We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

# WHH Board of Directors Meeting Part 1

## Supplementary Binder

# INDEX


**BM/19/05/42 – LFE**

**BM/19/05/51 - BAF**

**BM/19/05/52 – Board Sub Committee ToR and Cycles of Business**

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# We are WHH

## And together we

## make a difference

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Learning From Experience Q4 Report


## Ursula Martin

## Director of Integrated Governance & Quality


## April 2019

# Overview



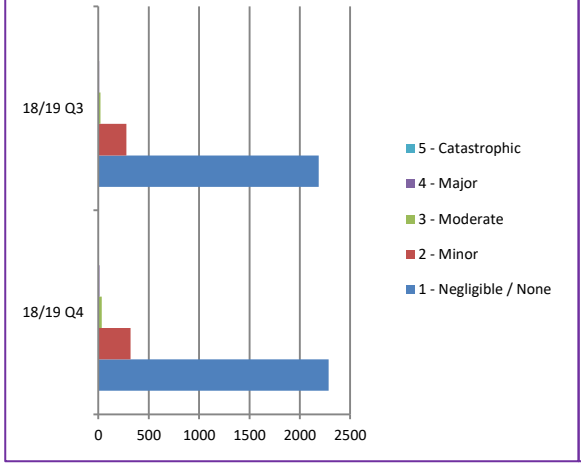
The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety and Inquests related to Quarter 4, 2018/19. They should be viewed in conjunction with the High Level Briefing Report.

# Incident Headlines

Warrington and Halton Hospitals NHS
NHS Foundation Trust

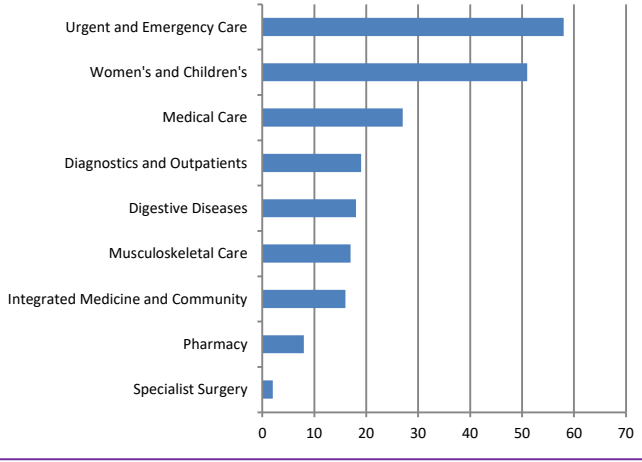
**How many staff are raising incidents Q3 vs Q4?**

- There was an **increase** in incident reporting within the Trust in Q4 (2501 in Q3 vs 2651in Q4).
- There was an **increase** in incidents causing Moderate to Catastrophic harm in Q4 (35 in Q3 vs 48 in Q4).
- The number of minor harm incidents increased slightly in Q4.



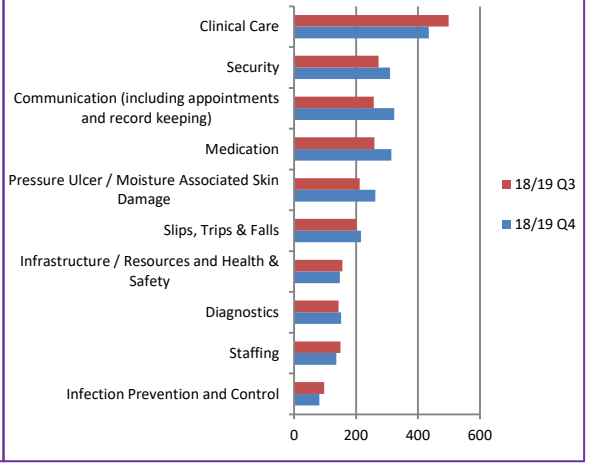

**How many incidents are open Q3 vs Q4?**

- The Trust reported 311incidents open in CBUs in the Q3 LFE. To date that has further reduced to 216. The graph below shows 9 CBUs with open incidents.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that current performance continues.
- Work continues in the Trust to monitor open incidents closely and ensure incident reviews are completed efficiently across the organisation.




**What type of incidents are we reporting Q3 vs Q4?**

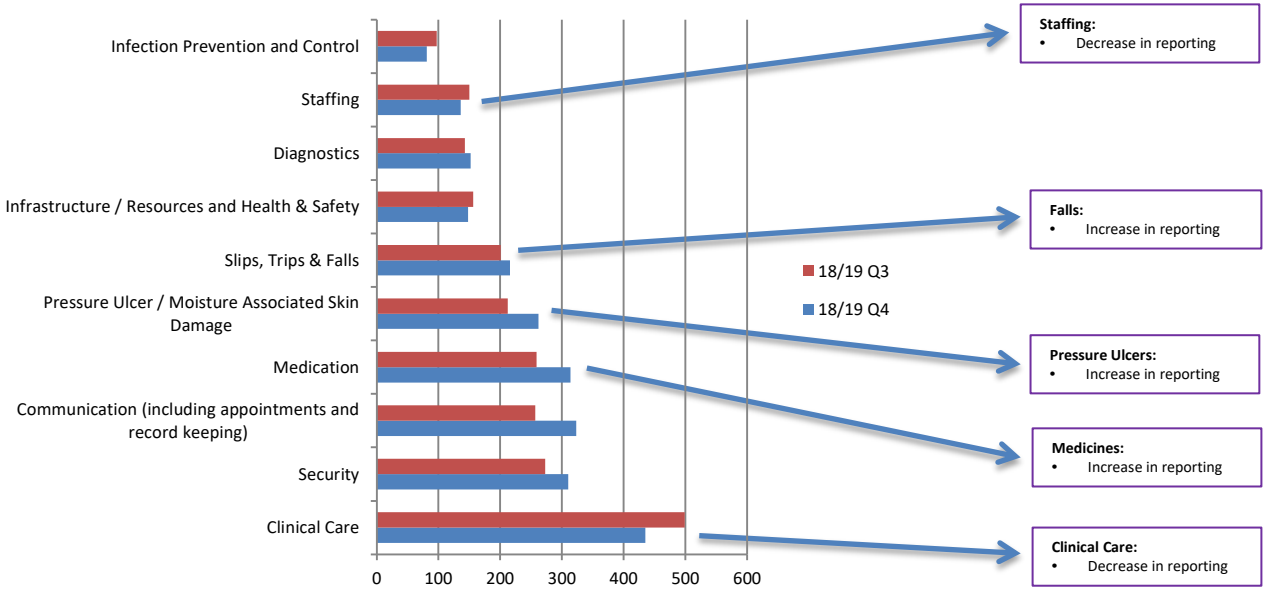
- As stated there was an increase in the amount of indents reported. Incidents relating to staffing and clinical care decreased in Q4; however, issues relating to pressure ulcers and medication increased.



# Incident Category Analysis Q3 vs Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

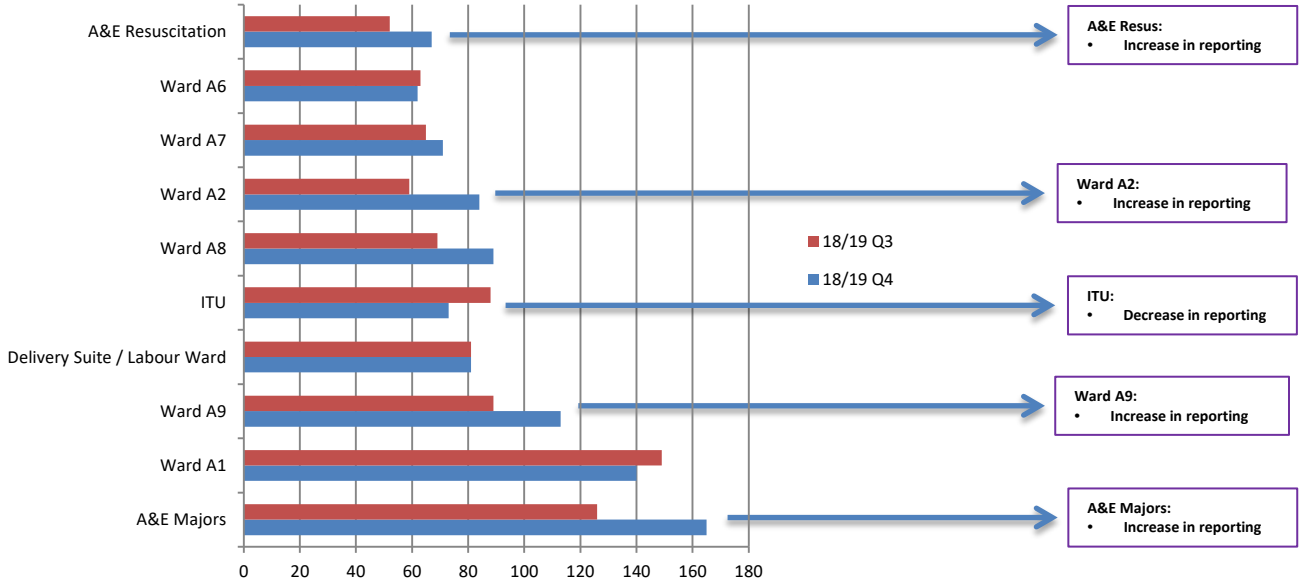
**The information shows the top categories reported incidents how they differ between the 2 quarters.**



# Incident Location Analysis Q3 vs Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

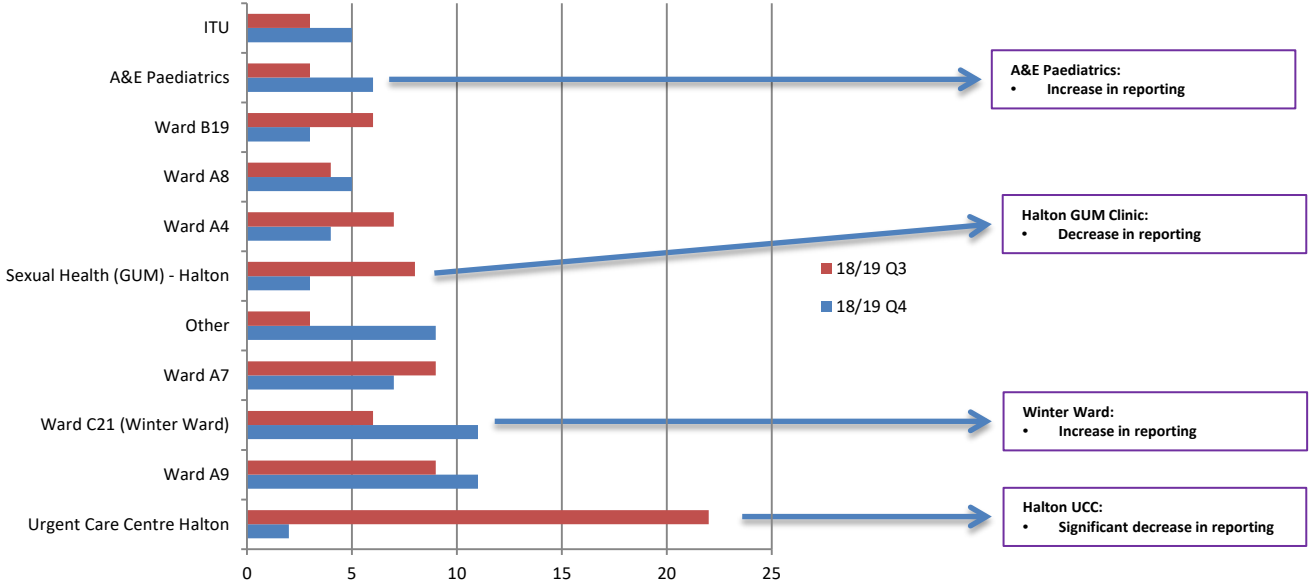
**The information shows the top reporting locations and how they differ between the 2 quarters.**



