Balance Sheet performance metrics and 2 year cash profile.<br>▪ CoS risk rating assessment current and forecast<br>▪ Reporting other compliance metrics: Private Patient Cap and Prudential Borrowing Code & limit.<br>▪ PMO arrangements<br>▪ Divisional management and governance accountability structures | 4 x 4 (16) | ▪ Audit Committee reporting to the Board<br>▪ Internal audit reports<br>▪ Annual Head of Internal Audit opinion<br>▪ SIC<br>▪ Statutory External Audit of accounts<br>▪ Audit Commission PbR audits<br>▪ Monitor risk assessment and level of involvement<br>▪ Internal Audit Programme<br>▪ Financial and Sustainability Committee formed<br>▪ Monthly Board reporting<br>▪ Budget and Annual Plan 14/15 and 15/16 | Updated risk<br>Realigned controls and assurances |

| Ref | Risk<br>(failure = key risk) | Risk Score Lxl | Control systems | Residual Score Lxl | Assurance | Action Plan<br>Gaps in Control/ Gaps in Assurance |
|---|---|---|---|---|---|---|
| | ▪ **Failure to comply with G6 of Provider licence** | | ▪ Standing financial instructions and scheme of delegations<br>▪ Legal contracts agreed with CCG. | | | |
| **4.3**<br><br>**DOF** | **Failure to agree and manage key contracts appropriately resulting in contract penalties or reduction in service standards (provision and receipt of services).** | 4 x 5<br>(20) | ~~Monthly Finance and Activity KPI Group as part of the performance management framework.~~<br><br>Monthly Divisional Bilateral Meetings.<br><br>Quality Group meetings with Warrington CCG<br><br>Contract Risk Report<br><br>Monthly Contract meetings with Warrington CCG | 3 x 5<br>(15) | ~~Board of Directors~~FSC to receive ~~monthly~~ contract risk reports.<br><br>Evidence of contract performance (provision of service) and contract management (receipt of service) provided through Divisional Bilateral Reports ~~and Monthly Finance and Activity KPI reports~~. | Establishment of a contract (including SLA) register with identified responsible leads for each contract.<br><br>Proactive management of contracts for receipt of services between operational teams, finance, procurement and business development.<br><br>Proactive management of contract performance and delivery for provision of services between operational teams, finance, procurement and business development. |

# Provider Licence Checklist

**Foundation Trusts and the Provider Licence**
The provider licence is the new main tool which Monitor will use to regulate providers of NHS Services.

Foundation Trusts do not need to apply for a licence; one will be issued to all Foundation Trusts in advance of 1 April 2013 through the Foundation Trust portal. The exact timing of this will be confirmed as soon as possible. In advance of licences being issued, Foundation Trusts will be asked to confirm the accuracy of some required information, such as names, titles and addresses.

The licence contains obligations for providers of NHS services that will allow Monitor to fulfil its new duties. It will also enable Monitor to continue 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.

There are four licence conditions that will apply only to Foundation Trusts. These conditions cover the provision of information that Monitor has a duty to maintain on the register of NHS Foundation Trusts and the possibility of associated fees, an obligation to provide information requested by an advisory panel, and a condition that enables Monitor to continue its oversight of the governance of NHS Foundation Trusts.

**Mandatory Services (see page 43)**
From 1 April 2013 all NHS funded mandatory services (as set out in schedule two of the old Terms of Authorisation) had automatically become ***'Commissioner Requested Services'***. Monitor intend for this "grandfathering" of mandatory services to last for up to three years and will provide commissioners with time to analyse, redefine and agree with Trusts what services they want to classify as CRS.

**Provider Licence Quarterly Checklist from 2013/14**
**Q4**

| Licence Reference | Licence Provision | Quarterly review – response | RAG | |
|---|---|---|---|---|
| **G2** | **Have Monitor given any direction regarding setting or limiting conditions within the Provider Licence?** | No | | Exec |
| **G4 (1)** | **Is the Trust aware of any reason why a newly appointed Governors or an appointed governor is unfit to be a Governor?** | A review of the Governor DBS will complete and any matters will be brought to the attention of the Director responsible for HR (in accordance with Trust Constitution). All candidates have signed a declaration that they comply with the requirements of the Trusts Constitution that includes the unfit person classification. At appointment Governors are required to sign a declaration of their fitness to be a governor.<br><br>Year-end self-certification declarations received from Directors and Governor confirming compliance. | | TS & DNOD |
| **G4 (2)** | **Is the Trust aware of any reason why a newly appointed Director or a director in post is unfit to be a Director?** | . Medical Director started 1 February 2014. A DBS has been obtained prior to appointment and the Service Contract includes "summary termination clause in the event of a director being or becoming an unfit person".<br><br>Self-certification declaration received from Medical Director re fit and proper person test (G4(1)) | | DNOD |
| **G5** | **Has Monitor issued new guidance relating to the provider licence in the quarter?** | Guidance on Monitor Code of Governance received and review undertaken to be reported to the Audit Committee in April. Guidance on the production of the Trusts Annual Report and Accounts and Annual Planning. Both refer to requirements of the provider licence. Actions taken to address any areas of where enhancements are required within the Trust. The Board at a workshop before the April Board meeting will undertake the Strategic Planning Self-Assessment toolkit. | | Exec/TS |
| **G6** | **Executive to consider any new licencing risks identified in the quarter – update of Board Assurance Framework for Board approval?** | Exec Directors review of Provider licence undertaken and BAF updated. | | Exec |

| | | | | |
|---|---|---|---|---|
| **G6 (3)** | **Publication of Annual Governance Statement in Q1?** | N/A until Q1 2014: statement made in Annual Report & Accounts 2013/14. AGS will be presented to the Audit Committee for review in line with previous practice. | | CE/TS |
| **G7** | **Consider CQC registration status in quarter – note cancellations and registrations (G7 (2))?** | None | | COO as Trust Lead for CQC registration |
| **G9 (12)** | **Have the contractual requirements to activities or any mandatory services been amended?** (see page 43 of the provider licence accountability document) | Yes in line with annual contract discussions levels of activity for 14/15 reflect the CCGs requirements. | | Dof&CD |
| **P1(4)** | **Have any Services been subcontracted?** | No | | Dof&CD |
| **C1(3)** | **Are clear systems in place for notifying individual patients about choice re '18 week' breaching when arranging alternative care?** | The Trust is revisiting its patient access policy to comply with the requirements - 'offering the choice options' and applying the rules when breached. | | COO |
| **IC1** | **Are there any Service changes that require staff/public consultation (need to be cognisant of Public Interest)?** | No | | Dof&CD |
| **CoS1** | **Have any contract variations of a material nature been completed to Service Specifications [if Yes action required CoS1(4)]?** | No material changes | | Dof&CD |
| **CoS2** | **Have any assets been disposed of that would impact on the ability to provide 'Commissioner Requested Services'?** | No - the asset register has been reviewed to reflect CRS assets and during the review assets have been identified that fit the CRS criteria and some that don't. There are a number of assets that require further consideration before the final decision on whether the CRS criteria are met. It is | | Dof&CD |

| | | | | |
|---|---|---|---|---|
| | | anticipated that this will be completed before financial year end. | | |
| **FT1** | **Has the Constitution been amended?**<br><br>**Publication of the Annual Report and Accounts in accordance with Monitor requirements – once published requires submission to Monitor with 28days.** | 2013/14 AR&AC's are being produced in accordance with previous practices. They will be presented to the Audit Committee at its meeting on 6 May and 23 May in time for Board approval on 28 May For submission to Monitor. | | TS/ Dof&CD |
| **FT4 (8)** | **Submit to Monitor Corporate Governance Statement following Board approval in Q1 by 30th June 2014**<br><br>**Has monitor requested an independent audit of the statements** | Strategic Plan 2014-19 submitted by 30th June 2014<br><br>No | | TS/ Dof&CD |

W&HHFT/TB/14/071

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Governance Statement Quarter 4 13/14 |
| **Date of Meeting** | 30th April 2014 |
| **Director Responsible** | Tim Barlow, Director of Finance & Commercial Development |
| **Author(s)** | Steve Barrow, Deputy Director of Finance |
| **Purpose** | To approve the Quarter 4 13/14 governance statement for submission to Monitor. |

| **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 |
|---|---|
| • To review and agree the recommended Board Statements for Q4 | Pages 1-3 |

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

The Board is asked to approve governance statement for submission to Monitor.

**Warrington and Halton Hospitals NHS Foundation Trust**

**Monitor In Year Governance Statement**

**Quarter 4 2013/14 (1st April 2013 – 31st March 2014)**

## 1. Background

In accordance with the Risk Assessment Framework published by Monitor on 27th August 2013, Boards of NHS Foundation Trusts are required to respond to the following statements (see attachment 1).

## 2. Statements (per Quarter 3 Monitoring Returns)

### 2.1 Finance Statement

The Board anticipates that the Trust will continue to maintain a continuity of services risk rating of at least 3 over the next 12 months.

### 2.2 Governance Statement

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forwards (see attachment 2).

### 2.3 Otherwise

The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 16 diagram 8 and the Risk Assessment Framework page 21 diagram 6) which have not already been reported. (Attachment 3).

## 3. Conclusion and recommendations

### Finance

The planned continuity of services risk rating as at 31st March 2014 is 4 but the actual risk rating achieved is 3.

The annual plan submitted to Monitor on 4th April 2014 covering the two financial years 14/15 and 15/16 showed that in 14/15 the planned risk rating for quarters 1 to 3 is 2 but this increases in quarter 4 to 3. The individual metrics are summarized in the table below:

| **Rating** | **Q1** | **Q2** | **Q3** | **Q4** |
|---|---|---|---|---|
| Liquidity | 2 | 2 | 2 | 2 |
| Capital Servicing Capacity | 1 | 1 | 2 | 3 |
| **Continuity of Services rating** | **2** | **2** | **2** | **3** |

The finance statement requires the Board to confirm that it anticipates it will maintain a continuity of services risk rating of 3 for "at least over the next 12 months" which therefore runs to Quarter 4 14/15. The table above shows that based on current projections it will achieve not achieve a risk rating of 3 until quarter 4.

**Therefore it is recommended that the Board states that whilst it is has plans to deliver a continuity of services risk rating of 3 by the end 14/15, at this stage, it cannot confirm that it anticipates maintaining a risk rating of at least 3 over the next 12 months.**

**Governance**

In quarter 4 all performance targets were achieved with the exception of Clostridium Difficile. (Clostridium Difficile is measured on the year to date not the quarterly numbers).

The annual target is set at 19 and the actual number of cases is 31, therefore the target is "not met" and scores 1 point against the governance risk rating.

The annual plan submitted to Monitor on 4th April covering the two financial years 14/15 and 15/16 showed that in responding to 14/15 the Board declared that there were no risks in meeting the targets or indicators included in the Risk Assessment Framework.

**Therefore it is recommended that the Board confirms that it is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets and a commitment to comply with all known targets going forwards.**

**Otherwise / Exception reporting**

- Based on the fact that there are no actual or prospective material changes which may affect the ability to comply with any aspect of authorisation and which have not been previously notified to Monitor, it is proposed that the board confirms the otherwise statement.

