We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

WHH Board of Directors Meeting Held in Public

Wednesday 28th September 2016
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.

Wednesday 28th September 2016, time 13:00 – 16:00
Trust Conference Room, Warrington Hospital

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
	PRESENTATION : Specialist Medicine CBU Deborah Hatton; John Quinn		Information	13:00	N/A
/160	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	13:20	Verbal
/161	Minutes of the previous meeting held on Wednesday 27th July 2016	Steve McGuirk, Chairman	Decision	13:22	Encl
/162	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	13:25	Encl
/163	Chief Executive's Report	Mel Pickup, Chief Executive	Assurance	13:30	Verbal
/164	Chairman's Report	Steve McGuirk, Chairman	Information	13:45	Verbal
	Quality People Sustainability				
/165	Integrated Performance Dashboard M5 2016-17 Including Trust Engagement Dashboard	All Executive Directors	Assurance	13:50	Encl
	Quality				
/166	Key Issues Report August Quality Committee	Margaret Bamforth, Committee Chair	Assurance	14:10	Encl
/167	Leadership Walkabouts	Kimberley Salmon-Jamieson, Chief Nurse	Decision	14:20	Encl
/168	Non-Executive Director Champions Role Descriptions	Pat McLaren, Director of Community Engagement	Decision	14:40	Encl
	People				
/169	Key Issues Report August Strategic People Committee	Anita Wainwright, Committee Chair	Assurance	14:50	Encl
/170	Key Issues Report September Charitable Funds Committee	Lynne Lobley, Committee Chair	Assurance	15:00	Encl.
/171	Charities Commission Corporate Trustee Checklist Position Report	Lynne Lobley, Charitable Funds Committee Chair	Assurance	15:10	Encl.
/172	Freedom to Speak Up Guardian Briefing (F2SUG)	Roger Wilson, Director of HR & OD	Assurance	15:20	Encl
	Sustainability				
/173	Key Issues Report August & September Finance & Sustainability Committees	Terry Atherton, Committee Chair	Assurance	15:35	Encl
/174	Emergency Preparedness, Resilience & Response Annual Report 2016-17	Sharon Gilligan, Chief Operating Officer	Information	15:45	Encl
/175	Governors Policy for Engagement with the Board of Directors	Pat McLaren, Director of Community Engagement	Information	15:50	Encl

/176	**Any Other Business**	**Steve McGuirk, Chairman**	**N/A**	**15:55**	**Verbal**
	Date of next meeting: Wednesday 26th October 2016				

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in public on Wednesday 27th July 2016
Trust Conference Room, Warrington Hospital

Present: **BM/16/161**

Steve McGuirk	Chairman
Mel Pickup	Chief Executive
Terry Atherton	Non-Executive Director
Margaret Bamforth	Non-Executive Director
Andrea Chadwick	Director of Finance & Commercial Development
Karen Dawber	Director of Nursing & Governance
Sharon Gilligan	Chief Operating Officer
Ian Jones	Non-Executive Director / Senior Independent Director
Lynne Lobley	Non-Executive Director & Deputy Chair
Anita Wainwright	Non-Executive Director

In Attendance:

Jason DaCosta	Director of IM&T
Lucy Gardner	Director of Transformation
Dr Nick Jenkins	Deputy Medical Director
Pat McLaren	Director of Community Engagement
Angela Wetton	Company Secretary
Roger Wilson	Director of Human Resources and Organisational Development

Apologies

Prof Simon Constable	Medical Director & Deputy Chief Executive

Agenda Ref BM/	
	The Board Meeting opened with a presentation from Peter Barrett, Clinical Director - Sheila Fields-Delaney, CBU Manager - Allen Hornby, Lead Nurse on the Specialist Surgery Clinical Business Unit
16/144	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed those attending the meeting, including Governors, members of the public and Dr Nick Jenkins who was deputising for Simon Constable, Medical Director. Apologies: Simon Constable, Medical Director. Declarations of Interest: none declared. The Chairman congratulated Pat McLaren on being appointed to the substantive role of Director of Community Engagement following the interview process held on 26th July 2016. As it was her last Board Meeting at the Trust before taking up her new post at Bradford Teaching Hospitals NHS FT, the Board thanked Karen Dawber, Director of Nursing & Governance, for all her work over the past four years and wished her well in her new post.

16/145	**Minutes of the Previous Meeting Held on 29th June 2016** The minutes of the previous meeting were approved as a true and accurate record of the meeting subject to an amendment to the title of the role that Kimberley Salmon-Jamieson would be taking up which was Chief Nurse.
16/146	**Action Plan** All actions were reviewed and progress was noted. The Board requested that the Director of Nursing & Governance compile a list of areas where best practice or legislation required a Non-Executive champion/lead e.g. End of Life Care; Emergency Planning etc for discussion at August Quality Committee. ***Action: Director of Nursing & Governance compile a list of areas where best practice or legislation required a Non-Executive champion/lead***
16/147	**Chief Executive Report** The Chief Executive updated the Board on items that had occurred or progressed since the last meeting at the end of June: • Cheshire & Merseyside Sustainability & Transformation Plans (STP) were submitted on 30th June 2016. These plans remained a high level proposition as to how partners would work together to achieve financial balance. • STP representatives met a delegation from NHS England for initial feedback earlier in the month which was positive but further work needed to be done to allow for more detailed plans to be submitted at the end of October 2016. • The monthly Performance Review Meeting (PRM) was held with NHS Improvement (NHSI) on 22nd July with focus on the financial improvement programme and the A&E performance. NHSI previously had concerns regarding the CIP programme deliver due to the size of the programme and the pace needed to deliver, however, whilst delivery remains a challenge, the Trust is currently on track with the programme. The Trust was able to articulate the work currently being undertaken with the Alliance and the potential high level efficiencies to be had. The Trust was able to demonstrate significant progress with its A&E performance and the action plans resulting from the CQC inspection during 2015 were all complete. The team from NHSI visited the maternity wards which had received criticism during the CQC visit. These PRMs will now move to bi-monthly which is a positive move. • The Trust recently appointed a new Head of Midwifery, Tracey Cooper who is currently at Lancashire Teaching Hospitals NHS FT. • Dr Nick Jenkins, Deputy Medical Director, would be leaving the Trust at the end of September to take up the post of Medical Director at West Suffolk NHS FT. Whilst they were sorry to lose him, the Board wished him well in his new post. The Board noted the report.
16/148	**Chairman's Report** The Chairman gave the Board an update of events since the previous Board meeting confirming that the recent PRM meeting with NHS Improvement had been positive. He also made reference to the success of the Trust Open Day and thanked everyone for their participation, in particular the communications and engagement team who had organised the event. The Board noted the report.

16/149	**Integrated Performance Dashboard M3 2016-17** The Executive Directors each presented the metrics relating to their portfolios, which now included workforce and quality KPIs, and the following points were highlighted: **Quality** • No cases of MRSA reported to date • 4 cases of C-diff reported in Q1 but not yet verified as avoidable. • Hospital Standardised Mortality Ratios – have increased to highest levels to date whilst SHMI has fallen. We have asked Healthcare Evaluation Data (HED) to help us understand this and commissioned monthly reports going forward, it is likely to be linked to coding of palliative patients but we do not want to presume this and are continuing to undertake our mortality reviews including a 72 hour review of all unexpected deaths. Death rate percentage (crude) is below the previous quarter and does not show any significant variation when compared year on year. • Safety Thermometer - this is a measure based on a monthly audit of all of the patients in the hospital. It is a national tool completed by all Trusts – nationally; harm free care is around 94%. Quality Committee we had a deeper dive into the ST methodology and an understanding of how we perform nationally. **People** • All workforce KPIs can now be seen as a dashboard at clinical business unit level • Sickness absence for June 2016 was 4.36%, a decrease in the previous month's performance however 0.68% higher than the same period last year. The latest figures for the North West absence performance currently stands at 5.1%. The YTD sickness % is 4.6% against a target of 3.75% • Recruitment times continue to reduce but disappointingly as a Trust it is still taking 6.7 days longer between advert closure and interview date than the 10 day target. • Turnover, now 14.44% is stagnant and continues to be above the Trust target of 8.5%. • Agency spend remains the highest element of Non-Contracted pay, accounting for 5% of the Trust's overall pay bill year to date. This has however reduced from 6% in April 2016. • Agency Nurse spend continues to reduce this Financial year, however the Trust is still spending more than it was this time last year and although agency medical spend increased for the first time since Feb-16 the Trust is still spending less than the previous year. **Performance** • A&E 4 hour target – whilst the national target of 95% was not being met, the Trust was meeting the improvement trajectory target set in agreement with the Regulator For the month of June against a trajectory of 91%, the Trust achieved 93.52% against the four hour standard. For Quarter 1 the outcome was 92.12%. • RTT – continue to perform above the 92% target • 62 Day Cancer target – the Chief Operating Officer reminded the Board that although this was a quarterly reported figure which the Trust always achieved, the monthly figures were constantly under surveillance. • Ambulance handover times are reducing and WHH now has among the best handover times in the region: <30mins target breaches April 158, May 107, June 59 <60mins breaches April 105, May 42, June 9 **Finance** • Cash balance £1.2m (the minimum requirement) – this is managed on a daily basis. • FSRR of 2 due to the financial position being slightly ahead of plan • Control target – received revised proposal from the Regulator which was agreed based

	on a planned deficit of £7.9m. • Better Payment Practice Code – the poor performance against the 95% national standard was highlighted and confirmed that the August meeting of the Finance & Sustainability Committee will carry out a 'deep dive' into the creditor position. It was confirmed to the Board that this performance is unlikely to improve until the cash position improves significantly. • July CIP schemes to a total of £8.977m PYE and £9.934m have been developed. At the end of Month 3 the Trust has delivered £1.685m in actual CIP savings, which exceeds the revised plan for Quarter 1 by £2k. The Board noted the report.
16/150	**Key Issues Report from July Quality Committee** The report from Margaret Bamforth, Chair of the Quality Committee was taken as read but the following items were highlighted: • Stanford Workshops – project group for medicines management 3 main recommendations ➢ EPM (electronic prescribing) ➢ Improving prescribing knowledge of frontline staff ➢ Whole system transformation • The Lorenzo risk was discussed. A clinical risk summit has requested by the Exec Team took place on the 15th July. Update and feedback from the summit to be given at the next QC. The Board noted the report and that there were no matters for escalation to the Board.
16/151	**Safeguarding Annual Report 2015-16** The Director of Nursing and Governance presented her report which included the following : • External and Internal Assurance • Learning from Serious Case Reviews, Domestic Homicide Reviews, Child Deaths and Other Serious Incidents • Review of Key Objectives from Previous Year • Safeguarding Activity • Domestic Abuse • Child Sexual Exploitation • Safer Working Practices The Board noted that the Trust was not part of any Serious Case Reviews in 2015/2016 and the progress against the 2015-16 action plans. Key Objectives for forthcoming year: • Training compliance at level 1 and 2 to be 85% • Maintain and improve on level 3 training figures • Work load and Capacity to be reviewed for the team • Safeguarding Supervision to be more robust and embedded across the trust. • Number of CAFS to be increased. The Non-Executive Directors remarked that the training statistics were still not at the levels the

	Board would hope for particularly in certain areas, e.g. unscheduled care. The Director of Nursing & Governance sought to reassure the Board by confirming that staff had received training and the statistics reported related to the annual renewal of that training rather than staff being completely untrained. The Board noted the report and recognised the work carried out by Katie Clarke, Matron / Named Nurse For Safeguarding Children and the safeguarding team.
16/152	**Director of Infection Prevention and Control – Healthcare Associated Infection - Annual Report April 2015 – March 2016** The Deputy Medical Director presented the report which outlined the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2015 to March 2016 financial year and the work-plan for 2016-17. The report was taken as read, however, he highlighted the following: • The Trust reported 4 MRSA bacteraemia cases (2 hospital apportioned and 2 community apportioned). This is an improvement to the previous financial year where 3 hospital apportioned cases were reported. • During 2015-2016 the Trust reported 31 MSSA bacteraemia cases (4 hospital apportioned and 27 community apportioned). This is a decrease of 8 hospital apportioned cases from the previous financial year. • Increase in wards reporting viral gastroenteritis incidents from January to March 2016 was noted to be reflective of the situation within the wider community. The work-plan for 2016-17 includes: • Clostridium difficile Reduction • MRSA/MSSA bacteraemia Reduction • Reports • Audits • HCAI surveillance data • Infection Control Risk Register • Estates (Legionella management, theatre ventilation, capital projects) • Facilities (Environmental hygiene, Laundry and waste management, Pest control) • Workplace Health and Wellbeing The Chairman highlighted the statement at the beginning of the report *"The Trust's vision is 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"* and queried whether the report gave assurance or otherwise as to whether this vision had been achieved. The Board agreed and asked that if future reports allude to vision statements, they should seek to answer whether the vision has been achieved or not and if not, what rectification would be made. The Board noted the report and the work of the infection prevention and control team.
16/153	**Part 1 Risk Register Q1 2016-17** The Director of Nursing and Governance presented the reformatted Risk Register and advised that it has been split into clinical and non-clinical risks, with the clinical risks reviewed by the

	Patient Safety and Effectiveness Sub-Committee and non-clinical risks reviewed by the Health and Safety Sub-Committee. The Board noted the three non-clinical and one clinical risk currently scoring 15+ on the register and the controls around these risks.
16/154	**Safe Staffing Levels Review** The Director of Nursing & Governance presented the report which recommended additional investment in a number of areas based on triangulation of SNCT information with professional judgement tool and quality indicators. Also taken into account were changes in acuity on surgical wards and the need for increased 1:1 care (specials). The paper had already been presented at the Strategic People Committee where the methodology applied had been agreed and a full business case for the additional posts would be progressed through the Executive Team Meetings. The Board queried whether the investment requested had been included in the budget setting exercise at the start of the financial year and the Director of Finance confirmed that it had. Following a challenge, it was confirmed that there would be no further request for investment in staffing unless there was a change to services that brought additional income and subsequently required additional staffing. The Board noted the report.
16/155	**Key Issues Report from the July Finance & Sustainability Committee** Terry Atherton, Chair of the Committee presented the key items of business from the July Finance & Sustainability Committee which reflected the information seen on the Integrated Performance Dashboard earlier in the meeting, and highlighted the following: • The Reforecast Plan now includes the sustainability & transformation funding • A presentation was received around Agency Caps from the Medical Director, the Deputy Medical Director and the Deputy Director of Nursing. This highlighted the historic position of the Trust, the current situation and the actions being taken to address our current challenges both within the Trust and the wider local Provider Network. The Finance and Sustainability Committee alongside Strategic People Committee both have a role to play in tracking progress towards CAP compliance and managing our overall pay bill. Waiting List Initiatives formed part of these discussions. • A presentation around the Outpatients Recovery Plan, not only to address historic issues but also issues arising out of the implementation of Lorenzo. The Committee will now receive regular progress reports through the monthly Corporate Performance reports. • The Finance and Sustainability Committee has not traditionally met in August; however a shorter agenda meeting will take place on 24th August around Financial, CIP and Corporate Performances for July and the outlook thereafter. The Board noted the report and that there were no matters for escalation to the Board.
16/156	**Key Issues Report July Audit Committee** The report from Ian Jones, Chairman of the Committee was taken as read. The Board noted the report and that there were no matters for escalation to the Board.

16/157	**Response to Lord Carter Report Q1 2016-17** The Director of Finance & Commercial Development presented her paper which updated the Board on the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016. She reminded the Board of the inextricable link to the sustainability & transformation funding and the importance of Board oversight. She confirmed that as part of their Performance Development Reviews, each Exec had been allocated one of the recommendations that related to their portfolio. The report detailed the 15 recommendations with a high level overview of the executive lead and the plans. It was confirmed that a quarterly update would continue to be presented at Board. The Board noted the report and the progress made against the recommendations.
16/158	**NHS Improvement Governance Declaration Q1 2016-17** The Director of Finance & Commercial Development presented the paper and her recommendations to the Board that **Finance** 1) The finance statement requires the Board to confirm that it anticipates it will "maintain a financial sustainability risk rating of at least 3 over the next 12 months" which therefore runs to Quarter 4 2016/17. Based on current and planned performance it is recommended that the Board states that it **cannot confirm** that it anticipates maintaining a risk rating of at least 3 over the next 12 months. Rationale for the declaration: The 2016/17 reforecast annual plan submitted to NHS Improvement on 29th June 2016 concluded that the planned Financial Sustainability Risk Rating in each quarter was a rating of 1. The actual Financial Sustainability Risk Rating for the period ending 30th June 2016 is a rating of 2, which is above the planned rating. 2) The planned capital expenditure for the year is £6.7m funded from internally generated depreciation and a carry forward of the 15/16 capital underspend. As at 30th June 2016 the actual capital spend is £0.7m which is in line with plan and is forecasting annual spend of £6.7m which is in line with plan, managed through the Capital Planning Group. Based on the actual performance it is recommended that the Board states that it can **confirm** that it anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return. **Governance** The declaration against healthcare targets and indicators is compared to the national target of 95%. NHS Improvement has confirmed that the declaration is against the national target not the improvement trajectory. NHS Improvement has also confirmed that Sustainability and

	Transformational funding will be focused on performance against the improvement trajectory not the national target. Based on current and forecast performance it is recommended that the Board states that it **cannot confirm** that it is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets and a commitment to comply with all known targets going forwards. Rationale for the declaration: In Quarter 1 the Trust achieved all national targets with the exception of A&E Clinical Quality – total time in A&E under 4 hours and (therefore reported as not met) is in breach in relation to moderate and major CQC concerns or impacts regarding the safety of healthcare provision (per Corporate performance report). The A&E Clinical Quality – total time in A&E under 4 hours performance for Quarter 1 is 92.1%, which is above the improvement trajectory agreed as part of the annual plan submission. **Otherwise / Exception Reporting** There are no actual or prospective material changes which may affect the ability to comply with any aspect of authorisation and which have not been previously notified to NHS Improvement. Based on the fact there are no actual or prospective material changes it is recommended that the Board **confirms** there are no matters arising in the quarter requiring an exception report which have not already been reported. The Board confirmed the above statements and requested that the Director of Finance & Commercial Development submit the declaration to the Regulator before the deadline.
16/159	**Any Other Business** There being no further business to discuss, the meeting closed at 15:45. **Next Meeting:** Wednesday 31st August 2016 in the Trust Conference Room

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BM/16/162

PUBLIC TRUST BOARD
ACTION PLAN – SEPTEMBER 2016

Meeting Date	Minute Ref BM/	Action	Lead	Date	Status
29th June 2016	16/137	Director of HR & OD to present revised People Strategy to August Board.	HRD	September Board	On-going – this has been rescheduled to Sept
29th June 2016	16/136	Director of Nursing to present revised Nursing Strategy to October Board.	DoN&G	October Board	On-going
29th June 2016	16/135	Director of Community Engagement to present position report referring to checklist issued by Charities Commission to September Board.	DoCE	September Board	On-going

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/165**	
SUBJECT:	**Integrated Performance Dashboard M5 2016-17**	
DATE OF MEETING:	**28th September 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Various Executives and Senior Managers**	
EXECUTIVE DIRECTOR SPONSOR:	**All Executive Directors**	
LINK TO STRATEGIC OBJECTIVES:	**All**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**All**	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**The Integrated Performance Dashboard will continue to be an iterative process with the potential for new metrics to be added.** **This dashboard contains the following areas:** • **Quality** • **People** • **Sustainability including operational activity & performance and finance** **With a separate dashboard for Engagement**	
RECOMMENDATION:	**The Trust Board is asked to note the trust performance as at M5 2016-17**	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Warrington and Halton Hospitals NHS
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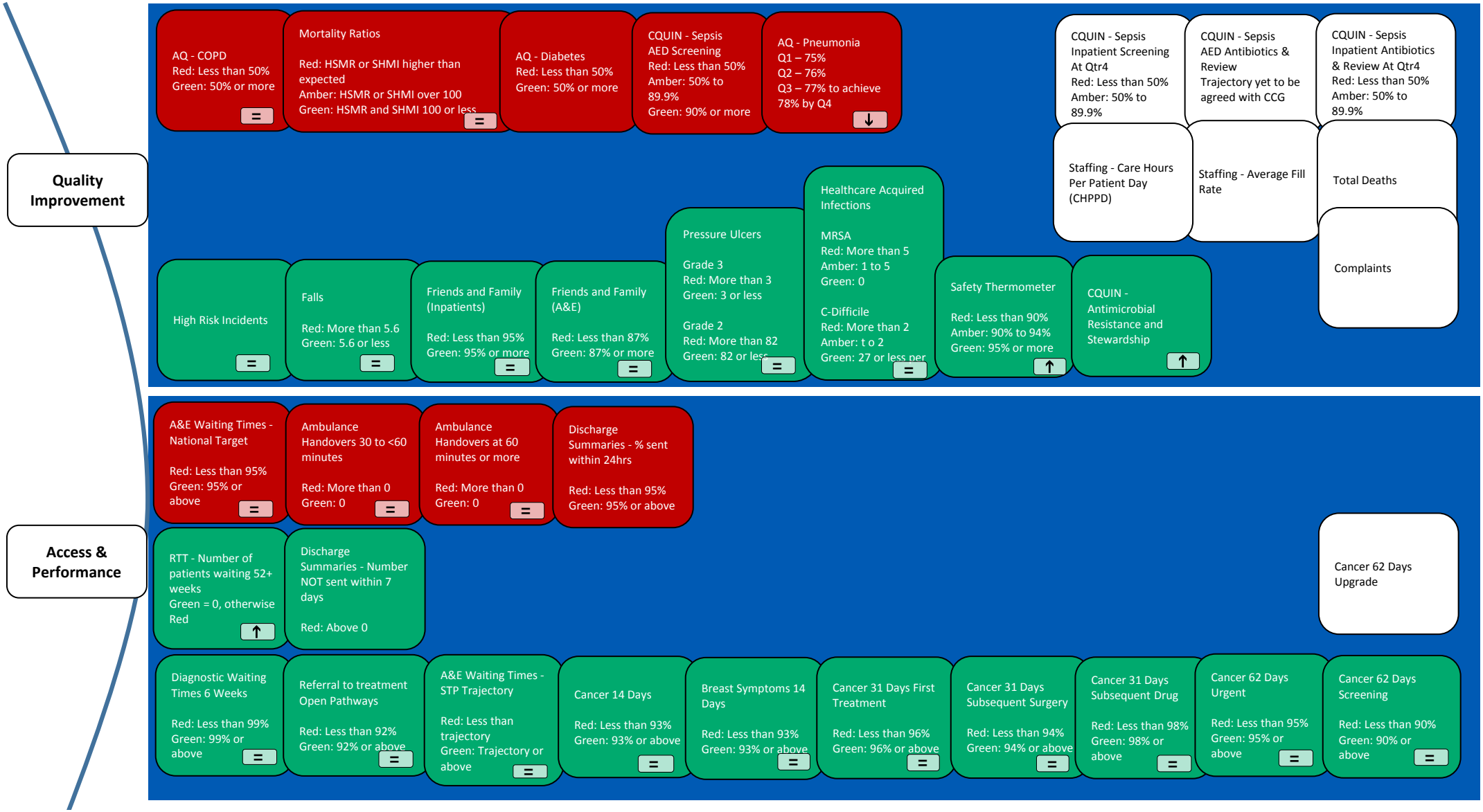
Integrated Dashboard - Board of Directors - August 16



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Integrated Dashboard - Board of Directors - August 16

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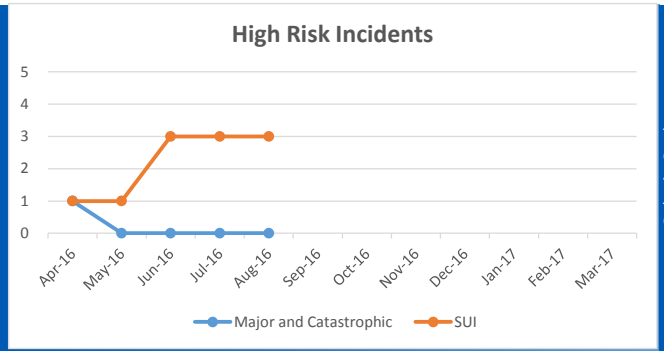
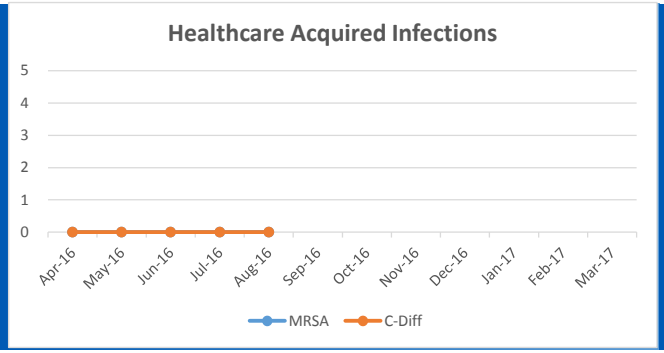
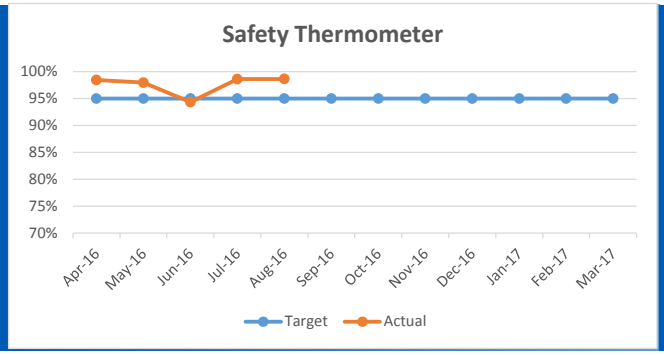
Integrated Dashboard - Board of Directors - August 16

Quality Improvement

	Description	Aggregate Position	Trend	Variation
High Risk Incidents	Major and Catastrophic Incidents and Serious untoward incidents (SUIs) Level 3	There are no approved incidents of major or catastrophic harm for August 2016		There are 2 unapproved incidents of major or catastrophic harm for August 2016 and there remain 4 ongoing incident reviews from April - July (April = 1, June = 1, July = 2) currently graded as Major or Catastrophic Harm.
Healthcare Acquired Infections MRSA Red: More than 5 Amber: 1 to 5 Green: 0 C-Difficile Red: More than 2 Amber: t o 2	MRSA and CLOSTRIDIUM DIFFICILE (due to lapses in care)	There were no cases of MRSA in August. The last Trust apportioned MRSA bacteraemia case was identified from a specimen dated 17/09/2015. YTD 8 cases of CDT have been reported. 4 cases have been reviewed by the CCG and 3 cases removed from contractual sanctions as no lapses in care were identified. The April case with lapses in care related to antibiotic prescribing.		
Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more	% of patients free from harm (Safety Thermometer)	Based on monthly snapshot audit of all inpatients, just over 1% had a fall, pressure ulcer, VTE or catheter acquired infection in August 2016. This is based on new harms.		