# Staffing Incidents Location Analysis Q3 vs Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

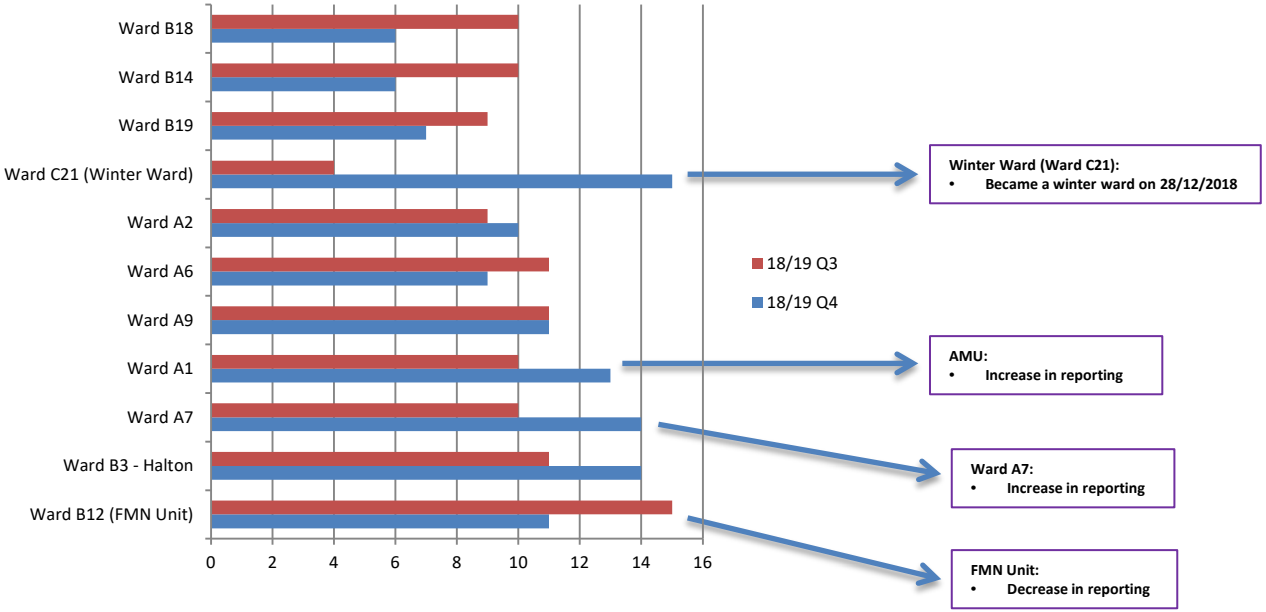
**The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.**



# Patient Falls Location Analysis Q3 vs Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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




**Winter Ward (Ward C21):**
- **Became a winter ward on 28/12/2018**

**AMU:**
- **Increase in reporting**

**Ward A7:**
- **Increase in reporting**

**FMN Unit:**
- **Decrease in reporting**

# Serious Incident (SI) Reporting

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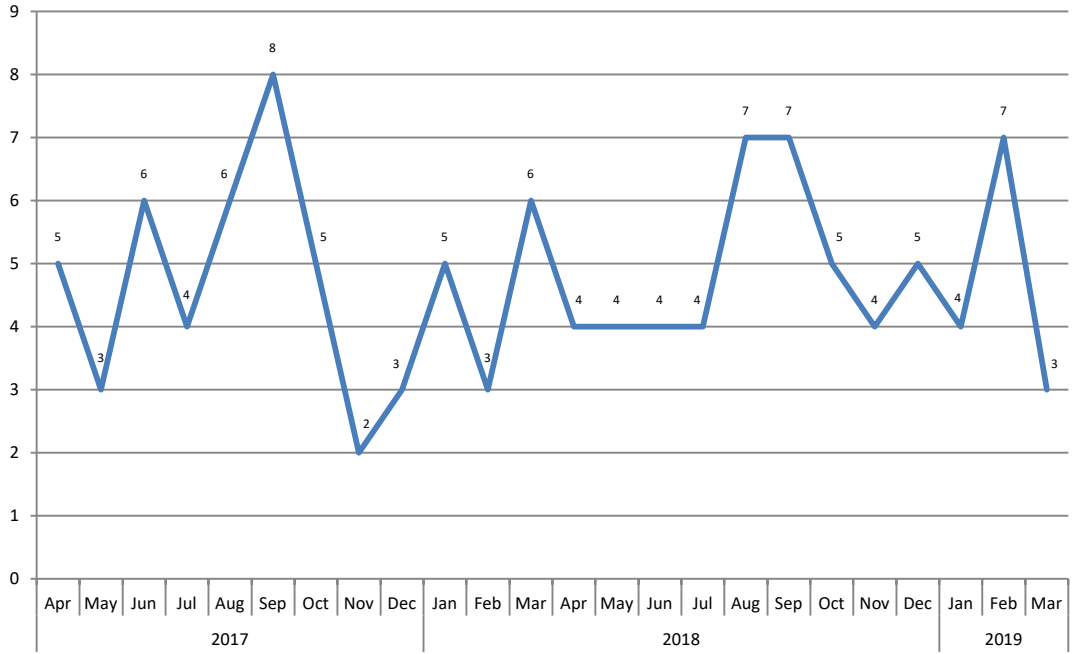
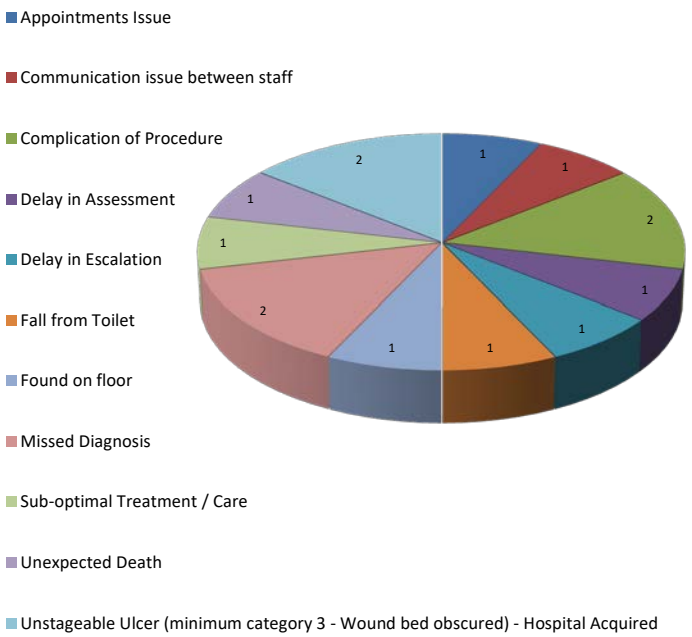


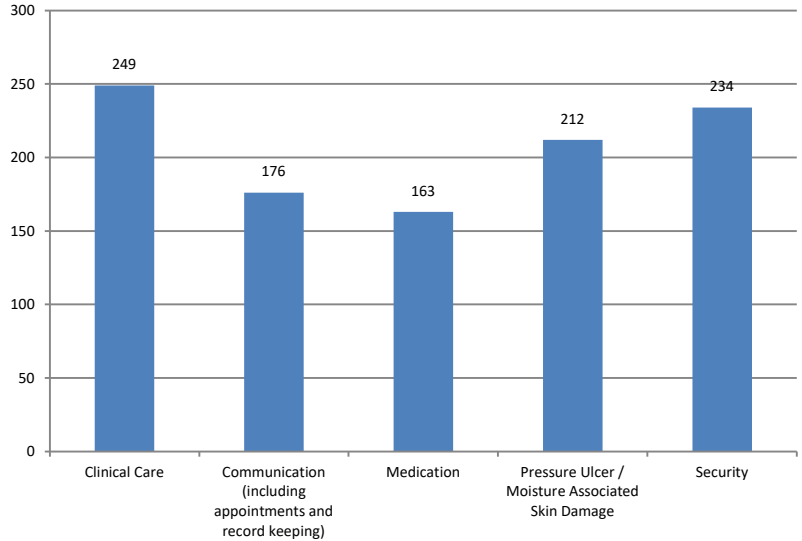

## SI Cause Groups Q4

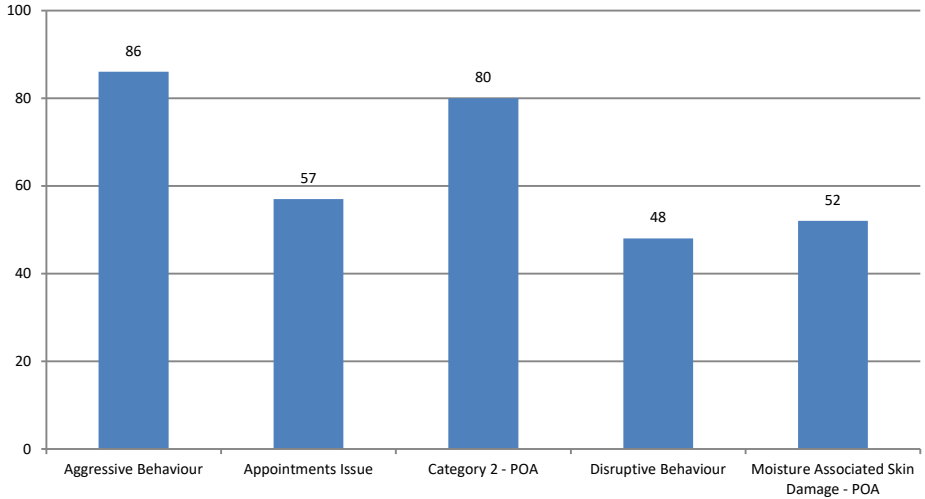


# Urgent & Emergency Care, Medical Care, Diagnostics & Outpatients and IM&C Incidents for Q4 (January to March 2019)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A total of 1564 incidents were reported across the 4 CBUs in Q4, this has increased from 1471 from Q3 . The top 5 categories and subcategories were reported as follows:

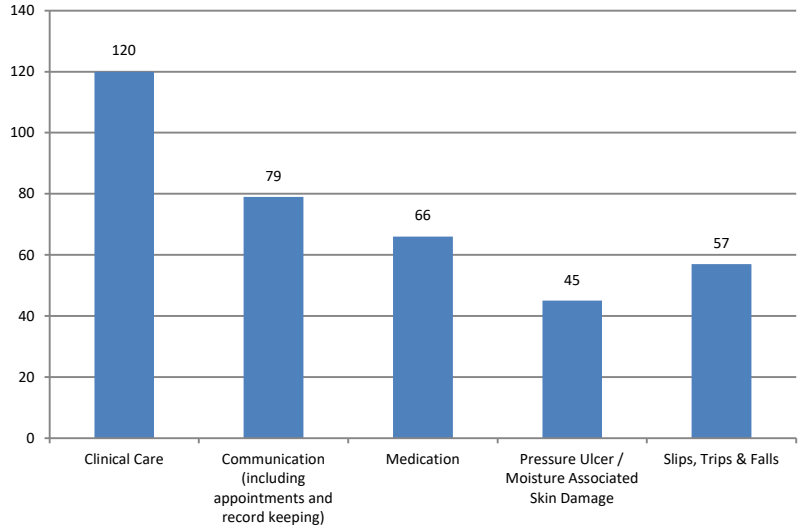


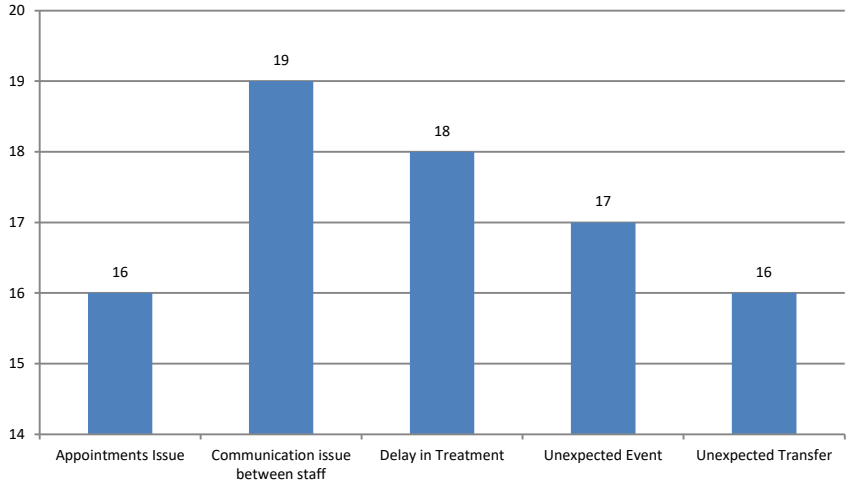



# Digestive Diseases, Musculoskeletal Care and Specialist Surgery Incidents for Q4 (January to March 2019)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A total of 523 incidents were reported across the 3 CBUs, this has increased from 495 from Q3. The top 5 categories and subcategories were reported as follows:

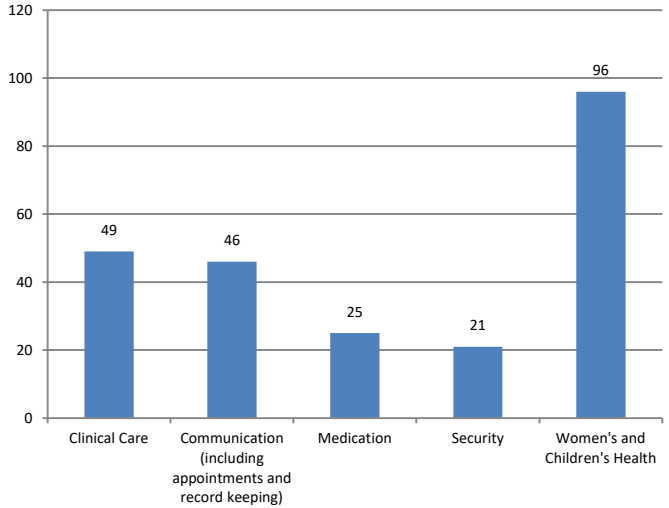


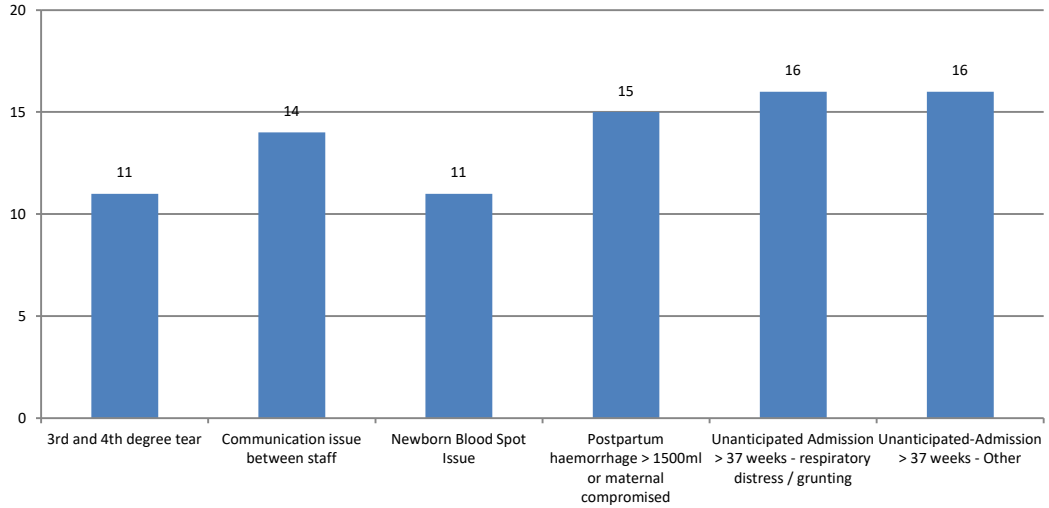



# Women's and Children's Health Incidents for Q4 (January to March 2019)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A total of 323 incidents were reported in the CBU, this has increased from 317 from Q3. The top 5 categories and subcategories were reported as follows:



# Learning from Incidents

Warrington and Halton Hospitals NHS
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| What staff told us……. | Actions taken/Lessons Learned |
|---|---|
| • SI investigation - Patient was admitted with a chest wall lesion from previous cancer diagnosis and chest infection. The patient was unable to lie on their left side for more than a few minutes. The patient had a reddened sacrum. The patient was nursed on a pressure relieving mattress. The mattress broke and the patient was nursed on a foam mattress until the new mattress was delivered 3 days later; by this time the patient developed a category 3 – sacrum pressure ulcer. | • During out of hours if a phase 3 mattress is required then another ward can be checked for a spare while waiting for a mattress to be delivered.<br>• A pressure relieving mattress should be used immediately following a high waterlow risk assessment. |
| • A patient was referred on the CFT pathway and was discharged without further investigation as indicated on the CT scan. The CT scan report was not completely descriptive. The patient attended four years later with a tumour at the site reported on the CT scan. | • Medical staff are responsible to act or refer a patient as indicated when an abnormality is reported on images of the patients in their care.<br>• Reporting of scans has changed in the last four years and describes findings fully and clearly. |
| • A request for appointment was made on ICE for a patient to have a procedure. The request was printed by the team responsible to book the appointment and the appointment was not made. The patient attended a year later and was diagnosed with cancer. | • Batch printing of appointment requests has discontinued and each request is actioned individually.<br>• Regular audit takes place in the department to ensure that unprocessed requests are identified and actioned. |

# Learning from Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

| What staff told us……. | Actions taken/Lessons Learned |
|---|---|
| Patient was admitted and diagnosed with a stroke and management and care was initiated under the stroke team. Patient became unresponsive overnight and was attended immediately. The patient had expressive dysphagia and new weakness. This was relayed to the stroke consultant on call from another organisation who covers Warrington out of hours. The advice was to transfer the patient. Once transferred the concern was that the patient had dysarthria and not dysphagia and the request for thrombolysis was inappropriate. The case was reviewed and the dysarthria was a new symptom. | • Ask specific questions when discussing a patient's symptoms;<br>• Clexane is not used routinely only for high risk patients after consultant review.<br>• There is no stroke consultant on call at Warrington Hospital during out of hours. The medical registrar appropriately sought advice out of hours with the stroke consultant on call who was covering Warrington. |
| A patient desaturated during surgery and became cyanosed. The surgery was stopped and immediate airway management was commenced successfully. | • The importance of good documentation was discussed with the team including how to amend when information is entered in error. |
| A patient fell on the ward and sustained a fractured neck of femur. At the time the patient's dosage of his diuretic medication had increased and consideration was not given to this new risk in the care plan that the patient would then have frequency of urine. | • There should be a clear management plan in place for patients at high risk of falls when given increased doses of diuretics e.g. regular support with going to the toilet on care and comfort rounds. The use of urinals for male patients should also be considered in the care plan when appropriate. |

# Learning from Incidents



## Urgent and Emergency Care


## Background

- A patient attended ED following an assault, the patient was triaged and asked to wait in the waiting area.
- The patient left the hospital before being seen by a clinician. This patient's first language was not English, and a friend was supporting communication.
- The patient re-attended ED later that day, and was assessed by a Nurse Practitioner who diagnosed a soft tissue injury and rib injury. The patient was discharged, after being given oral analgesia.
- Later that evening the patient attended the RLH, he was seen by a Consultant who requested a CT scan of his abdomen. The CT showed a liver and renal laceration and an adrenal injury. The patient was transferred by ambulance to the Major Trauma Centre at Aintree, where his injuries were managed conservatively.


## Lessons Learned

- *Translation services should be used to support communication*
- *Pain scores should be repeated to support escalation in analgesia after 60 minutes if in minimal to moderate pain, but after 30 minutes if in severe pain.*
- *Patients with MEWS2 scores >1 should not be streamed to primary care*

# Learning from Incidents

Warrington and Halton Hospitals NHS
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## Urgent and Emergency Care

### Background

A patient was admitted to ED feeling generally unwell. Regular medications were prescribed.

The patient usually takes **Humalog Mix 25** , However, **Humalog** was written up.

Whilst on AMU the patient was not eating and their insulin was omitted. The patient went on to develop DKA.


### Lessons Learned

*Insulin should not be omitted in patients with type 1 diabetes, if sub cut insulin cannot be given due the patient not eating then IV variable rate insulin should be commenced in place of the sub cut insulin.*

*This should be escalated to medics, so that they can prescribe the variable rate insulin infusion and IV fluids. Consider referral to DSN. Supplement diet with milky drinks or allow patient to eat what they feel like, even if this is not diabetic friendly.*

*SCR should be utilised where possible when prescribing patients own medications, paying particular attention to insulin types.*

# Learning from Incidents - WCH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

- There were four moderate incidents reported in Q4.
- Three Incidents required required a 72 hour review.
- Two Incidents were suspected Hypoxic Ischemic Encephalopathy HIE injuries and referred to HSIB.
- One Incident required an RCA (Currently in progress)

Below is feedback from the original 72 hour review:

**Background**

- A young patient, living in a care home was admitted with a history of attempted suicide, mental health concerns and suicidal ideation
- Admitted to the children's ward to await a CAMHS assessment, x2 carers from the care home present during stay
- Escalation to security was a feature of the admission
- Reviewed by CAMH's as suitable for discharge to be followed up in the community, but there were difficulties with this
- Issue were identified about the handling of complex situations involving young patients involving security

**What did we learn…**

- Security staff asked to reflect on the situation in relation to managing young patients with challenging behaviour. Safeguarding will support further training.
- Security staff to be reminded of the priority of de-escalating a situation especially those involving minors
- A safe room needs to be created (recently assessed for suitability and cost)
- The paediatric department to commence an electronic database of these type of admissions were challenging behaviour is a feature and particularly those with a history of self-harm
- Feedback will be provided to all paediatric staff and advice for any future incidents and paediatric staff to attend specialist mental health training provided by the Trust solicitors
- Feedback to be provided to the care home
- There is no document to provide the 'child's voice' this needs to be created to allow the child to have input into their own care
- The ED and paediatric department to issue a safety brief to remind their staff of the importance of recording the next of kin / legal guardian for a minor especially regarding a looked after child
- Review the system / pathway around children attending the Trust with self-harm. NICE guidance advises admission and a plan of care for each. There was nothing documented in the records to say why the patient was a Looked After Child to be able to provide the appropriate assessment and care

***These recommendations form part of an action plan to improve care and safety in Paediatrics around dealing with young people with mental health conditions****

# Learning from Incidents



## Radiation Safety Incidents

**We Found:** There had been several incidents where requests for Radiology examinations had been made for the incorrect patient. Although some of these were near misses, several patients received an unintended radiation dose, which was reportable to the CQC IR(ME)R team.

**We acted:**

**In Radiology:** encouraged all staff to chat to their patients about why they were at the hospital and what examination they were expecting to have to highlight any incorrect referrals, using a prompt **'What's brought you to the hospital today?'** in each x-ray room:

**Trust-wide:** Introduced a training session about the Radiology Department at medical induction, to include how to avoid incidents of this type and how to manage an incident effectively if one does occur.

Issued Trust- wide safety alert.

Highlight any incidents of this type at the Trust safety huddle so these can be passed on to medical handover.

