St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 27TH SEPTEMBER 2017
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month			Richard Fraser
		1.2	August		
		1.3	September – *deferred.*		
09:40	2.	Patient story			Sue Redfern
10:00	3.	Apologies for Absence			Richard Fraser
	4.	Declaration of Interests			
	5.	Minutes of the previous Meeting held on 26th July 2017		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(17) 078	Nik Khashu
		6.1	Quality Indicators		Rob Cooper
		6.2	Operational indicators		Rob Cooper
		6.3	Financial indicators		Nik Khashu
		6.4	Workforce indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.30	7.	Committee report – Executive		NHST(17) 079	Ann Marr
10:40	8.	Committee Report – Quality		NHST(17) 080	David Graham

10:50	9.	Committee Report – Finance & Performance		NHST(17) 081	Denis Mahony
11:00	10.	Committee Report - Audit		NHST(17) 082	Su Rai
		10.1	Audit letter sign off	NHST917) 083	Nik Khashu
BREAK					
Other Board Reports					
11:15	11.	Strategic & regulatory report		NHST(17) 083	Nicola Bunce
11.20	12.	Complaints, Claims & Incidents		NHST(17) 084	Anne-Marie Stretch
11:30	13.	Learning from Deaths in the NHS/Mortality Policy update		NHST(17) 085	Terry Hankin
11:40	15.	WRES update		NHST(17) 086	Anne-Marie Stretch
11:50	16.	EPPR Assurance		NHST(17) 087	Nicola Bunce
Closing Business					
12:00	17.	Effectiveness of meeting			Richard Fraser
	18.	Any other business			
	19.	Date of next Public Board meeting – Wednesday 25th October 2017			
LUNCH					

TRUST PUBLIC BOARD ACTION LOG – 27th September 2017

No	Minute	Action	Lead	Date Due
1.	31.05.17 (7.6)	Complaints, Claims and Incidents: More context and data analysis of report is required. *Agenda item*	SR	27 Sep 17
2.	31.05.17 (7.8.2)	Availability of staff to discuss patient care plans with relatives to be considered; wards to be encouraged to be more proactive. Executive Committee report back to Board.	SR	25 Oct 17
3.	31.05.17 (12)	Learning from deaths in the NHS – update back to Board.	KH	27 Sep 17
4.	28.06.17 (7.8)	Board Development agenda – AMS will ensure that CQC guidance is included 26.07.17: AMS and NB will meet with AM and RF to discuss.	AMS	25 Oct 17
5.	26.07.17 (11.7)	High mortality in COPD – KH will provide a report for Board.	KH	25 Oct 17

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)079
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to the Board key issues arising from the Executive Committee meetings.
Summary: 1. Between the13th July and 7th September eight meetings of the Executive Committee have been held. The attached paper summarises the issues discussed at the meetings. 2. Decisions taken by the Committee included; the introduction of ePayslips, the introduction of complex passwords, to increase emergency preparedness training, to move to alcohol hand gel across the Trust, to bid for the Marshalls Cross Primary Care Practice. 3. Assurance was received regarding agency usage, safer staffing, risks management, recruitment and retention, IT security, IT Replacement Programmes delivery, Health and Care System working. 4. Business cases regarding Mohs Surgery, Therapy staffing, were approved, funded from approved budgets. 5. There are no specific items requiring escalation to the Trust Board for approval.
Corporate objective met or risk addressed: Delivery of the Trusts Corporate objectives via the authority delegated to the Executive Committee from the Trust Board.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Trust Board note the report.
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 27th September 2017

EXECUTIVE COMMITTEE ASSURANCE REPORT

The following report highlights issues considered by the Executive Committee during the period since the last Board meeting.

20th July 2017

1. Safer Staffing and Vacancy Dashboard

a) Staffing levels for June were reported and the staffing levels reviewed
b) 6 wards experienced a monthly staffing headcount fill rate of below the accepted level of 90% for RNs.
c) Care Staff monthly fill rates is higher than the funded ward establishment because of extra staff employed to provide 1 to 1 care to vulnerable patients or to compensate for a shortfall in RN headcount levels when efforts to backfill RN gaps have proven unsuccessful.
d) Newton Intermediate Care Ward staff were now included in the monthly report.
e) The vacancy dashboard showed the gap for RNs against establishment. Further actions to mitigate this situation are being developed.

2. Mandatory Training and Appraisals Report

The monthly report was received and reviewed. Directors to follow up the services and departments which are not meeting the target.

3. Corporate Filing System Review

In response to the recent cyber-attacks the security of the corporate filing system is to be reviewed and a cost benefit exercise undertaken.

4. ePMA Pilot

a) The ePMA pilot had been suspended in response to risks identified with patients who were outliers. These were being assessed and mitigations found before an extended pilot would continue.
b) The cost of implementation need to be contained within the business case approved sum.

5. Mohs Business Case

a) The business case was to create a dedicated Mohs laboratory adjacent to the dermatology Mohs theatre at St Helens Hospital.
b) The Trust and Salford are the only two Dermatology centres offering Mohs in the North West region. Demand for the service is increasing. The capacity options, costs and additional income predictions had been reviewed.
c) The Executive Committee approved the case to invest.

6. SIRI Report

a) The Director of Nursing and Quality had met with the CQC engagement lead following their receipt of a draft SIRI into the unexplained paediatric death in ED. There were concerns regarding the delay in the Trust's reporting of the incident. However, the Trust could demonstrate that it has raised concerns as soon as the

Coroner's Report had been received, and therefore had been responsive and followed standard reporting procedures, once the concern had become known.

b) The Director of Nursing and Quality has asked the CQC for examples from other Trusts of how similar situations had been reported differently, to see if there are any lessons for the Trust to learn.

c) The Trust's action plan in relation to this SIRI was being developed and implementation reports would be made regularly to the Executive Committee.

7. ED Sepsis CQUIN

Performance against the Sepsis CQUIN was reviewed and the Director of Nursing and Quality had convened a meeting with clinical leads to develop a recovery plan.

8. St Helens Cares IT Developments

CW reported on proposals to develop a shared care record for St Helens

27th July 2017

1. Impact of Referral Management (RMS)

a) The Surgical Care Group had undertaken an analysis of the impact of RMS on income and activity and a comparison of referral rates over 4, 9 and 12 months.

b) From June 16 to June 17 outpatient referrals have dropped by 3.2%, across all CCGs.

c) The initial increase in urgent and two week referrals following the implementation of RMS had now settled and was not a cause for concern.

d) Options for future use of capacity in response to RMS were discussed, linked to theatre capacity, waiting lists and consultant job plans.

2. Debrief from Manchester Arena Attack

a) The Executive Committee reviewed the key learning summary and recommendations from NHSE following the recent terrorist attack on Manchester, to ensure the Trust was adapting its emergency preparedness plans to be able to respond to this type of incident.

b) Communication issues out of normal hours for Bronze Command needed to be reviewed for on call staff.

c) Further training and "dummy runs" are being arranged for the Executive team before May 2018.

d) Loggist refresher training is also being organised.

3. Recruitment and Retention Initiatives

As part of the on-going initiatives to improve nurse recruitment and retention, a priority is to maximise retention of staff. It was agreed that any staff choosing to leave the Trust would be offered the option to have their exit interview with an Executive Director. This would also be extended to student nurses following placements at the Trust.

4. CQPG Feedback

a) Cancer 62 day waiting times performance had been raised following a small dip in performance in May. Performance had subsequently recovered, and was due to a small number of patients, which the Director of Operations was investigating.
b) The CCG have signed off 9 SIRIs reports as green.

5. Management of Colorectal Cancer patients

The shared pathways for patient management between the Trust and Clatterbridge Cancer Centre were discussed. It was agreed that it was better for patient experience if they remained under the care of the Trust for the whole of their treatment.

3rd August 2017.

1. SafeCare Implementation Costs Business Case

a) The Executive Committee reviewed the outline business case for the on-going costs of maintaining the SafeCare staffing system, following its implementation in 2016/17.
b) The case required further financial analysis of the qualitative and quantitative benefits of the system and how it is being used by the Trust to support safe staffing, and is due to come back to the Executive Committee for further consideration in September.

2. Alcohol Hand Gel

Following the recent Coroners report and concerns about patients consuming alcohol gel the Director of Nursing and Quality presented research evidence that alcohol hand sanitisers were the most effective in killing germs, and therefore should continue to be used in all areas of the hospital. The risk of alcohol gels being consumed by alcoholic patients had to be evaluated against the benefits to patients at risk of infection and a management plan would be put in place for vulnerable patients.

3. Ophthalmology GIRFT

a) The GIRFT inspection had taken place earlier in the year and the national team had recognised that the Ophthalmology Service was a good, profitable department.
b) There were 7 improvement recommendations and the report gave an update on progress in implementing the changes.
c) The required changes to consultant job plans to facilitate improved theatre utilisation were approved

4. ePayslips

a) Following the pilot with Medirest staff it was agreed to start rolling out ePayslips to all staff, starting with those who have access to a PC at work.
b) Specific proposals for the circa 1,000 staff who do not have a Trust log in will be brought back to the Executive Committee for approval.

5. 7 day services provision

a) The Executive Committee reviewed the submission that was required by NHS Improvement detailing the current position in relation to 7 day services and the action plan to increase this provision.

b) The benefits and challenges of achieving 7 day services were debated and it was agreed that the business cases from previous investments in 7 day services should be reviewed to assess the return on investment i.e. improved patient outcomes. The critical challenges for 7 day services are affordability and the ability to recruit specialist staff in the necessary disciplines.

6. Data Security

a) On 28th July, a data breach had occurred, relating to the personal information of some Junior Doctors.

b) The information was removed from the internet the same day, and all staff affected had been contacted.

c) The incident has been reported to the ICO and a full investigation is being undertaken.

d) A review of the security of all the externally provided IT systems used by the Trust has been instigated.

10th August 2017

1. Therapy Business Case

a) The Clinical Support Services Care group presented a business case for additional therapy posts to achieve extended access to Therapy “at the front door” to support the discharge to assess approach. This initiative was supported in principle by the Executive with the care group needing to assess if the increased income generated could cover the costs.

b) There were also pressures in Stroke and Burns and Plastics driven by increases in activity that would be picked up via the increased income for these specialities and the business cases to commissioners.

2. National Cancer Patient Survey Results 2017

a) The results of the survey for the Trust were presented by Pat Gillis and Diane Dearden, prior to publication of the national results. The results were very good with an overall rating of 8.9 which is above the national average on all 6 key indicators.

b) The results were not consistent for all specialities providing care to patients with cancer, and specific action plans are being drawn up to respond to these identified areas for improvement.

c) A full report on the Cancer Patient Survey results will be made to the Quality Committee.

3. Medway Programme Delivery Report

a) The monthly programme delivery report was given by the Director of Informatics to provide assurance that the Medway programme is being implemented to plan and no new risks have been identified. All workstreams were currently on track or ahead of time with the exception of reporting, but this now has a mitigation plan to ensure that the key milestones are achieved.
b) An independent technical review of the data migration plans has been commissioned to provide additional assurance in this critical area to ensure all patient information is protected and transferred.
c) The Executive Committee was also informed that the St Helens Cares Board is working to develop a business case for a shared care record across the health and care system.

4. IT Systems Review

In light of the recent cyber-attacks and data breaches the security of all the Trusts IT systems is being reviewed, this includes those not currently managed by the HIS. The identified systems have been stratified and assigned to a lead Director to clarify the system owner and system administrator.

5. Risk Management Council /Corporate Risk Register Report

A report from the Risk Management Council reviewing the Trusts risk register in July was presented and the risks escalated to the Corporate Risk Register were reviewed. No new high scoring risks had been reported and 4 of the CRR risks had been closed or downgraded since June.

17th August 2017

1. Agency Usage

a) The Deputy CEO/Director of HR presented the report on agency and locum usage in July. The overall number of breaches has decreased but staffing in some areas remains extremely challenging, particularly in ED, Paediatrics and Critical Care. .
b) It was confirmed that the Premium Payment Scrutiny Council has now been established, to provide high level review of all premium payments being made to Trust staff, to ensure these represented value for money.