**Tim Barlow**
**Director of Finance & Commercial Development**
**22nd April 2014**

**Worksheet "Targets and Indicators"**

## Declaration of risks against healthcare targets and indicators for 2013-14 by Warrington and Halton Hospitals

These targets and indicators are set out in the Risk Assessment Framework

**Definitions can be found in Appendix A of the Risk Assessment Framework**

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

**Key:** must complete / may need to complete

| Target or Indicator (per Risk Assessment Framework) | Threshold or target YTD | Scoring under Compliance Framework | Scoring under Risk Assessment Framework | Risk declared at Annual Plan | Scoring under Compliance Framework | Quarter 1 Actual: Performance | Quarter 1 Actual: Achieved/Not Met | Scoring under Compliance Framework | Quarter 2 Actual: Performance | Quarter 2 Actual: Achieved/Not Met | Scoring under Compliance Framework | Quarter 3 Actual: Performance | Quarter 3 Actual: Achieved/Not Met | Scoring under Risk Assessment Framework | Quarter 4 Actual: Performance | Quarter 4 Actual: Achieved/Not Met | Any comments or explanations | Scoring under Risk Assessment Framework |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referral to treatment time, 18 weeks in aggregate, admitted patients | 90% | 1.0 | 1.0 | No | | 91.00% | Achieved | | 90.90% | Achieved | | 92.10% | Achieved | | 92.6% | Achieved | | |
| Referral to treatment time, 18 weeks in aggregate, non-admitted patients | 95% | 1.0 | 1.0 | No | | 98.00% | Achieved | | 97.80% | Achieved | | 97.80% | Achieved | | 97.7% | Achieved | | |
| Referral to treatment time, 18 weeks in aggregate, incomplete pathways | 92% | 1.0 | 1.0 | No | 0 | 92.20% | Achieved | 0 | 92.70% | Achieved | 0 | 93.50% | Achieved | 0 | 94.2% | Achieved | | 0 |
| A&E Clinical Quality- Total Time in A&E under 4 hours | 95% | 1.0 | 1.0 | No | 0 | 95.10% | Achieved | 0 | 95.30% | Achieved | 0 | 95.20% | Achieved | 0 | 95.7% | Achieved | | 0 |
| Cancer 62 Day Waits for first treatment (from urgent GP referral) | 85% | 1.0 | 1.0 | No | | 88.30% | Achieved | | 86.00% | Achieved | | 86.30% | Achieved | | 89.7% | Achieved | | |
| Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) | 90% | 1.0 | 1.0 | No | 0 | 100.00% | Achieved | 0 | 100.00% | Achieved | 0 | 100.00% | Achieved | 0 | 100.0% | Achieved | | 0 |
| Cancer 31 day wait for second or subsequent treatment - surgery | 94% | 1.0 | 1.0 | No | | 100.00% | Achieved | | 100.00% | Achieved | | 100.00% | Achieved | | 100.0% | Achieved | | |
| Cancer 31 day wait for second or subsequent treatment - drug treatments | 98% | 1.0 | 1.0 | No | | 100.00% | Achieved | | 100.00% | Achieved | | 100.00% | Achieved | | 100.0% | Achieved | | |
| Cancer 31 day wait for second or subsequent treatment - radiotherapy | 94% | 1.0 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Cancer 31 day wait from diagnosis to first treatment | 96% | 0.5 | 1.0 | No | 0 | 100.00% | Achieved | 0 | 100.00% | Achieved | 0 | 98.50% | Achieved | 0 | 98.7% | Achieved | | 0 |
| Cancer 2 week (all cancers) | 93% | 0.5 | 1.0 | No | | 95.00% | Achieved | | 95.20% | Achieved | | 94.10% | Achieved | | 94.5% | Achieved | | |
| Cancer 2 week (breast symptoms) | 93% | 0.5 | 1.0 | No | 0 | 96.00% | Achieved | 0 | 93.80% | Achieved | 0 | 96.40% | Achieved | 0 | 93.3% | Achieved | | 0 |
| Care Programme Approach (CPA) follow up within 7 days of discharge | 95% | 1.0 | 1.0 | No | | 0.00% | Not relevant | | 0.00% | Not relevant | | 0.00% | Not relevant | | 0.0% | Not relevant | | |
| Care Programme Approach (CPA) formal review within 12 months | 95% | 1.0 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Admissions had access to crisis resolution / home treatment teams | 95% | 1.0 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Meeting commitment to serve new psychosis cases by early intervention teams | 95% | 0.5 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Ambulance Category A 8 Minute Response Time - Red 1 Calls | 75% | 0.5 | 1.0 | No | | 0.00% | Not relevant | | 0.00% | Not relevant | | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Ambulance Category A 8 Minute Response Time - Red 2 Calls | 75% | 0.5 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Ambulance Category A 19 Minute Transportation Time | 95% | 1.0 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Clostridium Difficile -meeting the C.Diff objective | 0 | 1.0 | 1.0 | No | 0 | 12 | Achieved | 0 | 14 | Not met | 1 | 24 | Not met | 1 | 31 | Not met | | 1 |
| MRSA - meeting the MRSA objective | 0 | 1.0 | N/A | No | 0 | 1 | Achieved | 0 | 2 | Achieved | 0 | N/A | | | N/A | Not relevant | No longer applicable under RAF | |
| Minimising MH delayed transfers of care | <=7.5% | 1.0 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Data completeness, MH: identifiers | 97% | 0.5 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Data completeness, MH: outcomes | 50% | 0.5 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Compliance with requirements regarding access to healthcare for people with a learning disability | N/A | 0.5 | 1.0 | No | 0 | 0.00% | Achieved | 0 | 0.00% | Achieved | 0 | 0.00% | Achieved | 0 | N/A | Achieved | | 0 |
| Community care - referral to treatment information completeness | 50% | 1.0 | 1.0 | No | | 0.00% | Not relevant | | 0.00% | Not relevant | | 0.00% | Not relevant | | 0.0% | Not relevant | | |
| Community care - referral information completeness | 50% | 1.0 | 1.0 | No | | 0.00% | Not relevant | | 0.00% | Not relevant | | 0.00% | Not relevant | | 0.0% | Not relevant | | |
| Community care - activity information completeness | 50% | 1.0 | 1.0 | No | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.00% | Not relevant | 0 | 0.0% | Not relevant | | 0 |
| Risk of, or actual, failure to deliver Commissioner Requested Services | N/A | 4.0 | Report by Exception | No | 0 | | No | 0 | | No | 0 | | No | | | No | | |
| CQC compliance action outstanding (as at 31 Mar 2014) | N/A | special | Report by Exception | No | | | No | | | No | | | No | | | No | | |
| CQC enforcement action within last 12 months (as at 31 Mar 2014) | N/A | special | Report by Exception | No | | | No | | | No | | | No | | | No | | |
| CQC enforcement action (including notices) currently in effect (as at 31 Mar 2014) | N/A | 4.0 | Report by Exception | No | | | No | | | No | | | No | | | No | | |
| Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Mar 2014) | N/A | special | Report by Exception | No | | | No | | | No | | | No | | | No | | |
| Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Mar 2014) | N/A | 2.0 | Report by Exception | No | 0 | | No | 0 | | No | 0 | | No | | | No | | |
| Trust unable to declare ongoing compliance with minimum standards of CQC registration | N/A | special | Report by Exception | No | | | No | | | No | | | No | | | No | | |
| **Results left to complete** | | | | 0 | | | 0 | | | 0 | | | 0 | | | -1 | | |
| **Total Score** | | | | 0 | | | 0 | | | 1 | | | 1 | | | 1 | | |

## Worksheet "Governance Statement"

Click to go to index

# In Year Governance Statement from the Board of Warrington and Halton Hospitals

*The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)*

| | For finance, that: | Board Response |
|---|---|---|
| 4 | The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months. | Not Confirmed |

| | For governance, that: | |
|---|---|---|
| 11 | The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards. | Confirmed |

| | Otherwise | |
|---|---|---|
| | The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 21, Diagram 6) which have not already been reported. | Confirmed |

Signed on behalf of the board of directors

| | | | |
|---|---|---|---|
| Signature |  | Signature |  |
| **Name** | Mel Pickup | **Name** | Tim Barlow |
| **Capacity** | Chief Executive | **Capacity** | Director of Finance |
| **Date** | 28th April 2014 | **Date** | 28th April 2014 |

0

**Notes:** *Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.*

*In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.*

*This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.*

*Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.*

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C

**Risk Assessment Framework page 21, diagram 6**

**Examples of exception reports**

**Continuity of Services (all licensees)**

- Unplanned significant reductions in income or significant increases in costs
- Discussions with external auditors which may lead to a qualified audit report
- Future transactions potentially affecting the continuity of services risk rating
- Risk of a failure to maintain registration with the Care Quality Commission (CQC) for Commissioner Requested Services (CRS)
- Loss of accreditation of a CRS
- Proposals to vary CRS provision or dispose of assets including
  - cessation or suspension of CRS
  - variation of asset protection processes
- Proposed disposals of CRS related assets

**Financial Governance (NHS Foundation Trusts)**

- Requirements for additional working capital facilities
- Failure to comply with the statutory reporting guidance
- Adverse report from internal auditors
- Significant third party investigations that suggest potential material issues with governance
- CQC responsive or planned reviews and their outcomes
- Other patterns of patient safety issues which may reflect poor governance (eg serious incidents, complaints)
- Performance penalties to commissioners

**Governance (NHS Foundation Trusts)**

- Third party investigations that could suggest material issues with governance (eg fraud, CQC concerns, medical Royal Colleges' reports)
- CQC responsive or planned reviews and its outcomes / findings
- Other patient safety issues which may impact compliance with the license (eg serious incidents)

**Other risks**

- Enforcement notices or sanctions from other bodies implying potential or actual significant breach of a license condition (eg Office of Fair Trading)
- Patient group concerns
- Concerns from whistleblowers or complaints

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/072(i)**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Board Committee Annual Reports to the Board |
| **Date of Meeting** | 30 April 2014 |
| **Director Responsible** | Lead Executive and Chair of each Committee |
| **Author(s)** | |
| **Purpose** | To provide the Board with an overview of the work undertaken by its Board Committees for the period from 1 April 2013 to 31 March 2014 |

| **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 |
|---|---|---|
| • | The Strategic People Committee reviewed its Annual Report at its meeting on 7th April and is enclosed | |
| • | The Quality Governance Committee will be receiving its Annual Report at it meeting on 13th May 2014 and will be presented to the Board at the May Board meeting | |
| • | The Audit Committee is required to publish its Annual Report in the Trusts Annual Report and Accounts. The Board will therefore as part of the approval process for the Annual Report and Accounts 2013/14 see a copy of the Annual Audit Report | |
| • | The Charity Funds Committee, as a separate trust and registered charity is required to produce an Annual Report and Accounts for 2013/14. These will be presented to the Board as the Corporate Trustee towards the end of the calendar year. | |

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

1. The Board is asked to note the Strategic People Committees Annual Report 2013/14

**STRATEGIC PEOPLE COMMITTEE 7 APRIL 2014**

**ANNUAL REPORT 2013/14**

This is the first Annual Report of the Committee.

## 1. Meetings

During 2013/14 five meetings were held as follows:

- 8 April 2013
- 10 June 2013
- 12 August 201314 October 2013
- 10 February 2014

One meeting was cancelled which was due to be held in December 2013.