# Learning from Incidents



## Ultrasound Incidents

Calculator 1

| | Dating Scans | |
|---|---|---|
| LMP | Earliest | Latest |
| 21/05/2018 | 13/08/2018 | 23/08/2018 |

Enter the patients LMP in the WHITE date cell above. Must be entered in the following format DD/MM/YYYY

Calculator 2

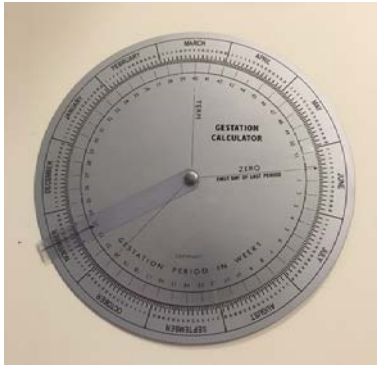
| | 20w 6d | 22w 5d | 28 w | 32 w | 34 w | 36 w | 40 w |
|---|---|---|---|---|---|---|---|
| Weeks | 12/12/2018 | 25/12/2018 | 31/01/2019 | 28/02/2019 | 14/03/2019 | 28/03/2019 | 25/04/2019 |

**** This calculator should only be used on the day of the dating scan ****
Select the fetus gestation from YELLOW box drop down, above. These dates are calculated based on the assumption that the scan for dating has taken place today.

Calculator 3

| 01/01/2018 | 20w 6d | 22w 5d | 28 w | 32 w | 34 w | 36 w | 40 w |
|---|---|---|---|---|---|---|---|
| Weeks | 02/01/2018 | 15/01/2018 | 21/02/2018 | 21/03/2018 | 04/04/2018 | 18/04/2018 | 16/05/2018 |

**** This calculator can be used any date after the dating scan ****
Select the Fetus gestation from the BLUE box drop down
Enter the date of the dating scan in the PINK box,
must be entered in the following format DD/MM/YYYY.




**We Found:** A number of obstetric ultrasound appointments had been booked outside the recommended timescales (as determined by the foetal abnormality screening programme). These were found to be partly due the booking process, which used an 'obstetric calculator wheel' which can be inaccurate to a day or two.

**We Acted:** We introduced an Excel based 'obstetric calculator' which has been made available to all members of the booking team following a training session in how to use it.

The calculator provides a very accurate method of determining the exact date when each scan needs to be performed.

# Learning from Medication Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

| We found…. | We Acted…. |
|---|---|
| A patient received an overdose of methotrexate. When their prescription chart was rewritten, their methotrexate was prescribed as 17.5mg to be taken each morning instead of ONCE weekly. | • A Safety Alert was issued with recommendations for safe prescribing, administering and supplying methotrexate for inpatients with non-malignant conditions. Teaching has been delivered.<br>• More education on methotrexate and learning from the incident to be cascaded to doctors/nurses through the CBU meetings, medical teaching and grand round. |
| A kink in an IV administration line prevented the delivery of metaraminol infusion to a patient. Additionally, the non-return valve had been incorrectly placed and caused the metaraminol infusion to "syphon" into the fluid line via the 3 way tap. When the line was unkinked the patient received a dose of metaraminol more quickly than intended resulting in bradyarrythmia followed by tachyarrythmia and severe hypertension. | The anaesthetic team agreed the following safety measures:<br>• Whenever practical, not to use a 3-way cannula for metaraminol (or similar) infusions.<br>• Whenever practical to use a separate line<br>• If the same IV access device has to be used for multiple infusions, appropriately place non-return valves or multiple extension sets with incorporated non-return valves.<br>The pharmacy team is updating the Guideline for the Prescribing and Administration of Metaraminol Injection/Infusion in Adult Critical Care. A section on line management is to be included. |
| A patient who was prescribed warfarin did not have his INR taken or his warfarin dosed/administered for 8 days, which caused a delay in his discharge from hospital. | • At the Pharmacy Safety Huddle ward pharmacists were advised to identify and regularly review warfarin patients to ensure warfarin is correctly prescribed, appropriately dosed and INRs are being taken.<br>• At Medical Handover doctors were advised to ensure warfarin patients have their blood taken for INR early in the day and ensure the warfarin dose has been prescribed for that day.<br>• Further action and learning to be undertaken on completion of the concise RCA. |

# Learning from Medication Incidents

Warrington and Halton Hospitals NHS

| We found…. | We Acted…. |
|---|---|
| There were issues regarding the management of a patient's insulin which included:<br>• Prescription of insulin at a higher dose than usual.<br>• Blood glucose levels not checked hourly whilst on IV variable insulin.<br>• Lunchtime dose of Humalog not administered.<br>• A 'when required' dose of Humulin S insulin administered at the same time as his usual dose of Humalog insulin due to elevated blood glucose levels. | • Immediate action was taken by the DNS with the medical/nursing team to ensure the patient's insulin was prescribed correctly and blood glucose levels were monitored appropriately.<br>• At the ward Daily Safety Briefing the incident was discussed<br>• A 72 hour review was organised.<br>• Insulin training sessions are being provided by the DNS for all the doctors working in that clinical area. |
| A number of discharge prescriptions were going through pharmacy without the allergy status of the patient being confirmed on Lorenzo. | • At the Pharmacy Safety Huddle, pharmacists advised to confirm allergies when clinical checking discharge prescriptions<br>• At Medical Handover doctors were advised, when clerking in patients, to document on Lorenzo the patient's allergies and if they have no allergies to confirm no known allergies.<br>• Safety Alert produced to take to the Trust Safety Huddle. |
| A number of patients who were on thickened oral fluids had been sent home without a supply of thickener on discharge leading to a risk of dehydration, choking, aspirational pneumonia and readmission to hospital. | • Communicated at the Pharmacy and Trust Safety Huddles<br>• Safety Alert issued to emphasise the importance of thickener being prescribed on their inpatient medication charts /EPMA/ discharge prescriptions if a patient is on thickened oral fluids, and to supply thickener at discharge. |

# Learning from Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Pressure Ulcers

| What staff told us……. | Actions taken/Lessons Learned |
|---|---|
| An elderly patient developed category 2 pressure ulcers over their ears from oxygen tubing. Nasal cannula without foam ear guards were used. | Oxygen nasal cannula stocked on ward were changed to cannula with foam ear guards.<br>Single point lesson on device related pressure ulcers revisited on ward. |
| A patient developed a category 3 heel and sacral pressure ulcer. There was a delay in upgrading the pressure relieving mattress and appropriate heel protection equipment was not used. | Matron audited care and comfort documentation focussing on prescribed care by qualified nurse.<br>New heel protectors were introduced on the ward.<br>Staff completed pressure ulcer e-learning and single point lessons. |
| A patient developed category 2 pressure ulcers whilst on delivery suite following an epidural. | Single point lesson devised and cascaded for pressure ulcer prevention during labour.<br>Maternity pressure area risk assessment revisited and new documentation introduced to ensure that women are encouraged to reposition regularly during labour and that this documented. |
| A patient was transferred from another hospital with a history of spinal cord compression. The patient rapidly developed lower limb paralysis and loss of sensation below the waist. This was not taken into account in the pressure ulcer risk assessment (Waterlow) leading to a lower risk score and inadequate pressure ulcer preventative care. There were also gaps in repositioning identified on Care and Comfort charts. The patient developed a category 4 pressure ulcer. | This was discussed at Safety Huddle and a safety alert was sent out across the Trust to remind staff that neurological deficit must be taken in to account when completing the Waterlow risk assessment.<br>The Ward Manager commenced an audit on Care and Comfort charts and risk assessments to ensure correct completion. |
| A patient admitted from home had a moisture lesion to his sacrum documented in nursing notes and a dressing had been applied. On removal of the dressing this was confirmed as a category 3 pressure ulcer not a moisture lesion. | The Moisture or Pressure (MOP) tool was re-launched in the area to assist nursing staff in differentiating between moisture lesions and pressure ulcers.<br>Nursing staff should seek advice from the Tissue Viability team if unsure of diagnosis of pressure ulcer or moisture lesion. |
| A patient with a fractured femur had a Thomas Splint applied which led to the development of a category 3 pressure ulcer. | Following the incident and subsequent investigation the decision was taken by Orthopaedic consultants that Thomas splints were no longer to be used for adult patients in the Trust. |

# Learning from Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Information Governance

**Antenatal screening QA assessment was submitted to Public Health England containing 14 dates of birth which are person identifiable information**

**Action Taken**

- Incident reported locally and escalated via the NHS Digital IG reporting tool.
- Received notification that the incident was not reportable to the Information Commissioner's Office
- Informed antenatal team of outcome

**Lessons Learned**

- All documents being sent to public health England to be thoroughly checked by Antenatal team for any embedded documents which may contain patient identifiable information (PII) and any further embedded documents are checked.
- Public Health England system is a secure IT platform and any documentation with personal identifiers is deleted by the PHE QA advisor and the Trust is notified.

**A patient submitted a request for access to records which could not be accessed until a legacy IT system was stabilised in order to complete the Subject Access Request made under the Data Protection Act 2018**

**Action Taken**

- Incident reported locally and escalated to the IT Team
- Meditech IT system stabilised by CloudWave specialist contractor

**Lessons Learned**

- Meditech systems stabilised and backup tapes restored to a virtual server which will allow access to records requested as part of future investigations and requests made under the Data Protection Act 2018 and the Access to Health Records Act 1990.
- The work carried out to move Meditech to a virtual server means that in future Meditech can be restored from the most recent backup copy to enable access to records.

# Complaints Headlines Q3 vs Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**How many people are raising complaints Q3 vs Q4?**

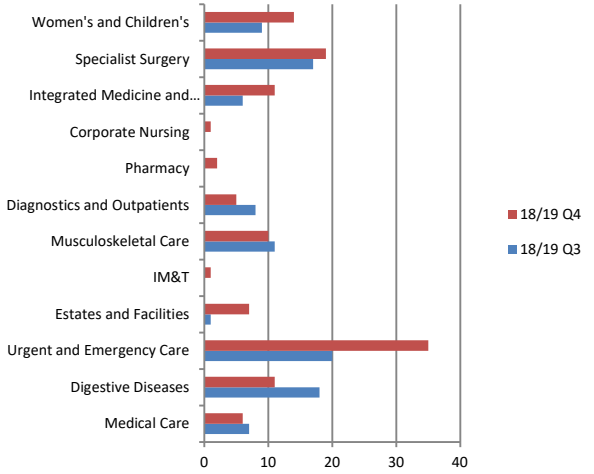
- There was an **increase** in complaints opened Trust wide in Q4 (122)versus 97 in Q3).
- Some CBU's saw an increase in the number of complaints received in Q4 (Urgent & Emergency Care, Integrated Medicine & Community, Estates and Facilities, and Women and Children's Services). Medical Care, Digestive Diseases and Diagnostics and Out-patients saw a decrease in the number of complaints received in Q4.

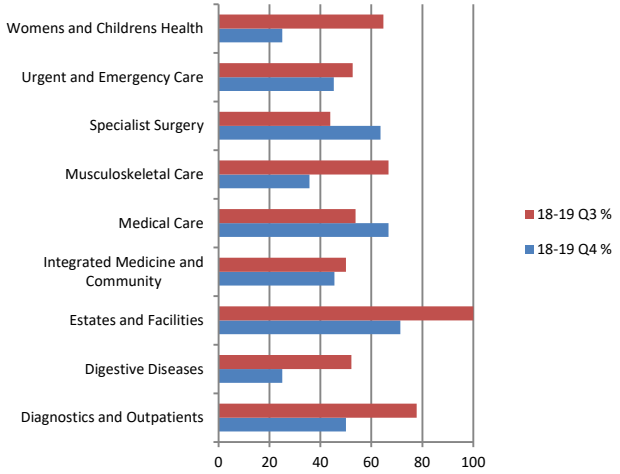
**Are we Responsive Q3 vs Q4?**

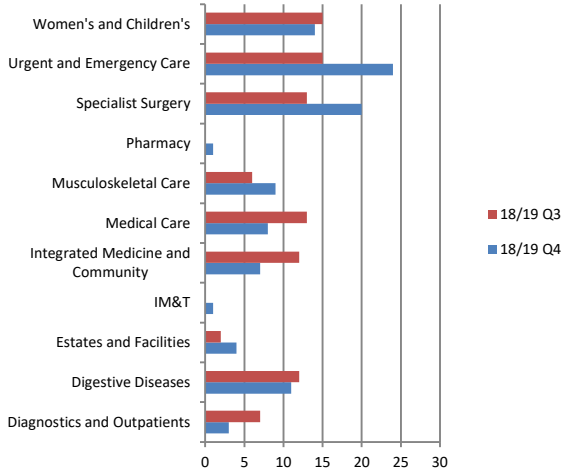
- Specialist Surgery and Medical Care increased their performance for responding to complaints on time. Remaining CBU performance was decreased.
- The Trust currently has 16 breached complaints
- There are no complaints over 6 months old.
- There is a plan in place to complete all the breached complaints.

