We are
WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

WHH Board of Directors Meeting

Tuesday 28 February 2017
1.00pm – 4:00pm
Trust Conference Room

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Warrington and Halton Hospital NHS Foundation Trust
Agenda for a meeting of the Board of Directors held in Public.

Tuesday 28 February 2017, time 13:00 -4.00pm

Trust Conference Room, Warrington Hospital

REF BM/17/02	ITEM	PRESENTER	PURPOSE	TIME	
BM17/02/14	Guardian of safe working presentation	Simon Constable Medical Director + Deputy CEO	Information	1.00pm	
BM/17/02/15	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	1.30pm	Verbal
BM/17/02/16	Minutes of the previous meeting held on 25 January 2017	Steve McGuirk, Chairman	Decision	1.32pm	Enc
BM/17/02/17	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance		Enc
BM/17/02/18	Chief Executive's Report	Mel Pickup, Chief Executive	Assurance	1.40pm	Verbal
BM/17/02/19	Chairman's Report including confirmation of Deputy Chair + Board resolution for sign off of further loan agreement	Steve McGuirk, Chairman	Information	1.55pm	Enc

Quality People Sustainability

BM/17/02/20	Integrated Performance Report Including Trust Engagement Dashboard and Key Issues Reports for: - Quality Governance Committee 7.2.17 - Finance & Sustainability Committee 22.2.17 - Strategic People Committee 20.2.17	All Executive Directors Margaret Bamforth, Committee Chair Terry Atherton, Committee Chair Anita Wainwright Committee Chair	Assurance	2.05pm	Enc

Quality

BM/17/02/21	Complaints Improvement Plan update report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	2.30pm	Enc
BM/17/02/22	Review of WHH NHS FT Safeguarding Services and action plan	Kimberley Salmon-Jamieson Chief Nurse	Assurance	2.55pm	Enc

People

BM/17/02/23	NHSI Strengthening financial performance + accountability 2016-17 NHSI Checklist	Pat McLaren, Director of Community Engagement + Corporate Affairs on behalf of Roger Wilson Director of HR & OD	Assurance	3.10pm	Enc

Sustainability

BM/17/02/24	Any Other Business	Steve McGuirk, Chairman	N/A		Verbal
	Date of next meeting: Wednesday 29 March 2017				

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Item No BM 17/02/15

TRUST BOARD ATTENDANCE RECORD 2016-17

	1.4.16	27.4.16	25.5.16	29.6.16	27.7.16	31.8.16 Xlled	28.9.16	26.10.16	30.11.16	21.12.16	25.1.17	28.2.17	29.3.17
Steve McGuirk, Chairman	√	√	√	√	√		√	√	√	√	√		
Mel Pickup, Chief Executive	√	√	√	√	√		√	√	√	√	√		
Simon Constable, Medical Director/ Deputy CEO	√	√	√	√	A		√	√	√	√	√		
Sharon Gilligan, Chief Operating Officer	√	√	√	√	√		√	√	√	√	√		
Kimberley Salmon-Jamieson, Chief Nurse							√	A	√	√	√		
Karen Dawber, Director of Nursing	√	√	√	√	√ R								
Andrea Chadwick, Director of Finance & Commercial Development	√	√	√	√	√		√	√	√	√	√		
Margaret Bamforth, Non-Executive Director			√	√	√		√	√	√	√	√		
Anita Wainwright, Non-Executive Director	A	A	√	√	√		√	√	√	A	√		
Ian Jones, Non-Executive Director	√	√	√	√	√		√	√	√	√	√		
Terry Atherton, Non-Executive	√	√	√	√	√		√	√	A	√	√		
Lynne Lobley, Non Executive	√	√	A	√	√		√	√	√	TE			
In Attendance													
Roger Wilson, Director of HR & Organisational Development	√	√	√	√	√		√	√	√	√	A		
Jason DaCosta, Director of Information Technology	√	√	√	√	√		√	√	√	A	√		
Lucy Gardner Director of Transformation	√	√	√	√	√		√	√	√	√	√		
Pat McLaren, Director of Comm Engagement & Corp Affairs	√	√	√	√	√		A	√	√	√	√		

Key: A = Apologies
A/D = apologies with deputy attending
X/D = Attendance as Deputy

Xp = Part TE = Term Ended R = Resigned/Left Trust

D R A F T

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in public on Wednesday 25 January 2017 Trust Conference Room, Warrington Hospital	
Present	
Steve McGuirk (SMcG)	Chairman
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Andrea Chadwick (AC)	Director of Finance & Commercial Development
Simon Constable (SC)	Medical Director & Deputy Chief Executive
Sharon Gilligan (SG)	Chief Operating Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Jason DaCosta (JDaC)	Director of IM&T
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement
Rachel Browning	Associate Director Nursing, Surgery, Women's and Children's
Sheila Murphy	Matron
Tracey Cooper	Head of Midwifery
Observing	
Tom Ross	Deloitte
Tom Berry	Deloitte
Norman Holding	Public Governor
Apologies	
Roger Wilson	Director of Human Resources and Organisational Development

Agenda Ref BM/17/01/01	
BM 17/01/01	The Board Meeting opened with a presentation from Dr Rachel Browning, Associate Director of Nursing, Surgery, Women's and Children's Division + Head of Midwifery and Sheila Murphy, Matron. Rachel Browning introduced Tracey Cooper who has recently joined the Trust as Head of Midwifery. The Midwifery Unit were a finalist in the recent Royal College of Midwives 2017 awards and recognised locally and nationally as an exemplar. On behalf of the Trust, the Chief Executive and the Chairman thanked Rachel and her team for their hard work and contribution to enabling the changes, working as a team to develop a rebranded Midwifery Unit. The Chief Executive presented Rachel with a behaviours badge on Excellence.

BM 17/01/02	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed those attending the meeting, including Governors, and members of the public and Deloitte who were observing the meeting as part of the Trust's Well Led Review. Apologies: as above. Declarations of Interest: none declared in respect of agenda items.
BM 17/01/03	**Minutes of the Previous Meeting Held on 30 November 2016** Page 6 – penultimate bullet point to read CIP schemes £8.5m in the latest reforecast plan Page 4 – last point to read… Romanian Nurses, 13 remain in post. Page 5 – November Quality Committee Key Issues – 3rd bullet point to read .. A paper was presented to the Private Board 30 November 2016 to review all CQIN's in more depth. Page 7 – Agency Spend, second paragraph to read, The Board assigned responsibility to the Finance and Sustainability Committee to undertake deep dive analysis of the Dashboard and review the NHSI Checklist. The Trust Board will continue to monitor the NHSI Checklist and will retain responsibility for sign off the NHSI Checklist. With these amendments, the minutes of the meeting held 30 November 2016 were approved as a true and accurate record of the meeting.
BM 17/01/04	**Actions and Matters arising** All actions were reviewed and progress was noted.
BM 17/01/05	**Rolling Programme of Attendance** M Bamforth joined the Trust 1 May 2016. Attendance log to be amended to reflect this.
BM 17/01/06	**Chief Executive Report including STP C&M Submission public document** The Chief Executive updated the Board on items that had occurred or progressed since the November Board meeting: • The Trust had experienced unprecedented demand within A&E and Urgent Care over December and January while other Trusts within the health economy had struggled to meet demand. In part this was due to the Trust being better equipped to deal with these pressures due to the strong clinical leadership within the CBU following the re-structure enabling the Trust to maintain reasonable levels of service and not create a sub-optimal care environment that some Trusts had experienced during this period. Pressure had not abated and the Trust remains within the top third of performing Trusts on achieving its 4 hour target, ranked as one of better performing within Cheshire and Merseyside. The Chief Executive asked for her thanks to be recorded on behalf of the Trust Board to all Directors and staff for their hard work and dedication that patients have experienced not only over the last couple of months but throughout the year. • 2017-18 Contract - The Trust concluded its contract discussions for 2017-18 with its Lead Commissioners, Warrington CCG within the revised timescales and the 2017-18 Contract has now been signed. Thanks were conveyed to the Director of Finance and the team

	for their efforts. • Consultant appointments – the Trust recently advertised 2 colorectal consultant posts. There was a strong field of candidates, 3 exceptional candidates who had previously worked at the Trust. The Trust successfully appointed 2 of the candidates, who were thrilled to be returning to the Trust and who will commence in post shortly. • STP – the Board formally received the Cheshire and Merseyside Sustainability and Transformation Plan which had been submitted and published in October 2016. These plans are currently being reviewed and revised plans will be submitted at the end of March 2017. • The published plans were subject to a single item agenda meeting at the Warrington Health Overview and Scrutiny Committee (WHOSC) recently attended by the Trust, CCG and Providers who were asked to expand on plans as local authority colleagues felt that they had not been engaged in producing the plans as fully as they would have liked due to the tight timescales. • The Warrington HOSC put forward a motion not to support the STP plans in its current form due to lack of detail within the plans. Discussion had taken place on how all could work towards an Accountable Care System (ACS) within this Borough. CCGs and Provider Trusts have been asked to report back to the Warrington Health & WellBeing Board on 26 January and how the narrative will become a reality. • Health system leaders had attended a recent Warrington Health Summit with a similar event in Halton. The concept and development an Accountable Care Organisation (ACO) is still embryonic on its form and function. There could be some support by Vanguard programmes as part of the 5 year Forward View. • Manchester plans are further developed, exploring a Partnership Board, Chaired by an independent Chair which could include integration of health and social care, integrated commissioning and integrated provision and pooled budgets. The direction of travel is still unclear but the narrative of STP plans needs to clearly describe its intent and how this will be done. • The Chairman made some observations regarding the media that the published STP plans had attracted, mainly due to the translation and mis-interpretation of information adding that the sustainability of health services will not be delivered by the Trust as a stand alone organisation, with all partners and stakeholders needing to work collaboratively to achieve this. • In relation to the question asked by AW if an ACO would include all Out of Hospital/District Nurses / Out Patient / community services, MP responded that for Warrington a decision would be needed on the scale of change at the outset of any plans and what could be done differently to ensure patient care is in the correct setting adding that the future cannot be defined on current activity. • In response to questions raised, MP added that Southport and Ormskirk Hospital crosses LDS boundaries due to the need to control patient flows and that S&O are very much still part of the STP / LDS plans. The Board noted the report and formally received the STP C&M Public submission documents.
BM	**Chairman's Report**

17/01/07	The Chairman gave the Board an update of events since the previous Board meeting: • Council of Governors (CoG) at their meeting on 19 January 2017 ratified the formal appointment of Anthony Whitfield as the Trust Non-Executive, commencement date to be confirmed. • The newly elected Governors were welcomed at their first CoG meeting on 19 January 2017. The Council debated the Integrated Dashboard in detail and the Chairman thanked Executive colleagues who attended for their contribution and summary of the Dashboard. • The CoG approved the proposal to redefine and formalise the role of Lead Governor in line with the NHSI Code of Governance. Declarations of interest are to be submitted by 31.1.2017 if uncontested, a Lead Governor will be appointed, if contested, the Council will receive a nomination form for completion and return to the Trust Office by 16 February. The Chair and NEDs are reviewing Sub Committee attendances and Chair roles. The Chairman to confirm a Deputy Chair prior to the next Board meeting. • Front Line/Ward visits are currently taking place, the Chairman emphasised the importance of the opportunity to meet front line staff. The Board noted the report.
BM *17/01/08*	**Integrated Performance Report Dashboard (December)** The Executive Directors each presented the performance metrics relating to their portfolios of responsibilities which included workforce and quality KPIs, and the following points were highlighted: **Quality:** The Medical Director and Chief Nurse took the Board through the Quality highlights of the dashboard, the Medical Director summarised: - HCAIs nil return to December 2016. The Trust has a period of 15 months MRSA free. - Mortality HMSR – borderline outlier with HSMR of 109.53. Time lag receiving the data to provide latest figures, due the end of January, in time for the Trust Board. SHMI in expected range, not a significant outlier. The recent Mortality Workshop for Executive and NED colleagues proved beneficial in further understanding of the breadth and complexities of recording of these figures. A future session to be planned. - Mortality Reviews and a Mortality Review Group established to understand issues. The Trust has volunteered to be a national pilot site for this work and is awaiting the outcome. Mortality Screening backlog review updated to be presented to the February Quality Committee. - MRSA screening – 100% screening target within 30 days this year. Backlog due to a number of reasons. The Chief Nurse summarised: - High Risk Incidents - Incidences will be analysed over the next couple of months with an approach to be developed with CCGs to manage SUIs. - Safety Thermometer – some wards off target but they all have individual action plans - CQUIN – moved from Red to Green for SEPSIS, an action plan is in place and two SEPSIS

nurses to commence with the Trust in February. Partial compliance with A&E screening.

- Antimicrobial Resistance CQUIN – waiting for confirmation of contract variation from Warrington CCG.
- Falls – green rating, data to be analysed and the way in which we record falls as indicators on the dashboard to be reviewed. Falls - all fractures investigated as part of SUI process.
- Ulcers – working to reduce Grade 2, 3 and 4 pressure ulcers. Root cause analysis to look at cause of Grade 3 and 4 and review to be undertaken of pressure ulcers and Tissue Viability across the Trust including beds.
- Family +Friends (A&E) – discussed at the Clinical Operations Board, exploring publicising better within A&E, using posters and dedicated staff to collect and collate information in A&E and offer texting service.
- Family + Friends (inpatients) – reduction in December, exploring electronic options to offer this and maximise take up of completing questionnaires.

  Complaints – paper and action plan to be presented to the February Quality Committee with improvement plan to be developed. Work on the backlog continues as well as those received daily.
- KSJ assured the Board that the process for managing the backlog is being closely monitored with detailed discussions through the Quality Committee. IJ added that MIAA will undertake an internal Phase 2 review which the Audit Committee will also receive.
- **The Board were asked to note and acknowledge the significant personnel and departmental changes since KSJ had been appointed and that staff now had clear responsibilities.**

Performance

The Chief Operating Officer took the Board through the Performance highlights of the dashboard:

- RTT - Continue to achieve the 6 week target.
- 4 hour A&E – did not achieve target or trajectory in December for the first time this year. Significant pressures experienced during December and January with improvements anticipated in February and March. Multifactorial reasons, not just Trust pressures. All staff working hard to achieve targets and quality services for patients.
- Working with ECIP on a number of workstreams through the AED Board which is challenging due to number of organisations involved across Mid Mersey and their own priorities.
- Agreed medical optimised patient baseline of 120 at WHH and St Helens & Knowsley Hospitals with collective aim to reduce to 60 by September 2017.
- TA added that the Finance and Sustainability Committee review this data which includes age profiling data and change in trends and suggested this is communicated with all staff and partners/stakeholders to understand the growing demand on A&E services.
- Cancer – achieved 14 day target
- Breast Symptoms 14 days – achieved in November. Remains problematic mainly due to patients deferring appointments. Not a Trust capacity issue but December and January targets could be compromised due to lack of radiographers for breast screening, teams working hard to address this.

- Ambulance handovers – aspirational target of zero tolerance. Trust experienced its worst performance in December, but regionally compared favourably with other Trusts and were commended by NWAS for its performance.
- STP funding will not be affected as Trust has met its trajectories throughout the year.
- Discharge summaries – back on track to deliver trajectory.

The Director of Finance + Commercial Development presented the Workforce dashboard in the absence of the Director of HR & OD.

- Sickness absence – above North West average, work continues to monitor this.
- RTW – improved but slight dip in February. SG meeting monthly with each manager to ensure recording of data on paperwork is then put on electronic systems, improvement should be reflected in next month's report.
- Recruitment – improvements noted.
- Agency spend – nationally recognised issue, continued work required across the Trust to reduce spend acknowledging the challenge due to locums choosing where to work.

The Director of Finance + Commercial Development presented the Finance dashboard:

- Remain on target at end of December 2016, with deficit of £6.6m against planned deficit of £6.7m following a challenging Quarter 3.
- Minimum cash balance of £1.2m in line with planned cash balance of £1.2m.
- Paperwork now received for the Trust Capital Loan Agreement to enact the balance transfer of £9.318k to the Capital Loan Facility, to be repaid by 2020. **The Board were asked to approve this Agreement.**

The Board approved the sign off of this Loan Agreement at the conclusion of today's meeting by the Chief Executive and Director of Finance.

- Capital programme spend £2.7m, £1.5m below planned spend of £4.2m. Behind plan due to changes of requirements for medical equipment. Medical Equipment Group scrutinising all requests.
- Use of Resources rating of 3.
- Better Practice Payment remains at 29%, the cash position is being managed on a daily basis and monitored through the Finance and Sustainability Committee.
- Agency spend £8.3m, £0.4m above ceiling of £7.9m and monitored as part of the NHSI Checklist. More context to be included on future dashboards for this indicator.
- £3m risk in forecast, discussed with NHSI and programme of mitigations being developed. No support for winter funding this year or tolerances, if control total not achieved could result in not receiving the remaining £2m of the £8m STP funding.
- No indication from NHSI re: capital to revenue transfer. Will continue to work closely with lead commissioners.
- LG commented that she was disappointed to be behind plan on CIP at month 9 but in context,£6.4m savings delivered, outwith of CIP schemes, ie waiting list initiatives realised £700k savings and significant improvements in T&O with sessions increasing from 76% to 81%.

	The Board noted the report:
	Engagement Dashboard The Director of Community Engagement highlighted key areas for the Board to note: - December 2016, six pieces of regional media coverage, a very positive month regarding sentiments conveyed. - Social media and website – demographics of people visiting the sites to engage with WWH being explored and working with the recruitment team to develop career opportunities for 18-24 year olds. 60% of users attend WHH with mobile devices. - Current website to be developed to ensure its compatibility with all mobile platforms. - On behalf of the Board, the Chairman asked Executive colleagues to convey thanks to all staff for their efforts to maintain targets, deliver challenging financial targets, their contribution to STP whilst maintaining excellent patient care. The Board noted the report.
BM 17/01/08 (a)	**Key Issues Report from December 2016 and January 2017 Quality Committee** The Key Issues Reports were taken as read and Margaret Bamforth highlighted the following <u>December 2016</u> - Membership was reviewed and discussed. ToR to be reviewed by the newly appointed Deputy Director of Governance to ensure alignment with the Board Assurance Framework and be presented to the January Committee for ratification. - Reviewing lessons learned following incidents and dissemination of information, important that this is by one method of communication via the Trust website to ensure two-way communication. To resolve potential risks to running two systems in parallel, one route of access has been agreed and training on its use and access will follow for staff. - Quality Dashboard reviewed. A review to take place on Pressure Ulcers, patient beds and mattresses. This has been added to the Risk Register and a business case for a programme of replacement beds will be required. - The Quality Committee scrutinised in depth the Theatres at Night project, and implementation will be monitored closely - Recruitment and Retention Nursing Strategy being developed. Complaints and Concerns Policy discussed and reviewed. Final changes to be incorporated for Ratification at its January Committee. The Board noted the report. <u>January meeting</u> - Draft Terms of Reference reviewed and the Committee agreed the revised Terms of Reference with minor amendments. - Dr Simon Constable, Medical Director, presented the Do Not Attempt Cardiopulmonary Resuscitation Review carried out by MIAA which identified a number of areas for action. The Committee was reassured by the appointment of a new Lead for Resuscitation, and

	monitoring arrangements in place, via the Patient Safety and Clinical Effectiveness Sub-group which reports to the Quality Committee via the bimonthly high level briefing paper. - Resuscitation Lead will be invited to present to a future meeting. MIAA are due to follow up in 6 months. - The Quarterly Governance Report was reviewed which will offer opportunity for triangulation of information, trends to be identified and improvement following intervention to be recognised. This will be overseen by the newly appointed Deputy Director of Integrated Governance and Quality. - The Breast Screening QA Report was presented by Sharon Gilligan, Chief Operating Officer following a visit which reviewed the Breast Screening Services across the Warrington, Halton and St. Helens/Knowsley area. The report was very positive and identified no immediate areas for improvement and included a number of recommendations, an action plan has been developed and some of the actions have already been completed. Challenges identified include work pressures and accommodation. A monthly steering group has been set up to monitor progress against the action plan. - Potential impact of winter pressures was discussed acknowledging that additional escalation beds had been opened and patients were being cared for on the Ambulatory Care Unit, as well as Daresbury Ward. Pressure on the service may be indicated in quality measures in the following months. Patient Access Policy approved following ratification by the CCG. Learning Identified: The importance of ensuring that the procedures for DNACPR are adhered to and the most optimal way of addressing an important training and education initiative to ensure that the right people receive the training. The Committee wishes to escalate the potential quality impact of winter pressure for the attention of the Board. The Board noted the report and matters for escalation.
BM 17/01/08 (b)	**Key Issues Report from December 2016 and January 2017 Finance and Sustainability Committee** The Key Issues Reports were taken as read and Terry Atherton, Chair of the Committee highlighted the following: - Main focus had been the oversight of achievement of the 2016-17 control total target and other financial requirements. Challenging month in both December and January from a financial perspective. - Performance of WHH robust and strong. - Capital Planning – the Committee reviewed, discussed and supported changes to the various expenditure approval levels within the Trust prior to the SORD being presented to the Audit Committee. - Lorenzo - the Committee debated in detail and felt unable to support a proposal to

	pursue a strategic partnership with CSC for a variety of reasons but supported a move to maximise Lorenzo benefits. The Board noted the report.
BM 17/01/08 (c)	**Key Issues Report from December 2016 Charitable Funds Committee** The Key Issues Reports were taken as read and Ian Jones, Chair of Charitable Funds Committee highlighted the following: - More income streams to be developed. Large amount of revenue is legacy funding. - Fundraising Manager now a substantive appointment and corporate funding streams being explored. - Last 12 months £192k income, £230k expenditure. - The Committee approved the Charities Commission checklist which is overseen by Director of Community Engagement. The Board noted the report.
BM 17/01/08 (d)	**Key Issues Report from January 2017 Audit Committee** The Key Issues Reports were taken as read and Ian Jones, Chair of the Audit Committee highlighted the following: - The Committee received and reviewed a number of MIAA Internal Audit reports, all of which had had recommendations, action plans and monitoring mechanisms in place. - IJ highlighted the evidence of triangulation of information between Committees, ie Lorenzo, tender waviers, locum spend and outsourced consultancy work, which is also being monitored through the FSC. The Board noted the report.
BM 17/01/09	**DIPC Bi-Annual Report** The Medical Director presented the Bi-Annual report and highlighted points to note: - MRSA – no cases over a 15 month rolling period of resistant MRSA. - CDiff – 49 reported cases, 13 considered hospital apportioned, further 2 cases in December. - Invest to save on in-house testing for viral gastroenteritis. System at initial stages but an assessment plan is in place to obtain data on the number of bed days saved. ACTION Future report to Board on operational impact. - Improvement areas: - Medicine cannulas, anti-microbial prescribing work in progress. SC acknowledged potential impact that the open ward visiting could have in this area and that all areas on wards will be reviewed. KSJ added that there has been no indication from national Infection Control team of adverse effect of opening visiting. The Board noted the report.
BM 17/01/10	**Strengthening Financial Performance + Accountability in 2016-17, High Bill Growth and Agency Staffing – NHSI Checklist** The CEO asked the Board to defer this item to its next meeting. Apologies had been

	received from the Director of HR & OD and the Board wanted this perspective since the last Board meeting and assurance on what is being submitted and that information submitted is corrected. The Board agreed to defer this item. TA as Chair of FSC asked the Board to note that the FSC on behalf of the Board have oversight of the Dashboard and emerging systems, the FSC receive this Dashboard on a monthly basis to monitor and ensure that the Trust are carrying out their duties in conjunction with the Regulators.
BM 17/01/11	**Quarterly Response to Lord Carter** The Director of Finance and Commercial Development presented the report and highlighted points to note: - The report consists of feedback and progress from Executive colleagues on the 15 recommendations made. - Where there is no update, this has been recorded as no change to current position. - AC reassured the Board that information within this report will inform part of the transformational plans across the LDS. - AW referred to Recommendation 1 and the development by NHSI of a National People Strategy and that there is no reference to the WHH Trust recently approved People Strategy of November 2016. - AC confirmed that data on back office /corporate service plans has been received. An initial review has been completed within the LDS of where savings could be made without any restructuring which shows a reduction of £12m, benchmarking to be undertaken at LDS level which will then be shared across the STP. - Procurement benchmarking undertaken, all processes compared across LDS to identify what can be procured at a later stage on a bigger footprint and what could be quick wins now that would not result in any changes to structures or governance process to maximise buying power. SG added that hospital pharmacy transformation plans are to be reviewed by Executives in March to be presented to a future board for sign off which will include the outcome of the rota review as will future Lord Carter reports. SC added that e-prescribing will have action plans in response to questions raised by MB. - TA added that nationally money is being taken out of community pharmacists and that the potential impact on community pharmacists needs to be taken into account by the Trust and within the community. **Hospital pharmacy transformation plans to be presented to a future Board Meeting, Medical Director** The Board noted the report.
BM 17/01/12	**Charitable Funds Annual Report** The Director of Finance and Commercial Development presented the report and highlighted points to note: - the annual report and accounts had been prepared. For the year ending March2016 income of £190k generated and incurred expenditure of £211k which decreased the

	balance of funds by £21k. At 31 March 2016 the balance of funds is £609k. - legacy donations increased by 25% in year. - Ambition and strategy in place to accelerate funding streams. - Auditors have reviewed and requested minor amendments which are: - Page 9, paragraph 2 take out the word **also.** - Page 20, Income 1.4 take out 2nd paragraph. - Page 26 note 13, take out word **in** in last sentence. - AC and PMcL assured the Board that controls are in place to ensure there is no overspend of funds, The Board approved the report and accounts and signing by Director of Commercial Development and Director of Community Engagement. Future Board workshop on strategy to develop income streams. **PMcL**
BM *17/01/13*	**Any Other Business** There being no further business to discuss, the meeting closed at 15:45 hrs **Next Meeting:** Wednesday 28th February 2017, 1pm Trust Conference Room.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/17/02/17	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	28th February 2017

1. ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/01/07	25 January 2017	Chairs Report	Chairman to confirm appointment of Deputy Chair.	Chairman	28 February 2017			

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/01/12	25 January 2017	Charitable Funds Commission	Board to receive refreshed strategy to maximise income streams as workshop	**Director of Community Engagement**	**July Board Session**	31 January 2017		

3. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
16/136	29th June 2016	Revised Nursing Strategy	Revised Nursing Strategy to be presented to Board	Chief Nurse	October 2016		The Board agreed that the Revised Nursing Strategy would be presented to the March 2017 Board.	

BM/17/01/08	25 January 2017	Integrated Dashboard	Follow-up Mortality Board workshop to be planned.	Medical Director	Date TBC			
BM/17/01/11	25 January 2017	Lord Carter – Pharmacy Transformation Plan	Detailed plans to be presented to future Board meeting.	Medical Director	Date TBC			
BM/17/01/09	25 January 2017	DIPC Bi-Annual Report	Future report to Board on operational impact	Medical Director	Date TBC			

RAG Key

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

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/ 17 / 02 / 19**	
SUBJECT:	Approval and Utilisation of Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) Agreements.	
DATE OF MEETING:	**8 February 2017 (via email – please see page 3)** **28 February 2017 Public Trust Board**	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Katie Armstrong, Financial Accountant	
EXECUTIVE DIRECTOR SPONSOR:	Andrea Chadwick, Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.4: Business Continuity	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
STRATEGIC CONTEXT	The purpose of the report is to obtain approval from the Board of Directors, by means of a Board Resolution, for the drawdown of funds from the Department of Health in lieu of STF Funds for the quarter ending 31st December 2016 and quarter ending 31st March 2017 by way of an Uncommitted Single Currency Interim Revenue Support Facility.	
EXECUTIVE SUMMARY (KEY ISSUES):	This document outlines the process for the Trust to secure the drawdown of funds in lieu of STF to 31st March 2017.	
RECOMMENDATION:	The Board of Directors is requested to delegate authority to obtain revenue support via loans up to the value of £2.6m. This relates to STF not yet received for Q3 and Q4. 9.2.17 this resolution was approved by email, see p3	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	

FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

1. BACKGROUND/CONTEXT

The purpose of the report is to obtain approval from the Board of Directors, by means of a Board Resolution, for the drawdown of funds from the Department of Health (DH) in lieu of Sustainability and Transformation Funds (STF) for the quarter ending 31st December 2016 (Q3) and quarter ending 31st March 2017 (Q4) by way of an Uncommitted Single Currency Interim Revenue Support Facility (ISUCL).