2. Mandatory Training

The Executive Committee reviewed the mandatory training report and highlighted any services/departments where the target was not being achieved.

3. Complex Passwords

In line with best practice recommendations for data security the Trust will be introducing complex passwords from September 2017.

4. Winter Planning – Bed Reconfiguration Proposals

The Deputy Director of Operations presented options for reconfiguring beds at Whiston Hospital to increase the amount of medical beds to support patient flow over the winter. The preferred options required capital and revenue investment. There was also a risk to the delivery of the elective programme. These options are to be further refined and discussed with the CEO.

5. OPERA

a) The Director of Informatics gave a briefing on the service outage for OPERA, which had occurred during a routine patching exercise.
b) Upon investigation, it was found that corrupted data had been introduced into the system storage area, which had impacted upon the OPERA and to some degree the HEARTS systems.
c) This was entirely the fault of the supplier, who then worked with the Trust to implement a solution. Negotiations are underway regarding compensation.
d) Business continuity plans had been enacted and had worked effectively.
e) A lessons learned exercise will take place
f) An independent examination of the storage systems has also been commissioned.

6. Cancer Services

The Director of Operations reported on new funding that had been secured for Cancer navigators, and also on developments with the regional cancer strategy.

7. Marshalls Cross Primary Care

a) The Director of Transformation reported on the progress in preparing for the mobilisation of the interim contract to provide the Primary Care practice at Marshall Cross from 1st September.
b) It was also reported that the process of re-tendering the substantive contract for providing the service had commenced with a closing date of 15th September for bids.

8. CQC Inspections

a) The Director of Operations reported on two CQC inspections involving the Trust;
    i. Section 136 Mental Health Review w/c 21st August.
    ii. Halton Whole System Review which was in progress with a number of the Trust's Executive Team being interviewed.

24th August 2017

1. Vacancy Dashboard

a) The Director of Nursing and Quality presented the vacancy dashboard for July. The biggest risk remains band 5 Nurse recruitment, in some specialities.
b) It was agreed that there should be a deep dive into specific areas and this would reported in September to agree a plan of action.
c) The vacancy dashboard and safer staffing figures need to report consistent information, and current discrepancies are to be addressed.

2. Marshalls Cross Primary Care

a) Proposals for an innovative service model to meet the tender specification issued by St Helens CCG were presented. It was agreed that the Trust bid should include these innovative approaches.

b) The final bid would be approved by the Executive Committee prior to submission

3. Policy on Policies

An updated Policy on Policies was presented by the Assistant Director of Governance. This was reviewed by the Executive and it was agreed that a further iteration was needed to make the policy more accessible to staff.

4. Storage Area Network (SAN)

a) The Director of Informatics reported that the storage systems are available again, and supplemented with additional capacity. Mirrored data has been replicated and restored, and all systems are being returned to normal operations and resilience.

b) The HIS team were thanked for their hard work on this.

c) A root cause analysis is being completed with the SAN supplier, and is expected to be complete in early September.

d) All necessary steps to prevent any similar occurrences in the future were being undertaken.

5. STP Update

It was noted that Mel Pickup had been appointed as the new STP Lead for Cheshire and Merseyside. She will undertake this role in conjunction with her current role as CEO of Warrington and Halton Hospitals NHSFT.

31st August 2017

1. CQPG Feedback

The Director of Nursing and Quality gave feedback from the last CQPG meeting, items discussed were;

- Ante-natal and new-born screening
- Hospital acquired thrombosis
- End of life patient discharge planning.
- Community acquired e-coli.
- E-discharge summaries and duplication of letters.
- 18 week waits performance
- Stroke service update, including access to community beds and pathways for repatriating patients

2. STP Feedback

a) The Alliance LDS was submitting bids against the second tranche of national capital that had been announced. These were the same 4 bids that had been submitted for the first round of capital in May.

b) The C&M STP would review the bids submitted by each LDS and decide which would be submitted to NHSE

3. Well led Framework and Use of Resources Assessment

a) The Interim Director of Corporate Services gave a briefing on the new Well Led Framework and Use of Resources assessment that had been included in the NHS Improvement (NHSI) Single Oversight Framework for 2017/18. The Well Led assessment would be carried out during the next new style CQC inspection of the Trust and the use of resources assessment would be undertaken by NHSI, with the rating published on the CQC website.

b) There was also discussion about the resource requirements needed to meet the expectations of the new style CQC inspections and how the Trust could prepare itself.

7th September 2017

1. Non Invasive Ventilation (NIV)

a) Tushar Mahambrey, Simon Twite and Julie Hendry presented proposals for services for patients needing NIV.

b) There were several suggestions for how the current service offered by the Trust could be improved to achieve better outcomes.

c) The existing arrangements had been agreed as the best for patient safety at the time, but should be reviewed if there was now capacity in the respiratory service.

d) The Executive Committee agreed that this change is now required, and it was decided that KH will create a task and finish group to agree a deliverable proposal and to report back within 6 weeks.

2. PMO Impact Assessment and ROI

a) The Trust had established a PMO in March 2015, and the impact and return on investment compared to the original business case were examined.

b) The original objectives were re-examined

c) It was acknowledged that the PMO had undertaken a lot if valuable work, the challenge for the organisation was whether this had resulted in sustained change, once the PMO resource was withdrawn.

d) It was agreed that the PMO programme required high profile Executive sponsorship and then formal handover with agreed KPIs for sustained performance once the improvement intervention had been completed.

e) Future priority areas were the discharge processes, pre op assessment and theatre productivity

f) The reasons why staff do not adhere to the agreed processes following improvement events was discussed.

g) Whilst it was recognised that ‘hearts and minds’ sustain change, it was agreed that more assertiveness is needed to install and maintain amended processes.

h) Governance assurance and reporting back to Executive Committee would be strengthened via the Team to Team meetings

3. Consultant Job Plans

a) The Deputy CEO/Director of HR gave an update the eJob Planning system
b) Some difficulties had been encountered and more work on standardisation is required.

4. RN/HCA Staff Ratio

a) The Director of Nursing and Quality reported on analysis of the current funded Registered Nurse to HCA staff ratios in each inpatient area within the Trust.
b) The Trust's funded establishment delivered the recommended ratio of RNs to patients for both day and night shifts for all the inpatient areas.
c) The funded establishment also included HCA posts, in addition to the minimum requirements, where the acuity of patients was high.
d) It was recognised that it was easier to achieve a consistent approach to staffing on standard 32 or 33 bed wards. The ward bed configuration would be reviewed to achieve the highest degree of standardisation possible.
e) The effectiveness of current recruitment and retention plans was debated and alternative ideas considered that could improve the current situation, in the context of national staff shortages. As previously noted, a priority is to retain our existing staff.
f) The report on staffing ratios for the next Quality Committee should reflect the discussions, and provide the assurance that the evidence shows the Trust's funded nursing establishment is sufficient to provide safe care when compared to the national best practice standards.

5. IT Systems Review

a) The Director of Informatics gave an update on the IT Systems Review and confirmed that all the identified systems now had identified System Owners and System Administrators
b) Following a trawl of procurement information, the current total count of systems is 187.
c) A proposal for enhancing IT security systems across the HIS, to meet security essential criteria for reaccreditation and management of CareCERT alerts from NHS Digital, was presented. This would be taken to the next HIS Board
d) The new EU regulations were noted along with the possibility of large fines for those organisations that breach.
e) The MIAA review of current security systems is now complete, and an action plan has been developed.
f) Financial implications were discussed, and it was noted that these relate to all partners of HIS. It was recognised that funding the proposals would be challenging for all the partner organisations in the current financial climate.
g) The Executive Committee acknowledged and fully supported the presented paper in principle, but expressed concern on how the Trust would find money to pay for the enhanced security.
h) It was agreed that CW must discharge her duty and present the paper to the HIS Board.

6. Medway Programme Update

The Director of Informatics reported that the programme update was progressing well and all major workstreams are on plan to deliver in line with the Stage 2 Plan as submitted to NHSI.

7. Trust Board Agenda

Draft agenda was reviewed and minor amendments proposed.

8. Mortuary Building – St Helens Hospital

a) The Director of Finance and Information presented a briefing note on the proposed lease of the vacant mortuary building at St Helens Hospital for Committee consideration.
b) There were several issues that required more clarity before the proposal could be fully considered.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)080

Title of paper: Committee report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 19th September 2017 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints. 25 1st stage complaints received in August 2017; a decrease of 11% in comparison to July 2017, when 28 were received. The Trust responded to 58.8% of 1st stage complaints within agreed time frames during August, a decrease compared to July (78.3%).

2. Mortality Review. An update was provided on recent actions around mortality national guidance and the situation at STHK. A number of issues have emerged which have resulted in the number of completed mortality reviews being less than that required under the current system. Further issues highlighted were engagement, consistency, training and ultimately, learning from the mortality review process.

3. Action plan for ED medicines security. The report summarised overall performance against the Trust's standards for medicines storage and security in the Emergency Department. Overall, ED performance has improved from the June audit where the 10 monitored areas ranged from 3.5% - 53% compliance upto 50% - 100% compliance in August. An action plan is in place and further audit and review planned.

4. Nursing workforce funded staffing levels review. The report is to assure the Quality Committee that the current funded nursing workforce staffing levels in the adult inpatient areas, meets national adult staffing levels guidance and the nurse to health care assistant staff skill mix ratios agreed by the Trust Board. Overall, the guidance is met in STHK.

5. Safer staffing report. Information provided regarding nursing and midwifery staffing levels. Overall staffing fill rates for August were RNs on days 91.95%, RNs on nights 94.51%, care staff on days 110.10% and care staff on nights 117.06%. 12 wards have % fill rate less than 90%.

6. IPR. A&E performance, infection control, finance and HR targets were discussed. VTE performance remains below target.

7. Safeguarding training update. Overall assurance for both safeguarding children and adults was reported as "amber" due to on-going training rates for safeguarding children, safeguarding adults (Level 2 training – workbook) and Prevent being below target. All other areas within the KPIs are rated as fully compliant.

8. Cancer patient experience:

- The Trust's average rating is 8.9 for overall care.
- Trust's performance against the six key performance indicators for patient experience (cancer dashboard) above national average on all six.
- Cancer network overall performed well in overall care.
- Concerns regarding information provided by colorectal.
- Evidence improvement in performance for some cancer sites.
- Comparative with neighbouring organisations; evidence of high standard of patient experience.

9. Feedback from Councils:
   (a) Patient Safety Council – The Trust is lowest regionally for hospital acquired pressure ulcers. Pressure ulcer prevention training is at 49.94%.
   (b) Patient Experience Council – Malnutrition scores are now much more improved.
   (c) Clinical Effectiveness Council
   (d) CQPG
   (e) Executive Committee:
      - Following review by the Executive Committee, alcohol hand gel will continue to be used.
      - The Business case for therapy staff was considered and approved.
      - There was an update on IT systems data breach and Medway
      - Lot of work being carried out regarding winter planning.
      - Progress was reported in preparing for the mobilisation of the interim contract to provide the Primary Care practice at Marshall Cross from 1st September.
      - A report is required for Quality Committee regarding delivery of services at Marshalls Cross.

   (f) Workforce Council – Action is being taken regarding staff engagement; the volunteer strategy is being updated and the WRES report will be coming to Board.

AOB
Nik Khashu raised the issue of community care and how its quality is reviewed by the Quality Committee. It was agreed that this should be through the IPR.

Items to be escalated to the Board:

- Mortality Review
- Level 2 Safeguarding training
- Flu vaccinations
- Quality Assurance of community care.

Corporate objectives met or risks addressed: Five star patient care and operational performance.

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff and commissioners

Recommendation(s): It is recommended that the Board note this report.
Presenting officer: David Graham, Non Executive Director
Date of meeting: 27th September 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)081

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 21st September 2017

Summary:

Agenda Items

For Information

- Future Bed Model
  - The committee were updated on the plans to convert 16 surgical beds over to medical use following a detailed modelling exercise. The benefits to patients from reduced Medical Outliers, improved quality of care and the productivity gains from a reduced length of stay were noted.

