TRUST BOARD
27 November 2019

ITEMS FOR APPROVAL/NOTE

BM/19/11/109/ Page 2 Learning From Experience Report Q2 **(For noting)**

BM/19/11/114 Page 41 GMC Revalidation Annual Report **(For noting)**

BM/19/11/119 Page 62 Board Assurance Framework **(For approval)**

BM/19/11/120 Page 91 Charities Commission Checklist **(For approval)**

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

And together we

make a difference

Learning From Experience Q2 Report

Layla Alani

Deputy Director of Integrated Governance

October 2019

We are WHH

The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 2, 2019/12. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines

How many staff are raising incidents Q1 vs Q2?

- There was a slight **decrease** in incident reporting within the Trust in Q2 (2590 in Q1 vs 2530 in Q2).
- There was an **increase** in incidents causing Moderate to Catastrophic harm in Q2 (38 in Q1 vs 44 in Q2).
- The number of minor harm incidents decreased in Q2.

19/20 Q1
19/20 Q2
0 500 1000 1500 2000 2500
5 - Catastrophic
4 - Major
3 - Moderate
2 - Minor
1 - Negligible / None

How many incidents are open Q1 vs Q2?

- The Trust reported 337 incidents open in CBUs in the Q1 LFE. To date that has increased slightly to 345. The graph below shows 9 CBUs with open incidents.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance improves.
- Significant improvements are noted for Medical Care and Diagnostics & Outpatients.

Urgent and Emergency Care
Women's and Children's
Digestive Diseases
Integrated Medicine and Community
Medical Care
Diagnostics and Outpatients
Musculoskeletal Care
Pharmacy
Specialist Surgery
0 10 20 30 40 50 60 70 80 90

What type of incidents are we reporting Q1 vs Q2?

- As stated, there was a decrease in the amount of indents reported. Incidents relating to security, communications and pressure ulcers decreased in Q2; however, issues relating to medication, clinical care and falls increased.

Clinical Care
Communication (including appointments and record...
Medication
Pressure Ulcer / Moisture Associated Skin Damage
Security
Slips, Trips & Falls
Diagnostics
Infrastructure / Resources and Health & Safety
Staffing
Infection Prevention and Control
0 200 400 600
19/20 Q1
19/20 Q2

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Incident Category Analysis Q1 vs Q2

The information shows the top categories reported incidents how they differ between the 2 quarters.

Infection Prevention and Control
Staffing
Infrastructure / Resources and Health & Safety
Diagnostics
Slips, Trips & Falls
Security
Pressure Ulcer / Moisture Associated Skin Damage
Medication
Communication (including appointments and record keeping)
Clinical Care

0 100 200 300 400 500

19/20 Q1
19/20 Q2

Security:
- Decrease in reporting

Medication:
- Increase in reporting

Incident Location Analysis Q1 vs Q2

The information shows the top reporting locations and how they differ between the 2 quarters.

Outpatient Department Warrington
A&E Resuscitation
Ward A2
Ward A8
Ward A4
Ward A9
ITU
Cardiology and Acute CCU (A3)
Ward A1
A&E Majors

0 50 100 150 200 250

19/20 Q1
19/20 Q2

Ward A4:
Increase in reporting

Ward A1 /AMU:
- **Increase in reporting**

A&E Majors:
- **Decrease in reporting**

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Staffing Incidents Location Analysis Q1 vs Q2

The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.

Warrington Outpatient Department:
- **0 Reported in Q2**

Ward A4:
- **Increase in reporting**

ACCU:
- **Significant decrease in reporting**

Patient Falls Location Analysis Q1 vs Q2

The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.

Ward A6
Ward A2
Ward B12 (FMN Unit)
Ward A8
Ward A7
Ward B3 - Halton
Ward A1
Ward B18
Ward B14
Ward A4

0 2 4 6 8 10 12 14 16 18

19/20 Q1
19/20 Q2

Ward A8:
- **Significant increase in reporting**

Ward A7:
- **Significant decrease in reporting**

Ward A4:
- **Increase in reporting**

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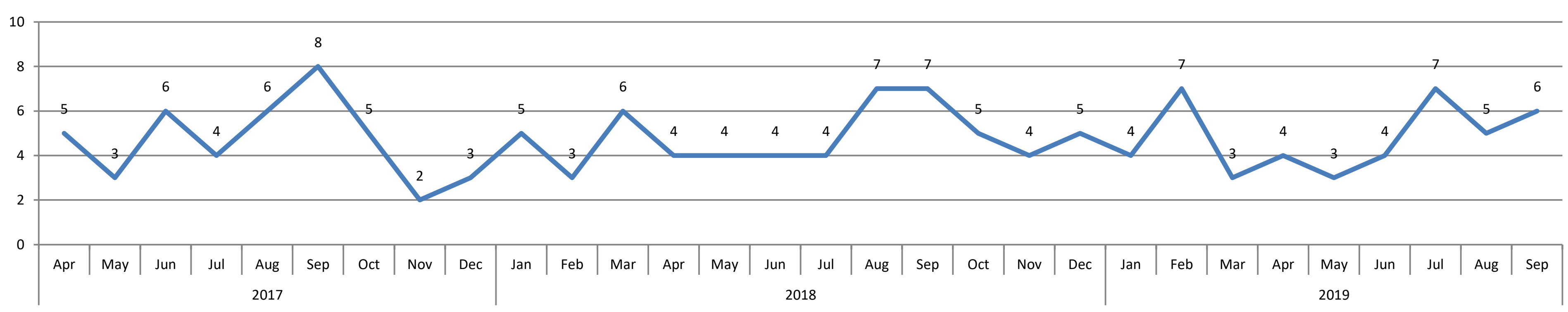
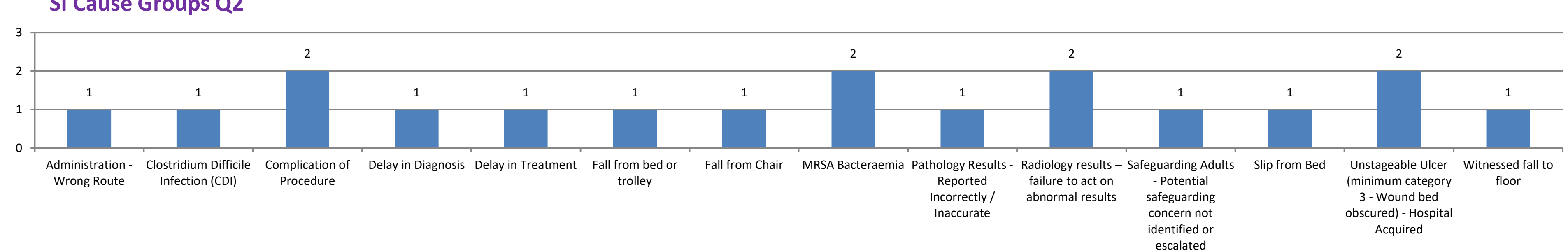
Serious Incident (SI) Reporting

SIs reported by Month

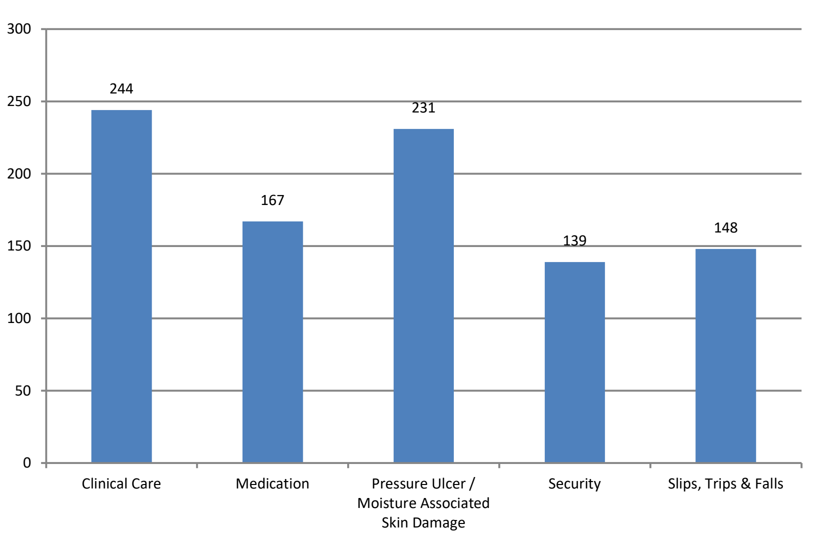


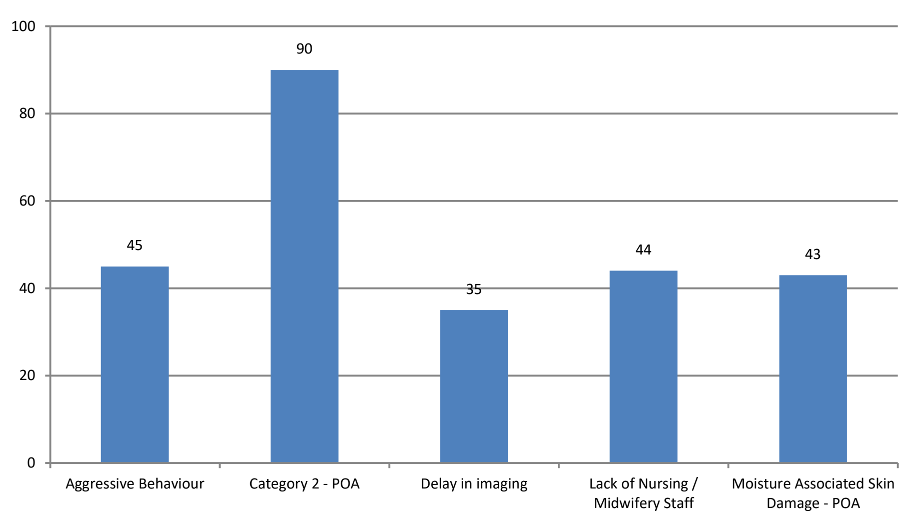
SI Cause Groups Q2



Urgent & Emergency Care, Medical Care, Diagnostics & Outpatients and Integrated Medicine & Community Incidents for Q2

A total of 1487 incidents were reported across the 4 CBUs in Q2, this has decreased from 1532 from Q1 . The top 5 categories and subcategories were reported as follows:





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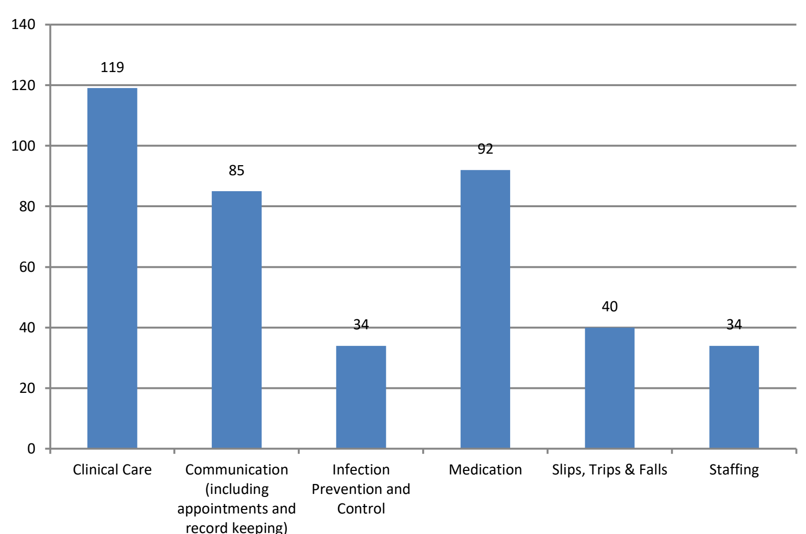
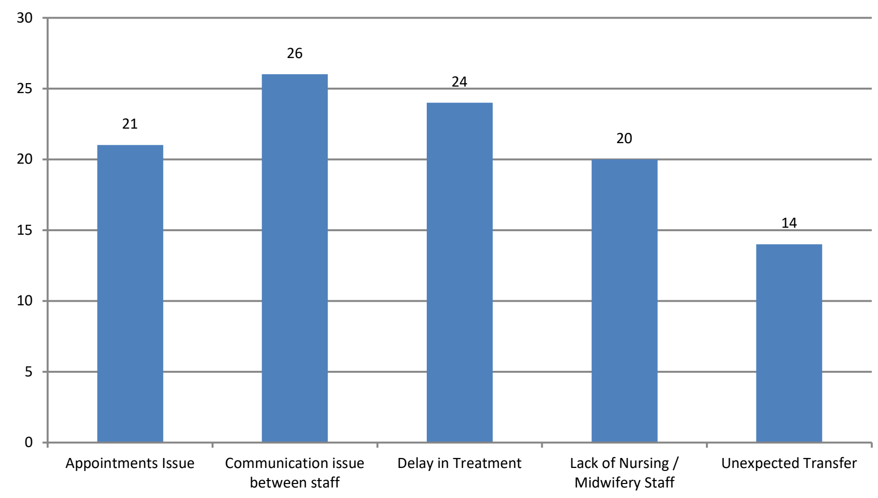
Digestive Diseases, Musculoskeletal Care and Specialist Surgery Incidents for Q2

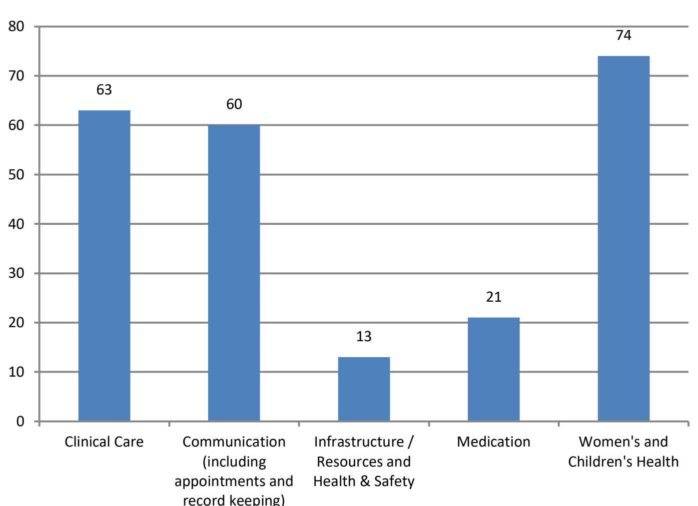
A total of 532 incidents were reported across the 3 CBUs, this has increased from 509 from Q1. The top 5 categories and subcategories were reported as follows:

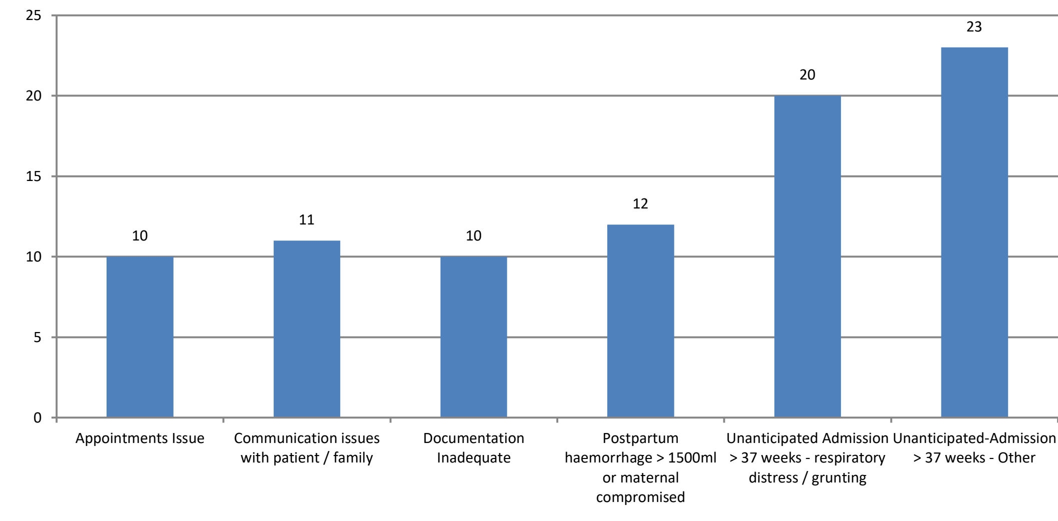




Women’s and Children’s Health Incidents for Q2

A total of 310 incidents were reported in the CBU, this has decreased slightly from 312 from Q1. The top 5 categories and subcategories were reported as follows:





Learning from Incidents

What staff told us…….	Actions taken
A patient with sub-optimally controlled diabetes with complications and extensive co-morbidities was admitted for management of anaemia. The patient deteriorated rapidly and had 2 cardiac arrest from which he did not recover.	Triage team must complete observations as part of triage and not transcribe from the ambulance team document. Observations must always be recorded on the NEWS charts. The frequency of observations should be completed in line with the Trust monitoring policy and escalate triggers for medical review.
A patient was admitted for elective procedure and discharged with advice and follow up appointment. The patient re-attended with complications of the procedure. Despite treatment the patient continued to deteriorate and sadly passed away.	A locally agreed clinical pathway is suggested for the management of a failed procedure. Consider early referral to regional centre on the management plan.
A patient was transferred to ITU for further management. One procedure failed as the patient was deteriorating. The patient continued to deteriorate	Escalate the deteriorating patient early to the Consultant on call. Following assessment of a critical patient to be admitted to ITU discuss limitations of treatment with the Consultant on call at an early stage. This may prompt a plan for further management and discussion with relatives.

Learning from Incidents

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What staff told us…….	Actions taken
A patient was admitted with suspected vascular compromised limb. There was a delay in transfer to another organisation. The patient was administered opiates and then naloxone when respiratory rate decreased. The patient recovered quickly and was transferred for further management.	Intravenous opiates should be administered cautiously with older patients. Time of review should be documented in in the patients' records and when documenting in retrospect. Specialty teams should ensure senior review of unwell patients and/or with complex injuries
A patient was admitted with a grade 2 pressure ulcer which evolved to an unstageable pressure ulcer.	Care and comfort round should also include assessment of the patient's heels. All care and assessments provided to patients must be documented accurately on the relevant assessment form. The date, time and arrival of pressure relieving mattress ordered for patients should be clearly documented.

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Learning from Incidents - WACH

- There was one moderate incident and no major incidents reported in Q2.
- Ten Incidents required a 72 hour review.
- There was one HSIB case reported for a suspected Hypoxic Ischemic Encephalopathy HIE injury
- There was one PMRT review for a premature home delivery of a concealed pregnancy, possibly 22 wks. gestation
- The moderate Incident required an RCA (Currently in progress) Below is feedback from the original 72 hour review:

Background RCA

- The patient attended EPAU with bleeding in early pregnancy
- Suspected miscarriage but could not exclude ectopic/molar pregnancy
- Returned three more times with bleeding and for review, each time bloods taken and follow up arranged
- No speculum examination at these visits
- Expected completion ~ end of October 2019.

