BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/11/ 126**	
SUBJECT:	**Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016/17**	
DATE OF MEETING:	29 November 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Keith A Preston Interim EPRR Co-ordinator**	
EXECUTIVE DIRECTOR SPONSOR:	**Jan Ross, Acting Chief Operating Officer** 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):	**BAF1.4: Business Continuity**	
	BAF1.3: National & Local Mandatory, Operational Targets	
	Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has undertaken the annual self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards. Of the 59 Core Standards, the Trust is fully compliant with 57, and non compliant in just 2 categories. This gives an overall compliance level of 'Substantial'. An improvement plan has been produced to address the 2 core standards that were rated as non-compliant. The Trust is required to report the outcome of the 2017 EPRR Audit to the Board.	
RECOMMENDATION:	The Board is asked to note the 'Substantial' compliance rating, and the Improvement Plan.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Trust Event Planning Group
	Agenda Ref.	EPG/16102017/03
	Date of meeting	16.10.17
	Summary of Outcome	Approved

1. Background
NHS Acute Hospital Trusts are defined as 'Category 1 Responders' by the 2004 Civil Contingencies Act. This carries legal duties to have up to date plans and procedures to underpin the response to a wide range of Major Incidents and Business Continuity challenges.

Under the Act, Acute Trusts must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

The range of scenarios is extremely wide and includes mass casualty incidents, infectious disease outbreaks, severe weather, and criminal/terrorist events, loss of power / utilities and staff absence.

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

2. The EPRR Assurance Process
All providers of NHS funded care are required to undertake an annual self-assessment against the EPRR Core Standards and rate their level of compliance (appendix 1). Once this has been completed organisations must report to their Board, though a statement of compliance.

The Trust's Accountable Emergency Officer has a responsibility to submit the self-assessment report, Core Standards ratings and improvement plan to the Clinical Commissioning Group and the NHS England EPRR Area Team. The NHS England Area Team will further assess the submission and supporting evidence, and submit a Regional assessment through to the NHS England National Board.

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

The Trust was rated against 59 applicable standards, and reported full compliance against 57. Two standards were rated as non-compliant but with evidence of progress towards full compliance. Both standards are included the EPRR work plan for the next 12 months.

4. Improvement Plan
For the 2 standards that were rated as non-compliant an improvement plan has been compiled (appendix 3), and will be monitored via the monthly Event Planning Group. The Event Planning Group is chaired by the Chief Operating Officer or Deputy Chief Operating Officer (Accountable Emergency Officer) and reports to the Quality Committee.

5. Conclusion

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

Appendix 1 – WHH 2017 EPRR Core Standards Assurance Excel Spreadsheet

Copy of 2 EPRR Core Assurance Standards

Appendix 2 – WHH 2017 EPRR Statement of Compliance

EPRR WHH Audit Statement of Complia

Appendix 3 – WHH 2017 EPRR Improvement Plan

WHH EPRR Core Standards Impoveme

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Warrington and Halton Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

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

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
59	0	2	57
Acute providers: **60**** Specialist providers: **51**** Community providers: **50**** Mental health providers:**48**** CCGs: **38**			

Also includes **HAZMAT/CBRN standards** applicable to providers: **Standards:** Acutes **14** / Specialist, Community, Mental health **7
Ambulance Service are required to report statements for 3 compliance levels as stated on page 6 of the Gateway letter 06967

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting Date signed

Emergency Preparedness, Resilience and Response (EPRR) 2017 Assurance- Governance 'Deep Dive' Assurance Plan 2017-2018

Organisation: ***Warrington and Halton Hospitals NHS Foundation Trust***

Plan owner: Events Planning Group (EPG), & Keith Preston -Interim Emergency Preparedness Co-ordinator

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level	The Accountable Emergency Officer (AEO) has previously devolved attendance at LHRP Strategic meetings to The Resilience Manager, who ensures the AEO is fully briefed. Ongoing Trust organisational developments have now elevated attendance to Director Level, reporting directly to the AEO.	The AEO will designate Trust Director level attendance at future LHRP Strategic meetings. Already commenced 25.8.17 LHRP meeting	September 2017 and ongoing through 2017-18
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	The Trust Major Incident Plan has an established and up to date EPRR Training Needs Analysis. Through 2016/17 staff Major Incident awareness and training has been comprehensive. The interim EPRR Co-ordinator will have Major Incident awareness and training as a priority task.	An Interim Trust EPRR Co-ordinator has been appointed to cover for EPRR Manager domestic leave absence. The Interim Co-ordinator has EPRR staff training and exercising as a priority task, referenced to The National Operational Standards for EPRR	December 2017 and ongoing through 2017-18

Emergency Preparedness, Resilience and Response (EPRR) 2017 Assurance- Governance 'Deep Dive' Assurance Plan 2017-2018

Organisation: ***Warrington and Halton Hospitals NHS Foundation Trust***

Plan owner: Accountable Emergency Officer, Events Planning Group (EPG), & Keith Preston -Interim Emergency Preparedness Co-ordinator

Ref	Deep Dive description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	The Accountable Emergency Officer (AEO) has devolved attendance at LHRP Strategic meetings to The Resilience Manager, who ensures the AEO is fully briefed. Ongoing Trust organisational developments have now elevated attendance to Director Level, reporting directly to the AEO. i.e. 25.8.17 meeting	LHRP meeting attendance at Director level, reporting to AEO, to be sustained throughout 2017-18	Commenced 25.8.17. Ongoing throughout 2017 -2018

NHS
Halton
Clinical Commissioning Group

One**Halton** Accountable Care Strategic Vision

One System, One Plan, One Halton

Version 9.1 LTG (November 2017)

Contents

Background and Introduction

The Health and Social Care Act 2012 placed a statutory duty on the NHS and local authorities to promote and enable integrated care, further reinforced by the Care Act 2014. A raft of policy initiatives and incentives have been implemented to support greater integration and partnerships including the Better Care Fund, a national pioneer programme and, most recently, actions to support the vision for the NHS in England described in the Five Year Forward View. The new care models proposed in the Five Year Forward View are particularly aimed at overcoming barriers between hospital and community services. They are aligned with the wider policy direction of organising care in the community around the needs of service users, shifting the focus from episodic and acute care to whole life care, expanding preventative support that encourages "self-care", independence and wellbeing.

In 2014/15 Halton as a borough started its journey towards an integrated model of care with a shared vison across health and social care.

Our Strategic Vision

To improve the general health and wellbeing of the people of Halton, working together to provide the right level of treatment close to home, so that everyone in the borough can live longer, healthier and happier lives.

We are building from the strong legacy and foundation of **One System, One Plan, One Halton**.

Our **values** are based on strong partnerships; Collaboration (engagement & participation), System leadership (values based approach) Strong relationships, shared goals and an agreed set of outcomes.

Ultimate responsibility for the implementation of One Halton lies with the Halton Health & Wellbeing Board, however, in order to deliver our vision and priorities we need everyone who lives and works in Halton to take an active role. We are passionate about improving the health and wellbeing of people living in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in achieving this goal.

The One Halton Health and Wellbeing Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on “self-care” prevention and early intervention. It does not replace existing strategies, commissioning plans and programmes, but influences them.

Integration is key to our strategic approach with all partners working together to deliver:

joint commissioning, culture change through community development, training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work.

A governance structure for One Halton will oversee the development and delivery of our priorities. Specific groups will be responsible for the development of an action plan setting out what all stakeholders will do to deliver the outcomes we want. They will use a life course approach and ensure each action plan includes action to maximise "self-care" prevention and early intervention, provide high quality treatment and care based on need close to home where this is possible and supports people in both the short and long term.

Transformation

Partners across Halton are developing new models of integrated working, based around the two towns of Runcorn & Widnes .These two towns will for this document be referred to as ***Service Delivery Footprints (SDFs).***

The SDFs are effectively a “functional geography” that can help us better plan and deliver our local services. SDF footprints are natural communities that are big enough to base services on but small enough to be sensitive to the populations needs. This work builds on the successful early implementation of hubs either side of the river, with integrated community services such as community nursing, social care in practice, wellbeing practitioners and the development of a single operating model.

Our ambition is for these SDFs to connect a number of services including community health services, GP surgeries, adult social care, housing, schools, children’s services and others. This is about creating integrated working that takes joint responsibility, working with residents, using new conversations, scaling our early intervention work to prevent reactive and unplanned cost, and knowing the assets of the community. services will work together in multi-disciplinary teams to offer early intervention and, if necessary, intensive support to families and individuals who are dealing with issues including mental health; debt; drug and alcohol misuse; domestic abuse; worklessness and long term health conditions.

Some of the potential wider integration could incorporate (but not exclusively):

- Integrated Community Services (including Community Nursing, Therapies and Adult Social Care)
- Primary care out of hospital services (Extended access/Out of hours)
- Mental Health
- Public Health Based Interventions
- Wellbeing
- Health Improvement teams
- Start Well, Live Well, Age Well
- Primary School Alignment
- Housing
- CCG Primary Care Commissioning and Improvement Capacity
- Consultant Outpatient Transitions (Tiers 3 & 4)
- Early Intervention and Prevention Services
- Improving Healthy Lifestyles
- National Probation Service
- Cheshire Fire and Rescue Services
- Alcohol and Drug Treatment Services
- Community Link Workers
- Children's centres
- Nursing and Residential Care
- Admiral (Dementia) nurses


PHARMACY

Design principles and objectives

We will;

- Manage demand for services by promoting self-care independence and prevention;
- Enable health and social care service integration wherever possible and appropriate;
- Design services around users and not organisations;
- Incentivise providers to work together to meet the needs of the whole person;
- Treat people in the home and community for as long as it is appropriate and possible;
- Reduce dependence on oversubscribed and expensive specialist resources such as emergency services, non-elective admissions and care homes;
- Manage length of stay in hospitals, avoid delays to discharge and prevent readmissions where possible;
- Allow system efficiencies to be realised – duplication and over supply is eliminated while “cost shift” from one service line or organisation to another is avoided;
- Create the climate for staff from different professional backgrounds to work together in a positive, open and trusting multi-disciplinary climate;
- Allow every member of staff to be trained in having new conversations with residents that focus on assets rather than need; and
- Make full use of digital technology, including development of a joined-up electronic record

An asset based approach is at the heart of One Halton, enabling staff to have a different conversation with patients and residents to promote self-care and independence and improved links to positive opportunities within the community to improve health and wellbeing.

Scope

NHS Halton Clinical Commissioning Group (HCCG), Halton Borough Council, Bridgewater Community Healthcare NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust, Warrington & Halton Hospital NHS Foundation Trust (WHHFT) and local GP federations have come together to develop a One Halton Accountable Care System model for Halton.

In the **first instance** the model will be formed around 2 GP service delivery footprints (SDFs) across Runcorn and Widnes and the integration of health and social care services.

In the **medium to long term** there is an ambition to extend this to integrate with public health and a wider set of public, voluntary and community services, such as leisure, housing and others.

In the **long term** there will be a badgeless provision of services with integration across organisational boundaries, increased investment in community based services and a sustainable primary care.

The approach is place based, based on SDFs using registered GP lists and a whole population budget to deliver a range of services against an agreed set of outcomes.

The scope of the One Halton Programme is to develop the vehicle to support both commissioner and provider integration to deliver a set of improvement outcomes delivering health and social care services across a whole population.


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Goals

Through this process we will deliver a set of key goals for the health and wellbeing system in Halton;

Goal 1

Services should enable people to take more responsibility for their own health and wellbeing

Goal 2

People should stay well in their own homes and communities as far as possible

Goal 3

When complex care is required it should be timely and appropriate

Prioritisation

It is our desire to change or 'transform' health and social care to make sure the people of Halton get the right care and support, the right way, when and where they need it.

To help us achieve this, we've identified the six themes prioritised within our **One Halton Health & Wellbeing Strategy**:

Our priorities for 2017-2022:

1. **Children and Young People**: improved levels of early child development
2. **Generally Well**: increased levels of physical activity, healthy eating and reduction in harm from alcohol
3. **Long-term Conditions**: reduction in levels of heart disease and stroke
4. **Mental Health**: improved prevention, early detection and treatment
5. **Cancer**: reduced level of premature death
6. **Older People**: improved quality of life

Our priorities contribute to our shared outcomes:

- More Halton children do well at school by reaching a good level of development educationally, socially and emotionally
- Healthy fit workforce to drive economic prosperity with fewer people suffering long term conditions from the age of 50
- More people will be supported to stay well and live independently for as long as possible
- People lead full, active lives using a wide range of facilities within local communities including good quality housing, parks, arts and cultural facilities, leisure services and safe cycling routes
- Reduced demand on services, improved quality and access
- More efficient use of financial resources

Our Commitments

Through signing up to deliver this One Halton Accountable Care Vision we are jointly:

- Taking ownership of where we are now. We all recognise progress has been made but that there is more work to do
- Being responsible for delivering on the agreed priorities and actions set out within our plans
- Making a commitment to make things better. For us to be successful all partners in Halton need to play their part including our local people
- Being accountable for developing systems that deliver more joined up approaches to delivering services

Strong leadership

Leadership is critical in the context of developing integrated systems and services. Stakeholders have different agendas and levels of understanding. A locally tailored leadership programme, supported by management is an essential component of One Halton.

Through our leadership we will talk to staff, ensure they understand the change and are motivated to change at both a strategic level and operational level. We are committed to work across all agencies with all staff and our population to collaboratively transform services for the future.

Integrated Strategic Commissioning

There is recognition that there are constraints that apply nationally and limit the flexibility in relation to local commissioning arrangements. Commissioning arrangements sit within NHS Halton ~~CCG~~ and Halton Borough Council. We will embrace learning from areas that have progressed in this area and take the opportunities that have arisen.

We will commit to and where permitted to, develop an integrated strategic commissioning function that will develop an alliance contracting model in line with our vision of “one system, one budget, one plan”.

Provider Partnerships (Alliance)

Providers are often constrained by contractual, legal and statutory constraints. Providers will need to work together to identify and agree who is best placed to deliver the best treatment and care for our population. They will need to agree a set of working principles that align with the national and local agendas.

Financial Resilience

Development and implementation of the detailed proposals will need to be completed from within existing expertise within partner organisations supported by the One Halton Programme Board.

In order to commission integrated services NHS Halton ~~CCG~~ and Halton Borough Council will be responsible for the commissioning budget allocation and the alignment of this to any decisions on pooling financial budgets. Proposals for pooled budgets will need to take into account that “health population” is funded by GP registered lists and LA funding by geographical population.

Partners will need to ensure any future integrated arrangements have robust financial accountability and governance. Estimates of the financial benefits of integration are constrained by the limited nature of the current evidence base.

Co-Located Service Provision (where appropriate)

Providers and commissioners will need to work together to build a community based service provision that supports patients, clinicians and multi-disciplinary workforce. Co-location of service provision should be the ultimate goal in the medium to long term. In the short term consideration of the constraints of existing building stock will need to be considered.

Governance

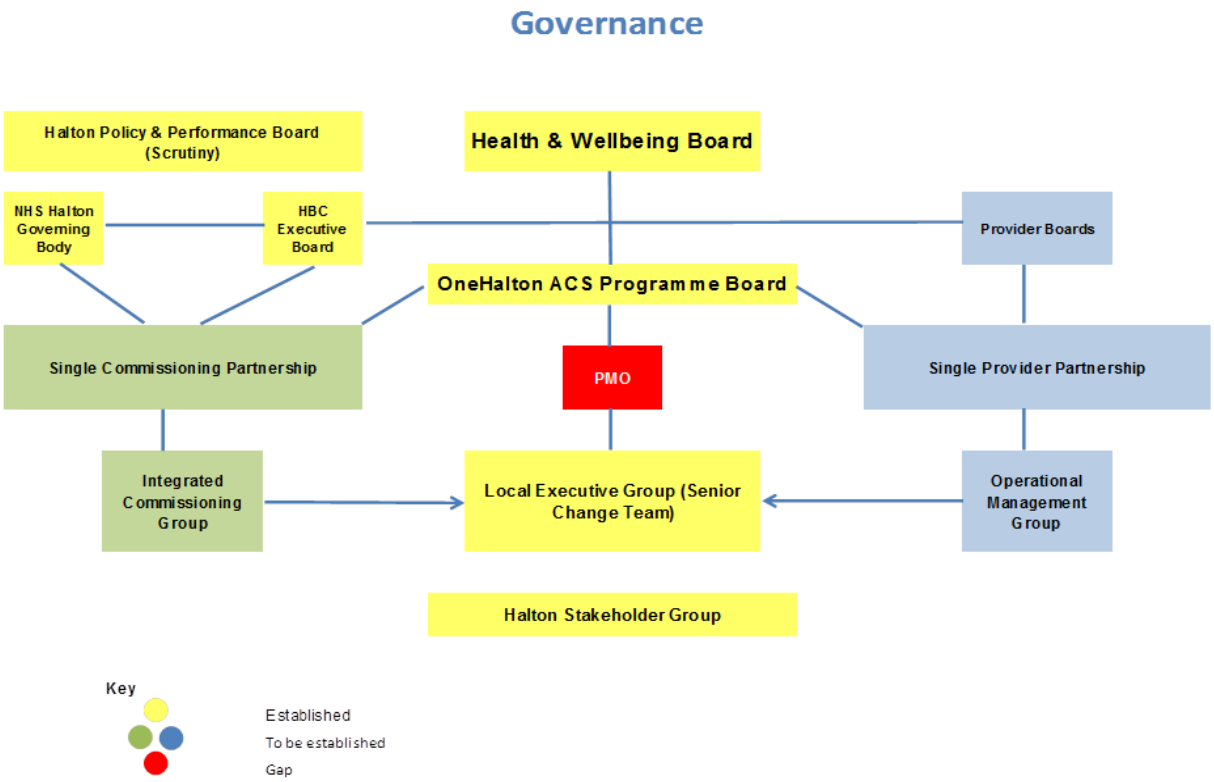
The integration of Health and Social Care in Halton will require the involvement of different commissioning and provider organisations, from both the statutory and non-statutory sector, working together in new ways.

Poor governance arrangements are one of the most frequently cited organisational barriers to successful integration so it will be vitally important to the success of this programme that robust governance arrangements are in place to oversee the delivery and evaluation of this complex work programme.

The following strategic groups and Boards will ensure effective governance of the programme:

- Halton Health and Wellbeing Board
- Halton Policy & Performance Board (Scrutiny)
- NHS Halton Governing Body
- Halton Borough Council Executive Board
- One Halton Accountable Care System Programme Board
- One Halton Single Commissioning Partnership
- One Halton Single Providers Partnership
- Local Executive group
- Halton Stakeholders group
- Engagement & Involvement of Population

Each agreed work stream will have a separate project group that will report into the One Halton Programme Management Office (PMO) reporting to the One Halton ACS Programme Board. Terms of reference and memorandum of understanding for the One Halton ACS Programme Board is attached in appendix 1. Each group will develop its own work plan to achieve the stated outcomes. Part of this work will involve engaging service users and residents in the co-production of new approaches. Project leads will also ensure alignment of activity with existing enabling programmes/groups.



Project implementation plans will be created which will form the basis of the monitoring process. This will be updated by the One Halton PMO as the project progresses, and referenced by the highlight reports. Regular reporting will be via a monthly highlight report, and will be produced by the programme/scheme lead to show actual and projected progress against plan.

The report will be submitted to the One Halton ACS Programme Board on a bi-monthly basis.

Project planning and control

The overall control of the project will be in line with Prince 2 methodology and adopts the “manage by exception” approach.

The Senior Responsible Officer (SRO) will have oversight of the whole programme and will be held to account by the Chief Executive Officer of Halton Borough Council and the Interim Chief Officer of NHS Halton CCG. The programme manager (when appointed) will carry out day-to-day management of the project within the delegations of authority.

Members of the project Team will raise or review project issues/changes/risks at the monthly project meetings. Project issues and risks will be reviewed and assessed for impact against the project timescales, cost and quality.

Programme approach

- Current services have been reviewed and evaluated against a number of criteria to establish which services should be in scope for the first phase of implementation.
- Phase 1 identifies the core services within the initial scope.
- Work is already progressing on these programs to redesign care pathways and integrate services from the bottom up.

Benefits & Outcomes

People will be supported to live longer healthier lives.
People with health and/ or social care needs will know how to navigate the health and social care system;
People with health and/or social care needs will be able to access the right information at the right time and will be able to access the support they need;
People will have an increased understanding of the benefits of wellbeing and will utilise local community resources to put this into practice;
People in local communities will have a range of locally grown support mechanisms such as carer led support groups, patient led self-management groups for long term conditions;
Through social prescribing GPs will support people to get to the right support and avoid more expensive and often unnecessary interventions;
Integrated teams will work closely with GP practices and will envelop individuals and work closely with provider services including local community and voluntary sector services;
People with long term conditions will have the ability to hold their own personalised care records and use Personal Budgets and Personal Health Budgets to manage their own care;
People with long term conditions and those defined at risk will have the ability to see and share their health and social care records;
People will be able to have repairs, adaptations and improvements made to their homes quickly and within timescales acceptable to them;
Carers will be supported to have a life outside of caring and will be supported in their caring role;
There will be improved access to services (parity of esteem) for all patients/clients, including children and young people, with mental health issues. Mental health conditions will be treated and assessed on a par with physical conditions;

Over time we will create a flexible workforce that can deliver more than one service for the benefit of patients and carers and the health and social care system;
We will manage demand for unplanned, emergency and urgent care services across the Borough where people choose the right place first time every time.
We will have greater control of our local pound and annual spend.
There will be Improved Value for Money through identifying cross-organisational efficiencies and economies of scale
Maintain financial resilience & sustainability of the Halton Health and Social Care System


OneHalton
Working better together
Welcome to OneHalton

One Halton Accountable Care Programme Board

Terms of Reference

The *One Halton* Accountable Care Programme Board (One Halton ACPB) is a forum for development and partnership working. It is not a decision making body but will seek delegated decision-making responsibilities from Joint Committee status at a later stage. For any strategic and/or significant decision-making, Programme Board members will be expected to make recommendations to appropriate bodies and committees.

