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Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 2

Wednesday 27 September 2017
1.30pm-5.30pm
Trust Conference Room

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospital NHS Foundation Trust
Agenda for a meeting of the Board of Directors held in public (Part 2).

Wednesday 27 September 2017, time 13:30 -5.30pm
Trust Conference Room, Warrington Hospital

REF BM/17	ITEM	PRESENTER	PURPOSE	TIME	
	PATIENT STORY	Kimberley Salmon Jamieson Chief Nurse Jenny Delea and Lesley Taylor		1.30	Verbal
BM/17/09/93	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	2.00	Verbal
BM/17/09/94 Pg 4	Minutes of the previous meeting held on 26 July 2017	Steve McGuirk, Chairman	Decision	2.05	Encl
BM/17/09/95 Pg 14	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	2.10	Encl
BM/17/09/96 Pg 15	Chief Executive's Report including Chair's Report from the Trust Operational Board and Terms of Reference for approval	Mel Pickup, Chief Executive	Assurance	2.20	Encl
BM/17/09/97	Chairman's Report	Steve McGuirk, Chairman	Information	2.45	Verbal

Quality People Sustainability

BM/17/09/98 Pg 57 Pg 72 Pg 78 Pge 82 Pg 85 Pg 88 Pg 92	Integrated Performance Dashboard Page 53 Including (b) Nurse Staffing Report July and August (c) Trust Engagement Dashboard and Chairs' Key Issues Reports for: (d) Quality Committee 1.8.2017 (e) Finance & Sustainability Committee 23.8.17 + (20.9.17 – to follow) (f) Audit Committee 10.7.2017 (g) Strategic People Committee 21 8.2017 (h) Charitable Funds Committee 7.7.2017 and Checklist	All Executive Directors Margaret Bamforth, Cttee Chair Terry Atherton, Cttee Chair Ian Jones, Cttee Chair Anita Wainwright Cttee Chair Jean Noel Ezingeard, Cttee Chair	Assurance	3.00	Encl

Quality

BM/17/09/99 Pg 100	Strategic Risks + BAF - Quarterly report - Monthly update	Kimberley Salmon-Jamieson Chief Nurse	Assurance	3.40	Encl
BM/17/09/100 Pg 156	Quarterly Complaints Improvement Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	4.00	Encl
BM/17/09/101 Pg 176	Quarterly Mortality Review report	Simon Constable Medical Director	Assurance	4.10	Encl
BM/17/09/102 Pg 190	Learning from Deaths Policy	Simon Constable Medical Director	Assurance	4.20	
BM/17/09/103 Pg 256	GMC Revalidation Annual Report	Simon Constable Medical Director	Assurance	4.30	Encl

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BM/17/09/104 Pg 300	NHSI Board Temporary Staffing Self-Certification Checklist	Michelle Cloney Interim Director of HR & OD	Assurance	4.40	Encl
BM/17/09/105 Pg 308	Theatres Industrial Action – briefing/update	Michelle Cloney Interim HRD	Assurance	4.50	Verbal

Sustainability

BM/17/09/106 Pg 312	Any Other Business • NHSI – application for lifting of Licence enforcement conditions – update • Governance – to note voting privileges for Deputy/Acting/Interim positions	Steve McGuirk, Chairman	N/A	5.00	Verbal Verbal Enc.
	Date of next meeting: Wednesday 25 October 2017 TBC				

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Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in Public (Part 2) on Wednesday 26 July 2017 Trust Conference Room, Warrington Hospital	
Present	
Steve McGuirk (SMcG)	Chairman
Terry Atherton (TA)	Non-Executive Director
Mel Pickup (MP)	Chief Executive
Margaret Bamforth (MB)	Non-Executive Director
Andrea Chadwick (AC)	Director of Finance and Commercial Development
Michelle Cloney (MC)	Interim Director of HR + OD
Simon Constable (SC)	Medical Director + Deputy Chief Executive
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Jan Ross (JR)	Acting Chief Operating Officer
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Jason DaCosta (JDaC)	Director of IM&T
Paula Gunner	Senior Executive Assistant
Apologies	
Jean-Noel Ezingeard	Non-Executive Director
Observing	
No members of the public were present	

Agenda Ref BM/17/07/	
BM 17/07/79	The Board meeting opened with a patient story from the Marc and his wife Clare Littlemore supported by Karen Wilson, Clinical Nurse Educator ICU and Jo Alcock Acute Nurse Practitioner with regards to 'Surviving Sepsis – a patient experience of our Intensive Care'. Marc Littlemore provided the Trust Board with a comprehensive overview from a patient's prospective of his time as a patient in ITU suffering from Sepsis and his wife Clare Littlemore provided an overview of a relative's perspective on how she was also cared for by staff and the support received. Marc Littlemore explained that the reason for talking about their experiences is to provide learning to Trust staff on what was good and what was not so good about their experiences. The Chairman on behalf of the Board thanked Marc and Clare Littlemore for presenting such a powerful patient story, saying although the Board has to manage the Trust finances we are here first and foremost for our patients. The Chief Executive thanked Marc and Clare Littlemore for attending the Board and good luck with Marc's continued recovery. The Chief Executive also requested their continued support for the Trust on social media. Marc and Claire Littlemore then left the meeting.

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BM17/07/80	**Welcome, Apologies &Declarations of Interest** The Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: none declared in respect of agenda items.
BM 17/06/81	**Minutes of the Previous Meeting Held on 28th June 2017** The minutes of the meeting held 28 June 2017 were agreed as an accurate record.
BM17/06/82	**Actions and Matters arising** All actions were reviewed and progress noted since the last meeting.
BM17/06/83	**Chief Executive Report** The Chief Executive updated the Board on matters that had occurred or progressed since the June Board meeting. – STP Executive Chair Andrew Gibson and heard speakers from NHSE Richard Baker and STP Louise Shepherd. The STP's are here to stay and the direction of Performance Review Meeting with NHSI took place on 17th July 2017. The areas of covered in the meeting were performance against constitutional standards, A&E, waiting times in particular where our significant improvement over the last 12 months was noted and our financial performance which again was performing to plan. Significant risks noted where in for example an incredibly challenging cost improvement programme this year. – On 20th July 2017 the Chief Executive attended an Action on A&E Regional event as Chair of the Mid Mersey A&E Delivery Board with several Board colleagues the event was organised by NHSI and was designed to support Boards and organisations to achieve the 95% A&E waiting time performance by March 2018. The event is an opportunity to share good practice in relation to expediting patient discharges and reducing delays which is a key area of concern at a national level within each Local Authority and Commissioners are being set improvement targets to achieve in relations to DTOC's. – The CQC have now an inspection assessment process that looks specifically at how systems are working together to improve the process of discharging patients from hospital. A National pilot involving 12 Local Authorities is about to begin and included in that is the Local Borough System - Halton patients are served by both ourselves and the neighbouring Acute Trust of St Helens & Knowsley NHS Trust. – STP – on 5th July the Chief Executive and the Chairman attended the inaugural meeting of the newly named C&M 5 Year Forward View System Leadership Group. The assembled meeting was introduced by the new travel is already set which largely represents a future where local integrated systems are networked into the STP to create new opportunities to achieve better health, better care and better value for the 2.4m people who live in Cheshire and Merseyside and this will need to be progressed at pace if the financial challenges are to be addressed and the Accountable Care Organisations / Accountable Care Programmes are key planning and delivery vehicles for that. Louise Shepherd announced ahead of the meeting that she is stepping down from the role of STP Lead and Andrew Gibson is seeking to identify a new lead as part of the 'refresh' of the STP. The Chief Executive suggested that it should be noted on record our thanks to Louise Shepherd for providing the leadership to the STP over the last 18 months, at a most difficult time when there was very little understanding or guidance to direct just how it should be

	established. – CQC the Chief Executive updated the Board fact that the Draft CQC Inspection report had still not been received. The noted the Chief Executive's report.
BM17/06/84	**Chairman's Report** The Chairman explained that as there are no observers from the public, he would not be repeating his report from the Part One of the Trust Board which took place earlier today as the Chief Executive had covered all the items.
BM17/06/85	**Integrated Performance Report Dashboard (June)** The Director of Finance + Commercial Development introduced the report to provide assurance to the Board in relation to delivery of KPIs across the following areas, Quality; Access and Performance; Workforce; Finance + Sustainability. - The Board was asked to note the movement in month in the rag ratings of a number of indicators in Section 2 of the report. - There are still a number of indicators with no threshold/RAG rating agreed and this number has stayed static at 9, they are to be discussed at the relevant sub-committees and the dashboard updated to reflect those discussion. The Chief Nurse highlighted areas for the Board to note relating to the Quality KPIs: - 5 Quality indicators rated red, an increase of 1 in month. Of the 4 indicators that were red in May 3 have remained red in June. - (1) Duty of Candour (DoC) –10 working day target of the 10 'moderate harm' incidents in June 33% were completed on target compared with 71.40% in May. A programme of training is being implemented for all Ward Managers/Matrons, CBU/Divisional Leads. - (2) NICE Compliance – The Trust achieved 55.26% in June against a target of 100% a process to manage the backlog has been implemented and the Medical Director has spoken to the Doctors regarding their duty with regards to NICE compliance. - (3) Mixed Sex Accommodation (MSA) – There has 14 breaches in June compared with 3 in April. A review of the breaches is taken place to ensure they are true breaches, and also a review of the escalation process at the Trust. - (4) Incidents – there has been 1 never event in June within Women's Children's Clinical Business Unit therefore this indicator has moved from green to red and root cause analysis is in progress. - (4) Pressure Ulcers – 2 pressure ulcers were reported in June compared with 7 in May. Route cause analysis is underway this indicator has moved in month from green to red. - Sepsis Inpatient Screening indicator has improved in June moved from amber to green. - Staffing Average Fill Rate – The Trust performance rate is 87.51% for June for registered nurses/midwives in the day against a target of 90%. Daily plans are in place to ensure the delivery of safe patient care by moving staff to support any area that is depleted. The Medical Director reported 1 MRSA bacteraemia in June this is the first in the Trust in 24 months and has been deemed unavoidable; a root cause analysis is underway.

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	Data is being collated with regards to blood stream infections and E-coli as they are to be measured. There are no monthly targets set but these will be agreed prior to the next Board meeting. VTE – The Medical Director continues to Chair weekly meeting to review the backlog of VTE's. In June 15 patients did not receive a VTE assessments, this requires that a root cause analysis is completed. The VTE Nurse has liaised with the coding department to ensure that the VTE cohort of patients is prioritised for coding. Mortality – The Medical Director informed the Board that a new Trust policy relating to mortality will be presented to the Quality Committee in August 2017 for discussion/approval and then to the Board in September 2017 for ratification. The Acting COO highlighted areas for the Board to note relating to Access and Performance KPIs - Of the 6 access and performance indicators rated red there has been decrease of 1 red indicators reported in June relating to the number of total cancelled operations on the day (for non-clinical reasons) and had been offered a date for re-admission within 28 days this indicator has moved from red to green. - A&E Waiting Times 4 hour 95% National Target – the Trust achieved 90.38% in month which is a deterioration in month this is a very challenging target but the Acting COO assured the Board that plans have been put in place to deliver the target. - Breast Symptomatic – The Trust achieved 92% in June against a target of 93% which is an improvement in performance from May's 88.16%. - Ambulance handovers 30/60 minutes – The Trust has seen an increased in the number of delayed handovers from 126 in May to 171 in June the cause seems to be early evening / early hours of the morning when there are reduced staffing levels. The Acting COO assured the Board that Medical staffing levels are being reviewed to address this issue. - Discharge summaries – The Trust has failed to achieve target of 95% with a performance for June of 88.64% due to this the Trust will receive a £15k financial penalty from Commissioners. Anita Wainwright, Non-Executive Director asked do the Commissioners appear to recognise that the Trust provides detailed good quality discharge summaries, and is the penalty fine reinvested to improve the service. The Acting COO answered that they do recognise the work the Trust has put into the discharge summaries and how challenging the target is with regards to the reinvestment of penalty fine the Director of Finance & CD explained that the Commissioners have not been successful in reinvesting the penalty fines. Margaret Bamforth, Non-Executive Director stated that the discharge summaries has a huge impact on patient outcomes, the Acting COO stressed that from a patient point of view no patients had been harmed. The Interim Director of HR and OD highlighted key points within the People KPIs: - Workforce - 3 indicators rated red in May and the same 3 indicators have remained red in June. - Agency medical spend performance the figure for June is £506k which is £64k higher than over the same period last year. At the Finance and Sustainability Committee (FSC) the

	Interim Director of HR & OD was asked to undertake a more detailed review of the top 10 earners in Nursing and Medical Workforce and report back through the FSC. Dr Alex Crowe, Deputy Medical Director is Chair of the Medical HR Staffing Group and is reviewing a number of priority areas with regards to impact on locum staff. - The Pay Spend and Review Group continues to monitor all pay spend and escalate issues through to the FSC as appropriate. - Recruitment - the Trust is utilising a number of different initiatives with regards to overseas recruitment such as the Indian sub-continent. Enforcing the price cap is continuing to be challenging as to maintain patient safety it is necessary to breach the cap in specialist medicine. - Turnover - in June turnover improved slightly to 13.09% compared with 13.29% in May the Trust's own target is 7-10% accordingly a number of measure have been implemented to reduce the turnover figure. - Sickness Absence - has improved from 4.57% in May to 4.46% in June the Trust's target is 4.3%. Margaret Bamforth asked how the Junior Doctors attendance is managed, the Interim Director of HR & OD explained that this is managed using the Trust Policy and they must report to the lead - Return to Work Interviews – the Trust has achieved 80.11% in June against a target of 85%. - PDR Compliance – the figure has deteriorating since March 2017 and has done so again June to 74.55% against a Trust target of 85% recovery plans are in place with CBU's to retrieve the situation. The Director of Finance and Commercial Development highlighted key points within the Finance Sustainability KPIs. There are 3 finance and sustainability indicators rated red an improvement of 1 in month which is due to the financial position indicator moving to amber. - Cash – continues to be a challenge and is under daily monitoring and management - The Trust cash balances at the end of June was £1.2m - Better payment practice compliance – this continues to underperform with a year to date performance of 36% against a 95% target this is due to cash challenges. - Agency spending – has exceeded the NHS Improvement threshold of £2.5m with a £2.8m year to date and of which 0.9m relates to June. Plans are required to reduce the level of spending and to support financial delivery. - The Use Resource rating is 3. - The Trust monthly financial deficit for June is £0.3m and the year to date deficit is £3.1m which is in line with plan. - The Trust has requested a 2017/18 working capital loan of £3.7m to support the planned deficit. The first instalment of £1.6m has been received in April at 1.5% interest. - The Trust has not applied for a capital loan in 2017/18. - T&O and Women's and Children's CBU's are overspent and are being provided mandated support to help improve their financial situation. The Director of Transformation provided an update on the current CIP/transformation performance. The Trust wide Cost Improvement Plan (CIP) in year position is amber, and the Director of Transformation has requested the RAG parameters be adjusted to more accurately

	reflect the position. The Board supported the proposed changes of the RAG parameters as follows: - Current RAG Parameters Red: Forecast is less than 50% of the annual target Amber: Forecast is between than 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target - Proposed RAG Parameters Red: 0-70% of plan delivered year to date Amber: 70% - 90% of plan delivered year to date Green: > 90% plan delivered year to date. **The Board noted the report and supported the changes to the RAG Parameters.**
	(b) Nurse Staffing Report The Chief Nurse highlighted key areas for the Board to note in the report which highlights areas where average fill rates fall below 90% of actual versus planned. The Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and that action plans and mitigation is provided then the actual falls below 90% of planned staffing levels. Margaret Bamforth commented that it is interesting to see if there is any correlation between staffing levels and complaints. **The Board noted the report.**
	(c) Trust Engagement Dashboard The Director of Communications and Corporate Affairs highlighted key areas for the Board to note: - Positive media coverage blood pressure checks at the Warrington Wolves Stadium - Negative media coverage on the Stroke Service which was reported heavily in Halton - There has been a 50% increase in activity on the Warrington website - The Trust is out to procurement for a new website as the current website is not mobile enabled. - The Communication department and the Staff Engagement department are now merged and KPI's will be developed to monitor performance. **The Board noted the report.**
	(d) Key Issues Report from July Quality Committee The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Committee highlighted the following area for escalation to the Board.

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	- Lack of assurance regarding the reduction of harm relating to falls particularly at night, the Quality Committee will continue to monitor this issue progress on the action plan will also be monitored directly by the Quality Committee. - Safe staffing continues to be an area of concern and remains a high level of risk. **The Board noted the report and the areas of escalation.**
	(e) Key Issues Report from July Finance and Sustainability Committee (FSC) The Key Issues Reports were taken as read and Terry Atherton, Chair of the Finance & Sustainability Committee highlighted the following: - The Trusts financial and cash position was discussed in detail at the private Board. There are no further areas of escalation to be noted by the Board. **The Board noted the report.**
	(f) Charitable Funds Committee Chairs Annual Report Ian Jones, Chair of the Charitable Funds Committee provided his annual report to the Board to provide assurance that the Committee has met its terms of reference and has gained assurance throughout the reporting period of the efficacy of the Trusts internal systems of control. It has been a busy year for the Charity, and the Charitable Funds Committee has ensured that the donated funds were used for direct patient benefit as well as investing appropriately to allow the charity to row and deliver its ambitious strategy to the benefit of our patients and their families. The Charitable Funds Strategy will be presented to Part 1 of the Trust Board in October 2017. **The Board noted the Charitable Funds Committee Annual Report.**
BM17/06/86	**Strategic Risk Monthly Update** The Chief Nurse Board to note the 2 new risks which have been added to the risk register and the updates on to existing risks. The Report is a statutory requirement as part of the Department of Health regulations. **1.** Failure to prevent harm to patients caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational financial and reputational consequences (Risk Score Amber 12). **2.** Risk of industrial action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation (Risk Score Red 16). Actions for both new risks are in place to mitigate the risks.

	Margaret Bamforth, Non-Executive Director explained that there is to be a deep dive into the some of the existing risks at the Quality Committee in August to review the risk level. **The Board noted the report with the new risks and the updates for existing risks.**
BM/17/06/87	**Annual Safeguarding Vulnerable Adults and Children Annual Report** The Chief Nurse highlighted key points for the Board to note: - Overall the safeguarding objectives for 2016/17 were met. - The Adult and Children's safeguarding reports will be a combined report next year. - The report has been discussed in detail at the Quality Committee along with the Trusts Safeguarding Action Plans. **The Board noted the Annual Safeguarding Vulnerable Adults and Children Annual Report.**
BM/17/06/88	**6 Monthly Bi-Annual Staffing Report** The Chief Nurse highlighted key points for the Board to note: - The report represents the outcome of the Safer Nursing Care Tool acuity and dependency review that took place in April 2017 which shows a deficit of 80.83 WTE. The Safer Nursing Care Tool will be re-run in October 2017 which will afford time to adequately train staff in the subtleties of the tool and to understand the position further. - The ongoing nursing and retention strategy is moving at pace. - Work is underway to better understand the supervisory time afforded to Ward Manager and also to ensure the maximum benefit from E-rostering. - The Trust has 45 nurses joining in September and this should have a positive impact on nurse staffing. - Romanian nurses all nurses with the exception of one have stayed with the Trust. - Nursing vacancies are managed on a monthly basis. - Daily shift checks by the Senior Nursing Team along with real time escalation is in place to ensure safe, high quality care continues to be delivered. **The Board noted the 6 Monthly Bi-Annual Staffing Report.**
BM/17/06/89	**DIPC Annual Report** The Medical Director / Deputy Chief Executive explained that the content within the DIPC Annual Report had been presented to Trust Board for discussion at various times over the last year. The report was discussed in detail at the Quality Committee on 4th July 2017 and the Medical Director / Deputy Chief Executive requested that the Board note the report. **The Board noted the DIPC Annual Report.**
BM/17/06/90	**Annual SIRO Report (deferred from May)** The Director of IM&T highlighted key points for the Board to note for the work undertaken and performance in relation to 2016/17 and key issues for 2017/18 - 2016/17 Mersey Internal IG Assurance Audit - Freedom of Information Act 2000 performance during 2016/17

	- Subject Access Request performance during 2016 - External Data Loss incidents 2016/17 - Work has been undertaken to update the Trusts Information Security Management System - Work ongoing for the introduction/implementation of the General Data Protection Regulations in May 2018 - Controls to mitigate IT/Information risks identified in the Board Assurance Framework - Key issues in 2017/18 Maintain an effective cyber security controls, The Information Security Management system may require some re-work as a result of the cyber essentials certification project which the Trust will be assessed as part of the ongoing work in conjunction with NHS England. Version 15 of the NHS Digital Information Governance Toolkit will be released in April 2018 and changes will be required to provide assurance on the Trusts arrangements with regards to the 10 data standards contained in the National Data Guardian Report which reviewed Data Security, Consent and opt-outs. Margaret Bamforth asked where the biggest risks would be for the Trust. The Director of IM&T explained they are in the following areas: - Case notes going missing - SMART cards issue - People compliance The above issues/risks are all managed through the bi-monthly IG Group and reports on Datix help with spotting trends. **The Board noted the content of the SIRO Annual report.**
BM/17/06/91	**Quarterly Responses to Lord Carter** The Director of Finance & CD provided an update and asked the Board to note progress made against the 15 recommendations from the Lord Carter report. The Trust has embraced the recommendations and already complies with some of key targets and performance indicators and is making progress on those applicable to the organisation. The Chairman asked if this paper could be presented in a dashboard format to allow the Board to focus on the key indicators which could be refreshed regularly. **The Board noted the Quarterly Responses to Lord Carter.**
BM17/06/92	**Any Other Business** The Chairman raised the following any other business items: – Nomination and Remunerations Committee (NARC) to be arranged it was suggested that the 30th August 2017 Board be cancelled and this time could then be used for the NARC with a Board workshop to follow. **The Board agreed to the cancellation of the Board in July in favour of a NARC and Board workshop.**

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	– The Chairman informed the Board that this is the Director of Finance & CD's last Board meeting prior to getting married and along with the whole of the Board wished her congratulations on Wedding day. **Next Meeting:** Wednesday 26 July 2017, Full Trust Board Meeting, Trust conference Room.

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BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/17/09/95	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	27th September 2017

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM 17/03/30	29 March 2017	IPR Dashboard	SC to present Learning from Deaths policy to future Board for approval.	Medical Director	27 September 2017			

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/01/08	25 January 2017	Integrated Dashboard - Mortality	Follow-up workshop Learning through Transparency with Board and Governors	Medical Director	6 October 2017		Added to Joint Exec/NED timeout agenda in October 20.9.17. Postponed to 2018. Replaced with Quality Strategy day on 24 October 2017.	
BM/17/04/49	26 April 2017	Proposal to change Trust Name	Process to commence to incorporate 'teaching' element into its Brand.	Director of Communications + Corporate Affairs	ASAP		24.5.17. This process has commenced. 20.9.17. Shared at Annual Members meeting in September.	
BM/17/01/12	25 January 2017	Charitable Funds Commission	Board to receive refreshed strategy to maximise income streams as workshop	Director of Community Engagement	25 October 2017	31 January 2017	7.7.2017. Deferred to Part 1 Board on 26 July 2017. 26.7.17. Deferred to Part 1 Board 25 October	

RAG Key

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

DRAFT TERMS OF REFERENCE

TRUST OPERATIONAL BOARD

1. PURPOSE

The purpose of the Trust Operational Board is to operationalise the Board Strategy and oversee the enabling strategies to deliver the Trust's overarching strategy and 5-year plan (eg, Finance, Workforce, Estates, IM&T etc.) and providing a forum for key stakeholders to inform Executive action and specifically to:

1. Oversee the management of the clinical and non clinical services on behalf of the Trust Board ensuring safe and effective services for patients;
2. Oversight of operational performance issues ensuring that the Trust operates safely, effectively and efficiently and in a patient focussed way;
3. Be responsible for the delivery and performance management of financial performance issues; quality and safety performance issues
4. Set the direction of travel for the organisation through making major operational and strategic decisions not reserved to the Board and the proposing and refining of issues and recommendations on matters reserved to the Board; and
5. Ensure there is an effective business planning process in place
6. Oversight of key strategies, plans, assurances plan (eg, Finance, Workforce, Estates, IM&T etc.)
7. Review the high level risks to achievement of trust objectives

2. FREQUENCY OF MEETINGS

Meetings shall be held at least Monthly, each Monday of the week of the Trust Board

3. QUORUM

Four (4) Executive Directors – at least one of whom is clinical (voting/non-voting) plus Chair/Deputy chair

4. MEMBERSHIP

- Executive Team (see quorum above)
- Associate Directors of Operations – SW&C and Acute Care
- Chiefs of Service - SW&C and Acute Care
- Associate Directors of Nursing - SW&C and Acute Care
- Chief Pharmacist
- Associate Director Estates and Facilities
- Deputy Director Quality Governance
- Deputy Director Finance (strategy, procurement, commercial development)
- Deputy Medical Director
- Deputy Chief Nurse
- Deputy COO

5. AUTHORITY

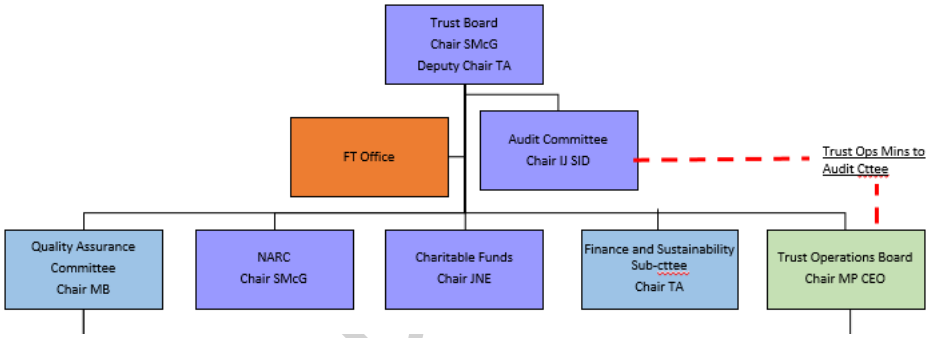
The Trust Operational Board is an Executive Committee which is accountable to the Trust Board. Its activities will be scrutinised by the Trust's Audit Committee.

It is authorised to seek any information it requires from any member of staff, hold individuals and teams to account. It is also authorised to alert or brief the Audit Committee to any concerns which warrant deeper investigation.

It is authorised to procure or commission services according to the Scheme of Reservation and Delegation and Standing Financial Instructions having followed the Trust's existing processes.

6. REPORTING

Governance



7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To agree performance related actions in line with the powers delegated by the Trust Board.
- To approve business cases for service developments and contracts in accordance with the limits as set out in the Scheme of Delegation.
- To approve Trust Core Policies, for which implementation issues will be raised by exception.

Duties – advisory:

- To advise the Board on operational and strategic matters reserved for decision by the Board, including external strategic footprint and any related risks and proposed mitigations
- To develop overall strategy, including mission and rules of conduct, for approval by the Trust Board.
- To develop corporate objectives as part of the business plan for approval by the Trust Board.
- To develop the capital programme for approval by the Trust Board.

Duties – monitoring:

- To review patient focussed monitoring reports in the following areas:

- operational and financial performance
- the performance of its sub-committees
- performance against the business plan
- results of any external reviews (e.g. PEAT, CQC, Patient Surveys, Staff Surveys) and progress with action plans
- Review any risks referred from Quality and Assurance Committee or any risk escalated by a sub-committee
- Progress against action plans following any external enquiry reports
- Proposed responses to internal and external audit reports aligned to delivery of the Operational Plan

Duties of members:
Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented

Sub-Committees:

Trust Operational Board Sub-committees include:

- ICIC
- CBU QPS Performance Review
- Workforce
- ED Taskforce
- OPD Transformation
- Emergency Planning and Resilience EPRR
- Estates & Facilities
- IM&T
- KPI Performance
- Strategy Development and Delivery

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected
Members unable to attend must send a deputy who is able to make decisions on their behalf. There must be at least one representative from each Division plus corporate service at each meeting.

9. ADMINISTRATIVE ARRANGEMENTS

The Trust Operational Board will be supported by the Foundation Trust Office, led by the Director of Community Engagement and Corporate Affairs.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established for review annually by the Trust Operational Board

Papers to this Board must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Wednesday preceding the Trust Operational Board meeting.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Divisional leads/service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed, alongside the CEO report, by the Friday following the Executive Board.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No later tabled papers will be accepted unless in an emergency AND with permission of the Chief Executive.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	TRUST OPERATIONAL BOARD
Version:	V2
Implementation Date:	
Review Date:	
Approved by:	TRUST BOARD
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	27th September 2017
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Jan Ross – Chief Operating Officer (interim) Michelle Cloney – Director of Human Resources & Organisational Development (interim) Andrea Chadwick - Director of Finance & Commercial Development Alex Crowe – Medical Director (Acting) Lucy Gardner – Director of Transformation
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	At the end of month 5 the Trust has a financial deficit of £4.4m which is £0.5m worse than plan. This poses a risk to the Trust's forecast outturn and cash position. Quality has seen an improvement in performance and is reporting 16 Green indicators at month 5 compared to 14 in July. The 2 indicators that have improved are Duty of Candour moving from Red to Green and Safety Thermometer moving from Amber to Green. Access and Performance indicators have remained static in month and are still reporting 13 Green and 5 Reds.

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Warrington and Halton Hospitals NHS Foundation Trust

	Workforce Red indicators have increased in month from 3 in July to 4 in August.	
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **2.** Approve that the 2 indicators with no RAG/threshold continue to be reported with no RAG rating. **3.** Approve the additional Workforce indicator. **4.** Approve the changes to the capital programme.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Integrated Performance Dashboard	**AGENDA REF:**	

1. BACKGROUND/CONTEXT

The RAG rating for all 63 indicators from April to August 2017 is set out in Appendix 1.

The Integrated Performance Dashboard (Appendix 2) has been produced to provide the Board with assurance in relation to the delivery of all KPI's across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

- Red – 21 in July to 20 in August
- Amber – 8 in July to 5 in August
- Green – 30 in July to 36 in August

There are 2 indicators with no RAG/threshold. The Quality Sub Committee has concluded that a RAG/threshold is not applicable. They are proposing that the 2 indicators remain with no RAG rating. The 2 indicators are:

- Quality
    - Staffing – Care hours per patient day
    - Total Deaths

Quality

Quality KPIs

Of the 6 indicators that were red in July 5 have remained Red in August as follows:

1. Health Care Acquired Infections – the Trust reported 1 MRSA in July, therefore this indicator will remain Red for the remainder of 2017/18.
2. Nice Compliance – the Trust achieved 63.52% in August against a target of 100%. This is an improvement in month from 61.75% in July.
3. Complaints – the Trust has 16 complaints that have been open for over 6 months.
4. Friends and Family (likely to recommend our AED to Friends and Family) – the Trust achieved 86% (month 4 was 85%) against a target of 87%.
5. Mixed Sex Accommodation (MSA) – there is a national zero tolerance approach to MSA breaches. There have been 10 MSA breaches in month. This is a reduction from 17 in July.

The 1 Quality Indicator that improved from Red to Green in month relates to Duty of Candour.

There is 1 Quality indicator rated Amber in month, compared to 2 in July. The Amber indicator that has improved from Amber to Green is Safety Thermometer which is now reporting overall harm free care above the 95% target. The 1 remaining Amber indicator is:

1. Staffing Average Fill Rate - Trust performance was 86.63% in August for registered nurse/midwives in the day, against a target of 90%. Plans are in place to ensure the delivery of safe patient care.

Access and Performance KPIs

There are 5 Access and Performance indicators rated red in August, the same number and indicators as July. The 5 red indicators are:

1. A&E Waiting Times 4 Hour 95% National Standard – the Trust achieved 94.39% in August, an improvement in month from 92.69% in July.
2. Ambulance Handovers 30 Minutes – the Trust has remained static in month for the number of delayed handovers between 30 and 60 minutes reporting 124 in August, the same number as July. The challenging time period has been identified as late evening to the early hours of the morning when medical staffing is reduced. Medical staffing levels are being reviewed to address the issue.

3. Ambulance Handovers 60 Minutes – the Trust has seen an improvement in performance in the number of delayed handovers over 60 minutes down from 31 in July to 15 in August.
4. Discharge Summaries % Sent Within 24 Hours – the Trust failed to achieve the target of 95% with performance for August reported at 87.30%. This is a slight deterioration in month from 88.22% in July. The Trust failed to achieve the overall quarter one and two target of 95% and will receive a £15k financial penalty per quarter from Commissioners.
5. Total Number of Cancelled Operations on the Day (for non-clinical reason) – the Trust has a zero tolerance approach to breaches. There were 24 breaches reported in August which was an increase on July's performance of 14. It should be noted that all 24 patients who had a cancelled operation were offered a new date within 28 days in line with the national target.

People

Workforce KPIs

There are 4 indicators rated Red in August, an increase of 1 in month. The 4 Red indicators are:

1. Return to Work Interviews (RTW) – this indicator has deteriorated from Amber (78.75%) in July, to Red (73.58%) in August.
2. Recruitment – the time taken to recruit has improved from 86.3 days to 66.5 days in the last 3 month period, against a Trust target of 65 days. This indicator was Red in July and has remained Red in August.
3. Non Contracted Pay remains above budget in August at 6.6% of the Trust's overall pay bill, compared to 6.27% in July. This indicator was Red in July and has remained Red in August.
4. Average Cost of the Top Ten Highest Cost Agency Workers – this indicator was not RAG rated in previous months. The Workforce committee has now set RAG parameters and the indicator is measuring Red in August.

There is 1 Workforce indicator rated Amber in August compared to 2 in July (RTW indicator has deteriorated in month from Amber to Red). The 1 Amber indicator is:

1. PDR Compliance –The Trust's target of 85% has not been met this financial year and performance in August is 77.13%, a slight improvement on July performance 76.14%.

Sustainability

Finance Sustainability KPIs

There are 6 Finance Sustainability indicators rated red in August the same number as in July. The 6 red indicators are:

1. Financial Position – the cumulative deficit of £4.4m is £0.5m worse than the planned deficit of £3.9m.

2. Cash Balance – cash continues to be a challenge and is under daily monitoring and management. The balance at the end of August was £1.2m.
3. Better Payment Practice Compliance – continues to underperform with year to date performance of 36% against a 95% target due to cash challenges.
4. Fines and Penalties – to date the Trust has been notified of fines and penalties of £18k for the period April – June 2017.
5. Agency Spending – the cumulative agency spend of £4.5m is £0.3m (8%) above the cumulative agency ceiling of £4.2m.
6. Cost Improvement Programme In year performance to date – the financial impact of transformation activities was £2.38m in M5, £0.65m below the Trust's M5 CIP target of £3.04m.

The Income Statement, Statement of Financial Position and Cash flow, as presented at the August Finance and Sustainability Committee, are attached in Appendix 3. This highlights the challenge to delivery of the control total of £3.7m. The forecast is under review with significant risks to delivery. A number of actions are being taken to address the risk including mandated support in three of the CBUs. Should the actions not be sufficient to assure recovery, the Trust will need to consider a revision to the forecast in line with NHSI guidance.

In month 4 and month 5, amendments to the capital programme were presented and supported by the FSC as set out in Appendix 4. The key changes are:

1. Delay MRI purchase £800k.
2. New spend on moving Coronary Care Unit to A3 £748k.
3. Delay replacing Ormis £147k.
4. Increased spend on Capital for various projects.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality Committee
- Trust Operational Board

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.
2. Approve that the 2 indicators with no RAG/threshold continue to be reported with no RAG rating.
3. Approve the additional Workforce indicator.
4. Approve the changes to the capital programme.

Appendix 1 – KPI RAG Rating April 2017 – March 2018

	KPI	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
	QUALITY												
1	Incidents												
2	Duty of Candour												
3	Safety Thermometer												
4	Healthcare Acquired Infections												
5	VTE Assessment												
6	Safer Surgery												
7	CQUIN Sepsis AED Screening												
8	CQUIN Sepsis Inpatient Screening												
9	CQUIN Sepsis AED Antibiotics												
10	CQUIN Sepsis Inpatient Antibiotics												
11	CQUIN Sepsis Antibiotic Review												
12	Total Falls & Harm Levels												
13	Pressure Ulcers												
14	Medication Safety												
15	Staffing – Average Fill Rate												
16	Staffing – Care Hours Per Patient Day												
17	Mortality ratio - HSMR												
18	Mortality ratio - SHMI												
19	Total Deaths												
20	NICE Compliance												
21	Complaints												
22	Friends & Family – Inpatients & Day cases												
23	Friends & Family – A&E and UCC												
24	Mixed Sex Accommodation Breaches												
	ACCESS & PERFORMANCE												
25	Diagnostic Waiting Times 6 Weeks												
26	RTT - Open Pathways												
27	RTT – Number Of Patients Waiting 52+ Weeks												
28	A&E Waiting Times – National Target												

Appendix 1 – KPI RAG Rating April 2017 – March 2018

29	A&E Waiting Times – STP Trajectory												
30	Cancer 14 Days												
31	Breast Symptoms 14 Days												
32	Cancer 31 Days First Treatment												
33	Cancer 31 Days Subsequent Surgery												
34	Cancer 31 Days Subsequent Drug												
35	Cancer 62 Days Urgent												
36	Cancer 62 Days Screening												
37	Ambulance Handovers 30 to <60 minutes												
38	Ambulance Handovers at 60 minutes or more												
39	Discharge Summaries - % sent within 24hrs												
40	Discharge Summaries – Number NOT sent within 7 days												
41	Cancelled Operations on the day for a non-clinical reason												
42	Cancelled Operations on the day for a non-clinical reason – Not offered a date for readmission within 28 days of the cancellation												
	WORKFORCE												
43	Sickness Absence												
44	Return to Work												
45	Recruitment												
46	Turnover												
47	Non Contracted Pay												
48	Agency Nurse Spend												
49	Agency Medical Spend												
50	Essential Training												
51	Clinical Training												
52	PDR												
53	Average cost of the top 10 highest cost Agency Workers												
54	Average length of service of the top 10 longest serving agency workers												
	FINANCE												
55	Financial Position												
56	Cash Balance												
57	Capital Programme												

Appendix 1 – KPI RAG Rating April 2017 – March 2018

58	**Better Payment Practice Code**												
59	**Use of Resources Rating**												
60	**Fines and Penalties**												
61	**Agency Spending**												
62	**Cost Improvement Programme – Performance to date**												
63	**Cost Improvement Programme – Plans in Progress**												

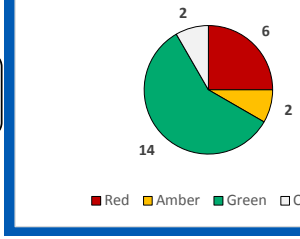
Warrington and Halton Hospitals NHS
NHS Foundation Trust

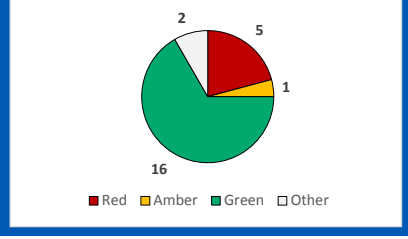
Integrated Dashboard - Board of Directors - August 2017

Appendix 2

Key Points/Actions

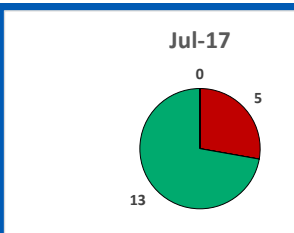
Quality Improvement

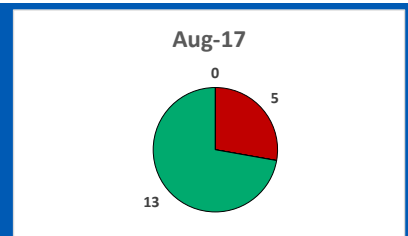




Regarding incidents, work continues regarding ensuring staff review incidents in a timely manner and ensuring Serious Incident actions do not breach. This has improved within month in relation to Serious Incidents actions, but work needs to continue. The overall number of open incidents at the time of reporting is 374. We have ensured 100% Duty of Candour for Serious Incidents; work continues to improve performance in moderate harm incidents. We have met the target for adult and maternity safety thermometer. We are on target regarding hospital acquired infection targets. Actions to improve VTE compliance are still in place, with daily monitoring. The Trust's SHMI has reduced to 105.3%. The Trust remains on track with the complaints improvement trajectory and we are achieving Friends and Family targets.

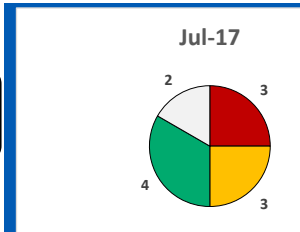
Access & Performance

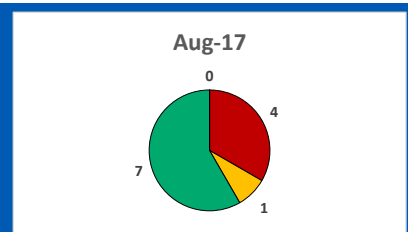




Of the 18 targets on the dashboard related to Access and performance 5 have a RAG rating of red. 1 related to achievement of the four hour standard although the improvement trajectory has been met. 2 are related to ambulance handover times. 1 is related to the timeliness of discharge summaries although they are all sent within 7 days and the remaining red target is cancelled operations on the day where all patients were offered a date within 28 days.

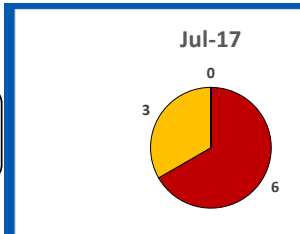
Workforce

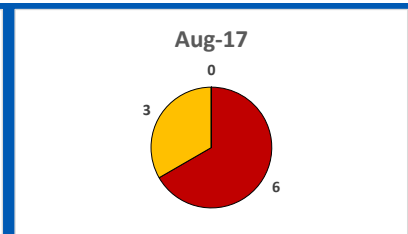




The Trust target for sickness absence was achieved in month. There is work still to be done in achieving the Return to Work Interview compliance target but this is achievable and support is in place from HR. The Trust target for turnover was achieved in month. There has been significant improvement in the time taken to recruit staff over the last 3 months. There is work sill to be done in achieving the PDR compliance rates and managers must place real focus on this over October 2017 to achieve the required 85%. Compliance for Essential and Clinical Training were above target. There needs to be a continued focus on reducing agency spend, although the nursing and medical spend is rated green for August 2017. Plans need to be finalised in relation to the high cost and longest serving agency workers but processes are in place to do so.

Finance





In the month the Trust recorded a deficit of £0.5m which increases the year to date deficit to £4.4m, which is £0.5m worse than the planned deficit. Year to date income is £0.7m above plan, expenses are £1.4m above plan and non operating expenses are £0.2m below plan. The year to date capital spend is £2.5m which is £0.6m below the planned capital spend of £3.1m. Due to the historic and current operating position the cash balance remains low and as at 31st August the cash balance is £1.2m which is £0.1m below the planned cash balance of £1.3m. However under the terms and conditions of the working capital loan the Trust is required to have a cash balance equivalent to 2 operational days (which equates to £1.2m) at some point during the month. The year to date performance against the Better Payment Practice Code is 36% which is 59% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

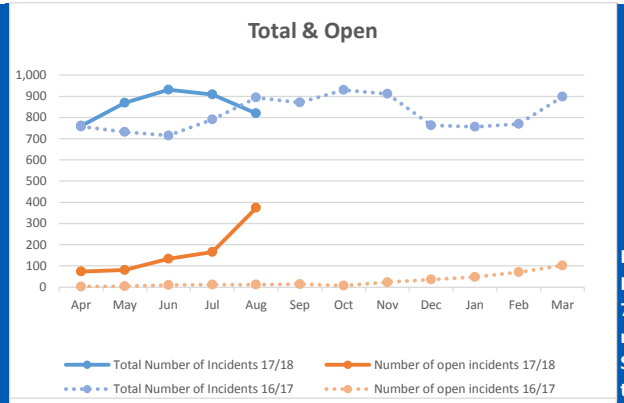
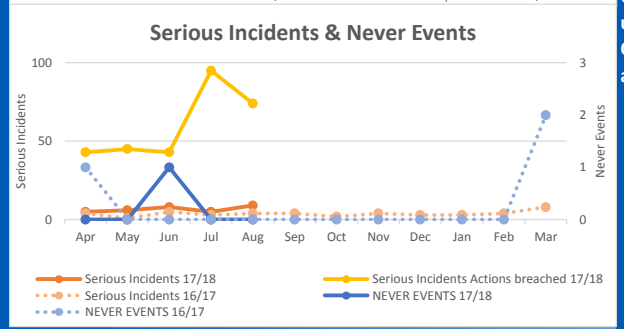
Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

Patient Safety

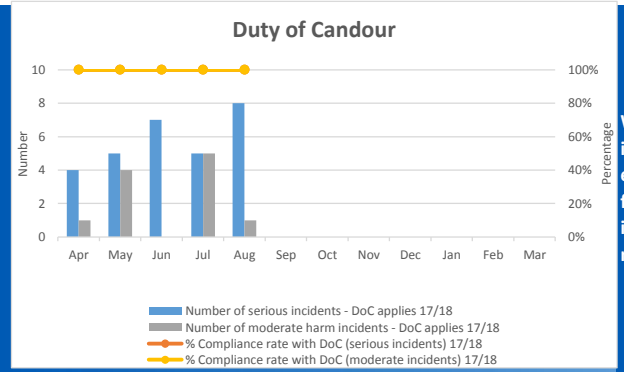
Incidents

Red: 1 or more Never Events
Green: Zero Never Events

Total number of incidents received during the month. Total number of Serious Incidents (SIs) received during the month. Never Events are serious, largely preventable patient safety incidents that should not occur. SI actions breached are the actions from closed serious incidents that are now overdue. Number of open incidents is the total number of incidents that we have awaiting review.	The target for Never Events is a zero tolerance.	 	During August 2017, the number of Serious Incident actions that are overdue within plans is 74, this has decreased from last month. There remains continued focus on ensuring actions from SIs are implemented. The Trust has put in place the first Lessons Learned audit. This will be undertaken quarterly and will report to Quality Committee, giving assurance that actions from SI are being audited and implemented.

Duty of Candour

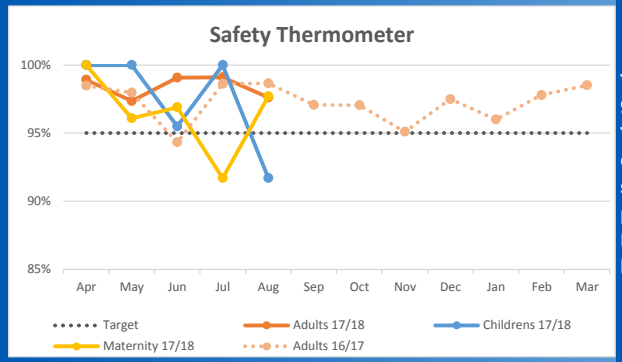
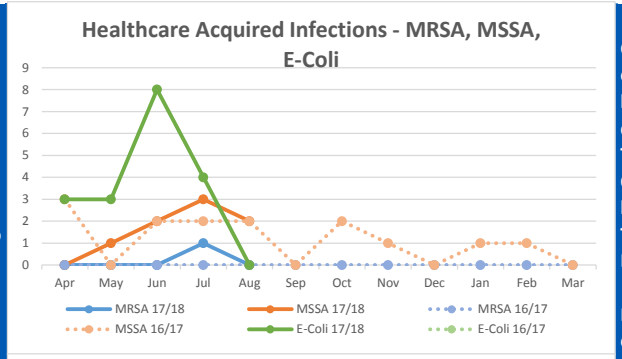
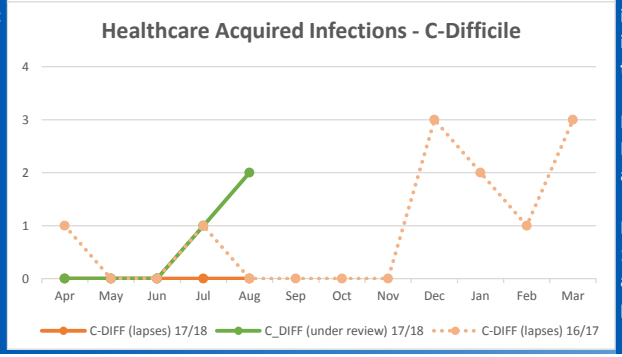
Red: <100%
Green: 100%

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days.	Duty of Candour has to be completed within 10 working days.		We have completed a review of all historical incidents where Duty of Candour has applied and ensured that we have contacted patients / familiies as appropriate. We are 100% compliant in being transparent in applying candour.We will monitor the 10 working day target going forward.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.	The target for all areas is to achieve over 95%.		The overall Harm free care % is above the target of 95%; Areas of harm caused in the Adult Thermometer related to a small number of catheter associated UTIs. Children's services scored lower due to an EWS noting escalated and pain not being addressed in a timely manner. Maternity scored below 100% due to 3 separate harms with no related trend.
Healthcare Acquired Infections MRSA Red: 1 or more Green: 0 C-Difficile Red: More than 2 Amber: 1 to 2 Green: 0	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Eschericia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.	MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.The focus for 2017/18 will be on Eschericia coli (E. coli) bacteraemia which is one of the largest GNBSI groups. Data reported is for hospital apportioned cases.	 	C-difficile – 2 hospital apportioned C-difficile cases was reported in August 2017. YTD the Trust has reported 7 hospital apportioned cases of C-difficile against the annual threshold of 27 cases. The CCG review panel assessed the 4 cases from Q1 and concluded 3 were unavoidable (not due to lapses in care) and 1 was a repeat/relapse case. The review panel for Q2 will take place in December. MRSA bacteraemia – one hospital apportioned case was reported in July 2017 (currently being investigated as an SI). Nil lapses in care were identified and the internal review panel concluded this was an unavoidable case. MSSA bacteraemia – YTD the Trust has reported 8 HAI cases. These are under review to identify any areas for care improvement. E-Coli bacteraemia – YTD the Trust has reported 18 HAI cases. Partnership working is in place across the health economy to develop an action plan for reduction in cases.