An attendance schedule of members of the Committee is attached at Appendix 1.

## 2. Terms of Reference

These were reviewed by the Committee on 10 June 2013 when the membership was reviewed and the Committee was renamed 'Workforce, Education and OD Committee'. The Committee was renamed again in February 2014 to the 'Strategic People Committee'.

## 3. Presentations

The following presentations were received by the Committee:

- TRM/Human Factors, Sue Norwood, Global Aviation – 10 June 2013
- Midwifery Staffing levels, Mel Hudson – 10 June 2013
- NHS Apprenticeship Scheme, Jane Birch – 12 August 2013
- Values and Behaviours Project, Suzanne Douglas/Will Murray – 14 October 2013
- Emergency Medicine: Workforce Shortages, Seif Ahmad – 10 February 2014

## 4. HR Risk Register

The major HR risk has been temporary staff both from a financial perspective and patient continuity. Despite various measures put in place to reduce temporary staffing expenditure, the level of expenditure has not significantly reduced and remains an extreme/high risk. Other risks which have not materially changed are appraisal rates and sickness rates the latter of which is still low at c.4% but above the trust target of 3.5%.

## 5. Employment Policies and Procedures

The following policies and procedures have been approved by the Committee:

- Work Experience Policy – 10 June 2013
- Disability and Equality Policy – 10 June 2013
- Equal Opportunities Policy - 10 June 2013
- Translation Policy – 10 June 2013
- Time for Trade Union Duties – 14 October 2013
- Organisational Change Policy – 14 October 2013
- Capability Procedure – 14 October 2013
- Raising Concerns (Whistleblowing) Policy – 10 February 2014

- Attendance Management Policy – 10 February 2014
- Remediation Policy for Medical and Dental Staff – 10 February 2014

## 6. Business Continuity

At each meeting the Chief Operating Officer submits a progress report and plans on maintaining business continuity to cover such issues as Winter Pressures, Creamfields etc.

## 7. Education and Development Update

Update Reports have been submitted for each of the Committee meetings and the main issues identified include the following:

- Mandatory training rates which have largely remained stable but below target with the exception of health and safety
- Appraisal rates which showed some improvement in the first 6 months of the year but have fallen since
- Induction rates which were achieving the target for corporate induction for permanent non-medical and medical staff but other induction rates are well below the target
- Education budget for Medical and Dental staff
- Mersey Deanery Annual Assessment visit
- Leadership Strategy
- Knowledge and Evidence Strategy
- Clinical Simulation Strategy
- Quality Surveillance – NW LETB Process update
- Service Line Management training
- Nurse Mentor numbers reducing
- Resuscitation training

## 8. HR Update

Update Reports have been submitted for each of the Committee meetings and the main issues identified include the following:

- Employment Tribunal/Claims – all cases successfully defended
- Policies and Procedures and JLNC updates
- Job Planning updates
- On-call and industrial action updates
- Progress on DBS checks and risk assessment
- Changes to terms and conditions of service for AfC staff
- Pension Changes
- Staff Survey update
- Advice and support to organisation change/developments

## 9. Workforce KPIs

Update Reports and performance dashboards have been submitted for each of the Committee meetings and the main issues arising include the following:

- Mandatory training, appraisal and induction rates as mentioned in section 5 above
- Progress on the Revalidation of medical and dental staff
- Sickness absence rates – stable
- Turnover rates – stable and meeting the target
- Staff in post figures – steady rise in the numbers employed
- Temporary staffing expenditure

- Equality and Diversity – all targets met
- Good progress and evidence of compliance from audits on NHSLA Standards for Harassment and Bullying, Professional Clinical Registrations, Employments Checks and Stress
- Reduced number of grievance cases but significant number of disciplinary cases

## 10. CQC Compliance

The Committee has received regular CQC Reports on compliance relating to Outcomes 12 and 13. These have shown a good level of assurance.

## 11. Divisional Assurance Reports

Over the year both the number and quality of the Divisional Assurance Reports has improved and regular reports are now received from:

- 3 Clinical Divisions
- HR
- Finance
- Estates
- Facilities
- IT

In recent meetings these reports have featured higher up the agenda to ensure that there is sufficient time devoted to considering the workforce issues identified in the reports.

## 12. Ad-hoc Reports

Throughout the year the Committee has received various ad-hoc reports as follows:

- HR Employment Legislation Update for 2013/14
- Duty of Candour/Francis 2 Update
- Corporate Action Plan for Saville Inquiry
- Care and Compassion CQUIN
- Self-Care at Work/Healthy Worker Project
- 'E' Rostering
- Volunteers Update
- Results of the Safety Climate Questionnaire
- Health Care Assistants Development Portfolio
- Monitor Review: Working Relationship to Quality
- Training – End of Life/Safeguarding/Equality and Diversity
- Medical Staff Induction
- Military Veterans Network Briefing
- Temporary Staffing Update Report for Nursing and Midwifery
- Temporary Staffing Update Report for Medical and Dental Staff
- Competency Based Workforce project

## 13. Minutes

The minutes/notes are routinely received from the following Committees/Groups:

- Joint Negotiating Consultative Committee
- Joint Local Negotiating Committee
- Education Governance Committee
- ESR Operational Group

- Temporary Staffing

Any particular issues from these meetings are drawn to the attention of the Committee by individual Committee members as applicable.

## 14. Recommendation

The Committee is requested to receive and approve this Annual Report and make any recommendations for the future format of this report.

Mick Curwen
Associate Director of HR
31 March 2014

**Attendance at the Strategic Workforce Committee/Workforce, Education & OD Committee/Strategic People Committee**

| | 06-Apr-13 | 10-Jun-13 | 12-Aug-13 | 14-Oct-13 | 10-Feb-14 | Attendance % | Comments |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Lynne Lobley | √ | √ | √ | √ | √ | 100% | |
| Carol Withenshawe | √ | √ | X | X | √ | 60% | |
| Karen Dawber | √ | √ | √ | √ | √ | 100% | |
| Mick Curwen | √ | √ | √ | √ | √ | 100% | |
| Kate Warbrick | √ | √ | √ | √ | √ | 100% | |
| Deb Mandal | √ | X | √ | X | | 50% | No longer Director of Medical Education |
| Wendy Johnson | √ | √ | √ | √ | X | 80% | |
| Simon Wright | √ | √ | X | √ | √ | 80% | |
| Ellis Clarke | √ | √ | | | | | Covering ADD for Unscheduled Care |
| Carol Lancaster | √ | √ | X | X | | 50% | Since left the trust |
| Hilary Baker | X | √ | √ | X | | 50% | Since left the trust |
| Mel Hudson | | √ | X | X | X | 25% | Attended for presentation |
| George Cresswell | X | √ | X | √ | √ | 60% | |
| Jim Eatwell | | | √ | | | | Covering for Ass. DN for Unscheduled Care |
| Darren Wardley | | | √ | | | | Covering Associate Director of Estates |
| Jane Scott | | | √ | | | | Covering for Ass. DN for Womens and Childrens |
| Richard Brown | | | √ | √ | X | 66% | ADDs only invited from August 2013 |
| Chris Horner | X | X | √ | √ | √ | 60% | |
| Karol Edge | | | X | √ | X | 33% | |
| Mike Lynch | | | | √ | | | Covering for CW Non Executive Director |
| Claire Blackman | | | X | √ | √ | 66% | Only invited from August 2013 |
| Belinda Tench | | | | | √ | | Covering for Ass. DN for Unscheduled Care |
| Sallie Kelsey | | | | | √ | | Covering Associate Director of Education & Development |
| Sharon Harper | | | | | √ | | Covering Associate Director of Education & Development |

**W&HHFT/TB/14/072(ii)**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Verbal update on the work of the Finance and Sustainability Committee held on 16 April 2014 |
| **Date of Meeting** | 30 April 2014 |
| **Director Responsible** | Carol Withenshaw - Chair of FSC |
| **Author(s)** | |
| **Purpose** | To update the Board on the work of the FSC – 16 April 2014 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/072(iii)**

# BOARD OF DIRECTORS

| | |
|---|---|
| **Paper Title** | Board Committee Minutes for noting only |
| **Date of Meeting** | 30 April 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) ***Audit Committee (unconfirmed) – 2nd February 2014***
b) ***Charitable Funds Committee (unconfirmed) - 2nd February 2014***
c) ***Quality Governance Committee – 14th January 2014***
d) ***Strategic People Committee - 10th February 2014***
e) ***Finance and Sustainability Committee – 20th March 2014***

Warrington and Halton Hospitals NHS
NHS Foundation Trust

*W&HH/AC/14/XX*

**AUDIT COMMITTEE MEETING**

**Draft Minutes of the meeting held on 2nd February 2014, 1500hrs**

**Trust Conference Room, Warrington Hospital**



**Present:**

| | |
|---|---|
| Rory Adam | Non-Executive Director (Chair of the Committee) |
| Carol Withenshaw | Non-Executive Director |
| Clare Briegal | Non-Executive Director & Deputy Chair |
| Lynne Lobley | Non-Executive Director |

**In attendance:**

| | |
|---|---|
| Tim Barlow | Director of Finance and Commercial Development |
| Karen Spencer | Head of Financial Services |
| Colin Reid | Trust Secretary |
| Karan Wheatcroft | Mersey Internal Audit Agency |
| Sarah Blackwell | Mersey Internal Audit Agency |
| Rebecca Gissing | PWC |

**Apologies:**

| | |
|---|---|
| Mike Lynch | Non-Executive Director |

**WHHFT/AC/14/01**

1 **Apologies -** See above listing.

2 **Declarations of Interest – in agenda items -** None

**WHHFT/AC/14/04 – Payments by Results Data Assurance Framework**

3 Chris White, Head of Information and Stephanie McCann, Clinical Coding Manager presented the report on the local audit programme for the Trust with regard to the Payment by results data assurance programme.

4 The Committee reviewed the report, in particular appendix 1 which set out the PBR Data Assurance Programme Action Plan 2012/13 and the management responses.

5 With regard to A&E it was noted that the audit and recommendations had been completed prior to the implementation of Symphony. With the new automated system improvements would be made in the input of data which would require more complete and up to date, records.

6 Clare Briegal asked what the reaction was from the Commissioners regarding the errors identified in the Report. In response the Head of Information advised that the net effect was not seen as an issue for the Commissioners.

7 The Chairman, referring to data integrity, asked what was being done to create awareness in the Trust on the importance of quality case notes. In response Chris White advised that the Trust has a Quality Case note policy which required compliance with, He also advised that better and more complete training was being provided to both junior doctors and coders so that each are aware of the importance of recording and coding.

8 The Committee reviewed the recommendations and noted that; the A&E recommendations had been superseded by the implementation of Symphony; the integrity of case notes still required closing out.

9 The Chairman thanked the Head of Information and The Clinical Coding Manager for presenting the Payment by results data assurance programme and looked forward to an update on closing out the action list at a future meeting.