2. KEY ELEMENTS

In September 2015 the Trust entered into an agreement with DH for an interim revolving working capital facility of £11.6m at an interest rate of 3.5%. The purpose of the facility was to enable the Trust to meet its day to day working capital commitments for 2016/17. In June 2016 the Trust submitted a revised 2016/17 planned deficit to NHS Improvement of £7.9m (control total) and requested a loan for the same value. The Trust has been required to utilise the interim revolving working capital facility whilst the loan was secured.

The Trust planned, in accordance with the payment timetable from NHSI, it would receive £2.0m STF each quarter with the payment for Q4 being received in February 2017. The payments have been delayed by NHSI which has increased the pressure on the Trust position. The Q1 and Q2 STF have been received in full. In September 2016 the Trust was advised to utilise the interim revolving working capital facility for the Q3 and Q4 STF should delays in receipt of funds put additional pressure on the Trust cash position. The Trust has drawn down £1.4m of STF for Q3 relating to achieving the finance element of the STF.

Approval for transfer of the utilised working capital facility into a loan of £9.3m (£7.9m plus £1.4m) at a 1.5% interest rate was approved at Trust Board 25th January 2017. The Trust no longer has a working capital facility which was a condition of the loan. By moving from a working capital facility to a loan the Trust is reducing the cost of borrowing from 3.5% to 1.5%. Following advice from NHSI the Trust is now applying for a loan of £0.6m for the performance element of Q3 STF. The same approach will be required for the £2.0m in Q4.

In line with the Trust's Scheme of Reservation and Delegation and Schedule 1 of the attached Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) Agreement (Appendix One) DH requires the Trust Board to approve the utilisation of a ISUCL, to authorise the Chief Executive Officer to sign the loan agreement for the initial £0.6m on its behalf and to confirm the Trust's undertaking to comply with the additional terms and conditions as contained in the agreement. DH also recommends that the Board supports the delegation to the Chief Executive Officer for a further £2.0m loan in lieu of Q4 STF.

3. RECOMMENDATIONS

The Board of Directors is requested to:-

(A) approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorise the Chief Executive Officer to execute the Finance Documents relating to uncommitted interim revenue support loans to the value of £2.6m to which it is a party on its behalf; and

(C) authorise the Director of Finance and Commercial Development, on its behalf, to despatch all documents and notices (including, if relevant, any Utilisation Request) to be signed and/or despatched by it under or in connection with the Finance Documents up to which it is a party.

(D) confirm the Borrower's undertaking to comply with the Additional Terms and Conditions.

The above is in accordance with the Trust's Scheme of Reservation and Delegation and Schedule 1 of the agreement for the Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) ref DHPF/ISUCL/RWW/2017-02-03/A for £0.6m and subsequent ISUCL agreement for £2.0m.

4. NOTES TO THE APPROVAL PROCESS

As the loan documentation was received and required approval and return within a very short time frame it was impossible to convene a physical Board meeting in time.

The Director of Community Engagement & Corporate Affairs therefore conducted the process electronically on 8 Feb 2017, at 17:58 as follows:

The following email was sent to all Board members:

URGENT BOARD RESOLUTION REQUIRED

Please see attached papers relating to the application for the loan which was discussed at the last Board meeting. Apologies for short notice but we have just received the detailed paperwork from NHSI who require an urgent turnaround of approvals.

Board members are therefore requested to read the attached papers and respond by 10am Thursday 9th February as follows:

The Board of Directors is requested to delegate authority to the Chief Executive to obtain revenue support via loans up to the value of £2.6m. This relates to STF not yet received for Q3 and Q4.

- ☐ ***Yes I support the resolution***
- ☐ ***No I do not support the resolution***
- ☐ ***I abstain***
- ☐ ***I would like to discuss further and will join a teleconference call at 9am Thursday 9th February hosted by Andrea Chadwick, Director of Finance.***

For governance purposes all members are asked to reply to this email - the resolution requires at least 6 voting members to be in agreement (as per our Constitution). This process, and the outcome of the vote, will be formally recorded in a paper to public Board on 28th February 2017.

If you have any concerns then please do let me know and I'll arrange for you to join the conference call tomorrow.

Thank you for your support,

Pat

Pat McLaren, Director of Community Engagement and Corporate Affairs

Returns were received as follows:

- ☐ ***Yes I support the resolution***

1. Chairman
2. Non-executive Director
3. Non-executive Director
4. Non-executive Director
5. Chief Executive
6. Medical Director
7. Director of Finance and Commercial Development
8. Chief Nurse
9. Non-executive Director

- ☐ ***I would like to discuss further and will join a teleconference call at 9am Thursday 9th February hosted by Andrea Chadwick, Director of Finance.***

10. Non-executive Director – subsequently voted YES

Absent:

11. Chief Operating Officer

The resolution was therefore supported and approved.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/02/20**
SUBJECT:	**Integrated Dashboard**
DATE OF MEETING:	Choose an item. 28th February 2017
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts & Performance
EXECUTIVE DIRECTOR SPONSOR:	Andrea Chadwick, Director of Finance & Commercial Development Sharon Gilligan, Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance
EXECUTIVE SUMMARY (KEY ISSUES):	• *Despite significant operational pressures in December the Trust has maintained good performance against many of its key performance indicators (KPI's).* • *To ensure a positive patient journey the Trust must continue to focus on achieving the 4 hour A&E trajectory and patient waiting list targets to include the 2 week breast symptomatic standard.* • *The Trust must continue to embed the People Strategy throughout the Trust to ensure all members of staff are treated in a consistent and fair manner.* • *Quarter 4 will be challenging as the Trust endeavours to meet its annual CIP target and 2016/17 financial control total.*

RECOMMENDATION:	The Trust Board is asked to: **1.** Note the continued delivery of many key performance indicators **2.** Gain assurance that those areas of performance currently below the required standard are subject to review and scrutiny with clear plans for recovery implemented.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

BOARD OF DIRECTORS

SUBJECT	Integrated Performance Dashboard	AGENDA REF:	

• BACKGROUND/CONTEXT

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

- Quality
- Access and Performance
- Workforce
- Finance

• KEY ELEMENTS

- Zero tolerance for MRSA maintained.
- Zero incidents of major harm in January.
- Sepsis CQUIN data collection for quarter 3 is ongoing.
- RTT targets achieved.
- A&E trajectory not met in January.
- Improvement required to 2 week breast symptomatic performance.
- 95% discharge summaries sent within 24 hours – Improvement on December`s performance but still slightly below target.
- Sickness absence for the Trust marginally above North West average (as at November).
- Decrease in the number of return to work interviews carried out in January
- Staff turnover reduced for the 7th consecutive month.
- Agency nurse spend continues to increase.
- Trust's cash balance is low and lower than the original plan.
- Cumulative deficit £0.1m better than plan.
- Cost improvement schemes savings (cumulative) £0.98m below plan.

• ACTIONS REQUIRED/RESPONSIBLE OFFICER

KPI's that are underperforming are being managed by the relevant sub-committees. Where action is required to bring underperformance back to acceptable levels the responsible sub-committee will provide assurance to the Board via the narrative contained in the main body of this dashboard.

• IMPACT ON QPS

Despite the increase in operational pressures throughout December the Trust maintained high quality and safe patient care. Members of staff were deployed throughout the Trust to ensure operational teams had the required skill mix.

• MEASUREMENTS/EVALUATIONS

All KPI's contained in this dashboard are in line with contractual and national requirements.

• MONITORING/REPORTING ROUTES

KPI's are monitored monthly via the Trust's Clinical Operational Board and the various Sub Committees of the Board.

• TIMELINES

KPI performance is reported monthly to the Board.

• ASSURANCE COMMITTEE

The following sub-committees provide assurance to the Trust Board via this dashboard:

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

• RECOMMENDATIONS

The Trust Board is asked to:

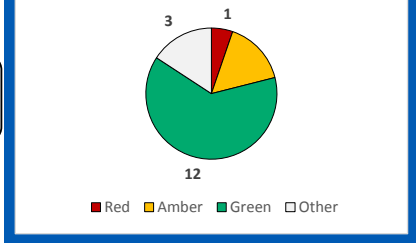
- Note the continued delivery of many key performance indicators.
- Gain assurance that those areas of performance currently below the required standard are subject to review and scrutiny with clear plans for recovery implemented.

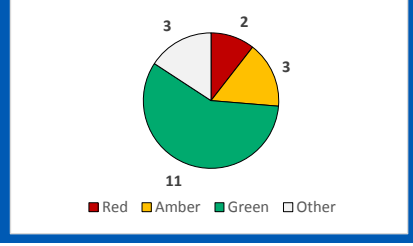
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

Key Points/Actions

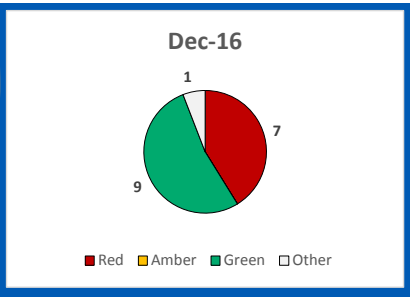
Quality Improvement

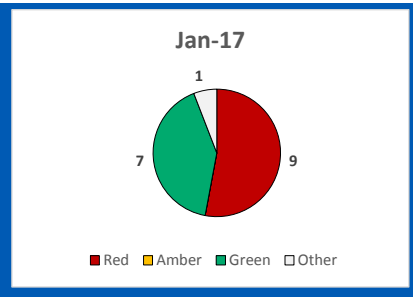




There are 0 incidents of major harm reported for January and 6 on-going Incident Reviews from April – December 2016 currently graded as a major or catastrophic harm. The latest 12 month rolling HSMR (December 2015 – November 2016 has decreased to 107.10 from 109.53. The national data used to model expected deaths has been updated and the SHMI is rebased at 108.84 from 109.51. The Trust has maintained its zero tolerance position for MRSA with no cases in January. The Trust has reported 17 hospital apportioned cases of Clostridium difficile against the annual threshold of 27 cases. This includes 6 cases removed from contractual sanctions following review of Q1 & 2 cases by the CCG. The 5 cases from Q3 will be reviewed in February. Data was collected for the Safety Thermometer in January 2017 but due to administrative issues the report will not be available until February 2017. Since April, the Trust has reported 3 (confirmed) avoidable grade 3 pressure ulcers with a further 3 cases of grade 3 and 1 grade 4 under review. To date there are 31 grade 2 approved grade 2 pressure ulcers and 14 under review. The falls per 1000 BD for December is slightly above the 5.6 threshold at 5.66 and it should be noted that whilst there has been an increase in overall falls none of these has resulted in a risk rating of moderate or above. The Trust is compliant with the SEPSIS National CQUIN Q3 with the exception of AED Screening which is deemed partially compliant at 81.33%. The AMR National CQUIN - awaiting outcome of discussions with CCG regarding baseline for antibiotic reduction and Empiric Review Q3 is compliant at 91.3%. Year to date the Trust has received 369 complaints with 26 returned complaints.

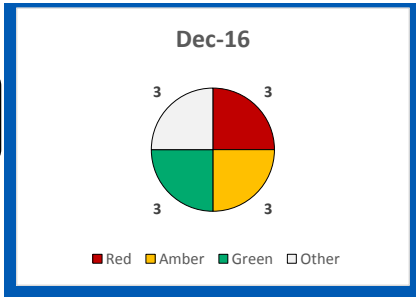
Access & Performance

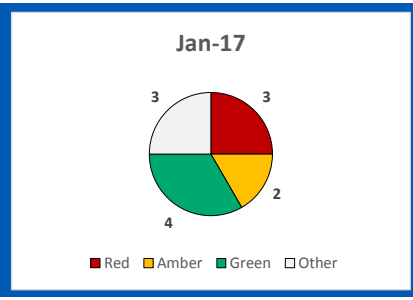




This reflects the first upload undertaken by the team on the 3rd Feb for the December activity from Somerset Cancer Registry. We have achieved the 62 day target for Quarter 3 although we did not manage to achieve December 16. We are in the process of fully implementing Somerset by the end of March 2017.

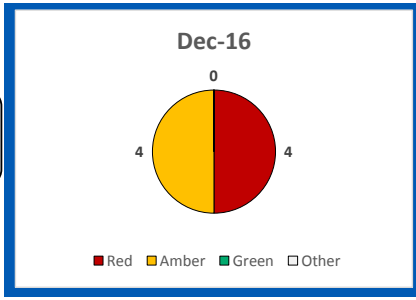
Workforce

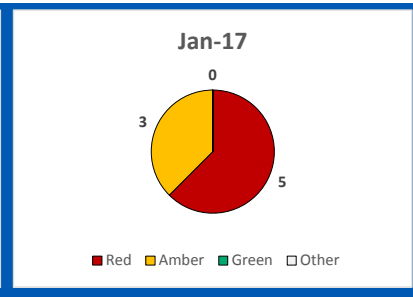




The sickness rate has fallen from the previous month with a marginal increase for the YTD. RTW rates have fallen in month but the YTD rate remains unchanged. Most of the Key elements of recruitment times have imporved, most notably pre-employment checks. Non contracted pay remains a concern, nurse agency expenditure has increased but is still less than last year. Medical agency expenditure is virtually the same as the previous month. Mandatory training and PDRs rates have all increased significantly and show an upward trend. Information for reporting 'high cost agency workers; and 'long term agency usage' has improved but continues. Medical and nursing staff feature in the top 20 earners and there are 7 medical staff who have worked for more than 6 months.

Finance



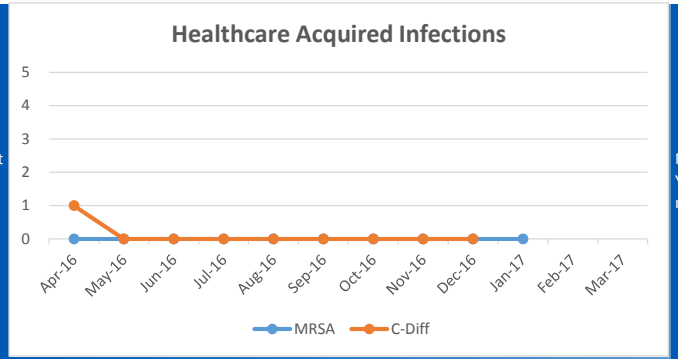
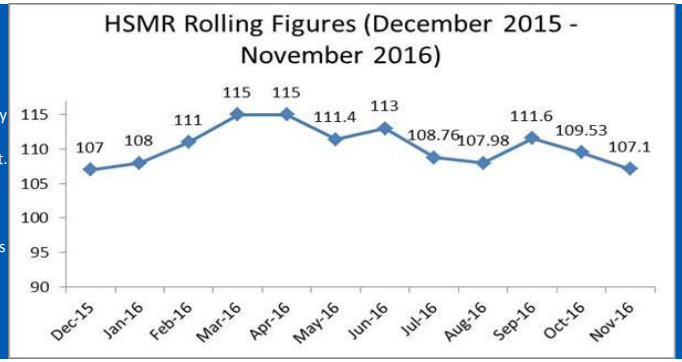
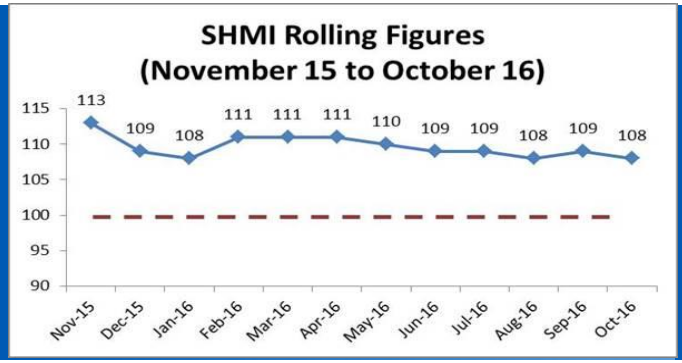


In January the Trust recorded a deficit of £0.4m which increases the year to date deficit to £7.0m which is £0.1m better than the planned deficit of £7.1m. For the year to date period income is £1.6m above plan, expenses are £2.7m above plan and non operating expenses are £1.2m below plan. To date the capital programme planned spend is £5.0m and the actual spend is £3.1m. Due to the operating position the cash balance remains low and as at 31st January the cash balance is £1.3m which is £1.0m less than the planned cash balance of £2.3m. The performance against the Better Payment Practice Code is 29% in the month and 29% to date so is significantly lower than the 95% target. For the period the Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating. The Trust is marginally ahead of the planned deficit but it is vital that financial controls and mitigating actions are robustly applied for the remainder of the year to ensure that the Trust remains on financial trajectory.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

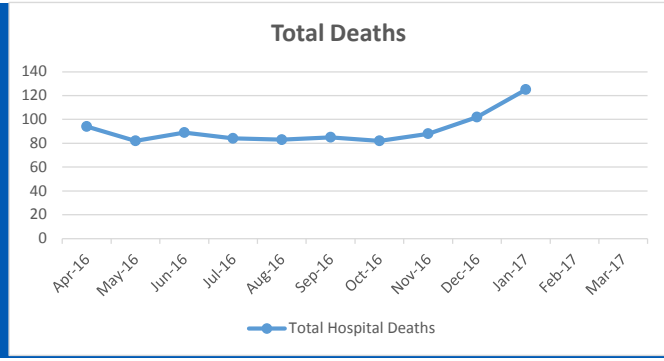
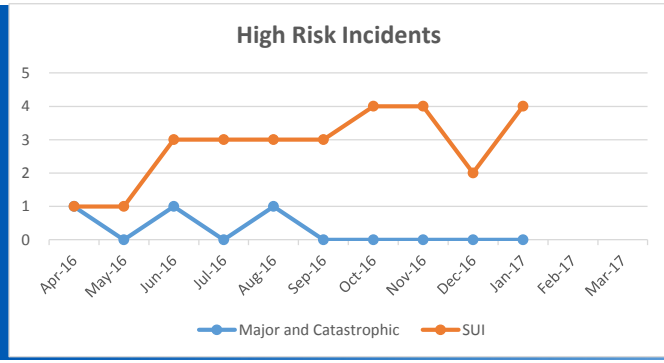
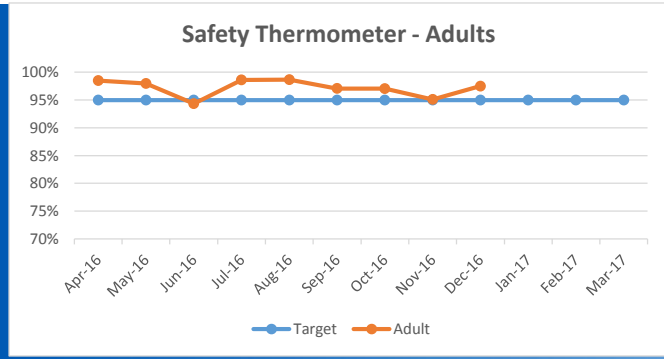
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Healthcare Acquired Infections MRSA Red: More than 5 Amber: 1 to 5 Green: 0 C-Difficile Red: More than 2 Amber: t o 2 Green: 27 or less per year	MRSA - National objective is zero tolerence of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. CLOSTRIDIUM DIFFICILE (due to lapses in care) agreed threshold is <=27 cases per year.	The Trust has maintained its zero tolerence position for MRSA. 4 hospital apportioned Clostridium difficile cases was reported in January 2017. YTD the Trust has reported 17 hospital apportioned cases of Clostridium difficile against the annual threshold of 27 cases. This includes 6 cases removed from contractual sanctions following review of Q1 & 2 cases by the CCG. The 5 cases from Q3 will be reviewed in February.		MRSA bacteraemia – a nil return was submitted for January 2017. YTD nil case have been reported. The Trust has a period of 16 months MRSA bacteraemia free.
Mortality ratio - HSMR Red: Higher than expected Amber: Over 100 Green: 100 or less	Hospital Standardised Mortality Ratio (HSMR 12 month rolling) The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	The latest HSMR for December 2015 - November 2016) is currently at 107.10. HSMR shows higher weekend mortality than weekday as per the national picture although looking at the confidence intervals, neither is statistically significant. When we look at the underlying trends, 12 month rolling HSMR weekend and weekday rates seem to be reducing slightly. The gap between weekend and weekday HSMR rates seems to be narrowing.		
Mortality ratio - SHMI Red: Higher than expected Amber: Over 100 Green: 100 or less	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling) SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	The latest SHMI is 108.84 (November 2015 to October 2016). National data which is used to model expected deaths has been updated and so direct comparisons between data reported this month and data reported last month are not appropriate.		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

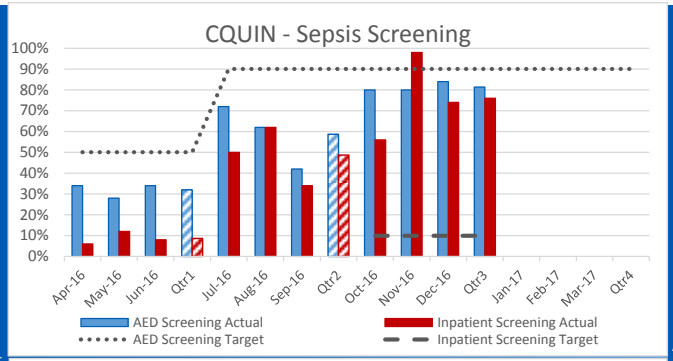
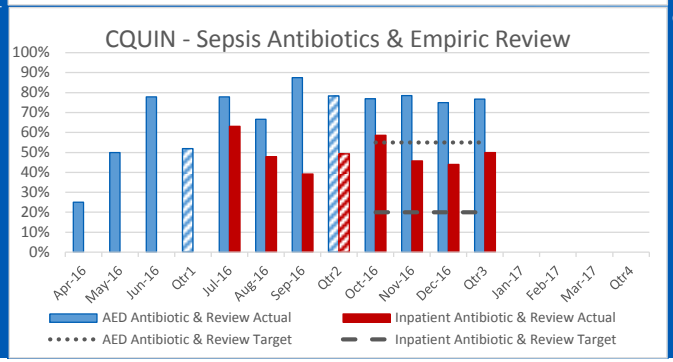
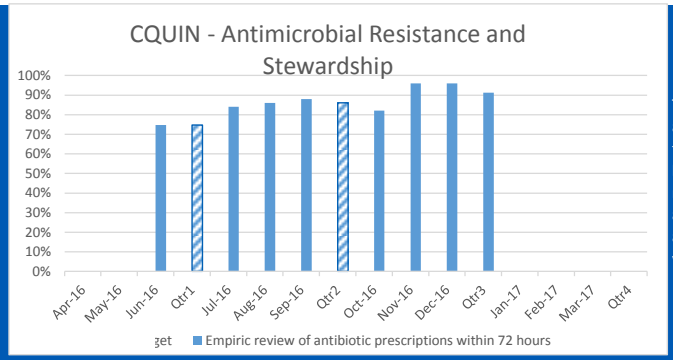
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Total Deaths	Total Deaths in Hospital			The Mortality Review Group is tasked with interpreting the data for the above and driving improvments including improving the percentage of completed mortality reviews. From April preventability from deaths data will be collected and therefore should enable us to RAG rate the total number of deaths.
High Risk Incidents	Major and Catastrophic Incidents and Serious untoward incidents (SUIs) Level 3	The Trust has reported 0 incidents of Major Harm for January		There remain 7 ongoing Incident Reviews from April - January (July = 1, November = 1, December = 1, January = 4) currently graded as Major or Catastrophic Harm.
Safety Thermometer - Adult Red: Less than 90% Amber: 90% to 94% Green: 95% or more	Measures % of patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer)	This measure only includes new harms. Based on monthly snapshot audit of all inpatients, just under 3% had a fall, pressure ulcer, VTE or Catheter acquired infection in December 2016. Data was collected for January but due to administrative issues the data will not be available until February 2017.		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

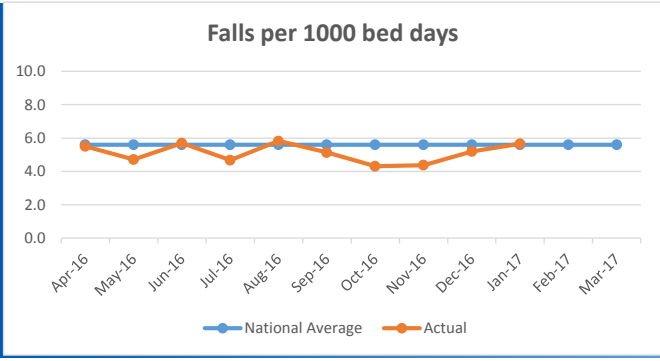
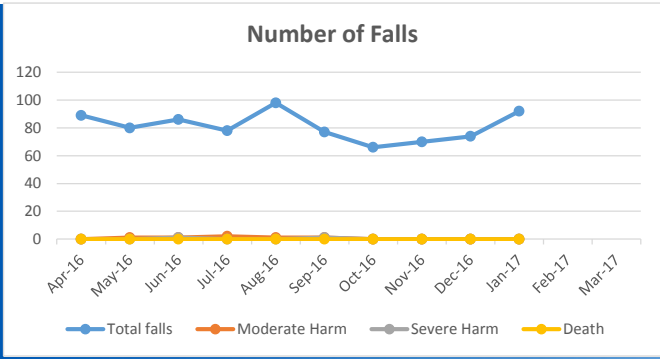
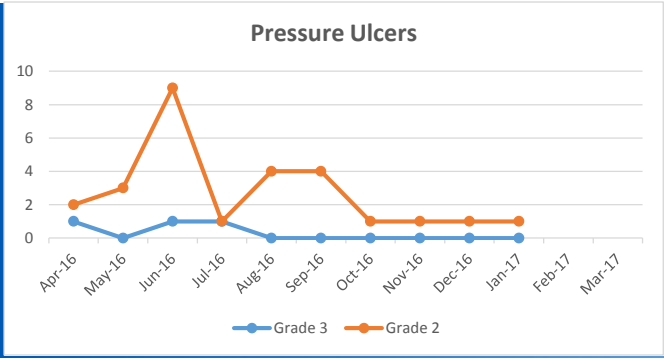
Quality Improvement