Overall Objective
To secure, via partnership working, the provision of system leadership and meaningful engagement in the development of the *One Halton* Accountable Care System. This aims to secure sustainable, high quality services which meet patient needs and optimise the health of the borough, delivering organisational sustainability.

Membership (to be confirmed)
Chief Executives / Chairs / Clinical Executive Officers from the following organisations:-

- Independent Chair
- NHS Halton Clinical Commissioning Group
- Halton Borough Council
- GP Health Connect
- Widnes Highfield Health Ltd
- St Helens & Knowsley Teaching Hospitals
- Warrington & Halton Hospital NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- North West Boroughs Partnership NHS Foundation Trust
- Halton & St Helens Voluntary and Community Action
- Halton Housing Trust
- Halton 3rd sector consortium (rota basis)

Key Tasks

- To ensure effective leadership in the *One Halton* AC Programme, ensuring SMART plans for future service models and that are ambitious, sustainable and achievable;

- To make recommendations for actions as appropriate to Halton Health & Wellbeing board but not to take decisions which are binding on other organisations;

- To ensure alignment between the *One Halton AC* Programme and the plans for each organisation, highlighting any tensions or interdependencies, and agreeing with all how these should be resolved;

- To ensure key staff from each constituent organisation are enabled to participate in the Programme work streams;

- To review the results of the programme at the end of Phase 1, and to advise on how these are taken forward;

- Develop and deliver a strategic vision for Halton with an agreed set of co produced outcomes;

- Support the development of a shadow integrated commissioner and local delivery partnership by 2018.

Reporting Arrangements
The *One Halton* AC Programme Board will meet on a bi-monthly basis. Standard progress reports will be produced for presentation to all relevant committees to ensure consistency of message.

It will be accountable to the Halton Health and Well Being Board

Administrative Support
NHS Halton CCG

Review Date
November 2017

One Halton Accountable Care System Board

Draft Memorandum of Understanding

The signatories to this MoU have come together to improve health and wellbeing services for local people and to encourage self-health.

In doing so we are committed to:

- Improving health and wellbeing outcomes for local people
- Collaboration between health and social care services, providing accessible high quality services to local people
- Developing new ways to prevent and better detect illness
- Reducing the levels of demand on hospital, acute care and healthcare services generally
- Delivering service closer to home and within local communities

Our Commitment

We agree to the following principles in the development of an integrated health and social care eco system in Halton Borough:

1. We agree that an integrated system of health and social care is the best way to ensure optimum health, wellbeing and care outcomes for our population and to ensure collective financial sustainability.

2. We agree that the Halton Health & Wellbeing Strategy provides the focus for our work together and sets out our vision to work together to reform health and social care services to improve the health outcomes of our residents and reduce health inequalities, as quickly as possible,.

3. We agree the One Halton ACS Board will provide a focal point for prevention and early intervention, proactively identifying potential future demand and shifting the focus from unplanned and reactive services to planned and targeted interventions.

4. We agree to put patients and residents at the heart of what we do.

5. We agree to put General Practice and other community practitioners at the centre of our care model.

6. We agree to design and plan services around functional geographical footprints with populations of 30,000 to 50,000 based on registered patient lists.

7. We agree to design services for users and not our organisational needs.

8. The Commissioners agree to deliver a single approach to commissioning health, wellbeing and care services in order to transform services and improve outcomes. This will enable collaboration integrated working and include the development of pooled budgets.

9. We agree that we will consider the options available to us, and select the best delivery model for the integrated care system in Halton, but not withstanding this, we will continue to integrate our services on the ground, at pace, using the existing options available to us to do so.

10. We acknowledge that creating a Locality Care Partnership will not resolve the significant budget challenges facing all organisations but it will go some way to reducing it and it will be necessary to continue to work closely together with all stakeholders to manage the deficit around health and social care

<u>Asset Based Approach</u>

11. We agree in an asset based approach to the design and delivery of our integrated services including:
    a) A commitment that staff delivering services in Halton will be trained and updated in having new conversations with residents that focus on assets rather than need.

    b) Managerial arrangements within our organisations create the climate for staff from different professional backgrounds to work together in a positive, open and trusting climate

    c) That people are supported to be in control of their own lives

    d) That services are co-ordinated in a place, in a way, that is informed by a deep understanding of the community assets and capability in that place to support residents to be connected to their community and each other.

    e) That service administration is organised in agreed functional geographical footprints, allowing alignment with key service providers organised on the same footprint.

    f) That the partnership encourages its workforce to be positive, courageous and accountable in the way they deliver their services to the public.

    g) That our partnership embraces positive risk taking and permission based working, with the workforce liberated to demonstrate innovation and creativity on a daily basis.

Governance

12. We agree to working together to reform health and social care services to improve health outcomes for residents, as quickly as possible, and enable system wide change to develop transparent, robust and inclusive governance structures.

13. The key principles of our governance arrangements will be:

a) The objective of providing governance arrangements which aim to provide streamlined decision making; excellent co-ordination of services for the residents of Halton; mutual co-operation; partnering arrangements, and added value to the way we deliver our services.
b) An acknowledgement that the arrangement does not affect the sovereignty of any party and the exercise and accountability of their statutory functions.
c) A commitment to open and transparent working and proper scrutiny and challenge of the work of the One Halton Accountable Care Services Board and any party to the joint working arrangements.
d) A commitment to ensure that any decisions, proposals, actions whether agreed or considered at the One Halton ACS Board carry with them an obligation for the representative at the One Halton ACS board to report these to their own constituent bodies, and seek agreement if required through the appropriate governance route.

14. We agree that the governance arrangements will be kept under regular review and be revised from time to time to reflect the changing status of the integrated care delivery vehicle.

15. We agree that any decision affecting the statutory duties of an organisation will be referred through that organisation's governing processes.

16. We agree to provide mutual assurance to the constituent bodies and that the minutes of the One Halton ACS board will be circulated to the Boards of the constituent bodies.

Resources

17. We agree to the formation of the One Halton ACS PMO to manage the implementation of our work programme, with a commitment to seek resources and expertise from partner organisations, as appropriate, to support our integration journey.

18. We agree to use the assets and resources available to us within our organisations, such as buildings, IM&T and other infrastructure to support the adoption and enablement of integrated working arrangements.

19. We agree to work together to transform our collective workforce to ensure we have the right skills, capabilities and resources to deliver sustainable integrated working arrangements across health and social care now and in the future.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/11/128**
SUBJECT:	**Well Led Framework 2017 and Action Plan for Q3**
DATE OF MEETING:	29 November 2017
ACTION REQUIRED	**For Information** **For Assurance**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Corporate Affairs
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality
	BAF2.4: Engaging & Involving Workforce
	BAF2.5: Right People, Right Skills in Workforce
STRATEGIC CONTEXT	To deliver well managed, value for money, sustainable services
EXECUTIVE SUMMARY (KEY ISSUES):	As part of a commitment to simplifying regulatory approaches, NHS Improvement worked closely with the Care Quality Commission (CQC) to bring together their respective approaches to Well-Led. This resulted in a NEW wholly joint Well-Led framework structured around eight key lines of enquiry. The satisfy the new guidelines, the Trust needs to undertake the following: 1. Self-Review 2. Commission external review 3. Report to the Board and action plan 4. Letter to NHS Improvement highlighting any material issues or areas of good practice 5. Implementation of action plan. The Trust underwent a Well Led review (under the old system) conducted by Deloitte between Jan-Mar 2017 and was assessed as 'Amber-Green'. An action plan to address the 31 recommendations was developed and is being progressed by Executive Directors. Of the 31 actions :

	• 16 have been completed; • 12 are underway but are incomplete; • 3 are yet to commence. The intention now is to transfer the incomplete or not yet started actions to the new framework draft action plan which will be built on following the self-assessment and see these through to completion. It is not the Trust's intention to commission another external review at this point but to consider this early in 2019.	
RECOMMENDATION:	• The Board is asked to note the New Well Led Framework and the Trust's required actions under this. • The Board is asked to note the intention to transfer incomplete or not yet started actions to the new framework. • The Board is asked to note the commencement of an internal Well-Led review in Quarter 4 2017/18 • The Board is asked to note the intention to commission an external review in 2019+	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

SUBJECT	New Well Led Framework from June 2017	AGENDA REF:	BM/17/11/130

1. BACKGROUND/CONTEXT

In June 2017, NHS Improvement published its new guidance on the well-led framework for leadership and governance developmental reviews: https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf

Well-led means that the leadership, management and governance of the organisation ensures the delivery of sustainable high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

As part of simplifying regulatory approaches NHS Improvement and the CQC have worked closely together to review how they both assess organisations for being well-led. In a change from previous frameworks, the structure of the framework (Key Lines of Enquiry (KLOEs) and the characteristics) is wholly shared with the Care Quality Commission (CQC), and supports the CQC's regular regulatory assessments of well-led. This means that the information prepared for regulations can also be used for development and vice versa.

Whilst the same well-led KLOEs will be used by the CQC and NHS Improvement, both organisations will continue to assess Trusts separately for well-led using their existing approaches. The guidance has been issued on a 'comply or explain' basis which means the Trust is strongly encourage to carry out developmental reviews every three years to ensure risks are identified before they turn in to issues.

2. KEY ELEMENTS

The 2017 guidance comprises of eight KLOEs encompassing 47 characteristics. These replace the previous guidance which incorporated four 'domains' and ten key questions. The eight KLOEs are highlighted below:

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

Whilst NHSI and the CQC are separate organisations with different statutory functions, and the methodologies for undertaking their respective reviews, assessments and inspections are different, they have jointly agreed a set of revised key lines of enquiry (KLOEs) for 'well-led' which they will both use when undertaking assessments of Trusts.

The differences between the Well Led activities of the CQC and NHS Improvement are highlighted below:

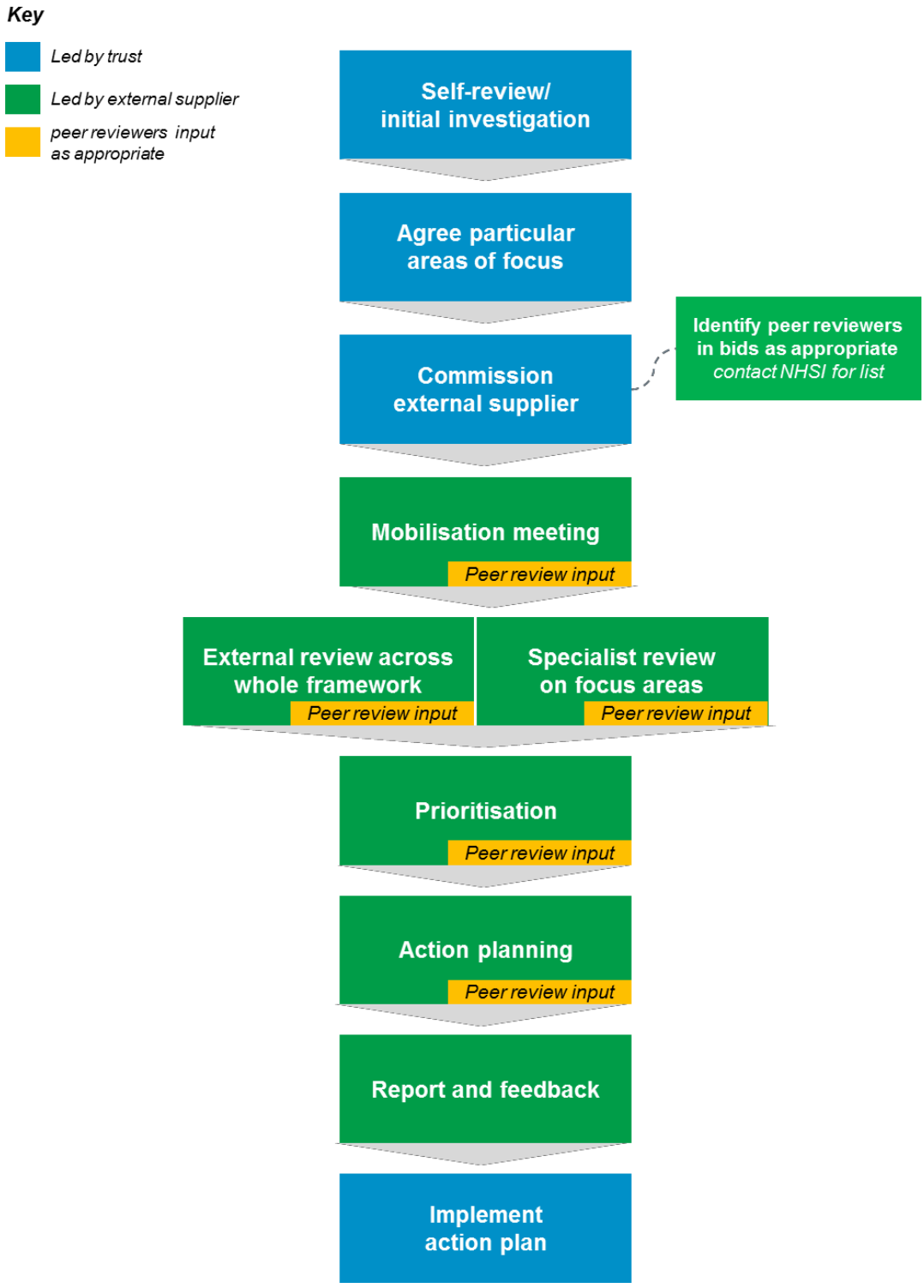
	CQC Inspection of Well-Led	NHSi Developmental Review of Leadership & Governance
Timing	Every financial year	External review at least every three years with a recommended annual internal review.
Announced	Yes – with up to 12 weeks' notice	No
Team	Small team of senior inspectors and advisors with board and/or executive experience	• Internal Review • Externally commissioned review (potentially including peer reviewers)
Site Visit	Yes	Yes

Methodology	• Follows the eight KLOEs;
	• Evidence will be gathered by:
	  ○ Interviews with members of the Board and senior staff;
	  ○ Obtain staff views through focus groups;
	  ○ Review of strategies, policies, procedures and guidelines;
	  ○ Information from external partners;
	  ○ Risk management data.
		• Follows the eight KLOEs;
		• Self-Review;
		• Commission external review (Trusts are encourage to consider including peer reviewers as part of the external team);
		• Report to Board on findings of external review and appropriate action plans set;
		• Letter to NHS Improvement confirming completion of review, any material issues found and/or any areas of good practice;
		• Implement action plan.

Rating	YES • Based on characteristics for the well-led domain key lines of enquiry • Published on the CQC's website	NO

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Detailed below is the process required to undertake and complete the requirements of the new framework.



The Trust underwent an external review against the previous Well-Led framework in early 2017; the results of which were Amber-Green indicating that the Trust 'partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe'.

Following the review, an action plan was produced. The existing action plan has been updated for Q3 and any existing, incomplete actions transferred to a new action plan by the end of December 2017.

John Culshaw, Head of Corporate Affairs will lead on the Well Led agenda and further dates, times and actions will be confirmed at a later date.

4. RECOMMENDATIONS

The Trust should commence an internal Well-Led review in Quarter 4 2017/18 with a view to commissioning an external review, to commence in 2019.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/11/129**	
SUBJECT:	**Charitable Fund Annual Report and Accounts for year ending 31st March 2017**	
DATE OF MEETING:	**29th November 2017**	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Katie Armstrong, Financial Accountant	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance & Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.4: Business Continuity	
	BAF3.3: Clinical & Business Information Systems	
STRATEGIC CONTEXT	The Annual Report and Accounts have been prepared in accordance with Part 8 of the Charities Act 2011, the Statement of Recommended Practice for charities and Financial Reporting Standard 102.	
EXECUTIVE SUMMARY (KEY ISSUES):	For the year ending 31st March 2017 the Charity has generated income of £132k and incurred expenditure of £244k which has decreased the balance of funds by £112k. The balance of funds held as at 31st March 2017 is £497k.	
RECOMMENDATION:	The Board of Directors is requested to approve the Charitable Funds Annual Report and Accounts for year ending 31st March 2017.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee
	Agenda Ref.	CFC/17/11/13
	Date of meeting	2nd November 2017
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

1. BACKGROUND/CONTEXT

The purpose of the report is to provide the Board of Directors with the Annual Report and Accounts for the Charitable Fund for the year ending 31st March 2017.

2. KEY ELEMENTS

In accordance with the Charities Commission in England and Wales the Corporate Trustee is required to produce an annual report and accounts for the charity on a yearly basis and file with the Charities Commission within ten months of the financial year end. Therefore the 2016/17 Annual Report and Accounts need to be submitted to the Charities Commission by 31st January 2018.

The draft 2016/17 Annual Report and Accounts were submitted to the Charitable Funds Committee on 2nd November 2017 and have been reviewed by Voisey & Co, Independent Examiners. The Annual Report and Accounts have been prepared in accordance with Part 8 of the Charities Act 2011, the Statement of Recommended Practice for charities and Financial Reporting Standard 102.

For the year ending 31st March 2017 the Charity has generated income of £132k and incurred expenditure of £244k which has decreased the balance of funds by £112k. The balance of funds held as at 31st March 2017 is £497k.

3. RECOMMENDATIONS

The Board of Directors is requested to approve the Charitable Funds Annual Report and Accounts for year ending 31st March 2017.

Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund

Trustee's Annual Report & Independently Examined Financial Statements

For the Year to 31st March 2017

Registered Charity No 1051858

Contents

Reference and administrative details

Address of Charity:	Lovely Lane Warrington Cheshire WA5 1QG Tel: 01925 662835
Registered Charity no:	1051858
Bankers:	Government Banking Service 7th Floor, Southern House Wellesley Grove Croydon CR9 1TR
Independent examiners:	Voisey & Co 8 Winmarleigh Street Warrington Cheshire WA1 1JW

Report of the Trustee for the year ended 31st March 2017

Foreword

Warrington and Halton Hospitals NHS Foundation Trust (the "Corporate Trustee") presents the Charitable Funds Annual Report together with the independently examined financial statements for the year ended 31st March 2017 of Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund ("the Charity"). Under Part 8 section 145 of the Charities Act 2011, the Corporate Trustee has exercised the Charity's exemption from audit. External scrutiny through *independent examination* is permitted and deemed appropriate for the Charity as its gross income is below a statutory threshold.

The Charity's Annual Report and Accounts for the year ended 31st March 2017 have been prepared by the Corporate Trustee in accordance with Part 8 of the Charities Act 2011 and the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16th July 2014. The Charity's report and accounts include all of the separately established funds for which the Warrington and Halton Hospitals NHS Foundation Trust is sole beneficiary.

Structure, governance and management

Corporate Trustee

The sole corporate trustee of the Charity is the Warrington and Halton Hospitals NHS Foundation Trust. The Charity was established in accordance with paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Corporate Trustee is managed by its Board of Directors which consists of executive and non-executive directors. It has responsibility for planning, directing and controlling the activities of the entity, ensuring that the NHS body fulfils its duties in managing the charitable funds.

The members of the Board of Directors of the Corporate Trustee who served during the financial year and up to the date of compilation of this report were as follows.

Name	Title	
Steve McGuirk	Chairman	
Lynne Lobley	Non-Executive Director / Deputy Chair	Resigned 30th November 2016
Jean-Noel Ezingeard	Non-Executive Director	Commenced 26th April 2017
Ian Jones	Non-Executive Director	
Terry Atherton	Non-Executive Director	
Anita Wainwright	Non-Executive Director	
Margaret Bamforth	Non-Executive Director	Commenced 1st May 2016
Mel Pickup	Chief Executive	
Simon Constable	Medical Director/Deputy Chief Executive	
Andrea McGee	Director of Finance and Commercial Development	
Sharon Gilligan	Chief Operating Officer	Resigned 30th April 2017
Karen Dawber	Director of Nursing and Organisational Development	Resigned 19th August 2016
Kimberley Salmon-Jamieson	Chief Nurse	Commenced 7th September 2016
Pat McLaren	Director of Community Engagement and Corporate Affairs(1)	
Jason DaCosta	Director of Information Technology(1)	
Roger Wilson	Director of Human Resources and Organisational Development(1)	Resigned 4th May 2017
Michelle Cloney	Director of Human Resources and Organisational Development(1)	Commenced 6th March 2017
Lucy Gardner	Director of Transformation(1)	

(1) Non-voting Executive Directors.

The Charity is established as an umbrella charity, registered with the Charity Commission (no. 1051858). The umbrella charity covers the existence of a single unrestricted general fund containing 4 (2015:4) designated funds as at 31st March 2017, and, currently, 8 restricted funds (2015:7). The Charity was first registered as both Halton General Hospital NHS Trust Charity and Warrington Hospital NHS Trust Charity in April 1996 under the Charities Act 1993, which is now been incorporated into the Charities Act 2011.

In April 2001, supplemental deeds were executed to amalgamate the administration, trustees, objects and powers of the two charities following merger of the two organisations, creating the single body known as North Cheshire Hospitals NHS Trust Charitable Fund. On 1st December

2008, the Trust changed its name to Warrington and Halton Hospitals NHS Foundation Trust, following its transition to Foundation Trust status. The name of the Charity was changed accordingly by way of a supplemental deed and registered with the Charity Commission on 16th March 2010.

Charitable Funds Committee

The Board of Directors (the Board) established a committee on 5th April 2001, known as the Charitable Funds Committee, (the Committee) reporting to the Board, in accordance with standing order 6 for the practice and procedure of the Board of Directors (annex 7 of the Trust's Constitution). The role of the Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee. The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

Aside from any restricted funds held, the Charity holds a single general fund, within which designated funds have been created to acknowledge expressions of wish from donors about the particular department or ward which should ideally benefit from their generosity. The Trustee has an intention to use the income of designated funds in the areas indicated by donors. However the Committee may choose to apply the funds to general purpose in any area of the Trust's hospitals in accordance with the Health Service Act 1977.