**WHHFT/CFC/14/02 – Minutes of Previous Meetings**

10 The minutes of the meeting held on the 18th November 2013 were approved subject to the removal of paragraph 36.

**WHHFT/AC/14/03 – Action Plan – Review Actions and update**

11 All actions were either complete or on the agenda for consideration.

**WHHFT/AC/14/05 – Counter Fraud Progress Report**

12 Karen Wheatcroft, MIAA Counter Fraud presented the Counter Fraud Progress Report which covered the period from 1st November 2013 to 20th January 2014 and referred the Committee to the Summary of work and the fraud and non-fraud investigations undertaken during the reporting period of the Report which was noted.

**WHHFT/AC/14/06 – Mersey Internal Audit Agency**

**i) MIAA Internal Audit Progress Report**

13 Sarah Blackwell, MIAA Internal Audit presented the Internal Audit Progress Report detailing the conclusions of reports which had been finalised, and provided an update in relation to the on-going reviews.

14 PMO Review: Significant Assurance - Sarah Blackwell provided a summary of the PMO review and advised that there were no critical or high recommendations arising from the review. The Chairman was pleased to see that the review had not highlighted any significant concerns and felt that the review supported the assurances the Board had received on the processes implemented in addressing the Trusts cost improvement plans.

15 Sarah Blackwell referred the Board to Page 6 of the report which requested approval to changes to the Audit Plan as follows:

- **CQC Review** – The Director of Nursing and Organisational Development had requested that this review be replaced with a review of staffing levels within the A&E department.
- **Francis Review** – The Director of Nursing and Organisational Development has requested that this review focuses on the complaints process within the Trust.

16 The Committee considered and approved the changes.

17 MIAA Internal Audit Progress Report was noted by the Committee.

**ii) MIAA Internal Audit Follow up Report**

18 Sarah Blackwell, MIAA Internal Audit presented the Follow up Report referring the Committee to the two areas that still required management actions. These included the IT Asset Management recommendation relating to Software Licencing were there had been partial implantation and pre-employment checks which required the implementation of a DBS policy. Both were being addressed by Management.

19 The Chairman thanked Sarah Blackwell for her report which was noted.

**WHHFT/AC/14/07 – External Audit Plan 2013/14**

20 Rebecca Gissing, PwC, provided an introduction on the External Audit to be undertaken on the Trust for 2013/14.

21 Rebecca Gissing provided a high level review of the External Audit Plan and advised that there were no significant changes to the scope of work from 2012/13. She advised that the audit timetable reflected the requirements for the Trust to approve the annual report and Accounts by the end of May 2014. Rebecca Gissing referred to the significant audit risks on page 4 of the report and provided a short overview of each.

22 With regard to materiality, Rebecca Gissing advised that PwC propose to treat misstatements less than £210,000 (2012/13: £180,000) as the clearly trivial reporting and would include a summary of any uncorrected misstatements identified during the audit in the year-end ISA (UK&I) 260 report. The overall materiality level was £4,200,000.

23 With regard to the section on 'Risk of Fraud', Rebecca Gissing reported on the respective responsibilities of the auditors, management and those charged with Governance and referred the views that would be required of the Committee as part of the audit process. The Committee noted the requirement.

24 Rebecca Gissing referred the Committee to page 14 of the plan which identified the need to consolidate Charitable Funds. She explained that although there was a requirement to consolidate the value of the fund was under the de minimis levels and therefore it was a management decision on whether to consolidate due to materiality. The Committee considered the position and agreed not to consolidate the Fund on the basis of materiality.

25 Rebecca Gissing referred the Committee to the non-audit work being undertaken by PwC and the requirements of the Audit to retain independence and objectivity in undertaking the external audit of the Trust. The Committee reviewed and noted that at the date of the External Audit Plan PwC had confirmed that in their professional judgement, PwC external audit team were independent accountants with respect to the Trust, within the meaning of UK regulatory and professional requirements and that the objectivity of the audit team was not impaired.

26 The PwC Audit Plan report was noted by the Committee.

27 The Chairman asked the Head of Financial Services to present her paper on the Key dates for completion of the Annual Report and Accounts 2013/14 which was noted.

**WHHFT/AC/14/08 – Tender Waivers - Quarter 3**

28 The Head of Financial Services presented the review of Quotation and Tender Waivers for the Quarter 3, for the consideration. The Committee reviewed the tender waivers questioning the reasons behind them.

29 The Committee having satisfied itself of the reasons for the tender waivers noted the content of the paper.

**WHHFT/AC/14/09 – Losses & Special Payments – Quarter 3**
**WHHFT/AC/14/10 – Q3 Claims Report (For Information)**

30 The Committee reviewed the Losses and Special Payments for Quarter 3. The Chairman thanked the Head of Financial Services for the summary table for the financial year to date included in the report which provided the Committee with the breakdown of the areas. The Committee noted that the majority of losses and compensation related to Employer liability claims with accounted for 50% of the total and felt that this should this should be investigated further to see if there were any trends between the compensation payments and the areas the complaints originated from.

31 The Committee noted the Losses and Special Payment for Quarter 3.

**WHHFT/AC/14/11 – Bad debt write-off – Quarter 3**

32 The Committee reviewed the bad debt write-off based on a review of the debtor's ledger as at Quarter 3, 2013/14 and approved the debt presented for write-off of £845.65 recognising that the majority of the write off related to an overseas patient (£628.97).

**WHHFT/AC/14/12 – Changes to the SORD**

33 The Committee considered and approved the proposed changes to the SORD.

**WHHFT/AC/14/13 – Board Assurance Framework**

34 The Committee received the updated Board assurance Framework which was reviewed noting that the Report had been presented to the Board meeting on 29th January 2014. The Committee recognised that were gaps existed and identified in the BAF there should be action plans to mitigate the gaps.

35 The Chairman referred to the risks identified in the BAF and felt one of the areas the Committee would need to do was to be clear that the risks reported include the risk of not only delivering the objectives of the Trust but also address compliance with the Trust's provider licence and that the risks are full mitigated. He also felt that an area of challenge that needed to be made related to any gaps identified in the document. He felt that sometimes gaps are identified by he was unsure that there were action plans in place to address them referring in particular to Risk 1.2.

36 The Committee agreed that the Chair would consider which Executive would be invited to the meeting in April to provide assurance on the appropriateness of the Risks, Assurances and Gaps identified in the BAF.

**WHHFT/AC/14/14 – Board Committee Report**

37 **Governance Committee:** Nothing to report

38 **Charitable Funds Committee:** Nothing to report

39 **Strategic Workforce Committee:** Nothing to report

**WHHFT/AC/14/15 – Any Other Business**

40 None

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.

Warrington & Halton Hospitals' Charity

**WHHFT/CFC/14/XX**

**CHARITABLE FUNDS COMMITTEE MEETING**

**Minutes of the meeting held on Monday 3rd February 2014**
**Trust Conference Room, Warrington Hospital**

**Present:**

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| Clare Briegal | Non-Executive Director (Chair of the Committee) |
| Lynne Lobley | Non-Executive Director |
| Carol Withenshaw | Non-Executive Director |
| Tim Barlow | Director of Finance and Commercial Development |
| David Ellis | Public Governor |
| Karen Spencer | Head of Financial Services |
| Chris Horner | Associate Director of Communications |

**In attendance:**

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| Colin Reid | Trust Secretary |
| Sarah Klaveness | Plum Marketing |
| Katie Armstrong | Assistant Financial Accountant |
| Helen Riley | Charity Administrator |

**Apologies:**

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| Mike Lynch | Non-Executive Director |
| Rory Adam | Non-Executive Director |

**WHHFT/CFC/14/01 – Apologies**

Apologies were noted as above.

**WHHFT/CFC/14/02 – Declarations of Interest – in agenda items**

There were no declarations of interest in the agenda items.

**WHHFT/CFC/14/05 – Financial Position as at 31st December 2013**

The Chair welcomed Karen Spencer, Head of Financial Services to her first meeting. The Chair also welcomed Jeff Green, Histopathology Service Manager to the meeting and advised that he would be presenting the proposal on the renovation of the Trust's Mortuary. With this in mind the Chair asked that the Committee consider items CFC/14/05, the Financial position of the Charity as at 31 December 2013 and the them CFC/14/06, the funding proposals.

The Head of Financial Services presented the financial Position of the Charity as at 31 December 2013. She advised that the total fund balance held as at 31st December 2013 was £652k which was £55k less that the position reported as at 30th September 2013 and covered the General Fund and its 31 unrestricted sub-funds, as well as the restricted Ophthalmology Fund. The Head of Financial Services referred the Committee to the breakdown of the total balance held within each fund and sub-fund within the paper. The total cash held by the Charity with the Government Banking Service at the end of December 2013 was £668k.

With regard to Dormant Funds, the Head of Financial Services reported that a review of funds held as at 31st December 2013 highlighted 9 sub-funds which had been dormant for at least 2 consecutive quarters. Therefore, in accordance with the Dormant Funds Policy, the Finance Department has contacted the current fund-holders to request details of any future spending plans that may be in place for the sub-funds in question. The Head of Financial Services advised that within the paper there was a request to approve the plans for 3 funds.

Lynne Lobley referred to the Just Giving section of the Report and noted there was a pattern of peaks and troughs and asked whether there was an action to try and smooth out the pattern. In response the Associate Director of Communications reported that the Charity was looking to increase the use of Just Giving as a way of managing sponsorship and donations however due to the nature of the activity undertaken by the fundraisers there will always be peaks and troughs. With regard to the financial information attached to the Report, the Chair asked whether comparable information could be provided surrounding the activity of the funds. She felt this would allow the Committee the opportunity to see and trends or significant changes in donations etc.

The Chair noted that in the table of fund balances, the Charity Development Fund had not reduced and advised that this amount had been set aside to pay Plum Marketing. She felt that Plum Marketing may have been charged to the wrong fund. The Head of Financial Services advised that she would look into this and make the necessary entre changes. It was noted that once the amendments were made the General Fund balance would be in the region of £70k rather that the £46k referred to in the report.

The Chair asked whether future reports to provide details of Yearly analysis of Income covering the last 5 years. She advised that this used to be provided and gave a useful graphical 'comparison' of income. She also felt that additional information on amounts committed and ongoing commitments would also be useful so that the Fund Balances can be understood in more detail.

David Ellis referred to the travel policy within the Trust and asked if it applied to staff using Charitable Funds. He referred the Committee to the Expenditure List and item 29 which related to a train fare to London of £480 for what seemed to be for one person when later in the report item 68, there was reference to two train journeys to London for two nurses at £211. The Head of Financial Service advised that she would look into this and see if there were errors in how the information was recorded.

**Action CFC/14/05: The Head of Financial Service to review the ledger entry for the train fare.**

The Director of Finance and Commercial Development advised that the policy for both the Trust and the Charity was the same. He advised that first class train travel has been banned as have open second class unless there was a valid reason to have an open ticket.

The Committee received and noted the financial position as at 31st December 2013 and approved the expenditure of the 3 funds reported.

**WHHFT/CFC/14/06 – Funding Proposals**

i. Mortuary Proposal – The Chair referred the Committee to the proposal for the upgrade of the current public areas in and around the Mortuary. The Committee noted that the Mortuary was built in the 1970s and despite having upgrades to some areas, there has been little change to the areas visited by the public. Carol Withenshaw advised that she agreed with what was being proposed in the paper in terms of the Mortuary requiring an upgrade. She felt that having visited the Mortuary she found it was totally inadequate and was not up to the standards expected particularly when you see what is provided externally. The Committee was reminded that the use of the mortuary was for a very short period of time and was used maybe 3 or 4 times a week. Lynne Lobley supported the need for an upgrade advising that in time when it is used by family and friends of the deceased the Trust should provide a more welcoming facility.