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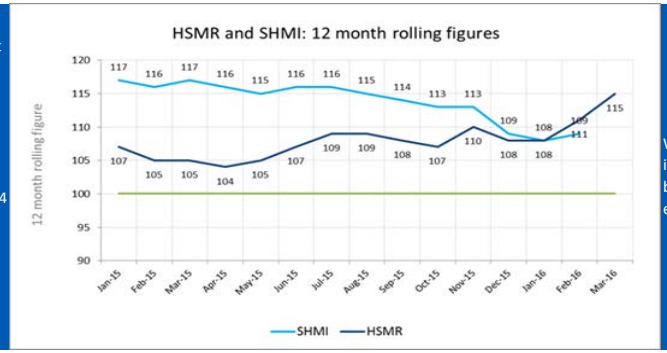
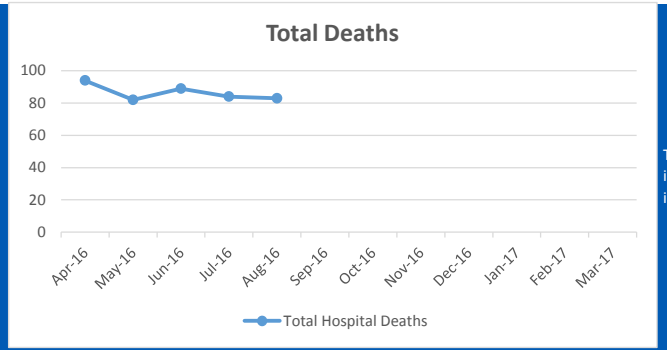
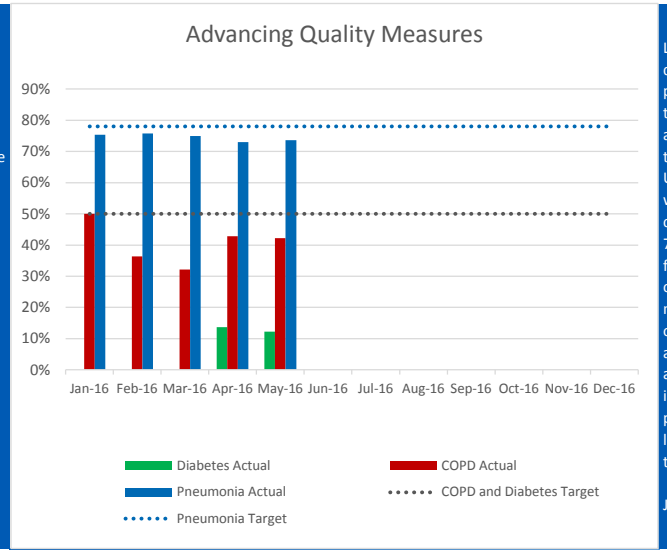
Integrated Dashboard - Board of Directors - August 16

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Mortality Ratios Red: HSMR or SHMI higher than expected Amber: HSMR or SHMI over 100 Green: HSMR and	HSMR (12 month rolling) SHMI (12 month rolling)	The latest HSMR has reduced from 'higher than expected' at 115.28 for May 2015 - June 2016 to 111.75 for June 2015 - May 2016. The latest SHMI was ' as expected' at 109 for March 2015 to February 2016 and has now increased for April 2015- March 2016 to 110.93. Following a seasonal rise in deaths in January, February and March, the figures have reduced to 94 in April ,82 in May, 89 in June, 84 in July and 83 in August.		We wanted to be in the 'as expected' range and ideally below 100 for HSMR. Ideally we want to be below 100 for SHMI, however, we are in the 'as expected' range.
Total Deaths	Total Deaths in Hospital	The death rate was 2.8% for Q4 2015/16. It is 2.1% for 01/04/16 to 16/06/2016		The Mortality Review Group is tasked with interpreting the data for the above and driving improvements
AQ - Diabetes Red: Less than 50% Green: 50% or more AQ - Pneumonia Q1 – 75% Q2 – 76% Q3 – 77% to achieve 78% by Q4 AQ - COPD Red: Less than 50% Green: 50% or more	Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Pneumonia	Diabetes was collected from April 2016 discharges. We have failed to achieve the threshold of 50% and the low compliance for April and May indicates possible non-compliance for the quarter. Poor performing measures relate to blood glucose within 30 minutes of hospital arrival, blood tests repeated at least once within 4 hours of DKA detection and foot inspection within 24 hours of hospital arrival. Possible issues with compliance for COPD include smoking cessation / review inhaler technique measures and corticosteroids administered within 4 hours of hospital arrival. The trust now has a smoking cessation advisor who could support this measure.		Last month we reported that we had introduced a quarterly sliding scale to the thresholds for pneumonia and as Quarter One is 75% we had therefore met this threshold. The CCG could not approve this outright and a paper was submitted to their Governance Meeting for approval. Unfortunately the CCG have informed us that they will not approve the sliding scale as such we were non compliant for Q1 against the original threshold of 78%. April and May results for pneumonia show a further reduction in compliance which could result in overall non-compliance for Q2. Poor performing measures include antibiotic received within 4 hours of hospital arrival and chest x-ray within four hours of arrival. These issues have been addressed and it is anticipated that antibiotics within 4 hours should improve as a result of the SEPSIS work) and new processes trialled from mid May 2016. The diabetes lead has suggested that we renegotiate diabetes thresholds based on process issues with DKA. June data is still being validated.

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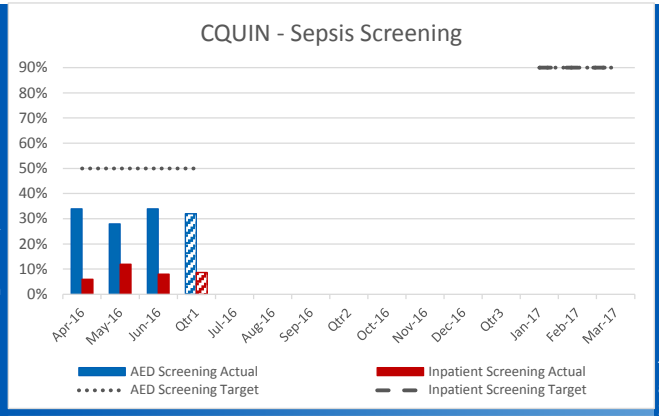
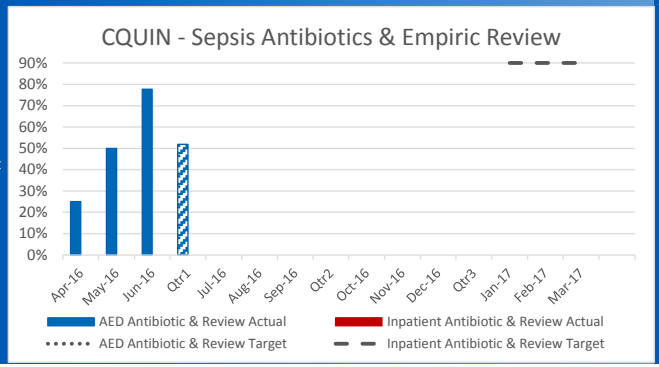
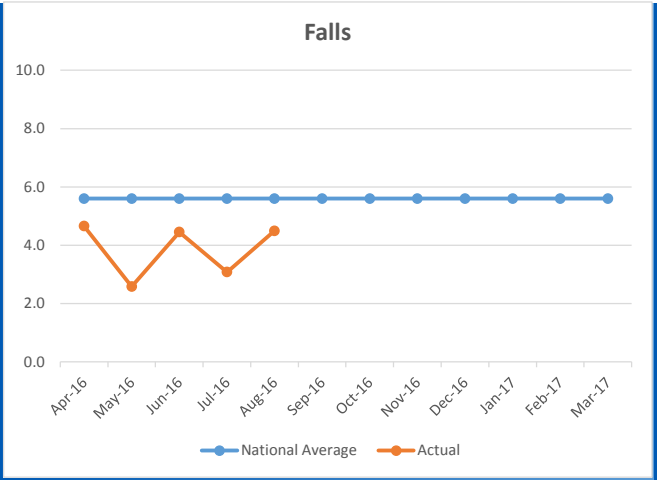
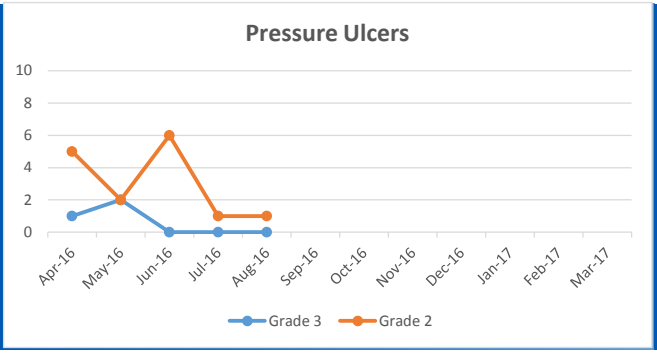
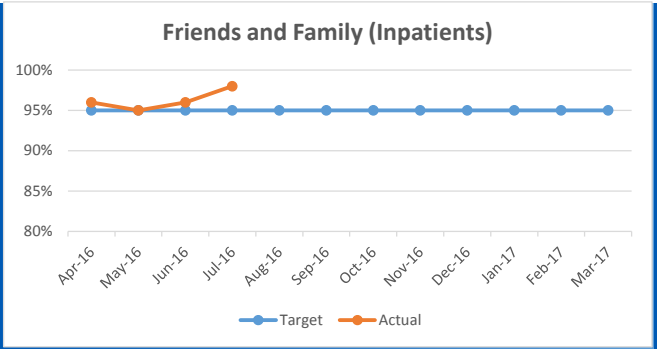
Quality Improvement

	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.	AED SCREENING- Resource issues in undertaking audit will need to be resolved going forward. Q1 results achieved 32% and payment awarded as follows: <50% - NO PAYMENT 50%-89.9% - £10,755 >=90% - £21,510 INPATIENT SCREENING- Both process and resource issues in undertaking audit will need to be resolved going forward. Q1 is about establishing with the CCG a local baseline for Q2 and at the end of Q2 for Q3. For Q1 the Trust achieved 8.67%. However at risk is when Q4 payment will be based on the national thresholds as follows: <50% - NO PAYMENT 50%-89.9% - £10,755 >=90% - £21,510 AED ANTIBIOTIC & EMPIRIC REVIEW - Both process and resource issues in undertaking audit will need to be resolved going forward. Q1 is about establishing with the CCG a local baseline for Q2-Q4 based on previous quarterly results. Q1 results = 51.85% INPATIENT ANTIBIOTIC EMPIRIC REVIEW -Both process and resource issues in undertaking audit will need to be resolved going forward. Q1 is about establishing with the CCG a local baseline for Q2 and at the end of Q2 for Q3. For Q1 the Trust achieved 0%. However at risk is when Q4 payment will be based on national thresholds as follows: <50% - NO PAYMENT 50%-89.9% - £10,755 >=90% - £21,510	 	This data is submitted on a quarterly basis, so there are no results available as yet for July and August 2016.
CQUIN - Antimicrobial Resistance and Stewardship	Antimicrobial Resistance and Stewardship - Reduction in antibiotic consumption per 1,000 admissions. Antimicrobial Resistance and Stewardship- Empiric Review of antibiotic prescriptions within 72 hours	The Trust has submitted the baseline data for antibiotic consumption as required for 2013/2014 - 2015/2016 and the 2016/2017 Q1 usage report. This part of the CQUIN relates to a reduction of 1% or more in total antibiotic consumption against the baseline including a reduction of 1% or more in carbapenem and a reduction of 1% or more in piperacillin-tazobactam. The CQUIN requires a quarterly report but payment is made in Q4. The pharmacist has been contacted to request quarterly reports on antibiotic consumption for this dashboard in order to evidence to the board antibiotic usage against baseline. The pharmacist reported that they are reviewing a system called Define which may support the production of these reports going forward. She has reported that they do not envisage problems with evidencing a 1% reduction in carbapenem however use of piperacillin-tazobactam as a first line antibiotic has doubled against the baseline data. The pharmacist is to undertake a focussed audit to show usage and review of this antibiotic to provide evidence to the CCG that this is acceptable prescribing in line with the Antibiotic Formulary and that it will be difficult to achieve the required reduction. This report now includes the results of the quarterly empiric antibiotic review which evidences 74.67% compliance against a quarter 1 threshold of 25%.		

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 16

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Falls Red: More than 5.6 Green: 5.6 or less	Falls per 1000 bed days	To date we are below the national average of 5.6 approved falls per 1000 bed days. Please note that we only include approved not all falls for this measure, this ensures that falls have been validated before inclusion. Approved falls/1000 BD has been reported in the Quality Report / Account since 2014. The total number of falls per month is obviously higher e.g. There were 98 falls in August with 76 approved and 22 requiring approval as such 4.49 reflects 76 approved falls per 1000 bed days. There is a view that we should record all falls / bed days because the majority would be deemed to be a fall after validation and thus could constitute under reporting. If this was applied to August the falls/bed days rate would increase to 5.79. Quarter 1 data would change as follows April - 5.53; May - 4.71; June - 5.71 and July - 4.71. Please can you confirm if the preferred reporting logic is to base the 1000 bed days on approved (validated) or all falls (not validated). If all falls is the preferred indicator the change will need to be articulated in the Quality Report / Account for 2016/2017.		
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 1 confirmed avoidable Grade 3 pressure ulcer and 14 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 4 cases of Grade 3 pressure ulcers under review from June - August and 15 Grade 2 pressure ulcers under review.
Friends and Family (Inpatients) Red: Less than 95% Green: 95% or more	% recommending the Trust : Inpatients.	This data is sourced from NHS England and is one month in arrears. We have met the monthly target to date for 2016.		

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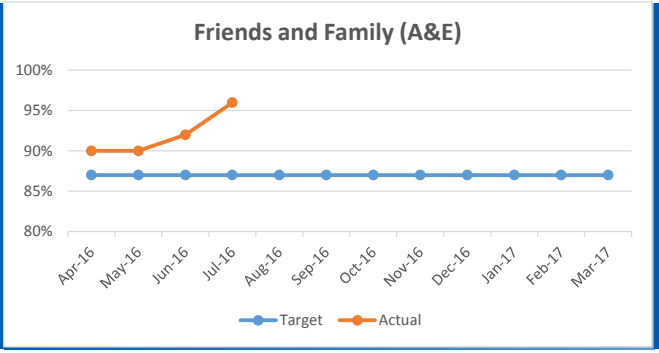
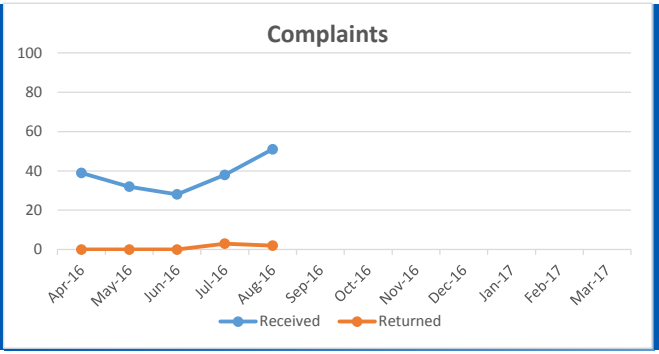
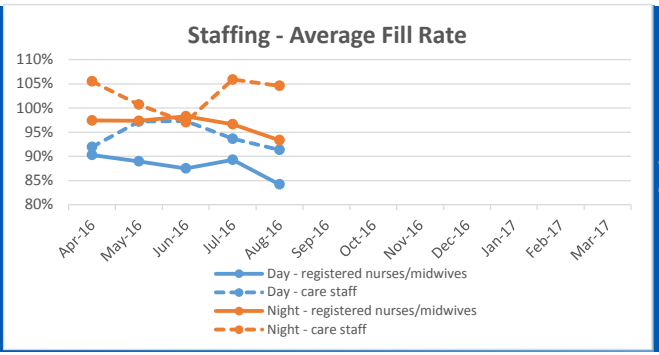
Integrated Dashboard - Board of Directors - August 16

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Friends and Family (A&E) Red: Less than 87% Green: 87% or more	% recommending the Trust : A & E	This data is sourced from NHS England and is one month in arrears. We have exceeded monthly target to date for 2016.		
Complaints				
Staffing - Average Fill Rate	Percentage of planned verses actual for registered and non registered staff by day and night	There continues to be escalation beds open and this will increase the staffing>100% in some areas.		When numbers are greater than 100% this is usually due to specialising

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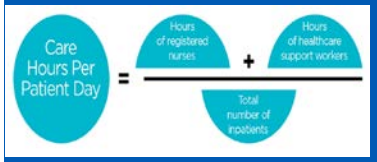
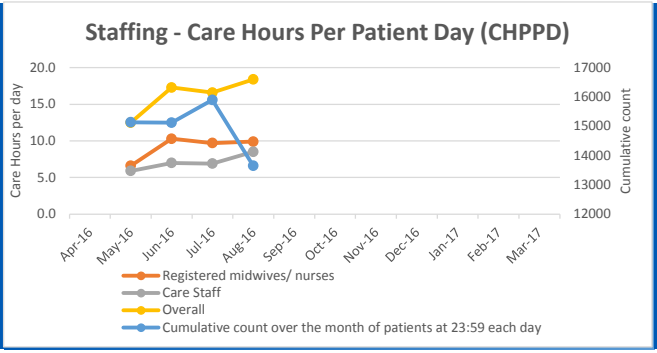
Integrated Dashboard - Board of Directors - August 16

Quality Improvement

	Description	Aggregate Position	Trend	Variation
Staffing - Care Hours Per Patient Day (CHPPD)	 Excluding ITU, CCU, Neonatal and Paediatric wards	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.

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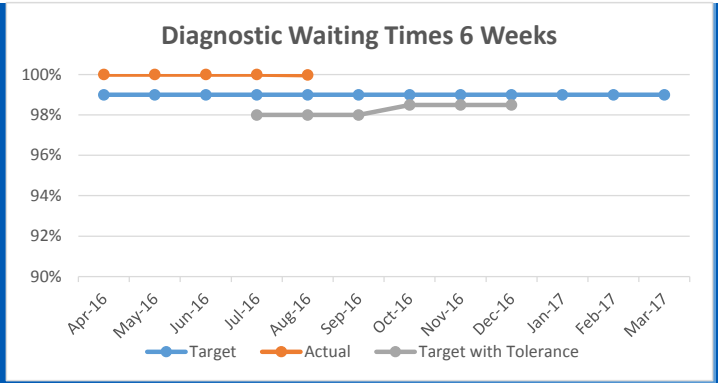
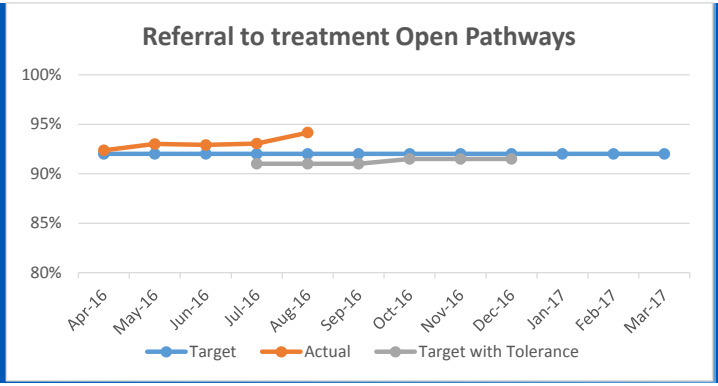
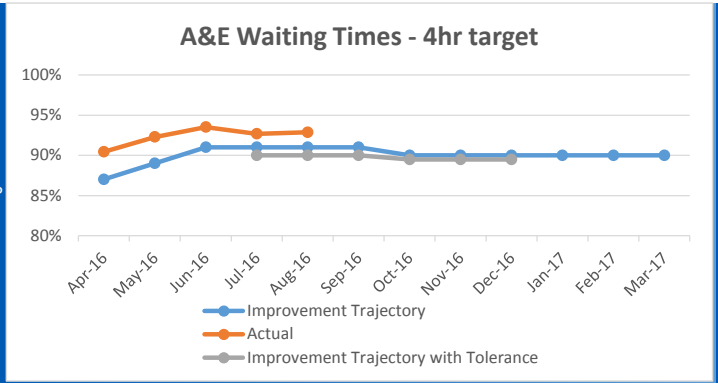
Integrated Dashboard - Board of Directors - August 16

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 99.98%. The Trust has also met the STP Improvement trajectory.		1 breaches of the 6 week standard in Respiratory physiology - sleep studies
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	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: • General Surgery – 90.71% • Urology – 90.65% • T&O – 89.05%
A&E Waiting Times - National Target Red: Less than 95% Green: 95% or above A&E Waiting Times - STP Trajectory Red: Less than trajectory Green: Trajectory or	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust is not achieving the 95% national 4 hour target. However the Trust is achieving against the STP improvement trajectory.		Whilst the Trust is not achieving the 95% national target improvement in performance continues with the Trust meeting the STP Improvement trajectory.

Warrington and Halton Hospitals NHS
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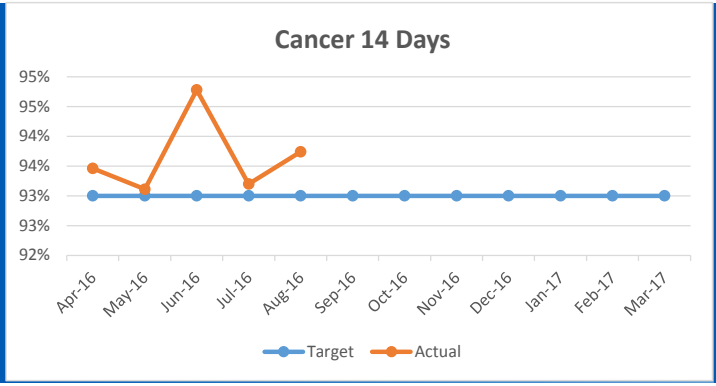
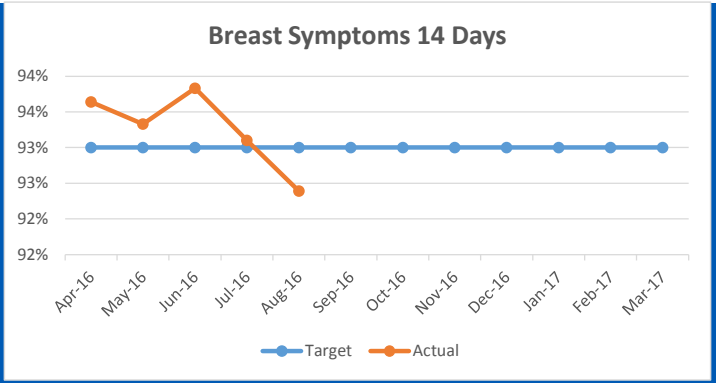
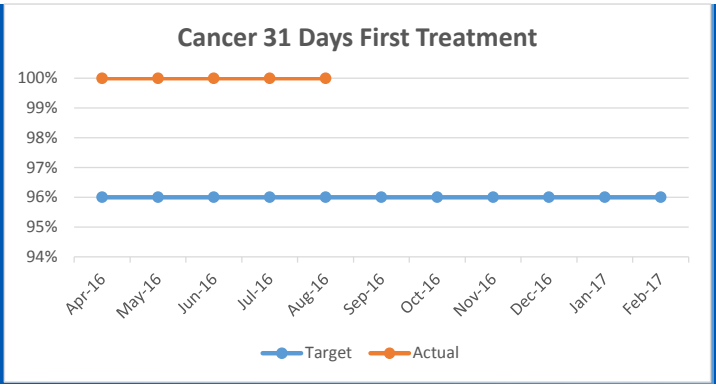
Integrated Dashboard - Board of Directors - August 16

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.			
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.			This target is becoming more and more challenging each month due to patient choice.
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.			

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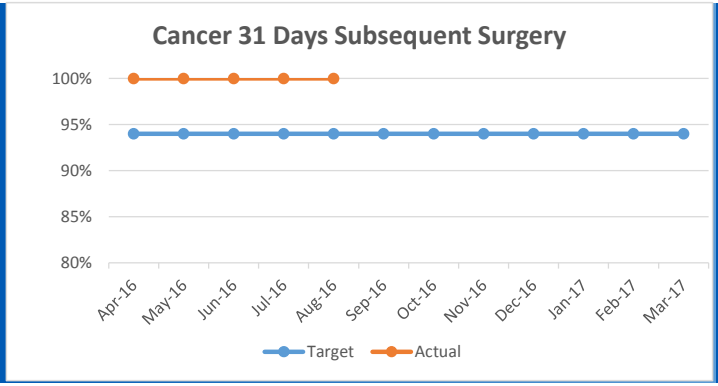
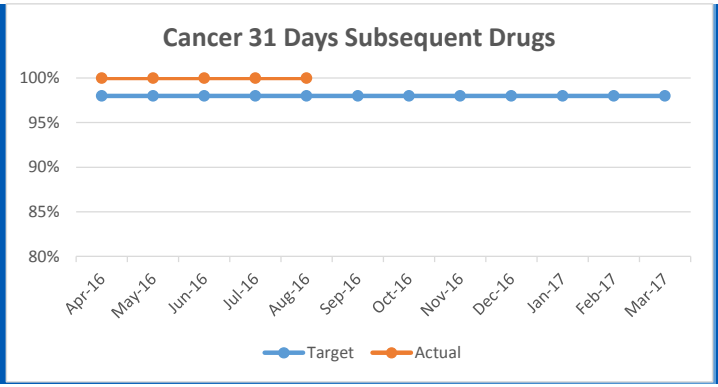
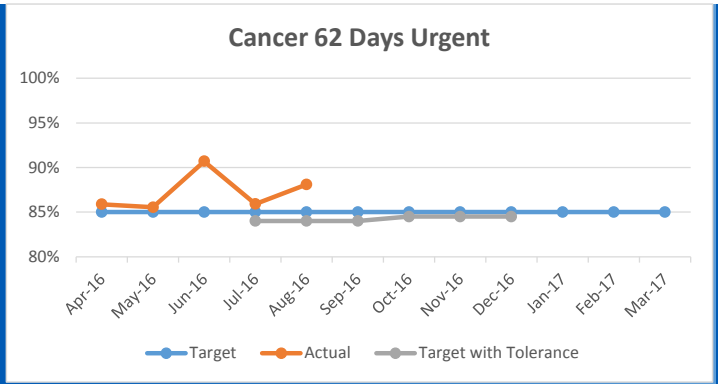
Integrated Dashboard - Board of Directors - August 16

Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.			
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.			
Cancer 62 Days Urgent Red: Less than 95% Green: 95% 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.			

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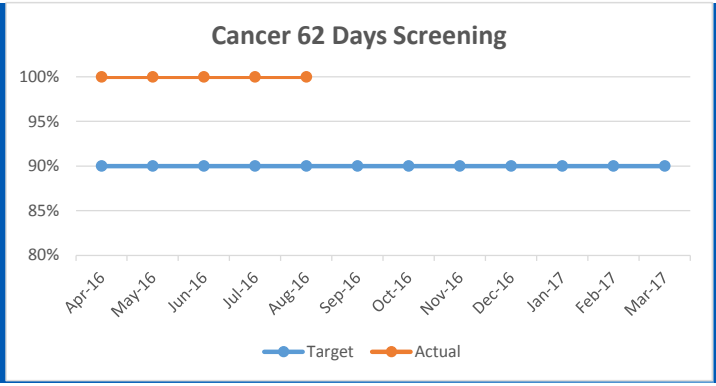
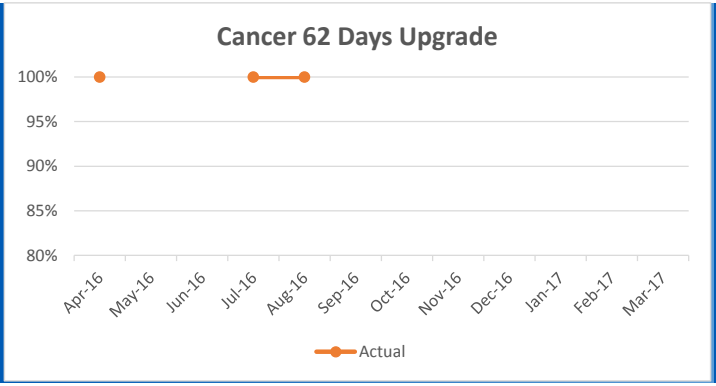
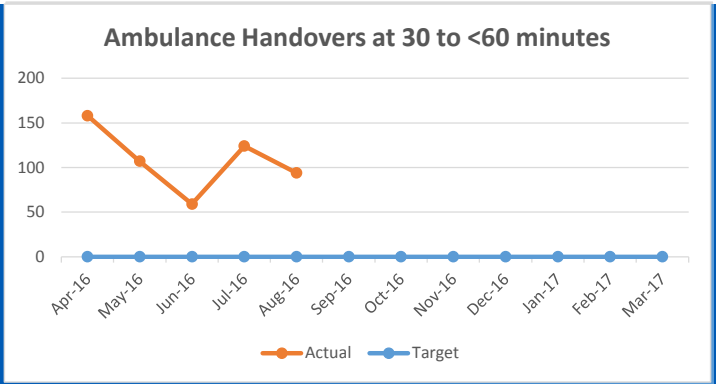
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 16

Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis			
Cancer 62 Days Upgrade	62 day upgrade			
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)			Trust introduced the Ambulance Clinical Co-ordinator (ACC) role from November 2015, the aim of this role was to support compliance whilst educating WHH staff in use of the HAS screen. The investment in this role has now been withdrawn by the CCG and no alternative solution provided. The Trust however does continue to focus on handover times and some improvements have been seen in the 30-60 minute delays.