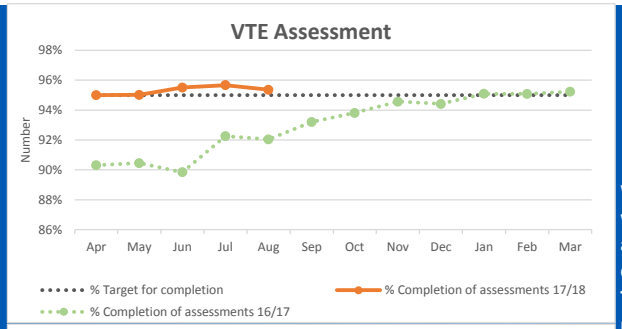
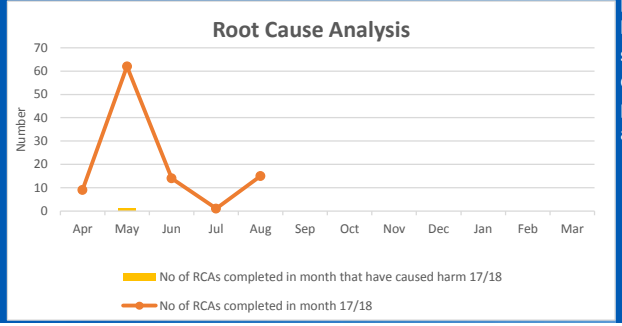
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

Quality Improvement - Trust Position

VTE Assessment

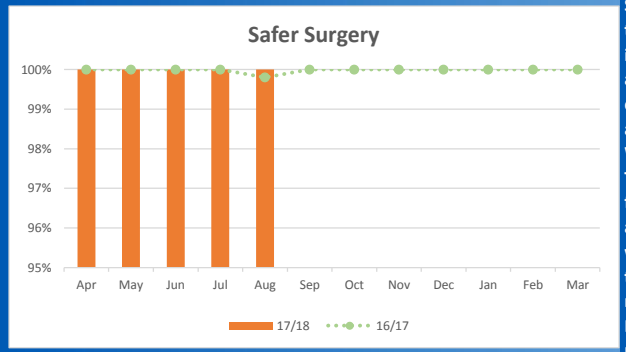
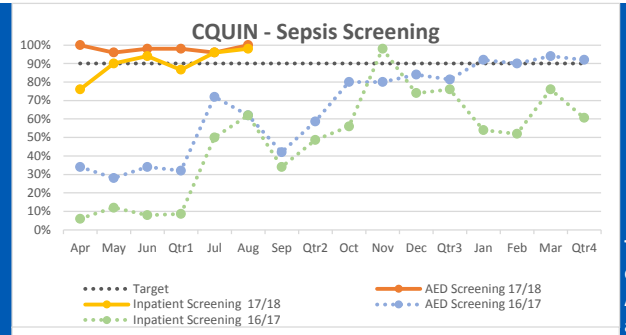
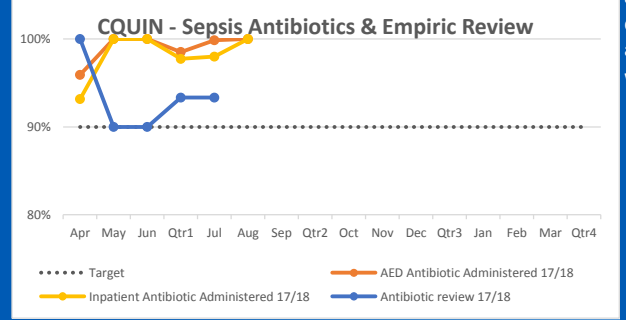
Red: <95%
Green >=95%

Description	Aggregate Position	Trend	Variation
Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. The Trust achieved 95.09% in January, 95.08% in February and 95.23% in March following manual validation of patient level records and data. Technical issues with Lorenzo are being worked through with the relevant teams to ensure accurate VTE data going forward. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/16, 16/17 (risk assessed by harm and occurrence of PE). A revised process has been put in place for April 17 onwards. This has been communicated to Divisions.	 	Weekly data is sent from the Information Team where patients have been admitted from ED and are showing as missing VTE risk assessment. This data is validated and sent back to the Information Team. This is required to ensure inclusion of patients where the DTA (decision to admit time) has not been recorded in ED. Some patients are showing as missing VTE risk assessment where cohort logic needs to be applied to exclude these patients from the requirement to have a VTE risk assessment.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

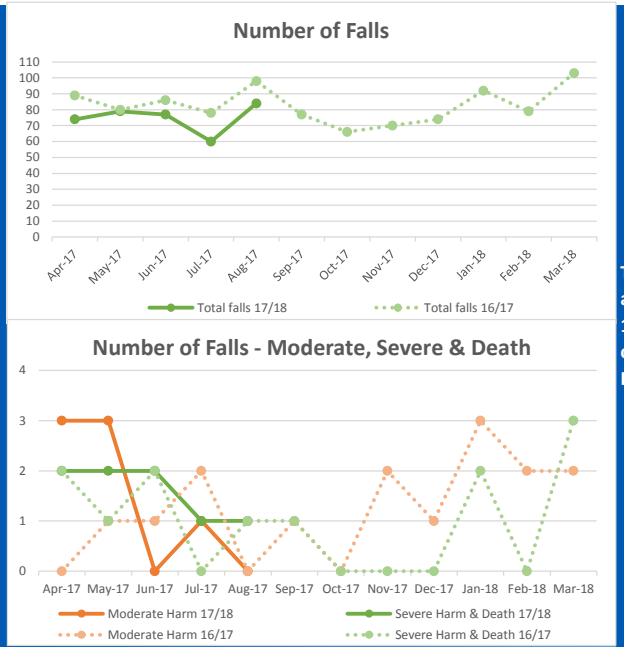
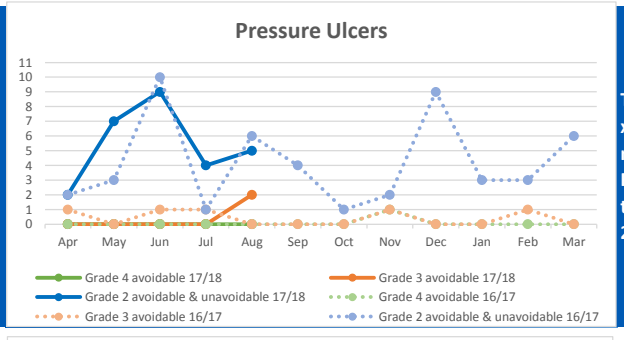
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Safer Surgery Red: <100% Green: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.	The target is to achieve 100%.		Of the Safe Surgery checklists we have continued to see 100% within this area. In relation to improving Safer Surgery across the Trust, we are taking forward the recommendations within the Never Event investigations – which has included observation audits, process review, review of our IT systems to ensure safety elements like laterality is recorded appropriately. We have conducted a safety culture survey across the Trust, which we are going to analyse and decide on focused areas of work. A gap analysis of what LocSSIPs are in place across the Trust (as part of the NAtSSIP work we did last year) . We are reviewing what training we have in place for safer surgery and reviewing our training needs analysis – e.g. training in LocSSIPs, Human Factors etc. There has been one related Never Event in W&C in May 17 related to procedural checking which has been investigated.
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	The target is to achieve 90%	 	The ongoing work by the Sepsis nurse team is clearly demonstrating positive achievements. In August 17 we have achieved 90% or above in all areas. However, we are awaiting validation of the data relating to the assessment of clinical antibiotic review between 24-72 hours of patients with Sepsis who are still inpatients at 72 hours.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

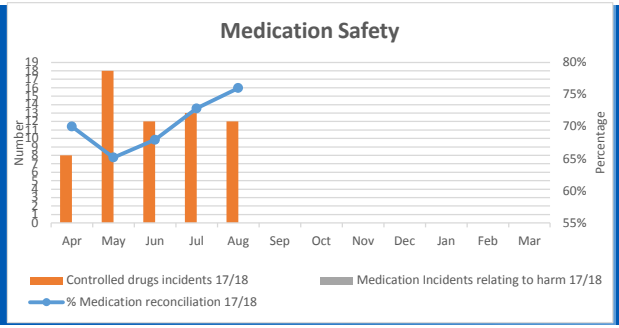
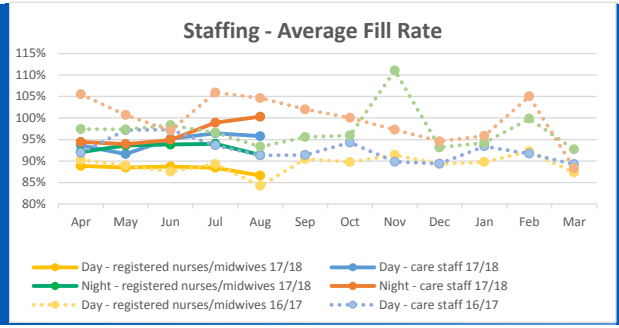
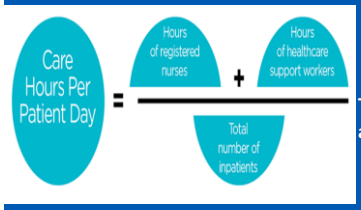
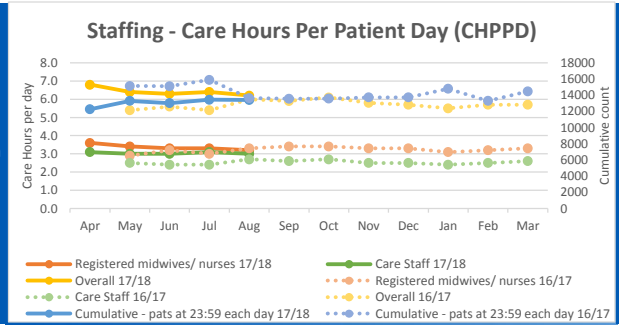
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels	Total number of approved falls per month and their relevant harm levels.	10% reduction in falls in 2017/18 using 2016/17 data as a baseline.		There have been 2 moderate harm falls reported and 1 SI investigation commenced during August. 1 of the moderate harm falls relates to a member of staff falling on site and has been reported under RIDDOR- Linked to estates (corporate).
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 6.83	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.	Grade 4 hospital acquired (avoidable) Grade 3 hospital acquired (avoidable) Grade 2 hospital acquired (avoidable and unavoidable)		There have been 5 x grade 2 Pressure Ulcers and 2 x grade 3 reported for August 17. It should be noted that root cause analysis is underway. Following root cause analysis hearing on 3/8/17 the grade 3 pressure ulcer from Ward A3 (May 2017) was deemed as unavoidable.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

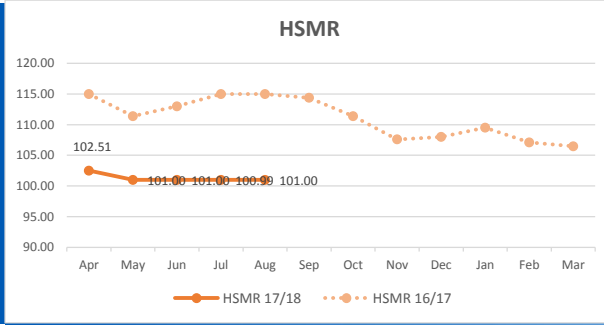
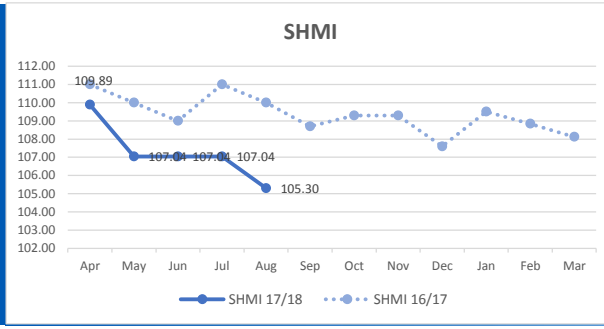
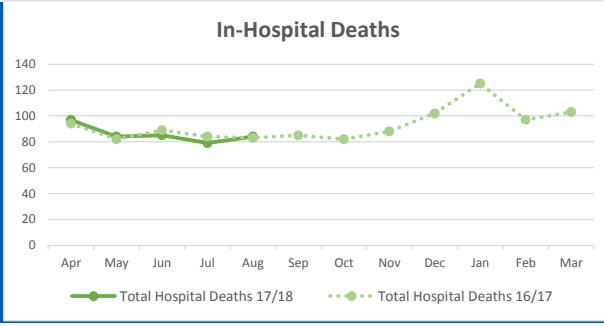
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Medication Safety Red - any incidents of harm. Green - no incidents of harm.	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	The target for Medication Safety is a zero tolerance for incidents of harm.		Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking. YTD the % of patients with an electronic medicines reconciliation record is on an upward trend. The total number of patients requiring this in August was 1494 (excluding Paediatrics, Maternity and patients with a length of stay <1 day). Of these 1494, 1135 medication reconciliations were recorded electronically; 316 (28%) occurred within 24 hours of admission (requires improvement) & 673 (59%) within 48 hours of admission. There were 12 controlled drugs incidents for the month of August and no medication incidents related to harm (grade 3 or above). Most commonly reported incidents relate to diabetic, anticoagulant and opioid medication. Attention is being focussed on diabetic medication incidents.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	Percentage of planned verses actual for registered and non registered staff by day and night	Target of >90%. The data produced excludes CCU, ITU and Paediatrics.		Although most areas are above the 90% target it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate.
Staffing - Care Hours Per Patient Day (CHPPD)		The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.		We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

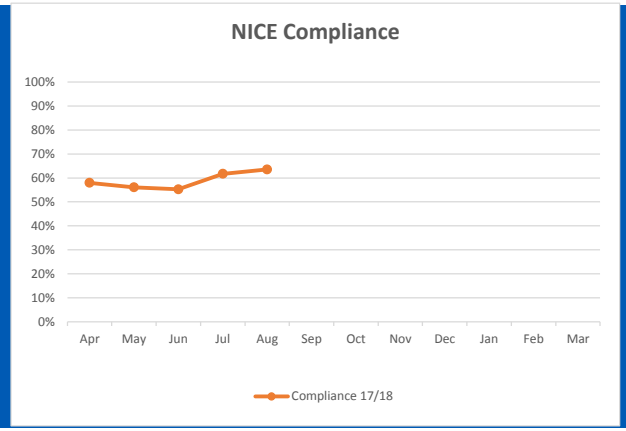
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Target for Green would be to be within expected ranges.		Our HSMR has stabilised and as reported previously we have been on or around 101 for the past three months and are well within expected ranges.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Target for Green would be to be within expected ranges.		After a few months of our SHMI being around 107, it has now reduced to 105.3; again our SHMI is within expected ranges.
Total Deaths	Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group.	The Trust will be publishing data on deaths in October; this data will then be reviewed for targets to be set and sent to Quality Committee. Targets will be set on the IPR in January 2018.		We are currently an outlier (our observed deaths are above our expected deaths for patients being treated for a condition) in the following diagnositic groups: Cardiac Dysrhytmias (HSMR) - review of case notes ongoing Liver disease - alcohol-related (HSMR & SHMI) - 30 against an expected 19 - review required. Intestinal Infection (SHMI) - 23 deaths against an expected 14 - review required. Urinary Tract Infections - action plan in place and we are ready to promote UTI pathway with clinicians and ensure patients are not incorrectly diagnosed as having a UTI. All the reviews are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub Committee.

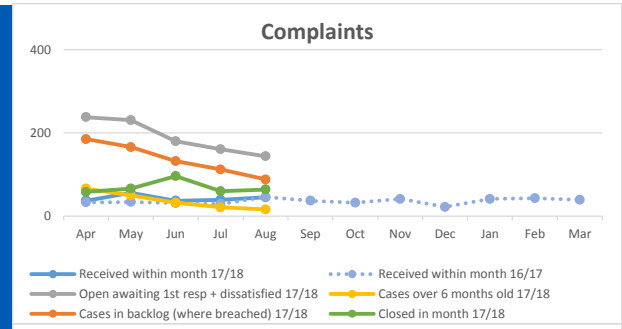
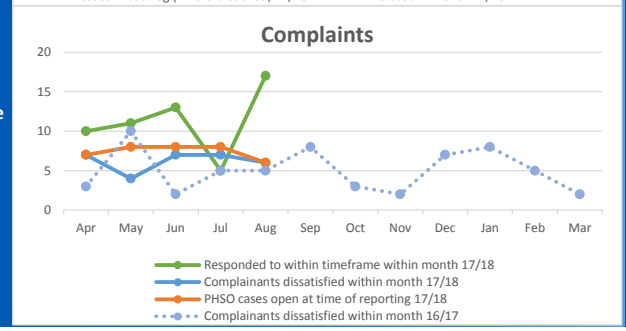
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.	The target is to achieve 100% compliance against all NICE guidance.		NICE Guidance has moved across from CIRIS to SharePoint. CIRIS has higlighted a number of data issues, which we commenced validating, to ensure removal of duplication etc. to focus on the right areas. The data has been cleansed and from this month will provide an accurate picture as to the Trust's current position on compliance with NICE. August's Divisional Quality Bilaterals were focused solely upon NICE and audit and assurances were given that Governance leads are working on assessing compliance where we are "unknown" and creating actions plans where we are partially or non-compliant with recommendations. This is tracked through Patient Safety & Effectiveness Sub Committee.

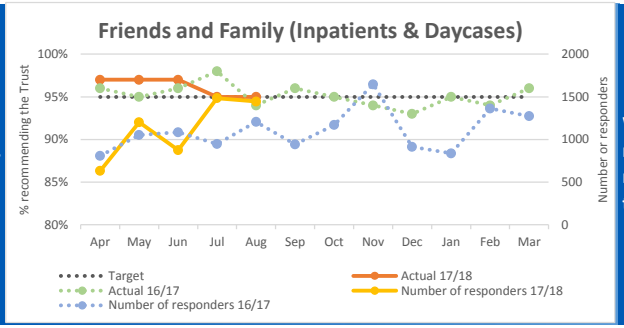
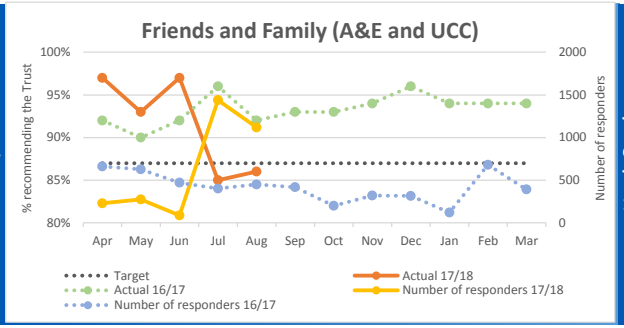
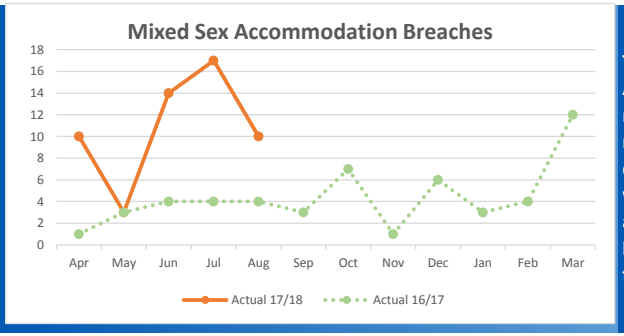
Patient Experience

Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.	Red - Trust not meeting improvement trajectories or complaints open over 6 months old. Amber - No complaints over 6 months old, Trust meeting backlog improvement targets Green - No backlog, complaints responded to within agreed timescales. Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan.	 	The number of complaints received is based on those cases "opened" in month, and not date "first received", in order to ensure a more accurate picture given the historic issues with missed cases. The Trust wide figure will not always match the total cases assigned to ACS or SWC as there are additional complainants assigned to the Corporate Directorate. In month 6 cases were treated as "high" risk and therefore the subject of a 72hr review. Weekly performance meeting with Divisions and the Chief Nurse / Deputy Director of Governance have been reinstated to monitor complaints performance and to focus areas for improvement. The Trust tracks performance against a trajectory to ensure the backlog is cleared by end Dec. The Trust remains on tracjectory with this target.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

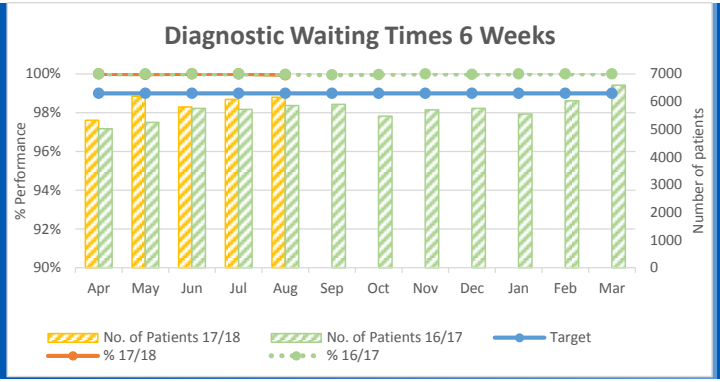
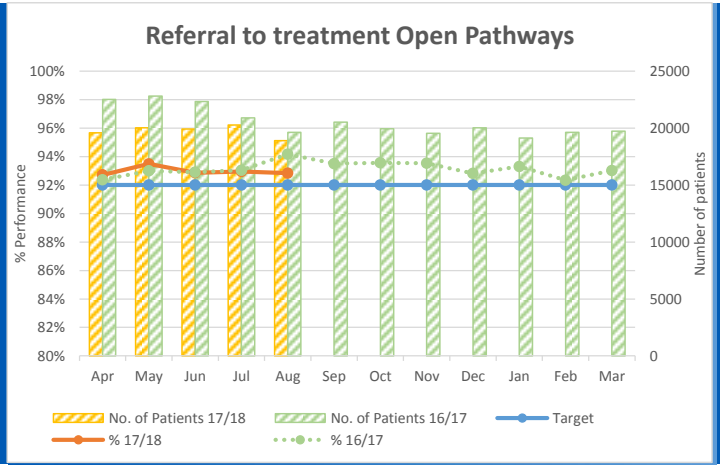
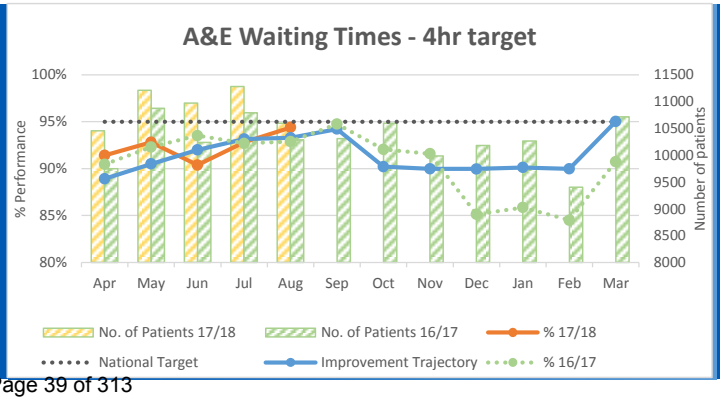
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	Percentage of Inpatients and daycase patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	The target set is to achieve over 95%.		We have continued to achieve 95% of our patients recommending the Trust. The overall number of responders is similar to the previous month, 1485 to 1445 from 4871 eligible responders.
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.		The target set is to achieve over 87% and 86% of our patients recommending the Trust in August. The overall number of responders dropped from 1439 to 1118 from 6162 eligible responders.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.		There has been a reduction in breached for August to 10. MSA breaches continue to be closely monitored by the operational teams. It should be noted that only Critical Care & Coronary Care step down breaches occur due to capacity challenges within the Trust. The CCG's have now agreed that an RCA is not required for each MSA breach, they have requested the breach information in the form of a spreadsheet each month.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

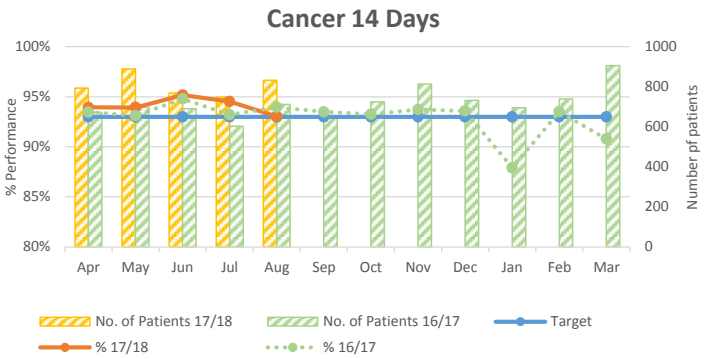
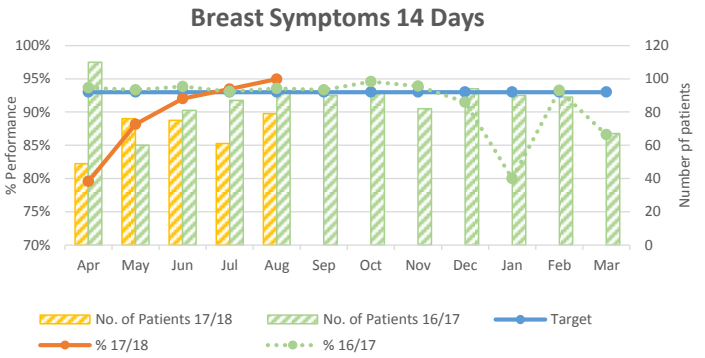
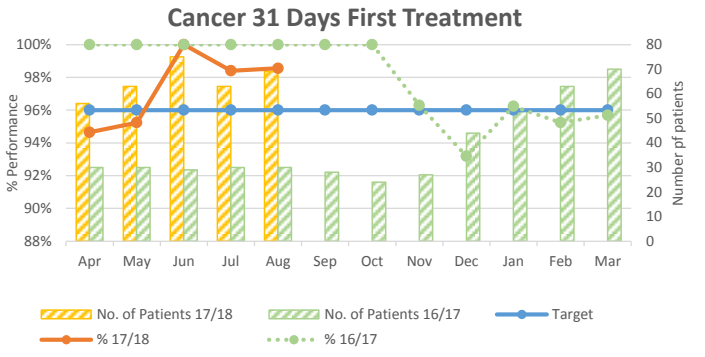
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The national target of 99% for Diagnostic waiting times has been achieved with actual performance at 100%. The Trust has also met the STP Improvement trajectory.		The Trust has achived this target 100% performance for August.
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 Trust achieved the 18 week referral to treatment target, achieving 92% against a target of 92%.
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	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 but is meeting the STP improvement trajectory.		The Trust has been set an improvement trajectory by NHSI to deliver against the four hour standard. The Trust delivered this improvement trajectory for Q1 91.55% against a target of 90.5%. Q2 was much more challenging however we are currently on target to deliver this.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

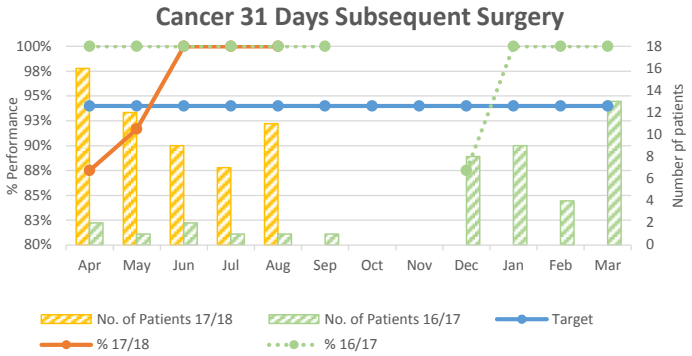
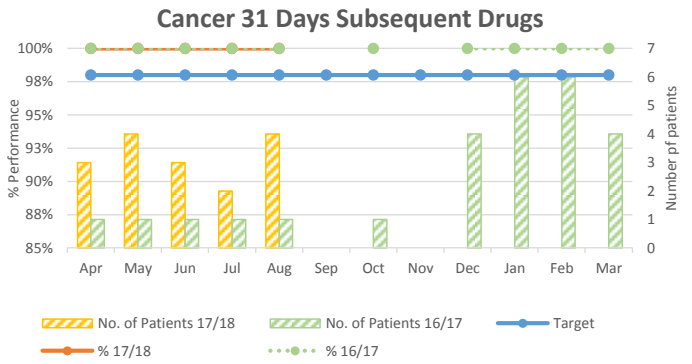
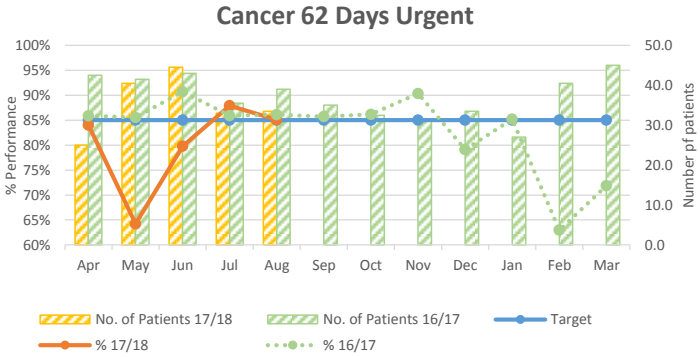
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.			This target has been consistently delivered.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.			The team have worked hard to ensure all patients receive their first appointement within 14 days of a referal this is a challenging target as patient choice has been an issue in previous months we have worked closely with our partners and OPD department to ensure we offer 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.			This target has been achieved.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

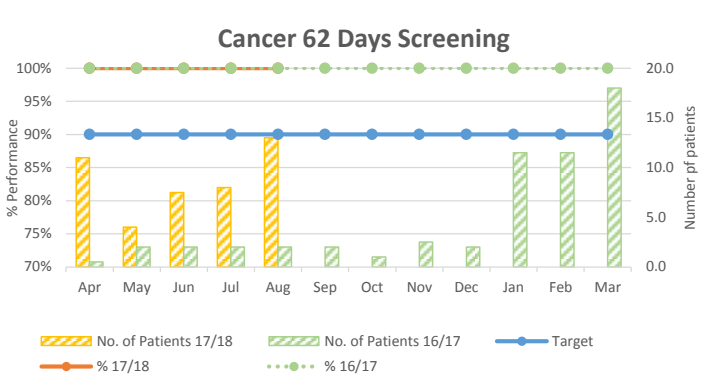
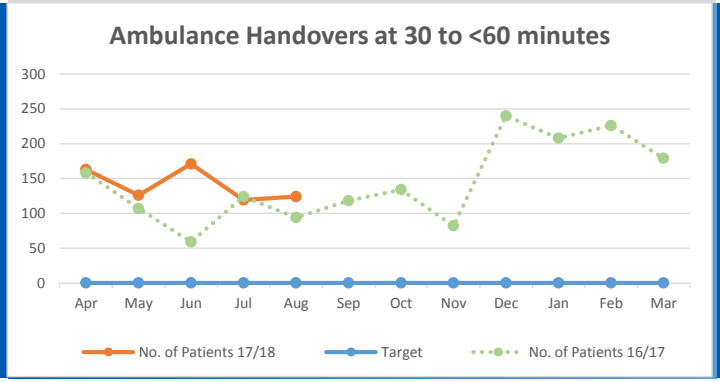
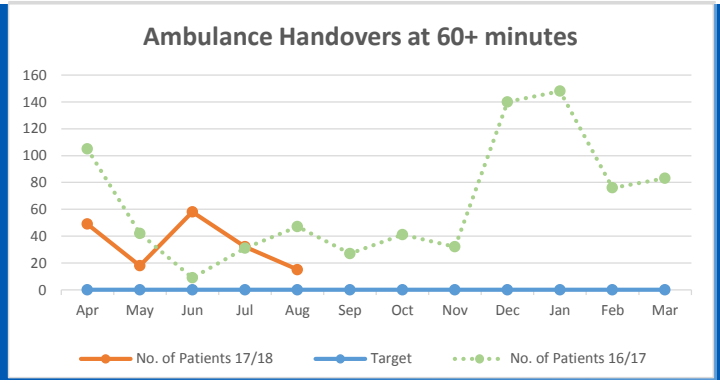
Mandatory Standards - Access & Performance - Trust Position

	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.			This target has been achieved.
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.			This target has been achieved.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.			The quarter position for cancer has yet to be submitted and will improve further when all data is included. The Trust has been included in a regional initiative to support improvement of the 62 day cancer target there is a regional action plan.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

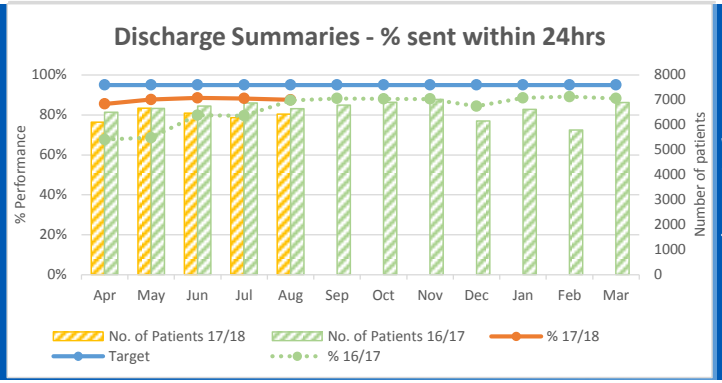
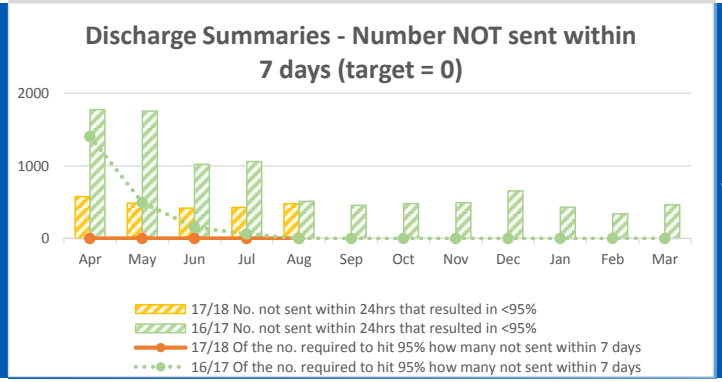
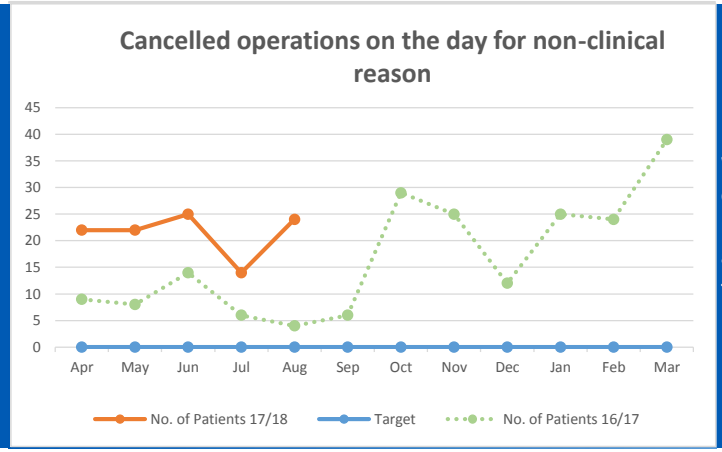
Mandatory Standards - Access & Performance - Trust Position

	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.			This target has been achieved.
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).			Ambulance handovers remain a challenge. The trust has taken part in an improvement event which concluded this month. The team have now implemented 'fit to sit' for appropriate patients as well as moving the ambulance handover desk, to support improvement against this target.
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).			We have seen improvements in this target however the tolerance is 0.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

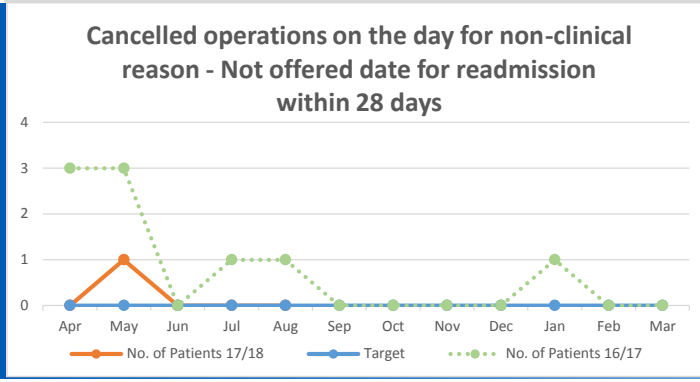
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
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.			We have made significant improvements against this target however we remain below the 95% target.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.			We have achieved this target.
Cancelled Operations on the day for a non-clinical reason Red: Above zero	Number of operations cancelled on the day or after admission for a non-clinical reason.			We continue to have patients cancelled on the day for non-clinical reasons the main issues in August relate to use of anaesthetic agency staff calling in on the day.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

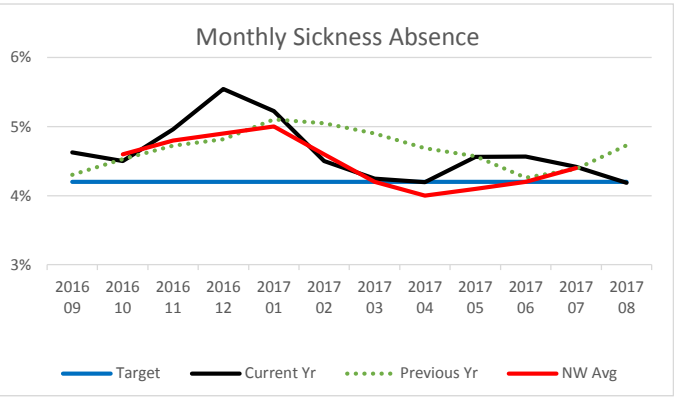
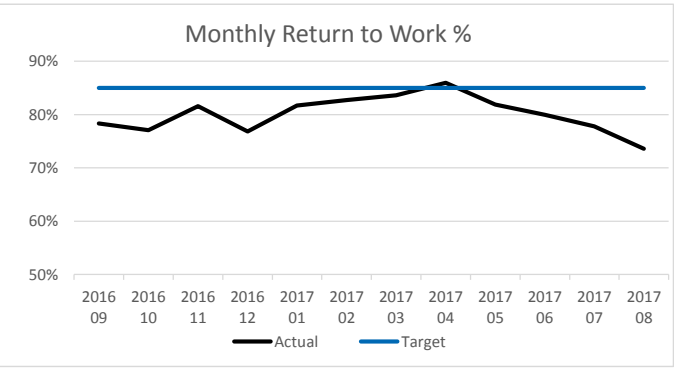
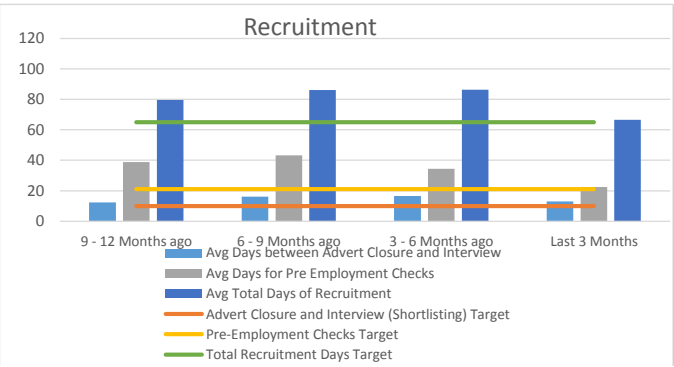
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	**All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.**			**This target has been achieved for August.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

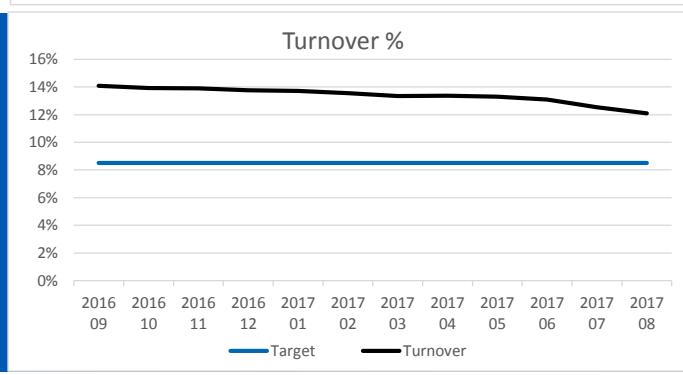
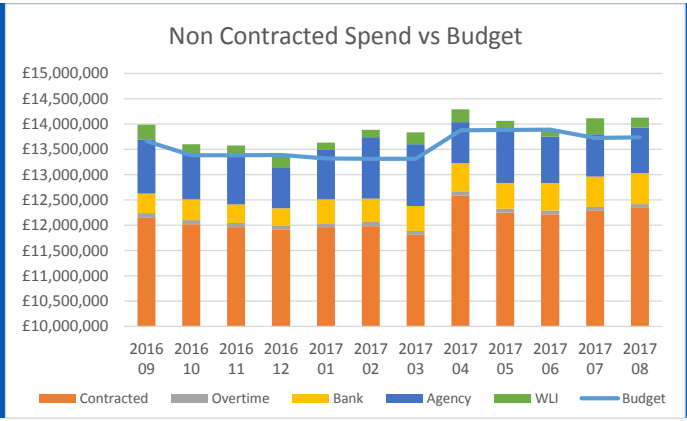
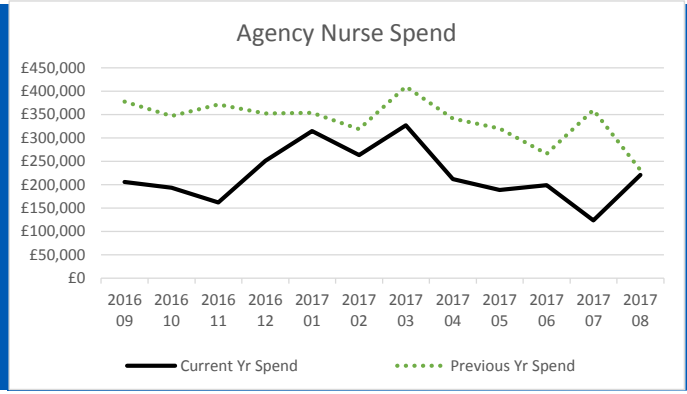
Workforce

	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 was 4.18% in August 2017 and the Trust target was achieved. Sickness absence has continued to reduce and is significantly lower than the same period last year.		An audit has been completed on compliance with the Trust Attendance Management Policy and a number of recommendations will be implemented including: Empowering experienced managers to undertake stage 1 reviews independently therefore freeing up Senior HR Advisors to provide additional and more timely support to less experienced managers, producing a 'Policy on a Page' and refreshing the Attendance Management Policy toolkit. The audit is going to be extended throughout September and early October in order to obtain sufficient data to report at CBU level. Stress/Anxiety/Depression remains the highest occurring reasons for absence. The Trust is currently exploring the option of training Mental Health First Aiders across the workforce to support staff.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	Return to Work Interview compliance was 73.58% in August 2017 which is significantly below the Trust target of 85%		The completion and recording of Return to Work Interviews has formed part of the Attendance Management audit. The audit has shown that there are instances where the interview is completed but is not recorded on either ESR or E Rostering. The audit has also shown that there are instances where no interview is completed when a member of staff returns to work. Additional support and monitoring is going to be provided over October and November by the HR team prior to the 'close down' date to ensure that completed all interviews are recorded. The refreshed Attendance Management Toolkit will reinforce the importance of undertaking a return to work interview after every episode of absence. Return to Work Interview compliance is reported at divisional, CBU and ward level on a monthly basis, along with a list of outstanding interviews to be completed.
Recruitment Red: Above Target Green: On or Below Target	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks	The average total days to recruit over the last 3 months was 66.5. Whilst this is above the Trust target of 65 days, it does represent a significant reduction from previous months.		Recent feedback from applicants on the Trust recruitment process has been very positive and the Trust have improved across all measures. In addition, there has been a reduction in Staff Nurse vacancies of circa. 25%. Two further recruitment open days are planned across the coming months to build on recent successes.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

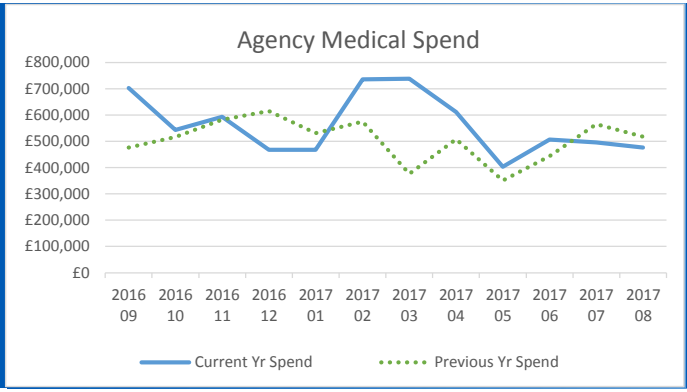
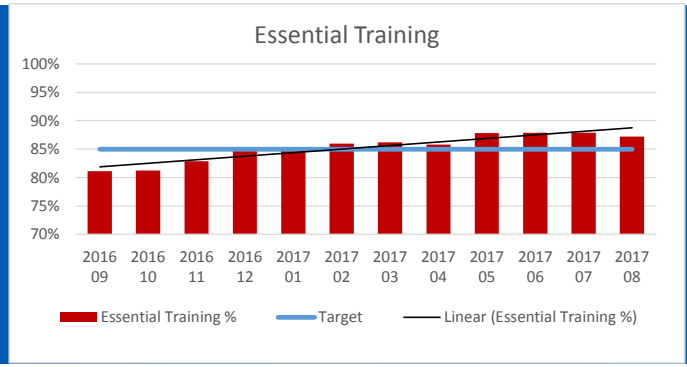
Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	A review of the turnover percentage over the last 12 months	Turnover reduced to 12.1% in August 2017 and the Trust target was achieved.		There has been a continuation in the downward trend for turnover, evidencing the work done to recruit and retain staff. This work will continue across all staff groups, with targeted support offered to areas experiencing a high level of turnover.
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Non-contracted spend remains above budget. Agency spend is the highest element of non-contracted pay at 6.6%, followed by bank spend at 3.8%		Key actions are in place to address agency spend for Nursing, Medical and Dental, and Allied Health Professionals, and are outlined below. Non-contracted pay is reviewed via the Premium Pay Spend Review Meeting.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on Agency Nurses	There has been an increase in Nurse Agency Spend to £221k in August 2017.		The Recruitment and Retention Plan for Nursing continues to be implemented. The trust was represented at an RCN Open Day in Liverpool on 5 September 2017 and there is an ongoing social media campaign through WHH careers.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

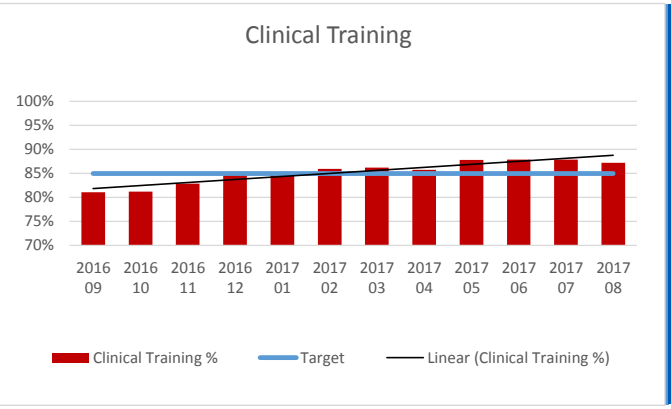
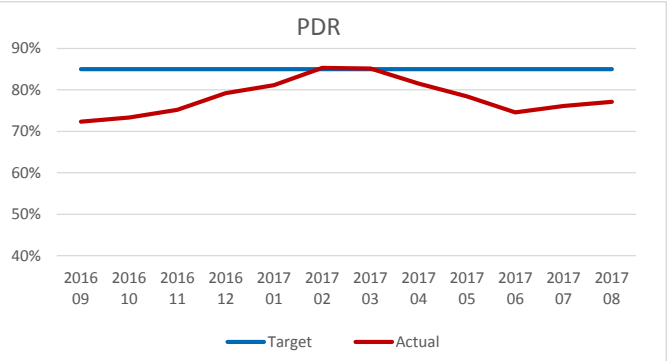
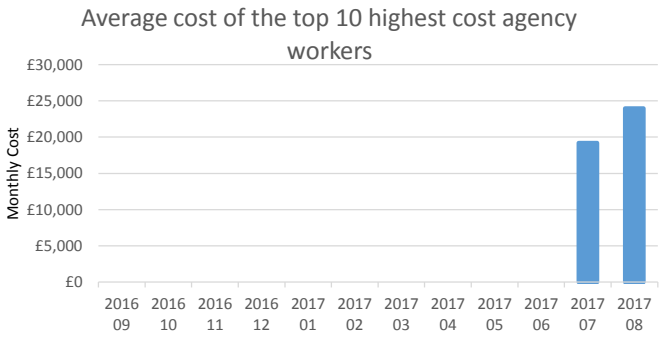
Workforce

	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 has reduced slightly to £476k in August 2017 and is lower than the spend for the same period last year.		Medical agency spend is reported to the Deputy Medical Director via the Medical HR Group. The group focus on forward planning for the medical workforce to reduce the usage of temporary medical staff. In addition, the breach form process will be amended to strengthen the challenge in place for booking which breach the price cap.
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	Essential Training compliance was 88.8% in August 2017 meaning that the Trust target was achieved.		Essential Training compliance will continue to be reported at divisional, CBU and ward level, with additional monitoring and support in place for any areas with low compliance rates.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

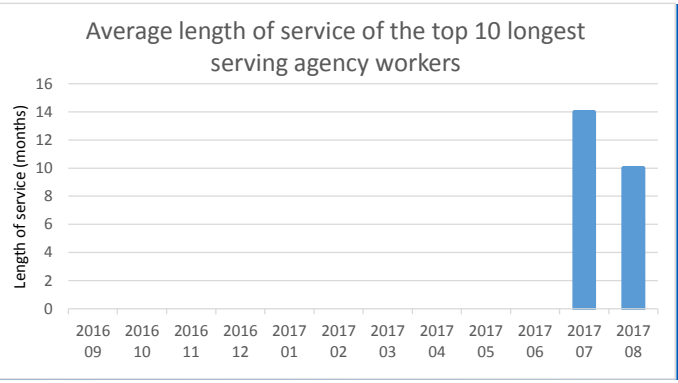
Workforce

	Description	Aggregate Position	Trend	Variation
Clinical Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	**A summary of the Clinical Mandatory Training Compliance, this includes:** **Infection Control** **Resus** **Safeguarding Procedures (Adults) - Level 1** **Safeguarding Procedures (Adults) - Level 2** **Safeguarding Procedures (Children) - Level 1** **Safeguarding Procedures (Children) - Level 2** **Safeguarding Procedures (Children) - Level 3** **SEMA**	**The upward trend continues and the compliance rate for June is 87.87% which is above the trust target of 85%.**		**Clinical Training compliance will continue to be reported at divisional, CBU and ward level, with additional monitoring and support in place for any areas with low compliance rates.**
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	**A summary of the PDR Compliance rate**	**PDR compliance was 77.13% in August 2017, which is below the Trust target of 85%.**		**There has been slight increase in PDR compliance. HR Business Partners have worked with divisional managers to put in place a 3 month recovery plan which commenced in August and the early signs are that this is having a positive effect.**
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than	**Average cost of the top 10 highest cost agency workers**	**The average cost of the top 10 highest cost agency workers has increased in August 2017 to £24K.**		**All of the top 10 highest cost agency workers are within the Medical and Dental staff group. This data is reported to the Deputy Medical Director via Medical HR meeting in order to ensure plans are in place to reduce spend.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

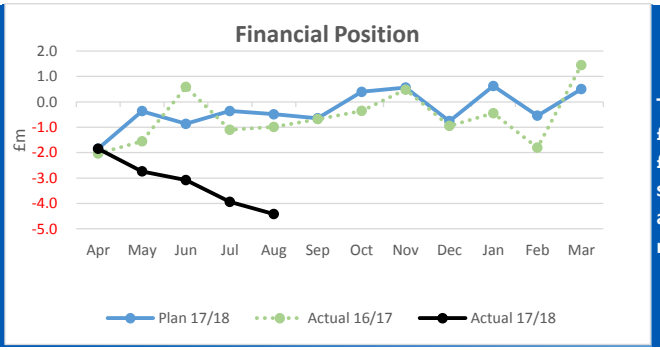
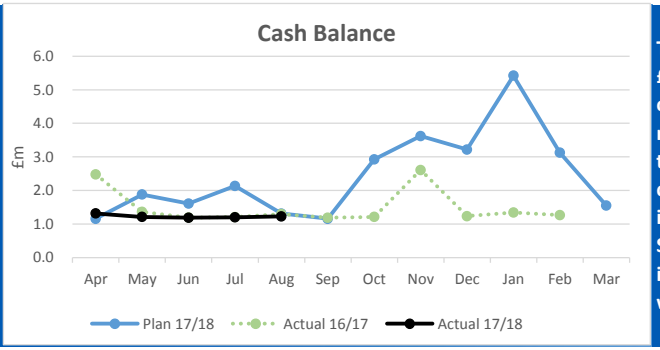
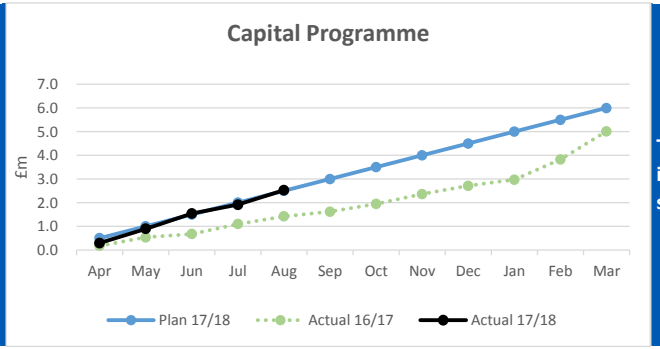
Workforce

	Description	Aggregate Position	Trend	Variation
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month Green: Less than	**An average length of service (months) of the Top 10 agency workers who have been working at the trust for a minimum of 3 shifts per week for a consecutive period of 6 weeks.**	**The average length of service of the top 10 longest serving agency workers has reduced in August 2017.**		**Of the 10 workers, 6 are within the Medical and Dental staff group and this data is reported to the Deputy Medical Director via Medical HR meeting in order to ensure plans are in place to reduce usage and mitigate risk. The remaining 4 workers are Allied Health Professionals (AHPs). The usage of AHPs will be addressed as vacancies are filled following the successful recruitment outlined above.**

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

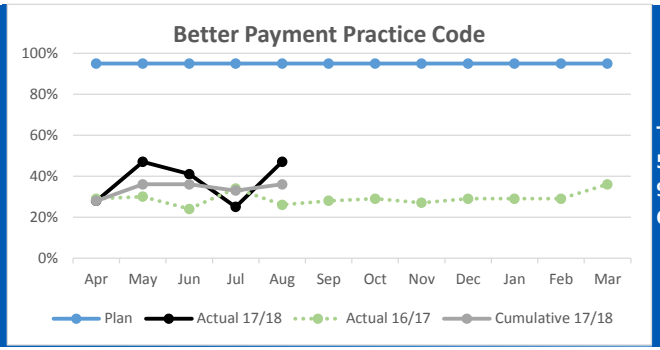
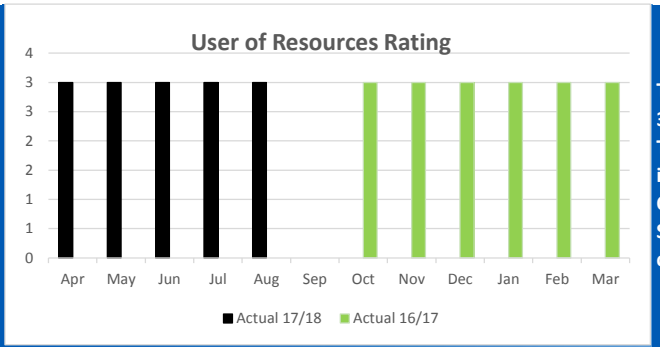
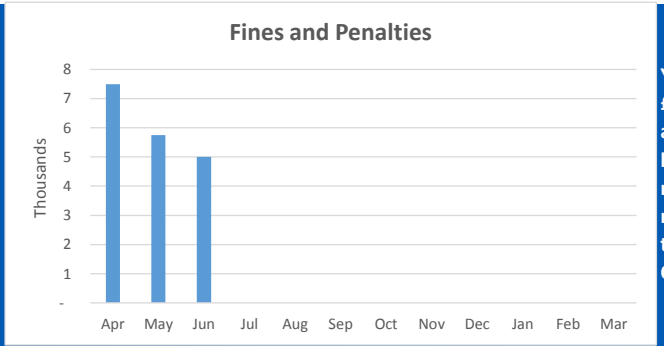
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position	Surplus or deficit compared to plan	The actual deficit in the month is £0.5m which increases the cumulative deficit to £4.4m.		The cumulative deficit of £4.4m is £0.5m worse than the planned deficit of £3.9m. Forecast outturn under review - significant risks to delivery, a number of actions are being taken to address the risks.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	Cash balance at month end compared to plan	Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.2m equates to circa 2 days operational cash.		The current cash balance of £1.2m is £0.1m below the planned cash balance of £1.3m but the balance of £1.2m at month end is required to comply with the terms and conditions of the working capital loan. The forecast cash position is at risk due to the financial position. Should the actions not be sufficent to improve the fianncial position the Trust will require additional cash support.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan. The capital plan has been increased to by £1.0m to £7.0m in respect of the Department of Health funding for the implementation of A&E Primary Care Streaming.	The actual capital spend in the month is £0.6m which increases the cumulative capital spend to £2.5m.		The cumulative capital spend of £2.5m is £0.6m below the planned capital spend of £3.1m.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

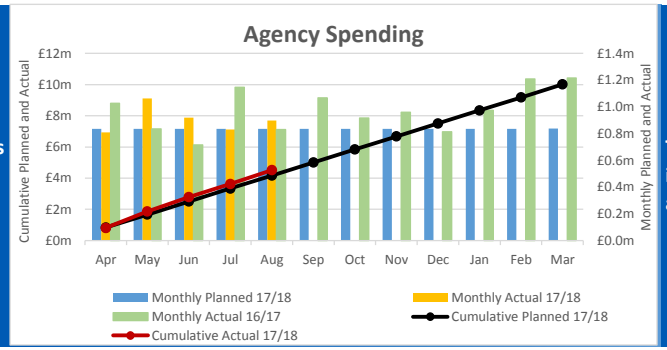
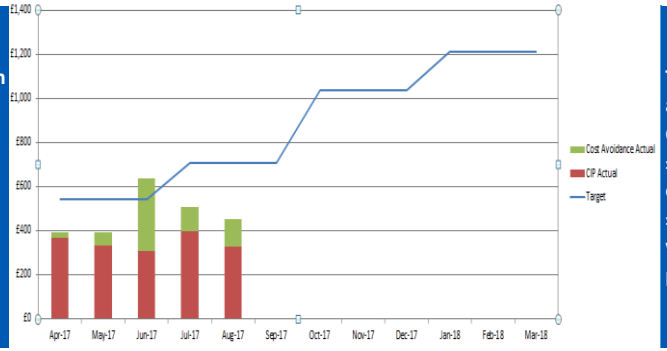
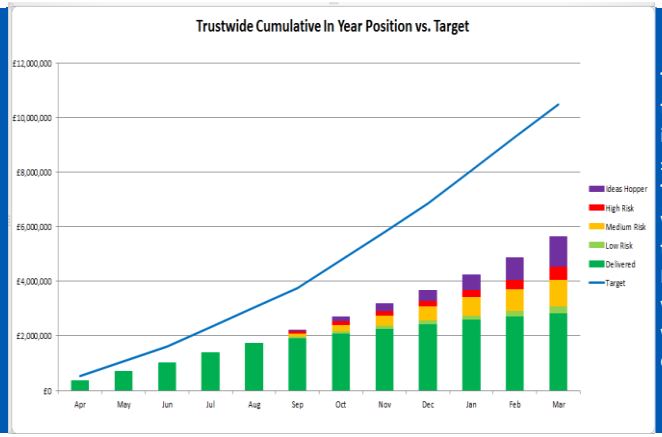
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 47% of suppliers within 30 days which results in a year to date performance of 36%.		The cumulative performance of 36% is 59% below the national standard of 95%, this is due to the low cash balance. Cash is being managed on a daily basis.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	Use of Resources Rating compared to plan.	The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity and I&E margin are all scored at 4, Agency Ceiling is scored at 2 and Variance to Control Total is scored at 2.		The current Use of Resources Rating of 3 is in line with the planned rating of 3. The Use of Resource Rating was introduced as an indicator by NHSI in October 2016. Therefore April 2017 - September 2017 will have no comparable previous year data.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties	Fines and Penalties applied by commissioners year to date is £18k. Due to the reconciliation process, the Trust is informed of fines and penalties up to 2 months later than the month of activity.		Year to date the fines and penalties are £18k. The main issues are mixed sex accomodation and 24 hour discharge letters. Other fines and penalties relating to Non valid NHS number and not our patient have been excluded as these are being queried with the Commissioners.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - August 2017

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £0.9m which increases the cumulative spend to £4.5m.		The cumulative agency spend of £4.5m is £0.3m (8%) above the cumulative agency ceiling of £4.2m.
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	Cost savings delivered year to date compared to year to date plan.	CIP savings delivered in M5 are £0.323m against the M5 target of £0.709m, a further £0.128m was delivered in cost avoidance. The YTD M5 position for CIP is £1.723m against a YTD plan of £3.037m with a further £0.66m YTD M5 delivered in cost avoidance / income recovery.		The financial impact of transformation activities was £2.383m in M5 (£1.723m CIP & £0.660m cost avoidance) this is £0.654m below the Trust M5 CIP target of £3.037m. After closedown a further £350k CIP YTD has been confirmed this will be reflected in the month 6 position.
Cost Improvement Programme - Plans in Progress - In Year/Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	Planned improvements in productivity and efficiency - In Year & Recurrent forecast vs £10.5m target	In Year - The best case forecast for Trust CIP schemes in year is £5.620m. Best case assumes full delivery of all schemes on the tracker including all hopper ideas. The worst case forecast for CIP in year is around £3.792m. Worst case assumes the risk adjusted value of all schemes on the tracker and excludes all hopper ideas. Recurrent - The best case forecast for recurrent CIP is around £5.947m The worst case forecast for recurrent CIP is around £1.746m.		The worst case current in year forecast for Trust CIP schemes is £3.792m which is £6.708m below the CIP target of £10.5m. The best case for CIP in year is £5.620m which is still £4.88m below the CIP target. Best case cost avoidance of £1.574m will help mitigate the position but would still leave a bottom line shortfall of £3.306m.