The Chair felt that there was enough support from the Committee to proceed with the upgrade however she was unsure whether the Charity had enough funds to enable it to fund both the internal and external upgrade and wondered if the Trust would be able to provide matched funding with the Charity upgrading the internal aspects of the proposal and the Trust the external. The Director of Finance and Commercial Development advised that the Trust Estates Strategy did not include the upgrade of the Mortuary and therefore any upgrade would need to be found out of capital.

The Committee discussed in detail the proposal recognising that the General fund balance of approximately £70K and that with the 'earmarked funds' (those not actually identified as restricted funds) the balance that could be used amounted to approximately £200k. The Chair felt that taking £83k out of this fund for one item was, given the size of the fund, not appropriate and asked that the Committee support the upgrade of the internal parts of the mortuary and that the Trust be asked to consider upgrading the external parts.

The Committee approved the funding of the upgrade to the internal parts of mortuary as proposed in the paper which amounts to £40k. It further agreed that the Trust should look to see if some of the internal and external funds can be found through donations, suggesting that there may be opportunities to receive donations in the form of sponsorship and asked the Associate Director of Communications and Sarah Klaveness to investigate what opportunities exist.

ii. Update on Paintings in hospital proposal – The Associate Director of Communications reported that although the Charity had signed off the proposal to update paintings in the Hospital, he was looking at other ways this could be done. The Associate Director of Communications advised that the Trust had sought from staff and public photographs associated with the local area that could be blown up and mounted as part of the dementia project. He felt there was an opportunity to expand this across the Trust.

**WHHFT/CFC/14/03 – Minutes of the previous meeting held on the 14th October 2013**

The minutes of meeting held on 14th October 2013 were approved subject to minor amendments.

**WHHFT/CFC/14/04 – Action Plan**

All actions were either complete or on the agenda with exception of the following:

The Deputy Director of Finance and Assistant Financial Accountant to look at the 'restricted' and 'unrestricted' funds to find evidence as to what has been specified in previous donations. The Committee noted that this action was ongoing, recognising the benefits in bringing the 'earmarked funds' under the umbrella 'General Fund' whilst noting that agreement from the individual fund holders would be sought before merging. A plan would be developed in order to facilitate the merging of the funds.

The Director of Finance and Commercial Development and Sarah Klaveness, Plum Marketing to review and rephrase the Charity Fund Strategy report based on the discussions at the meeting. The Director of Finance and Commercial Development reported that this item continued to be developed so that the formal launch of the rephrased strategy can take place in the next financial year (2014/15). He advised that there was a desire to sort out the funds and move forward the Charity in order to support patient care at the Trust. With this in mind the concept of having 10 separate funds had been dismissed and was driving towards having one fund, recognising that where funds are restricted then these would have to remain.

The Director of Finance and Commercial Development advised that the Structure of the management of the Charity was still being address internally within the Trust however reported that the appointment of the Charity Administrator had now been finalised. Other structural requirements needed to be addressed including direct management reporting. He explained that currently the Charity Administrator reported to the Associate Director of Communications, supported by Plum Marketing however there was a need to assess appropriateness of reporting once Plum Marketing contract expires. Other areas that were being addressed included the formation of the advisory board/fundraising committee and focus groups.

**WHHFT/CFC/14/07 – Strategy**

i. Quarter 3 Strategy Update & Operational Plan: The Associate Director of Communications reported on the progress of delivery on the operational plan 2013/14. He advised that after a delay in the appointment of the Charity Administrator, She was now in place and the development of the charity database was on target to be completed by the year end. The Associate Director of Communications reported on the activities undertaken since the last meeting advising on the conclusion of the mascot competition and on events being promoted in the Trust.
ii. Lead Charity Phasing: The Associate Director of Communications reported this was still ongoing and would be reported at the meeting in April. The Director of Finance and Commercial Development advised that it was important that the Trust had a policy on designated charities that were allowed to be active on the Trusts property. He felt that having a number of non-Trust related charities can become a distraction against the work of the Charity.
iii. Donation thanking process: Sarah Klaveness reported on the donation Thanking process which had been adopted. The committee noted the process.
iv. Income coding guidelines: The Committee noted the income Coding Guidelines.

**WHHFT/CFC/14/08 - Charity Risk Register**

The Charity Risk Register was presented and reviewed noting that the register had been split into risk categories. The Committee noted that there were a large number of actions arising in the register that needed closing off and asked the Trust Secretary to issue the action list for review.

The Chair thanked the Deputy Director of Finance for reviewing the register on behalf of the

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| | Committee. |
| | **WHHFT/CFC/14/09 – Any Other Business**<br><br>There being no further business the Chair closed the meeting. |
| | **Date and time of next meeting**<br><br>The next meeting will take place on Monday 28th April 2014, 1.00 pm 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.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# QUALITY GOVERNANCE COMMITTEE

## Minutes of the Meeting held on Tuesday 14th January 2014 at 9:00 am
## Trust Conference Room, 1st Floor, Burtonwood Wing, Warrington Hospital

**Present:**

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| Mike Lynch | Non-Executive Director (Chair) |
| Tim Barlow | Finance Director |
| Alison Lynch | Associate Director of Nursing, Quality and Patient Experience |
| 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 |
| 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 | Head of AHP, WC&SS |
| Clare Fozard | FY2 Doctor, Paediatrics (Aug-Dec 2013) |

**In Attendance:**

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| Jennie Taylor | Executive PA (minutes) |



| | WHHFT/GC/14/001 Apologies for Absence and Introductions | Responsibility and Target date |
|---|---|---|
| 1 | Apologies received from Carol Withenshaw, Non Executive Director, , John Wharton, Nurse Quality Lead, CCG, Jan Snoddon, Chief Nurse, Halton CCG, Paula Chattington, Consultant, Mark Halliwell, Interim Medical Director, Amanda Risino Associate Director of Operations, Unscheduled Care, Richard Denton CE Lead, Mel Hudson, Associate Director of Nursing, WC&SS/Head of Midwifery, Emma Buckley, Governance Compliance Manaer, Jason DaCosta, Director of IT, Diane Whitfield, Therapy Manager. | |
| | **WHHFT/GC/14/002 – Declarations of Interest** | |
| 2 | There were no declarations of interest made in relation to the agenda items for the Governance Committee meeting. | |
| | **WHHFT/GC/14/003 – Minutes of the previous meeting held on 19th November 2013** | **Members** |
| 3 | The minutes of the meeting held on 19th November 2013 were agreed as an accurate record with no amendments.<br><br>Discussion took place around whether Divisional Medical Directors should be members of this Committee. It was agreed the Chair and Associate Director of Governance and Risk meet with the new Medical Director to discuss further. | **Chair/Associate Director of Governance & Risk/ Medical Director** |

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| | **WHHFT/GC/14/004– Action Plan** | |
| 4 | WHHFT/GC/13/137 Corporate Risk Register<br>The Associate Director of Governance and Risk advised that the risk around shortage of medical staff for cardiac emergencies at Halton. The management of risk has been passed to relevant managers, no underlying evidence of risk was identified and has now been removed from the register. –Item complete | |
| 5 | Item 13 on Minutes – Risk 00319 – Midwives<br>The Chief Executive queried the minutes as new midwives have been appointed which should have reduced the risk. The Associate Director of Operations, WC&SS explained that although appointments have been made there is still sickness and maternity leave affecting the service. Lynne Lobley, Non Executive Director advised that this item was resolved at the Board meeting where high level assurance was provided. | |
| 6 | Item 17 on Minutes – Risk 00520 – Telemetry Beds<br>The Chief Operating Officer/Deputy Chief Executive advised that these beds have been available, the numbers are recorded at bed meetings and patients who don't need them are actively moved. | |
| | **WHHFT/GC/14/005 – Revised Work Plan** | |
| 7 | The Associate Director of Governance and Risk has updated the work plan and was seeking approval from the Committee for these changes. | |
| 8 | The changes were noted and approval was given. | |
| | **WHHFT/GC/14/006 Summary of Changes / Corporate Risk Register (15+) Review and Update** | |
| 9 | The Associate Director of Governance and Risk explained that the Safety and Risk Committee is due to meet on Thursday this week therefore the Risk Register has not been reviewed in full. | |
| 10 | A discussion took place among the members on the flow of the Register and how to make it easily understandable to non medical readers. The Associate Director of Governance and Risk explained that currently it is populated as per the Risk Process, ie. Risks are entered and action plan implemented to mitigate this risk. | |
| 11 | Discussion took place on **Risk 00027** – The risk around not all pathology blood diagnostic test results being seen. The Chief Operating Officer/Deputy Chief Executive explained that he has assurance that pathology and radiology contact clinicians if there is an abnormal result but not currently with histology. Tests are requested but there is currently no way of knowing whether results have been reviewed. Proving that it has been reviewed is a way of giving a clear result for assurance purposes. Progress to be reviewed at next meeting. | **Chief Operating Officer/Associate Director of Governance and Risk March 2014** |
| 12 | The Associate Director of Governance and Risk explained that the Risk will be mitigated by the rollout of "ICE" which was discussed at the IMT board yesterday. The target date has been missed but work on a Business Case is underway | |

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| 13 | **Risks 00139/00304 Information Governance**<br>Discussion took place around the wording of this risk. The Chief Executive commented that describing the problem is not mitigating the risk. It was agreed that the wording of this risk be revisited. | **Associate Director of Governance and Risk March 2014** |
| 14 | General Discussion around the Risk Register took place with the Chief Operating Officer/Deputy Chief Executive concerned that escalating the risk to ensure that capital funding is made available to resolve the issue causes anxiety if no capital is available. | |
| 15 | **Risk 000482 – Information Technology**<br>Director of IT described the mitigation that has already taken place within the IT division but explained that there is a capacity issue. The Finance Director referred to the presentation given by the IT Director on 17th December which provided a solution to this problem. The Director of IT explained that nothing had yet been purchased therefore agreed to look at the wording adding that the problem is yet to be resolved. | **Associate Director of Governance and Risk /Director of IT March 2014** |
| 16 | **Risk Register discussion**<br>L. Lobley, Non-Executive Director asked if the descriptions could be a little sharper, she agreed that improvements have been made but a clearer description of the risk would be of benefit. The Associate Director of Governance and Risk agreed to raise this issue at the next Safety and Risk meeting. | **Associate Director of Governance and Risk March 2014** |
| 17 | The Director of Nursing and OD described in detail the improvement in Governance processes and how these provide assurance around mitigation and action, | |
| | **WHHFT/14/007 - CQC Intelligent Monitoring** | |
| 18 | No report available from CQC. | |
| | **WHHFT/14/008 - CQC Quarterly Monitoring of Completed Outcomes** | |
| 19 | The Associate Director of Governance and Risk described how she sends out a monthly report and this report details the recommendations. The Associate Director of Nursing, Quality and Patient Safety explained that some of the outcomes are not applicable ie Outcome 16 has been been completed but the link in CIRIS would not work. The assurance is in place but it had not been possible to record it. The Associate Director of Governance and Risk advised that all the evidence is in the one place and she can reassure the Committee that excellent work is going on, this report provides at a glance recognition of progress. | |
| | **WHHFT/CG/14/009 – Health and Safety Update** | |
| 20 | The Associate Director Governance and Risk presented the report and explained the evidence will provide evidence for Outcomes 10 and 11. She believed the audit results were excellent. | |