Membership of the Committee

The Committee comprises:

- at least two non-executive directors of the Board*;
- the Director of Finance and Commercial Development or the delegated deputy;
- the Chief Nurse;
- Head of Financial Services;
- Director of Community Engagement and Corporate Affairs; and
- One public governor
- Fundraising Manager

* All non-executive directors of the Trust are members of the Charitable Funds Committee and are entitled to attend and vote at any meeting of the Committee.

During the year under review and up to the date of compilation of this Report, the members of the Charitable Funds Committee were as follows.

Name	Position held	
Steve McGuirk	Chairman	
Lynne Lobley	Non-Executive Director (Chair of Charitable Funds Committee)	Resigned 30th November 2016
Jean-Noel Ezingeard	Non-Executive Director	Commenced 26th April 2017
Ian Jones	Non-Executive Director (Interim Chair of Charitable Funds Committee)	From 1st December to 25th April 2017(1)
Terry Atherton	Non-Executive Director	
Anita Wainwright	Non-Executive Director	
Margaret Bamforth	Non-Executive Director	Commenced 1st May 2016
David Ellis	Public Governor of Warrington and Halton Hospitals NHS Foundation Trust	Resigned 30th November 2016
Alison Kinross	Public Governor of Warrington and Halton Hospitals NHS Foundation Trust	Commenced 19th January 2017(2)
Pat McLaren	Director of Community Engagement and Corporate Affairs	
Andrea McGee	Director of Finance and Commercial Development	
Karen Spencer	Head of Financial Services	
Karen Dawber	Director of Nursing and Organisational Development	Resigned 19st August 2016
Kimberley Salmon-Jamieson	Chief Nurse	Commenced 7th September 2016

(1) Relates to time as Interim Chair, permanent member of Charitable Funds Committee.

(2) Relates to membership of the Charitable Funds Committee.

The Director of Finance and Commercial Development is responsible for day to day control of the administration of the charitable funds, and, in conjunction with the Chief Executive, approves expenditure on behalf of the Corporate Trustee with an upper limit of £5,000.

Expenditure in excess of £5,000 is referred to the Charitable Funds Committee on a quarterly basis.

Members of the Trust Board and the Charitable Funds Committee are not individual Trustees under Charity Law, but act as agents on behalf of the Corporate Trustee.

Corporate Trustee's appointments

The methods of appointment to the key governance roles within the Board of Directors and Council of Governors of the Corporate Trustee are reported in the Corporate Trustee's Annual Report and Accounts 2016/17 and contained within the Corporate Trustee's Constitution. Copies of these documents can be obtained from the Corporate Trustee's website or from its Communications office, located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

All appointments to the Charitable Funds Committee are made in accordance with the Charitable Funds Committee's approved Terms of Reference.

Trust staff including executive and non-executive directors, are required to complete the Trust's corporate induction programme, and are encouraged towards continuous professional development through the Trust's on-going performance management arrangements. Directors are able to seek individual professional advice or training at the Trust's expense in the furtherance of their duties.

Governors' knowledge is refreshed through a range of briefing sessions and workshops. The Board of Directors, Charitable Funds Committee and governors all have direct access to advice from the Board Secretary who is responsible for ensuring that the Corporate Trustee's procedures are followed and that applicable regulations are complied with.

Administration

The accounting records and day to day financial administration of the funds are dealt with by the Finance Department. Fund raising and promotion of the charity is administered by the Trust's Fundraising team located within the Communications office, both are located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

Risk management

The major risks to which the Charity is exposed have been identified and considered. A risk register has been compiled which is reviewed by the Charitable Funds Committee on a biannual basis. Income and expenditure is monitored as part of the risk management process, to avoid unforeseen calls on reserves.

The Charities Commission Checklist for Trustees is reviewed bi-annually by the Committee and submitted by the Chair to the Trust Board thereafter.

Objectives and strategy

The objective of the Charity is to provide for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Warrington and Halton Hospitals NHS Foundation Trust.

The Charity raises funds to provide the additional comforts, care or experiences for the direct benefit of patients and their families beyond that which the NHS provides. This is achieved by:

- Providing state-of-the-art equipment, technology or training
- Funding WHH-related research
- Improving the hospital environment
- Providing enhancements to support the care and comfort of our patients

The Corporate Trustee attempts to balance the purchasing of essential equipment for essential services against expenditure which improves the general environment and facilities of the hospitals for its patients. In achieving this balance, the Corporate Trustee always has in mind the wishes of the donors to the Charity.

Public interest benefit

The Corporate Trustee ensures that the *public interest benefit* criteria, as detailed in the Charities Act 2011, are met by critically assessing each funding application from sub-fund holders. Applications for funding can be made by any department within the hospitals, and applications are only restricted by the availability of funds and the quality of the application.

Where possible, funds are used to provide benefit to a wide range of patients, and funds used for staff enablement are allocated to projects that will directly benefit patients. A summary of major purchases made by the Charity during the year under review is contained in the Annual Review of Income and Expenditure Activities (page 8).

Reserve policy

Requirement

In accordance with Charity Commission guidance, the Corporate Trustee acknowledges that there is a requirement to hold reserves. The reserves policy should take into account future commitments from the general unrestricted funds held by the Charity. Assuming that funds have been designated appropriately and will be spent within a reasonable timescale the charity should not rely on the unrestricted designated funds for the absorption of overheads on a continuing basis. Therefore the level of reserves held in the general unrestricted funds of the charity should be sufficient to cover the annual support costs and overheads of the charity.

The charity approves expenditure on a case by case basis taking into account the level of funds available and the Corporate Trustee reserves the right to cancel any past delegation and transfer monies to the general unrestricted funds of the Charity. This may be considered where designated funds have not been spent within a reasonable timescale or where the original purpose of the designation no longer exists. Likewise the Corporate Trustee may choose to designate funds for a particular purpose.

Level of reserves

As at 31st March 2017 the Corporate Trustee considers that a minimum reserve of £90,000 (£90,000 as at 31st March 2016) in the unrestricted general purpose fund should be permanently maintained.

Monitoring

The Director of Finance and Commercial Development will report on the progress of the reserves and make recommendations to the Charitable Funds Committee in order to comply with the policy. The Charitable Funds Committee has authority to vary the minimum level of reserves.

At 31st March 2017 the unrestricted general purpose fund held reserves of £111,885 (£119,147 as at 31st March 2016). The difference between the reserves of £111,885 and the £90,000 per the reserves policy is due to existing commitments not yet realised as at 31st March 2017.

Investment policy

Introduction

Where NHS charitable funds have surplus monies in excess of the minimum reserves plus those required to fund commitments that have not yet been realised, Trustees may elect to invest some or this entire surplus in order to generate additional income to fund future charitable activities.

Investment criteria

The investment policy of the Corporate Trustee is to deposit the entire value of the fund with the Government Banking Service in an interest-bearing account. This decision is based upon the intention in the short term to spend the funds, such that long-term investment would not be appropriate.

Interest receivable, interest payable and bank charges

It is the policy of the Corporate Trustee to apportion interest payable and bank charges across all funds, and to credit all funds with the proceeds of the Charity's investments based on the average balance of the funds held.

Annual review of income and expenditure

During 2016/17, the Charity continued to support a wide range of charitable and health-related activities, by purchasing supplementary and complementary equipment or services which may not ordinarily have been provided from NHS sources.

Total income in 2016/17 from fundraising activities, donations, and legacies was £131,551 (£187,515 in 2015/16). The main source of income received in 2016/17 by the Charity has been voluntary donations from members of the public totalling £82,627 (£101,621 in 2015/16). The Charity received legacy income of £4,857 (£86,094 in 2015/16). Legacy income where subject to a legal trust is held as restricted funds.

The Charity's unrestricted general fund contains a number of designated funds in order to assist the donors in matching their donation with a particular department. All donations are accepted taking into account the donors' intentions and are held in the general fund unless a restriction has been applied; in this case, a separate restricted fund may be created.

In 2016/17 Income from fundraising activities was £44,067 (£0 in 2015/16). In 2016/17 the charity's fundraising team spent £13,589 on fundraising (£1,790 in 2015/16) and spent £2,396 (£1,220 in 2015/16) in advance of fundraising events scheduled to take place in 2017/18.

Income from fundraising activities for 2016/17 includes the realisation of donations in kind of £16,198.

The Corporate Trustee is committed to ensuring that all funds are directed to patient benefit as soon as possible. Expenditure on charitable activities for 2016/17 was £229,728 (£209,013 in 2015/16). This includes expenditure in relation to governance costs of £18,988 for 2016/17, (£17,470 in 2015/16).

Analysis of significant expenditure in 2016/17 (items costing more than £1,000) *

• George Lloyd Restaurant for use by patients, staff and visitors at the Halton site.	£70,217
• Clinical Interface system to enhance the service provided to cardiac patients.	£17,087
• Mobile telemetry unit for maternity unit	£14,000
• Enhancements to the facilities and environment in ward B14 for use by Stroke patients.	£12,342
• Washing machine and drier for use in the neonatal unit.	£ 5,321
• New wheelchairs to enhance the patient experience for visitors with mobility difficulties.	£3,564
• Patient therapies and support services in the Macmillan Delamere Centre.	£3,239
• Items for use in clinical training to enhance patient care.	£2,890
• Spirometer device for use by patients with pulmonary diseases.	£1,548
Total expenditure on individual items costing more than £1,000	**£130,208**
Other Charitable purchases (under £1,000 per item)	£15,052
Total Charitable expenditure	**£145,260**

*Items listed relate to expenditure on patient welfare, medical equipment and staff welfare with direct benefit to patients contained within note 6 on page 20.

Future plans

The Corporate Trustee does not expect significant changes in the objectives of the Charity in the forthcoming year and is committed to utilising funds to ensure that funds expended are directed to patient benefit as soon as is practicable. During the period under review the Charitable Funds Committee sought spending plans from holders of both restricted and designated income funds with the intention of significantly reducing reserves where suitable projects or programmes can be identified.

At the date of compilation of the financial statements, the following schemes, each involving commitments in excess of £1,000 have been approved.

- Mobile telemetry unit for use in the Antenatal Unit in accordance with a restriction on income received £9,159

- Cuddle cots £4,522
- Syringe drivers £4,064
- Cot thermometers £2,283
- Music Licences for all sites £1,684
- Observation equipment £1,477

In addition the Charity has commitments to fundraising for the following appeals.

- Children's playground £94,680
- Forget me not garden extension £66,952
- Improvement to patient areas in the maternity unit £15,000

Statement on future strategy

Our strategy for 2017-18 builds on our work in 2016-2017 and has seen the charity brand continue to be established through branded events, greater links with community and corporate supporters, the wider distribution of collection tins, a strengthened community profile, professional database management, donation tracking and administration functions – along with increased support for staff teams fundraising. We were also pleased to appoint a permanent Fundraising Manager in year.

Our new strategy for 2017-2020 was approved by the Charitable Funds Committee in April 2017 and sets the following objectives, with the ultimate objective of significantly increasing income to the charity from community sources:

1. **Raise the profile** of the WHH Charity across the local community and across our internal communities;
2. Be **clear about why the trust is fundraising**, and more transparent about how donations are invested for the benefit of patients (including the difference Gift Aid makes);

3. **Engage supporters and local communities** in ways they can fundraise or volunteer for the charity, with an emphasis on fundraising activities which do not require extensive management or investment by the trust;

4. **Build long-term relationships** with supporters through effective donor communications and stewardship;
5. **Internally, engage all wards and departments** in thinking of their area as being part of one charity, with fundraising benefitting all areas equally.
6. **Launch and deploy capital campaigns** to accelerate fundraising and keep our offer fresh.

This strategy does consider the current resources of the Charity, in order to set realistic and achievable delivery aims, and as such focuses on a smaller number of areas to make a bigger impact.

Our priority areas are:

1. Launch of giving campaigns to ask people to fundraise for clearly identified projects.

Two large fundraising projects were supported in year to enable the Charity to create a strong and sustained call for support, with single focus for community and corporate fundraising across all charity and trust communications. In the year two key capital campaigns brought significant community interest and support for the Children's Ward and the Forget Me Not dementia unit:

- **Making Waves: -** Children's ward outdoor play area. This campaign is working to provide a new outdoor play and garden area for the Children's Ward and launched in early 2016/17 with a target of circa £100k.

- **Dig Deep for Dementia**: – The second phase of dementia garden will make the space usable throughout the year and we have commissioned designs with a value of circa £60K.

2. Increase of 'In Memory' and Tribute Funds

The charity already attracts a good level of "In Memory" fundraising with the majority of *Just Giving* pages being set up in memory of a patient who had received care from the Trust. Research into this area was undertaken in year to support plans to make tribute-giving simpler and more effective.

3. Increase recognition of our Brand

Significant awareness programmes throughout the year has seen the brand become more recognisable and our communities becoming more engaged and involved in fundraising on our behalf. The development of a new website and associated social media vehicles continues to support this and includes multiple 'donate now' and 'get involved' opportunities. Community events and recruitment of volunteers for our collection tins has underpinned this.

A WHH Charity fundraising brochure was published (wholly funded by advertising).

WHH Charity relocated to the main entrance of Warrington Hospital occupying the former foundation trust office in the retail area. A small office was similarly opened at entrance 1 at Halton Hospital. Both offices have really enhanced visibility and engagement with the Charity with both public and our staff.

4. Charity volunteer recruitment

We continued to focus on the recruitment of WHH Charity volunteers to assist with events and community involvement. With a very small staff these self-less volunteers form a crucial support element and significantly enhance our ability to fundraise.

5. Developing the charity function in the trust

We were delighted in year to appoint our Fundraising Manager Helen Higginson to a permanent position with the Charity, reflecting the Trustees' increasing confidence in the direction of travel. Helen had already served two years in a 'fixed term' role with WHH Charity and brings many years of fundraising experience and the passion and commitment to drive WHH Charity fundraising forward for the future.

Helen always welcomes fundraising thoughts and ideas – contact her at helen.higginson@whh.nhs.uk or call 01925 662666.

Acknowledgement

The Corporate Trustee would like to extend its sincere thanks on behalf of the patients and staff who have felt the impact of this year's donations and legacies, received at our charity offices at Warrington and Halton hospitals, through our Cash Offices, by post or through *Just Giving* or other gift making websites. Many of our donors have contributed in times of personal difficulty.

Gratitude is also extended to the Leagues of Friends at both Warrington and Halton Hospitals. These independent charities operate alongside the Charity, sharing similar objectives, and the Charity occasionally co-purchases items with them.

The Corporate Trustee would also like to acknowledge the increasing fundraising activities of our donors and our staff, who have been holding events and undertaking a variety of sponsored feats to generate awareness and funds for the Charity. Their contributions, imagination and enthusiasm are greatly appreciated.

Information regarding the independently examined accounts can be obtained from the Finance Department on 01925 662835.

Approved on behalf of the Corporate Trustee.

PAT MCLAREN …… Date: 29th November 2017
Director of Community Engagement and Corporate Affairs

Statement of Trustee's responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation;
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed; and
- Safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 15 to 25 attached have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

Approved by the Corporate Trustee on 29th November 2017 and signed on its behalf by:

STEVE MCGUIRK ……..
Chairman

ANDREA MCGEE……
Director of Finance and Commercial Development

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST CHARITABLE FUND

I report on the accounts for the year ended 31st March 2017 set out on pages 15 to 25

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144 of the Charities Act 2011 ("the Charities Act") and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act,
- to follow the procedures laid down in the general Directions given by the Charity Commission (under section 145(5)(b) of the Charities Act, and
- to state whether particular matters have come to my attention.

Basis of independent examiner's statement

My examination was carried out in accordance with general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from the trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that in, any material respect, the requirements:

- to keep accounting records in accordance with section 130 of the Charities Act; and
- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the Charities Act

have not been met; or

2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Philip Urmston BSc FCA
Voisey & Co, Chartered Accountants
8 Winmarleigh Street
Warrington, Cheshire WA1 1JW …… December 2017

Statement of Financial Activities

	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Prior Year Total Funds
		2016/17	2016/17	2016/17	**2016/17**	2015/16
		£000	£000	£000	**£000**	£000
Incoming and endowments from:						
Incoming resources from generated funds	2	20	24	-	**44**	-
Donations and legacies	3	50	37	-	**87**	188
Other trading activities		-	-	-	**-**	-
Income from Investments	4	-	1	-	**1**	2
Total income and endowments		70	62	-	**132**	190
Expenditure on:						
Raising funds	5	(11)	(3)	-	**(14)**	(2)
Charitable activities	6	(48)	(182)	-	**(230)**	(209)
Total expenditure		(59)	(185)	-	**(244)**	(211)
Net income/(expenditure)		11	(123)	-	**(112)**	(21)
Transfers between funds	16	(15)	15	-	**-**	-
Net movement in funds		(4)	(108)	-	**(112)**	(21)
Reconciliation of funds						
Total funds brought forward		143	466	-	**609**	630
Total funds carried forward		**139**	**358**	**-**	**497**	**609**

Balance Sheet as at 31st March 2017

	Note	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Prior Year Total Funds
		2016/17	2016/17	2016/17	**2016/17**	2015/16
		£000	£000	£000	**£000**	£000
Fixed Assets						
Intangible assets	9	14	-	-	**14**	17
Total fixed assets		14	-	-	**14**	17
Current assets						
Cash at Bank and in hand	10	131	380	-	**511**	554
Debtors	11	10	8	-	**18**	40
Total current assets		141	388	-	**529**	594
Current liabilities						
Creditors: amounts falling due within one year	12	(16)	(30)	-	**(46)**	(2)
Net current assets		125	358	-	**483**	592
Total assets less current liabilities		139	358	-	**497**	609
Non current liabilities		-	-	-	**-**	-
Net assets		139	358	-	**497**	609
The funds of the Charity						
Total Charity funds	16	139	358	-	497	609
Total funds carried forward		**139**	**358**	**-**	**497**	**609**

The funds of the Charity:

The notes on pages 17 to 25 form part of these accounts.

Signed:

Chairman……Date 29th November 2017

Director of Finance

and Commercial Development……Date 29th November 2017

Notes to the accounts

Note 1 Accounting policies

The financial statements have been prepared under the historical cost convention and in accordance with Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16th July 2014 and the Charities Act 2011.

The financial statements are presented in Pounds Sterling, rounded to the nearest thousand.

There is no requirement for the Charity to prepare a cash flow statement since it is exempt due to being a 'smaller' charity (i.e. income less than £500,000).

1.1 Accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates, and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

The following are the areas of critical judgements that management have made in the process of applying the entity's accounting policies.

Going concern

After making enquiries, the Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing these financial statements.

There are currently no sources of estimation or uncertainty that are judged to cause a significant risk of material adjustment to the financial statements.

1.2 Funds structure

Restricted funds are to be used in accordance with the specific restrictions imposed by the donor. The Charity held 9 restricted funds at the end of the year under review.

The Charity did not hold any endowments, expendable or otherwise, during the year under review.

Unrestricted funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of the Charity's charitable objects. The Charity has a single unrestricted general fund containing several designated funds. These unrestricted designated funds are created to honour donors' expressions, or are created by the Trustee, at its discretion, to designate monies for specific future purposes. Any funds held within a designated fund can be merged or transferred within the general fund at any time, at the discretion of the Trustee, in accordance with the Health Service Act 1977 and the Charity's dormant funds policy.

1.3 Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

The cost of donations in kind for charitable activities is deemed to be the fair value of those gifts at the time of their receipt. They are recognised on receipt as income from fundraising activities in the reporting period in which the goods are received.

Donations in kind are recognised as an expense at the carrying amount of the goods upon application to charitable activities.

1.4 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt, or where the receipt of the legacy is probable. This would require that confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred, and that all of the conditions attached to the legacy have been fulfilled.

1.5 Resources expended

All expenditure is accounted for on an accruals basis, and has been classified under the headings that aggregate all costs related to that category. All expenditure is recognised once there is a legal or constructive obligation committing the Charity to the expenditure.

The Charity does not make grants to third parties.

Contractual arrangements are recognised as goods or services are supplied.

1.6 Costs of raising funds

These are costs associated with generating incoming resources, and are recognised as per the Charity's other expenditure.

1.7 Charitable activities

The costs of charitable activities include all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise the direct costs of charitable purchases, support costs, overheads and governance costs as shown in Note 6.

Governance costs comprise all costs incurred in the governance of the Charity. These costs include fees pertaining to the provision of governance and financial papers to the Charitable Funds Committee, the creation of this Annual Report and Accounts, the audit or independent examination of the accounts, and any associated support costs.

1.8 Intangible fixed asset investments

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Charity's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to or service potential be provided to, the Charity and where the cost of the asset can be measured reliably.

Intangible assets are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating.

Intangible assets are amortised over a useful economic life of 5 years using a straight line on cost method.

1.9 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

Note 2. Analysis of income from generated funds

	Unrestricted Funds 2016/17 £000	Restricted Funds 2016/17 £000	**Total Funds 2016/17 £000**	Total Funds 2015/16 £000
Income from fundraising events	3	-	**3**	-
Income from third party fundraisers	13	10	**23**	-
Donations in kind	2	14	**16**	-
Other	2	-	**2**	-
Total	20	24	**44**	-

Note 3. Analysis of voluntary income

	Unrestricted Funds 2016/17 £000	Restricted Funds 2016/17 £000	**Total Funds 2016/17 £000**	Total Funds 2015/16 £000
Donations	48	34	**82**	102
Legacies	2	3	**5**	86
Total	50	37	**87**	188

Note 4. Analysis of investment income

	Unrestricted Funds 2016/17 £000	Restricted Funds 2016/17 £000	**Total Funds 2016/17 £000**	Total Funds 2015/16 £000
Bank interest	0.3	0.7	**1.0**	1.5
Total	0.3	0.7	**1.0**	1.5

Note 5. Analysis of expenditure on raising funds

	Unrestricted Funds 2016/17 £000	Restricted Funds 2016/17 £000	**Total Funds 2016/17 £000**	Total Funds 2015/16 £000
Expenditure on fundraising events	1	-	**1**	-
Promotional items and branding	8	-	**8**	2
Consultancy fees	2	3	**5**	-
Total	11	3	**14**	2

Note 6. Analysis of charitable activities

	Unrestricted Funds 2016/17 £000	Restricted Funds 2016/17 £000	**Total Funds 2016/17 £000**	Total Funds 2015/16 £000
Patient welfare	11	91	**102**	105
Staff enablement	5	-	**5**	4
Medical equipment	4	34	**38**	21
Sub Total	**20**	**125**	**145**	**130**
Support costs and overheads*	7	14	**21**	18
Staff costs	17	28	**45**	44
Governance costs	4	15	**19**	17
Total	48	182	**230**	209

*Support costs and overheads comprise of an apportionment from the Trust's administration charge (Note 6) of £16,000 (£16,000 in 2015/16) plus other sundry items not categorised elsewhere.