Warrington & Halton Hospitals NHS Foundation Trust **Appendix 3**

Income Statement, Activity Summary and Use of Resources Ratings as at 31st August 2017

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Clinical Income									
Elective Spells	2,990	2,814	-176	15,162	14,113	-1,049	36,228	36,228	0
Elective Excess Bed Days	12	3	-9	65	76	11	155	155	0
Non Elective Spells	4,894	5,271	377	24,265	25,245	979	59,452	59,452	0
Non Elective Excess Bed Days	181	104	-78	898	858	-39	2,199	2,199	0
Outpatient Attendances	2,905	2,777	-128	14,107	13,580	-527	33,774	33,774	0
Accident & Emergency Attendances	1,101	1,070	-31	5,516	5,569	53	13,066	13,066	0
Other Activity	5,281	5,558	277	26,248	27,057	809	62,999	62,999	0
Sub total	**17,364**	**17,596**	**232**	**86,261**	**86,498**	**237**	**207,873**	**207,873**	**0**
Non NHS Clinical Income									
Private Patients	9	6	-3	45	50	5	106	106	0
Other non protected	107	94	-13	535	450	-85	1,284	1,284	0
Sub total	**116**	**100**	**-16**	**580**	**499**	**-81**	**1,390**	**1,390**	**0**
Other Operating Income									
Training & Education	641	641	0	3,205	3,205	0	7,693	7,693	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Sustainability & Transformation Fund	469	469	0	1,991	1,991	0	7,029	7,029	0
Miscellaneous Income	830	947	117	4,141	4,680	539	10,081	10,081	0
Sub total	**1,940**	**2,057**	**117**	**9,337**	**9,876**	**539**	**24,803**	**24,803**	**0**
Total Operating Income	**19,420**	**19,753**	**333**	**96,178**	**96,873**	**695**	**234,066**	**234,066**	**0**
Operating Expenses									
Employee Benefit Expenses	-13,738	-14,130	-392	-69,115	-70,495	-1,380	-164,359	-164,359	0
Drugs	-1,443	-1,434	9	-7,227	-6,925	302	-17,285	-17,285	0
Clinical Supplies and Services	-1,545	-1,738	-193	-7,785	-8,369	-584	-18,264	-18,264	0
Non Clinical Supplies	-2,414	-2,430	-16	-12,136	-11,969	167	-28,730	-28,730	0
Depreciation and Amortisation	-463	-445	18	-2,315	-2,227	88	-5,552	-5,552	0
Restructuring Costs	0	0	0	0	-14	-14	0	0	0
Total Operating Expenses	**-19,603**	**-20,177**	**-575**	**-98,579**	**-100,000**	**-1,421**	**-234,189**	**-234,189**	**0**
Operating Surplus / (Deficit)	**-183**	**-424**	**-242**	**-2,401**	**-3,127**	**-726**	**-123**	**-123**	**0**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0	0	0
Interest Income	2	2	0	10	7	-3	26	26	0
Interest Expenses	-35	-36	-1	-173	-184	-11	-426	-426	0
PDC Dividends	-273	-23	250	-1,364	-1,114	250	-3,275	-3,275	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-306**	**-58**	**248**	**-1,527**	**-1,291**	**236**	**-3,675**	**-3,675**	**0**
Surplus / (Deficit)	**-489**	**-482**	**7**	**-3,928**	**-4,417**	**-490**	**-3,798**	**-3,798**	**0**
Depreciation on Donated and Granted Assets	12	12	0	60	62	2	141	141	0
Control Total	**-477**	**-469**	**7**	**-3,868**	**-4,356**	**-488**	**-3,657**	**-3,657**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,351	2,983	-368	16,630	14,913	-1,717	39,931	39,931	0
Elective Excess Bed Days	59	13	-46	309	311	2	732	732	0
Non Elective Spells	3,243	3,172	-71	16,082	15,704	-378	39,402	39,402	0
Non Elective Excess Bed Days	865	434	-431	4,290	3,503	-787	10,512	10,512	0
Outpatient Attendances	28,265	27,073	-1,192	137,261	132,016	-5,245	328,622	328,622	0
Accident & Emergency Attendances	8,910	9,305	395	44,626	48,086	3,460	105,704	105,704	0
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-0.05	-0.27	-0.22	1.43	1.43	0.00
Liquidity Ratio (Days)				-51.7	-41.3	10.4	-48.9	-48.9	0.0
I&E Margin (%)				-4.02%	-4.50%	-0.47%	-1.56%	-1.56%	0.00%
Variance from control total (%)				0.00%	-0.47%	-0.47%	0.00%	0.00%	0.00%
Agency Ceiling (%)				0.00%	8.31%	8.31%	0.00%	0.00%	0.00%
Ratings									
Capital Servicing Capacity (Times)				4	4	0	3	3	0
Liquidity Ratio (Days)				4	4	0	4	4	0
I&E Margin (%)				4	4	0	4	4	0
Variance from control total (%)				1	2	1	1	1	0
Agency Ceiling (%)				1	2	1	1	1	0
Use of Resources Rating				**3**	**3**	**0**	**3**	**3**	**0**

Warrington and Halton Hospitals NHS Foundation Trust **Appendix 3**

Statement of Financial Position as at 31st August 2017

Narrative	Audited Position as at 31/03/17 £000	Actual Position as at 31/07/17 £000	Actual Position as at 31/08/17 £000	Monthly Movement £000	Forecast Position as at 31/03/18 £000
NON-CURRENT ASSETS					
Intangible Assets	2,308	2,274	2,366	92	1,047
Property, Plant and Equipment	117,890	118,057	118,133	76	124,091
Trade and Other Receivables, non-current	991	903	912	9	1,205
Total Non-Current Assets	**121,189**	**121,234**	**121,411**	**177**	**126,343**
CURRENT ASSETS					
Inventories	3,437	3,358	3,265	(93)	3,312
Trade and Other Receivables, current	13,163	11,350	12,272	922	8,398
Cash and Cash Equivalents	1,201	1,204	1,227	23	1,555
Total Current Assets	**17,801**	**15,912**	**16,764**	**852**	**13,265**
Total Assets	**138,990**	**137,146**	**138,175**	**1,029**	**139,608**
CURRENT LIABILITIES					
Trade and Other Payables	(16,405)	(18,291)	(20,753)	(2,462)	(22,824)
Other Liabilities	(4,070)	(4,924)	(4,785)	139	(3,880)
Borrowings, current	(454)	(14,657)	(14,654)	3	(14,491)
Provisions	(279)	(247)	(246)	1	(256)
Total Current Liabilities	**(21,208)**	**(38,119)**	**(40,438)**	**(2,319)**	**(41,451)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**117,782**	**99,027**	**97,737**	**(1,290)**	**98,157**
NON-CURRENT LIABILITIES					
Borrowings, non-current	(28,152)	(13,374)	(12,394)	980	(13,562)
Provisions	(1,377)	(1,338)	(1,343)	(5)	(1,198)
Total Non Current Liabilities	**(29,529)**	**(14,712)**	**(13,737)**	**975**	**(14,760)**
TOTAL ASSETS EMPLOYED	**88,253**	**84,315**	**84,000**	**(315)**	**83,397**
TAXPAYERS' EQUITY					
Public dividend capital	87,742	87,742	87,908	166	88,742
Income and expenditure reserve	(21,967)	(25,905)	(26,386)	(481)	(27,823)
Revaluation Reserve	22,478	22,478	22,478	0	22,478
TOTAL TAXPAYERS' EQUITY	**88,253**	**84,315**	**84,000**	**(315)**	**83,397**

Warrington and Halton Hospitals NHS Foundation Trust **Appendix 3**

Cash Flow Statement For 2017/18

	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Annual
	April £000's	May £000's	June £000's	July £000's	August £000's	September £000's	October £000's	November £000's	December £000's	January £000's	February £000's	March £000's	Position £000's
CASH FLOW FROM OPERATING ACTIVITES													
Operating Surplus/(deficit)	**(1,535)**	**(586)**	**(30)**	**(551)**	**(424)**	**(341)**	**699**	**868**	**(451)**	**929**	**(237)**	**1,536**	**(123)**
Non-cash income and expense	463	463	381	475	445	463	463	463	463	462	462	549	5,552
Operating cash flows before movement in working capital	**(1,072)**	**(123)**	**351**	**(76)**	**21**	**122**	**1,162**	**1,331**	**12**	**1,391**	**225**	**2,085**	**5,429**
(Increase)/decrease in working capital	1,911	657	306	497	1,495	326	1,177	(268)	(183)	1,305	(1,966)	(1,262)	**3,995**
Net cash generated from/(used in) operations	**839**	**534**	**657**	**421**	**1,516**	**448**	**2,339**	**1,063**	**(171)**	**2,696**	**(1,741)**	**823**	**9,424**
CASH FLOW FROM INVESTING ACTIVITIES													
Interest received	1	2	1	1	2	2	2	2	2	2	3	6	**26**
Purchase of property, plant and equipment and investment property	(291)	(604)	(645)	(368)	(623)	(663)	(663)	(463)	(463)	(463)	(463)	(1,291)	**(7,000)**
Net cash generated from/(used in) investing activities	**(290)**	**(602)**	**(644)**	**(367)**	**(621)**	**(661)**	**(661)**	**(461)**	**(461)**	**(461)**	**(460)**	**(1,285)**	**(6,974)**
CASH FLOW FROM FINANCING ACTIVITIES													
Public dividend capital received	-	-	-	-	166	316	120	130	268	-	-	-	**1,000**
Public dividend capital repaid	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Loans from DH - received	1,603	-	-	-	1,054	1,503	-	-	-	-	-	551	**4,711**
Loans from DH - repaid	(2,000)	-	-	-	(2,053)	-	-	-	-	-	(53)	-	**(4,106)**
Interest paid	(30)	(33)	(36)	(37)	(36)	(33)	(31)	(32)	(33)	(31)	(33)	(19)	**(384)**
Interest elements of finance leases	(3)	(4)	(3)	(2)	(3)	(3)	(3)	(4)	(4)	(4)	(4)	(5)	**(42)**
PDC dividend (paid)/refunded	-	-	-	-	-	(1,637)	-	-	-	-	-	(1,638)	**(3,275)**
Net cash generated from/(used in) financing activities	**(430)**	**(37)**	**(39)**	**(39)**	**(872)**	**146**	**86**	**94**	**231**	**(35)**	**(90)**	**(1,111)**	**(2,096)**
Increase/(decrease) in cash and cash equivalents	**119**	**(105)**	**(26)**	**15**	**23**	**(67)**	**1,764**	**696**	**(401)**	**2,200**	**(2,291)**	**(1,573)**	**354**
Cash and cash equivalents at start of period	1,201	1,320	1,215	1,189	1,204	1,227	1,160	2,924	3,620	3,219	5,419	3,128	**1,201**
Closing Cash and Cash equivalents less bank overdraft	**1,320**	**1,215**	**1,189**	**1,204**	**1,227**	**1,160**	**2,924**	**3,620**	**3,219**	**5,419**	**3,128**	**1,555**	**1,555**
Forecast cash position as per original plan	1,160	1,881	1,609	2,135	1,313	1,160	2,924	3,620	3,219	5,419	3,128	1,555	**1,555**
Actual cash position	1,320	1,215	1,189	1,204	1,227	1,160	2,924	3,620	3,219	5,419	3,128	1,555	**1,555**
Variance	**(160)**	**666**	**420**	**931**	**86**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Warrington and Halton Hospitals NHS Foundation Trust **Appendix 4**

2017/18 Capital Programme

Proposed Amendments

Description	Approved Programme	Approved Amendments M1 - M4	Proposed Amendments M5	Revised Programme
Trust Funded Schemes	**£000**	**£000**	**£000**	**£000**
Estates				
Backlog - Replace emergency back-up generators	300	0	0	300
Backlog - All areas, lift replacement	250	0	0	250
Staffing	169	0	8	169
Backlog - Emergency Flooring Repairs	150	0	0	150
Fire - Appleton Wing, Fire Damper Second Phase, Installation	100	0	0	100
Backlog - All Wards, upgrade sanitary facilities	100	0	(40)	100
Facilities - Security, Install Galaxy door alarm system with speech dialling link, both sites	100	0	0	100
Backlog - All areas, fixed installation wiring test	50	0	0	50
Backlog - footpath, road and car park surface repairs	150	0	0	150
Backlog - Upgrade BMS system include survey	60	0	0	60
Halton Phase 1 Replace Essential supply switchgear	80	0	0	80
Backlog - Water Safety Compliance	50	0	0	50
Backlog - Appleton Wing, replace 5 No LV changeover switches	40	0	0	40
Six Facet Survey (rolling programme done every year) to include dementia & disability	45	0	0	45
Backlog - Asbestos re-inspection & removals	30	0	0	30
Substations A, B & C Emergency Lighting	20	0	0	20
Halton Endoscopy Essential power supply to rooms 1 & 2	20	0	0	20
Backlog - Air Conditioning / Cooling Systems upgrade. Phase 1 - Survey	10	0	0	10
Warrington Wards A1-A4 & A7 Replace Emergency Bus Bar Switch	10	0	0	10
Halton and Warrington Improvements to internal and external wayfinding	10	0	6	10
Automatic sliding / entrance doors across all sites	30	0	0	30
External Fire Escapes Replace (Kendrick & Appleton)	40	0	0	40
Halton Phase 2 - Emergency lighting to Ward B4	25	0	0	25
Estates Minor Works	65	0	(40)	65
Infrastructure for IT Network - Halton		0	0	0
High Voltage Maintenance		0	0	0
Server Room UPS Alarm		0	0	0
Co2 Fire Supression System - Phase 1 Sub 1		0	0	0
Fixed Electrical Testing - A Wards		0	0	0
Changeover Switchgear - Halton Phase II		0	0	0
Fire Dampers, Ihr Fire Walls - Halton Phase II		0	0	0
Endoscopy Area (Improvement Works)		0	0	0
Wards A2 & A7 Re-instate Sluices		0	0	0
Fire Doors 1 Hr Fire Walls Halton Phase 2		0	0	0
Kendrick Wing Emergency		0	0	0
Installation of Dishwashers	0	79	0	79
Integrated Discharge Hub	0	60	0	60
Move CCU to Wrad A3	0	748	10	748
Removal of redundant chillers - Croft Wing	0	0	30	0
CMTC Compressor & Chiller Replacement	0	0	26	0
Cheshire House Refurbishment (IM&T Team)	0	0	60	0
	1,904	**887**	**60**	**2,791**
Medical Equipment				
AER Machines (4 W 2 H)	700	0	0	700
LifePak Defibrillators	82	0	0	82
Spacelabs Monitoring System	188	0	0	188
Warrington MRI Scanner (Upgrade)	800	(800)	0	0
Operating Tables	50	0	0	50
Cell Saver	15	0	0	15
Diathermy Energy Systems	9	0	0	9
ECG stress test system	32	0	0	32
Replacement Laboratory Autoclaves	0	0	0	0
Image Intensifier x 2	150	0	0	150
Mobile X Ray Machine	90	0	0	90
Anaesthetic Monitor	35	0	0	35
Diathermy Energy Systems x2	55	0	0	55
Theatre equipment - Operating Lights		0	0	0
ICU Ventilators x3	104	0	0	104
Sonosite Machine	20	(20)	0	0
New Born Hearing System	8	(8)	0	0
CTG Machines	16	(16)	0	0
CMTC CT Scanner (Deferred)		0	0	0
Spacelabs Telemetry [16/17]		0	0	0
Mammography DR System		0	0	0
Pathology - Anaerobic Cabinet		0	0	0
Radiology - DEXA Scanner (Dental) Room		0	0	0
Theatre Equip - Induction Machines		0	0	0
Theatre Equip - Operating Theatre Lights		0	0	0
Theatre Equip - Diathermy (x2)		0	0	0
Radiology - Reporting room refurbishment		0	0	0
Blood Fridge (Halton)	0	10	0	10
V60 Non-Invasive Bipap Ventilators x 2	0	0	25	0
	2,354	**(834)**	**25**	**1,520**
IM&T				
DR SAN upgrade inc. review of Warrington	156	0	0	156
Desktop refresh and developments	233	0	0	233
UPS Phase 2	38	0	0	38
CMTC resilient link (VOIP and data)	18	0	0	18
Replace anti-virus software	24	0	24	24
NHSmail 2	30	0	0	30
Network upgrade for SAN (Warrington and Halton)	38	0	0	38
Replace Ormis with Lorenzo Theatres	147	0	(147)	147
ePR optimisation	442	0	0	442
Procurement of Lorenzo work list activity	95	0	0	95
Implementation of policy app to ensure use on Windows devices	80	(80)	0	0
Medicode Licences	65	0	0	65
Virtual Servers		0	0	0
Theatres IT - ORMIS		0	0	0
VOIP		0	0	0
MOLIS		0	0	0
CostMaster Software		0	0	0
Lorenzo EPR Phase 2		0	0	0
Network Resilience - UPS Comms		0	0	0
Desktops & Tablets		0	0	0
RTT (Referral to Treatment)		0	0	0
VDI Proposal (Phase 1)	0	78	0	78
Datxi Software	0	0	0	0
	1,366	**(2)**	**(123)**	**1,364**
Contingency	**376**	**(51)**	**38**	**325**
Total (Trust funded schemes)	**6,000**	**0**	**0**	**6,000**
Externally funded schemes				
Primary Care Streaming (PDC)	0	1,000	0	1,000
Delamere Centre (Can Treat) Enhancements (Charitable)	0	84	0	84
LifePak 15 Defib x1 (HEE)	0	19	0	19
Total (Externally funded schemes)	**0**	**1,103**	**0**	**1,103**
Grand Totals	**6,000**	**1,103**	**0**	**7,103**

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/98 (b)**	
SUBJECT:	**Safe Staffing Assurance Report**	
DATE OF MEETING:	27th September 2017	
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**	
AUTHOR(S):	John Goodenough – Deputy 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):	BAF2.2: Nurse Staffing	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.1: CQC Compliance for Quality	
STRATEGIC CONTEXT	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.	
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when actual falls below 90% of planned staffing levels.	
RECOMMENDATION:	It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

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NHS Foundation Trust

Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during July & August 2017. It is forms part of the expectation set out in the National Quality Board (NQB) guidance published in November 2013 that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery.

All Trusts are to submit staffing data to NHS England via the Unify Safe Staffing return and provide assurance to the Board of Directors via the Chief Nurse.

The safer staffing data consists of the actual numbers of hours worked by registered nursing and health care support staff on a shift by shift basis, measured against the numbers of planned hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill of 90% and over is considered acceptable nationally.

The July & August Trust wide staffing data was analysed and cross referenced for validation by Divisional Matrons and Divisional Associate Director of Nurses.

Appendix 1 & 3 identifies the fill rates for staff across the Trust with Care Hours Per Patient Day (CHPPD) for July & August 2017 respectively. The table also triangulates this information by illustrating the harms reported within each area.

Appendix 2 & 4 identifies the mitigating actions taken in July & August respectively in areas where the actual numbers of registered nurses and health care support staff were below 90% of the planned numbers of staff. This report demonstrates the monthly CHPPD per ward across the Trust and provides assurance of the divisional actions taken to provide adequate staffing levels on a day to day / shift by shift basis.

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Appendix 1 **MONTHLY SAFE STAFFING REPORT –July 2017**

Monthly Safe Staffing Report – July 2017

	Day		Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night				
Division	Ward	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Falls (Mod and Above)	Cdiff	MRSA	Pressure Ulcers
		= above 100%		= above 90%			= above 80%			= below 80%							
SWC	SAU	930	877.5	697.5	631	94.4	90.5	0	0	0	0	-	-				
SWC	Ward A5	1782.5	1479.5	1314	1134	83.0	86.3	1069.5	989	713	690	92.5	96.8				1
SWC	Ward A6	1782.5	1420.5	1426	1663	79.7	116.6	1069.5	954.5	713	701.5	89.2	98.4				
SWC	Ward C22	1069.5	1058	1069.5	966	98.9	90.3	713	713	713	713	100.0	100.0	1			
SWC	Ward B4	762	609.5	520.5	376	80.0	72.2	241.5	218.5	241.5	218.5	90.5	90.5				
SWC	Ward A9	1782.5	1410.5	1426	1489.5	79.1	104.5	1069.5	1046.5	1069.5	1069.5	97.8	100.0				
SWC	Ward B1	1552.5	1477	954.5	904	95.1	94.7	713	713	713	667	100.0	93.5				
SWC	Ward B11	1935.2	1935.2	784.2	773.8	100.0	98.7	1616.8	1616.8	0	0	100.0	-				
SWC	NCU	1782.5	1511	356.5	293.5	84.8	82.3	1782.5	1380	356.5	264.5	77.4	74.2				
SWC	Ward C20	954.5	954.5	667	652	100.0	97.8	705	713	0	0	101.1	-		1		
SWC	Ward C23	1426	1230	713	563.5	86.3	79.0	713	713	713	621	100.0	87.1				
SWC	Delivery Suite	2495.5	2294	363.5	349	91.9	96.0	2495.5	2438	356.5	333.5	97.7	93.5				
ACS	Ward A1	2325	1857.5	1550	1550	79.9	100.0	1953	1543.5	651	672	79.0	103.2				
ACS	Ward A2	1426	1158	1594	1404.5	81.2	88.1	1069.5	1039	713	828	97.1	116.1				
ACS	Ward A3	1426	1195.5	1426	1725.5	83.8	121.0	1069.5	977.5	713	1035	91.4	145.2	1		1	
ACS	Ward A4	1197	1164	1529.5	1443	97.2	94.3	920	862.5	1069.5	1023.5	93.8	95.7				
ACS	Ward A8	1782.5	1327	2139	1730.5	74.4	80.9	1069.5	1046.5	1782.5	1368.5	97.8	76.8				
ACS	Ward B12	1069.5	1010	2495.5	2273	94.4	91.1	713	713	1426	1426	100.0	100.0				1
ACS	Ward B14	1426	1318.5	1426	1985.5	92.5	139.2	713	713	713	1437.5	100.0	201.6				
ACS	Ward B18	1426	1255	1426	1398.5	88.0	98.1	1069.5	885.5	1069.5	977.5	82.8	91.4				
ACS	Ward A7	1782.5	1573.5	2035.5	1787.5	88.3	87.8	1426	1378.5	1782.5	1357	96.7	76.1				

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ACS	Ward C21	1069.5	1069.5	713	1106	100.0	155.1	713	713	713	988.9	100.0	138.7				1
ACS	CCU	1782.5	1338.25	372	272.5	75.1	73.3	1069.5	1030.5	0	0	96.4	-				
ACS	ICU	4991	4807	1069.5	609.5	96.3	57.0	4991	4830	713	356.5	96.8	50.0				

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Appendix 2

July 2017 Mitigating Actions

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
Ward A5	83.0	86.3	92.5	96.8	All vacancies currently being recruited to. Long term sickness managed as per policy. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
Ward A6	79.7	116.6	89.2	98.4	All vacancies currently being recruited to. Long term sickness managed as per policy. Several enhanced care patients throughout the month. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
Ward B4 - Halton	80.0	72.2	90.5	90.5	Risk assessment undertaken by Matron and Lead Nurse – staff moved as appropriate to ensure safety.
Ward A9	79.1	104.5	97.8	100.0	Enhanced care required throughout the full month. RN vacancies currently being recruited to. Daily cross divisional

					staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
NSC - Neonatal Unit	84.8	82.3	77.4	74.2	All vacancies currently being recruited to. Long term sickness managed as per policy. Not BAPM compliant, but currently all vacancies available are recruited into. Maternity Leave not backfilled (2.5 wte).
Ward C23	86.3	79.0	100.0	87.1	All vacancies currently being recruited to. Long term sickness managed as per policy. Staff used flexibly from other areas during periods of escalation.
A1	79.9	100.0	79.0	103.2	All vacancies currently being recruited to. Long term sickness managed as per policy. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
A2	81.2	88.1	97.1	116.1	Ward has AP to support the RN's manage the care of the patients during the week. All shifts out on NHSP and staff moved across the division to support when possible.
A3 OPAL	83.8	121.0	91.4	145.2	A3 have reduced their bed numbers from 34 to 29 for a trial period due to large gaps in establishment. Over established on CSW to support the care

					needs of the patients.
A8	74.4	80.9	97.8	76.8	Increased acuity in month and ward has increased number of bays requiring enhanced care- ward reliant on temporary staffing, to support RGN vacancies which are being addressed by recruitment and retention campaign. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
B18	88.0	98.1	82.8	91.4	Short term sickness in month, managed in line with policy. Qualified staff moved to ensure safety in other areas after risk assessment by lead nurse and matron.
A7	88.3	87.8	96.7	76.1	All vacancies currently being recruited to. Long term sickness managed as per policy Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
CCU	75.1	73.3	96.4	0	3 RN on maternity leave , vacancies filled due to start end of August
ICU	96.3	57.0	96.8	50.0	Increased capacity of unit. Recruited into some of the posts and back out to advert. Supported by Band7 and Lead Nurse. Health Care Support Worker short term sickness in

					month managed in line with policy. Regular Lead Nurse visits for support to the Unit.

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Monthly Safe Staffing Report – August 2017

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night				
Division	Ward	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Falls (Mod and Above)	Cdiff	MRSA	Pressure Ulcers
		= above 100%		= above 90%			= above 80%			= below 80%							
SWC	SAU	930	930	697.5	465	100.0	66.7	0	0	0	0	-	-				
SWC	Ward A5	1426	1409.5	1069.5	1114	98.8	104.2	1069.5	1058	713	747.5	98.9	104.8				
SWC	Ward A6	1782.5	1439.5	1069.5	1137.5	80.8	106.4	1069.5	1012	713	713	94.6	100.0				
SWC	Ward C22	1069.5	793.5	1035	1069.5	74.2	103.3	713	713	713	713	100.0	100.0				
SWC	Ward B4	788.9	781.7	536	528	99.1	98.5	356	241.5	356	241.5	67.8	67.8				
SWC	Ward A9	1782.5	1398.5	1426	1458.5	78.5	102.3	1069.5	989	1069.5	1069.5	92.5	100.0				
SWC	Ward B1	1552.5	1394	977.5	907	89.8	92.8	713	701.5	713	644	98.4	90.3				
SWC	Ward B11	1874.8	1726.5	853	821.1	92.1	96.3	1465.4	1312.6	0	0	89.6	-				
SWC	NCU	1782.5	1509.5	356.5	253	84.7	71.0	1782.5	1426	356.5	253	80.0	71.0				
SWC	Ward C20	966	931.6	713	644	96.4	90.3	713	713	0	0	100.0	-				
SWC	Ward C23	1426	1272.5	713	563.5	89.2	79.0	713	713	713	494.5	100.0	69.4				
SWC	Delivery Suite	2495.5	2388	356.5	306	95.7	85.8	2495.5	2438	356.5	333.5	97.7	93.5				
ACS	Ward A1	2325	1825	1550	1550	78.5	100.0	1953	1543.5	651	693	79.0	106.5	1			
ACS	Ward A2	1426	1082	1506.4	1289.8	75.9	85.6	1069.5	943	713	782	88.2	109.7		1		
ACS	Ward A3	1426	1068.5	1426	1751.5	74.9	122.8	1069.5	885.5	713	1516.5	82.8	212.7				
ACS	Ward A4	1159.5	1011.5	1426	1399.5	87.2	98.1	736	736	1046.5	1058	100.0	101.1				
ACS	Ward A8	1782.5	1203.5	2139	1805.5	67.5	84.4	1069.5	1023.5	1782.5	1299.5	95.7	72.9				1
ACS	Ward B12	1069.5	1052.5	2426.5	2200.25	98.4	90.7	713	713	1426	1445	100.0	101.3				
ACS	Ward B14	1426	1138.5	1426	1870.5	79.8	131.2	713	713	713	1383.5	100.0	194.0				2
ACS	Ward B18	1426	1195.92	1418.5	1314.58	83.9	92.7	1069.5	782	1069.5	1035	73.1	96.8				1

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ACS	Ward A7	1782.5	1449	2104.5	1764.5	81.3	83.8	1426	1288	1817	1357	90.3	74.7				1
ACS	Ward C21	1069.5	1069.5	713	1105.5	100.0	155.0	713	713	713	977.4	100.0	137.1				1
ACS	CCU	1426	1264	356.5	261	88.6	73.2	1069.5	996	0	0	93.1	-				
ACS	ICU	4991	4611.5	1069.5	626	92.4	58.5	4991	4623	713	356.5	92.6	50.0		1		1

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Appendix 4

August 2017 Mitigating Actions

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	
SAU	100.0	66.7	0	0	Unit closes at 22:00. HCA sickness currently being monitored via the sickness/ absence policy. Regular visits / support by Matron and Lead Nurse.
Ward A6	80.8	106.4	94.6	100.0	Extra HCAs booked for enhanced care. All vacancies currently being recruited into. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting. Staff moved across the division to ensure ward safety
Ward C22	74.2	103.3	100.0	100.0	Extra HCA s booked for enhanced care. Ward fully established. Staffing reduced due to sickness. Long term sickness currently monitored by Trust Sickness/Absence policy.
Ward B4 - Halton	99.1	98.5	67.8	67.8	Staffing levels will flex according to activity. The ward has closed overnight over the weekends.
Ward A9	78.5	102.3	92.5	100.0	3 full time RN vacancies to be filled September 2017. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to

					mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
B1 HICU	89.8	92.8	98.4	90.3	Staffing short fall in month due to vacancy, daily review by matron and lead nurse.
NSC - Neonatal Unit	84.7	71.0	80.0	71.0	All vacancies currently being recruited to. Long term sickness managed as per policy. Not BAPM compliant, but currently all vacancies available are recruited into. Maternity Leave not backfilled (2.5 wte). Ward manager supporting activity when required
Ward C23	89.2	79.0	100.0	69.4	Staffing shortfalls due to long and short term sickness and support carer vacancies which are now filled. Staff flexed around the unit to meet acuity.
Delivery Suite	95.7	85.8	97.7	93.5	Staffing flexed across the maternity unit to support acuity on delivery suite when staff shortages occur.
A1	78.5	100.0	79.0	106.5	AP or TAPs to support the RNs on shift, matron supporting clinically when needed. Pharmacy techs on ward to support with administering medications across the ward.
A2	75.9	85.6	88.2	109.7	AP on during the week to support the management of the patients in the bays, Ward manager to cover shifts. All shifts out to agency and escalated when needed
A3 OPAL	74.9	122.8	82.8	212.7	Bed base reduced down to 29 patients. Ward manager and matron supporting clinically when needed. Extra CSW shifts out to support the RN staff.
A4	87.2	98.1	100.0	101.1	Ward escalated to 26 patients, criteria being met on admission to the ward. Ward manager supports clinically during the day. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill

					identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
A8	67.5	84.4	95.7	72.9	Staffing short fall in month due to vacancy, daily review by matron and lead nurse. Enhanced care required daily reliant on temporary staffing. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting.
B14	79.8	131.2	100.0	194.0	Vacancies in month increased due to promotion in trust, patient requiring 1:2 reliant on temporary staffing. Daily review of staffing by matron and lead nurse.
B18	83.9	92.7	73.1	96.8	Sickness in month managed in policy. Ward staffing assessed and reviewed daily by matron and lead nurse, staffing moved after review of acuity to support other areas.
A7	81.3	83.8	90.3	74.7	Increase in establishment - Band 6 post to be filled – recruitment underway. Increased enhanced care patients. Daily cross divisional staffing meeting at 11:45 where Trust wide staffing template populated. Cross cover and backfill identified initially within division with wider organisation considered after to mitigate risk. Staffing levels reviewed again following the 4pm capacity & flow meeting. Shortfalls supported by senior team & Matron.
CCU	88.6	73.2	93.1	0	Reduced RN numbers due to vacancies and maternity leave x 3 .

					Vacancies filled and staff in post. Shortfall of staff supported by Matron and C21 staffing.
ICU	92.4	58.5	92.6	50.0	Staff vacancies, actively recruiting into posts. Supported by Lead nurse.

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/98 (c)**
SUBJECT:	**Engagement Dashboard August 2017**
DATE OF MEETING:	27 September 2017
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Pat McLaren Director of Community Engagement + Corp Affairs
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Corp Affairs Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.4: Engaging & Involving Workforce
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The Trust is required to engage with its patients, public, staff and partners and many other stakeholders as set out in the Foundation Trust's membership and engagement strategy.
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high-level overview of how well the Trust is engaging and involving key stakeholder groups i.e. those who use, work, visit, volunteer, support, commission, partner or donate to our hospitals. It shows clear trends and progress against our key communication and engagement objectives. **Media dashboard:** • Volumes were high in month with positive national reporting of the Halton Healthy New Town design challenge which exceeded readership of >10m, the WHHCharity Dragon Boat event and our A&E nurse who is also a Royal Navy reservist. • Most negative reporting related to revival of an historic report by the Daily Mail relating to A&E closures, an eventer who suffered a riding accident and actions relating to a former Trust director. • Positive and neutral media totalled 69% of all reporting. **Social Media:** • Twitter followers continue to climb at circa 500 per month • Tweets and reach were both down in month as expected for August • Facebook engagement similarly remains steady at 4.2K likes per month • Posts and reach were both down in month as expected but page views were up by 18% with the Live Waiting times on website launch.

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	Website whh.nhs.uk • The Trust's website continued to receive circa 25K visitors but with a large increase in social media referrals linked to the publication of live website data on the home page. • Average dwell time continues low at 1m30s which we believe is due to the site not being mobile enabled • 70% of all visitors to the website used mobile devices (mobile, tablet) • We commenced the new website procurement exercise in month via competitive commercial tender. **Staff Engagement** • Attendances at Team Brief continue variable across all CBUs as are overall attendances. • The revised communications and engagement plan for 2017-18 is addressing this • Alternatives are being found for Halton site which is seeing reduced engagement. **Patient Engagement** • We were pleased to launch our new Friends and Family test via text message and automated voice call in addition to paper methodology in month. Response rates rose to more than 3K in month, 10x usual rates. • Many services received both high responses and high ratings • Staff attitude was the most positive theme followed closely by implementation of care • Patient feedback via Health Watch Warrington and Health Watch Halton local websites for all three hospitals is growing and we were pleased to note Halton Hospital reaching 4.5* while CMTC and Warrington received an average of 4*	
RECOMMENDATION:	The Board is asked to note the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

Media Sentiment 1 – 31st August 2017

Total Media Coverage = 123 Reports
(↑from 78 last month)

Date	Headline	Publication	Reach	Sentiment
1-Aug-2017	reveals exactly how long patients have to wait before they can go home (so, how long can you expect to wait	Daily Mail Online	51,793,875	Negative
26-Aug-2017	Eventer who broke her neck issues plea to those competing alone	Horse & Hound	244,922	Negative
18-Aug-2017	Hospital theatre staff in North East to go on strike over weekend working deal	Nursing Times	213,395	Negative
16-Aug-2017	Warrington Hospital's theatre staff will strike this weekend over four-year dispute - number of operations set to be cancelled	Warrington Guardian	45,756	Negative
25-Aug-2017	REVEALED: The number of operations cancelled due to strike action at Warrington Hospital	Warrington Guardian (eClips Web)	45,756	Negative
22-Aug-2017	Warrington Hospital ward evacuated following fire in early hours	Warrington Guardian (eClips Web)	45,756	Negative
16-Aug-2017	Warrington Hospital's theatre staff will strike this weekend over four-year dispute - number of operations set to be cancelled	Warrington Guardian	45,756	Negative
16-Aug-2017	Warrington Hospital staff will strike this weekend over four-year dispute - number of operations set to be cancelled	Warrington Guardian (eClips Web)	45,756	Negative
15-Aug-2017	Woman suffers neck injury after falling from horse during event at equestrian centre	Warrington Guardian	45,756	Negative
14-Aug-2017	Woman suffers neck injury after falling from horse at equestrian centre	Warrington Guardian	45,756	Negative
12-Aug-2017	Former Warrington Hospital director Roger Wilson referred to the Care Quality Commission over involvement in deaths of 11 babies and one mum at Furness General Hospital	Warrington Guardian	45,756	Negative
5-Aug-2017	Mum-of-five Jan Faulkner's warning after suffering serious health problems due to Essure procedure	Warrington Guardian	45,756	Negative
14-Aug-2017	Protestors want bridge tolls scrapped	Runcorn and Widnes World	13,388	Negative
1-Aug-2017	Expect a 2 hour 24 minute trip to A&E: Official data reveals exactly how long patients have to wait before they can go home (so, how long can you expect to wait at your nearest?)	Mail On Sunday	8,455	Negative
2-Aug-2017	Expect a 2 hour 24 minute trip to A&E	Health Medicine Network	5,999	Negative
26-Aug-2017	Eventer who broke her neck issues plea to those competing alone	Horseweb.de [EN]	252	Negative
22-Aug-2017	UK families could get money off shopping bills if they hit exercise goals	The Guardian	4,881,227	Positive
22-Aug-2017	UK families could get money off shopping bills if they hit exercise goals	Yahoo! News UK	3,697,765	Positive
22-Aug-2017	Designers chosen to reshape Runcorn as a 'healthy new town'	Liverpool Echo (eClips Web)	1,550,771	Positive
3-Aug-2017	Dad-of-one picks up gold at British Transplant Games a year after life-saving liver operation	Warrington Guardian (eClips Web)	46,827	Positive
23-Aug-2017	Hospital issues plea for former patients to return crutches and walking sticks	Warrington Guardian (eClips Web)	45,756	Positive
24-Aug-2017	Matron on hospital's children's ward retires after more than 30 years of caring for poorly young patients	Warrington Guardian (eClips Web)	45,756	Positive
22-Aug-2017	Hospital patient funds ward equipment by asking friends to donate money instead of buying her birthday presents	Warrington Guardian (eClips Web)	45,756	Positive
19-Aug-2017	MP and hospital boss discuss potential challenges posed by local plan	Warrington Guardian	45,756	Positive
17-Aug-2017	Very thankful	Warrington Guardian	45,756	Positive
17-Aug-2017	Footballers hoping to raise £20,000 for coach James 'Jimmy' Hayes' treatment following cancer diagnosis	Warrington Guardian	45,756	Positive
16-Aug-2017	Meet Warrington Hospital A&E nurse Alex McEnaney, who combines his role in the department with serving in the Royal Navy Reserves	Warrington Guardian	45,756	Positive
14-Aug-2017	Warrington Hospital programme sees 1,000 primary school pupils given tips to keep heart healthy in six months	Warrington Guardian	45,756	Positive
10-Aug-2017	Angels at work	Warrington Guardian	45,756	Positive
10-Aug-2017	Aidan Dickenson holds supercar show at Stretton Fox for baby loss charity Harry & Co in memory of stillborn daughter Lilly-Rose	Warrington Guardian	45,756	Positive
9-Aug-2017	Rowers raise nearly 20,000 for new children's play area at Warrington Hospital	Warrington Guardian (eClips Web)	45,756	Positive
23-Aug-2017	El NHS podría ofrecer premios y descuentos por cumplir objetivos de ejercicio saludables	El Ibérico	30,965	Positive
22-Aug-2017	International design challenge reveals how Runcorn's trailblazing healthy new town could look	Runcorn and Widnes World (eClips Web)	13,388	Positive
29-Aug-2017	Children's matron retires after almost 30 years	Runcorn and Widnes World (eClips Web)	13,388	Positive
28-Aug-2017	Patient donates specialist blood pressure monitor to thank hospital staff for 'wonderful care'	Runcorn and Widnes World (eClips Web)	13,388	Positive
28-Aug-2017	Patients asked to return crutches in walking aid amnesty	Runcorn and Widnes World (eClips Web)	13,388	Positive
22-Aug-2017	International design challenge reveals how Runcorn's trailblazing healthy new town could look	Runcorn and Widnes World (eClips Web)	13,388	Positive
29-Aug-2017	NHS invites retailers to join new health programme	Convenience Store	13,353	Positive
23-Aug-2017	Free bikes for residents suggested by NHS competition winner	The Planner	9,078	Positive
22-Aug-2017	People to get discounts off shopping in exchange for exercising	Health Business	1,475	Positive
22-Aug-2017	UK families could get money off shopping bills if they hit exercise goals	24 365 News	385	Positive

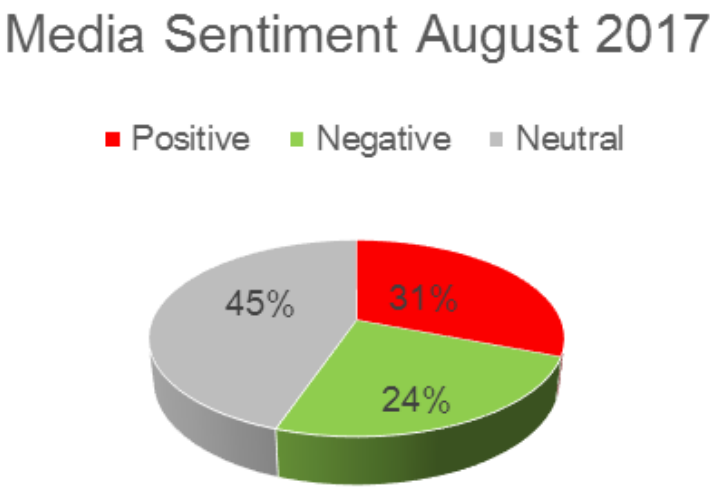
Designers chosen to reshape Runcorn as a 'healthy new town'

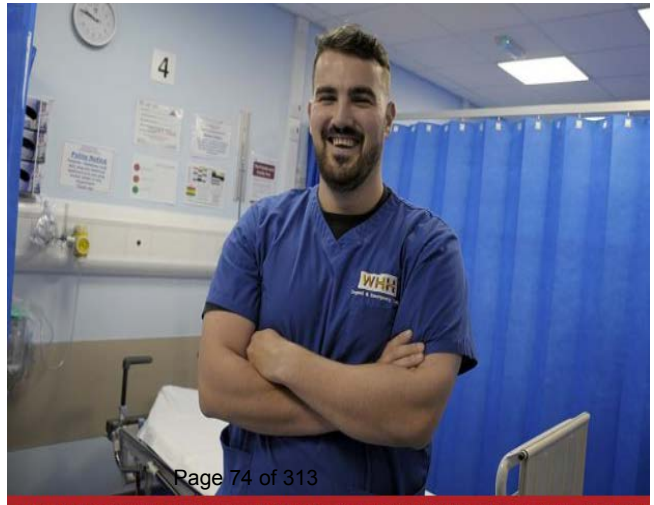
Warrington Hospital launches walking aid amnesty

Adam Everett
Reporter

Warrington Hospital has launched on amnesty for unused crutches and walking sticks.

CMTC will be at the heart of the new health and wellbeing campus

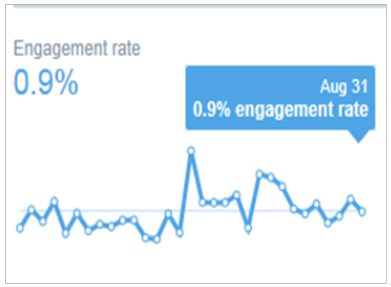


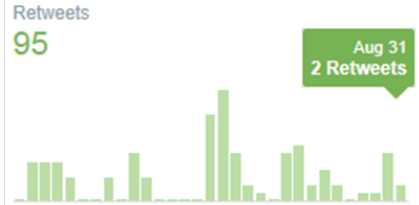


Alex McEnaney, an A&E nurse at Warrington Hospital who also serves as a Navy reservist

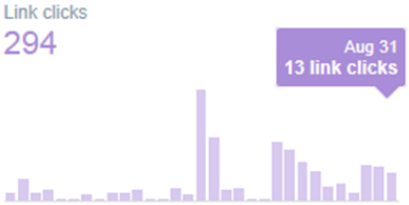
Children's matron retires after more than 30 years

Warrington&HaltonNHS @WHHNHS · Aug 22
You can now check our LIVE waiting times for Halton Urgent Care Centre and Warrington A&E department here: ow.ly/mKK430evgzX





On average, you earned **3 Retweets** per day



On average, you earned **9 link clicks** per day

On average, you earned **5 likes** per day

Twitter

8,572 Followers (Last month: 8,506)

31 WHH Tweets (Last month: 73)

69.3K Reach (Last month: 99.9K)

Top Tweet earned 3,300 impressions

Jaqui Rostron,Paediatric A&E Nurse receives her Commended Nurse of the Year badge from our Chief Nurse Kimberley Salmon Jamieson.Well done pic.twitter.com/9CVi4cxMye

Warrington and Halton Hospitals NHS Foundation Trust — Like Page
Published by Hootsuite [?] · 22 August at 11:50 ·
You can now check our LIVE waiting times for Halton Urgent Care Centre and Warrington A&E department on our website here: http://ow.ly/mKK430evgzX

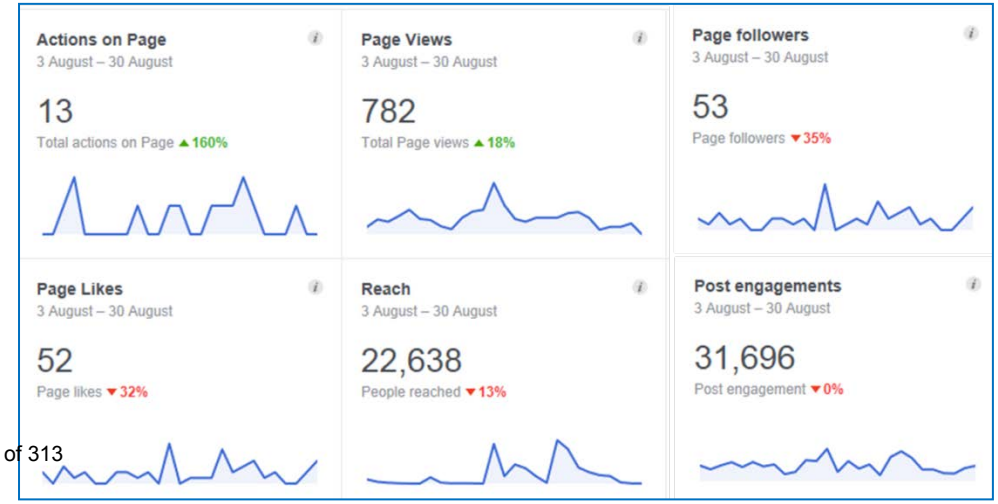
Published	Post
31/08/2017 08:30	Today is International Overdose Awareness Day. Do you know what an overdose looks like? Read t
25/08/2017 09:40	Our walking aid amnesty will be launched on Frida y 1st September 2017 and are asking patients to r
24/08/2017 11:50	Jonathan Casteel works in our Charity office as ou r Charity Administrator. Jonathan would like to sha
23/08/2017 17:59	Launching on September 1st, drop your metal wal king aids off in our drop off bays. Help us reduce
23/08/2017 08:00	Our new style hospital newspaper 'Your Hospitals' summer edition is now out - with information aroun
22/08/2017 14:59	We are looking to improve your experience of our hospitals and we need you! Come along to our firs
22/08/2017 11:50	You can now check our LIVE waiting times for Hal ton Urgent Care Centre and Warrington A&E depa
18/08/2017 11:50	Did you know about your pregnancy working right s. Take our survey here: http://ow.ly/33AP30e2b9

Facebook

4,258 Total Likes (Last month: 4219)

13 WHH Posts (Last month: 26)

3.8K Reach (impressions) (Last month: 14.4K)



Website Dashboard

Website

WHH

25,273 Visits

Last month: 25,161

1600 Social Media Referrals

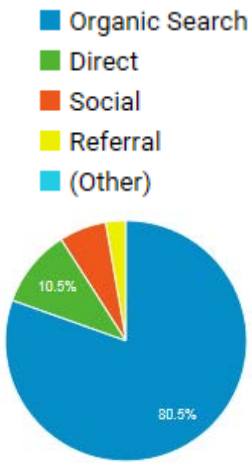
Last month: 513

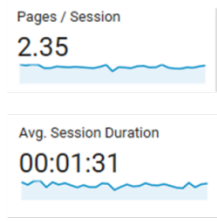
1min 31s Length of average time

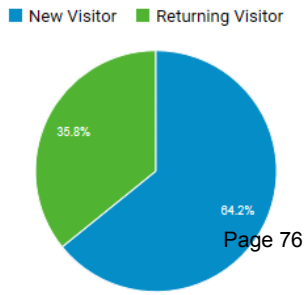
Last month: 1.36s

Device Category	Sessions	% New Sessions
	25,273 % of Total: 100.00% (25,273)	64.18% Avg for View: 64.17% (0.01%)
1. mobile	**14,046** (55.58%)	60.91%
2. desktop	**7,639** (30.23%)	72.76%
3. tablet	**3,588** (14.20%)	58.70%

Mobile Device Info	Sessions	% New Sessions
	17,634 % of Total: 69.77% (25,273)	60.46% Avg for View: 64.17% (-5.79%)
1. Apple iPhone	**7,516** (42.62%)	60.05%
2. Apple iPad	**2,281** (12.94%)	61.16%
3. Samsung SM-G920F Galaxy S6	**591** (3.35%)	57.53%
4. Samsung SM-G930F Galaxy S7	**554** (3.14%)	59.39%
5. Samsung SM-G935F Galaxy S7 Edge	**542** (3.07%)	56.27%
6. (not set)	**424** (2.40%)	68.16%
7. Microsoft Windows RT Tablet Windows RT Tablet	**409** (2.32%)	32.76%
8. Samsung SM-G925F Galaxy S6 Edge	**249** (1.41%)	55.42%
9. Apple iPhone 6s	**205** (1.16%)	71.71%
10. Samsung SM-G950F Galaxy S8	**191** (1.08%)	58.12%





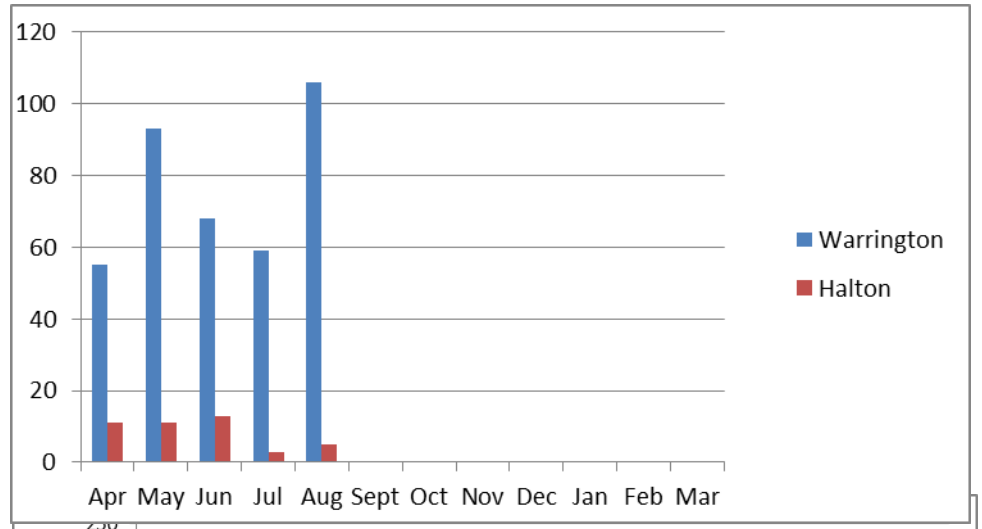


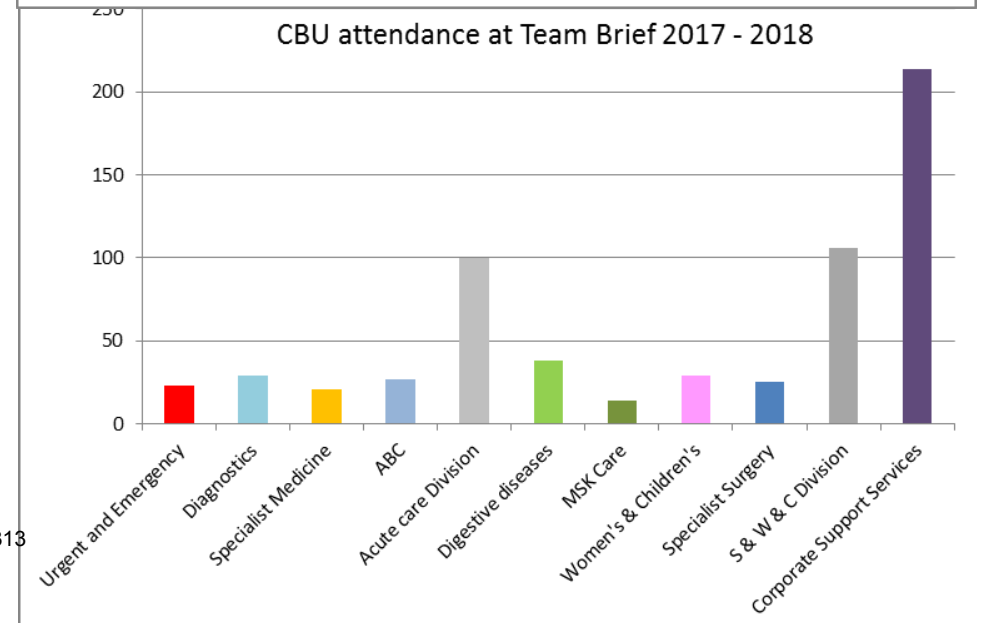
Staff Engagement

We are WHH

Team Brief Attendances

Staff engagement with Team, delivered at two sites on two separate days following Board each month, has got off to a challenging start in 2017-18. Additional programmes are being implemented to drive this engagement. Team Brief is a proven large, multi-site organisation engagement tool.