Background PMRT

- A concealed pregnancy prematurely delivered at home unsure regarding the gestation but estimated approx. 24 weeks – the age of viability
- PMRT review completed – further information requested from NWAS
- Meeting to be arranged to discuss the importance of recording every detail surrounding the delivery and any efforts made for resuscitation
- Coroner informed no further action required

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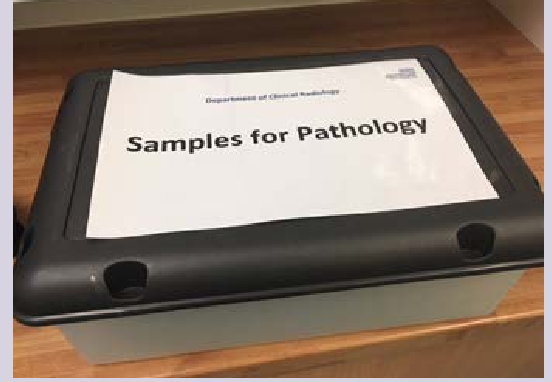
Learning from Incidents - Paediatrics

We found….	We Acted….
➢ 11 month baby attended ED with a large soft swelling to the head, Parents unable to explain the injury. ➢ No safeguarding or social care input requested by ED or paediatrics. Risk of NAI considered low. ➢ CT scan revealed an un-displaced fracture and subdural bleed ➢ Baby placed in grandparents care ➢ Follow up skeletal scan showed a previous healed fracture ➢ Baby and sibling removed by social services	➢ Feedback to all clinicians who did not complete the relevant paperwork ➢ Staff reminded it's ok to challenge decisions and to always escalate any concerns. ➢ case discussed at the peer review meeting ➢ issues raised at the Trust Safety Huddle ➢ Produce a 7 minute briefing ➢ The anonymised review shared via CBU / speciality meetings.
❑ Female infant born at 37 weeks gestation normal delivery, second child, early discharge but severely jaundiced <24 hours Required immunoglobulins and triple phototherapy ❑ Remained an inpatient/ attended daily for nearly 3 weeks with jaundice levels varying ❑ Blood tests were required to diagnose an ABO incompatibility ❑ Parents concerned if we could have pre-empted diagnosis	❑ Early discharge was appropriate, baby was feeding well and mum had harvested milk also. ❑ An ABO incompatibility could not have been anticipated in a rhesus positive mother with no antibodies and that there would have been a rapid rise in the Bilirubin levels due to this incompatibility. ❑ A postnatal appointment has been arranged with mums consultant and the paediatric consultant to advise regarding future pregnancies

Learning from Incidents - Women's Health

We found....	We Acted....
Background: A lady in her first pregnancy, high risk : raised BMI of 50. 39/40 induction of labour good progress but delay in the second stage = forceps delivery and a PPH. Transferred first to Maternity HDU room the to ITU. Following the event there was a table top meeting between the whole multidisciplinary team where the Gibbs Reflective Cycle was used to share experiences and learning. Some of the issues discussed were:	
There appeared to be a lack of recognition of the level of blood loss up until the point the loss was weighed.	Staff involved felt that the blood loss whilst excessive did respond to the drugs administered very quickly and this was not an ongoing loss. However the team agreed that they did not feel the total loss would be as excessive as was revealed when weighed.
There are examples of poor documentation	It was agreed as a collective that documentation should have been better and there is some individual learning
There was a slow recognition / reaction to the observations throughout the morning prior to transfer to the HDU of: low BP and a raised HR until the review by the anaesthetist which prompted the siting of an arterial line and midline and transfer to ITU	There was a review by a consultant obstetrician twice who thought that the registrar had documented the review. There is documentation by 2 anesthetists on the Lorenzo system regarding the management and difficulties.

Learning from Incidents - Radiology

We found....	We are doing....
Radiology were contacted following a patient's renal biopsy as Pathology had no record of the sample being received. A search of the Radiology Interventional unit failed to recover the sample. The sample was found incidentally in the 'biopsy box' under a patient's trolley several days later. The sample was still viable and it was possible to obtain a diagnosis.	There is now a 'sample book' in the interventional unit to keep records of specimens taken to pathology to include: date, time, type of specimen, and staff involved in transferring the specimen to Pathology to ensure there are accurate records. There is also a designated box on the nurses station for specimens to ensure they are not overlooked or lost. An SOP has been produced for transfer of specimens. Each 'biospy box' - the boxes used to store all the necessary equipment for an interventional procedure is now numbered so if a box goes missing it can be easily identified. 

Learning from Incidents - Radiology

We found….

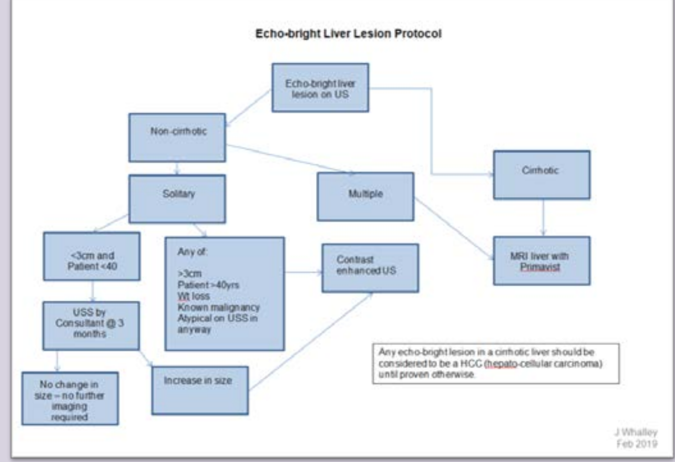
A patient attended for an Ultrasound scan was an echo-bright lesion was identified as a haemangioma and no further imaging was suggested.

The patient was subsequently diagnosed with a gastric carcinoma with liver metastases.

There was a delay in diagnosis of several months which limited the patient’s treatment options.

We are doing….

Radiology have introduced an ‘echo- bright’ liver lesion pathway which ensures ***all*** patients who have an identified echo-bright liver lesion go on to have further imaging, irrespective of the patient’s age or level of suspicion, and also utilising the recently introduced technique of contrast enhanced ultrasound.



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Learning from Medication Incidents

We found….	We Acted….
An interscalene block was performed on the wrong side of a patient scheduled for left shoulder surgery. The wrong side block was recognised at the time of positioning for the surgery and a decision was taken to not proceed with the left shoulder surgery due to the risks with bilateral phrenic nerve blocks. This is a never event as defined by NHS Improvement.	Learning and actions from the 72 hour review included: • Stop Before you Block information included in daily theatre debrief. • Stop Before you Block is everyone's responsibility, just before needle is put in the skin. If something is a distraction, then to stop and check again. • If there is an incident with a machine – sort out immediate threat to patient (e.g. swap machine), then to stop – regroup and re-check to ensure safe to continue • Stop before you Block laminate now placed on patient's chest, and second check is done before laminate is removed. If there is an interruption, the process begins again. At this time, the mark will be checked on the patient again. • Not over reliance of positioning of equipment and on positioning of patient. • Everyone will complete training in human factors, LOCSSIPS and NATSSIPS. • A single point lesson to be completed, which everyone in theatres will read and sign. A full investigation of the incident under the Serious Incident framework is now being completed to identify further learning and actions.
A significant number of incidents have been reported where patients have had omitted or delayed doses of critical medicines.	The Hot Topic at the Trust Safety Huddle was used to provide learning about omitted or delayed critical medicines with examples of recent incidents. Learning included: • What are critical medicines. • Ordering of critical medicines. • Dealing with Critical Medicines required but not Prescribed or Re-prescribed. • Dealing with Clinically Unsuitable Critical Medicine Prescriptions. • Dealing with Patient Refusal of Critical Medicines. Further actions have been identified to reduce omitted or delayed doses of critical medicines within the trust.

Learning from Pressure Ulcer Incidents

Actions taken/Lessons Learned
Areas with high incidence of pressure ulcers to have daily oversight from senior nursing team.
Patient facing qualified and unqualified nursing staff to attend face to face pressure ulcer prevention training.
Improvements required in relation to transfer documentation and ongoing management plan.
Patients in ED at risk of pressure ulcers should be nursed on Repose trolley topper or dynamic mattress and hospital bed. This must be recorded in the patients notes.
Patients with orthopaedic devices to receive regular input from orthopaedic team.
Dynamic mattress stores to be used out of hours if mattress required urgently.
Avoid delays in upgrading mattress.
Accurate documentation needed on Care and Comfort Charts including prescribed care.
Pressure ulcer prevention care plan to be personalised to reflect patients needs.
Patients at risk of heel pressure ulcers to have heels floated to alleviate pressure and Patients at risk of friction damage to heels should be fitted with Parafricta bootees.
Education required for new starters in ITU on use of Authbert technique for securing NG tubes and for preventing pressure ulcers from all medical devices.

Learning from Incidents

Information Governance

We found….	We Acted….
Health records were released as part of a subject access request under the Data Protection Act 2018. The records were released to an individual that claimed to be the representative of the data subject but the requester did not have the authority to see the records. The incident was reported to the Information Commissioner's Office and safeguarding concerns were raised.	The incident was reported to the Information Commissioner's Office and steps were taken to improve processes to prevent a reoccurrence. The steps included: • Making changes to the Datix system to record consent and a legal basis to access health records when requests are received under the DPA 2018 and Access to Health Records Act 1990. • The Access to Health Records Policy was re-drafted in order to include new processes and checks • Up-to-date training for the Medico-legal team was recommended.
A trend in incidents involving mail being sent to incorrect recipients was identified when scrutinising bi-monthly Information Governance incident reports generated from Datix. These reports are routinely provided to the Information Governance and Corporate Records Sub-Committee.	• Caldicott Guardian and SIRO (Senior Information Risk Owner) informed of the issue of incorrectly addressed mail at the October 2019 meeting of the Information Governance and Corporate Records Sub-Committee. • Data subjects whose confidentiality had been compromised were informed as per the requirements of the Data Protection Act 2018. • It was established that the use of communal printers is the root cause of many of these incidents. • The feasibility of introducing measures to introduce controlled printing, which will involve staff entering a pin to release documents in print queues, will be explored.

Complaints Headlines Q1 vs Q2

How many people are raising complaints Q1 vs Q2?

- There was an **increase** in complaints opened Trust wide in Q2 (131 in Q2 versus 100 in Q1).
- Some CBU's saw an increase in the number of complaints received in Q2 (Urgent and Emergency Care, Digestive Diseases, Specialist Surgery and Women's and Children's). Medical Care and Integrated Medicine and Community saw a decrease in the number of complaints received in Q2.

Are we Responsive Q1 vs Q2?

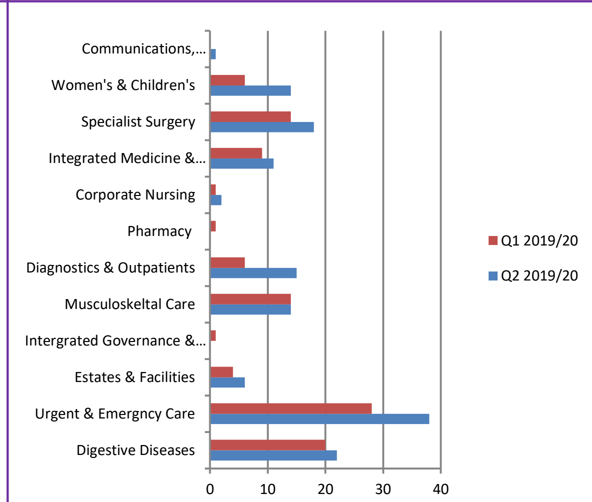
- All main CBU's increased their performance for responding to complaints on time.
- The Trust currently has 0 breached complaints
- There are no complaints over 6 months old

How many complaints has the Trust closed Q1 vs Q2?

- There was an **increase** in complaints closed in the Trust in Q2 (152 in Q2 versus 118 in Q1).
- All main CBU's, with the exception of Musculoskeletal Care which remained consistent to Q1, increased the amount of complaints they have closed.

Women's and Children's
Specialist Surgery
Integrated Medicine and Community
Corporate Nursing
Diagnostics and Outpatients
Musculoskeletal Care
Integrated Governance and Quality
Estates and Facilities
Urgent and Emergency Care
Digestive Diseases
Medical Care
0 10 20 30 40 50
Q1 2019/20
Q2 2019/20

Women's & Children's
Specialist Surgery
Integrated Medicine & Community
Corporate Nursing
Diagnostics & Outpatients
Musculoskeltal Care
Intergrated Governance & Quality
Estates & Facilities
Urgent & Emergncy Care
Digestive Diseases
Medical Care
0% 20% 40% 60% 80% 100% 120%
Q1 19/20 %
Q2 19/20 %



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Complaints Analysis Q1 vs Q2

The information shows the top subjects in complaints in Q1 vs Q2. Note: Complaints can have more than one subject.

Clinical treatment
Attitude and behavior
Communication (oral)
Premises
Admissions / transfers / discharge procedure
Personal records
Date for appointment
Communication (written)
Patient Property/Expenses
Failure to follow agreed procedures

0 10 20 30 40 50 60 70 80

Q1 2019/20
Q2 2019/20

Clinical treatment:

- There was an increase in the number of complaints received in Q2 compared to Q1 regarding clinical treatment (68 in Q2 verses 47 in Q1). Concerns include wrong diagnosis, treatment didn't have expected outcome, poor nursing care, coordination of medical treatment and delay in treatment.
- A lack of communication in relation to on going clinical treatment makes a perception that the treatment is incorrect.
- Theses issues can also be linked to when the Trust is on full capacity.

Communication and Attitude and Behaviour:

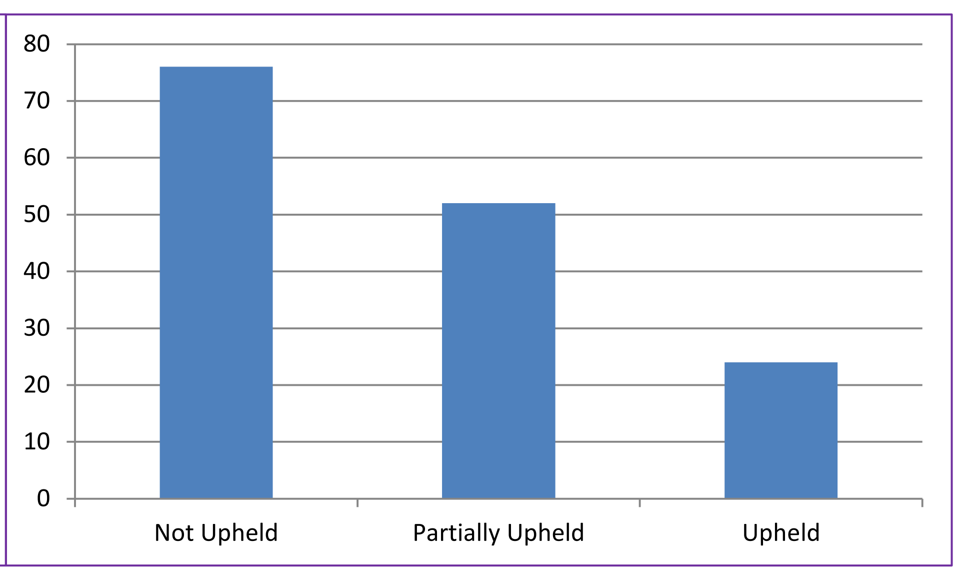
- Poor communication and staff attitude and behaviour has increased by one in Q2 compared to Q1.
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.

Date for an appointment:

- In Q2 there has been an increase in complaints relating to inappropriate discharge which can be linked with communication and patient expectations.

Complaints Outcomes Q2

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation. A complaint will be “upheld”, “upheld in part” or “not upheld”.



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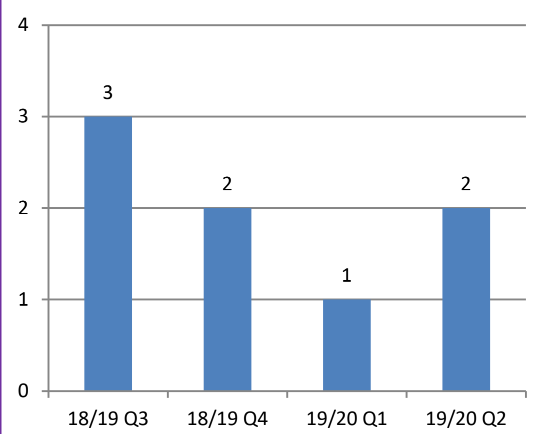
PHSO Q2

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

NOTE: The PHSO have changed how they investigate complaints and when investigations start; therefore previous graphical data may have changed in this report.

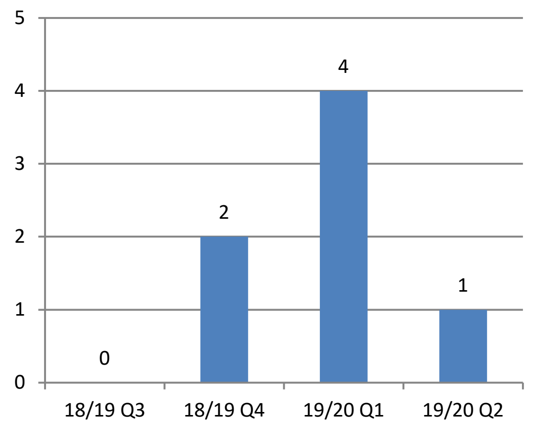
So how many complaints do they investigate?

The PHSO has commenced 2 investigations into the Trust in Q2. The PHSO closed 4 investigations during Q2.



And what are the outcomes?

The Trust currently has 5 open PHSO cases. The PHSO finalised 1 investigation during Q2, which was upheld with an apology, financial redress and an action plan drafted and implemented.



PALS Analysis Q2

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The information shows the top subjects in PALS.
Note: PALS can have more than one subject.

Chart: top PALS subjects, Q1 2019/20 and Q2 2019/20 (x-axis 0–100)

- Clinical treatment
- Date for appointment
- Communication (oral)
- Communication (written)
- Attitude and behavior
- Premises
- Patient property / expenses
- Date of admission / attendance
- Admissions / transfers / discharge procedure
- Personal records

Legend: Q1 2019/20, Q2 2019/20

Clinical Treatment:
- Co-ordination of medical treatment
- Treatment did not have expected outcome
- Delay in treatment
- This is also mirrored in the complaints analysis.

Date for appointment:
- Unacceptable time to wait for an appointment
- Cancellation of appointment
- Appointment date continues to be rescheduled
- Too short notice given for appointment

Communication:
- Lack of clear explanation
- Patient has been sent no communication
- Test results not communicated to patient

Attitude and Behaviour:
- Issues in relation to communication have increased - may be linked to when the Trust is on full capacity
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.
- This is mirrored in the complaints analysis.

PALS to Complaints:

Q1	Q2
3	2

The average response time for a PALS concern of those closed:

Q1	Q2
5 days	7 days

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Learning from Complaints and PALS

You Said....	We Did....
Family were concerned that patient was offered food when the sign above the bed clearly stated he was he was nil by mouth.	A meal safety huddle has been introduced and this takes place before the meal service. Staff on the ward will discuss and review meal management plans for each patient on the ward, to ensure that patients who are nil by mouth are not offered food or drink.
Family were unhappy that patient was not given any assistance with eating and drinking and food had been unopened and left to go cold.	The ward has joined a nutrition and hydration collaborative and from this have devised a patient safety 'at a glance board'. This links in with the above and also provides staff with a visual alert to patients who have additional needs.
Family were concerned that their child was not triaged promptly in the Emergency Department.	A process flow chart has been devised and is to be implemented when there are increased demands in the ED results in triage time going beyond 15 minutes to manage the waiting times.

Complaints Headlines

- There was an increase in the number of complaints the Trust received in Q2 compared to Q1.
- There was an increase in complaints closed in the Trust in Q2 compared to Q1.
- The complaints meeting room has improve the experience of those complainants who agree to meet with us and the team continue to offer meeting to patients/families so that they can meet with staff to resolve their concerns.
- Many of the issue raised with the PALS relate to delays in treatment and prolonged periods of waiting for appointments and cancellation of appointments. There has been a decrease in the timeliness of responding to concerns during Q2 compared to Q1, CBU's have been reminded of the timescales required and to improve the promptness of providing relevant information.
- There is continued improvement in the Trust culture to resolve complaints locally and rapidly.
- Reporting on actions from complaints to ensure compliance. CBU staff are continuing to complete actions as they have access through DatixWeb.
- Auditing of actions from complaints takes place to ensure that they have made the desired change.
- The CBU staff and managers have access to Governance dashboards to review their live data and meetings are held with the CBU to discuss the current positions and to plan responses.
- There continues to be a low number of complaints being referred to the PHSO and Trust continues to try and resolve all concerns locally at the Trust.
- There is a focus on learning in order to reduce the amount of complaints the Trust received.
- The main focus is to increase the timeliness of responding to complaints and the Trust has seen a significant improvement following on from the Quality Improvement project.