6.1 Governance costs

	Unrestricted Funds 2016/17 £000	Restricted Funds 2016/17 £000	**Total Funds 2016/17 £000**	Total Funds 2015/16 £000
Independent examination/audit fees	0.8	1.4	**2.2**	1.5
Administration Charge	2.8	13.2	**16.0**	16.0
Fees and subscriptions	0.3	0.5	**0.8**	-
Total	3.9	15.1	**19.0**	17.5

Independent examination/ audit fees consist of an accrual for the independent examination fee of £1,560 (£1,470 in 2015/16) for the period of this review, plus an additional charge of £678 for 2015/16.

Note 7. Staff Costs

	2016/17 £000	2015/16 £000
Salaries and wages	**37**	32
Social Security costs	**3**	6
Pension Costs	**5**	6
Total	**45**	44

During the period under review no employees received employee benefits (excluding employee pension costs) of more than £60,000.

The Trustee is defined as the corporate trustee that does not constitute employment with the charity. Accordingly no Trustees are paid any remuneration nor receive any other benefits and expenses from employment with the charity.

Note 7.1. Average number of employees in the year (Whole time equivalent)

	2016/17	2015/16
Fundraising	**1.0**	1.0
Administration	**0.4**	0.4
Total	**1.4**	1.4

Note 7.2. Pension Costs

Employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. It is not possible for the Corporate Trustee to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to the Statement of Financial Activities as and when they become due.

Note 8. Allocation of administration charge

The costs of administering the Charity have been split between support costs and overheads (Note 6) governance costs (Note 6.1) and staff costs (Note 7).

During the year under review an administration charge was raised to cover the governance, financial and procurement resources of Warrington and Halton Hospitals NHS Foundation Trust. The charge for 2016/17 was £32,000 (£32,000 in 2015/16) the charge is apportioned equally between support costs and overheads and governance costs. The element of the administration charge that is attributed to governance costs pertains to the costs associated with the preparation of Committee papers and this Annual Report and Accounts.

During the year under review the Corporate Trustee considered the charity's policy on the allocation of overheads in conjunction with guidance as issued by the Charities Commission.

As at 31st March 2017 all shared costs for administration and governance costs have been apportioned across all funds using a combination of transactional and average balance techniques.

Overheads will continue to be apportioned on an annual basis. In the event that a restriction does not permit the allocation of overheads the costs will be met by way of a transfer from the unrestricted funds held by the charity.

Note 9. Analysis of Intangible Fixed Assets

	2016/17 £000 Software
Cost	
Balance brought forward at 1st April 2016	**17**
Additions in year	**0**
Disposals in year	**0**
Balance carried forward at 31st March 2017	**17**
Amortisation*	
Balance brought forward at 1st April 2016	**0**
Charge in year	**3**
Balance carried forward at 31st March 2017	**3**
Net Book Value at 31st March 2017	**14**
Net Book Value at 31st March 2016	**17**

*The cost of intangible fixed assets relates to the purchase of the Harlequin fund raising database and associated finance package. The asset was purchased in 2015/16 and came into use from 1st April 2016.

Note 10 Analysis of cash at bank and in hand

	2016/17 £000	2015/16 £000
Bank current account	**511**	554
Total	**511**	554

Note 11. Analysis of debtors

	2016/17 £000	2015/16 £000
Prepayments and accrued income	**6**	38
Other debtors	**12**	2
Total	**18**	40

During the year under review other debtors represent amounts to be reclaimed by the Charity in respect of Gift Aid and VAT. In the prior year other debtors represented the balance owed to the Charity by Warrington and Halton Hospitals NHS Foundation Trust.

Note 12. Analysis of current liabilities and long term creditors

	2016/17 £000	2015/16 £000
Accruals and purchases made on behalf of the Charity	**46**	2
Total	**46**	2

Note 13. Related party transactions

The Charity is a subsidiary of the Trust and is therefore a related party. Warrington and Halton Hospitals NHS Foundation Trust is the sole beneficiary of the Charity. The Charity provides funding to the Trust for approved expenditure made on behalf of the Charity. During 2016/17 the Charity made payments to Warrington and Halton Hospitals NHS Foundation Trust totalling £185,156 (£359,694 in 2015/16)

At 31st March 2017 the Charity owed Warrington and Halton Hospitals NHS Foundation Trust £38,199 for purchases made by the Trust on behalf of the Charity. At 31st March 2016 Warrington and Halton Hospitals NHS Foundation Trust owed the Charity £2,194 for refunds relating to purchases made on behalf of the Charity which had been received into the Trust at 31st March 2016.

All transactions entered into during the year were conducted on an arm's length basis.

During the year, none of the members of the Trust Board or senior Trust staff, or parties related to them, were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the Trust Board has received honoraria, emoluments or expenses in the year. The Corporate Trustee has not used the funds of the Charity to purchase trustee indemnity insurance.

Board members, and other senior staff, take decisions on both Charity and exchequer matters, but endeavour to keep the interests of each discrete, and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public in the Corporate Information section of the Trust's website.

From 1st April 2013 NHS charitable funds considered to be subsidiaries are to be consolidated within the Trust accounts in accordance with an accounting direction issued by Monitor, now NHS Improvement. For 2016/17 the Trust has opted not to consolidate charitable funds with the main Trust Accounts because they are immaterial. This will continue to be reviewed each year for appropriateness.

Note 14. Post Balance Sheet events

There have been no events since the Balance Sheet date that would indicate that any revision to the accounts is necessary.

Note 15. Legacies

Legacy income received between 31st March 2017 and the date of compilation of this Annual Report and Accounts has been recognised within the legacy income figure for 2016/17 on the basis that the income was probable as at 31st March 2017. Such income is included within note 3 on page 20 and is included within accrued income in note 11 on page 23.

Note 16. Fund structure and summary of movements

Charitable funds

The Charity has 10 funds. These are the (unrestricted) General Fund, and 9 Restricted Funds. The restriction has arisen due to the legacy donor's stipulation that the monies be spent within a particular department.

During the year under review the maternity fund received income for which a restriction was applied. Overheads allocated to the fund were met by way of a transfer from the unrestricted funds held by the charity.

Overheads allocated to the Halton legacy fund were met in part by way of a transfer from the unrestricted funds held by the charity. The transfer represented the residual balance of the fund once all committed expenditure had been applied to the benefit of service users at Halton Hospital.

A summary of fund movements is given overleaf.

Fund	Balance as at 1st April 2016	Incoming resources	Outgoing resources	Transfers	Balance as at 31st March 2017

	£	£	£	£	£
General Unrestricted	143,019	70,788	(58,851)	(15,129)	139,827
Breast Screening	35,031	69	(149)	-	34,951
Cancer Patient Support	9,622	7,267	(5,993)	-	10,896
Halton Hospital Legacy	90,787	111	(96,033)	5,135	-
Heart Unit	42,088	512	(23,549)	-	19,051
Intensive Care	182,549	10,011	(4,788)	-	187,772
Maternity	-	23,160	(23,994)	9,994	9,160
Neonatal	80,507	16,152	(13,358)	-	83,301
Ophthalmology	2,185	182	225	-	2,592
Stroke Unit	23,417	4,287	(17,815)	-	9,889
Total Funds	**609,205**	**132,539**	**(244,305)**	**-**	**497,439**

Unrestricted general fund: sub-fund balances

Fund	Balance as at 1st April 2016	Incoming resources	Outgoing resources	Transfers	Balance as at 31st March 2017
	£	£	£	£	£
General Unrestricted	119,147	49,706	(41,839)	(15,129)	111,885
Children's Unit Appeal	2,611	13,493	(10,579)	-	5,525
Forget Me Not Appeal	11,929	7,585	(6,396)	-	13,118
Heartbeat Halton Appeal	2,347	4	(10)	-	2,341
Ophthalmology Appeal	6,985	-	(27)	-	6,958
Unrestricted Fund Total	**143,019**	**70,788**	**(58,851)**	**(15,129)**	**139,827**

Corporate Calendar
Jan 2018 - Mar 2019

TB	WED Board 6xyr ALL NEDs/Eds	10:00 - 4:00 SAME MONTH AS Q&A
AC	THURS Audit 6xyr ALL NEDs	9:00 - 12:00 ALTERNATIVE MONTH TO BOARD
Q&A	TUES Quality + Assurance 6xyr NED Chaired	2:00-5:00 SAME MONTH AS BOARD
NARC	WED NARC as req NED only	4:00 - 5:30
OB	MON Trust Ops Board Mthly Eds	1:00 - 5:00 2 DAYS BEFORE BOARD (except where Bank Holiday Monday)
CFC	THURS Charitable Funds 1/4ly NEDs	1:30-3:30
COG	THUR Council of Governors 1/4ly ALL	4:00 - 6:00 1st THURSDAY Alternate venues Warrington + Halton
FSC	WED Finance+Sustainability Mthly	2:00-5:00 WEDNESDAY BEFORE TRUST BOARD
BTO	WED Board Time Out 4xyr NEDs/Eds	ALL DAY at HALTON

QiC	TUES 11-1pm 4x yearly
GEG	WED 11-1pm 4 x yearly

		Jan		Feb		Mar		Apr		May		June		July		Aug		Sep		Oct		Nov		Dec		2019 Jan		2019 Feb		2019 Mar	
Mon	1	BH															1														Mon
Tue	2								1	QIC/Q&A							2							1	BH					Tue
Wed	3								2						1		3							2						Wed
Thu	4		1		1	CFC			3						2		4		1					3						Thu
Fri	5		2		2				4		1				3		5		2					4		1		1		Fri
Sat	6		3		3				5		2				4		6		3		1			5		2		2		Sat
Sun	7		4		4		1		6		3		1		5		7		4		2			6		3		3		Sun
Mon	8		5		5		2	BH	7	BH	4		2		6	BH	8		5		3			7		4		4		Mon
Tue	9	QIC/Q&A	6		6	Q&A	3		8		5		3	Q&A	7		9	QIC/Q&A	6	Q&A	4			8	QIC/Q&A	5		5	Q&A	Tue
Wed	10		7	GOVIND	7		4		9		6		4		8		10		7		5			9		6		6		Wed
Thu	11		8		8		5		10		7	CFC	5		9		11		8		6			10		7		7	CFC	Thu
Fri	12		9		9		6		11		8		6		10		12		9		7			11		8		8		Fri
Sat	13		10		10		7		12		9		7		11		13		10		8			12		9		9		Sat
Sun	14		11		11		8		13		10		8		12		14		11		9			13		10		10		Sun
Mon	15		12		12		9		14		11		9		13		15		12		10			14		11		11		Mon
Tue	16		13		13		10		15		12		10		14		16		13		11			15		12		12		Tue
Wed	17	GEG	14		14		11	GEG	16		13		11	GEG	15		17	GEG	14		12			16		13		13		Wed
Thu	18		15	COG	15		12		17	COG	14		12		16	CFc COG	18		15	CFC COG	13			17		14	COG	14		Thu
Fri	19		16		16		13		18		15		13		17		19		16		14			18		15		15		Fri
Sat	20		17		17		14		19		16		14		18		20		17		15			19		16		16		Sat
Sun	21		18		18		15		20		17		15		19		21		18		16			20		17		17		Sun
Mon	22		19		19		16		21		18		16		20		22		19		17	OB		21		18		18		Mon
Tue	23		20		20		17		22	END	19		17		21		23		20		18			22		19		19		Tue
Wed	24	FSC	21	FSC	21	FSC	18	FSC	23	FSC	20	FSC	18	FSC	22	FSC	24	FSC	21	FSC	19	FSC		23	FSC	20	FSC	20	FSC	Wed
Thu	25		22	AC	22		19		24	TB+End	21		19		23		25		22	AC	20			24		21	AC	21		Thu
Fri	26		23		23		20		25		22		20		24		26		23		21			25		22		22		Fri
Sat	27		24		24		21		26		23		21		25		27		24		22			26		23		23		Sat
Sun	28		25		25		22		27		24		22		26		28		25		23			27		24		24		Sun
Mon	29	OB	26	OB	26	OB	23	OB	28	BH	25	OB	23	OB	27	BH	29	OB	26	OB	24			28	OB	25	OB	25	OB	Mon
Tue	30		27		27		24		29	OB	26		24		28	OB	30		27		25	BH		29		26		26		Tue
Wed	31	TB	28	BTO	28	TB	25	BTO	30		27	BTO	25	TB	29		31	TB	28	TB	26	BH		30	TB	27	BTO	27	TB	Wed
Thu					29		26	AC	31		28		26	AC	30				29		27			31		28		28		Thu
Fri					30	BH	27				29		27		31				30		28							29		Fri
Sat					31		28				30		28								29							30		Sat
Sun							29						29								30							31		Sun
Mon							30						30								31									Mon
Tue													31																	Tue

School Hols 30 March-13 April 2018: 28 May-8 June 2018: Summer 23 July-1 September 2018: 22 October-26 October 2018: 21 December-2 January 2019: 18 February-22 February 2019
Easter 2019 5-23 April 2019

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 CEO/Deputy CEO. At least one member EACH from SW&C AND Acute Care

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

In Attendance:

- Where members above are unable to attend, their nominated (decision-making) deputies should attend and present reports/take actions on their behalf.
- Heads of Corporate Services should attend where the Cycle of Business requires a report.

5. AUTHORITY

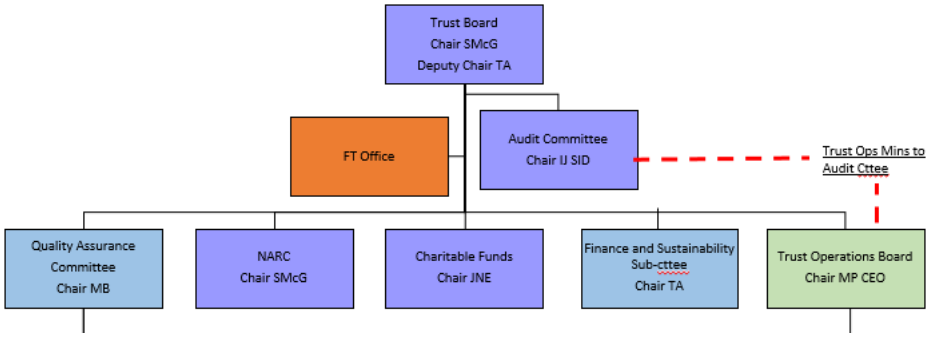
The Trust Operational Board is an Executive Committee which is accountable to the Trust Board. Its activities will be scrutinised by the Trust's Audit Committee.

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 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 and attendees

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
- Workforce
- Patient Flow
- 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

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.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	TRUST OPERATIONAL BOARD
Version:	V3
Implementation Date:	
Review Date:	
Approved by:	TRUST BOARD
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
23.10.17	**Quorum**	To reflect required attendance of Divisional triumverates	
23.10.17	**Membership**	To reflect those normally or occasionally 'In attendance'	
23.10.17	**Sub-Committees**	Removal of CBU QPS sub-Committee Change ED Delivery to Patient Flow	

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

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/11/131**
SUBJECT:	**Corporate Governance – Update to Acting up arrangements and voting privileges during the part-time secondment of the Chief Executive to the C&M STP.**
DATE OF MEETING:	29th November 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):	At the Trust Board Meeting in September the Board was advised of the acting up arrangements for the Medical Director/Deputy CEO and Acting Medical Director. This proposed arrangement has caused some confusion given that the Medical Director/Deputy CEO remains the senior responsible medical officer in the organisation and is therefore required to retain voting rights on the Trust Board. The following is therefore proposed:

	1. CEO Mel Pickup remains CEO of the Trust and the Accountable Officer in addition to her STP duties (unchanged) 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 (unchanged) Prof Constable will become **Executive Medical Director** and remain senior responsible medical officer. He will pass his operational Medical Director portfolio to Dr Alex Crowe, currently Deputy Medical Director, for a fixed term of 12 months. Dr Crowe will become **Operational Medical Director** (non-voting unless deputising for the Executive Medical Director) 3. An interim Deputy Medical Director will be appointed for the same period and will deputise for Dr Crowe **The Board is asked to approve these amended 'acting up' arrangements.**	
RECOMMENDATION:	1. The Board is asked approve the acting up arrangements for the initial period	
PREVIOUSLY CONSIDERED BY:	**Committee**	Trust Board
	Agenda Ref.	BM 17 09 106 ii
	Date of meeting	27th September 2017
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

COMPLAINTS AND CONCERNS POLICY

Contents

Executive Summary/Introduction

Warrington and Halton Hospitals NHS Foundation Trust is committed to consistently providing the highest possible standard of care for patients, though we accept that from time to time patients and or relatives may have a cause for concern. It is important that patients and their relatives and carers feel confident that feedback is positively welcomed by the Trust and that we encourage them to inform us whenever standards of care and service fall below their expectations.

Complaints and the raising of concerns are an important source of information from service users, a valuable opportunity to learn from any mistakes made, to prevent recurrence in the future and to help evaluate and improve future service delivery.

This policy has been written in accordance with the statutory requirements set out in NHS Service Complaints (England's) Regulations (2009) and follows the Good Practice Standards for NHS Complaints Handling (Sept 2013) and in accordance with Regulation 16: Receiving and acting on complaints (CQC 2016) and reflects the NHS Constitution for England (DOH 2015) this policy also reflects the recommendations set out in the Francis Report (2013).

Purpose and Scope

This policy aims to ensure that all complaints and concerns received by Warrington and Halton NHS Foundation Trust are consistently, fairly and effectively handled across the Trust, by all staff. When dealing with complaints we aim to:

- Offer opportunities to resolve concerns and complaints at ward or department level, without recourse to the formal complaints process, wherever possible;
- Ensure patients, their families and carers receive the information they need to understand the complaint investigation process;
- Provide reassurance that if errors have occurred, everything possible will be done to ensure lessons learned will help prevent the incident recurring;
- Ensure openness and transparency throughout the complaints and concerns process, complying with *Duty of Candour* Regulations (2013);
- Investigate complaints thoroughly and effectively in a timely manner, keeping complainants informed of the progress of investigations. This is vital in cases that are complicated or involve multi agencies;
- Ensure we are logical and rational in our approach;
- Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, we will cooperate with any independent review;
- Provide a level of detail that is relevant to the seriousness of the complaint;
- Ensure all patients, families and carers, healthcare professionals and managers feel supported during any complaint investigation;

- Generate reports and intelligence from complaints data and themes to identify learning and make service improvements both organisationally and within CBU's, services and teams;
- Develop a culture where complaints are seen as opportunities to learn and improve and exhibit robust systems and processes;

Complaints relating to non-compliance with requests for information under the Freedom of Information Act 2000 are covered by this policy and will be handled in the same way as all other concerns and/or complaints.