- Carter Non-Pay Metric for Depreciation & Impairments
  - Discussion arising from the recent Carter benchmarking results which show Trust Depreciation as an outlier. Investigation proved a one off impairment had influenced an unfavourable result. The Committee were assured that excluding impairments from this benchmark would bring the Trust in line with peers.

- Trust SLR Quarter 1 2017/18
  - The report showed the placement of individual specialties on a matrix that measures financial and non-financial performance. The Committee noted the movement of some specialties at Q1 from 16/17 to 17/18 and a discussion around the impact of HRG4+ and activity performance took place. The Committee have asked for a development plan to outline the journey of SLR to SLM.

- Forecast Outturn 2017/18
  - Committee welcomed an early insight into the possible financial risks for the year. Included issues of STF achievement requirements, contracting issues, HRG4+ and CIPs.

- CIP Council briefing was accepted.

- Procurement Council briefing was accepted.

For Assurance

- 2017/18 CIP Update
  - The Committee accepted a report that showed the profile of transacted CIPs this year was broadly in line with previous years. However the balance of schemes remaining that are 'red' risk rated or unidentified has grown from 34% in 16/17 to 54% in 17/18. The Committee acknowledged the recovery actions presented in the paper and the risk remaining in the final 6 months of the programme.
  - The provisional timetable for the 2018/19 CIP programme was presented and it was asked for this to be monitored monthly basis.

- A & E update
    - Committee were assured about the progress seen from the year on year comparisons in performance.
    - The escalation of Delayed Transfers of Care (DTOC) to be strengthened.

- Integrated Performance Report Month 5 was reported
    - Discussion around ward dashboard performance and backlog waiting list was discussed.

- Finance Report Month 5 2017/18
    - Delivered year to date surplus of £2.0m, £1.0m behind planned surplus levels. In achieving this performance it was noted slippage in reserves and non-recurrent measures have been used. This will have to be replenished later in the year.
    - Specific risks in achieving outturn were discussed and included the ability to fully recover activity, exposure to tariff change, cost control / CIP risk and STF funding.
    - The Committee noted the risk associated with cash noting the forecast cash balance of £0.5m in December.

Actions Agreed

- Escalation to NHS Improvement calling for the exclusion of Impairments in the Carter Depreciation Metric. Verbal feedback at next F&P Committee. Action Nik Khashu.
- Winter plan paper to be presented to the October F&P Committee. Action Rob Cooper.
- Activity recovery plan and backlog recovery plan to be combined and presented to the October F&P Committee. Action Rob Cooper.
- Development plan to be presented to the Committee that outlines the steps needed to move SLR to SLM. Action Nik Khashu.
- Analysis of August 'pay spike' to be presented to the October F&P Committee, to triangulate areas of sickness, annual leave and attrition. Action Ann-Marie Stretch.
- Timetable for the roll-out of E-Rostering for all staff groups to be presented to the October F&P Committee. Action Ann-Marie Stretch.
- October F&P Committee to approve 18/19 CIP delivery programme plan. Action Nik Khashu.

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members, NHSI

Recommendation(s): Members are asked to note the contents of the report

Presenting officer: Denis Mahony Non-Executive Director

Date of meeting: 27th September 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)082

Title of paper: Committee Report – Audit

Purpose: To feedback to members key issues arising from the Audit Committee.

Summary: The Audit Committee met on 30th August 2017.

The following matters were discussed and reviewed:

External Audit (Grant Thornton):

- The Annual Audit letter which was agreed by the Committee.

Internal Audit (Mersey Internal Audit Agency – MIAA):

- Progress report on Internal Audit programme and report on follow-up audits

Anti-Fraud Services (MIAA):

- The Committee received an update on progress being made against the current anti-fraud plan.

Trust Governance and Assurance:

- The Director of Nursing update (DoN).

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the period 1 April 2017 to 31 July 2017 (ADoF).
- Aged debt analysis as at end of July 2017 (ADoF).
- Tender and quotation waivers (ADoF).

Any Other Business:

- Costing Assurance Review (HoCF)
- Update on progress re amending the Trust's Standards of Business Conduct policy to incorporate the model Managing Conflicts of Interest in the NHS policy (ADoF).
- For operational reasons, some minor amendments to proposed limits (Scheme of reservation and delegation) relating to the Pathology and Radiology Manager posts were agreed by the Committee (ADoF).

Key: Chair = Audit Committee Chair

DoF = Director of Finance

DoN = Director of Nursing, Midwifery & Governance

DoCS = Director of Corporate Services

ADoF = Assistant Director of Finance (Financial Services)

HoCF = Head of Corporate Finance

NB. There was no meeting required of the Auditor Panel required on this occasion.
Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): For The Board to be assured on the Trust Audit programme
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 27th September 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)083
Title of paper: Annual Audit Letter 2016/17
Purpose: This report summarises the work your external auditor, Grant Thornton has performed at the Trust for the Audit year 2016/17
Summary: The Annual Audit Letter was discussed and accepted at the Audit Committee on the 30th August. The key points to note from the audit are that the Auditors: **Financial statements opinion** Issued an unqualified opinion on the Trust's financial statements for 2016/17 on 23rd May 2017. **Value for money conclusion** Were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources. **Quality Accounts** Were satisfied that the Quality Account and the indicators reviewed were prepared in line with the regulations and guidance.
Corporate objectives met or risks addressed: N/A
Financial implications: N/A
Stakeholders: N/A
Recommendation(s): That the Trust Board sign off the Annual Audit Letter
Presenting officer: Nik Khashu, Director of Finance
Date of meeting: 27th September 2017

TRUST BOARD

Paper No: NHST(17)084

Title of paper: Strategic and Regulatory Update Report

Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.

Summary:

1. NHS Improvement – Changes to the Single Oversight Framework for 2017/18

   To advise the Board of the changes to the Single Oversight Framework (SOF) that have been proposed by NHS Improvement (NHSI) for 2017/18, and the performance information that will be used by NHSI to assess the Trusts regulatory status.

2. Consultation – NHS Standard Contract Regulations

   To inform the Board of changes being proposed by the Department of Health to the NHS Standard Contract to facilitate the development of Integrated Service Providers.

3. Consultation - Oversight of NHS Controlled Providers

   To inform the Board of proposals being made by NHSI to extend the scope of their regulatory oversight to “NHS Controlled Providers”

4. Board Development Programme

   To seek Board agreement to schedule 2 Board time out events in the next 12 months.

5. C&M FYFV Sustainability and Transformation Partnership - Update

   To bring the Board up to date with developments since July.

Corporate objectives met or risks addressed: Provide high quality sustainable services

Financial implications: This paper does not include a request for additional funding

Stakeholders: Patients, Staff, Alliance LDS Partners, C&M FYFV, Commissioners, NHSI

Recommendation(s):

1. The Board notes the report 2. The Board approves the proposed Board time out events
Presenting officer: Nicola Bunce, Interim Director of Corporate Services
Date of meeting: 27th September 2017

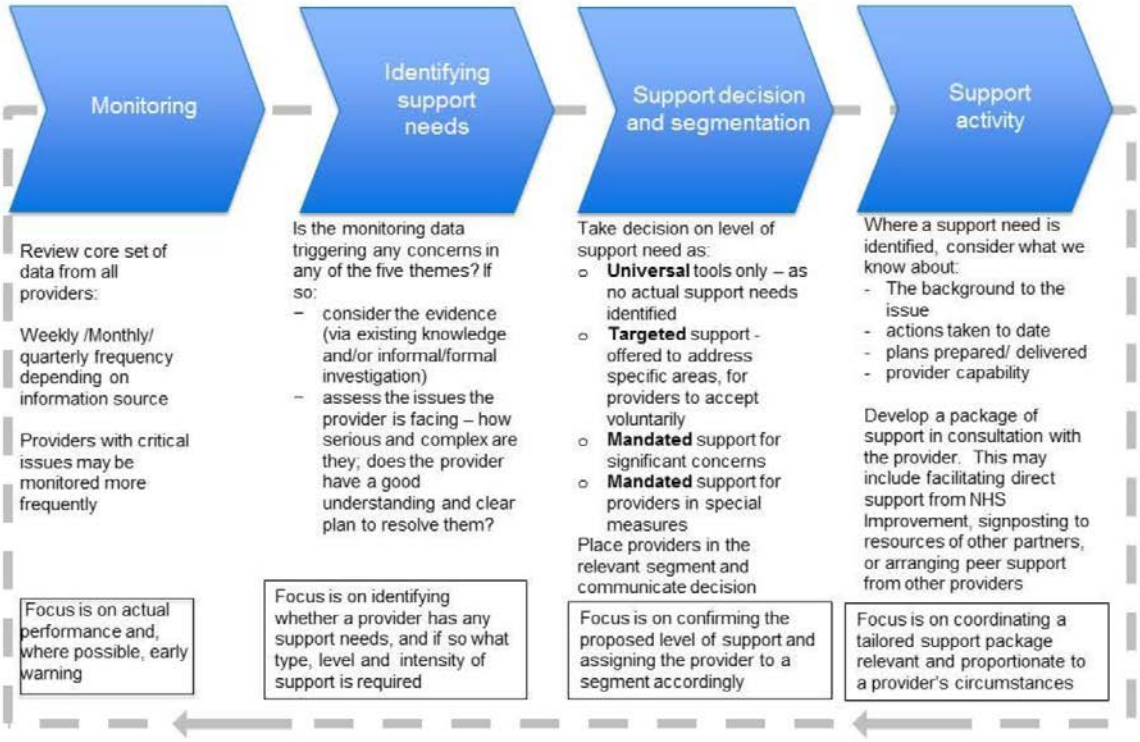
Strategic and Regulatory Update Report

1. Changes to the Single Oversight Framework for 2017/18

The Single Oversight Framework (SOF) is the regulatory framework developed by NHS Improvement (NHSI) to oversee the development and support needs of both NHS Trusts and Foundation Trusts, when the Trust Development Authority and Monitor came together in 2016.

NHSI are now proposing to make some changes to the SOF that will come into effect from October 2017.

SOF Oversight Cycle



The main changes are;

- To use the overall CQC rating as a trigger for intervention, rather than the ratings on individual domains
- To include E coli bacteraemia blood stream infection monitoring as a quality measure in line with national reduction target
- Put an explicit obligation on Providers to notify NHSI of significant actual or prospective changes against the organisations financial or performance plans
- Acute provider metrics to include dementia assessment and referral and the efficiency of patient flow at a provider and local progress in reducing DTOCs
- Performance triggers will **only** be linked to Sustainability and Transformation Fund (STF) trajectories for the A&E access target

Use of Resources Framework

A new Use of Resources (UoR) metric is being introduced. This has been developed to support the Care Quality Commission (CQC) to be able to include a UoR rating as part of its inspection regime.

The UoR assessment will be undertaken by NHSI and will give an overall assessment of a Provider based on;

- Finance metrics from the SOF
- Productivity metrics from the Model Hospital
- Local intelligence
- Evidence gathered on a site visit

The UoR will be rated using the CQC system of outstanding, good, requires improvement or inadequate and the results will be published by the CQC.

The UoR assessments will not necessarily be linked to a planned CQC inspection and will be undertaken "periodically" by NHSI, with the initial assessments starting for General Acute Trusts in 2017/18 and the aim of completing the first assessment of all Providers by 2019.

The Trust is currently reviewing its internal systems to ensure that it can collect measure and report all of the UoR metrics (Appendix A).

Well Led Framework

The SOF also formally introduces the revised Well Led Framework which was published in June 2017. To comply with the SOF NHS Providers are expected to use the framework to self-assess their own practice and meet the good practice requirement of commissioning an independent review of their governance and leadership practices every 3 – 5 years.

The Well Led Framework key lines of enquiry (KLOE) will be used by the CQC, when undertaking their new style inspections. The revised KLOEs are appended (Appendix B)

A working group including a number of the Trusts Directors has started to undertake the self-assessment and the results of this, with an accompanying action plan to address any identified areas for development will be reported to a future Board meeting.

The outcome of the self-assessment will also be used to inform the Board development programme.