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Claims Closed

Clinical Claims Closed in Q2:

CBU	Repudiated	Settled with Damages	Withdrawn	Grand Total
Diagnostics and Outpatients			1	1
Digestive Diseases	1	1	2	4
Medical Care			1	1
Musculoskeletal Care	1	2	5	8
Specialist Surgery		1	3	4
Urgent and Emergency Care		2	6	8
Women's and Children's		2	4	6
Grand Total	2	8	22	32

Payments for clinical claims settled with damages totalled:

£699,715.04 including costs

Non Clinical Claims Closed in Q2:

CBU	Repudiated	Settled with Damages	Withdrawn	Grand Total
Diagnostics and Outpatients		1		1
Estates and Facilities	2	2	2	6
Integrated Medicine	1		1	2
Medical Care	1			1
Urgent and Emergency Care	1			1
Grand Total	**5**	**3**	**3**	**11**

Payments for non clinical claims settled with damages totalled:

£20,720.64 including costs

Actions Taken from Clinical Claims

Emergency Department (ED) – What did we do?

Failure to identify fractured finger	All Emergency Nurse Practitioner (ENP) involved had retired at time of claim, case shared with all ENP's and clinical staff
Failure to examine all possible areas of injury resulting in failure to diagnose injury to hand	The case is included in a teaching sessions which is delivered regularly to all new medical staff at induction. The Clinical lead also gave a talk to the regional ED registrars, in which this case is discussed. The specific learning point relates to the importance of performing a full secondary survey of patients managed as 'trauma calls'.

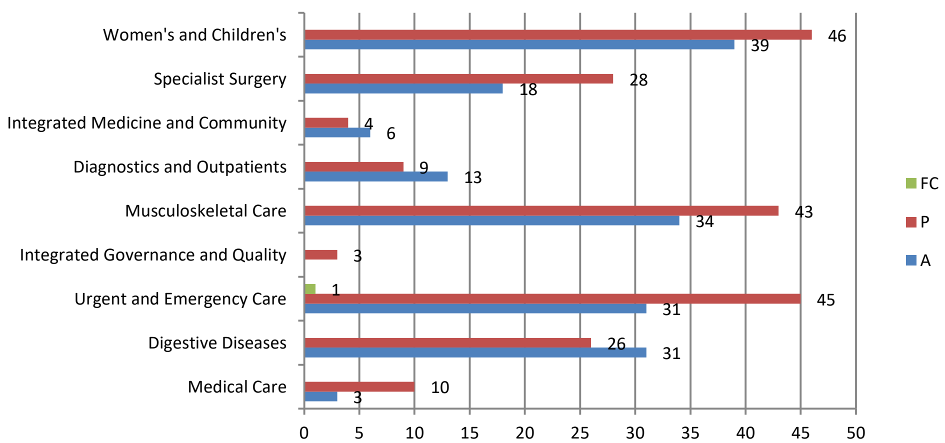
Women's Health - What did we do?

Delay in diagnosing left ovarian torsion	The claim was discussed at WHGG (Women's Health Governance Group) to make medical staff aware of this claim i.e. torsion of ovarian cyst resulting in oophorectomy and the learning that this can be a consequence of ovarian cyst accident without timely intervention.
Failure to diagnose ectopic pregnancy	Shared learning with early pregnancy assessment unit regarding early signs

Open Claims

Number of Open Claims as of 30 September 2019

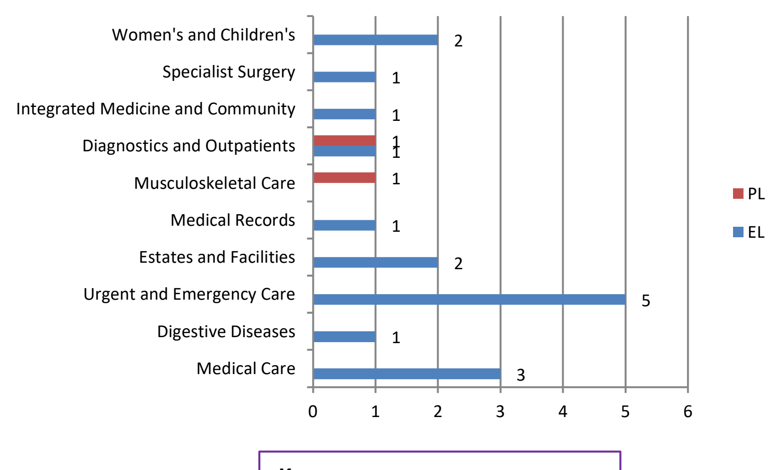
Actual 175 | Potential 214 | Coroners Funding 1 (that has not been received as a claim)



Key:
FC – Coroners Funding
P - Potential = Request for notes
A - Actual = Formal claim, Letter of Claim / Proceedings

Number of Open Non-Clinical Claims as of 30 September 2019:

Public Liability 3 | Employer Liability 21



Key:
PL – Public Liability
EL – Employer Liability

Mortality Headlines

Q2 CBU Mortalities

As expected, the three CBUs with the most mortalities are the ones with the greatest throughput and largest number of patients with multiple comorbidities: Medical Care, Integrated Medicine & Community and Urgent & Emergency Care.

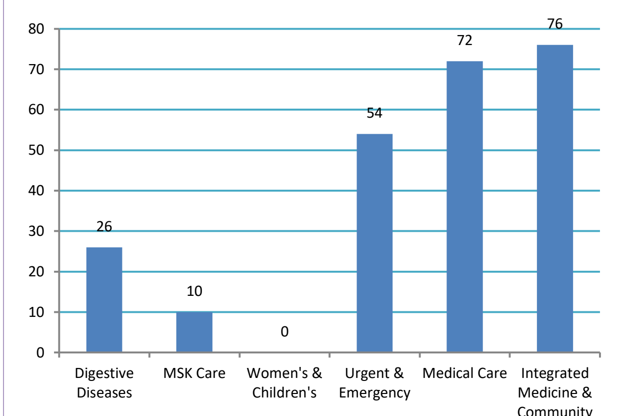
Q2 SJRs – Overall Care Grading

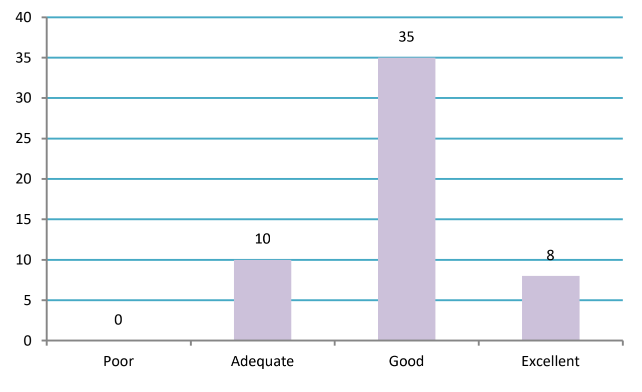
The majority of SJRs conducted have found that our overall standard of care is rated as “Good” followed by “Adequate”, although “Excellent” care was also evident within the reviews.

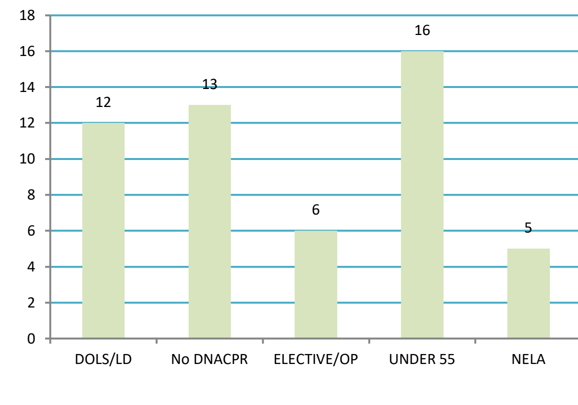
13 cases came for discussion at MRG. Most of these cases were rated “Adequate” with some “Good” also being discussed.

Q2 Triggers for SJRs

The below chart displays the triggers for conducting SJRs across Quarter 2. Comparing to Quarter 1, Under 55 has become one of the largest triggers for an SJR. No DNACPR and DOLS/LD are the second largest triggers for an SJR, their frequency has increased by 1-2 since Q1. There has also been an increase of 4-5 in Elective and NELA SJR triggers.







HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

We are WHH

Learning from Deaths

We found....	We are doing....	
40y/o male with autism/Asperger's and moderate learning disability. Patients' mother had approached GP re DNACPR prior to admission. GP refused as it was felt that the patient would not be able to understand to consent as he lacked capacity, despite mother having power of attorney.		DNACPR is a clinical decision. It was clearly appropriate in this case and the patients Mother had Power of attorney. The DNACPR could and should have been done by the GP. This learning has been fed back to all GPs via the Primary Care GP Newsletter which is coordinated by the CCG.
SHMI/HSMR have stabilised.		A Task and Finish group to look at Finished Consultant Episodes is established, led by the Trust Mortality Lead. A SOP has been developed to enable ward clerks to edit the system instead of multiple episodes being created each time a patient is moved. Although this will take some time to action it is believed that this will have a positive impact on HSMR/SHMI going forwards.
Perinatal deaths were presented to MRG, 5 cases were summarised.		Learning disseminated; Mothers should be reviewed for physical fitness if there is sleep deprivation and prolonged or difficult labour. Physical fitness of carers should be assessed (both parents exhausted). Advice on safe sleeping environments for baby and other aspects of preventing cot death should be reinforced.
Working Diagnosis: Repeated use of R Codes in documentation.		MRG members are working with the Lorenzo team to develop CDC forms from a mortality perspective. To reduce R codes the team are looking at removing the possibility for clinicians to input words such as 'likely' or 'possibly' into their working diagnosis.

We are WHH

Headlines of Learning from Deaths

- Mortality & Morbidity Meetings (M&M) are underway with feedback being provided back to MRG.
- SHMI and HSMR, are within the expected range and stabilising.
- A Task and Finish group to look at Finished Consultant Episodes is established, led by the Trust Mortality Lead. A SOP has been developed to enable ward clerks to edit the system instead of multiple episodes being created each time a patient is moved.
- MRG members are working with the Lorenzo team to develop CDC forms from a mortality perspective. To reduce R codes the team are looking at removing the possibility for clinicians to input words such as ‘likely’ or ‘possibly’ into their working diagnosis.
- Learning from MRG for Primary Care has been fed back to all GPs via the Primary Care GP Newsletter which is coordinated by the CCG.

Learning from National Audits

Quality of stroke care in 2017/2018

Urgent Care

- **53%** Patients scanned within 1hr of arrival at hospital
- **57%** Patients directly admitted to a stroke unit within 4 hours of arriving at hospital.
- **722** Patients received intra-arterial intervention (thrombectomy) after stroke.

Assessments & Rehab

- **27%** Patients have intermittent pneumatic compression (IPC) applied while in hospital.
- **88%** Patients received formal swallow assessment within 72hrs of arriving at hospital if required.
- **95%** Patients received physiotherapy assessment within 72hrs of arriving at hospital if required.

Longer term care

- **81%** Patients screened for malnutrition and seen by a dietitian by discharge if required.
- **92%** Patients received mood and cognition screening by discharge if required.
- **30%** Applicable patients received a six month assessment after stroke.

National results raise a number of issues which WHH have already addressed by the collaboration with Whiston and the movement of the hyper acute stroke service. The latest SSNAP scores have been published (Sept 2019) for the first quarter (April 19 – June 2019) since the collaboration and have shown an improvement in performance.

Learning from Local Audits

Patient Controlled Analgesia (PCA) for acute pain management in adults – Ward A6

Background:

Patient Controlled Analgesia (PCA) is a well-established technique for delivering metered doses of intravenous opiates in the management of acute pain that is under the control of the patient. To ensure safe and effective use of PCA, it is important that practitioners have access to relevant information and guidance that sets the minimum requirement for competent practice.

Key Findings:

It is clear that monitoring was overall inadequately performed. The areas of good practice include those functions that required only a short non-repeated intervention such as handover, programme checks. The more repetitive activities such as monitoring were not well adhered to and these are the most vital in ensuring patient safety. Patient safety on utilising PCA was severely compromised and presents a significant risk.

Recommendations:

- Further Prospective Audit of all clinical areas that use PCAs and to include level of relevant training of qualified carer staff
- Consider job specific mandatory training status
- Alternative ways of providing pain management training (i.e. workbooks , e-training, scenarios training sessions)
- Consider training provision for bank nurses
- Consider whether PCA observations can be expanded into associate nursing roles

Assurance:

Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts achievement of the system objectives at risk.

Non Clinical Incidents

From 1st July to 30th September 2019, there were 328 non clinical incidents. The top 2 categories were:

Security incidents = 98	Infrastructure/Health and Safety incidents = 84
The top sub-categories are: • Aggressive Behaviour • Alarm activation • Loss	The top sub-categories are: • Injury to staff • Equipment Malfunction • Needlestick Injury

Sharps Audit – August 2019

On 20th and 21st August 2019, the Health and Safety Department carried out an unannounced Trust-wide Sharps Audit in relation to the use and disposal of sharps. In total 63 areas were visited over a two day period. In advance of this audit taking place, all wards and departments were provided with individual sharps packs containing information and guidance.

Only 14 areas were compliant. It was disappointing to find increases of non compliance, some of which were:

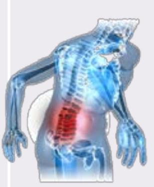
- 27 areas had temporary lids left open when not in use,
- 19 had no labels completed upon assembly,
- 8 areas had loose lids which had the potential of the contents to be spilled out and
- 3 areas had items protruding from the lids.

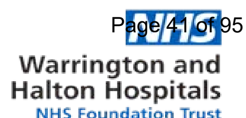
Moving forward, each area to be graded on their results following a further audit later in the year and the results will be featured in the CBU dashboards so areas can monitor progress and ensure compliance is visible

Stay Alert – Don't get hurt

We are WHH

Learning from Non Clinical Incidents

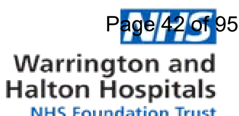
We found….	We Acted….
When carrying out inspections, an area was identified whereby secret smoking was taking place on site near to the CT Scanner. There were cigarette butts, gloves, pop cans and a broken chair that staff had placed there to sit down	Estates were contacted immediately and their staff cleaned the area thoroughly. Two promotional days were organised in September to publicise "Stoptober". The Warrington Livewire Smokefree Team and Halton Health Improvement Team accompanied the Health and Safety Department to promote this event which was well attended
There has been a recent increase in staff injuries due to the manoeuvring of faulty beds. This has been caused by defects with wheels, brakes and steering. There have been occasions when the bed has been visibly faulty and staff have still continued to manoeuvre the bed. The beds have not been reported and stay in situ for the next member of staff to experience problems	 A Safety Alert was produced stating the process to follow - All staff to clearly identify any faulty beds found to have any defectives. That these are labelled as faulty, describe what the fault is, reported to Estates and taken out of use immediately. If a patient is found to be in a faulty bed, another bed must be sourced to carry out the transfer and the faulty bed removed. This information was also duplicated in the Health and Safety Newsletter and distributed to wards and departments
There has been an increase in the number of mental health patients being treated within the Trust. It was identified that there was no environmental ligature risk assessment in place and not all areas had ligature cutters	A generic environmental ligature risk assessment was produced by the Health and Safety Department to support wards and departments to assess their working areas. Also supporting information was provided with regards to details to purchase and obtain ligature cutters. These are single use and must be kept on the Resus trolleys at all times
Medical Records staff were found not using the "A" framed ladders correctly in secondary storage areas	The Health and Safety Department helped to produce posters and provide additional training to support staff when working at a height



A Framework of Quality Assurance for Responsible Officers and Revalidation

Warrington and Halton Hospitals NHS Foundation Trust

Annual Board Report



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

Publications Gateway Reference:	**03551**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template
Author	Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team
Publication Date	16 June 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs
Description	A template board report for use by designated bodies to monitor their organisation's progress in implementing the Responsible Officer Regulations.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template, version 4 April 2014.
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.
Timing / Deadlines (if applicable)	**From June 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

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Annual Board Report Template

Version number: 2.0
First published: 4 April 2014
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Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England
Classification: OFFICIAL

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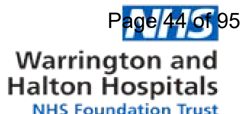


1. Executive Summary

This Report provides assurances to the Board that our Medical Appraisal System and Processes for monitoring the completion of Annual Appraisals to support GMC Revalidation for the Medical Workforce are robust. In order to meet the GMC Requirements for Revalidation, every Doctor MUST participate in an Annual Appraisal; ensure FIVE Consecutive Appraisals are completed within their Revalidation Cycle and have acquired a 360® Patient/Colleague Feedback Report.

This process then informs the GMC directly via GMC Connect which contains the names of every doctor who holds a Registration Number and is licensed to practise in the UK. They identify the Employer – (also referred to as the Designated Body) - for whom they have a prescribed connection to an RO - Responsible Officer – Professor. Simon Constable and for whom either a Recommendation/Non-Engagement/Deferral for Revalidation is able to be made. All NHS Designated Bodies (Employers) throughout the UK must engage in this system and failure to do so can remove the doctor from the GMC Register and remove their license to practise. The GMC have also made clear the minimum requirements for each Appraisal and relevant Supporting Information.

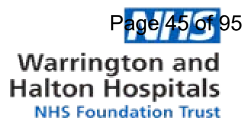
In line with GMC Guidance, the Supporting Information is collated via **CRMS** – a web-based portal that enables safe and secure data and documentation to be held and when the Appraisal moves to Final Sign-Off, this is further triangulated via Revalidation Panel Meetings which are convened and chaired by the RO and relevant colleagues.

In summary, our process and systems enable, track and monitor the completion rates via a robust Notification System with a comprehensive Policy to identify the practice and procedure and accountability which has enabled a very successful 7th Year Set of Results:-

- YEAR 1 – 1st MAY 2012 (GO LIVE DATE) – end of April 13 – 99.4%
- YEAR 2 - April 2013 – end of March 2014 - 93%
- YEAR 3 - April 2014 – end of March 2015 - 96%
- YEAR 4 – April 2015 – end of March 2016 - 94%
- YEAR 5 - April 2016 - end of March 2017 - 94% -**end of 1st GMC Revalidation Cycle**
- YEAR 6 – April 2017 – end of March 2018 - 90% -**beg. of the 2nd GMC Revalidation Cycle***
- YEAR 7 = April 2018 – end of March 2019 - 93%

2. Purpose of the Paper

The Purpose of this Report is to ensure NHS England is cognisant of our continued commitment to results and the systems and process that WHH have in place to demonstrate our Quarterly returns to NHS Revalidation North. There is a further emphasis on these approaches from NHS Revalidation North via engagement with the NHS England template for 2018-19. We will continue to monitor our systems and adopt changes that can further demonstrate our success and engagement to ensure every doctor affiliated with WHH as their Designated Body is provided with the required support to submit a robust Annual Medical Appraisal which enables a “seamless” approach to retention of GMC Revalidation and their Licence to Practise.