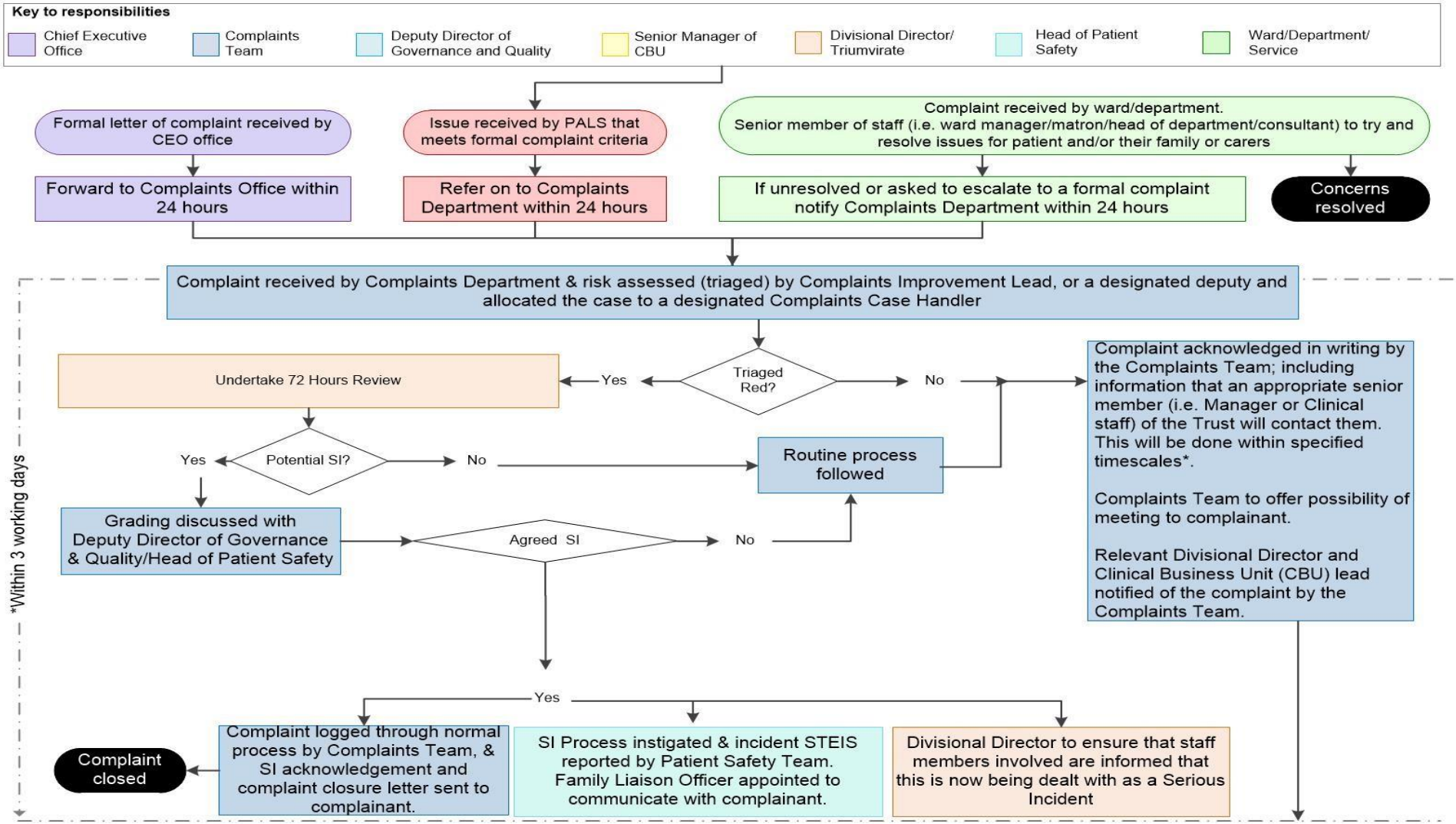
Duties and Responsibilities

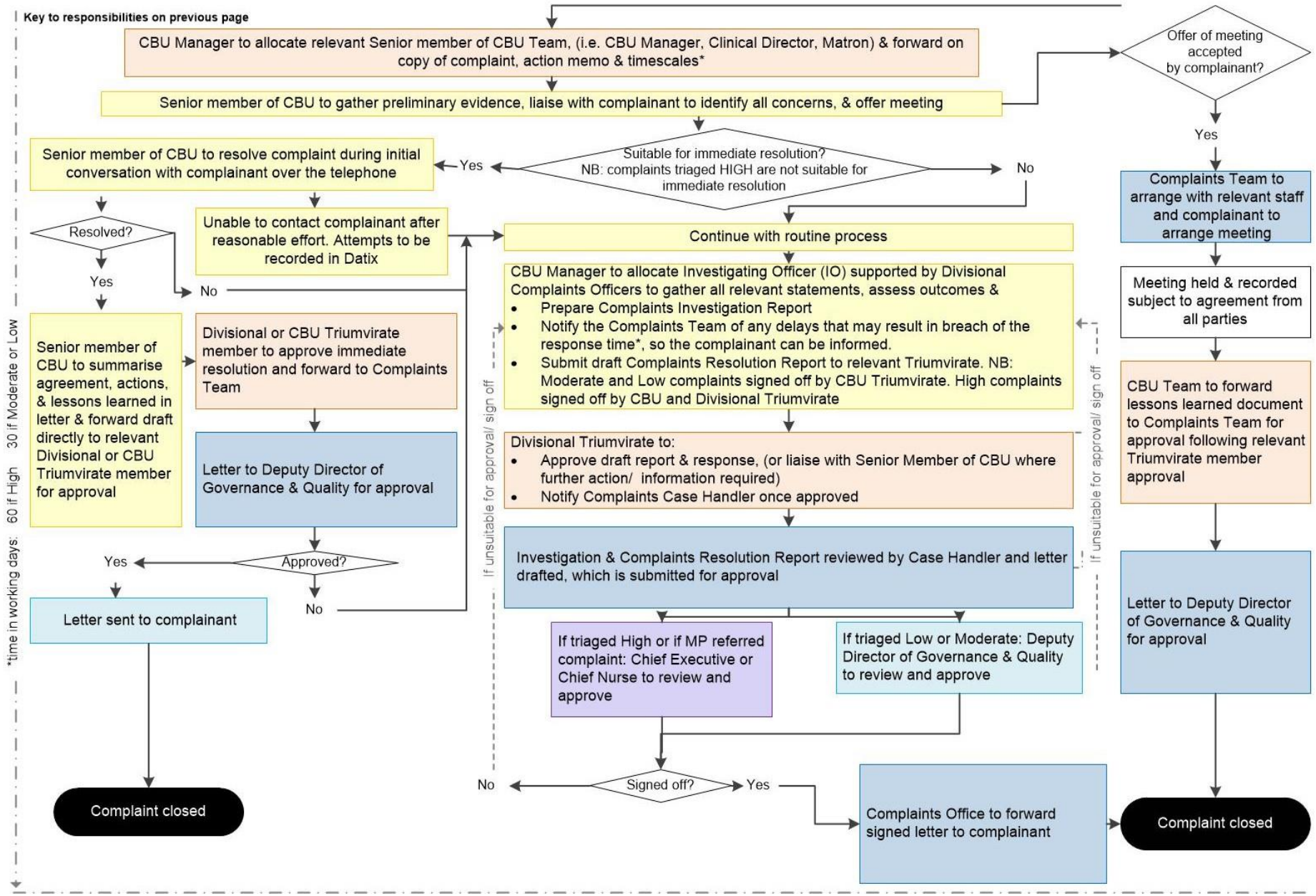
Chief Executive	The Chief Executive is the "responsible person" (Complaints Regulations 2009) with responsibility for ensuring compliance with the arrangements made under the regulations, and in particular ensuring that action is taken if necessary in the light of the outcomes of a complaint. All complaint responses are signed by or on behalf of the Chief Executive, and the investigation and presentation of responses to complaints are delegated to appropriate members of staff.
Chief Nurse	The Chief Nurse has delegated responsibility as executive lead and guardian of the integrity of the complaints process, and for reporting to the Chief Executive and the Board on complaints related issues.
Deputy Director of Governance and Quality Improvement	The Deputy Director of Nursing has strategic overview of the complaints and concerns feedback process, with overarching responsibility for ensuring Trust compliance with national guidance, and provides line management support to the Trust's Complaints Manager and Patient Experience Team.
Complaints Improvement Lead	The Complaints Improvement Lead is responsible for overall management of the complaints and concerns process, and for implementing the strategic direction for complaints and PALS; ensuring these services are congruent with the Trust's objectives and actively enhance the organisations reputation. The Complaints Improvement Lead will, as part of the wider patient experience agenda, ensure that systems and reporting are compatible with delivery of patient feedback intelligence that supports service improvement and oversee the generation of a range of reports from complaints data and themes, to support the Divisions and CBUs to identify failures and make service improvements. The Complaints Improvement Lead will also develop and deliver training to staff who are expected to investigate complaints.
Complaints Team (CT)	The CT is responsible for assisting the Complaints Improvement Lead in the management of complaints and concerns and in providing advice and liaison as part of the PALS provision of the Patient Experience Team. The CT will ensure that a file is maintained for every complaint/concern/PALS contact in line with Trust guidelines. Once

	closed, complaints files will be uploaded to the Datix system and stored. The CT will provide a professional and compassionate service to complainants whilst listening to their concerns. They will liaise between complainants and frontline staff, ensuring that lines of communication are open and everyone involved knows the timescales/progress of the investigation. The CT will refer formal complaints to Divisions/CBUs lead nurses/manager's dependent upon the level of complaint (Low, Moderate or High). Where possible, concerns will be dealt with at Complaints Resolution Officers (CRO) level and outcomes logged and shared with the relevant CBUs for learning. The CT will ensure that timescales for all steps of the complaints and concerns processes are flagged and met by the CBUs and that contemporaneous record are kept. All complaints, concerns and PALS are registered on DATIX upon receipt, and that the team's role is to ensure all relevant case information is entered on the DATIX system accurately and in a timely manner throughout the complaint process. The CT will build good working relationships with staff across the Trust, and provide guidance and support to the CB's and individual members of staff throughout the complaints process as required.
Patient Advice and Liaison Service (PALS)	PALS offer confidential advice, support and information on health-related matters to patients and their families and carers, whilst also providing a point of contact. PALS will provide help with health-related questions and to resolve concerns or problems when patients and their families and carers are dissatisfied with a service they have used in the Trust. PALS can offer information on the NHS complaints procedure, including how to get independent help to make a complaint and the PALS/officer will manage the service, directing the PEO in making PALS contacts and supporting the demand for the service. The PALS service will ensure a professional and compassionate service is provided to enquirers and that all concerns are logged on the Datix system. PALS will liaise with the relevant manager of the service and the enquirer to resolve their concerns locally.
Senior Management Team in Divisions and Clinical Business Units (CBUs)	If issues are raised locally, the senior management teams within the CBU will ensure that where possible, these are resolved informally and locally, and that any issues not resolved within 24 hours of receipt are forwarded to the patient experience department, and put onto the DATIX system in a timely manner. The Division and CBU Triumvirates are responsible for allocating investigating officers and quality checking the complaints response. CBU senior leads are responsible for ensuring that complaints are investigated appropriately and that any learning is communicated appropriately and any changes in practice as a result of complaints is

	actioned. It is the responsibility of the Investing Officer to independently review the care of the patient, with the appropriate clinical or senior input.
Employees	All staff has a responsibility to act in the best interests of patients and will receive feedback from complaints and concerns in a constructive and sensitive manner. All staff will seek to ensure the early and effective resolution of concerns and complaints where possible, referring to their line manager, manager on call or the CT if at any stage they do not feel they can resolve the concerns. All staff need ensure that their departments and wards have PALS and Complaints leaflets at hand for patients and service users.
Board of Directors	Responsible for the ratification of the Trust's Complaints Policy. Receipt of the Trust's annual report on Complaints and receipt of regular updates on themes and learning from complaints.
Quality Assurance Committee	Approval and oversight of the Trust's Complaints Policy and oversight of complaints reports produced by the Department.
Patient Experience Sub Committee	The Patient Experience Sub-Committee receive reports from the Complaints Improvement Lead that include intelligence on complaints and PALS to identify themes and provide assurance that lessons are learnt and improvements made.

Local Resolution Process




Key to responsibilities on previous page
CBU Manager to allocate relevant Senior member of CBU Team, (i.e. CBU Manager, Clinical Director, Matron) & forward on copy of complaint, action memo & timescales*
Senior member of CBU to gather preliminary evidence, liaise with complainant to identify all concerns, & offer meeting
Offer of meeting accepted by complainant?
Yes
Complaints Team to arrange with relevant staff and complainant to arrange meeting
Meeting held & recorded subject to agreement from all parties
CBU Team to forward lessons learned document to Complaints Team for approval following relevant Triumvirate member approval
Letter to Deputy Director of Governance & Quality for approval
Suitable for immediate resolution?
NB: complaints triaged HIGH are not suitable for immediate resolution
Yes
No
Senior member of CBU to resolve complaint during initial conversation with complainant over the telephone
Resolved?
Yes
No
Unable to contact complainant after reasonable effort. Attempts to be recorded in Datix
Continue with routine process
CBU Manager to allocate Investigating Officer (IO) supported by Divisional Complaints Officers to gather all relevant statements, assess outcomes &
Prepare Complaints Investigation Report
Notify the Complaints Team of any delays that may result in breach of the response time*, so the complainant can be informed.
Submit draft Complaints Resolution Report to relevant Triumvirate. NB: Moderate and Low complaints signed off by CBU Triumvirate. High complaints signed off by CBU and Divisional Triumvirate
Divisional Triumvirate to:
Approve draft report & response, (or liaise with Senior Member of CBU where further action/ information required)
Notify Complaints Case Handler once approved
Investigation & Complaints Resolution Report reviewed by Case Handler and letter drafted, which is submitted for approval
If triaged High or if MP referred complaint: Chief Executive or Chief Nurse to review and approve
If triaged Low or Moderate: Deputy Director of Governance & Quality to review and approve
Signed off?
No
Yes
Complaints Office to forward signed letter to complainant
Complaint closed
Senior member of CBU to summarise agreement, actions, & lessons learned in letter & forward draft directly to relevant Divisional or CBU Triumvirate member for approval
Divisional or CBU Triumvirate member to approve immediate resolution and forward to Complaints Team
Letter to Deputy Director of Governance & Quality for approval
Approved?
Yes
No
Letter sent to complainant
Complaint closed
If unsuitable for approval/ sign off
If unsuitable for approval/ sign off
*time in working days: 60 if High 30 if Moderate or Low

Dealing with Concerns Raised at the Point of Care

A concern or complaint is an expression of dissatisfaction when expectations (even unreasonable ones) have not been met. Even the best managed wards and departments will receive complaints. People may express concerns or complain because they are anxious, frightened, upset or in pain. Often they are unhappy about an aspect of communication that is lacking. Whatever the reason, it is important to ensure that they feel able to express their concerns without feeling that their care may be affected in any way.

These comments are a constructive method of gaining feedback on how users view our service. How we handle complaints, queries and concerns affects our reputation with service users and the community that we serve and any member of staff can successfully deal with a concern, complaint or enquiry.

When you encounter someone with a concern:

- Don't immediately advise them to speak to PALs or make a formal complaint. Often, action at this point can solve problems locally, prevent escalation of concerns and ensure the patient's experience is satisfactory;
- Remain calm, be friendly and always introduce yourself;
- Respect the need for privacy – take them to a private/quiet area if possible. If it is a patient in a bed, pull the curtains/close door and ensure you are on eye level and close enough to have a quiet conversation;
- Ask how they would like to be addressed, e.g. Mr, Mrs, Ms or first name if you have not met before;
- If possible, deal with the matter there and then, or within 1 working day;
- Always ensure that the health needs of the patient continue to be met;
- Take responsibility – if you are unable to help, find someone who can;
- Listen carefully and, if necessary, make notes;
- Ensure you establish the key concerns and what is the ideal outcome for the patient, i.e. what do they want you to do, say, arrange, fix;
- Try to put yourself in their shoes – would you feel unhappy if this were happening to you or your relative?;
- If possible, provide an explanation about how the problem may have arisen and what steps have been taken to prevent a recurrence;
- Apologise for the fact they are unhappy and thank the individual for bringing the issues to your attention;
- Tell them what you will do and when you aim to feed back;
- Don't be defensive – never blame or criticise other colleagues, departments or Trust policies;
- Ensure the person is satisfied with the action you have taken;

If you are unable to resolve the matter:

- Ask the Ward or CBU Manager, Matron, or other relevant practitioner to come and talk to the person with concerns.
- PALS can offer advice and liaison if the person prefers to speak to someone not connected to direct care delivery.

If the person wishes to make a formal complaint either:

- Follow the process as detailed above and send the information to the CT within 24 hours of receipt.

Patient Advice and Liaison Service (PALS)

The PALS service is a free and confidential service run by the hospital for patients, families and carers. The PALS service has an important role to play in the resolution of informal complaints and concerns and aims to provide immediate information and assistance for patients, their families and carer's and informal resolution to all concerns in the first instance. If this is not possible the PALS officer will provide complainants with information and access to the formal complaints process.

All staff should be aware of the assistance that the service can give to people who do not necessarily wish to make a formal complaint but would benefit from the help PALS can offer. Where appropriate, staff should direct people to PALS only if they are unable to resolve the issue at ward/departmental level unless any of the following apply:

- There has been a serious outcome of care, including permanent harm/death
- There is potential adverse publicity
- There is potential litigation.

In these cases, the matter should always be passed to a senior manager or the Complaints Improvement Lead immediately. The PALS Officer can be contacted on 01925 275512 from 9am – 5pm.

Support for Patients, Families and Carers

For many different reasons, people using Trust services often need support if they wish to complain, or want to suggest ideas for improvement. It is vital that staff are able to help people find and use this advice and support effectively.

The Trust will ensure equal access to the complaints process regardless of age, disability, gender and race. Reasonable adjustments will be made to accommodate access to the complaints process, based on the complainant, patient or representative informing the CT of their needs. Where necessary, the Trust will provide assistance through an interpreter when the complainant's first language is not English. The Trust will also provide a British Sign Language interpreter to sign if the complainant is deaf. However this may require some advance notification to arrange. Patients requiring support from Independent Mental Capacity Advocacy teams (IMCA) or other advocacy services should be referred appropriately and supported by Trust safeguarding.

Ensuring that Patients, Families and Carers are not Treated Differently as a Result of a Complaint

The Trust expects all staff to treat patients and/or complainants with respect at all times and where a complaint or concern is raised, staff should ensure that the patient's on-going health needs are met. The fact that a complaint is made should not have any adverse effect upon a patient's care. When dealing with a complaint trust staff are instructed that they should:

- Reassure the complainant/patient that the health needs of the patient will continue to be met;
- Ensure full details of any complaint made to them are forwarded to the CT;
- Ensure no correspondence concerning a complaint is held in the patient's health records;
- Ensure no investigation correspondence i.e. staff accounts/reports are held in the patient's health records or sent externally;
- Record the date time and details of the complaint on DATIX.

Under no circumstances should staff display any form of discrimination towards either the patient and/or complainant as a result of a complaint being raised. If any form of discrimination is proven, then the Trust's disciplinary procedures will be invoked and where applicable, the matter may be referred to a professional body.

Consent for the Release of Information

Under the Data Protection Act (1998), confidential patient information should never be disclosed to a third party unless the patient has given their consent.

Where a complaint is made on behalf of a patient who is 18 years of age or over, the CT will seek the patient's written consent, within 3 working days of receipt of the complaint, by providing a consent form for the patient to sign. This empowers the Trust to disclose personal information (relating to the complaint) to the representative as part of the complaints procedure. The CT is responsible for ensuring that no complaint response letter containing personal information is sent without consent.

If a complainant is the next of kin of the patient whose care the complaint is the subject of, the wishes of the patient must be sought before releasing any information. Where consent is provided by the patient's next of kin or other representative, the Complaints Improvement Lead will seek assurance that where possible, this has been done with the patient's permission.

Where it is considered that, under the terms of the Mental Capacity Act (2005), the patient lacks capacity to provide informed consent for disclosure of information; the Complaints Improvement Lead must be satisfied that the representative acting on behalf of the patient has formal authority to act on behalf of the person who lacks capacity. Further guidance can be found in the Trust Mental Capacity Act Guideline.

Once consent has been obtained, information must only be disclosed to those people who have a demonstrable need to know for the purpose of investigating the complaint. Care must be taken at all times throughout the complaints procedure to ensure that any information disclosed about the patient is confined to that which is relevant to the investigation of the complaint. If the appropriate consent is not received once an investigation has been completed the information will not be released to the complainant until the consent is received.

The Patient Advice and Liaison Service (PALS) has a much shorter turnaround of patient issues and relies on verbal consent being obtained, where the person raising a concern or issue is not the patient. This is always recorded on the PALS record that is completed at every contact before closing the case.

Formal Complaints of Patients, Families and Carers

The first contact the Trust has with a person who is unhappy with the service they have received is crucial. A patient, or a patient's representative, may wish to raise a concern, not necessarily wishing to make a formal complaint. The way in which this is handled can, on many occasions, prevent this from progressing to the formal complaints process.

A formal complaint may be lodged verbally or in writing (by letter, or email). If a formal complaint is received in writing, this should be forwarded to the CT immediately to ensure that response times can be met in line with this policy and current legislation.

Whilst it is preferred that formal complaints should be made in writing, it is recognised that many people, for a number of reasons, may not be able to do so. In these cases, the CT is responsible for establishing and agreeing the facts of the complaint with the complainant. Consent is required in writing from the patient to confirm that the individual has the right to act upon the patient behalf. It is a legal requirement that all formal complaints are acknowledged within 3 working days.

Exclusions from the Formal Complaints Process

The Trust is not statutorily obliged to investigate complaints received from:

- A responsible body, for example a local authority, NHS body, primary care provider or independent provider, unless there was an element of shared care across the boundaries.
- An employee about any matter relating to that employment. The complaints procedure is concerned with resolving complaints made by patients, not staff complaints or grievances. Staff should use the appropriate Human Resources policies and procedures if they wish to raise concerns.

Where it is determined that a complaint is not to be investigated as per the points above, the complaints manager will write to the complainant as soon as reasonably practicable to inform them of this and the reasons why. If a patient's death has been referred to the Coroner's Office this does not affect the relatives' right to make a formal complaint.

In instances whereby a complaint is deemed to be a Serious Incident, the Trust will report this incident to the Strategic Executive Information System StEIS and formally close the complaint, as

the Serious Incident Policy will be conducted. The Trust will ensure that the complainants are aware of this.

Timeframe to Respond

The Trust aims to resolve complaints within 30 working days to Low and Moderate graded complaints and 60 working days to High graded complaints. If these timescales are not going to be met, the complainant will be contacted with an updated timeframe.

CBU Process for Investigation of Complaints

The investigation process is detailed in the Local Resolution Process diagram. The CT will send every investigator a guide on how to investigate complaints thoroughly.

Process for the Handling of Joint Complaints between Organisations

If a complaint received by the Trust involves another NHS body or Local Authority, the Trust will work closely with those other organisations to ensure that the complainant receives one full response to their concerns, and that the complainant has one key point of contact in relation to their complaint.

The CT will, (before contacting any other involved organisation), seek consent from complainant/their representative consent to share information with the relevant external organisation/organisations. Where this consent is not received, the CT will seek to clarify any issues with the complainant about remit and responsibility, the parts of the complaint the Trust is unable to answer, and advise that these are forwarded to the relevant body.

In cases where Warrington and Halton Hospitals NHS Foundation Trust is the lead organisation, the complaints manager will take the lead in coordinating a response from all involved parties which addresses all points raised within the complaint.
The CT will:

- Contact each NHS body or Local Authority and provide details of the complaint which relates to each organisation.
- Confirm a timeframe for the other organisation to provide their written response to the concerns raised.
- Ensure all reports are received and a written response to the complainant detailing all the issues raised, concerning all involved organisations, is drafted and provided to the Chief Executive for signature.

The CT will, as soon as possible, confirm to the complainant which part of the complaint will be investigated by which organisation. Complaints will be graded upon receipt, and an overarching action plan will be developed and monitored by the CT. Where learning points are taken up, these will be shared across all agencies involved.

Where the lead organisation is not Warrington and Halton Hospitals NHS Foundation Trust, the CT will ensure that any information required by the other body in dealing with any aspect of the complaint relevant to the Trust is provided as soon as possible following request. The Complaints Improvement Lead will ensure that the information is accurate, appropriate, and answers all issues raised.