2. Consultation – NHS Standard Contract Regulations

The Department of Health has started a consultation on changes to the regulations that underpin the NHS Standard Contract, to facilitate the development of Integrated Service Providers. Most significantly this allows for Primary Care Providers to

"suspend" their existing GMS or PMS contracts to be part of a new care model with other providers.

Additionally there is provision for Integrated Services Providers to be subject to the same regulatory and oversight frameworks as existing NHS Provider organisations.

If the changes go ahead as proposed this would remove some of the existing structural barriers to delivering Accountable Care.

3. Consultation – Oversight of NHS Controlled Providers

NHSI has started a consultation to extend the scope of their regulatory oversight to "NHS Controlled Providers". These proposals are also designed to ensure that where subsidiaries or joint ventures are used as vehicles to hold contracts or deliver care i.e. accountable or integrated care, they would be subject to the same regulatory framework e.g. the SOF, as all other NHS Provider organisations.

This would include subsidiaries and joint ventures between existing NHS Providers or with independent providers or general practices, if there is an annual turnover of over £10m.

The purpose of these changes is to create a single regulatory framework for all providers of NHS care, where care is carried out on behalf of or ultimately controlled by NHS Providers.

4. Board Development Programme

To facilitate the Board development described in section 1 it is proposed that in addition to the 5 strategy Board meetings the Board members should arrange two longer time-out sessions each year, to give time to explore areas of Board performance in more depth and to develop the Trusts future strategy.

5. C&M FYFV Sustainability and Transformation Partnership – Update

5.1 Mel Pickup, CEO of Warrington and Halton NHSFT has been appointed as the new STP lead for Cheshire and Merseyside (C&M).

She will work with Andrew Gibson the Executive Chair who was appointed by NHSE & NHSI in July.

The C&M STP have also advertised for a Director of Delivery.

5.2 NHSE has now published performance ratings for each STP Footprint based on the combined performance of all the member organisations. There are 4 potential ratings;

- Outstanding
- Advanced
- Making progress

- Needs most improvement

C&M was given a rating of 3 “Making Progress”

C&M STP Performance Dashboard July 2017

		Hospital Performance					Patient Focused Change							Transformation				
		Emergency	Elective	Safety			General practice		Mental health		Cancer			Prevention			Leadership	Finance
STP	Overall performance	A&E waiting time performance[1]	Referral to Treatment waiting time performance[2]	Providers in special measures[3]	Healthcare associated infections - MRSA[4]	Healthcare associated infections - c. difficile[5]	Extended access[6]	Patient satisfaction with opening times[7]	Improving Access to Psychological Therapies recovery rate[8]	Early Intervention in Psychosis 2-week waits[9]	% of cancers diagnosed at stage 1 or 2[10]	62-day waits[11]	Cancer patient experience score[12]	Emergency admissions rate[13]	Total bed days rate[14]	Delayed Transfers of Care rate[15]	System-wide leadership[16]	CCG/Trust performance vs. financial control total[17]
		Mar-17	Mar-17	May-17	2016/17	2016/17	Mar-17	Jul-17	Q4 2016/17	2016/17	2015	Q4 2016/17	2015	2016/17	2016/17	2016/17	Jun-17	2016/17
Cheshire and Merseyside	Category 3 - making progress	90.2%	91.8%	No	0.7	14.5	17.3%	78.0%	45.9%	76.3%	51.1%	84.3%	8.8	122	601	4,738	3 - Developing	-1.3%

The dashboard will be refreshed and published quarterly and will be used by NHSE and NHSI in their performance management of the “system”.

5.3 NHSI have issued proposals to develop 29 Pathology Networks across England based on a hub and spoke model to maximise efficiency and reduce unwarranted variation, in line with Lord Carter’s recommendations. The Network that StHK have been allocated to is;

- Aintree University Hospital NHSFT
- Countess of Chester Hospital NHSFT
- Royal Liverpool University Hospitals NHST
- Southport and Ormskirk Hospitals NHST
- Warrington and Halton Hospitals NHSFT
- Wirral University Teaching Hospital NHSFT

Workshops to explore how these proposals can be taken forward are being arranged in each of the suggested Networks.

ENDS

Appendix A

Use of Resources Proposed Metrics

Area	Initial Metric
Clinical Services	Pre-procedure non-elective bed days
	Pre-procedure elective bed days
	Emergency readmissions
	DNA rates
People	Staff retention rate
	Sickness absence rate
	Pay cost per weighted activity unit(WAU)
	Doctors cost per WAU
	Nurse cost per WAU
	AHP cost per WAU
Clinical Support Services	Overall cost per test
	Top 10 medicines
Corporate services, procurement , estates and facilities	Non-pay cost per WAU
	HR cost per £100m turnover
	Finance cost per £100m turnover
	Procurement process efficiency and price performance score
	Estates cost per Square Metre
Finance	Capital service capacity
	Liquidity (days)
	Income and expenditure (I&E) margin
	Distance from financial plan
	Agency spend

Appendix B

Well Led Framework - KLOEs

1. Is there the capacity and capability to deliver high quality sustainable care?

2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?

3. Is there a culture of high quality sustainable care?

4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

5. Are there clear and effective processes for managing risks, issues and performance?

6. Is appropriate information being effectively processed, challenged and acted on?

7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

8. Are there robust systems and processes for learning, continuous improvement and innovation?

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)085
Title of paper: Aggregated incidents, complaints & claims report for Quarter 1 2017/18
Purpose: This paper provides the Trust Board with a summary of quantitative and qualitative analysis of incidents, complaints, claims and inquests in the first quarter of 2017/18 (using information obtained from the Datix system). The report includes a summary of key issues identified and actions taken.
Summary for 01 April 2017 to 30 June 2017: **Incidents:** • Number of incidents affecting patients per 1,000 bed days: 47.61 • Number of incidents resulting in moderate harm or above per 1,000 bed days: 0.93 **Complaints:** • 53 1st stage complaints received, a significant decrease of 50% compared to Quarter 4 16/17. • Clinical treatment and admissions & discharges were the primary reasons for complaints. **PALS:** • 465 PALS concerns raised, representing a 7% decrease from Quarter 4 • Communication was the main cause of PALS concerns **Clinical Negligence Claims:** • 29 new clinical negligence claims received, a 7% increase compared to Quarter 4
Corporate objectives met or risks addressed: Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.
Financial implications: There are no direct financial implications arising from this report
Stakeholders: Patients, carers, commissioners, CQC and Trust staff.
Recommendation(s): Members are asked to consider and note the report.
Presenting officer: Anne-Marie Stretch, Director of HR
Date of meeting: 27th September 2017

1. Introduction

The Datix electronic reporting system allows incidents, complaints, claims and PALS information to be collated and cross-referenced. This report attempts to draw out the trends and learning derived from the aggregation and analysis of internal incident reporting and of the complaints, claims and PALS enquiries received by the organisation. The emphasis is on patient experience and safety. The information includes, reported incidents, serious incidents (SIs) reported on the Strategic Executive Information System (StEIS), complaints, PALS and litigation (claims and inquests).

The data included in this report covers 01 April 2017 to 30 June 2017.

2. Quantitative analysis

There were 3280 incidents during this period with 7 incidents reported to StEIS and 61 categorised as moderate harm or above. The Trust received 53 1st stage complaints, a 50% decrease compared to Quarter 4 2016/17, and 465 PALS concerns, a 7% decrease from Quarter 4. There were 29 new clinical negligence claims in Quarter 1 which represents a 7% increase from the previous quarter.

3. Top five themes

Table 1: Top five themes from incidents, complaints, PALS and claims

Incidents		Complaints		PALS		New clinical negligence claims	
Accident that may result in personal injury	782	Clinical Treatment	19	Communications	109	Failure to diagnose/ treat	11
Implementation of care or on-going monitoring/ review	530	Values and Behaviours (Staff)	9	Admissions and Discharges (excl. delayed discharge re care package)	86	Failure to warn (informed consent)	5
Access, Appointment, Admission, Transfer, Discharge	372	Admissions and Discharges (excl. delayed discharge re care package)	8	Appointments	69	Failure to recognise complication of treatment	3
Medication	333	Communications	8	Patient Care/ Nursing Care	46	Intra-operative problems	2
Clinical assessment (investigations, images and lab tests)	251	Patient Care/ Nursing Care	4	Clinical treatment	42	Fail/ Delay treatment	2

Note: The chart above should be used as guidance only as the claims received often fall into more than one category, for example there may have been negligent performance of a surgical procedure followed by a fall on the ward, or failure to diagnose a condition with general unhappiness regarding the care received.

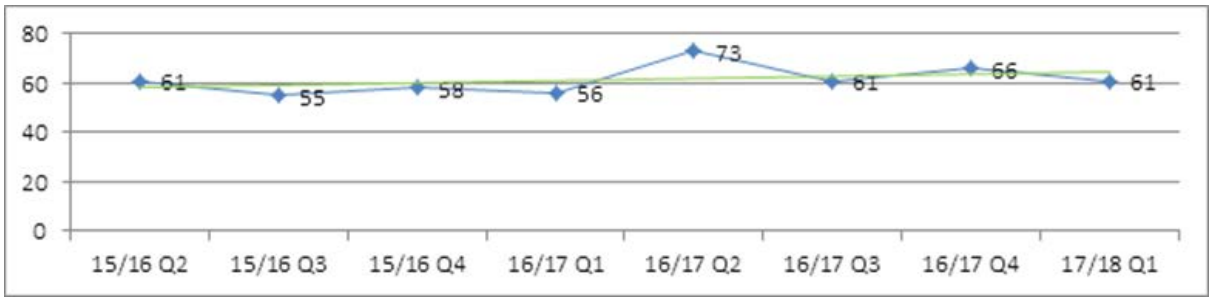
Colour key for top ten themes

Clinical care
Communication and records
Access/admission/discharge issues
Attitude/behaviour/competence

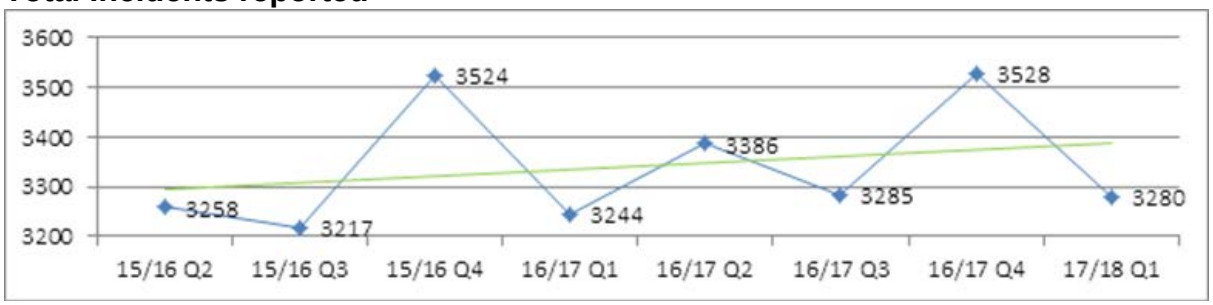
4. Incident data

The charts below shows the organisation's activity for reporting against harms (moderate and above) for Quarter 2 2015-16 to Quarter 1 2017-18, showing a slight decrease overall. The Trust tends to experience a slight increase in incident reporting during Q4 which is in keeping with winter pressures. Incident reporting appears to resume to average reporting numbers in Q1 onwards. This trend is evident over the last 18 months.

Moderate Harm and above



Total Incidents reported



4.1. Thematic analysis of incidents reported to StEIS in quarter 1 2017/18

Incidents reported to StEIS in quarter 1 2017/18 by top three categories:

	Q1 2017/18
Slips, Trips & Falls	4
Sub optimal care of a deteriorating patient	2
Alleged abuse by a health professional	1

4.2. Actions taken as a result of serious incidents

A root cause analysis investigation is undertaken of each serious incident, with recommendations and an action plan produced to reduce the risk of a reoccurrence.