The purpose of this Report is to all brief Warrington and Halton Hospitals NHS Foundation Trust Board on the process and progress of Medical Appraisals to support GMC Revalidation and to offer an overview of the annual position for 2018/19 with the following Recommendations:

- **For Discussion**
- **For Information**
- **For Assurance to Board**

3. Background

GMC Revalidation and a “strengthened” Medical Appraisal was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

As such, WHH has a statutory duty to support our Responsible Officer in discharging their duties under the Responsible Officer Regulations[1] and it is expected that WHH will oversee compliance by:

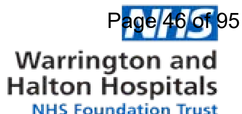
- monitoring the frequency and quality of medical appraisals in their organisations
- checking there are effective systems in place for monitoring the conduct and performance of their doctors
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The GMC have strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. Where any doctor fails to meet those standards, the GMC acts to protect patients from harm, if necessary, by removing the doctor from the Register and removing their right to practise.

The introduction of GMC Revalidation across the UK in early December 2012 provided a new way of regulating licensed doctors that seeks to provide extra confidence to patients that their doctors are up to date and fit to practise. Only licensed doctors have to revalidate, usually every five years, by having Annual Appraisals based on the GMC’s Core Guidance for doctors, Good Medical Practice.

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

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013’ and ‘The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012’



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

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

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

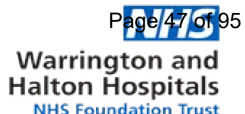
The GMC have also made clear that the minimum requirements for each Medical Appraisal and relevant supporting information are as follows:

- Evidence of Continuing Professional Development
- Review of Significant Events, Complaints and Compliments which relate to the 12 month period prior to the appraisal that precedes any Revalidation Recommendation.
- Evidence of regular participation in Quality Improvement activities that demonstrate the doctor reviews and evaluates the quality of their work which must be considered at each appraisal. The activity should be relevant to the doctor's current scope of practice.
- Evidence of feedback from patients and colleagues (once if the five year cycle) must have been undertaken.
- Focused on the doctor, their practice and the quality of care delivered to patients
- Gathered in a way that promotes objectivity and maintains confidentiality

4. Governance Arrangements

Doctors who are becoming due for revalidation are identified from the list of those for whom this Trust is the Designated Body via GMC Connect. Supporting evidence is collated for each Doctor and presented at the next Revalidation Decision Making Panel. This consists of the Responsible Officer, Deputy RO, Governance Lead, Revalidation Lead and Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed if possible. Three months prior to the submission date each Doctor becomes 'under notice' with the GMC and the trust is then able to submit their recommendation. The 3 options which can be made to the GMC are for a Positive Recommendation for Revalidation, to request a Deferral of up to 12 months or to report the Doctor for Non-Engagement in the Appraisal Process.

The Revalidation Lead prepares evidence for each doctor to support whether they meet the GMC's criteria for a positive recommendation to be made or whether there are deficiencies. The information is presented to the Revalidation Decision Making Panel and includes whether an appraisal has been undertaken in each calendar year during the 5 year revalidation cycle. If the Doctor is new to the Trust, they are expected to provide either their ARCP/CCT dates or evidence that previous appraisals have taken place elsewhere. Copies of any Claims, Complaints or Serious Incidents are also considered by the panel and a copy of a valid 360 Feedback Report from both patients and colleagues is also provided for their consideration. If any work is undertaken outside the trust then a current Independent Sector Checklist from each additional employer is also shared with the panel. A revalidation response is sought from both the Doctor's Appraiser and their Clinical Director to supplement. Following consideration the decision is made. The Revalidation Lead then submits the decision electronically to the GMC and e-mails each



doctor accordingly including details of why a positive recommendation couldn't be made and how this can be resolved if appropriate.

A report is produced on a monthly basis to identify those doctors who have either commenced employment with this trust or who have left our employment. The Revalidation Lead will then decline those doctors from the list of proscribed connections via GMC Connect. For those doctors who have joined the trust, the Revalidation Lead will add them to our list if they are employed on a full-time basis. For doctors who are employed on either a part-time basis or zero hours contract, they are individually contacted to ascertain whether or not this trust should be their Designated Body or whether they undertake more work elsewhere. They are then either connected to this trust or advised that we cannot be their designated body and they should make a connection to the employer where they undertake the majority of their work.

It is possible for a doctor to attach themselves directly to our list via their own section of the GMC. When this occurs we receive an automatic e-mail from the GMC into our 'Revalidation' Inbox which was set up specifically for this purpose. The Revalidation Lead checks the in-box regularly and decides whether the connection is appropriate and either retains the doctor on our list of proscribed connections or declines them as appropriate.

Doctors are given adequate notification that their appraisal is becoming due in accordance with the trust schedule. Doctors are expected to undertake an appraisal each year in the month of their birth. If there is an acceptable reason this may be changed, for example upon return from maternity or sick leave or if a doctor is new to the trust and only recently been appraised elsewhere. The Trust aims to ensure every doctor has undergone an appraisal in every calendar year to ensure they satisfy the GMC's requirements for revalidation purposes.

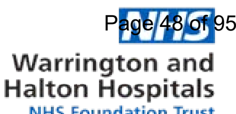
Appraisals are undertaken via an electronic system, the contents of which are mapped to the NHS England Medical Appraisal Guide (MAG) and are updated as and when required. Each appraisal requires sign-off by both the Appraiser and Appraisee following which the Deputy RO/Trust Medical Appraisal Lead quality assures the content of the appraisal to ensure it meets the level expected. If the appraisal has fully covered all domains to the required standard then Final Sign-Off is given. However, if the appraisal has not been fully documented or events not reflected upon then it is returned with comments for further attention and re-submission.

Doctors who do not undertake their appraisals on time are subject to the trust Non-Engagement Policy unless there are mitigating circumstances which have been agreed by the Medical Director/Responsible Officer. If a doctor exhausts the non-engagement process without having complied then a REV6 Form is completed to report the doctor to the GMC for their Non-Engagement in the Appraisal Process following which the GMC contact the doctor accordingly.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

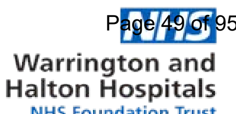
WHH have implemented a comprehensive tracking process as we are required to track evidence for Financial Year - for reporting purposes to NHS Revalidation North and also



the Calendar Year to track the "Annual Appraisals for the Revalidation Cycle" to include Notification Periods via our databases:

- Tracking of End of Month Completion Rates – for both the **Financial Year** and **Calendar Year**
- Delivery of End of Month 'Medical Appraisal Exception Reports' to the Clinical Directors for every Specialty, including the "Stages" of Notification/reasons for why the Appraisal has not achieved final Sign-off.
- Creation and Delivery of "In-Month" Compliance Rates – By Specialty
- Notification emails and Letters as required

Here are our auditable Data sets for Medical Appraisal Completion Rates as below:



Warrington and Halton Hospitals
NHS Foundation Trust

Description	Medical Workforce Appraisals Completion Rate - Financial Year	Comments
The completed percentage of Appraisals compared with the NHS Revalidation North target of 100% completion		The completed percentage reflects medical appraisals completed by scheduled monthly cohort not the total medical workforce to be appraised. In month completion of appraisals is being reviewed to see how completion rates can be improved further.

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Appraisal Completion Rate	63.16%	60.53%	62.26%	80.26%	82.02%	82.24%	85.94%	90.00%	87.00%	92.00%	91.00%	93.00%

Legend: NHS Revalidation North target; Appraisal Completion Rate

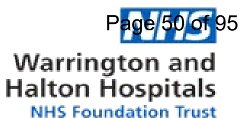
Medical Appraisal Completion Rate
Calendar Year - January 2018 to December 2018
Actual vs Projected

Date	31.01.2018	28.02.2018	31.03.2018	30.04.2018	31.05.2018	30.06.2018	31.07.2018	31.08.2018	30.09.2018	31.10.2018	30.11.2018	31.12.2018
Rate	69%	66%	66%	79%	78%	77%	85%	86%	86%	89%	92%	90%

% completed appraisals in 2018 within month of birth

Cluster for birth month	January	February	March	April	May	June	July	August	Septem...	October	Novemb...	December
% appraised	69%	50%	39%	63%	58.00%	33%	70%	54%	44%	48%	42%	32%

9



Description

A graph showing the total amount of appraisals to be completed in the month with the amount of appraisals actually completed in the month, and the amount of appraisals completed at current month end

Medical Appraisals Completed by Month of Birth

Month	Total no. to be appraised	Total no. appraised in month	Total no. appraised at current month end
April	19	12	19
May	19	11	19
June	15	5	15
July	23	16	23
Aug	13	7	13
Sept	18	8	18
Oct	21	10	19
Nov	19	8	19
Dec	19	6	17
Jan	17	9	16
Feb	17	7	13
March	18	9	9

Comments

From the 19 doctors due to have an appraisal in March 2019, only 9 did so. The remaining 9 have until the end of April to have their meeting before the non-engagement process commences. The non-engagement process has been reviewed by the Appraisal and Revalidation Group (ARG) and will be stricter moving forward to improve in month completion rates, however in month completion has remained around 50% for the last few months.

Description

The amount of submissions which are either positive recommendation, deferred request, or non-engagement to the GMC for revalidation

GMC Revalidation

Month	Cohort Number	Positive recommendation	Deferred request	Non-engagement
April	1	6	0	
May	6	1	0	
June	1		0	
July	3	3		0
Aug	2		0	
Sept	6	8	0	
Oct	2			4
Nov	6	11	0	
Dec	1	0	0	
Jan	7	3		0
Feb	1	0		0
March	4	12		2

Comments

January 2019

There were 7 revalidation submissions due to be made to the GMC in January, some of which had been submitted in an earlier month.

3 Doctors had positive recommendations submitted.

There were no requests for deferrals and no reports of non-engagement made.

Below are the WHH timelines for completion, tracking and and notification periods for medical appraisals:

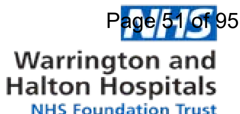
1. The Appraisal Meeting must take place during the birth month of the Appraisee – but can be between 9 and 15 months of the birth month.

2. The Appraisal Meeting, PDP, Summary and Feedback Evaluation are required to be completed by the end of the following month of the birth month.

3. If completion has not happened by the 1st of the next month (month 3) – **Letter 1** of the “non-engagement” Letters will be sent to the Appraisee.

4. If completion has then not happened by the middle of the third month, **Letter 2** of the “non-engagement” Letters will be sent to the Appraisee

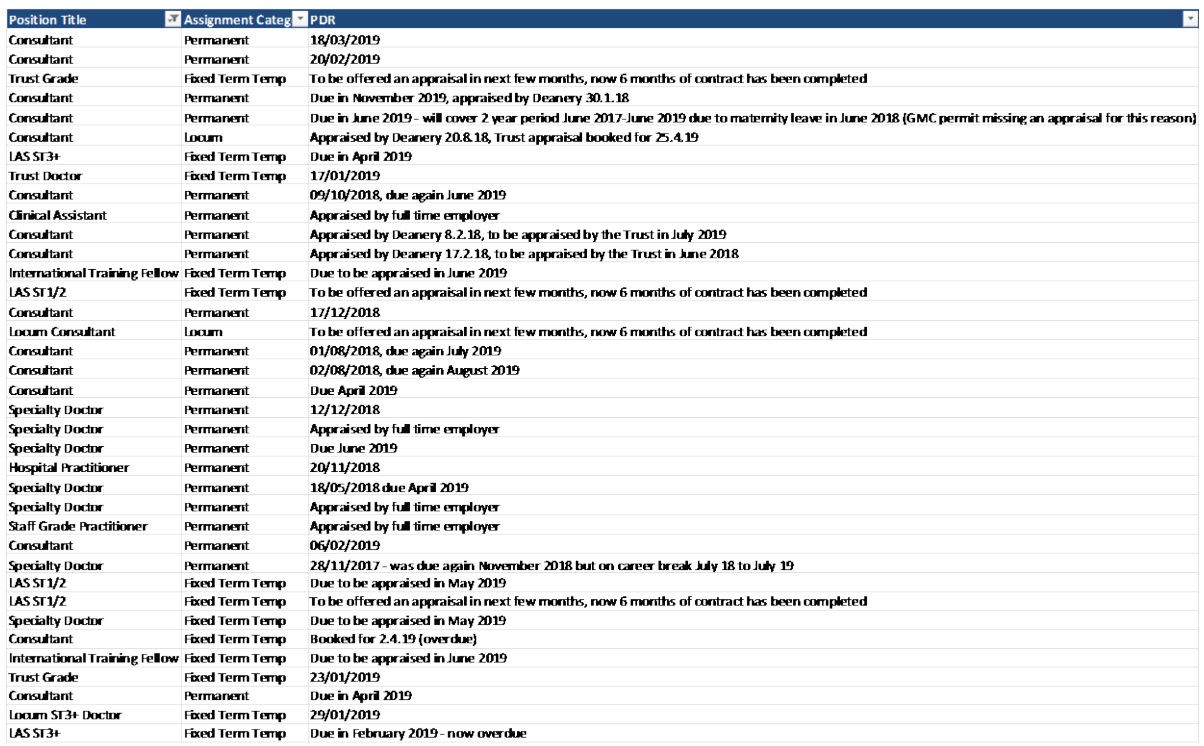
5. If completion has not then happened by the end of the third month, **Letter 3** of the non-engagement Letters will be sent to the Appraisee, informing them that the doctor will be reported to the GMC for non-engagement



Below are the detailed activity levels of appraisal outputs by individual departments such as:

Row Labels	Count of Employee	Count of PDR	PDR Compliance
370 Warrington and Halton Hospitals NHS Foundation Trust	**215**	**178**	82.79%
370 Diagnostics RWW356	26	24	92.31%
370 Digestive Diseases RWW350	51	46	90.20%
370 Integrated Medicine and Community RWW358	3	3	100.00%
370 Medical Care RWW357	33	28	84.85%
370 Musculoskeletal Care RWW351	20	17	85.00%
370 Specialist Surgery RWW353	34	21	61.76%
370 Trust Execs RWW365	2	2	100.00%
370 Urgent & Emergency Care RWW355	22	15	68.18%
370 Womens & Childrens Health RWW352	24	22	91.67%

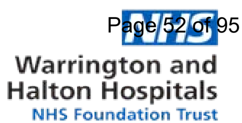
WHH hold details of any exceptions – by individual doctor for all missed and/or incomplete medical appraisals and below is an example of the reasons for all incomplete and delayed appraisals

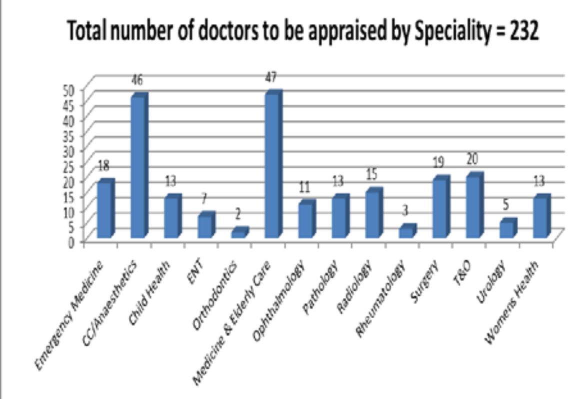


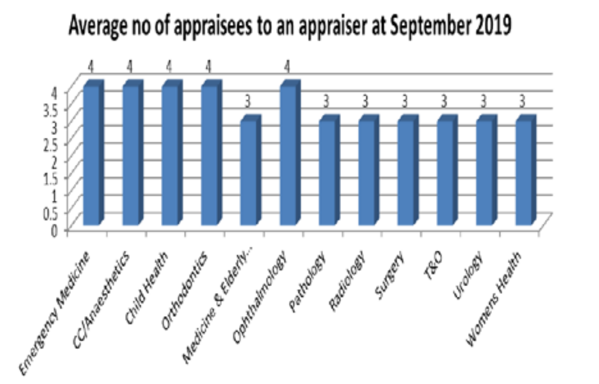
Position Title	Assignment Categ	PDR
Consultant	Permanent	18/03/2019
Consultant	Permanent	20/02/2019
Trust Grade	Fixed Term Temp	To be offered an appraisal in next few months, now 6 months of contract has been completed
Consultant	Permanent	Due in November 2019, appraised by Deanery 30.1.18
Consultant	Permanent	Due in June 2019 - will cover 2 year period June 2017-June 2019 due to maternity leave in June 2018 (GMC permit missing an appraisal for this reason)
Consultant	Locum	Appraised by Deanery 20.8.18, Trust appraisal booked for 25.4.19
LAS ST3+	Fixed Term Temp	Due in April 2019
Trust Doctor	Fixed Term Temp	17/01/2019
Consultant	Permanent	09/10/2018, due again June 2019
Clinical Assistant	Permanent	Appraised by full time employer
Consultant	Permanent	Appraised by Deanery 8.2.18, to be appraised by the Trust in July 2019
Consultant	Permanent	Appraised by Deanery 17.2.18, to be appraised by the Trust in June 2018
International Training Fellow	Fixed Term Temp	Due to be appraised in June 2019
LAS ST1/2	Fixed Term Temp	To be offered an appraisal in next few months, now 6 months of contract has been completed
Consultant	Permanent	17/12/2018
Locum Consultant	Locum	To be offered an appraisal in next few months, now 6 months of contract has been completed
Consultant	Permanent	01/08/2018, due again July 2019
Consultant	Permanent	02/08/2018, due again August 2019
Consultant	Permanent	Due April 2019
Specialty Doctor	Permanent	12/12/2018
Specialty Doctor	Permanent	Appraised by full time employer
Specialty Doctor	Permanent	Due June 2019
Hospital Practitioner	Permanent	20/11/2018
Specialty Doctor	Permanent	18/05/2018 due April 2019
Specialty Doctor	Permanent	Appraised by full time employer
Staff Grade Practitioner	Permanent	Appraised by full time employer
Consultant	Permanent	06/02/2019
Specialty Doctor	Permanent	28/11/2017 - was due again November 2018 but on career break July 18 to July 19
LAS ST1/2	Fixed Term Temp	Due to be appraised in May 2019
LAS ST1/2	Fixed Term Temp	To be offered an appraisal in next few months, now 6 months of contract has been completed
Specialty Doctor	Fixed Term Temp	Due to be appraised in May 2019
Consultant	Fixed Term Temp	Booked for 2.4.19 (overdue)
International Training Fellow	Fixed Term Temp	Due to be appraised in June 2019
Trust Grade	Fixed Term Temp	23/01/2019
Consultant	Permanent	Due in April 2019
Locum ST3+ Doctor	Fixed Term Temp	29/01/2019
LAS ST3+	Fixed Term Temp	Due in February 2019 - now overdue

b. Appraisers

The Trust currently has 67 Medical Appraisers who are employed by WHH and are trained and fully engaged as Medical Appraisers, this is approximately 35% of our eligible Medical Workforce. WHH also ran a Training Workshop for New Appraisers in March 2019 (4 internal delegates attended) and are reviewing further training for New Appraisers and Refresher Training for existing Appraisers. We also host two Appraiser Forum events per year to provide updates to appraisers and to share best practice.







c. Quality Assurance

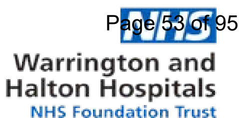
Quality Assurance of appraiser input is completed by the Deputy RO & Medical Appraisal Lead when reviewing every doctor's appraisal documentation before it is able to achieve sign-off. Furthermore, the Deputy RO/Medical Appraisal Lead also provides interim feedback and guidance via the portfolio (CRMS – e-system) to ensure the Appraisal can achieve a robust sign-off and his advice and guidance has been noted.