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 50% Amber: 50% to 89.9% Green: 90% or more CQUIN - Sepsis Inpatient Screening At Qtr4 Red: Less than 50% Amber: 50% to 89.9% CQUIN - Sepsis AED Antibiotics & Review Trajectory yet to be agreed with CCG CQUIN - Sepsis Inpatient Antibiotics & Review At Qtr4 Red: Less than 50% Amber: 50% to 89.9%	Screening of all eligible patients - acute inpatients (*to be validated). Screening of all eligible patients admitted to emergency areas (*to be validated). Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	The four elements of the SEPSIS CQUIN are required to achieve the following thresholds in Q2- AED Screening is based on the national threshold and AED Antibiotic Review - 55%; Inpatient Screening - 10% and Inpatient Antibiotic Review - 20%. Data collection for Q3 is ongoing.	 	AED Screening achieved >=50% so deemed partially compliant, all other measures deemed compliant against Q3 thresholds.
CQUIN - Antimicrobial Resistance and Stewardship	Antimicrobial Resistance and Stewardship (AMR) National CQUIN AMR Reduction in antibiotic consumption per 1,000 admissions. AMR Empiric Review of antiobiotic prescriptions within 72 hours	The Trust has submitted the baseline data for antiobiotic consumption as required for 2013/2014 - 2015/2016 and the 2016/2017 Q1 usage report. In Q3 the Trust has performed an empiric review on 82% (October) & 96% (November) of prescriptions thus achieving the required threshold that at least 75% of cases in the sample are reviewed and is therefore compliant.		The pharmacist has been contacted to request quarterly reports on antibiotic consumption so that it can be included in this dashboard to evidence antibiotic usage against baselin. Achievement of the baseline reduction in antibiotics is deemed unrealistic and a number of local Trusts have either agreed or are in the process of agreeing a contract variation with the CCG. The Trust has produced and submitted an AMR Report to CCG to negotiate contract variation around revised consumption methodology.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

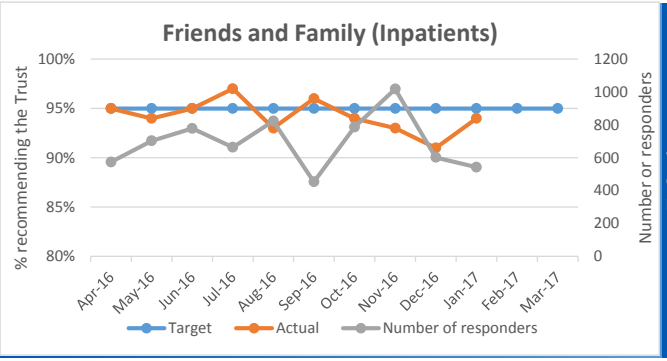
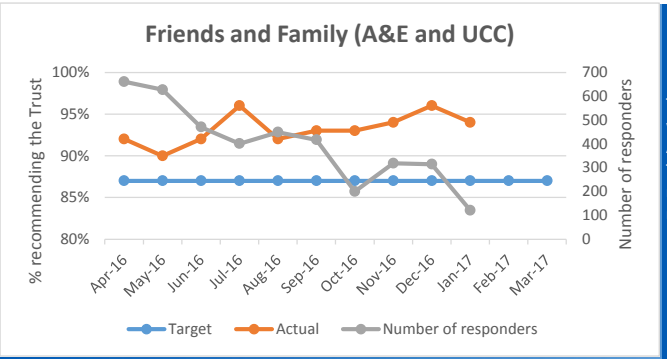
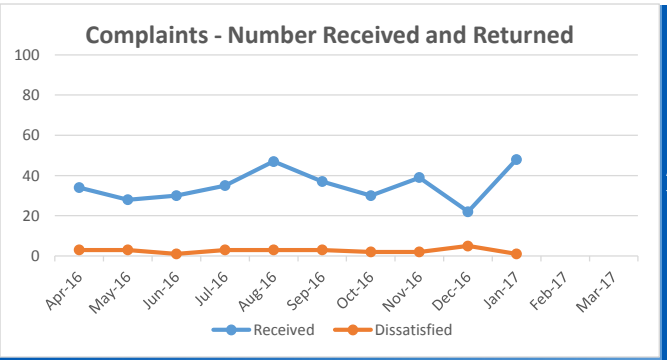
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Falls per 1000 bed days Red: More than 5.6 Green: 5.6 or less	Falls / 1000 BD. This measure relates to the number of falls per 1000 bed days. The national threshold is 5.6.	As part of our drive to ensure harm free care for our patients, we have recruited a Falls Practitioner to lead and strengthen the Trust wide falls agenda		A Trust action plan has been formulated. It should be noted that whilst there has been an increase in the number of falls occurring, none of these have resulted in a risk rating of moderate or above.
Total number of Falls & harm levels	Total number falls including a breakdown of moderate, major and castastrophic.			There have been 8 falls resulting in fractured neck of femurs of which 4 were deemed unavoidable, 2 resulting in moderate harm and 1 resulting in major harm. The investigation is still ongoing on the final fall with fractured neck of femur.
Pressure Ulcers Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 82	Grade 3 hospital acquired (avoidable). Grade 2 hospital acquired (avoidable and unavoidable)	To date we have 3 confirmed avoidable grade 3 pressure ulcers against an improvement priority threshold of >=3. There are 31 approved grade 2 pressure ulcers. The grade 2 threshold of 82 for the year equates to 6 per month and 20.5 per quarter.		There are 3 cases of Grade 3 pressure ulcers under review from April - December and 14 Grade 2 pressure ulcers under review. There is one Grade 4 pressure ulcer which is currently under review.

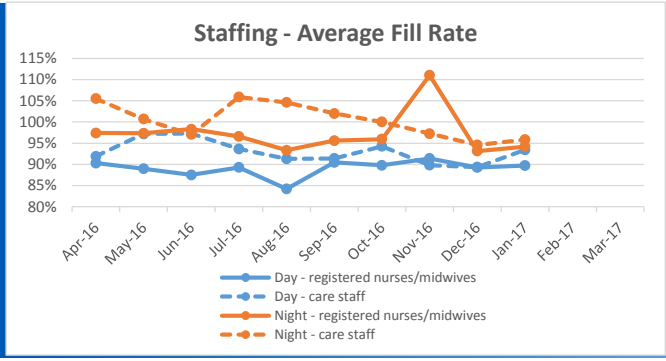
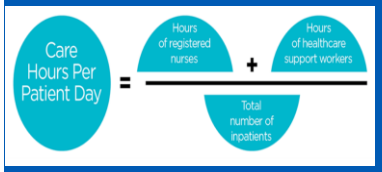
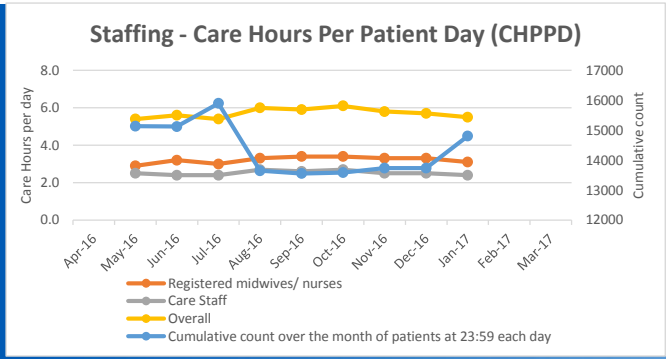
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Friends and Family (Inpatients & Daycases) Red: Less than 95% Green: 95% or more	Percentage of Inpatients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	We had achieved the monthly target with the exception of August, November and December when it reduced to just below the threshold of 95%.		Whilst it is acknowledged that the number of responders has decreased in Jan 17, it is pleasing to note that the percentage of patients recommending the Trust has increased.
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	Results show an improving situation we have exceeded the monthly threshold 87% to date for 2016		There has been a steady decline in the number of responders, which aligns with the national view that paper based systems in an A&E setting are not the most effective. The Trust is currently procuring an electronic system, i.e. SMS text messaging, which has been shown to significantly increase response rates. It should be noted that recommendations remain high.
Complaints - Number Received and Returned	Total number of complaints received and returned for further local resolution	Year to date the Trust has received 369 complaints with 26 returned complaints. Please note that the data for the number of complaints and concerns are reviewed on a monthly basis and can be subject to change as complaints can become concerns (and vice versa), with the agreement of complainants.		A data cleansing of DATIX (Complaints system) has taken place and therefore revised figures have been entered.

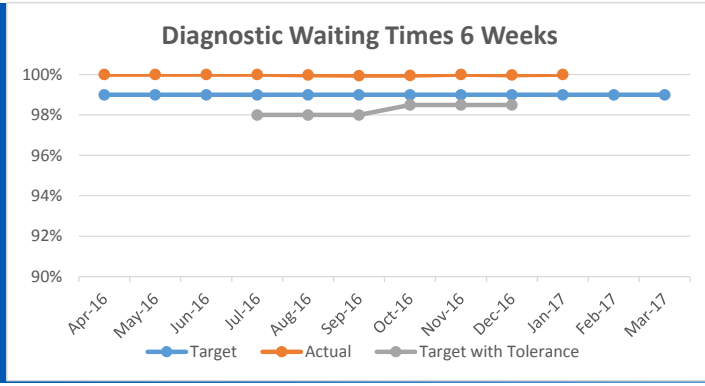
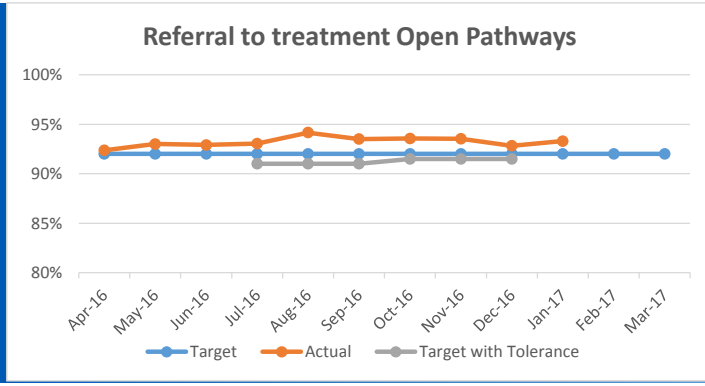
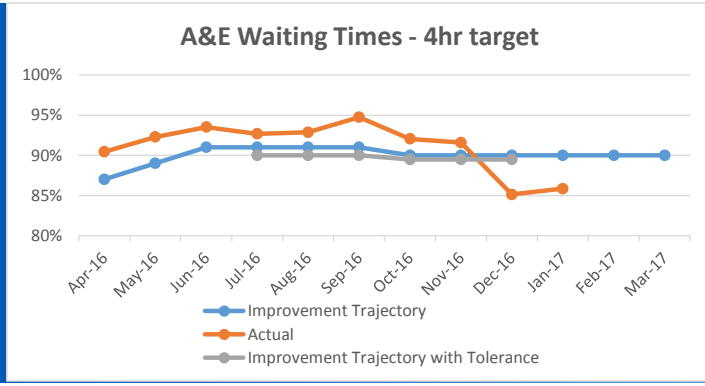
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	Percentage of planned verses actual for registered and non registered staff by day and night	To ensure the wards are safe, risk assessments are undertaken and staff resource is allocated appropriately.		Trust wide recruitment and retention strategy developed. E-Rostering and "safe care" acuity tool is being rolled out across the Trust, to be completed by April 2017. On the occasion when numbers are above 100% this is due to enhanced care.
Staffing - Care Hours Per Patient Day (CHPPD)		Trusts to be benchmarked against each other and tolerance agreed by NHSI		Analysis of data from over 1,000 wards, in the pilot stage, found a wide variation in the care hours provided per patient day - ranging from 6.33 to 15.48 hours with an average of 9.1 hours. The data produced excludes CCU, ITU and Paediatrics.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

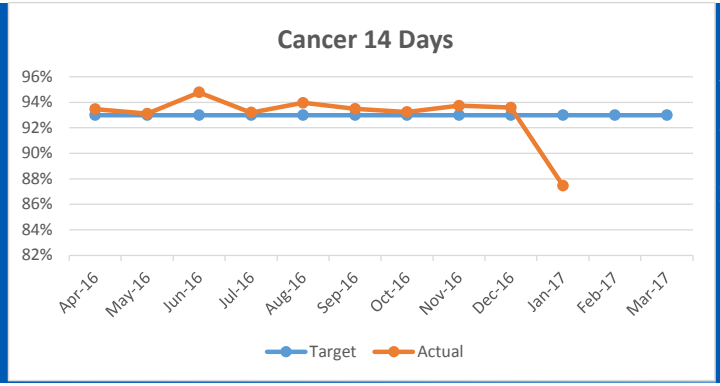
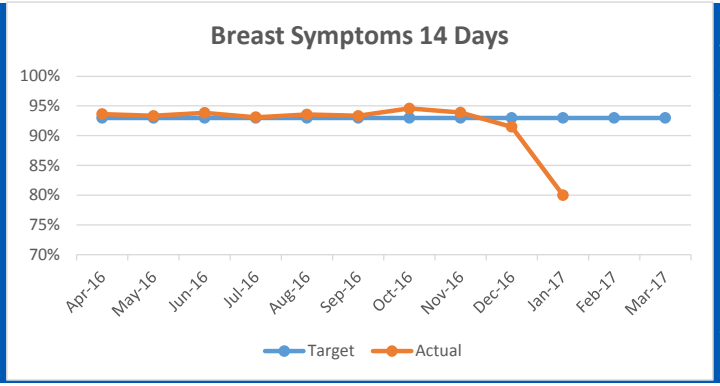
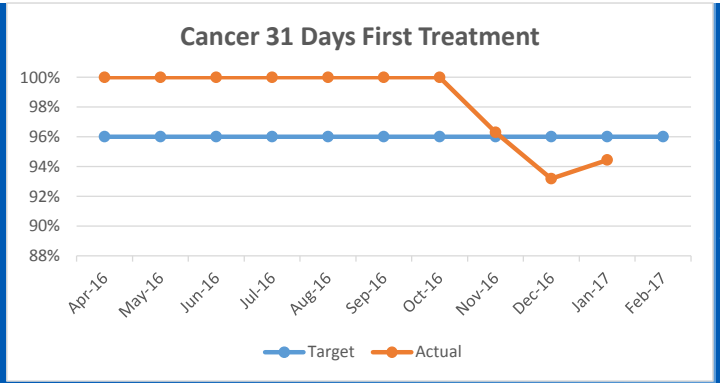
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The national target of 99% for Diagnostic waiting times has been achieved with actual performance at 100%. The Trust has also met the STP Improvement trajectory.		
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory.		The only specialities not to achieve the target are: • Urology – 86.69% • T&O – 83.93% There was one breach of 52+ week in General Surgery
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red				
A&E Waiting Times - National Target Red: Less than 95% Green: 95% or above	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust is not achieving the 95% national 4 hour target or the STP improvement trajectory.		January was another very challenging month for the Trust in relation to the four hour standard. We failed to meet the 95% standard and also missed the improvement trajectory of 90% achieving 85.85%. This moves the year to date position to 91.15%. The trust is being supported by the Emergency Care Improvement Program (ECIP) They identified four priority areas. B19 remains open as a winter pressures ward. We have closed the additional escalation ward Daresbury on the 3rd February which has added to the increased pressure, however it was necessary as this ward was unfunded and increasingly difficult to staff.
A&E Waiting Times - STP Trajectory Red: Less than trajectory Green: Trajectory or				

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

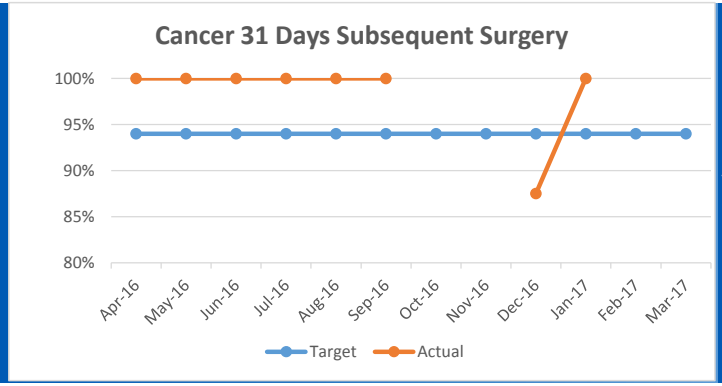
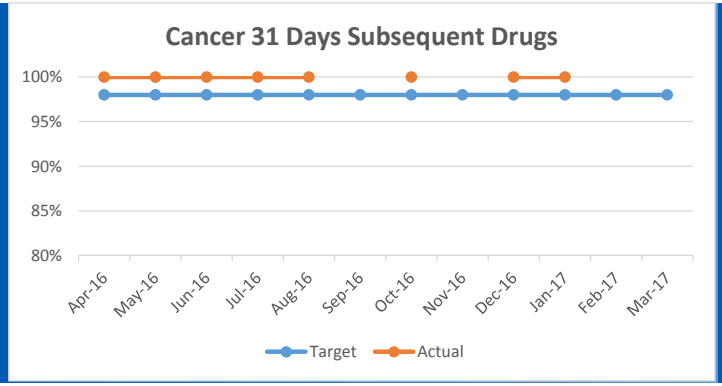
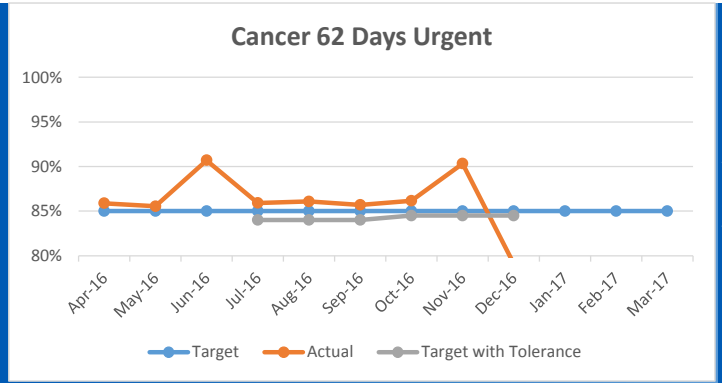
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.			The knock on effect of the 2 week screening has a direct impact on this target and as described below there were capacity issues in December which have affected the January targets. However, due to firm grip and process since this problem was identified there have been no breaches of the 2 week wait for capacity issues although patient choice does remain problematic. We are feeding this information to our CCG colleagues so they can send out comms to the GP's.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.			The 2 week breast symptomatic remains problematic with the November target slightly under the 93% in the main due to patient choice. This has been discussed with the Cancer Lead for the CCG regarding patients who defer appointments more than twice and about the message that the GP is giving the patient on referral. In November this was not a Trust capacity issue. However, it should be noted that the December and January targets for 2 week waits and breast symptomatic could be compromised due to a lack of available capacity in breast (radiology),although the teams are working very hard to address this.
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.			There were four patients that breached in December due to patient choice and capacity issues (1 cancelled due to no HDU), patient illness. Unable to put pause in for these reasons. The denominator is low for this target (usually approx115 but only 95 in December)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

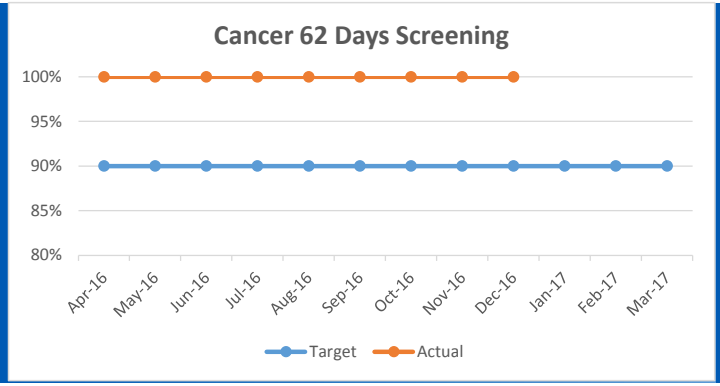
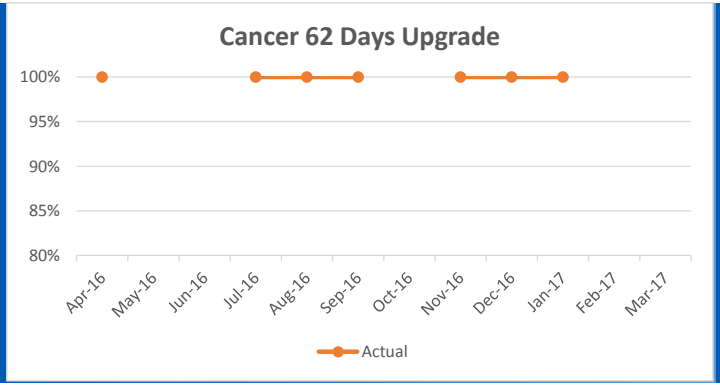
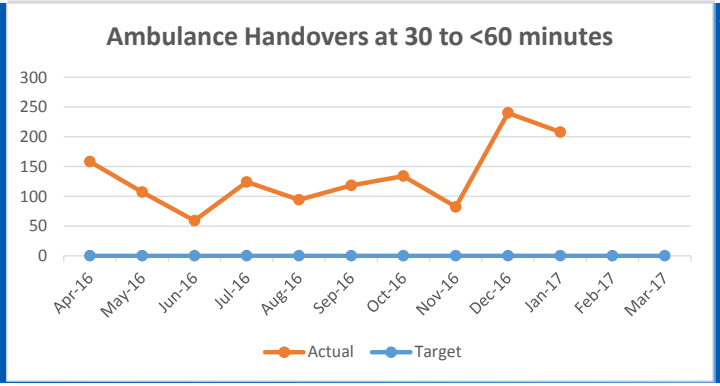
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.			There was one patient that has breached this target due to the low denominator (15 patients)
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.			No issues to note.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.			Although the December target was not met due to a mixture of capacity (Christmas Holidays), complex diagnostic pathways and Patient choice. However, the quarter was achieved.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

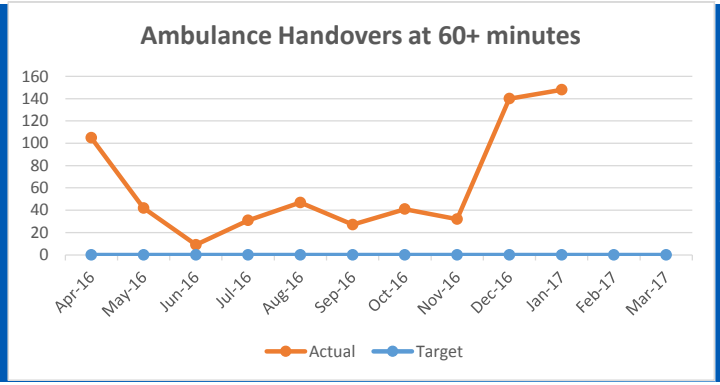
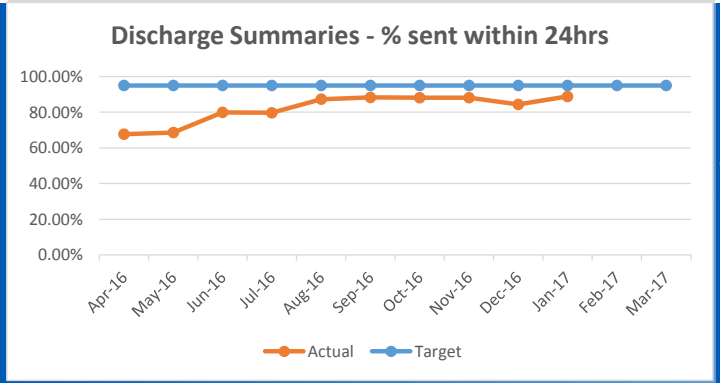
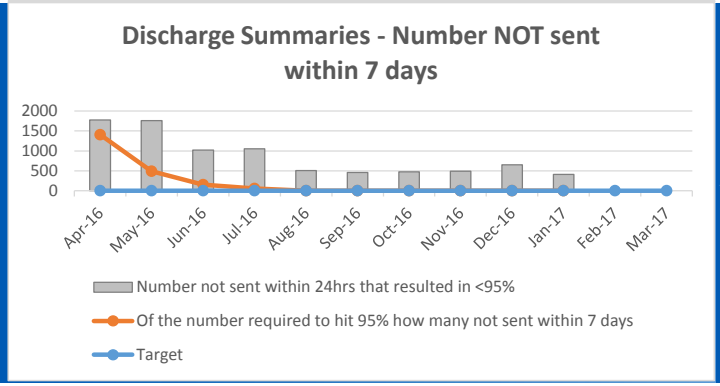
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis			No issues to note.
Cancer 62 Days Upgrade	62 day upgrade			No issues to note.
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system)			The increased pressure within the Trust has resulted in a number of ambulance handover delays. We continue to compare favourably compared to neighboring trusts however strive to improve the performance to ensure our patients are handed over safely and efficiently. This continues to be a key area of focus. A Service Improvement Team has been formed by NWAS and supported by ECIP to apply focus and identify and examine improvement opportunities; propose and implement improvement measures, and discuss ways of improving quality service, systems, processes and procedures in relation to handover delays

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

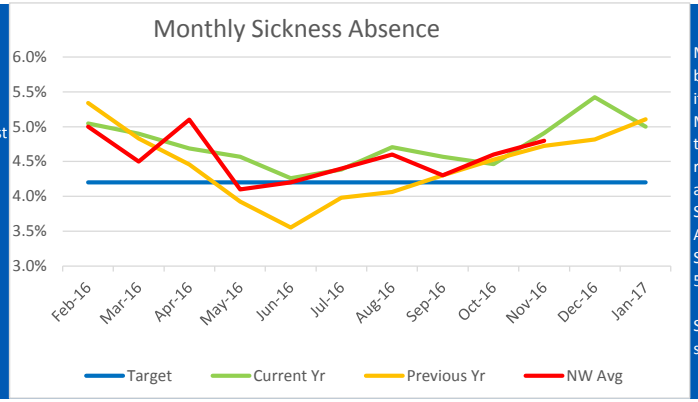
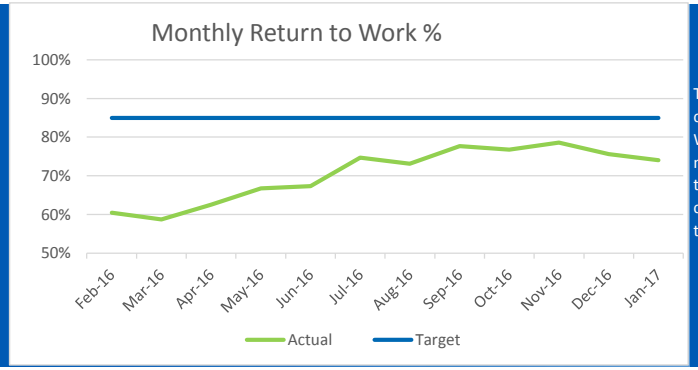
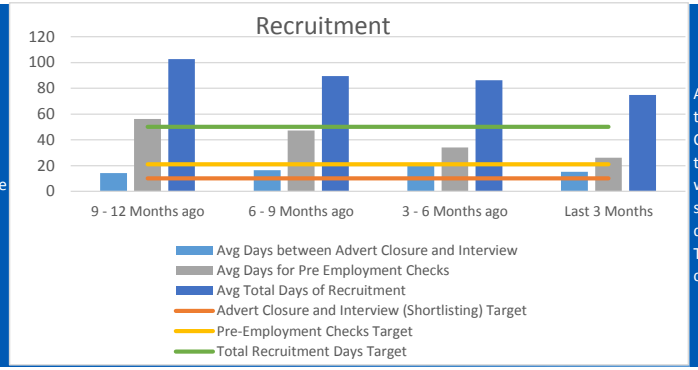
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system)			As above the deterioration in performance against this measure is related to flow. A new process is being tested to support improvement and ensure patients are handed over in a timely manner.
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge			The divsions continue to focus on this progress and a daily report is circulated and reported through COB. Improvements continue however still below target.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge			Again as above significant improvements have been seen.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