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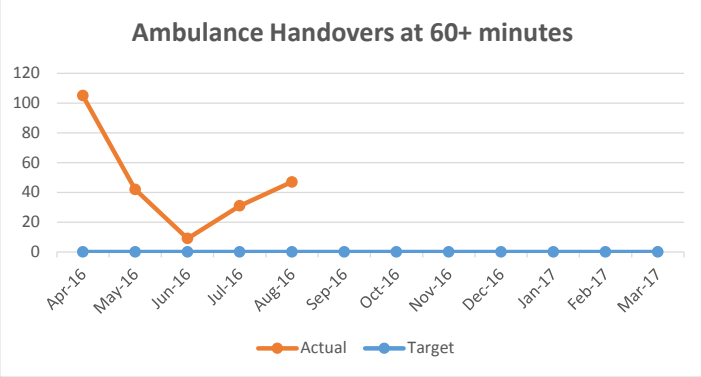
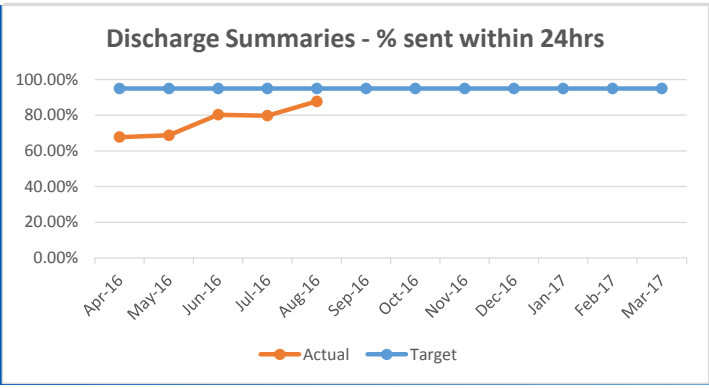
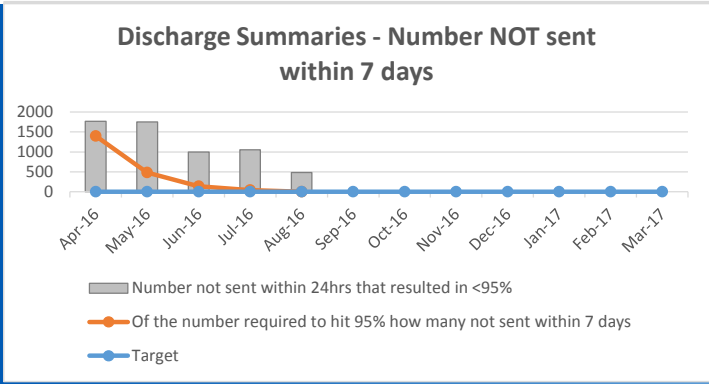
Integrated Dashboard - Board of Directors - August 16

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)			
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			Since Lorenzo go live the way we send discharge summaries has changed, which should support more accurate summaries. However we have seen a reduction in performance since November. We have therefore set up new report enabling each area can measure their performance against the target, and there is also an escalation process in place. We are seeing the impact and improvements have been made in the last month. We are currently investigating an SUI related to a delay in discharge summaries being sent to GPs, the issue was raised through the quality contract meeting and a full investigation is taking place.
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			

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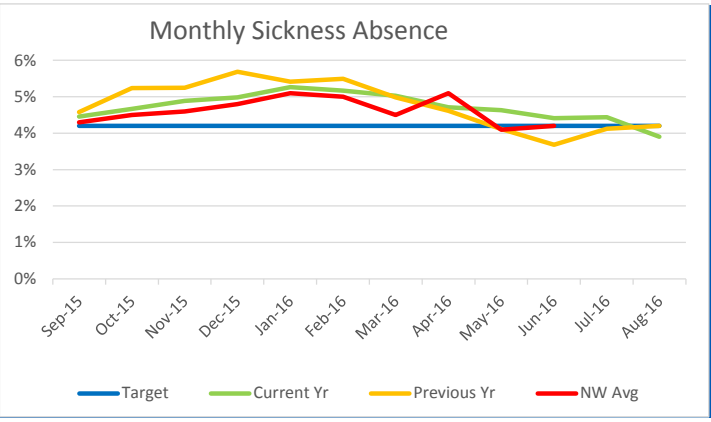
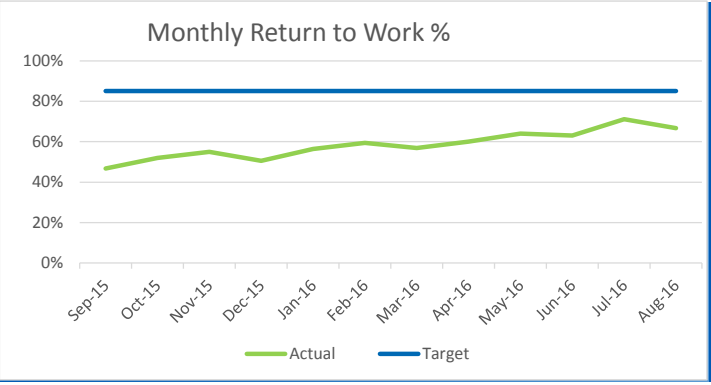
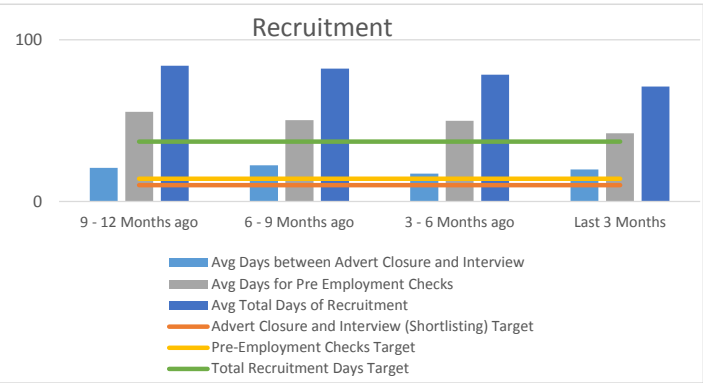
Integrated Dashboard - Board of Directors - August 16

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 August 2016 was 3.90%, a slight deterioration from the previous month's performance of 0.14% but meeting the target for the month. The latest figures for the North West absence performance currently stands at 4.2% (June) The YTD sickness has marginally increased to 4.42% against a target of 4.2%		The target for sickness absence has been revised to 4.2%. The trust is at 4.42% and 'amber' and WHH is slightly above the North West Average. Discussions on the Attendance Management policy continue and whilst agreement has been reached with Staff Side on many aspects, some differences remain. Stress remains the number one reason for absence with 23% of all sickness absence due to stress. ACS - August-16 = 3.89%, YTD = 4.83% SWC - August-16 = 3.83%, YTD = 4.45% Corp - August-16 = 4%, YTD = 3.7%
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 was 66.67% for August which was a slight improvement but continues to be below the Trust Target. However, the trend is generally upward but taking rather longer that was expected. The YTD RTW rate is 59% an increase of 3%.		Completion of RTWs is considered key to good sickness management. Divisional review meetings held during August and discussed regularly at SMT meetings. Audit of RTW to be undertaken by HRBPs. For the avoidance of doubt, the RTW can be recorded in either ESR or E-Rostering, there is no need to record the date in both. HRBPs continue to support their managers to increase compliance.
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	Recruitment times continue to reduce to an overall total of 71 days but much better than the position 9 - 12 months ago when it was 84 days. Disappointingly as a Trust we are still taking longer to shortlist/interview and to complete employment checks than we would like.		The Employment Services Team continue to improve their processes to ensure the pre-employment stage is as efficient as possible and this is reflected in the period reducing from 50 to 42 days. Currently e-Forms are being explored - this will require some investment. All recruiting managers are encouraged to plan their shortlisting and interview dates ahead of time. The period taken to shortlist and interview has increased from 17 to 20 days (almost 3 weeks) which is not acceptable against a target of 10 days.

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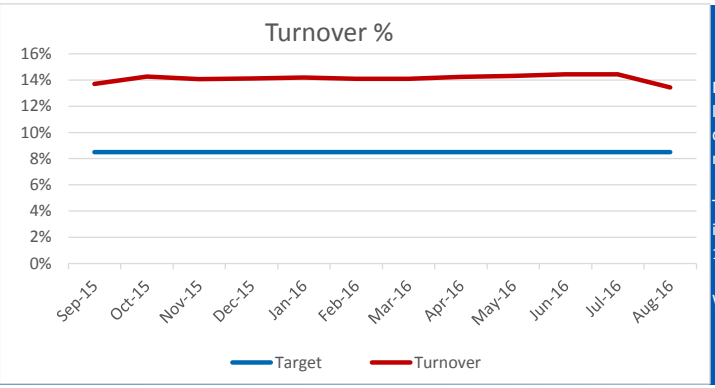
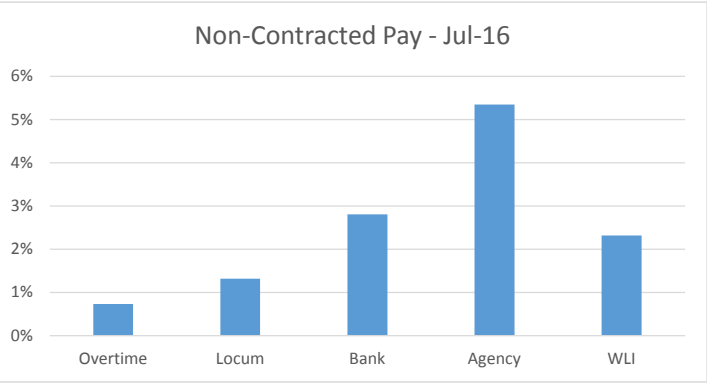
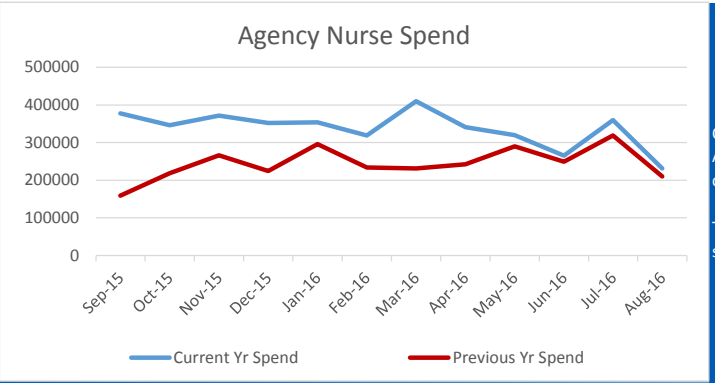
Integrated Dashboard - Board of Directors - August 16

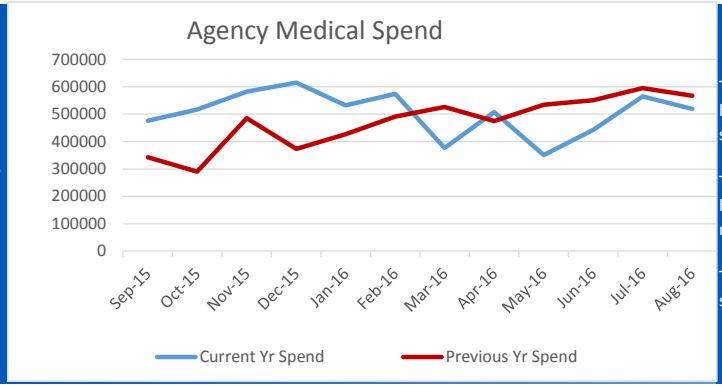
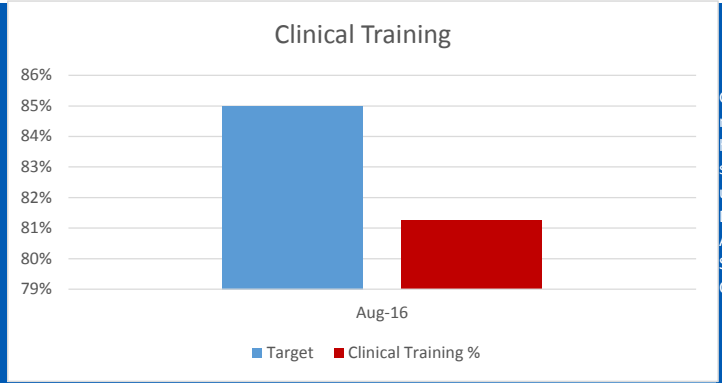
Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Below 5% Above 12% Amber: 5% to 7% or 10% to 12%	A review of the turnover percentage over the last 12 months	Turnover reduced by almost 1% to 13.45% and is the lowest for over 12 months. Continues to be above the Trust target of 7 - 10%.		During the last month there were slightly more leavers than starters which was influenced by the doctors changeover but overall there continues to be more starters (41.2 wte) than leavers (38 wte) The main reasons people are leaving WHH is for an improved Work Life Balance (107) people in the last 12 months). Work continues within the CBUs to address this.
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 5.35% of the Trusts overall pay bill year to date but better than the position at April of 5.93%. Bank spend is 2.81% followed closely by WLI spend at 2.32% of the pay bill. Overall Non-Contracted pay now makes up 12.53% of the pay bill compared to 13.02% in April - moving in the right direction.		Work continues on implementing the action plan developed alongside E&Y. Chief operating officer has agreed that WLI payments will be reduced on a phased basis wef 17 October 2016. The comms for this change is currently being circulated and shared with staff.
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 decreased in August to its lowest level this financial year of £231k. Although expenditure is more than 2015/16 the differential is now closing.		On-going work continues to reduce the reliance of Agency Nurses and it is hoped this reduction will continue. Trust working with NHS Employers to setup an agency spend summit meeting over the next few months

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 16

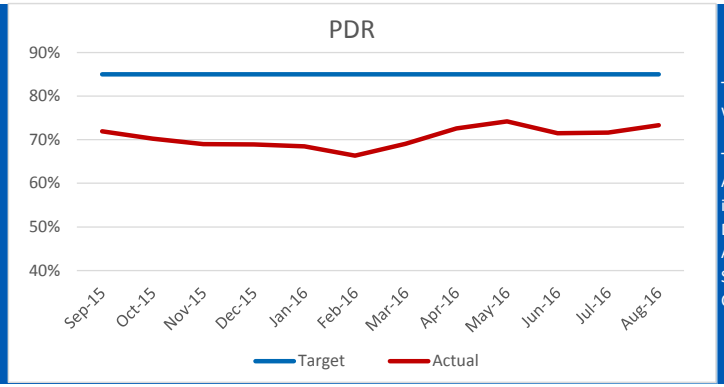
Workforce

	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 decreased in August by £46k to £519k and was £48k less than the same month last year.		The Trust continues to enforce the Price Cap rules, however it's proving difficult and the majority of our shifts worked each week breach the Price Cap. The extra scrutiny by the Chiefs of Service however has seen a reduction in the number of Locum shifts required through increased Grip and Control Trust working with NHS Employers to setup an agency spend summit meeting 0ver the next few months
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 current compliance for August is 85.47% which is marginally above the trust target of 85%		Grouping the Mandatory Training in this method is new way of reporting compliance, historic figures are however not yet available but the August rate was a slight increase from the previous month and shows an upwards trend. Divisional progress is as follows: ACS August = 83.94% Amber SWC August = 83.74% Amber Corp August = 89.83% 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 current compliance for August increased to 81.24% but is below the trust target of 85%.		Grouping the Mandatory Training in this method is new way of reporting compliance, historic figures are however not yet available but the August rate was a slight increase from the previous month and shows an upward trend. Divisional progress is as follows: ACS August = 77.75% Amber SWC August = 81.10% Amber Corp August = 88.07% Green

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 16

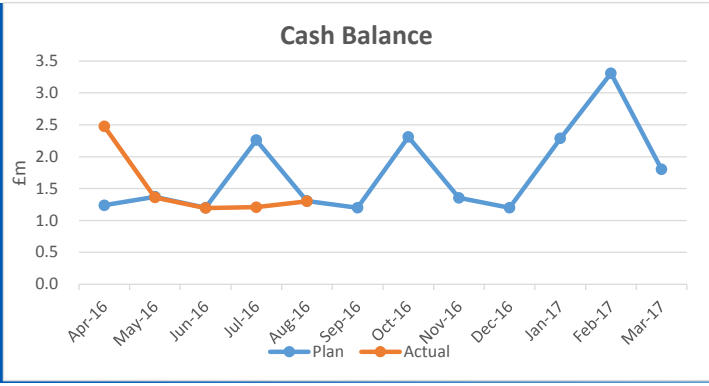
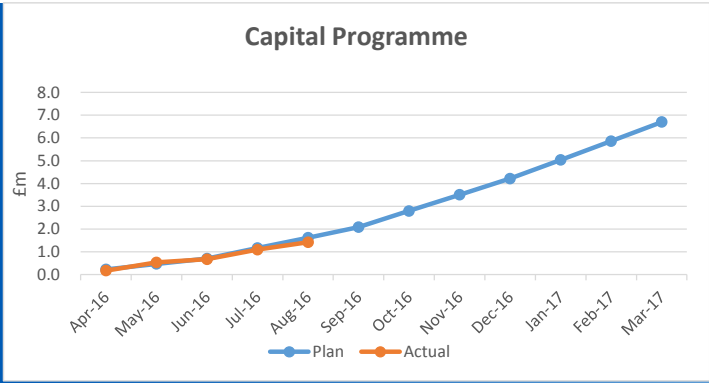
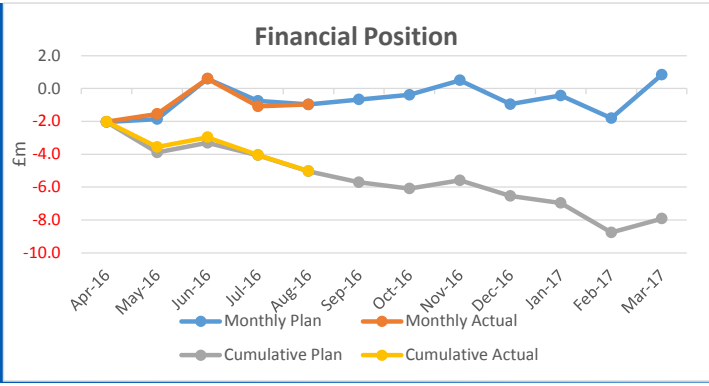
Workforce

	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	The PDR compliance rate increased by 1.69% to 73.32% but this is still below the Trust target of 85%.		The HR team are offering further support to managers who are struggling with their PDR Compliance. The Director of HR & OD met with the Divisions during August to emphasise the importance of PDR rates increasing. Divisional progress is as follows: ACS August = 69.95% Red SWC August = 72.36% Amber Corp August = 78.96% Amber

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 16

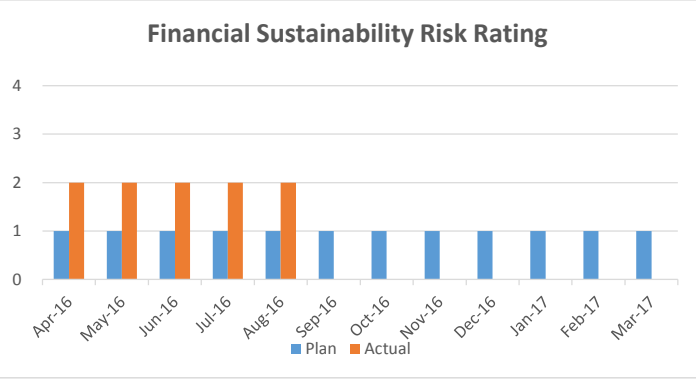
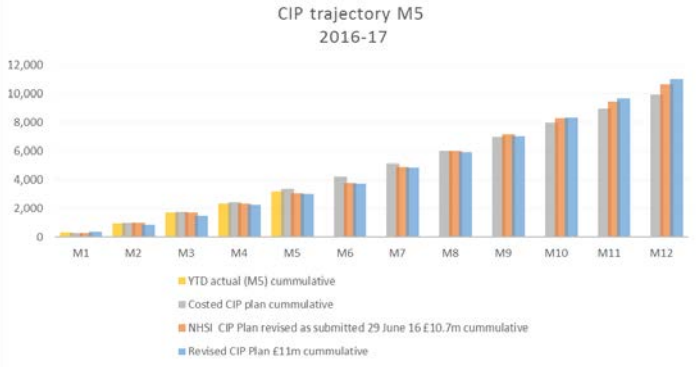
Safely Reducing Costs & Mandatory Standards - Finance

	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 of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.3m equates to circa 2 days operational cash.		The current cash balance of £1.3m is in line with the planned cash balance of £1.3m
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 £0.3m which increases the year to date spend to £1.4m		The cumulative capital spend of £1.4m is £0.2m below the planned spend of £1.6m.
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 £1.0m which increases the cumulative deficit to £5.0m		The cumulative deficit of £5.0m is in line with the planned deficit of £5.0m. Further detail can be found in Appendix 1.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 16

Safely Reducing Costs & Mandatory Standards - Finance

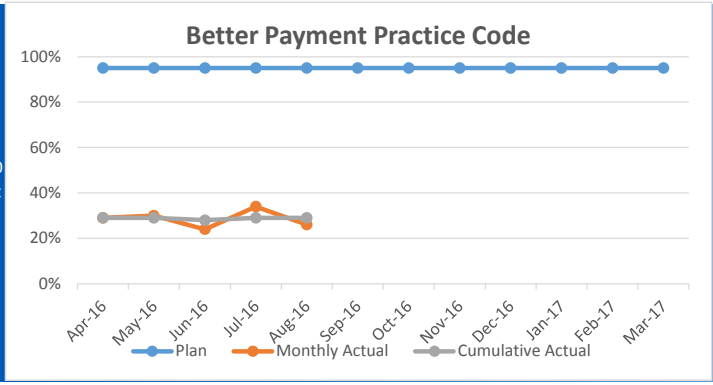
	Description	Aggregate Position	Trend	Variation
Financial Sustainability Risk Rating Red: Risk Rating 1 Amber: Risk Rating 2 Green: Risk Rating 3 or 4	Year to date Financial Sustainability Risk Rating compared to plan.	The current Financial Sustainability Risk Rating is 2. Capital servicing capacity, Liquidity and I&E margin are all at the highest risk (Level 1) whilst I&E margin as a percentage of plan is at the lowest risk (Level 4).		The current Financial Sustainability Risk Rating of 2 is better than the planned rating of 1.
Cost Improvement Programme - Plans in Progress Red: Plan is less than 50% of annual plan Amber: Plan is between 51% and 89% of annual plan Green: Plan is over 90% of annual plan	Planned improvements in productivity and efficiency.	The Trust has a CIP target of £11m and delivery of £10.7m is currently assumed in the reforecast financial plan. To date the Trust has developed schemes worth £9.95m in year (£11.16m recurrently).		The part year effect of costed schemes is £9.95 m which is £0.75m below plan. This is offset by £1.18 m part year effect of costed cost avoidance schemes. The full year effect of costed schemes is £11.16m which is £0.46m ahead of 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 cost savings delivered compared to plan.	The savings delivered in month are £0.8m which increases the cumulative savings delivered to £3.2m		The cumulative savings of £3.2m are £0.1m ahead of the planned savings of £3.1m.