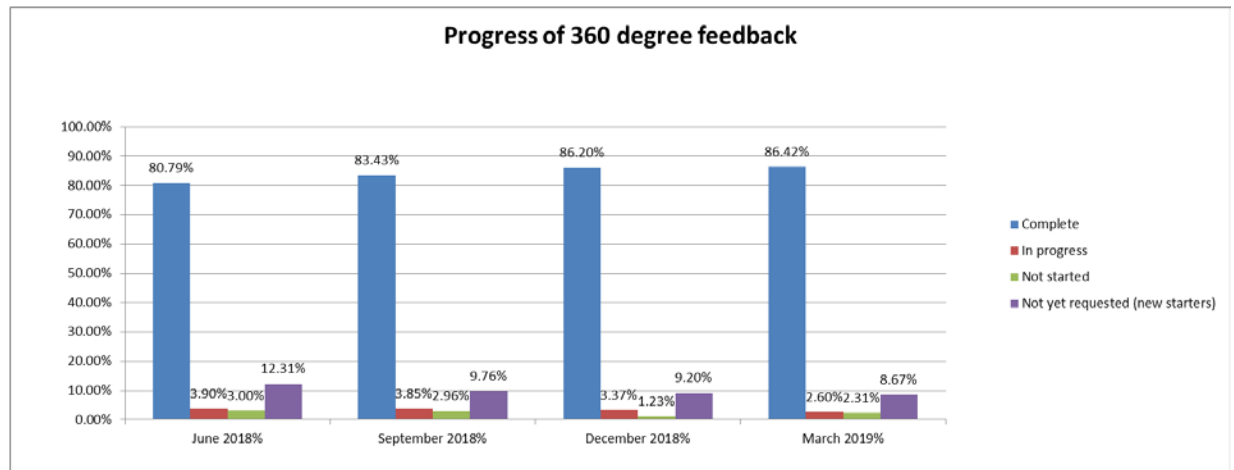
Appraisal portfolios:

- Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is appropriate and available - by the Deputy RO/Medical Appraisal Lead prior to sign-off. For example, if information that is required to be seen is not held in the portfolio, this will be returned with instructions the Appraisee/Appraiser as required.
- Review of appraisal folders to provide assurance that the appraisal outputs: personal development plan, summary and sign offs are complete and to an appropriate standard - by the Deputy RO/Medical Appraisal Lead prior to sign-off.
- Review of appraisal outputs to provide assurances that any key items identified pre-appraisal as needing discussion during the appraisal is included in the appraisal outputs - by the Deputy RO/Medical Appraisal Lead prior to sign-off.

For the individual appraiser:

- An annual record of the appraiser's reflection on his or her appropriate continuing professional development.
- An annual record of the appraiser's participation in appraisal calibration events such as reflection on appraisal network meetings.
  - WHH Medical Appraisal Forum Attendance Registers are used to demonstrate engagement of the Appraisers.
  - 360° Patient and Colleague Feedback Reports are provided from the web-based system **360© Clinical** and these Reports are uploaded onto the Medical Appraisal portfolio. These Reports offer a "national confidence interval" in the assessment of a Doctor.





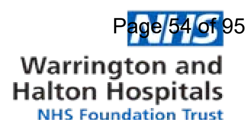
To further enhance the QA process and stimulate robust responses to feedback following appraisals; the CRMS Tool has now been developed to support this functionality. Following completion of the appraisal, the appraisee will be required to immediately complete the "electronic evaluation questions" which will not only ensure 100% completion rate following completed appraisals but also "rate" the overall performance of the Appraisers. These **CRMS Appraiser Evaluation Summary Reports** can be run on a quarterly basis

To provide further assurances that appraisals are robustly reviewed prior to "final sign-off"; the Medical Appraisal Lead meticulously reviews and subsequently rejects all completed appraisals where there are any gaps in the sections of the appraisal tool and necessary supporting information has not been included along with reflection. A Panel convenes who collectively concur the medical appraisal meets the GMC Requirements for subsequent recommendation for Revalidation.

The Appraisal and Revalidation Team lead on delivering the bi-annual "Appraiser Forums" which provide an opportunity for the RO/Team to discuss any overall issues that have arisen and to maintain a high level of support to the RO for the Trust.

CRMS Evaluation Questions	NAME OF APPRAISERS					**Av. Total per Question**
	No. Cons					
Organisation of Appraisal	No. Appr					
I was given adequate notice to allow preparation for my appraisal						
I received the support and explanation I needed to prepare for my appraisal						
I knew where to get copies of my appraisal documents and forms						
I was happy with the venue arranged for the appraisal						
My Appraiser						
The appraiser was skilled in conducting my appraisal						
The appraiser discussed the content of the appraisal with me beforehand						
The appraiser appeared to have prepared well for the appraisal						
The appraiser put me at my ease						
The appraiser listened to me						
The appraiser was challenging in his or her questions						
Summary Forms were agreed and are an accurate record of what we discussed						
The Personal Development Plan reflects my main priorities for development						
The appraiser provided the support I needed						
The appraiser made me think about new areas for development						
The Appraisal						
The appraisal process was useful in my professional development						
Time spent preparing for appraisals was worthwhile						
The appraisal will enhance my work as a clinician						
I will be able to achieve the goals I have agreed in my appraisal summary						
My appraisal was worthwhile						
Av. Total per appraiser						

KEY
1 = Strongly Agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly Disagree



d. Access, Security and Confidentiality

The CRMS web-based system for medical appraisals has been successfully utilised following the mapping exercise to the Medical Appraisal Guide – MAG tool. The system is web-based and requires individual log-in to access. Administration rights are given to those who utilise the system functionality only.

e. Clinical Governance

- The Team remain engaged in the **NHS Revalidation North Network** and the Appraisal & Revalidation Administration Network in the NW where we attend Meetings and Conferences, share ideas and receive updates as required.

- **WHH Bi-Monthly ARG Meetings** – Terms of Reference/Minutes/Action Plans/National Updates –Networks/NHS England/maintain up-to-date knowledge – *informs the Education Governance Committee*
  - Collation and upload of a comprehensive "Suite of Reports" (12 month data sets) for every Doctor prior to their Appraisal Meeting.
- Incomplete/Overdue Appraisal Tracker /Revalidation Panels– both shared and discussed to ensure Team/Specialty are engaged and all necessary actions are taken.

- **WHH 10th Bi-Annual Appraiser Forum Meeting -** coordinated to "listen and support the Appraisers" - with Action Notes
  - Individual **Appraiser FEEDBACK Reports** directly from CRMS are given to each Appraiser to drive quality and expertise in the process and evidence their skills as Appraisers.
  - Discussion of subjects such as **"Quality of Appraisals"** – **"In-Month Completion Rates"** – **"Documentation required for Sign-Off"** – **"Reflections on Complaints, Claims and SUI's**" – **"WHH Medical Appraiser Survey - Key Findings"**

In line with GMC Guidance, the **Supporting Information** [2] is collated via CRMS – a web-based portal that enables safe and secure data and documentation to be held and when the Appraisal moves to Final Sign-Off, this is further triangulated via Revalidation Panel Meetings which are convened and chaired by the RO and relevant colleagues.

Our Suite of Reports that our uploaded onto the CRMS System - as below - have been mapped to the GMC Supporting Information requirements. Doctors appreciate the "Suite of Reports" and we continue to strive to improve the reliability/validity of the data/reports.

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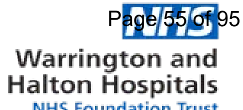
[2] Guidance on supporting information for appraisal and revalidation - https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation



Services who provide Corporate Data	"Suite of Reports" (10) uploaded onto CRMS for every Doctor
Medical Staffing	*Job Plan, Annual Leave* ➢ ESR Sickness Reports
Medical Education (CPD)	➢ Teaching & Attendance Report ➢ Evaluation/Feedback Reports ➢ Medical Education Excellence Awards
Audit (CPD)	Clinical Audit Activity Report
Complaints	Complaints Reports
Claims	Claims Reports
360◦ Clinical MSF	e-system generated reports ***Colleague and Patient Feedback***
Research & Development (CPD)	R&D Activity Report ***to include funding and achievement***
Learning & Development (CPD)	Statutory & Mandatory Training Activity Report ***(Inc. e-learning)***
Lorenzo/PAS System	Clinical Activity Reports
Risk Management - Clinical Governance	Significant Events/SUI's/Incidents

- ✓ **all reports are saved as pdf files – *(locked down by the services prior to upload)***
- ✓ **all "patient identifiable data" is removed**
- ✓ **The full Suite of Reports are uploaded for *every doctor 4 weeks before their appraisal is due***
- ✓ **ALL Doctors can also provide evidence/upload directly within the CRMS Tool**

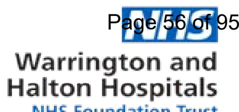
In summary, our processes and systems enable, track and monitor the completion rates via a robust Notification System.

6. Revalidation Recommendations

Revalidation Figures - 5 Year Tracker and Financial Year Position

The Doctors who are becoming due for revalidation are identified from the list of those for whom this Trust is the Designated Body via GMC Connect. Supporting evidence is collated for each Doctor and presented at the next Revalidation Decision Making Panel. This consists of the Responsible Officer, Deputy RO, Governance Lead, Revalidation Lead and Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed if possible. Three months prior to the submission date each Doctor becomes 'under notice' with the GMC and the trust is then able to submit their recommendation. The 3 options which can be made to the GMC are for a Positive Recommendation for Revalidation, to request a Deferral of up to 12 months or to report the Doctor for Non-Engagement in the Appraisal Process.

The table below shows the number of submissions made over the last 5 year period. The Trust has a robust approach to the tracking and monitoring of revalidation deadlines which is



demonstrated by every submission in the last 5 years being made either ahead of time or on the date it was due.

Financial Year	Deferrals	Reported for Non-Engagement	Revalidate	Total Submissions *(ahead of time on submission date)*
2014 - 15	6	0	66	72
2015 - 16	12	0	69	81
2016 - 17	3	0	14	17
2017 - 18	5	1	14	20
2018 - 19	4	0	45	49
Totals	30	1	208	239

7. Recruitment and engagement background checks

Annual Report Template Appendix E. – Audit Completed

8. Monitoring Performance

The Trust has a procedural document as part of our Policies which is referred to as **"Maintaining High Professional Standards Procedures for Medical and Dental Staff"** which was reviewed and ratified in March 2019. The Trust also has a Remediation Policy for Medical and Dental Staff and documents actions required when concerns arise.

9. Responding to Concerns and Remediation

The Trust has a procedural document as part of our Policies which is referred to as **"Maintaining High Professional Standards Procedures for Medical and Dental Staff"** which was reviewed and ratified in March 2019. The Trust also has a Remediation Policy for Medical and Dental Staff and documents actions required when concerns arise.

10. Risks and Issues

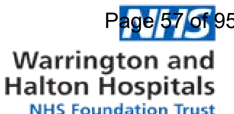
There are no risks or issues have been identified to be escalated to the Board.

11. Board / Executive Team Reflections

The Board are required to note the delivery of medical appraisals and GMC Revalidation to support the Medical Workforce at WHH and to review the data provided for assurance.

12. Corrective Actions, Improvement Plan and Next Steps

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



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

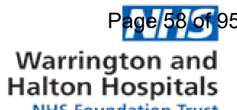
3. Continuation of current practice for Reporting and Monitoring Systems for WHH

4. Annual Review of the following Policies and SOP’s:
   - WHH The Strengthened Medical Appraisal Policy to support GMC Revalidation 2019
   - WHH GMC Revalidation Policy 2019
   - WHH SOP – Medical Workforce NEW Starter Process 2019
   - WHH SOP – Medical Workforce 360© Clinical Feedback Reports Process 2019
   - WHH SOP – Medical Practice Information Transfer 2019
   - WHH SOP – Revalidation Process 2019

13. Recommendations

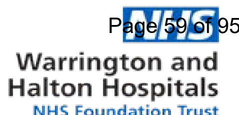
We ask the Board to accept the report (noting it will be shared, along with the annual audit, with the higher level responsible officer) and to consider any needs/resources.

The Board should also be requested to approve the ‘Statement of Compliance’ confirming that the organisation, as a Designated Body, is in compliance with the regulations. This is also submitted annually to the higher level responsible officer.



14. Annual Report Template Appendix D Audit of Revalidation Recommendations

Revalidation recommendations between 1 April 2018 to 31 March 2019	
Recommendations completed on time (within the GMC recommendation window)	**49**
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	49
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	N/A
New starter/new prescribed connection established within 2 weeks of revalidation due date	N/A
New starter/new prescribed connection established more than 2 weeks from revalidation due date	N/A
Unaware the doctor had a prescribed connection	N/A
Unaware of the doctor's revalidation due date	N/A
Administrative error	N/A
Responsible officer error	N/A
Inadequate resources or support for the responsible officer role	N/A
Other	N/A
Describe other	N/A
TOTAL [sum of (late) + (missed)]	N/A



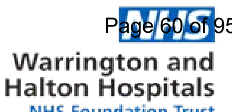
15. Annual Report Template Appendix E
Audit of Recruitment and Engagement Background Checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	14
Temporary employed doctors	62
Locums brought in to the designated body through a locum agency	208
Locums brought in to the designated body through 'Staff Bank' arrangements	27
Doctors on Performers Lists	-
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	-
TOTAL	311

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	14	14	14	14	14	14	14	14	0	14		14	0**	0**	0**	14
Temporary employed doctors	62	62	62	62	62	49*	62	62	0	62		62	0**	0**	0**	62

*13 International Doctors started on a Letter of good standing, DBS is conducted after 3 months in the UK.



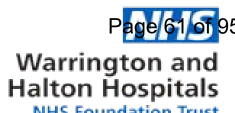
** This Information is requested from the doctor upon starting so will not be available within 1 month.																
Locums brought in to the designated body through a locum agency	208	208	208	208	208	208	208	208	0	208		208	0***	0****	0****	208** ***
Locums brought in to the designated body through 'Staff Bank' arrangements	27	27	27	27	27	27	27	27	0	27		0***	0****	0****	0****	27*** **
Doctors on Performers Lists																
Other (Independent contractors, practising privileges, members, registrants, etc.)																
Total	311	311	311	311	311	298	311	311	0	311		284	0	0	0	311
***Reliant on the Agency CV for the Qualification Check																
****Only require if they change Responsible Officer – at this point we would request this information																
*****as part of the GMC check or notification from the Responsible Officer																

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	83.89	397	201	16	614



Medicine	77.95	1485	13	2252	3750
Psychiatry	0	0	0	0	0
Obstetrics/Gynaecology	29.86	13	0	126	139
Accident and Emergency	40.19	223	234	600	1057
Anaesthetics	44.62	295	52	48	395
Radiology	26.58	0	0	0	0
Pathology	23.05	0	0	0	0
Other	116.87	888	0	635	1523
Total in designated body (This includes all doctors not just those with a prescribed connection)	443.01	3301	500	3677	7478
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	40	40	1	0	0
3 days to one week	40	40	7	0	0
1 week to 1 month	45	45	10	0	0
1-3 months	30	30	10	0	0
3-6 months	24	24	1	0	0
6-12 months	19	19	1	0	0
More than 12 months	10	10	0	0	0
Total	208	208	30	0	0

Appendix 1

Board Assurance Framework

Board Assurance Framework

The Board Assurance Framework (BAF) focusses on the key strategic risks i.e. those that may affect the achievement of the Trust's Strategic Objectives

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
115	Kimberley Salmon-Jamieson	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	1	20 (5x4)	12 (4x3)	TBC	Trust Operations Board
134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
135	Phill James	Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	1	16 (4x4)	10 (5x2)	TBC	Trust Operations Board
224	Chris Evans	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.	1	16 (4x4)	8 (4x2)	TBC	Trust Operations Board
125	Chris Evans	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	16 (4x4)	4 (4x1)	TBC	Trust Operations Board
701	Chris Evans	Failure to provide continuity of services caused by the planned EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables and the associated risk of increase in cost.	3	16 (4x4)	4 (2x2)	TBC	Trust Operations Board
145	Mel Pickup	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the	3	15 (5x3)	8 (4x2)	TBC	Trust Operations Board

Board Assurance Framework

		Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.					
143	Phill James	Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	1	12 (4x3)	8 (4x2)	TBC	Trust Operations Board
414	Phill James	Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches.	3	12 (4x3)	8 (4x2)	TBC	Quality Assurance Committee
241	Alex Crowe	Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.	2	8 (4x2)	4 (4x1)	TBC	Trust Operations Board

Strategic Objective 1: We will … always put our patients first through high quality, safe care and excellent patient experience.
Strategic Objective 2: We will … be the best place to work with a diverse, engaged workforce that is fit for the future.
Strategic Objective 3: We will … work in partnership to design and provide high quality, financially sustainable services.

Board Assurance Framework

Risk ID:	115	Executive Lead:	Salmon-Jamieson, Kimberley	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.			Initial:	20 (5x4)
				Current:	20 (5x4)
				Target:	12 (4x3)
Assurance Details:	Recruitment and Retention strategy has been developed for nursing and is being operationalised Nursing Recruitment and Retention meetings held 3 weekly Nursing Recruitment Leads x 2 Matrons in place Business case developed to support Nursing recruitment and retention Senior staffing meeting put in place and processes at an operational level to ensure safe nurse staffing along with staffing checks at every capacity meeting Reporting on safe staffing monthly to Board and staffing will be reported on all wards in line with national requirements. Risk Management Systems allow for reporting of incidents re staffing and escalation of risk, when required Individual staffing action plans for high risk areas Review of skill mix and creating roles in teams e.g. pharmacy technicians to support medication administration With regards to Consultant Recruitment – an external company has been appointed to recruit at Consultant Level with a review of JD's/Marketing of our posts; supported by EXIT Interviews for Leavers. Staffing rates monitored on a shift by shift basis (actual versus planned numbers) and reported to the Board 6 monthly acuity & Dependency review undertaken across all areas – Adults, Paediatric, Maternity & NICU. Results to be reported to Board. Incident data regarding staffing reviewed by Chief Nurse Escalation protocols in place – evidence of these being activated by nursing team We have recently been successful in appointing 4 Cardiology Consultants and are attending ES Training in due course and will be allocated Trainees as required. The Trust is ensuring safe medical staffing via use of long term locums in some specialities and also by breaking the cap, when required. There is an action plan in place following concerns raised by HENW/Deanery Approval for 7 Trust grades across the Acute Care division (3 appointed) , with a business case for additional 3 (Dec 17) 3 speciality Drs recruited in acute care Division in past 6 months (Dec 17) -Daily nurse staffing report which forms part of the bed management reporting framework, underpinned with the staffing escalation process. This was audited in April 2018 with further Audit due October 2018. -Sickness pilot commenced in August 2018 for a period of three months. This is due for evaluation in March 2019. -Red Flag Events which relate to unmet care need due to staffing are now in place across the Trust and are responded to by the Lead Nurse or Matron on a daily basis. •Undertaking 'itchy feet' conversations with staff who are thinking of leaving to improve retention. •Undertaking a staffing escalation audit in Oct to review the effectiveness of the staffing escalation plans. - Joined cohort 4 of the NHSi retention improvement programme which commences in Nov 2018. - First meeting of the NHSi Retention Collaborative on 22nd November 2018 – retention plan underway to include full data review and staff engagement. NHSI site meetings planned for February 2019 in relation to the Retention Collaborative Paediatric Staffing Review undertaken Birthrate + Business Case approved Staffing Update – January 2019 -Full review of ward establishments in 2017/18 -Approval of a staffing business case with 3 million investment in nurse staffing			INITIAL 20, CURRENT 20, TARGET 12	

	-Recruitment campaign for the uplift of establishment in registered nurses and health care assistants -Targeted recruitment campaigns for registered nurses, open days careers events both locally in the Trust and regionally with the Universities RCN and Nursing times – plan in place for the next 12months -Career advice events in local colleges and schools 'steps to success' focus groups for year 10's Recruited 95 registered nurses and 92 health care assistants since the beginning of the 2018 -Robust process in place for staffing escalation actions • Daily staffing meeting • Monthly staffing operational meeting Workforce Development as part of the retention campaign • Strengthened preceptorship programme • Band 5 competency programme • Advance Practice Development programme 28 nurses currently in training • Registered Nurse with Specialist Interest – Nursing Times Workforce Awards Finalists • Introduction of Nursing Associates • Ward Managers Development Programme • Lead Nurse Development Programme WHH are part of Cohort 4 Retention Collaborative with NHSI Joined in Dec 2018 • Staffing data review • Deep dive on retention • Developed a retention plan with implementation initiatives -Nursing Retention and Recruitment Group in place to review track and monitor progress -Recruitment and Retention KPI dashboard in place and report monthly to the Recruitment and Retention Group -Monthly Safe Staffing Assurance Report to Board -6 monthly Safe Staffing Report to Board in March 2019 -12monthly staffing review with Ward Managers undertaken by the Chief Nurse - reporting on 22nd March 2019 First site meeting with NHSi in February 2019 – Plan to be submitted in March 2019 Nursing & Midwifery Dashboard reviewed monthly at the Recruitment & Retention Group Retention Strategy Completed and will be presented on 15th March 2019 Nursing and Midwifery Turnover monitored at the Recruitment & Retention Group and reduction is in line with the plan. Staffing escalation Audit Update. Staffing escalation audit was undertaken in October and presented to the Recruitment and Retention Group in November. Recommendations have been undertaken and a further audit will be undertaken in April 2019. Retention plan in place and submitted to NHSi end of March 2019. The plan commits to reduce registered nurse turnover by 1.5% in the next 12 months. Progress will be monitored monthly at the Recruitment & Retention Group. The Retention Plan is being monitored at the Recruitment and Retention Group and we have seen a reduction in Registered Nurse Turnover for the past 4 months the current rate is 12.91% which is less than the National rate of 13%. Current vacancies are as follows: Registered Nurses 92 vacancies with 72 nurses having accepted an offer of a post at WHH and are due to commence no later than Sept 19 Further recruitment events are planned as part of the recruitment calendar. Winter Ward (K25) closed on 7th June 2019 releasing staff back to their base Wards. Associate Chief Nurse undertaken 6 month staffing review on all patient areas - September intake of nurses – 45 new recruits - 18 HCAs currently going through pre-employment checks - Further reduction in RN turnover – now 11.77% reduction of 3.22% since Nov 2018 - WHH are finalists in 3 categories in Burdett National Retention awards in London, presentations on the 19th Nov. o best use of data diagnostic to inform retention initiatives. o best staff engagement and communication offer.	