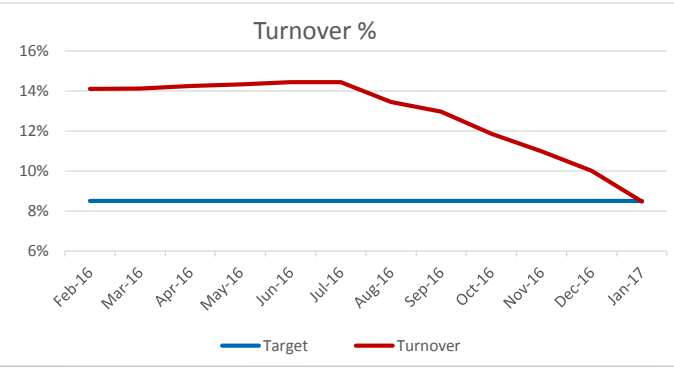
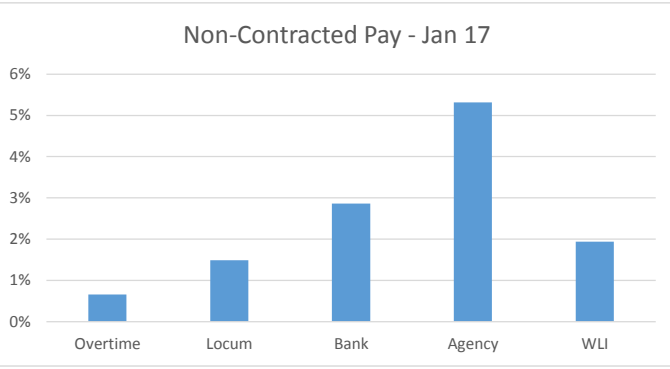
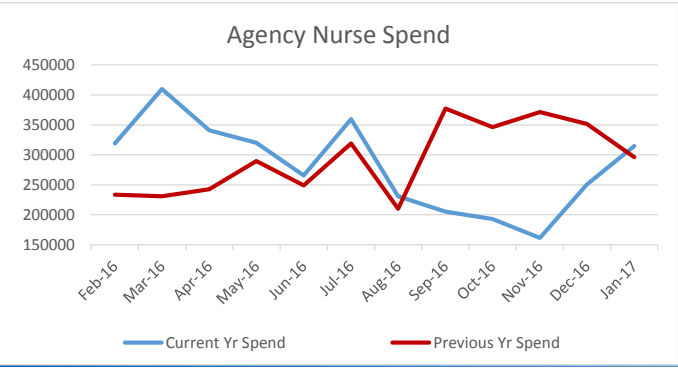
Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence for January 2017 improved and was 5% which was slightly better than the same month last year (5.11%). The latest figure(November) for the North West absence performance was 4.8% (WHH was 4.91%) The YTD sickness has increased marginally to 4.7% against a target of 4.2%		Managers are reminded each month about the need for absence being input in a timely manner. Historically, sickness absence is att its highest in the Winter months. The revised Attendance Management Policy was implemented on 1.12.16 but this will take time to have some impact. However, the number of sickness reviews has increased significantly.. WHH continues to be slightly above the North West Average. Sickness for the Divisions is as follows: ACS - Jan-17 = 4.82%, YTD = 4.84% SWC - Jan-17 = 5.01%, YTD = 4.87% Corporate - Jan -17 = 5.36%, YTD = 4.36% Stress remains the number one reason for absence with 24% of all sickness absence due to stress.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly Return to Work Interviews	RTW compliance slightly reduced to 74.06% for January against a target of 85%. However, this is still an improvement of 14% from 12 months ago. The YTD RTW rate remains the same at 73%.		The HRBPs are continuing to highlight the importance of the completion and recording of RTWs at Divisional meetings and at Ward/Departmental meetings. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. It is suspected that in respect of the clinical areas, the performance has dipped due to how busy the trust is.
Recruitment Red: Above Target Green: On or Below Target	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks	The average total days to recruit has marginally increased to 74.7 days against a target of 50 days. The position 9 - 12 months ago was 102.7 days.		All of the key stages in the recruitment process have improved over the last 3 months when compared to the position 9 - 12 months ago. One of the significant improvements is the average number of days taken to complete pre-employment checks. 9 - 12 months ago this was 56.1 days but within the last 3 months this has been significantly reduced to 26 days and much closer to the target of 21 days. There is unlikely to be much further improvement until investment can be made with other electronic systems.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

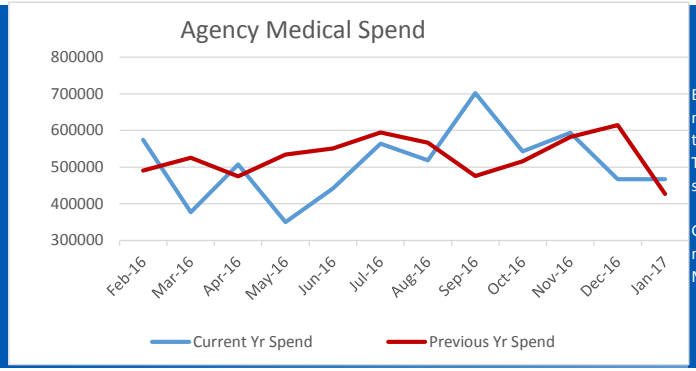
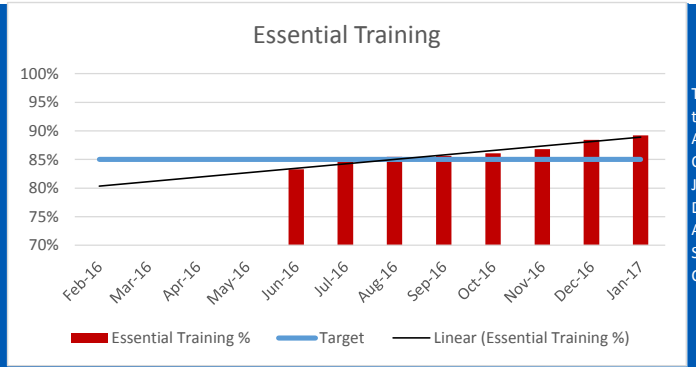
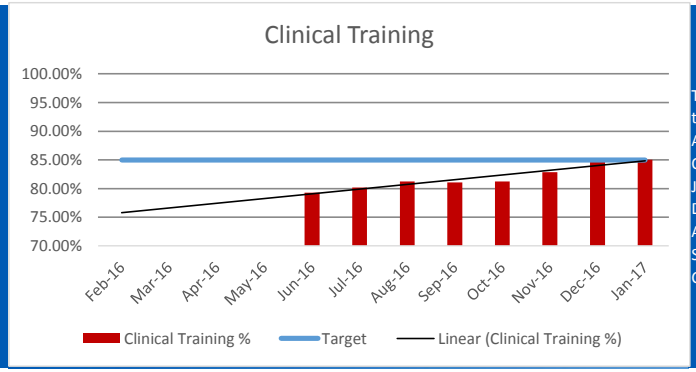
Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 12% Amber: 10% to 12% Green: Below 10%	A review of the turnover percentage over the last 12 months	Turnover has reduced again for the seventh consecutive month to 8.48% and is the lowest for over 12 months. The status remains as 'green' and the target of 7 - 10% is being met.		The various measures put in place such as exit interviews, on-boarding, improved induction, development opportunities, flexible working etc do seem to be having a positive impact on reducing labour turnover. The new Recruitment and Retention Plan for Nursing staff will continue with this good work. The trust continues to have more starters than leavers.
Non Contracted Pay	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Agency spend remains the highest element of Non-Contracted pay, accounting for 5.32% of the Trusts overall pay bill. Bank spend is 2.87% followed by WLI spend at 1.94% of the pay bill. Overall Non-Contracted pay now makes up 12.27%.		Work continues on implementing the action plan developed alongside E&Y with some degree of success. WLI payments as a proportionate of total spend are now under 2% for the first time. This reflects the reduction implemented in October 2016. More rigorous review and monitoring of Agency expenditure is now undertaken at FSC in response to NHSI letter on 'Strengthening financial performance & accountability in 2016/17'.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on Agency Nurses	Agency Nurse spend increased in January to £315k which was an increase of £64k from December and was higher than the same moth last year (£296k). Expenditure is less than in 2015/16 for the same period.		The effect of high sickness absence levels in some areas and increased clinical activity has led to an increase in agency expenditure in month. Vacancies also remain high but once the Recruitment and Retention Plan for Nursing is fully implemented, this should assist in reducing agency expenditure.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

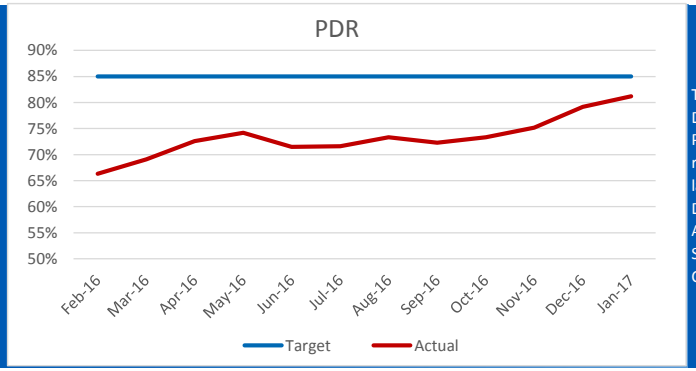
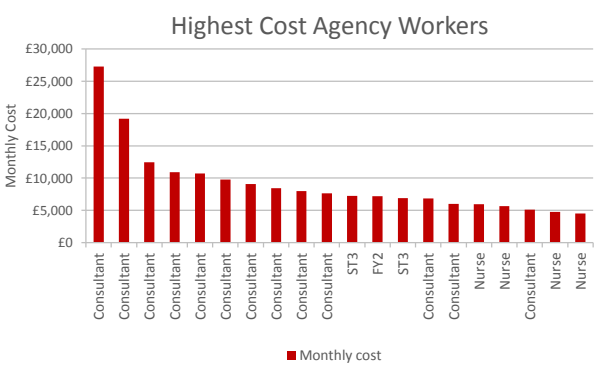
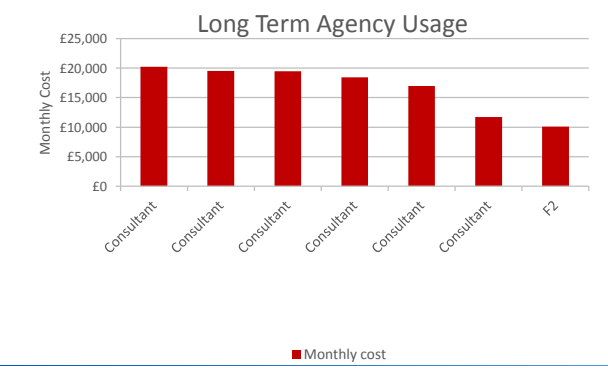
Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Locums	Agency Medical spend was almost identical to December at £467k and was more than the same month last year (£427k).		Enforcing the Price Cap rules is continuing to prove difficult and the majority of our shifts worked each week breach the Price Cap but these are necessary to maintain patient safety. There continues to be some progress in appointing new consultant staff but it will be some time before these can commence. Gatenby Sanderson have almost finalised their work on their microsite which links with NHS Jobs and this should go live in early March.
Essential Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Essential Mandatory Training Compliance, this includes: Corporate Induction Dementia Awareness, Fire Safety Health and Safety Moving and Handling	The upward trend continues for the seventh consecutive month and the current compliance for January is 89.19% which is above the trust target of 85%		The HRBPs are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Since June there has been an increase of almost 6%. Divisional progress is as follows: ACS January = 89.67% Green SWC January = 87.54% Green Corp January = 90.89% Green
Clinical Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Clinical Mandatory Training Compliance, this includes: Infection Control Resus Safeguarding Procedures (Adults) - Level 1 Safeguarding Procedures (Adults) - Level 2 Safeguarding Procedures (Children) - Level 1 Safeguarding Procedures (Children) - Level 2 Safeguarding Procedures (Children) - Level 3 SEMA	The upward trend continues for the fourth consecutive month and the current compliance for January is 85.05% which is above the trust target of 85% and for the first time is showing Green.		The HRBPs are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Since June there has been an increase of almost 6%. Divisional progress is as follows: ACS January = 84.75% Amber SWC January = 83.25% Amber Corp January = 89.5% Green

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

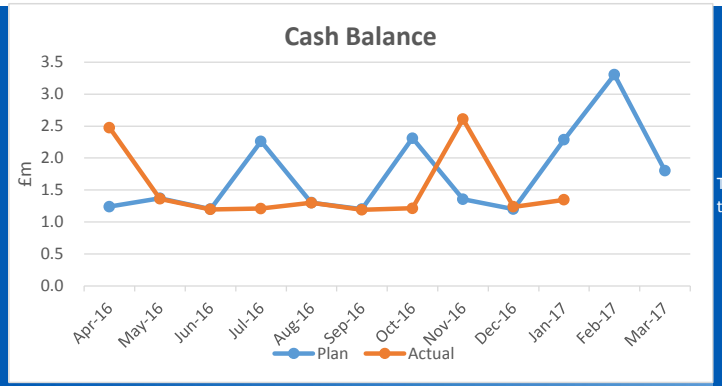
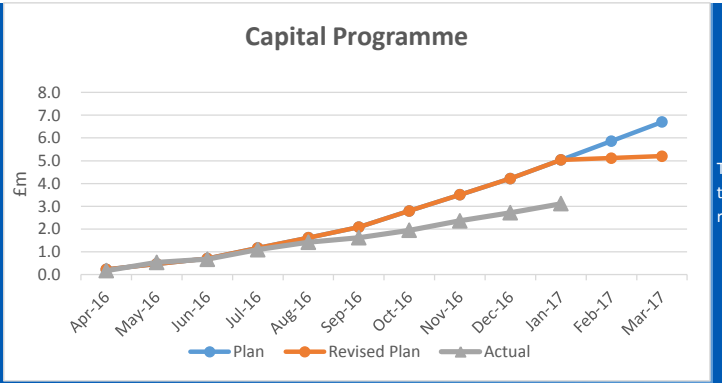
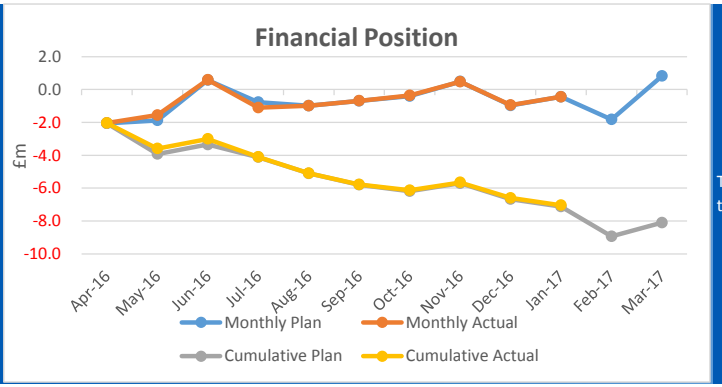
Workforce

	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	The upward trend continues for the fourth consecutive month and the current PDR compliance for January is 81.17% but this is still below the Trust target of 85%. This is the highest the trust has ever achieved and the first time the 80% barrier has been broken.		The HRBPs are continuing to highlight the importance of PDRs at Divisional meetings and at Ward/Departmental meetings. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Over the last 12 months PDRs have risen by almost 15%. Divisional progress is as follows: ACS January = 79.8% Amber SWC January = 77.85% Amber Corp January = 87.62% Green
Highest Cost Agency Workers	A summary of the Top 20 highest agency earners over the last 12 months	It is important to clarify what the table shows as systems are developed and refined (further work continues). The Trust uses TempRe for medical staff but has only done so since October 2016. For nursing staff the trust uses information supplied by NHSP and this covers the full 12 month period. The graph shows the average monthly cost of the top 20 agency earners but for medical staff this only covers 4 months.		16 of the highest earners are medical staff and 15 of these occupy the first the first 15 places. There are 4 nursing agency staff in the Top 20 Efforts are continuing with NHSP and medical agencies to try and reduce the rates for the remaining agency workers or to attract them onto the trust payroll.
Long Term Agency Usage	A summary of agency workers who have been working at the trust every month for over 6 months	It is important to clarify that at this stage the graph only shows medical agency workers who have been working at the trust for more than 6 months. Further work is being undertaken to try and capture other staff groups. The table shows that there are 7 agency doctors who have worked for the trust for over 6 months. The red columns show the average monthly cost for each doctor since commencement.		4 of the 7 medical staff are in Acute Care and the remaining 3 are in Surgery, Women's and Children's. In all cases they are covering vacancies and have fixed term contracts which are regularly reviewed dependent upon progress with the filling of substantive posts. In 2 of the cases the agency staff are employed through Staff Flow to ensure the trust receives better value for money. Efforts continue to try and persuade these doctors to work directly for the trust.

Varrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

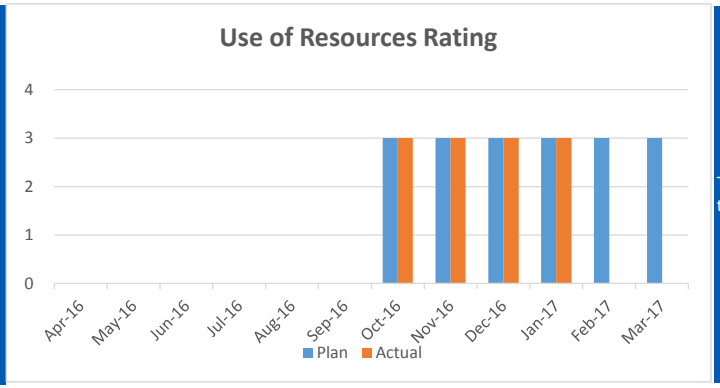
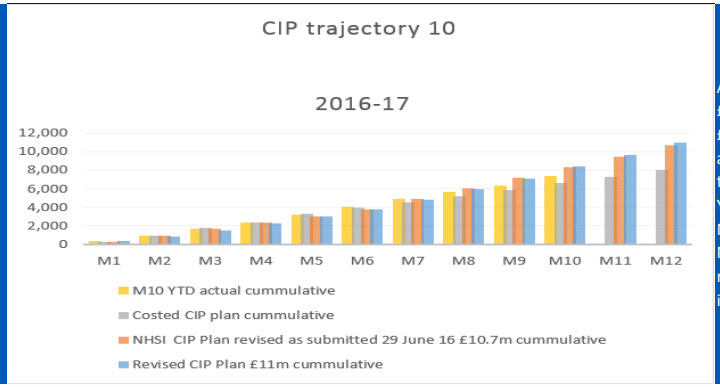
Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	Cash balance at month end compared to plan	Under the terms and conditions of the working capital facility the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.3m equates to circa 2 days operational cash.		The current cash balance of £1.3m is £1.0m less than the planned cash balance of £2.3m.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Year to date capital expenditure compared to plan	The actual capital spend in the month is £0.4m which increases the year to date spend to £3.1m.		The cumulative capital spend of £3.1m is £1.9m below the planned spend of £5.0m. The capital plan has been reduced.
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	Year to date surplus or deficit compared to plan.	The actual deficit in the month is £0.4m which increases the cumulative deficit to £7.0m.		The cumulative deficit of £7.0m is £0.1m better than the planned deficit of £7.1m.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

Safely Reducing Costs & Mandatory Standards - Finance

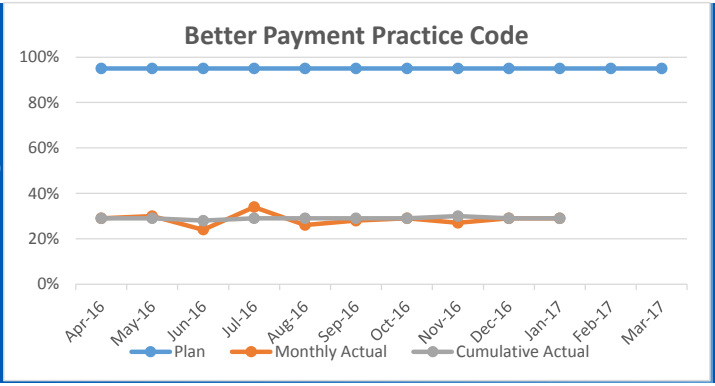
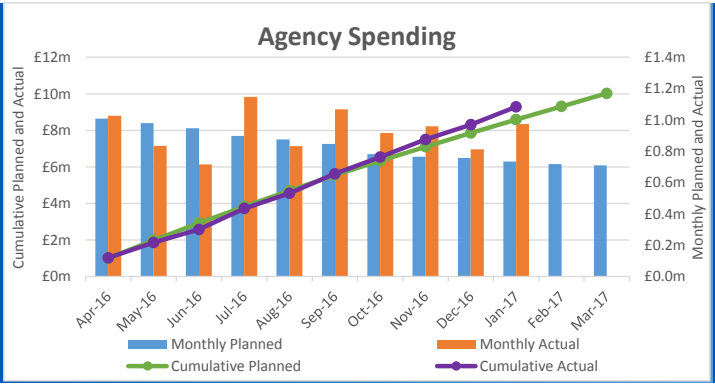
	Description	Aggregate Position	Trend	Variation
Use of Resources Rating Red: Use of Resources Rating 4 Amber: Use of Resources Rating 3 Green: Use of Resources Rating 1 and 2	Year to date Use of Resources Rating compared to plan	The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity and I&E margin are all scored at 4 (lowest), agency ceiling is scored at 2 and Variance from plan is scored at 1 (highest).		The current Use of Resources Rating of 3 is in line with the planned rating of 3.
Cost Improvement Programme - Plans in Progress Red: Plan is less than 50% of annual plan Amber: Plan is between 51% and 89% of annual plan Green: Plan is over 90% of annual plan	Planned improvements in productivity and efficiency.	The Trust has a CIP target of £11m and delivery of £10.7m is currently assumed in the reforcecast financial plan. To date the Trust has developed schemes worth £8.0m in year (£8.3m recurrently).		The value of the in year planned savings is £8.0m which is £2.7m below the annual target uncluded in the reforecast annual plan.
Cost Improvement Programme - Performance to date Red: Cumulative savings less than 90% of planned savings Amber: Cumulative savings between 90% and 100% of planned savings Green: On or above plan	Year to date savings delivered compared to plan.	At the end of M10 2016/17 YTD CIP delivered is £7.359m (88%) of planned savings £8.335m. £1.782m YTD in cost avoidance/income recovery has also been delivered, taking total impact on bottom line to £9.141m. In M10 £1.006m CIP and £0.313m cost avoidance and income recovery was delivered (£1.319m total) against an in month CIP plan of £1.156m.		At the end of M10 2016/17 YTD CIP delivered is £7.359m (88%) of planned savings £8.335m. YTD CIP is £0.976m behind plan. However, £1.782m YTD in cost avoidance/income recovery has also been delivered, taking total impact on bottom line to £9.141m. Note: YTD delivery is higher than the £7.083m reported to NHSI, as the draft position was used in NHSI reporting. NHSI have been informed of the difference and a refined process agreed to ensure this does not occur in the future.

Clinical Business Units / Corporate Support area	CIP Internal Target £11m	CIP costed PYE	CIP costed FYE	% of £11m target costed PYE
	£000s	£000s	£000s	%
Surgery and Women's and Children's	4,161	2,158	2,516	52%
Acute Care Services	4,516	3,540	3,704	78%
Schemes not allocated to CBUs	0	484	474	-
Controls	277	0	0	0%
Outpatients	121	121	182	100%
Corporate support areas	1,925	1,745	1,397	91%
Total Trust	11,000	8,048	8,273	73%

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - January 17

Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 29% of suppliers within 30 days which results in a year to date performance of 29%.		The cumulative performance of 29% is 66% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Year to date agency spend compared to agency ceiling	The actual agency spend in the month is £1.0m which increases the year to date spend to £9.3m.		The cumulative agency spend of £9.3m is £0.7m above the year to date agency ceiling of £8.6m.

Trust Engagement Dashboard Summary: January 2017

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Media dashboard:

A mixed month in the media during January, with sentiment overall more positive than negative. Key positive stories focused on patient experience stories with the car parking changes receiving very balanced reporting and very few comments.

Negative reporting focused unsurprisingly on winter pressures which was reflected nationally. There was also some negative reporting which was linked to incorrect speculation about the future of Halton hospital following temporary relocation of surgical day case unit as is usual practice in winter.

Social Media:

Twitter engagement continues to grow with followers exceeding 8K. In month Tweets and reach were slightly down on the previous month however engagement remained as expected for January. Top Tweets related to Dry January progress, our car parking changes and WHH Charity.

Facebook reach increased considerably in month with multiple posts generating interest – top post engagement related to our car parking changes followed by engagement around our public health campaigning.

Website whh.nhs.uk

Website statistics showed significant increases in month, with a large spike in social media referrals directly linked to click-throughs from our Facebook and Twitter feeds relating to our car parking changes.

Mobile phones continued to be the largest source of visits with over 50% of visitors arriving this way – which correlates with high interaction with social media on these devices. The Trust is planning to upgrade its website in the Spring as the current template is unsuitable for mobile/tablet use.

Patient Experience

In month NHS Choices scoring for Warrington fell by half a star to 3-star with Halton and CMTC remaining 5*. We know that patients rate Warrington significantly higher than this however few rate the Trust on NHS Choices with scoring based on 1-2 reviews per month. We plan to encourage greater use of NHS Choices by campaigning on our website using a home page banner 'Tell Us'.

Staff Engagement

Staff interaction with the extranet continues to grow with >3,000 staff now registered which is 75% of the workforce. Development of this platform continues at pace. Staff FFT for Q2 fell very slightly over Q1 but there continues to be promising engagement with Team Briefings. The NHS Staff Survey for 2016 will be published in April 2017.

We are WHH

Media Dashboard 1-31 January 2017

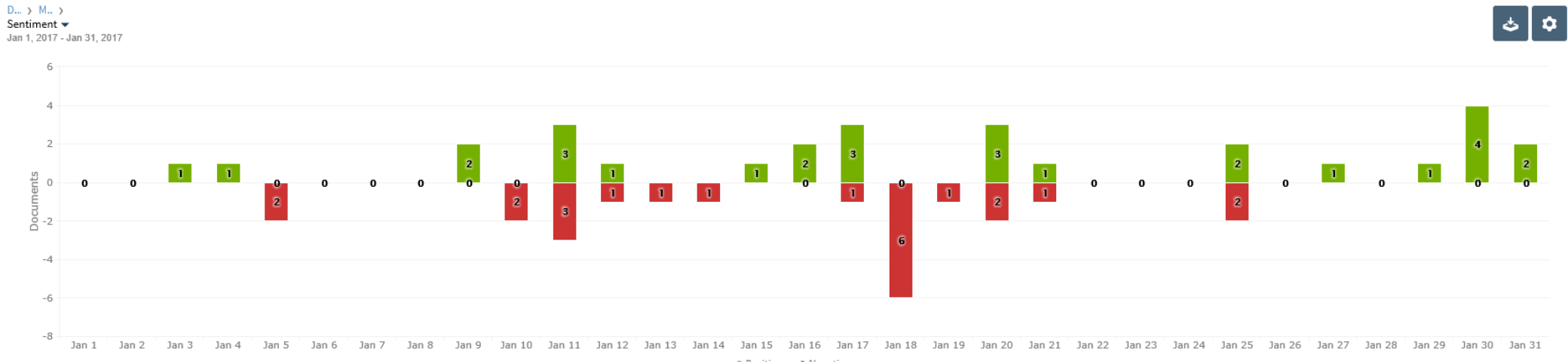
Warrington and Hal	
Volume Trend	120
Reach Trend	41.5 M
AVE Trend	$384,132

Total media coverage = 120 Reports (↑from 97 last month)

Warrington and Halton Hospitals

Top 10 Publications by Reach

13.9 M	Inside Government -
13. M	Express.co.uk
6.9 M	Liverpool Echo (eClip
4.6 M	Liverpool Echo
1.5 M	Warrington Guardian
905,992	Warrington Guardian
176,636	InsideHalton.com
134,963	Runcorn and Widnes
95,268	Runcorn and Widnes
74,055	Insider Media Limited



We are WHH

1-31 January 2017

Warrington Guardian

NEWS

Pub regulars raise more than 400 for hospital's dementia ward

Warrington Hospital doctor Ahmed Farag teaches secrets of a healthy heart to Chapelford Village Primary School pupils

Warrington Hospital doctor Ahmed Farag has teaching Chapelford Village Primary School pupils how to keep their hearts healthy.