Clinical Business Units/Corporate Support areas	CIP Internal Target £11m	CIP costed PYE	CIP costed FYE	% of CIP internal target £11m costed PYE
Surgery and Women's and Children's	*4,161*	*3,253*	*4,125*	*78%*
Acute Care Services	*4,516*	*3,889*	*3,798*	*86%*
Schemes not allocated to CBUs	0	992	1,521	
Controls	277	0	0	0%
Outpatients	121	121	181	100%
Corporate Support Areas	*1,925*	*1,694*	*1,531*	88%
Trust	*11,000*	9,949	*11,156*	90%

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 16

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 26% of suppliers within 30 days which maintains the year to date performance at 29%.		The cumulative position 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.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

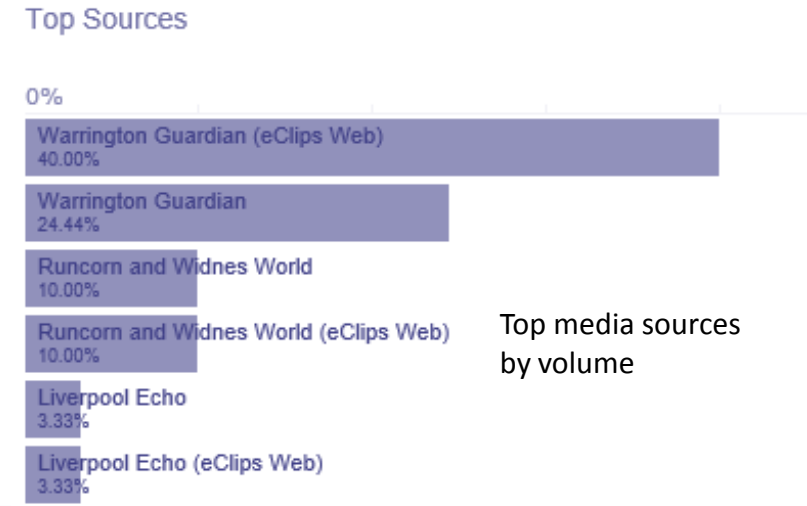
Trust Engagement Dashboard August 2016

Pat McLaren
Director of Community Engagement

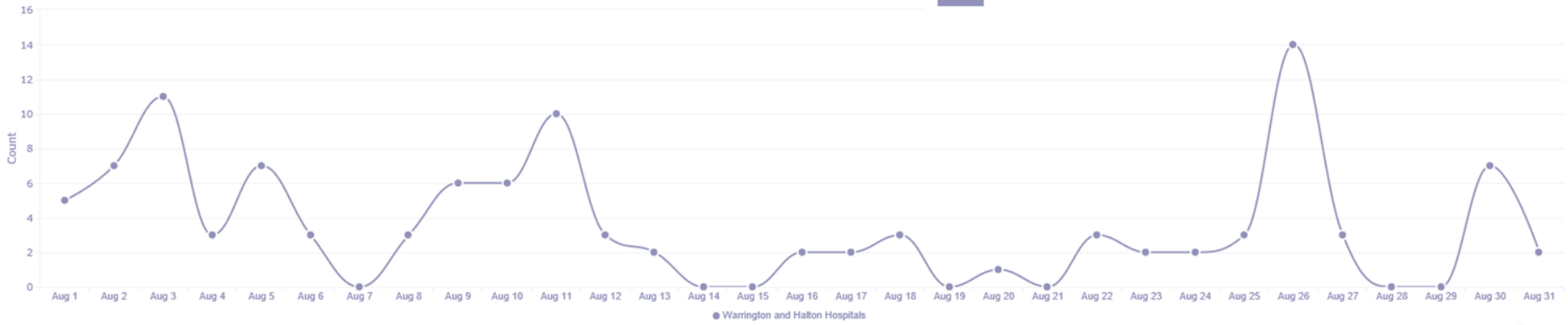
We are WHH

Media Dashboard (Public Engagement) 1-31 August 2016

Total media coverage = 110 reports (↓ from 143 last month)



Top media sources by volume



We are WHH

Media Dashboard (Public Engagement)/2

Headline	Source	Reach
Widnes nursing student hoping to qualify for national UK Skills competition	Liverpool Echo (eClips Web)	168559
Widnes nursing student hoping to qualify for national UK Skills competition	Liverpool Echo	137495
Warrington Hospital signs up to Royal College of Midwives' Caring for You campaign	Warrington Guardian	61875
Hospital pledges to improve health and wellbeing of midwives	Warrington Guardian (eClips Web)	54547
Grandad surprised by Vikings player after charity challenge in memory of wife	Runcorn and Widnes World (eClips Web)	53048
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Hospital chaplain raises 1,300 on London to Paris charity ride	Runcorn and Widnes World (eClips Web)	53048

Headline	Source	Reach
Doctors' watchdog places one in four hospitals on danger watch list	The Telegraph (eClips Web)	28775492
Nurse banned after 'faffing around' as hospital patient stopped breathing	Liverpool Echo	181861
A&E nurse used 'excessive force' to remove 'abusive' and 'intoxicated' patient	Liverpool Echo (eClips Web)	168559
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More than 66,000 staff sickness days reported at Warrington Hospital last year	Warrington Guardian	61875
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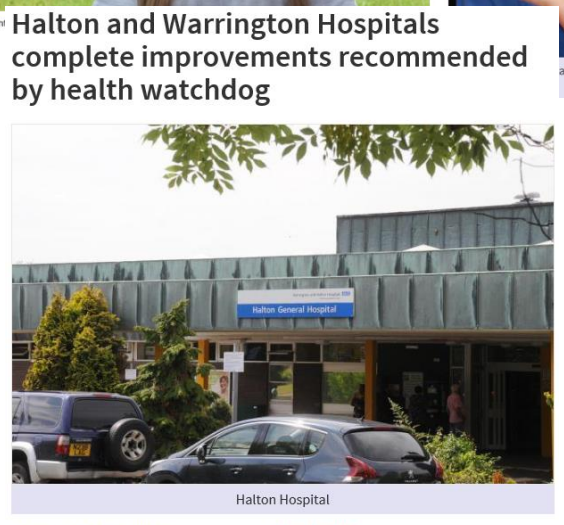

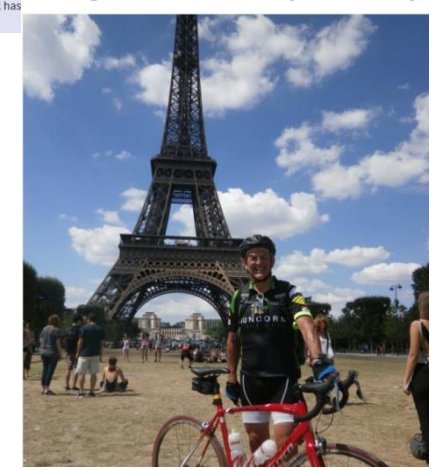

Media Dashboard

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Negative coverage included:
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We are WHH

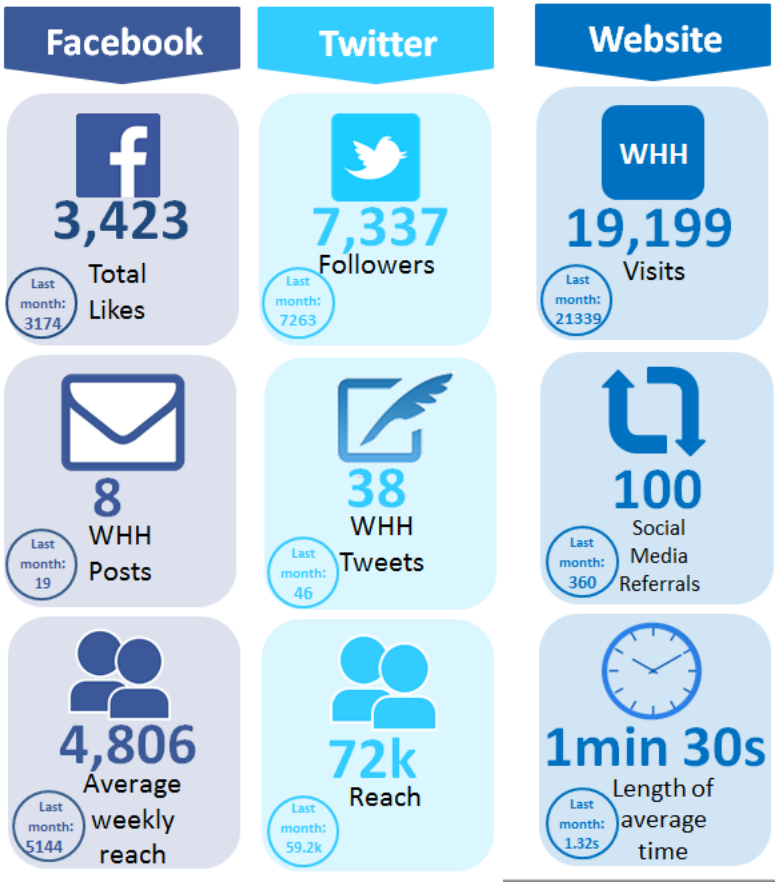
Social Media/Website Dashboard August 2016

↑ Facebook likes increased in month by 249
↓ Average weekly FB reach reduced to 4.8K from 5.1K
↑ Twitter followers increased by 74 in month
↓ Tweets decreased to 38 in month (down by 8)
↑ Twitter reach increased to 72K followers

WEBSITE ACTIVITY

↑Website traffic was stable at around 20K visits
↑ Social media referrals reduced by two thirds
→Dwell time was roughly static

- New visitors continued to account for two thirds of all traffic
- Visitors by country (new metric) 3.5% visitors from Russia, USA and India
- Most visited pages: Home/Vacancies/Contact Us/Getting Here/Volunteer



	Page Title
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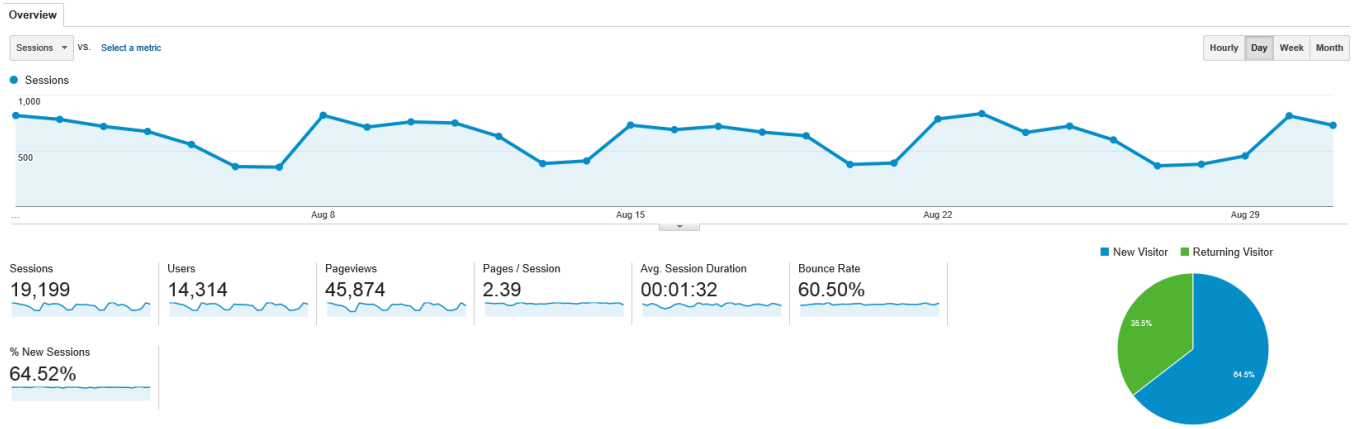
	Country	Sessions	% Sessions
1.	United Kingdom	18,498	91.70%
2.	Russia	416	2.06%
3.	United States	295	1.46%
4.	India	130	0.64%
5.	Kyrgyzstan	73	0.36%
6.	Australia	52	0.26%
7.	Ireland	47	0.23%
8.	Germany	44	0.22%
9.	Malaysia	42	0.21%
10.	Canada	35	0.17%



We are WHH

Patient Engagement

NHS Choices

6
No. of comments posted
Last month: 5

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

Halton – 5 stars
CMTC - 5 stars
Warr – 3.5 stars

Warrington and Halton Hospitals NHS Foundation Trust

Date: 01 August - 31 August

Your average score for all questions this period: 4.78

Reviews this period: 2221

Your recommend scores

5 Star Score	% Likely to recommend	% Unlikely to recommend
4.73	94.1%	1.9%

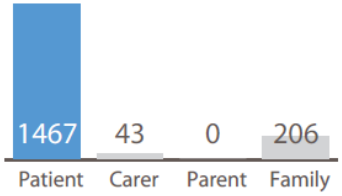
Top three services (with 5 reviews or more)

Community Midwives	5.00
Ward Day Case Unit Halton	4.98
Endoscopy Unit Halton	4.98

Bottom three services (with 5 reviews or more)

Clinical Decisions Unit	4.25
Ward C22	4.11
Ward A3	3.94

Reviews by reviewer type



Demographics completion rate

Question	Blanks	% Completed
Age	55	97.47
Gender	239	89.01
Ethnicity	260	88.05
Long-term Conditions	491	77.43
Reviewer type	58	96.73

NHS Choices
↑ Increase in comments in month by 1
→ Star Rating remains unchanged in month

Friends and Family Test (Adult services)

↓ Responses decreased by 266 in month
↓ Star rating decreased by 0.05 in month
↓ % likely to recommend decreased by 3%
↑% unlikely to recommend decreased by 1.2%

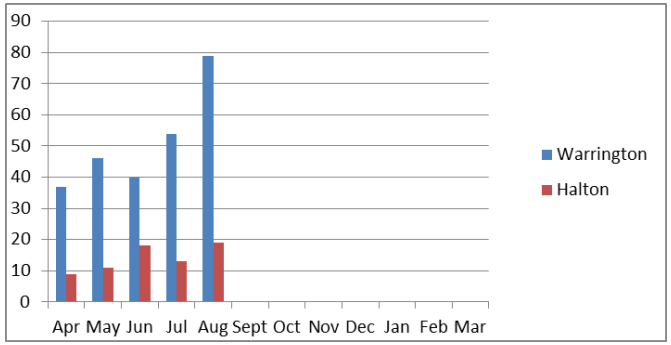
Staff Engagement

WHH new Extranet engagement:

↑ 2327 staff registered on the new extranet since launch 24.2.16 (increase in month of 108 new registrants)
→ Bounce rate 35-40% (Bounce rate is indication of interaction with site: Good is 26% – 40%, average is 40% – 55%, bad is 56-80%

Team Brief Attendances

We are very encouraged By the increasing engagement with Team Brief which is a proven large, multi-site Organisation engagement tool.



❑ Staff nominating colleagues for :
↓ Employee of Month = 7 (Increase of 3 since July)
↑ Team of Month = 12 (Increase from 3 in June)

Quarterly Data (*latest quarter is Q1 – data is incomplete at time of reporting*)

❑ Q1 Staff FFT responses (online results only) 102 (Q4– 315 responses)

- **Staff FFT Recommend for Care / treatment**
  ↑ 72% extremely likely or likely (Q4 70%)
  ↑ 16% extremely unlikely or unlikely (Q4 16%)
- **Staff FFT Recommend as Place of Work**
  ↑ 66% extremely likely or likely (Q4 64%)
  ↑ 24% extremely unlikely or unlikely (Q4 21%)

❑ Q2 20 Staff attending Solutioning workshop 'From Concept to Completion' hosted by Director of Transformation:

Annual Data:
❑ NHS Staff Survey 2015 – Engagement score 3.74 (worse than similar Trusts)
❑ 2016 survey launched end Sept 2016

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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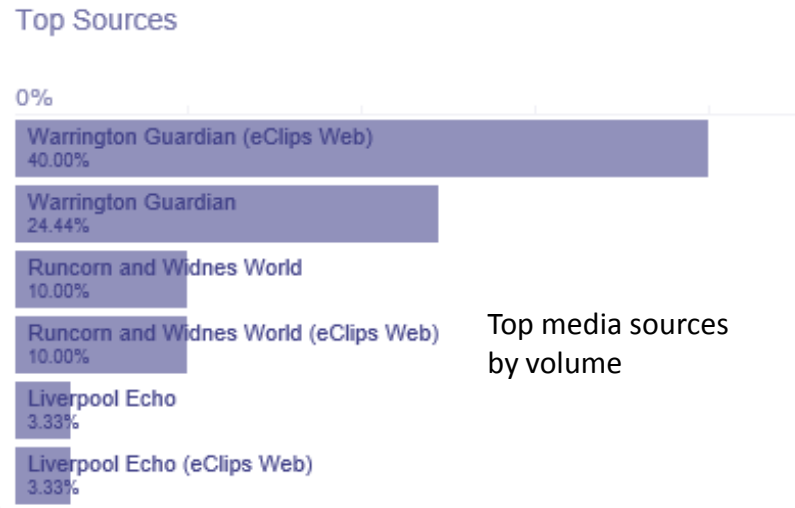

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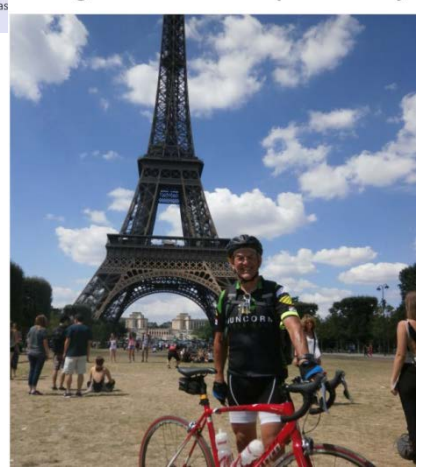

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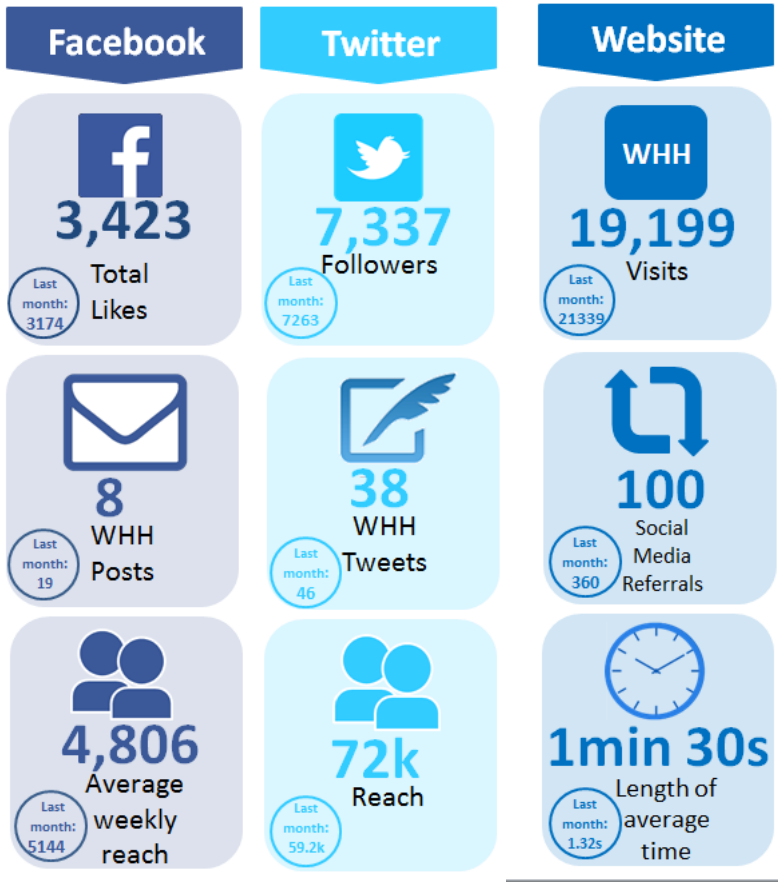

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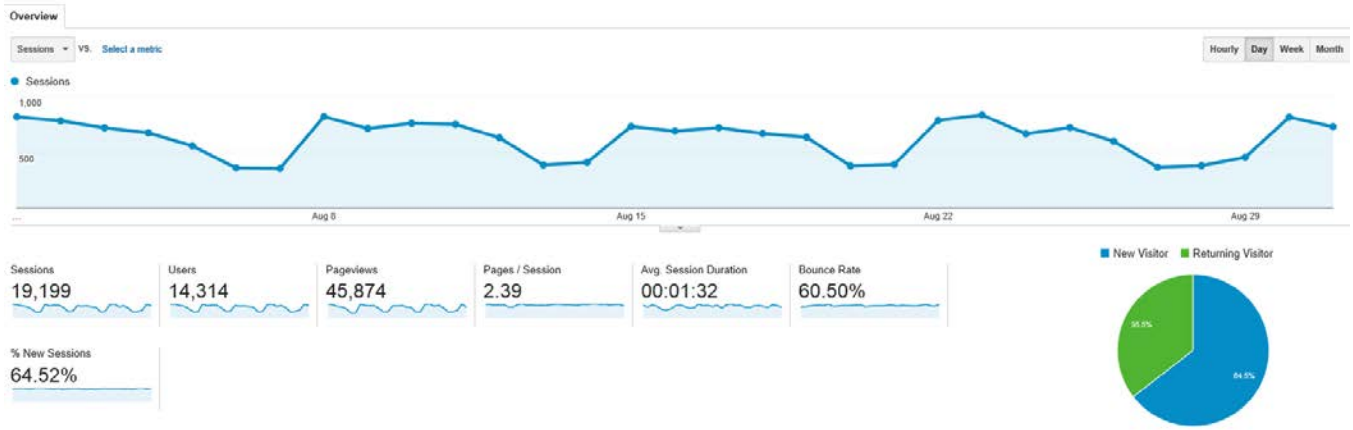
9.	Urgent Care Centre - Runcorn | Warrington & Halton Hospitals
10.	Getting here, maps and transport | Warrington & Halton Hospitals

	Country	Sessions	% Sessions
1.	United Kingdom	18,498	91.70%
2.	Russia	416	2.06%
3.	United States	295	1.46%
4.	India	130	0.64%
5.	Kyrgyzstan	73	0.36%
6.	Australia	52	0.26%
7.	Ireland	47	0.23%
8.	Germany	44	0.22%
9.	Malaysia	42	0.21%
10.	Canada	35	0.17%



We are WHH

Patient Engagement

NHS Choices

6
No. of comments posted
Last month: 5

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

Halton – 5 stars
CMTC - 5 stars
Warr – 3.5 stars

Warrington and Halton Hospitals NHS Foundation Trust

Date: 01 August - 31 August

Your average score for all questions this period: 4.78

Reviews this period: 2221

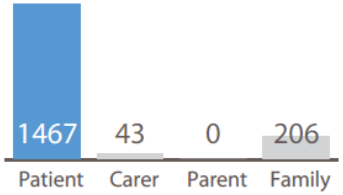
Your recommend scores

5 Star Score	% Likely to recommend	% Unlikely to recommend
4.73	94.1%	1.9%

Top three services (with 5 reviews or more)	
Community Midwives	5.00
Ward Day Case Unit Halton	4.98
Endoscopy Unit Halton	4.98

Bottom three services (with 5 reviews or more)	
Clinical Decisions Unit	4.25
Ward C22	4.11
Ward A3	3.94

Reviews by reviewer type



Demographics completion rate

Question	Blanks	% Completed
Age	55	97.47
Gender	239	89.01
Ethnicity	260	88.05
Long-term Conditions	491	77.43
Reviewer type	58	96.73

NHS Choices
↑ Increase in comments in month by 1
→ Star Rating remains unchanged in month

Friends and Family Test (Adult services)

↓ Responses decreased by 266 in month
↓ Star rating decreased by 0.05 in month
↓ % likely to recommend decreased by 3%
↑% unlikely to recommend decreased by 1.2%

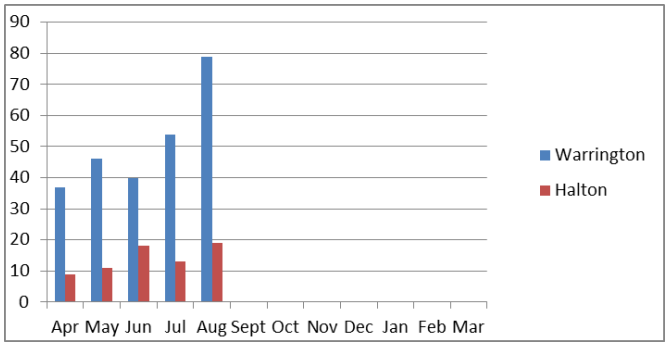
Staff Engagement

WHH new Extranet engagement:

↑ 2327 staff registered on the new extranet since launch 24.2.16 (increase in month of 108 new registrants)
→ Bounce rate 35-40% (Bounce rate is indication of interaction with site: Good is 26% – 40%, average is 40% – 55%, bad is 56-80%

Team Brief Attendances

We are very encouraged By the increasing engagement with Team Brief which is a proven large, multi-site Organisation engagement tool.



❑ Staff nominating colleagues for :
↓ Employee of Month = 7 (Increase of 3 since July)
↑ Team of Month = 12 (Increase from 3 in June)

Quarterly Data (*latest quarter is Q1 – data is incomplete at time of reporting*)

❑ Q1 Staff FFT responses (online results only) 102 (Q4– 315 responses)
- **Staff FFT Recommend for Care / treatment**
  ↑ 72% extremely likely or likely (Q4 70%)
  ↑ 16% extremely unlikely or unlikely (Q4 16%)
- **Staff FFT Recommend as Place of Work**
  ↑ 66% extremely likely or likely (Q4 64%)
  ↑ 24% extremely unlikely or unlikely (Q4 21%)

❑ Q2 20 Staff attending Solutioning workshop 'From Concept to Completion' hosted by Director of Transformation:

Annual Data:
❑ NHS Staff Survey 2015 – Engagement score 3.74 (worse than similar Trusts)
❑ 2016 survey launched end Sept 2016

TRUST BOARD

SUBJECT:	**Finance Report as at 31st August 2016**	
DATE OF MEETING:	28st September 2016	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR:	Andrea Chadwick, Director of Finance & Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO4/4.2 Failure to maintain a liquidity ratio and capital servicing capacity necessary to deliver a financial sustainability risk rating of 3 on a quarterly basis; remain a going concern at all times; remain solvent and comply with section G6 of the licence. SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:		
EXECUTIVE SUMMARY (KEY ISSUES):	For the period ending 31st August 2016 the Trust has recorded a deficit of £5.0m, a cash balance of £1.3m and a Financial Sustainability Risk Rating score of 2. For year ending 31st March 2017 the Trust is forecasting delivery of the £7.9m planned deficit.	
RECOMMENDATION:	***The Trust Board is asked to note the contents of the report.***	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

FINANCE REPORT AS AT 31st AUGUST 2016

1. PURPOSE

This report sets out the financial position of the Trust as at 31st August 2016.

2. EXECUTIVE SUMMARY

Year to date performance against key financial indicators is provided in the table below and further supplemented by the dashboard (Appendix A) and schedules (Appendices B to I) attached to this report. The planned key financial indicators have been updated to reflect the reforecast plan submitted to NHS Improvement on 29th June 2016.

Key financial indicators:

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	18.8	18.4	(0.4)	94.2	94.9	0.7
Operating expenses	(18.9)	(19.1)	(0.2)	(94.8)	(96.1)	(1.3)
EBITDA	(0.1)	(0.7)	(0.6)	(0.6)	(1.2)	(0.6)
Non-operating income and expenses	(0.9)	(0.3)	0.6	(4.5)	(3.9)	0.6
Surplus / (deficit)	(1.0)	(1.0)	0.0	(5.0)	(5.0)	0.0
Cash balance	-	-	-	1.3	1.3	0.0
CIP target	0.7	0.8	0.1	3.1	3.2	0.1
Capital Expenditure	0.4	0.3	0.1	1.6	1.4	0.2
Financial Sustainability Risk Rating	-	-	-	1	2	1

Headlines:

- The monthly position is a deficit of £1.0m which is on plan. The year to date position is a deficit of £5.0m (on plan) and delivers a Financial Sustainability Risk Rating score of 2.
- The annual cost savings target is £11.0m of which £10.7m is included within the reforecast financial plan. To date the planned savings target is £3.1m and £3.2m has been delivered (See agenda item Cost Improvement Report for further details).
- The planned capital expenditure to date is £1.6m and the actual spend to date is £1.4m (section 4).
- The cash balance is £1.3m per the planned balance of £1.3m. (section 5).
- The Better Payment Practice Code performance is 26% for the month and 29% for the year to date period (section 5).
- The value of aged debt is £3.0m (section 7).
- The value of aged creditors is £9.4m (section 8).
- The Trust has applied for a working capital loan of £7.9m in 2016/17. Until this application is approved the Trust has access to an interim revolving working capital facility and has drawn down £1.6m in August and £6.5m year to date (section 9).

- The Trust has not applied for a capital loan in 2016/17 (section 10).
- The forecast deficit is £7.9m which is in line with plan (section 11).

3. INCOME AND EXPENDITURE (APPENDIX B)

In August the Trust has recorded a deficit of £1.0m which is on plan. Year to date the deficit is £5.0m which is also on plan.

Operating Income

In month operating income is £0.4m below plan which reduces the year to date operating income to £0.7m better than plan. An analysis by income category is summarised in the table below.

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

Narrative	Monthly Variance £m	YTD Variance £m
NHS Clinical Income	(0.4)	0.4
Non NHS Clinical Income	(0.1)	0.0
Other Operating Income	0.1	0.3
Total Operating Income	**(0.4)**	**0.7**

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

Contracts Update

The performance access standards and improvement trajectories have now been agreed and the criteria to access the Sustainability and Transformation fund have been confirmed. The access standards cover the following targets:

- A&E 4 hour performance
- Referral to Treatment Times (RTT)
- 62 Day Cancer Waits
- 6 Weeks Diagnostics.

These targets will not be subject to national penalties in 2016/17 but in order to secure the appropriate share of the Sustainability and Transformation fund the Trust needs to deliver the agreed milestones included in the plan. All other national and local targets are subject to fines and penalties by commissioners.

The financial position does not include any fines or penalties relating to the STP trajectory (as described above). An assessment of non STP fines and penalties and non-achievement of CQUIN has been undertaken estimated at £1.1m year to date. This has been reflected in the financial position. Key areas are patient data errors, discharge summaries, cancelled operations and the frailty CQUIN scheme. Lead directors for each of these areas are reviewing the penalties to assess where there is the opportunity to reduce year to date and to seek reinvestment where possible. In addition each Director has been asked

to provide action plans to improve performance and to provide a forecast for the remainder of the year. Incurring additional penalties, and/or non delivery of CQUIN is a risk to delivery of the Trust's control total.

Clinical Income

Sustainability & Transformational Fund

Access to the Trust's £8.0m fund is dependent upon the Trust achieving a number of criteria that cover performance against both financial control totals and access standards. The financial control totals are a binary on/off switch to secure funding, in other words if the financial control total is not achieved then no funding is allocated for the access standards.

The £8.0m funding is split between financial control totals (70%) and access standards (30%) with the access standards weighted against RTT (12.5%), A&E (12.5%) and cancer days (5%). Diagnostics has been included as an improvement trajectory but carries a 0% weighting.

The funding is allocated at the end of every quarter based on performance and the amount due in each quarter against each standard is summarised in the table below.