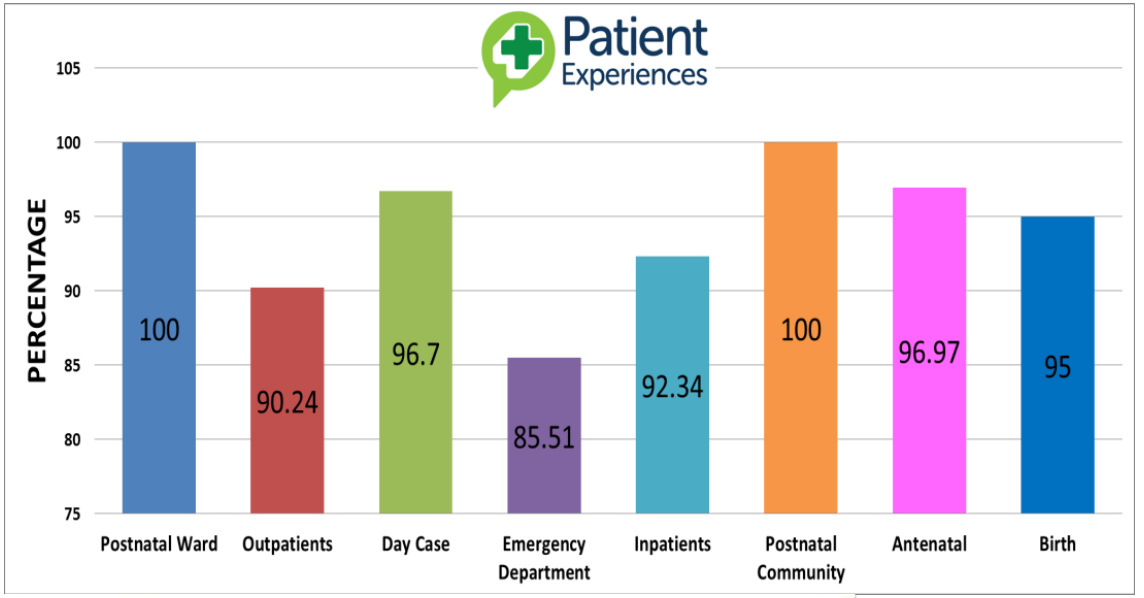
Patient Engagement/Experience 1 – 31st August 2017

Average Rating by NHS Choices

3.5
Average rating at Warrington
Last month: 3.5

5
Average rating at Halton
Last month: 5

4.5
Average rating at CMTC
Last month: 5



Top 10 Themes

	+ Positive		− Negative	
1.	Staff attitude	2709	Staff attitude	198
2.	Implementation of care	1726	Waiting time	169
3.	Environment	930	Environment	155
4.	Waiting time	876	Implementation of care	127
5.	Communication	710	Communication	109
6.	Patient Mood/Feeling	557	Patient Mood/Feeling	90
7.	Clinical Treatment	533	Clinical Treatment	90
8.	Admission	490	Admission	85
9.	Staffing levels	109	Staffing levels	28
10.	Catering	64	Catering	16

healthwatch

Warrington Hospital

Feedback Rating

★★★★☆

Based on 317 reviews

Halton Hospital

Feedback Rating

★★★★½

Based on 57 reviews

CMTC

Feedback Rating

★★★★☆

Based on 8 reviews

93% of the nearly 3,000 patients that responded in August commented on excellent staff attitude.

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/98 (d)**	
SUBJECT:	**Key Issues Report from the Quality Committee 1st August 2017**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Margaret Bamforth, Committee Chair	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	BAF2.2: Nurse Staffing	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the September meeting.	
RECOMMENDATION:	**The Board note the report and that there are no matters arising for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
QUALITY COMMITTEE

Date of meeting:	**1st August 2017**
Standing Agenda Items	Quality Dashboard Board Assurance Framework and Corporate Risk register
Formal Business	This month's key issues report focuses on the positive developments in Quality which include providing safe patient care, improving patient outcomes and ensuring patients have a positive experience. There are no specific concerns to escalate to Board from August's Quality Committee. Of the concerns escalated previously, progress is being made and the Quality Committee are continuing to seek assurance through the governance structures reporting into the Quality Committee. There are concerns, some of them at ward level, which are being closely monitored and managed with actions in place but none were considered necessary to escalate to Board level. The **Quarterly Quality Report** for quarter 1 was presented by Ursula Martin, Deputy Director of Integrated Governance and Quality. This report summarises the work being carried out to ensure that both quality standards are met and quality improvement takes place. It is therefore a positive account that acknowledges the considerable amount of work carried out by Staff across the Trust at all levels to ensure that patients are safe and have a positive experience. The report includes the areas of required statuary reporting, progress against the 9 quality priorities, some of the learning shared across the Trust and concludes with some of the fantastic achievements of members of Staff. The report will feed into the Annual Quality Account. The Committee received the **Serious Incident, Complaints and Inquest Monthly Report** and the **Learning and Experience Quarterly Report.** As well as setting out the number of serious incidents, of which there were 6, it also provides information about the investigations carried out, the trends and the key learning and recommendations. Discussion took place about how this report is being utilised at Divisional and CBU level to drive quality improvement and particularly clinical practice. The Learning from Experience Report then provides the quantitative and qualitative analysis from incidents, complaints and claims and makes recommendations to the CBUs, highlighting areas of improvement. Issues covered in this quarter's report are, falls, pressure ulcers, staffing levels and learning that

	has resulted in improvements in the delivery of Women's Health. One issue that has been identified through the analysis has been a concern about "wrong blood in tube" – where the correct identity of the patient is not identified on the request form or sample tube. Although these were near miss incidents, a trend has been identified and an action plan put in place. This is one example of how learning is being disseminated, although it also demonstrates that there is a need to gather evidence that ensures that the actions put in place have been effective in order to close the loop. The **Mortality Review Quarterly Report** was discussed. Several issues were highlighted in the report, in particular the learning from the secondary and focussed reviews. There have been 12 secondary reviews conducted between April 2017 and June 2017 (4 identified through a screening review and 8 triggered by a SI investigation or complaint). The planned reviews include, Cancer of the Rectum and Anus, Cardiac Dysrhythmias and Fractured Neck of Femur. The action plan from the recent UTI focussed review was included in the report. The draft **Learning from Deaths Policy** was also presented for comments. This policy is still being developed and will come back to next month's Quality Committee. **Tissue Viability Service Review.** This external review, commissioned by the Chief nurse, was conducted by Maureen Benbow, Independent Nursing Consultant. It provides good assurance that the Trust Tissue Viability Service operates at an acceptable level of practice and provides evidence of a good standard of knowledge and expertise in the area of tissue viability. However, there is evidence that the current Tissue Viability Team which consists of two Specialist Nurses assisted by Ken Jukes, Medical Photographer, is very stretched. Recommendations include the development of link nurses and emphasise the importance of working with the community to enhance pressure ulcer prevention. The high level briefing paper from the **Patient Experience Sub-Committee** outlined a number of excellent pieces of work that are currently on-going. Another piece of good news is that the number of volunteers is increasing month on month and now stands at 200. The first **Quarterly Quality Impact Assessment report** was presented and discussed. Of 54 completed QIAs, 5 schemes have recorded a potential adverse impact. These schemes and the potential issues were presented in detail. This report will develop as more schemes become live and will enable the Quality Committee to monitor any adverse impacts. One issue that the Board should be made aware of but which should

	hopefully be resolved in the near future is the difficulty in identifying those patients who present to the Trust who also have significant learning disabilities. The flagging system is not yet in place and on-going work with community colleagues and partner agencies is taking place.
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.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/ 98 e**	
SUBJECT:	**Key Issues Report from the Finance and Sustainability Committee held 23 August 2017**	
DATE OF MEETING:	20 September 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, 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 August meeting.	
RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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KEY ISSUES REPORT
FINANCE AND SUSTAINABILITY COMMITTEE

Date of meeting:	23 August 2017
Standing Agenda Items	The Meeting was quorate. The Minutes of the F&SC of 19 July were approved with one amendment. The Interim Director of HR & OD supported by the Deputy Medical Director presented the Pay Assurance Dashboard alongside a comprehensive and detailed Report. The Nursing Team were not represented. F&SC considered the July position on an overall Trust wide basis, Doctors, Nurses and "AHPs" which cover a multitude of disciplines. Whilst the use of Agency staff and the number of breaches has declined Month on Month in respect of Nursing Staff, the position in respect of Medical Staff over the last 3 Months shows an upward trend. Overall expenditure is on the rise. The Deputy Medical Director advised that the underlying issue remains that of vacancies. In respect of AHPs the position continues to cause concern and it is vital that the steps outlined to address are actioned promptly. Pay for Month 4 was £400k above plan; ytd £1m above plan. The Committee requested that an urgent review is carried out to review compliance with Breach Policies, possibly involving Internal Audit. F&SC signalled the need for an update at its September Meeting. There is much activity being carried out the overall position continues to give cause for concern. In Month 4, the Trust incurred a deficit of £900k against a planned deficit of £400k taking the ytd loss to £3.9m against a planned loss of £3.4m. In order to deliver the loss to date, reserves have been utilised & the delivery of the Annual Plan is now at risk. Capital expenditure to date is £1.9m, some £500k behind plan. F&SC receive a proposal around proposed changes to this years plan, which it supported, subject to final Board Approval. Whilst the cash balance is in line with the terms of our working capital loan agreement, our better payment practice code performance is deteriorating. F&SC received a detailed presentation around activity and income, broken down into elective spells, non-elective spells, outpatient attendances, A&E attendances and other activity. The details compared current year performance against plan alongside the 2016/17 performance and plan. Pay and non-pay costs were then reviewed on a like basis. CBU and Divisional performance was then considered, compared to last Month evidencing there is considerable vital recovery work still needed. F&SC will receive these Reports on a monthly basis for the time being. The F&SC will now escalate the situation to Trust Board, especially around

	potentially an emerging gap in our cash position. For 2017/18, the Trust has a CIP Target of £10.5m, which is built into our Financial Plan. At Month 4 the Trust has delivered CIP, cost avoidance and income recovery to a total of £1.929m against a ytd CIP target of £2.33m. A review of our best case CIP and cost avoidance for the full year suggests a growing gap of some £3.2m against the Target of £10.5m – the gap was previously estimated to be £1.8m. The Committee noted the additional actions taken to support the further development and delivery of this savings programme. This work is part of and complimentary to the programme of work with CBUs and Divisions as already highlighted. A detailed update was provided respect of IM&T activities alongside a paper starting to look at options around equipment replacement and financing options. The Acting Chief Operating Officer presented the Corporate Performance Report for Month 4. In terms of the 4 hour performance, this is currently 92.82% against the agreed trajectory with NHSI of 93.5% for Q2. Patient flow and delayed transfers of care have been especially challenging in August. Ambulance handovers remain difficult at times but our performance compares favourably. It is important to recognise the progress that continues to be made with some spectacular daily performances. The move to Primary Care Streaming remains on track albeit that the main risks are now around workforce and the associated costs. RTT and Diagnostic targets continue to be met. We continue to be on track to deliver cancer indicators. F&SC received an update in respect of the activity around the Delayed Transfer of Care reduction trajectory set by NHSI. The introduction of an Outpatients reminder service is now progressing. A presentation was received around the Costing Transformation Programme & Service Line Reporting. This will be of great assistance in improving understand of service line data. A Paper was brought in respect of the Combined costs process and Committee approval for the 2016-17 submission which F&SC were happy to endorse. The Trust has a very strong track record in this area. Finally a number of Sub Committee Reports were considered.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/98 f**	
SUBJECT:	**Key Issues Report from the Audit Committee held 10 July 2017**	
DATE OF MEETING	**27 September 2017**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Ian Jones, Committee Chair**	
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):	**This report provides a high level summary of business at the January meeting.**	
RECOMMENDATION:	**The Board note the report and the matters arising for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
AUDIT COMMITTEE

Date of meeting:	**10th July 2017**
Standing Agenda Items	The meeting was quorate. Minutes of the meetings held on 24th April 2017 and 23rd May 2017 were approved as a correct record.
Formal Business	• Internal Audit (MIAA) presented four reports: (1) Significant Assurance was given in respect of Mortality Review (2) Limited Assurance was given in respect of Patient Falls. Audit Committee noted the actions in place to address the identified shortcomings. These actions include the recruitment of a Patient Falls Specialist and a full review of the Trust Policy for Slips, Trips and Falls. The Quality Committee is monitoring progress against the agreed timescales and the underlying trends (3) Limited Assurance was given in respect of the systems and controls to record, grade and monitor incidents which trigger Duty of Candour actions. The main issues related to a shortfall in numbers of staff receiving training and delays in the dissemination of lessons learned. A Head of Patient Safety is to be appointed and the action plan will be monitored against agreed timescales. (4) Limited Assurance was given in respect of a Review of Cancer Data. This review had been commissioned by the Acting COO in response to some inconsistencies coming to light with the Cancer Target data uploads as seen by the CCG. Improvement measures were in course of development, and these will include accuracy and quality checks and improved training. The timescale for the implementation of the improvements is September 2017. • An amendment has been made to the Annual Audit Plan to include a review of Agency and Bank Spending. • The Counter Fraud Annual Report was reviewed and noted. The Committee was reassured that the processes are robust and this was borne out by the low incidence of reportable Fraud during the past 12 months. • Routine business completed at Committee included reviews of (1) Special Payments and Losses (2) Quotations and Tender Waivers and (3) Bad Debt Write-offs. Additionally, an amendment to the Scheme of Reservation and Delegation was approved. • In respect of Tender Waivers a discussion took place about some specific items where it was questionable whether waivers were appropriate. Committee was reassured that the relevant items had all been scrutinised and signed off by the Director of Finance & Commercial Development. Having worked hard, over the past two

	years, to reduce the level of waivers a slightly upwards trend is noticeable recently and this will be monitored to ensure the Trust Policy is adhered to. • Two policies were presented to the Committee for review and ratification. These were (1) a new Disposals and Condemnation of Assets Policy and (2) a refreshed Treasury Management Policy. • In keeping with routine procedures, triangulation of relevant information with the Chairs of Board Committees took place and assurance gained that appropriate monitoring was in place.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/98 (g)**	
SUBJECT:	**Key Issues Report for the Strategic People Committee Held on 21 August 2017**	
DATE OF MEETING:	27 September 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Anita Wainwright, Committee Chair	
EXECUTIVE DIRECTOR SPONSOR:	Choose an item. Choose an item.	
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):	BAF2.1: Engage Staff, Adopt New Working, New Systems	
	BAF2.4: Engaging & Involving Workforce	
	BAF2.2: Nurse Staffing	
STRATEGIC CONTEXT	Strategic People Committee meets bi-monthly. There was a significant number of policies requiring approval for immediate effect.	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the August 2017 meeting.	
RECOMMENDATION:	The Board receives the report and notes the matters identified for escalation.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	
	Date of meeting	21 August 2017
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Key Issues Report – Strategic People Committee

Date of meeting	21 August 2017
Standing Agenda Items	The meeting was quorate. The minutes of the SPC meeting held on 19 June 2017 2017 were accepted as a true record.
Formal Business	<u>Changes to Risk Register to reflect changes to SPC-assigned risks and named leads for key themes within each risk area to be identified.</u> The Committee noted the Risk Register presented to Trust Board in July 2017 and the inclusion of 2 new risk. One of these new risks related to risks as a result of Industrial Action in Theatres. Currently 2 of the risks on the Corporate Risk Register (CRR) align to the SPC as the Assurance Committee to provide assurance to the Board which relate to: - Failure to provide adequate staffing levels in some specialties and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets and - Failure to successfully engage workforce. The SPC also noted that although the Industrial Action by Theatres risk was monitored through the weekly Executive meeting that it should also be considered within the remit of the SPC for providing assurance to the Trust Board. The SPC recognised the overlap of 'People' elements / measures / risks with a number of risks within the CRR and that to provide assurance to the Board, monitoring and scrutiny of these elements should be part of remit of the SPC. The Committee noted that other elements of these risks are reported to the Board for assurance purposes through the Chairs reports of the Finance + Sustainability Committee (FSC) and Quality Committee (QC) The SPC agreed that the Industrial Action (Theatres) risk to be monitored by the SPC and that key themes within <u>ALL</u> risks to be clearly assigned to named leads to ensure appropriate assurance to the Board across all risks. <u>Summary of all amended / changes to policies since April 2017 to be produced and shared with staff</u> A communication campaign to be conducted to inform staff and managers of the changes to existing or new policies during 2017. <u>Industrial Action by Theatre staff and impact of potential future action</u> SCP members were reminded of the outcome of the ballot by theatre staff at Warrington Hospital for strike action, including a continuous ban on overtime. A number of half day strikes (up to September 2017) and three 24 hour continuous strike days are scheduled in September 2017. Negotiations continue

	with Unite to enable planning and scheduling for emergency cover and to try to resolve the outstanding issues currently not agreed. Matters still being negotiated: **Break cover** – Request by Unite for one hours overtime per night shift per Operating Department Practitioner or time of in lieu. The Trust has agreed to 'restart the clock' if break disturbed or to give time off in lieu **Weekend Cover** – Request by Unite for ODPs to work only one weekend per month contractually. The Trust has not agreed to this as it is out of step with all other staff groups and the eRostering policy which indicates that good practice is to work to providing one weekend off in four. The Trust has made a number of offers to Unite and these still remain available to members. <u>Agreed to changes to HR performance measures Key Performance Indicators (KPIs) for inclusion in the Trust Board IPR.</u> The Integrated Performance Report HR performance measures KPIs were reviewed. Specifically attention was given to any which did not have an improvement target: Agency Spend and Turnover A revised target will be included in the IPR to Trust Board in September 2017. <u>Reports received:</u> • People Strategy Report & Dashboard • People Measures Performance Report • Education and Learning Report • Employee Relations Report • On Boarding 6 month update report • Consultant Job Planning Report • Junior Doctor Change over report • Freedom to Speak Up Update Report • Medical Education and Medical Staffing Update • Knowledge and Evidence Service Annual Report
Local Policies and Guidance Approved:	The Committee ratified the following policies which had been discussed and approved through the appropriate governance routes, including JLNC, JNCC, staff side and Operational People Committee: - Remediation Policy - Attendance Management Policy extract - Flexible Working Policy - Temporary Staffing Policy - Paternity and Partner Leave Policy - Adoption Leave Policy - Training and Development Policy - Recruitment and Selection Policy

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Matters for Escalation	• Theatres – Ballot for Strike Action OR Action Short of Strike • Agency & Premium Spend continues to rise with high costs associated with Medical Staff. Reported through Finance & Sustainability Committee. SPC reviewing interdependencies impacting on use of agency staff such as recruitment and retention strategies and good people management to reduce for example attendance.

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CHAIR KEY ISSUES REPORT

AGENDA REF	BM 17 09 98 (h)	COMMITTEE OR GROUP:	Charitable Funds Committee	DATE OF MEETING	27th September 2017	CHAIR:	Jean-Noel Ezingeard

REF	AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
CFC/17/07/15	Action plan & Matters Arising	JNE	a) The Committee noted that a substantial bid from ICU for an immersive training suite had not been progressed by the service, despite the ICU fund being substantial and the Committee being in favour of funding pending further information. b) The WHH Dragon Boat Race – the Committee was very pleased to note the organisation and outcome of this event at Manley Mere on 18th June 2017 which saw 11 boats participate. Circa £18K had been pledged for the Children's Ward Outdoor Playground Appeal c) Timing of CFC meetings – the Committee noted the timing difficulties in terms of producing quarterly reports when committee meetings were early in the month.	a) The Fundraising and Finance team to pursue this with the service as the Trustees have an obligation to ensure that donor funds are distributed in a timely manner for the benefit of patients. b) That the WHH Charity team and Staff be recognised for outstanding support of the charity c) The Director of CE & Corporate Affairs to reschedule and note for the 2018 corporate calendar	a) CFC November 2017 b) Complete c) Complete
CFC/17/07/17	Charitable Commission Checklist	PMc	The Trustee Checklist was received and noted all indicators reviewed and remain on GREEN without change since the last review. To be presented to Trust Board as required by the Charities Commission.	The Committee was ASSURED by the report.	To accompany this report - complete
CFC/17/07/18	Finance Report	AC	a) The Committee received the finance report for Q1 and noted the fund balances, bid applications and expenditure. It also noted that a large Gift Aid claim had been made to HMRC but that the refund had not	a) The Committee was ASSURED by the report	

			yet been received. b) The Committee received a proposal to establish an 8 week limit for Fund holders to decide on what their donation is to be used for to ensure timely distribution of donor funds for the benefits of patients	b) The Committee APPROVED this proposal	
CFC/17/07/19	Fundraising Report	PMc/HH	The Committee received the Fundraising report for the Q1 and noted progress in: a) Communications and Engagement with donors especially significantly increased staff involvement with the charity; b) Community fundraising: a new relationship with the Hope Academy in Newton with Charity Ambassadors, NotCutts continued generosity for the FMN garden and the MacIntyre tea party again for FMN Unit. c) Corporate fundraising: Sellafield Ltd site visit, Marsh Manchester staff fundraising and Tesco Bags of Help d) Capital Campaigns: a. The Children's Ward was the recipient of the Dragon Boat event and a bid for a grant from the DM Thomas Foundation has progressed to the next stage of review b. Maternity and Neonatal has now launched its Unit refurbishment campaign e) Legacy and In Memory campaign progress report provided The Committee noted that a continued key risk for the Charity is its inability to grow due to restrictions on staffing.	The Committee was ASSURED by this report	
CFC/17/07/20	Annual Work Plan 2017-18	PMc/HH	The Annual work plan for the charity was received in draft form and the Committee was briefed that fundraising forecast, KPI and risks were still be assigned to each element.	The Committee asked for this plan to be re-submitted in final form at the next meeting.	Agenda for November meeting.
CFC/17/07/22	New General Data	PMc/HH	The Committee received a timely brief from the FR	The Committee was ASSURED by this	Agenda for

	Protection Regulation		Manager on the incoming new GDPR and its impact on the Charity	report and asked to be kept informed of progress up to 'go live' in May 2018	November meeting
CFC/17/07/23	CanSupport Charity and the Delamere Centre	PMc	Delamere Centre – the Committee was pleased to note that an agreeable conclusion had been reached for this long standing issue relating to CANSUPPORT charity and 1. Volunteers 2. The reimbursement of expenses and 3. Clarity around fundraising for service users and donors	The Committee was ASSURED by this report and asked that the CanSupport Annual Report and Accounts be brought before the next CFC	CFC Agenda November 2017
CFC/17/07/24	Revision to Bid Approval Process	AC/KS	The Financial Accountant requested that the charitable expenditure request and capital funding request forms be combined. The Committee noted concerns from the FR team that initial bid applications are normally completed by ward housekeepers and that a lengthier process would deter applicants.	It was agreed that the new process would be trialled and a report provided at the next committee meeting.	CFC Agenda November 2017
CFC/17/07/25	Chair's annual report to the Board 27 July 2017	JNE/IJ/PMc	The draft report was submitted for approval ahead of presentation to the Trust Board, NED IJ would take this report as outgoing Chair for 2016-17.	The report was APPROVED	Trust Board July 2017

JNE/PMc September 2017

Charitable Funds Committee

AGENDA REFERENCE:	**CFC/17/07/17**	
SUBJECT:	**Charities Commission Check List**	
DATE OF MEETING:	5 July 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Pat McLaren, Director of Community Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement Choose an item.	
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 at Trust Board on 29th June 2016. 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. The following is a position statement setting out our position at July 2017	
RECOMMENDATION:	**The Committee is asked to note the current position and mitigations/actions/risk assessments.**	
RECOMMENDATION:	**Agenda Ref. 16/028**	
PREVIOUSLY CONSIDERED BY:	**Date of meeting** **5 December 2016**	Charitable Funds Committee
	Summary of Outcome	To present to Board in January 2017 and to review at CFC in July 2017.
FREEDOM OF INFORMATION STATUS (FOIA): **FOIA EXEMPTIONS APPLIED:** ***(if relevant)***	Release Document in Full	
	None	

Charitable Funds Committee

SUBJECT	Charities Commission Check List	AGENDA REF:	CFC/17/07/17

1. BACKGROUND/CONTEXT

In June 2016 the Charities Commission issued new guidance for Charity Trustee Duties. This was circulated to the CFC and the Corporate Trustee at Trust Board on 29th June 2016.

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. The following is a position statement setting out our position at December 2016.

2. KEY ELEMENTS

The Charities Commission sets out six key guiding principles for Trustees in its 2016 Guidance. These are:

1. Planning effectively
2. Supervising your fundraisers
3. Protecting your charity's reputation, money and other assets
4. Identifying and ensuring compliance with the laws or regulations that apply specifically to your charity's fundraising
5. Identifying and following any recognised standards that apply to your charity's fundraising
6. Being open and accountable

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- The CFC requested a current position be established against the Checklist.
- Responsible officer: Pat McLaren, Director Community Engagement and Corporate Affairs

4. MEASUREMENTS/EVALUATIONS

The Checklist has been RAG rated and will be reviewed bi-annually.

5. MONITORING/REPORTING ROUTES

- CFC to review bi-annually
- CFC Chair to report to Corporate Trustee via Chair's Key Issues Report
- Board to receive annually.

6. TIMELINES

Next review February 2018 (tbc)

7. ASSURANCE COMMITTEE(s)

CFC, Trust Board

Charities Commission – Checklist for WHH Charity Trustees

JULY 2017

Guidance	Current status	Mitigations/actions/notes
Section 4: Planning effectively	RAG	
4.1 We have set out our fundraising plan		• Our refreshed fundraising strategy was approved at the April 2017 committee meeting • The accompanying annual plan is reviewed at each CFC meeting.
4.2 It reflects our charity's values		WHH Charity's values are: Ethical, Transparent, Accountable, Compassionate, Creative and the Charity also adopts the values of the Corporate Trustee of Working Together, Excellent, Accountable, Role Models and Embracing Change.
4.3 The resources we use and the costs we incur in our fundraising		• Our overheads are subject to scrutiny at each CFC meeting as part of the Finance Report • The refreshed FR Strategy has identified limits to overhead expenditure based on income growth with the intention of reducing cost/income ratios to ensure that donated funds are used in majority for patient benefit
4.4 The key financial and reputational risks we may face		This has been identified in the Risk Strategy developed in Feb 2016, key risks are reviewed bi-annually
4.5 We monitor progress		A fundraising activity and financial report is reviewed by the CFC at each meeting
4.6 We manage key risks		The key risks are reviewed bi-annually
Section 5: Supervising our Fundraisers		
5.1 We have considered and decided which fundraising issues we will not delegate		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		Current and in place
5.3 Our fundraising staff are doing the job successfully		PDR process initiated in June 2017, weekly 1:1s with Director
5.4 Our volunteers know who they report to and who to approach with problems or concerns		WHH Volunteers assumed responsibility for all volunteers in September 2016, those on placement with WHH Charity report to and are supervised by the Fundraising Manager
5.5 Our volunteers understand the boundaries within which they must work when representing the charity		They receive Trust induction from WHH Volunteers and 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		We undertake all procurement through the Corporate Trustee and 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		We procure using the Corporate Trustee's procurement team

5.9 Our fundraising values and expectations are communicated		These are agreed upon contract
5.10 The costs are justifiable and can be explained		All expenditure is reviewed by the Budget Holder and reported through the Finance Report
5.11 Proper control is kept of the money raised		• All monies are routed into the WHHCharity bank account, no other methodology is permitted. • Staff training and awareness on the correct processing of charitable donations is continuous and written into the WHH Staff Handbook
5.12 Fundraising communications used are reviewed		All communications are approved by the Fundraising Manager and/or Director
5.13 Compliance with the agreement is monitored		Compliance is be monitored following contract
5.14 Any conflicts of interest are recognised and dealt with		The Corporate Trustee has a Declarations of Interest register which has been adopted by WHH Charity
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		Reputational risks have been identified in our Risk Strategy
6.2 Likely donor, supporter and public perception is considered when income expectations and other goals are considered		Our bid application process includes this to ensure compliance of all parties via capital campaigns
6.3 The legal rules and recognised standards which apply to our fundraising are followed		We follow the Code of Fundraising Practice, the Institute of Fundraising and the NHS Charities guidance. We are registered with and regulated by the Charities Commission
6.4 Our values are communicated to the people who work on our fundraising		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		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		We have an annual plan in place which is reviewed at each CFC meeting, a refreshing of our strategy completed in April 2017
6.7 Effective financial controls are in place and followed		The Corporate Trustee's Finance Team monitor all expenditure
6.8 Risks of financial crime and fraud are reduced		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		• 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		• 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		• NHS Protect may also be contacted where NHS

Commission, police and other agencies		Employees or their families are involved.
6.12 Our data, name, image, logo and IP are protected		• 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		We follow the Code of Fundraising Practice, Institute of Fundraising and the NHS Charities guidance
7.2 These rules and standards are followed		We follow the Code of Fundraising Practice, Institute of Fundraising and the NHS Charities guidance
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		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		• 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		Our website is maintained and updated regularly.

PMc Last updated 30.6.17

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/17/09/99**	
SUBJECT:	**Board Assurance Framework and Strategic Risk Register**	
DATE OF MEETING:	27 September 2017	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Deputy Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
STRATEGIC CONTEXT	Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures.	
EXECUTIVE SUMMARY (KEY ISSUES):	There are key updates to strategic risks. There is a recommendation to downgrade and archive a risk from the strategic register since the Board last reviewed the Strategic Risk Register and Board Assurance Framework	
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Board Assurance Framework. It has been agreed that the Board receives a monthly update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Committee. The Board Assurance Framework and full strategic risk register will be presented on a quarterly basis.

The strategic risk register is outlined in Appendix 1. The following gives notable updates since the strategic risks were last presented to the Board of Directors. These updates have been mapped into the Board Assurance Framework (BAF) (Appendix 2).

2. KEY ELEMENTS

2.1 **New Risks** – there are no new risks that have been added to the Strategic Risk Register. The newly convened Risk Review Group will be meeting on 21st September and reviewing all the risk on the risk register over 15 for consideration to escalate to Board Assurance Framework. These include

Risk over 15	Is the Risk already on the BAF?	BAF Risk	Date Identified
Not meeting KPIs set out in the NHS complaints regulations. **Score - 16**	Yes	Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints. Score - 16	24/11/2016
Risk of loss of HV electrical supply and subsequent failure to generator(s) to start during power failure. **Score - 16**	Yes	Failure to maintain an old Estate could result in staff and patient issues, increased costs and unsuitable accommodation.	08/09/2016
Risk of failure to comply with Fire	Yes		19/09/2016

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Risk over 15	Is the Risk already on the BAF?	BAF Risk	Date Identified
(RRO) Regs due to inadequate emergency escape lighting in substations A, B and C. **Score - 15**		Score - 15	
Risk of expenditure on temporary staffing significantly exceeding budget/affecting future viability of the Trust with reports to NHS Improvement. **Score - 16**	Yes	Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. Score 20	01/08/17
Risk of not meeting Quality CQUINS which impact significantly to the financial risk to the Trust. **Score -20**	Yes	Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. Score - 20	10/11/2016
The risk that patients will not be seen in a timely manner due to process and system delays within OPD. **Score - 16**	Yes	Failure to deliver national and local performance targets will impact on patient care, reputation and financial position. Score – 20	12/04/2016
There have been a number of patient falls resulting in moderate and major harm. **Score - 16**	Yes	Failure to identify and manage patients risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the Trust. Score - 16	10/11/2016
The Trust has a large number of mechanical beds which require replacing with electrical profiling beds. **Score - 15**	Yes		10/11/2016

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Risk over 15	Is the Risk already on the BAF?	BAF Risk	Date Identified
Demand for isolation facilities may exceed capacity for suspected and/or confirmed infections resulting in patients not being appropriately isolated. **Score – 16**	No	Not aligned to the BAF	04/10/2016
Lack of adequately resourced surveillance system. **Score – 16**	No	Not aligned to the BAF	05/03/2015
Business continuity risk due to poor educational experience and removal of doctors in training. **Score - 16**	Yes	Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	19/04/2016

As can be seen the majority of risk already have been escalated previously. There are some risks regarding infection prevention and control which need further consideration. There is also a current risk being scoped regarding anaesthetic cover, which will be discussed at Risk Review Group.

2.2 Existing Risks – updates

Strategic Risk	Update since last Risk review	Impact of update on risk rating
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	There has been 28 new starters for nursing throughout September 2017 Temporary bed closures (4) in place on A3 and A8 following staffing risk assessments A new action has been added as follows: *Ensure practice reviews are undertaken across all areas reporting high staffing incidents to understand level of risk* ***Deputy Chief Nurse/Divisional Directors of Nursing – end November 2017*** A gap in assurance has been flagged regarding anaesthetic cover – this has been risk assessed and is being considered at Risk Review Group on 21st September 2017.	No impact on risk rating

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Strategic Risk	Update since last Risk review	Impact of update on risk rating
Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.	Recommendation that this risk can be regraded to target risk (8 – impact: 4, likelihood: 2) and archived.	Reduce and archive risk
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	Bed replacement business case going to Executive Directors for discussion 28th September 2017. Integrated falls action plan in place – combining actions from internal MIAA audit to actions from Serious Incidents.	No impact on risk rating
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	There has been a 50% reduction in the complaints backlog since April 2017 and an 82% reduction in cases over 6 months old since April 2017. The Trust is on trajectory to meet the complaints backlog target (end December) The following action has had timeframes moved: Development of a Lessons Learned Framework for the Trust **Deputy Director of Governance & Quality – end July 2017** **Work has commenced – action moved to end October 2017.**	No impact on risk rating
Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation	The following actions have had timeframes moved: Ensure there is an assessment of which areas need to have training **Divisional Nurse Directors – end July 2017 moved to end October 2017** Assess what staff in the areas identified have received training and develop a plan for all relevant staff to have received training **Divisional Nurse Directors/Transfusion Practitioner – end July 2017 moved to end**	

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Strategic Risk	Update since last Risk review	Impact of update on risk rating
	October 2017 Report transfusion/administration of blood training monthly into the Patient Safety & Effectiveness Sub Committee **Transfusion Practitioner – from June 2017 onwards moved to end October 2017** Ensure the results of the transfusion audit are presented to all relevant clinical areas **Transfusion Practitioner/Governance Leads – end July 2017 moved to end October 2017**	
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	Regarding RCA backlog, whilst there has been an improvement, the position is 15/16 – all RCAs been completed 16/17 – 1 patient o/s- accessing records 17/18 – 46 patients The Medical Director has asked that the backlog is given priority and an assessment of harm undertaken. To date, there has been one Serious Incident reported and 2 near misses, currently under review.	No impact on risk rating
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	The Trust has written to NHSI and completed their template requesting the removal of the current enforcement, if successful this will move the Trust from a rating of 3 to a 2. The request is due to be reviewed at the NHSI Regional support group on the 20th September. Market analysis tool was rolled out in June for use across the Trust and training given where requested – this will also be utilised with CBU managers as part of the business planning cycle which is due to commence in September, further enhancements to the Market share information are planned. Financial Strategy – Was presented and discussed at the Trust Board Development on the 7th July	No impact on risk rating
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences.	The following action timeframes have been amended as follows Ensure that a review of policy, procedures and training for discharge summaries is undertaken to ensure that they are fit for purpose **Deputy Medical Director /Task and Finish**	

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Warrington and Halton Hospitals NHS Foundation Trust

Strategic Risk	Update since last Risk review	Impact of update on risk rating
	Group – end July 2017 moved to end Dec 2017 Ensure an audit programme reviewing the quality of discharge summaries is established across the Trust **Deputy Medical Director/Deputy Director of Governance & Quality - end August 2017- audit plan agreed moved to end Oct 2017**	
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	The action regarding having a Disaster recovery plan and its relevance to key IT systems has been completed. An action date has been moved from end August 2017 to end October 2017 for the following: Improve the disaster recovery for the ICE system (currently hosted on a physical server with limited resilience). Cover for both sites is in place but SQL upgrade is in progress.	No impact on risk rating
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	Draft strategy developed and aligned to Trust planning priorities and external agenda. Draft strategy enables decisions on new opportunities to be assessed against agreed priorities.	No impact on risk rating
Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	The following action timeframes have been amended as follows • Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment – development of a plan **Director of IT – end July 2017 moved to end March 2018** • Act on recommendations made in the Cyber essentials report to ensure improved cyber security. **Director of IT – end July 2017 moved to end October 2017** • Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan	No impact on risk rating

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Strategic Risk	Update since last Risk review	Impact of update on risk rating
	Director of IT – end July 2017 moved to end March 2018	

With regard to the roll out of the revised risk management strategy the following has been undertaken:

- A pilot has commenced across wards and depts. In the Trust regarding an integrated risk assessment tool. This tool is aligned to the CQC domains and fundamental standards and will enable wards/depts. To assess risk against statutory, regulatory and professional requirements, in order to develop local risk registers.
- Training has been developed for senior managers on risk management and quality impact assessments and is due to roll out from October onwards. Training is also being out in place for risk assessment development.
- Datix Web for Risks is currently being scoped out, with configuration of the system to commence w/c 25th September 2017. Members of the governance team are visiting other Trusts to see how this is configured to support this roll out. Pilots are expected to commence on the new datix system in November 2017.
- The Risk review Group convenes on 21st September 2017. Chaired by the Chief Nurse, this will provide overview and scrutiny of risk registers at Clinical Business Unit level and ensure any escalated risks are discussed.

The project plan to support the implementation of the risk management strategy will be tracked at Risk Review Group reporting to Quality & Assurance Committee and also as part of the action plan in response to the Trust's CQC report.

3 RECOMMENDATIONS

The Board of Directors are asked to note the updates to the strategic risks and the Board Assurance Framework.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1- Strategic Risk Register

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (4x5)	20 (4x5)	20 (4x5)	20 (4x5)	20 (5x4)	20 (5x4)
Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.					16 (4x4)	Recommend to downgrade to target risk 8 (4x2) and archive
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	20 (5x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17
in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints						
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Failure to maintain an old estate	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17
could result in staff and patient safety issues, increased costs and unsuitable accommodation.						
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences.					12 (4x3)	12 (4x3)
Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	N/A	N/A	N/A	12 (4x3)	12 (4x3)	12 (4x3)
Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation.	N/A	N/A	N/A	12 (4x3)	12 (4x3)	12 (4x3)
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	N/A	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care	12 (3x4)	12 (3x4)	12 (3x4)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements	12 (4x3)	12 (4x3)	12 (4x3)	12 (3x4)	12 (3x4)	12 (4x3)

Appendix 2 - Strategic Risk Register and Board Assurance Framework – June 2017

Risk	Residual Risk Rating (Impact xLIkelihood)
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	20 (5x4)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (4x5)
Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.	16 (4x4)
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	16 (4x4)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	16 (4x4)
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	16 (4x4)
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)
Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.	16 (4x4)
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	15 (5x3)
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15 (5x3)
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences.	12 (4x3)
Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	12 (4x3)
Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation.	12 (4x3)
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based	12 (4x3)

practice, potential patient harm and reputational impact.	
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	12 (4x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)
Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care	12 (3x4)
Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements	12 (4x3)

Strategic Objective 1	Risk: Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Nurse/ Medical Director**
	Operational Lead **Divisional Nurse Directors/Chiefs of Staff**
	Assurance Committee: **Strategic People Committee**
	Date to be reviewed **Monthly:**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Recruitment and Retention strategy has been developed for nursing and is being operationalised • Nursing Recruitment and Retention meetings held 3 weekly • Nursing Recruitment Leads x 2 Matrons in place • Business case developed to support Nursing recruitment and retention • Senior staffing meeting put in place and processes at an operational level to ensure safe nurse staffing along with staffing checks at every capacity meeting • Reporting on safe staffing monthly to Board and staffing will be reported on all wards in line with national requirements. • Risk Management Systems allow for reporting of incidents re staffing and escalation of risk, when required • Individual staffing action plans for high risk areas • Review of skill mix and creating roles in teams e.g. pharmacy technicians to support medication administration • With regards to Consultant Recruitment – an external company has been appointed to recruit at Consultant Level with a review of JD's/Marketing of our posts; supported by EXIT Interviews for Leavers.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • 6 monthly nursing acuity & dependency review undertaken, Results being collated • Recruitment and Retention Strategy developed December 2016 and in being operationalised and implemented • The Trust has had concerns raised by Health Education North West/Deanery regarding supervision and education of junior doctors in some medical specialities (acute medicine and geriatric care) • There is a gap in control regarding implementation of IR35 across the Trust

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Staffing rates monitored on a shift by shift basis (actual versus planned numbers) and reported to the Board • 6 monthly acuity & Dependency review undertaken across all areas – Adults, Paediatric, Maternity & NICU. Results to be reported to Board. • Incident data regarding staffing reviewed by Chief Nurse • Escalation protocols in place – evidence of these being activated by nursing team • We have recently been successful in appointing 4 Cardiology Consultants and are attending ES Training in due course and will be allocated Trainees as required. • The Trust is ensuring safe medical staffing via use of long term locums in some specialities and also by breaking the cap, when required. • There is an action plan in place following concerns raised by HENW/Deanery • There has been 28 new starters for nursing throughout September 2017 • Temporary bed closures (4) in place on A3 and A8 following staffing risk assessments	Undertake the Allocate Safer Nursing Care Acuity review to understand establishments with regard to acuity Acuity / Dependency review undertaken in May 2017. Results being collated. **Deputy Chief Nurse/Divisional Associate Director of Nursing – end June 2017** **This has been undertaken and will be being presented to June Quality Committee and July 17 Board of Directors.** Develop a risk assessment process for opening/closing beds/ward **Deputy Chief Nurse – end March 2017** **COMPLETED** Monthly reporting of Recruitment and Retention Strategy to Strategic People Committee and Nursing and Midwifery Board. **Chief Nurse – monthly** **ON-GOING** Ensure a report is given to the Board of Directors regarding medical staffing in medical specialities, including a progress update of the action plan **Medical Director – end March 2017** **COMPLETED** Ensure a report is given to the Board on nurse staffing assurance processes **Chief Nurse – end March 2017** **COMPLETED** All areas to have risk assessed implications of IR35 **CBU Managers – end April 2017** **COMPLETED** Ensure a deep dive is undertaken of the risk regarding staffing and reported to Quality Committee **Chief Nurse/Deputy Chief Nurse/Deputy Director of Governance & Quality – end June 2017** **COMPLETED** Ensure a monthly incident report on staffing incidents is presented to Patient Safety & Effectiveness Sub Committee **Deputy Director of Governance & Quality – end June 2017** **COMPLETED** Ensure practice reviews are undertaken across all areas reporting high staffing incidents to understand level of risk **Deputy Chief Nurse/Divisional Directors of Nursing – end November 2017**
Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**

Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	**Risk: Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.**
Risk Source: Performance Reporting	**Exec Lead:** **Chief Operating Officer**
	Operational Lead Associate Directors of Operations
	Assurance Committee: **Finance and Sustainability**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Weekly monitoring of all performance indicators • KPI meeting attended by all CBU managers • IT support to develop accurate data reports • Business case approved to have a centralised RTT function with a lead manager • Business case approved to increase outpatient call centre and reception staff to locally manage issues • Four hour performance meeting in place weekly to monitor performance and required actions • Reporting on all key performance metrics to FSC on a monthly basis • Risk Management Systems allow for reporting of incidents • Individual action plans for high risk areas including outpatients • ECIP support to establish key areas for improvement	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Electronic solution to data reporting including e outcomes • Further validation of migrated patients from meditec to Lorenzo • Further capacity and demand work required

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Outpatients is on the Trust Internal Audit Plan for 2017 • An outpatients steering group takes place monthly and feeds into the outpatient board chaired by the CEO there are 8 identified work streams all with individual KPIs and dashboards • All performance metrics are reported monthly externally • ECIP dashboard benchmarks against other trusts • Daily performance metrics circulated • FSC and board papers • CCG contract review meeting	Development of an OPD dashboard **Outpatient and Medical records Service Manager – end June 2017** The dashboard has been developed a draft version has been shared with the team and it was agreed at the last OPD board that it will be shared at the next meeting. Live accurate data – business intelligence review to be undertaken **Head of Information – end September 2017** Capacity and demand work to be undertaken across the trust **Director of Operations – end September 2017** Review of WLI payments to be undertaken **Director of Operations – end July 2017** WLI payment review was supported by the transformation team and a paper was presented to executive team and supported Ensure a review of cancer processes is undertaken **Director of Operations – end June 2017** **COMPLETED – reported to June Quality Committee**

Residual Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	Risk: Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.

Risk Source - Escalated from risk assessments	Exec Lead: Chief Operating Officer
	Operational Lead Divisional Director Surgery Division
	Assurance Committee: Executive Directors
	Date to be reviewed: Daily review currently

Initial Risk Rating (1-25)	**4**
Impact (1-5)	**4**
Likelihood (1-5)	**16**

Controls: *(What are we doing about the risk?)*

- Regular briefing submitted to Trust Board and Executive Team
- On-going negotiations to avoid IA with support of Trust Board
- Negotiations on going around emergency cover – to be in place for first strike action.
- Strike action card in place and operational team meeting regularly.
- Operational contingency plans are in progress
- Independent Review received which confirmed both proposals (i.e. Resident & Non-Resident on Call or Night Shift with Non Resident On Call) are safe.
- Recommendations were made from the Independent Review and are now included in future proposals.

Gaps in Assurance *(What additional assurances should we seek?)*

Proposal to strike

Overtime ban:

- 18/7/17 continuous

Strike action 08:00 to 12:00:

- 24/7/17, 31/7/17, 7/8/17, 14/8/7, 21/8/17, 29/08/17

Strike action 13:00 to 17:00:

- 18/8/17, 25/8/17, 1/9/17

24 our stoppage from 00:01:

- 4/9/17, 11/9/17, 18/9/17

This week (w/c 17/7/17- we had to cancel five patients as an impact of overtime)

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Currently discussing possibility of postponing first 2 weeks of strike action to allow further negotiations around a resolution • Patients will be rearranged by risk factors – all patients with cancer, emergency and trauma will not be affected by the strikes	Continue to work with Unions – to further negotiate to avoid a strike – review proposal being currently discussed **Chief Operating Officer/Director of HR – by 7th August 2017** **COMPLETED** Develop an operational plan to have in place should strike action go ahead **Chief Operating Officer/Divisional Director of Surgery, Woman's and Children's- by 21st July 2017** **COMPLETED**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	**Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.**
Risk Source: Incident Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Falls Policy in place. • The Trust participates in NHS Safety Thermometer, which gives benchmarking data. • Risk Management systems and incident policy require staff to report incidents regarding falls so that any incidents can be appropriately investigated and learning can be cascaded.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • There have been a number of falls within the Trust causing Serious Harm • There is a requirement to review falls prevention equipment • There is a requirement to have a bed replacement programme in place • Falls training is not mandated for staff • Lack of senior specialist input for falls prevention • MIAA audit into falls showed limited assurance

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Audits undertaken of falls policy on at least an annual basis • All patients have falls Positive risk factor and bed-rails assessments completed on admission, and are reassessed in accordance with policy. • Trust is meeting the required performance in NHS Safety Thermometer- • Projects are being piloted in the Trust for falls prevention e.g. slippers socks and yellow blankets for patients etc. • Falls RCAs in place with Senior Nurses reviewing this post fall. Quarterly reporting of falls analysed within the Trust Governance Report. • Falls nurse has commenced in roll	Recruit Falls Nurse Specialist **Chief Nurse – end February 2017** **COMPLETED** Develop a business case for bed replacement programme **Chief Nurse – end February 2017 rescheduled to end April 2017** **Tender process underway. Trial of various beds has been undertaken by operational staff.** Bed replacement business case going to Executive Directors 28th September 2017. Ensure Falls Prevention training is mandated for staff **Chief Nurse – end March 2017** **COMPLETED** Ensure a review of falls equipment is undertaken across the Trust to assess requirements **Deputy Chief Nurse- end March 2017** **COMPLETED** Ensure internal audit actions are incorporated into overarching action plan re falls prevention **Deputy Chief Nurse- end July 2017** **COMPLETED**

Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	**Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints**
Risk Source: Performance Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Director of Governance & Quality**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • An external review has been undertaken of the complaints function in the Trust • Complaints Policy been updated • Central and divisional complaints teams in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • The Trust is not meeting performance targets with regard to complaints – a significant number of complaints are greater than 6 months old • Data quality issues with regard t complaints – multiple databases and systems to record complaints • There are a lack of standardised processes for complaints handling centrally and divisionally/CBU level • There is a lack of training in the Trust with regard to complaints management and handling • Lack of being able to evidence lessons learned and action plan monitoring as a result of complaints • A review of PALS and complaints function needs to be undertaken • Lack of patient experience strategy in the Trust to promote local resolution

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Additional capacity has been put into the complaints team – including integration of the divisional and corporate complaints teams • Process mapping of complaints has been undertaken, to ensure the process is streamlined and everyone understands their roles and responsibility- Standard Operating procedures have started to be developed • Mapping of complaints spreadsheets into Datix has started and will complete by end March 2017 • The Chair of the Trust will chair a Complaints Quality Assurance Group – terms of reverence being agreed by Quality Committee March 2017	Develop a complaints improvement plan following the external review **Deputy Director of Governance & Quality – end February 2017** **COMPLETED** Put in place additional capacity in the complaints team to improve performance **Deputy Director of Governance & Quality – w/c 1st February 2017** **COMPLETED** Ensure the complaints process in the Trust is process mapped **Deputy Director of Governance & Quality – end March 2017** **COMPLETED** Ensure a review is undertaken of complaints data, all complaints spreadsheets are mapped over to Datix, and new KPIs are developed for Board/Quality Committee and Divisions/CBUs **Interim Complaints Improvement Lead – end March 2017** **COMPLETED** Convene a Complaints Quality Assurance Group **Deputy Director of Governance & Quality – end March 2017 – first meeting scheduled June 2017** **Ensure a new complaints training programme is developed** **Interim Complaints Improvement Lead – end April 2017** **COMPLETED** Ensure KPIs are developed to monitor effectiveness of complaints improvement plan and report to Quality Committee **Deputy Director of Governance & Quality – end March 2017** **COMPLETED** Development of a Lessons Learned Framework for the Trust **Deputy Director of Governance & Quality – end July 2017** **Work has commenced – action moved to end October 2017.** Ensure the pilot of the new complaints process commences **Deputy Director of Governance & Quality with selected specialities – end July 2017** **COMPLETED** **Ensure trajectories are set for improvement** **Deputy Director of Governance & Quality– end July 2017** **COMPLETED**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**

Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 1	**Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.**
Risk Source: External review	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly:**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • External review conducted • Safeguarding teams in place • Training in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Review of safeguarding governance structure required • Review of the safeguarding team and functions • Requirement to review practices of chemical restraint • A review of safeguarding training required • A policy review • Representation at Local Safeguarding Boards to be reviewed • A review of policies to be undertaken • Development of an electronic system for use by the safeguarding team • Lack of LD specialist support • CQC raised issues regarding mental capacity assessments and DOLS

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• External support put in place re safeguarding with newly appointed Deputy Chief Nurse • Supervision put in place for named nurses • Commissioning of level 3 safeguarding training	Development of an action plan following on from external review Deputy Chief Nurse – end February 2017 **COMPLETED** Progress update on action plan bi-monthly to Quality Committee **Deputy Chief Nurse – March 2017 onwards** **COMPLETED** Ensure an audit of Mental Capacity is undertaken **Safeguarding Adults lead – end March 2017** **COMPLETED** Following a stocktake of the action plan in place – determine if the risk is reducing **Deputy Chief Nurse – end July 2017 moved to end October 2017 (following audit and feedback)**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 1	Risk: Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences.	
Risk Source: Performance reporting		**Exec Lead:** **Medical Director** **Operational Lead** **Deputy Medical Director** **Assurance Committee:** **Quality Committee** **Digital Optimisation Group** **Date to be reviewed:** **Monthly**
Initial Risk Rating (1-25)	**4**	
Impact (1-5)	**4**	
Likelihood (1-5)	**16**	
Controls: *(What are we doing about the risk?)* ▪ Discharge summary performance, both the 95% and 7 day standard, is now monitored through an electronic dashboard, and is overseen by the monthly Clinical Operational Board (and also Finance and Sustainability Committee). ▪ Performance is managed at ward level, with an escalation protocol through the Clinical Business Unit and division. ▪ Discharge Policy and processes in place to support staff ▪ Training provided to staff, including junior doctors on induction, on Lorenzo	**Gaps in Assurance** *(What additional assurances should we seek?)* ▪ In Q1 of 17/18, there is a backlog of c160 discharge summaries, which suggests more work is needed ▪ Communication meeting with primary care (June 2017) suggest improvement still needed in handover of care and discharge summaries	

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
▪ The current performance shows that we meet the 95% target for sending discharge summaries within seven days, whilst recognizing that improvement needs to continue to improve regarding sending discharge summaries within 24 hours. Current performance is 88% within 24 hours. ▪ Sample audit work undertaken with regard to the backlog to date (June 23rd 2017) has not revealed that a patient has been harmed ▪ A review of incidents and complaint information in the timeframe of the backlog has not identified that a patient has come to harm or that a patients has complained	Ensure a daily report tracking discharge summary performance is established and sent out to Clinical Directors **Deputy Medical Director – end June 2017** **COMPLETED** Establish a Task and Finish Group, reporting to Digital Optimisation Group, to support taking the work of discharge summaries forward **Deputy Medical Director – end July 2017** **COMPLETED – task and finish established to report to Patient Safety & Effectiveness Sub Committee** Ensure that a review of policy, procedures and training for discharge summaries is undertaken to ensure that they are fit for purpose **Deputy Medical Director /Task and Finish Group – end July 2017 moved to end Dec 2017** Ensure an audit programme reviewing the quality of discharge summaries is established across the Trust **Deputy Medical Director/Deputy Director of Governance & Quality - end August 2017- audit plan agreed moved to end Oct 2017** Ensure an update report of improvement is presented to Trust Patient Safety & Effectiveness Sub Committee **Deputy Medical Director – end September 2017**

Residual Risk Rating (1-25)	**4**
Impact (1-5)	**3**
Likelihood (1-5)	**12**
Target Risk Rating (1-25)	**4**
Impact (1-5)	**2**
Likelihood (1-5)	**8**

Strategic Objective 1	**Risk: Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Nurse/ Medical Director**
	Operational Lead **Divisional Nurse Directors/Chiefs of Service**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Controls: *(What are we doing about the risk?)* • Hospital Transfusion Committee in place • Audit processes in place • Transfusion Practitioners • Education Programme	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • In the most recent audit the Trust met 3 out of 6 standards relating to administration of blood. Concerns related to: a. Documentation b. 36% of patients did not have their transfusion observations performed correctly c. 51% of staff had not received the administration of blood competency assessment d. 10% of transfusions had been administered by agency staff e. 22% had not received a mandatory training session

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Reports regularly from Hospital Transfusion Committee into Patient Safety & Effectiveness Sub Committee	Ensure there is an assessment of which areas need to have training **Divisional Nurse Directors – end July 2017 moved to end October 2017** Assess what staff in the areas identified have received training and develop a plan for all relevant staff to have received training **Divisional Nurse Directors/Transfusion Practitioner – end July 2017 moved to end October 2017** Report transfusion/administration of blood training monthly into the Patient Safety & Effectiveness Sub Committee **Transfusion Practitioner – from June 2017 onwards moved to end October 2017** Ensure the results of the transfusion audit are presented to all relevant clinical areas **Transfusion Practitioner/Governance Leads – end July 2017 moved to end October 2017**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Operating Officer**
	Operational Lead **Associate Director of Estates**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**

Controls: *(What are we doing about the risk?)*	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)*
• Estates strategy • PLACE assessment action plan • Risk Management systems and incident reporting • General capital investment • Compass reporting re: water flushing • Matron and estates walkabouts • Reporting structure for maintenance • On call service for OOH issues • Maintenance log	• Maintenance improvement program • Medical equipment maintenance is managed by a risk assessed approach whereby equipment is identified as: High Medium Medium/Low Low All high and medium is fully maintained. Medium/low and low is operator assessed and reported to medical equipment engineering as required. A significant gap in control and assurance relates to breach of fire regulations regarding emergency lighting in some of the areas. There are mitigations in place, Cheshire Fire and Rescue Service are aware and the Trust has no enforcements in place. There is also a significant risk regarding the age and repair of generators in the Trust, for which there are mitigation and continuity plan in place for- which are under review.