Examples of the actions taken include:

- Conducted a review of how the Trust reviews and actions histology reports;
- Agreed a standard communication process for changes in care made outside the cancer MDT pathways;
- Provision of ward based falls training as part of a programme of falls walk around conducted by the Falls Service;
- Raise awareness of falls risk as part of a trust wide falls campaign;
- eMEWS now show details of previous MEWS score and observation after entering each set of patient data allowing staff to assess the MEWS score in the context of previous observations;
- Frailty and falls assessment tools have been added to the assessment record used in ED

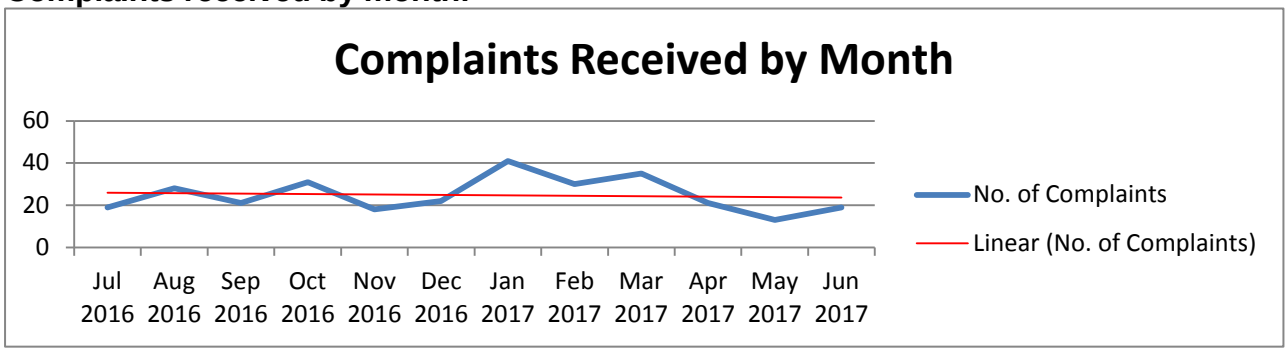
- Radiology have introduced a process of random audit of cases where a sample of images are double reported by external radiologists;
- All cord and clip alarms have been removed across the organisation and replaced with pressure pad alarms;
- The bedrails policy has been reviewed and the bedrail assessment has been redesigned to ensure that bedrails are used by exception.

5. Complaints and PALS

The following data is based on figures that are generated via DatixWeb and are correct at the time of reporting.

The chart below highlights the complaints received in the previous 12 months. The chart details the significant decrease in the number of complaints received in Quarter 1 2017/18 compared to Quarter 4 2016/17. This decrease is also reflected in both the number of incidents and PALS concerns recorded.

Complaints received by month:



5.1. Actions taken as a result of complaints

Each complaint response includes any learning that has been identified and the necessary actions in each area. This has included:

- Staff training and awareness raising
- Individual reflections by staff
- Dissemination of required changes at team meetings
- Development of a new ambulatory care pathway to speed up and improve care for urgent cases that do not require inpatient treatment.
- Production of a specific leaflet detailing the complications of a procedure.
- Introduction of sepsis stickers and posters to alert staff to patients who are suspect of having neutropenic sepsis.
- Prompt added to ED documentation to remind staff to consider the possibility of sepsis.
- Formulation of a formal process to support women with babies on the Neonatal Unit whilst they are in the postnatal period.
- ED now stock plastic bottles for the safe transport od paediatric blood cultures.
- Educational sessions being conducted by Paediatric Consultant in relation to Upper GI problems in children.
- New posters/signage in relation to safety of valuables.

6. PALS data

There were 465 PALS contacts/enquiries during Quarter 1 2017/18. This represents a 7% decrease compared to Q4 2016/17. The main themes for PALS contacts are shown in table 1above.

7. Legal Services Department Activity

7.1. Clinical Negligence Claims

The Trust received 29 new claims in Quarter 1, representing a small increase compared to the 27 new claims in previous quarter and a 12% decrease compared to the equivalent period in 2016/17.

18 new claims were received by the Surgical Care Group, 10 by Medical Care Group and 1 for Clinical Support Services.

7.2. Actions taken as a result of claims

Learning is identified following each claim and improvements are undertaken to prevent a repeat of the incident. The following are examples of changes made as a result of claims:

- Teaching sessions have been delivered by Falls Nurse Specialists to ward teams.
- Publication in the Radiology Newsletter relating to protecting patients from skin to skin contact during an MRI scan.
- Ward staff oxygen management training.
- New Falls Assessment Tool and Care Plan introduced.
- New Bedrail Assessment Tool Introduced.

7.3. Inquests

The Trust, via the Legal Department, proactively manages non-routine Inquests. These Inquests are when members of Trust staff are called to give evidence and/or there are novel or contentious issues. In many cases there are lessons to be learned and require a corporate witness to inform the Coroner of these lessons and what action has been subsequently taken to prevent recurrence. The Press and Public Relations Office are also kept informed if there is any potential for media interest and therefore a risk to the organisation's reputation.

Currently there are 9 open Inquests that fall within the above criteria

One Inquest was conducted in Quarter 1 and the outcome was Accidental Death.

Conclusion

In Quarter 1 2017/18, the number of incident, complaints and PALS enquiries all fell. The primary causes for incidents, complaints and clinical negligence claims throughout Quarter 1 2017/18 have been of a clinical nature. In comparison, the primary reason for PALS concerns has been communication. However, complaints often include multiple reasons for a complaint and communication is cited as the main secondary cause of complaint in the same time period.

The second leading cause of both complaints and PALS concerns are, however, similar and related to admissions and discharges.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)086
Title of paper: Learning From Deaths Policy
Purpose: To present the Policy on Learning from deaths' for approval.
Summary: The paper summarises the key points of the national guidance that was published in March and the responsibilities and accountability of the Trust Board to oversee the process. The paper also details the data collection and reporting requirements from quarter 3 of 2017/18.
Corporate objectives met or risks addressed: To deliver safe care
Financial implications: None initially as a direct consequence of this paper
Stakeholders: Patients, the public, patient representatives, commissioners, regulators
Recommendation(s): 1. The board approves the Policy to ensure that the Trust can respond appropriately and learn lessons from unexpected deaths 2. The Board confirms the Medical Director as the Executive Director with responsibility for the deaths agenda 3. The Board confirms the Deputy Chair as the Non-Executive Director who will take oversight of the process
Presenting officer: Professor Kevin Hardy, Medical Director
Date of meeting: 27th September 2017

Learning from Deaths Policy

1. Purpose

1.1 To set out the responsibilities and accountabilities of the Board to meet the national guidance on reviewing deaths, and provide assurance that the trusts proposed policy and governance arrangements satisfy these requirements.

1.2 To present the Policy on learning from Death for approval by the Board

2. Background

2.1 Following the recent reviews in to hospital deaths; Mid Staffordshire, Morecombe Bay, the Southern Health, guidance was published jointly by NHS England, NHS Improvement and the Care Quality Commission.

2.2 Following a review of 14 hospitals with the highest mortality it was observed that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

2.3 The findings of the Care Quality Commission (CQC) report '*Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also identified that there is more to be done to engage families and carers and to recognise their insights as a vital source of learning.

3. **The Guidance**

3.1 The guidance sets out a number of requirements for NHS Boards and a timetable for action;

- To fulfil the standards and new reporting for acute, mental health and community NHS Trusts and Foundation Trusts, Trusts should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care.

- Have an Executive Director take responsibility for the learning from deaths agenda (Annex A)

- Have an Non-Executive Director take responsibility for oversight of progress (Annex B)

- Providers should review, and if necessary, enhance the skills, protected time and training of staff to review and investigate deaths to a high standard

- Develop a clear policy for engagement with bereaved families and carers

4. Timetable

Requirement	Deadline	Current Status
Board approved Policy on learning from Deaths, which includes how it identifies, responds to and learns from deaths to patients including individuals with a learning disability, mental health needs, an infant or child and a still birth or maternal death.	September 2017	September 2017 Board Meeting for approval
Collect and publish on a quarterly basis specified information on deaths, including identified learning points, in accordance with the suggested format (Annex C)	Q3 2017 (reported January 2018)	In development
Include summarised data in the Trust Quality Account, with evidence of learning and actions taken	June 2018	In development

5. The policy

5.1 To comply with the guidance the Trusts policy must set out how providers will:

- determine which patients are considered to be under their care and included for case record review if they die (it should also state which patients are specifically excluded);
- report the death within the organisation and to other organisations who may have an interest (including the deceased person's GP), including how they determine which other organisations should be informed;
- respond to the death of an individual with a learning disability or mental health needs, an infant or child death and a stillbirth or maternal death and the provider's processes to support such deaths;
- review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past;
- review the care provided to patients whose death may have been expected, for example those receiving end of life care;
- record the outcome of their decision whether or not to review or investigate the death, which should have been informed by the views of bereaved families and carers;
- engage meaningfully and compassionately with bereaved families and carers - this should include informing the family/carers if the provider intends to investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that

they wish to be involved. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this.

- offer guidance, where appropriate, on obtaining legal advice for families.

5.2 The proposed policy for the Trust (Annex D) addresses all of these issues.

6. Current Position

The existing Mortality Review processes used by the Trust have been reviewed and the strengths and areas for further improvement have been identified;

- The Trust has well-established processes to monitor and report mortality data using a national standardised methodology.
- The Trust has well-established governance structures and escalation processes for monitoring and reporting untoward incidents and responding to any identified concerns in patient care
- A mortality review process to screen/review all deaths.
- Well established Mortality and Morbidity meetings across all major specialties
- There is also a Mortality Review Group with Non-Executive Director involvement
- The Trust has the resource necessary to support the revised policy on Learning from Deaths
- Additional performance monitoring of the identified KPIs is now required to deliver a consistent approach and oversight of the process. This will be provided by the Medical Director to ensure that the Trust is fully compliant with the new guidance.
- The first quarterly report will be presented to the Board in January 2018.

7. Further national developments

The agenda on learning from deaths will continue to be strengthened and further national developments highlighted in the guidance are:

- The Care Quality Commission will strengthen its assessment of providers learning from deaths during its inspections including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- NHS England, will develop guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour1 and the *Serious Incident Framework*2 and cover how families should be engaged in investigations.
- Health Education England will review the training of doctors and nurses on engaging with bereaved families and carers.
- Acute Trusts will receive training to use the Royal College of Physicians' Structured Judgement Review case note methodology.
- Health Education England and the Healthcare Safety Investigation Branch will engage with system partners, families and carers and staff to understand

broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.

- NHS Digital is assessing how to facilitate the development of provider systems and processes so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.
- The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled particularly how providers and the wider care system may better capture necessary learning from these incidents3.

ENDS

Annex A

BOARD LEADERSHIP – KEY POINTS

The board should ensure that their organisation:

• has a board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and a non-executive director to take oversight of progress
• pays particular attention to the care of patients with a learning disability or mental health needs
• has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review
• adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented
• ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur
• ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised
• ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts
• shares relevant learning across the organisation and with other services where the insight gained could be useful
• ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths
• offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death
• acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved
• works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

Annex B

Non-Executive Director

1. The board of directors of an NHS Trust or Foundation Trust is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the board of governors.

2. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Learning from Deaths

Executive and non-executive directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

- the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;
- quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and
- the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5. From April 2017, providers will start to collect and publish new data to monitor trends in deaths. Alongside this, they will need to establish an ongoing learning process. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. The roles and responsibilities of non-executive directors include:

Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:

- be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?

- seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons;
- ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
- is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
- how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
- are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
- for coordination of responses to reviews/investigations through the provider's clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?

Champion and support learning and quality improvement such as:

- ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
- understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
- understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients – ensuring that learning and improvements are reported to the board and relevant providers;
- supporting any changes in clinical practice that are needed to improve care resulting from this learning;
- ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
- paying attention to the provision of best practice and how the learning from this can be more broadly implemented.

Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:

- ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
- checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
- checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;

- ensuring the organisation can demonstrate to stakeholders that “this is what we said we would do, and this is what we did” (learning and action), and explain the impact of the quality improvement actions.