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| 21 | The Director of Nursing and Organisational Development praised the report and commented that needlestick incidents were not being helped by the introduction of new devices. It was agreed to show clean needlestick injuries separately in future reports. She also commented that the incident relating to hazardous waste had been dealt with quickly and effectively with an SOP in place already. | |
| 22 | The Finance Director raised the diabetes audit result as it appeared quite low in comparison. The Associate Director of Governance and Risk confirmed that this would be raised at the Unscheduled DIGG meeting. | |
| 23 | The Director of Nursing and Organisational Development commented that progress is being made against compliance and congratulated all for the work they are doing. | |
| | **WHHFT/GC/14/010 – Serious incident completed level two investigations** | |
| 24 | The report advised that there were no non clinical SUI's reported in November 2013. | |
| 25 | There was one new SUI reported in November 2013 relating to orthopaedics. The Associate Director of Operations, Scheduled Care advised that the SOP has been revised and agreed. The WHO checklist was used and it appears that it was the labelling of the box that was the problem. | |
| 26 | A new serious incident was reported in December in maternity. External consultants have been asked to help with the investigation. | |
| 27 | There was one Grade 3 pressure ulcer reported which has an identified lead and target date for investigation completion | |
| | **WHHFT/CG/14/011 – State of the Nation Report** | |
| 28 | The Associate Director of Governance and Risk had produced a briefing paper for the larger report. She explained that the CQC highlighted the pressures that an aging population is putting on the care system and this needs to be taken into consideration when making future plans. L.Lobley, Non-Executive Director considered it important to make reference to this report when documents are used in planning as it all shows good evidence and the demand for more evidence is going to be a requirement and also a challenge for the future. | |
| 29 | The contents of the report were noted by the Governance Committee. | |
| | **WHHFT/CG/14/0112 – Inquest Summaries** | |
| 30 | Two summaries were provided. The inquest into patient MW had concluded on 5th December 2013 and resulted in a regulation 28 being issued. The Chief Operating Officer/Deputy Chief Executive explained that a significant amount of work had been undertaken and the family have been met with on several occasions. | |

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| | A final report is to be produced which will see the end of the formal process. It has been a very sad case but the Coroner did praise WHHFT for the transparency and candour shown. An action plan is to be submitted to the Coroner by 5th February. | |
| 31 | Patient GT inquest concluded on 10th December 2013 and again the Coroners thanked the witnesses and the Trust for their openness and honesty. A series of recommended and specific actions has been produced. | |
| 32 | L. Lobley, Non-Executive Director explained that as a Trust we can mitigate any further incidents of the GT case by ensuring that any allergies are very clearly identified by wrist bands. Clear handover communication is vital. The Chair explained that although it is very traumatic for staff to attend or be part of a Coroners Inquest there will be a lasting effect lessons learned will certainly influence their future clinical practice. | |
| | **Items for Discussion** | |
| | **WHHFT/CG/14/013** | |
| 37 | Terms of Reference – Event Planning Group<br>It was agreed to add ITU Matron to the membership of EPRR | **Exec PA March 2014** |
| 38 | L.Lobley, Non-Executive Director asked about whether these plans are practiced. The Chief Operating Officer/Deputy Chief Executive explained that there are regular exercises and table top events taking place. The results of these are shared with the divisions. After events, "wash up" meetings take place where information is shared and the evidence is recorded and any lessons learned are noted. | |
| | **WHHFT/CG/14/014** | |
| 39 | Evacuation Policy | |
| | **WHHFT/CG/14/015** | |
| 40 | Incident Response Plan | |
| 41 | The Evacuation Policy and Incident Response Plan were ratified by the Governance Committee | |
| | **HIGH LEVEL BRIEFING AND MINUTES FROM REPORTING COMMITTEE CHAIRS** | |
| | **WHHFT/CG/14/147 – Information Governance and Corporate Records** | |
| 42 | The Director of IT expressed concern about the capacity of this department having only one staff member, requests for information have increased by 29.6%. He is preparing a paper for submission to Execs around increasing the size of the department. | |
| 43 | Discussion took place around the item regarding the loss of 135 ED cards containing demographic details and some clinical information. The Director of IT explained that the loss was discovered over a month ago. It was agreed that the Director of IT would provide further information on the loss and he would also report the loss on STEIS once the Chief Operating Officer has conducted his investigation. | **Director of IT March 2014** |

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| 44 | It was also reported that the Caldicott Guardian is to be a full member of the Information Governance Sub-Committee. | |
| 45 | Information Governance toolkit training is not compliant and is being reviewed in the Bi-Lateral meetings. | |
| | **WHHFT/CG/13/148 – Safety and Risk Sub Committee** | |
| 46 | The High Level Report was noted by the Committee. The two areas discussed were the number of needlestick injuries and the lack of bariatric equipment. | |
| | **WHHFT/CG/13/149– Workforce, Education and Organisational Development** | |
| 47 | The High Level Report was noted by the Committee, the risks were around temporary staffing and consultant vacancies. | |
| | **WHHFT/CG/13/150– Event Planning Group and Local Health Resiliance Group** | |
| 48 | The High Level Report was noted by the Committee. | |
| | **WHHFT/CG/13/151– Clinical Governance, Audit and Quality Sub Committee** | |
| 49 | The High Level Report was noted by the Committee, the Cancer Services Assurance report had not been received. | |
| 50 | M. Lynch, Chair drew attention to the high number of apologies noted on the minutes and commented that this is not unusual. This will and does result in actions not reaching conclusion. The general consensus was that once the new Medical Director is in post then he will make his mark on this Sub Committee. | |
| 51 | L. Lobley, Non-Executive Director asked if there was any deliberate learning from this sub-committee, the Associate Director of Governance and Risk responded that this is a very important meeting but it is not appearing to record the important improvements that are being made. Assurance at a glance is provided at the workplan stage where learning improvement is on the Assurance Templates. | |
| | **WHHFT/CG/13/152 – Infection Control Sub Committee** | |
| 52 | The High Level Report was noted by the Committee, the risks were around<br>• Clostridium difficile cases being above the threshold<br>• Cannulation documentation<br>• An increase in blood and body fluids has been identified some related to safer needle devices. | |
| 53 | M. Lynch, Chair referred to paragraph 35 of the minutes regarding hand hygiene. L. Lobley, Non-Executive Director also recommended reminders for visitors is important. The Chief Operating Officer complemented the Infection Control Team who are very quick to respond to any incidents as we do not have many isolation facilities. | |

| | W&HHFT/GC/13/54 - Any Other business | |
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| 54 | Clare Fozard reviewed a report she had produced following a forum she and a registrar had organised, it was not well attended but she does hope that will improve in time. | |
| 55 | Items identified from this forum were:<br>• There is only one bleep available for F1 on-call, a 2nd bleep would be a very useful addition.<br>• Bank holiday on-call – rota to be looked at<br>• MET team being introduced on 1st February and although exciting it was felt that junior doctors were not fully aware or involved and they are all keen to be included.<br>• Junior doctors would like to be involved in committees and sub committees but are not made aware or invited. | |
| 56 | M.Lynch, Chair responded that Board and Execs are concerned about the gaps in rota provision and a lot of care has been taken, C. Fozard did agree that the situation had improved. | |
| 57 | The Chief Operating Officer believed that obtaining a 2nd bleep would be quickly resolved. | |
| 58 | The Chief Executive advised that Jeremy Hunt had called to congratulate the hospital on the achievement of the 4 hour target and of his impression with our resilience over Christmas. | |
| 59 | **Date and time of next meeting:**<br>11thMarch 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.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Strategic People Committee

## Minutes of the Meeting held on Monday, 10th February 2014
## Trust Conference Room

**Present:**

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| Lynne Lobley | Non Executive Director (Chair) |
| Karen Dawber | Director of Nursing and Organisational Development |
| Chris Horner | Associate Director of Communications |
| George Cresswell | Associate Director of Estates and Facilities |
| Kate Warbrick | Associate Director of Operations, Scheduled Care |
| Mick Curwen | Associate HR Director |
| Carol Withenshaw | Non Executive Director |
| Belinda Tench | Matron representing Unscheduled Care |
| Sallie Kelsey | Representing Associate Director of Education and Development |
| Sharon Harper | Education Governance Manager |
| Simon Wright | Chief Operating Officer/Deputy CEO |
| Claire Blackman | Occupational Health Manager |

**In Attendance:**

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| Jennie Taylor | Executive PA |



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| | **WHHFT/SPC/14/001 - Apologies and Welcome** | |
| 1 | Apologies for absence were received from<br>Millie Bradshaw, Associate Director of Governance<br>Amanda Risino, Associate Director of Operations, Unscheduled Care,<br>Richard Brown, Associate Director of Operations, WC&SS<br>Mel Hudson, Associate Director of Nursing, WC&SS.<br>Karol Edge, Associate Director of Nursing, Unscheduled Care | |
| | **WHHFT/SPC/14/002 – Declarations of Interest** | |
| 2 | It was noted that L. Lobley, Chair/Non-Executive Director also works for the Mersey Deanery. | |