LIVERPOOL ECHO .co.uk

Overhaul of parking charges at Halton and Warrington hospitals

Short-stay rate cut by 16%, sliding scale and concessions for patients on treatment courses and visitors introduced

By Oliver Clay

30 Jan 2017 13:18:15

Headline	Source	Reach	Sentimer
Family of young cancer sufferer say Steven Gerrard visit was a wonderful surprise	Liverpool Echo	1158321	Positive
Overhaul of parking charges at Halton and	Liverpool Echo	1081600	Positive
Everything you need to know about changes to parking charges at Warrington Hospital	Warrington Guardian	45329	Positive
Lower Angel regulars raise more than £400 for Warrington Hospital's Forget Me Not ward	Warrington Guardian	45329	Positive
Warrington Hospital's patient visiting times	Warrington Guardian	45329	Positive
Warrington Hospital doctor Ahmed Farag teaches secrets of a healthy heart to Chapelford Village	Warrington Guardian	45329	Positive
Meet Warrington Hospital's first newborn babies	Warrington Guardian	45329	Positive
Changes to parking charges at Halton and	Runcorn and Widnes World	7939	Positive
Have a say on proposed hospital changes	Runcorn and Widnes World	7939	Positive
Praise for Halton Hospital's day case unit	Runcorn and Widnes World	7939	Positive
Widnes' urgent care centre treated 45,528	Runcorn and Widnes World	7939	Positive
Halton and Warrington Hospital visiting times	Runcorn and Widnes World	7939	Positive
First class care at hospital	Runcorn and Widnes World	7939	Positive

Headline	Source	Reach	Sentimer
Halton MP discovers more than 40,000 hospital beds blocked by care shortfall	Liverpool Echo (eClips Web)	1158321	Negative
More than 14,000 patients waited over four hours for treatment in Warrington Hospital's A&E last year	Warrington Guardian	45329	Negative
Warrington Hospital's A&E department placed on OPEL 3 'red' alert for four-day period of first week in 2017	Warrington Guardian	45329	Negative
Council tax increase 'will not bridge gap' in social care funding – leader slams ministers	Warrington Guardian	45329	Negative
Halton Hospital's surgical day unit shut in bid to ease shortage of beds at Warrington Hospital	Warrington Guardian	45329	Negative
Warrington Borough Council's executive board expected to oppose £909m health cuts that could see Warrington Hospital's A&E opening times reduced	Warrington Guardian	45329	Negative
One in five cancer patients in Warrington wait more than two months for treatment following diagnosis	Warrington Guardian	45329	Negative
17 questions we need an answer to in Warrington in 2017	Warrington Guardian	45329	Negative
'Halton Hospital to shut within two years'	Runcorn and Widnes World	7939	Negative
Staff fear Halton Hospital ward closure is permanent	Runcorn and Widnes World	7939	Negative

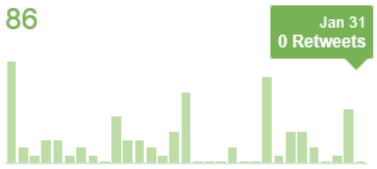
Link clicks
82

On average, you earned **3 link clicks** per day

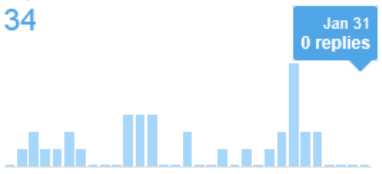
Likes
136

On average, you earned **4 likes** per day

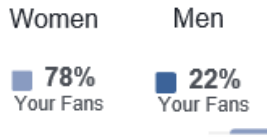
Retweets
86

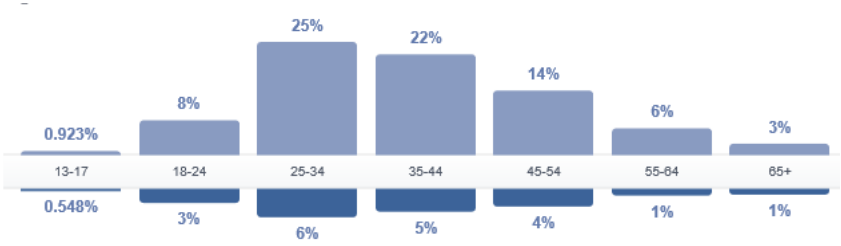


Replies
34



The people who like your Page





Facebook

Twitter

Tweets | Top Tweets | Tweets and replies | Promoted

Warrington&HaltonNHS @WHHNHS · Jan 31
Woo hoo! Congratulations you have completed **#DryJanuary** pic.twitter.com/bdQipvXITV
View Tweet activity

Warrington&HaltonNHS @WHHNHS · Jan 30
We are changing our car parking prices and concessions today, find out more here: - whh.nhs.uk/page.asp?fldAr… pic.twitter.com/2ozXN8lxTU
View Tweet activity

Warrington&HaltonNHS @WHHNHS · Jan 29
Almost there.. **#DryJanuary** pic.twitter.com/cahiJ05MXS
View Tweet activity

Warrington&HaltonNHS @WHHNHS · Jan 27
Find out about some of the fab events that our dedicated **@whhcharity** has lined up this year by following the link: ow.ly/dJyn308boJL
View Tweet activity

Warrington&HaltonNHS @WHHNHS · Jan 26
Even your bank account should be feeling healthier after all these booze free weekends! **#DryJanuary**
View Tweet activity

Published	Post	Type	Targeting	Reach
30/01/2017 09:43	We are changing our car parking prices and concessions today, fi			4.5K
26/01/2017 09:52	Warrington and Halton Hospitals NHS Foundation Trust shared W			64
26/01/2017 09:51	Warrington and Halton Hospitals NHS Foundation Trust shared W			404
24/01/2017 16:26	Huge thanks to the regulars at th e Lower Angel Pub on Buttermar			1.4K
20/01/2017 14:01	Warrington and Halton Hospitals NHS Foundation Trust shared W			1.1K
16/01/2017 15:54	Warrington and Halton Hospitals NHS Foundation Trust shared W			88
16/01/2017 10:30	WHH Cardiologist Dr Ahmed Far ag recently visited the Santa Ro			1.4K
16/01/2017 07:10	Please remember that WHH is a smoke free zone, this means do			1.3K
13/01/2017 09:43	How's your New Year's Resoluti ons going? Need support to Sto			1.5K

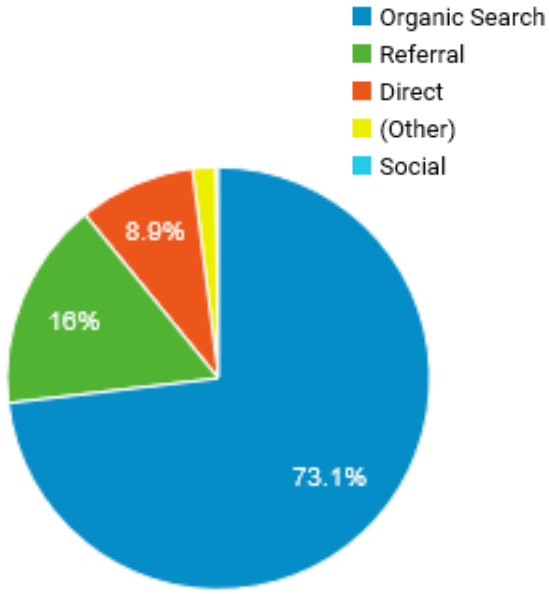
Website

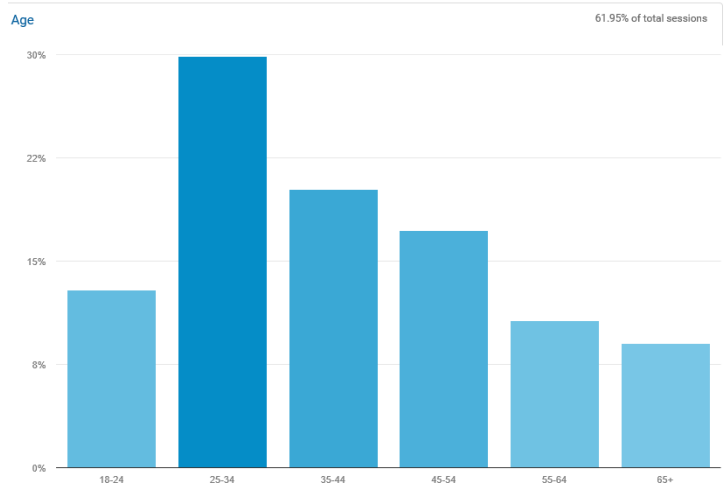
WHH

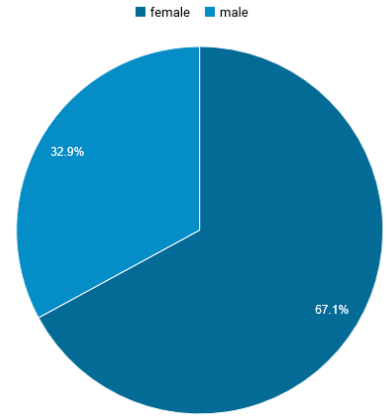
24,601
Visits
Last month: 18,146

928
Social Media Referrals
Last month: 56

1min 25s
Length of average time
Last month: 1.21s







		Acquisition		
		Sessions	% New Sessions	New Users
1. mobile	**10,958** (49.96%)			
2. desktop	**7,963** (36.31%)	13,969 % of Total: 63.69% (21,932)	59.52% Avg for View: 65.11% (-8.60%)	8,314 % of Total: 58.22% (14,281)
3. tablet	**3,011** (13.73%)			
1. Apple iPhone		**6,112** (43.75%)	61.19%	3,740 (44.98%)
2. Apple iPad		**2,214** (15.85%)	59.94%	1,327 (15.96%)
3. Samsung SM-G920F Galaxy S6		**542** (3.88%)	54.80%	297 (3.57%)

Country	Acquisition Sessions
	18,146 % of Total: 100.00% (18,146)
1. United Kingdom	**16,869** (92.96%)
2. United States	**269** (1.48%)
3. (not set)	**254** (1.40%)
4. Russia	**125** (0.69%)
5. India	**75** (0.41%)
6. Ireland	**36** (0.20%)
7. Malaysia	**35** (0.19%)
8. Australia	**32** (0.18%)
9. Canada	**30** (0.17%)
10. Germany	**26** (0.14%)

Patient Engagement

NHS Choices

4
No. of comments posted
Last month: 10

100%
No. of comments responded to within five working days
Last month: 100%

Halton – 5 stars
CMTC - 5 stars
Warr – 3 stars

Warrington and Halton Hospitals NHS Foundation Trust

Date: 01 January - 31 January

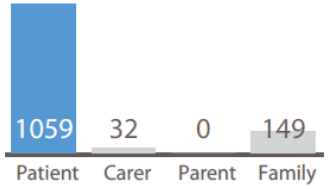
Your average score for all questions this period: 4.82

Reviews this period: 1482

Your recommend scores

5 Star Score	% Likely to recommend	% Unlikely to recommend
4.81	95.7%	0.9%

Reviews by reviewer type



Demographics completion rate

Question	Blanks	% Completed
Age	33	97.67
Gender	151	89.35
Ethnicity	146	89.70
Long-term Conditions	291	79.48
Reviewer type	44	96.57

Top three services (with 5 reviews or more)

Catheter Lab Warrington	5.00
Intensive Care Unit	5.00
Ante Natal Day Unit	5.00

Bottom three services (with 5 reviews or more)

Ward A3	4.39
Clinical Decisions Unit	4.35
Ward A8	4.28

NHS Choices
↑ Increase in comments in month by 4
→ Star Ratings remains unchanged in month

Friends and Family Test (Adult services)

↓ Responses decreased by 331 in month
↑ Star rating increased by 0.06 in month
↑ % likely to recommend increased by 1.1%
↓ % unlikely to recommend decreased by 0.5%

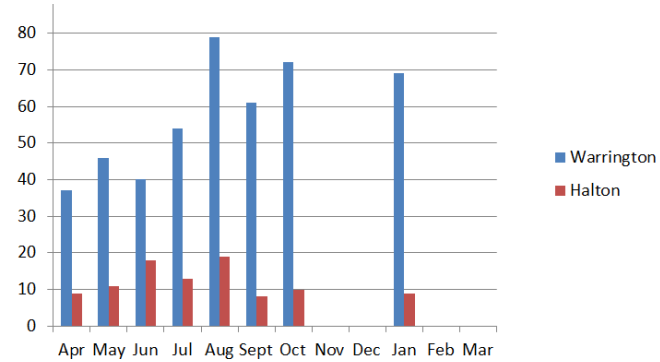
Staff Engagement

WHH new Extranet engagement:

↑ 3135 2504 staff registered on the new extranet since launch 24.2.16 (increase in quarter of 631 new registrants)
→ Most viewed workspaces: Staff Wi-Fi 1079, e-learning Login Details Request, Employee and team of the month nomination form, Staff lottery

Team Brief Attendances

We remain encouraged by the engagement with Team Brief which is a proven large, multi-site Organisation engagement tool.



❑ Staff nominating colleagues for :

↑Employee of Month = 1 (focus on Thank You Awards)
↑ Team of Month = 6 (decrease of4 in month focus on Thank You Awards)

Annual Data:

❑ NHS Staff Survey 2015 – Engagement score 3.74 (worse than similar Trusts)
❑ 2016 survey published April 2017

Quarterly Data

❑ Q2 Staff FFT

- **Staff FFT Recommend for Care / treatment**
  ↑ 70% extremely likely or likely (Q1 72%)
- **Staff FFT Recommend as Place of Work**
  ↑ 56% extremely likely or likely (Q1 66%)

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 17/02/20**	
SUBJECT:	**Key Issues Report from the Quality Committee**	
DATE OF MEETING:	28th February 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Margaret Bamforth, Committee Chair	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	BAF2.2: Nurse Staffing	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the February 2017 meeting.	
RECOMMENDATION:	**The Board note the report and the matters identified for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT - QUALITY COMMITTEE

Date of meeting:	**7th February 2017**
Standing Agenda Items	The Quality Dashboard Corporate Risk Register
Formal Business	The Complaints and Concerns Policy was received and reviewed. Ursula Martin, Deputy Director of Integrated Governance and Quality then presented the review of the complaints process and action plan. A number of areas had been reviewed and these included, best practice, staffing structure, local resolution, resolving of complaints, training, data quality and performance. The review identified 139 complaints that are outside the regulation timescale of 6 months. Other issues identified included a lack of training for handling complaints and a need to strengthen the complaints process. A full and detailed action plan is in place to manage this backlog and to address the objectives identified. A follow-up audit is due to be carried out by MIAA and the Quality Committee will receive an update on the action plan in March and monthly thereafter. The current position regarding complaints handling has been identified as a risk and will be added to the risk register. **The Committee has escalated the Complaints Review to the Board**. Jason DaCosta, Director of IM&T briefed the Committee on the current position regarding the Lorenzo issue which has led to outpatient letters not printing. This in turn led to patients not receiving their out-patient appointment letters. This was not a local issue and other Trusts had raised an alert. A report was presented which addressed the following actions and questions. • Identify all patients who had not received a printed letter • Check deceased status • Had a manual letter been printed subsequently • Did the patient DNA • Does the patient have an open or closed referral • Does the patient have any future appointments/activity • Has a DNA letter been sent The Committee was presented with a Flow Chart that showed that of the 6,972 letters that were not sent, none of the patients were deceased and 4,104 had received a subsequent appointment. Of the 2,749 that had no future activity, 1,231 were new appointments and 1,518 were follow-ups. Further action has been taken to identify if these have had DNA letters and been closed. There remain 207 cases identified for further review and these will be risk stratified. Where pathways have to be reopened there is a risk of the Trust being in breach of the 18 week and 52 week trajectories

	and the **Committee have advised that this issue be added to the Risk Register and that it should be escalated to the Board.** Simon Constable, Medical Director, updated the Committee on the Mortality Screening Review. There is currently a backlog of 690 screening reviews across the Trust. The backlog accumulated over the Summer due to a number of reasons. The reviews have been assessed using a set of criteria to identify those that are high risk, for example, an unexpected death. There is a plan in place to review the 87 deaths that have been identified. The Committee approved this proposal. An update and position statement will be presented to the March Quality Committee. Kimberley Salmon-Jamieson, Chief Nurse, presented the Safeguarding Review. While the review recognised that there is good practice a number of areas that required improvement were identified. These included, training, especially level 3, urgent analysis of chemical restraint, restraint and bedrails, and the implementation of the CPIS Policy. The report also recommended a restructuring of the Safeguarding Teams into a single provision with clear lines of accountability to the Board and strengthened governance arrangements. Other recommendations were that a safeguarding strategy should be developed, there should be improved care for people with learning disabilities and everyday safeguarding practice should be enhanced. The safeguarding leads have developed an action plan to implement the recommendations and this will be monitored through the Quality Committee bi-monthly. **The Safeguarding Review is to be escalated to the Board.** Ursula Martin, briefed the Committee on the key points from the report on the Strategic Risk Register and Board Assurance Framework. A review has been undertaken of the Risk Management Strategy and the proposal is to align the Strategic Risk Register with the Board Assurance Framework. The Committee agreed to escalate to the Board the concern that the current risks may not reflect the actual risks. The role of the Quality Committee, as the overarching Committee responsible for risk, will be developed following the presentation in February to the Board of the Board Assurance Framework. Deborah Hatton, Lead Nurse Specialty Medicine, presented the Dementia Strategy. The support to patients suffering form dementia is an area of good practice within the Trust and the strategy aims to build on the existing practice and develop the care provided throughout the Trust by focussing on a number of key priority areas.

	• Governance arrangements • Comprehensive assessment • Improving the experience of people with dementia • Dementia training • Information and communication • Hospital admissions, transfers and discharges The Patient Experience Strategy is in development following a successful Patient Experience Strategy Day. This was attended by clinical and non-clinical colleagues and a number of areas were identified which will be taken forward. The Deputy Chief Nurse will be leading on this initiative. High Level Briefing paper received: • Event Planning Group • Medicines and Governance Sub Committee • Health and Safety Sub Committee • Infection Control Sub Committee
Local Policies and Guidance Approved:	Complaints and Concerns Strategy Hospital Catering Policy Management of Taxi Policy Business Continuity Plan (Chair's approval following amendments) Lock Down Policy
Any Learning and Improvement identified from within the meeting:	None.
Any other relevant items the Committee wishes to escalate?	None.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 17/02/20**	
SUBJECT:	**Key Issues Report from the Finance and Sustainability Committee held 22 February 2017**	
DATE OF MEETING:	28 February 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, Committee Chairr	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF3.3: Clinical & Business Information Systems	
	BAF1.3: National & Local Mandatory, Operational Targets	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the February 2017 meeting.	
RECOMMENDATION:	**The Board note the report and the matters identified for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT - FINANCE and SUSTAINABILITY COMMITTEE

Date of meeting:	**22 February 2017**
Standing Agenda Items	The Meeting was quorate albeit there were a number of apologies from Members of the Exec team. The Minutes of the Meeting of 18 January were accepted as a correct record.
Formal Business	The Medical Director and Chief Nurse presented the Pay Assurance Dashboard as at January 2017, in the absence of the Director of HR & OD. This indicated that the upward trend shown in the December 2016 Dashboard has continued into January. Benchmarking data has not been updated for January. The distance between the actual Agency Spend and the Cap has accelerated to £700k at the end of January. The trajectory for medical staff continues to show an upward trend for both breaches and expenditure which is clearly as concern albeit that the overwhelming reason is directly related to vacancies. The Medical Bank establishes in March; it is expected progress will then start to emerge. ICIC is responsible for the oversight of top earning locums. The trajectory for nursing has been more positive though December and January has seen a marked increase in expenditure, coupled with an increase in the number of breaches. Winter pressures are the root cause. A new Nursing Recruitment and Retention Plan is being rolled out which will be reviewed by SPC as part of its review of Recruitment and Vacancy position management assurance. It should be understood that the bulk of the challenges remain in Urgent and Emergency Care and Specialist Medicine. The expected co-ordinated approach across a wider footprint to control expenditure has just not happened in the dash to fill places. Trust Board might wish to consider the need to represent our position with NHSI. FSC reviewed the NHSI Board Self – Certification Checklist – Agency Spend on behalf of the Board. Whilst this is early days in the Committee oversight of Pay, the Committee stressed that the necessary grip and control will be vital in the achievement of the Trusts 2017/18 Savings Plan. The Finance Report for Month 10 was received. In January, a loss of £0.4m was incurred which was on plan. The year to date loss of £7.0m is £0.1m better than plan. It has been necessary for inpatient activity in the Month to be estimated due to the lack of data. A methodology concerning this was detailed to FSC. Capital expenditure to date is £3.1m some £1.9m behind plan (see later). The funds behind the recently approved loan of £600k have now been received but Cash remains tight and the safety valve of our working capital loan has now been removed.

	The impact of the Junior Doctors Contract has been forecast at circa £21k in 2016/17 and once rotas have been completed the 2017/18 pressure can be calculated. The impact of the Apprentice Levy has been assumed in our 2017/18 plans. NHSI has recommended that the Trust consider an alternative valuation method in respect of our Estate and discussions are being held with our (new) external Auditors in this respect. The Capital Programme for 2016/17 has been revised to reflect a reduction of £1.5m to £5.2m. Initial proposals in respect of the Capital Programme 2017/18 were presented. Depreciation for 2017/18 is estimated at £5.5m and together with a carry forward of £0.5m from the current years Programme, resulting in the sum of £6.0m being proposed. there is no prospect of a Capital based loan. Details of the allocations were noted and the final Plan will be presented to both FSC and Trust Board in March for formal approval. Some concern was expressed around restrictions for Medical Equipment; additionally as yet there is no STP focus around Capex. In respect of CIP at 31 January CIP delivered is £7.359m against plan of £8.335m, a shortfall of £0.976m behind plan. However, ytd £1.782m has been delivered in cost avoidance/income recovery taking total impact on bottom line to £9.141m. Whilst the position remains extremely challenging, progress is significant. Full year CIP forecast was updated alongside a further update on the mitigations proposed and in place around the identified risk to the achievement of our 2016/17 Control Total of £3m. FSC received details of the CIP target setting for 2017/18 against the target already committed to NHSI of £10.5m. Proposals have been considered by ICIC on two occasions. It should be noted that there is a significant shift in emphasis in the plans which are far more transformational, involving cost removal. Next steps were considered noting the intention to review joint opportunities with Commissioners. The Deputy Chief Operating Officer presented the Corporate Performance Report for January. December 2016 challenges have continued into the new year. Against the NHSI Trajectory, the A&E four hour performance for the month was 85.85% taking the ytd performance to 91.15%. Pressure on the department has clearly spilt over into a worsening performance in respect of Ambulance handover delays. We continue to receive support from the ECIP concentrating on the agreed 4 priority areas. B19 remains open as a winter pressure ward; however the additional escalation ward Daresbury was closed on 3 February as it was unfunded and difficult to staff. There has been an increase in GP referrals & various actions are in place to try to manage this. NWAS have their own improvement plan in place supported by ECIP to apply

	focus and to examine improvement opportunities. Given we continue to receive diverted ambulances, which are not always obvious, FSC considered that there could be merit in seeking to identify the scale of this via NWAS, who it is understood do not collect such data. This detail could well be used to support our discussions with our own Regulator. The Trust continues to perform well in relation to RTT – 18weeks with exceptions in relation to T&O and Urology. As winter pressures have continued, there will be increased pressure on RTT following the difficulties in raising elective activity from the NHSI national instruction. There have been disappointing deterioration in two key cancer targets in January, namely 2 week wait and breast symptom 2 week wait. This has been primarily due to capacity rather than patient choice. The necessary improvement plan is in place and the Deputy COO is confident that we will now be back on trajectory. In respect of the 31 & 62 day cancer targets, there might be more of a capacity issue and accordingly, an Action Plan will be put forward via Quality Committee. The Chair highlighted to the Committee the elements of the Q4 Sustainability and Transformation Fund that relied upon Corporate Performance rather than Financial Performance. FSC received a comprehensive update on IM&T activities including the work undertaken around Lorenzo Benefits realisation with NHS Digital. Whilst not wishing to duplicate this work, FSC requested that a reporting mechanism be agreed between Finance and IM&T, so that progress can be monitored by F&SC in the realisation of benefits (or otherwise) especially as these will accrue over an extended period of time. Confirmation was provided that in respect of the proposed IM&T Capital allocation for 2017/18, there is nothing available for the Warrington Care Record. A very detailed update was received in respect of the Letters not printing Correction Process showing that the action plan put in place has indicated that the scale of the potential challenge has been reduced to more modest proportions. The action plan is now nearing conclusion. This has proved to be a Lorenzo wide issue subject to a Lorenzo user wide “Alert” An e-Rostering Presentation was deferred to the March Meeting. A number of Sub Committee Minutes were received and noted by FSC.
Local Policies and Guidance Approved:	FSC received an update to the Chargeable Patient Policy and having noted the changes, approved the Policy.
Any Learning and Improvement identified from within the meeting:	
Any other relevant items the Committee wishes	

to escalate?	