Table: analysis of fund by category by quarter.

Category	**Quarter 1 £m**	**Quarter 2 £m**	**Quarter 3 £m**	**Quarter 4 £m**	**Total £m**
Financial	1.4	1.4	1.4	1.4	5.6
RTT	0.25	0.25	0.25	0.25	1.0
A&E	0.25	0.25	0.25	0.25	1.0
Cancer	0.1	0.1	0.1	0.1	0.4
Total	**2.0**	**2.0**	**2.0**	**2.0**	**8.0**

Tolerances on delivery of the access standards exist which are weighted towards the earlier part of the year when current performance is expected to be turned around. The tolerances are of 1.0% in quarter 2 and 0.5% in quarter 3 there is no tolerance in quarter 4. There are no tolerances around the quarterly finance control totals.

The finance aspect of the fund will operate on a cumulative basis so that if the trust misses the year to date control total in a quarter but achieves the control total in a subsequent quarter it could receive the full amount of funding. There is also the ability to recover the previous month's access target for both RTT and A&E.

The clinical income plan for the month and year to date now includes the share of funding relating to the Sustainability and Transformation funding which increases the monthly plan by £0.7m each month. The actual income for the month and year to date assumes that the Sustainability & Transformation funding (£0.7m in month and £3.3m year to date) will be received in full as the control total for the period has been delivered and the trajectories for the access targets have been agreed and exceeded.

As at 31st August there are 2,623 uncoded elective, day case and non elective spells. This is a decrease of 740 uncoded spells from the position as at 31st July. The Clinical Coding team is reviewing performance to ensure that the level of uncoded activity continues to reduce.

In month NHS clinical income is £0.4m below plan which reduces the year to date NHS clinical income to £0.4m better than plan with the variances across the points of delivery summarised in the table below.

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

Narrative	**Monthly Variance Activity**	**Monthly Variance £m**	**YTD Variance Activity**	**YTD Variance £m**
Elective Spells	(134)	(0.2)	(754)	(0.6)
Elective Excess Bed Days	(27)	0.0	5	0.0
Non Elective Spells	573	0.6	2,472	1.8
Non Elective Excess Bed Days	467	0.1	1,332	0.3
Outpatient Attendances	(1,023)	(0.1)	(7,285)	(0.3)
Accident & Emergency Attendances	8	0.1	53	0.1
Other Activity	-	(0.9)	-	(0.9)
Total NHS Clinical Income	**-**	**(0.4)**	**-**	**0.4**

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

The £0.4m under recovery in August is due to the inclusion of £1.1m fines and penalties levied by commissioners relating to discharge summaries and non-compliance of specific CQUIN schemes.

The non elective over performance of £1.8m includes £1.3m year to date for ambulatory care with zero length of stay. This is part of an interim agreement up to 3rd September and both the trust and commissioners are in discussion regarding contracting arrangements on how this will work going forward.

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

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

Narrative	**Monthly Variance £m**	**YTD Variance £m**
Acute Care Services	0.6	2.4
Surgery, Women's and Children	0.2	(0.2)
Non divisional	(1.3)	(1.8)
Total	**(0.4)**	**0.4**

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

A year to date analysis of NHS clinical income by category and Division, Clinical Business Unit and specialty is available at Appendices C and D. The main headlines for each division are as follows:

Acute Care Services

There is a significant over performance in Urgent & Emergency Care both in Emergency Medicine and General Internal Medicine. This relates to ambulatory care income where a local tariff is in place and no income was included in the plan for 2016/17.

Surgery, Women's and Children

There is an underperformance in month for in Specialist Surgery £0.03m of which Urology is £0.06m below plan. A Urology consultant has been on leave throughout August which has contributed to the underachievement of plan. Maxillofacial Surgery and Ophthalmology ARMD have over performed in month by £0.04m and £0.03m respectively which has improved Specialist Surgery's position.

Women's & Children's Health is £0.05m below plan in month, of which, Breast Surgery is £0.07m below plan. There is an issue with the recording of planned Breast Surgery procedures where work is ongoing with the CBU manager and Lorenzo team to resolve this issue.

Musculoskeletal Care is £0.02m below plan in month. Rheumatology and Pain Management have overachieved by £0.06m collectively but this is offset by an underperformance in T&O of £0.08m which relates to elective procedures.

Non divisional

The main reason for the year to date variance relates to the provision for potential fines and penalties partially offset by the over recovery against excluded PbR drugs.

Non Mandatory / Non Protected Income

Year to date Private Patients and the Compensation Recovery Unit income is £0.04m below plan, mainly resulting from the number of claims submitted for recovery against the Compensation Recovery Unit.

Other Operating Income

Year to date other operating income is £0.3m above plan mainly due to an over recovery on miscellaneous income relating to a range of service level agreements and miscellaneous recharges.

Operating Expenses

In month operating expenses are £0.2m worse than plan which has increased the year to date variance to £1.4m worse than plan. An analysis by expense type is summarised in the following table.

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

Narrative	Monthly Variance £m	YTD Variance £m
Pay	0.3	(0.2)
Drugs	(0.2)	(0.5)
Clinical Supplies	(0.1)	(0.5)
Non Clinical Supplies	(0.2)	(0.2)
Total Operating Expenses	**(0.2)**	**(1.4)**

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

Pay Costs

Pay costs in month are £13.4m which is £0.3m below plan. The year to date pay costs are £68.3m which is £0.2m above plan.

The pay spend includes the continued cost of temporary staffing including Bank, Agency and Locum costs, Waiting List Initiatives and additional hours paid at overtime rates. To date the total cost of temporary spend is £8.6m which equates to £20.6m per annum. Reduction in temporary spend is a key feature of the cost savings target so it is vital that these costs are minimised as much as possible.

It should be noted that there are no recurrent cost pressures resulting from the move from the old divisional structure to the new CBU structure in respect of management, nursing and AHPs. The exercise relating to the medical staff is due to be completed by the end of the month and an update will be provided at the next meeting. At this time the exercise is assumed to be cost neutral.

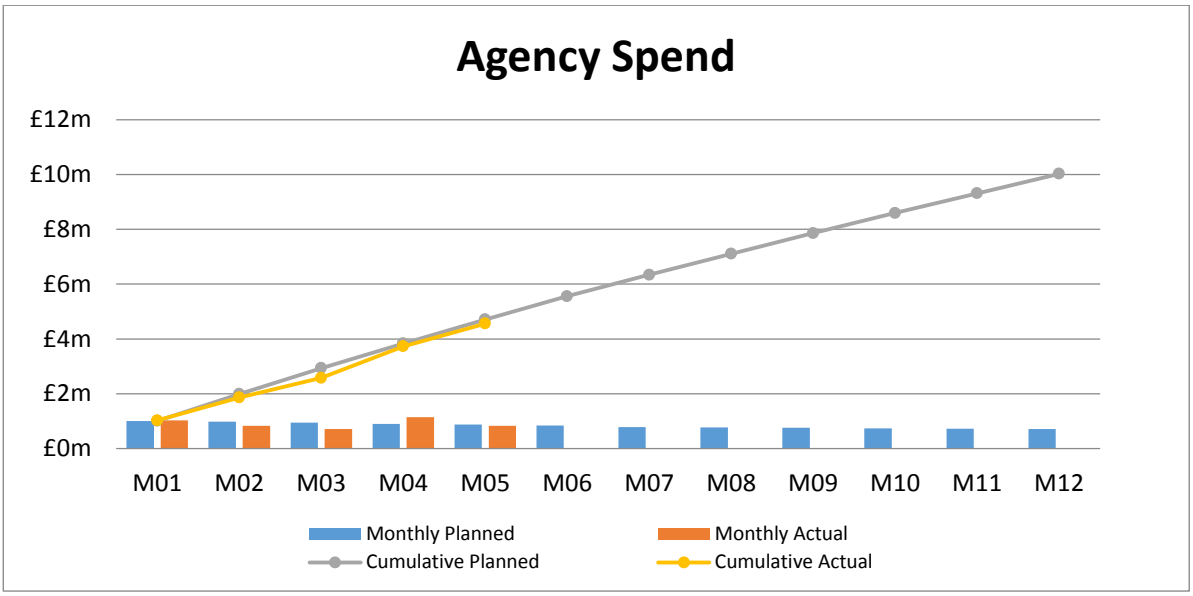
The pay position for the period includes funding to cover two service pressures to 30th September 2016, namely the Anaesthetics Medical Staff on call and Acute Medical Unit rotas. As there is no funding earmarked for these pressures from 1st October onwards it is vital that alternative working solutions are introduced to eradicate these costs and avoid any unfunded cost pressures. Continuation of the current position will result in cost pressures of £0.5m for the period 1st October 2016 to 31st March 2017.

The pay position includes costs of £0.4m associated with the Intermediate Care Unit on the Warrington site which closed on 19th August. Commissioner funding ceased in April 2016.

Agency

The annual plan submitted to NHSI included an annual agency spend (including locums) across all staff groups of £10.0m. To date the actual expenditure is £4.6m which is £0.1m below the planned expenditure of £4.7m. A reduction in agency spend is a key feature of the cost savings target so it is vital that agency costs are minimised across all divisions. The following graph summarises the monthly and year to date agency spend against the planned spend.

Graph: Analysis of monthly and cumulative agency spend.



Drugs Costs

Drug costs in month are £1.5m which is £0.2m above plan. The year to date costs are £6.9m which is £0.5m above plan. This overspend relates to excluded PbR drugs which are funded by commissioners, with the additional income shown against other income within NHS clinical income.

Clinical Supplies and Services

Clinical Supplies and Services costs in month are £1.7m which is £0.1m above plan. The year to date costs are £8.9m. This is £0.5m above plan mainly due to the over spend on pathology and radiology consumables and maintenance contracts, and payments to Platform 7 for patient activity. These costs are being offset by additional income.

Non Clinical Supplies

Non Clinical Supplies costs in month are £2.5m which is £0.2m above plan. The year to date costs are £12.0m which is £0.2m above plan.

Divisional Performance

The financial position (net divisional income and expenditure) as at 31st August across all divisions is an over spend of £1.5m as summarised in the following table.

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

Division	Monthly Budget £m	Monthly Actual £m	Monthly Variance £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Acute Care	6.6	6.9	(0.3)	33.2	35.0	(1.8)
Surgery, Women's & Children's	7.2	7.0	0.2	35.3	34.8	0.5
Outpatients	0.3	0.3	0.0	1.5	1.6	(0.1)
Corporate	3.7	3.8	(0.1)	19.4	19.5	(0.1)
Total	**17.8**	**18.0**	**(0.2)**	**89.4**	**90.9**	**(1.5)**

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

An analysis of the monthly and year to date income and expenditure position by each division is included in the dashboard attached at Appendix A and an analysis by each Clinical Business Unit and Corporate Division is attached at Appendix E. The main headlines are as follows:

Acute Care Division

Whilst the division is overspent on expenditure it has over recovered on income resulting in a year to date contribution of £0.6m.

All Clinical Business Units are overspent and the main reasons are due to nursing pay costs resulting from one to one nursing care (£0.3m), A4 escalation beds (£0.2m), Warrington Intermediate Care Unit (£0.4m), the Ambulatory Care Unit (£0.3m), covering vacancies and rota gaps in the Acute Medical Unit (£0.2m) and external diagnostic tests (0.4m).

Surgery, Women's and Children's Division

Whilst the division is under spent on expenditure it has under recovered on income resulting in a year to date contribution of £0.3m.

Musculoskeletal Care and Digestive Diseases are underspent although this is partially offset by over spends in Specialist Surgery and Women's and Children's Health. The under spend is mainly due to the number of medical and non medical vacancies across the division.

Outpatients

The overspend is due to agency costs necessary to cover vacancies. A recruitment process to appoint substantive staff has commenced.

Corporate Divisions

The corporate divisions have a year to date overspend of £0.1m. Overspends within Human Resources & Organisational Development, Nursing & Governance, Commercial Development and Trust Executives are partly offset by underspends within Estates & Facilities, IT and Pharmacy.

It is vital that all managers take corrective action as soon as possible in order to ensure that services

remain within the allocated resources.

Reserves

The Trust started the year with reserves of £19.9m including £9.1m related to high cost drugs that are funded non recurrently on a monthly basis dependent upon the spend. The remaining balance of £10.8m covers both committed reserves (£8.7m) and uncommitted reserves (£2.1m).

Committed Reserves - to date £6.1m has been transferred to divisions to fund agreed cost pressures.

Uncommitted Reserves – to date £1.0m has been transferred to divisions to fund agreed costs pressures and developments leaving a balance of £1.1m of which £0.5m has been earmarked and a £0.3m contingency. The balance of available reserves not yet committed is £0.3m.

The annual and year to date position is summarised in the following table.

Table: Analysis of committed and uncommitted reserves (excluding high cost drugs).

Narrative	**Committed £m**	**Uncommitted £m**	**Total £m**
Annual Position			
Opening balance as at 1st April	8.7	2.1	10.8
Transfer to Divisions (April to July)	(5.7)	(0.8)	(6.5)
Reserve balance as at 31st July	**3.0**	**1.3**	**4.3**
Transfer to Divisions (August)			
- Outpatients funding	0.0	(0.2)	(0.2)
- Nursing pressure funding	(0.2)	0.0	(0.2)
- Training and education pressure funding	(0.1)	0.0	(0.1)
- Volunteers pressure funding	(0.1)	0.0	(0.1)
Total Transfer to Divisions	**(0.4)**	**(0.2)**	**(0.6)**
Reserve balance as at 31st August	2.6	1.1	3.7
Commitments	(2.6)	(0.5)	(3.1)
Contingency	0.0	(0.3)	(0.3)
Reserve Balance Available	**0.0**	**0.3**	**0.3**

Non Operating Income and Expenses

Non operating income and expenses in month is £0.3m which is £0.6m below plan. The year to date cost is £3.9m which is £0.6m below plan. The variance is due to the reforecast of PDC dividends and depreciation charges. There is a £0.1m unfunded cost for restructuring expenses due to MARS payments however this is offset by a £0.1m underspend on interest expenses.

4. CAPITAL

The annual capital programme for the year is £6.7m which is a combination of in year internally generated depreciation and a carry forward of a £0.7m underspend from 2015/16. The capital spend to date is £1.4m which is £0.2m less than the planned spend of £1.6m as summarised in the table below.

Table: Analysis of performance against the revised draft capital programme.

Category	**Annual Budget £m**	**Budget to date £m**	**Actual to date £m**	**Variance to date £m**
Estates	1.8	0.5	0.6	(0.1)
IM&T	1.3	0.4	0.5	(0.1)
Medical Equipment	3.6	0.7	0.3	0.4
Total	**6.7**	**1.6**	**1.4**	**0.2**

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

5. CASH FLOW (APPENDIX F)

The cash balance at the end of August was £1.3m which is on plan. The terms and conditions of the working capital facility require the Trust to have a minimum cash balance of £1.2m. The monthly movements are summarised in the table below.

Table: Summary of monthly cash movement.

Cash balance movement	**£m**
Balance as at 1st August	1.2
In month deficit	(1.0)
Non cash flows in operating surplus	0.2
Decrease in trade receivables (debtors)	0.1
Increase in trade payables (creditors)	(0.2)
Capital expenditure	(0.3)
Sustainability & Transformation Funding	2.0
Drawdown of interim working capital facility	1.6
Other working capital movements	(2.3)
Balance as at 31st August	**1.3**

The operating performance continues to have an adverse effect on the amount of cash available to the Trust. At 31st August 2016 the value of trade creditors stands at £9.3m, although this is partially covered by the value of trade receivables at £2.0m.

The current cash balance of £1.3m equates to circa 2 days operational cash. The liquidity metric is -27.4 days which results in a liquidity rating of 1 under the Financial Sustainability Risk Rating criteria.

Active management of the working balances continues in order to maintain a cash balance sufficient to

pay creditors (see section 8 for further details).

Performance against the Non NHS Better Payment Practice Code (BPPC) is 26% in month and 29% for the year to date.

The actual cash flow movements for the year to date and cash plan to 31st March 2017 are detailed in Appendix F. The following table summarises the short term cash flow anticipated over the next 3 months which reflects the requirement of the loan to hold a balance of £1.2m.

Table: Short term cash flow movements.

Cash balance movement	**September £m**	**October £m**	**November £m**
Opening balance	1.3	1.2	1.2
In month surplus/(deficit)	(0.7)	(0.4)	0.5
Non cash flows in surplus/(deficit)	0.9	0.9	0.9
Movement in trade receivables	0.0	0.0	0.0
Movement in trade payables	1.6	(4.0)	(0.6)
Capital expenditure	(0.4)	(0.7)	(0.7)
Drawdown of working capital facility	0.0	1.4	0.0
Sustainability & Transformation Funding	0.0	2.0	0.0
Payment of PDC Creditor	(1.2)	0.0	0.0
Other working capital movements	(0.3)	0.8	(0.1)
Closing balance	**1.2**	**1.2**	**1.2**

The cash flow assumes that future Sustainability & Transformational quarterly payments will be achieved and received in accordance with the NHS Improvement timetable so Quarter 2 funding has been included in the table above.

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

6. STATEMENT OF FINANCIAL POSITION (APPENDIX G)

Non current assets have increased by £0.1m in the month with capital spend exceeding the depreciation charges.

Current assets have decreased by £1.6m in the month mainly due to a decrease in accrued income and inventories. The reduction in accrued income of £1.3m is due to the receipt of Q1 Sustainability & Transformational Funding received on 12th August 2016.

Current liabilities have decreased by £0.4m in the month mainly due to the decrease in trade payables, accruals and other liabilities offset by the loan drawdown.

Non current liabilities have remained constant during the month.

7. AGED DEBT (APPENDIX H)

Aged debt has increased by £0.9m in the month to £3.0m (with £2.0m overdue).

During September £1.5m of this debt has been recovered due to the additional focus on the recovery of debt by the finance team. There will however be a continued focus to further minimise the value of aged debtors which will assist in the reduction of aged creditors.

8. AGED CREDITORS (APPENDIX I)

Aged creditors have decreased by £0.3m in the month to £9.4m (with £5.6m overdue).

As at 31st August there are 7,225 invoices outstanding for payment with 4,717 overdue and there are 874 individual creditors. The operating position reduces the amount of cash available to pay creditors in a timely manner and until the operating position improves the level of aged creditors will remain high. This may affect the reputation of the Trust and could potentially have an impact on local businesses that undertake a significant amount of work with the Trust who rely on regular payments. There is currently insufficient cash to pay all creditors. Priority is given to the payment of small local suppliers and then the selection criteria is based on the number, value and age of the invoices and the avoidance of potential interest charges levied by the creditors. The largest non NHS creditor by value is Johnson and Johnson Ltd who have £0.2m outstanding as at 31st August. The volume and value of outstanding invoices is summarised in the table below (see Appendix I for further details).

Table – analysis of outstanding invoices by volume and value.

Narrative	Volume Number	Volume %	Value £000	Value %
Largest 15	2,043	28	4,344	46
Others	5,182	72	5,085	54
Total	**7,225**	**100**	**9,429**	**100**

9. WORKING CAPITAL LOAN

In 2015/16 the Trust secured a working capital loan of £14.2m to support the cash position resulting from the planned deficit. The interest rate is 1.5% with interest repayments made twice yearly (May and November) and the principle repayable in full in 2018/19. The Trust has applied for a working capital loan of £7.9m to match the 2016/17 planned annual deficit. Until this loan application is approved the Trust has access to an interim revolving working capital facility. The Trust has drawn down £1.6m in August and £6.5m year to date.

10. CAPITAL LOAN

In 2015/16 the Trust secured a capital loan of £1.6m to support the balance of the capital programme that could not be funded from internally generated depreciation or cash reserves. The loan is repayable over 15 years at an interest rate of 1.78%. Principle and interest repayments commenced in 2016/17 and will be paid twice yearly (August and February).

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

11. RISK AND FORECAST

For the period ending 31st August the Trust has recorded a deficit of £5.0m which is in line with plan. It is important that the Trust continues to focus on the mitigation of any financial risks to ensure the financial plan is delivered, namely:

- Failure to meet the eligibility criteria to secure all the Sustainability & Transformation funding.
- Failure to comply with all contractual data requirements, quality standards, access targets and CQUIN targets that may result in commissioner levied fines or penalties.
- Failure to deliver the income target or remain within approved budgets.
- Identified cost savings target not fully identified and delivered in accordance with profile.
- Failure to manage escalation or partner's inability to provide services to withdraw medically fit patients from the hospital.
- Failure to appropriately reduce bank, agency, locum, overtime and waiting list initiatives.
- Failure to increase clinical efficiency and productivity.

The 2016/17 Plan provides increasing financial challenge. Over the next month the finance department will work with operational teams to review the key risks and the actions required to ensure delivery of the control total. A detailed analysis will be provided to the next Finance and Sustainability Committee.

12. CONCLUSION

For the period ending 31st August 2016 the Trust has recorded a deficit of £5.0m, a cash balance of £1.3m and a Financial Sustainability Risk Rating score of 2. For year ending 31st March 2017 the Trust is forecasting delivery of the £7.9m planned deficit.

13. RECOMMENDATION

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

Andrea Chadwick
Director of Finance & Commercial Development
14th September 2016

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/166**	
SUBJECT:	**Key Issues Report from the Quality Committee September 2016**	
DATE OF MEETING:	28th September 2016	
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 September meeting.	
RECOMMENDATION:	**The Board note the report and that there are no matters arising for escalation.** **The Board satisfies itself that the revised Terms of Reference will ensure the Committee delivers the assurance It requires and either makes amendments or ratifies accordingly.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
QUALITY COMMITTEE

Date of meeting:	
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 5th July were approved as a correct record.
Formal Business	**Clinical Summit to review any potential Patient Safety risks posed by Lorenzo** The Committee received the notes from the Clinical Safety Summit held to review any patient safety and effectiveness issues remaining following the implementation of Lorenzo. The action notes from the paper gave a detailed summary of the current issues which included, an update from Clinical Silver, Datix incidents, complaints and PALS reports, Maternity Data Sets and clinical correspondence. The risk has been split into three main areas: Discharges (lead – N Jenkins) eOutcome backlog (lead – J Ross) Maternity (lead – E Hasan) There was reassurance that other risks identified, such as the new intake of Foundation doctors and the rotation of Junior doctors in the first week of August was being addressed through robust training and induction. A view was expressed that the current issues that remain are more to do with staff compliance with processes and less to do with remaining IT issues. The clinical teams will now have responsibility for ensuring compliance and will receive regular reports to support this. Although this was a one off meeting, the actions and outcomes from the Summit will need to be tracked. There is still a feeling that the system could be used to greater advantage, for example in the area of bed management. **National Safety Standards for Interventional Procedures (NATSSIPS)** This is an important Patient Safety initiative which sets standards for invasive interventional procedures. These could lead to errors, such as the procedure being performed on the wrong side, in much the same way as surgical never events. Therefore, all invasive procedures should have clear local implementation of safety standards. This requires staff being involved in initial training, developing the standards and then further training to implement them. This is therefore a significant piece of work but an important development to improve patient safety. 2 Trust workshops have been held in June and July and a Project Group is in place

	and due to meet in September. Therefore, progress is being made according to the requirements but as this initiative could have an impact on patient safety it should receive an appropriate level of support and prioritisation. **Infection Control** The Committee received the DIPC Annual Report that came to Board in July. There are some issues which the Committee would like to explore further and Lesley McKay, who couldn't attend in August, is being invited to the October meeting. **Quality Dashboard** HMSR continues to be higher than expected. Expert advice has been received and has informed the investigation into the underlying reasons for the increase. It is still thought to be due to errors in coding and a report is to go to the August board. There was some discussion about mortality reviews and the small percentage of consultants that are not complying but this is moving in the right direction and the Committee will continue to review. **SUI report** – the committee looked at how the data could be presented differently so that open SUIs could be tracked. **Claims data** The Clinical Claims Data was presented in a very clear and well-written report. This is clearly a significant paper for a number of reasons, the cost, the opportunity to triangulate with other patient safety data and the clear evidence of learning that comes from analysis of the claims. Simple lessons, such as good record keeping, full clinical assessment and examination and following policies and procedures were evident. **Safeguarding Gap analysis** This highlighted the loss of a liaison nurse formally funded through the Bridgewater Trust but lost because of a withdrawal of funding due to a CIP. There are still on-going discussions with the CCG about how this post could be reinstated and funded. **Other papers received included:** • Seen/Heard Partnership Pack – a tool to educate staff about the possible signs and indicators of possible child sexual abuse in a young person. • CQUIN Quarterly Report • Quality Account • Maternity Annual Review

Local Policies and Guidance Approved:	
Any Learning and Improvement identified from within the meeting:	None.
Any other relevant items the Committee wishes to escalate?	None.

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/167**	
SUBJECT:	**Board Leadership Walkabouts**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Kimberley Salmon-Jamieson, Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
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	
	BAF2.4: Engaging & Involving Workforce	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	Board Leadership Walkabouts are a robust way of helping to strengthen engagement between Board members and frontline staff. High quality patient centred care with measurable clinical outcomes is key and direct staff and patient engagement can help support this. The ability to engage with frontline staff directly will help to maintain the on-going focus of clinical excellence, patient safety and staff retention. Patient safety and experience, alongside developing quality initiatives and transformation will be the focus during the walkabouts, promoting an open and transparent culture within the Trust.	
RECOMMENDATION:	**Approval of the Board of Directors Leadership Walkabouts**	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of	

	Outcome	

Introduction

This paper describes options for the reintroduction of a rolling programme of Board Leadership Walkabouts for both clinical and non-clinical areas.

Background

Throughout 2012 and 2013 a series of Reports (Francis, Berwick and Keogh 2012, 2013, 2013) were published following findings of reviews undertaken in response to serious lapses in patient care resulting in significant harm to patients and reputational damage to a number of Trusts and organisations. These Reports raised a number of concerning trends in relation to the lack of a voice of the patient and carers, also organisational cultures, patient safety and care and compassion issues. The Reports indicated the need for fundamental change in the oversight, scrutiny and accountability across care providers.

In response to the recommendations in 2014, Warrington and Halton FT (WHH) instigated a programme of Executive Walkabouts to address some of the findings. The Walkabouts continued for approximately 18 months and were put on hold due to the implementation of the new Clinical Business Units. (CBU's) Patients and carers are at the heart of what we do at WHH and providing our patients and their families with an excellent experience is key to delivering our corporate objectives: The WHH Five Core Values will be linked in with the Walkabout Programme:

- Working together – we promise an environment where patient care is paramount and our staff matter
- Excellence – we ensure excellence across our teams in providing the best care for our patients
- Accountable – we make sure everyone is involved in decision making
- Role Models – we inspire and innovate through great leadership to provide excellent care for our patients
- Embracing Change – we are open to new ideas from patients, public and everyone in our team

Focus of a Board Leadership Walkabout

The purpose of the Board Leadership Walkabouts is to provide clinical and non-clinical teams the opportunity to engage with members of the Board on a regular basis, sharing feedback and offering staff the opportunity to share any areas of concern and best practice. Equally, there is an opportunity for the leadership team to observe what is happening within all areas of the hospital and 'test' through questioning, areas of current and on-going challenge and any particular Executive or Board of Directors focus.

Through the facilitation of dialogue with patients and staff directly, a culture of openness and transparency can be demonstrated with the key focus on high quality care. We are committed to improving and measuring quality outcomes and demonstrating an awareness of what staff and patients feedback can be very informative.

Board Leadership Walkabout structure

There are a number of 'walkabout' models in place in healthcare organisations, some structured and some informal. Some walkabouts offer a specific topic each month to consider for review and discussion. Both structured and informal models have been successful approaches taken by other organsiations. Two simple models are detailed below.