The CT will also ensure that, where necessary, appropriate representatives from the Trust attend any meeting held by the other body in the course of their complaints process.

Occasionally the Trust receives complaints that are not related to the care or services provided by the Trust, but are the responsibilities of another organisation. Where this happens the CT will contact the complainant within three working days to acknowledge receipt of the complaint, to confirm that we are unable to deal with the complaint and ask the complainant if they would like the complaint to be forwarded to the correct organisation.

During the course of an investigation, it may become necessary to notify external agencies where a serious incident has occurred e.g. CCG, HM Coroner, Police, Health & Safety Executive. This decision will be made following consultation with the Deputy Director of Integrated Governance and Quality Improvement, Chief Nurse, and Medical Director.

It may also become necessary to obtain external clinical advice during the course of an investigation where it is felt that an independent opinion of a patient's care is required to aid resolution of the complaint. Where appropriate, this decision will be made by the Complaints Improvement Lead, on the advice of the Chief Nurse, Deputy Director of Integrated Governance and Quality Improvement Associate/Deputy Directors of Operations and Nursing and/or Medical Director.

Returned Complaints

A complainant may sometimes remain dissatisfied with the Trust's investigation, response and/or action following receipt of the final response and any meeting that may have taken place. Where a complaint is returned for further review the CT will:

- Contact the complainant to discuss the reasons for their continued dissatisfaction and will agree a further written response to be sent, or offer to arrange a meeting, according to the complainant's preference.
- Will agree the timeframes for a further investigation to be completed and a further written response to be sent by the Trust
- Notify the relevant CBU of the complainants continued dissatisfaction and provide details of any outstanding issues to be investigated further.

CBU leads will ensure that all returned complaints are managed and investigated in accordance with the above Local Resolution Process.

On completion of any further investigation a written response will be sent to the complainant on behalf of the Chief Executive. The further final response letter should:

- Cover all the relevant aspects of the complaint which the complainant remained dissatisfied with.

- State if the complainant feels there are any further outstanding issues they should contact the Complaints Improvement Lead to discuss their concerns further

Or

- State why the Trust believes local resolution has been achieved and if the complainant remains dissatisfied they have the right to request that their complaint is reviewed by the Parliamentary and Health Service Ombudsman (PHSO).

Guidelines for Handling Unreasonably Demanding Complainants

The Trust views complaints as a valuable and positive contribution to the development of high quality healthcare and is committed to the effective and timely resolution of complaints. However, these guidelines are necessary for responding to the very small numbers of complainants who are unreasonable in their expectations of the Complaints Procedure.

It is important to remember that a person making a complaint may be distressed due to the events that have happened. They may be bereaved or have health problems. This policy should only ever be considered when all other avenues and reasonable measures to deal with the complainant have been exhausted.

Definition of an unreasonable complaint

Where previous or current contact shows that they meet at least two of the following criteria:

- Persist when the Trust complaints procedure has been fully and properly exhausted e.g. when an investigation has been deemed as "out of time" or where the complainant is unwilling to pursue the next stage by referring to the Parliamentary and Health Service Ombudsman (PHSO).
- Change the substance of the complaint or continually raise additional issues when the complaint has been answered. Care must be taken to ensure that new facts are not excluded from the primary complaint when they are genuinely identified late in the process. Care must also be taken not to discard new issues which are significantly different from the original complaint - these should be considered as new complaints.
- An unwillingness to accept documented evidence of treatment given as being factual or will not accept that facts can be difficult to verify when a long period of time has elapsed.
- Do not clearly identify their precise issues of complaint despite reasonable efforts of staff to clarify their concerns.
- Focus on a trivial matter to an extent where it is out of proportion to its significance and continue to focus on this point. Careful judgement must be used in applying the description "trivial".
- Repeatedly verbally abuse staff during the investigation of their complaint and have threatened physical violence or present a danger to staff.
- Place unreasonable demands by an excessive number of contacts. This may be in person, by telephone, email or letter.
- The publication of online threats or abuse regarding staff in a variety of web based platform. For example social media or public blogs.

Options for handling unreasonable/vexatious complaints

Where a complainant has been identified as unreasonable in accordance with the above criteria, the decision to treat a complainant as unreasonably persistent or vexatious will only be taken by, and with, the authorisation of the Chief Executive of the Trust. Sanctions may include exclusion from the Trust for all but emergency care**.**

The Chief Executive will notify the complainant in writing of any action and the reason the Trust finds this necessary. Once a complainant has been deemed as unreasonable, discretion must be used to determine when this status is withdrawn. The Trust Board will be informed where there are vexatious complainants. It may also be necessary at this stage to seek legal advice from the Trust solicitors.

Withdrawal of unreasonable or vexatious status

Having deemed a complainant as unreasonable or vexatious, this status may be withdrawn at any time. This should be exercised where for example, the complainant agrees to, and demonstrates a more reasonable approach or they submit a further complaint for which the normal complaints procedure would appear appropriate. The Trust Chief Nurse will discuss options with the Chief Executive and if considered appropriate, the Trust's complaints procedure will apply and the complainant will be notified.

Regulatory and Statutory Issues

Duty of candour

New rules to toughen transparency in NHS organisations and increase patient confidence were announced following a public consultation that closed in January 2012. This has resulted in the Government creating new regulations that require the NHS Commissioning Boards to include a contractual duty of openness in all contracts from April 2013. This ensures that all NHS organisations are required to tell patients if their safety has been compromised in a way that has resulted in moderate (non-permanent) harm and/or severe (permanent) harm and/or death as a result of something not being done.

At all times during the investigation of a complaint, any Trust employee will provide clear and honest information to complainants, explaining, updating and summarising a range of information.

Independent Complaints Advocacy

Since April 2013, NHS Advocacy is provided by Merseyside and Cheshire Independent Complaints Advocacy. This service replaces the previous service (ICAS) and will continue to be delivered by the Carers Federation. Health watch Advocacy provides practical support and information to people who want to make an NHS complaint.
Email: merseysideandcheshire@healthwatchadvocacy.co.uk
Tel: 0808 801 0389

Medical or Complaint Investigation Records

If complainants require access to, or copies of their medical records during the complaints process this must be done in conjunction with the Data Protection Act (1998). If the patient

about whom the complaint is regarding is deceased, access to the medical records will be dealt with by the Trust under the Access to Health Records Act (1990).

Requests relating to access to health and medical records will be processed upon receipt of the appropriate form being completed by the complainant, patient and/or next of kin. The complainant will be sent an Access Request Form for the relevant medical records. This will then be processed by the relevant department.

Time Limits for making a formal complaint

Generally, the Trust will accept complaints which are made not later than 12 months after the date on which the matter which is the subject of the complaint occurred, or 12 months after the date on which the matter came to the notice of the complainant.

The Trust is not statutorily obliged to investigate complaints made later than the timeframes documented in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which states a complaint, must be made not later than 12 months after:

a) the date on which the matter which is the subject of the complaint occurred; or
b) If later, the date on which the matter which is the subject of the complaint came to the notice of the complainant.

However, in certain circumstances the Trust can apply discretion if it is satisfied that the complainant had good reasons for not making the complaint within that time limit and that it is still possible to investigate the complaint effectively and fairly. For example if a Serious Incident or mortality review indicates harm has been caused and Duty of Candour is instigated, a family may then raise a legitimate complaint regardless of the timeframe.

In this circumstance, the Deputy Director of Integrated Governance/ Complaints Improvement Lead will review the complaint with the appropriate service head. If a decision is taken not to investigate the complaint for the reason listed above, this decision and the reasons why will be communicated by the Complaints Improvement Lead to the complainant in writing as soon as possible.

Complaints referred to the Parliamentary and Health Service Ombudsman (PHSO)

Whilst every effort will be made to address concerns raised, and resolve all complaints received. If a complainant remains dissatisfied, they have the right to request that their complaint is reviewed by the PHSO.

The PHSO have the power to request any formal documentation from the Trust that may relate to the investigation of a complaint. The CT will submit copies of all complaints files and any relevant medical records to the named Investigating Officer at the PHSO, all documentation will be sent by recorded delivery. The CT will check any copies of medical records to be sent to ensure confidentiality and all documentation relates to the patient concerned. The CT will ensure all documentation is sent within the timescales specified by the PHSO (usually 10 working days). The PHSO will then make a deliberation and will inform the Trust if they intend to investigate.

If following the PHSO investigation the complaint is not upheld, the PHSO will write to the Trust to advise of the results of the investigation and the CT will record this on DATIX and the file will remain closed.

If following the PSHO investigation the complaint is upheld, the PHSO will write to the Trust to advise of the results of the investigation and any recommendations.

The CT will forward the full details of the investigation and recommendations to the CBU, Associate Directors for Operations and Nursing. A clear timescale for further response / action from the CBUs will be provided. Once further actions have been completed a further written response will be sent to the complainant, with a copy being sent to the PHSO if requested. The file will then be closed on DATIX.

Legal Action or criminal proceedings

Complaints must be investigated even where the complainant has indicated that they intend to pursue legal action against the Trust.

Where an investigation is associated with an alleged, or actual criminal offence, the Trust will consult with its legal advisors and/or the police to determine whether investigating the complaint might prejudice subsequent legal or judicial action. If so, the Trust will notify the complainant in writing that further investigation is not possible.

Support for Staff

The Trust recognises it can be extremely distressing for staff when they are involved in a complaint investigation whether this is an internal review or an external investigation conducted by the Health Service Commissioner. Therefore, staff involved in any part of the complaints process may require additional support from their immediate line manager throughout this process. The trust also provides a confidential staff counselling service via OH.

The Trust's key aims are:

- To appropriately value, support and protect staff.
- To ensure any disciplinary processes prompted by a complaint is fair and objective.
- To provide support in the best interests of the individual concerned.
- To provide individuals with appropriate and relevant information necessary for them to make a positive contribution to any investigative or procedural case.
- To minimise negative effects on staff caused by involvement in investigations and proceedings.
- To reduce instances of staff leaving or being absent from the profession due to poor experiences of investigations and/or proceedings.
- To reduce instances of inappropriate exclusion of staff.
- To protect patients and improve service provision.

Divisional leads, CBU leads, line managers and heads of department have a responsibility to ensure that their staff are appropriately supported during this process and in serious cases or where the member of staff is experiencing difficulty, and managers must advise staff of the availability of the confidential staff support service provided by the Occupational Health Department.

Training and Development

The Complaints Improvement Lead delivers a rolling programme of complaints investigation training. Please contact the CT for details.

Disciplinary Processes

If, following the investigation of a complaint, it is decided to pursue a disciplinary investigation; the complainant will be notified of this as part of the final response, details of individuals will not be included. The complainant has no right to be notified of the outcome of the disciplinary investigation and the complaints process ceases.

Organisational Learning

Good complaints handling is not limited to providing a response or remedy to the complainant it should focus on ensuring that the feedback received through complaints is used to learn lessons and contribute to service improvement. Lessons learnt from complaints will be fed back to the trust staff via a number of sources including: DATIX, ward meetings, action plans and safety briefs to ensure change in practice were necessary.

Following investigation the CBU lead should include details of any risk reduction measures, lessons learnt and actions taken as a result of the complaint in their final report. Managers are responsible for following up relevant action plans and monitoring progress of any actions agreed by providing feedback within the CBU's and ensuring that all action plans are entered on the Ciris system and are regularly updated. Action plans and outcomes of the learning will be included in Governance and other quality reports to show evidence of "closing the loop" with regard to complaints.

Lessons learnt and safety lessons identified by complaints investigations are disseminated to internal and external stakeholders through:

- Quarterly Governance report to the Board of Directors and Commissioners;
- Quarterly reports on action plans resulting from complaint investigations will be provided to the Patient Experience Committee;
- Reports will be generated to support monitoring of themes and trends at Divisional, CBUs and corporate Quality Group meetings;
- Quarterly Complaints and Clinical Benchmarking information is provided to Trust Board of Directors by the relevant CBUs;
- Learning from Joint Complaints is shared with any external organisations involved via the complaints investigation process;
- Quarterly Learning from Experience report to Quality Committee.

Quality Assurance Group

Following the recommendations made in several reports into NHS Complaints Handling, there has been a consensus that there needs to be improvements in providing assurance to the Board that there are robust systems and processes in place, in order to deal with complaints from patients, families or carers. This will come in part, through proper use of internal governance systems, and following the correct legislative documents; namely the Complaints Regulations 2009. A further part will come through the production of papers for the Board around complaints, including things such as number of new complaints, themes/trends and grading of complaints etc., and the Trust already has reports of this type implemented. The QAG group will further see this assurance enlightened, by enabling the Board to hold to account the systems and processes, and the individuals responsible, for ensuring that complaints are answered in an open, honest and transparent fashion whilst also in a timely manner.

The key elements are mainly detailed in Appendix 4. The aim of the group is to ensure the Trust Complaints Policy is adhered to. There is a rolling programme of complaint reviews by divisions, complaint responses are timely, and of sufficient quality, trends have been identified, lessons learned and actions have been identified and acted on.

The Complaints Quality Assurance Group will provide assurance to the Board, via Quality Committee, that the Complaints Policy is appropriate and meets the requirements of the NHS Complaints Regulations 2009, and the Parliamentary Heath Service Ombudsman's recommendations, in their detailed in their report, '*My Expectations for Raising Concerns and Complaints, Parliamentary and Health Service Ombudsman, 2013.'*

The group will also support the Trust's values and enhance divisional accountability, through increased senior scrutiny and evaluation of complaints handling.

Sources and References

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (No. 309, Office for Public Sector Information
- Department of Health Listening, Responding, Improving – A guide to better customer care (Gateway reference 11215, February 2009)
- Advice sheet 1: Investigating complaints Department of Health, 200
- Advice sheet 2: Joint working on complaints – an example protocol Department of Health, 200
- Advice sheet 3: Dealing with serious complaints Department of Health, 200
- Care Quality Commission Essential Standards for Quality and Safety 2009
- NHSLA Risk Management Standards for Acute Trusts 2013
- The Mid Staffordshire NHS Foundation Trust Public Inquiry, Robert Francis QC, 2013
- A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture, Ann Clwyd, 2013
- Good practice standards for NHS Complaints Handling, Patients Association, 2013
- Complaints Matter, CQC, 2014
- My Expectations for Raising Concerns and Complaints, Parliamentary and Health Service Ombudsman, 2013.

Associated Documents

- The Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Data Protection Act 1998
- The Local Authority Social Services and National Health Service complaints (England) Regulations 2009
- Public Interest Disclosure Act 1998
- Trust Incident Reporting and Investigation Policy
- Trust Mental Capacity Act Guidelines
- Trust Violence and Aggression Policy
- Trust Risk Management Strategy
- Trust Being Open/Duty of Candour Policy

Glossary of Terms

CBU	Clinical Business Unit
Concern	An issue raised by a patient, or a representative of a patient, with the potential to become a formal complaint. Concerns may be resolved informally and within 24 hours if possible.
Complaint	An expression of dissatisfaction" received from a patient, or a representative of a patient about any aspect of the local health services which require a response, whether it be verbally or in writing.
PALS	Patient Advice and Liaison Service
CT	Complaints Team
PHSO	Parliamentary and Health Service Ombudsman
SOP	Standard Operating Procedure

Appendix 1: Risk Grading of Complaints

Step 1: How serious is the issue?

Seriousness	Description
Low	Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care **OR** Unsatisfactory service or experience related to care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Medium	Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.
High	Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity. Any complaint received via an MP should be classed as high risk. **OR** Serious issues that may cause long-term damage, such as grossly sub -standard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.

Step 2: How likely is the issue to recur?

Likelihood	Description
Rare	Isolated or 'one off' – slight or vague connection to service provision.
Unlikely	Rare – unusual but may have happened before.
Possible	Happens from time to time – not frequently or regularly
Likely	Will probably occur several times a year
Almost certain	Recurring and frequent, predictable

Step 3: Categorise the risk

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

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

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

Appendix 2: Complaint Investigation Report

Complaints Investigation Report	
Complaint reference:	
Name:	
Date first received:	
Date of acknowledgement:	
Date of feedback meeting with complainant (if applicable):	
Date of response:	
Key issues of complaint set out by complainant:	
Details of policies or guidelines relevant to the complaint:	
How have you investigated the complaint:	
Summary – findings against each key issue identified by complainant:	
Key Findings and Conclusions:	
Actions required/undertaken:	
Investigation Officer:	
Verified by:	

Appendix 3: Staff Support Letter

Insert name of CBs /Dept.
Warrington and Halton Hospitals NHS Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Insert telephone number
Insert Name and address to which letter is being sent
Insert Date

Re: Complaint (reference number)

I am writing to invite you to an informal meeting to discuss a recent complaint made about the care provided to (patient name) on (ward/department).

I have been designated as the lead investigator for the CBU's and as part of the investigation I am talking to staff members who were involved in the care and treatment of the patient during the period of time identified in the complaint.

Several issues have been raised in the complaint and I need to discuss your recollections and reflections on these. I will have the case notes available when we meet, so that we can review the relevant records.

I know that you may be anxious about being involved in the investigation of this complaint and it is hard to acknowledge that our patients might not be satisfied with the care we have provided. At the end of the letter there is some information on who can offer you support during this investigation. Please be assured that the only object in investigating complaints is to ensure that we can learn from the feedback we receive from patients and their families and improve our services.

Following my investigation I will produce a report of the findings so that a written response can be sent to the complainant. Locally, we will develop an action plan that will identify any improvements that need to be implemented to ensure we maintain high standards of care and a positive patient experience.

The proposed day, date and time of the meeting is (date/ time) and may take up to one hour. I will take notes of the discussion, or you may be asked to write an account of your involvement with the patient and you understanding of the events in question. If asked to write an account you can find guidance in the Complaints and Concerns Policy. You may bring along a colleague should you wish. If you want to do this, your colleague must ensure that patient confidentially during and after the investigation is maintained.

If you have some concerns about this process, we may be able to offer support in the following ways:

- Advice on the Occupational Health Service and/or Staff Counselling Service, ext. 2345
- The Chaplaincy Team who are available for all staff to speak on an informal and strictly confidential basis, please contact the Chaplaincy Co-ordinator, ext. 2146

- Medical Educational Supervisor, Director of Medical Education, Supervisor of Midwives, Clinical Leads, and CBU are al Heads of Nursing (and Midwifery) or other team member.
- Line Manager and or the CBU's al Clinical Governance Facilitators
- Complaints Improvement Lead , ext. 2191

Please do not hesitate to contact me on the telephone number at the top of the letter with any questions.

Yours sincerely

Name/title of investigator
cc. Manager of the Ward/Dept

Appendix 4: Quality Assurance Group Terms of Reference

1. PURPOSE

The aim of the group is to ensure the Trust Complaints Policy is adhered to, there is a rolling programme of complaint review by divisions, complaint responses are timely and of sufficient quality, trends have been identified, and lessons learned and actions have been identified and acted on.

The Complaints Quality Assurance Group will provide assurance to the Board, via Quality Committee, that the Complaints Policy is appropriate and meets the requirement of the NHS Complaints Regulations 2009 and the Parliamentary Heath Service Ombudsman's recommendations in their 'My Expectations for raising concerns and complaints.'

(https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf)

The group will also support the Trust's values and enhance divisional accountability, through increased senior scrutiny and evaluation of complaints handling.

2. AUTHORITY

The Group is authorised by the Quality Committee to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

3. REPORTING ARRANGEMENTS

The action notes of the Group meetings will be formally recorded and submitted with the Quality Committee, with a high level report.

4. DUTIES & RESPONSIBILITIES

The Group will undertake the following duties:

1. Quality assess a 'RED' triaged complaint from the appropriate division to assess the following:
    - All aspects of the complaint were addressed.
    - The response was appropriately allocated, and the response was appropriately co-ordinated.
    - The response was open, honest and transparent.

- The complaint was responded to within timescales.
- The language used was appropriate.
- The complainant was advised of the next steps.
- Lessons learned and actions plans have been documented with appropriate timescales for completion agreed.
- Apologies were offered as appropriate.

2. Feedback by the presenting division, areas of good practice, and areas for improvement.

3. Review monitoring of the implementation of the Trust's Complaints Policy.

4. Review of the Trust's Complaints Annual Report.

5. Highlight and report any emerging trends and themes, seeking assurance that appropriate actions and learning is in place across the Trust.

6. Oversight that the Trust's Complaints Improvement Plan is being implemented effectively.

7. Review the position of the PALS service.

8. Review a briefing paper, provided by the Complaints Improvement Lead in relation to PALS cases incorporating themes and trends from the previous month.

5. MEMBERSHIP

Core Members

Chair of the Trust (Chair)
Chief Nurse (or nominated deputy) (Deputy Chair)
Medical Director (or nominated deputy)
Deputy Director of Integrated Governance & Quality
Trust Complaints Improvement Lead

6. ATTENDANCE

Members

Members will be required to attend a minimum of 75% of all meetings.

Core Attendees

Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate, when an issue relating to their area of operation or responsibility is being discussed. There will be a rolling programme of complaints reviewed across the Trust. The Medical, Nursing and Operational leads of the area being discussed, will expect to be in attendance. Clinicians will be given six weeks' notice, where possible.

7. QUORUM

A quorum shall be three members: the chair of deputy, either the Chief Nurse/Medical Director or their nominated representative, and a representative from the Clinical Governance Department (either Deputy Director of Integrated Governance & Quality or Trust Complaints Improvement Lead).

8. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee, the agenda and papers will be sent out five working days, before the date of the meeting. No Papers will be tabled at the meeting, without prior approval of the Chair. The Group will be supported by Clinical Governance Department.

10. REVIEW / EFFECTIVENESS

The Group will undertake an annual review of its performance against its duties, in order to evaluate its achievements. These terms of reference will normally be reviewed at least annually by the Committee.