BOARD OF DIRECTORS

AGENDA REFERENCE:	**PM /17/02/20**	
SUBJECT:	**Key Issues Report from the 20 February 2017 Strategic People Committee meeting**	
DATE OF MEETING:	28 February 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Anita Wainwright, Committee Chair	
DIRECTOR SPONSOR:	Roger Wilson, Director of HR&OD	
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.4: Engaging & Involving Workforce	
	BAF2.2: Nurse Staffing	
	BAF2.3: Medical Staffing	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the February 2017 meeting.	
RECOMMENDATION:	**The Board note the report and that there are no matters arising for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT - STRATEGIC PEOPLE COMMITTEE

Date of meeting:	**20 February 2017**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 5 December 2016 were approved as a correct record.
Formal Business	Associate Director of HR reported that plans are in place for St Helens and Knowsley Hospitals Trust to shortly manage the HR services at Southport and Ormskirk Hospitals Trust. Payroll Services are being considered across the wider footprint of Cheshire and Mersey STP. Data Quality on ESR is monitored monthly, externally and WHH has achieved No 1 status out of 449 trusts for 4 months in succession. An ET case has been lodged claiming constructive dismissal and disability discrimination. The Junior Doctors contract for 36 FY1 doctors was implemented on 7 December 2016. Implications of the IR35 legislation changes are being assessed. The Terms of Reference were reviewed and some amendments agreed. Further changes will be made and brought to the April Board meeting for approval. The Committee received the Workforce Integrated Dashboard Report together with the Trust Dashboard, People Measures Dashboard and People Dashboard and received assurance that these were discussed and acted upon at various levels within the trust. All of the metrics in the Integrated Dashboard were discussed with the request that some of the targets be reviewed to ensure that they were realistic but challenging. CPD and Business Support Manager highlighted aspects of the Apprenticeship Levy; progress on Nursing Associates and an update on Resuscitation Training which the Committee specifically asked to include Paediatrics. Progress on Employee Relations cases including Suspensions/Exclusions was received. The Top 5 cases were highlighted and the Committee received assurance that these were now being progressed as quickly as possible with agreed action points. Medical Education Manager gave a positive report on progress with the 'Enhanced Monitoring' in place for trainees. Nonetheless, the Committee was pleased to hear that this remained on the trust Risk Register. The Committee also noted progress with the filling of some consultant posts and work undertaken by Gatenby Sanderson to support consultant recruitment. Head of Workforce Strategy and Engagement presented the Operational People Action Plan which was to be read in conjunction with the

	previously agreed People Strategy. The Plan in principle was agreed subject to the baseline data being completed and clear targets being identified for Year 1. The Committee also recommended that there needed to be greater stakeholder engagement to ensure buy in. This will form one of the main elements of the Committee Work Plan to monitor progress on the work streams contained within the Action Plan. Chief Nurse presented the Nursing Recruitment and Retention Strategy which is one of the work streams in the Operational People Action Plan. The Committee supported and approved the Strategy, timelines and associated project plan. As the scheduled Equality and Diversity Committee meeting in January 2017 had been cancelled, the Committee noted and approved the publication of the Equality Duty Assurance Report and Workforce Equality Analysis Report on the trust website. Head of Workforce Strategy and Engagement presented an Exit Interview Report and On-Boarding Report which were measures taken to improve retention within the trust. The Committee approved the Reports and Action Plans and agreed to review progress in 6 months.
Local Policies and Guidance Approved:	The following policies were approved: - Stress Policy: Staff Mental Wellbeing and Emotional Resilience - Uniform and Workwear Policy approved - Nurse Rostering Policy - Nursing and Midwifery Temporary Staffing Policy - VIP, Celebrity and Media Visits and Endorsements Policy The following existing policies were agreed to be formally extended by 6 months until 31 August 2017: - Remediation Policy for Medical and Dental Staff - Raising Concerns (Whistleblowing) Policy - Maintaining High Professional Standards Policy for Medical and Dental Staff - The Strengthened Medical Appraisal Policy
Any Learning and Improvement identified from within the meeting:	None.
Any other relevant items the Committee wishes to escalate?	None.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 17/02/21**
SUBJECT:	**Complaints Improvement Plan Update**
DATE OF MEETING:	**28 February 2017**
ACTION REQUIRED	The Board is asked to discuss the paper and note the attached updated action plan
AUTHOR(S):	Ursula Martin Deputy Director of Integrated Governance and Quality
EXECUTIVE DIRECTOR	Kimberley Salmon Jamieson Chief Nurse
EXECUTIVE SUMMARY	The following report provides the Board with an update on progress in the complaints handling review, currently being undertaken in the Trust.
RECOMMENDATIONS	• Note the position in terms of complaints handling and the actions taken to date; • Note progress against objectives within the action plan outlined within Appendix 1; • Receive assurance on the implementation of the approved complaints action plan via monitoring at Quality Committee and via the Integrated Performance Report.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

SUBJECT	Complaints Improvement Plan Update

1. BACKGROUND/CONTEXT

The Quality Committee received a report at its last meeting in February 2017, outlining an improvement plan, following a review of the Trust's complaint handling function. A high level review was undertaken in October which identified deficiencies in performance against the 2 national targets (which are time taken to acknowledge and time taken to respond being within 6 months) outlined within the NHS Complaints Regulations 2009, with a significant accumulated backlog of historic complaints, some almost 2 years old. In addition the review identified a need to review systems and processes in managing complaints within the Trust.

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

2. KEY ELEMENTS

The review undertaken in WHH found that the complaints team had not been adequately resourced for periods of time. This had been caused due to staff leaving and a member of staff being on maternity leave. Whilst temporary staffing arrangements were put into place, at times the establishment was decreased by 1WTE.

There were limited systems and processes in place, and some ineffective processes between Clinical Business Units and the Patient Experience Team and there was also an inadequate overview of the full caseload of complaints within the Trust.

The review highlighted that the compliance against some Trust targets was significantly worse than previously reported. For example, the percentage compliance of closed complaints within 6 months; the revised average compliance across the 6 months, from April 2016 to September 2016, being 31%.

In addition a significant backlog of complaints was declared – as at 1st November 2016, there were 197 backlog complaints against a total open of 220, with the oldest complaint from February 2015.

A substantial amount of e-mails was uncovered, relating to formal and informal concerns (c3000). These had not been actioned or in some cases, not acknowledged due to the lack of systemised processes for handling complaints.

The following actions have been taken to date

- Programme Consultant – Complaints, was appointed October 16.

- Case of need agreed at Executive Team resulting in additional interim staff recruitment to support the Team.
- Executive Lead (Chief Nurse) has established weekly meetings to review open complaints with Senior Divisional staff, which has currently been overseen by CQC Operational meetings.
- Database developed to capture all complaints -open/returns/PHSO and MP.
- Weekly review of all complaints between Patient Experience Team staff/Divisional leads and Programme Consultant to ensure appropriate case tracking where prioritisation and actions are agreed.
- Data cleansing of the Datix system has been undertaken to ensure data quality of complaints reporting.
- The Trust Complaints Handling policy has been reviewed.
- A new Patient Experience Manager has been appointed, who is an internal senior clinician, on an interim basis.
- An action plan has been developed (Appendix 1), which the Quality Committee has approved.
- Actions outlined in this report will be audited using the Trust's internal auditors to give the Board assurance regarding effective implementation.

The current position is as follows (as at 20th February 2017) :

	Total No of Complaints in Divisions	No Over 6 months target	No between 35days and 6 months	Under 35 days = within timescales for internal target
ACS	97	28	43	26
SWC	126	40	47	39
CORP	16	12	3	1
Total	239	80	93	66

80 complaints over 6 months

- Additional temporary resource has been allocated to the Patient Experience Team plus the 3 Divisional Complaints Managers have relocated to the PET department for 4 weeks. The primary objective of all additional staff is to eradicate the backlog of complaints and progress as many of the complaints as possible received from September onwards.
- Process mapping of all systems within the complaints handling function has commenced and will be completed by 24th February 2017

Work continues to achieve objectives within the Complaints Management Action Plan.

Action commenced and progressing well

- A review of the departmental staffing establishment and skill mix has commenced and additional interim resource has been put in place.

- Identification of how informal complaints are handled and managed has commenced and additional interim resource has been put in place.

- A process has commenced to ensure all complainants have a point of contact in the Trust, Complainants are being contacted by telephone to provide a name of their case handler should they nor have been contacted upon receipt of their complaint. Due to the backlog and interim staff requirements, this has taken some time to implement, but by the end of February 2017 all complainants (new and old) will have a point of contact in the Trust.
- A Complaints Handling Toolkit for Trust staff for all investigating officers is under development.
- The quality of complaint responses is under constant review, to examine language used, grammar, style and empathy demonstrated in tone.
- Reporting arrangements to Clinical Business Units and within the Trusts' Clinical Governance Framework is being reviewed to performance manage complaints within the Trust. This is currently being reported into the Trust's weekly CQC Operational meeting and the Trust Executive Team.

By the end of February 2017

- A review of the complaints handling training within the Trust will be undertaken, ensuring it is in line with the revised policy.
- A monthly report on complaints handling will be developed, mapping progress against action timeframes and trajectories, as well as monitoring KPIs in the revised complaints policy.

By the end of March 2017

- A full review against compliance with National complaints handing recommendations as set out in *'A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture' and My Expectations for raising concerns and complaints'* will be undertaken.
- A Complaints Quality Assurance Group (recommended that this is chaired by a Non Executive Director) will be established.

By the end of April 2017

- The Trust Complaints Annual Report will be drafted, ensuring that this is in line with statutory and regulatory requirements.
- A full training and development programme will be established for complaints case handlers within the Trust.
- A full review of the Datix system for complaints will have been undertaken.
- There will be an appropriate system for capturing and monitoring lessons learned from complaints and concerns so we can identify patient experience and quality improvement priorities, so that we can systematically show that we have made improvements and listened to our patients and public.

3. TRAJECTORIES/OBJECTIVES AGREED

At its next meeting, the Quality Committee will receive detailed trajectories outlining the current position and for the reduction of backlog complaints and those outside of the Trust's internal target of 35 working days. An update on all of the actions as outlined in the action plan will also be reported.

4. MONITORING/REPORTING ROUTES

A bi-monthly report on complaints management will be presented to the Trust Quality Committee

5. TIMELINES

As outlined within the action plan

6. RECOMMENDATIONS

Whilst work has been undertaken regarding complaints handling, further work and review is required. A risk has been added to the strategic risk register regarding complaints handling and Quality Committee will have increased scrutiny on this agenda under the risk is mitigated further.
The Board of Directors are therefore asked to:

- Note the position in terms of complaints handling and the actions taken to date;
- Note progress against objectives within the action plan outlined within Appendix 1;
- Receive assurance on the implementation of the approved complaints action plan via monitoring at Quality Committee and via the Integrated Performance Report.

Review of the Complaints Management Department and Function

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

Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
	Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture' and My Expectations for raising concerns and complaints'. And update this action plan accordingly				
	Introduce a Complaints Quality Assurance Group (recommended that this is chaired by a Non Executive Director).	To commence – first meeting to be held by end March 2017	End March 2017	**ON TRACK**	Deputy Director of Governance & Quality
	Write the Trust Complaints Annual Report and ensure it is in line with statutory and regulatory requirements.	To commence	End April 2017	**ON TRACK**	Deputy Director of Governance & Quality
Ensure that the complaints team establishment and structure is reviewed	Review the departmental staffing establishment and skill mix and take any action as required	This has commenced and additional interim resource has been put in place. The Deputy Director of Governance & Quality will review this upon commencement of their role.	End March 2017	**ON TRACK**	Deputy Director of Governance & Quality/Complaints Programme Consultant
Review how complainants are engaged in the resolution of their complaint	Identify how informal complaints are handled and managed; Review the PALS function, resource and accessibility;	This has commenced and additional interim resource has been put in place. The Deputy Director of Governance & Quality will review this upon	End March 2017	**ON TRACK**	Deputy Director of Governance & Quality/Complaints

Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
		commencement of their role.			Programme Consultant
	Ensure all complainants have a point of contact in the Trust	The complainant will be contacted by telephone to provide a name of the case handler and to establish the exact issues that require investigation. This encourages a relationship with the complainant at the outset. Case Handlers will keep complainant informed of progression in the investigation. Due to the backlog and interim staff requirements, this has taken some time to implement, but by the end of February 2017 all complainants (new and old) will have a point of contact in the Trust.	End February 2017	**ON TRACK**	Complaints Programme Consultant
Ensure training in the complaints handling process is in place within the	Undertake a review of the complaints handling training within the Trust , ensuring it is in line with the revised policy.	To commence	End February 2017	**ON TRACK**	Complaints Programme Consultant

Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
Trust	Develop a Complaints Handling Toolkit for staff for all investigating officers	In progress	End March 2017	**ON TRACK**	Complaints Programme Consultant
	Review the training requirements for the complaints cases officers within the Trust and put in place a training programme	To commence	End March 2017	**ON TRACK**	Complaints Programme Consultant
	Review the quality of complaint responses, to examine language used, grammar, style and empathy demonstrated in tone;	An initial review has taken place. Considerable work is required to ensure all PET staff as able to write an appropriate response	Ongoing Improvements will be incremental	**ON TRACK**	Complaints Programme Consultant
Ensure that data quality in complaints handling improves	Develop a live spread sheet of all cases which will provide ' a single version of current position' This report will have the ability to be 'filtered' to enable various staff group to effectively use the data	Live spread sheet populated with all cases. Relevant dates added for each case. Systematic review of each case ongoing with Divisional Complaints Managers to establish the current status of each complaint. Weekly meetings with Divisional Governance/Complaints leads and PET officers to take place to update current progress with every case.	End December 2016	**COMPLETED**	Complaints Programme Consultant

Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
	Undertake a full data cleanse of the Datix Software package, examining every open case rectify and to ensure: • Develop Standard Operating procedures for all staff regarding complaints management on the Datix system • That all current cases have the correct data fields completed. (a number of file have crucial data missing) • That all current cases have the relevant documentation uploaded to the case file to ensure this is always up to date with the current status.(a number of cases have documentation gaps on the case files) • In liaison with the CBUs and Divisional Complaints Managers, ensure high risk profile cases have been	This has been commenced and significant progress has been made	End March 2017	**ON TRACK**	Complaints Programme Consultant

Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
	downgraded (if required) following the 72 hour review. • Ensure that cases which are actually closed are marked as such on Datix. • Highlight cases which have had no action which should be progressed. • Take appropriate action to progress the case. • Identify and action cases where they have stalled. e.g. Draft letter on file but not followed up (sometimes for a number of weeks) (action being taken to rectify this) • Keep contemporaneous records of all actions taken to complete a comprehensive data cleanse, this will enable production of a report noting all anomalies corrected				

Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	• Undertake a full review of the functionality of the Datix Risk Management Software – Complaints Module to ensure it is fit for purpose. • Work with the Datix organisation to develop the software package as appropriate. • Liaise with internal colleagues and Datix Administrator to make any changes necessary.	To commence	End June 2017	**ON TRACK**	Complaints Programme Consultant/ Complaints Manager
Ensure that performance in complaints handling improves	Calculate a trajectory to ensure the backlog of complaints is resolved	This has progressed and improvements are being made with regard to performance.	End February 2017	**ON TRACK**	Complaints Programme Consultant
	Review reporting arrangements to Clinical Business Units and within the Trusts' Clinical Governance Framework to performance manage complaints within the Trust	This has progressed and a weekly meeting is in place chaired by the Chief Nurse with reporting into the Executive Team meeting weekly.	End February 2017	**ON TRACK**	Complaints Programme Consultant
	Develop a monthly report on complaints handling mapping progress against action timeframes	To commence	End February 2017	**ON TRACK**	Deputy Director of Governance &

Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	and trajectories, as well as monitoring KPIs in the revised complaints policy.				Quality Complaints Programme Consultant
Ensure that lessons are learned as a result of informal and formal concerns raised	Ensure there is an appropriate system for capturing and monitoring lessons learned from complaints and concerns	To commence	End March 2017	**ON TRACK**	Deputy Director of Governance & Quality Complaints Programme Consultant
	Ensure that there is triangulation of complaints data at a ward level with incidents, staffing etc.	To commence	End July 2017	**ON TRACK**	Deputy Director of Governance & Quality Deputy Chief Nurse
	Ensure there is an aggregate learning report developed for incidents, Serious Incidents, complaints, concerns and claims	There is currently a report in place which will be reviewed	End June 2017	**ON TRACK**	Deputy Director of Governance & Quality Complaints Programme Consultant

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

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/02/22**
SUBJECT:	**Review of WHH NHS FT Safeguarding Services**
DATE OF MEETING:	28 February 2017
ACTION REQUIRED	The Committee are asked to endorse the report and support the development of an action plan.
AUTHOR(S):	Dr Susan Smith, Safeguarding Consultant Wendy Turner, Lead Nurse Adult Safeguarding Katie Clarke, Specialist Nurse, Safeguarding Children
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality BAF1.1: CQC Compliance for Quality Choose an item.
STRATEGIC CONTEXT	To examine the report from the Trust Wide Safeguarding review; this was undertaken in December 2016. To review the resulting action plan and discuss the outcome of the recommendations.
EXECUTIVE SUMMARY (KEY ISSUES):	A review of WHH NHS FT Safeguarding Services was commissioned by the Chief Nurse, Kimberley Salmon-Jamieson in December 2016 under the following terms of reference: To undertake a review and critical analysis of safeguarding arrangements at Warrington and Halton NHS Foundation Trust including examination of the following: • Governance and Quality Assurance arrangements and structure. • Benchmarking of arrangements against national regulatory, statutory and non-statutory guidance. • Self-Assessment (analysis of CCG assurance framework) • Peer assessment (walk round and staff interviews). To provide a written report for the Chief Nurse detailing findings, highlighting areas of good practice and strength and areas for potential and further development.

To provide recommendations and facilitate action plan development.

The review concluded that WHH has a strong and resourceful Safeguarding Children and Adults provision.

The key areas for improvement include:

- ensuring that there is a clear line of accountability to the Board which is reflected in the reporting and meeting structure and which demonstrates that the wider safeguarding agenda is integral to the quality assurance and improvement strategic direction of the Trust.
- Combining the leadership of both teams under a single management structure will facilitate the achievement of this aim. Rationalising time spent producing reports, attending meetings and undertaking 'case work' which will enhance the ability for both teams to increase the quality of the service they provide and concentrate on initiatives to empower professionals in their safeguarding work such as the innovative supervision model pilot.
- Review of how all information is shared and handled which will result in efficient use of resources in terms of time for the teams and staff.
- Review the provision of learning disability support and specialist advice including the services and support provided to patients.
- Development of a Safeguarding Strategy and Safeguarding Training Strategy which would help focus attention on the improvements required in these areas. Levels and content of all training will be scrutinised and assurance given that they are congruent with the Intercollegiate Document (2014) and NHS England Prevent training guidance.
- An audit of the use of chemical restraint, restraint and bed rails is currently being undertaken to establish if this practice is occurring within the Trust and to provide assurance that the least restrictive option of restraint methods are considered within a best interest framework based on a clearly documented assessment of mental capacity.

There Review also cited numerous examples of how the safeguarding teams have intervened positively to safeguarding an adult or child. The challenge is balancing this intervention with the need to encourage staff to intervene as part of the patient's overall care plan. Getting this balance right would allow more time to further

	develop the areas of innovation and positive practice.	
RECOMMENDATION:	The Review makes a total of 23 recommendations. The Board of Directors are asked to receive assurance on the implementation of the approved action plan via monitoring at Quality Committee.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

BOARD OF DIRECTORS

SUBJECT	Safeguarding Adult Review; Report and Action Plan	AGENDA REF:	BM/17/02/23

1. BACKGROUND/CONTEXT

A full review of the Trust Safeguarding Service was requested. This included a review of the separate Children's and Adult Services, a review of where Learning Disability and MCA/DoLS sat within the trust and how the Dementia Service worked alongside the Safeguarding service.

2. KEY ELEMENTS

- Report of findings and recommendations
- Action plan

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Kimberley Salmon-Jamieson is the responsible officer. The action plan detailing the recommendations and time lines require the safeguarding leads to take forward some of the responsibilities with support from Chief and Deputy Chief Nurses.

4. IMPACT ON QPS?

The quality and efficiency of the service will improve, staff will benefit from a better organised structure and delivery of the Trust Safeguarding Service

5. MEASUREMENTS/EVALUATIONS

This will be reviewed following required audits of the relevant recommendations and following a review of the changes required in how the teams work and function.

6. TRAJECTORIES/OBJECTIVES AGREED

Objectives and trajectories of the actions are detailed in the action plan

7. MONITORING/REPORTING ROUTES

- Quality and patient effectiveness committee
- Trust Board

8. TIMELINES

Time lines are set out in the action plan.

9. ASSURANCE COMMITTEE

- Quality Committee

10. RECOMMENDATIONS

Recommendations are detailed in the report and the action plan.

Warrington and Halton NHS Foundation Trust.

Safeguarding Review.

Commissioned by:	Mrs Kimberley Salmon-Jamieson	October 2016
Author:	Dr Suzanne Smith	
Date:	December 2016	

Contents

1. Introduction

1.0 Safeguarding adults and children at risk of abuse or neglect is complex. It is an area under constant review as definitions shift following large scale inquiries such as Francis and Lampard and with the introduction of new legislation such as the Care Act 2014 and revised intercollegiate training and competency guidance (2014). NHS England (2015) highlight how:

> "Fundamentally, it remains the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the well-being of those adults and children at the heart of what we do. All NHS organisations need to ensure that there is sufficient capacity in place to fulfil their statutory duties and should regularly review their arrangements to assure themselves that they are working effectively."

1.1. I was asked to undertake a review of safeguarding provision at Warrington and Halton NHS Foundation Trust (WHH NHS FT) in 2016.by Kimberley Salmon-Jamieson, Chief Nurse who has recently started in post. The review took place in December 2016 and included 2 days of visits to the Warrington site, interviews with the safeguarding professionals, staff and walkrounds to adults and children's areas in the hospital plus consideration of training materials, policies, assurance reports and governance structure. In the interests of focus and brevity, this report will not describe the structures in place but will concentrate on where the structures, systems and processes add strength, or present difficulty to the business of safeguarding within the Trust.

1.2 Terms of Reference

1.1.2. To undertake a review and critical analysis of safeguarding arrangements at Warrington and Halton NHS Foundation Trust including examination of the following:

- Governance and quality assurance arrangements and structure.
- Benchmarking of arrangements against national regulatory, statutory and non-statutory guidance.
- Self Assessment (analysis of CCG assurance framework)
- Peer assessment (walkround and staff interviews).

1.1.3. To provide a written report for the Chief Nurse detailing findings, highlighting areas of good practice and strength and areas for potential and further development.

1.1.4. To provide recommendations and facilitate action plan development.

1.3 Staff interviewed included:

- Named Nurse/Matron Safeguarding Children
- Specialist Midwife Safeguarding Children
- Lead Nurse Safeguarding Adults
- Matron Safeguarding Adults
- Patient Safety Co-ordinator
- Sister Children's Unit
- Staff Nurse post natal ward
- Staff Nurse children's A/E
- Dementia Lead Nurse
- Sister Dementia Unit (B12)
- Sister Stroke Unit (B14)

1.4 Policies/reports reviewed included:

- Mental Health Guidance under the Mental Health Act 1983 in acute hospitals without a psychiatric unit.
- Mental Health Act training content
- Safeguarding Children and Adult level 2 training content
- Safeguarding Children Annual Report
- Safeguarding Adults Annual Report
- Provider Quarterly Safeguarding Adult Assurance Report
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Staff Domestic Abuse Policy
- Clinical Holding Policy (for review)
- CCG Assurance Audit documents x 2

2. Governance and quality assurance arrangements and structure.

2.1 Structure

2.1.1 The structure and governance reporting structure are such that there is little opportunity for the overall safeguarding agenda to blend or for the team to function as an integrated team. The safeguarding adults team reports to the Deputy Director of Nursing and the safeguarding children team report to Women and Children's Health. The copy of the Clinical Business Unit structure provided to me does not include safeguarding. As such assumptions could be made regarding the invisibility of safeguarding within the Trust. National guidance e.g. NHS England (2015) places the safeguarding of adults and children beneath the same umbrella and from experience, doing so ensures the holistic, consistent and conscientious approach that is called for.

2.1.2 The different elements that make up the wider safeguarding agenda (children, adults, MCA/DoLS, MHA) are operationally and strategically disconnected. The point at which they come together is at the level of Chief Nurse who is Executive Lead for Safeguarding on the Trust Board. There is a need to embed safeguarding as a part of the quality agenda at a corporate level within

the Trust. The need for strong, single leadership of both agendas is required to ensure the wider safeguarding agenda is seen as part of the Trust's strategic agenda which is visible and understood from Board to ward.

2.1.3 The Safeguarding Children Steering Group meets bi-monthly and is attended by senior nurses in the Trust and the Named Doctors. It is concerning that no other medical representation is engaged at this level other than the Named Doctors. The minutes of the Safeguarding Children Steering group go to Patient Safety and Effectiveness Committee and a bi-annual safeguarding adults report is sent to this committee. However, the Named Nurses do not attend to summarise their reports or to take questions. Neither nurse is aware of how their reports are received.

2.1.4 It is recommended that the safeguarding governance and reporting structure is revised detailing a clear line of accountability for an integrated safeguarding adults and children team. This should include the bringing together of senior nursing, midwifery, medical and AHP staff at a safeguarding forum/committee chaired by the Chief Nurse/Deputy Chief Nurse which measures progress against the Trust's safeguarding children and adults priorities, KPIs, actions from audits and serious case/incident reviews and safeguarding adult reviews. The current Safeguarding Children and Adult Steering Groups terms of reference should be revised with the introduction of the senior level forum/committee. The revised structure and terms of reference should show clear alignment with the wider quality agenda within the Trust.

2.2 Resource

2.2.1 There is an inequity between the resource dedicated to the Safeguarding Children Team and the Safeguarding Adults Team. The Safeguarding Children Team comprises a Named Nurse (1 WTE), Specialist Nurse (1WTE), Named Midwife (0/6 WTE) and an administrator (1 WTE, 7.5 hours of which is devoted to Care Of Next Infant (CONI)). An extra 15 hour a week is provided for support with MARAC functions. An Independent Domestic Violence Advocate (IDVA) provides support to both Safeguarding Children and Safeguarding Adult teams but is not part of either management structure. A Paediatric Liaison Nurse sits in the Safeguarding Children Team office and provides a safeguarding children function but is not part of the team or their management structure. Both of these roles should be reviewed in terms of their function and their fit with the Safeguarding Teams and in terms of their support to and impact on the safeguarding agenda. In comparison, the Safeguarding Adult team is a Named Nurse (1WTE) and a Matron (1WTE) with a vacancy for admin support for 35 hours a week. Given the proportion of adult and child patients the allocation of resource to both Safeguarding Teams should be considered further.

2.2.2 The Named Midwife is 0.6 WTE. The bulk of her time is spent doing the 'must do' element of safeguarding support for maternity services at the child protection end of the safeguarding agenda. However, there is a need for more focus on early help, embedding a safeguarding supervision framework and for more interaction and support with the Neonatal Unit. Enhancing the

Named Midwife provision within a revised job description that includes the need for interface with the safeguarding adult agenda is recommended.

2.2.3 There are a number of opportunities to rationalise the work of both teams particularly in relation to the number of meetings team members attend (internal and external), the amount of intervening with individual cases that occurs and the involvement in non-safeguarding incident reviews. The attendance and reports provided to LSCBs/SABs and MARAC is excessive and of questionable value. Neither Named Nurses felt that the information shared or their attendance at MARAC in particular served to help protect women and children subject to domestic abuse. Attendance at all the LSCB/SAB subgroups is also burdensome with little evidence of meaningful impact. Agreements could be made with LSCBs/SABs and MARAC which focus on smarter, less resource intensive, ways of working. A review of all meetings and prioritisation of those meetings where attendance of the Named professionals is of value to either party should take place as priority in order to maximise current resource.

2.2.4 There is a significant opportunity for the team to share resource. For example, the Named Midwife only becomes involved with mothers who have a learning disability after the baby has been born. Up till then, the work to ensure capacity assessments are completed correctly and reasonable adjustments are made is the remit of the Named Nurse: Safeguarding Adults. The Named Midwife should work with the Named Nurse at all stages of similar cases to ensure both professionals can form a view of needs and strengths in partnership with midwifery colleagues. The opportunity for administrative support to work across adults and children team boundaries should also be explored to maximise the potential of what is a generous resource including provision of cover during periods of absence.

2.3 Titles

2.3.1 The titles of the professionals who make up the Safeguarding Teams are confusing. For the sake of clarity these should be amended to align with statutory post titles e.g. Named Nurse: Safeguarding Adults/Children, Named Midwife, (which should span children and adults) etc.. The title of Matron is used differently in both teams and should be reviewed.

2.4 Learning Disabilities (LD)

2.4.1 The needs of people with learning disabilities and the responsibilities of health care professionals to meet those needs is clearly identified in a variety of reports such as “Six Lives: Progress Report on Healthcare for People with Learning Disabilities” (DH 2013) and the “Confidential Inquiry into premature deaths of people with learning disabilities” (CIPOLD 2013). There is a need to grasp this agenda with some urgency in order to ensure safeguards are in place for some of the most vulnerable people in our society. The need for LD support within the acute sector and removing reliance on specialist LD units is given strong emphasis in the NHS England document ‘Leading Change, Adding Value: A framework for nursing, midwifery and care staff’ (2016). Extra LD resource within the Safeguarding Adults Team should be given consideration in order to meet the requirements supported by the Department

of Health in these and other reports and in order to respond effectively to the regional self- assessment framework.