Model One

Using a simple framework, Leadership Walkabouts are carried out on an ad hoc basis with a focus deriving from current quality priorities of the Trust. Information gained from the walkabout is fed back to the Divisional leaders and / or Executive Team. Leadership Walkabouts will involve engagement with both patients and staff.

Suggested walkabout questions/conversations for staff may be:

- What is good / best about working within this area?
- What achievement over the last six months are you / team most proud of?
- What do you think is the biggest risk in your area?
- Do you feel able to escalate concerns?
- What do think is needed to make your environment safer for our patients?
- Ask "why are we doing it this way"?
- How are we doing in delivering our WHH values?

Suggested walkabout questions/conversations for staff may be:

- Questions around discharge planning
- Being kept informed
- Quality of food
- Observation of hand washing
- Caring staff
- Are they aware of who is in charge and know how to raise a question or concern

Model Two

Rolling Programme of Board Leadership Walkabouts

A planned 'rota' of Board Leadership Walkabouts is devised covering all areas of the Trust. Board members are supported by 'guides' who are both clinical and non-clinical leaders and managers throughout the Trust. Ward and department areas will be aware of the visiting rota pattern and Walkabouts can be pre-arranged with the area if deemed more appropriate.

A standard format would be followed allowing for a more structured process to be followed, asking both patients and staff questions and gaining feedback on areas around patient experience and staff engagement, using priorities from both the National Inpatient Survey and the Staff Survey. The 'guide' will complete a simple proforma and return to the Divisions and a central collation point for discussion and action.

Other Trust Walkabouts

Safety Walkabouts are also be considered for introduction which will be regular walkabouts carried out by the senior leaders and managers across the Trust and will a focus on safety using a detailed and more structured approach in line with the NHS National Safety Campaign. This information will be collated and triangulated for review of themes and correlating with complaints, incidents and claims. The Board Leadership Walkabouts for discussion will not prevent unannounced visits or walkabouts from the Executive Team and Non-Executive Directors (NEDS), for best practice these will continue on an ad-hoc basis and should not be omitted given the potential rolling programme.

Next Steps

A Standard Operating Procedure (SOP) will be created for the agreed model. Following on from the walkabouts, the data collected will be shared with the Divisions and discussed as appropriate at the relevant meetings.

Conclusion

Board Leadership Walkabouts are often an evolving programme of work and it is important to note that the do not stay stagnant and are evaluated an reviewed annually and re aligned if appropriate to current priorities or changing challenges arising for both patients and staff.

The reintroduction of Board Leadership Walkabouts will support the Trust strategy around high quality patient care and staff and patient engagement. Regular visibility and the support of Board members will help to create an open and honest culture within which to work and/or be treated, is a clear model that supports our Trust strategy around our core values and beliefs.

Recommendations

Discuss and approve Board Leadership Walkabouts.

References

- Francis, R. (2013). *Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry – Volume 3: Present and future. London:* The Stationery Office. Available at www.midstaffpublicinquiry.com/report
- Berwick, J. Berwick review into Patient Safety (2013), Recommendations to improve patient safety in the NHS in England. DH
- Keogh, B. A review into hospital mortality rates (2013). DH
- The Kings Fund (2013) P*atient centred leadership – rediscovering our purpose.*

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/168**	
SUBJECT:	**Non-Executive Director Champions Role Descriptions**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Discussion & Decision**	
AUTHOR(S):	Angela Wetton, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust is required to identify a Board champion or lead in relation to specific areas of Board responsibility and this paper is a summary of the areas with the specific responsibilities for the Executive Director Lead and the Non-Executive Director Lead. The paper also contains proposals for the Non-Executive leads.	
RECOMMENDATION:	The Board reviews the proposals and agrees the Non-Executive Champions.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Purpose

The Trust is required to identify a Board champion or lead in relation to specific areas of Board responsibility.

Before she left the Trust, the previous Company Secretary reviewed the statutory requirements and other guidance and attached is a summary of this information.

The table sets out the role requirements and the proposed non-executive director (NED) leads to champion each required area of Board responsibility for discussion and approval.

Background

Over the last few years within the NHS, there has been an increasing focus on the designation of Board Champions and nominated leads designed to engender board level commitment and focus around key areas of service development or delivery. For the Non-Executive Directors, this has provided an opportunity to gain a deeper level of insight and knowledge around these key areas with the aim of better equipping them and the whole Board to fulfil its role.

Below is a summary of the statutory and other guidance setting out a requirement for a Champion or Board lead with the specific responsibilities for the Executive Director Lead and the Non-Executive Director Lead.

For the following areas, there is reference to nominate a Board Champion / Lead with no preference over whether this should be an Executive Director or Non-Executive Director:

Safeguarding Vulnerable Adults - It is proposed that this is a NED lead

Equality & Diversity – It is proposed that this is a NED lead

Maternity Services - It is proposed that this is a NED lead

Recommendation

The Board reviews the proposals and agrees the Non-Executive Champions.

Statutory or Regulatory Roles	Regulation / Guidance	Exec Lead	Executive Director Lead Role	Non-Executive Director Lead Role	Proposed NED Lead
Security	Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)	Chief Operating Officer	To be the accountable person for security at an Executive Level within the NHS Trust. To promote security management policy and measures. To liaise with appropriate persons in promoting a pro-security culture. To develop and agree an annual work plan related to security matters.	To promote security management policy and measures. To give support and where appropriate, challenge the ED on issues relating to security management at Board level.	**Terry Atherton**
Emergency Planning	The Civil Contingencies Act (2004). NHS Emergency Planning guidelines. Health & Social Care Act 2012.	Chief Operating Officer	To provide the Board with levels of assurance for emergency preparedness, planning and response as appropriate. To act as Board Champion for all emergency planning matters for staff and patients. Ensure strategic review of the Trust's emergency planning occurs	To provide scrutiny and challenge to all emergency planning information and assurance presented to the Board. To ensure that the patient's perspective is considered in all related discussions.	**Terry Atherton**
Safeguarding Vulnerable Adults	Mental Capacity Act Mental Health Act	Chief Nurse	Liaising with the Trust's safeguarding leader on a regular basis and participate in awareness raising activities. Liaising with the Trust's lead for overseeing the mechanisms in place to identify and cater for patients with Learning Disabilities. Liaising with the Trust's Dementia Lead to encourage the Trust to operate as a dementia friendly hospital and participate in awareness raising activities as appropriate.		**Margaret Bamforth**
Safeguarding Children	Department of Health working together to safeguard children (2010)	Chief Nurse	Act as Board Champion for all safeguarding issues.	To offer scrutiny and challenge to safeguarding risks, performance and evidence presented to the	**Margaret Bamforth**

Statutory or Regulatory Roles	Regulation / Guidance	Exec Lead	Executive Director Lead Role	Non-Executive Director Lead Role	Proposed NED Lead
	Children Act (2004) section 11, duty to safeguard and promote welfare Children Act (2004) section 13, statutory partners in the local safeguarding children board Children Act (1989) section 27, help with children in need Children Act (1989) section 47, help with enquiries about significant harm.		Inform Board of level of assurance re compliance with safeguarding regulations. To act as the Trust's safeguarding ambassador for the local safeguarding children's board. Ensure that safeguarding systems are robust and appropriately monitored. Ensure that any gaps in compliance are addressed resulting in improvements to safeguarding of vulnerable children. Demonstrate strong leadership for all safeguarding issues. Respond to national policy proposals.	Trust Board. To act as advocate for patients in all safeguarding issues.	
Infection Control	Health & Social Care Act 2008 – Code of Practice on the prevention and control of infection and related guidance.	Medical Director	Be accountable directly to the Chief Executive and to the Board. Report directly to the Trust Board. Be responsible for the Trust's Infection Prevention and Control Team (IP&CT). Oversee local control of infection policies and their implementation. Be a full member of IP&CT and	To act as Board Champion for all infection control related issues and advocate for patient safety. To ensure that the patient's perspective is considered in all related discussions and Board level scrutiny.	**Margaret Bamforth**

Statutory or Regulatory Roles	Regulation / Guidance	Exec Lead	Executive Director Lead Role	Non-Executive Director Lead Role	Proposed NED Lead
			regularly attend its Infection Prevention and Control meetings. Have the authority to challenge inappropriate practice and inappropriate antibiotic prescribing decisions. Assess the impact of all existing and new policies on Healthcare Associated Infections (HCAI) and make recommendations for change. Be an integral member of the Trust's clinical governance and patient safety teams and structures. Produce an annual report and release it publicly. Set objectives that meet the needs of the Trust and ensure the safety of the service users.		
Counter Fraud	Directions to NHS bodies on counter fraud measures 2004.	Director of Finance	To champion the counter fraud message throughout the Trust. To monitor the effective discharge of the counter fraud function in relation to compliance with the Secretary of State Directions.	To promote counter fraud measures. The LCFS must be enabled to attend the Trust's Audit Committee meetings.	**Ian Jones**
Procurement	Government's Better Procurement, Better Value, Better Care published in August 2013.	Director of Finance	N/A	To act as a voice for procurement related matters at Board meetings and ensure that any implications arising from items	**New NED**

Statutory or Regulatory Roles	Regulation / Guidance	Exec Lead	Executive Director Lead Role	Non-Executive Director Lead Role	Proposed NED Lead
	Recommendation 4 requests that a NED be nominated as the contact for the national procurement team			discussed have been considered and appropriately addressed. To gain assurances that the Trust has in place an effective and robust procurement strategy. To work closely with the Director of Finance and to support delivery of the Procurement and Commercial strategy.	
Whistleblowing	Public Interest Disclosure Act (1998) (PIDA) NHS Constitution Freedom to Speak Up Review (2015)	Director of HR	The Freedom to Speak Up report does make some very clear recommendations about the role of designated Executive and Non-Executive leads with specific responsibility for whistleblowing. Trusts are now required to have both, demonstrating the commitment of the Board as a whole to effective handling of concerns raised by staff. The report recognises that it would not be practicable for a Non-Executive Director to act as a sole point of contact for whistle-blowers in an organisation, given the time constraints inherent in the role. However, it would be desirable to use a Non-Executive Director's ability to act as an independent voice and Board level champion for those who raise concerns. The Non-Executive Director would work closely with the Freedom to Speak up Guardian and, like them, could act as a conduit through which information is shared between staff and the Board. The Non-Executive Director should be expected to provide challenge alongside the Freedom to Speak up Guardian to the Executive Team on areas specific to raising concerns and the culture in the organisation.		**Ian Jones (SID)**

Statutory or Regulatory Roles	Regulation / Guidance	Exec Lead	Executive Director Lead Role	Non-Executive Director Lead Role	Proposed NED Lead
			Also to: To act as a voice for whistleblowing management and related issues at Board meetings and ensure that any implications arising from items discussed have been considered and appropriately addressed. To gain assurance that the Trust has in place effective and robust whistleblowing management procedures and response systems. To work closely with the Director of Human Resources with regard to monitoring whistleblowing. To be the lead representative at meetings with members of the public, staff or volunteers as required, and with appropriate management support and briefings. To be recognised as one of the channels for members of staff to raise their concern with.		
End of Life Care	RCP. National Care of the Dying Audit Round 4 2014 Neuberger Pathway. 2013 LACDP. One Chance to get it Right. 2014 National Hospitals End of Life Care Audit 2015 CQC Inspection Framework: NHS Acute Hospitals 2016	Chief Nurse	Take responsibility for and champion End of Life Care at Board level. Ensure strategic view and provides board level assurance of End of Life Care. Promote discussion about death and dying, using appropriate vocabulary. Ensure End of Life Care within the Trust, and provided by the Trust, is appropriately monitored. Demonstrate strong leadership and role model for all Trust staff regarding End of Life Care. Support and encourage education in	To have specific responsibility of care of the dying, focusing on the dying patient, their relatives and carers and reviewing how End of Life Care is provided. Champion End of Life Care at Board level, promoting discussion about death and dying, using appropriate vocabulary. Support , and where necessary challenge, the Executive Director for End of Life Care Act as a patient, family and public voice & ensure that the patient, family and public perspective is considered in all End of Life Care	**New NED**

Statutory or Regulatory Roles	Regulation / Guidance	Exec Lead	Executive Director Lead Role	Non-Executive Director Lead Role	Proposed NED Lead
			Palliative & End of Life Care and related topics e.g. communication skills and attitudes, because 'it matters' and not because ' it is mandatory' Assess the impact of all existing and new policies on End of Life Care and make recommendations for change. Recognise the impact of the perception of poor end of life care on bereaved families and provides Board assurance that complaints and incidents are dealt with in a way that reduces this impact.	related discussions and Board level scrutiny. Provide scrutiny to the monitoring of End of Life Care, oversight for End of Life complaints, and the handling of the bereaved within the Trust. Support and encourage education in Palliative & End of Life Care for patients, families and the public.	
Equality & Diversity	Equality Act 2010 - Public Sector Duty. It is important for Board Members to be aware of the equality duty in how they set strategic direction, review performance and ensure good governance of the organisation.	Director of HR	To act as a Board champion to set an example and demonstrate that the Board is committed to promoting equality. To challenge and promote the E&D agenda in the Trust. Act as a voice at Board meetings for the E&D agenda. To have oversight of the (insert committee/subgroup name) agenda. To actively participate in the Trust's E&D initiatives as necessary.		**Anita Wainwright**
Maternity Services	National Maternity Review: Better Births (2016)	Chief Nurse	Provider organisation boards should designate a board member as the board level lead for maternity services. The Board should routinely monitor information about quality, including safety and take necessary action to improve quality. Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training.		**Anita Wainwright**

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/169**	
SUBJECT:	**Key Issues Report from the August Strategic People Committee 2016-17**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Anita Wainwright, Committee Chair	
DIRECTOR SPONSOR:	Anita Wainwright, Committee Chair	
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):	A summary of the key issues discussed at August's committee meeting.	
RECOMMENDATION:	The Board note the contents of the discussions 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
AUGUST STRATEGIC PEOPLE COMMITTEE

Date of meeting:	**1st August 2016**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 26th June were approved as a correct record.
Formal Business	Strategic People Committee now meets with a smaller group of members enhancing focus and effectiveness. The Committee undertook a detailed review of the newly developed HR & OD KPI report. I t was agreed that Director of HR & OD would engage with Divisions to review performance across People measures. Consideration was given to the current People targets and it was agreed that trajectory points would be developed within each CBU and Division. The committee held a further discussion on the People Strategy, it was agreed to hold a workshop on 3rd October 2016, to consider in more detail? It was felt that there needed to be a greater focus on Learning and Development and Wendy Johnson undertook to meet with Non-Executive colleagues outside of the meeting, to discuss further. An expanded Employee Relations Case Report was considered and recommendations made for future presentation. It was agreed that a RAG rating system be developed denoting organisational risk e.g. financial risk or organisational reputational risk. It was agreed that this report would be developed as a standing agenda item. The NHS Workforce Race Equality Standard Report was considered by the Committee, it was agreed to undertake an on-going review of Equality and Diversity issues. It was agreed that best practice examples of Board Reporting be sourced and as this is a key agenda item in the Trust where the Director of Nursing and Governance would be taking up post, the two trusts agreed to form strategic links. A detailed discussion took place relating to Retention issues, in the light of improved recruitment times and an improving position on Additional Staff Spend. A range of initiatives and approaches for new starters were discussed, examples of which are meet the CEO and a strengthening of on-boarding questionnaire reach, as well as rotational programmes for newly-qualified clinical staff. The Committee considered the emerging Health and Well-Being CQuin. A range of related issues were discussed and it was noted that we had developed close working relationships with LiveWire and had launched our internal branding of Fit To Care. The Trust will look to build further on the success of the 2015 Flu Fighter campaign, which had earned national recognition.

	The Committee received Operational People Sub Committee meeting minutes from June 2016
Local Policies and Guidance Approved:	Adoption Leave and Pay Guidance, Disability Equality Policy, Maternity Leave and Pay Guidance and Scheme of Delegation for Disciplinary Sanctions
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/16/170**	
SUBJECT:	**Key Issues Report from September Charitable Funds Meeting**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Lynne Lobley, Committee Chair	
EXECUTIVE DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):		
RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Standing Items

The meeting was quorate and the minutes of the previous meeting held on the 23rd June were confirmed.

Formal Business

The Committee considered the progress made by the Charity Team in selecting a potential provider company for the WHH Charitable Funds Lottery. It was agreed that further work would be done to look at start up costs and charges, value of prizes and the financial benefits to our Charity. This will be circulated to the Committee. There was also agreement to include a "Responsible Gambling Policy" in the documentation we adopt.

At the previous meeting of the Committee, assurance was sought regarding the governance arrangements of other Charities linked to WHH. The Director of Community Engagement was able to report that she has a meeting with the first of these taking place shortly. The Committee also supported the proposal that the Director of Finance also be involved in this work going forward.

Financial Summary

Fund Balance is 490K as at 30th June 2016 (total for all funds held)

There was discussion around the allocation of overheads and in particular the need to make clearer the administrative costs of the fund. It was agreed that a separate schedule will be developed to make these costs more transparent.

The appointment of an administrative assistant was agreed as this is an existing role and essential to enable the team to function. However, consideration was given to this role being a temporary 6 month appointment but this was rejected on the grounds that it would be difficult to recruit a suitable person for such a short contract.

It was agreed that a small working group of the Committee to include, Director of Community Engagement, members of the Finance Team and a NED would meet to review the presentation and layout of the Finance Report so that it better reflects recent developments in the way our fundraising is operating.

Fundraising

The following fundraising proposals were agreed to be taken forward:

Dementia Ward Garden
Enhancing Birth Experience
Improvements to enhance stroke unit lighting and curtains.

A calendar of events until June 2017 was shared and will be promoted internally and externally.

Key Risk Review

All risks were reviewed. It was agreed that the key risk around loss of staff and succession planning required further action and will be an item on the December Agenda.
A key risk around reserves has also been identified and added to the document. This will be circulated following the meeting.

Charities Commission Check List Position Statement

This is has been completed and in most areas we are fully compliant. However, there are 6 standards from a total of 36 that require further work. The CFC will review these at each meeting until compliance is achieved and then move to a twice yearly review.

Changes to Bid Approval

A new way of approaching bid approval was agreed. One that gives a greater level of support to staff, in the early phase of making an application to the funds.

Date and Time of Next Meeting and changes to Committee Membership

The next meeting will be held on 5th Dec 2016 from 2-4pm. Please note that the November Meeting has been cancelled.

The Committee would like to recommend that a new Chair be nominated by the Board (Corporate Trustee) and that a replacement Governor be nominated by the COG to act as an independent member. Both need to be in place for the December meeting.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/172**	
SUBJECT:	**Charities Commission Corporate Trustee Checklist Position Report**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Pat McLaren, Director of Community Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement	
LINK TO STRATEGIC OBJECTIVES:		
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	In June 2016 the Charities Commission issued new guidance for Charity Trustee Duties. This was circulated to the CFC and the Corporate Trustee via Trust Board. This checklist is designed to help CFC evaluate the charity's performance at suitable intervals against the legal requirements and good practice recommendations set out in the guidance. It is recommended that this checklist be reviewed twice per year.	
RECOMMENDATION:	**The Committee is asked to note the checklist current status and mitigations/actions to be taken.** **The Committee is asked to review this checklist twice per year.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Charitable Funds Committee**
	Agenda Ref.	
	Date of meeting	**September 2016**
	Summary of Outcome	**Noted**

TAKING RESPONSIBILITY FOR OUR CHARITY'S FUNDRAISING: A CHECKLIST FOR TRUSTEES

August 2016

Guidance	Current status	Mitigations/actions/notes
Section 4: Planning effectively		
4.1 We have set out our fundraising plan	YES	Our fundraising strategy was reviewed by Trustees in February 2016 and our annual plan is reviewed at each CFC meeting
4.2 It reflects our charity's values	YES	
4.3 The resources we use and the costs we incur in our fundraising	YES	
4.4 The key financial and reputational risks we may face	YES	This has been identified in the Risk Strategy developed in Feb 2016 and of which the key risks are reviewed at each CFC meeting
4.5 We monitor progress	YES	A fundraising activity and financial report is reviewed by the CFC at each meeting
4.6 We manage key risks	YES	The key risks are reviewed at each CFC meeting
Section 5: Supervising our Fundraisers		
5.1 We have considered and decided which fundraising issues we will not delegate	YES	Our Fundraising team is directly accountable to and line-managed by a member of the executive team
5.2 Our fundraising staff have job descriptions	YES	Current and in place
5.3 Our fundraising staff are doing the job successfully	YES	PDR completed in June 2016, weekly 1:1s with Director
5.4 Our volunteers know who they report to and who to approach with problems or concerns	YES	WHH Volunteers will assume responsibility for all volunteers in September 2016, those on placement with WHH Charity report to the Fundraising Manager
5.5 Our volunteers understand the boundaries within which they must work when representing the charity	YES	They receive local induction from the Fundraising Manager and are supervised at all times
5.6 Our subsidiary trading company is monitored for effectiveness and only enters into commercial partners in the charity's best interest	N/A	
5.7 Our arrangements with commercial providers fully comply with relevant legal requirements	TBC	We are about to enter into a commercial relationship with a professional not-for-profit lottery promoter – we will ensure through contract that all legal requirements are met and maintained
5.8 Are in our charity's best interest because appropriate due diligence is undertaken	TBC	We will procure a partner using the Corporate Trustee's procurement team
5.9 Our fundraising values and expectations are communicated	TBC	These will be agreed upon contract
5.10 The costs are justifiable and can be explained 5.11	YES	The costs have been fully identified in a paper to CFC in June 2016
5.12 Proper control is kept of the money raised	YES	All monies will be drawn down directly into the WHHCharity bank account, no other methodology is

		permitted
5.13 Fundraising communications used are reviewed	YES	All communications are approved by the Corporate Trustee's Communications Department
5.14 Compliance with the agreement is monitored	TBC	Compliance will be monitored upon contract
5.15 Any conflicts of interest are recognised and dealt with	TBC	We will ensure that we monitor future partnerships for conflict of interest
Section 6: Protecting our charity's reputation, money and other assets		
6.1 The reputational risks our charity may face are identified, assessed and managed	YES	Reputational risks have been identified in our Risk Strategy of February 2016
6.2 Likely donor, supporter and public perception is considered when income expectations and other goals are considered	TBC	Our review of our bid application process will include this section to ensure compliance of all parties via capital campaigns
6.3 The legal rules and recognised standards which apply to our fundraising are followed	YES	We follow the Code of Fundraising Practice, the Institute of Fundraising and the NHS Charities guidance
6.4 Our values are communicated to the people who work on our fundraising	YES	All WHH staff adopt and practice the values of the Corporate Trustee, they and the public are further briefed on the aims and objectives of WHH Charity and are guided on how to proceed with fundraising initiatives on a personal/team/company level.
6.5 The costs of our fundraising are managed and explained	YES	We control our costs through a bid application process We review our costs at each CFC meeting
6.6 Our fundraising finance is planned and monitored	YES	We have an annual plan in place which is reviewed at each CFC meeting
6.7 Effective financial controls are in place and followed	YES	The Finance Team monitor all expenditure
6.8 Risks of financial crime and fraud are reduced	YES	WHH Charity provides a letter of authorisation to every fundraiser who is requested to sign acceptance of the 'contract' between us.
6.9 Our charity is alerted to any suspicious donations	YES	Our Finance Team review all bank statements and incoming direct funds Provenance of all cheque and cash donations is tracked through the donor journey and recorded via Harlequin, with a receipt and thank you letter posted out to the donor.
6.10 our charity can stop or authorise any unauthorised fundraising activity using its name	YES	We use a letter of authorisation to authorise fundraisers to raise funds on our behalf. We would alert the police to any suspicious activity undertaken in our name.
6.11 Serious incidents are reported to the commission, police and other agencies	YES	This will be actioned. NHS Protect may also be contacted where NHS Employees or their families are involved.
6.12 Our data, name, image, logo and IP are protected	YES	We do not issue our logo independently for 3rd party use We use letters of authorisation for 3rd party fundraisers

		We provide our own branded materials for support Our intellectual property is protected to the best of our ability and knowledge
Sections 7 and 8 Following the Law and recognised standards		
7.1 the Code of Fundraising Practice and other resources are used to find out about the legal rules and recognised standards which apply to our fundraising	YES	We follow the Code of Fundraising Practice, Institute of Fundraising and the NHS Charities guidance
7.2 These rules and standards are followed	YES	
Section 9: Be Open and Accountable		
9.1 Any legal rules and requirements that apply to how our charity reports and accounts for its fundraising are complied with	YES	We are audited periodically and produce an annual report and accounts each autumn.
9.2 Our open and accessible complaints procedures are followed if concerns are raised	YES	In the first instance complaints should be raised to the Fundraising Manager or Director The Charity uses the resources of the Corporate Trustee ie PALS and Complaints procedure. The Charity will make this process clear via its website
9.3 Our fundraising aims and achievements are clearly communicated to the public and donors/supporters	YES	Our website is maintained and updated regularly.

For Review: August 2017

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/172**	
SUBJECT:	**Freedom to Speak UP Guardian**	
DATE OF MEETING:	26th October 2016	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Candice Ryan	
EXECUTIVE DIRECTOR SPONSOR:	Roger Wilson, Director of Human Resources & Organisational Development	
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.1: Engage Staff, Adopt New Working, New Systems	
	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	The paper provides an update on the work already done at WHH to implement the cultural change identified by the Francis report around staff raising concerns. It details action taken, the role of a FSUG and the impact this will make and recommends a model for the appointment of the FSUG at the Trust.	
RECOMMENDATION:	Interim appointment of FSUG Model for implementation Funding to be agreed	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Freedom to Speak Up Guardian
Update and recommendations for continued progress.

1. Introduction

This report provides an update in terms of the actions taken by the Trust to implement the recommendations made in the Freedom to speak up (FSU) report in February 2015 by Sir Robert Francis QC, specifically the introduction of a Freedom to Speak up Guardian (FSUG) to the trust.

The FSU report came about as a result of an independent review of how staff within the NHS are able to raise genuine concerns about safety and other matters of public interest, and the handling of those concerns. The purpose of an FSUG's is to give staff a point of contact who will address those concerns on their behalf or guide them as to the appropriate channel for their concerns.

2. How are we doing?

At present we can have a number of measures which allow us to identify how confident our staff feel about raising concerns; the annual NHS staff survey and the utilisation of the Speak out Safely campaign and access to the utilisation of the Raising Concerns (Whistleblowing) Policy.

The Annual Staff Survey

The national staff survey identifies that during 2014 and 2015 that staff feeling secure to raise concerns about unsafe clinical practice has remained stable but below average for an acute Trust. However, the Trust ranks above average for the number of staff who believe the trust to have fair and effective procedures for reporting errors, near misses and incidents.

Speak Out Safely

As a trust we are signed up to the national Speak Out Safely (SOS) campaign that encourages staff to have the confidence to report unsafe practice and concerns that they see at work.

The motivation for signing up to SOS was to demonstrate that as a trust we want all of our staff to know it is safe for them to speak up when they feel something is wrong.

We initially encourage staff to raise their concerns with their line manager, or another member of our management team. However this form also provides an anonymous route available to those staff who aren't feeling confident about raising their concerns.

We promise that where staff identify a genuine patient safety concern, we will support them, fully investigate and, if appropriate, act on their concern. We will also give them feedback on how we have responded to the issue they have raised if they want us to.

Since SOS was introduced in November 2014 there have been 34 issues raised. Only 1 SOS has been received in this financial year.

Raising Concerns (Whistleblowing) Policy.

We have had some cases in recent years which, although not strictly lodged under this policy, we have classified under this policy. These have come from staff across the organisation and at differing levels showing a degree of confidence across departments to raise concerns. However, the fact that the majority of these issues have not formally accessed the policy but have been channelled this way demonstrated the need for the FSUG role to direct and guide staff and raise awareness.