Sample – Learning From Deaths Dashboard

NHS Anytown Foundation Trust: Learning from Deaths Dashboard - September 2017-18

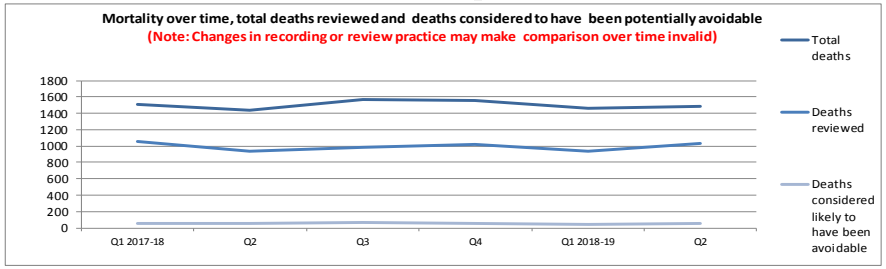
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

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

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



Total Deaths Reviewed by RCP Methodology Score

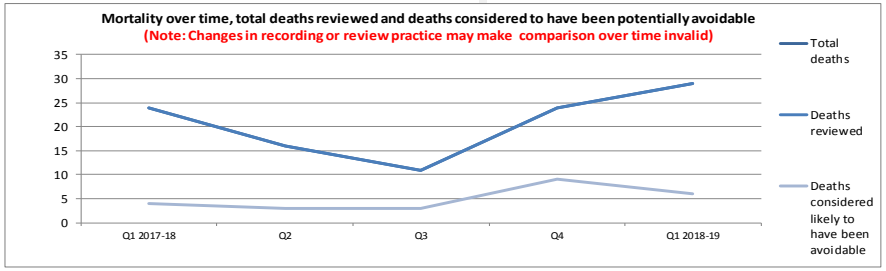
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	4	1.2%	This Month	10	2.9%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

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

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

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

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



St Helens and Knowsley Teaching Hospitals NHS Trust

MORTALITY REVIEW – RESPONDING TO, AND LEARNING FROM, THE DEATH OF PATIENTS UNDER THE MANAGEMENT AND CARE OF THE TRUST

Document Summary-

This document outlines the policy on Learning from Deaths in response to the *National Guidance on Learning* from deaths published by the National Quality Board in March 2017

DOCUMENT NUMBER	*Will be added by the Governance team*
APPROVING COMMITTEE	Trust Board
DATE APPROVED	27th September 2017
DATE IMPLEMENTED	1st October 2017
NEXT REVIEW DATE	30th September 2018
ACCOUNTABLE DIRECTOR	Professor Kevin Hardy
POLICY AUTHOR	Dr Terence Hankin
TARGET AUDENCE	Consultant Medical Staff
KEY WORDS	Mortality Review

Important Note:

The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as "uncontrolled" and, as such, may not necessarily contain the latest updates and amendments.

CONTENTS

1 SCOPE

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

2 INTRODUCTION

St Helens & Knowsley NHS Trust has an established mortality review process. The Care Quality Commission (CQC) report **Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients** in England was published in late 2016 and found that learning from deaths across all Trusts was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report highlighted the need to engage families and carers more to use their insights as a vital course of learning. Following the CQC report the National Quality Board issued guidance in March 2017. To meet these new standards the process at STHK has had to be amended.

This policy sets out how the Trust will implement the national guidance and describes the governance that will assure consistency, reliability and resilience of delivery.

3 STATEMENT OF INTENT

The Trust will implement the requirements outlined in the Learning from Deaths framework to supplement the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Trust.
It describes how the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff that may have been affected by the death of someone in the Trust's care.

It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the Trust's procedures: for reporting and managing incidents, Serious Incidents, quality improvement, complaints management and the existing mortality governance processes.

4 DEFINITIONS

The National Guidance on Learning from Deaths includes a number of terms. These are defined below.

Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review

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

Mortality review

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology, to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.

https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Severe Mental Illness

This is defined in terms of five groups of disorders from the International Classification of Diseases (ICD):

- schizophrenic and delusional disorders

- mood (affective) disorders, including depressive, manic and bipolar forms
- neuroses, including phobic, panic and obsessive–compulsive disorders
- behavioural disorders, including eating, sleep and stress disorders
- personality disorders of eight different kinds.

Investigation

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

Death due to a problem in care

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

Quality improvement

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

Patient safety incident

A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

5 DUTIES ACCOUNTABILITIES AND RESPONSIBILITIES

Role	Responsibility
Trust Board	The National Guidance on Learning from Deaths places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the National Guidance on Learning from Deaths

Chief Executive	To identify a lead Executive Director to be accountable for compliance with the policy and reporting the avoidable deaths dashboard to the Trust Board
Medical Director	On delegation of the Chief Executive is accountable to the board of directors for compliance with this policy across the Trust and, as such, has responsibility for the learning from deaths agenda
Director of Nursing	Acting as patient safety director to take responsibility for learning from deaths agenda
Non-executive Director	Responsibility for oversight of the investigation, review and learning process. In summary, non-executive director responsibilities relating to the framework include: • understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny • championing quality improvement that leads to actions that improve patient safety • assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.
Chair Mortality Surveillance Group (MSG)	This multi-disciplinary, multi-professional group is responsible for overseeing the process of mortality reviews; highlighting areas for particular investigation, tracking reviews and assuring that learning has been disseminated. Is responsible for ensuring and assuring that the Duty of Candour is fulfilled in feeding back findings to bereaved relatives and carers.
Medical Examiner	Responsible for operational role out and development of the policy. To have operational oversight of the whole process to ensure KPI's are met. Reports to the Deputy Medical Director.

Principal Analyst	Is a member of the MSG and is responsible for reporting mortality indices and trends in HED data to the group thereby highlighting diagnostic groups for particular review.
Chair Clinical Outcomes Committee (COC)	To oversee the process of retailed case review and advise on learning outcomes to the MSG
Paediatrics/children and young people	Is informed of the death of any infant or child as defined in annex F of the national guidance
Lead Clinician Palliative Care	To inform the MRG where possible failures of care may have influenced 'death' expectancy in palliative care patients
Head of maternity/maternity lead	To inform the MSG of any stillbirth or maternal death as defined in annex G of the national guidance
Mental health lead	To inform the MSG of every death involving patients with Mental health need as defined in Annex E of the National Guidance
Safeguarding lead	To inform the MSG of every death of a patient with a learning disability in the Trust and is responsible for completing the notification form and submitting it to The Learning Disabilities Mortality Review (LeDeR) Programme delivered by the University of Bristol.
Complaints and Legal Services Manager	To identify and report to the MSG all complaints and legal claims relating to any patient who has died in the Trusts care
Patient Safety Manager	To monitor DATIX and report to the MSG any deaths that have a DATIX entry associated with them
Assistant Director Patient safety	To identify and report any patient safety concerns possibly leading to the death of a patient in the Trusts care
All staff	All staff have a responsibility to report concerns to their line manager or the Trust Executive regarding perceived failures of care, in reference to this policy

6 THE PROCESS FOR REVIEWING DEATHS IN CARE

Case record review

The principles to be applied for case record review are:

- The Structured Judgement Review (SJR) methodology developed by the Royal College of Physicians will be used for the initial review
- Reviewers will be selected by the MSG to include expressions of interest from senior clinicians (fully registered for more than 5 years) from any discipline
- Reviewers will be trained in the use of the methodology to ensure consistency
- Case record reviews will be carried out by clinician's not directly involved in the care of the patient unless the expertise resides only in that specialty, in which circumstances the review should include clinicians not involved in the care of the deceased
- A quality assurance framework will be implemented to audit a proportion of the reviews to ensure consistency of reviewing, this representing a minimum of one review by each reviewer each quarter
- In the event that major failings of care are identified during a case record review the reviewer will escalate the findings to the MSG for consideration of investigation under the Serious Incident Framework

7. LINKS WITH EXISTING PROCEEDURES

The Trust already has an established governance system for managing untoward incidents. There is a Mortality Review Group (MSG), which reports through to the Board via the Quality Committee.

There are systems in place for capturing and reporting and escalating untoward incidents via DATIX, Serious Incident (SI) reporting and Strategic Executive Information System (StIES)

Any deaths where a concern has been raised outside of the established pathways will be cross referenced with them to inform any detailed review of the case where it has not already taken place.

8. THE PROCESS FOR RECORDING DEATHS IN CARE

Currently all inpatient deaths are captured from the PAS system and reported monthly in the Integrated Performance Report (IPR) and also on Qlickview. Each death is then assigned to a trained consultant reviewer.

The Trust also use Healthcare Evaluation Data (HED) which allows healthcare organisations to utilise analytics which harness HES (Hospital Episode Statistics), national inpatient and outpatient and ONS (Office of National Statistics) Mortality data sets. Key mortality statistics from HED are also reported monthly in the IPR.

Deaths of patients within 30 days of discharge are currently reported in the IPR by using SHMI (Summary Hospital-level Mortality Indicator) methodology. This is reported in the IPR however there is lag in the reporting of this. For the purpose of reviewing deaths within 30 days of discharge the Trust will capture this information by making requests to the 'Spine'. The 'Spine' is provided by NHS digital to support the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations.

9. SELECTING DEATHS FOR CASE RECORD REVIEW

Cases will be identified for investigation or review in a number of ways. Some are mandated by the national guidance:

- All deaths where bereaved families, carers or staff have raised significant concerns about the quality of care provided (which will be collected from a number of sources including PALS, Datix incident reports, PALS, Complaints and Speak Out Safely reports)
- All deaths where others outside the Trust e.g. the Clinical Commissioning Group, Community and/or Mental Health Trusts, Primary Care, other Acute Trusts have raised significant concerns about the quality of care provided
- Death in an individual with a learning disability
- Death in an individual with severe mental illness
    - Neonatal or Maternal Deaths
    - All unexpected deaths e.g. following elective procedures
    - All Cardiac arrest deaths

In addition, all deaths within a particular diagnosis group or specialty that have been subject to, for example, a CQC "mortality outlier alert" or that have identified by the MSG as an outlier via SHMI or HSMR will be subject to case record review.

A further random sample of case records representing 25% of the total deaths.

75% of inpatient deaths will be screened by the certifying doctor for concerns during the death certification/ medical certification for Cremation process.

Deaths within 30 days of discharge will be examined by the MSG to identify themes such as diagnostic groups. Any trends that give concern will be further investigated at the direction of the MSG.

Any case subject to the issue of a Coroner's "Regulation 28 Report on Action to Prevent Future Deaths" should be reviewed or re-reviewed; this in order to consider the effectiveness of capturing significant incidents, and to ensure that the learning from a previous review is consistent with the report.

10. REVIEW METHODOLOGY

In those circumstances in which either the Serious Untoward Incident Panel or the MSG decide that a death warrants an investigation this should follow the circumstances for investigation in the Serious Incident Framework.

Case record review
The principles to be applied for case record review are:

- The Structured Judgement Review (SJR) methodology developed by the Royal College of Physicians will be used except for-
- Children. Reviews of these deaths are mandatory and should be undertaken in accordance with Working together to safeguard children (2015) and the current child death overview panel processes.
- Learning Disability. The Trust will use the LeDeR method to review the care of individuals with learning disabilities, once it is available in their area.
- Perinatal and Maternity. All perinatal deaths should be reviewed, using the new perinatal mortality review tool once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly
- Reviewers will be selected by the MSG from senior clinicians (greater than 5 years post qualification) from any discipline
- Reviewers will be trained in the use of the methodologies to ensure consistency
- Case record reviews will be carried out by clinician's not directly involved in the care of the patient unless the expertise resides only in that specialty, in which circumstances the review should include clinicians not involved in the care of the deceased
- A quality assurance framework will be implemented to audit a proportion of the reviews to ensure consistency of review, this representing a minimum of one review by each reviewer each quarter
- In the event that major failings of care are identified during a case record review the reviewer will escalate the findings to the MSG for consideration of investigation under the Serious Incident Framework

From the date of identification of a concern, the full review process and intial contact with the bereaved will be completed within 6 months.