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Water quality group • Fire safety group • Medical gasses group • Estates safety • Medical Equipment group • Capital Planning group • Six Facet survey – condition appraisal of estate (annually) 5 Year program 20% each year • Asbestos survey annually • Premises Assurance model (PAM) Self-assessment tool estate compliance • Good Corporate Citizen self-assessment (review of sustainability)	Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy **Associate Director of Estates – end September 2017** Participate in Halton Healthy Hospitals strategy **Director of Transformation/Associate Director of Estates – ongoing** Review of the Health & Safety risks aligned to estates and facilities to be undertaken **Associate Director of Estates/Deputy Director of Governance & Quality/Head of Health & Safety – end July 2017** **COMPLETED** **Review the governance/meetings structure regarding Estates** **Chief Operating Officer/ Associate Director of Estates/Deputy Director of Governance & Quality – end September 2017**

Residual Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	**Risk: Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.**
Risk Source: Performance Reporting	**Exec Lead:** **Medical Director**
	Operational Lead **Divisional Chiefs of Staff**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Policy and guidelines in place regarding VTE • Process in place regarding VTE investigations	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Performance report shows numbers of VTE RCAs outstanding and poor compliance in some areas with risk assessments • Lack of assurance that that numbers of hospital associated VTEs are being monitored within clinical governance processes within Divisions/CBUs and being fed back to individuals • Thrombysis Committee terms of reference need to be reviewed

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Monitor of progress by Patient Safety and Clinical Effectiveness committee, Quality Committee; monthly assessment of progress with number of RCAs • Harm free care figures • Mortality/coroners data does not suggest that the Trust is an outlier in terms of harm being caused to patients	Develop a revised process for VTE RCAs **Lead Clinicians VTE/Deputy Director of Governance/Deputy Medical Director** **End April 2017** **COMPLETED** Develop a plan for VTE RCA backlog to be delivered **Lead Clinicians VTE** **End June 2017 – reviewed** **COMPLETED** Ensure information regarding VTE assessments and RCAs are circulated to individuals/CBUs and Divisions **Lead Clinicians VTE** **COMPLETED** Review Terms of Reference for Thrombosis Group **Lead Clinicians VTE** **COMPLETED – to be ratified by Patient Safety & Effectiveness Sub Committee** Ensure there is a trajectory for undertaking backlog of VTE assessments and ensuring that the process going forward is monitored at Patient Safety & Effectiveness Sub Committee **Medical Director – end July 2017** **COMPLETED**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	**Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Medical Director**
	Operational Lead **Associate Medical Director Quality**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Policies and procedures in place across the Trust governing systems and processes to minimise potential for service failure. • Incident reporting regime enables issues to be raised and lessons learnt. • Governance structure– Quality Committee and Patient Safety & Effectiveness Committee and high level reporting from Divisional Bi-lateral Committees • Integrated Performance Report in place. • Dashboards to assess against standards • Mortality review processes • Mortality action group strengthened focusing on reducing mortality with detailed action plan developed. • Independent mortality review process • Associate Medical Director overseeing Mortality Review process	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Clinical Governance systems within the Trust need to be reviewed e.g. Lack of integrated effectiveness agenda corporately • Clinical/CBU leadership model still embedding • Further work to develop integrated performance report, dashboards and cross referencing / escalation of issues • The Trust is reporting higher than expected mortality rates in HSMR, although SHMI showing a significant downward trend. • UTI outlier in term of mortality • Lack of co-ordinated learning framework within the Trust • Lack of assurance regarding NICE guidance compliance within the Trust • Inpatient survey showed significant decrease in performance in some areas • Concerns regarding spinal surgery services raised internally and externally by NHSE

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Risk based internal audit programme linked to potential identified gaps in controls with Trust policies. • External audit process • Incident analysis completed monthly and weekly updates on SI/red incidents given to Senior Management Team. • Review of Quality Committee terms of reference and workplan been undertaken • Integrated Performance Report reported at monthly Board, prior to this scrutiny given at Trust and Divisional Quality & Governance meetings • Good Clinical audit participation in the national programme • A recent JAG visit described our endoscopy services as an 'excellent service', demonstrating cohesive leadership, exceptional governance standards and robust processes both clinically and administratively. • The Trust has been named as the best performing Trust in the region for providing hip and knee replacement surgery by AQUA. • Excellent feedback received in the Cheshire and Merseyside Critical Care Network report.	Ensure a governance review is undertaken, including a review of integrated effectiveness agenda **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality – end June 2017** **COMPLETED** Ensure a review of quality indicators reporting on dashboard undertaken **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality/Deputy Chief Nurse – end June 2017** **COMPLETED** Ensure there is a review of Patient Safety and Effectiveness Sub Committee terms of reference and reporting groups **Director of Integrated Governance & Quality Improvement- end May 2017** **COMPLETED** Ensure that there is a UTI deep dive on mortality **Associate Medical Director Mortality/Clinical Effectiveness Manager – end July 2017** **COMPLETED** Development of a Lessons Learned Framework **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality/Deputy Chief Nurse – end July 2017 – moved to end October 2017** Ensure the Trust's NICE policy is reviewed **Head of Clinical Effectiveness – end June 2017** **COMPLETED**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care
Risk Source: Incident Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**12**
Impact (1-5)	**3**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Increased staff at night and robust escalation process in place • Review of paediatric service in A&E underway via an external consultant from Alderhey. • Review of paediatric A&E staffing (nursing and medical) to be considered and pathways of care.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Staffing and skill mix • Pathway of care to be reviewed
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Increased staff at night to ensure service is safe • A review of incidents and complaints undertaken to seek assurance that service is safe	**Mitigating Actions** *(What more should we do?)* Commission a review of Paediatric care in A&E **Director of Transformation – end March 2017** **COMPLETED** Development of an action plan following on from external review **Service leads – by end April 2017** **COMPLETED** **Ensure the action plan us presented to Quality Committee for approval** **Head of Midwifery – end June 2017** **COMPLETED**
Residual Risk Rating (1-25)	**12**

Impact (1-5)	**3**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 2	**Risk: . Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives**
Risk Source: Performance Reporting	**Exec Lead:** **Director of Workforce & Organisational Development/Director of Communications**
	Operational Lead **Head of HR/Head of Communications**
	Assurance Committee: Strategic People Committee
	Date to be reviewed: Monthly
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Communications: We have developed a Communications and Engagement Work plan 2017-18 which is being delivered across the WHH workforce • We have merged the Communications and Staff Engagement teams to consolidate and maximise staff engagement • There is a revised leadership model in place within the Trust • Priorities for the Trust are promoting learning and development, driving clinical leadership, having efficient job plans, celebrating success through staff awards and supporting innovation and working with partner organisations • There is an established Strategic People Committee of the Board • Investment in training and Support for staff • Open Mic sessions/Team Talk in place to engage staff and offer them a voice • *Established weekly planning meetings with the Transformation team to identify any possible schemes that could negatively impact staff and take pre-emptive planning action*	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • CBU leadership structure still embedding • Gaps in information/data due to lack of service line reporting in place enable it difficult to analyse significance of staffing impact on productivity e.g. staff sickness levels due to work related stress etc. • Periodic staff survey (added to Staff FFT Qs) to include communications awareness/engagement • Establishment of evaluation parameters linked to 'communication tools' ie google analytics • Theatre at Night Consultation – staff have raised significant concerns
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Engagement Dashboard reported to Trust Board (includes monitoring of Team Brief attendance)	**Mitigating Actions** *(What more should we do?)* Further diversification of communication tools – greater use of social media and developing site-specific communications. This is partially complete, social media working well with multiple ward/service Facebook groups and a WHH Staff FB

• Staff FFT and Annual NHS Staff Survey (published March each year) both reported to SPC	group. The creation of the People Champions network (see below) will significantly enhance site specific engagement **Director of Communications – end July 2017** Further opportunities for staff to engage with senior managers/executive Team – Open Mic **Director of Communications – ongoing** Following development of Trust Strategy, ensure staff engagement events/communications are developed **Director of Communications – end September 2017 the Trust Strategy is continuing to develop and engagement/consultation is underway in partnership with the Transformation Team and Trust Governors. This work will be extended to patients and external stakeholders upon approval of strategy at Trust Board at October time out.** Creation of 'People Champions' network **Director of Communications – end July 2017 People Champions launch conference is 13th October 2017 at Widnes Stadium** Ensure there is an external review of the Impact Assessment of Theatre at Night Transformation work **Director of HR and Organisational Development – end August 2017**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 3	Risk: Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.
Risk Source: Performance Reporting	**Exec Lead:** **Director of Finance**
	Operational Lead **Deputy Director of Finance**
	Assurance Committee: **Finance and Sustainability Committee**
	Date to be reviewed: **Monthly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**

Controls: *(What are we doing about the risk?)*	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)*
• Core financial policies controls in place across the Trust • Revised governance structure within the Trust to enable strengthened accountability • Finance and Sustainability Committee (FSC) established overseeing financial planning • CIP programme in place aligned to the Transformation agenda • Monthly financial monitoring with NHSI • Regular review at Executive team meeting and development sessions • Attendance at the STP boards and Committee • Annual plan development process • Health economy commissioning meetings to identify any financial performance issues/demand management etc. – aim to accelerate LDS/STP • Support agreed to help achieve CQUIN monies with weekly Executive review • Performance monitoring of financial governance within the Trust. • Negotiations with Commissioners on Contract income on going • Monitor SLAs and contracts to enable extension of contracts or tenders to be managed • Charitable funds strategy in place • Review of non pay expenditure daily • Fortnightly income meeting – Executive Lead • Mitigating actions to avoid cost remain in place	• Failure to achieve Financial control total may result in loss of STF and worsening cash position. • The Trust was found in breach of its licence in August 2015 and was subject to enforcement. Significant improvements have been made. The Trust continues to be financially challenged and has a control total for 2017/18 of £3.7 million deficit. The Trust has written to NHSI and completed their template requesting the removal of the current enforcement, if successful this will move the Trust from a rating of 3 to a 2. The request is due to be reviewed at the NHSI Regional support group on the 20th September. • Failure to manage fines and penalties and CQUIN which may result in loss of STF and worsening cash position • Risk to financial stability due to loss of income relating to STP changes • Inability to develop a strategic plan to deliver a breakeven position over the next 5 to 10 years • Loss of contracts due to competitive market which may result in Trust no longer being sustainable. There is a gap in Market analysis and Knowledge of our competitors • Loss of income through the failure of WHH Charity • Risk of under delivery of CIP

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• New Director of Finance appointed 2016, with a Deputy Director of Finance also appointed and a reconfiguration of the finance function • Robust financial controls introduced • Director of Transformation appointed as a new post in the Trust in 2016 • Increased focus on delivering CIPs, via the Trust Transformation agenda • Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board • Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports • Annual external audit and reporting to Charities Commission • Trust achieved better than planned for deficit 2016/17 and achieved STF bonus • Successful bid for £1 million capital funds from Primary Care Streaming	Continue to seek support from Commissioners **Director of Finance – ongoing** Continue to seek support from NHSI approach to management and repayment of loans **Director of Finance – ongoing** Development of a Market analysis of Trust competitors to understand imminent and future risk to income **Director of Finance – end May 2017- revised date end July 2017** Market analysis tool was rolled out in June for use across the Trust and training given where requested – this will also be utilised with CBU managers as part of the business planning cycle which is due to commence in September, further enhancements to the Market share information are planned. Development of a Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery **COMPLETED -** Was presented and discussed at the Trust Board Development on the 7th July Greater involvement of the Corporate Trustee in Charitable Funds strategy development (planned for Board Workshop in 2017) **Director of Communications – end December 2017**

Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**10**
Target Impact (1-5)	**5**
Target Likelihood (1-25)	**2**

Strategic Objective 3	Risk: Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT**
	Operational Lead **IT Leads/CIO**
	Assurance Committee: **Finance and Sustainability Committee** **Digital Optimisation Group** **e PR Programme Board**
	Date to be reviewed: 15/03/2017
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**

Controls: *(What are we doing about the risk?)*	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)*
• IT Strategy in place • Routine RAG reporting of IM&T projects to ePR Programme Board and upwards to Finance and Sustainability Committee • Reviewing EPR system upgrade plans with suppliers and agreeing revised dates based around resource contention • Working with CBUs to involve more admin and clinical staff for testing upgrades • Reviewing contingency plans • Cross training staff to increase leveraging of resources and minimise single points of failures • Cross skilling help desk to strengthen first line support • IG sub-group reviews contingency plans with Information Asset Owners from the CBUs • Anti-virus has been added to IM&T Capital Shortlist for 17/18 and will be agreed at the next Capital Planning Group • IT Seniors routinely act upon CareCERT information security bulletins released by NHS Digital's Data Security Centre. Actions performed in response to bulletins are documented. • Information Security Management System reports to Information Governance and Corporate Records Sub-Committee to provide assurance on the effectiveness of controls • Inspection by Trust's auditors on IT infrastructure security • Capital paper submitted to secure funding for hardware to improve infrastructure in time for requisite Windows 10 migration	• Failure to provide IMT system support caused by lack of staff or single points of expertise in the structure; resulting in systems being unavailable for longer periods of time in the event of a failure. Impact on trust access, quality of care and financial targets with potential for reputational damage. • Failure to secure trust's IMT systems from cyber-attacks due to poor end user training and awareness, limited and out of date security systems and increasing complexity of attacks. Impact is loss of patient data resulting in fines, organisational reputational damage or extended downtime of systems, resulting in loss of financial information and loss of ability to treat patients. • Failure of IMT infrastructure to be available 24*7 due to increasing demands requiring additional hardware which cannot be purchased due to funding restraints. • Assurance that DQ reports available within the BIS are being accessed and acted upon by operational staff • Sufficient time for engagement from CBUs around system management • Certification to the Cyber Essentials standard in quarter 1 Financial year 2017/18 is required. This was recommended in the National Data Guardian/CQC report of 2016

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Monitoring of Data Quality in systems implemented and reporting of DQ metrics via Data Quality and Management Steering Group • Monitoring of external data quality reports such as the NHS Digital Data Quality Maturity index and benchmarking with other organisations • Clear communications of upgrades changes • Good user engagement for testing • Monitoring of helpdesk tickets to understand trends after upgrades • Assess hot stops from IMT Helpdesk calls • Critical systems continuity plans identify key staff who will work to ensure systems return to normal as quickly as possible • Capital programme spend reviewed by Capital group and F&S, hardware inventory maintained to ensure end user equipment remains fit for purpose. • ePR programme Board reviews each project progress against Programme Plan expectations • Internal IMT department progress recorded at Seniors meetings • New diagnostic post being recruited linking to identifying single points of failure • The Director of IT has undertaken a review regarding IT infrastructure risks, which may impact upon 24/7 availability of key services and systems and the capital programme has been updated to reflect these risks. • Actions have been completed regarding commencement of a information and IT restructure. An additional diagnostic team member has been recruited. • Regular analysis of data to show compliance with processes in place – Data Quality dashboard work and links back to Clinical Directors.	Work with other Trusts to share testing resources **Director of IT – COMPLETED September 2017** Invest in additional IMT staffing as workload increases, restructures based on work being reviewed with IMT management **Director of IT – COMPLETED – new application support staff in place** Comprehensively identify all single points of failure and assess risks surrounding each **Director of IT – end June 2017** **COMPLETED – quarterly test of backups are now scheduled and results will be documented and reported on** Test contingency plans regularly- development of a plan **Director of IT – end May 2017** **COMPLETED** Routinely report all Cyber-attacks via Datix incident reporting system to ensure SIRO and Caldicott Guardian are sighted on the issues **Director of IT – end June 2017** **COMPLETED** Include Cyber Security element in annual SIRO report **Director of IT – end April 2017** **COMPLETED** IT Manager to produce a report detailing IT infrastructure risks which may impact upon 24/7 availability of key services and systems **Director of IT- end April 2017** **COMPLETED** Continuous audit of IMT infrastructure- development of a plan **Director of IT – end May 2017** **COMPLETED** Disaster recovery plan and its relevance to key IT systems to be reviewed **Director of IT – end August 2017** **COMPLETED** Improve the disaster recovery for the ICE system (currently hosted on a physical server with limited resilience) **Director of IT – end August 2017 – this has been moved to end October 2017** Undertake a Training Needs Analysis and assessment of training on Critical systems in the Trust and develop a plan as appropriate **Director of IT – end Sept 2017**
Residual Risk Rating (1-25)	**20**

Impact (1-5)	**5**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**10**
Impact (1-5)	**5**
Likelihood (1-5)	**2**

Strategic Objective 3	**Risk: Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.**
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT** **Operational Lead** **CCIO** **Head of Information** **Assurance Committee: ePR Programme Board** **Date to be reviewed: 15/03/2017**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Prioritising work around BAU i.e. statutory and contractual dataset returns such as daily/weekly Sitreps, monthly Board reporting, FOI's, Ad-hoc information requests and CQC inspection. • Providing regular updates to the project board and current plans, progress and risks/issues • Recruited one temporary staff to cover Maternity datasets as replacement for one of the Band 6 staff that has left. • Re-planned and allocated work to the team for other Band 6 staff that has now left. • Recruiting for a Band 5 replacement that leaves end of March. • Taking on the NVQ data quality staff from Lorenzo team. He will initially work 2/3 days per week from 27th Feb and permanently then once a DQ backfill has been recruited.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • The new Head of Information will be joining end of March who will review the overall strategy for delivering information services, she has already started to look at this following a meeting on 15/02/17 – on going • New interactive tools to allow users to manually 'data mine' the reports is in pilot.

• Appointed new Head of Information that starts at the beginning of April • Interim Head of Information re-developing plans and prioritising work	
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • The key objective is to ensure all BAU work is being maintained i.e. statutory returns, adhocs and FOI's and support CQC inspection. Escalate to Exec level if any delays are likely • Continue to Access reports via the BIS application, new reports are being made available all the time • Continue to report progress, risks and issues through finance and project board meetings	**Mitigating Actions** *(What more should we do?)* Continue to work with the Business and clinical teams to help manage expectations and ensure work is prioritised around key objectives (BAU, CQC, etc) and then by the high priority datasets **Head of Information – ongoing** Establish new information reporting structure lead by the new Head of Information starts **Head of Information – End September 2017** Develop interactive Business Intelligence system for end users for self-service to reduce demand for routine information enquiries **Head of Information – End September 2017**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 3	**Risk: Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Director of Communications & Corporate Affairs**
	Operational Lead **Board Secretary**
	Assurance Committee: **Audit Committee**
	Date to be reviewed: Ongoing
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Compliance with license conditions – reportable quarterly via Audit Committee • Appointment of Advisor to Board • Re-establishment of Foundation Trust Office • Recruitment of Secretary to Board and support	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Need to relaunch the Board Assurance Framework and align to the Strategic Risk Register • Lack of ongoing regular review of Well Led standards • Lack of assurance regarding a centralised system to monitor Duty of Candour compliance

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Well Led Review and CQC inspection 2017 • NHS Improvement Assessment • Board Evaluation Surveys • Well-led Self-Assessment • Assurance has been received following the Well Led review commissioned by the Trust from Deloitte. Actions from this review will be monitored by the Board.	Complete the Well-led Self-assessment and develop an action plan **Chief Executive/Director of Communications – end May 2017** **COMPLETED – action plan underway and being monitored through Trust Board** Ensure there is an annual review of Well –led assessment mapped into the Audit Committee and Board business cycles **Chief Executive/Director of Communications – end May 2017** **COMPLETED** Review the Trust Risk Management Strategy **Chief Nurse/Deputy Director of Integrated Governance & Quality – end May 2017** **COMPLETED** Ensure a Duty of Candour protocol and centralised system is developed, which is reported monthly to the Board of Directors **Deputy Director of Integrated Governance & Quality – end March 2017** **COMPLETED** Ensure Head of Corporate Governance role recruited to **Director of Communications – end August 2017** **COMPLETED**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**10**
Impact (1-5)	**5**
Likelihood (1-5)	**2**

Strategic Objective 3	Risk: Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT** **Operational Lead** **CCIO** **Head of Information** **Assurance Committee: ePR Programme Board** **Date to be reviewed: 15/03/2017**
Initial Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Controls: *(What are we doing about the risk?)* • Anti-virus/anti-spam measures deployed on servers and desktops. The McAfee product used is due for review/renewal in September 2017. Capital funds allocated for this purpose. • Firewall deployed to protect the network by filtering the traffic that is permitted in and out of the WHH network. The Stonegate Firewall product is due for renewal in March 2018. Capital funds being sought as part of improvements to the overall security suite. • Blocking file extensions recommended by NHS Digital on WHH Fileshare areas. CareCert bulletins containing information security measures which need to be implemented are produced by NHS Digital and measures taken to implement their requirements are documented at IT Seniors meeting on a weekly basis. • Information Security Management System (ISMS) in use to protect WHH IT assets. The ISMS is based on the principles contained within the ISO27001 standard in use to control physical and network access and the controls required to protect said assets. • Daily backups and 4 hour replication to the Halton site which replicates data on the Halton site storage area network (SAN). Data loss in the event of a Cyber-attack would be minimised due to the replication of data. • Achievement of Cyber essentials certification and completion of the requisite network penetration testing. Certification to the Cyber Essentials standard has been recommended for all Trusts and compliance with its requirements can enhance	**Gaps in Assurance** *(What additional assurances should we seek?)* • Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment. • Act on recommendations made in the Cyber essentials report to ensure improved cyber security. • Ensure upgrade of security systems such as web filtering, anti-virus and firewalls. • Routine, quarterly reporting of attacks to the Information Governance and Corporate Records Sub-Committee

protection against circa 80% of Cyber-attacks. • Removal of obsolete operating systems (eg Windows XP) and automatic patching of critical updates offered by Microsoft. Removal of XP operating system across WHH continues and three tier patching regime is proposed	
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Cyber Essentials network penetration testing to be completed as soon as possible. This will provide evidence that robust protection is in place. • Evidence that the WHH network wasn't infected during the recent Cryptolocker cyber-attack can be provided MIAA have been provided with evidence that patching of operating systems is carried out. Significant assurance awarded. • MIAA Information Governance assurance audit 2017-significant assurance awarded.	**Mitigating Actions** *(What more should we do?)* • Ensure capital monies are available in 2018/19 for upgrade of vital security software and hardware **Director of IT/Director of Finance – end April 2018** • Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment – development of a plan **Director of IT – end July 2017 moved to end March 2018** • Act on recommendations made in the Cyber essentials report to ensure improved cyber security. **Director of IT – end July 2017 moved to end October 2017** • Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan **Director of IT – end July 2017 moved to end March 2018** • Ensure that Information Governance messages around safe use of IT assets are reiterated via corporate induction and training **Director of IT – ongoing** • Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system – send out an alert to all staff on a regular basis and report quarterly to Information Governance and Corporate Records Sub-Committee **Director of IT – ongoing**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 4	**Risk: Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.**
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Executive** **Operational Lead: Divisional triumvirates** **Assurance Committee: Finance and Sustainability Committee, Strategic People Committee, Quality Committee** **Date to be reviewed: Quarterly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Members of the board have secured lead roles on a range of programmes within the LDS and STP, most notably High Quality Hospital Care, which is led by our Chief Executive and Medical Director for the STP. • The board is further developing the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • We are developing plans, with partners, to establish Accountable Care Organisations in both Halton and Warrington. • We have developed an engagement strategy in partnership with our Governing Council • We have developed a Communications and Engagement Work plan 2016-17 • We are delivering a programme of 'Your Health' Events across all of our services to which public, partners, members and governors are invited/involved • We have established a community-wide newsletter Your Hospitals • We have a programme of visiting GP practices on a 'customer care' platform	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Our CQC rating will likely impact our ability to influence and at this stage is not known. • Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. • Failure to successfully engage with all of our stakeholders across our catchment population • Measurement of GP engagement

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Evidenced by lead roles in STP and LDS. • No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the STP. • The Trust has developed effective clinical networking and integrated partnership arrangements: • The Trust is successfully leading and co-ordinating the delivery of new integrated care pathways for the frail elderly with partners from primary and social care, the voluntary sector, 5 Boroughs NHSFT and Bridgewater Community NHSFT. • The Trauma and Orthopaedic service has developed excellent links with the Walton Centre for all complex spinal patients. • The Musculoskeletal team are undertaking collaborative work with Warrington CCG and Walton Neuro Vanguard developing a CPMS service meeting patients' needs. • Monitoring engagement by stakeholders (attendance at events, membership survey) • Well Led Review and CQC inspection 2017 • Reports and Feedback from Healthwatch • Board Talk reinstated for partners and stakeholders – The first issue will be June Board – Purdah completed. Staff comms is continuing as per existing work plan/strategy • 'What Matters to Me' conversation cafes being established across both sites (17/18) in partnership with patient experience committee and governors. Will also include WHH volunteers, WHH careers and WHH charity	Continue to hold lead roles. **Chief Executive – ongoing** Ensure evidence is provided to support decision making. Development of Trust Strategy document aligned to Trust planning priorities and external agenda **Director of Transformation – end June 2017** Draft strategy developed and aligned to Trust planning priorities and external agenda. Draft strategy enables decisions on new opportunities to be assessed against agreed priorities. Ensure robust communications, engagement and consultation. Review the internal/external communications strategy for staff and partners **Director of Communications – end June 2017** **COMPLETED** Re-establish 'Board Talk' stakeholder newsletter **Director of Communications – end May 2017** **COMPLETED** Create more opportunities for stakeholder engagement at our hospitals **Director of Communications – end June 2017** **COMPLETED** Revisit the Your Hospitals newsletter/membership communications to ensure optimised **Director of Communications – end May 2017** **COMPLETED** Establish clinician-led GP engagement opportunities **Director of Communications – end June 2017 – date rescheduled to end December 2017, due to capacity and conflicting priorities**

Residual Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**

Impact (1-5)	**4**
Likelihood (1-5)	**2**

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/100**
SUBJECT:	**Complaints Improvement Report**
DATE OF MEETING:	27 September 2017
ACTION REQUIRED	**Review, Discuss and note**
AUTHOR(S):	Ursula Martin, Deputy Director of Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
STRATEGIC CONTEXT	Complaints Handling is a statutory and regulatory requirement.
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • There has been a 50% reduction in the complaints backlog since April 2017 and an 82% reduction in cases over 6 months old since April 2017 (Graph 1). • The Trust is on trajectory to meet the complaints backlog target (end December) • The Trust is working with Datix to improve the functionality even further and has purchased Datix Web. Project plans for the implementation of this system are currently being developed. • The Complaints Team and function within the Trust have been reviewed and additional substantive resource has been put in place, as well as temporary resource. • KPI performance has shown complaints improvement in relation to timeliness of responses. • Performance meetings with divisions have been reinstated on a weekly basis. • PALS service has been reviewed and the PALS Office has now been re-opened. • The Complaints Improvement Lead is in the

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	process of gathering feedback from the new complaints process pilot in order to roll this out across the Trust and embed it in policy. • There is a rolling program of Complaints Investigation training taking place. Dates for this have been added to induction packs and advertised through CBUs.	
RECOMMENDATION:	Review, Discuss and note the Trust Annual Health & Safety Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Date of meeting	
	Summary of Outcome	Approved for receipt by Board of Directors
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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SUBJECT	Complaints Improvement Report	AGENDA REF:	

1. BACKGROUND/CONTEXT

The Board of Directors and Quality Committee received a report in May/June 2017, outlining an improvement plan, following a review of the Trust's complaint handling function. A high level review identified deficiencies in performance against the two national targets (time taken to acknowledge and time taken to respond) and a significant accumulated backlog of historic complaints. In addition the review identified a need to review systems and processes in managing complaints within the Trust.

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

2. KEY ELEMENTS

The complaints improvement plan update is given in Appendix 1.

Since the last report, the following additional actions have been taken

- Weekly detailed reports continue to be sent to CBUs in order to allow them to review their outstanding complaints. These are discussed at weekly CBU meetings where Senior Complaints Resolution Officers are in attendance.
- The PALS Service has been increased through the moving of staff within the department. The Complaints Improvement Lead is in the process of recruiting another Complaints Resolution Officer to provide seamless cover for both PALS and Complaints.
- The Trust is working with Datix to improve the functionality even further and has purchased Datix Web. Project plans for the implementation of this system are currently being developed.
- KPI performance has shown complaints improvement in relation to timeliness of responses.
- Performance meetings with divisions have been reinstated weekly. These are attended by the Senior Complaints Resolution Officers in order to gain updates on complaints and hold Investigators to account on deadlines.
- The PALS Office has now been re-opened in order to allow patients and families to make concerns without email or telephone.

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- The Complaints Improvement Lead is in the process of gathering feedback from the new complaints process pilot in order to roll this out across the Trust and embed it in policy.
- There is a rolling program of Complaints Investigation training taking place. Dates for this have been added to induction packs for staff and advertised through CBUs.
- There has been a 50% reduction in the complaints backlog since April 2017 and an 82% reduction in cases over 6 months old since April 2017.
- A review of the staffing structure has taken place in order to provide seamless coverage within the department whilst allowing for an increase in Divisional support in relation to complaints.
- The Complaints and PALS function was advertised and explained via a week of Internal Communications to all Trust staff.

The current position is as follows (as at 18 September 2017):

	Awaiting Acknowledgement	72 Hour Review Required	Awaiting Consent	Awaiting Investigation By CBU	Meeting To Be Arranged	Meeting Date Set	Awaiting Drafting	Further Information Required From CBU	Awaiting Divisional Approval	Dissatisfied - Awaiting Acknowledgement	Dissatisfied - Awaiting Investigation By CBU	Dissatisfied - Further Information Required from CBU	Total	Total Over 6 Months
Acute Care Services	3	2	0	35	2	4	3	6	2	1	4	1	63	8
Corporate Departments	0	0	1	5	0	0	0	0	0	0	0	0	6	0
Surgery and Women's and Children's	0	3	0	37	4	3	3	10	1	0	5	0	66	5
Totals:	3	5	1	77	6	7	6	16	3	1	9	1	135	13

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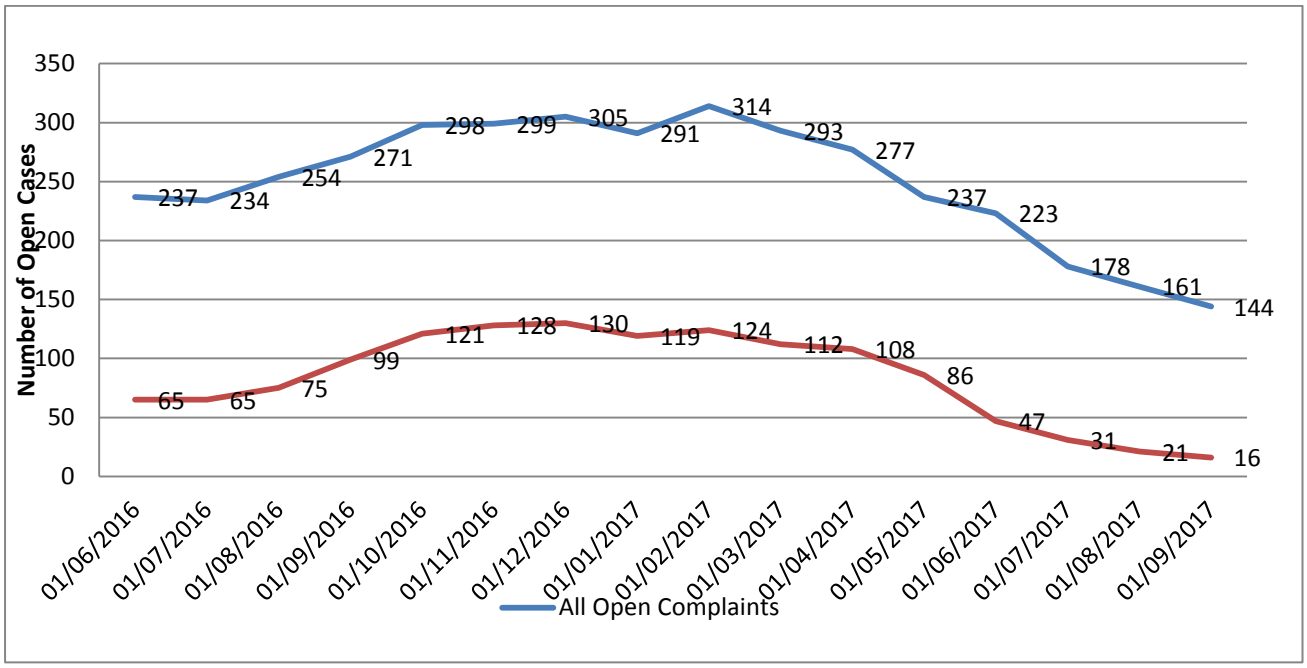
Graph 1 below shows the trend over time of open cases and those over 6 months old:



The data below shows the decrease in complaints over the last 6 months, as detailed in the Graph 1:

Dates	01/03/2017	01/04/2017	01/05/2017	01/06/2017	01/07/2017	01/08/2017	01/09/2017
Total	293	277	237	223	178	161	144
Over 6 months old	112	108	86	47	31	21	16

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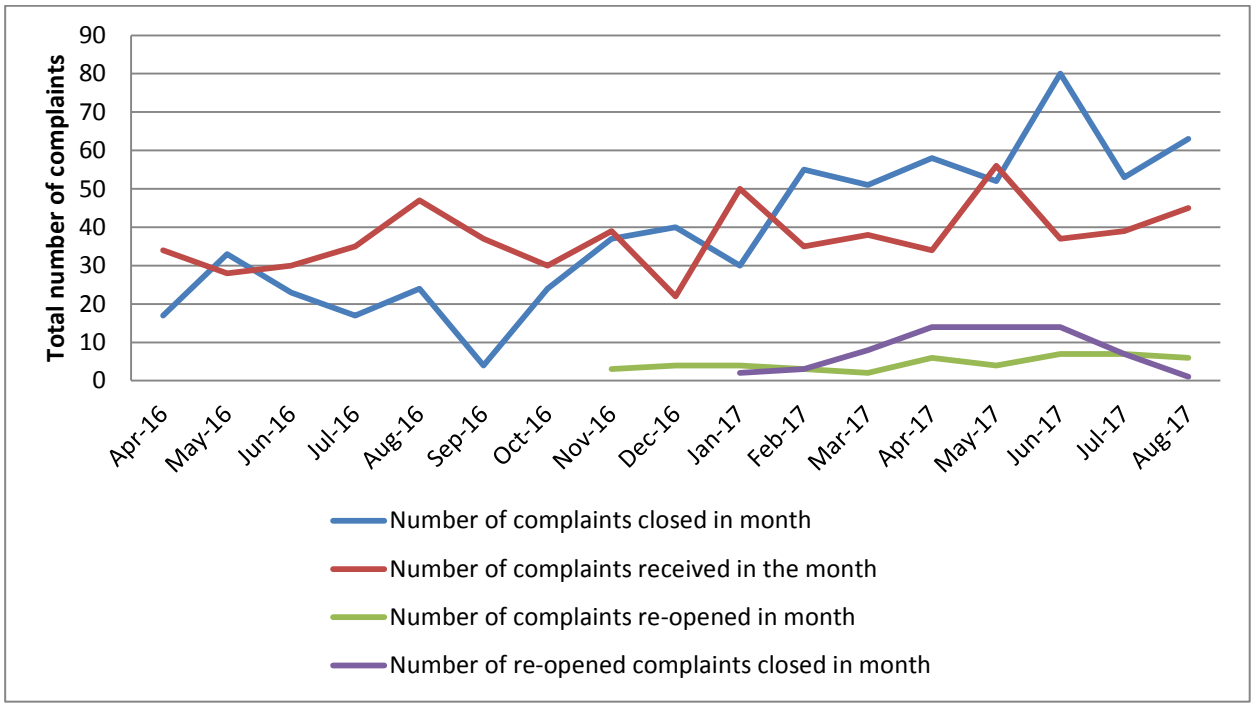
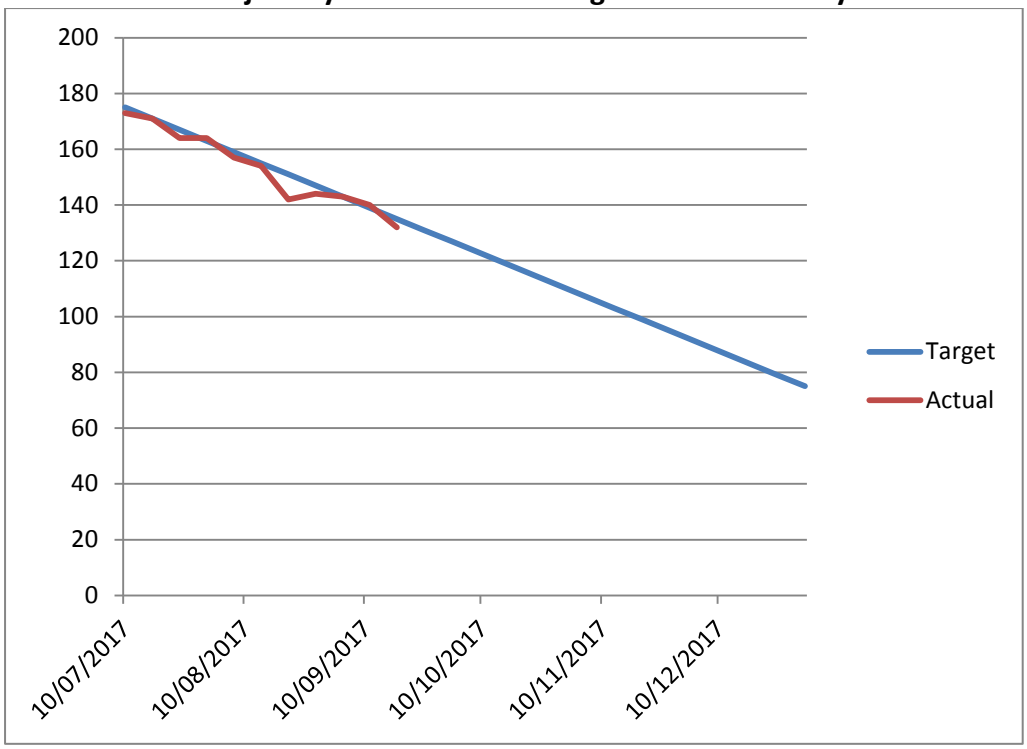
Since 1 April 2017 – 18 September 2017 the Trust has closed 367 complaints and has received 233. The graph below shows the complaints receveied against those closed:



The Trust is on trajectory to have the backlog of cases closed by end December 2017



Key actions going forward:

- The new process detailed in Appendix 2 has been piloted and the Complaints Improvement Lead is currently gathering feedback in order to role this out Trust wide.
- Training in complaints handling has been delivered in June 2017 and a rolling programme put in place. This has been advertised via CBUs and induction packs for new staff.
- A system has been devised for the recording of actions that have been identified in complaints. The Complaints Improvement Lead is currently creating a report in order to circulate this information to the Divisional teams.
- Datix Web implementation for complaints has been purchased and its implementation is being project planned.
- A new Trust policy on complaints will be devised by the Complaints Improvement Lead. This will simplify the current policy and align the policy to these held by the PHSO.
- Continued work on the backlog and new complaints timeliness in order to improve the Trust KPI and improve complainants' satisfaction with the complaint process.

3. RECOMMENDATIONS

Whilst significant work has been undertaken regarding complaints handling, further work and review is required to ensure the backlog is completed.

The Quality Committee are therefore asked to:

- Note the position in terms of complaints handling and the actions taken to date;
- Note the update with regard to the complaints improvement plan;
- Note the revised process, which will be finalised and rolled out across the Trust by the end of October 2017.

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Review of the Complaints Management Department and Function

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

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture' and My Expectations for raising concerns and complaints'. And update this action plan accordingly				
	Introduce a Complaints Quality Assurance Group (recommended that this is chaired by a Non Executive Director).	Terms of Reference have been developed	End March 2017	**COMPLETED**	Deputy Director of Governance & Quality
	Write the Trust Complaints Annual Report and ensure it is in line with statutory and regulatory requirements.	The report has been completed – will be presented to the Board in June 2017.	End April 2017	**COMPLETED**	Deputy Director of Governance & Quality
Ensure that the complaints team establishment and structure is reviewed	Review the departmental staffing establishment and skill mix and take any action as required	This has been completed. An administrative member of staff employed, a substantive Complaints Improvement Manager and the divisional complaints function has been integrated into corporate team.	End March 2017	**COMPLETED – A new Complaints improvement Manager has been appointed and a review undertaken**	Deputy Director of Governance & Quality/Compl aints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
Review how complainants are engaged in the resolution of their complaint	Identify how informal complaints are handled and managed; Review the PALS function, resource and accessibility;	The review of PALS has been completed – the requirement for additional resource has been flagged to the executive team and a business case is underway.	End March 2017	**COMPLETED – a business case is in development**	Deputy Director of Governance & Quality/Complaints Programme Consultant
	Ensure all complainants have a point of contact in the Trust	The complainant will be contacted by telephone to provide a name of the case handler and to establish the exact issues that require investigation. This encourages a relationship with the complainant at the outset. Case Handlers will keep complainant informed of progression in the investigation. Due to the backlog and interim staff requirements, this has taken some time to implement, but	End February 2017	**COMPLETED**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
		by the end of February 2017 all complainants (new and old) will have a point of contact in the Trust.			
Ensure training in the complaints handling process is in place within the Trust	Undertake a review of the complaints handling training within the Trust , ensuring it is in line with the revised policy.	A review of the training has been undertaken.	End February 2017	**COMPLETED – training review undertaken**	Complaints Programme Consultant
	Develop a Complaints Handling Toolkit for staff for all investigating officers	This has been completed.	End March 2017	**COMPLETED**	Complaints Programme Consultant
	Review the training requirements for the complaints cases officers within the Trust and put in place a training programme	SOPs have been developed and a competency framework also developed – to be implemented in full by Complaints Improvement Manager	End March 2017	**COMPLETED - SOPs and a training programme developed - to be implemented**	Complaints Programme Consultant
	Review the quality of complaint responses, to examine language used, grammar, style and empathy demonstrated in tone;	This is ongoing	Ongoing Improvements will be incremental	**ONGOING**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
Ensure that data quality in complaints handling improves	Develop a live spread sheet of all cases which will provide ' a single version of current position' This report will have the ability to be 'filtered' to enable various staff group to effectively use the data	Live spread sheet populated with all cases. Relevant dates added for each case. Systematic review of each case ongoing with Divisional Complaints Managers to establish the current status of each complaint. Weekly meetings with Divisional Governance/Complaints leads and PET officers to take place to update current progress with every case. Following DATIX data cleanse this spreadsheet has been decommissioned and all live data is available direct from DATIX.	End December 2016 End April 2016	COMPLETED COMPLETED	Complaints Programme Consultant

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

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	• In liaison with the CBUs and Divisional Complaints Managers, ensure high risk profile cases have been downgraded (if required) following the 72 hour review. • Ensure that cases which are actually closed are marked as such on Datix. • Highlight cases which have had no action which should be progressed. • Take appropriate action to progress the case. • Identify and action cases where they have stalled. e.g. Draft letter on file but not followed up (sometimes for a number of weeks) (action being taken to rectify this) • Keep contemporaneous			**ongoing** **Completed** Completed Ongoing Ongoing ongoing	

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
	records of all actions taken to complete a comprehensive data cleanse, this will enable production of a report noting all anomalies corrected				
	• Undertake a full review of the functionality of the Datix Risk Management Software – Complaints Module to ensure it is fit for purpose. • Work with the Datix organisation to develop the software package as appropriate. • Liaise with internal colleagues and Datix Administrator to make any changes necessary.	DATIX have planned site visit to work with teams to improve data accessibility	End June 2017	**COMPLETED** **On track – Datix purchased and project plans for implementation are being developed.**	Complaints Programme Consultant/ Complaints Manager
Ensure that performance in complaints handling	Calculate a trajectory to ensure the backlog of complaints is resolved	This has progressed and improvements are being made with regard to performance.	End February 2017	**COMPLETED – The Trust is currently on**	Complaints Programme Consultant

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Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
improves				**track to meet the targets**	
	Review reporting arrangements to Clinical Business Units and within the Trusts' Clinical Governance Framework to performance manage complaints within the Trust	This has progressed and a weekly meeting is in place chaired by the Chief Nurse with reporting into the Executive Team meeting weekly.	End February 2017	**COMPLETED**	Complaints Programme Consultant
	Develop a monthly report on complaints handling mapping progress against action timeframes and trajectories, as well as monitoring KPIs in the revised complaints policy.	Monthly KPIs have been reviewed and are in new quality dashboard	End February 2017	**COMPLETED**	Deputy Director of Governance & Quality Complaints Programme Consultant
Ensure that lessons are learned as a result of informal and formal concerns raised	Ensure there is an appropriate system for capturing and monitoring lessons learned from complaints and concerns	Any learning identified during an investigation is captured within Datix to assist in ongoing audit	End March 2017	**ONGOING - Lessons are captured on the Datix system**	Deputy Director of Governance & Quality Complaints Programme

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Objective	Actions required	Progress to date	Timescales	On track/ Off track SIGNIFICANTLY OFF TRACK SLIGHTLY OFF TRACK COMPLETED OR ON TRACK	Responsible Officer
					Consultant
	Ensure that there is triangulation of complaints data at a ward level with incidents, staffing etc.	To commence	End July 2017	**COMPLETED**	Deputy Director of Governance & Quality Deputy Chief Nurse
	Ensure there is an aggregate learning report developed for incidents, Serious Incidents, complaints, concerns and claims	There is currently a report in place produced on a quarterly basis – Learning from Experience Report	End June 2017	**COMPLETED**	Deputy Director of Governance & Quality Complaints Programme Consultant
	Ensure there is a lessons learned framework developed, which sets out how to learn lessons across the Trust	To commence	End June 2017	**ON TRACK - report currently being devised**	Deputy Director of Governance & Quality
	Ensure there is a lesson learned audit put in place within the Trust, as part of the Trust's annual clinical	To commence	End June 2017	**TO COMMENCE**	Deputy Director of Governance &

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Objective	Actions required	Progress to date	Timescales	On track/ Off track **SIGNIFICANTLY OFF TRACK** **SLIGHTLY OFF TRACK** **COMPLETED OR ON TRACK**	Responsible Officer
	audit cycle				Quality

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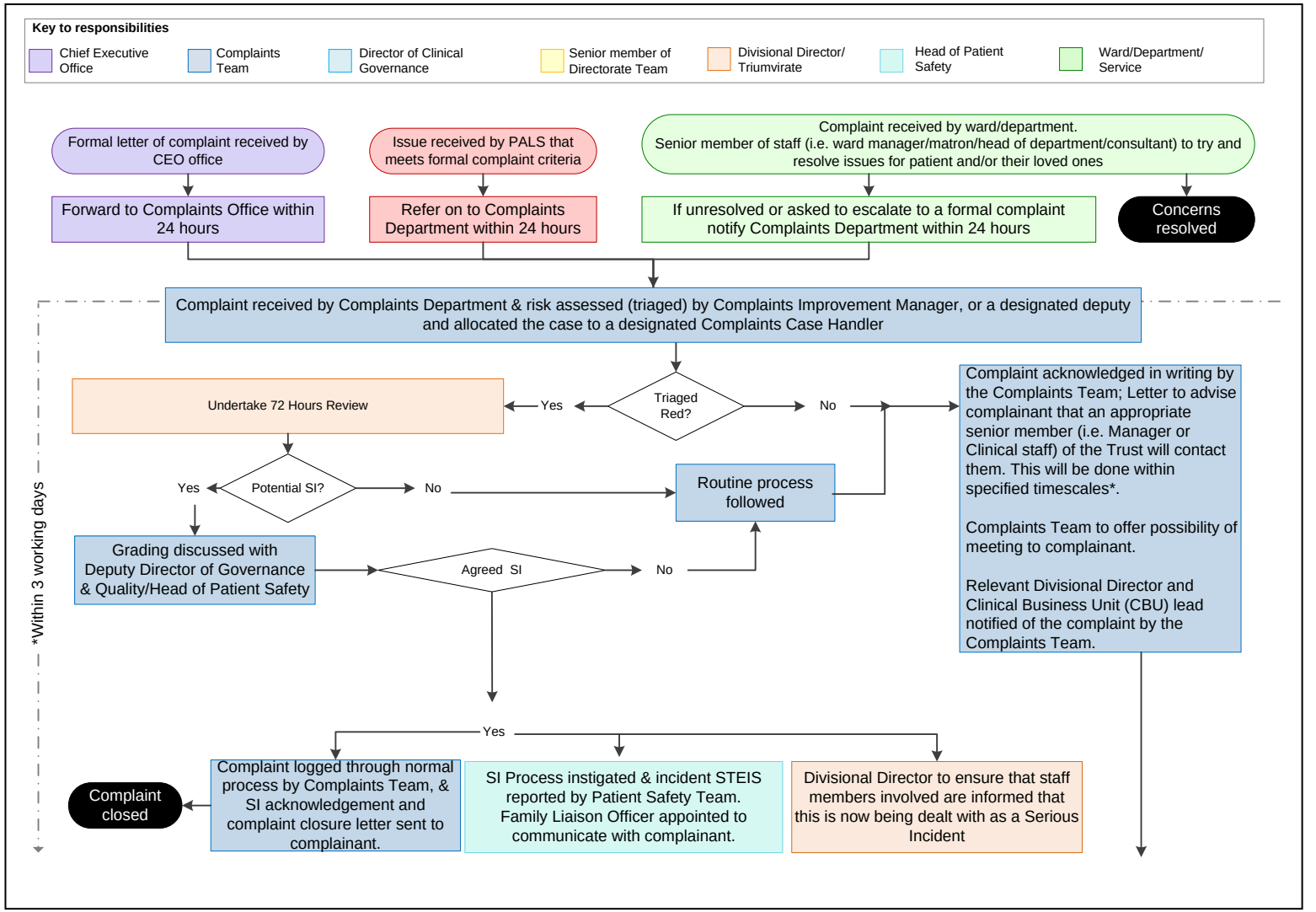
Appendix 2 – revised complaints process being piloted



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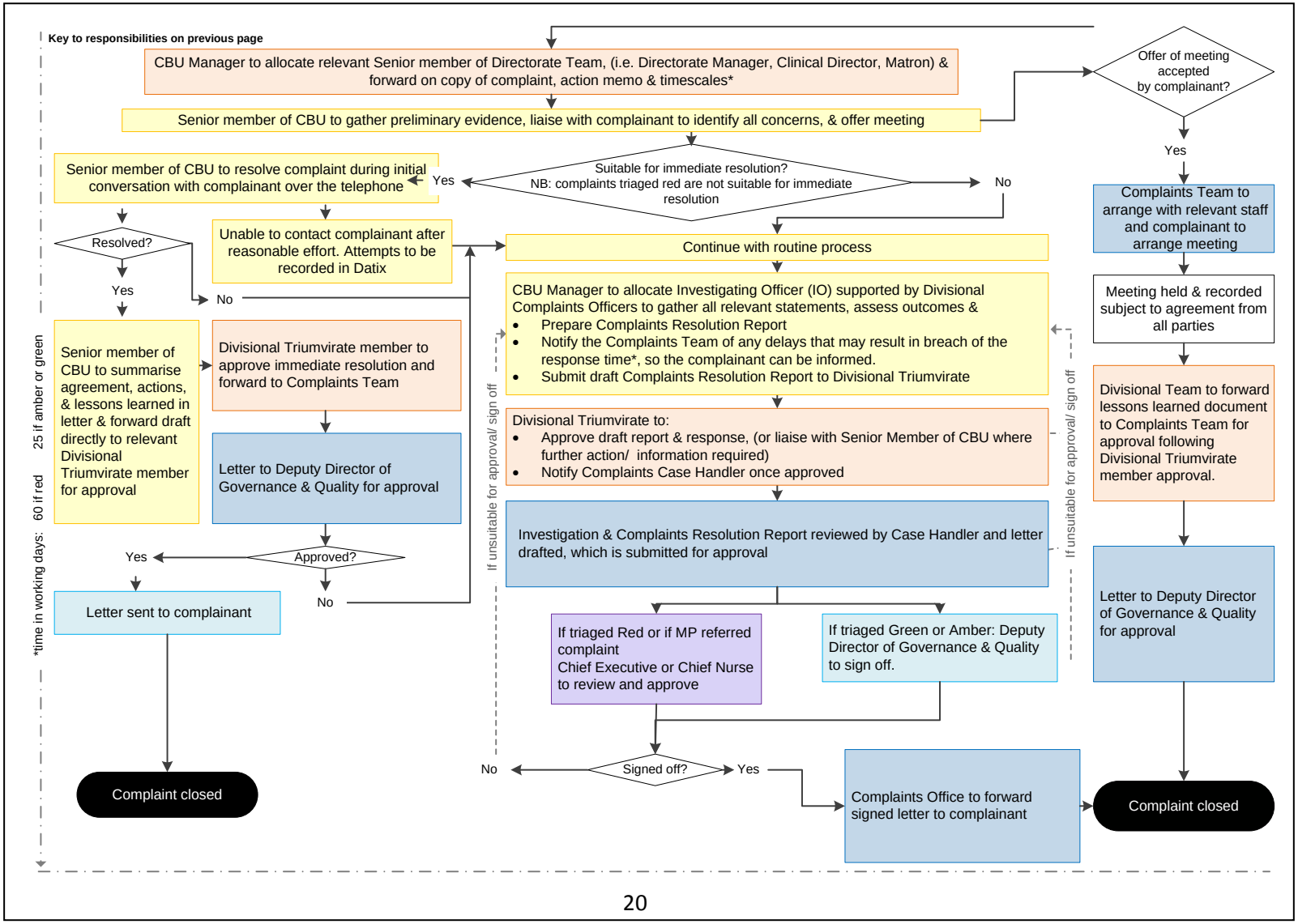

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/101**	
SUBJECT:	Mortality Review Findings Report	
DATE OF MEETING:	27 September 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Dr P. Cantrell, Lead Clinician for Mortality G. Sutton, Clinical Effectiveness Manager	
EXECUTIVE DIRECTOR SPONSOR:	Professor Simon Constable, Medical Director & Deputy CEO	
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):	Choose an item.	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT		
EXECUTIVE SUMMARY (KEY ISSUES):	This briefing paper overviews Trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce Trust mortality rates and the Trust mortality ratio figures.	
RECOMMENDATION:	Quality Committee is asked to note the contents of the briefing paper and discuss and approve the recommended options.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Agenda Ref.	**QC/17/08/179**
	Date of meeting	1 August 2017
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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SUBJECT	Trust Mortality Report

1. BACKGROUND/CONTEXT

The importance of reporting mortality statistics at Board level was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010) to which Warrington and Halton Hospitals NHS Foundation Trust provided a full position response reported at Board in September 2010.

The CQC has developed a national framework at the request of the Department of Health which was launched in March 2017. There is a requirement for all Trusts to collect and publish specified information on deaths on a quarterly basis. By the end of Quarter 2 of 2017/18, the Trust is required to have a policy and approach as to how it will publish the data. The actual publication of the data and learning points should be available as an agenda item at the Trust Board from Quarter 3 of 2017/18 onwards.

We are currently in the process of developing a Trust policy which will be available from the end of Quarter 2 2017/18. This will include our processes, the deaths which have been subjected to a case record review and the estimates of how many of those deaths were judged to be: "*more likely than not to have been due to problems in care*". The learning and actions taken from these reviews will be incorporated into this quarterly report to Trust Board. These reports will be available to a public Board Meeting.

This report is currently based upon the process which is in existence. It will be modified to meet the above requirements from Quarter 3 2017/18 onwards.

2. KEY ELEMENTS

We use the HED (Healthcare Evaluation Data) system to asses our overall mortality data. This allows us to produce graphs and assess our position against other Trusts nationally. We evaluate areas for concern or trends which points us towards focused reviews in these particular areas.