Appendix 5: Equality Impact Assessment

Title	
What is being considered?	Policy ☑ 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 ☐
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 and Diversity Lead Date	S Hunter	Title / Committee	Equality

Appendix 6: Complaints and PALS Leaflets

CONTACT DETAILS

If you want to discuss the issue contact **PALS**

Telephone: **01925 275 512** *Warrington*
01928 753 507 *Halton*

If you want to make a formal complaint

By post: **Chief Executive**
Warrington & Halton NHS Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Email: **Patient.experienceteam@whh.nhs.uk**

Telephone: **01925 66 2281**

Contact your local Healthwatch if you would like the support of an advocate to make your complaint.

Healthwatch Warrington
Telephone: **01925 246 892**

Healthwatch Halton
Telephone: **03007 776 543**

Complaints

How to make a formal complaint about your hospital care

Easy to read

High Quality, Safe Healthcare

Warrington and Halton Hospitals NHS
NHS Foundation Trust

This leaflet tells you how to make a formal complaint about the care you, a family member or a friend have received at Warrington and Halton Hospitals.

We value your comments about the service you have received in our hospitals as this helps us to improve the quality of care for all our patients.

We would always recommend that you try to solve any issues at the time that they happen. You can ask to speak to the person in charge, for example the ward manager or matron.

You can contact the PALS officer who will often be able to support you to resolve any issues before the need to make a formal complaint.

If you feel your issue has not been dealt with at the time you can make a formal complaint. We investigate all formal complaints fully and respond to you in writing and/or arrange to meet with you.

If you are complaining on behalf of a friend or a relative they or their next of kin must give consent for us to share information with you.

We will confirm that we have received your complaint within three working days.

We will investigate your complaint fully (once we have the consent of the person the complaint is for).

Your complaint will be handled by our Patient Experience Team (PET) who will coordinate the response with the relevant wards or departments.

We will let you know when we will be able to respond to your complaint. How long the investigation takes will depend on how complicated the issue is.

We will keep all information about your complaint totally separate from your medical records. Your current or future medical treatment will not be affected in any way.

The NHS has set a time limit of 12months for accepting complaints. That is 12 months from the actual event or from the time you became aware that you had cause to complain.

WHAT IS PALS?

PALS stands for **P**atient **A**dvice and **L**iaison **S**ervice.

PALS is part of the Patient Experience Team.

PALS is a confidential service.

PALS can advise or support patients, relatives and carers.

PALS can provide information on hospital services.

PALS can listen to your compliments, comments and concerns.

PALS can help address any difficulties quickly on your behalf.

PALS can signpost you to other organisations that are able to offer support and assistance.

WHERE IS PALS

ton Hospital.
e main entrance.
The office is open at these times:

Monday	Tuesday	Wednesday	Thursday	Friday
10am - 3pm	10am – 3pm	10am – 3pm	1pm – 3pm	10am – 3pm

Or you can contact a PALS officer by phone
Monday to Friday 9.30am – 5pm

01925 275 512

Halton General Hospital
By appointment only.
There is a PALS office near the entrance to ward A1 at Halton General Hospital but there are no staff based here.

CONTACT PALS?

By post:
PALS Office
Warrington & Halton NHS Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Email:
pals@whh.nhs.uk

Telephone:

01925 275 512	*Warrington*
01928 753 507	*Halton*
01925 635 911	*Switchboard*

If no one is available to take your call please leave a voicemail message. A member of the PALS team will call you back as soon as possible.

PALS

Patient Advice and Liaison Service

Hospital advice service for when you need information or have concerns

Easy to read

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
South West	2gether NHS Foundation Trust	Mental health / learning disability	Small	0	0	0	0	0
North West	Aintree University Hospital NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
Yorks and Humber	Airedale NHS Foundation Trust	Acute	Small	36	2	13	3	0
North West	Alder Hey Children's NHS Foundation Trust	Acute specialist	Small	1	0	1	1	0
South East Coast	Ashford and St. Peter's Hospitals NHS Foundation Trust	Acute	Medium	12	3	8	5	1
South West	Avon and Wiltshire Mental Health Partnership NHS Trust	Mental health	Small	3	2	2	1	0
London	Barking, Havering and Redbridge University Hospitals NHS Trust	Acute	Medium	13	12	0	6	0
London	Barnet, Enfield and Haringey Mental Health NHS Trust	Mental health	Small	12	1	2	7	0
Yorks and Humber	Barnsley Hospital NHS Foundation Trust	Acute	Small	7	0	2	2	0
London	Barts Health NHS Trust	Combined acute and community	Large	8	7	0	2	0
East of England	Basildon and Thurrock University Hospitals NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
East of England	Bedford Hospital NHS Trust	General	Small	11	1	1	10	0
Thames Valley/Wessex	Berkshire Healthcare NHS Foundation Trust	Combined mental health / learning disability / community	Small	6	2	5	3	2
West Midlands	Birmingham and Solihull Mental Health NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
West Midlands	Birmingham Community Healthcare NHS Foundation Trust	Community/ learning disability	Medium	3	0	2	1	1
West Midlands	Birmingham Women's and Children's NHS Foundation Trust	Womens and childrens	Medium	6	0	2	4	0
West Midlands	Black Country Partnership NHS Foundation Trust	Combined mental health / learning disability / community	Small	0	0	0	0	0
North West	Blackpool Teaching Hospitals NHS Foundation Trust	Acute	Medium	8	0	3	5	0
North West	Bolton NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
Yorks and Humber	Bradford District Care NHS Foundation Trust	Combined mental health / learning disability / community	Small	4	0	2	1	1
Yorks and Humber	Bradford Teaching Hospitals NHS Foundation Trust	Acute	Medium	6	1	2	2	0
North West	Bridgewater Community Healthcare NHS Foundation Trust	Community	Small	1	1	1	1	0
South East Coast	Brighton and Sussex University Hospitals NHS Trust	Acute	Medium	15	0	11	10	0
Thames Valley/Wessex	Buckinghamshire Healthcare NHS Trust	Combined acute and community	Medium	19	1	10	4	0
West Midlands	Burton Hospitals NHS Foundation Trust	Acute	Medium	15	2	1	15	1
Yorks and Humber	Calderdale and Huddersfield NHS Foundation Trust	Acute	Medium	0	0	0	0	0
East of England	Cambridge University Hospitals NHS Foundation Trust	Acute	Medium	14	5	5	10	1
East of England	Cambridgeshire and Peterborough NHS Foundation Trust	Combined mental health / learning disability / community	Small	9	3	1	2	0
East of England	Cambridgeshire Community Services NHS Trust	Community	Small	3	1	0	1	0
London	Camden and Islington NHS Foundation Trust	Mental health	Small	2	0	0	2	0
London	Central and North West London NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
London	Central London Community Healthcare NHS Trust	Community	Small	25	18	8	21	0
North West	Central Manchester University Hospitals NHS Foundation Trust	Combined acute and community	Large	0	0	0	0	0
London	Chelsea and Westminster Hospital NHS Foundation Trust	Acute	Small	5	0	3	3	0
North West	Cheshire and Wirral Partnership NHS Foundation Trust	Combined mental health / learning disability / community	Small	11	0	1	0	0
East Midlands	Chesterfield Royal Hospital NHS Foundation Trust	Acute	Small	19	1	11	12	3
North East	City Hospitals Sunderland NHS	Acute	Small	2	0	0	2	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
	Foundation Trust							
East of England	Colchester Hospital University NHS Foundation Trust	Acute	Small	11	5	5	8	4
South West	Cornwall Partnership NHS Foundation Trust	Combined mental health / learning disability / community	Small	0	0	0	0	0
North West	Countess of Chester Hospital NHS Foundation Trust	Acute	Small	3	0	3	0	1
North East	County Durham and Darlington NHS Foundation Trust	Combined acute and community	Medium	6	0	3	3	0
West Midlands	Coventry and Warwickshire Partnership NHS Trust	Combined mental health / learning disability / community	Small	2	1	2	0	0
London	Croydon Health Services NHS Trust	Combined acute and community	Small	8	2	3	3	0
North West	Cumbria Partnership NHS Foundation Trust	Community	Small	0	0	0	0	0
South East Coast	Dartford and Gravesham NHS Trust	Acute	Small	4	1	3	0	0
East Midlands	Derby Teaching Hospitals NHS Foundation Trust	Acute	Medium	26	0	1	25	9
East Midlands	Derbyshire Community Health Services NHS Foundation Trust	Community	Medium	5	1	0	4	0
East Midlands	Derbyshire Healthcare NHS Foundation Trust	Mental health / learning disability	Small	0	0	0	0	0
South West	Devon Partnership NHS Trust	Combined mental health / learning disability / community	Small	9	9	3	2	1
Yorks and Humber	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Acute	Medium	1	0	1	0	0
Thames Valley/Wessex	Dorset County Hospital NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
South West	Dorset Healthcare University NHS Foundation Trust	Combined mental health / learning	Medium	3	1	0	2	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
		disability / community						
West Midlands	Dudley and Walsall Mental Health Partnership NHS Trust	Mental health	Small	3	0	2	3	0
East of England	East and North Hertfordshire NHS Trust	Acute	Medium	1	0	0	1	0
North West	East Cheshire NHS Trust	Combined acute and community	Small	2	1	0	1	0
South East Coast	East Kent Hospitals University NHS Foundation Trust	Acute	Medium	1	0	0	1	0
North West	East Lancashire Hospitals NHS Trust	Acute	Medium	39	0	3	10	0
London	East London NHS Foundation Trust	Combined mental health / learning disability / community	Medium	4	2	2	2	1
East Midlands	East Midlands Ambulance Service NHS Trust	Ambulance	Small	11	2	3	4	3
East of England	East of England Ambulance Service NHS Trust	Ambulance	Medium	3	0	2	0	0
South East Coast	East Sussex Healthcare NHS Trust	Combined acute and community	Medium	61	4	2	36	1
London	Epsom and St Helier University Hospitals NHS Trust	Acute	Small	8	1	1	6	0
East of England	Essex Partnership University NHS Foundation Trust	Combined mental health / learning disability / community	Medium	2	2	0	0	0
South East Coast	Frimley Health NHS Foundation Trust	Acute	Medium	16	3	7	13	0
North East	Gateshead Health NHS Foundation Trust	Acute	Small	6	2	2	4	0
West Midlands	George Eliot Hospital NHS Trust	Acute	Small	13	4	4	5	0
South West	Gloucestershire Care Services NHS Trust	Community	Small	7	0	5	3	0
South West	Gloucestershire Hospitals NHS Foundation Trust	Acute	Medium	1	1	1	0	0
London	Great Ormond Street Hospital for Children NHS Foundation Trust	Acute specialist	Small	3	1	0	2	0
South West	Great Western Hospital NHS Foundation Trust	Combined acute and community	Medium	1	1	0	1	0
North West	Greater Manchester Mental	Mental	Small	1	0	1	0	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
	Health NHS Foundation Trust	health						
London	Guy's and St Thomas' NHS Foundation Trust	Combined acute and community	Large	32	2	6	3	0
Thames Valley/Wessex	Hampshire Hospitals NHS Foundation Trust	Acute	Medium	7	3	2	3	0
Yorks and Humber	Harrogate and District NHS Foundation Trust	Combined acute and community	Small	2	0	0	2	1
West Midlands	Heart of England NHS Foundation Trust	Acute	Large	7	2	1	6	0
East of England	Hertfordshire Community NHS Trust	Community	Small	2	0	1	1	0
East of England	Hertfordshire Partnership University NHS Foundation Trust	Mental health / learning disability	Small	8	6	2	2	0
London	Homerton University Hospital NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
London	Hounslow and Richmond Community Healthcare NHS Trust	Community	Small	8	0	7	0	0
Yorks and Humber	Hull and East Yorkshire Hospitals NHS Trust	Acute	Medium	1	0	0	1	0
Yorks and Humber	Humber NHS Foundation Trust	Combined mental health / learning disability / community	Small	1	1	1	0	0
London	Imperial College Healthcare NHS Trust			No data received	No data received	No data received	No data received	No data received
East of England	Ipswich Hospital NHS Trust	Acute	Small	6	3	5	2	1
South East Coast	Isle of Wight NHS Trust	Acute, community and mental health	Small	9	0	3	5	0
East of England	James Paget University Hospitals NHS Foundation Trust	Acute	Small	0	0	0	0	0
South East Coast	Kent and Medway NHS and Social Care Partnership Trust			No data received	No data received	No data received	No data received	No data received
South East Coast	Kent Community Health NHS Foundation Trust	Community	Medium	9	0	5	4	0
East Midlands	Kettering General Hospital NHS Foundation Trust	Acute	Small	0	0	0	0	0
London	King's College Hospital NHS Foundation Trust	Acute	Large	9	9	2	8	0
London	Kingston Hospital NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
North West	Lancashire Care NHS	Combined	Medium	4	0	3	1	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
	Foundation Trust	mental health / learning disability / community						
North West	Lancashire Teaching Hospitals NHS Foundation Trust	Acute	Medium	0	0	0	0	0
Yorks and Humber	Leeds and York Partnership NHS Foundation Trust	Mental health	Small	0	0	0	0	0
Yorks and Humber	Leeds Community Healthcare NHS Trust	Community	Small	9	10	11	11	0
Yorks and Humber	Leeds Teaching Hospitals NHS Trust	Acute	Large	8	2	2	3	1
East Midlands	Leicestershire Partnership NHS Trust	Combined mental health / learning disability / community	Medium	14	6	10	3	0
London	Lewisham and Greenwich NHS Trust			No data received	No data received	No data received	No data received	No data received
East Midlands	Lincolnshire Community Health Services NHS Trust			No data received	No data received	No data received	No data received	No data received
East Midlands	Lincolnshire Partnership NHS Foundation Trust	Mental health / learning disability	Small	7	3	3	2	0
North West	Liverpool Community Health NHS Trust			No data received	No data received	No data received	No data received	No data received
North West	Liverpool Heart and Chest Hospital NHS Foundation Trust	Acute specialist	Small	3	0	2	2	0
North West	Liverpool Women's NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
London	London Ambulance Service NHS Trust	Ambulance	Medium	1	1	1	1	0
London	London North West Healthcare NHS Trust			No data received	No data received	No data received	No data received	No data received
East of England	Luton and Dunstable University Hospital NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
South East Coast	Maidstone and Tunbridge Wells NHS Trust			No data received	No data received	No data received	No data received	No data received
South East Coast	Medway NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
North West	Mersey Care NHS Foundation Trust	Combined mental health / learning disability / community	Medium	14	2	3	10	1
North West	Mid Cheshire Hospitals NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
East of England	Mid Essex Hospital Services NHS Trust	Acute	Medium	2	2	0	2	0
East Midlands	Milton Keynes University Hospital NHS Foundation Trust	Acute	Small	10	10	4	6	0
London	Moorfields Eye Hospital NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
East of England	Norfolk and Norwich University Hospitals NHS Foundation Trust	Acute	Medium	4	0	1	0	0
East of England	Norfolk and Suffolk NHS Foundation Trust	Mental health	Small	8	1	4	2	0
East of England	Norfolk Community Health and Care NHS Trust			No data received	No data received	No data received	No data received	No data received
South West	North Bristol NHS Trust			No data received	No data received	No data received	No data received	No data received
North East	North Cumbria University Hospitals NHS Trust	Acute	Small	4	0	0	4	0
North East	North East Ambulance Service NHS Trust	Ambulance	Small	4	1	4	2	1
London	North East London NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
London	North Middlesex University Hospital NHS Trust	Acute	Small	4	0	0	4	0
West Midlands	North Staffordshire Combined Healthcare NHS Trust			No data received	No data received	No data received	No data received	No data received
North East	North Tees and Hartlepool NHS Foundation Trust	Acute	Medium	1	0	1	0	0
North West	North West Ambulance Service NHS Trust	Ambulance	Medium	16	1	2	5	0
East of England	North West Anglia NHS Foundation Trust	Acute	Medium	2	0	0	0	0
North West	North West Boroughs Healthcare NHS Foundation Trust	Combined mental health / learning disability / community	Small	2	1	2	0	0
East Midlands	Northampton General Hospital NHS Trust	Acute	Small	9	4	2	2	1
East Midlands	Northamptonshire Healthcare NHS Foundation Trust	Combined mental health / learning disability / community	Small	14	1	5	0	0
South West	Northern Devon Healthcare NHS Trust			No data received	No data received	No data received	No data received	No data received
Yorks and Humber	Northern Lincolnshire and Goole NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
North East	Northumberland, Tyne and Wear NHS Foundation Trust	Combined mental health /	Medium	3	1	1	2	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
		learning disability / community						
North East	Northumbria Healthcare NHS Foundation Trust	Combined acute and community	Large	25	2	11	20	0
East Midlands	Nottingham University Hospitals Trust	Acute	Large	15	3	0	3	1
East Midlands	Nottinghamshire Healthcare NHS Foundation Trust	Combined mental health / learning disability / community	Medium	33	29	4	12	2
Thames Valley/Wessex	Oxford Health NHS Foundation Trust	Combined mental health / learning disability / community	Medium	15	0	8	3	0
Thames Valley/Wessex	Oxford University Hospitals NHS Foundation Trust	Acute	Large	2	0	2	2	2
London	Oxleas NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
East of England	Papworth Hospital NHS Foundation Trust	Acute	Small	0	0	0	0	0
North West	Pennine Care NHS Foundation Trust	Combined mental health / learning disability / community	Medium	1	1	1	1	0
South West	Plymouth Hospitals NHS Trust	Acute	Medium	10	9	1	9	2
South West	Poole Hospital NHS Foundation Trust	Acute	Small	3	1	1	1	0
Thames Valley/Wessex	Portsmouth Hospitals NHS Trust	Acute	Medium	3	0	1	3	3
South East Coast	Queen Victoria Hospital NHS Foundation Trust	Acute	Small	15	0	2	3	1
Yorks and Humber	Rotherham Doncaster and South Humber NHS Foundation Trust	Combined mental health / learning disability / community	Small	8	0	2	2	2
Thames Valley/Wessex	Royal Berkshire NHS Foundation Trust	Acute	Small	5	0	1	3	0
London	Royal Brompton and Harefield NHS Foundation Trust	Acute specialist	Small	9	0	2	8	0
South West	Royal Cornwall Hospitals NHS Trust	Acute	Medium	3	0	2	0	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
South West	Royal Devon and Exeter NHS Foundation Trust	Acute	Medium	6	1	0	2	0
London	Royal Free London NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
North West	Royal Liverpool and Broadgreen University Hospitals NHS Trust	Acute	Medium	4	0	3	1	0
London	Royal National Orthopaedic Hospital NHS Trust	Acute specialist	Small	3	0	2	1	0
South East Coast	Royal Surrey County Hospital NHS Foundation Trust	Acute specialist	Small	2	1	0	2	0
South West	Royal United Hospitals Bath NHS Foundation Trust	Acute	Small	31	30	0	31	0
North West	Salford Royal NHS Foundation Trust	Acute specialist	Medium	6	0	3	3	0
South West	Salisbury NHS Foundation Trust	Acute	Small	6	4	4	1	0
West Midlands	Sandwell and West Birmingham Hospitals NHS Trust			No data received	No data received	No data received	No data received	No data received
Yorks and Humber	Sheffield Children's NHS Foundation Trust	Specialist stand alone childrens trust : acute, community, mental health, learning disability	Small	4	1	4	2	1
Yorks and Humber	Sheffield Health and Social Care NHS Foundation Trust	Mental health	Small	4	1	3	0	0
Yorks and Humber	Sheffield Teaching Hospitals NHS Foundation Trust	Acute	Large	1	0	0	0	0
East Midlands	Sherwood Forest Hospitals NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
West Midlands	Shrewsbury and Telford Hospital NHS Trust	Acute	Small	7	0	1	6	0
West Midlands	Shropshire Community Health NHS Trust			No data received	No data received	No data received	No data received	No data received
Thames Valley/Wessex	Solent NHS Trust			No data received	No data received	No data received	No data received	No data received
South West	Somerset Partnership NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
Thames Valley/Wessex	South Central Ambulance Service NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
South East Coast	South East Coast Ambulance Service NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
London	South London and Maudsley NHS Foundation Trust	Combined mental health / learning disability /	Small	4	0	1	2	1

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
		community						
West Midlands	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	Combined mental health / learning disability / community	Small	2	1	1	1	2
North East	South Tees Hospitals NHS Foundation Trust	Acute	Medium	0	0	0	0	0
North East	South Tyneside NHS Foundation Trust	Combined acute and community	Small	2	0	1	1	0
West Midlands	South Warwickshire NHS Foundation Trust	Combined acute and community	Small	5	0	2	3	0
London	South West London and St George's Mental Health NHS Trust	Mental health / learning disability	Small	14	12	4	3	1
Yorks and Humber	South West Yorkshire Partnership NHS Foundation Trust	Combined mental health / learning disability / community	Small	2	0	1	1	2
South West	South Western Ambulance Service NHS Foundation Trust	Ambulance	Small	0	0	0	0	0
East of England	Southend University Hospital NHS Foundation Trust	Acute	Medium	0	0	0	0	0
Thames Valley/Wessex	Southern Health NHS Foundation Trust	Combined mental health / learning disability / community	Medium	18	8	5	6	1
North West	Southport and Ormskirk Hospital NHS Trust	Acute	Small	4	1	2	0	0
London	St George's University Hospitals NHS Foundation Trust	Acute	Medium	1	0	0	1	0
North West	St Helens and Knowsley Teaching Hospitals NHS Trust	Acute	Small	2	1	1	0	0
West Midlands	Staffordshire and Stoke on Trent Partnership trust	Combined acute and community	Medium	12	2	4	5	1
North West	Stockport NHS Foundation Trust	Combined acute and community	Medium	3	0	1	2	0
South East Coast	Surrey and Borders Partnership NHS Foundation Trust	Mental health / learning	Small	9	0	5	3	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
		disability						
South East Coast	Surrey and Sussex Healthcare NHS Trust	Acute	Medium	1	0	1	0	0
South East Coast	Sussex Community NHS Foundation Trust	Community	Small	22	1	17	6	0
South East Coast	Sussex Partnership NHS Foundation Trust	Mental health / learning disability	Small	11	0	10	4	2
North West	Tameside and Glossop Integrated Care NHS Foundation Trust	Combined acute and community	Small	10	1	7	6	3
South West	Taunton and Somerset NHS Foundation Trust	Acute	Small	7	0	3	4	1
London	Tavistock and Portman NHS Foundation Trust	Mental health	Small	9	0	4	5	0
North East	Tees, Esk and Wear Valleys NHS Foundation Trust	Mental health / learning disability	Medium	8	1	4	7	0
North West	The Christie NHS Foundation Trust	Acute specialist	Small	5	1	0	1	0
North West	The Clatterbridge Cancer Centre NHS Foundation Trust	Acute specialist	Small	0	0	0	0	0
West Midlands	The Dudley Group NHS Foundation Trust	Combined acute and community	Medium	14	3	4	10	0
London	The Hillingdon Hospitals NHS Foundation Trust	Acute	Small	15	0	6	2	0
Yorks and Humber	The Mid Yorkshire Hospitals NHS Trust	Combined acute and community	Medium	45	1	8	14	1
North East	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Acute	Large	6	0	0	6	0
North West	The Pennine Acute Hospitals NHS Trust	Combined acute and community	Medium	0	0	0	0	0
East of England	The Princess Alexandra Hospital NHS Trust	Acute	Small	0	0	0	0	0
East of England	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Acute	Small	3	2	2	0	0
West Midlands	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust	Specialist Orthopaedic NHS Foundation Trust	Small	3	0	0	3	0
Yorks and Humber	The Rotherham NHS Foundation Trust	Combined acute and community	Small	5	0	3	1	1