**How many complaints has the Trust closed Q3 vs Q4?**

- There was an **increase** in complaints closed in the Trust in Q4 (102 in Q4 versus 95 in Q3).
- Urgent and Emergency Care, Specialist Surgery, and MSK have increased the amount of complaints they have closed. Digestive Diseases, Women's and Children's Services , Diagnostics and Outpatients , Integrated Medicine, and Medical Care have decreased the amount of complaints they have closed.



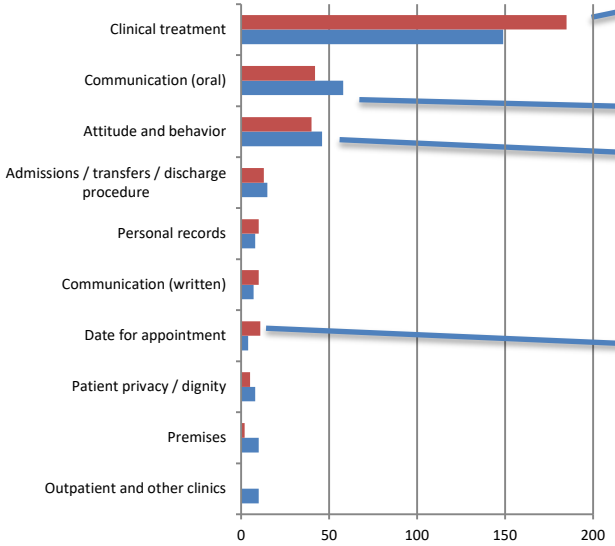



# Complaints Analysis Q3 vs Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The information shows the top subjects in complaints in Q3 vs Q4. Note: Complaints can have more than one subject.




**Clinical treatment:**

- There was a decrease in the number of complaints received in Q4 compared to Q3 regarding clinical treatment. Concerns include inadequate follow up care, poor nursing care , and concerns regarding clinical treatment whilst a patient is waiting for discharge etc.
- A lack of communication in relation to on going clinical treatment makes a perception that the treatment is incorrect.
- Theses issues can also be linked to when the Trust is on full capacity.

**Communication and Attitude and Behaviour:**

- Poor communication increased in Q4
- Staff attitude and behaviour increased in Q4 in line
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.

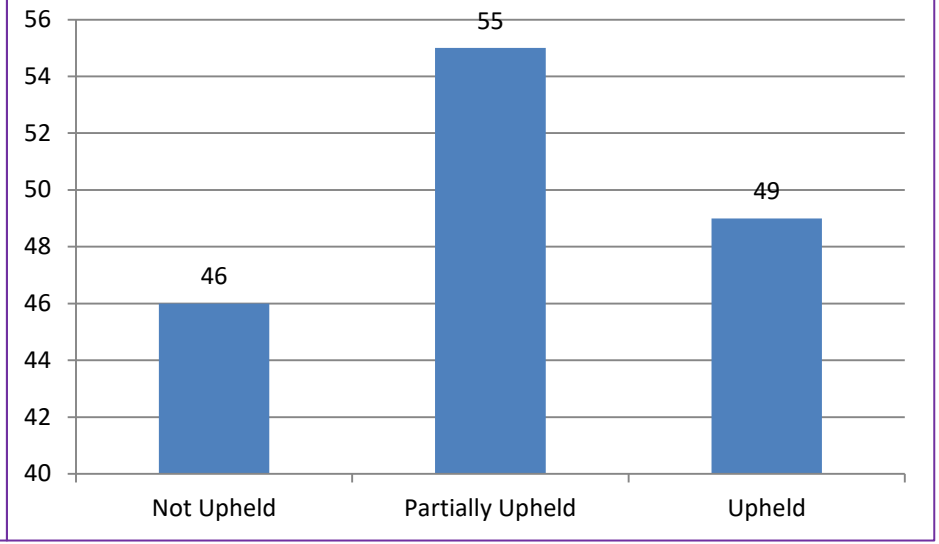
**Date for an appointment:**

- Occurs when Out-patient Clinics are at full capacity, and appointments cannot be brought forward.
- Cancellation of appointments

# Complaints Outcomes Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

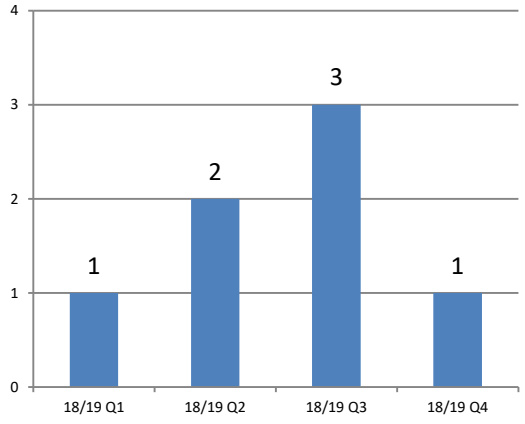


# PHSO Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## So how many complaints do they investigate?

The PHSO has commenced 1 investigation into the Trust in Q4, however, they are provisionally proposing to investigate 2 complaints. The PHSO closed 2 investigations during Q4.

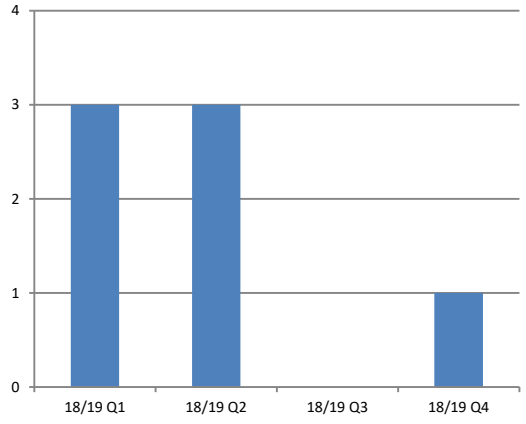



Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further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

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

## And what are the outcomes?

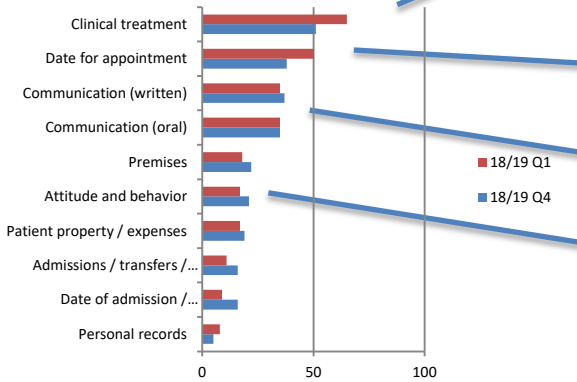
The Trust currently has 4 open PHSO cases. The PHSO finalised no investigations during Q3. All closed cases from Q2 have had actions plans drafted and implemented.



# PALS Analysis Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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




**Clinical Treatment:**
- Delay in treatment.
- Concerns raised about care on the ward.
- Patients and relatives would like a second opinion as unhappy with treatment plan.
- This is also mirrored in the complaints analysis.

**Date for appointment:**
- Increase in trend which includes:
- Patients waiting prolonged periods for appointments.
- Patients would like their appointment dates bringing forward.
- Cancellation of appointments.

**Communication:**
- Improvement with communication has remained the same in Q3 and Q4

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

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

| Q3 | Q4 |
|---|---|
| 6 days | 5 days |

PALS to complaints:

| Q3 | Q4 |
|---|---|
| 10 | 17 |

# Learning from Complaints and PALS in Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

| You Said…. | We Did…. |
|---|---|
| Patient concerned about the lack of communication being fed back to patients about waiting times and delays in the ophthalmology out-patient clinics. | Ophthalmology Department now have a volunteer at the Nurses Hub, to help communicate waiting times and general enquiries from patients. This will be for a trial period every Tuesday and Wednesday, and if successful, the plan would be to roll this out, and recruit more volunteers throughout the week. |
| Delay in medication at triage. | SOP for Paediatric Emergency Triage completed. This will assist with nurse triage training. Action supported by ED Consultant team. |
| Complainant concerned about lack of breast feeding advice and support. | A focus group to help support breast feeding has been arranged by feeding coordinator and information shared by the feeding specialist midwife. |

# Complaints Headlines

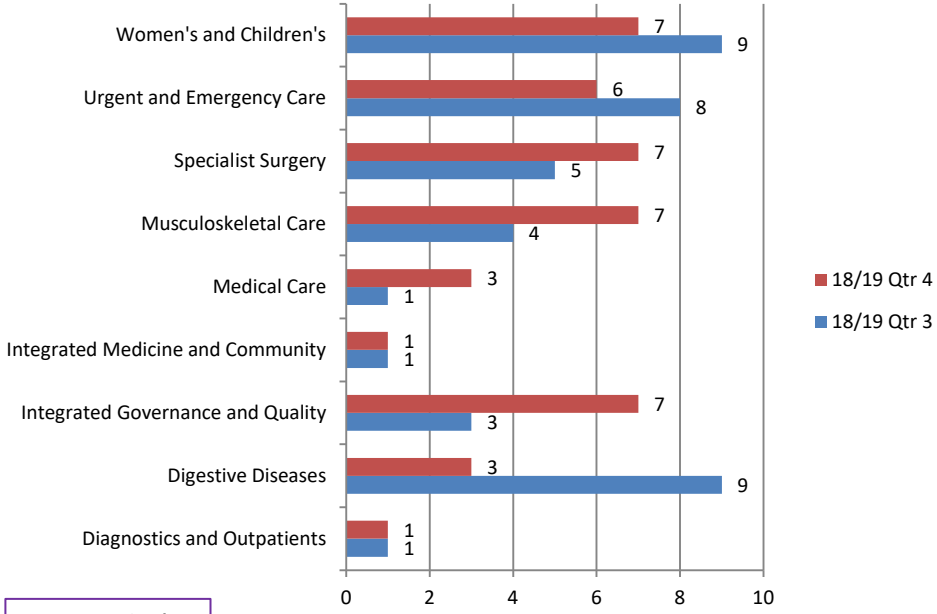
Warrington and Halton Hospitals NHS
NHS Foundation Trust

- There was an increase in the number of complaints the Trust received in Q3 compared to Q4.
- There was an increase in complaints closed in the Trust in Q4.
- Many of the issue raised with the PALS relate to delays in treatment and prolonged periods of waiting for appointments and cancellation of appointments. There has been a decrease in timeliness of response over the last two months.
- There is continued improvement in the Trust culture to resolve complaints locally and rapidly.
- Reporting on actions from complaints to ensure compliance. CBU staff are now starting to complete actions as they have access through the Datix Web project.
- Auditing of actions from complaints takes place to ensure that they have made the desired change.
- The PALS office has now been refurbished and is a more accommodating area for our patients and service users.
- The CBU staff and managers now have access to Governance dashboards to review their live data.
- Regular Internal quality audits of the complaints process are taking place within the complaints team to measure compliance against policy.
- There has been an increase in PHSO referrals and the Trust will continue to try and resolve all concerns locally at the Trust. The PHSO closed 3 investigations in Q4. The Trust has closed a significant amount of complaints in backlog and therefore there will be more PHSO referrals.
- Focus on learning to reduce the amount of complaints the Trust received. This is part of a QI project.