2.5 Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

2.5.1 The Mental Health Act (MHA) resource sits within Governance at present. The MCA/DoLS lead is the Assistant Director of Governance but the training and policy development and quality monitoring are supported by the Safeguarding Adult Team. The apparent straddling of different departments for these elements of the safeguarding agenda is unnecessary and could increases the risk of miscommunication and fragmentation. Consideration should be given to all MHA, MCA and DoLS strategic leadership and operational resource being part of a single accountability and responsibility structure via the Deputy Chief Nurse to the Chief Nurse.

2.6 LSCB/SAB and CCG interface

2.6.1 The representation at Warrington Safeguarding Children's Board and Safeguarding Adults Board is disproportionate to that of Halton which seems at times to be forgotten. The Safeguarding Children Annual Report makes no reference to Halton Safeguarding Children Board despite the fact that over 50% of referrals to the Safeguarding Children Team relate to children from Halton and a quarter of all referrals to Children's Social Care are to Halton Local Authority.

2.6.2 The Named Nurse: Safeguarding Children meets with the Designated Nurse from Warrington on a regular basis but not the Designated Nurse from Halton. No explanation was offered about why this is the case and it is not known if there is an agreed 'hosting' arrangement between the two CCGs. The Halton Designated Nurse is said to represent the Trust at Halton Safeguarding Children Board but how effective the representation is in the absence of any formal arrangement and review of information and performance, is not clear. Representation at Warrington and Halton Safeguarding Children and Safeguarding Adult Boards should be reviewed with particular reference to ensuring adequate engagement with Halton CCG and Safeguarding boards.

2.7 Information Sharing

2.7.1 There are a variety of different methods by which both safeguarding teams hold, share and monitor information. These range from the use of systems such as ICE and Datix, to hand written communication books and Special Circumstances Forms. Some of this adds burden to staff who are required to complete different forms e.g. to make a referral and inform the safeguarding teams. I randomly picked an example of ICE information sharing form, which was about a 17 year old who had hurt his ankle, was a Cared for Child but where there were no other concerns. This was sent to the Safeguarding Children Team and the specialist nurse spent time undertaking a variety of different checks to confirm that it was not a safeguarding concern. Consideration should be given to combining referral/information sharing form to reduce burden on staff and to differentiate between sharing information, asking for advice, asking for intervention and making a statutory referral. A system should be introduced for the Safeguarding Team as a whole to

electronically record their interactions with staff which is accessible by all members of the team at any time.

2.7.2 The response to information shared is probably an indication of how both teams operate and an indication of the need to 'case work' and check every piece of information. This resonates with the apparent culture of the organisation, which I gleaned from conversations with staff, relating to the Safeguarding Teams being seen as the people who 'do' the business of safeguarding. Safeguarding cases seem to be frequently passed to the teams to sort out rather than a focus being on safeguarding as an integral part of the health professionals' work that the team are there to support through the provision of expert advice, education and supervision. An example of this is the amount of time that the Safeguarding Children Team spend on Early Help Assessments (EHAs) or Common Assessment Framework documents (CAFs). These are received by the Safeguarding Children Team, who then review each EHA and make comments. This practice is good to support a new midwife who has never completed an EHA before but the expectation should be on more experienced midwives to submit EHAs themselves without the need for them to be 'marked'.

2.7.3 A good example of professionals taking responsibility for safeguarding is the process for the submission of a DoLS request for authorisation to the local authorities. The submission goes directly to the local authority from the professional and the conversion rate from urgent to standard is high indicating that their understanding of DoLS and the quality of their request is good. The Safeguarding Adult Team support to the DoLS process is to provide training and to keep a thorough database so that they can remind professionals when the urgent authorisation is about to expire.

2.7.4 The current Safeguarding Children Policy includes a requirement for all 'Did Not Attend' (DNA) notifications to be investigated by the Safeguarding Children Team when the child has not attended on the 3rd occasion. This is resource intensive work and arguably should be completed by the professionals involved as part of their wider assessment of the child and their needs. When the clinician has exhausted avenues of enquiry and remains concerned that there may be a safeguarding issue, then advice and support with further intervention should be sought from the Safeguarding Children Team. Liaising with health visitors/GPs etc. to establish the level of concern when a child DNAs is indicative of the professional curiosity expected of professionals who work with children and should be enshrined in policy. It is recommended that the current DNA policy for children and the point at which the Safeguarding Children Team become involved is reviewed.

2.7.5 The system by which midwifery Special Circumstances Forms (SCF) are completed requires prompt review. Present practice is that community midwives have to come into the hospital site in order to view/update the SCFs. This carries some risk in that information may not be updated contemporaneously which may impact on a midwife's assessment. The Named Midwife has indicated her wish to review the system and it is recommended that this takes place.

2.7.6 A reflective piece of work completed by the safeguarding teams should be undertaken as part of a development exercise, which considers why and how information is collated, shared and held, following which recommendations should be made to streamline data handling.

2.8 Domestic Abuse

2.8.1 Many trusts find it a challenge to create an opportunity whereby they can see a woman on her own to routinely undertake domestic abuse screening. At WHH, a simple and transparent remedy is to send a letter to the woman stating that she will be seen on her own at some point. Although there may be a perceived risk in this approach, as there are with all overt approaches, there is no evidence that this has caused problems for women. The documentation that the question has been asked is thorough and easy to identify.

2.9 Flagging

2.9.1 The CCG assurance audit that forms part of the contract monitoring process, requests information about how vulnerable children and adults are 'flagged' on hospital systems. The information and evidence provided is confusing in that the flow charts referred to do not mention flagging. Halton children are apparently 'flagged' if they are subject to a child protection plan but Warrington children are not. CQC recommended the Trust give this urgent consideration at their last inspection. However, since then national focus is on making the national Child Protection Information Sharing system (CP-IS) sponsored by NHS England operational across all acute providers and local authorities. WHH do not have CP-IS and Warrington local authority are not making progress with CP-IS. However, Halton local authority are about to go live and other local authorities in the surrounding area are already live. Consideration should be given to urgently implementing CP-IS at WHH as there is no need to wait for Warrington local authority to go live in order for this to happen.

2.10 Working together

2.10.1 An excellent example of good working together across professional and organisation boundaries exists within safeguarding children arrangements in monthly joint liaison meetings. These meetings include social care, early help professionals, health visitors, mental health colleagues, midwives and safeguarding teams. The meetings include a discussion of cases, review of EHAs and will result in social care taking some cases forward as a referral.

2.10.2 Safeguarding Adults and Dementia: There is potential for the Safeguarding Adult team and the Dementia team to work much more closely together. During my visit I was made aware of concerns relating to a case where a 'confused' adult had been prescribed sedation. The patient suffered a fall and a Root Cause Analysis was underway to explore the links between use of sedation in disorientated patients and falls. As part of my review of paperwork, I asked to see examples of records relating to patients subject to DoLS. I randomly selected a case which involved the use of sedation and bed rails in a disorientated patient with no evidence of exploration of a lesser

restrictive option. In addition, in my interviews with staff, I was informed by a senior nurse that all DoLS requests included the need for chemical restraint. The Chief Nurse was informed about this finding immediately and work is now underway to explore practice around the use of restraint, chemical restraint, bed rails and related falls in more detail.

3. Benchmarking

3.1 Training

3.1.1 WHH provides no in house level 3 safeguarding training. Levels 1 and 2 are mandatory. There is confusion about what Level 3 is as some staff I spoke with referred to the annual hourly update as level 3. The annual reports make reference to uptake of Level 3 safeguarding children training but it is unclear where this was accessed from. The LSCBs provide level 3 safeguarding children training, but it is not clear how the requirement regarding content and the amount of time as described by the Intercollegiate Document (2014) is met. The provision and reporting of compliance with Level 3 training needs urgent review.

3.1.2 The Safeguarding Level 1 training needs wholesale revision. The training was not observed. However, consideration of the powerpoint slides show that the training is of poor structure and clarity. Although trainers may indicate some of the points listed below verbally, this requires staff to remember them or write them down where a prompt which is accessible on a slide, would avoid that necessity. It is hard to see how the learning outcomes that focus on knowing who to contact and where to find further information are met.

3.1.3 Some key points of criticism include:

- Learning outcomes refer only to safeguarding children training.
- No reference is made to WHH policy.
- Indicates that staff should seek advice within one working day but doesn't say who from.
- The quiz at the end asks where one would find hospital policy and procedures but this information is not included in the slides (not even in the notes section).
- Notes suggest use of Graded Care Profile for discussion of neglect – not appropriate for induction training.
- Levels of training slide does not give information about how to access training.
- Slide 32 lists 'warning signs' and refers to 'pressure area problems'?

3.1.4 Discussions with staff indicated confusion about what level of training should be accessed at which point. There was also some confusion about how to make a referral to adult and/or children's social care. Professionals knew how to contact the different safeguarding teams but not how to make a referral. The process is not clearly described either in training or in policy. The means by which staff are made aware of the relevant level of training and guidance about making a referral in both policy and training requires attention and should form part of a Safeguarding Training Strategy.

3.1.5 Level 2 Safeguarding Children Training: The Learning Outcomes are congruent with Intercollegiate Document (2014) guidance and the reference to the NICE pathway is a positive addition. However, there are some points that should be reviewed:

- The definitions of abuse are taken from the 2013 version of "Working Together to Safeguard Children". This needs updating.
- Slide 11 refers to 'culture' and lists forced marriage. This needs to be reframed in terms of abuse rather than culture.
- The training includes 5 slides on FGM and 4 slides on SUDIC procedures which I suggest is disproportionate given the intended audience.
- Throughout, reference is made to obsolete versions of policies (2012) and national statutory guidance which should be removed.
- Again, this training does not describe how to make a referral.

3.1.6 The mandatory requirement to report all known cases of FGM in the under 18s identified in the course of professional work to the police is absent in training and in policy. The FGM mandatory reporting requirement needs to be clarified in training and policy immediately including the fact that this is a personal responsibility and cannot be undertaken by colleagues such as the Safeguarding Teams.

3.1.7 The PREVENT basic awareness training is included at Level 2 Safeguarding Adults training. Guidance should be provided to indicate how staff can access WRAP training and how this is provided.

3.1.8 Good progress has been made with training about Child Sexual Exploitation (CSE). Staff are encouraged use the Pan-Cheshire CSE screening tool and there is evidence that this is happening.

3.2 CCG assurance self-audit

3.2.1 The first thing to note is that this document is presented as a single document for children and adults but the responses have been divided into two separate documents reflecting the disconnect and division between the two teams that is apparent throughout the organisation. It is recommended that the gradings/rag ratings are reconsidered along the lines described below.

3.2.2 Challenges to the completion of the CCG assurance self-audit are as follows - children:

- 1.4 has been graded at 4 (the highest grade) without evidence provided of existing child forums or programmed child involvement. Evidence provided relates only to Early Help Assessments and Friends and Family Test indicating the need for more engagement with the patient experience agenda. The grading should be reviewed.
- 1.5 The evidence refers to 'survey monkey distributed'. This requires explanation and clarification.
- 2.5 I would recommend adopting 'walkrounds' as a means of getting to grade 4.

- 2.6 This has been self assessed as grade 4 but the safeguarding children policy does not include reference to trafficking or unaccompanied asylum seeking children as required.
- 2.1 there is no evidence that the Safeguarding Children Team are involved with complaints.
- 2.12 The 'allegations against professionals' part of the safeguarding children policy is very weak and does not provide sufficient guidance or make any reference to the role of the Local Authority Designated Officer. The grading requires revision.
- 4.2 E-Safety is not properly evidenced. There is no apparent reference to e-safety in the Safeguarding Children policy nor is there evidence of a separate policy on e-safety.
- 12.2 refers to FGM and is graded at 4 but the policy does not refer to mandatory reporting arrangements.
- 12.3 No evidence is submitted re: forced marriage and there is no reference to this in the Safeguarding Children policy.
- 12.12 There is no apparent Safeguarding strategy and quality indicators seem to fall within the remit of the CCG contracting process only.
- 12.13 Transition arrangements for children moving across to adult services does not start until a child is 16 years. Although not part of any statutory requirement, this process is generally started at age 14 years to ensure smooth transition.
- 12.15 Flagging (please see comments above).
- 12.22 No evidence is submitted.
- 12.34 refers to training requirements for A/E. The evidence states that 'staff are trained to Level 3'. Given the confusion stated earlier in this report, this should be revised.

3.2.3 Challenges to the CCG assurance self-audit are as follows – adults:

- The adult protection flow chart provided as evidence refers to 'social services' rather than social care. The flow chart does not direct staff to inform/consult social care from the outset, just the police and directs staff to refer to 'social services' when there are no suspicious circumstances.
- The reference to allegations against professionals is weak.
- 3.3 is explicit about establishing a robust connection between safeguarding adults and complaints and quality. The evidence provided includes a selection of Trust policies and an example that does not reflect safeguarding. This is a reflection of the governance and reporting structure of safeguarding within the Trust and should be amended.
- 8.2 evidence refers to Level 2 Safeguarding Adult training incorporating PREVENT training. However, it is unclear if this is the workshop to Raise Awareness about Prevent (WRAP) training or basic awareness.
- 9.5 Requests a clear policy and procedure for allegations against professionals which is not available.
- 11.1 Asks for lines of accountability which are not clear.

3.2.4 Prevent training (basic awareness and WRAP) should be reviewed to ensure that the correct groups of staff are receiving the correct level of training aligned to the NHS England 'PREVENT training and competencies framework'.

3.3 Policy

3.3.1 The Trust would benefit from a clear Safeguarding Strategy that combines quality indicators for Safeguarding adults and children. A robust training strategy aligned with the Intercollegiate Document (Safeguarding children and young people roles and competences for health care staff, 3rd edition (RCPCH 2014)) would also establish a clear plan to move towards compliance and clarification of levels of training.

3.3.2 ***Safeguarding Children Policy***: The policy is a series of different style flow charts followed by an appendix of narrative which makes the policy difficult to contextualise and navigate. Whilst the content is comprehensive there are some notable omissions such as Honour Based Violence, Forced Marriage, Modern Slavery and Trafficking and the mandatory, personal duty to report FGM. The policy states that people should not ring to see if a child is on a child protection plan apart from cases of child death or if the paediatrician has concerns. This is outside of statutory guidance 'Working Together to Safeguard Children' (HM Government 2015) which states:

> "all professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care;" (para 12).

3.3.3 The Allegations Against professionals section of the policy lacks detail. Consideration should be given to having a separate policy that addresses this complex issue for both adults and children. The omissions in the Safeguarding Children Policy should be addressed as part of a revision within 3 months.

3.3.4 A separate policy detailing procedure for the management of allegations of abuse against professionals should be produced

3.3.5 ***Safeguarding Adults Policy:*** The policy is comprehensive and includes contemporary safeguarding concerns such as Honour Based Violence, Forced Marriage and Trafficking. However, the policy is difficult to navigate and does not flow. As with the Safeguarding Children Policy, FGM does not include the mandatory duty to report. The process for making a referral is extremely confusing as it attempts to give a different process for different SABs. The Allegation against professionals section of the policy is weak.

3.4 Supervision

3.4.1 The challenge of providing a robust and effective model of safeguarding supervision has long been recognised within the acute provider environment. The traditional models described in statutory guidance do not lend themselves to large complex organisations with high numbers of staff. The Named Nurse: Safeguarding Children is piloting an innovative model of supervision within a

flexible structure and based on cascade training and service delivery. Professionals within the Trust have been identified to undertake the identified model of training with a view to introducing safeguarding supervision to case holding midwives and paediatric specialist nurses then introducing supervision drop in sessions across the Trust starting with paediatrics and A/E staff. Although in its early stages, plans are to develop an emergent practice based model of supervision in consultation with colleagues. This innovative piece of work could provide a model for other acute trusts and is a potential 'trail blazer'. Consideration should be given to releasing extra resource to support this exciting work and approaches made to the local universities with a view to exploring research grant capture.

3.4.2 The Named Nurse: Safeguarding Children reported that paediatricians hold monthly peer review meetings which is positive practice and a form of supervision/reflective practice. Nurses are invited to these meetings but rarely attend. It is important to recognise the culturally different requirements and expectations between nurses and doctors when exploring appropriate models of supervision which adds value to the emerging model described above.

4. Peer Assessment

4.1 Walkround findings:

- Welcome. It was notable that 'Hello my name is…' is not embedded in practice within the Trust. On some wards little attempt was made to appear helpful or welcoming. However, there were exceptions.
- B14 appeared very chaotic, untidy and cluttered.
- The post natal ward had staff sat at or stood round the nursing station but staff were keen to give an impression of being extremely busy and we were reminded on several occasions that there were only 2 qualified staff on duty.
- Confusion about levels of training – all staff. As mentioned above, staff are unclear about the level of training they should be accessing or what Level 3 training was and how to access it. Safeguarding Children Level 3 training was described as the annual update.
- There was uncertainty about how to make a safeguarding children or safeguarding adult referral. Staff could describe how they would ask the Trust Safeguarding Children and Adult teams for advice but only one person (Sister on the Children's Ward) could accurately describe how they would make a referral by telephone, confirm in writing and where she could access the appropriate form.
- The confusion around function of hospital social work team echoed the confusion about how to make a referral. Senior staff questioned felt that hospital social work staff were the agency who received safeguarding adult referrals and one member of staff referred to the s2 referrals process.
- Those adult areas visited and staff questioned showed uncertainty around the application of the Mental Capacity Act 2005. Some staff highlighted how they would contact the Safeguarding Adults team for support and have approached the team to provide some sessions.

- All staff knew who the lead safeguarding professionals were and how to contact them. However, the expectation expressed to me, was that the team would attend the ward and 'do' the safeguarding work for them. This is especially the expectation with safeguarding adults who are expected to respond to requests for advice by going to see patients themselves, undertaking assessments and making decisions about levels of risk. Not only is that the expectation but this also happens in practice.
- There is general uncertainty among the safeguarding teams and staff about how to address allegations of abuse against professionals. This uncertainty is reflected in the weak policy guidance.

4.2 ***Safeguarding Team interviews:*** All members of both Safeguarding Teams are person centred, quality focused individuals who have a passion for their subject area and are keen to improve their service delivery. They all recognised the need to balance their role of intervening in cases with empowering and educating staff. Their key concerns related to the time spent writing reports for and attending meetings both internally and externally. There is a willingness for both the teams to work together, be co-located and have stronger links with the dementia and alcohol teams whilst bringing specialisms of MHA/MCA and DoLS within the same team.

Both Named Nurses have a well informed vision for the future. They both find the current CBU arrangement does not support the corporate function of safeguarding within the Trust. They are cognisant of areas requiring improvement and welcome the opportunity to explore new ideas. All team members interviewed are willing to further their own professional development.

5. Conclusion:

5.1 WHH has a creative and resourceful Safeguarding children and adults provision.

5.2 The key areas for improvement include ensuring that there is a clear line of accountability to the Board which is reflected in the reporting and meeting structure and which demonstrates that the wider safeguarding agenda is integral to the quality assurance and improvement strategic direction of the Trust. Combining the leadership of both teams under a single management structure will facilitate the achievement of this aim. At the same time rationalising time spent producing reports, attending meetings and undertaking 'case work' will enhance the ability for both teams to ramp up the quality of the service they provide and concentrate on initiatives to empower professionals in their safeguarding work such as the innovative supervision model pilot. A complete review of how all information is shared and handled will result in efficient use of resources in terms of time for the teams and staff. The introduction of specialist LD resource into an integrated team will be an efficient means of providing the necessary enhancement to quality of service provision.

5.3 The development of a Safeguarding Strategy and Safeguarding Training Strategy would help focus attention on the improvements required in these areas. Levels and content of all training should be scrutinised and assurance given that they are congruent with the Intercollegiate Document (2014) and NHS England Prevent training guidance. The absence of any in-house Level 3 training is a concern that should be addressed as soon as possible.

5.4 Addressing policy omissions and reviewing resource intensive policy additions, such as the DNA policy, and ensuring amendments are evidence based will strengthen the quality of the safeguarding service delivery. There is a need to introduce a policy which addresses allegations made against professionals as current guidance embedded in the different safeguarding policies is weak.

5.4 An urgent and in-depth audit of the use of chemical restraint, restraint and bed rails should be undertaken to establish culture and practice within the Trust and to provide assurance that the least restrictive option of restraint methods are considered within a best interest framework based on a clearly documented assessment of mental capacity.

5.5 There are numerous examples of how the safeguarding teams have intervened positively to safeguarding an adult or child. The challenge is balancing this intervention with the need to encourage staff to intervene as part of the patient's overall care plan. Getting this balance right would allow more time to further develop the areas of innovation and positive practice such as the CSE screening and emerging supervision model. The teams are encouraged to review the balance of their activities by interrogating those activities e.g 'How does this activity help protect children/adults at risk?'. The teams are in a good position to reflect on their service provision and build on the improvements they have made thus far.

6. Recommendations.

1. It is recommended that the safeguarding governance and reporting structure is revised detailing a clear line of accountability and assurance to the Trust Executive Safeguarding Lead from an integrated safeguarding adults and children team. This should include the bringing together of senior nursing, midwifery, medical and AHP staff at a safeguarding forum/committee chaired by the Chief Nurse/Deputy Chief Nurse which measures progress against the Trust's safeguarding children and adults priorities, KPIs, actions from audits and serious case/incident reviews and safeguarding adult reviews. The current Safeguarding Children and Adult Steering Groups terms of reference should be revised with the introduction of the senior level forum/committee. The revised structure and terms of reference should show clear alignment with the wider quality agenda within the Trust.

2. The parity of allocation of resource to both Safeguarding Teams should be considered further and include:

a. Enhancing the Named Midwife provision within a revised job description that includes the need for interface with the safeguarding adult agenda is recommended.
b. Exploring the opportunity for administrative support to work across adults and children team boundaries to maximise the potential of what is a generous resource including provision of cover during periods of absence.
c. Provision of specialist LD resource within the Safeguarding Adults Team in order to meet national requirements supported respond effectively to the regional self-assessment framework.
d. Reviewing the role, position and management of the IDVA and Paediatric Liaison function and the 7.5 hours provided to CONI by the Safeguarding Administrator.

3. A review of all meetings and prioritisation of those meetings where attendance of the Named professionals is of value to either party should take place as priority in order to maximise current resource.

4. A detailed audit and deep dive into cases to explore and understand the use of restraint, including chemical restraint, bed rails and the relation to 'incidents' and falls should be undertaken immediately.

5. The provision and reporting of compliance with Level 3 training should be reviewed immediately.

6. The FGM mandatory reporting requirement needs to be clarified in training and policy immediately including the fact that this is a personal responsibility and cannot be undertaken by colleagues such as the Safeguarding Teams.

7. The means by which staff are made aware of the relevant level of training and guidance about making a referral in both policy and training requires attention.

8. Prevent training (basic awareness and WRAP) should be reviewed to ensure that the correct groups of staff are receiving the correct level of training aligned to the NHS England 'PREVENT training and competencies framework'.

9. The omissions in the Safeguarding Children Policy and Safeguarding Adult Policy identified in this report should be addressed as part of a revision within 3 months.

10. A separate policy detailing procedure for the management of allegations of abuse against professionals should be introduced.

11. Safeguarding Team post titles should be amended to align with statutory post titles e.g. Named Nurse: Safeguarding Adults/Children, Named Midwife, (which should span children and adults) etc.. The title of matron and specialist nurse is used differently in both teams and should be reviewed.

12. Consideration should be given to all Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards strategic leadership and operational resource

being part of a single accountability and assurance structure via the Deputy Chief Nurse to the Chief Nurse.

13. Clear communication pathways should be formalised between the Dementia team and the Safeguarding Adults Team as part of the Safeguarding Strategy.

14. Representation at Warrington and Halton Safeguarding Children and Safeguarding Adult Boards should be reviewed with particular reference to ensuring adequate engagement with Halton CCG and Safeguarding boards.

15. The Trust would benefit from a clear Safeguarding Strategy that combines quality indicators for Safeguarding adults and children. A robust training strategy aligned with the Intercollegiate Document (Safeguarding children and young people roles and competences for health care staff, 3rd edition (RCPCH 2014)) would also establish a clear plan to move towards compliance and clarification of levels of training.

16. Consideration should be given to combining referral/information sharing form to reduce burden on staff and to differentiate between sharing information, asking for advice, asking for intervention and making a statutory referral. This should include a review of the handwritten Special Circumstances Forms and seeking an electronic solution to community midwives needing to be on site to view/update the forms.

17. A system should be introduced for the Safeguarding Team as a whole to electronically record their interactions with staff which is accessible to all members of the team at all times.

18. A reflective piece of work completed by the safeguarding teams should be undertaken as part of a development exercise, which considers why and how information is collated, shared and held, following which recommendations should be made to streamline data handling.

19. The current DNA policy for children and the point at which the Safeguarding Children Team become involved should be revised.

20. The gradings/rag ratings applied and the evidence provided as part of the CCG assurance self-audit should be revised.

21. Consideration should be given to releasing extra resource to support the work to develop a model of safeguarding supervision within the Trust and approaches made to the local universities with a view to exploring research grant capture.