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
Thames Valley/Wessex	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Acute	Small	14	1	5	13	3
London	The Royal Marsden NHS Foundation Trust	Acute specialist	Small	6	0	2	2	0
West Midlands	The Royal Orthopaedic Hospital NHS Foundation Trust	Acute specialist	Small	4	2	3	1	1
West Midlands	The Royal Wolverhampton NHS Trust	Combined acute and community	Medium	8	1	3	7	1
West Midlands	The University Hospitals of North Midlands NHS Trust	Acute	Large	6	1	2	4	1
North West	The Walton Centre NHS Foundation Trust	Acute specialist	Small	6	0	1	2	0
London	The Whittington Hospital NHS Trust	Combined acute and community	Small	23	3	7	5	4
South West	Torbay and South Devon NHS Foundation Trust	Combined acute and community	Medium	12	0	2	3	1
East Midlands	United Lincolnshire Hospitals NHS Trust	Acute	Medium	4	1	0	4	2
London	University College London Hospitals NHS Foundation Trust	Acute specialist	Medium	6	4	0	0	0
North West	University Hospital of South Manchester NHS Foundation Trust	Combined acute and community	Medium	1	1	1	0	0
South East Coast	University Hospital Southampton NHS Foundation Trust	Acute	Large	0	0	0	0	0
West Midlands	University Hospitals Birmingham NHS Foundation Trust	Acute	Large	3	2	1	1	0
South West	University Hospitals Bristol NHS Foundation Trust	Acute specialist	Medium	3	3	0	3	0
West Midlands	University Hospitals Coventry and Warwickshire NHS Trust	Acute	Medium	9	0	0	3	0
East Midlands	University Hospitals of Leicester NHS Trust	Acute	Large	40	13	13	8	0
North West	University Hospitals of Morecambe Bay NHS Foundation Trust	Acute	Medium	16	1	4	6	0
West Midlands	Walsall Healthcare NHS Trust			No data received	No data received	No data received	No data received	No data received
North West	Warrington and Halton Hospitals NHS Foundation Trust	Acute	Small	5	1	2	2	0
East of England	West Hertfordshire Hospitals NHS Trust	Acute	Small	5	1	1	4	0
London	West London Mental Health NHS Trust	Combined mental health / learning	Medium	5	0	3	1	0

Region	NHS trust	Type of trust	Size of trust	#cases raised	#raised anonymously	#element of patient safety/quality	#element of bullying/harassment	#suffering detriment
		disability / community						
West Midlands	West Midlands Ambulance Service NHS Foundation Trust	Ambulance	Small	3	1	1	2	0
East of England	West Suffolk NHS Foundation Trust	Acute	Small	3	0	1	2	0
South East Coast	Western Sussex Hospitals NHS Foundation Trust	Acute	Medium	5	0	0	5	0
South West	Weston Area Health NHS Trust	Combined acute and community	Small	14	0	12	1	0
North West	Wirral Community NHS Foundation Trust	Community	Small	14	1	11	1	0
North West	Wirral University Teaching Hospital NHS Foundation Trust			No data received	No data received	No data received	No data received	No data received
West Midlands	Worcestershire Acute Hospitals NHS Trust	Acute	Medium	1	0	1	0	0
West Midlands	Worcestershire Health and Care NHS Trust	Combined mental health / learning disability / community	Small	7	0	1	6	0
North West	Wrightington, Wigan and Leigh NHS Foundation Trust	Acute	Medium	5	3	2	3	1
West Midlands	Wye Valley NHS Trust	Combined acute and community	Small	10	1	4	2	0
South West	Yeovil District Hospital NHS Foundation Trust	Acute	Small	3	0	1	0	0
Yorks and Humber	York Teaching Hospital NHS Foundation Trust	Combined acute and community	Large	31	0	7	21	2
Yorks and Humber	Yorkshire Ambulance Service NHS Trust	Ambulance	Medium	19	0	4	11	1

NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

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

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017-18(blue) tab)

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

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

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

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

This document is V50. The following changes have been made :

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	**Yes Jan Ross The Acting Chief Operating Officer is the Director Accountable Emergency Officer. Supported by the**		**Chief Operating**	Complete & ongoing
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y		**The Trust has an active 'Event Planning Group (EPG) ' which meets monthly. The group has a remit to provide leadership on EPRR issues and ensure compliance with the civil Contingencies Act 2004 and EPRR Core Standards. Group membership is representative of all key areas clinical and non clinical. The group are responsible for reporting on EPRR issues to the board. Most recent 23.6.2017. The highly experienced Trust Resilience Manager is a key member of the group. The post is being temporarily covered by an**		**Resilience Manager & EPG**	Complete & ongoing
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y		**The EPG Terms of reference , records of meetings and reports to The Board clearly evidence that EPRR is embedded in the organisation. The Trust Major Incident Plans and Business Continuity Planning (BCP) process is up to date and ongoing . The MIP and associated Action Cards were updated in March 2017. The Trust Business Continuity Plan was approved in January 2017. Individual Clinical Business Units are completing their respective BCP's.**		**Resilience Manager & EPG**	Complete & ongoing
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y		**All significant incidents are subject to debrief and report to the EPG . Most recently the May 2017 NHS Cyber attack. In addition outcomes and learning points from recent incidents e.g. Manchester Arena Bomb, are briefed to the EPG. Key outcomes will be included in High Level reports to The**		**Resilience Manager & EPG**	Complete & ongoing
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heat wave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	**Risk assessment is an ongoing process. The EPG Group has a responsibility to identify and review new risks i.e. August 2017 Cream Fields event and changes in the UK terrorist threat assessment. Board Report ref BM/17.06/77 dated 28.6.17**		**Resilience Manager & EPG**	Complete & ongoing
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y		**Any updates to the Cheshire Local Resilience Forum (CRF) Risk Register are briefed by NHS England and cascaded through EPG. The location and hazards areas of Top Tier COMAH sites and Major Pipelines are known. Lessons learned from recent incidents e.g. Manchester Arena bombing are distilled and briefed to EPG.**		**Resilience Manager & EPG**	Complete & ongoing
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y		**The role and function of The Trust is included in local COMAH plans. Trust participates in formal multi agency COMAH plan testing programme**		**Resilience Manager & EPG**	Complete & ongoing
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	**Major Incident Plan- March 2017**		**Resilience Manager**	Complete & ongoing
9		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y		**Trust and Service Level Business Continuity Plans Jan 2017**		**Resilience**	Complete & ongoing
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y		**Trust Hazmat and CBRN e Plan August 2016**		**Resilience Manager & ED Matron**	Complete & ongoing
11		Severe Weather (heatwave, flooding, snow and cold weather)	Y		**Heat wave Plan June 2017 & Winter/ Cold Weather plans . Weekly monitoring of Met Office forecasts**		**Resilience Manager**	Complete & ongoing
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y		**Pandemic Flu Plan February 2017**	Trust will be responsive to any new national guidance	**Resilience Manager & Infection Control Lead**	Complete & ongoing
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y		**Major Incident Plan- March 2017**	Trust will be responsive to any new national guidance	**Resilience Manager & Infection Control Lead**	Complete & ongoing
14		Mass Casualties	Y		**Major Incident Plan- March 2017**	Trust is monitoring recent incident debrief reports and will be responsive to any new national guidance/ good practice identified	**Resilience Manager & ED EPRR Lead**	Complete & ongoing
15		Fuel Disruption	Y		**Major Incident Plan- March 2017 & Business Continuity Plans**	Trust will respond to new UK Government guidance once published	**Resilience Manager**	Complete & ongoing
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y		**Major Incident Plan March 2017**		**Resilience**	Complete & ongoing
17		Infectious Disease Outbreak	Y		**Major Incident Plan March 2017 & Pandemic Flu Plan Jan 2017**		**Resilience Manager & Infection Control Lead**	Complete & ongoing
18		Evacuation	Y		**Trust Evacuation Policy May 2017 provides policy guidance on both internal and external evacuation. High risk areas are identified as well as alternative accommodation options within the Trust estate.**	The Policy includes the potential for a full site evacuation, but the detail of managing the logistics of such an event would benefit from a multi agency area table top exercise. The trust would fully support such an initiative.	**Resilience Manager & EPG**	Complete & ongoing
19		Lockdown	Y		**Trust Lockdown Policy 2017**	Series of Lockdown exercises ongoing and continuing through Autumn 2017	**Resilience Manager & LSMS**	Complete & ongoing
20		Utilities, IT and Telecommunications Failure	Y		**Trust Corporate and Service Level BC Plans**	Outcomes of May 2017 NHS hacking incident to be reviewed and plans updated where appropriate	**Resilience Manager. I.T. Leda & EPG**	Complete & ongoing
21		Excess Deaths/ Mass Fatalities	Y		**Major Incident Plan March 2017 & multi agency plan to use Halton Hospital Site**		**Resilience Manager & Mortuary Manager**	Complete & ongoing
22		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			**Not applicable - NWAS**	N/A	**NWAS**	N/A
23		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			**Not applicable - NWAS**	N/A	**NWAS**	N/A

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	**Major Incident Plan March 2017, approved by EPG. Peer reviewed August 2017**	Trust will be responsive to any new national guidance and outcomes of debrief reports of recent incidents	**Resilience Manager & EPG**	Complete & ongoing
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• On call Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	**Major Incident Plan March 2017 & On Call roll specific Action Cards . Activation flowchart included in MI plan and BC plan**	Testing and exercising of decision making planned Autumn 2017.	**Resilience Manager & EPG**	Complete & ongoing
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y		**Major Incident Plan March 2017 & On Call roll specific Action Cards. Template Incident activation meeting agenda with Business Continuity as standing item**		**Resilience Manager & EPG**	Complete & ongoing
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y		**The Major Incident Plan Communication Team Action Card sets out arrangements for managing the media response**	VIP scenarios will be specifically included in future training/testing	**Resilience Manager &**	Complete & ongoing
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specify who has been consulted on the relevant documents/ plans etc.	**Current Major Incident plan -March 2017 updated in line with latest NHS EPRR guidance and known learning from recent incidents. EPG Group fully consulted on updated plan**		**Resilience Manager & EPG**	Complete & ongoing
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an incident.	Y		**Major Incident Plan March 2017, contains hot and cold debrief guidance and reporting structure. Recent UK wide**		**Resilience Manager &**	Complete & ongoing
Command and Control (C2)								
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	**The Trust Switchboard and ED Department are the 24/7 points of contact for the Trust. Switchboard maintain call out lists for Major Incident Staff and additional switchboard**		**Resilience Manager & EPG**	Complete & ongoing
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England published competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (i.e. operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	**A Major Incident On call Training programme is in place . 25 Managers have been trained in the last 12 months. Further dates are scheduled up to December 2017. CBRNe**	Work is scheduled to continue the staff training programme through the interim EPRR Co-	**Resilience Manager & EPG**	Complete & ongoing
32	Documents identify where and how the emergency or business continuity incident will be managed from, i.e. the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	**Major Incident Plan and Action Cards detail Incident Control Room location, set up and staffing. The room has dedicated additional equipment to support the Silver Control function.**	Work is scheduled to review the equipment and guidance for setting up the Control Room	**Resilience Manager & EPG**	Dec-17
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y		**Major Incident Plan and Action Cards detail Incident Control Room decision and event logging procedures. The Trust has a cadre of trained loggists**	Work is scheduled to review the role and function of the Trust Loggist, including out of hours availability	**Resilience Manager & EPG**	Complete & ongoing
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y		**Major Incident Plan and Appendix 5 provides guidance on SITREP and reporting. In addition the Trust has recent experience of utilising the UNIFY reporting system to NHS**		**Resilience Manager & EPG**	Complete & ongoing
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		**Major Incident Plan provides guidance on obtaining specialist advice from arrange of sources. i.e. Health and Clinical advice via Public Health England- Infectious**		**Resilience Manager & EPG**	Complete & ongoing
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		**Major Incident Plan . Trust assistance via Trust Health and Safety Advisor. External support and assistance available through Public Health England On Call.**		**Resilience Manager & EPG**	Complete & ongoing
Duty to communicate with the public								
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	**Major Incident Plan details communications arrangements. The Trust has an Information Sharing agreement with Cheshire Resilience Forum. The Agreement sets out the Police co-ordinating role and the types and extent of information to be shared with other responders and released to the media. There is Senior comms representation in the Major Incident Control Room to lead on internal and external communications format and content.**		**Resilience Manager & Associate Director of Comms**	Complete & ongoing

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	**The Major Incident Plan details the options for communications, ranging from IT, telephony, Internet, Intranet, Mobile phones, radios, signage and in person**	The outcomes of the May 2017 NHS Cyber attack will be reviewed to identify any further	**Resilience Manager & IT Lead**	Oct-17
Information Sharing – mandatory requirements								
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and include DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supersedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	**Major Incident Plan details communications arrangements. The Trust has an Information Sharing agreement with Cheshire Resilience Forum. The Cheshire LHRP EPRR Practitioner Group is vibrant and meet regularly. Members freely share initiatives, experiences and good practice.**		**Resilience Manager & EPG**	Complete & ongoing
Co-operation								
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and membership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	**The NHS England Area team cascade LRF information, updates and policy . The Resilience Manager attends the**		**Resilience Manager &**	Complete & ongoing
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y		**Ambulance Service and the wider Health Economy have representatives at LHRP meetings. The Practitioner network is well established and an active information sharing and support network**		**Resilience Manager & EPG**	Complete & ongoing
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y		**Mutual aid would be co-ordinated through NHS England**		**Resilience**	Complete & ongoing
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				**Not applicable - NHS England Area Team**		**N/A**	
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.				**Not applicable - NHS England Area Team**		**N/A**	
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y		**The Trust has representation at the Strategic LHRP and it's Practitioner Group. The communications flow between The**		**Resilience Manager &**	Complete & ongoing
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared				**Not applicable - NHS England Area Team**		**N/A**	
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months				**Not applicable - NHS England Area Team**		**N/A**	
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y		**The Accountable Emergency Officer (AEO) has devolved attendance at LHRP Strategic meetings to The Resilience Manager ,who has fully**	Attendance at Director level reporting to AEO to be sustained	**AEO and Identified**	Commenced and ongoing through
Training And Exercising								
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate •Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective •Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidents have been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	**The Trust Major Incident Plan has an established and up to date EPRR Training Needs Analysis. Through 2016/17 staff Major Incident awareness and training has been comprehensive. The interim EPRR Co-ordinator will have Major Incident awareness and training as a priority task, ensuring reference to the National Operational Standards for EPRR.**	Work is scheduled to continue the staff training programme through the interim EPRR Co-ordinator referenced to The National Operational Standards for EPRR	**Resilience Manager & EPG**	December 2017 and continuing
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. •If possible, these exercises should involve relevant interested parties. •Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y		**The Trust EPG sets and maintains an annual exercise and training programme. In 2016 Exercises subjects have included Pandemic Flu. Heat wave. Trust Capacity and Escalation . Cheshire LRF away day. Mass Casualties & Communications. The 2017 exercise plans include Initial Major Incident notification, Decision making and Command and Control familiarisation and testing**	.	**Resilience Manager & EPG**	Complete and ongoing
51	Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises		Y		**in the year 2016-7 Trust staff have attended and participated in a number of multi agency exercises, including; Exercises Bluebird, Sizzler, ELSA , Foxglove and Warrington Capacity and Escalation Exercise. Cheshire LRF Briefing day**		**Resilience Manager & EPG**	Compete and ongoing
52	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y		**Participation in Training Exercises and actual incidents is logged and formally recorded.**		**Resilience Manager &**	Compete and ongoing

	Core standard	Clarifying information	Acute healthcare providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive								
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	Y	• Organisation's public Board/Governing Body report • Organisation's public website	Trust Board Paper Ref BM/17/06/77 refers. This comprehensive paper is the annual EPRR report to The Board. Dated 28th June 2017 and includes the annual EPRR work programme. The outcome of the current 2017 EPRR Assurance audit will be reported to the board Autumn 2017		Accountable Emergency Officer and EPG	Complete
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	• Organisation's Annual Report • Organisation's public website	The Trust EPRR Board report Ref MB/17/06/77 is published in full and available to The Public on The Trust Web site.		Accountable Emergency Officer and EPG	Complete
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings	The Trust EPRR Board report Ref MB/17/06/77 identifies Mr. Terry Atherton as the Non Executive Director with responsibility for EPRR within the Trust. This information is publicly available on the Trust web site.		Accountable Emergency Officer and EPG	Complete
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	Y	• Minutes of meetings	The Trust has an 'Event Planning Group' (EPG). The group is chaired by The Deputy Chief Operating Officer and has Trust wide representation at a senior level. The Terms of Reference		Accountable Emergency Officer and	Complete
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	Y	• Minutes of meetings	Throughout 2016-17 the Acting Chief Operating Officer and AEO has attended and chaired the Trust Event Planning Group. Temporarily the chair of the group has been taken over by The Interim Director of Estates, in order to ensure continuity. The		Accountable Emergency Officer and EPG	
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	Y	• Minutes of meetings	The Accountable Emergency Officer (AEO) has devolved attendance at LHRP Strategic meetings to The Resilience Manager, who ensures the AEO is fuly briefed . Ongoing Trust organisational developments have now elevated attendance to	Attendance at Director level, reporting to AEO to be sustained	Accountable Emergency Officer nominated	Throughout 2017-18

Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
	Preparedness							
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	Trust HAZMAT and CBRN(E) Plan updated Sept. 2016. Comprehensive with bi annual review process. Also externally reviewed as part of annual EPRR audit process.. The plan links with Trust Major Incident Plan ,	Minor updates to be made following independent assessment and planned Table Top exercise for late 2017	Resilience Manager and EPG	Dec-17
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	• Site inspection • IT system screen dump	Familiarity with the plan is a key element of annual staff training. A hard copy of the plan is available in ED with Senior Nurse. The plan can		Resilience Manager & ED Major Incident	Complete & ongoing
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	Trust HAZMAT and CBRN(E) Plan updated Sept. 2016. CBRN(E) risk assessments included with emphasis on maintaining safe business continuity The plan links with Trust Major Incident Plan		Resilience Manager & ED Major Incident Lead Nurse	Complete & ongoing
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y	• Resource provision / % staff trained and available • Rota / rostering arrangements	All ED staff are annually trained in Hazmat/ CBRNe and decontamination. Rotas always ensure trained staff availability		Resilience Manager & ED Major Incident	Complete & ongoing
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	• Provision documented in plan / procedures • Staff awareness	24 hrs Contact numbers and details included in the HAZMAT /CRRN (E) Plan. The role and availability of specialist advice is included in		Resilience Manager & ED Major Incident	Complete & ongoing
	Decontamination Equipment							
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	See attached equipment checklist tab.		ED Major Incident Lead Nurse	Complete & ongoing
59						Urgently awaiting delivery of new PRPS suits from DoH. Also requested formal assurance that existing out	AEO & EPG	DoH solution urgently required
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Named ED Major Incident and Decontamination Lead Nurse carries out regular checks of equipment		ED Major Incident Lead Nurse	Complete & ongoing
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Named ED Major Incident and Decontamination Lead Nurse carries out regular checks of equipment and will organise and repairs required		ED Major Incident Lead Nurse	Complete & ongoing
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Currently out of date suits are being retained as a contingency reserve. Any future disposal will be in accordance with NHS guidance		ED Major Incident Lead Nurse	Complete & ongoing
	Training							
63	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		Y		Yes NWAS Trained and up to date		ED Major Incident Lead Nurse	Complete & ongoing
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	The Senior ED Nurse Major Incident and Decontamination Lead carries out staff training annually. Most recently 7.Sept.2017. Staff are trained in all Decontamination roles to provide maximum flexibility. Training records are maintained .		ED Major Incident Lead Nurse	Complete & ongoing

Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		Yes		ED Major Incident Lead Nurse	Complete & ongoing
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y		Trust HAZMAT and CBRN(E) Plan updated Sept. 2016. The plan sets out importance of limiting cross contamination and the need to communicate clearly with casualties. The responsibility is shared by ED staff and Security Staff. The Trust has basic Initial Operational Response decontamination equipment and a plan for Halton non ED Hospital. This has		Resilience Manager & ED Major Incident Lead Nurse	Complete & ongoing

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

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame	MDU at Warington, Single decontaminaytion tent at	
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		N/A
	OR: Built structure		
E3	Decontamination unit or room	Yes shower area with external access	
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)	Original equipment	
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		Only 3 in date useable PRPS suits . Urgently awaiting new allocation from DoH
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients	Second tent	
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		N/A Fire Service would supply and deploy
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		N/A .None held. Would be supplied by PHE
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

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

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