# Claims Received Analysis

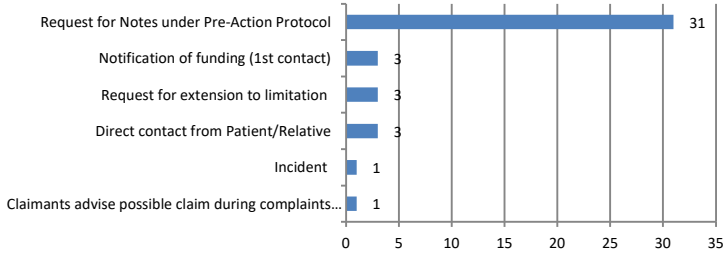
Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Clinical Claims Received Q3 vs Q4




**Q3: 41 Received**
**Q4: 42 Received**

### Analysis of Clinical Claims Received Q4




- 32 of the claims were received as a request for notes under the preaction protocol for clinical disputes.
- 3 Direct for compensation from patient
- 3 Request for extension to limitation
- 3 Notification of funding (subsequent request for notes)
- 1 Incident
- 1 Complaint

### 3 Non-Clinical Claims received

| | |
|---|---|
| **Accident (staff)** | Catering |
| **Fall (public)** | Cardiology |
| **Assaulted (staff)** | Acute Medicine |

# Claims Closed Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Clinical Claims Closed Q4

| CBU | Settled with Damages | Claim Successfully Repudiated | Withdrawn |
|---|---|---|---|
| Diagnostics and Outpatients | 0 | 0 | 1 |
| Digestive Diseases | 1 | 1 | 4 |
| Integrated Governance and Quality | 0 | 0 | 5 |
| Integrated Medicine and Community | 0 | 0 | 1 |
| Medical Care | 0 | 0 | 2 |
| Musculoskeletal Care | 1 | 1 | 2 |
| Specialist Surgery | 1 | 1 | 2 |
| Urgent and Emergency Care | 0 | 2 | 3 |
| Women's and Children's | 0 | 0 | 3 |

Payments for claims settled with damages totalled £ (£253.910.38 including costs)

**5 Non-Clinical Claims closed during Q4; 1 with payment:**

| Incident | Action Taken |
|---|---|
| **Fall over raised paving slab** | Area has been repaired |

# Action taken on claims settled with damages in Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Trauma and Orthopaedic What did we do?

| | |
|---|---|
| **Failure to diagnose ruptured Achilles tendon** | Reiterated to registrars the importance of flagging up cases they are unsure about and request senior review |

## Gastroenterology – What did we do?

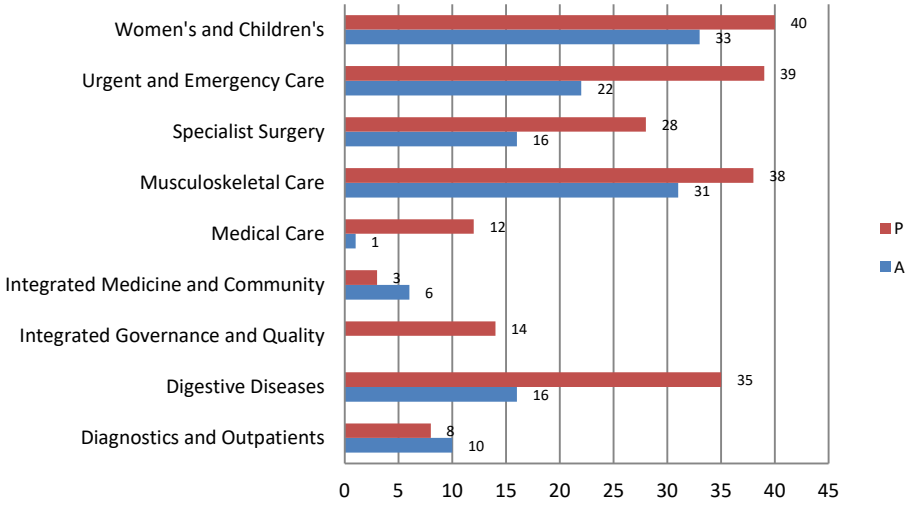
| | |
|---|---|
| **Failure to undertaken sufficient preoperative assessment prior to procedure** | Changes made to process following updated guidelines in 2018/19. There is now a preoperative action plan that is monitored by the Patient Safety & Clinical effectiveness Committee |

# Open Claims

Warrington and Halton Hospitals NHS
NHS Foundation Trust

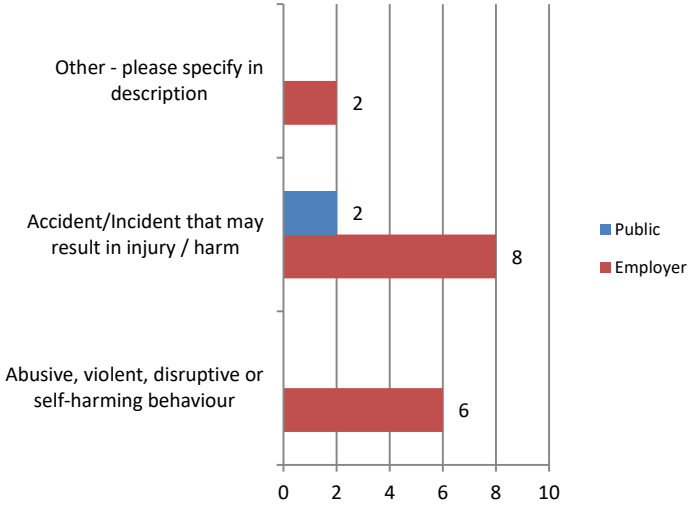
## Number of Open Claims as of 31st March 2019:

### Actual 135 | Potential 217




Potential = Request for notes
Actual = Formal claim, Letter of Claim / Proceedings

## Number of Open Non-Clinical Claims as of 31st March 2019:

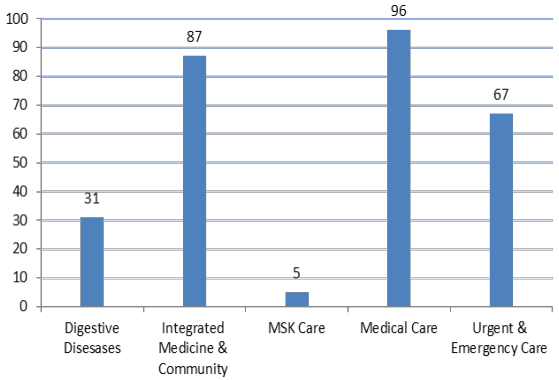


# Mortality Headlines Q4

Warrington and Halton Hospitals NHS
NHS Foundation Trust

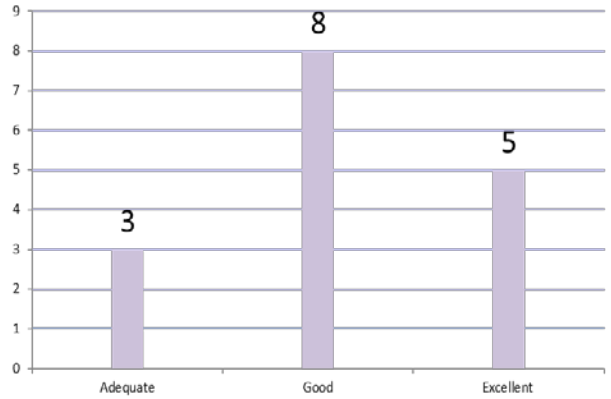
## Q4 CBU Mortalities

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



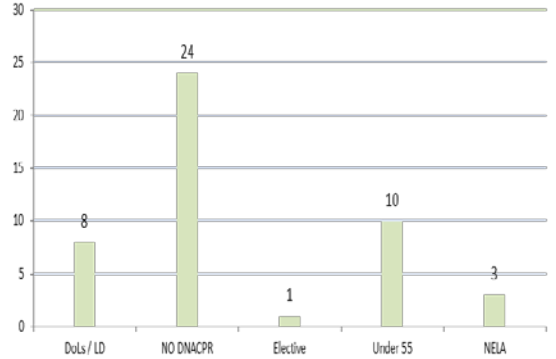

## Q4 SJRs – Overall Care Grading

The majority of SJRs conducted have found that our overall standard of care is rated as “Good” or “Excellent.” There was has been ‘no poor or very poor ‘ ratings for QTR 4 to date.




## Q4 Triggers for SJRs

The below chart displays the triggers for conducting SJRs across Quarter 4. Comparing to Quarter 4, no DNACPR continues to be the largest trigger for SJR. This will explain the themes around a lack of earlier recognition of end of life.



# Learning from Deaths

Warrington and Halton Hospitals NHS
NHS Foundation Trust

| We found…. | We are doing…. |
|---|---|
| Patient presented to ED following recent chemotherapy. The patient was very unwell and there was a delay in discussing ceiling of care with the patient and their family. | Ceiling of care is now being piloted as an area of review on the Ward Rounds.<br>We will share learning with the Clatterbridge Oncologists to ensure that they are considering earlier conversations in relation to ceiling of care and end of life care. |
| Elderly patient was admitted. Family had been unable to provide a history but this patient did have a Red Bag containing her relevant clinical information but this was not reviewed. | The following learning will be communicated to staff:<br>• Ensure that the following information about the Red Bag Scheme is disseminated, particularly to the junior doctors.<br>**RED BAG SCHEME FOR CARE HOME RESIDENTS**<br>  <br>The Red Bag Scheme has been developed to support improved communication between Care Homes and Hospital in the event that a decision is made to transfer to hospital.<br>Documents containing vital medical information will enable hospital staff to understand the patient's general health and will allow efficient treatment and reduce avoidable delays.<br>The patient benefit is an improved hospital experience and a safe proactive discharge. |

# Headlines of Learning from Deaths



- Mortality & Morbidity Meetings (M&M) are underway.
- SHMI and HSMR, although within the expected range, are both showing signs of deterioration.
- The SHMI is being reviewed as it has been selected as an indicator to be audited as part of the Trust's annual Quality Account.
- Analysis of 2018/19 data is underway in relation to learning from all deaths within the Trust and this will be reported in both the Q4 Learning from Deaths report and the annual Quality Account.
- We continue our work with the Coding Team to identify improvements that can be made with documentation. The Coding Team provide representation at each Mortality Review Group.

# Learning from National Audits

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People

- A section of the National report focuses on the necessity of Mental Health provision for patients with epilepsy, currently WHH does not have appropriate mental health provision- a business case has progressed in light of this report
- Transitioning from Child to Adult Services is referenced in the report- in preparation for Transition WHH is introducing the Ready-Steady-Go paperwork along with an epilepsy nurse-led teenager session

## National Hip Fracture Database Report

The recent National Hip Fracture database Report highlighted that there were a number of the key standards not being met at WHH:

- Pressure Ulcer in Fracture Neck of femur patients
- Case Ascertainment
- Perioperative Medical cover by Orthogeriatric Service

The Trust is addressing this by:

1. The rate of pressure ulcers is improving- robust reporting systems of pressure ulcers and that each one is investigated and lessons learnt provides assurance
2. Increased resource for data entry will continue to improve quality of data inputting and will be sustained
3. Acknowledging the newly approved joint Consultant post, there will need to be further investment and recruitment into the Orthogeriatrician Service to ensure that standards can be met

# Learning from Local Audits

Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Use of Bilirubinometers in Community Midwifery

- Identification of jaundice in healthy term babies (>37 weeks gestation) using a bilirubinometer in the community midwifery setting was introduced in April 2018 to reduce the number of referrals by community midwives to Paediatric Assessment Response Team (PART) and improve care for families with new born babies through correct identification of those requiring further support.
- Post introduction of bilirubinometers 8% of babies were referred to PART, whereas previously ALL babies identified with jaundice would have been referred. The use of bilirubinometers by the Community Midwifery Team is meeting the aim of improving care by identifying those babies requiring further investigation while more efficiently using NHS resources.

## UTI Audit

During 2017, WHH received multiple alerts from HED [Healthcare Evaluation Data] highlighting excess mortality from patients diagnosed with UTI.