Board Assurance Framework

	o best career planning and development offer - Further deep dive into band 5 turnover currently underway	
Assurance Gaps:		

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Undertake the Allocate Safer Nursing Care Acuity review to understand establishments with regard to acuity	Allocate Safer Nursing Care Acuity	Acuity / Dependency review undertaken in May 2017. Results being collated	Goodenough, John	30/06/2017	30/06/2017
Develop a risk assessment process for opening/closing beds/ward	Risk assessment	Develop a risk assessment process for opening/closing beds/ward	Goodenough, John	31/03/2017	31/03/2017
Monthly reporting of Recruitment and Retention Strategy to Strategic People Committee and Nursing and Midwifery Board.	Recruitment and Retention Strategy	Monthly reporting of Recruitment and Retention Strategy to Strategic People Committee and Nursing and Midwifery Board.	Salmon-Jamieson, Kimberley	30/04/2018	30/04/2018
Ensure a report is given to the Board of Directors regarding medical staffing in medical specialities, including a progress update of the action plan	Report for Board of Directors	Ensure a report is given to the Board of Directors regarding medical staffing in medical specialities, including a progress update of the action plan	Constable, Simon	31/03/2017	31/03/2017
Ensure a report is given to the Board on nurse staffing assurance processes	Report to the Board nurse staffing assurance processes	Ensure a report is given to the Board on nurse staffing assurance processes	Salmon-Jamieson, Kimberley	31/03/2017	31/03/2017
All areas to have risk assessed implications of IR35	All areas to have risk assessed implications of IR35	All areas to have risk assessed implications of IR35	Carmichael, Mark	28/04/2017	28/04/2017
Ensure a deep dive is undertaken of the risk regarding staffing and reported to Quality Committee	deep dive is undertaken of the risk regarding staffing	Ensure a deep dive is undertaken of the risk regarding staffing and reported to Quality Committee	Salmon-Jamieson, Kimberley	30/06/2017	30/06/2017
Ensure a monthly incident report on staffing incidents is presented to Patient Safety & Effectiveness Sub Committee	Monthly incident report	Ensure a monthly incident report on staffing incidents is presented to Patient Safety & Effectiveness Sub Committee	Martin, Ursula	30/06/2017	30/06/2017
Ensure practice reviews are undertaken across all areas reporting high staffing incidents to understand level of risk	Practice reviews are undertaken	Ensure practice reviews are undertaken across all areas reporting high staffing incidents to understand level of risk	Goodenough, John	30/11/2017	04/09/2018
Medical staffing dashboard to be in place	Medical staffing dashboard	Medical staffing dashboard to be in place	Constable, Simon	29/12/2017	29/12/2017
Develop Terms of Reference for Medical Staffing HR Group	Terms of Reference for Medical Staffing HR Group	Develop Terms of Reference for Medical Staffing HR Group	Constable, Simon	31/01/2017	31/01/2017
Identify KPIs to be monitored Development of e-rostering Dashboard Monitor implementation of KPIs and any subsequent improvements.	Roster Management	This is reviewed at the monthly Operational Staffing Meeting. Review performance against the E-Rostering Guidance	Browning, Mrs Rachael	31/08/2018	31/07/2018

Board Assurance Framework

Risk ID:	134	Executive Lead:	McGee, Andrea
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.		
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.		
Assurance Details:	•Core financial policies controls in place across the Trust •Revised governance structure within the Trust to enable strengthened accountability •Finance and Sustainability Committee (FSC) established overseeing financial planning •Monthly financial monitoring with NHSI •Regular review at Executive team meeting and development sessions •Annual plan development process •Performance monitoring in QPS meeting •Signed up to a Controlled Expenditure Programme (CEP) process with main Commissioners to support financial planning, sharing of risk and agreement of schemes that are in the interest of the whole local economy •Entered in to a Block Contract with Warrington & Halton CCGs for 2019/20 supported by an agreed set of principles under the CEP Lite Framework •Work with the Commissioners on QIPP and CIP schemes through the Collaborative and Sustainability Group to ensure the schemes have a positive impact on sustainability across the whole health economy •Monthly FRG meeting with CBU led by Dof •Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board •Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports •Regular updates to Executive Team, FSC and Trust Board •Regular updates to NHSI regarding the risks linked to the current financial position; including regular performance review meetings to discuss the current position and financial risk. These meeting have resulted in the Trust's change from segment three to segment two. •Accepted offer from NHSi of a control total for 2019/20 giving the Trust access to £17.9m additional funds. This also exempts the Trust from national fines and penalties. •Transfer of resources in to operational teams to support CIP delivery at the front line. •Transfer of reporting of CIP to DoF and delivery to Chief Operating Officer •Trust teams are working within the place based teams to bid for additional STP monies to improve sustainability •Regarding the aged debt in dispute, a pack of evidence for each invoice is being collated in preparation for a joint legal actions with other providers. The matter has been escalated to NHSi & NHSE and financial support has been requested while this is under review by the regulators. •Legal advice obtained re: aged debt dispute Control re employment legislation - Sub group established for OT payments reporting through premium pay spend and review group - Commissioned an audit review of OT processes subject to Chair of Audit Chair Approval - Recommendation for internal OT processes to be presented to Exec Team - Introduced the Financial Resources Group (FRG)that reports to FSC - CIP Workshops taking place to improve the CIP Position - Memorandum of understanding agreed with Bridgewater Community Trust - WLI process reviewed and strengthened.		

Rating	
Initial:	20 (5x4)
Current:	20 (5x4)
Target:	10 (5x2)

	INITIAL	CURRENT	TARGET
	20	20	10

Board Assurance Framework

	•Regular planning meetings in place with Commissioners. Activity plans and contract agreed for 2019/20. • Workshop undertaken with - Exec, CBU, Corporate to review of 2019/20 cost pressures •Market Analysis is now included in the CBU monthly dashboard and forms part of the monthly review •Financial Strategy approved by Trust Board in March 2019 • In relation to the aged debt, the supplier/debtor has gone in to administration; this will avoid further growth of the debt. The Trust has provided the Administrator with proof of debt. • The Trust will write to Wirral CCG in relation to financial support for the existing debt. • Submitted System Recovery Plan on 2nd August 2019. • Update on System Recovery Plan to be provided to NHSE/I by 13th September 2019, along with the first draft of the 5 year plan. • CEO / Accountable Officer led Financial System Recovery Group established to oversee the system financial recovery plan • Capital prioritisation process in place • Review of CBU Forecast Outturns has taken place. • Following £1b increase in NHS Capital investment, NHSE/I have instructed Trusts to revert to their original capital plans. • Regular system assurance meeting taking place with the Regulator. • Submitted 5 Year Plan on 1st Nov 2019, jointly with Warrington 7 Halton CCGs & Bridgewater Community Healthcare NHS FT and accepted the control total for the next 4 years. Support provided from CCGs to enable stability while undertaking the transformational changes required to improve sustainability.	
Assurance Gaps:	•Failure to achieve Financial control total may result in loss of FRF, MRET and STF and worsening cash position. •Failure to manage fines and penalties and CQUIN which may result in loss of STF and worsening cash position •Risk to financial stability due to loss of income relating to STP changes •Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years •Loss of contracts due to competitive market which may result in Trust no longer being sustainable. There is a gap in Market analysis and Knowledge of our competitors •Loss of income through the failure of WHH Charity •Failure to repay existing loans leading to the inability to apply for future financial support and threat to the Trust as a going concern. •Risk of under delivery of CIP due to insufficient schemes identified to deliver the full program and the organisational ability to translate improvement work into financial improvement - Extended Loan repayment confirmation of further extension from NHSi received and extended to Nov 19. Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims. •Medical Staffing pressures identified at budget settings have not all been addressed putting pressure on the financial position. •Halton additional capacity may not be able to close if the Commissioner's alternative community plans are not put in place by the end of February 2019 This service remains open and funding has yet to be agreed •No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Mitigated system risk of circa £10m – plans required to address across the system of Warrington & Halton CCGs. WHH NHS FT and Bridgewater Community Healthcare NHS FT. • Risk that capital needs exceed capital funding resources available. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation. • Awaiting response from Administrators in relation to bad debt.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continue to seek support from Commissioners	Continue to seek support from Commissioners	Continue to seek support from Commissioners	Hurst, Jane	31/12/2018	31/12/2018
Continue to seek support from NHSI approach to management and repayment of loans	Continue to seek support from NHSI approach to management and repayment of loans	Continue to seek support from NHSI approach to management and repayment of loans	Hurst, Jane	31/03/2019	31/03/2019
Development of a Market analysis of Trust competitors to understand imminent and future risk to income	Development of a Market analysis of Trust competitors to understand imminent and future risk to income	Development of a Market analysis of Trust competitors to understand imminent and future risk to income	Hurst, Jane	31/03/2019	31/03/2019

Board Assurance Framework

Review of a Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery	Review Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery	Reviewed strategy to be presented to Trust Board in February 2019	Hurst, Jane	27/02/2019	27/02/2019

Board Assurance Framework

Risk ID:	135	Executive Lead:	James, Phill	Rating
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.			
Risk Description:	Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands or enhanced system functionality which results in additional effort required by staff manifesting as poor data quality, reduced patient access to services, inferior quality of care provided, potential patient harm and missed financial & performance targets.			Initial: 20 (5x4) Current: 16 (4x4) Target: 10 (5x2)
Assurance Details:	• IT Governance Structure including Risk Register Reviews, Digital Board highlight reports to Trust Operations Board and Data Standards Group to Quality Assurance Committee plus other ad-hoc submissions as required. • IT Change Management regime including robust Trust communication channels and structured Capital Planning submissions. • IT Operations Governance including supplier management, product management, cyber management and customer relationship management with CBUs. • IT Business Continuity And Disaster Recovery Governance. • Annual IT audit plan. • Data Quality policy and procedures. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • Example 1: Recent (Sep 19) completion of planned replacement of ICE Results & Reporting solution to resolve unplanned loss of service and improve performance. • Example 2: MIAA have produced the draft report entitled 'IT Service Continuity & Resilience Review'. The action plan to address findings has been formulated and contains actions to address 36 separate findings. • The IM&T EPR Training team provide training to all necessary new starters including doctor's rotation. • IT Senior Leadership team including Capital Planning and budget reviews has submitted a range of investment needs including EPR procurement funding. • Digital 7 Year investment profiling			20 → 16 → 10 INITIAL CURRENT TARGET
Assurance Gaps:	Published revised Digital Strategy and approval and action of underpinning investment plan and associated workforce plan.			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Work with other Trusts to share testing resources	Work with other Trusts to share testing resources	Work with other Trusts to share testing resources	Caisley, Sue	29/09/2017	29/09/2017
Invest in additional IMT staffing as workload increases, restructures based on work being reviewed with IMT management	Invest in additional IMT staffing	Invest in additional IMT staffing	Caisley, Sue	27/03/2018	27/03/2018
Comprehensively identify all single points of failure and assess risks surrounding each	Comprehensively identify all single points of failure and assess risks surrounding each	Comprehensively identify all single points of failure and assess risks surrounding each	Caisley, Sue	30/06/2017	30/06/2017
Test contingency plans regularly-development of a plan	Test contingency plans regularly-development of a plan	Test contingency plans regularly-development of a plan	Caisley, Sue	31/05/2017	31/05/2017
Routinely report all Cyber-attacks via Datix incident reporting system to ensure SIRO and Caldicott Guardian are sighted on the issues	report all Cyber-attacks via Datix incident reporting system	report all Cyber-attacks via Datix incident reporting system	Caisley, Sue	30/06/2017	30/06/2017
Include Cyber Security element in annual SIRO report	Include Cyber Security element in annual SIRO report	Include Cyber Security element in annual SIRO report	Caisley, Sue	28/04/2017	28/04/2017
IT Manager to produce a report detailing	IT Manager to produce a report detailing	IT Manager to produce a report detailing	Caisley, Sue	28/04/2017	28/04/2017

Board Assurance Framework

IT infrastructure risks which may impact upon 24/7 availability of key services and systems	IT infrastructure risks	IT infrastructure risks			
Continuous audit of IMT infrastructure-development of a plan	Continuous audit of IMT infrastructure-development of a plan	Continuous audit of IMT infrastructure-development of a plan	Caisley, Sue	31/05/2017	31/05/2017
Disaster recovery plan and its relevance to key IT systems to be reviewed	Disaster recovery plan and its relevance to key IT systems to be reviewed	Disaster recovery plan and its relevance to key IT systems to be reviewed	Caisley, Sue	31/08/2017	31/08/2017
Improve the disaster recovery for the ICE system (currently hosted on a physical server with limited resilience)	Improve the disaster recovery for the ICE system	Improve the disaster recovery for the ICE system Business case for ICE has been submitted to Execs Meeting(Complete) Obtain budget code (Complete) Submit tender waiver form (Complete) Scope of work discussed (Started - Sept 2018) Place order (Started - Sept 2018) Install and configure (Required Oct 2018)	Caisley, Sue	30/03/2018	07/09/2018
Undertake a Training Needs Analysis and assessment of training on Critical systems in the Trust and develop a plan as appropriate	Training Needs Analysis and assessment of training on Critical systems	Training Needs Analysis and assessment of training on Critical systems - 07/09/18 will be completed after additional staff start in the team.	Caisley, Sue	31/01/2019	07/02/2019
ICE has a business case in for SQL (database licensing) to enable to help virtualise the physical servers to help reduce unplanned downtime.	We would be able to switch ICE from Warrington over to Halton server rooms.	05/06/19--Migration to the new hardware environment by mid-July 2019. 05/09/19 - Data Migration to start on the 25/09/19 08/10/19 – Migration to the new ICE hardware platform was completed on 15th September 2019. The new infrastructure provides resilience ensuring that should the primary system suffer an outage, failover to the secondary system is provided ensuring system continuity and data recovery	Garnett, Joe	30/09/2019	15/09/19
We would be able to switch ICE from Warrington over to Halton server rooms.	ICE has a business case in for SQL (database licensing) to enable to help virtualise the physical servers to help reduce unplanned downtime.	05/06/19--Migration to the new hardware environment by mid-July 2019. 05/09/19 - Data Migration to start on the 25/09/19 08/10/19 – Migration to the new ICE	Deacon, Stephen	30/09/2019	15/09/2019

Board Assurance Framework

		hardware platform was completed on 15th September 2019. The new infrastructure provides resilience ensuring that should the primary system suffer an outage, failover to the secondary system is provided ensuring system continuity and data recovery			
Publish revised Digital Strategy with associated 7 Year Investment profile and delivery plan.	Draft Digital Strategy to be completed, approved and issued and multi-year investment profile to be supported by Trust.	December 2019 – Publish approved Strategy March 2020 – Sign off agreed multi-year investment profile	Phill James	30/03/2020	

Board Assurance Framework

Risk ID:	224	Executive Lead:	Evans, Chris	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.			Initial:	16 (4x4)
				Current:	16 (4x4)
				Target:	8 (4x2)
Assurance Details:	Regular Trust Wide Capacity meetingsled by the Senior Site Manager for the day Systemwide relationships including social care, community, mental health and CCGs Discharge Lounge/Patient Flow Team Red to Green - Discharge Planning ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing Controller Chloe Care Transport to complement patient providers out of hours FAU/Hub operational from June 2018 - Now operating 5 days per week. Discharge Lounge opened 26th November 2018 Full ED business case approved from Q4 18/19 re: vision for ED Footprint creating assessment capacity. System actions agreed supporting the Winter Plan Warrington Together Board have asked for focussed work to take forward outputs from the Venn Work 1. Further development of Rapid Response to avoid admission 2. Increase IMC 3. Increase IMC at home Regular monitored at the Mid Mersey A&E Board Long Length of Stay Collaborative in association with ECIST / NHSI. Bespoke approach for the Trust in embedding and sustaining LLoS review. To commence May 19 through until October 19. Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. Co-location of teams approved in April 19. This will support harmonisation of pathways and increase integrated working between health and social care. Co-location of teams to take place in June 2019 (Kendrick Wing) Urgent Care Improvement Committee to commence form May/June 2019 focussing on 5 priorities: 1. CQC Actions 2. Acute Medicine 3. Assessment Capacity/Environment 4. Decision to admit 5. Collective decision making The Committee will report to the Quality Assurance Committee and Exec Team New ED 'at a glance' dashboard gone live – supports organisational visibility and proactive response from specialties. Participating as a pilot site for recording of Same Day Emergency Care (SDEC) in association with NHSi & NHSE Urgent Care Improvement Committee High Level Briefing received at Quality Assurance Committee. Pilot of a co-located medical and surgical assessment unit taking place between 3 Sept – 10 Sept 2019. A review will then take place to inform the long term strategy for an Assessment Plaza. Co-located medical & surgical assessment unit to launch on 1st Dec 2019. Subject to consultation Trajectory achieved in Month 1, Month 2, Month 3, Month 4, Month 5 (84.97%) and Month 6 (81.67%) Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput – reports monitored via Patient Flow Sub-Committee and Trust Operations Board 8 IMC live from 27th September 2019 Integrated discharge Team now in place Urgent Care Improvement Committee – 1 regulatory breach complete and 15/35 actions complete			Chart: 16 / 16 / 8 — INITIAL / CURRENT / TARGET	