Other work

We are currently reviewing both our Raising Concern (Whistleblowing) Policy and our Dignity at Work policy in line with national guidance, working closely with our Staff Side colleagues.

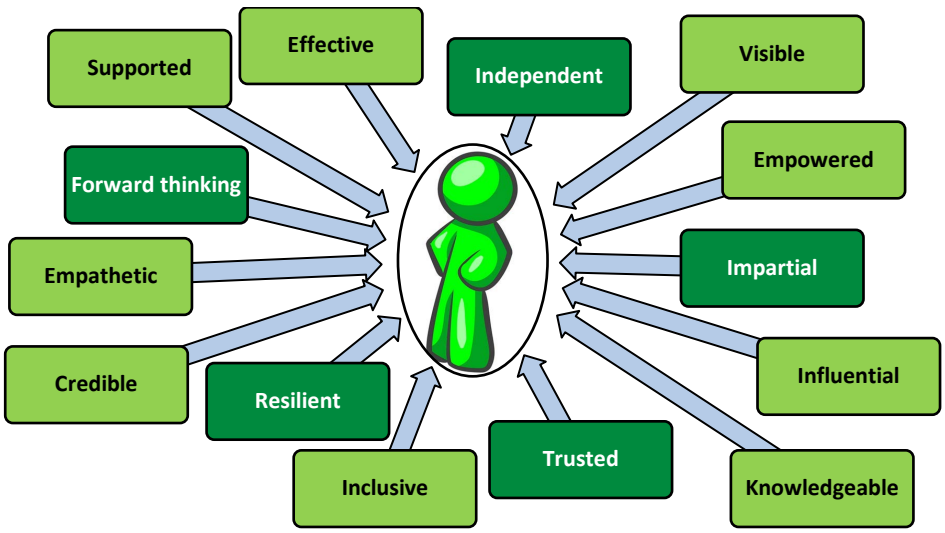
3. Freedom to speak up guardian

Following Sir Francis's recommendations the NHS contract 2016/2017 specifies that NHS Trusts should have nominated a Freedom to Speak Up Guardian (FSUG) by 1 October 2016.

The purpose of the FSUG is to work alongside the leadership team to support a more open and transparent place to work, where all colleagues are actively encouraged and enabled to speak up safely.

The role of the FSUG is to be an independent and impartial source of advice to staff, to provide access to anyone in the organisation, including the Chief Executive Officer, to raise issues. A key part of the role is also to support a focus on safety, learning and proper handling of cases and be an honest broker – monitor separation of performance from speaking up issues.

The diagram below highlights the key elements of the guardian role.



4. What are the key challenges to the Organisation?

The Francis report recommendations aim is to initiate cultural change in the NHS where by staff feel confident and able to raise concerns without fear of the consequences.

Cultural change is not achieved by one action or the introduction of a role but an overarching strategic approach with key actions that staff can 'believe in' and 'see' make a difference.

The principles of Freedom to Speak up:

Getting the culture right

- *Leadership is key*
- *Zero tolerance of bullying*

Handling cases well

- *Swift action*
- *Proportionate investigation and record keeping*
- *Feedback*

Support for the system

- *Training*
- *Freedom to Speak up Guardians*

5. What has everyone else done?

The NHS England guidance on the introduction of FSUG into your organisation is clear that one size won't fit all and that the needs of our own organisations culture should be considered and an appropriate model implemented. Although it has recommend that the role be at least a part-time permanent appointment.

Numerous models have been implemented with some Trusts having taken on paid full or part time FSUGs to undertake the role. While others have utilised or supplemented this with champions / ambassadors across the organisation (a main guardian must be established).

There are some lessons learnt which we can benefit from.

- Although no one role was initially implemented common themes, roles and duties have emerged and therefore the National Guardians Office has published a national job description and role profile the banding for which is around a band 7 or 8a.
- Trusts have found that the main guardian role is significant and needs a dedicated individual.
- The person needs to have a genuine interest in the role and understand the organisation and when to escalate.
- A comprehensive case management system needs to be established.
- The individual needs to be visible and have recognition from the top and cross trust respect.
- A combination of channels to support staff to raise concerns should be utilised and that the FSUG should be confident in directing staff to the most appropriate channel.

6. Proposed model for WHH

Interim arrangements
The organisation must identify an individual as its FSUG from 1st October. The appointment of the FSUG is the responsibility of the Board.

It is recommend that as an interim measure the Trusts Equality & Diversity Specialist is asked to undertake the role of FSUG. This will give staff an identified FSUG point of contact and allow us to start to communicate the purpose of the role and develop the model.

The E&D Specialist has experience in dealing with confidential and sensitive issues for staffing and has developed relationships with hard to reach groups of staff through her substantive role.

The E&D Specialist is funded for 2 days per week only and would only be able to undertake this role for a short period alongside her current duties otherwise we would risk legislative non-compliance for the E&D agenda. The FSUG part-time role set out below would complement the E&D Specialist current role making and utilises many of the same skills set.

Permanent arrangements
There are no roles in the organisation with capacity to take on and fully implement the job description identified by the National Guardians Office. Our staff survey results show that the organisation is not in an advanced position with regard to raising of concerns and staff confidence. The role of the FSUG will be significant in facilitating the cultural change required by the Francis Report.

A new permanent role should therefore be created using the national job description at 22 hours per week at Band 7 or 8a (subject to job matching), although whether this is sufficient capacity should be reviewed after 12 months. The operational model at the trust of Clinical Business Units lends itself to employing an overarching FSUG who is supported by a network of CBU champions / ambassadors. The maximum cost (assuming the post is established at Band 8a) would be £30,000 including on costs.

The organisational focus on giving CBU's autonomy and developing strong team ethos will it is felt allow local champions / ambassadors greater contact / visibility and enable them to develop a greater level of trust. Hopefully enabling where possible issues to be resolved quickly and giving an opportunity for learning.

The FSUG would also therefore give an additional level of reporting and advice and would be responsible for sharing the learning trust wide and senior level advice and support.

It should be noted that the FSUG reports directly to the Chief Executive but can be supported in the development of robust processes and staff engagement by the Head of Workforce Strategy & Engagement. There is no budget allocated for a FSUG for this financial year although it was identified during the budget setting process as a potential pressure.

7. Implementation of the FSUG role

The FSUG will have a number of actions to endeavour to undertake before the end of the financial year.

Key initial actions:

- Promotion of their role
- Formal launch event
- Ongoing communication of access to FSUG – Leaflets, posters, wage slips, meeting Senior Staff, attending team meetings
- Develop the role descriptions for local champions / ambassadors
- Recruit to local champions / ambassadors (ongoing support needed)
- OD programme to support cultural change, include induction
- Monthly meeting with staff side
- Identify a Non-Executive FSUG lead to work alongside the Chief Executive.
- Staff engagement and involvement – ensures progress is made by reflection and learning
- Develop a quarterly report and annual report

What will good look like?

- Clear processes in place for receiving and addressing concerns
- Staff know what to do
- Clear feedback methods
- Lessons learnt communicated widely to improve patient safety across the Trust
- Business as usual….. low escalation numbers
- Receiving Concerns
- Addressing Concerns
- Making Change happen
- Feedback and closing the loop
- Targeting vulnerable and hard to reach groups
- Learning Lessons

What promotion do we need to do now?

- Publicise access for interim arrangement to be communicated at Team Brief, published on the Extranet and for posters to be displayed throughout the hospital.
- Team Brief
- All User Email / CEO Friday message first week in October

8. Recommendation

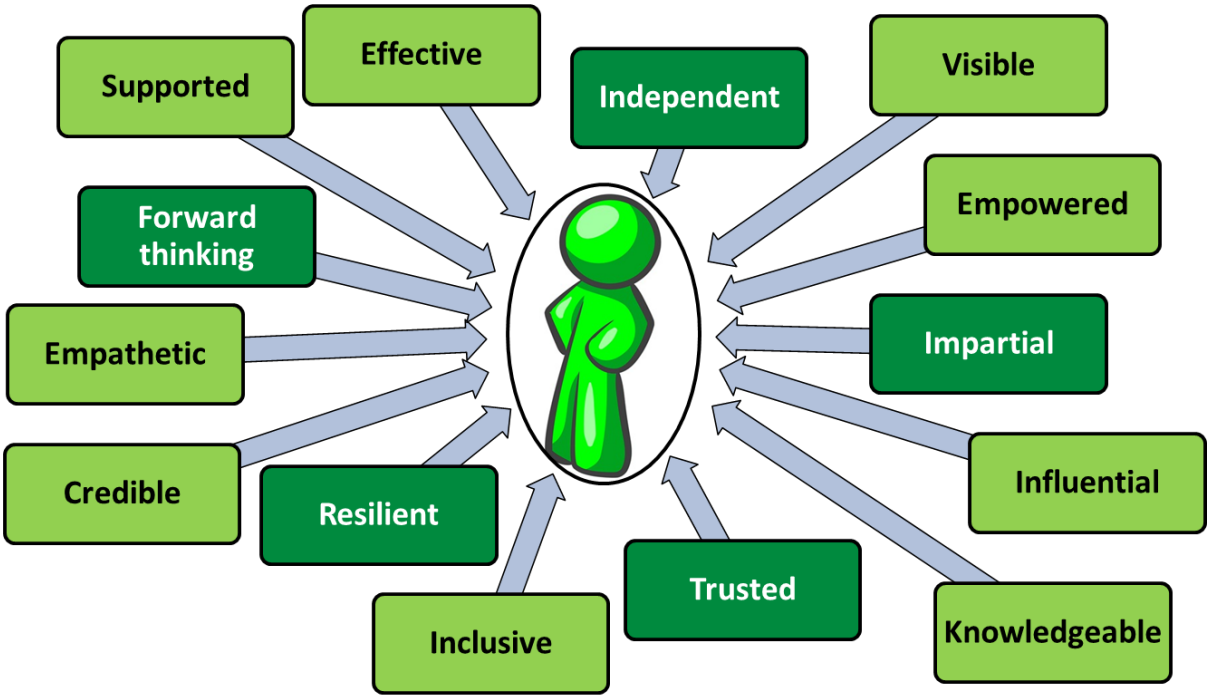
a) That the trust model for the implementation of FSUG and network of local champions / ambassadors is adopted
b) That from the 1st October Sophie Hunter, Equality & Diversity Specialist be appointed as he Trust Interim Guardian based on the job description to be found at appendix 1.
c) That the salary cost of the permanent FSUG will need to be funded from when the post holder is in post or formal agreement from the Executive Team that this can be an agreed overspend until this can be treated as a cost pressure for 2017/18 and funded from 1 April 2017 (see Section 6 above).
d) That the Job description is job matched and then recruited to. Further discussions are needed to identify the day to day working of the role. A report recommending the permanent appointment will be made to the Board.
e) That a Non-Executive FSUG lead is identified
f) An update on progress is returned to Board following the end of the financial year.

Roger Wilson, Director of HR & OD
September 2016

Appendix 1 - Job description and person specification.

Example job description - Freedom

Example Job Description (Freedom to Speak Up Guardian) (July 2016)



Purpose of the role

The Freedom to Speak Up (FTSU) Guardian will work alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

Outcomes

The FTSU Guardian role is designed to contribute to achieving the following outcomes:

- A culture of speaking up is instilled throughout the organisation
- Speaking up processes are effective and continuously improved
- All staff have the capability to speak up effectively and managers have the capability to support those who are speaking up
- All staff are supported appropriately when they speak up or support other people who are speaking up
- The Board is fully sighted on, and engaged in, all Freedom to Speak Up matters and issues that are raised by people who are speaking up
- Safety and quality are assured
- A culture of speaking up is instilled throughout the NHS

Role Description

The role of the FTSU Guardian is to:

Culture

- Develop and deliver communication and engagement programmes to increase visibility of the Freedom to Speak Up Guardian amongst all staff.
- Promote local speaking up processes and sources of support and guidance, demonstrate the impact that speaking up is having in the organisation, and celebrate speaking up.
- Ensure that all 'frontline' staff are aware of, and have access to, support to help them speak up.
- Where appropriate, develop and support a network of 'advocates' to ensure that Freedom to Speak Up reaches all parts of the organisation and everyone has easy access to someone outside their immediate line-management chain who can advise and support them.

Process improvement

- Work with HR professionals and others to ensure that speaking up guidance and processes are clear and accessible, reflect best practice, and address any local issues that may hinder the speaking up process.
- Assess the effectiveness of Freedom to Speak Up processes and the handling of individual cases, intervening when these are failing people who speak up, and making recommendations for improvement.

Capability

- Assess the knowledge and capability of staff to speak up and to support people when they speak up.
- Ensure that all staff have the relevant skills and knowledge to enable them to speak up effectively, and those supporting, managing or investigating speaking up issues have the capability and knowledge to do this effectively.
- Ensure that appropriate items on speaking up are incorporated into induction programmes for all staff.
- Ensure that groups of staff and individuals who may find it difficult to speak up are given particular support.

Supporting staff

- Ensure that information and data are handled appropriately, and personal and confidential data are protected.
- Ensure that individuals receive appropriate feedback on how issues that they speak up about are investigated, and the conclusion of any investigation.

- Where necessary, give extra support, including 1-2-1 support, to people who are experiencing difficulty with speaking up, or those who are experiencing difficulty in handling or supporting someone who is speaking up.

Working with and challenging the Board

- Develop strong and open working relationships with the CEO, NEDs and other Directors, with direct access to Trust leaders as required.
- Attend board meetings regularly to report on Freedom to Speak Up activities. Reports should include assessment of issues that people are speaking up about (and trends in those issues), and barriers affecting ability of people to speak up. Particular attention should be given to concerns which may suggest a link to patient safety and quality.
- Hold the Board to account for taking appropriate action to create a Freedom to Speak Up culture, assess trends, and respond to issues that are being raised.

Safety and quality

- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.
- Develop measures, data sets, and indicators to monitor trends and identify linkages between issues raised through people speaking up, and issues raised through other safety and quality routes.

NHS culture

- Take part in National Guardian Office activities and training, actively supporting fellow Freedom to Speak Up Guardians, developing personal networks and peer-to-peer relationships, contributing to wider networking events, and sharing and learning from best practice.
- Raise issues that cannot be resolved locally with the National Guardian's Office, including where Trusts appear to be failing in their obligations.
- Keep abreast of developments and best practice, assessing their own development and training needs, and seeking support in addressing these.

Personal qualities:

FTSU Guardians are expected to have the qualities and experience that will enable them to uphold these key principles:

Key principles	…what this means
Independent	… in the advice they give to staff and trust's senior leaders, and free to prioritise their actions to create the greatest impact on speaking up culture … and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up
Impartial	… and able to review fairly how cases where staff have spoken up are handled
Empowered	… to take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder
Visible	… to all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade
Influential	… with direct and regular access to members of trust boards and other senior leaders
Knowledgeable	…in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up
Inclusive	… and willing and able to support people who may struggle to have their voices heard
Credible	… with experience that resonates with frontline staff
Empathetic	… to people who wish to speak up, especially those who may be encountering difficulties … and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible
Trusted	… by all to handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate
Resilient	… and able to handle difficult situations professionally, setting boundaries and seeking support where needed
Forward thinking	… and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally
Supported	… with sufficient designated time to carry out their role, participate in external Freedom to Speak Up activities, and take part in staff training, induction and other relevant activities … with access to advice and training, and appropriate administrative and other support
Effective	… monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/173**	
SUBJECT:	**Key Issues Report August Finance & Sustainability Committee**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, Committee Chair	
DIRECTOR SPONSOR:	Terry Atherton, Committee Chair	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF3.3: Clinical & Business Information Systems	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	A summary of the key issues discussed at August's committee meeting.	
RECOMMENDATION:	The Board note the contents of the discussions 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
AUGUST FINANCE AND SUSTAINABILITY COMMITTEE

Date of meeting:	**24th August 2016**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 20th July 2016 were approved as a correct record.
Formal Business	Finance and Sustainability Committee has not normally met in August; however, in the light of Regulatory and System pressure the committee met on the 24th August on a restricted agenda. Financial Report for Month 4 year to date was reviewed. July incurred a deficit of £1.1m against a planned deficit of £800k. Whilst operating income was some £200k above plan, this was more than outstripped by operating expenses being £500k above plan. Pay costs for the month were £300k above plan. Clinical supplies were £200k above plan. All CBUs are overspent mainly due to nursing costs. For the September Finance and Sustainability Committee we have requested that the Director of Human Resources and Organisational Development attends the committee with a wide ranging update on 'Pay' together with core members of the committee. At the end of Month 3, our financial performance was better than plan; however, in the light of the Month 4 outturn, we have lost that comfort with the deficit at Month 4 now on plan at £4.1m. Cash remains tight at month end. The in year working capital loan required of £7.9m has still not been approved and in the meantime we have drawn £4.9m by way of an interim facility. The committee spent some time reviewing our aged creditor position and especially non-public sector and local creditors. Our position is unlikely to improve. Capital expenditure is slightly behind plan. 2016/17 forecasts include the expected flow of Sustainability and Transformation funds as well as our CIPs. The criteria for access in respect of the Sustainability and Transformation funding were considered both from a finance and operational perspective and the need for scenario planning. Turning to the Financial Improvement Programme, as at 11th August CIP schemes have been developed to the value of £9.223m PYE and £10.552m FYE month on month progress continues; indeed as at 24th

	August PYE schemes now total £9.99m and FYE schemes total £10.7m. As at the end of M4, the Trust has delivered £2.348m in actual CIP savings against the revised plan of £2.344m. The 2016/17 target remains at £10.7m. The committee was updated in respect of the Phase 2 Ernst and Young work which will conclude in early September – report to go to NHS Improvement will be shared with us – alongside the build-up in our own Transformation Team. The A&E performance for July was 92.69% against the agreed trajectory of 91%. However, the second half of July was very difficult in terms of flow which continued into August. NHS Improvement are in contact with the Trust in these circumstances and understand that the remaining days of August will be crucial if we are to get over the line against the August trajectory of 91%. This pressure has resulted in a drop in performance around ambulance handover times but we remain one of the higher performing Trusts in the region. The Daresbury Intermediate Care Unit closed on Friday 19th August, saving approaching £100k each month. Commissioner funding ceased in April. This will present operational challenges. Funding for the post of Ambulance Clinical Coordinator ceased at the end of June and options are being explored. A local A&E Delivery Board is expected to be in place by 1st September. RTT remains on plan with 2 specialities not achieving target – T&O and general surgery. At the end of July a 52 week waiter was identified and the situation has been addressed. The overall indicators for cancer continue to be achieved. The Outpatients Turnaround Board will meet on 7th September and through the monthly Corporate Performance Reports. The Finance and Sustainability Committee will be able to see progress. In conclusion, the areas of Financial Performance, the Financial Improvement Programme and Corporate Performance reporting into Finance and Sustainability Committee remain challenging.
Local Policies and Guidance Approved:	None.

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/16/173**	
SUBJECT:	**Key Issues Report September Finance & Sustainability Committee**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, Committee Chair	
DIRECTOR SPONSOR:	Terry Atherton, Committee Chair	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF3.3: Clinical & Business Information Systems	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	A summary of the key issues discussed at September committee meeting.	
RECOMMENDATION:	The Board note the contents of the discussions and that there are no matters arising for escalation	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

KEY ISSUES REPORT
MAY FINANCE AND SUSTAINABILITY COMMITTEE

Date of meeting:	**21st September 2016**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 24th August 2016 were approved as a correct record subject to one minor amendment.
Formal Business	The Finance Report for Month 5 was reviewed. August incurred a deficit of £1m which is on plan. The year to date deficit of £5.0m is also on plan. The usual variances in both income and expenditure were reviewed together with ongoing service pressures. The performance reported now reflects the imposition of local commissioner fines and penalties and the non-achievement of CQUIN for Quarter 1 very disappointingly to a total of £1.1m year to date. A significant proportion relates to discharge letters – £716k and the Deputy Medical Director attended FSC to cover the background and the remedial work undertaken which has reduced the ongoing challenge to modest proportions. However, there will be additional commissioner fines and penalties for Quarter 2 at least. There was considerable debate around the whole aspect of local commissioner fines and penalties and the effort needed to avoid these going forward. The Chair highlighted the letter sent by both NHS England and NHS improvement dated 28th July requesting that where appropriate they are implemented by commissioners in a robust and timely way. A review was undertaken in relation to the access standards covering the Sustainability and Transformation fund of £8m. The underlying targets are not subject to National Penalties but it is vital that we continue to meet all standards if we are to continue to receive the underlying funding which forms an integral part of our 2016/17 Financial Plan. Cash remains tight with no relief in sight. Capex is slightly behind plan.

	It was highlighted that the final 7 Months' of our financial year require us to be absolutely on plan in all areas of the financial and operational performance of the Trust. Turning to the Financial Improvement Plan as at 14th September CIP schemes have been developed to the value of £9.949m PYE and £11.156m FYE demonstrating further progress. At the end of Month 5 the Trust has delivered £3.107m in actual CIP savings, against the YTD plan of £3.064 and the annual target of £10.7m. Presentations were received in respect of Controls Reporting and both Women`s and Children`s CIP plans and performance. FSC received the Ernst and Young Phase 2 Report which is due at NHS Improvement by 23rd September. Given this was only received on the morning of the committee, NED members agreed to reflect on this report overnight and provide feedback. On initial review, the report was considered satisfactory though slightly bias in relation to contribution levels. For the month of August the A&E performance was 92.88% against the agreed trajectory of 91%. This was a tremendous team achievement in view of the late July and early August pressures. Ambulance turnaround dipped in August and a deep dive is in course. Funding for the role of Ambulance Clinical Coordinator has been withdrawn by Warrington CCG and options are now being tested. The local A&E Delivery Board will hold its initial meeting on 22nd October. All remaining performance targets are at or close to plan. The Outpatients Turnaround Board held its first Meeting on 7th September. The Committee received a comprehensive update on all IM&T activities and issues covering the last 2 months. A detailed presentation was received in respect of the whole aspect of Pay Controls from the Director of Transformation. This was very well received indicating the progress made and the further challenges ahead. It was stressed that there is both cross Executive and Committee responsibility. A verbal update was received in respect of Waiting List Initiatives. Finally a Paper was noted by the Committee in respect of the Trusts

	participation in a Costing Transformation Programme initiative.
Local Policies and Guidance Approved:	None.
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/16/174**	
SUBJECT:	**Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016/17**	
DATE OF MEETING:	31st August 2016 workshop	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Emma Blackwell, Resilience Manager	
EXECUTIVE DIRECTOR SPONSOR:	Sharon Gilligan, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.4: Business Continuity	
	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):	The Trust has undertaken the annual self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards and has been rated as a 'Substantial' compliance. An improvement plan has been produced to address the 4 core standards that were rated as Amber/Non-compliant. The Trust is required to take a statement of compliance to the Board before the assurance rating is submitted to NHS England.	
RECOMMENDATION:	The Board is asked to note the 'Substantial' compliance against the EPRR core standards.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Emergency Planning Group
	Agenda Ref.	19/8/5
	Date of meeting	19.08.16
	Summary of Outcome	Approved

1. Background

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

2. Assurance Process

All providers of NHS funded care are required to undertake an annual self-assessment against the EPRR Core Standards and rate their compliance (appendix 1). Once this process has taken place, organisations are expected to take a statement of compliance to their Boards. The Board report along with the Core Standards ratings and improvement plan will then form the submission to the Clinical Commissioning Group and Local Health Resilience Partnership (LHRP). Following this, the LHRP will submit reports to the NHS Regional Teams so that a national report can be prepared and considered by the NHS England Board.

3. Warrington and Halton Hospital Statement of Compliance

Following the self-assessment and in line with the definitions of compliance (appendix 2), Warrington and Halton Hospital has declared itself as demonstrating a **Substantial** compliance against the EPRR Core Standards.

The Trust was rated against 51 applicable standards, and reported full compliance with 47 standards. 4 standards were rated as non-compliant but there was evidence of progress and are in the EPRR work plan for the next 12 months.

4. Improvement Plan

For the 4 standards that were rated as non-compliant an improvement plan has been compiled (appendix 3) and will be monitored via the monthly Event Planning Group. The Event Planning Group is chaired by the Chief Operating Officer or Deputy Chief Operating Officer (Accountable Emergency Officer) and reports to the Quality Committee.

5. Conclusion

The Trust has completed a self-assessment against the NHS England EPRR Core Standards and has been rated a 'Substantial' compliance level. An action plan has been produced to address the four standards that did not achieve full compliance and progress will be reported via the monthly Event Planning Group.