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| | **WHHFT/SPC/14/003 - Minutes of the Previous meeting held on 14th October 2013** | |
| 3 | The minutes of the meeting held on 14th October were accepted as an accurate record. | |
| 4 | **Item 32 page 5 of minutes of 14th October**<br>The Chief Operating Officer explained that work has identified what is required and that reliance on WLI has been reduced. It was found that about a third of WLI related to gaps, a third relates to budgeted costs and the remaining third is the opportunity for improvement. | |
| | **WHHFT/SPC/14/004 – Action Plan** | |
| 5 | WHHFT/WEOD/13/099 – NHSLA Standard 9<br>Item is included on the agenda. Action complete and can be removed from the action plan. | |
| 6 | WHHFT/WEOD/13/100 – Risk Register<br>Risk 00400 to be discussed at 1:1 meeting with Director of Nursing and OD and Associate Director of HR. This item is now complete and can be removed from the action plan. | |
| 7 | WHHFT/WEOD/13/0101 - Finance<br>Sickness – discussion has taken place between Chief Operating Officer and Director of Finance. This item is now complete and can be removed from the action plan | |
| 8 | WHHFT/WEOD/13/102 HR Update<br>Disclosure and barring update – it was agreed that this issue should be recorded on the Risk Register and has now been added. With the existing controls in place the risk is relatively low. This item is now complete and can be removed from the action plan. | |
| 9 | WHHFT/SWC/13/083 – Volunteers Update<br>For next agenda as Patient Experience Matron not in attendance. | Patient Experience Matron April 2014 |
| 10 | **Study Leave Policy**<br>Approved | |
| 11 | **12.5 hour Shift**<br>These are being implemented, all wards are keen to start. Expected to be active by April 2014. | |
| 12 | **NHSLA Standard 9**<br>The Associate Director of Governance and Risk advised that a lot of work has been undertaken in performing the audits. Not all of the data is currently available however it is hoped that the results will be brought to the next Committee meeting. | |
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| | **WHHFT/SPC/14/005 – Presentation**<br>**Emergency Medicine – proposals to address workforce shortages Action Plan** | |
| 13 | Seif Ahmad Consultant here for 2½ years gave a presentation on dealing with the known shortage of Emergency Medicine Consultants. | |
| 14 | He explained that sometime ago a decision was made to change the way the emergency departments worked. This included:<br>• Increase consultants to provide 24 hour cover<br>• Core trainees given more emergency medicine exposure at an earlier stage<br>• Explore new routes into emergency medicine from other specialties<br>• Support SAS doctors to help improve retention<br>• GP support<br>• Expanding the use of ANP's, ENP's, paramedics | |
| 15 | The presentation is attached for information. | |
| 16 | He continued by explaining various solutions including training changes and other non-doctor initiatives, improving recruitment. | |
| 17 | L. Lobley, Non-Executive Director asked how realistic Seif felt these changes are. In response he advised that the training proposed in "The Shape of Training" changes appear helpful. He believed the time spent in anaesthetics etc do show what other options are available without the long shift patterns in emergency medicine. The problems he thinks are both recruiting and retaining because of the shifts and workload although he expects that all specialties will move to longer hours and an on-call rota including GPs, who will be expected to work nights. | |
| 18 | The Chief Operating Officer asked about middle grade doctors from India and whether there is any value going there to attract interest. Seif Ahmad thinks that this is a possibility and will write to EMWIG (the Emergency Medicine Workforce Implementation Group) to explore possibilities. | |
| 19 | The Chief Operating Officer asked if that by removing some patients to primary care would it diminish the life of emergency consultants ie. only having very emergency care patients could it add to 'burn out'? Seif Ahmad responded by explaining that on the whole emergency consultants are the type of people that like short spell treatment. | |
| 20 | The Director of Nursing and Organisational Development asked Seif Ahmad what it was that attracted him to emergency medicine and does it still exist? Seif responded that the biggest appeal is the variety of cases that are seen in a single shift. | |
| 21 | Seif was thanked by the Committee for an extremely interesting presentation. | |

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| | **WHHFT/SPC/14/006– HR Update Report** | |
| 22 | The Associate Director of HR reviewed his update report drawing attention to the following: | |
| 23 | • Employment Tribunal/other legal cases. An appeal hearing took place on 28th January and the Trust was successful, no other new cases have been lodged and the other two outstanding have progresses satisfactorily. | |
| 24 | • Job Planning – little activity although one formal mediation meeting has taken place and the outcome appears to be encouraging. | |
| 25 | • On-Call arrangements – difficult discussions have taken place, last meeting was on 21st January and we are awaiting formal response from staff side. | |
| 26 | • Industrial Action / Pay 2014-15 staff side response awaited. | |
| 27 | • Disclosure and Barring update – no change waiting to hear from CCG on their expectations for 2014/15. | |
| 28 | • Staff survey – slight improvement in responses, final report expected soon and this will be submitted to Board in March. | |
| 29 | • Pensions – rates to be increased, staff to be informed via leaflet within February or March payslips. | |
| 30 | • Organisational changes/developments – capacity issue but department is managing to cope. | |
| 31 | Director of Nursing and Organisational Development thanked the Associate Director of HR and his team for all the work that they are coping with currently. | |
| | **WHHFT/SPC/14/007– Employment Policies and Procedures** | |
| 32 | **Raising Concerns (Whistleblowing) Policy** | |
| 33 | **Attendance Management Policy** | |
| 34 | **Remediation policy for Medical and Dental Staff** | |
| 35 | All 3 policies were ratified by the Committee | |
| | **WHHFT/SPC/14/008 – KPI Report** | |
| 36 | The Associate Director of HR advised that there is little change, mandatory training has not achieved and appraisal figures have dipped. The Director of Nursing and Organisational Development commented that the Trust made a pledge to keep everyone in work and therefore training was stopped in Quarters 3 and 4. Discussions took place around whether discussions around winter, financial turnaround etc are causing a lack of focus on mandatory training, PDRs etc. It was agreed that this is the worst time of year to be focussing on these but all agreed that it would be beneficial to understand the pressures like long term sickness etc. | |

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| 37 | L. Lobley, Chair/Non-Executive Director advised that the Governors are concerned about the figures and would like to see an improvement. | |
| 38 | **Sickness** - to achieve 3.5% is a challenging target, Occupational Health Manager met with Associate Director of Operations, Scheduled Care and they had some good ideas. The Occupational Health Manager is intending to attend the ward manager's meetings and will discuss any options for improvement. It was agreed that reporting on ESR is not accurate and this does need to improve mainly as return to work interviews are taking place but these are not being recorded. | |
| 39 | The Chief Operating Officer raised the subject of A&E staff who are appointed, trained and then resign in order to work back in the same area but on agency. He asked if anything could be done to stop this. The Director of Nursing and Organisational Development recommended applying a rule that where you have left and tried to return via agency then this is not allowed until after six months have passed. A new policy around this was approved in December. L. Lobley, Chair/Non-Executive Director was confident that the correct steps have been put in place. | |
| 40 | **Staff induction** - The Associate Director of HR reported that figures are good in some areas but poor for temporary staff. He is looking at changing the policy around medical staffing to defer pay until training is complete. | |
| 41 | **Bullying -** the Associate Director of HR reported that the number of cases has increased, investigation is time consuming and most cases are not upheld although mediation is applied. Further details to be provided at the next meeting. | Deputy Director of HR April 2014 |
| 42 | **NHSLA Criterion 9 -** as covered in the action plan section. | |
| 43 | **Disciplinaries –** The Associate Director of HR reported that currently there are 45 cases so far, suspensions have also increased. It does reflect that we are less tolerant of poor behaviour and also that staff are not prepared to put up with poor peer behaviour. This area though is a drain on resources. | |
| 44<br><br>45<br><br>46 | **Medical Staffing Report**<br>The report is self explanatory, it does show that Locums are very expensive and the Risk Register entry has a detailed action plan behind it.<br><br>The reported increase in locum overspend in December actually showed a pay bill decrease once a 'deep dive' of the costs was undertaken.<br><br>The Chief Operating Officer asked that if we know we are going to overspend where there is a supply and demand issue then we ought to invite the Divisional Medical Directors to this Committee so they can be asked to take ownership and responsibility for these costs. L. Lobley, Chair/Non-Executive Director suggested a task group is established to look into this and ought to be headed up by the Medical Director once he is in post. | |

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| 47 | Associate Director of Operations, WC&SS remarked that it appears we are spending money we have not got. In his area this cost is within agreed budget. | |
| 48 | Director of Nursing and Organisational Development explained that we pay a premium for non permanent staff and agreed that the Divisional Medical Directors are involved in discussions as different rates apply to locums and if they were to all want the same rate that would not be an affordable situation. | |
| 49 | Associate Director of HR explained that the recruitment process is being looked at via the Locum/Vacancy Management Group and Alison Parker, Head of Procurement has instigated a plan. | |
| 50 | It was agreed the Chief Operating Officer will speak to the Medical Director when he takes up his post. | |
| | **Nursing and Midwifery Staffing report** | |
| 51 | The Chief Operating Officer queried the numbers around the staffing and asked if it was adequate in the Emergency Department. | |
| 52 | The Director of Nursing and Organisational Development and the Chief Operating Officer then had a discussion around staffing of A&E and setting a budget which is to be adhered to. | |
| 53 | The Director of Nursing and Organisational Development asked the Committee to support the actions identified in the report. | |
| 54 | Support was given by the Committee. | |
| | **WHHFT/SPC/14/009 – Briefing Paper on Agenda for Change changes** | |
| 55 | Associate Director of HR briefly explained the paper he had circulated. The change around incremental pay progression was the main issue for discussion, he explained that this area has been looked at by other trusts but believes that the more factors put into the decisions will make it harder to manage. Added to this is the opportunity that if someone does not receive an increment then they can appeal which puts more pressure on the HR department. | |
| 56 | The Associate Director of Estates and Facilities agreed that consistency would need to be paramount, hospitals that do not have an acute facility will not be under the same pressure around mandatory training and PDR's. | |
| 57 | The Chief Operating Officer asked if these changes could be applied only to Band 7 and above. It is important for those who have strategic responsibilities not to see this as an area of CiP. The Director of Nursing and Organisational Development explained that one of the contentious areas is receiving an increment after receiving a warning. | |
| 58 | L. Lobley, Chair/Non-Executive Director asked what other Trusts are doing, the Associate Director of HR responded that not many have implanted the changes. He explained that the discussions on any changes are taking place at HR Director meetings. | |

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| 59 | Associate Director of Estates and Facilities enquired if sickness levels dropped when sick pay stopped being paid. The Director of Nursing and Organisational Development advised that this did happen but other changes were also introduced with the revised Sickness Policy which also had an effect. | |
| 60 | It was agreed that before a decision is reached the Associate Director of HR will produce a report on the incremental changes being considered. | |
| | **WHHFT/SPC/14/010 – CQC Update Report** | |
| 61 | Outcome 12 – showing as being compliant, three areas have yet to complete their assessment. | |
| 62 | Outcome 13 – showing as being compliant but with a 'minor concern'. Three areas have yet to complete their assessment. | |
| 63 | The CQC have changed the way they now report to trusts. It is more difficult to read. It was agreed to report compliance with both outcomes but with a 'minor concern' for Outcome 13. L. Lobley, Chair/Non-Executive Director, C. Withenshaw, Non-Executive Director and Chief Operating Officer all support this recommendation. | |
| | **WHHFT/SPC/14/011 – Directorate Assurance Reports** | |
| | <u>WC&SS</u> | |
| 64 | The Associate Director of Operations, WC&SS advised: | |
| 65 | A major skill mx review has taken place under the Trust's Corporate CiP scheme 'competency based workforce planning'. A saving of £80k is likely to be realised and all staff being dealt with in accordance with Management of Change Policy. | |
| 66 | Locum/Agency usage costs are reducing. | |
| 67 | Three hotspots reported: consultant radiologists, radiographers and sexual health service. | |
| 68 | The contents of the report were noted. | |
| | <u>Unscheduled Care Division</u> | |
| 69 | Belinda Tench representing the Associate Director of Operations, Unscheduled Care advised hot spot issues are | |
| 70 | Sickness in the division standing at 4.68% which is higher than the Trust target of 3.5%. Work is being undertaken with the Occupational Health Manager on a targeted approach to supporting staff proactively with staying in work. Following this pilot scheme a review will take place to see if it has had any impact on the sickness levels. | |
| 71 | The contents of the report were noted. | |
| | <u>Scheduled Care Division</u> | |
| 72 | The Associate Director of Operations, Scheduled Care advised the hot spot issues are: | |