Board Assurance Framework

	CAU Business Case approved by Executives on 31st October 2019 with a plan to implement in December 2019 Winter plan developed with system support	
Assurance Gaps:	Fully embedding actions associated with system wide capacity & demand review undertaken by Venn Consulting – 3 key actions being progressed for Winter 2019 – 8 IMC Beds agreed via IBCF, Rapid Response Service and increased home reablement capacity (c 20 beds worth of capacity total) ED footprint with a view of right sizing for the future based on demand trends – review taking place in Sept 19	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
A Weekend Bed Meeting following the Discharge Ward Rounds to support Flow in the ED	Weekend Bed Meetings	Discuss with Trust SMT	Liversedge, Tom	29/03/2019	10/06/2018
Discharge Lounge available 24/7 to enhance Flow in the Hospital to aid Flow and Patient Journey in ED	Discharge Lounge	Discuss with Trust SMT	Palin, Bradley	30/11/2018	26/11/2018
RN is available on each Shift to Nurse Patients in the ED Escalation Area	RN Cover for Escalation Areas	ED off duty to be checked and Escalation procedure followed to ensure Staffing level matches demand	Smith, Rachel	27/07/2018	15/05/2018
Frailty Unit to assess up to Max 50 Patients weekly Mon - Fri 09:00 to 17:00 - has the potential to relieve pressure on the ED	Frailty Unit	To discuss with SMT	Liversedge, Tom	29/06/2018	10/06/2018
Discharged Lounge to be renovated.	Discharge Lounge	Discharge lounge approved for renovation; estimated date of completion is December 2018.	Liversedge, Tom	12/12/2018	26/11/2018
Urgent and Emergency Improvment Committe	The Trust Executive team an Improvement Committee to monitor the actions, regulatory breaches from CQC visit April 2019	Create Action Plan . with identified actin needs to demonstrate the improvements in ED	Fields-Delaney, Sheila	01/01/2020	
Operationalise Combined Assessment Unit 24/7	Launch Combined Assessment Unit	HR Consultation with SAU & GPAU workforce	Sheila Fields-Delaney & Sharon Kilkenny	01/12/2019	

Board Assurance Framework

Risk ID:	125	Executive Lead:	Evans, Chris	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.			Initial:	20 (5x4)
				Current:	16 (4x4)
				Target:	4 (4x1)
Assurance Details:	Controls: Estates strategy PLACE assessment action plan Risk Management systems and incident reporting General capital investment Compass reporting re: water flushing Matron and estates walkabouts Reporting structure for maintenance On call service for OOH issues Maintenance log Assurance: Water quality group Fire safety group Medical gases group Estates safety Medical Equipment group Capital Planning group Six Facet survey – condition appraisal of estate (annually) 5 Year program 20% each year Asbestos survey annually Premises Assurance model (PAM) Self-assessment tool estate compliance Good Corporate Citizen self-assessment (review of sustainability) Estates 10 year capital program Risk based approach to managing gaps in capital investment Medical equipment maintenance is managed by a risk assessed approach whereby equipment is identified as: High Medium Medium/Low Low All high and medium is fully maintained. Medium/low and low is operator assessed and reported to medical equipment engineering as required. - Generator sets are regularly serviced and tested and inspected by the Estates Operational Team.. Replacement of the generator sets is included within the Estates 10 Year Plan.. Two generator sets, with the highest risk of failure, have been replaced this financial year as part of the capital program. All generator sets regardless of age or condition are subject to monthly and annual testing and maintenance and resilience issues brought to the attention of the capital planning group should emergency funding be required to mitigate any risk of failure. - Work undertaken with Cheshire & Merseyside Fire & Rescue to mitigate any potential breaches of fire regulations resulting in enforcement. - Daily checks on main power supplies carried out to the system and maintenance service agreement in place with the manufacturer. 18.09.18 - - Order raised and parts ordered by contractor. Completion date is now 29.4.19 - Draft Estates & Facilities Strategy presented to the Trust Operations Board 25.03.2019			Chart: INITIAL 20, CURRENT 16, TARGET 4	

Board Assurance Framework

	Main power supply work commenced Work completed to main power to Trust Main IT Network Room equipment.	
Assurance Gaps:	-Remaining generator sets are approaching the end of their useful life and spare parts are difficult to obtain and without investment for replacement there is a risk of loss of HV resilience for the Trust. Limited capital funding to replace items beyond lifecycle	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy	Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy	Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy	Wright, Ian	30/06/2019	30/06/2019
Participate in Halton Healthy Hospitals strategy	Participate in Halton Healthy Hospitals strategy	Participate in Halton Healthy Hospitals strategy	Gardner, Mrs Lucy	31/12/2018	30/04/2018
Review of the Health & Safety risks aligned to estates and facilities to be undertaken	Health & Safety risks aligned to estates and facilities	Health & Safety risks aligned to estates and facilities	Wardley, Darren	31/07/2017	31/07/2017
Review the governance/meetings structure regarding Estates	Review the governance/meetings structure regarding Estates	Review the governance/meetings structure regarding Estates	Wardley, Darren	29/09/2017	29/09/2017
Obtain quotation from supplier in relation to the main power equipment with a view to an order being placed and installation completed	Obtain quotation from supplier in relation to the main power equipment with a view to an order being placed and installation completed	Paperwork and permits required for the ITU replacement. Once that is complete, we are going to take 2 of the racks from that UPS which are still ok and install them in the IT server room UPS to ensure this risk is also completed and addressed. By the time we have the plates manufactured to cover the holes from the 2no. missing UPS racks, the spare racks from the ITU UPS will be ready. Therefore we plan to wait until the end of May for the ITU UPS to be completed.	Wright, Ian	30/07/2019	05/08/2019

Board Assurance Framework

Risk ID:	701	Executive Lead:	Evans, Chris
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.		
Risk Description:	Failure to provide continuity of services caused by the scheduled March 2019 EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost.		

Rating	
Initial:	16 (4x4)
Current:	16 (4x4)
Target:	4 (2x2)

16 12 16 4
INITIAL REDUCED CURRENT TARGET

Assurance Details:	Standard agenda item on the Trust wide Event Planning Group. Brexit Sub Group has been established with key leads for the 7 key areas of activity outlined in the DHSC operational readiness guidance. A readiness tracker has been produced and is being monitored by the Brexit Working Group. The Procurement department completed the national self assessment contract review tool and continues to review suppliers which are out of the national scope. Service level business continuity plans continue to be refreshed. The IT department have reviewed all the Trust key IT systems and non have been identified as having a touch point in the EU. Nationally a 6 week stockpile of goods will be maintained. Daily SitReps are being submitted to the DHSC. May 2019 - the Government has agreed an EU Exit extension to the 31st October 2019. If the Withdrawal Agreement is ratified earlier the UK will leave the EU earlier, but it would be with a deal. All reporting has been stood down and the planning that had been in place will be adapted to support the extension. A debrief session has taken place to capture lessons learnt and has been shared with the regional EU exit team and will be used to support our preparations closer to the leave date. Re-instigated the Brexit Sub-Group which will meet again on 14th August and will meet fortnightly thereafter. NHSE/I to undertake an assurance exercise with NHS Trusts to ensure EU Exit SRO and EU Exit Team in place. NHSE/I to arrange regional events in September 2019 to discuss further details of the operational response and what is needed at the local level. September 2019 - Regional NHSE/I roadshow attended by Deputy COO, EPRR lead and representatives from Procurement and Pharmacy. NHSE/I reported that overall preparation has improved with national procurement of alternative delivery routes, an express freight channel and national engagement with key suppliers to create a replenishing 6 week buffer stock. Key concern is the planned exit date coinciding with the start of the winter period and the impact on workforce capacity and UEC demand, with the potential challenges of adverse weather, seasonal flu and changes to supply requirements. The clear message from NHSE/I is that the risk remains as high as earlier in the year. Brexit Daily Sit Rep commencing 21st October 2019 EU Exit Operation Plan – Pre & Post Brexit Escalation plan in place Following the extension to the Article 50 period to 31 January 2020, daily SitReps have been suspended. NHSE/I have amended Brexit preparation timetables to further enhance preparedness. Stand up monitoring to take place from 20/01/20
Assurance Gaps:	Continued national uncertainty on the terms of the EU exit and the date when this will be. Trusts being requested not to stock pile supplies. Risk to Supply BAU/CIP whilst resources are redirected to complete national work. National concern on shortages of radiopharmaceuticals and blood products. Potential price increases to supplies. Increased possibility of a no deal exit at the end of the extension period on 31 October 2020 Winter pressures and increase demand on Workforce and UEC.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Supplies department to complete self-assessment tool in order to ascertain suppliers who have a point of contact in the EU.	Supplies department to complete self-assessment tool	Contact supplies to triage and if necessary complete a deep dive.	Steve Barrow	30/11/2018	30/11/2018

Board Assurance Framework

The Trust needs to identify any data flows that may be at risk if we leave the EU with a no deal exit.	Data control flows	Information Asset owners to complete a flow mapping template that has been produced by the Information Governance manager.	Phillip James	12/03/2019	31/05/2019
All corporate and clinical business units should have an up to date business continuity plan.	Services to review and update busines continuity plans	Review and update service BCP's.	Emma Blackwell	28/03/2019	10/04/2019

Board Assurance Framework

Risk ID:	145	Executive Lead:	Pickup, Mel
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.		
Risk Description:	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.		
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. We are developing plans, with partners, to establish Accountable Care Organisations in both Halton and Warrington. We have developed an engagement strategy in partnership with our Governing Council We have established a community-wide newsletter Your Hospitals No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the STP. The Trust has developed effective clinical networking and integrated partnership arrangements: The Trust is successfully leading and co-ordinating the delivery of new integrated care pathways for the frail elderly with partners from primary and social care, the voluntary sector, NW Boroughs NHSFT and Bridgewater Community NHSFT. The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool for complex spinal patients. Monitoring engagement by stakeholders (attendance at events, membership survey) Reports and Feedback from Healthwatch 'What Matters to Me' conversation cafes held across both sites in partnership with patient experience committee and governors. Will also include WHH volunteers, WHH careers and WHH charity - Memorandum of Understanding and work plan with Bridgewater Community Healthcare NHS FT approved. - Working in partnership with GP Federation in Halton on relation to improving joint clinical pathways. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. - Agreement of sustainability contract with Warrington CCG. - Work plan agreed with StHK - Shared a presentation demonstrating Halton Hospital's suitability to host the Eastern Sector Cancer Hub with Clatterbridge and other stakeholders. This forms part of the formal decision making process on the location of the hub - Regular GP engagement events held. - Regular Strategy updates are provided to the Council of Governors. - Clinical strategy engagement held with Trust Board - Submitted bid to provide UTCs in Runcorn & Widnes - Financial feasibility assessment for Halton Healthy New Town completed following unsuccessful bid to NHSE - Clinical Strategy approved by Trust Board - CBU specialty level strategies complete and incorporated in business plans - Successful in One Public Estate revenue funding bid for Halton - Initial talks held with Elective Care STP Lead in relation to the suitability of Halton as a potential Elective Care Hub Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review. NHSE and local Commissioners supportive of draft strategy for breast screening. First Group Committee in Common held with BCH and Joint Sustainability plan developed. Revised process for evaluation of potential sites for the Eastern Sector Cancer Hub shared with the Trust, StHK, Clatterbridge		

Rating	
Initial:	20 (5x4)
Current:	15 (5x3)
Target:	8 (4x2)

20 15 8
INITIAL CURRENT TARGET

Board Assurance Framework

	and NHSE by Knowsley CCG. Submission due 24th July 2019. Decision expected January/February 2020. UTC Procurement process abandoned Initial meeting for Cheshire & Merseyside respiratory review held. Trust presentation well received. No funding received in latest capital allocation. Additional £1b capital promised but allocation criteria yet tbc. DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. 27 Trusts have received funding with a further 13 TBC. The Trust has written to NHSP to seek support in raising the profile of our needs – NHSP have agreed to use the Trust as a case study in their national campaign Positive meeting the Medical Director and Director of Strategy at Alderhey confirming their intention to work with the Trust to repatriate WHH patients Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include an Essential Services Lab (ESL) at WHH. Currently providing detailed feedback on strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESL Pathology OBC received by the Trust Board and feedback provided has been included in the re-issued draft Eastern Sector Cancer Hub – Letter received providing feedback following submission. Letter has been sent from the Trust to the Lead for the Eastern Sector Cancer Hub process requesting details of the public consultation and formal procurement process as well as requests for further information in relation to our submission and the scoring under the evaluation process. Response received from Eastern Sector Cancer Hub SRO – Further clarification requested. Lead CCG Awaiting results from the NHSE stage 2 assurance process. Consultation now unlikely to take place before January 2020 at the earliest. A Decision is therefore not anticipated until mid 2020 Further Committee in Common with Bridgewater and consensus reached on operational model. Confirmation received that there will be a new single lot open tender process to commence to determine the provider for both Runcorn and Widnes UTCs. Intention for the contract to commence 1 April 2020. Confirmation received from the CCG that the procurement process re: UTC is no longer being pursued. Requirement to deliver the UTC specification at Runcorn by January 2020 Detailed BCH/WHH Collaboration plan developed and received at the Joint Executive Meeting	
Assurance Gaps:	Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. Limitations of the size of the catchment area. Risk to Women's and Children's future provision due to Cheshire & Merseyside led review.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure WHH are in a strong position to influence the agenda	Influencing the agenda	CEO to ensure that she continues in her role as STP Chair to ensure that we can have an influence in the agenda	Pickup, Mel	31/03/2019	31.12.2019
Ensure evidence is provided to support strategic development and decision making.	Development of Trust Strategy document aligned to Trust planning priorities and	Development of Trust Strategy document aligned to Trust planning and priorities	Gardner, Mrs Lucy	30/06/2018	30/06/2018
Re-establish 'Board Talk' stakeholder newsletter	Re-establish 'Board Talk' stakeholder newsletter	Re-establish 'Board Talk' stakeholder newsletter	McLaren, Patricia	31/05/2017	31/05/2017
Create more opportunities for stakeholder engagement at our hospitals	Create more opportunities for stakeholder engagement at our hospitals	Create more opportunities for stakeholder engagement at our hospitals	Ryan, Candice	30/06/2017	31/05/2017
Revisit the Your Hospitals newsletter/membership communications to ensure optimised	Revisit the Your Hospitals newsletter/membership communications to ensure optimised	Revisit the Your Hospitals newsletter/membership communications to ensure optimised	Ryan, Candice	31/05/2017	31/05/2017
Establish clinician-led GP engagement	Establish clinician-led GP engagement	Establish clinician-led GP engagement	Crowe, Dr Alex	31/12/2018	10/07/2018

Board Assurance Framework

opportunities	opportunities	opportunities			
Ensure clinical strategies in place for all specialties.	Ensure clinical strategies in place for all specialties	Ensure clinical strategies in place for all specialties.	Crowe, Dr Alex	30/11/2018	14/12/2018
Establish formal partnership with Bridgewater. Establish formal partnership with St Helen's and Knowsley.	Formalise partnerships with other local organisations	Signed memorandums of understanding and agreed workplans.	Gardner, Mrs Lucy	30/11/2018	30/11/2018

Board Assurance Framework

Risk ID:	143	Executive Lead:	James, Phill	Rating	
Strategic Objective:	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.				
Risk Description:	Failure to deliver essential Digital services, caused by a successfully executed Cyber Attack, resulting in loss of access to data and vital IT systems, resulting in potential patient harm, loss in productivity and damage to the Trust reputation.			Initial:	12 (4x3)
				Current:	12 (4x3)
				Target:	8 (4x2)
Assurance Details:	• Implementation of a range of Cyber defence measures including network access (perimeter) and traffic controls and file content controls in accordance with CareCert advice and guidance and hardware encryption built into key data stores. • IT Governance Structure including Risk Register Reviews, Digital Board highlight reports to Trust Operations Board, MIAA Cyber Audit report outcomes to Information Governance and Corporate Records Sub Group and the Data Standards Group highlights to Quality Assurance Committee plus other ad-hoc submissions as required. • Implementation of an Information Security Management System (ISMS), based on the principles of ISO27001 security standard and achievement of Cyber essentials certification. • IT Operations Governance including daily data backups including a 4 hour replication to the Halton site, Windows Advanced Threat Protection is 100% commissioned and high levels of patching success (over 95% of all Microsoft Windows assets) are being maintained. • Upgrading of some systems, especially Medical Devices, constrained by affordability of application vendor demands; systems moved to protected network environments as a workaround but management risks then remain. • Responses to MIAA IT Health Check and Vulnerability Assessment Application Vulnerability Technical Report successfully completed.			12 12 8 INITIAL CURRENT TARGET	
Assurance Gaps:	Upgrading of all assets to Windows 10 are reporting 83% complete by NHS Digital leaving 17% to complete. Target completion of end of current financial year but potential for vulnerabilities remain in the meantime. Updating some vulnerabilities (mainly Java browser plug-in) is threatened by incompatibility of some national/regional software products. Resolution remains outstanding. Awaiting agreement and approval of an STP wide cyber business case. Progress by another local Trust awaited.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure capital monies are available in 2018/19 for upgrade of vital security software and hardware	capital monies are available in 2018/19 for upgrade of vital security software and hardware	capital monies are available in 2018/19 for upgrade of vital security software and hardware	McGee, Andrea	30/04/2018	27/04/2018
Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment – development of a plan	Implement security 'bubble' around the medical VLAN	Implement security 'bubble' around the medical VLAN	Caisley, Sue	30/03/2018	05/09/2018
Act on recommendations made in the Cyber essentials report to ensure improved cyber security.	Act on recommendations made in the Cyber essentials report to ensure improved cyber security.	The following actions remains to be completed: 29/11/2019 - C&M Cyber funding opportunity (business case sign off) 31/12/2019 – Upgrade W2003/W2008 servers to 2016 31/01/2020 – Upgrade W7 desktops/laptops to W10 30/04/2020 – Add medical devices to V-LAN bubble	Deacon, Stephen	30/06/2021	

Board Assurance Framework

		29/05/2020 - Migrate Office 2010 to latest revision (relies upon NHS Digital negotiations). 30/06/2021 – Implement measures over and above the Cyber essentials report to strengthen cyber security further, as recorded within Trust Cyber Essentials action plan.			
Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan	Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan	Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan	Caisley, Sue	30/03/2018	31/03/2017
Ensure that Information Governance messages around safe use of IT assets are reiterated via corporate induction and training	Information Governance messages around safe use of IT assets	Information Governance messages around safe use of IT assets	Caisley, Sue	31/12/2018	31/03/2017
Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system – send out an alert to all staff on a regular basis and report quarterly to Information Governance and Corporate Records Sub-Committee	Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system	Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system	Caisley, Sue	31/12/2018	05/09/2018
NHS Digital issues CareCERT advisory bulletins to support the NHS in maintaining high standards of cyber security. Trusts are to confirm that they have acted on the most critical of these, where applicable to their IT infrastructure. All Trusts give a template setting out 39 of the critical CareCERT advisories, all issued over the last three months after WannaCry, which have been deemed most critical in preventing successful cyber-attacks.	Complete actions on NHS England's CareCERT 39	Download template and update it with current status and when all 39 CareCERTS are to be completed. 07/11/2018 All CareCERT's are now completed and sent back to NHS Enlgand.	Deacon, Stephen	30/11/2018	07/11/2018
Several desktop devices still on Windows XP due to systems not compatible with Windows 7 onwards. IT working closely with the departments and third party supplies to ascertain a plan to migrate to Windows 7/Windows 10	Removal of Unsupported Windows XP from Desktop Devices	08/08/18 Supporting each department helping them to remove Windows XP from their areas replacing them with Windows 7 onwards, some systems will need upgrading or replacing dependant on funding (On-going) 04/09/2018 A report has been created for the IM&T Programme Board the following XP	Whitfield, Simon	26/10/2018	10/10/2018