11. STAFF TRAINING AND SUPPORT

In light of the publication of Learning from Deaths, the RCP received a request from the contract commissioners (HQIP) to deliver training for Structured Judgement Review (SJR). A cohort of committed reviewers from the Trust will access this training.

The trained cohort will then offer training and support to all potential reviewers within the Trust.

All Doctors employed by the Trust will receive DATIX training to support the learning from deaths agenda.

The Medical Examiner will ensure that there is sufficient expertise and training to support the review of deaths of Children, patients with learning disability, perinatal and Maternal Mortality.

12. SELECTING DEATHS FOR INVESTIGATION

Where a review carried out by the Trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the Trust's Serious Incident policy
http://nww.sthk.nhs.uk/MANAGE/library/documents/9854905_IncidentReportingPolicy.pdf

13. REVIEWING OUTPUTS FROM REVIEW AND INVESTIFGATION TO INFORM QUALITY IMPROVEMENT

- The Chair of the MSG, the Medical Examiner and the Chair of the Clinical Outcome Group, will review and agree the lessons learned for circulation to the relevant groups or individuals using established pathways and forums.
- Clinical directors will be accountable for ensuring that speciality specific lessons learned are embedded in the practice of that speciality, and provide assurance to the Medical Examiner to that effect.
- The Deputy Medical Director will set up a network to share lessons learned across the region via Medical Directors.
- The medical appraisal system will be reviewed by the Responsible Officer to
- Encourage the recording and prioritising of 'learning from deaths'.
- Divisional Directors will ensure that 'leaning from deaths' is a fixed agenda item at all Mortality Meetings.

14. PRESENTING THE RELEVANT INFORMATION IN BOARD REPORTS

In accordance with the NQB guidance: From Q3 2017-18 a report will be published through a standard agenda item to a public Board each quarter. This report will include:

- Total number of the Trust's in-patient deaths (including Emergency Department)
- Number of deaths that the Trust has subjected to case record review.
- An estimate of how many deaths reviewed were judged more likely than not to have been due to failures in care.
- The number of adult inpatient deaths for patients with identified learning disabilities and the number reviewed through the LeDeR methodology
- The total number of deaths reviewed through the LeDeR methodology that were considered potentially avoidable

In addition, the report will detail how we have responded to the requirements to learn from deaths in individuals with mental health needs or from an infant or child death and a stillbirth or maternal death.

The report will also detail how the results of investigations have been shared with the bereaved family and carers.

From June 2018 a summary of the data collected and lessons learnt will be published in the Trust's Quality Accounts.

15. SUPPORTING AND INVOLVING FAMILIES AND CARERS

The National Guidance on Learning from Deaths specifies that providers should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death, and details the key principles that trusts should follow.

The 'Serious Incident Framework' update March 2015, Section 4 currently offers guidance and will act as the template for the engagement of the bereaved.

16. SUPPORTING AND INVOLVING STAFF

Staff involved in the care of a patient who may have died following a failure of care will be debriefed by this line manager and offered support by Health Work and Wellbeing.

Referrals to Clinical Psychology may also be made where appropriate.

17. KEY PERFORMANCE INDICATORS OF THE POLICY

Describe Key Performance Indicators (KPIs) **Must reflect**	**Frequency of Review**	**Lead**
A random 25% of all inpatient deaths to be reviewed	3 monthly	Medical Examiner/Deputy Medical Director
All deaths mandated to be reviewed such as death of a patient with a learning disability will have been captured and reviewed	6 monthly	Medical Examiner/DMD
Time from identification of a case for detailed review by the MSG to informing the bereaved where a failing of care has been identified by said review no more the 6 months in 90% of cases	6 monthly	Chair MRG
75% of inpatient deaths screened for concerns via the death certification/medical certification for cremation process	monthly	Medical Examiner

18. PERFORMANCE MANAGEMENT OF THE POLICY

Responsibility for the operational performance management and reporting on the effectiveness of the policy will lie with the Medical Examiner and the Deputy Medical Director.

The Medical Examiner will report directly to the Deputy Medical Director.

19. REFERENCES/ BIBLIOGRAPHY

Serious Incident Framework-

https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Learning from Deaths-

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

Care Quality Commission-

https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Being Open framework-

http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726

Saying Sorry-

http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

20. RELATED TRUST POLICY/PROCEDURES

Incident Reporting and Management Policy Inclusive of Serious Incident Procedure Version 9.
DOCUMENT NUMBER
STHK0082

Being open a duty to be candid Policy Reference number:STHK0057

Medical Care Group (MCG) Incident/Near Miss Management Inclusive of Serious Incidents Protocol. DOCUMENT NUMBER STHK0482

APPENDIX 1

Equality Analysis

"St Helens and Knowsley Teaching Hospitals NHS Trust is committed to creating a culture that promotes equality and embraces diversity in all its functions as both an employer and a service provider. Our aim is to provide a safe environment, free from discrimination, and a place where all individuals are valued and are treated fairly. The Trust adheres to legal requirements and seeks to mainstream the principles of equality and diversity through all its policies, procedures and processes.

The Trust takes a zero tolerance approach to all forms of discrimination, harassment and victimisation and will make every effort to ensure that no patient or employee is disadvantaged, either directly or indirectly, on the basis that they possess any of the "protected characteristics" as defined by the Equality Act 2010 . The protected characteristics are as follows: - race; disability; sex; religion or belief; sexual orientation; gender reassignment; marriage and civil partnership; pregnancy and maternity; and age.

This policy will be implemented with due regard to these commitments.

All authors of policy documents must include a completed equality analysis Stage 1 screening. Policy authors must refer to the Trust Equality and Diversity Policy 2011 and the equality analysis toolkit and associated guidance documents (Stage 1 and Stage 2) available on the intranet.

Equality Analysis for this policy

Equality Analysis Stage 1 Screening		
1	Title of Policy:	Learning from Deaths
2	Policy Author(s):	Terry Hankin
3	Lead Executive:	Kevin Hardy
4	Policy Sponsor	Kevin Hardy
5	Target Audience	Trust staff, patients, regulators, commissioners
6	Document Purpose:	This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the trust
7	Please state how the policy is relevant to the Trusts general equality duties to: • eliminate discrimination • advance equality of opportunity • foster good relations	Eliminate discrimination by ensuring that all deaths are screened and investigations take place for protected groups
8	List key groups involved or to be involved in policy development (e.g. staff side reps, service users, partner agencies) and how these groups will be engaged	Key clinical and corporate staff. Policy modelled on national template guidance
NB Having read the guidance notes provided when assessing the questions below you must consider; • Be very conscious of any indirect or unintentional outcomes of a potentially discriminatory nature		

- Will the policy create any problems or barriers to any protected group?
- Will any protected group be excluded because of the policy?
- Will the policy have a negative impact on community relations?

If in any doubt please consult with the Patient and Workforce Equality Lead

9	Does the policy **significantly** affect one group **less** or **more** favourably than another on the basis of: answer 'Yes/No' (please add any qualification or explanation to your answer particularly if you answer yes)		
		Yes/No	**Comments/ Rationale**
	• Race/ethnicity	No	
	• Disability (includes Learning Disability, physical or mental disability and sensory impairment)	Yes - favourable	All LD and Mental Health deaths are subject to full screening and further investigation where required
.	• Gender	No	
	• Religion/belief (including non-belief)	No	
	• Sexual orientation	No	
	• Age	Yes - Favourable	All Paediatric and neonatal deaths are subject to full screening and further investigation where required
	• Gender reassignment	No	
	• Pregnancy and Maternity	Yes - Favourable	All maternal deaths are subject to full screening and further investigation where required
	• Marriage and Civil partnership	No	
	• Carer status	No	
10	Will the policy affect the Human Rights of any of the above protected groups?	No	
11	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	Yes	Additional screening requirements for these groups, to ensure there is no discrimination
12	If you have identified a negative impact on any of the above-protected groups, can the impact be avoided or reduced by taking different action?	N/A	
13	How will the effect of the policy be reviewed after implementation?	The policy will be audited at least annually in line with the key performance indicators	

If you have entered yes in any of the above boxes you **must** contact the Patient and Workforce Equality Lead (ext. 1042/ Annette.craghill@sthk.nhs.uk) to discuss the outcome and ascertain whether a **Stage 2 Equality Analysis Assessment** must be completed.

Name of manager completing assessment: (must one of the authors)	Terry Hankin
Job Title of Manager completing assessment	Deputy Medical Director
Date of Completion:	September 2017

The Trust has a duty as a public body to publish all completed Equality Analysis Screening and Assessments. Please forward a copy of your completed proforma to Cheryl Farmer@sthk.nhs.uk The Patient Inclusion and Experience Lead will conduct an audit on all completed Screening and Assessments every six months.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)087
Subject: Annual Workforce Race Equality Standard Report WRES 2017
Purpose: To provide the Board with the annual WRES indicator report and update regarding associated action plan.
Summary: Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated. WRES has been part of the NHS standard contract, starting in 2015/16 and included in the 2016/17 NHS standard contract. This report provides the Board with 2017 data against the nine indicators within the WRES and action plan update. The WRES 2016/17 Action Plan was closed off at July's Workforce Council to allow for the introduction of the 2017/18 action plan aligned with the WRES 2017 results.
Corporate Objective met or risk addressed: Developing organisational culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to accept the report and after sign off, publicise its indicators on our website in line with our annual duty. To continue tracking indicators to provide progress for equality in the Trust.
Presenting Director: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Board Date: 27th September 2017

Equality, Diversity & Inclusion

Workforce Race Equality Standard Annual Update 2017 (WRES)

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015. Since then, NHS organisations have been compelled to review their workforce race equality performance and develop action plans to make continuous improvement on the challenges within this agenda.

The WRES is made up of nine indicators; the first four measure staff experience over a 12 month period for harassment, bullying, or abuse from patients, relatives or the public. Another four measure workforce data, in relation to fellow colleagues, managers or team leaders and progression opportunities. Indicator nine considers BME representation on executive boards, in relation to the workforce.

The main purpose of the WRES is:

- ✓ to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- ✓ to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- ✓ to improve BME representation at the Board level of the organisation.

This report provides the Board with the Trust's 2017 results against the nine indicators within the WRES and an update regarding its associated action plan. The WRES 2016/17 Action Plan has been closed off to allow for the introduction of the 2017/18 action plan. The Trust is required to submit and publicise these indicators on our website following Trust Board sign off.

The Equality and Diversity Steering Group monitors the Trust WRES programme and alongside the WRES, the Trust use the Equality and Diversity Systems (EDS2) to help in discussion with local partners including HealthWatch, to review and improve the performance for people with characteristics protected by the Equality Act 2010.

The E&D Steering Group, Chaired by the Deputy Director of Human Resources has members from HealthWatch Knowsley, Halton and St Helens attending the Steering Group. Each local Healthwatch is part of its local community and works in partnership with us on issues such as the needs, experience and concerns of people who use health and social care and speak out on their behalf. They are an invaluable source of information with 'eyes and ears' on the ground' about a range of patient and workforce matters. The Steering Group also has management, staff side and staff participation to ensure inclusive engagement and participation across the Trust; this also includes a Non-Executive Director who is to be nominated following Bill Hobden's departure. Any issues and or concerns raised within the Steering Group are escalated to the Workforce Council and on to the Quality Committee if required.

The data presented refers to the following periods

Indicator 1	1st April 2016 – 31st March 2017
Indicator 2	1st April 2016 – 31st March 2017
Indicator 3	1 April 2014 – 31 March 2016 two year rolling average
Indicator 4	1st April 2016 – 31st March 2017
Indicator 5,6,7 & 8	Staff Survey Results 2016
Indicator 9	31st March 2017

2017 Action Plan Update

Since 2015, the Trust has produced its results and associated action plans, noting that the first two years of the WRES programme focussed on implementing the WRES, raising awareness of its introduction and also ensuring our systems and data collection are fit for purpose.

Formulation of the Trust 2017/18 WRES Action Plan cannot be developed in isolation from the wider Equality and Diversity agenda.