2.1 Screening Reviews

All deaths have a 'screening review' by a Consultant (not the Consultant in charge of the patient) for an overview on the quality of care received by that patient. This review assesses whether a more in-depth review by a member of the Mortality Review Group (MRG) is required.

2.2 Secondary Reviews

Particular groups of patients are reviewed at the MRG:

1. All deaths of patients on DoLs (Deprivation of Liberty)
2. All deaths of patients with learning disabilities
3. All deaths following admission under the Mental Health Act
4. All deaths of patients admitted for an elective surgical procedure
5. All deaths occurring in theatre

Any member of staff can flag a patient to the MRG if there are concerns regarding a patient death for a secondary review. Secondary reviews are presented to the MRG, an assessment of the preventability is made and any actions or lessons to be learned are sent to the appropriate fora.

2.3 Focused Reviews

We conduct focused reviews where the HED system indicates we are an outlier in a particular diagnosis group, for example Pneumonia. It is important to note that the diagnosis group relates to the condition the patient was being treated for during their stay in hospital and not their cause of death. It is also important to note that excess unexpected deaths does not equate to preventable deaths.

Where we are above our expected number of deaths in a diagnosis group for over three months we will work alongside specialists within the appropriate specialty to perform case note reviews of the patients' stay.

This deep dive provides us with valuable learning as to what is needed to be implemented to ensure we have no further triggers within diagnosis groups. Some aspects of learning are applicable to reduce the likelihood of triggering in the future, such as improved documentation and coding, whereas others are specifically of relevance to that treatment, such as using a dip stick before diagnosing a patient as having a urinary tract infection.

2.4 Mortality Data Analysis

There are three main types of overall data used:

2.4.1 Crude Mortality Rates

This is the percentage/number of deaths against the total number of discharges in a particular timeframe. It needs to be used with caution as it does not take into account complexity of patients.

2.4.2 HSMR (Hospital Standardised Mortality Ratio)

All spells culminating in death at the end of a patient pathway defined by the primary diagnosis for the spell. It uses 56 diagnosis groups which account for about 80% of in-hospital deaths; therefore it does not included 'all' deaths.

Adjustments are made for:

• sex	• month of admission

• age • admission method • comorbidities (based on Charlson score) • number of previous emergency admissions • history of previous emergency admissions in the last 12 months	• socio economic deprivation quintile (using Carstairs) • primary diagnosis sub-group • palliative care • year of discharge

2.4.3 SHMI (Summary Hospital Mortality Indicator)
All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities.

Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we still look at HSMR and the crude mortality rates, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

3. MEASUREMENTS/EVALUATIONS

3.1 Screening Reviews

Month	1: Definitely not preventable	2: Slight evidence of preventability	3: Possibly preventable but not very likely	4: Probably avoidable (more than 50:50)	Screening Review Return (%)
March	25	2	2	1	95%
April	67	1	5	1	77%
May	56	3	6	0	80%
June	21	1	0	1	32%[1]

- The **3** reviews returned as *"4: Probably avoidable (more than 50:50)"* are subject to a secondary review by a member of MRG. One of the reviews concurred with the screening review and is now a serious investigation.
- The **13** reviews marked as *"3: Possibly preventable but not very likely"* have been reviewed by the Lead Clinician for Mortality and a further **3** reviews have been put

[1] These reviews are still within 30 day return period so the % return is expected to be low.

forward for secondary review by a member of MRG. The remaining **10** reviews relate to:

Themes	Examples
Confusion over using the Hogan score[2]	**9** of these reviews are patients that arrived at ED after a cardiac arrest. Therefore the Clinicians advised that providing a true preventability was difficult.
End of Life Care	Delayed discharge resulted in two HAPs, an earlier discharge and he could have died peacefully in a better environment.

3.2 Secondary Reviews

There have been **12** secondary reviews conducted between April 2017 and June 2017. **4** of these reviews were identified via a screening review. The remaining **8** were triggered as a result of them being elective deaths (*n*=5) or specifically requested due to an investigation or complaint (*n*=3).

Case	Brief Summary	Hogan Preventability Score
JL	67yr old patient admitted for elective spinal surgery. Operation completed and arrived on ward. Early the following day (05:03) his NEWS score was 4 due to tachycardia, O2 therapy and slight raised temperature. Paracetamol given. At 12:05 was assessed by physio and was independently mobile. At 12:45 consultant ward round undertaken. Patient was keen to go home. To be followed up in 6 weeks. Patient collapsed suddenly at home and died.	Now a serious incident
CA	69 year old female. Lived in a nursing home and was dependent for all care. Not able to communicate verbally. PMH: Cerebral palsy, quadriplegia, epilepsy, registered blind and fixed flexion deformities. Multiple admissions with PEG issues. Admitted with a history of vomiting/feeding. Jejunostomy tube in-situ, it was examined and found to be split. Slowed down feeds. Tube re-sited and then a MET call due to a post-op bleed. Patient then begun to improve, but then developed aspiration pneumonia. Gastric contents pooled in mouth. Desaturation. No escalation to ITU. Discussed with mental capacity advocate present. Patient later died.	1: Definitely not preventable

[2] It would seem logical to only use the Hogan score on Structured Judgement Review Forms rather than screening review forms. This will be discussed at MRG on the 27th June 2017 and a decision made as to how best to proceed.

PN	Received timely senior review within 45 minutes of arrival in ED, initial plan was appropriate and was reviewed by a Consultant within 4h of presentation. The Consultant who reviewed the patient initially decided on laparotomy that night but decision was changed after discussion with a second Consultant who suggested CT scan. Lactate was not repeated as planned, Critical Care admission was sought but this seems inconsistent with the decision not to go to theatre. On the morning following admission he is reviewed by two Consultants and it was unclear which Consultant was the final decision maker. Again that morning the plan to repeat lactate measurement was not carried out until he deteriorated. There were significant problems with delayed intervention in this case which reduced his chances of survival. His original treatment plan was not followed. If lactate had been measured it may have revealed prior to his deterioration that he needed urgent operative management.	5: Possibly preventable This is now a serious incident.
LC	Patient presented at ED critically ill following a hysterectomy at Liverpool Women's Hospital. She received rapid surgical treatment for generalised peritonitis presumably related to an anastomotic leak. Post-operatively cared for on ITU and deteriorated.	1: Definitely not preventable
DP	78yr old admitted with a sigmoid volvulus successfully managed with sigmoid decompression. Patient was ready for discharge when he developed further pain and a decision made to proceed to a Hartmann's procedure. This was delayed as he was anticoagulated, developed confusion, raised WCC and very distended abdomen. He was seen by an F1 and was not escalated to a Senior. Patient collapsed in the toilet and subsequently died.	5: Possibly preventable This is now a serious incident.
DP	Patient presented at ED late after onset of multi-organ failure. The patient had fast AF, however DC cardioversion was not considered due to a high risk of Stroke given her severely impaired LV. Patient was kept comfortable and a ceiling of care put into place.	1: Definitely not preventable

The remaining **6** reviews are due to be presented at MRG on the 27th June and are therefore too late to be included within this report.

3.3 Focused Reviews

The below table sets out the focused reviews that have been planned to be conducted during Quarter 1 due to being mortality outliers:

Diagnosis Group	Trigger	Observed deaths versus expected deaths	Date due for completion	Learning Identified
Cancer of the Rectum & Anus	HSMR & SHMI	7/2.78	June 2017	Report due 25/7/17

Cardiac Dysrhythmias	HSMR	14/7	June 2017	Report due 25/7/17
Fractured Neck of Femur	SHMI	41/30	July 2017	Report due 12/9/17

The above reviews have surpassed their original date for completion due to a number of factors:

- Staffing shortages within Clinical Effectiveness to pull notes and manage the process.
- Clinical pressures affecting the completion of reviews.

The focused reviews provide excellent learning, however, significant medical manpower is needed in order to undertake in-depth structured judgement reviews in these as well as the routine secondary reviews coming through Mortality Review Group. This has been an issue in all of the focused reviews done to date, Regional Enteritis, Pneumonia and UTI. It is our intention to have a fully trained team of Reviewers who will provide adequate manpower to provide both secondary reviews and focused reviews in a timely manner. A business case is underway to allow us to put the team in place to provide this important service.

3.4 Crude Mortality

- Crude mortality should be viewed with caution, as it does not take into account the complexities of the patients, but it is useful to monitor numbers of observed deaths.
- Because of the relative consistency of the relationship between in hospital crude mortality and crude mortality including deaths with 30 days out of hospital, it can give an 'early warning' with regards to mortality including deaths within 30 days out of hospital.

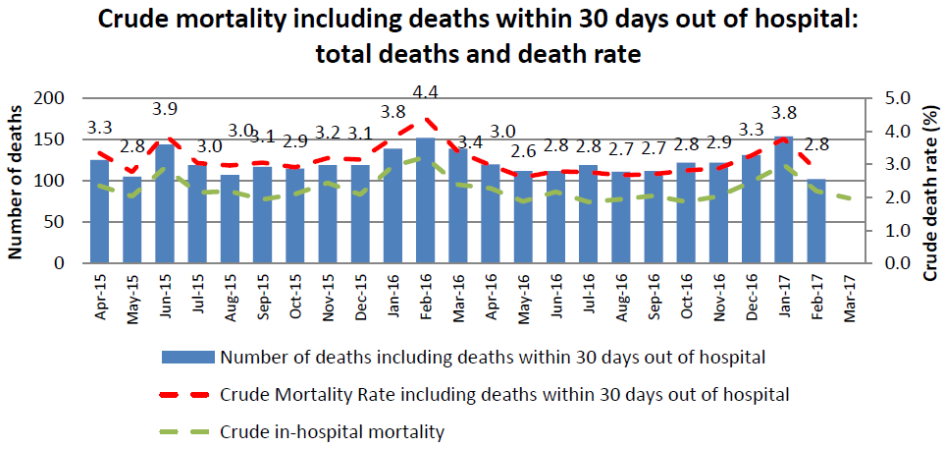


Figure 1: (

- This year's winter peak to date does not seem as high as last year.

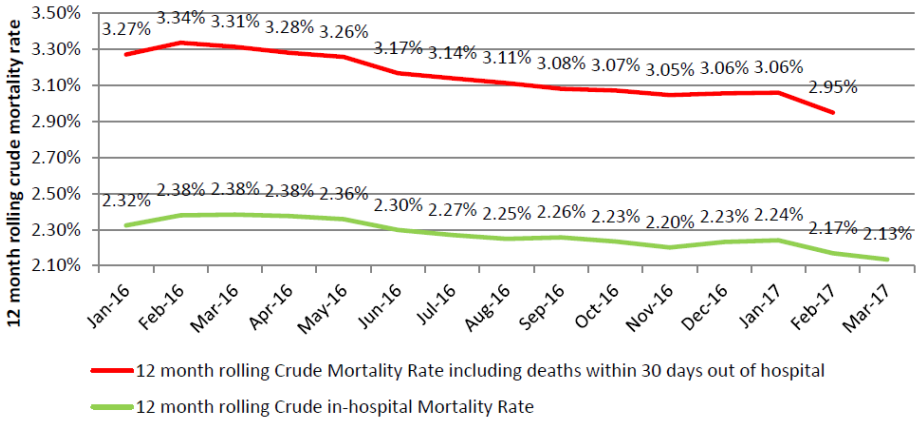


Figure 2: Crude mortality 12 month rolling figures

- Using 12 month rolling rates removes the effect of seasonal variation.
- With this adjustment it is clear to see an improvement in crude mortality, both in-hospital and including deaths within 30 days out of hospital.

3.5 HSMR

- **We are not a national outlier, with a HSMR of 100.98 for April 2016 –March 2017.**
  - This result is not significant at 95% level for the latest 12 months.

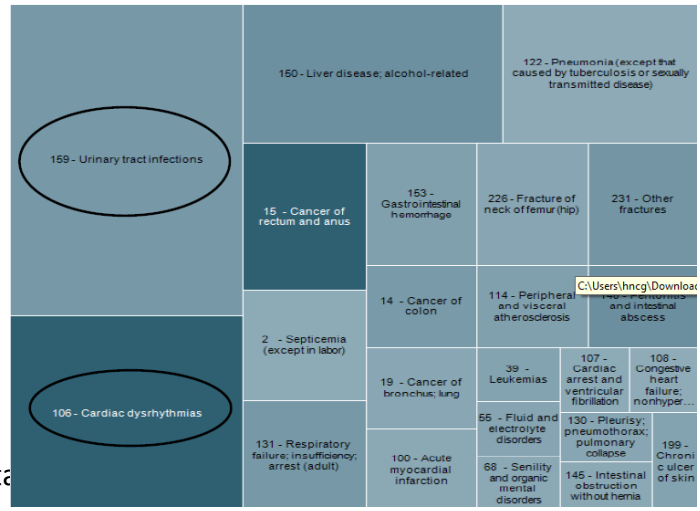
Quarter 1 HSMR:

Our continuing downward trend is due to the appropriate coding of palliative care patients. Since the first quarter of 2016, our levels of palliative care coding has increased consistently and we are

now in line with other acute Trusts nationally. HSMR allows for palliative care, whereas SHMI does not account for this cohort of patients.

3.5.1 HSMR by diagnostic grouping

Deaths following admission with a diagnosis of urinary tract infection is statistically significantly high for both HSMR and SHMI and has also been subject to an alert from the Care Quality Commission (CQC) who requested a report into this cohort of patients. Lessons from this report are contained within Section 3.7



The size of the box denotes the number of patients under a diagnosis group.

The darker the colour, the higher the number of observed deaths against "expected" deaths.

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3.5.2 HSMR Cardiac Dysrhythmias Outlier

If we look at the patients in this category, and split them into 'high risk' and 'low risk' based on the mortality risk which the model has attributed to the patients (mortality risk >0.3 – 'high risk', mortality risk <=0.3 'low risk', say):

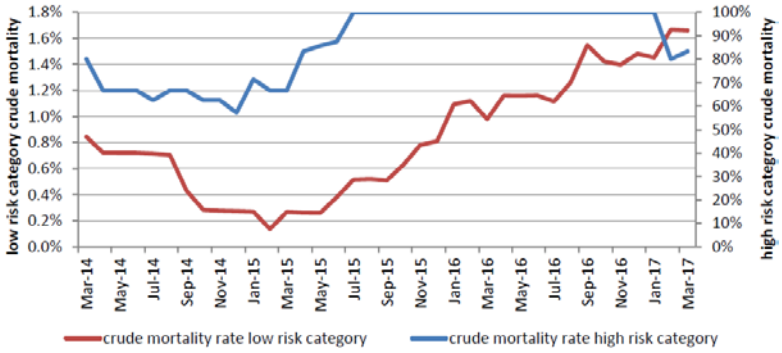
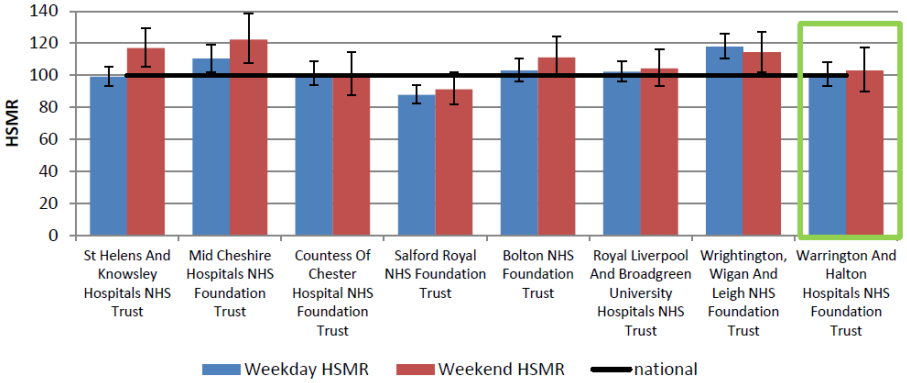


Figure 3: Crude Mortality trend for high risk vs low risk identified Cardiac Dysrhythmia patients

- The number of high risk patients identified is a very small proportion of the cardiac dysrhythmia population captured, but the crude mortality rate in this cohort is extremely high.
- Although much lower, the crude mortality rate for the patients identified as 'low risk' is increasing.
- Either some of the patients who are currently identified as low risk should actually be a higher risk than has been predicted based on the coding, or the mortality rate for this tranche of 'low risk' patients is worsening.

- Focused review into these patients is due at MRG in July 2017.

3.5.3 Weekend/Weekday HSMR



This graph shows there is very little difference between the weekday and weekend HSMR for Warrington, and neither score is statistically significantly high.

3.6 SHMI

We are a 'green rating' for this indicator, with a SHMI of 107.04 for the period March 2016 to February 2017. We are not an outlier for this indicator.

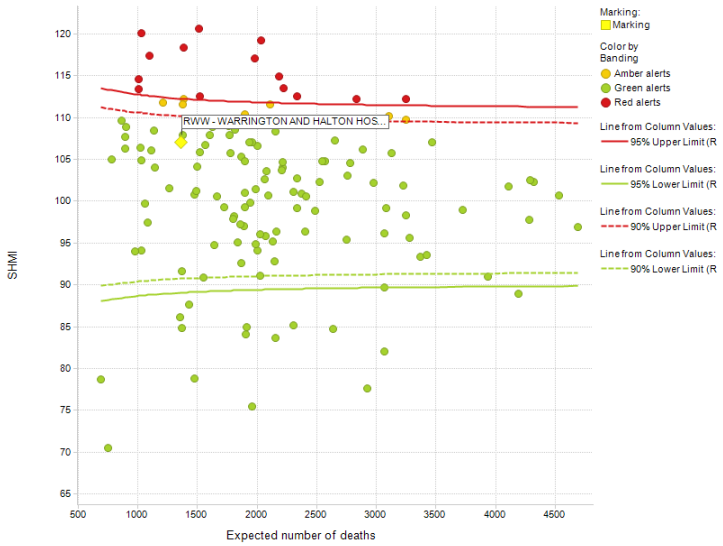
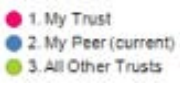
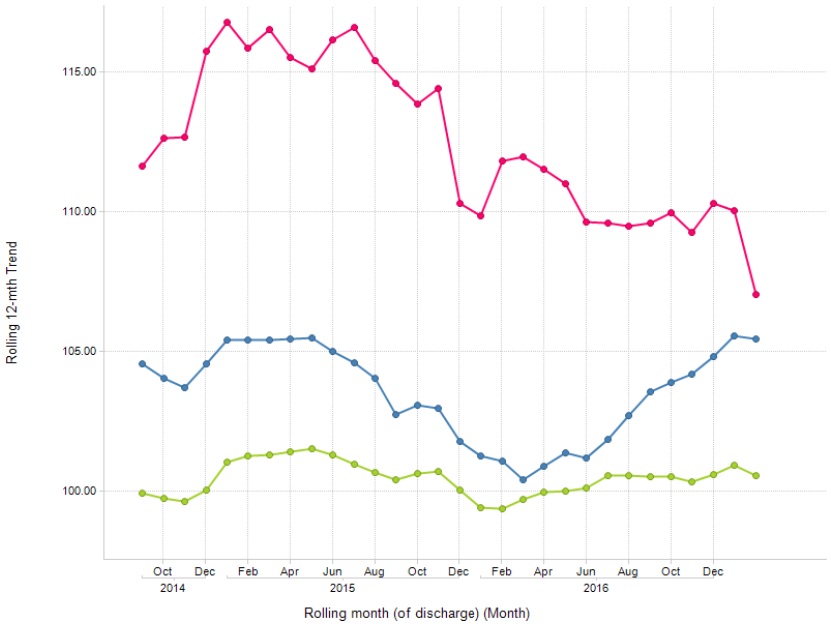


Figure 4: SHMI Funnel Plot (December 2015 - November 2016)

- We have had a higher SHMI than our peers and the average for all other acute Trusts.
- Whilst our rate remains mostly higher than the average for all other acute trusts, its monthly SHMI figures have been broadly on a par with its peer group since April 2016.





- Warrington is showing a downward trend while the peer group is showing an upward trend.

St Helens & Knowsley	Mid Cheshire	Countess of Chester	Salford Royal	Bolton	Royal Liverpool	Wrightington, Wigan & Leigh	Warrington & Halton

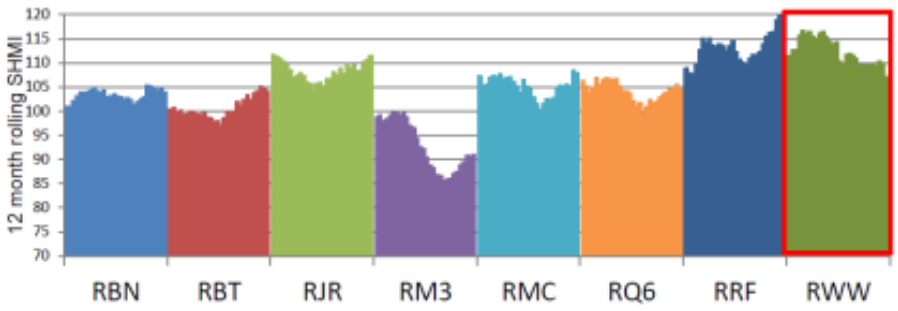


Figure 6: 12 month rolling SHMI over last 3 years for Warrington compared to peers

- 12 month rolling SHMI has been used to eliminate seasonal variation
- Our continuing improvement can be seen
- Salford shows the greatest improvement although their SHMI may be starting to rise slightly.

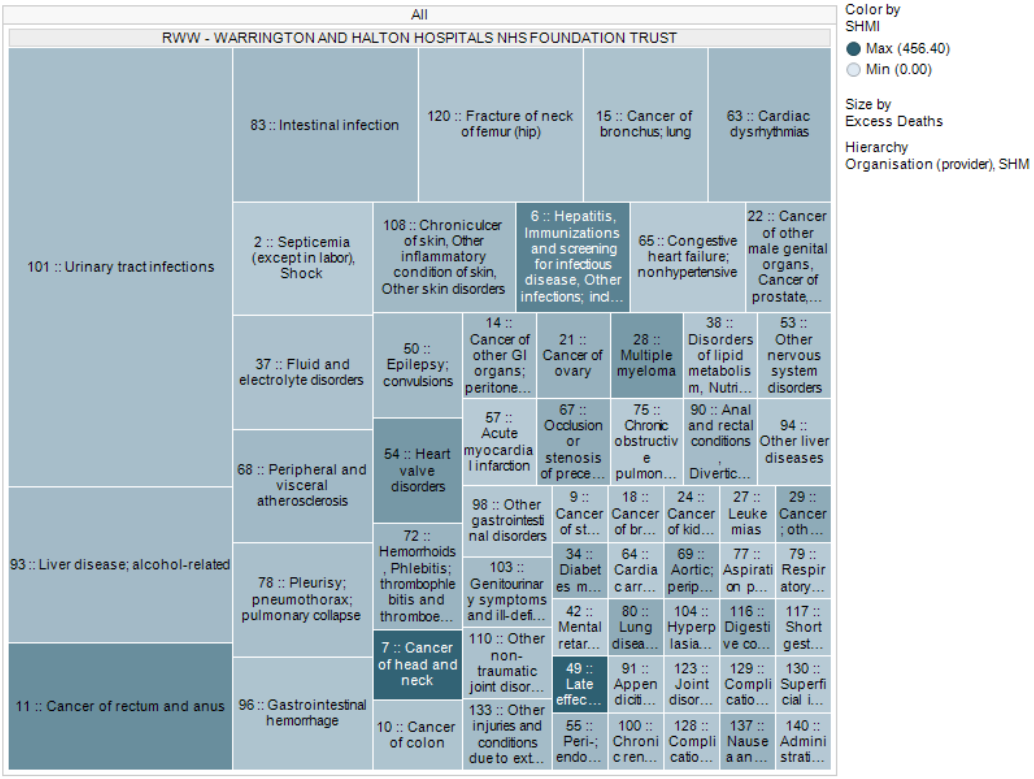


Figure 7: SHMI excess deaths by diagnostic grouping; tree diagram

- CCS groups which are statistically significantly high are ringed red.

3.6.1 Weekend/Weekday SHMI

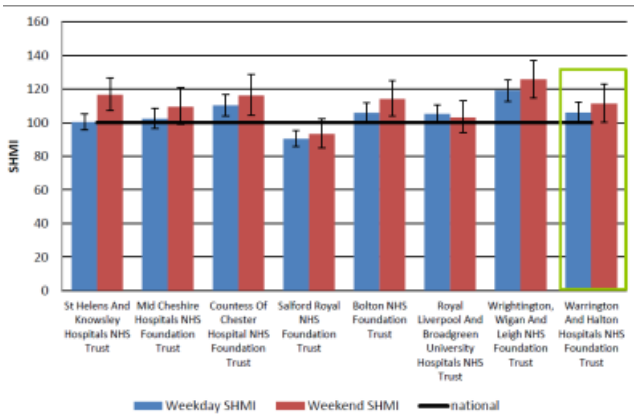


Figure 8: Weekend / weekday SHMI compared to peers

- Weekend SHMI is higher than the weekday SHMI for Warrington and the same is true for all of its peers except Royal Liverpool.
- Weekend SHMI is statistically significantly higher than expected for Warrington but not weekday. The confidence interval for Warrington's weekend SHMI result of 111.15 is (100.1, 123.1); very close to not being a statistically significant result.

- Weekend SHMI is also significant for St Helens and Knowsley, Countess of Chester, Bolton and Wrightington, Wigan and Leigh.
- SHMI is statistically significantly low for Salford for weekdays.
- The ratio of weekend SHMI to weekday SHMI is relatively low for Warrington. From the peer group only Liverpool and Salford are lower.

3.7 Learning Identified from Mortality Reviews

Action Plan for Recent UTI Focused Review:

No adherence to existing UTI Pathway Pathway not easily visible (embedded within Antibiotic Formulary). Doctors probably unaware of existence of Pathway.	• Review and relaunch Pathway • Ensure Pathway is visible and accessible in all admitting areas in the Trust e.g. AED, AMU, SAU & A1. • Ensure all doctors are aware of Pathway • Audit adherence in 6/12.
Poor documentation Unclear diagnosis difficult for Coders to be sure of primary diagnosis.	• Safety Alert – Do not make a diagnosis unless the criteria fulfil the UTI pathway recommendations. • Education for F1, F2 doctors regarding how to document and importance of correct early diagnosis. • Post-take ward round consultants to check accuracy of junior doctor's diagnosis in Lorenzo. Audit that this is occurring. • Coder Audit to review the number of FCEs in an admission before definitive diagnosis is reached. • All notes where R-Codes in 1st/2nd FCE with no definitive diagnosis to be returned to consultant in charge of patient to review and ensure a definite diagnosis is documented.
Co-morbidity levels lower than Peer Groups Abnormal blood results written as a figure: Coders are not allowed to interpret this.	• All abnormal blood results to be indicated by comment 'high' or 'low' to allow Coders to document. • Introduce recording co-morbidities in 'Health Issues' section of Lorenzo (this allows co-morbidities to be carried across FCEs & admissions). • We expect an audit from each CBU in February 2018 to show this is in place.
Better communication between Coders and Junior Doctors is likely to improve both documentation and	Coders to be on wards twice weekly to discuss coding queries for specific cases with junior doctors.

coding.	
Medical staff unaware that a urine culture was available showing that the antibiotic which the patient is on was not sensitive for that infection.	• Safety alert to ensure **ALL** doctors check results in a timely manner. • Microbiology to review practice of ensuring doctors/wards aware.
Evidence of probable preventable death in one case	Escalate to Level 2 investigation.
Delays in recognising and initiating end-of-life care	Send examples to Medical Education to be included in existing mandatory training for Consultants.
Confusion between delirium and dementia	Safety alert to all medical staff to be aware of difficulty in this group of patients.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/102**
SUBJECT:	**Learning from Deaths Policy**
DATE OF MEETING:	27th September 2017
ACTION REQUIRED	**For approval**
AUTHOR(S):	Simon Constable, Medical Director + Deputy CEO
EXECUTIVE DIRECTOR SPONSOR:	Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality
	BAF1.3: National & Local Mandatory, Operational Targets
	Choose an item.
STRATEGIC CONTEXT	The Trust must adopt and publish a Learning from Deaths policy by the end of September 2017 with a view to publishing the number of probably or definitely avoidable deaths in our care from Quarter 3 and 4 2017 – 2018.
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has seen a steady reduction in crude mortality rates, HSMR and SHMI over the last two years such that both of the latter are within the "as expected" range as published by NHS Digital. The pure statistical nature of HSMR and SHMI means that they can be particularly hard to explain and be understood by patients, their families and the wider public. Rates higher than the expected range should be regarded as "smoke signals" for further investigation as opposed to an automatic assumption of excess avoidable and preventable death. Their methodologies and inherent flaws have been subject to some criticism over recent years with a national desire to supplement the reporting of HSMR and SHMI with a qualitative assessment of potentially avoidable deaths utilising the tool of Subjective Judgement Review (SJR). The emphasis is on genuine learning from deaths. Since late 2015, under the Trust Mortality Review Group, the Trust has had a Mortality Peer Review process utilising a screening tool with escalation to an in-

	depth secondary review where concerns about care have been flagged. Latterly this has involved the SJR tool. This new policy is the natural development of the existing process utilising the SJR tool for all deaths in scope. A pilot period of implementation of six months is recommended to ensure the system and reporting operate effectively and meet the requirements of key stakeholders including HM Coroner.	
RECOMMENDATION:	This policy is approved by the Board.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Agenda Ref.	
	Date of meeting	1st August 2017
	Summary of Outcome	Further development of policy
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Learning from Deaths	AGENDA REF:	PBM/17/09/65

1. BACKGROUND/CONTEXT

The Care Quality Commission published its review "Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England" in December 2016. The report's recommendations were accepted by NHS England and a range of commitments were made as to how we can improve how we learn when we review the care provided to our patients that have died. As a result, the National Quality Board published a framework for NHS Acute Trusts to utilise to meet the report's recommendations.

The commitments underpin this policy which outlines how we will strengthen our governance and capability, increase our transparency via improved data collection and reporting when our patients die, and fundamentally, improve how we engage with families and carers.

It provides guidance on what the inclusion and exclusion criteria are to trigger a review into the care provided to our patients. As indicated within this document, a number of statutory processes are already in existence for patients neonatal, maternity and child with learning disability deaths; therefore they are included within the process for learning from deaths.

Learning from the care provided to our patients who have died is an essential part of clinical governance and our quality improvement work. This document formalises our approach and will describe the standards and reporting which has been agreed nationally.

2. KEY ELEMENTS

This policy describes how we meet the National Quality Board's recommendations as listed below:

- Our process for responding to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death.
- Our evidence-based approach to undertaking case record reviews
- The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
- How we engage with and support bereaved families and carers.
- The method in which we involve them in investigations

- The themes and issues identified from review and investigation, including examples of good practice
- Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

3. IMPACT ON QPS?

5.1 Quality

- Timely and comprehensive review of deaths where a complaint is made.
- Focused reviews into areas for quality improvement to ensure learning is identified, extracted and made available for future quality planning.

5.2 People

- Enhanced Consultant engagement as the focus is shifted from screening to learning from deaths.
- Consultants are supported to use the SJR methodology to identify learning from deaths within their Specialities where HED triggers an alert for a relevant diagnosis outlier.

5.3 Sustainability

- Learning that has been identified using the methodology will feed into the Trust's medium term quality programme and reinforce the appropriateness and reliability of those services.

4. TRAJECTORIES/OBJECTIVES AGREED

The policy will have a six month period of pilot implementation allowing a smooth transition from existing processes.

5. MONITORING/REPORTING ROUTES

We have a requirement to collect and publish specific information every quarter on:

- the total number of inpatient deaths
- the number of deaths we have subjected to case record review (desktop review of case notes using a structured method) (NB: information relating to deaths reviewed using different methodologies – eg inpatient adult deaths, child deaths, deaths of patient with learning disabilities – may be separated in the report to provide distinction/clarity where required)
- the number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents)

- of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care

6. TIMELINES

September 2017	Policy ratified and made available on Trust external website.
October 2017	Patient deaths within the categories for SJR will be reviewed using the aforementioned methodology.
December 2017	Screening reviews no longer required.
January 2018	Quarter 3 Learning from Deaths dashboard at Public Board.
March 2018	Policy reviewed by Mortality Review Group
April 2018	Amendments to processes and policy ratified through Patient Safety & Clinical Effectiveness Sub-Committee
April 2018	Quarter 3 and Quarter 4 figures published within Quality Account

7. ASSURANCE COMMITTEE

The Quality Committee.

8. RECOMMENDATIONS

This policy is approved by the Board.

LEARNING FROM DEATHS

CONTENTS AND PAGE NUMBER

EXECUTIVE SUMMARY/ INTRODUCTION

The Care Quality Commission published its review "*Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England*" in December 2016. The report's recommendations were accepted by NHS England and a range of commitments were made as to how we can improve how we learn when we review the care provided to our patients that have died. As a result, the National Quality Board published a framework for NHS Acute Trusts to utilise to meet the report's recommendations[1].

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Learning from the care provided to our patients who have died is an essential part of clinical governance and our quality improvement work. This document formalises our approach and will describe the standards and reporting which has been agreed nationally.

Professor Simon Constable
Medical Director & Deputy Chief Executive

PURPOSE AND SCOPE

This document sets out our approach for reviewing patients who have died under our care, bringing together the different mechanisms we have for investigating deaths, including the Serious Incident Process, internal mortality review process and external requirements regarding certain deaths. It describes the scope of the patients for review and what deaths will be selected for case review, using either Root Causes Analysis methodology or the Structured Judgement Review form as a means of assessing the care.

It describes the process for reviewing deaths and the next steps should a case record review identify a problem in care that meets the definition of a patient safety incident. A flow chart is provided in 1.2 Mortality Review Process, which sets out the steps from a patient's death, through to the conclusion of the review and any further actions required.

This document describes how we support bereaved families and carers, our standards on the information to be offered – for example, how and when families may be contacted about investigations, what support is available locally, what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement, and how this will be communicated, nationally and locally.

[1] National Quality Board https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

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The scope is Trust-wide and incorporates the stages from the review to the interface with Trust governance processes.

We describe how the review of case notes and serious incident investigations identify actions and areas which will lead to effective and sustainable quality improvement work.

DUTIES AND RESPONSIBILITIES

Board of Directors
It is the responsibility of the Board of Directors to ensure systems and processes are in place to monitor and implement this procedural document.

Chief Executive
In line with the requirements of Governance, the Chief Executive, as Accountable Officer, carries ultimate responsibility for assuring the quality of the services provided by the Trust that is included within this procedural document.

Delegated Executive Lead
The Medical Director has been delegated by the Chief Executive to take the Executive ownership for Learning from Deaths within the Trust.

Chief Nurse
The Chief Nurse has Executive accountability for Clinical Governance within the Trust and ensuring that the framework to deliver this policy is in place within the Trust.

Senior Clinician and Managers
The Lead Clinician for Mortality, Clinical Effectiveness Manager, Deputy Director of Integrated Governance and Quality and Associate Medical Director for Quality are responsible for supporting the Medical Director with the execution, monitoring and evaluation of the policy as follows:

Role	Area of Responsibility
Deputy Director of Integrated Governance & Quality	▪ Ensuring there is an integrated governance strategy in place, to enable delivery of this policy. ▪ To ensure that the Trust's review and learning from deaths policy and procedures meet statutory and regulatory requirements. ▪ To ensure there is a Learning Framework in place within the Trust, to support areas for quality improvement. ▪ To ensure that the Trust meets its requirements of Duty of Candour with regard to review and learning from deaths.

Associate Medical Director for Quality	▪ Working with Executive Lead and the Deputy Director of Integrated Governance & Quality, ensure that there are appropriate governance and quality improvement processes in place aligned to delivery of the Learning from Deaths policy. ▪ Ensure that learning from deaths is integrated into quality improvement priorities within the Trust. ▪ Ensure that learning is cascaded, via the Trust's Lessons Learned Framework.
Lead Clinician for Mortality	▪ Chair of Trust Mortality Review Group and senior strategic medical leadership with regard to Mortality review processes within the Trust; ▪ Ensure that any internal/external alerts regarding mortality are investigated and reported appropriately. ▪ Have a system in place to ensure reporting of preventable deaths. ▪ Ensure there is adequate capacity and training for individuals regarding the investigation of deaths within the Trust. ▪ Promote assurance role (Board reports).
Clinical Effectiveness Manager	▪ Management and evaluation of the mortality review process. ▪ Link in with the appropriate roles to ensure the execution of this policy and its contents. ▪ Liaise with key personnel to ensure compliance with this policy. ▪ Prepare monthly reports to the appropriate fora ▪ Prepare quarterly dashboards
Quality Committee	Approval and oversight of this policy on behalf of the Board of Directors.
Mortality Review Group	A Group established to review deaths from a stratified sample within the Trust, and ensure that there is escalation, where appropriate, and learning cascaded.
Consultants' Secretaries/Clerks	Secretarial/clerical staff will support the process by ensuring that doctors are aware of their requests for participation in the review and by providing case notes as necessary.
Medical Records	Staff in Medical Records will make case notes available for collection by Secretaries/ Clerks so that case note reviews can be undertaken.

DOCUMENTED PROCESS/PROCEDURE TO BE FOLLOWED

Chapter 1: Mortality Review Process

1.1 Definition of the total number of deaths in scope for case review

1) The deaths of all in-patients and those that die within our Emergency Department are within the scope of review using the Structured Judgement Review (SJR) methodology[2] (See Appendix 1 for a copy of the form).

2) All deaths of pregnant women or women up to 42 days following the end of the pregnancy (regardless of the place and circumstances of the death).

3) Perinatal or infant deaths including:
   - Stillbirths – the baby is delivered from 24+0 weeks gestation showing no signs of life.
   - Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
   - Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

4) Infant or child deaths.

5) Deaths of patients with a learning disability. These patients will be subject to an external review as per national guidance alongside a Structured Judgement Review.

1.2 Mortality Review Process

There are a number of different processes used to review deaths dependent upon the type of death. Maternal deaths, perinatal deaths, child deaths, trauma deaths and deaths of patients with learning disabilities all have separate national processes. These all fit into a single Trust mortality review via the Mortality Review Group (MRG). Please see 1.3 for further details. The majority of the deaths within the Trust are adults. Those adult deaths, indicated for further review as part of the mortality review filter process will be coordinated by the Clinical Effectiveness Manager and conducted by a member or members of the Mortality Review Group using the Structured Judgement Review (SJR) methodology.

Review findings will be discussed initially through the monthly Mortality Review Group where a decision will be arrived as to:

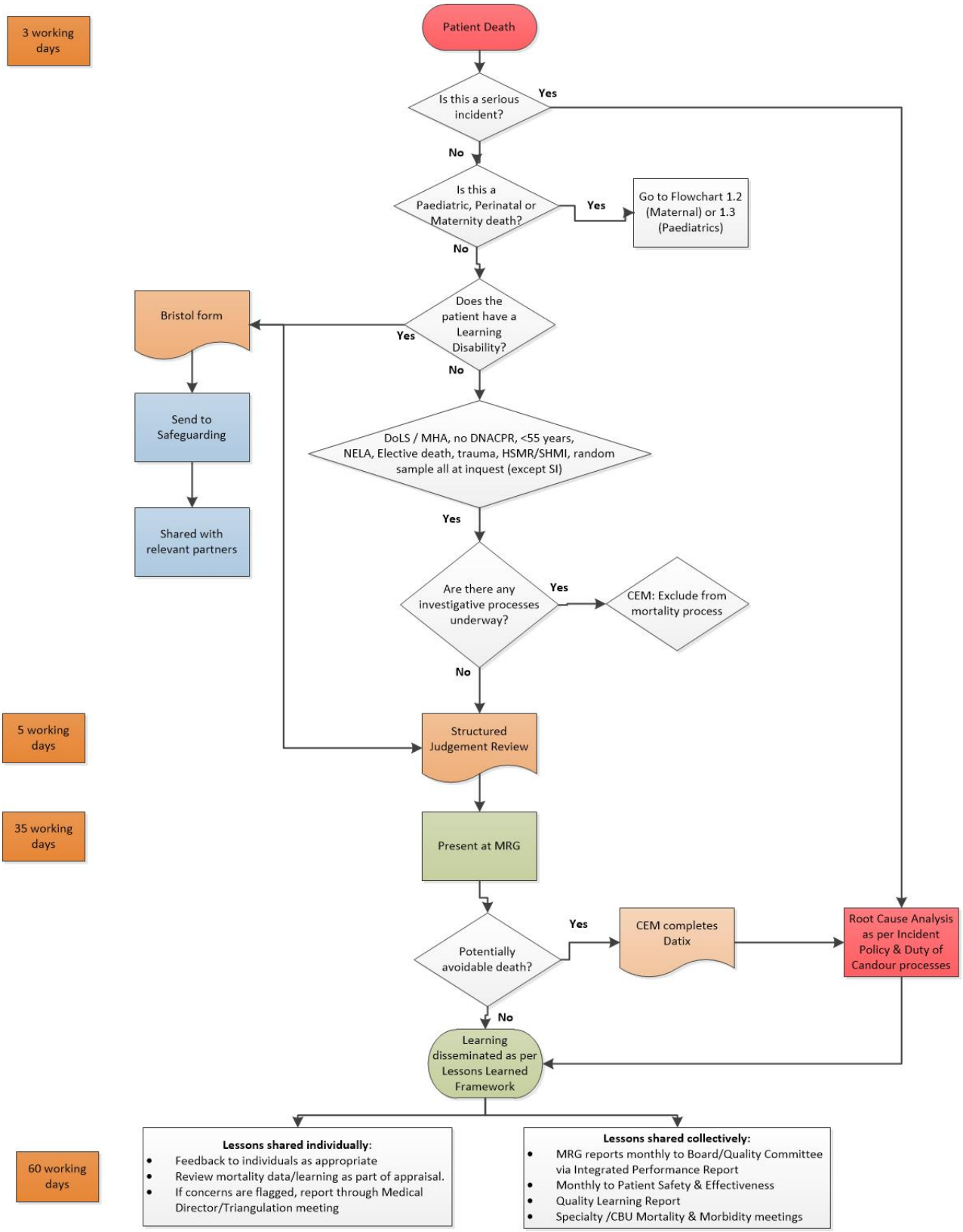
1) Whether a death was due to problems related to the care of the patient, in this case a Datix incident form will be completed and a Root Cause Analysis investigation will be carried out.
2) What action or actions are required following results of the review.

[2] Royal College of Physicians of London, 2016

The findings will then be taken forward through, but not limited to, the following fora:

- Patient Safety & Clinical Effectiveness Sub-Committee
- Medical Cabinet
- Divisional Bilateral Governance meetings
- CBU Governance meetings
- Mortality and Morbidity meetings across the Trust

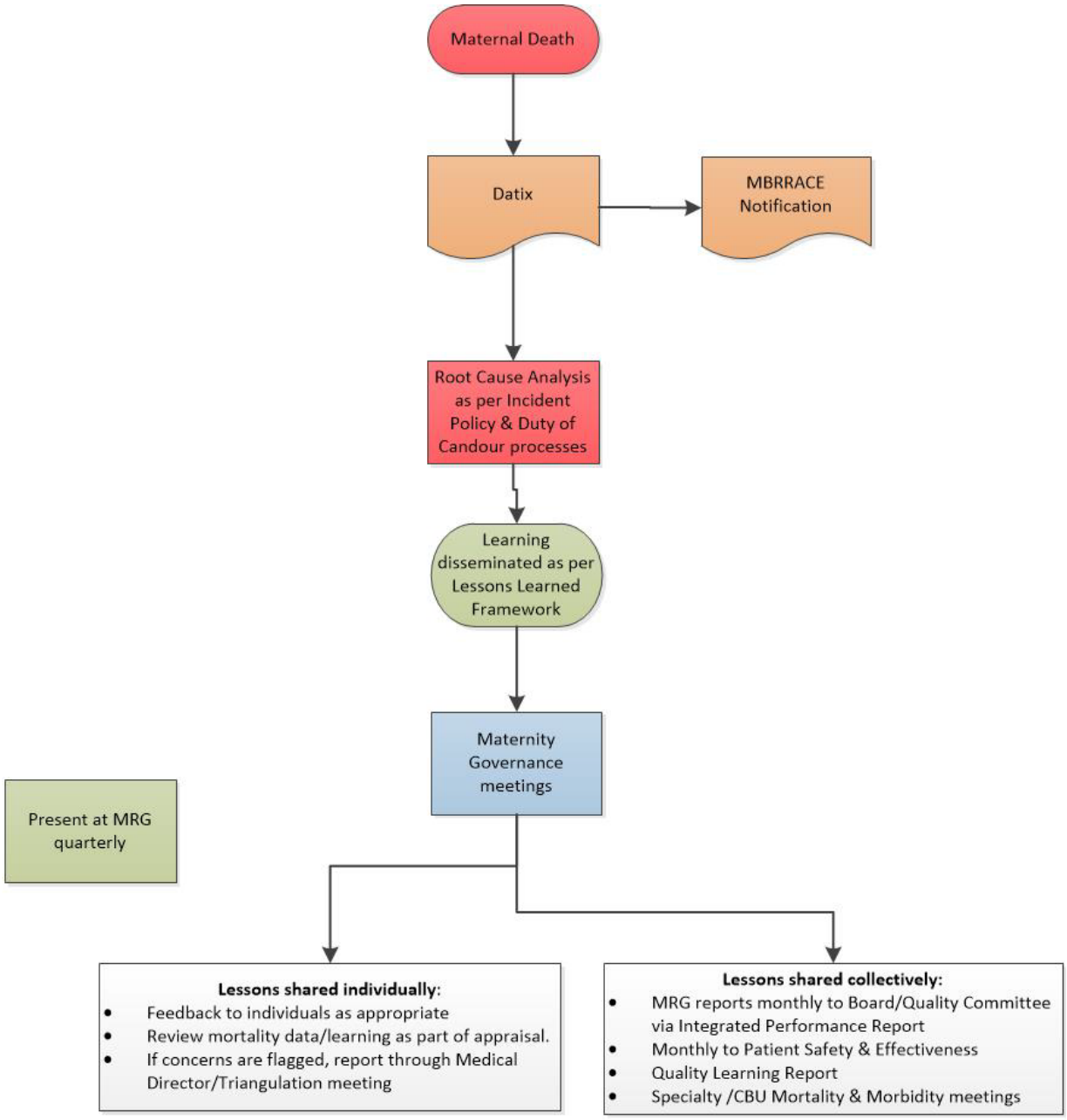
Flowchart 1.1 Mortality Process



Key/Abbreviations

CEM – Clinical Effectiveness Manager
CDOP – Child Death Overview Panel
DoLS - Deprivation of Liberty Safeguards
EBC – Every Birth Counts
HSMR – Hospital Standardised Mortality Ratio
MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MRG – Mortality Review Group
SHMI – Summary Hospital-level Mortality Index

Flowchart 1.2 Trust Mortality Process for Maternal Deaths



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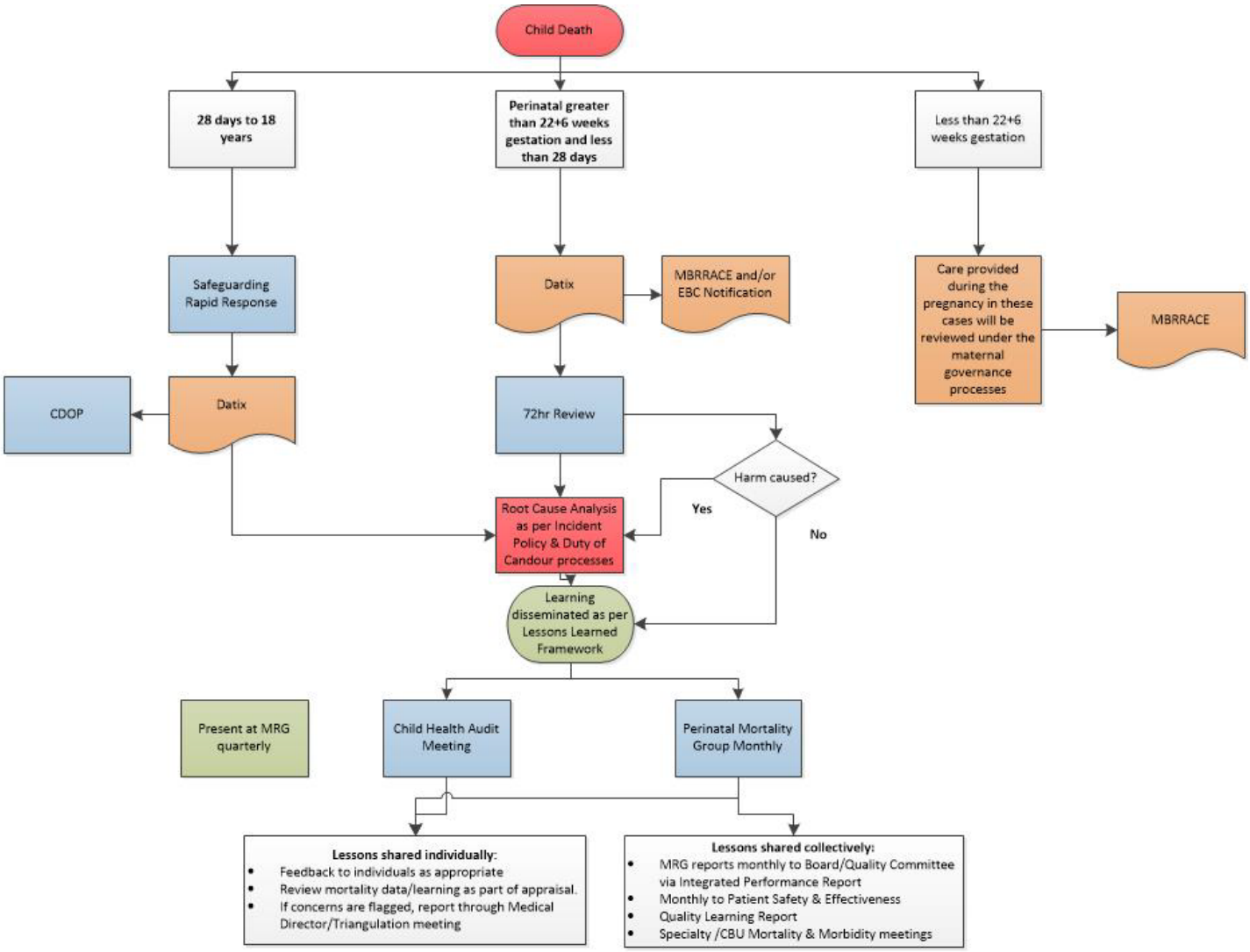
Flowchart 1.3 Trust Mortality Process for Paediatric Deaths



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SHMI – Summary Hospital-level Mortality Index

1.3 Inclusion criteria for selecting deaths for case review

We capture all deaths which occur within the Trust, including those which occur in the Emergency Department on a monthly basis.

In order to provide a high level of scrutiny to those patients who die in our care deemed, at least initially, to be at relatively low risk of death, not all deaths will be subject to the in-depth review afforded by the SJR process. Of these deaths specific groups will undergo an SJR from the case notes. The following categories of patients will be subject to a case review:

- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- All deaths of patients subject to care interventions with elective procedures. These will be identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform our existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the specific request of the Chief Executive, Medical Director or Chief Nurse.

Triangulation of deaths where a prior or existing investigation of their care has taken or is taking place will be undertaken by the Clinical Effectiveness Manager, especially in cases where there is a recorded incident, complaint or claim. This is to reduce duplication and ensure sharing of information is available. The Clinical Effectiveness Manager will interrogate Datix to search for instances where investigations or a complaint is ongoing and this information will be made available to the Consultant undertaking the SJR.

All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.

Certain groups of patient deaths have existing review processes already in place:

1.3.1 Infant or Child (under 18 years of age) Death (excluding still births/neonatal deaths)

The investigation of these deaths will be undertaken using the Trust's Level 1/Level 2 investigation process. There is a requirement to inform statutory bodies in accordance with *Working Together to Safeguard Children* using the Department for Education form (Appendix 2). A national review of child mortality review processes is currently underway, in order to provide a simplified and standard mortality review process in the community and hospitals. This is due towards the end of 2017 and will replace these existing Trust processes once

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available. A quarterly report of all infant and child deaths will be presented to MRG.

1.3.2 Perinatal Deaths

All extended perinatal deaths should be reported on the Datix Incident Reporting system. Incidents eligible for notification to *Each Baby Counts* and incidents deemed to be moderate/severe harm incidents should have an initial review of the incident using the Trust

72 hour review template document. A decision should be taken at this review regarding the level of review/investigation to be undertaken i.e. perinatal mortality review using the locally approved perinatal mortality review tool (Appendix 2) or if harm has been caused a Level 1/Level 2 investigation will be conducted as per Trust processes.

A standardised Perinatal Mortality Review Tool is being developed by the RCOG to enable maternity and neonatal services to systematically review and learn from every stillbirth and neonatal death in a standardised way. The Trust currently uses a structured review tool (see Appendix 2) whilst awaiting availability of the RCOG Perinatal Mortality Review Tool (this is due to be available towards the end of 2017 and this policy will be amended accordingly).

All extended perinatal deaths are presented and discussed at the monthly Perinatal Mortality meeting to identify learning outcomes and action plans. Quarterly figures on extended perinatal deaths and maternal deaths with identified learning outcomes and action plans are submitted to the Women's Health Governance Group, CBU Governance Meeting and then reported up to Mortality Review Group on a quarterly basis.

1.3.3 Maternal Deaths

All maternal deaths, which include all deaths in women occurring during or in the 42 days after the end of the pregnancy, will be subjected to a standardised review process to identify learning outcomes.

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK), appointed by Health Quality Improvement Partnership and funded by NHS England, run the national Maternal, Newborn and Infant Clinical Outcomes Review to conduct surveillance of all late fetal losses, stillbirths and neonatal deaths and confidential enquiries of all maternal deaths. The designated lead reporters for the Trust report the above deaths to MBRRACE.

All maternal deaths will have an investigation using the Trust's Level 1/Level 2 process as appropriate and outcomes will be reported quarterly to MRG.

1.3.4 Deaths in patients who have learning disabilities

All deaths are notified to the LeDeR program where the case is allocated to a case reviewer who assess whether a full, multiagency review is required. At Trust level, all of these cases will have a full review of the case notes using the SJR methodology. This will be in place and available for the case reviewer who has been allocated by the LeDeR program. The Clinical Effectiveness Manager will liaise with the Trust Lead Nurse Adult Safeguarding to ensure the sharing of case reviews of patients, with a learning disability, who have died.

1.4 Exclusion criteria for SJR case reviews

Any deaths which are currently being reviewed by other processes – e.g. serious incident process, will be excluded from having a SJR, unless specifically requested by the Governance Department.

1.5 Mortality Review Group (MRG)

There will be a team of fully trained Consultants who will review deaths using the SJR. There will also be nursing staff who attend the group who will also be trained and will have input into the nursing aspect of deaths where relevant. The Adult Safeguarding Nurse Lead will be involved in all of the safeguarding SJR reviews. The Chief Pharmacist/Deputy Chief Pharmacist will be consulted on a case-by-case basis depending upon the nature of the review.

All patients will have their reviews discussed at the wider MRG where the decision on whether the patient's death was due to a problem in care (ie avoidable mortality) will be made. The group will meet monthly, excluding August.

MRG members will be fully trained using the Structured Judgement Review method. They will review all deaths using this methodology and provide a short summary for presentations at the MRG meetings for discussion by the group. All reviews should be presented within an 8 week timeframe.