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| | • Staffing of unfunded escalation beds<br>• PDR/Mandatory Training<br>• Consultation period with staff who are affected when vascular transfer is complete.<br><br>The contents of the report were noted. | |
| 73<br><br>74 | <u>HR</u><br><br>The Deputy Director of HR advised that vacancies and sickness are the two main areas of concern in the department.<br><br>The contents of the report were noted. | |
| 75 | <u>Finance</u><br><br>No representation from Finance, the contents of the report were noted. | |
| 76<br><br>77 | <u>Estates</u><br><br>The Associate Director of Estates and Facilities reported no notable hot spots absence is low and although turnover appears high this is due in part to flexible retirements.<br><br>The contents of the report were noted. | |
| 78<br><br>79 | <u>Facilities</u><br><br>The Associate Director of Estates and Facilities reported no notable hot spots.<br><br>The contents of the report were noted. | |
| 80<br><br>81<br><br>82 | <u>IT</u><br><br>The Chief Operating Officer reviewed the report, hot spots include sickness but this is due to one member of staff being on long term sick.<br><br>Retirement/resignation of two senior members of staff is enabling a review of the structure of the management and direction of the department.<br><br>The contents of the report were noted. | |
| 83 | It was agreed to remove any identifying initials from any reports in future. | |
| | **WHHFT/SPC/14/012 – Healthy Worker Report** | |
| 84<br><br>85 | This report was due to be discussed at the December meeting but since then 3 people have attended training and all feedback from them has been positive. The Associate Director of HR is looking for support from managers to roll out this course, training is 1.5 days.<br><br>Support was agreed by the Committee. | |

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| | **WHHFT/SPC/14/013 - Competency Based Workforce** | |
| 86 | The Director of Nursing and Organisational Development reported that great inroads are being made | |
| | **WHHFT/SPC/14/014 - Risk Register** | |
| 87 | Director of Nursing and Organisational Development reported that the Temporary Staffing Risk is correctly scored. L. Lobley, Chair/Non-Executive Director reported she has looked at the other risks on the register and has no further comment. | |
| | **WHHFT/SPC/14/015 - Education and Development Report** | |
| 88<br><br>89 | Sallie Kelsey, representing Associate Director of Education and Development reported that:<br><br>• work is on-going with Health and Safety Mandatory Training.<br>• Nurse mentor numbers are reducing and 'action plan' to address this is in progress – an update to be provided at next meeting<br>• Resuscitation training is undergoing a full review. New courses will commence in April 2014.<br>• PDR recording is going to return to training department for inputting.<br>• SMS reminders about training/courses is to commence shortly | |
| | **WHHFT/SPC/14/016 – Business Continuity Update** | |
| 90 | Minutes from the Event Planning Group and Local Health Resilience Partnership meetings of 18th October and 20th December were received. | |
| | **WHHFT/SPC/14/017 – Minutes and Reports from Reporting Groups** | |
| 91<br><br>92<br><br>93<br><br>94<br><br>95 | Minutes and reports from the following reporting groups were received.<br><br>Joint Negotiating Consultative Committee of 3rd September 2013, 13th November 2013, 5th December<br><br>ESR Operational Group meeting of 7th August, 2nd October, 6th November and 4th December 2013 and 8th January 2014<br><br>Temporary Staffing Group notes of 21st January, 17th December, 19th November, 22nd October, 13th September<br><br>The contents of these minutes/reports were noted. | |
| | **WHHFT/SPC/14/018– Any Other Business** | |
| 96 | There was no further business. | |
| | **Date and time of next meeting** | |
| | The next meeting is to be held on 7th April the Trust Conference Room, Warrington. | |

**The agenda and minutes of this meeting may be made available to public and persons outside of Warrington & Halton Hospitals NHS Trust as part of the Trust's compliance with the Freedom of Information Act 2000.**

FSC/14/14

# *FINANCE AND SUSTAINABILITY COMMITTEE*

Approved Minutes of Meeting of the Committee held on 20th February 2014

***Present***

| | |
|---|---|
| Carol Withenshaw | Non-Executive Chair |
| Rory Adam | Non-Executive Director |
| Mel Pickup | Chief Executive |
| Simon Wright | Chief Operating Officer/ Deputy Chief Executive |
| Tim Barlow | Director of Finance and Commercial Development |

***In attendance***

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| Steve Barrow | Deputy Director of Finance |
| George Creswell | Associate Director of Estates |
| Colin Reid | Trust Secretary |

***Apologies:***

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| Jason DaCosta | Director of IT |
| Karen Dawber | Director of Nursing and Organisational Development |
| Paul Hughes | Medical Director |

### *Apologies and Declarations of Interest – FSC/14/06*

1 Apologies: As stated above
Declarations: None

### *Minutes of meeting – FSC/14/07*

2 The minutes of the meeting held on 20 February 2014 were approved and the actions discharged or were included on the agenda.

### *Budget 2014/15– FSC/14/08*

3 The Director of Finance and Commercial Development provided a presentation on the Trust Budget 2014/15. The presentation provided details of the proposed budget which, with phase 1 of the Annual Plan, would be presented to the Board at its meeting on 26th March 2014. He advised that the budget represented work in progress at this time given that certain assumptions were still to be addressed.

4 The Director of Finance and Commercial Development ran through the presentation and gave an explanation of the headline financial strategy and assumptions With regards to the income and expenditure slide, Rory Adam asked why there was an assumption that the Trust would be loss making in Q1 and Q2. In response the Director of Finance and Commercial Development advised that both quarters were mainly cost based. The Deputy Director of Finance explained that income is lower in Q1 and Q2 mainly due to the seasonality of activity income and the reduced number of working days (associated with bank holiday and summer

holiday periods) but the costs are generally spread evenly throughout the year with the exception of cost savings which weighted towards Q3 and Q4.

5 The Committee noted the headline position of the Trust for each quarter of the 2014/15 financial year, which provided for a breakeven at the end of Q4, This would result in a COS rating of 2 for Q1 and Q2 and a 3 and 4 for Q3 and Q4 respectively. The Committee further recognised the financial risks arising from the assumptions. The Chief Executive felt that once the Budget and Plan were approved by the Board there was a need for each of the divisions' triumvirate (Divisional General Manager, Divisional Medical Director and Lead Nurse) to attend the Committee and provide assurance on their ownership of both the budget and plan for their own division. She felt it was important that the Divisions recognise their accountability and responsibility in delivering the approved budget and plan.

6 The Committee approved assumptions and plans for 14/15 described in the presentation noting that the plans agreed will form the basis of the 14/15 and 15/16 annual plan submission to the Board of Directors. The Committee recognised that there was still some parts of the budget that required development, in particular the gap in CIP.

7 The Director of Finance and Commercial Development asked the Committee to reflect on the assumption that the Trust would be presenting for approval a breakeven budget and asked whether this was appropriate given the deficit the Trust was forecasting for 2013/14.

8 The Committee reflected on the position and recognised that although a surplus would an optimistic position it would be extremely difficult to achieve and therefore felt that it would be more appropriate to target breakeven given the financial issues that the Trust would need to address. The Chief Operating Officer felt that achieving a breakeven at the end of the financial year would still be stretching however supported the breakeven position as he felt reporting a deficit would not been seen in a good light and would give negative messages to staff and stakeholders.

9 The Chief Executive agreed with the proposal feeling that the Trust should not set its sights lower than breakeven. She however wondered what the profile of the Trust would be to achieve a COS rating of 3 in Q2. The Director of Finance and Commercial Development advised that the Trust would need to have a £2million improvement on the proposed budget in the first two quarters of the year, either through CIP or increased activity. If CIP was brought forward, which he was unsure could happen, then the COS for Q3 and Q4 may be impacted upon and could push the Trust into a deficit position. The Chief Operating Officer felt that if it was agreed to deliver CIP earlier than plan then he felt there are areas that could be looked at, he also felt that the Trust needed to look at reviewing its risk profile and address whether it should increase the profile to achieve CIP savings. The Deputy Director of Finance felt that bring forward CIP would be a big ask of the divisions and supported a breakeven budget. He did not feel it would not be appropriate to deliver a deficit budget.

10 Rory Adam noted the comments made by the Executive and management team and advised that he would feel uncomfortable if the Trust was to announce a deficit budget. He also felt that given the budget would already be very stretching to deliver a breakeven he would not be able to support a surplus budget. Rory Adam advised therefore that the Trust should drive delivery of a breakeven budget recognising the CIP challenge was huge.

11 The Chair supported the comments made and agreed that the Trust should deliver a breakeven budget for 2014/15.

12 The Committee agreed with the proposed breakeven budget for 2014/15 for recommendation to the Board.

13 The Director of Finance and Commercial Development thanked the divisions and finance team for all their hard work and support in getting the budget to the current stage it was at given the difficult challenges the Trust faced.

***Corporate Performance Report – FSC/14/09***

14 The Chief Operating Officer distributed his corporate performance report to attendees. He advised that the Board had agreed at the February Board meeting that he produce a Corporate Performance Dashboard and Exception Report at the April Board meeting. This was currently being developed.

15 With regard to the Committees review of the corporate performance indicators, the Chief Operating Officer asked that the Committee run through his current report and identify what its future reporting requirements would be.

16 The Committee reviewed the report and identified the areas that required reporting. In particular the Committee felt that were indices were already reported at other Board committees, such as the quality indicators, then these should be removed.

17 The Chair thanked the Chief Operating Officer and advised that she looked forward to seeing a slimmed down Corporate Performance Report for review by the Committee, recognising that the first slimmed down report would be presented to the May meeting, following the Dashboard and Exception Report presented to Board in April.

***Terms of Reference of Sub Committees/Groups – FSC/14/10***

18 i. Chief Operating Officer update on operational committees reporting.
The Chief Operating Officer advised that the four KPI Groups would in future report through the Committee.

19 ii. Temporary Staffing – Nursing and Midwifery
The Director of Finance and Commercial Development advised that having given further thought to this Groups reporting requirements he felt that it should report through the Strategic People Committee (SPC). He explained that this was the most appropriate reporting structure advising that if any issues relating to finance was to arise then this could be dealt with through referral from the SPC. The Committee agreed the position.

20 iii. Commercial and Business Development Committee.
The Director of Finance and Commercial Development advised that the TORs had not as yet been produced and would be developed when the Associate Director of Commercial Development was in post.

***Review of Minutes of Reporting Committees/Groups – FSC/14/11***

21 i. Capital Planning Group
The minutes of the Capital Planning Group was noted. The Director of Finance and Commercial Development advised that there was still some misunderstanding on the role

of the Medical Devices Group and in particular whether it was to remain a reporting group to the Capital Planning Group. He explained that the Associate Director of Governance had merged the role of the group into the Safety and Risk Committee, however following comments on the appropriateness of whether this should have happened from the Chief Operating Officer at the last Committee meeting there was now a hiatus on whether this group existed. The Medical Director, who was previously Chair of the Group, was asked to look into whether this Group should be re-instated as a reporting group to the Capital Planning Group.

Action FSC/14/11: Medical Director to consider whether it was appropriate to re-instate the Medical Devises Group.

22 ii. IM&T Steering Committee
The minutes of the IM&T Steering Committee was noted.

23 iii. Temporary Staffing – Nursing and Midwifery
The minutes of the Temporary Staffing – Nursing and Midwifery was noted recognising that future reporting would be to the SPC.

***Any Other Business – FSC/14/12***

24 There being no further business the Chair closed the meeting.

# Action List

Finance and Sustainability Committee

April 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 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**W&HHFT/TB/14/073**

# BOARD OF DIRECTORS

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|---|---|
| **Paper Title** | **Any Other Business** |
| **Date of Meeting** | 30 April 2014 |