Further investigation by MRG and a Clinical Case Note Review by a multidisciplinary group assessed forty patients who had triggered the HED system in 2017 who had 'died' with a diagnosis of UTI.

Following this an improved UTI Pathway was developed and launched in March 2018 emphasising the following points:

- Trust wide ward-based education programme
- Focus on documentation of diagnosis
- Include co-morbidities
- Focus on clinical symptoms
- Results of urine dipstick made available on ICE
- Local Pathway reflects NICE Guidance 2015
- Asymptomatic bacteriuria should not be treated in over 65s

Since the introduction of the new UTI Pathway there has been no further alerts for deaths from UTI.

# Non Clinical Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

From 1st January 2019 to 31st March 2019, there were 392 non clinical incidents. The top 2 categories were:

| Security incidents = 117 | Infrastructure/Health and Safety incidents = 122 |
|---|---|
| The top sub-categories are:<br>• Aggressive Behaviour<br>• Violence due to patients condition<br>• Doors not locked<br>• Malicious Violence | The top sub-categories are:<br>• Injury to staff<br>• Needlestick<br>• Equipment Malfunction<br>• Car Parking |

| We found…. | We Acted…. |
|---|---|
| Member of staff used a chair to gain height to write on a white board. Fell on descending from chair. | Advised to use a step ladder and use a cable tie to tidy up trailing wires. Step ladders have been ordered and are now in use to prevent this from happening again. |
| A member of staff was checking the spare anaesthetic machine. When they went round the back of the equipment, the top monitor moved and fell. Staff member took the weight of the monitor. | Strapping has been applied to secure the monitor in place and has been relocated into recovery to prevent further movement. |
| Member of public fell on the tail gate of the catering trailer after accessing a barrier there to protect them. | Temporary in-fill barriers put in place immediately and waiting to in fill the current voids in the barriers so the barrier is solid to prevent a re-occurrence. |

Appendix 1

# Board Assurance Framework

## Board Assurance Framework

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

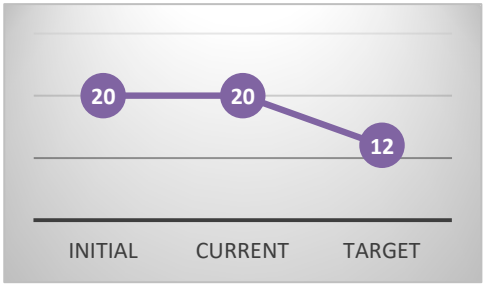
| Risk ID | Executive Lead | Risk Description | Strategic Objective at Risk | Current Rating | Target Rating | Risk Appetite | Monitoring Committee |
|---|---|---|---|---|---|---|---|
| 115 | Kimberley Salmon-Jamieson | Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. | 1 | 20 (5x4) | 12 (4x3) | TBC | Trust Operations Board |
| 134 | Andrea McGee | Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. | 3 | 20 (5x4) | 10 (5x2) | TBC | Finance & Sustainability Committee |
| 135 | Phill James | Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets. | 1 | 16 (4x4) | 10 (5x2) | TBC | Trust Operations Board |
| 138 | Phill James | Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data. | 3 | 16 (4x4) | 8 (4x2) | TBC | Trust Operations Board |
| 224 | Chris Evans | Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience. | 1 | 16 (4x4) | 8 (4x2) | TBC | Trust Operations Board |
| 125 | Chris Evans | Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. | 1 | 16 (4x4) | 4 (4x1) | TBC | Trust Operations Board |
| 701 | Chris Evans | Failure to provide continuity of services caused by the scheduled March 2019 Brexit resulting in difficulties in procurement of goods and services, | 3 | 16 (4x4) | 4 (2x2) | TBC | Trust Operations Board |

# Board Assurance Framework

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | workforce and the associated risk of the increase in cost of supplies. | | | | | |
| 145 | Mel Pickup | Influence within Cheshire & Merseyside<br>a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.<br>b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. | 3 | 15 (5x3) | 8 (4x2) | TBC | Trust Operations Board |
| 123 | Simon Constable | Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety,<br>Operational, financial and reputational consequences. | 1 | 12 (4x3) | 8 (4x2) | TBC | Quality Assurance Committee |
| 143 | Phill James | Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation | 1 | 12 (4x3) | 8 (4x2) | TBC | Trust Operations Board |
| 414 | Phill James | Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches. | 3 | 12 (4x3) | 8 (4x2) | TBC | Quality Assurance Committee |
| 695 | Kimberley Salmon-Jamieson | Failure to keep the national invasive cancer audit up to date to comply with NHS Cervical screening programme standards; which caused a backlog of cervical screening reviews which resulted in a non-compliance with the cervical screening specification 2018/2019. | 1 | 9 (3x3) | 6 (2x3) | TBC | Quality Assurance Committee |
| 241 | Alex Crowe | Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation. | 2 | 8 (4x2) | 8 (4x2) | TBC | Trust Operations Board |

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

# Board Assurance Framework

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

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| | Staffing Update – January 2019<br>-Full review of ward establishments in 2017/18<br>-Approval of a staffing business case with 3 million investment in nurse staffing<br>-Recruitment campaign for the uplift of establishment in registered nurses and health care assistants<br>-Targeted recruitment campaigns for registered nurses, open days careers events both locally in the Trust and regionally with the Universities RCN and Nursing times – plan in place for the next 12months<br>-Career advice events in local colleges and schools 'steps to success' focus groups for year 10's<br>Recruited 95 registered nurses and 92 health care assistants since the beginning of the 2018<br>-Robust process in place for staffing escalation actions<br>• Daily staffing meeting<br>• Monthly staffing operational meeting<br>Workforce Development as part of the retention campaign<br>• Strengthened preceptorship programme<br>• Band 5 competency programme<br>• Advance Practice Development programme 28 nurses currently in training<br>• Registered Nurse with Specialist Interest – Nursing Times Workforce Awards Finalists<br>• Introduction of Nursing Associates<br>• Ward Managers Development Programme<br>• Lead Nurse Development Programme<br>WHH are part of Cohort 4 Retention Collaborative with NHSI Joined in Dec 2018<br>• Staffing data review<br>• Deep dive on retention<br>• Developed a retention plan with implementation initiatives<br>-Nursing Retention and Recruitment Group in place to review track and monitor progress<br>-Recruitment and Retention KPI dashboard in place and report monthly to the Recruitment and Retention Group<br>-Monthly Safe Staffing Assurance Report to Board<br>-6 monthly Safe Staffing Report to Board in March 2019<br>-12monthly staffing review with Ward Managers undertaken by the Chief Nurse - reporting on 22nd March 2019<br>Number of staff and workforce developments in place across the Trust.<br>• 28 staff currently undertaking the Advanced Clinical Practice Course<br>• 3 Staff working with specialist teams as part of the Registered Nurse with Special Interest initiative<br>• 8 Nursing Associates register in January 2019 and a further 8 are due to commence their training in March 2019<br><br>First site meeting with NHSi in February 2019 – Plan to be submitted in March 2019<br>Nursing & Midwifery Dashboard reviewed monthly at the Recruitment & Retention Group<br>Retention Strategy Completed and will be presented on 15th March 2019<br>Nursing and Midwifery Turnover monitored at the Recruitment & Retention Group and reduction is in line with the plan.<br>Staffing escalation Audit Update. Staffing escalation audit was undertaken in October and presented to the Recruitment and Retention Group in November. Recommendations have been undertaken and a further audit will be undertaken in April 2019.<br>Retention plan in place and submitted to NHSi end of March 2019. The plan commits to reduce registered nurse turnover by 1.5% in the next 12 months. Progress will be monitored monthly at the Recruitment & Retention Group.<br>The Retention Plan is being monitored at the Recruitment and Retention Group and we have seen a reduction in Registered Nurse Turnover for the past 4 months the current rate is 12.91% which is less than the National rate of 13%.<br>Current vacancies are as follows: Registered Nurses 92 vacancies with 72 nurses having accepted an offer of a post at WHH and are due to commence no later than Sept 19 | |

# Board Assurance Framework

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| | HCA 88 vacancies with 47 staff currently undergoing pre-employment checks and are commencing with the Trust in the next month<br>Further recruitment events are planned as part of the recruitment calendar. | |
| **Assurance Gaps:** | - Escalation beds open - additional staff required. | |

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

# Board Assurance Framework

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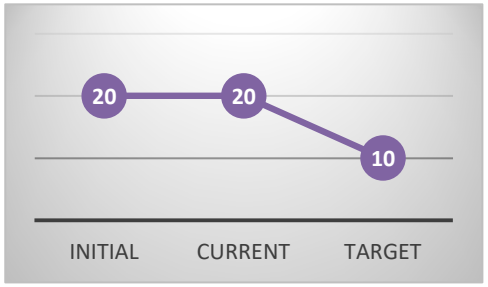
|---|---|---|---|---|---|
| **Risk ID:** | 134 | **Executive Lead:** | McGee, Andrea | **Rating** | |
| **Strategic Objective:** | Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services. | | | | |
| **Risk Description:** | Financial Sustainability<br>a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken.<br>b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. | | | **Initial:**<br>**Current:**<br>**Target:** | 20 (5x4)<br>20 (5x4)<br>10 (5x2) |
| **Assurance Details:** | •Core financial policies controls in place across the Trust<br>•Revised governance structure within the Trust to enable strengthened accountability<br>•Finance and Sustainability Committee (FSC) established overseeing financial planning<br>•Monthly financial monitoring with NHSI<br>•Regular review at Executive team meeting and development sessions<br>•Annual plan development process<br>•Performance monitoring in QPS meeting<br>•Signed up to a Controlled Expenditure Programme (CEP) process with main Commissioners to support financial planning, sharing of risk and agreement of schemes that are in the interest of the whole local economy<br>•Entered in to a Block Contract with Warrington & Halton CCGs for 2019/20 supported by an agreed set of principles under the CEP Lite Framework<br>•Work with the Commissioners on QIPP and CIP schemes through the Collaborative and Sustainability Group to ensure the schemes have a positive impact on sustainability across the whole health economy<br>•Monthly FRG meeting with CBU led by Dof<br>•Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board<br>•Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports<br>•Regular updates to Executive Team, FSC and Trust Board<br>•Regular updates to NHSI regarding the risks linked to the current financial position; including regular performance review meetings to discuss the current position and financial risk. These meeting have resulted in the Trust's change from segment three to segment two.<br>•Accepted offer from NHSi of a control total for 2019/20 giving the Trust access to £17.9m additional funds. This also exempts the Trust from national fines and penalties.<br>•Transfer of resources in to operational teams to support CIP delivery at the front line.<br>•Transfer of reporting of CIP to DoF and delivery to Chief Operating Officer<br>•Trust teams are working within the place based teams to bid for additional STP monies to improve sustainability<br>•Recruited agency staff and additional substantive staff to support clinical coding recovery. Trajectories have been set and are being monitored and are being overachieved.<br>•Regarding the aged debt in dispute, a pack of evidence for each invoice is being collated in preparation for a joint legal actions with other providers. The matter has been escalated to NHSi & NHSE and financial support has been requested while this is under review by the regulators.<br>•Legal advice obtained re: aged debt dispute<br>Control re employment legislation<br>- Sub group established for OT payments reporting through premium pay spend and review group<br>- Commissioned an audit review of OT processes subject to Chair of Audit Chair Approval<br>- Recommendation for internal OT processes to be presented to Exec Team<br>- Introduced the Financial Resources Group (FRG)that reports to FSC<br>- CIP Workshops taking place to improve the CIP Position | | |  | |