There will be groups of deaths to be reviewed from time to time, such as those patients identified as outliers on the HED report, random samples (such as weekend deaths) or particular groups chosen for quality improvement work which will require members of the MRG to work together and produce a unified report for presentation to the group.

1.5.1 Recruiting to MRG

This process will be underpinned by having a well-trained, committed team of medical case note reviewers. There is an expectation that Consultants may leave the group for any number of reasons and so a recruitment process is in place to ensure we have the right membership. Consultants will be invited to apply and a job description will be available (please see Appendix 5). Interviews will take place to appoint using a set criteria and specification. It is important to note that we require a defined number of Consultants at MRG within certain specialties, to ensure we have the clinical expertise to correctly review the deaths.

The specialties we have identified as essential are as follows:

General Surgery
General Medicine
Intensive Care
End of Life
Elderly Care

The following specialties have been identified as desirable:

Cardiology
Gastroenterology
Respiratory Medicine
Orthopaedics
Diabetes & Endocrinology

Consultants from other specialties are welcome as long as they have the appropriate skills to provide a full review. The recruiting panel will consist of Lead Clinician for Mortality, Associate Medical Director for Quality Governance, Warrington CCG Chief Nurse and Clinical Effectiveness Manager.

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1.6 Morbidity & Mortality Meetings

Morbidity and mortality (M&M) meetings have been taking place in various forms for over a century. Initially they were used as an aid to training, by taking time during the working week to discuss adverse outcomes. In modern healthcare settings, these meetings are no longer just an opportunity to educate trainees. Healthcare staff make use of these meetings to learn lessons from clinical outcomes and drive improvements in service delivery. Healthcare staff will regularly attend morbidity and mortality meetings as a key activity for reviewing the performance of the team and ensuring quality. The M&M meeting has a central function in supporting services to achieve and maintain high standards of care.

M&M meetings are a Trust requirement in:

- Medicine
- Surgery
- Orthopaedics
- Intensive Care
- Paediatrics
- Neonatology
- Obstetrics & Gynaecology
- Emergency Department

There is a requirement that they take place on the Trust's allocated audit days to ensure all relevant Consultants are available and present. They will be chaired by a member of the MRG or the relevant governance/quality lead and will discuss:

- Cases provided by the MRG with any actions/learning disseminated.
- Any mortality cases which have been investigated as an SI along with any actions from the learning.
- Any other mortality cases which the Department wish to discuss.
- Feedback of any issues from the M&M is required back to MRG via the Chair. The learning from the Neonatal and Paediatrics Morbidity and Mortality meetings will be fed into the CDOP, to prevent duplication.

1.7 Board Reports

Reports on our learning from deaths will be sent to Trust Board on a quarterly basis. These reports will include, but not limited to the following:

- Total number of inpatient deaths (including ED deaths)
- Total number of deaths subject to a SJR
- Estimates of the number of deaths which have had a SJR judged to have been "likely due to problems in care" (Hogan score 4, 5 and 6 = RCP score 1, 2 and 3 respectively)
- Numbers of focused reviews that have been undertaken
- Learning and actions from all of the reviews

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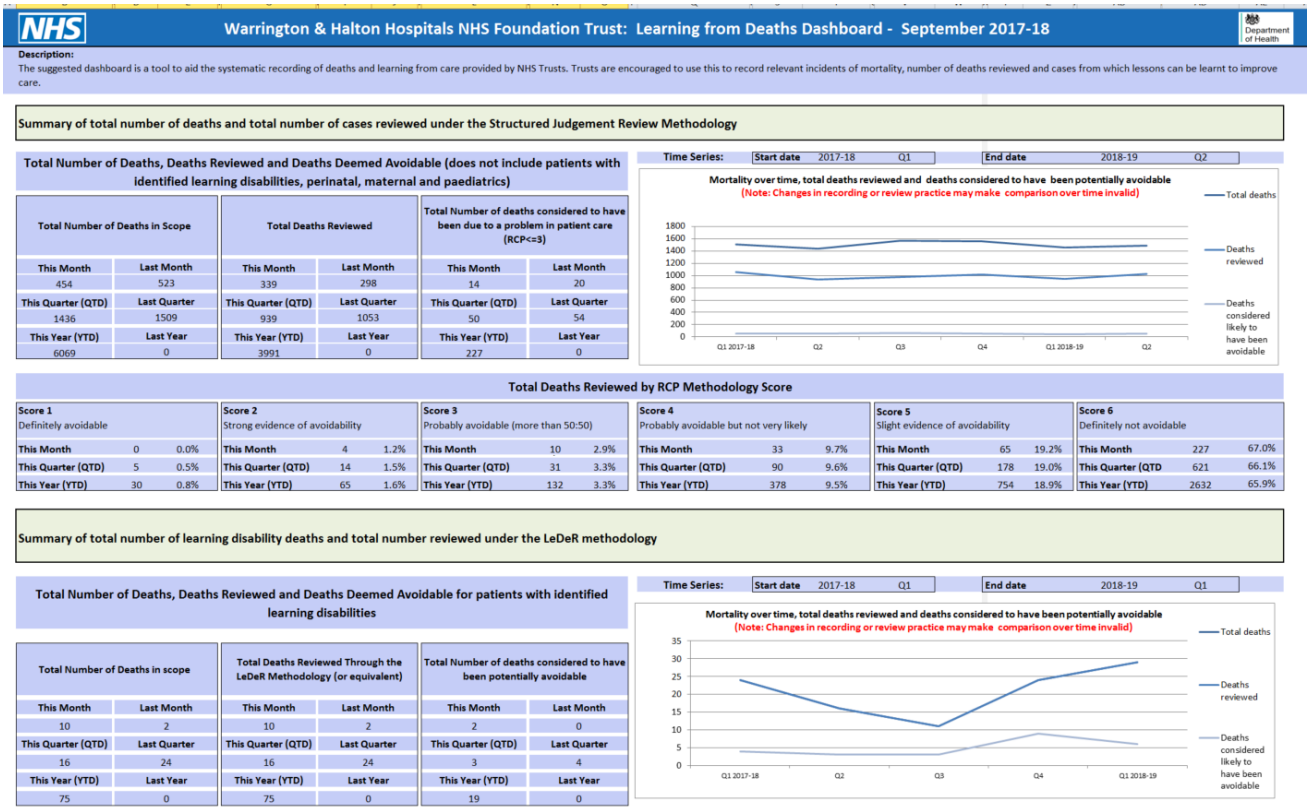
An example of our dashboard, which will be used to report the data and learning from deaths during the past quarter, is below:



Warrington & Halton Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - September 2017-18

Department of Health

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities, perinatal, maternal and paediatrics)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been due to a problem in patient care (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
454	523	339	298	14	20
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1436	1509	939	1053	50	54
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
6069	0	3991	0	227	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)

Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	4	1.2%	This Month	10	2.9%	This Month	33	9.7%	This Month	65	19.2%	This Month	227	67.0%
This Quarter (QTD)	5	0.5%	This Quarter (QTD)	14	1.5%	This Quarter (QTD)	31	3.3%	This Quarter (QTD)	90	9.6%	This Quarter (QTD)	178	19.0%	This Quarter (QTD	621	66.1%
This Year (YTD)	30	0.8%	This Year (YTD)	65	1.6%	This Year (YTD)	132	3.3%	This Year (YTD)	378	9.5%	This Year (YTD)	754	18.9%	This Year (YTD)	2632	65.9%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
10	2	10	2	2	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
16	24	16	24	3	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
75	0	75	0	19	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)

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CHAPTER 2: ENGAGEMENT WITH BEREAVED FAMILIES

2.1 Bereaved Families

When a patient dies the relations/carers should be treated with compassion and care. They should be provided with a leaflet (Appendix 3) which informs them of what happens next and the fact that their loved one may be subject to a review. The leaflet will explain the rationale and purpose of these investigations: to identify any problems, which will ensure we alter practice if appropriate and disseminate any learning. Families or carers will have a Liaison Lead appointed who will be their contact in the Trust for any advice to help with any questions they may have.

The Liaison Lead could be a doctor, nurse or manager, depending upon individual circumstances, for example, if a serious investigation is taking place, a manager would be appropriate. Members of staff who already have an established positive relationship with family members prior to the patient death may be most appropriate. This individual will be the single point of contact for the family and they will ensure there is a coordinated approach in place, particularly where multiple agencies are involved, such as the Coroners or police.

Bereaved families or carers may wish to have discussions with the Consultant who was in charge of their loved one's care and this will be facilitated by the Liaison Lead.

Following an SJR, if any problems in care have been identified, Duty of Candour must take place and a serious incident logged onto Datix.

2.2 Serious Incident Process

If a serious incident review is being undertaken, the deceased relatives or carers will be informed of this, as well as the reason for the review and the family will be asked if they would like the review to cover other areas where they may have concerns. It is also an opportunity for them to express concerns and raise questions, as their input can provide valuable understanding into what happened and aid the terms of reference for the investigation.

Duty of Candour will be conducted as per legal requirements and the Trust policy and we will keep families updated regularly as to the progress of the investigation. We will ensure families know what to expect from an investigation and the length of time it is estimated to take. All actions that are being taken will be explained through their Liaison Lead who will keep in touch regularly with updates and inform families if there any delays. This will be confirmed in writing as well.

Should the family require counselling, the Liaison Lead will be in a position to signpost them to the appropriate service which will be able to support them during this time.

Once the findings and recommendations of the investigation have been written, these will be sent to the family or carer for their comments. We will make families or carers aware that comments or feedback not considered relevant or appropriate following discussion will not be included in the report.

All reports – including SI reports or the results of SJR – may be shared with HM Coroner at the earliest possible opportunity, and will be shared as a matter of routine where there is greater than a 50% probability of avoidability/preventability (Hogan score 4, 5 and 6 = RCP score 1, 2 and 3 respectively).

TRAINING

Training will be provided to support the use of the Royal College of Physicians Structured Judgement Review case note methodology. Initially, members of MRG will be offered the training to complete the reviews using the SJR methodology. The initial training would then be cascaded down to a new member of MRG and Consultants to provide the Trust with a cohort of trained reviewers.

AUDIT OF THE DOCUMENTED PROCESS OF THE POLICY

Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
	Review of mortality review process	Mortality Review Group	Six months	Patient Safety & Clinical Effectiveness Sub-Committee	Mortality Review Group	Patient Safety & Clinical Effectiveness Sub-Committee

SOURCES/ REFERENCES

Royal College of Physicians of London. (2016). Using the Structured Judgement Review Method: A Clinical Governance Guide to Mortality Case Record Reviews.

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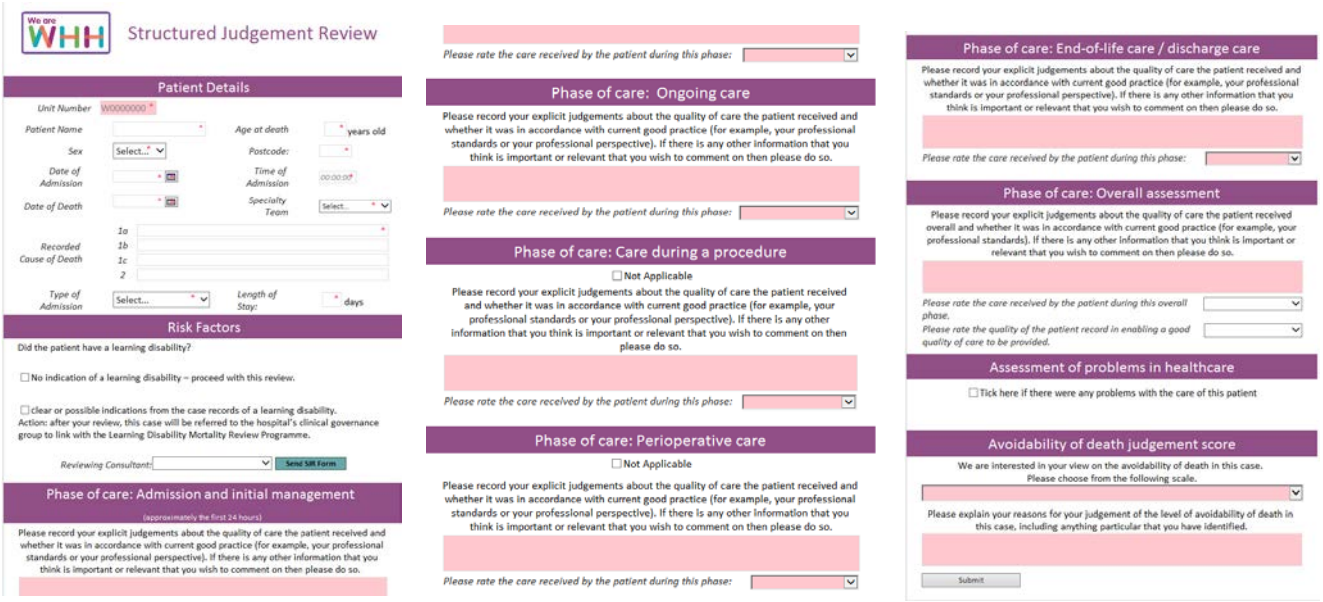
APPENDIX 1: EXAMPLE OF A STRUCTURED JUDGEMENT REVIEW FORM



We are WHH

Structured Judgement Review

Patient Details

Unit Number W0000000 *

Patient Name * Age at death * years old

Sex Select... * Postcode: *

Date of Admission * Time of Admission 00:00:00*

Date of Death * Specialty Team Select... *

Recorded Cause of Death 1a * 1b 1c 2

Type of Admission Select... * Length of Stay: * days

Risk Factors

Did the patient have a learning disability?

☐ No indication of a learning disability – proceed with this review.

☐ clear or possible indications from the case records of a learning disability.
Action: after your review, this case will be referred to the hospital's clinical governance group to link with the Learning Disability Mortality Review Programme.

Reviewing Consultant: Send SJR Form

Phase of care: Admission and initial management

(approximately the first 24 hours)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase:

Phase of care: Ongoing care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase:

Phase of care: Care during a procedure

☐ Not Applicable

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase:

Phase of care: Perioperative care

☐ Not Applicable

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase:

Phase of care: End-of-life care / discharge care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase:

Phase of care: Overall assessment

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

Please rate the quality of the patient record in enabling a good quality of care to be provided.

Assessment of problems in healthcare

☐ Tick here if there were any problems with the care of this patient

Avoidability of death judgement score

We are interested in your view on the avoidability of death in this case.
Please choose from the following scale.

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.

Submit

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APPENDIX 2: STRUCTURED REVIEW TOOL

Proforma to monitor care received by women who have suffered an antenatal or intrapartum fetal loss from 24 weeks gestation, had a baby diagnosed with HIE, or neonatal death

Hospital Provider:		
Mother's details		**Baby's details**
Unit Number:		Unit Number:
NHS Number:		NHS Number:
Date of Birth (Age):		Date of Birth:
Ethinicity:		Sex of baby:
Gravida:	Para:	Gestation at delivery:
Height:	Weight:	Birthweight:
BMI at booking:		Gestation at booking:
Postcode of mum:		Estimated Due Date:
		Outcome: Livebirth ☐
		Stillbirth ☐

Past Obstetric History		
Previous pregnancy problems?	YES ☐	NO ☐
Recurrent Miscarriage ☐	*Gestational Hypertension* ☐	*Pre-eclampsia* ☐
Gestational Diabetes ☐	*Fetal Growth Restriction* ☐	*Pre-term birth* ☐
Placental abruption ☐	*Placental preavia* ☐	*Stillbirth* ☐
Other, please specify:		
Past Gynaecological /Medical History		
Relevant gynaecology history:		
Relevant surgical history:		
Relevant medical history:		
Medication in pregnancy:		

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Is there a history of mental illness?	YES ☐	NO ☐
If yes, details of PNMH involvement:		
Social History		
Is the mother from an ethinic minority?	YES ☐	NO ☐
Is the mother English speaking?	YES ☐	NO ☐
Is the mother a current smoker?	YES ☐	NO ☐
If yes, how many?		
If no, did she stop smoking in pregnancy?	YES ☐	NO ☐
Is there a history of substance misuse?	YES ☐	NO ☐
Is there a history/concern of domestic violence?	YES ☐	NO ☐
Has there been social services/safeguarding involvement?	YES ☐	NO ☐
If yes, please elaborate:		

Details of Pregnancy			
Was this pregnancy booked late?		YES ☐	NO ☐
Is this pregnancy high risk at booking?		YES ☐	NO ☐
Tick all that apply:	Medical disorder ☐		
	Multiple pregnancy ☐		
	Previous caesarean section ☐		
	Maternal age >39 years ☐		
	Poor obstetric history ☐		
	Fetal abnormality ☐		
	Other fetal conditions (eg fetal anemia, IUGR)		
	Details:		
Was this pregnancy referred to consultant led care?		YES ☐	NO ☐
How many ANC appointments did she attend?			
Were any visits defaulted?		YES ☐	NO ☐
If yes, at what gestation and why?			
Was the DNA policy adhered to?		YES ☐	NO ☐

Were GROW charts completed?	YES ☐	NO ☐
When were the charts commenced?		
How many SFH measurements were plotted?		
If had USS, how many EFW plotted?		
Were appropriate action taken if abnormal SFH or EFW?	YES ☐	NO ☐
Details:		
Was mother referred to the Fetal Centre?	YES ☐	NO ☐
If yes, why?		
Were there any scans over and above the routine scans?	YES ☐	NO ☐
If yes, when and why?		
Did the mother attend maternity assessment unit (MAU)?	YES ☐	NO ☐

Tick all that apply:	Reduced fetal movements ☐
	Suspected SGA ☐
	Suspected LGA ☐
	Antepartum Haemorrhage ☐
	BP Profile ☐
	Suspected SROM ☐
	Infection/Sepsis ☐
	Other:

Details of MAU attendances

	1st attendance:	Date:
		Gestation:
		Reason for attendance:
		Investigations:
		Follow-up:
	2nd attendance:	Date:
		Gestation:
		Reason for attendance:
		Investigations:
		Follow-up:

Add details if more than 2 attendances:

Was mother admitted to hospital at any other time?			YES ☐	NO ☐
Details of hospital admissions:				
	1st admission:	Date:		
		Gestation:		
		Duration of stay:		
		Reason for admission:		
	2nd admission:	Date:		
		Gestation:		
		Duration of stay:		
		Reason for admission:		
Add details if more than 2 admissions:				

If **antenatal stillbirth**, please complete **section A**

If **intrapartum stillbirth**, please complete **section A and B**

If baby **diagnosed with HIE**, please complete **section B and C**

For all cases, complete **section D**

SECTION A – Details of stillbirth and investigations

Details of stillbirth				
When was the stillbirth diagnosed?			Date:	
What was the preliminary reason for the stillbirth?				
Was a formal examination of the fetus undertaken?			YES ☐	NO ☐
If yes, by who?	Consultant ☐	StR ☐ *Year*:	Midwife ☐	
Was the correct documentation aid used for description?			YES ☐	NO ☐
Were there any obvious abnormalities noted at delivery?			YES ☐	NO ☐
If yes, details:				
Were there any obvious abnormalities with the placenta?			YES ☐	NO ☐
If yes, details:				

Causes and associations of stillbirth:			
Congenital Anomaly	☐	*Iso-immunisation*	☐
Pre-eclamptic Toxemia	☐	*Antepartum/Intrapartum Haemorrhage*	☐
Mechanical	☐	*Maternal Disorder*	☐
Infection	☐	*Specific Fetal Conditions*	☐
Specific Placental Conditions	☐	*Intrauterine Growth Restriction*	☐
Associated Obstetric Factors	☐	*No Associated Obstetric Factors*	☐
Unclassified	☐		

Stillbirth Investigations			
Was a post-mortem carried out?		YES ☐	NO ☐
If yes:	Full ☐	Limited ☐	
Details of results:			
If no:	Not requested ☐		
	Requested and refused by patient ☐		
	Requested and not carried out ☐		
	If not carried out, why?		
Was placenta sent for histology?		YES ☐	NO ☐
Details of histology results:			
Were post stillbirth routine investigations carried out?		YES ☐	NO ☐
Results of investigations:			

SECTION B – Intrapartum Assessment/Review

Onset of labour	
Spontaneous	☐
IOL Prostin only	☐

IOL Prostin + Oxytocin ☐		
Augmentation with syntocinon 1st stage ☐		
Augmentation with syntocinon 2nd stage ☐		
If labour was induced,		
Was IOL protocol followed?	YES ☐	NO ☐
Was there a delay in IOL?	YES ☐	NO ☐
Fetal Heart Monitoring		
Was there continuous fetal heart monitoring?	YES ☐	NO ☐
If no, please go to section on intermitted fetal monitoring		
Indication for CTG:		

	IOL ☐	*PROM* ☐	
	Mec stained liquor ☐	*Fetal abnormality* ☐	
	Blood stained liquor ☐	*Details:*	
	Audiable deceleration ☐	*Medical disorder* ☐	
	APH ☐	*Details:*	
	Previous C/S ☐	*Other:*	

Was there hourly assessment of CTG?	YES ☐	NO ☐
Was there an hourly 'fresh eyes' assessment?	YES ☐	NO ☐
If no, why?		
Were there any concerns with CTG/fetal distress?	YES ☐	NO ☐
If yes, were appropriate action taken?	YES ☐	NO ☐
What actions were taken?		

	Watch and observe ☐	
	Conservative measures ☐	
	FBS ☐	
	Delivery ☐	

If no actions, why? _____		
Was there evidence of hyperstimulation?	YES ☐	NO ☐
If yes, what action was taken?		

Were there concerns of mis-interpretation of CTG?		YES ☐	NO ☐
If yes,	Non-reassuring CTG unrecognised ☐		
	Abnormal CTG unrecognised ☐		

Results of FBS	**Sample 1**	**Sample 2**	**Sample 3**
pH			
BE			

Additional comments about CTG:

Intermittent Fetal Heart Monitoring

Did pregnancy meet criteria for intermitted FH monitoring?	YES ☐	NO ☐
Was FH auscultated every 15 mins in the 1st stage?	YES ☐	NO ☐
Was FH auscultated every 5 minutes in the 2nd stage?	YES ☐	NO ☐

If no, why?

Details of delivery

Was there a delay for delivery?	YES ☐	NO ☐

If yes, why?

Time of decision to delivery if emergency CS or instrumental delivery:

Mode of delivery

	Normal vaginal delivery ☐
	Ventouse ☐
	Rotational Ventouse ☐
	Forceps ☐
	Rotational forceps ☐
	Failed ventouse to forceps ☐
	Failed vaginal delivery to CS ☐

	Elective caesarean section	☐
	Emergency caesarean section GA	☐
	Emergency caesarean section Spinal	☐

Grade of clinician who made decision for delivery:
Additioanl comments surrounding delivery:
Length of labour –

1st stage:	2nd stage:

APGAR Score	**1 minute**	**5 minutes**	**10 minutes**

Cord pH	**Arterial**	**Venous**
pH		
BE		

Was placenta sent for histology?	YES ☐	NO ☐
If yes, results:		

SECTION C – Neonatal Assessment/Review

Details of resuscitation			
Indication for review:			
Resuscitation	**Ventilation breaths**	**CPAP**	**Intubation**
Additional comments regarding resuscitation:			
Neonatal Outcome			

	Transfer to NICU	YES ☐	NO ☐
	Transfer to post-natal ward	YES ☐	NO ☐
	Neonatal Death	YES ☐	NO ☐

Reason for transfer to NICU		
Low APGAR	YES ☐	NO ☐
Low cord pH	YES ☐	NO ☐
Seizures	YES ☐	NO ☐
Additional postnatal findings:		

Criteria For Cooling			
A criteria			
Apgar score ≤ 5 at 10 minutes of age			
Continued need for resuscitation, including endotracheal or mask ventilation, at 10 minutes after birth			
Acidosis within 60 minutes of birth (defined as any occurrence of umbilical cord, arterial or capillary pH <7.00)			
Base Deficit ≥ 16 mmol/L in umbilical cord or any blood sample (arterial, venous or capillary) within 60 minutes of birth			
B criteria			
Altered state of consciousness (reduced response to stimulation or absent response to stimulation) AND			
Abnormal tone (focal or general hypotonia, or flaccid) AND			
Abnormal primitive reflexes (weak or absent suck or Moro response).			
HIE Grading	Grade 1 ☐	Grade 2 ☐	Grade 3 ☐

Discharge from NICU	
Duration of stay in NICU	Days
Follow-up arranged:	
Discharge from NICU	days old
If transferred to other hospital, why?	
Neonatal death in NICU	

Neonatal Death Investigations

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Was a post-mortem carried out?		YES ☐	NO ☐
If yes:	Full ☐	Limited ☐	
Details of results:			
If no:	Not requested ☐		
	Requested and refused by patient ☐		
	Requested and not carried out ☐		
	If not carried out, why?		

SECTION D – MDT Reviews and Recommendations

Initial Postnatal Reviews			
What was the outcome of the initial Adverse Clinical Event (ACE) review?			
	Appropriate care	☐	
	Room for improvement	☐	
	Near miss	☐	
Summary of case and comments from the initial ACE reviews?			
Was a further review requested (eg: SUI or RCA)?		YES ☐	NO ☐
If yes, give details:			
Is there a postnatal appointment with a consultant?		YES ☐	NO ☐
Appointment made with:	Obstetrician ☐	Neonatologist ☐	Both ☐
Did the patient attend?		YES ☐	NO ☐
If yes, any comments?			

MDT / External Review Comments
Learning Outcomes from Review

Action Points and Recommendations from Review

Saving Babies' Lives Care Bundle Elements	
Elements that may have contributed to the adverse outcome. Please give details and elaborate for each element identified	
1. Smoking in pregnancy	☐
Details:	
2. Detection of fetal growth restriction	☐
Details:	
3. Awareness of fetal movement	☐
Details	
4. Fetal monitoring in labour	☐
Details	
Other Contributory Factors	
5. Communication (eg: staff, patient)	☐
Details	
6. Equipment issues	☐
Details:	
7. Environment (eg: caseload, staffing, organisational)	☐
Details:	
8. Training, Supervision and Education	☐
Details:	
Further Comments:	

Grading of Care (MBRRACE – UK)

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Panel opinion on overall grade of care		
1	Appropriate care	☐
2	Improvements in care identified which would have **made no difference** to outcome	☐
3	Improvements in care identified which **may have made a difference** to outcome	☐

APPENDIX 3: PATIENT DEATH LEAFLET FOR FAMILIES AND CARERS

Important Information for Bereaved Families

Information to Help You Through This Difficult Period

We extend to you and your family our deepest sympathy at this time of great sadness

First Steps

The Bereavement Office will deal with all the arrangements for you in order for you to register the death. If your loved one passed away on a hospital ward then you will need to contact the Bereavement Office. If they passed away during the weekend or overnight, please contact the Bereavement Office after 10.00 am the next working day.

The doctor who cared for your loved one will either complete a Cause of Death form or discuss the death with the Coroner if it is not clear what caused the death.

The Coroner may request that the deceased is examined in a procedure called a Post Mortem. Further information on post mortem examination and the role of the Coroner can be found later in this leaflet.

Please be advised that you cannot make an appointment to register the death until the Bereavement office has confirmed that a Death Certificate can be issued.

The Bereavement contact details are shown below:

Bereavement Office
Appleton Wing
Warrington Hospital
Lovely Lane Warrington WA5 1QG
Tel: 01925 662294

Organ and Tissue Donation

When a relative, child or friend dies in hospital or at home, it may be possible to donate organs or tissues (eyes, heart, valves, skin, bone and tendons) for transplant or research. If the deceased was suitable for organ donation you will have already discussed the option of organ donation with the specialist nurse at the hospital.

After death has occurred, tissue donation normally happens within 24 hours. However, it is sometimes possible to donate up to 48 hours later. Donation may improve the quality of life for others – as many as 50 people can be helped by the donation from one person.

You may receive a call from a Tissue Donation Specialist Nurse to discuss the option of donation. Please note that:

- only tissues for which you have given permission will be donated
- donation will not delay any funeral arrangements
- the donor is treated with dignity and respect
- the specialist team will ensure that the donor maintains a natural appearance after donation
- you may see the deceased after donation, if you wish.

Sudden or Unexpected Death of a Child

If a child under the age of 18 years dies suddenly or unexpectedly then the Rapid Response Team will be involved. The Rapid Response Team is a team of senior people led by a children's doctor, a police officer and a Coroner's Officer (acting on behalf of the Coroner).

This Team will work with the Coroner's Office to sensitively investigate the cause of cause and explain the investigation process to the family.

They will support the bereaved family and siblings in reaching an understanding as to why their child has died. We will provide you with a Liaison Lead who will also provide support during and after this tragic time.

Support

You can stay with your child after their death. A Nurse will accompany you and your child to the mortuary when you are ready to leave the hospital.

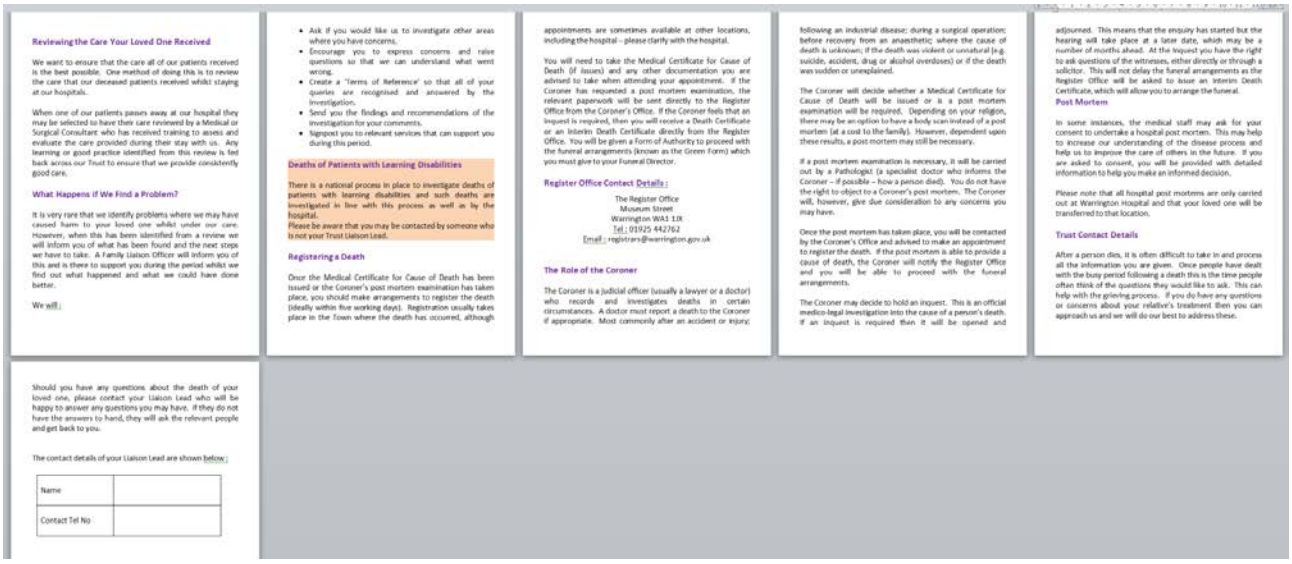
Following the loss of your child, the grief you are feeling can make everyday life feel very difficult and lonely. You may be finding it very difficult to cope, as most people feel a variety of emotions. Friends and family may provide support at this time. Some families may wish to have a brief ceremony or blessing (regardless of religion) which we can arrange for you.

Spiritual Care

When a loved one or someone we know dies, we may need someone to talk to. Often this support comes from family and friends, although sometimes it can help to talk to someone who is impartial.

Grief and loss can also raise spiritual and/or religious concerns. At times, what you are experiencing may be different from that felt by your family or friends and you may want to speak to someone about this. Chaplains are here to ensure that your beliefs and values are respected and that your spiritual needs are met, ensuring that confidentiality is maintained at all times.

Providing an opportunity to remember a loved one who has recently died can help a person with their grief. Chaplaincy can organise a Remembrance Service where the name of the deceased is read out and a candle is lit in their memory. Refreshments are available afterwards. Chaplains are available to speak to everyone and can be contacted via the Switchboard.



Reviewing the Care Your Loved One Received

We want to ensure that the care all of our patients received is the best possible. One method of doing this is to review the care that our deceased patients received whilst staying at our hospitals.

When one of our patients passes away at our hospital they may be selected to have their care reviewed by a Medical or Surgical Consultant who has received training to assess and evaluate the care provided during their stay with us. Any learning or good practice identified from this review is fed back across our Trust to ensure that we provide consistently good care.

What Happens if We Find a Problem?

It is very rare that we identify problems where we may have caused harm to your loved one whilst under our care. However, when this has been identified from a review we will inform you of what has been found and the next steps we have to take. A Family Liaison Officer will inform you of this and is there to support you during the period whilst we find out what happened and what we could have done better.

We will:

- Ask if you would like us to investigate other areas where you have concerns.
- Encourage you to express concerns and raise questions so that we can understand what went wrong.
- Create a 'Terms of Reference' so that all of your queries are recognised and answered by the investigation.
- Send you the findings and recommendations of the investigation for your comments.
- Signpost you to relevant services that can support you during this period.

Deaths of Patients with Learning Disabilities

There is a national process in place to investigate deaths of patients with learning disabilities and such deaths are investigated in line with this process as well as by the hospital.
Please be aware that you may be contacted by someone who is not your Trust Liaison Lead.

Registering a Death

Once the Medical Certificate for Cause of Death has been issued or the Coroner's post mortem examination has taken place, you should make arrangements to register the death (ideally within five working days). Registration usually takes place in the Town where the death has occurred, although appointments are sometimes available at other locations, including the hospital – please clarify with the hospital.

You will need to take the Medical Certificate for Cause of Death (if issues) and any other documentation you are advised to take when attending your appointment. If the Coroner has requested a post mortem examination, the relevant paperwork will be sent directly to the Register Office from the Coroner's Office. If the Coroner feels that an Inquest is required, then you will receive a Death Certificate or an Interim Death Certificate directly from the Register Office. You will be given a Form of Authority to proceed with the funeral arrangements (known as the Green Form) which you must give to your Funeral Director.

Register Office Contact Details:

The Register Office
Museum Street
Warrington WA1 1JX
Tel: 01925 442762
Email: registrars@warrington.gov.uk

The Role of the Coroner

The Coroner is a judicial officer (usually a lawyer or a doctor) who records and investigates deaths in certain circumstances. A doctor must report a death to the Coroner if appropriate. Most commonly after an accident or injury; following an industrial disease; during a surgical operation; before recovery from an anaesthetic; where the cause of death is unknown; if the death was violent or unnatural (e.g. suicide, accident, drug or alcohol overdoses) or if the death was sudden or unexplained.

The Coroner will decide whether a Medical Certificate for Cause of Death will be issued or is a post mortem examination will be required. Depending on your religion, there may be an option to have a body scan instead of a post mortem (at a cost to the family). However, dependent upon these results, a post mortem may still be necessary.

If a post mortem examination is necessary, it will be carried out by a Pathologist (a specialist doctor who informs the Coroner – if possible – how a person died). You do not have the right to object to a Coroner's post mortem. The Coroner will, however, give due consideration to any concerns you may have.

Once the post mortem has taken place, you will be contacted by the Coroner's Office and advised to make an appointment to register the death. If the post mortem is able to provide a cause of death, the Coroner will notify the Register Office and you will be able to proceed with the funeral arrangements.

The Coroner may decide to hold an inquest. This is an official medico-legal investigation into the cause of a person's death. If an inquest is required then it will be opened and adjourned. This means that the enquiry has started but the hearing will take place at a later date, which may be a number of months ahead. At the inquest you have the right to ask questions of the witnesses, either directly or through a solicitor. This will not delay the funeral arrangements as the Register Office will be asked to issue an Interim Death Certificate, which will allow you to arrange the funeral.

Post Mortem

In some instances, the medical staff may ask for your consent to undertake a hospital post mortem. This may help to increase our understanding of the disease process and help us to improve the care of others in the future. If you are asked to consent, you will be provided with detailed information to help you make an informed decision.

Please note that all hospital post mortems are only carried out at Warrington Hospital and that your loved one will be transferred to that location.

Trust Contact Details

After a person dies, it is often difficult to take in and process all the information you are given. Once people have dealt with the busy period following a death this is the time people often think of the questions they would like to ask. This can help with the grieving process. If you do have any questions or concerns about your relative's treatment then you can approach us and we will do our best to address these.

Should you have any questions about the death of your loved one, please contact your Liaison Lead who will be happy to answer any questions you may have. If they do not have the answers to hand, they will ask the relevant people and get back to you.

The contact details of your Liaison Lead are shown below:

Name	
Contact Tel No	

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APPENDIX 4: PERSON SPECIFICATION FOR MORTALITY REVIEW GROUP MEMBERSHIP

JOB DESCRIPTION

Job Title:	Mortality Review Group Member
Hours:	To be determined and subject to job-planning discussion.
Responsible to:	Lead Clinician for Mortality
Accountable to:	Medical Director
Responsible For Supervising:	No staff supervision

Job Summary:

The Clinical Effectiveness Team (CET) is within the Medical Director Support function and also works closely with the Quality Governance Team. The primary purpose of the CET is to promote and enable clinical effectiveness; doing the right thing at the right time for the right patient and demonstrating improvements in quality and performance. A member of Mortality Review Group (MRG) will:

- Conduct reviews of the care of patients who have died; this may include aspects where we could have done better, including individual consultants' practice
- Playing a key role in the mortality review group (including CCG members) at which cases are discussed; this can be tense, with differing views and heightened emotions and requires diplomacy and a supportive and positive approach
- Plan own workload to meet cyclical deadlines (often involving coordination of others' activity when leading on a focused review)

Confidentiality:

Working within the Trust you may gain knowledge of confidential matters which may include personal and medical information about patients and staff. Such information must be considered strictly confidential and must not be discussed or disclosed. Failure to observe this confidentiality could lead to disciplinary action being taken against you.

Codes of Conduct and Accountability:
You are expected to comply with relevant Trust codes of conduct and accountability.

Health and Safety:

- In accordance with the Health and Safety at Work Act 1974 and other supplementary legislation, you are required to take reasonable care to avoid injury during the course of work and co-operate with Trust and others in meeting statutory regulations. You are also required to attend statutory training as required to fulfil your duties.
- To comply with safety instructions and Trust policies and procedures.
- To use in a proper safe manner the equipment and facilities provided.
- To refrain from wilful misuse of, or interference with, anything provided in the interest of health and safety and any action, which might endanger yourself and others.
- To report as soon as practical any hazards and defects to your senior manager.
- To report as soon as practical accidents and untoward/department incidents and to ensure that accident forms are completed.

Infection Control

All staff are expected to promote infection prevention and control and to comply with Infection Control policies and guidelines. This requires all staff to be aware of the Uniform/Workwear policies which clearly state that any staff visiting or working in a clinical area must adhere to the 'bare below the elbows' rule and follow the hand hygiene precautions at all times.

PERSON SPECIFICATION

Job Title: Mortality Review Group Member

	Essential	Desirable
Experience	• Experience in one of the below specialties: General Surgery General Medicine Intensive Care Cardiology Emergency Department Gastroenterology Respiratory Medicine Elderly Care Diabetes & Endocrinology End of Life Orthopaedics	
Skills / Knowledge/ Competencies	• Excellent communication skills, both written and verbal • Tenacious and investigative approach • Excellent organisation skills • Methodical and organised approach to work • Understanding of data protection and confidentiality • Ability to pay attention to detail	• Understanding of Duty of Candour • Understanding of incident reporting and investigation processes

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EQUALITY IMPACT ASSESSMENT

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

Title: Learning from Deaths	
What is being considered?	Policy [x] Guideline [ ] Decision [ ] Other (please state) [ ]
Is there potential for an adverse impact against the protected groups below? Age Disability Gender Reassignment Marriage and Civil Partnership Pregnancy and Maternity Race Religion and Belief Sex (Gender) Sexual Orientation Human Rights articles	Yes [ ] No [x]
If you are unsure, please contact the Equality and Diversity Specialist - 5229	
On what basis was this decision made? National Guidelines e.g NICE / NSPA / HSE / DH (other) [ ] Committee / Other meeting [ ] Previous Equality screening [ ]	
With regard to the general duty of the Equality Act 2010, the above function is deemed to have no equality relevance Equality relevance decision by Title / Committee Date	
The Equality Act 2010 has brought a new equality to all public authorities, which replaced the race, disability and gender equality duties. This Equality Relevance Assessment provides assurance of the steps Warrington and Halton Hospitals NHS foundation Trust is taking in meeting its statutory obligation to pay due regard to: Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act Advance equality of opportunity between people who share a protected characteristic and those who do not	

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NHS Improvement

Implementing the Learning from Deaths framework: key requirements for trust boards

July 2017

Contents

Introduction – purpose

This pack is for acute, specialist, mental health and community trust boards and specifically trust non-executive directors (NEDs) and non-clinical executive directors. It explains what boards are expected to do in relation to the new Learning from Deaths framework.

NEDs and non-clinical executives may be less familiar with case record review and serious incident investigation as means to supporting quality improvement. However, recent reports from the Care Quality Commission (CQC) and others show that the whole board must support and encourage these activities to identify areas in need of change and to inform improvement.

Trust NEDs in particular have been identified as having a critical role to play in holding their organisations to account for: conducting robust case record reviews and serious incident investigations; and crucially for implementing effective and sustainable changes designed to improve safety and wider quality in response.

We explain the requirements of the National Quality Board's (NQB) new Learning from Deaths framework, which requires acute, specialist, mental health and community trusts to adopt a more standardised and transparent approach to learning from the care provided to patients who die, and what boards need to do to implement this. We also outline what NHS Improvement will do.

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Introduction – background

CQC published its report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The Secretary of State accepted all these recommendations and asked NQB to develop a framework for the NHS on identifying, reporting, investigating and learning from deaths in care.

The NHS has a long tradition of learning from care provided to patients. The framework builds on that tradition but recognises that the NHS can do better particularly in relation to the care of vulnerable people.

Key findings of the CQC report

- Families and carers are not treated consistently well when someone they care about dies.
- There is variation and inconsistency in the way that trusts become aware of deaths in their care.
- Trusts are inconsistent in the approach they use to determine when to investigate deaths.
- The quality of investigations into deaths is variable and generally poor.
- There are no consistent frameworks that require boards to keep deaths in their care under review and share learning from these.

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Introduction – background (contd)

CQC's recommendations have been translated into seven national workstreams.

The Department of Health (DH) has set up a Learning from Deaths programme board to support their implementation. Each workstream is led by the relevant healthcare body.

The first step in this programme was the publication of the new Learning from Deaths framework in March 2015.

In particular this identifies a need to focus on learning from the care provided to patients with learning disabilities and severe mental health needs who die. Most of these deaths will occur in acute settings.

Workstreams

1. Delivering a new national Learning from Deaths framework (DH)
2. Improving how trusts engage with and support bereaved families/carers (NHS England)
3. Improving learning from deaths of service users with learning disabilities or serious mental illness (NHS England)
4. Improving the recording of information about patient deaths and sharing of this between organisations to learn from review of the care provided to patients who die (NHS Digital)
5. Improving the quality and consistency of investigations into patient deaths (Health and Safety Investigation Branch – HSIB and Health Education England – HEE)
6. Supporting trust boards to implement the new requirements (NHS Improvement)
7. Improving how CQC assesses trusts' learning from deaths (CQC)

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An explanation of key terms

Some terms used in the Learning from Deaths framework and in relation to case record review and investigation can be misunderstood. In this framework the following terms have specific meanings:

Case record review: A structured desktop review of a case record/note carried out by clinicians to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when the bereaved or staff raise concerns about care (see also page 8).

Investigation: A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigation draws on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first (see also page 8).

Death due to a problem in care: A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision. Note, this is not a legal term and is not the same thing as ‘cause of death’. The term ‘avoidable mortality’ should not be used as this has a specific meaning in public health that is distinct from ‘death due to problems in care’.

Quality improvement: A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

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Why focus on engaging bereaved families and carers?

The recent CQC report and other evidence show that too often the NHS exacerbates the distress felt by families and carers of patients who die.

The transformation required in response to the Learning from Deaths framework is first and foremost about the way carers and families are engaged after a death.

Families and carers are unlikely to be greatly concerned about the minutiae of the methodology used for case record review or trust clinical governance structures. People do highlight the unacceptable way in which they are sometimes treated, the inconsiderate and unthinking communications they sometimes receive, and the lack of information sometimes provided.

Trusts should:

- ✓ Provide a clear, honest and sensitive response to bereavement in a sympathetic environment
- ✓ Offer a high standard of bereavement care, including support, information and guidance
- ✓ Ensure families and carers know they can raise concerns and these will be considered when determining whether or not to review or investigate a death
- ✓ Involve families and carers from the start and throughout any investigation as far as they want to be
- ✓ Offer to involve families and carers in learning and quality improvement as relevant

NHS England is leading work to determine what support bereaved relatives and carers can expect from trusts (likely to be published early in 2018). Some guidance is already available in the Learning from Deaths framework and the Serious Incident framework, summarised on page 21.

Why focus on case record review and investigation?

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work. Review also identifies good practice that can be spread.

Investigation starts either after case record review or straight after an incident, where problems in care that need significant analysis are likely to exist. Investigation is more in-depth than case record review as it gathers information from many additional sources.

The investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.

Trusts should focus on how case record review and investigation lead to effective and sustainable quality improvement work. Our framework for leadership and improvement sets out how trusts can begin to implement their quality improvement approach.

Data generated from case record review and investigation, for example estimates of the number of deaths thought more likely than not to be due to problems in care, are subjective and so not useful for making external judgements about the safety of trusts.

"Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems, none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient."

(*National guidance on learning from deaths*, March 2017)

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New requirements

The Learning from Deaths framework placed a number of new requirements on trusts:

- From **April 2017** onwards, **collect** new quarterly information on deaths, reviews, investigations and resulting quality improvement (see page 10 for the required information).
- By **September 2017**, publish an **updated policy** on how the trust responds to and learns from the deaths of patients in its care (pages 17 to 21 give more detail on what this policy should include, as does the Learning from Deaths framework published in March 2017 and other information available from the NHS Improvement Learning from Deaths website).
- From **Q3 2017** onwards, **publish** information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings (see page 10 for the required information) including information on reviews of the care provided to those with severe mental health needs or learning disabilities.
- From **June 2018**, **publish** an annual overview of this information in Quality Accounts, including a more detailed narrative account of the learning from reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

NHS Improvement is fully aware that many organisations, particularly mental health and community care providers, have less clarity on methodologies and scope for the new requirements. We are clarifying with national partners and providers what good looks like and we do not expect providers to have developed perfect processes by Autumn 2017. We will support the system to learn over the course of the next 12 months.

The main purpose of this initiative is **to promote learning** and improve how trusts **support and engage with the families and carers** of those who die in our care; it is not to count and classify deaths.

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New requirements (contd)

The Learning from Deaths framework states that trusts must collect and publish, via quarterly public board papers, information on:

- number of deaths in their care*
- number of deaths subject to case record review (desktop review of case notes using a structured method)
- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.

Information on deaths should be published in the quarter after that in which the death occurred. Where reviews or investigations are ongoing, state how many are ongoing and update this in subsequent publications.

An example dashboard for publication is available from the NHS Improvement Learning from Deaths webpage.

The Learning from Deaths framework requires trusts to collect and publish information on deaths of both adults and children (under 18s). Note however that the child death review process is distinct (see page 19).

* Trusts can define locally which patients are considered to be 'in their care' according to what makes sense for their services. At a minimum this must include all inpatients but, if possible, also patients who die within 30 days of discharge from inpatient services. Be aware that this means all inpatients are **in scope** for review, not that all inpatient deaths need to be reviewed. On page 18 we propose which inpatient deaths acute trusts should review.

A simple rule of thumb is that trusts should consider leading the review of the care of a patient if that trust is the healthcare provider best placed to do so.

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New requirements (contd)

Publication is designed to:

- ✓ support trusts to learn from each other
- ✓ ensure transparency and openness as part of a publicly funded healthcare system
- ✓ highlight good and innovative practice
- ✓ encourage action in relation to identified problems in care.

Publication is **not** designed to:

- ✖ name and shame
- ✖ support comparison of trusts on the basis of the number of deaths or the number of deaths judged likely to be due to problems in care
- ✖ encourage blame.

! There is no meaningful measure of 'avoidable' mortality at trust level.

! Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. That is why this data in not comparable.

! Case record reviews and Serious Incident investigations are not inquiries into how people died – that is a matter for coroners. Criminal investigations are a matter for the police.

! Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading its readers.

In the period leading up to publication, NHS Improvement will develop further support resources for providers that will help them to help the public understand this data.

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The trust board's role

Boards are responsible for the quality of the healthcare their trusts provide, including its safety. The Learning from Deaths framework places particular responsibilities on boards, as well as reminding boards of their existing duties.

Board responsibilities

- Ensuring their trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate.
- Ensuring their trust learns from problems in healthcare identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care.
- In this context 'learning' means taking effective, sustainable action (via appropriately resourced quality improvement work) to address key issues associated with problems in care.
- Providing visible and effective leadership to support their staff to improve what they do.
- Ensuring the needs and views of patients and the public are central to how the trust operates.

Boards should ensure the case record review process sits within their wider clinical governance processes:

- incident reporting and response
- risk management
- clinical audit
- staff management
- patient and public involvement
- research and development
- education and training
- clinical effectiveness
- information management.

Evidence shows that deaths caused by problems in care will occur in every single NHS trust and every hospital worldwide. The key is to learn from them as part of well-functioning clinical governance processes.

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The trust board's role – NEDs

NEDs play a crucial role in bringing an independent perspective to the boardroom, constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible.

The Learning from Deaths framework requires each trust's board to identify a NED to oversee the trust's approach to Learning from Deaths.

NEDs need to be curious about their organisation's approach to the delivery of healthcare and constructively challenge their trust to identify where care can be improved, then support that improvement. Evidence shows that adverse events are usually due to weaknesses in systems rather than the fault of individuals. Blame is therefore not a useful approach.

Within this role, NEDs have an opportunity to model the behaviour within high reliability organisations, which treat problems as an opportunity to genuinely learn and encourage 'problem sensing' not 'assurance seeking' among teams and organisation-wide.

NED responsibilities in relation to the framework

- **Understand the review process:** ensure the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.
- **Champion quality improvement** that leads to actions that improve patient safety.
- **Assure published information:** that it fairly and accurately reflects the organisation's approach, achievements and challenges.

The following pages give more detail on these responsibilities.

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Understanding the review process – what questions should NEDs ask?

- How is the case record review process carried out?
- How are cases selected for case record review (see advice for acute hospitals on page18)?
- What is the quality of data collected by the trust and what are its limitations?
- Are those reviewing cases trained to do so according to a robust method such as PRISM or structured judgement review?
- Is the LeDeR method used to review deaths of people with learning disabilities?
- How are deaths of those with severe mental illness reviewed (see page 19)?
- How are perinatal and maternal deaths reviewed (see page 19)?
- How are infant and child deaths reviewed (see page 19)?
- Is there multidisciplinary review of cases?
- Is there objective review of cases – wherever possible **not** carried out by those involved in the care of the patient who died?
- Are there arrangements for periodic review of the trust's processes and findings by peer trusts?
- Are families/carers given the opportunity to request a review?
- Are all cases where problems with care are thought likely to have led to the death investigated in line with the best practice outlined in the Serious Incident framework?
- Are all families and carers engaged properly where problems are found?
- Are all families and carers involved in investigations from the start, and kept informed of subsequent improvement work if they wish to be?
- How is case record review data triangulated with other quality data collected outside the review?
- What does the data say about what drives mortality in the trust?

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Championing learning and quality improvement – what questions should NEDs ask?

- What are the trust's most significant problems? Where should quality improvement be prioritised?
- What is the organisation's strategy for improving the quality of the care it provides?
- What approach and method(s) does it use?
- How well is quality improvement work resourced?
- How does the trust use Learning from Deaths, Serious Incidents and other patient safety-related events to inform quality improvement work? Is good practice identified as well as problems?
- Who is the board executive lead and how well sighted is the board on this work?
- How are the necessary changes in clinical practice supported and enabled?
- How are the wider themes and trends from case record reviews or investigations shared across the organisation and with any others that may have an interest? Are these processes effective?
- How are patients, families and carers involved in quality improvement and sharing learning?
- What changes have been made as a result of this work? Has quality of care improved as a result? How do you know?

Changing trust policies, training staff and reminding them how something should be done are all relatively weak barriers to error. NEDs should consider how their trust avoids resorting to these weak, simplistic barriers to risk wherever possible and instead invests in more effective and sustainable changes to practice, underpinned by human factor approaches, systems thinking and quality improvement techniques.

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Assuring published information – what questions should NEDs ask?

- Do I understand the information we publish? Do I know how many deaths occur and where, and what problems are associated with them?
- What is **not** shown by the data? Are there gaps/incomplete information?
- Is the information published in board papers:
  - easy to understand and interpret
  - accurate
  - timely
  - proportionate?
- Does the information identify improvement needs and how these could be met?
- Does the information reveal how previous information was acted on and what has changed as a result? Sharing both successful and unsuccessful quality improvement work is important.
- Does the information clearly describe how the trust uses Learning from Deaths, Serious Incidents and other patient safety-related events to inform quality improvement work?
- How well sighted is the board on this published work?
- How are arrangements for gathering stakeholder feedback in response to published information working?
- Does the information demonstrate that the trust has done what it said it would do?

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Policy publication requirements

By the end of September 2017, trusts should publish on their website an **updated policy** on how they respond to and learn from the deaths of patients in their care.

The policy should include:

- The trust's case record review process, including the method used, how the scope of deaths for potential review is determined and how deaths are selected for review.
- How the trust responds to the death of someone with a learning disability or severe mental health needs, of an infant or child, or a stillbirth or maternal death.
- How the trust decides which deaths – whether reviewed or not – require an investigation under the Serious Incident framework.
- How the trust engages with bereaved families and carers, including how they are supported by the trust and involved in investigations where relevant.

The policy should set out what trusts are doing currently. It should reflect the requirements of the Learning from Deaths framework and related policies (for example, the Serious Incident framework). NHS Improvement will not routinely assess the content of published trust policies or collate those policies. Publication is designed to support openness and transparency and enable peer learning.

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Policy publication requirements – case selection and review method

A trust's published policy should include the case review method used, how it decides which deaths are in scope for potential review and how it selects the cases for review.

Trusts can use any relevant evidence-based case record review method (see page 19 for requirements for certain specific patient categories), but the chosen method must collect the required information (see page 10). Options include structured judgement review (SJR; training and documentation is available from the Royal College of Physicians – note this is adult inpatient specific) and the PRISM method. We encourage trusts to avoid tick-box/checklist review tools if possible as these only assess the issues listed, missing those not directly assessed, and do not consider the right care for a specific patient (they consider the right care for a 'typical' patient).

Acute trusts: The Independent Advisory Group to RCP's national mortality case record review programme recommends that **all inpatient deaths in the following categories** are reviewed:

- deaths where the **bereaved or staff raise significant concerns about the care**
- deaths of those with **learning disabilities or severe mental illness**
- deaths in a **specialty, diagnosis or treatment group where an 'alarm' has been raised** (for example, an elevated mortality rate, concerns from audit, CQC concerns)
- deaths where the patient was **not expected to die** – for example, in elective procedures
- deaths where **learning will inform the provider's quality improvement work**.

A sample of other deaths should be reviewed to clarify where learning and improvement are needed most. If possible, patients who die within 30 days of discharge from inpatient services should be considered in scope for potential review.

Mental health and community trusts: Taking a proportionate approach, trusts should develop and publish a rationale for the categories of outpatient/community patient considered in scope. It is assumed all inpatient deaths will be reviewed.