Safeguarding Review Action Plan **Item BM 17/02/22**

Action Plan Lead: Deputy Chief Nurse

Reviewing /Oversight Committee – Quality Committee

Version 1 – 31st January 20167

RECOMMENDATION	ACTION	RESPONSIBILITY	PROGRESS	IMPLEMENTATION Date COMPLETED
1. It is recommended that the safeguarding governance and reporting structure is revised detailing a clear line of accountability and assurance to the Trust Executive Safeguarding Lead from an integrated safeguarding adults and children team. This should include the bringing together of senior nursing, midwifery, medical and AHP staff at a safeguarding forum/committee chaired by the Chief Nurse/Deputy Chief Nurse which measures progress against the Trust's safeguarding children and adults priorities, KPIs, actions from audits and serious case/incident reviews and safeguarding adult reviews.	**1**. Meet with Divisional leads to discuss and plan the structure and governance arrangements of the Children's and Adults Safeguarding Teams. Upon agreement of the new formalised plan and reporting structure, approval should be sought from the Trust Executive Team.	Named Nurses and Deputy Chief Nurse.	Meeting to be arranged and to take place by 31/3/17	31/3/17
2. The current Safeguarding Children and Adult Steering Groups terms of reference should be revised with the introduction of the senior level forum/committee. The revised	**1.** Safeguarding Adult and Children's leads to meet with the Deputy Chief Nurse in order to review the Terms of Reference and membership to all Trust Safeguarding meetings, ensuring that there is one		Meeting to take place by 31/3/17	31/3/17

structure and terms of reference should show clear alignment with the wider quality agenda within the Trust.	overarching structure and safeguarding agenda. **2.** Discussion to happen about the membership of the Steering Group and Forum, ensuring that there is a multi-professional approach to safeguarding across the trust with clear lines of accountability and assurance to the Trust Executive Safeguarding Lead.		Upon completion of the review of the team structure and safeguarding meetings plans should be ready for implementation by 30/4/17	30th April 2017
3. The parity of allocation of resource to both Safeguarding Teams should be considered further and include:				
a. Enhancing the Named Midwife provision within a revised job description that includes the need for interface with the safeguarding adult agenda is recommended.	**a**. Business case to be produced in which the provision of the Named Midwife and a review of the job description will be considered. The case will also examine the Learning Disability requirements and provision for the Trust.	Safeguarding lead nurses Chief Nurse/Deputy Chief Nurse	Safeguarding lead nurses to complete a business case by 30/4/17	30th April 2017
b. Exploring the opportunity for administrative support to work across adults and children team boundaries to maximise the potential of what is a generous resource including provision of cover during periods of absence.	**b**. Safeguarding lead nurses to discuss combining the administration team support for both Adults and Children in order to ensure the most efficient way of working is delivered to also include administration team members cross covering to reduce the impact of annual	Safeguarding lead nurses	Meeting to take place by 30/3/17 ahead of completion of the business case.	30/3/17

	leave on the safeguarding teams.			
c. Provision of specialist LD resource within the Safeguarding Adults Team in order to meet national requirements supported respond effectively to the regional self-assessment framework.	**c.** Safeguarding lead nurses to discuss the requirement and resource of LD provision within the safeguarding teams ensuring that the national requirements and regional self – assessment frame work recommendations are considered this information is to be used to support the business case.	Safeguarding lead nurses	Meeting to take place by 30/3/17 ahead of completion of the business case.	30/3/17
d. Reviewing the role, position and management of the IDVA and Paediatric Liaison function and the 7.5 hours provided to CONI by the Safeguarding Administrator.	**d**. Discussion and review will take place of the role, position and management of the IDVA and Paediatric liaison function within the Safeguarding Teams. This discussion will include a review of the 7.5 hours provided by the current children's administrator to the CONI function which in turn will require consideration by the CBU associate and lead nurses.	Safeguarding lead nurses	Meeting to take place by 30/3/17 ahead of completion of the business case.	30/3/17
4. A review of all meetings and prioritisation of those meetings where attendance of the Named professionals is of value to either party should take place as priority in order to maximise current resource.	**1.** Discussions will be held with the Deputy Chief Nurse in order to examine the current programme of meetings. This will ensure that, in line with the current resource, service provision and the need for information sharing from attendance of the Safeguarding Board Sub Groups meetings will have an equitable balance.	Safeguarding lead nurses Deputy Chief Nurse	Meeting to take place by 30/3/17	30/3/17

	2.Reviewed plan to be presented to the Safeguarding Steering Groups and the Clinical Effectiveness and Patient Safety Committee Meetings		Information about meetings to be attended to be shared by 30/4/17	30/4/17
5. A detailed audit and deep dive into cases to explore and understand the use of restraint, including chemical restraint, bed rails and the relation to 'incidents' and falls should be undertaken immediately.	**1.** Complete the audit and include the following; **a.** A review of the use of chemical restraint **b.** Use of bed rails **C.** Incidents relating to falls **d.** A review to check if the least restrictive option was undertaken and how this was explored and implemented. **2.** The outcome of the audit will be used to inform the team of the next steps to be addressed. This information will form an addition to this action plan. **3.** Assess the knowledge and skills of the trust teams around restrictive techniques and develop a training plan.	Named Nurse Safeguarding Adults Dementia specialist nurse Lead Nurses from CBU's	**1.** Audits are underway and will be completed by 30/3/17. **2.** The results from this will create further actions and further follow up audits to check progression. The first check on progression of the audit outcomes should take place by 30/4/17 **3.** MAYBO training has been source. The course is two days long and we have booked two courses which will address the high risk areas first. They are scheduled to take place on, 12/4/17 & 13/4/17 and on 2/5/17 & 3/5/17. **3.** Staff from the first two training sessions will then be responsible for training other staff across the trust.	30/3/17. 30/4/17 30/5/17 30/12/17

6. The provision and reporting of compliance with Level 3 training should be reviewed immediately.	**1.** Level 3 provision for Adult and Children's training will need to be reviewed immediately and an action plan produced. A log will need to be circulated in line with the Children's intercollegiate document for completion to capture what range of training staff are accessing. This information will be collated and reviewed against the action plan and further review will need to take place following the feedback. **2.** A meeting is to be arranged with the Associate Director of Education and the Organisational Development Team to discuss Level three training to look at the content of level three provision and how to support its delivery. **3.** Training sessions with multi agency speakers needs to be arranged. Flyers and applications forms need to be circulated to ward and dept. and made accessible at all times via the extranet. **4.** A peer review of the training at the trust should be sought and include; **a.** Internal Level three Domestic Abuse **b.** WRAP / prevent	Named Nurses.	**1.** A review of the training has occurred January 2017 and the action plan can be found at appendix A. Children's training log sheets can be found at appendix B. An electronic survey has been circulated to capture staffs level of understanding regarding their training requirements. **2.** A meeting has been held Jan ' 17 **3.** Four sessions each of internal level 3 training for Children and Adults has been arranged with external speakers to attend for 2017. Dates are throughout the year and awaiting confirmation. **4.** Attendance of the peer trust training sessions have been organised for June 2017 so that similar	Review completed Jan'17 Survey completed Jan '17 Completed Jan'17 30/03/18 30/6/17

	c. Mental capacity DoLS **d.** FGM and CSE Safeguarding champions to be identified and implemented in order to support the trust teams in understanding of Adult and Children's Safeguarding, the Champions will need to be trained to Level 3.		processes can be adopted and embedded at the Trust in the form of master classes.	
7. The FGM mandatory reporting requirement needs to be clarified in training and policy immediately including the fact that this is a personal responsibility and cannot be undertaken by colleagues such as the Safeguarding Teams.	**1.** The policy is to be updated to include the mandatory FGM reporting information **2.** Named Midwife to produce a single point lesson on FGM and distribute trust wide as a safety alert.	Named Midwife for children's policy Named Adult lead for adult policy	**1.** FGM national reporting procedure has been included in the relevant policies **2.** Named Midwife has circulated a safety brief ad single point lesson	Completed March 2017 Safety Alert 10th February 2017
8. The means by which staff are made aware of the relevant level of training	**1.** Safeguarding Children briefing needs to be produced to explain roles and responsibilities in line with the Intercollegiate Document 2014 The briefing will need to be circulated to lead nurses, matrons and managers. This should be shared with all staff members at safety briefings, ward / department meetings. **2.** Safeguarding Adults Lead Nurse to discuss training levels and provision with the Chief Nurse Safeguarding and the training department. **3.** The delivery of the training needs to be reviewed. This information will need to be circulated to all teams with a request for this to be shared at meetings and safety	Named Nurses.	**1.** Safeguarding Children briefing to be produced and shared by 30/3/17 **2.** Training levels for qualified and support staff have been agreed. All clinically facing staff regardless of grade are to be trained to level 2 adult safeguarding. **3.** All staff will now access level one and two training	March 2017 Completed Feb '17

	briefs with ward and dept teams via local meetings to be completed by June 2017		via e-learning, freeing up time for teams to attend wrap and other level three master classes, this has been shared through the Adult steering group	June 2017
9. Guidance about making a referral in both policy and training requires attention.	**1.** Safeguarding Adults Lead Nurse to add a slide regarding referrals. **2.** Adult Named Lead Nurse has become aware that the local authority is changing the referral process and is awaiting clarification from the Warrington Local Authority. Changes will then need be made to the Trust Policy to reflect the new Local Authority process, it is suggested that the process will be ratified and in place by July 2017 and the trust policy will need to reflect this. **3.** CP-IS – child protection information services needs to be circulated amongst the teams	Lead Nurses	**1.** The slide has been added to the training and explanation is given around this. **2.** When the local authority changes are ratified further policy amendments will be made and information will be shared with the ward teams along with support in learning about the new process. Work is underway to support this transition. **3.** Lead for safeguarding Children to circulate information	Training slide action is complete Jan'17 July 2017 July 2017
10. Prevent training (basic awareness and WRAP) should be reviewed to ensure that the correct groups of staff are receiving the correct level of training aligned to the NHS England 'PREVENT training and competencies framework'.	**1.** A review of the current training is required and discussion needs to be had with head of training and the organisational development team.	Named Nurse Safeguarding Adults	**1.** Consultation with the NHSE Northwest lead and a review of the national Prevent training agenda in conjunction with the training team has	Completed Jan'17

	2. A plan is needed detailing the roll out of WRAP across the trust with dedicated training sessions throughout the year.		happened. WRAP is required for all clinically facing staff and is now delivered at induction for this group. **2.** Master classes are now planned throughout the year for staff to attend.	30/3/18
11. The omissions in the Safeguarding Children Policy and Safeguarding Adult Policy identified in this report should be addressed as part of a revision within 3 months.	**1.** Safeguarding Adults Policy needs to be updated with all omissions	Named Nurses.	**1.** Adult policy now completed and reflects the omissions it has been ratified in February 2017. This is with the exception of the points raised about referral processes; there are two separate instructions in place for staff to follow for the two different local authorities. This was escribed as confusing for staff however the two local authorities we serve have different referral processes and do not plan to merge them at the moment.	Completed Feb '17

	2. Safeguarding Children Policy needs to be been updated with all omissions.		**2.** Children's policy will be updated by April 2017 – Due to ongoing work regarding DNA process	April 2017
12. A separate policy detailing procedure for the management of allegations of abuse against professionals should be introduced.	A separate policy is required in line with LSCB / LASB arrangements. Discussions are required with HR to inform the policy and its procedures and recommended processes.	Named Nurses.	A separate policy is to be written and ratified in line with LSCB / LASB arrangements by June 2017.	June 2017
13. Safeguarding Team post titles should be amended to align with statutory post titles e.g. Named Nurse: Safeguarding Adults/Children, Named Midwife, (which should span children and adults) The title of matron and specialist nurse is used differently in both teams and should be reviewed.	There will be a review of the safeguarding team titles. This should address the current disparities and ensure that all titles and roles are aligned across all grades in both teams.	Named Nurses and Deputy Chief Nurse.	**1.** Both Lead Nurses have reviewed their titles and have suggested that they be known as Named Lead nurse for Adult Safeguarding and Named Lead nurse for Children's Safeguarding. The titles are to be confirmed following a meeting with the Deputy Chief Nurse, to take place by April 2017 **2.** The specialists and midwife titles are to be discussed and amended following a meeting with the Deputy Chief Nurse. All titles will need to be agreed with the Chief Nurse and due process will be observed where required. This process is to be completed by May 2017	30/4/17 30/5/17

14. Consideration should be given to all Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards strategic leadership and operational resource being part of a single accountability and assurance structure via the Deputy Chief Nurse to the Chief Nurse.	Discussion is to take place with the Deputy chief Nurse that will require agreement from the Chief Nurse around the structure of the Adult Safeguarding roles responsibilities to reflect this recommendation. Consideration will need to be given to how this will be resourced and managed with in the overarching safeguarding structure and function.	Chief Nurse/Deputy Chief Nurse. Lead Nurse Adult Safeguarding.	**1.** Meeting to take place by the end of March 2017 to review the recommendation. **2.** Further work then to follow about how the recommendation will be resourced; this will be detailed in business case.	30th April 2017 30/4/17
15. Clear communication pathways should be formalised between the Dementia team and the Safeguarding Adults Team as part of the Safeguarding Strategy.	Communication and sharing of information needs to improve between the Dementia and Safeguarding teams. Work is required to establish formal communication pathways between the teams with regard to how possible safeguarding concerns are shared between the Dementia and Safeguarding Teams and similarly the sharing of MCA and DoLS information between teams.	Named Nurse: Safeguarding Adults	**1.** Nurse Practitioner now attends the Safeguarding Adults Steering Group. **2.** Discussion has taken place about highlighting potential safeguarding issues to the adult team. **3.** Better collaborative working around DoLS MCA has been discussed. Education sessions around DoLS and MCA have been held to update the knowledge of the Cognitive Assessment Team.	Feb '17 Feb '17 Feb'17
16. Representation at Warrington and Halton Safeguarding Children and Safeguarding Adult Boards should be reviewed with particular reference to ensuring adequate engagement with Warrington and Halton CCG and	Discussion is to take place to agree Safeguarding / Adults Children Warrington and Halton main Boards and the Domestic Abuse Partnership representation along with all sub groups.	Named Nurses and Deputy Chief Nurse.	Following a meeting with the Chief Nurse it was agreed that; **1.** The Domestic Abuse Partnership is to be	Completed Feb'17

Safeguarding boards.			attended by the Head of Midwifery or Lead Nurse for Emergency Services. **2.** Safeguarding / Adults Children Warrington and Halton main Boards to be attended by Chief or Deputy Chief Nurse. Warrington Executive Board is to be attended by the Chief Nurse. **3**. The Children's and Adult Lead Nurses are to attend all sub groups for the above main boards.	
17. The Trust would benefit from a clear Safeguarding Strategy that combines quality indicators for Safeguarding adults and children. A robust training strategy aligned with the Intercollegiate Document (Safeguarding children and young people roles and competences for health care staff, 3rd edition (RCPCH 2014)) would also establish a clear plan to move towards compliance and clarification of levels of training.	Safeguarding Adults and Children's Lead Nurses need to meet with the Deputy chief Nurse to discuss developing a safeguarding strategy. A plan will need to be put in place to launch this and ensure that the ward and depts. have the information they require to share this with their teams.	Named Nurses. Deputy chief Nurse.	A strategy will be written and agreed via a series of meetings. A plan will be put in place to prepare a launch of the strategy.	August 2017.

18. Consideration should be given to combining referral/information sharing form to reduce burden on staff and to differentiate between sharing information, asking for advice, asking for intervention and making a statutory referral. This should include a review of the handwritten Special Circumstances Forms and seeking an electronic solution to community midwives needing to be on site to view/update the forms.	Safeguarding children documentation is to be reviewed and updated. The electronic option requires discussion with the LORENZO team. Reviewed forms will need to be agreed and submitted to the LORENZO team for approval.	Named Nurses and Named Midwife.	Safeguarding Named Lead Nurse and Named Midwife will meet to update the documentation and following this meet the with the Lorenzo Team to install this electronically into the Lorenzo system for staff to use.	August 2017
19. A system should be introduced for the Safeguarding Team as a whole to electronically record their interactions with staff which is accessible to all members of the team at all times.	**1.** The LORENZO system should be utilised to ensure that all contacts are recorded. **2.** There needs to be a process within each team for recording all referral contacts so that all team members can view the information.	Safeguarding Adult and Children's Lead Named Nurses	**1.** The Lorenzo system is utilised to record contacts with patients at ward level when a safeguarding request / review is made. **2.** Both teams now have a data base that records all patient/safeguarding referrals, outlining type of abuse and patient demographics along with the outcome of the referral. It is available for all team members to view.	Completed Jan'17 Completed Jan '17
20. A reflective piece of work completed by the safeguarding teams should be undertaken as part of a development exercise, which considers why and how information is collated, shared and held,	Safeguarding Adults/Children need to complete the reflective work. Safeguarding Children and Adult Team meeting arranged to begin to discuss and explore how this can be undertaken. Location of the teams	Safeguarding Adult and Children's Lead Named Nurses	This work links to recommendation 17. A planning meeting has been held to look at how to take this work forward and head	August 2017,

following which recommendations should be made to streamline data handling.	also needs to be a consideration in this development.		of facilities has been approached to ask for a space large enough to house the teams together.	
21. The current DNA policy for children and the point at which the Safeguarding Children Team become involved should be revised.	Safeguarding Children Lead Named Nurse to review the 'Did Not Attend section within the Safeguarding Children Policy'.	Named Nurse: Safeguarding Children.	Safeguarding Children's Lead Named Nurse has reviewed the Safeguarding Children's policy and WHHFT has asked for this to be discussed at the next Local Safeguarding Children's Board Health Subgroup (Due to take place in march 2017). The policy will need to be updated following these discussions.	May 2017
22. The grading's/rag ratings applied and the evidence provided as part of the CCG assurance self-audit should be revised.	**1.** Safeguarding Children. The CCG assurance self-audit will need to be reviewed and updated in conjunction with the section 11 audit submission. 27/02/2017 **2.** Safeguarding Adults will need to discuss the review of the reporting criterion with the CCG lead for Adult Safeguarding.	Named Nurses.	**1.** Safeguarding Children. The CCG assurance self-audit has been reviewed and updated in conjunction with the section 11 audit submission. 27/02/2017 **2.** The current self-assessment audit used for CCG assurance has been re-assessed prior to the quarter three submission. Agreement between all health stakeholders has been reached and the new audit criteria will be used	March 2017 Feb ' 17

			from Quarter one of 2017/18	
23. Consideration should be given to releasing extra resource to support the work to develop a model of safeguarding supervision within the Trust and approaches made to the local universities with a view to exploring research grant capture.	**1.** Safeguarding Children Lead Nurse to draft a policy to be reviewed through a task and finish group. **2.** Consideration needs to be given to having additional Named Midwife resource as this would strengthen the implementation of the supervision policy and support the Adult Safeguarding agenda with in the maternity speciality particularly with regard the patients with Learning disabilities.	Chief Nurse/Deputy Chief Nurse.	**1.** Supervision Policy to be completed and ratified by June 2017 **2.** This information is to be written into the Safeguarding business case in order to attempt to secure the extra resource.	June 2017 30/4/17

Action plan authors;

Wendy Turner Lead Named Nurse Safeguarding Adults.

Katie Clarke Lead Named Nurse Safeguarding Children.

Key Roles;

Chief Nurse; Kimberley Salmon-Jamieson

Deputy Chief Nurse; John Goodenough

Head of Midwifery and Lead Nurse for Children; Tracey Cooper

Appendix A

Safeguarding Adults and Children's Action Plan

	ACTION PLAN

Title: Safeguarding Procedures Mandatory Training Compliance 2017/2018	Key 1 – Agreed but not yet actioned 2 – Action in progress 3 – Made partial implementation 4 – Full implementation completed

	Actions	Responsible Person	Change stage (see Key)	Progress	Date Action(s) to be Completed
1.	**a**. Lead Nurse Safeguarding Children to review the Intercollegiate Document 2014 in order to ascertain which staff require specific levels of training. **b.** Lead Nurse Adults to review the core skills for prevent and LD and review training material for DoLS and MCA	**a**. Lead nurse Safeguarding Children **a.** Lead nurse Safeguarding Adults	4 2	Meetings have taken place to address prevent and WRAP requirements LD DoLS/MCA work in progress	Completed June 2017

2	Named Nurse Adults and Children/ Midwife Safeguarding Children to review copy of the detailed report to identify staff groups that are out of date with training and to contact Managers / Divisional Nurses for assistance regarding improving training compliance in their areas of influence from Level 3 downwards.	Lead nurse Safeguarding Children and Adults	4	This is reviewed and completed on a quarterly basis	Completed on a quarterly basis
3	Training compliance to be discussed at the Safeguarding Steering Group and Forum Group. Members of both meetings to support the safeguarding team and attempt to influence the training compliance for their areas.	Members of safeguarding Children and Adults steering group / Forum group.	3		Completed
4	Level 1 Children's briefings to be cascaded. All staff who require a level 1 update need access the workbook. Staff to sign to state they are happy with the content and the procedures to follow. All staff signed sheets to be returned to the Training Team for inputting onto ESR.	Lead nurse Safeguarding Children / Safeguarding Chidlren Team	3	Briefing updated and ready for circulation with the newsletter	28th February 2017
5	All matrons/ ward managers and specialist Nurses to complete Level 2 Adults and Children's e learning if not already up to date	Ward Managers /Specialist nurse	3		30/3/17
6	Level 2 training presentation to be reviewed in line with the intercollegiate document and WTG 2015. Level 2 training presentation to be reviewed in line with the Trust Safeguarding review to add information about referral processes	Lead nurses and Safeguarding Children / Adults Teams	4		Completed
7	Level 2 face to face training sessions to be arranged monthly for 4 months then quarterly thereafter.	Lead nurses and Safeguarding Children / Adults Teams	4	Dates arranged and flyer circulated.	Completed
8	Level 3 presentation to be developed and offered on a quarterly basis to all level 3 staff across the trust.	Lead nurses Safeguarding Children / Adults Teams	2	Frist date has been booked. Outside speakers have	April 2017

				been identified and have agreed to attend. Agenda is developing.	
9	CSE E-learning link to be re-circulated.	Lead nurse Safeguarding Children / Safeguarding Chidlren Team	2	Safeguarding Children newsletter detailing e-learning links is being produced for circulation.	28h February 2017
10	FGM E-learning link to be re-circulated.	Lead nurse Safeguarding Children / Safeguarding Chidlren Team	2	Safeguarding Children newsletter detailing e-learning links is being produced for circulation.	28h February 2017
11	Trafficking E-learning link to be re-circulated.	Lead nurse Safeguarding Children / Safeguarding Chidlren Team	2	Safeguarding Children newsletter detailing e-learning links is being produced for circulation.	28h February 2017
12	Maternity level 3 update to be reviewed and refreshed in line with the intercollegiate document 2014	Lead nurse Safeguarding Children / Safeguarding	4	Presentation reviewed and changed.	Completed

		Chidlren Team			
13	Monthly Domestic Abuse training to be arranged.	Lead nurses Safeguarding Children / Adults Teams	4	Dates arranged and flyer circulated. Communications have supported with circulating information.	Completed
14	An annual Local Multi-Agency Safeguarding Children and Adults conference to be considered.	Lead nurses Safeguarding Children and Adults	2	Added to joint LSCB and SAB health sub group agenda for discussion, March 2017	August 2017

Appendix B

Name:-

Warrington and Halton Hospitals NHS
NHS Foundation Trust

SAFEGUARDING CHILDREN ~ LEVEL 3 - TRAINING LOG

The Intercollegiate document gives guidance of what constitutes levels 3 training. ESR only counts attendance at a Level 3 event.

It is the responsibility of practitioners to provide/keep evidence of training. This should be kept as part of your professional portfolio and discuss at PDR.

Intercollegiate Document 2014 Third Edition

For those individuals moving into a permanent …….who have as yet not attained the relevant knowledge, skills and competence required at level 3 it is expected that within a year of appointment additional education will be completed equivalent to a minimum of 8 hours of education and learning related to safeguarding/ child protection, and those requiring specialist-level competences should complete a minimum of 16 hours.

- Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core this equates to a minimum of

  2 hours per annum) and a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill – this includes children nurses / midwives)

- Training at level 3 will include the training required at level 1 and 2 and will negate the need to undertake refresher training at levels 1 and 2 in addition to level 3

- Training, education and learning opportunities should be multi-disciplinary and inter-agency, and delivered internally and externally. It should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit, as well as communicating with children about what is happening. This should be appropriate to the speciality and roles of the participants. At level 3 this could also for example include attendance at a Health-WRAP/prevent workshop where appropriate. Organisations should consider encompassing

safeguarding/child protection learning within regular multi-professional and/or multi-agency staff meetings, vulnerable child and family meetings, clinical updating, clinical audit, reviews of critical incidents and significant unexpected events, and peer discussions.

DATE	DESCRIPTION	ORGANISER	TIME TAKEN
01/01/15	Level 3 Paediatric Update	In house	1.5 hours
31/01/15	Neglect Awareness	WSCB	2 hours

Updated 2017

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/02/23**	
SUBJECT:	**NHS Improvement – Board Self-Certification Checklist – Agency Spend**	
DATE OF MEETING:	28 February 2017	
ACTION REQUIRED	**Assurance**	
AUTHOR(S):	Pat McLaren, Director Communications and Corporate Affairs and Carl Roberts, Head of Recruitment	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren on behalf of Roger Wilson, Director of Human Resources & Organisation Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.5: Right People, Right Skills in Workforce	
	BAF2.2: Nurse Staffing	
	BAF2.3: Medical Staffing	
STRATEGIC CONTEXT	NHS Improvement has developed a Board self-certification checklist to ensure enhanced scrutiny on Trust performance on the management of Agency spend. The Trust has sought assurance on this issue for several years.	
EXECUTIVE SUMMARY (KEY ISSUES):	The check list provides a position statement relating to the systems and processes that we have in place to control, manage and reduce agency spend. Progress against this checklist is monitored through the Finance and Sustainability Committee on a monthly basis and brought before Board for assurance.	
RECOMMENDATION:	• That the Trust Board note the position and progress made on key elements. • That Trust Board continues to delegate responsibility for the on-going scrutiny the checklist to Finance and Sustainability Committee and that a quarterly update be brought to Board throughout 2017-18.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC 17 02 17
	Date of meeting	22 February 2017
	Summary of Outcome	N/A
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
	Governance and accountability		
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	• Long term locums are reviewed at ICIC • Finance and Sustainability Committee (FSC) scrutinises agency spend monthly • Board receives data via the Integrated Performance Dashboard monthly • Fortnightly reviews of Workforce Controls has been established between the Medical Director, Chief Nurse and Head of Recruitment • A tracker has been established to monitor agency spend and the CEO personally approves anything over the 'break glass' limit	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Yes – included for both Medical Director and Chief Nurse	
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	The Medical Director and Chief Nurse meet on this ahead of each Finance and Sustainability Committee	
4	We are not engaging in any workarounds to the agency rules.	We can confirm that we are not engaged in any workarounds to the Agency Rules	
	High quality timely data		
5	We know what our biggest challenges are and receive regular (e.g. monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (e.g. vacancy, sickness) and how this differs across service lines.	Scrutiny of spend and root causes at a divisional level is undertaken at FSC monthly	

Clear process for approving agency use			
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	For Agency staff being booked for longer than two weeks, then approval is sought through our Establishment Control processes. For periods shorter than 2 weeks it is centralised.	The Trust does not currently have centralised booking arrangements in place for AHP and A+C staff: However, we are currently exploring this option with Liaison and exploring other options to introduce this.
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	This is in place for Nursing and Medical staff and requires requestors and approvers to follow an established process.	Further rigor to be introduced for AHP and Admin and Clerical staff to mirror processes used for Medical and Nursing.
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	Revised scheme of approval in place with senior Medics/Nurses signing these shifts off. Chief Executive sign off on bookings over £120	

Actions to reducing demand for agency staffing			
9	There are tough plans in place for tackling unacceptable spending; e.g. exceptional over- reliance on agency staffing services radiology, very high spending on on-call staff.	A revised performance management regime was approved by the Clinical Operations Board. This covers a range of people measures, including % of agency spend against overall pay bill. The revised regime mirrors NHSI performance classifications.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	This has been in place for Nursing staff for some considerable time. The Medical Staff Bank went live on 6th February 2017.	Use of a staff bank for AHP and A+C staff is limited and requires further work.
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by e-Rostering.	This is partly in place, with an average of 3-6 weeks for nursing staff.	Further work ongoing in this area with aim have this in place for nursing and medical staff by 1st April 2017
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	This measure has been discussed with NHSI, it has been agreed that whilst we await further clarity on the measure from them, that we look at this measure as the time elapsed between an advert for a post closing and the time taken for an offer to be made to the successful candidate. Our current process requires us to do this within 14 days. Variance is monitored and reported through the Integrated Performance Dashboard	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	The Board and Executive team have supported a range of workforce innovations including supporting bids for Physician Associates, Associate Nurses, developments in Vanguard Wards and the roll out of the Calderdale Framework.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	Significant work continues on workforce planning with partner Trusts in the Alliance LDS (part of the C&M STP). At a local level the Board has tabled to discuss workforce planning during its 2017-18 Board workshops (first session on 3rd March) in conjunction with the revisiting of its five year strategy.	

Working with your Local Health Economy			
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	The Board and executives are sighted on the areas of high agency spend through the Clinical Operations Board (Chief of Service report) FSC and SPC. Key are of focus is Acute Care.	
16	The trust has regular (e.g. monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	Regular contact is made with Executive colleagues to explore shared rotas and 'holding the line' on agency caps Through LDS/STP work sustainable services are a key focus for future developments. The Trust brokered a Cheshire and Merseyside summit on the challenges facing provider organisations on this agenda.	