The Trust's Equality and Diversity agenda as a whole requires particular focus to ensure the Trust WRES Action Plan is fit for purpose, has real impetus and engages with and actively seeks participation. It also requires involvement from essential stakeholder groups such as the Equality &Diversity Steering Group, noting that the Trust is required to demonstrate continuous improvement in closing the gaps in experience and opportunity between our White and BME workforce.

An external Equality and Diversity expert will be supporting the Trust in formulating the 2017/18 action plan and will also review our current Equality &Diversity workforce agenda. An action plan will therefore be shared at Trust Board in the forthcoming months.

St Helens & Knowsley Teaching Hospital NHS Trust WRES Indicator Report 2017

Indicator	Data for reporting year 2017	Data for previous year 2016	Narrative – the implications of the data and any additional background explanatory narrative
Workforce Indicators : for each of these four indicators, compare the data for White and BME Staff			
1) Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Overall Staff Workforce BME: 7.87% Non-Clinical BME: 0.67% (10/1471) Clinical BME: 10.6% (403/3768)	Overall Staff Workforce BME: 7.54% Non-Clinical BME: 0.84% (12/1435) Clinical BME: 10.23% (375/3664)	7.87% of staff identify themselves as being BME at STHK. This is an increase from last year's reporting year. While the number of BME staff represented in the population is important, the Trust understands that a workforce must be representative of the population which it serves. The most recent Census (2011) regarding the local BME population : St Helens (2.4%) & Knowsley (2.9%) Liverpool (12.3%) North West (11%) England (14%) Census Data 2011, next census is 2021.
2) Relative likelihood of White staff being appointed from shortlisting across all posts.	Relevant likelihood of White staff being appointed from shortlisting is 1.35 times greater than BME Staff. Source : Trust Trac Recruitment System	Relative likelihood of White staff being appointed from shortlisting is 1.26 times greater than BME Staff.	There has been a 0.09% increase in this year's results which indicates a higher likelihood that White staff are going to be hired from shortlisting.

3) Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	BME staff are 3.68 times as likely to enter the disciplinary process compared to white staff	BME staff are 3.79 times as likely to enter the disciplinary process compared to white staff	Since the last WRES, there has been a positive reduction of 0.11% of BME staff entering the formal disciplinary process. It has been acknowledged that nationally there are higher disciplinary rates of BME staff across the NHS and that the reason for this can be complex and wide ranging.
4) Relative likelihood of staff accessing non-mandatory training and CPD.	White staff are 0.97 as likely to access non-mandatory training and CPD as compared to BME staff	White staff are 0.41 as likely to access non-mandatory training and CPD as compared to BME staff	White staff are 0.97 more likely to access non-mandatory training and CPD than BME staff, a slight increase from last year. Over the next 12 months, L&D and Workforce Planning will develop the ESR function for capturing this information which will support further analysis.
National NHS Staff Survey Findings: for each of the four staff survey indicators, compare the Trust outcomes of the responses for White and BME Staff.			
5) Key Finding 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 24% BME: 26%	White: 22% BME: 32%	There has been a significant reduction in percentage of BME staff from 32% to 26% (-6%) who have experienced bullying or harassment in the last 12 months (albeit it is still an unacceptable level) White staff have seen a slight increase of 2%. The average for Acute Trusts : White 27% and BME 26%
6) Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White: 17% BME: 13%	White: 20% BME: 28%	There has been a significant decrease of 15% for BME staff experiencing harassment, bullying or abuse from staff in last 12 months, albeit it is still an unacceptable level. It is however now lower than White staff figure of 17% which has also reduced by 3% since 2016. The average for Acute Trusts: White 24% and BME 27%

7) Key Finding 21. Percentage believing that the trust provides equal opportunities for career progression or promotion.	White: 92% BME: 81%	White: 93% BME: 75%	There has been a positive increase of 6% from the BME respondents that the Trust provides equal opportunity in career progression. The average for Acute Trusts : White 88% and BME 76%
8) Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White: 3% BME: 13%	White: 6% BME: 12%	The BME response show a 1% increase in employees experiencing discrimination at work from colleagues. The figure for the BME workforce remains higher than White staff. The figure for White staff has reduced from 6% to 3%. The average for acute Trusts : White 6% and BME 14%
Board representation indicator: For this indicator, compare the difference for White and BME staff			
9) Percentage difference between the organisations' Board voting membership and its overall workforce. Note: only voting members of the Board should be included when considering this indicator	Trust Board BME is 18.18%	Trust Board BME is 18.18%	The Trust Board figure as at 31st March 2017 was made up of 11 board members, six are Non Executives and five are Executive voting members. When compared to the local BME population of St Helens & Knowsley, Liverpool, North West and England in total, we can see how our Board reflects this: St Helens (2.4%) & Knowsley (2.9%) Liverpool (12.3%) North West (11%) England (14%) Census Data 2011, next census is 2021.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)088

Title of paper: National Core Standards Assurance for Emergency Planning Risk & Resilience (EPRR) - Trust Statement of Compliance 2017-18

Purpose:

All Acute Hospitals are designated as level 1 responders under Civil Contingencies Legislation, and have a statutory duty to plan for emergencies and be able to respond and work with the other emergency services in the event of a major incident.

The Trust Board is responsible for ensuring that the Trust has adequate plans in place with the Director of Nursing being the "accountable officer" for this function.

In light of major incidents and the terrorist attacks that have been experienced in the last 12 months, additional recommendations have been made to the National Core Standards, to support NHS organisations to improve their preparedness.

This paper provides assurance to the Board that St Helens and Knowsley Teaching Hospitals NHS Trust has undertaken the annual self-assessment, against the Department of Health EPRR National Core Standards Framework; remains compliant with the standards and has submitted the statement of compliance by the required deadline of 22nd September 2017. This statement has to be published on the Trusts website.

The paper also details the Trusts self-assessment against the additional standards, and any actions required.

Summary: Proof of assurance of EPRR preparedness to DoH via NHS-E

Corporate objectives met or risks addressed:

Compliance with Civil Contingencies Act and Emergency Planning Resilience and Response (EPRR) National Operating Framework

Financial implications: None as a direct consequence of this paper

Stakeholders: CCGs, NHS England, STHK Trust, EPRR partners

Recommendation(s):

Members are asked to note the submission of the annual statement of compliance.

Presenting officer: Nicola Bunce, Interim Director of Corporate Services

Date of meeting: 27th September 2017

National Core Standards Assurance for Emergency Planning Risk & Resilience (EPRR) - Trust Statement of Compliance 2017-18

1. Introduction

1.1. As a category 1 responder the Trust has a statutory obligation to complete an annual self-assessment to provide assurance of compliance with the national EPRR core standards for acute hospitals. This must be submitted to NHSE.

1.2. The Director of Nursing and Quality is the Accountable Officer for the Trust in respect of this obligation and must sign the Statement of Compliance (Appendix A)

1.3. EPRR must form part of the Trust's annual report and the statement of compliance must be published on the Trusts public website.

1.4. The self-assessment core standards template (see appendix B) consists of 50 questions (applicable to the Trust) on major incident preparedness and business continuity and a further 13 questions on Hazardous Materials and Chemical, Biological, Radiological or Nuclear preparedness.

1.5. In 2016/17 the Trust was fully complaint.

1.6. The 2017/18 self-assessment shows that the Trust is almost fully compliant (98.4%).

1.7. Changes to the national standards have caused the change in the compliance rating, rather than the Trust position worsening against the 2016/17 baseline.

2. EPRR Assurance Process

2.1. The Trust self-assessment has been conducted through the Trust Emergency Preparedness Group and was reported to Risk Management Council on 12 September 2017.

2.2. The self-assessment of the core standards indicates that the Trust remains fully compliant in all but one core standard.

2.3. This relates to Number 19, "Lockdown", which is rated as 'substantially complaint' (Appendix B). The Trust has a lockdown plan, but has not yet undertaken practical exercises to test the plan, which is a recommendation from the NHSE Clinical Debrief report from the Manchester Arena Attack.

2.4. An action plan has been produced to address this. (Appendix C).

2.5. A series of live exercises both in and out of office hours on both sites will be undertaken by December 2017.

3. National Assurance Process Timeframes

3.1. Organisations are required to take a statement of compliance to a public Board meeting by the end of September 2017.

3.2. The Local Health Resilience Partnership will undertake a formal review via a 'confirm and challenge' meeting.

3.3. Following this, Local Health Resilience Partnership submits their reports to the NHSE regional teams, where there will be a regional consolidation process.

3.4. By 31st December 2017, regional teams must submit their consolidated data to the central team. This will be complete by February so that the national report can be considered by the NHSE Board in April 2018.

3.5. This year's EPRR includes a new assurance standard; to undertake a deep dive into EPRR organisational governance.

3.6. This deep dive includes assurance of areas such as internal organisational EPRR accountability, regular reports to public Board meetings, a realistic work programme and a solid training and exercise programme.

3.7. The deep dive results are reported separately and not included in the overall organisation compliance rating.

4. Deep Dive of EPRR Governance - Results

4.1. There are 6 'deep dive' governance standards. (Appendix D)

4.2. The Trust is fully compliant with 4 of the standards. The two standards that the Trust does not currently meet are detailed below;

4.3. DD3: The organisation has an identified Non-Executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation. All Cheshire and Merseyside organisations have fed back to the NHSE local team that it is impractical to have a designated NED? Governing Body Representative, due to the existing demands on their time. A response from NHSE is awaited.

4.4. DD6: The organisation's Accountable Officer must attend 75% of the Local Health Resilience Partnership meetings. The Trust is 50% compliant, because the LHRP meetings have been scheduled at the same time as Trust Board meetings. However, it has now been agreed with NHSE that it will be acceptable for an Assistant Director to attend, to achieve compliance with this standard.

ENDS

Appendix A

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2017-18

STATEMENT OF COMPLIANCE

St Helens & Knowsley Teaching Hospitals NHS Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR (v4.0).

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

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the Core Standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more Core Standard that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address multiple Core Standards that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address several Core Standards that the organisation is expected to achieve.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Non-compliant**	Standards rated as **Partial**	Standards rated as **Substantial**	Standards rated as **Full**
59	00	00	01	58
Acute providers: **59** Specialist providers: **38** Community providers: **38** Mental health providers: **38** CCGs: **30**	*Not complied with and not in an EPRR work plan for the next 12 months*	*Not complied with but evidence of progress and in an EPRR work plan for the next 12 months*	*Between 80% and 95% of the Core Standards have been achieved*	*Fully complied with*

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

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

Signed by the organisation's Accountable Emergency Officer

Date of board / governing body meeting	15/09/2017 *Date signed*

Appendix B

Appendix 1 - EPRR Core Assurance Stan

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

Appendix C

Organisation: 5T

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
				100% COMPLIANCE NO IMPROVEMENT REQUIRED

Add further rows as required

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
19	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive): LOCKDOWN	Development of a Lockdown Emergency Response summary and staff Action Cards as an appendices to the current Lockdown Policy. Planning and running of live lockdown exercises in and out of hours	Lockdown Emergency Response summary to be completed and staff Action Cards as appendices to the current Lockdown Policy. Exercises agreed in principle dates tba by year end 2017	December 2017 December 2017

Add further rows as required

Please attach a copy of the responses to the governance deep dive standards

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

Appendix D

STHK 2016-17 CORE STANDARDS DEEP DIVE - GOVERNANCE

	Core standard	Clarifying information	Evidence of assurance	Self-assessment RAG
2016 Deep Dive				
DD 1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	• Organisation's public Board/Governing Body report • Organisation's public website	GREEN
DD 2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	• Organisation's Annual Report • Organisation's public website	GREEN
DD 3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings no capacity in NED's work plan, however, RMC and Board fall under their overall remit and they will be made aware of key issues as needed.	AMBER
DD 4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	• Minutes of meetings. MIPG, RMC, EXEC BOARD	GREEN
DD 5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	• Minutes of meetings. Executive representation at MIPG. Chair of MIPG reports to Accountable officer monthly and to accountable officer as chair of RMC	GREEN

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

DD 6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	• Minutes of meetings. Accountable Officer has 50% attendance but will schedule attendance of accountable officer or executive nominee for meetings next year when the schedule is available	AMBER