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Policy publication requirements – how the trust responds to the death of particular patients

A trust's published policy should include how the trust examines the care provided to specific types of patients as outlined below:

Learning disability

All trusts should adopt the LeDeR method to review the care of individuals with learning disabilities, once it is available in their area. See http://www.bristol.ac.uk/sps/leder/
Trusts must have systems to flag patients with learning disabilities so their care can be reviewed.

Severe mental health needs

Trusts must have systems that flag those with severe mental health needs so that their care can be reviewed. NHS England is co-ordinating work to develop a mental health review method. Acute trusts can use SJR or another relevant method to review the acute care of those with severe mental health needs who die in an acute hospital.

Infant or child (under 18) death

Reviews of these deaths are mandatory and must be undertaken in accordance with *Working together to safeguard children* . The Department for Education Form C should be used for these deaths. New child death review guidance is being developed and will be published by the end of 2017.

Perinatal or maternal death

All perinatal deaths should be reviewed, using the new perinatal mortality review tool once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly.

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Policy publication requirements – selection of deaths to investigate

A trust's published policy should include how it determines which deaths should be investigated under the Serious Incident framework.

This framework defines what constitutes a Serious Incident. These are so designated because the consequences of the adverse event are so significant to patients, families and carers, staff or organisations, or the potential for learning is so great that a heightened level of response is required.

The required response is an effective investigation involving patients, families and others to the extent they wish to be, focused on learning why things went wrong and identifying effective and sustainable changes to reduce the risk of recurrence.

Serious incident investigations are **not** undertaken:

- to hold individuals or organisations to account
- to determine the cause of death.

Trusts should describe how they:

- decide which deaths are declared and investigated as Serious Incidents
- keep an audit trail of these decisions.

Deciding whether an incident should be declared a Serious Incident or not can require finely balanced judgement, taking account of the costs and benefits of investigation. This means there can well be a range of opinions about whether a particular death constitutes a Serious Incident.

But the way in which the decision is reached to declare a Serious Incident should always be clear and defensible.

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Policy publication requirements – engagement with families/carers

Trust policies should describe how the trust engages with bereaved families and carers, including how they are supported and involved in any investigation process. We summarise below content from the Serious Incident and Learning from Deaths frameworks, setting out what needs to be done following an incident. But trusts should ensure effective engagement with **all** bereaved people in a sensitive manner, including, for example, support for the practical aspects of burial (or equivalent).

- Begin with a genuine apology and early meeting.
- All staff supporting the bereaved must have the necessary skills and knowledge of the incident.
- One person should be identified as the lead for liaison with the family/carer; consider the need for an independent advocate with the skills to work with bereaved individuals.
- Involvement of the clinicians caring for the patient who died should be considered on a case-by-case basis; this is not always appropriate.
- Action being taken should be explained in person and in writing.
- Set out how the will be kept informed and supported.
- Describe what to expect from an investigation, including timescales and outcomes.
- Clearly explain the Serious Incident investigation's rationale and purpose: these investigations are conducted to support learning, not to hold anyone to account. Be clear: if wrongdoing is found, separate processes are followed.
- Give the family/carer the chance to express concerns and raise questions. Their contribution can provide valuable insight into what happened.
- Provide an opportunity for family/carers to inform the terms of reference for the investigation.
- Once agreed, terms of reference should be shown to the family/carer so they can see their questions are reflected.
- Explain how the family/carer can contribute to the investigation: for example, by providing evidence.
- Provide access to the findings, including interim findings.
- Provide the family/carer with the opportunity to comment on the findings and recommendations in the final report and ensure their comments are considered in the quality assurance process. Be clear: their feedback may not be included if it is not considered relevant/appropriate.
- Keep them informed of any delays in the process.
- Consider meeting transport, disability and language/translation costs/needs.
- Consider the need for counselling and referral to organisations that can provide this.
- Ensure there is a co-ordinated approach if multiple agencies need to contact the family/carer; for example, where regulators, coroners or the police are involved. A single point of contact with the family should be appointed to keep them engaged.

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NHS Improvement's role

NHS Improvement will **not** collect data on numbers of case record reviews or use quantitative information from reviews to direct our regulatory or performance management activity.

Trusts cannot be meaningfully compared by looking at the number of deaths judged more likely than not to be due to problems in care.

NHS Improvement's national patient safety team reviews all patient safety incidents reported as resulting in death, to identify opportunities for national learning. We will continue to do this for any information submitted to the National Reporting and Learning System (NRLS) following case record review.

This is one reason why it is important that patient safety incidents identified from case record review are recorded via local risk management systems on to the NRLS. More information on the process of NRLS review is available on the NHS Improvement patient safety webpage and in a short animation.

NHS Improvement's regional teams will support providers in their region to improve their mortality processes, including how they undertake case record review.

This support will primarily be advice and guidance on implementing the new requirements, signposting further advice and facilitating peer support (see page 25).

We will not be using information in relation to implementation of this policy to inform a trust's Single Oversight Framework segmentation or our regulatory activity.

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Medical examiners

Reforms to death certification, when implemented in England, will result in all deaths being either scrutinised by a medical examiner or investigated by the coroner in prescribed circumstances. Additionally, medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

The introduction of the medical examiner's role, expected to be in April 2019, should therefore further clarify which deaths should be reviewed under the Learning from Deaths framework. Medical examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s). This new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death.

NHS Improvement and the Department of Health have commissioned research to explore whether medical examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Before the implementation of the medical examiner system, trusts are advised to allow any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

A report on seven pilot medical examiner schemes in the NHS, including the two main pilot sites in Sheffield and Gloucester, was published last year and demonstrated the value of Medical Examiners. These systems appear supportive of and consistent with the requirements of the Learning from Deaths framework. Providers should feel free to consider establishing their own medical examiner systems, building on the learning from the pilot sites, ahead of the national roll-out if they consider this to be appropriate.

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Link with mortality rates

The Learning from Deaths work does not replace the need to consider mortality data. Hospital standardised mortality ratio (HSMR), summary hospital-level mortality indicator (SHMI), crude mortality rates and other data are all sources of information that support trusts to understand where to focus improvement work.

Mortality governance processes should consider mortality rates **and** the results of case record reviews and investigations as part of a single clinical governance framework. Multiple sources and types of data and information – not just limited to mortality – should be used to help a trust understand how to improve care.

Boards should be aware that their organisations can have low mortality rates and discover substantial problems in care of patients who die, or high mortality rates but relatively few identified problems in care. Mortality rates are a statistical construct that is based solely on what is in the coded data and hence are limited in measures of acuity and pathology compared to the depth of clinical information available in case note reviews.

While there is no single approach to follow, boards should:

- Engage with the combined information from mortality rates, case record reviews and investigations
- Be curious and seek out issues – if case record review flags a problem in one patient's care, what do mortality rates tell you about the care of all patients in that service/pathway? Remember that problems in care may exist even if mortality rates are relatively low
- Recognise that improving mortality will likely improve the standard of care for all patients and reduce complications, speed recovery and enable faster discharge
- Provide visible leadership and establish a focus on mortality as a trust-wide issue
- Prioritise reduction in mortality and increased safety as a core strategic aim
- Link and cross-reference mortality data to other qualitative and quantitative data, outcomes, adverse incidents, feedback, complaints, social media, staff and patient surveys
- Not assume an individual death is an isolated incident.

Next steps

Sharing policies We are working with a number of trusts to identify policies and processes already being used that we can share more widely to help other trusts develop their own policies.

We encourage trusts to learn from each other and challenge each other to continuously improve the quality of their Learning from Deaths processes and the implementation of effective and sustainable improvements as a result.

Guidance and support Further development of tools/guidance – particularly by NHS England concerning the engagement of bereaved families/carers – will be reflected in later versions of this guidance. HEE are working to develop eLearning by March 2018.

We anticipate that while NHS Improvement will endorse and promote a set of principles for implementing the Learning from Deaths policy, it is unlikely that a single detailed process will be mandated or enforced.

Role of NHS Improvement's regions We are working across NHS Improvement to ensure a consistent and pragmatic approach to supporting implementation of the Learning from Deaths policy.

These new requirements are challenging for many trusts. NHS Improvement will take a pragmatic approach to overseeing implementation. Trusts will be supported to learn.

Supporting boards NHS Improvement is presenting sessions on this new policy at a number of meetings over the summer, particularly board development and networking meetings.

If you would like NHS Improvement to come and talk about Learning from Deaths at a forthcoming meeting or event, please contact us at patientsafety.enquiries@nhs.net

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Resources

National guidance on Learning from Deaths
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England
https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Learning from deaths dashboard
https://improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance

Resources from the national patient safety team
https://improvement.nhs.uk/resources/patient-safety-alerts

The Improvement Hub
https://improvement.nhs.uk/improvement-hub/

Developing people – improving care for leadership and improvement
https://improvement.nhs.uk/resources/developing-people-improving-care/

Mortality review resources

Royal College of Physicians mortality review materials
https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

Learning disabilities mortality review programme
http://www.bristol.ac.uk/sps/leder/

Hogan et al Research on mortality review
http://www.bmj.com/content/351/bmj.h3239
http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159

Related guidance and publications

Serious incident framework
https://improvement.nhs.uk/resources/serious-incident-framework/

Root cause analysis tools and resources
http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Duty of candour
http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

Being open guidance
http://www.nrls.npsa.nhs.uk/beingopen/

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Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

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This publication can be made available in a number of other formats on request.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/103**
SUBJECT:	**Medical Appraisal and Revalidation Annual Report 2016/2017**
DATE OF MEETING:	27th September 2017
ACTION REQUIRED	**For assurance**
AUTHOR(S):	Simon Constable, Medical Director + Deputy CEO
EXECUTIVE DIRECTOR SPONSOR:	Choose an item.
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):	BAF1.1: CQC Compliance for Quality
	BAF1.3: National & Local Mandatory, Operational Targets
	BAF2.5: Right People, Right Skills in Workforce
STRATEGIC CONTEXT	In order to meet the GMC Requirements for Revalidation, every Doctor must participate in an Annual Appraisal, ensuring five Consecutive Appraisals are completed within their Revalidation Cycle and have acquired a 360 Patient/Colleague Feedback Report. Trust Boards are obliged to assure themselves of the medical appraisal and revalidation process through an annual report.
EXECUTIVE SUMMARY (KEY ISSUES):	This Report provides assurances to the Board that our Medical Appraisal System and Processes for monitoring the completion of Annual Appraisals to support GMC Revalidation for the Medical Workforce are robust. The appraisal and revalidation process informs the GMC directly via GMC Connect which contains the names of every doctor who holds a Registration Number and is licensed to practise in the UK. They identify the Employer - Designated Body - for whom they have a prescribed connection to a RO - Responsible Officer – and for whom a Recommendation/Non-Engagement/Deferral for Revalidation is able to be made. All NHS Designated Bodies (Employers) throughout the UK must engage in this system and failure to do can remove the doctor from the GMC Register and remove their right to practise medicine. In summary, our process and systems enable, track and

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	monitor the completion rates via a robust Notification System with a comprehensive Policy to identify the practice and procedure and accountability which has enabled a very successful 5th Year set of results that have consistently exceeded the GMC appraisal Target of 80%: YEAR 1 – 1st MAY 2012 (the go live date) – end of April 13 – 99.4%; YEAR 2 - April 2013 – end of March 2014 - 93%; YEAR 3 - April 2014 – end of March 2015 - 96%; YEAR 4 – April 2015 – end of March 2016 - 94%; YEAR 5 - April 2016 - end of March 2017 – 94%.	
RECOMMENDATION:	The Board is asked to note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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SUBJECT	Medical Appraisal and Revalidation Annual Report 2016/2017

1. BACKGROUND/CONTEXT

The GMC have strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. Where any doctor fails to meet those standards, the GMC acts to protect patients from harm - if necessary, by removing the doctor from the Register and removing their right to practise medicine. The introduction of Medical Revalidation across the UK in early December 2012 provided a new way of regulating licensed doctors that seeks to provide extra confidence to patients that their doctors are up to date and fit to practise. Only licensed doctors have to revalidate, usually every five years, by having Annual Appraisals based on the GMC's Core Guidance for doctors, *Good Medical Practice*[1]. The majority of licensed Doctors are expected to be revalidated for the first time by the end of March 2016.

The GMC have agreed supplementary guidance with the four health departments of the UK to help doctors understand how they can meet GMC requirements in the first cycle of Revalidation, which will last from early December 2012 to the end of March 2018. This is in line with the GMC Guidance that was published for all licensed doctors.

The Guidance, which is for Doctors and Responsible Officers, will ensure Doctors are recommended for Revalidation in a consistent way.

In order for a Recommendation to be made, a Doctor **must**, as a minimum:-

- ✓ be ***participating*** in an Annual Appraisal process
- ✓ to ensure ***FIVE consecutive appraisals*** have been completed in preparation for their Revalidation cycle
- ✓ 360 Colleague Feedback
- ✓ 360 Patient Feedback

The GMC have also made clear that the minimum requirements for each Appraisal and relevant supporting information are as follows:-

- Evidence of Continuing Professional Development.
- Review of significant events, complaints and compliments which relate to the 12 month period prior to the appraisal that precedes any revalidation recommendation.
- Evidence of regular participation in quality improvement activities that demonstrate the doctor reviews and evaluates the quality of their work which must be considered at each appraisal. The activity should be relevant to the doctor's current scope of practice.

[1] **GMC – Good Medical Practice 2013 –** http://www.gmc-uk.org/static/documents/content/GMP_2013.pdf_51447599.pdf

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- Evidence of feedback from patients and colleagues (once if the five year cycle) must have been undertaken.
- Focused on the doctor, their practice and the quality of care delivered to patients
- Gathered in a way that promotes objectivity and maintains confidentiality

2. KEY ELEMENTS

Below are the identified 10 Steps to GMC Revalidation that every practising Doctor is required to complete

1. Register on GMC Online
2. Confirm your responsible officer
3. Get a date from the GMC
4. Find out the local appraisal format
5. Gather supporting information
6. Prepare for appraisal
7. Participate in appraisal
8. Sign-off appraisal
9. Repeat steps 5-8 every year
10. Receive your revalidation confirmation from the GMC

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

NONE

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4. MEASUREMENTS/EVALUATIONS

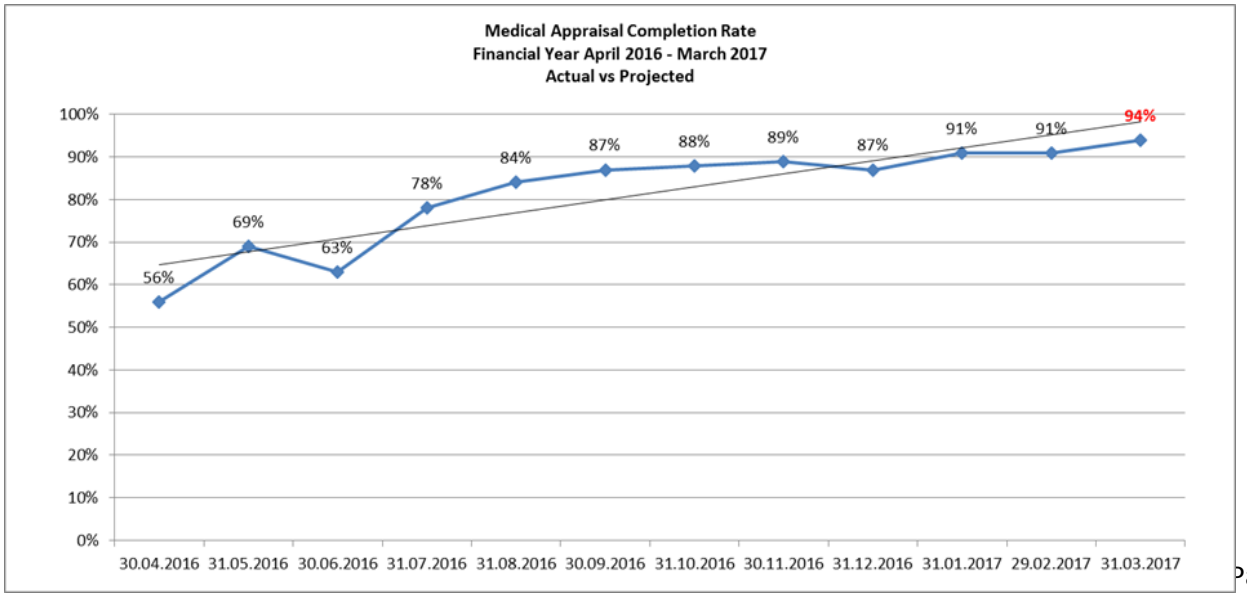
HEE Revalidation North - Quarterly Return Data Sets Submitted

Framework of Quality Assurance for Responsible Officers and Revalidation, Annex B -

Please complete this quarterly information template for the period 1 January 2017 to 31 March 2017 and return to

	Indicator	Q1 (1 Apr to 30 Jun)	Q2 (1 July to 30 Sep)	Q3 (1 Oct to 31 Dec)	Q4 (1 Jan to 31 Mar)
1	**Name of designated body** (or NHS England Area Team or Region) Note: Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	Warrington & Halton Hospitals NHS Foundation Trust			
2	Number of doctors with whom the designated body has a **prescribed connection**	224	218	220	223
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	46	46	58	43
	Percentage of total			26%	
3.1	Number of those within #3 above who **held an appraisal meeting** in the reporting period	29	35	41	34
	Percentage of appraisals held			71%	
3.2	Number of those within #3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	17	11	17	9
	Percentage of appraisals not held			29%	
	Data entry checker				
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	4	2	6	2
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**	13	9	11	7
	Data entry checker				
4	**Any Comments** you wish to raise (e.g. new RO, new appraisal lead etc.):				

Medical Education Tracker Tool - Financial Year - Apr 16- Mar 17 - Completion Rates = 94%



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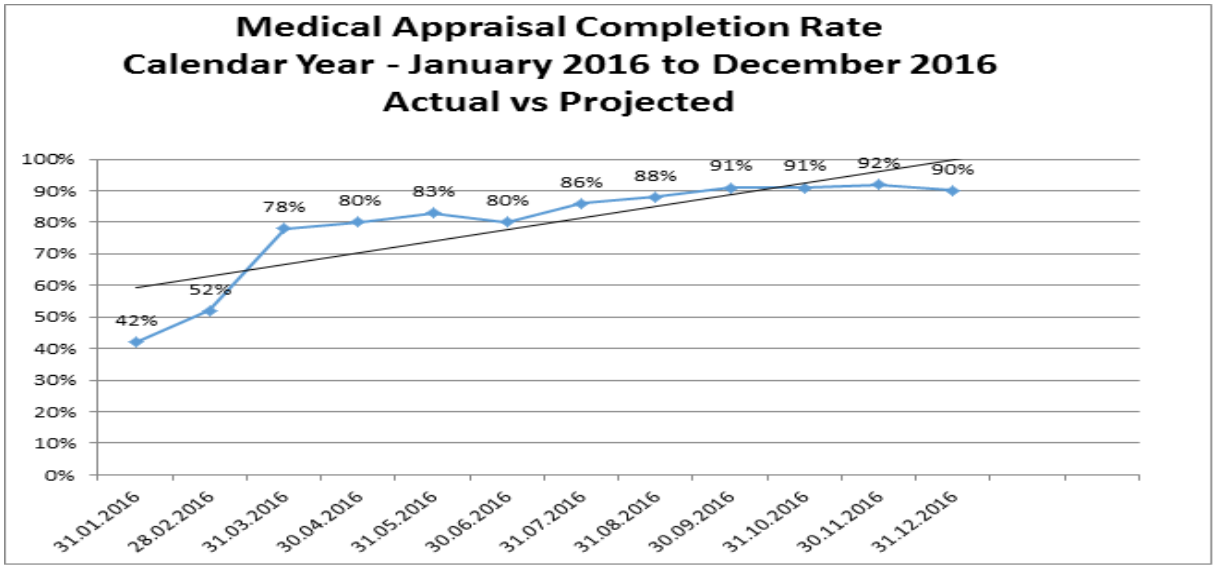
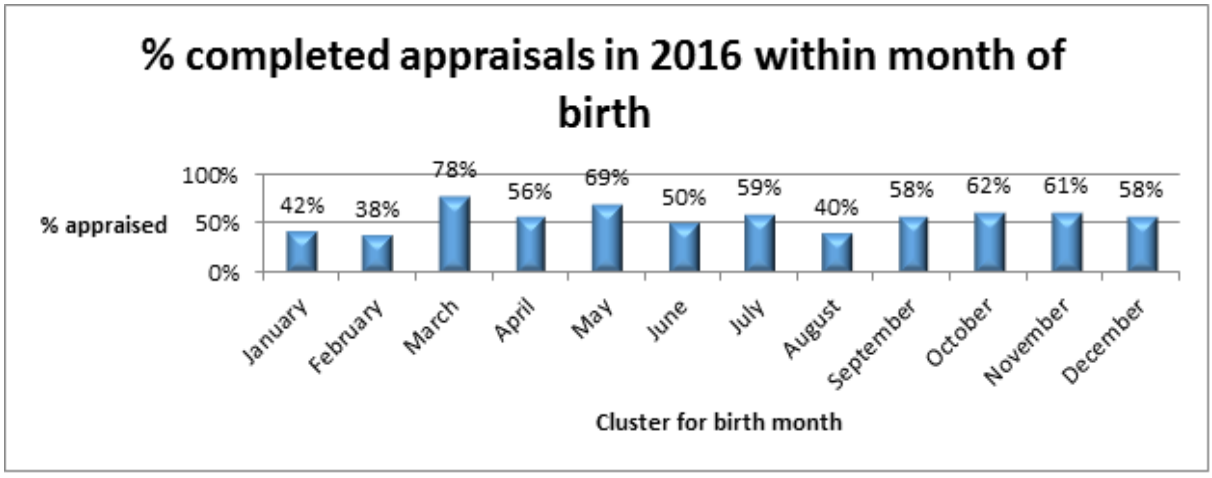
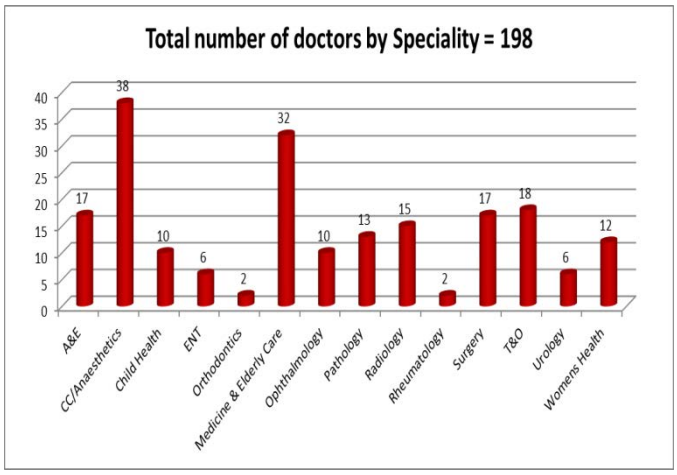
Medical Education Tracker Tool - Calendar Year 2017 Completion Rates = 90%

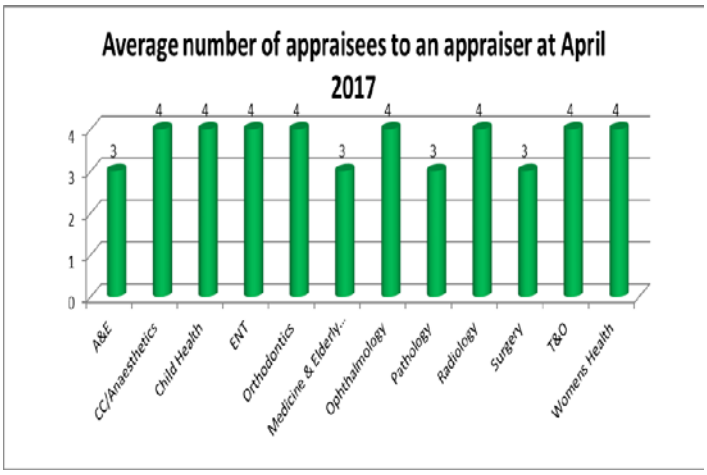


Medical Education Tracker Tool - Calendar Year 2017 Birth Month Compliance Rates



Medical Education – Data Sets - Appraiser/Appraisee Ratios





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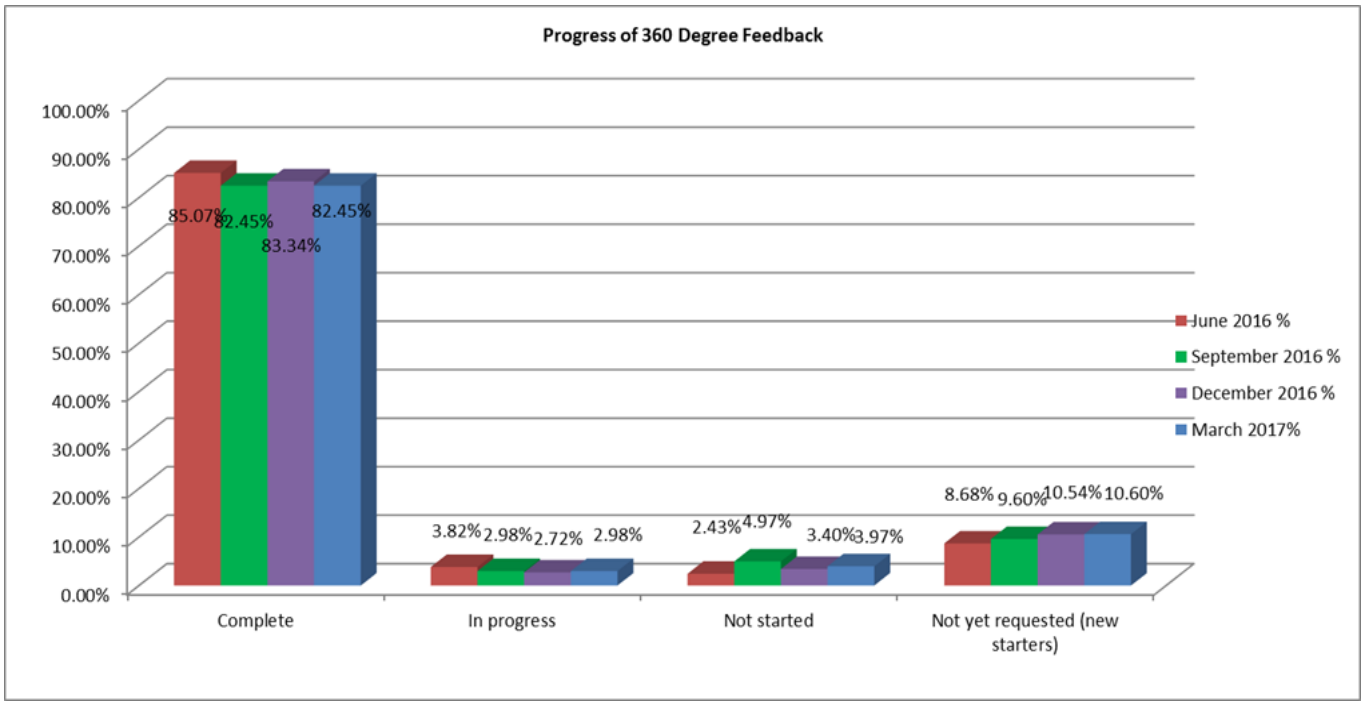
Progress Engagement Tracker – 360© Feedback (5 year cycle) - Monitor Completion Rates and Trigger Communications.



360 Degree Status	June 2016 %	Sept 2016 %	Dec 2016 %	March 2017%
Complete	85.07%	82.45%	83.34%	82.45%
In progress	3.82%	2.98%	2.72%	2.98%
Not started	2.43%	4.97%	3.40%	3.97%
Not yet requested (new starters)	8.68%	9.60%	10.54%	10.60%

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Revalidation Figures - 5 Year Tracker and Financial Year Position

Revalidation Figures for 2016/17 Board Report
As at 31st March 2017

Submissions to GMC since commencment of Revalidation in December 2012

Calendar Year	Number of Submissions	Positive Recommendations	Deferrals Requested
2013	37	32	5
2014	73	63	10
2015	87	78	9
2016	22	16	5
2017 (Year to 31/3/17)	5	3	2
TOTALS	224	193	31
	100%	86.2%	13.8%

Financial Year	Number of Submissions	Positive Recommendations	Deferrals Requested
1 April 2016 - 31-Mar-17	17	14	3
	100%	82.35%	17.65%

DEFFERALS	Number	%
Doctors who have successfully revalidated following previous deferral	16	51.62
Doctors awaiting reconsideration once submission date arises again	4	12.90
Doctors who have left the trust before new submission date occurred	11	35.48
Total Number of Deferrals	31	100%

Reasons for Deferrals Being Requested:

Lack of evidence for doctors new to the trust, particularly Locums
Criteria not met - insufficient appraisal record or 360 feedback not obtained
Too short a time period from starting employment and revalidation date
Pending conclusion of investigation (internal/external/on hold with GMC)
Non-Engagement in Appraisal process (pre-cursor to being reported to the GMC)

Revalidation & GMC Submissions Tracker.xls

5. TRAJECTORIES/OBJECTIVES AGREED

Key Elements of Current (Notable) Practice – Progress Update

- **Bi-Monthly ARG Meetings** – Terms of Reference/Minutes/Action Plans/National Updates – Networks/NHS England/maintain up-to-date knowledge – *informs the Strategic People Committee/Education Governance Committee/Medical Education Quality Committee*
  - Collation and upload of a comprehensive Suite of Reports (12 month data sets) for every Doctor prior to their Appraisal Meeting.
  - Incomplete/Overdue Appraisal Tracker /Revalidation Panel Tracker – both shared and discussed to ensure Team are engaged and all necessary actions are taken.
- **9th Bi-Annual Appraiser Forum Meetings -** coordinated to "listen and support the Appraisers" - 3rd April 17 – with Action Notes

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- Individual ***FEEDBACK Reports*** directly from CRMS are given to each Appraiser to drive quality and expertise in the process and evidence their skills as Appraisers.
- Discussed subjects such as "Quality Control" and "Standards in Clinical Noting via Lorenzo"

6. MONITORING/REPORTING ROUTES

- Continue to track both the Calendar Year **(90%)** and Financial Year end data **(94%). – Reports submitted for: MEQC/Education Governance /OPC**
- Continue to deliver Monthly Appraisal Completion Reports to each Clinical Lead/Speciality
- Continue to present the Trust's Figures via the **COB Dashboard** for CBU assurance
    - Present all Data Sets directly in the Bi-Lateral Board Reports
    - BY DIVISION
    - BY OVERAL TRUST POSITION
    - BY % COMPLETE/INCOMPLETE per month.
    - HEE North Revalidation Figures – Submissions/Recommendations to the GMC
- Continue to meet the deadlines and present the Trust's figures to HEE North Revalidation Team
- Continue to present the Trust's Annual Organisational Assessment - "AOA" data to HEE North Revalidation Team
- Continue to complete the HEE Revalidation Annual "Statement of Compliance"
- Continue to track the - 360© Completion and Progress to ensure every Doctor has a completed Report in line with their GMC Revalidation date. (Renewal of the Contract underway for the next 5year Revalidation Cycle.
- Continue to track the ratios of Appraisers to Appraisees – manage all request changes and respond to training needs.
- Continue to track and deliver the Training needs of the Medical Workforce to ensure Appraisers remain up-to-date

7. TIMELINES

- Robust monthly reporting processes are in place
- Due Friday 2nd June 2017 - NHS England Mandatory Return for 2016/17 "**Annual Organisation Audit" – AOA** – submitted 25th May 2017
- June 2017 - ALL Trust required to submit an Annual Report to their Board
- 29th September 2017 - NHS England Mandatory Return for 2016/17 – **"Statement of Compliance" - SoC**

8. ASSURANCE COMMITTEE (IF RELEVANT)

The Board is asked to note the contents of the Report and to be assured that our systems of monitoring and managing Medical Appraisals to support GMC Revalidation are robust and adhere to GMC Guidance and Practice. The APPRAISAL & REVALIDATION Group – ARG Team Meetings - will continue to review and improve on practice as required.

- Present all Data Sets directly in the **COB Dashboard Reports**
    - BY DIVISION/CBU

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- BY OVERAL TRUST POSITION
- BY % COMPLETE/INCOMPLETE per month.
- Revalidation Figures – Submissions/Recommendations to the GMC

- AS GMC Revalidation is a 5-yearly cycle – we also track completion rates by **Calendar Year**:-The Trust continues to achieve excellent results for the completion of Medical Appraisals in 2016- n=90%. The level of engagement is further evidenced by the "in month" completion rates and the mean average for the year held steady at 56%, with the highest month in March at 78% and lowest month in February at 38%.

***The GMC Target is 80% based on a 20% margin which allows for those Doctors who may have Sickness, Long-Term absence and/or Maternity Leave*

- **GMC Good Practice... "Allocation Process"** - "New Appraiser Training and Allocation of Appraisees" – Clustering exercise within the Specialties - NEW Medical Appraiser Training Course was held on the 13th March 2017 (13 WHH doctors/7 external delegates). This has increased the Trust's total number of Medical Appraisers to **66.** We also arranged a Medical Appraiser Refresher Course on the 14th March 2017 (n=9 attendees)
  - *"A doctor should normally have no more than three consecutive appraisals with the same appraiser and must then have a period of at least three years before being appraised again by the same appraiser... a doctor should not act as an appraiser to a doctor who as acted as their appraiser within the previous 5 years"*
  - ALL Clinical Leads respond and review their Clusters in agreement with the Deputy RO and identify the changes as required.

  - ALL trained Physician Associates will be given access to use CRMS to allow then to complete and engage in an annual appraisal, however it should be noted that the quality assurance of these appraisals need not be as stringent as they are not **GMC Registered** doctors. Student PAs are exempt from appraisal as they are still students and complete a University portfolio. Their allocated educational supervisors should appraise the PAs.

- Delivered a Medical Appraisers Competence Self-Assessment Tool in April 2017 – RESULTS - based on the NHS England Assurance Template - Appendix 4

WHHFT Medical Appraiser Self Assess

- **All Doctors (temp/locum/agency)** with a prescribed connection to the Trust and are employed for **six months or more** are included in the Trust Medical Appraisal and Revalidation process.

- Continue to track the engagement of **360° Feedback** - monitor completion rates and trigger communications (required once within a 5-yearly cycle for revalidation)

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9. RECOMMENDATIONS

- Ensure all **Locum/Temporary/Short-Term Doctors** are provided with EXIT Reports (template is available) in line with the Strengthened Medical Appraisal Policy and that this Action is recorded for all locum and short-term contracts. This will also ensure their practice is reported for *every contractual movement whilst employed within the health service/health care setting*. Data sets required.

- Strengthen and review the quality of the **Supporting Information** – Trust Data - Delivery of robust Reports that may be able to be offered through the HED system (only for surgical specialties) and Clinical Governance Reports in relation to Complaints/Incidents.

- Ensure Remediation "maintaining high professional standards" MHPS - Processes are factored and robustly coordinated to ensure a doctor can be appropriately supported (e.g. further training and resources (financial and otherwise) provided and recognised accordingly.

- Review the **Audit Templates** provided by NHS England to provide further assurances in the coming year 2017/18.

- To complete the Annual NHS England - Medical Appraiser Competency Self-Assessment Tool

NO FURTHER ACTIONS ARE REQUIRED

Appendix 1: Annual Organisational Audit from HEE England – NHS Revalidation North

Warrington Halton Hospitals NHS Founda

Annual Organisational Audit (AOA)
End of year questionnaire 2016-17

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	06491
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2017
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2015/16 AOA cleared with Publications Gateway Reference 04543
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2016-17

Version number: 4.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016 & 24 March 2017

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Please do not use this version of the form to submit your response.

Contents

Please do not use this version of the form to submit your response.

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2017** for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

Please do not use this version of the form to submit your response.

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

Please do not use this version of the form to submit your response.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Warrington & Halton Hospitals NHS Foundation Trust	
	Head Office or Registered Office Address if applicable line 1 Warrington Hospital	
	Address line 2 Lovely Lane	
	Address line 3	
	Address line 4	
	City Warrington	
	County Cheshire	Postcode WA5 1QG
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

Please do not use this version of the form to submit your response.

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☑
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

Please do not use this version of the form to submit your response.

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☑
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

Please do not use this version of the form to submit your response.

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

Please do not use this version of the form to submit your response.

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

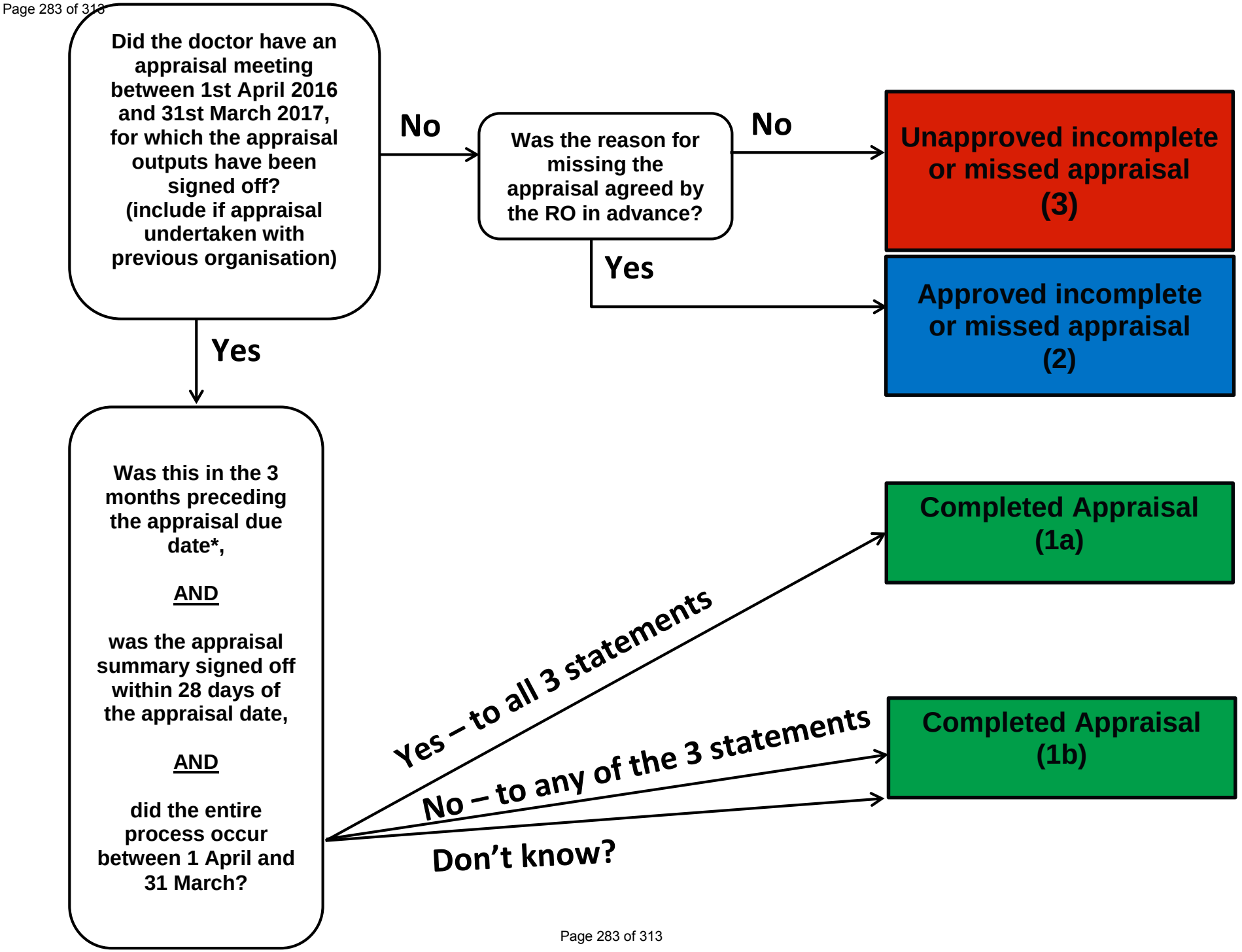
1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**	Number of Prescribed Connections	1a Completed Appraisal (1a)	1b Completed Appraisal (1b)	2 Approved incomplete or missed appraisal (2)	3 Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	130	61	64	3	2	130
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	47	19	28	0	0	47
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	36	10	13	11	2	36
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	213	90	105	14	4	213


Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

Please do not use this version of the form to submit your response.

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2016/17 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

Please do not use this version of the form to submit your response.

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☐ Yes ☑ No

Please do not use this version of the form to submit your response.

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1		

Please do not use this version of the form to submit your response.

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012, updated 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/104**	
SUBJECT:	**NHS Improvement – Board Self-Certification Checklist – Agency Spend**	
DATE OF MEETING:	27 September 2017	
ACTION REQUIRED	**Assurance**	
AUTHOR(S):	Michelle Cloney, Interim Director of HR & OD	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Medical Director Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.5: Right People, Right Skills in Workforce	
	BAF2.2: Nurse Staffing	
	BAF2.3: Medical Staffing	
STRATEGIC CONTEXT	NHS Improvement has developed a Board self-certification checklist to ensure enhanced scrutiny on Trust performance on the management of Agency spend. The Trust has sought assurance on this issue for several years.	
EXECUTIVE SUMMARY (KEY ISSUES):	The check list provides a position statement relating to the systems and processes that we have in place to control, manage and reduce agency spend. Progress against this checklist is monitored through the Finance and Sustainability Committee on a monthly basis and brought before Board for assurance.	
RECOMMENDATION:	• That the Trust Board note the position and progress made on key elements. • That the Trust Board continues to delegate responsibility for the on-going scrutiny of the checklist to Finance and Sustainability Committee and that a quarterly update be brought to Board throughout 2017-18.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	N/A
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication	

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	Self-Certification Checklist Please discuss this in your Board meeting	Yes – please specify steps taken	No. We will put this in place Please list actions
		Governance and Accountability	
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	• Long term locums are reviewed at Innovation Control and Cost Improvement Committee (ICIC) on a monthly basis • Finance and Sustainability Committee (FSC) scrutinises agency spend monthly • Board receives data via the Integrated Performance Dashboard monthly • Weekly (draft) report for approval prior to submission to NHSi Unify is provided by Employment Services to Director of Nursing, Medical Director and Director HR & OD. • Fortnightly reviews of Workforce Controls has been established between the Medical Director, Chief Nurse and Head of Employment Services • A tracker has been established to monitor agency spend and the CEO personally approves anything over the 'break glass' limit • Pay Spend and Review Group established in April 2017 – subgroup of Finance & Sustainability Committee. Focus is on all areas of spend and plans/initiatives to review and address these	

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		• Medical HR Group established chaired by Deputy Medical Director. High level Action Plan being developed with input from CBUs to develop medical workforce plans for the next 2 years	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	• Yes – included for both Medical Director and Chief Nurse	
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	• The Medical Director, Chief Nurse and Director Human Resources & Organisational Development meet on this ahead of Finance and Sustainability Committee. • A Finance & Sustainability Committee Subgroup – Pay Spend & Review Group – has been established in April 2017 to provide additional scrutiny of pay spend across all staff groups and to develop policies / procedures to support the reduction in agency spend. This has also included a review of IR35 processes in the Trust and continuing monitoring of how the Trust is holding the line with regards to maintaining agency rates. A monthly HR Directorate meeting has been established which has recently been expanded to	

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		include Procurement and Finance representatives. The purpose is to review all IR35 workers and to agree changes to processes in order to minimise any risk to the Trust – including SOPs, negotiations with NHSP, Tempre.	
4	We are not engaging in any workarounds to the agency rules.	• We can confirm that we are not engaged in any workarounds to the Agency Rules	
		High quality timely data	
5	We know what our biggest challenges are and receive regular (e.g. monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (e.g. vacancy, sickness) and how this differs across service lines.	• Scrutiny of spend and root causes at a divisional level is undertaken at FSC monthly. • Comprehensive information produced on a weekly basis for consideration and approval of the Chief Nurse and Medical Director showing details of agency expenditure and forecasted expenditure; details/names of the 'top earners' and how long these workers have worked at the trust and the reasons for engaging these workers.	The Trust received a letter from Lyn Simpson (NHSI) regarding a Trust target to reduce the use of Medical Locum staff. This new target has been incorporated within the Pay Spend Dashboard reported to FSC monthly – commencing June 2017. Our ability to collect accurate data for non-medical and non-nursing staff is compromised by not having a centralised bank.
		Clear process for approving agency use	
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	• For Agency staff being booked for longer than two weeks, then approval is sought through our Establishment Control processes. For periods shorter than 2 weeks it is centralised for nursing staff through NHSP.	The Trust does not currently have centralised booking arrangements in place for non-medical and non-nursing staff, however, we are currently exploring this option with

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			Liaison & NHSP and exploring other options to introduce this and to respond to the implementation of IR35 legislation changes. Initial costs have been obtained and an Option Appraisal paper has been produced.
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	• This is in place for all staff and requires requestors and approvers to follow a newly introduced SOP and Flowchart which has been publicised via Communications and is on the Extranet. A new Temporary Staffing Policy has been agreed and published on the Extranet.	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	• Revised scheme of approval in place with senior Medics/Nurses signing these shifts off. Chief Executive sign-off on bookings over £120. • The process for price cap breaches has been audited. This has shown that completion of the breach price form for medical staff is not 100% compliant and 50 shifts (10%) in August were not covered by a breach form. These are being followed up and the process tightened. Any future breaches will be reported by name with the expectation that these should be short term and plans put in place to mitigate further agency expenditure.	

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		• The Director of HR & OD has introduced regular 1:1 meetings with key clinical managers to review workers who breach the price caps and plans in place to reduce these.	
Actions to reducing demand for agency staffing			
9	There are tough plans in place for tackling unacceptable spending; e.g. exceptional over- reliance on agency staffing services radiology, very high spending on on-call staff.	• A revised performance management regime was approved by the Clinical Operations Board. This covers a range of people measures, including % of agency spend against overall pay bill. The revised regime mirrors NHSI performance classifications.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	• This has been in place for Nursing staff for some considerable time using NHSP. The contract with NHSP has been extended from September 2017, as part of a collaboration with 4 other local trusts to maximise the purchasing power and reduce costs – anticipated savings of c£40k.	Use of a staff bank for AHP and A+C staff is limited and requires further work.
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by e-Rostering.	• All wards now have 6 week 'e' rostering in place.	
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled)	• This measure has been discussed with NHSI, it has been agreed that whilst we await further clarity on the measure from them, that we look	

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	of less than 21 days.	at this measure as the time elapsed between an advert for a post, closing and the time taken for an offer to be made to the successful candidate. Our current process requires us to do this within 14 days. Variance is monitored and reported through the Integrated Performance Dashboard at the Trust Board	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	• The Board and Executive team have supported a range of workforce innovations including supporting bids for Physician Associates – which have been successful (open day planned for 22.9.17); 10 Associate Nurses have commenced their training and developments in Vanguard Wards which will include the introduction of the WRaPT workforce repository tool and a framework for workforce planning and workforce transformation.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	• Significant work continues on workforce planning with a visit planned to Countess of Chester to understand how the Wrapt tool was used on their Vanguard Ward.	
		Working with your local health economy	
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by	• The Board and executives are sighted on the areas of high agency spend through the Clinical Operational Board (Trust Operational	

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	agency staffing.	Board) via the Chief of Service report, FSC and SPC (Workforce Committee) .	
16	The trust has regular (e.g. monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	• Regular contact is made with Executive colleagues to explore shared rotas and 'holding the line' on agency caps Through LDS/STP work sustainable services are a key focus for future developments. • The Trust brokered a Cheshire and Merseyside summit on the challenges facing provider organisations on this agenda.	

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/105**	
SUBJECT:	**Theatres at Night**	
DATE OF MEETING:	27 September 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Deborah Erskine-Smith, Head of HR Business Partners	
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Interim Director of HR and OD Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.5: Right People, Right Skills in Workforce	
	BAF2.1: Engage Staff, Adopt New Working, New Systems	
	BAF2.4: Engaging & Involving Workforce	
STRATEGIC CONTEXT	The purpose of this report is to update the Board of Directors on the closure of the industrial dispute in the Theatres Department	
EXECUTIVE SUMMARY (KEY ISSUES):	On 6 June 2017, the Trust was informed that Unite the Union would be balloting for action short of strike (ban on overtime) and strike action. The Unite ballot was conducted from 12 June 2017 until 3 July 2017. 44 staff completed ballot papers. 43 were recorded with 100% in favour of both action short of a strike and strike action. On 4th July 2017 the Trust was given notice of industrial action. A number of strike events were subsequently cancelled due to on-going negotiations. The Trust entered into negotiations with Unite and a number of offers were made. On 15 September 2017 the Trust was notified by Unite that theatres staff had voted 'overwhelmingly' in favour of accepting the Trust offer and the dispute was therefore closed.	
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.

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	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	**Theatres at Night**

1. BACKGROUND/CONTEXT

Following the transfer of vascular emergency surgery to the Countess of Chester Hospital and trauma surgery to Aintree Hospital there has been a decrease in the Trust's non-elective surgical activity, in particular between the hours of midnight and 8am. In addition, NCEPOD guidance, supported by the Royal College of Surgeons and Royal College of Anaesthetists, means that no patients who require surgery, other than life or limb saving or those that need to be performed as soon as possible (WH-CODE 1 & 2), should be taken to theatre after 10pm or before 8am.

More effective and efficient management of our emergency theatre utilisation is therefore required in order to see more patients receiving their procedure during the day and early evening when it is safest and less operations being carried out throughout the night when it is not.

The theatres staffing model at night was therefore reviewed and staff were consulted on proposed changes in May 2016. Following the consultation and a subsequent grievance submitted by staff, a working group was set up to implement the changes in partnership with theatres staff.

Theatres staff submitted a counter proposal via the working group which was considered by the Trust Executive Team. The proposal could not be taken forward but the proposed changes were amended in an attempt to take account of staff's concerns around working hours. In addition, the Trust commissioned Melanie Pickering, Head of Nursing, University Hospitals of South Manchester to undertake the independent review into the proposed changes. The independent review recommended a small amendment to the staffing model (the inclusion of a Care Support Worker at night) and confirmed that the proposal is safe.

2. KEY ELEMENTS

Industrial Action

On 6 June 2017, the Trust was informed that Unite the Union would be balloting for action short of strike (ban on overtime) and strike action. The Unite ballot was conducted from 12 June 2017 until 3 July 2017. 44 staff completed ballot papers. 43 were recorded with 100% in favour of both action short of a strike and strike action.

On 4th July 2017 the Trust was give notice of industrial action. A number of strike events were subsequently cancelled due to on-going negotiations.

- **18 July 2017: Continuous Overtime Ban**
  The overtime ban has taken place with the exception of the 6 hours contracted overtime for ODP staff.
- **24 July 2017: Strike Action 8am to 12pm**
  This strike action was cancelled due to on-going negotiations.
- **31 July 2017: Strike Action 8am to 12pm**
  This strike action was cancelled due to on-going negotiations.
- **7 August 2017: Strike Action 8am to 12pm**
  This strike action was cancelled due to on-going negotiations.
- **14 August 2017: Strike Action 8am to 12pm**
  This strike action was cancelled due to on-going negotiations.
- **18 August 2017: Strike action 1pm to 5pm**
  Strike action took place. 10 staff took strike action.
- **21 August 2017: Strike Action 8am to 12pm**
  Strike action took place. 10 staff took strike action.
- **25 August 2017: Strike Action 1pm to 5pm**
  Strike action took place. 7 staff took strike action.
- **28 August 2017: Strike Action 8am to 12pm**
  Strike action took place. 2 staff took strike action.
- **1 September 2017: Strike Action 1pm to 5pm**
  Strike action took place. 7 staff took strike action.
- **4 September 2017: Strike Action 24 hours**
  Strike action took place. 13 staff took strike action.
- **11 September 2017: Strike Action 24 hours**
  Strike action took place. 6 staff took strike action.
- **18 September 2017: Strike Action 24 hours**
  Strike action cancelled as agreement reached.

Negotiation Process

The Trust entered into negotiation with Unite in order to work together to reach agreement. The Trust offered early engagement with ACAS to support the discussions but this was declined by Unite, following discussions with theatres staff.

Throughout the negotiation process the Trust made a number of offers to theatres staff via Unite. In addition to the drivers for change set out in section 1 above, the Trust have aimed to develop an offer which would bring the terms and conditions for Operating Department Practitioners in line with other staff groups in the department, thus offering equity across all staff groups.

Unite undertook several workplace ballots, recommending the offers to the staff. On 15 September 2017 the Trust was notified by Unite that theatres staff had voted 'overwhelmingly' in favour of accepting the Trust offer and the dispute was therefore closed.

Agreement

A night shift staffing model will be implemented on 1 November 2017, which includes the recommendations of the independent review as well as amendments agreed throughout negotiations with Unite.

A partnership working group will be launched in November 2017 with representatives from each staff group in the Theatres Department. The group will focus on exploring new ways to work together and engage theatres staff.

3. RECOMMENDATIONS

The Board of Directors are asked to note the contents of this report.

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/09/106 ii**
SUBJECT:	**Corporate Governance – Acting up arrangements and voting privileges during the part-time secondment of the Chief Executive to the C&M STP.**
DATE OF MEETING:	27 September 2017
ACTION REQUIRED	**For Decision**
AUTHOR(S):	Pat McLaren Director of Community Engagement + Corp Affairs
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren Director of Community Engagement + Corp Affairs
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The Trust's Chief Executive has been invited to undertake a part-time secondment as Lead of the Cheshire and Merseyside STP with effect from 18th September 2017 for an initial period of one year, this secondment application was made following approval from the Trust Board in July 2017. Under our Foundation Trust Constitution, last updated July 2017, the Trust Board is required to have: a non-executive chair, five non-executive directors and five executive directors, one of whom must be the chief executive. The Trust Board is required to approve 'acting up' arrangements to address quoracy and voting privileges for the individuals identified in this briefing.
EXECUTIVE SUMMARY (KEY ISSUES):	The Chief Executive Mel Pickup will take up a part-time secondment as STP Lead for C&M sustainability and transformation partnership wef 18.9.17. During this period the Board is requested to approve the following interim acting up arrangements: 1. CEO Mel Pickup remains CEO of the Trust and the Accountable Officer in addition to her STP duties 2. Existing Deputy Chief Executive and Medical Director Prof Simon Constable will assume full-time CEO duties to support Ms Pickup during the initial secondment period. Prof Constable will pass his Medical Director portfolio to Dr Alex Crowe, currently Deputy Medical Director, for the initial

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	period, who will become Acting Medical Director 3. An interim Deputy Medical Director will be appointed for the initial period and will deputise for Dr Crowe **The Board is asked to approve these 'acting up' arrangements in order to enact the following composition and voting rights according to the Standing Orders of the Board Annex 7** • **Composition of the Board Item 3.6**, where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly and shall count as one person and • **Voting Item 4.11.5**, An officer who has been appointed formally by the Board to act up for an executive director during a period of incapacity or temporarily to fill a vacancy, shall be entitled to exercise the voting rights of the executive director. Therefore, in Ms Pickup's absence from any Trust Board meeting the Deputy CEO will assume her voting rights. Should Ms Pickup be present, then the Deputy CEO will not have a vote. In acting up to the Medical Director role, Dr Alex Crowe will exercise voting rights as an executive director. In Dr Crowe's absence the Interim Deputy Medical Director (to be appointed) will assume Dr Crowe's vote.	
RECOMMENDATION:	1. The Board is asked approve the acting up arrangements for the initial period and 2. Acknowledge the voting arrangements for the Deputy CEO, Acting Medical Director and Interim Deputy Medical Director.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	