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		Unable to use due to issue of disposing of waste and ventiallation issues
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).	12 live suits expired May/June/July, Respirex could only service in January 2017	
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme	12 Training suits	
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)	Serial No 2305658 and 2305656	
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

NHS England Core Standards for Emergency preparedness, resilience and response

v4.0

The EPRR Core Standards spreadsheet has 7 tabs:

Introduction - this tab,. outlining the content of the other 6 tabs and version control history

EPRR Core Standards tab - with core standards nos 1 - 37 (green tab)

Business Continuity tab:- with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and NHS ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard (NHS Ambulance Services only): designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards (NHS Ambulance Services only): designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy
- update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of samples

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																				
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas	Jan Ross, Deputy Chief Operating Officer			
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	Annual Work Plan for the year ahead is produced in the Annual EPRR Report and is based on a combination of factors; - national targets, LHRP objectives, results of audits and external assessments, internal priorities identified by the Event Planning Group.			
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		The Corporate Business Continuity Policy and Major Incident Plan. Policies are reviewed annually at the Event Planning Group and sent to the Quality Governance Committee for formal ratification. All policies are shared in the Emergency Planning community on the Trust intranet site.			
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Annual Report for EPRR is presented to the Trust Board by the Chief Operating Officer in May each year. Other reports are made to the board periodically to keep them informed of changes, e.g. major incidents, results of external assessments.			
Duty to assess risk																				
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages;	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages	The EPRR Risk Register is a standard agenda item on the Event Planning Group which reports into the Quality Governance Committee			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	• surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	The risk assessment process is consistent with national and local risk registers adopted by LHRP and health partners.			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Safety & Risk Committee and Event Planning Group are the two main vehicles for progressing the risk assessment process. All divisions and departments consider new risks as part of an ongoing process.			
Duty to maintain plans – emergency plans and business continuity plans																				
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	The Trust has relevant emergency plans in place to achieve this. Some of the plans mentioned in this section are the responsibility of other organisations, e.g. Local Authority or SBP, but the Trust will respond to the wider response as part of the mutual aid response.			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y											
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y					
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y					
		Mass Casualties	Y	Y	Y			Y		Y	Y				Y					
		Fuel Disruption	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y					
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y					
		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y			Y					
		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y					
		Lockdown	Y	Y	Y			Y	Y						Y					
		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y					
		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y				Y					
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y															
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y															
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	EPRR plans are developed using appropriate national guidance and are assessed externally as part of the process for providing assurance to the LHRP and Commissioners. Any recommendations from external assessments are implented as part of an action plan to ensure continuous improvement. The Trust's Incidednt Response Plan includes the bullet point guidance in column C.			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	This is outlined in the Business Continuity and Major Incident Plan. An activation flow chart is included in both corporate and local business continuity plans to show how such incidents will be managed. An Induction plan is in place for Senior Managers/Directors new to the on-call rota.			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Critical functions are identified in both the corporate and local business continuity plans via the Business Impact Analysis (BIA). This shows the critical functions, the Maximum Acceptable Outage (MAO) that can be tolerated before a loss of a business function becomes critical to the organisation. It also shows the potential impact to the Trust of a loss of a critical function.			
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y			Y	Y								Within the Trust consent to treatment policy, there is a section on visiting celebrities			
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	Planning is done in collaboration with other stakeholders internally via the Event Planning Group and externally via the LHRP and System Resilience Group.			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, coldjat the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		The Trust has an internal debrief strategy which is outlined in the incident Resonse Plan. Multi-agency debriefs are also organised by the Local Resilence Forum in Cheshire.			
Command and Control (C2)																				
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	The Trust switchboard at Warrington Hospital is the single point of contact for emergencies at all times (24/7/365). This is the official contact point for alerting the Trust of Major Incidents or Major Incident standby situations. We have a 2 tier management on-call rota which means that senior managers can be contacted at any time. There is also an e-mail address (controlroom@whh.nhs.uk) which automatically informs senior managers of any urgent correspondence.			
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y		Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	Recent review of the on-call system has led to the production of an on-call policy, guidance document and handbook. Training sessions have been undertaken by NHS England and internally by the Deputy Chief Operating Officer			
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	An incident Control Room is available and maintained together with a back up control room. This is described in the Major Incident Plan which also includes details of the role of the Loggist. An action card for the Loggist is also in place.			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Decisions are recorded by a Loggist. Details of trained loggists are kept in the Incident Control Room.			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		Arrangements for completing sitreps are included in the appendices of ther Incident Response Plan. We don't have any guidance on CRIP/COP at the moment.			
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y												CBRN plan details arrangements for contacting PHE for specialist advice. Security Policy details advice for firearms incidents.			
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y												Arrangements in place with Royal Liverpool (per Dr Crowder, ED Lead)			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Duty to communicate with the public																			
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	Warning & Informing the public is undertaken by the Comms team in conjunction with key stakeholders. The Head of Communications is a member of the Incident Control Team and is therefore able to get messages out quickly to the public about the nature and extent of the incident, who it might affect, how it might affect the Trust's services etc. Director of Communications has a media plan and action card for major incidents.			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	Following a recent telecoms failure, it has been identified that the Switchboard Business Continuity Plan requires updating. Event Planning Group are also progressing purchasing hand held radios to increase resilience in the event of a failure.	Update Telecommunications Business Continuity Plan. Explore the possibility of purchasing hand-held radio's in case of telecommunication failure.	Emma Blackwell	Dec-16
Information Sharing – mandatory requirements																				
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	The Trust participates in an information sharing agreement with other emergency services. This is co-ordinated via the LHRP. The Trust is signed up to Resilience Direct.			
Co-operation																				
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y			Y	Y	Y	Y	Y			Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	Representatives from the Trust participate in vaious LRF exercises. The Trust is also represented at the Cheshire Local Resilience Forums via the LHRP and is kept informed of progress etc at these meetings.			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Via the LHRP and participation in LRF exercises and awareness sessions			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y			Y	Y	Y	Y	Y			Y		All Trusts in CWW have signed up to the Memorandum of Understand re- mutual aid. This is maintained via the LHRP.			
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y					Y	Y				Y					
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y						Y				Y					
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y			Y	Y			Y		Y			Via the LHRP meetings and relevant plans.			
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared										Y									
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months									Y	Y									
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y	Y	Y		Y			Y		Deputy Chief Operating Officer attends LHRP meetings, Resilience Manager attends the LHRP Practitioners Sub-Group meetings.			
Training And Exercising																				
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs.	Representation from Trust staff at all LRF and LHRP training exercises. On-Call Staff receive an induction guide which details training requirements. ED staff have received in house major incident and CBRN training.			
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	Exercise programme is devised in collaboration with LHRP and based on local needs and priorities identified internally via identified risk areas.			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y			Y		Representation from appropriate Trust staff at all LRF and LHRP training exercises.			
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y		Y	Y	Y	Y	Y	Y			Y		Resilience Manager maintains details of all exercises and training for senior managers . This is included in the annual EPRR report to the Trust Board.			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive																				
DD1	Organisation has undertaken a Business Impact Assesment	• The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers • The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers • Risks identified thought the Business Impact Assessment are present on the organisations Corporate Risk Register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• updated Business Imact Assessment • corporate risk register	BIA in place using the NHSE template but requires updating.	Trust wide BIA to be updated.	Emma Blackwell	Nov-16
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolorable Peroiods of disruption for these	• The organisaiton has identified their Critical Functions through the Business Impact Assesment. • Maximum Tolerable Periods of Disruption have been set for all organisaional functions - including the Critical Functions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity plan explicitly details the Critical Functions • Business Continuity plan explicitly outlines all organisations functions and the maximum torlerable period of disrution	Trust has a business continuity plan that is in the process of being updated.	Business Continuity Management Workplan in place which is monitored via the Event Planning Group. The newly established Clinical Business Units are currently producing BIA's/BCP's which will then inform the Trust wide BCP.	Emma Blackwell	Dec-16
DD3	There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event.	• The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions • The plan outlines roles and responsibilities for key staff and includes how a disrutive event will be communicated both internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body	The Trust Business Continuity Plan was agreed by the Governance Committee in Sept 2014.	Business Continuity Management Workplan in place which is monitored via the Event Planning Group. The Trust wide Business Continuity Plan is scheduled to be updated in December.	Emma Blackwell	Dec-16
DD4	Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel	• The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business.	Section within the BCP detailing loss of Fuel but this refers to a Trust Emergency Fuel Plan which is only in draft format.	Update Fuel demand section in the Trust BCP.	Emma Blackwell	Dec-16
DD5	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this .	EPRR Framework 2015 requirement, page 17	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Business Continuity work plan in place and progress being monitored via the monthly Event Planning Group.	Ensure progress continues against Business Continuity Workplan	Jan Ross	Dec-16
DD6	Review of Critical Services Fuel Requirement Data Collection Programme (F1.F18)	Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the "Other comments" free text box.	Y	Y		Y	Y	Y	Y						Y	• NHS Ambulance Trusts have already provided this information in a national collection in May 2016.				

Fuel Demand Summary

When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:

Total Daily fuel use (F1) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)

Section 1: Business as Usual Demand

		Petrol	Diesel	Other (inc LPG, Kerosene
F1	How much fuel do you use daily when providing a business as usual service? (litres)	43	43	0

Section 2: Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene
F2	Do you hold bunkered fuel (Yes/No) If no go to F6	No	No	No
F3	What is the total bunkered fuel capacity? (litres)			
F4	On average, what volume of bunkered fuel do you hold? (litres)			
F5	Do you use your own bunkered fuel when providing a business as usual service? If no go to F6			
F6	Do you access a 3rd party or another service's bunkered fuel when providing a business as usual service? If no go to F8	0	0	0
F7	If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.			

1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?
DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock.

2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?
The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that estimates are required, or where you have had to average data in order to fit the template.

3) Our choice of bunkered fuel supplier varies depending on supply cost or availability. Who do I record as the primary supplier?
Please provide the supplier you get most of your fuel from, but also note that this varies and provide details of the other suppliers and average quantities.

4) The terminal our bunkered fuel is supplied from varies depending on who our supplier is. What should we report?
Please report your largest supplier based on average BAU, but also provide notes on any secondary service providers and average quantities obtained from those providers.

Section 3: Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene
F8	Do you use forecourts to operate a business as usual service? (Yes/No) If no go to F10	Yes	Yes	No
F9	What is the average daily forecourt fuel use to operate a business as usual service? (litres)	43	43	

Critical Service Operation Only

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a Critical Service activity can be carried out remotely, and therefore does not require the use of fuel, this should be removed from the supply requirements to deliver
The below section refers to the fuel requirements to deliver a Critical Service only.

Section 4: Critical Service Demand

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F10	How much fuel would you use daily if you were providing a critical service? (litres)	33	33	

Section 5: Critical Service Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F11	Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mutual supply agreements)? (Yes/No) If no go to F14	No	No	No
F12	What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres)			
F13	What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily if you were providing a critical service? (litres)			
F14	If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any agreement(s), amount of supply and companies / organisations involved. If no go to F15			

Section 6: Critical Service Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F15	Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? (Yes/No) If no go to F17	Yes	Yes	No
F16	What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres)	33	33	

Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of vehicles required to operate a critical service
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide sites giving a good geographic coverage of the UK to meet the predicted regional demand for fuel for critical services.

Vehicles	Number of Vehicles required to operate a critical service		
	Petrol	Diesel	Other (inc LPG)
With NHS Logo			
Without NHS Logo			
Private vehicles	523	523	
Total			

F18 If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local or regional supply depot or terminal does the fuel gets delivered from. Please select from drop down list provided or select "other" and please detail.

Who primarily supplies your bunkered fuel? Please Select from drop down list:	If other or multiple suppliers please state:	Which Terminal is your bunkered fuel supplied from? Please Select from drop down list:	If other please state:	Average Number of Deliveries per Month

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	The Trust CBRN Plan has been approved in principle and is awaiting formal ratifcation through the Governance committee.	Trust Plan to be ratified via Governance committee.	Emma Blackwell	Oct-16
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump	All Emergency Prepardeness documents are available on the Trust Extranet and action cards are printed in each area.			
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	Risk assessments completed and monitored via the Event Planning Group			
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements	Due to the high turnaround of staff within ED not all staff have received training. This is documented on Trust risk register.	Identified CBRN Leads to attend NWAS refresher trainining and to commence	Ali Crawford	Nov-16
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness	Staff aware, documentation displayed in ED and information contained within plan.			
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	Inventory list completed			
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y				All PRPS suits are booked to be reserviced in Jan 17.			
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y				This is being done on an ad-hoc basis.	CBRN Lead to have identified time each month to undertake checks.	Ali Crawford	Sep-16
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y				Included as part of inventory checklits			
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y				MOU with NWAS as detailed in CBRN Plan			
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y				Rachel Smith is the CBRN lead and has been on the train the trainer course			
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	Training attendance records kept from 2014 onwards of staff training.			
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		Y		Y				4 members of staff attended NWAS train the trainer sessions in November 2015			
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y		Lessons learnt from recent chemical incidents. Detailed in CBRN plan and action cards (including Reception) and IOR DVD included in staff training sessions.			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organisations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organisations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organisations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organisations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organisations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organisations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organisations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016-17

STATEMENT OF COMPLIANCE

Warrington and Halton Hospital has undertaken a self-assessment against the NHS England Core Standards for EPRR (v4.0).

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating **Substantial** compliance against the EPRR Core Standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as Red[1]	Standards rated as Amber[2]	Standards rated as Green[3]
51	0	4	47
Acute providers:51 Specialist providers: 44 Community providers: 44 Mental health providers: 44 CCGs: 35	*[1] Not complied with and not in an EPRR work plan for the next 12 months*	*[2]Not complied with but evidence of progress and in an EPRR work plan for the next 12 months*	*[3]Fully complied with*

Where areas require further action, this is detailed in the attached *EPRR Core Standards Improvement Plan* and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

Signed by the organisation's Accountable Emergency Officer

31/08/2016
Date of board / governing body meeting

17/8/16
Date signed

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Improvement Plan

Organisation: Warrington and Halton Hospital

Plan owner: Emma Blackwell

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures	Following a recent telecommunications failure, it has been identified that the Telecommunications Business Continuity Plan requires updating. The purchase of hand-held radios would increase the Trust resilience in the event of a communication equipment failure.	Review and update the Telecommunications Business Continuity Plan. Identify funding for the hand-held radios.	December 2016 December 2016
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	The draft Trust HAZMAT/CBRN plan to be formally ratified and communicated to all relevant areas.	The HAZMAT/CBRN plan to be taken to the August Event Planning Group for approval. Once approved, it will go to the Quality Committee for formal ratification.	October 2016
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.	All ED and UCC staff to receive up to date CBRN training based on the new Initial Operating Response (IOR) standards.	21 staff received training in 2015 and will now require refresher training. Identified CBRN leads to attend NWAS refresher training in October 2016. All new staff to attend CBRN training sessions.	November 2016
45	There are routine checks carried out on the decontamination equipment including: A) Suits	ED to identify a member of staff to ensure these checks are undertaken on a monthly basis.	Meet with new AED Matron to determine who will undertake these checks. Ensure time is identified each month for equipment checks to be undertaken.	September 2016

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Improvement Plan

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
	B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment			

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/175**	
SUBJECT:	**Governors Policy for Engagement with the Board of Directors**	
DATE OF MEETING:	28th September 2016	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Angela Wetton, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	**This policy has been written in response to the recommendations contained in principle A.5.6 of The NHS Foundation Trust Code of Governance (Monitor, 2013) whereby:** • **The Council of Governors should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the conditions of the Provider Licence with Monitor or other matters related to the general wellbeing of the NHS Foundation Trust; and** **The policy was presented at July's Council of Governors Meeting and is now presented to the Board for information only.**	
RECOMMENDATION:	**The Board note the contents of the policy and the role that various members of the Board, particularly the Senior Independent Director, would have in any dispute.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Council of Governors**
	Agenda Ref.	
	Date of meeting	**July 2016**
	Summary of Outcome	

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS POLICY FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

1. Introduction

This policy has been written in response to the recommendations contained in principle A.5.6 of The NHS Foundation Trust Code of Governance (Monitor, 2013) whereby:

- The Council of Governors should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the conditions of the Monitor Provider Licence with Monitor or other matters related to the general wellbeing of the NHS Foundation Trust; and
- The Council of Governors should ensure its interaction and relationship with the Board of Directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and use, where possible of clear, unambiguous language.

2. Purpose and Scope

This policy is intended to:

- outline the mechanisms by which Governors and Board Directors will interact and communicate with each other and takes into account the expanded role of Governors, set out in the Health & Social Care Act 2012, including the duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;
- describe the methods by which Governors may engage with the Board when they have concerns about the performance of the Board of Directors, compliance with the Provider Licence or the welfare of the NHS Foundation Trust; and
- provide details of the panel that has been set up by Monitor for supporting Governors of Foundation Trusts in their role and to whom Governors may refer a question as to whether the Trust has failed or is failing to act in accordance with its Constitution, once due process has been exhausted.

3. Key Provisions

This Policy provides guidance to Governors in two important areas;

- Holding to account; and
- Raising Concerns

Holding to Account

The Health and Social Care Act 2012 specifies that it is the duty of the Council of Governors to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. The definition of this is open to interpretation, but broadly speaking this duty requires Governors to question Non-Executive Directors about how they have set the Trust's proposed strategy and forward plan and measured its performance against them, to ensure they are satisfied that the Board has taken the interests of members and of the public into account and the Trust is not at risk of breaching the conditions of its Licence. In performing this duty, Governors should keep in mind that the Board of Directors manages the Trust and bears ultimate responsibility for the Trust's strategic planning and performance and must promote the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public in general.

The process of engagement between the Council of Governors and Board of Directors is clearly one which is already ongoing and routine, however, this policy,

agreed between the Board of Directors and the Council of Governors, aims to outline existing and additional mechanisms which will be used by the Trust to ensure communication between the Council of Governors and the Trust Board and ensure that Governors are able to discharge the above duty effectively, harmoniously and recognising the different and complimentary roles. In support of the duty to hold to account, the Council of Governors also has the statutory power to require one or more of the Directors to attend a Council of Governors' meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or Directors' performance). Should this power be invoked, it must be reported in the report and accounts. The aim of this policy is to have agreed levels of engagement which will eliminate or at least minimise the need of Governors to ever invoke this statutory power.

Raising Concerns

Where material concerns exist regarding the performance of the Board of Directors; compliance with the conditions of the Provider Licence or matters relating to the general well-being of the Trust, this policy should be followed. This policy is not to be invoked for minor issues raised by an individual governor. A concern, in the meaning of this policy, must be directly related to:

- the performance of the Board of Directors;
- compliance with the conditions of the Monitor's Provider Licence;
- the welfare of the Foundation Trust.

The procedure for a situation in which the Council of Governors as a whole is in dispute with the Board of Directors is covered in clause 46 of the Trust Constitution. Governors should acknowledge the overall responsibility of the Board of Directors for the strategic and operational running of the Trust and should not try to use the powers of the Council of Governors, or the provisions of this policy, to challenge unnecessarily the decisions of the Board of Directors or to impede the Board in fulfilling its duty.

To support Governors in their expanded role, Monitor set up a 'Panel for Advising Governors of FTs' to whom Governors may refer a question as to whether the Trust has failed or is failing to act in accordance with its Constitution. The Council of Governors should only consider referring a question to the panel in *exceptional circumstances*, where there is uncertainty within the Council about whether the Trust may have failed, or is failing, to act in accordance with the Trust's Constitution or with Chapter 5 of the 2006 Act, and this uncertainty cannot be resolved through repeated discussions with the Chair or another Non-Executive Director.

4. Individual Duties

Chairman

The Trust Chairman:

- acts as the principal link between the Council of Governors and the Board of Directors. He/she will, therefore, have the main role in dealing with any issues raised by Governors, and will involve the Chief Executive and/or other Directors as necessary;
- ensures that the Board of Directors and Council of Governors work together effectively and enjoy constructive working relationships (including the resolution of

any disagreements);

- ensures good information from and between the Board of Directors, Committees of the Board, Council of Governors and members and between the Senior Management and Non-Executive Directors, members of the Council of Governors and Senior Management;
- ensures that the Council of Governors and Board of Directors receive accurate, timely and clear information that is appropriate for their respective duties;
- constructs the agendas for both the Board of Directors and Council of Governors (with the input of others as appropriate).

Chief Executive

The Trust Chief Executive:

- ensures the provision of information and support to the Board of Directors and Council of Governors and ensures that Board of Directors' decisions are implemented;
- facilitates and supports effective joint working between the Board of Directors and Council of Governors;
- supports the Chairman in his/her task of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Board of Directors, elected and appointed members of the Council of Governors and between the Board of Directors and Council of Governors;
- with the Chairman, ensures that the Council of Governors and Board of Directors receive accurate, timely and clear information that is appropriate for their respective duties;
- with the Chairman, constructs the agendas for both the Board of Directors and Council of Governors (with the input of others as appropriate).

Senior Independent Director

The Senior Independent Director (SID):

- acts as an alternative source of advice to Governors and is available to members and governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Director of Finance has failed to resolve or for which such contact is inappropriate.

Governors

Individual Governors have a responsibility to act in accordance with this policy, to raise concerns (as defined in this policy) and to assure themselves that issues have been resolved. In addition, the Council of Governors as a body has a duty to inform Monitor if the Trust is at risk of breaching the conditions of its Licence.

5. Actions Holding to Account

The relationship between the Council of Governors and Board of Directors is critical and there are a number of ways an open and constructive relationship can be achieved between the two. Board members and Governors should have the opportunity to meet at regular intervals, governors should feel comfortable asking questions regarding the management of the Trust and Directors should keep Governors appropriately informed, particularly about key Board decisions and how they affect the Trust and the wider community.

Governors will hold the Chairman and other Non-Executive Directors to account

partly through effectively undertaking the specific statutory duties summarised below:

- governors are responsible for appointing the Chairman and other Non-Executive Directors and may also remove them in the event of unsatisfactory performance;
- governors have the right to receive the annual report and accounts of the Trust, and can use these as the basis for their questioning of Non-Executive Directors;
- governors have the power to appoint or remove the Trust's Auditor;
- directors must take account of Governors' views when setting the annual forward plan for the Trust, giving Governors the opportunity to feed in the views of Trust members and the public and to question the Non-Executive Directors if these views do not appear to be reflected in the strategy. Since 1 October 2012, where Directors put a proposal in the annual forward plan for an activity outside of the principal purpose of the Trust, the Governors must decide whether carrying on the activity, to any significant extent, interferes with the Trust's principal purpose, and must notify the Directors of its determination. However, Governors should understand there may be valid reasons why member views cannot always be acted upon.

Governors and Non-Executive Directors should have enough time to discuss these matters so Governors can be satisfied with the reasons behind the Board decisions;

- since 1 October 2012, Governors have also had the specific power of approval on any proposal by the Board of Directors to increase non-NHS income by 5% a year or more. They therefore need to be satisfied with the reasons behind any such proposals;
- governors now have the power, to approve amendments to the Trust's Constitution, approve 'significant transactions' and approve any mergers, acquisitions, separation or dissolution and will need to be satisfied with the Board's reasons behind any such proposals.

Whilst there is still scope for significant improvement, there are already a number of well-defined mechanisms in existence within the Trust for Governors to receive or seek information from and hold the Board and the Directors and Non-Executive Directors to account including:

- receiving Board meeting papers. Governors are also invited to attend Board meetings and have the opportunity to ask questions on the contents of the Board minutes and decisions at briefing meetings with the Chairman or at any other time as appropriate;
- receiving the annual report and accounts and asking questions on their content;
- receiving the monthly quality dashboard and annual quality account and asking questions on and / or challenging their content;
- receiving in-year performance updates e.g. finance and performance, quality, [mortality] and asking questions on and / or challenging their content;
- receiving performance appraisal information for the Chairman and other Non-Executive Directors, via the Council of Governors' Nominations & Remuneration Committee, and using this to inform decisions on remuneration for the Chairman and the other Non-Executive Directors;
- the attendance of the Chief Executive, other Non-Executive Directors and where considered appropriate, other Executive Directors at Council of Governors meetings and using these opportunities to ask them questions;

- receiving information on issues or concerns likely to cause any adverse media interest and providing Governors with the opportunity to raise questions or seek information or assurances.

Note:

It is clear however that further mechanisms will be required to ensure that governors are not only able to fulfil their role but are well briefed about the decisions which they may be required to make and about the context in which the Board of Directors is working including the requirements of relevant external stakeholders including Commissioners, NHS Improvements and the CQC and some suggestions are provided below. Governors are asked to note that much of what follows creates additional obligations on Governors in terms of attendance at meetings and forums, reporting back and importantly, scrutiny and challenge.

Other suggested methods – some of which are mandatory under the Act include**:**

- involvement of Governors in the Trust's strategy and business planning process through the holding of an annual planning session for Governors led by the Director of Finance & Commercial Development.

- engagement with Directors to share concerns or raise questions about performance, such as by way of joint meetings between the Council of Governors and Non-Executive Directors with or without the Chairman;
- receiving information on proposed significant transactions, mergers, acquisitions, separations or dissolutions and questioning the directors on these;
- receiving information on documents relating to non-NHS income, in particular any proposals to increase this by 5% a year or more, and questioning the directors on these;
- the holding of annual development workshops – not least in order to ensure that Governors are equipped with the skills and knowledge they require in order to fulfill their role;
- the holding of at least one joint meeting in private between the Council of Governors and the Board of Directors per annum.
- a monthly briefing with the Chairman on key decisions made following each Board meeting;
- governor attendance as observers at certain Board sub-committee meetings chaired by Non-Executive Directors
- incorporate specific responsibilities in terms of Governor and Board engagement into the Lead Governor role description;

Additional means available to Governors for holding Non-Executive Directors to account (where serious concerns exist and in extreme circumstances):

- dialogue with Monitor via the Lead Governor.
  Note: "The existence of a Lead Governor does not, in itself, prevent any Governor making contact with Monitor directly if they feel it is necessary";
- putting questions to the Monitor Governor Panel where the circumstances meet the requirements in the 2012 Act.

Raising Concerns

Governors should not raise concerns that are not supported by evidence. That evidence must satisfy the following criteria:

- any written statement must be from an identifiable person or persons who must sign the statement and indicate that they are willing to be interviewed about its contents; and
- other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

Newspaper or other media articles will not be accepted as prima facie evidence, but may be accepted as supporting evidence.

Notwithstanding the central role of the Chairman in providing the link between the Council of Governors and the Board of Directors, it is highly recommended that any Governor or group of Governors who have concerns covered by this policy should, in the first instance, consult the Company Secretary for advice and guidance. He/she will seek to resolve the matter informally and will certainly be able to advise the Governor(s) on the acceptability of the evidence offered and so whether it is appropriate to take their concerns to the Chairman. The advice of the Company Secretary is not, however, binding upon the Governor(s) and they retain at all times the right to raise the matter with the Chairman. For concerns which it would be inappropriate to raise with the Chairman, for example regarding his or her own performance, the role of the Chairman as described in this section will be undertaken by the SID.

The Chairman shall investigate all concerns brought to him by Governors, involving the Chief Executive and/or the Director of Finance at his discretion. The investigation shall include a review of the evidence offered and discussions with Trust Officers as appropriate

As soon as practicable after the conclusion of the investigation the Chairman shall meet with the Governor(s) to discuss the findings. This meeting has three possible outcomes:

- the Governor/(s) are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required;
- the Governor/s are satisfied that their concerns have been resolved during the course of the investigation. The Chairman shall write a report on the concerns and the actions taken and present this the Council of Governors.
- the matter is not resolved to the satisfaction of the Governor/s. The Chairman shall call a closed extraordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution to consider the matter further. That meeting may choose either to take no further action or, if two thirds of the governors present agree, to invoke the escalation process described from section 6 onwards.

6. Escalating Concerns

At this stage of the process the SID takes over the lead role from the Chairman. Should the SID be unavailable, or be prevented from participating because of a conflict of interests, then the Council of Governors may choose any other Non-Executive Director to fulfill the role.

The first duty of the SID is to establish the facts of the matter. This will be accomplished by reviewing the evidence offered by the petitioner/s, the process of

the investigation and any documentation produced and also by meetings/interviews with the governor/s and any trust officers involved. In carrying out this process the SID shall seek the agreement of all interested parties and shall have the authority to commission whatever legal or other advice is required.

Once the facts are established to his/her satisfaction, the SID shall make a decision on the course of action to be followed in the best interests of the Trust and shall describe the reasons for that decision in a written report. The decision of the SID shall be binding upon the Trust. In the first instance, the SID shall present the decision and the report to the Governor/s and to interested parties within the organisation.

The Chairman shall then, at the request of the SID, call a closed extraordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution. The purpose of this meeting, and the sole item on the agenda, will be for the SID to present his/ her report and decision and for the Council to give its response. Three outcomes are possible:

1) The Council accepts the decision of the SID. In this case no further action is necessary.
2) The council does not accept the decision of the SID but chooses not to escalate the matter further. No further action is prescribed by this policy but the Council of Governors may choose to keep the matter under review at future meetings.
3) The Council votes to refer a question for legal review or make a formal notification to the Panel for Advising Governors of FTs. The seriousness of the latter cannot be overemphasised. If such a question or any other important issue or uncertainty arises, Governors should always seek to discuss it in the first instance with the Chairman or another Non-Executive Director. Monitor strongly encourages all FTs and Governors to try to resolve questions internally before posing a question to the Panel only as a last resort. The Council of Governors should only consider referring a question to the Panel in *exceptional circumstances,* where there is uncertainty within the Council about whether the Trust may have failed, or is failing, to act in accordance with the Trust's Constitution or with Chapter 5 of the 2006 Act, and this uncertainty cannot be resolved through repeated discussions with the Chairman or another Non-Executive Director. A Governor may only refer a question to the Panel if more than half of the members of the Council of Governors voting approve the referral. Individual Governors may not bring a question to the Panel without the approval of the Council as a whole. The Panel will then decide whether to carry out an investigation on a question referred to it. If an investigation is carried out, the Panel will publish a report on the conclusion. It is noted that the Trust will not necessarily be required to adhere to the Panel's decision.

7. Equality Impact Assessment

An equality impact assessment has not been carried out on this policy. Should there be an occasion when the policy is use; an assessment will be carried out retrospectively to review any issues with regard to equality.

8. Review

This policy will be implemented once agreed (and periodically reviewed) by the Board of Directors and the Council of Governors every two years and formally recorded in the

minutes of their respective meetings.

9. **Monitoring Compliance and Effectiveness**

This policy will kept under review, compared with the provisions developed by other Foundation Trusts and revised in accordance with emerging best practice and guidance from Monitor.

10. **Dissemination**

This policy will be distributed to all Governors as soon as possible after their election or appointment, or as part of their formal induction and whenever it is revised.

This policy will be distributed to all Board members on appointment or as part of their formal induction and whenever it is revised.

11. **References**

- Monitor's 'The NHS Foundation Trust Code of Governance'.
- Trust Constitution.
- Monitor's 'Your statutory duties: a draft reference guide for NHS Foundation Trust Governors' (2012)