Board Assurance Framework

		devices/systems using XP have been identified: 26/09/2018 Paper was presented to the IM&T Programme Board, discussions with Radiology has reduce the numbers further due to hardening of the XP Servers.			
Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff.	Add medical devices to VLAN bubble	04/01/2019 Network Manager has begun pre work on the VLAN protective bubble 05/09/2019 Network Manager to liaise with PACS Manager to arrange 3rd party support for migration over to VLAN	Smith, Mr Philip	31/04/2020	
Additional network security (Phase 2) to replace aging hardware around web filtering and file blocking is required.	Additional network security	Submit capital form to capital meeting (Complete) Obtain budget code (Complete) Place order (Complete) Install and configure (Complete) 04/09/18 Waiting on arrival of the ASA firewalls for remote access , but training required to utilise the product	Smith, Mr Philip	31/12/2018	14/09/2018
Review of security options with HSCN when upgrading our N3 link to HSCN.	Review security options with HSCN	Review of security options with HSCN when upgrading our N3 link to HSCN (Completed - Sticking with local security)	Smith, Mr Philip	29/03/2019	14/06/2018
Requiring to beef up our Cyber Security including patching for servers This includes server security patches.	Implement robust server patching regime	20/11/18 Automatic software has been purchased and will require a period of time to configure before we can automate majority of servers. 05/12/18 The Server Manager and Technical Specialist are meeting this week to start looking at looking at configuration the server. 04/01/2019 Reviewed, no further action	Garnett, Joseph	31/05/2019	10/04/2019
There are 39 out of 150 outstand hidden shares that are accessible by specialist software to view contents of those shares. This includes e-outcome, these need to be secured.	E-outcome hidden share accessible to all users	10/10/2018 We have been told this is no longer an issue, the IG Manager and IT Manager cannot access the area, but passing over the IT Specialist to double check as he	Deacon, Stephen	19/10/2018	19/10/2018

Board Assurance Framework

		raised the issue originally, however, waiting for him to return back from A/L			
Part of the Cyber Essentials+ recommendations the Trust needs a corporate policy for IT logs retention	Corporate Policy for IT Logs Retention	Update the ISMS to contain the corporate policy for IT logs retention	Deacon, Stephen	28/09/2018	26/09/2018
26/09/2018 Update the infrastructure for the ASA's (Remote Access Secure Token System).	Renew the ASA (Remote Access Secure Token System)	26/09/2018 Update the hardware infrastructure for the ASA's (Remote Access Secure Token System. The new hardware is in the department but requires configuration from the supplier (SoftCat) next week, currently waiting on an action plan. Once configured will be put through change control to replace the old hardware, however, there will be downtime for remote access (token based) , mainly suppler based, NHS guest Wi-Fi and staff Wi-Fi and IPAD users using VDI externally but will be minimal. 10/10/2018 ASA's are being replaced w/c 15/10/18	Smith, Mr Philip	19/10/2018	24/10/2018
As part of the Windows 10 agreement from NHS Digital, ATP (Advance Threat Protection) across all our desktop devices before the end of December 2018	Install Advance Threat Protection on all desktop PC's and laptops	Install ATP across the desktop estate	Whitfield, Simon	31/12/2018	30/11/2018
From the C&M Cyber Group: To share those Cyber Essentials Plus questionnaires that were unsuccessful? As they may reveal common areas of improvement that we could work on together.	Provide the C&M Cyber Group with the answers from the CE+	To send to the C&M Cyber Group the answers from the Cyber Essentials+ assessment.	Deacon, Stephen	31/10/2018	10/10/2018
Encrypt backup data to stop any successful cyber-attack from affecting the backup data	Encrypt backups	03/12/18 The Data Domain is now configured and has been tested with one server. The Server Manager will perform a phased migration of all other servers. With the speed being faster we are able to look at changing/when how the backups are performed. 04/01/2019 The Trust prioritised the Domain Controller migration over other IT projects	Garnett, Joseph	30/04/2019	05/06/2019

Board Assurance Framework

		04/01/2019 SharedData and 12 SQL servers have been added, however, 6 of them are not truncating, will require resolving. 10/01/2019 18 servers have been migrated to the new backup system. The 6 SQL servers issues with truncation of their logs has also been resolved. 15/03/2019 Server manager to ascertain how to implement encryption on data domain			
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system)	Review Server 2003 and 2008 servers	24/10/2018 Obtained a list of servers using Server 2003 and provide a report to the next Digital Board. Currently, the Trust still has 20 servers which use Windows Server 2003, however today we have been able to decommission 1 of the servers already. 20/11/18 The paper was discussed at the digital board. Estates are migrating the rest of the users to the cloud for Resman system and one more can be shutdown. 04/01/2019 Reviewed, no further action 15/03/2019 17 2003 servers left to complete 08/10/19 – 24% of the 2003 and 2008 Servers have now been either migrated to Server 2016 or decommissioned Dedicated resource remains in place to progress this work but unknown costs (supplier upgrade demands/issues) are a potential barrier.	Garnett, Joseph	31/12/2019	
Wirral are the lead for the STP Cyber Group. They required to create a business case which covers a programme of work with a number of project areas which together will provide joint and collective assurance on the work around cyber security for the Health and Care Partnership. The strands of work include support for	WHHT to help Wirral create the STP Cyber Business Case	07/11/2018 The cyber business case is in draft and Director of IT and Information at the Wirral has asked for feedback from the other two trusts. WHHT have feedback to Wirral. 20/11/18 Final draft has been sent out for comment. 05/09/19	Deacon, Stephen	30/09/19	18/09/19

Board Assurance Framework

joint work on: - Cyber Essentials Plus accreditation - Strategy and Policy Development - Training and skills development - Business Continuity Planning - Procurement and Vendor relations The creation of the business case is restricted to a limited number of Trusts within the STP to ensure we are able to meet the deadline. WHHT along with Mid-Cheshire and Wirral are the only Trusts involved with the business case, allowing WHHT to be at the forefront of cyber security.		IT Manager will enquire at the next STP Cyber meeting			
To upgrade all windows 7 to Windows 10 before end of January 2020	To upgrade all windows 7 to Windows 10 before end of January 2020	Deployment and Desktop Team to go out and reimage the devices around the Trust	Deacon, Stephen	30/01/2020	

Board Assurance Framework

Risk ID:	414	Executive Lead:	James, Phill	Rating	
Strategic Objective:	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.				
Risk Description:	Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches.			Initial:	12 (4x3)
				Current:	12 (4x3)
				Target:	8 (4x2)
Assurance Details:	the following mechanisms are in place: • Data Security and Protection Toolkit Returns (NHS Digital) • MIAA Annual Data Security and Protection Toolkit Assurance Audit (significant assurance in 2018) • Cyber Essentials Plus Certification Audits • MIAA Cyber Security baseline • Firewall Health Check • Reporting to Information Governance and Corporate Records Sub-Committee and Quality Committee • MIAA GDPR Readiness assessment MIAA IG Assurance Review delivered a moderate assurance rating for 2018/19.			Chart: INITIAL 12, CURRENT 12, TARGET 8	
Assurance Gaps:	• The future of SMARTcard use is to be reviewed as NHS Digital appraise Trusts of their future user ID vision. • Published revised Digital Strategy and approval and action of underpinning investment plan and associated workforce plan. Staff reporting lines have been amended to remove risk of a single point of dependency in the meantime. • Full compliance with EU NIS Directive remains to be demonstrated. • Ongoing audit of information governance and application of IG controls in the general environment including storage of records and training requirements • Delivery of remaining unmet assertions on Data Protection Security Toolkit • Re-enforce adherence to IG Policy & Procedures in ward/clinical areas following reporting of a number of incidents. • Maintenance of an effective asset register and information flow mapping to be completed.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
IT operational restructure in order to provide information governance support to deal with the burgeoning IG/Cyber Security agenda	Digital workforce planning and business case to align resources with increasing Information Governance workload	IT Manager to advise of IG workload CIO will introduce the information to the Digital workforce plan Business Case for additional Cyber Security staffing has been drafted and will be provided to Commercial Development for review before submission to Execs	James, Phill	30/12/19	

Board Assurance Framework

Risk ID:	241	Executive Lead:	Constable, Simon	Rating	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.			Initial:	12 (4x3)
				Current:	8 (4x2)
				Target:	4 (4x1)
Assurance Details:	Regular monthly meetings taking place with HENW involving The Deanery. An agreed action plan has commenced and is progressing. Regular weekly journal/ educational meetings on Mondays co-ordinated by a clinical fellow. Trust Locum Consultants have been approved as educational supervisors and are providing educational supervision to the ST3s in geriatric medicine. Appointment of a Chief Registrar; popular interest by doctors for future Chief Registrar appointments. Recruited to Medical Utilisation Manager Role. Trust wide work stream for rota management. An E-Rostering Bid has been made to NHSi Working on getting more bank doctors, rather than agency. Establishment of Medical Trainees Experience Improvement Group. Deputy Medical Director to have Director of Medical Education portfolio. Senior management presence at Medical handover to review any safety issues, escalated to Trust Wide Safety Brief. Weekly Medical Educational Huddle. Business Case currently being developed to support the recruitment of substantive consultant physicians. Clinic attendance for trainees to ensure they can be released from wards to attend – record log in place and escalation process if not occurring. Subsequent plans to improve training available clinics. 3 substantive consultant appointments in Acute Medicine, 1 consultant in Care of the Elderly who is also Clinical Director for Integrated Medical and Social Care CBU. Ward Round Accreditation quality improvement work stream. Access for trainees to Quality Academy and Quality Improvement work streams. Monthly Medical Education newsletter From August 2019, the Trust will have 3 additional International Training Fellows in Acute, Gastroenterology and Rheumatology. Completed HEENW Action Plan returned to HEENW GMC National Training Survey results received in July 2019, noting 6 Category 1 (minor) risks, no patient safety issues resulting in an overall Trust risk score of Category 1. This is a significant improvement compared to 2018, when the Trust was scored as Category 2. Key areas to note: Decreases in category 1 and 2 risks; significant improvement in GMC training feedback scoring; there is an action plan in place to resolve any concerns. Currently awaiting feedback in relation to enhanced monitoring. Enhanced monitoring position to be reviewed in Q4 2019/20 when HEE visit Medicine			12 8 4 INITIAL CURRENT TARGET	
Assurance Gaps:	Recruitment of substantive consultant physicians ongoing Review of Digital Strategy on going				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Identify lead to create a biweekly newsletter for trainees to provide vehicle for educational supervisors to deliver updates and good news.	improving experience for trainees	medical education business manager to co-ordinate across the Trust for all trainees	McKee, Spencer	29/03/2019	01.03.2019
To provide timetabled clinic slots for CMTs co-ordinated by the MUM and to be communicated through the ward cover rota	protected clinic time for CMTs across medicine	MUM to implement	Barker, Sophie	06/08/2018	13/07/2018

Board Assurance Framework

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/120**				
SUBJECT:	**Charities Commission Checklist**				
DATE OF MEETING:	27 November 2019				
AUTHOR(S):	Pat McLaren, Director of Community Engagement + Fundraising				
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Fundraising				
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.				√
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.				√
LINK TO BAF RISK: ***(Please DELETE as appropriate)***					
EXECUTIVE SUMMARY *(KEY ISSUES):*	This is presented on a twice-yearly basis to the CFC with delegated authority from the Trust Board which is the Corporate Trustee. This checklist is designed to help CFC evaluate the charity's performance at suitable intervals against the legal requirements and good practice recommendations set out in the Charities Commission guidance of 2016. The following is a position statement setting out our position at September 2019: There are minor amendments to the WHH Charity Checklist as highlighted in yellow, to sections 4.1, 4.3, 4.4 and 4.6 following actions taken since the last review in March 2019.				
PURPOSE: *(please select as appropriate)*	Information	Approval X	To note	Decision	
RECOMMENDATION:	Trust Board to approve				
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors			
	Agenda Ref.	CFC/19/09/33			
	Date of meeting	12 September 2019			
	Summary of Outcome	Approved			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full				
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.				

TRUST BOARD OF DIRECTORS

SUBJECT	Charities Commission Checklist	AGENDA REF:	BM/19/11/119

1. BACKGROUND/CONTEXT

In June 2016 the Charities Commission issued new guidance for Charity Trustee Duties.

This checklist is designed to help CFC evaluate the Charity's performance at suitable intervals against the legal requirements and good practice recommendations set out in the guidance. The following is a position statement setting out our position at September 2019.

2. KEY ELEMENTS

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

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- The CFC requests a current position re compliance with the Checklist at periodic intervals.
- Responsible officer: Pat McLaren, Director Community Engagement and Fundraising

4. MEASUREMENTS/EVALUATIONS

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

5. MONITORING/REPORTING ROUTES

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

6. TIMELINES

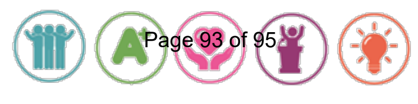
Next review March 2020

7. ASSURANCE COMMITTEE

Charitable Funds Committee
WHH FT Trust Board

8. RECOMMENDATIONS

Trust Board to approve



Charities Commission – Checklist for WHH Charity Trustees

September 2019

Guidance	Current status	Mitigations/actions/notes
Section 4: Planning effectively	RAG	
4.1 We have set out our fundraising plan		• Our refreshed fundraising strategy was approved at the April 2017 committee meeting and KPIs are monitored at each CFC • The accompanying annual plan is reviewed at each CFC meeting • We continue to review our Strategy periodically in line with changing trends in charitable giving. A draft strategy for 2019-22 is being reviewed in September 2019
4.2 It reflects our charity's values		WHH Charity's values are: Ethical, Transparent, Accountable, Compassionate, Creative and the Charity also adopts the values of the Corporate Trustee of Working Together, Excellent, Accountable, Role Models and Embracing Change.
4.3 The resources we use and the costs we incur in our fundraising		• Our overheads are subject to scrutiny at each CFC meeting as part of the Finance Report • The refreshed FR Strategy has identified limits to overhead expenditure based on income growth with the intention of reducing cost/income ratios to ensure that donated funds are used in majority for patient benefit • Income and expenditure (actual and forecast) are scrutinised and challenged at each CFC • A revised reserves policy was adopted in June 2019.
4.4 The key financial and reputational risks we may face		This has been identified in the Risk Strategy developed in Feb 2016. All WHH Charity risks are now managed through the Trust's DATIX system and reported to each CFC
4.5 We monitor progress		A fundraising activity and financial report is reviewed by the CFC at each meeting
4.6 We manage key risks		The key risks are reviewed at each meeting
Section 5: Supervising our Fundraisers		
5.1 We have considered and decided which fundraising issues we will not delegate		Our Fundraising team is directly accountable to and line-managed by a member of the executive team
5.2 Our fundraising staff have job descriptions		Current and in place
5.3 Our fundraising staff are doing the job successfully		PDR planned for September 2019, Income objectives subject to approval of WHH Charity refresh forecast Monthly 1:1s with Director and informal catch ups in between meetings
5.4 Our volunteers know who they report to and who to approach with problems or concerns		WHH Volunteers assumed responsibility for all volunteers in September 2016, those on placement with WHH Charity report to and are supervised by the Fundraising Manager
5.5 Our volunteers understand the		They receive Trust induction from WHH Volunteers and

boundaries within which they must work when representing the charity		local induction from the Fundraising Manager and are supervised at all times
5.6 Our subsidiary trading company is monitored for effectiveness and only enters into commercial partners in the charity's best interest	N/A	
5.7 Our arrangements with commercial providers fully comply with relevant legal requirements		We undertake all procurement through the Corporate Trustee and ensure through contract that all legal requirements are met and maintained
5.8 Are in our charity's best interest because appropriate due diligence is undertaken		We procure using the Corporate Trustee's procurement team
5.9 Our fundraising values and expectations are communicated		These are agreed upon contract
5.10The costs are justifiable and can be explained		All expenditure is reviewed by the Budget Holder and reported through the Finance Report
5.11Proper control is kept of the money raised		• All monies are routed into the WHH Charity bank account, no other methodology is permitted. • Staff training and awareness on the correct processing of charitable donations is continuous and written into the WHH Staff Handbook
5.12Fundraising communications used are reviewed		All communications are approved by the Fundraising Manager and/or Director
5.13 Compliance with the agreement is monitored		Compliance is monitored following contract
5.14 Any conflicts of interest are recognised and dealt with		The Corporate Trustee has a Managing Conflicts of Interest Policy which has been adopted by WHH Charity
Section 6: Protecting our charity's reputation, money and other assets		
6.1 The reputational risks our charity may face are identified, assessed and managed		Reputational risks have been identified in our Risk Strategy
6.2 Likely donor, supporter and public perception is considered when income expectations and other goals are considered		Our bid application process includes this to ensure compliance of all parties via capital campaigns
6.3 The legal rules and recognised standards which apply to our fundraising are followed		We follow the Code of Fundraising Practice, the Institute of Fundraising and the Association of NHS Charities guidance. We are registered with and regulated by the Charities Commission
6.4 Our values are communicated to the people who work on our fundraising		All WHH staff adopt and practice the values of the Corporate Trustee, they and the public are further briefed on the aims and objectives of WHH Charity and are guided on how to proceed with fundraising initiatives on a personal/team/company level.
6.5 The costs of our fundraising are managed and explained		We control our costs through a bid application process We review our costs at each CFC meeting
6.6 Our fundraising finance is planned and monitored		We have an annual plan in place, the KPIs of which are reviewed at each CFC meeting.
6.7 Effective financial controls are in place		The Corporate Trustee's Finance Team monitor all

and followed		expenditure
6.8 Risks of financial crime and fraud are reduced		WHH Charity provides a letter of authorisation to every fundraiser who is requested to sign acceptance of the 'contract' between us.
6.9 Our charity is alerted to any suspicious donations		• Our Finance Team review all bank statements and incoming direct funds • Provenance of all cheque and cash donations is tracked through the donor journey and recorded via Harlequin, with a receipt and thank you letter posted out to the donor.
6.10 our charity can stop or authorise any unauthorised fundraising activity using its name		• We use a letter of authorisation to authorise fundraisers to raise funds on our behalf. • We would alert the police to any suspicious activity undertaken in our name.
6.11 Serious incidents are reported to the Commission, police and other agencies		• NHS Protect may also be contacted where NHS Employees or their families are involved.
6.12 Our data, name, image, logo and IP are protected		• We do not issue our logo independently for 3rd party use • We use letters of authorisation for 3rd party fundraisers • We provide our own branded materials for support • Our intellectual property is protected to the best of our ability and knowledge
Sections 7 and 8 Following the Law and recognised standards		
7.1 the Code of Fundraising Practice and other resources are used to find out about the legal rules and recognised standards which apply to our fundraising		We follow the Code of Fundraising Practice, Institute of Fundraising and the Association of NHS Charities guidance
7.2 These rules and standards are followed		We follow the Code of Fundraising Practice, Institute of Fundraising and the NHS Charities guidance
Section 9: Be Open and Accountable		
9.1 Any legal rules and requirements that apply to how our charity reports and accounts for its fundraising are complied with		We are audited periodically and produce an annual report and accounts each autumn.
9.2 Our open and accessible complaints procedures are followed if concerns are raised		• In the first instance complaints should be raised to the Fundraising Manager or Director • The Charity uses the resources of the Corporate Trustee ie PALS and Complaints procedure. • The Charity will make this process clear via its website
9.3 Our fundraising aims and achievements are clearly communicated to the public and donors/supporters		Our website is maintained and updated regularly, Our social media platforms are updated regularly.

PMc Last updated 12.8.19