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| | - Refreshing Financial Strategy<br>- Memorandum of understanding agreed with Bridgewater Community Trust<br>- WLI process reviewed and strengthened.<br>•Regular planning meetings in place with Commissioners. Activity plans and contract agreed for 2019/20.<br>• Workshop undertaken with - Exec, CBU, Corporate to review of 2019/20 cost pressures<br>•Cheshire and Merseyside Healthcare Partnership Task and Finish Group setup to review and resolve the impact of VAT on Agency staff. Tax advice is being procured via the STP. Legal advice being obtained regarding potential termination of contract. Plus Us have an alternative model which may be introduced, 3-4 weeks implementation following decision to proceed. Plan to be resolved by June 2019.<br>•Market Analysis is now included in the CBU monthly dashboard and forms part of the monthly review<br>•Financial Strategy approved by Trust Board in March 2019 | |
| **Assurance Gaps:** | •Failure to achieve Financial control total may result in loss of FRF, MRET and STF and worsening cash position.<br>•Failure to manage fines and penalties and CQUIN which may result in loss of STF and worsening cash position<br>•Risk to financial stability due to loss of income relating to STP changes<br>•Inability to develop a strategic plan to deliver a break even position over the next 5 to 10 years<br>•Loss of contracts due to competitive market which may result in Trust no longer being sustainable. There is a gap in Market analysis and Knowledge of our competitors<br>•Loss of income through the failure of WHH Charity<br>•Failure to repay existing loans leading to the inability to apply for future financial support and threat to the Trust as a going concern.<br>•Increased risk relating to an aged debtor as continuing dispute regarding charges levied by the Trust are being challenged.<br>•Risk of under delivery of CIP due to insufficient schemes identified to deliver the full program and the organisational ability to translate improvement work into financial improvement<br>- Extended Loan repayment confirmation of further extension from NHSi received and extended to Nov 19.<br>Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims.<br>•Medical Staffing pressures identified at budget settings have not all been addressed putting pressure on the financial position.<br>•Halton additional capacity may not be able to close if the Commissioner's alternative community plans are not put in place by the end of February 2019 This service remains open and funding has yet to be agreed<br>• The Trust has agreed the 2019/20 Contract value<br>• The 2019/20 Pressures have been reviewed to work within the financial envelope, plans are now required to turn off / manage the unfunded pressures<br>• Control total has now been accepted<br>•No external funding support for Halton Healthy New Town or Warrington Hospital new build.<br>•HMRC changed its view regarding the VAT treatment of the model of services provided by Plus Us with effect from 11 February 2019 resulting in the Trust paying VAT on Medical and AHP agency bookings. Financial impact c£100k per month. Service commenced August 2018. | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Continue to seek support from Commissioners | Continue to seek support from Commissioners | Continue to seek support from Commissioners | Hurst, Jane | 31/12/2018 | 31/12/2018 |
| Continue to seek support from NHSI approach to management and repayment of loans | Continue to seek support from NHSI approach to management and repayment of loans | Continue to seek support from NHSI approach to management and repayment of loans | Hurst, Jane | 31/03/2019 | 31/03/2019 |
| Development of a Market analysis of Trust competitors to understand imminent and future risk to income | Development of a Market analysis of Trust competitors to understand imminent and future risk to income | Development of a Market analysis of Trust competitors to understand imminent and future risk to income | Hurst, Jane | 31/03/2019 | 31/03/2019 |
| Review of a Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery | Review Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery | Reviewed strategy to be presented to Trust Board in February 2019 | Hurst, Jane | 27/02/2019 | 27/02/2019 |

# Board Assurance Framework

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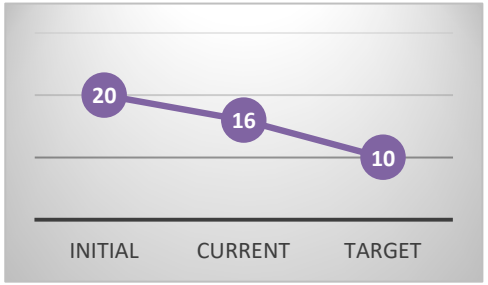
| **Risk ID:** | 135 | **Executive Lead:** | James, Phill | **Rating** | |
| **Strategic Objective:** | Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience. | | | | |
| **Risk Description:** | Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets. | | | **Initial:** | 20 (5x4) |
| | | | | **Current:** | 16 (4x4) |
| | | | | **Target:** | 10 (5x2) |
| **Assurance Details:** | IT Strategy in place<br>Routine RAG reporting of IM&T projects to ePR Programme Board and upwards to Finance and Sustainability Committee<br>Reviewing EPR system upgrade plans with suppliers and agreeing revised dates based around resource contention<br>Working with CBUs to involve more admin and clinical staff for testing upgrades<br>Reviewing contingency plans<br>Cross training staff to increase leveraging of resources and minimise single points of failures<br>Cross skilling help desk to strengthen first line support<br>IG sub-group reviews contingency plans with Information Asset Owners from the CBUs<br>Anti-virus has been added to IM&T Capital Shortlist for 17/18 and will be agreed at the next Capital Planning Group<br>IT Seniors routinely act upon CareCERT information security bulletins released by NHS Digital's Data Security Centre. Actions performed in response to bulletins are documented.<br>Information Security Management System reports to Information Governance and Corporate Records Sub-Committee to provide assurance on the effectiveness of controls<br>Inspection by Trust's auditors on IT infrastructure security<br>Capital paper submitted to secure funding for hardware to improve infrastructure in time for requisite Windows 10 migration<br>Monitoring of Data Quality in systems implemented and reporting of DQ metrics via Data Quality and Management Steering Group<br>Monitoring of external data quality reports such as the NHS Digital Data Quality Maturity index and benchmarking with other organisations<br>Clear communications of upgrades changes<br>Good user engagement for testing<br>Monitoring of helpdesk tickets to understand trends after upgrades<br>Assess hot stops from IMT Helpdesk calls<br>Critical systems continuity plans identify key staff who will work to ensure systems return to normal as quickly as possible<br>Capital programme spend reviewed by Capital group and F&S, hardware inventory maintained to ensure end user equipment remains fit for purpose.<br>ePR programme Board reviews each project progress against Programme Plan expectations<br>Internal IMT department progress recorded at Seniors meetings<br>New diagnostic post being recruited linking to identifying single points of failure<br>The Director of IT has undertaken a review regarding IT infrastructure risks, which may impact upon 24/7 availability of key services and systems and the capital programme has been updated to reflect these risks.<br>Actions have been completed regarding commencement of a information and IT restructure. An additional diagnostic team member has been recruited.<br>Regular analysis of data to show compliance with processes in place – Data Quality dashboard work and links back to Clinical Directors.<br>A business case for ICE resilience has been approved by the Executive Team with the installation and configuration will be completed by the end of Oct 2018.<br>A TNA analysis and plan is currently being developed for critical systems. The TNA for critical systems is now available and due to be published with supporting guidance for managers. | | |  | |

# Board Assurance Framework

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| | The ICE infrastructure has been migrated to an existing server however this only adequate in the short term. A paper on the options for the medium to long-term was prepared which included an option for external hosting and covered - Using the current new internal hardware, Improving the current new internal hardware with extra resilience, providing new hardware A paper on the potential options and preferred solution was presented at the Digital Board on 18/3/19. Following the meeting the preferred option is to be presented to Execs in April for consideration.<br>Approval secured to procure teo new servers to create a resilient platform for the ICE system which supports disaster recovery. | |
| **Assurance Gaps:** | • Certification to the Cyber Essentials standard in quarter 1 Financial year 2017/18 is required. This was recommended in the National Data Guardian/CQC report of 2016.<br>• Routine training for all staff, including Locums, on all Trust Key systems | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Work with other Trusts to share testing resources | Work with other Trusts to share testing resources | Work with other Trusts to share testing resources | Caisley, Sue | 29/09/2017 | 29/09/2017 |
| Invest in additional IMT staffing as workload increases, restructures based on work being reviewed with IMT management | Invest in additional IMT staffing | Invest in additional IMT staffing | Caisley, Sue | 27/03/2018 | 27/03/2018 |
| Comprehensively identify all single points of failure and assess risks surrounding each | Comprehensively identify all single points of failure and assess risks surrounding each | Comprehensively identify all single points of failure and assess risks surrounding each | Caisley, Sue | 30/06/2017 | 30/06/2017 |
| Test contingency plans regularly-development of a plan | Test contingency plans regularly-development of a plan | Test contingency plans regularly-development of a plan | Caisley, Sue | 31/05/2017 | 31/05/2017 |
| Routinely report all Cyber-attacks via Datix incident reporting system to ensure SIRO and Caldicott Guardian are sighted on the issues | report all Cyber-attacks via Datix incident reporting system | report all Cyber-attacks via Datix incident reporting system | Caisley, Sue | 30/06/2017 | 30/06/2017 |
| Include Cyber Security element in annual SIRO report | Include Cyber Security element in annual SIRO report | Include Cyber Security element in annual SIRO report | Caisley, Sue | 28/04/2017 | 28/04/2017 |
| IT Manager to produce a report detailing IT infrastructure risks which may impact upon 24/7 availability of key services and systems | IT Manager to produce a report detailing IT infrastructure risks | IT Manager to produce a report detailing IT infrastructure risks | Caisley, Sue | 28/04/2017 | 28/04/2017 |
| Continuous audit of IMT infrastructure-development of a plan | Continuous audit of IMT infrastructure-development of a plan | Continuous audit of IMT infrastructure-development of a plan | Caisley, Sue | 31/05/2017 | 31/05/2017 |
| Disaster recovery plan and its relevance to key IT systems to be reviewed | Disaster recovery plan and its relevance to key IT systems to be reviewed | Disaster recovery plan and its relevance to key IT systems to be reviewed | Caisley, Sue | 31/08/2017 | 31/08/2017 |
| Improve the disaster recovery for the ICE system (currently hosted on a physical server with limited resilience) | Improve the disaster recovery for the ICE system | Improve the disaster recovery for the ICE system<br>Business case for ICE has been submitted to Execs Meeting(Complete)<br>Obtain budget code (Complete)<br>Submit tender waiver form (Complete)<br>Scope of work discussed (Started - Sept 2018)<br>Place order (Started - Sept 2018)<br>Install and configure (Required Oct | Caisley, Sue | 30/03/2018 | 07/09/2018 |

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| | | 2018) | | | |
| Undertake a Training Needs Analysis and assessment of training on Critical systems in the Trust and develop a plan as appropriate | Training Needs Analysis and assessment of training on Critical systems | Training Needs Analysis and assessment of training on Critical systems - 07/09/18 will be completed after additional staff start in the team. | Caisley, Sue | 31/01/2019 | 07/02/2019 |

# Board Assurance Framework

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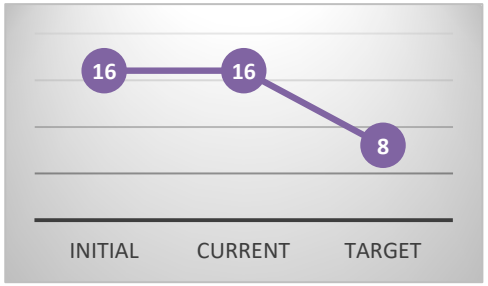
| **Risk ID:** | 138 | **Executive Lead:** | James, Phill | **Rating** | |
| **Strategic Objective:** | Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services. | | | | |
| **Risk Description:** | Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data. | | | **Initial:** | 16 (4x4) |
| | | | | **Current:** | 16 (4x4) |
| | | | | **Target:** | 8 (4x2) |
| **Assurance Details:** | Controls:<br>Prioritising work around BAU i.e. statutory and contractual dataset returns such as daily/weekly Sitreps, monthly Board reporting, FOI's, Ad-hoc information requests and CQC inspection.<br>Providing regular updates to the project board and current plans, progress and risks/issues<br>Recruited one temporary staff to cover Maternity datasets as replacement for one of the Band 6 staff that has left.<br>Re-planned and allocated work to the team for other Band 6 staff that has now left.<br>Recruiting for a Band 5 replacement that leaves end of March.<br>Taking on the NVQ data quality staff from Lorenzo team. He will initially work 2/3 days per week from 27th Feb and permanently then once a DQ backfill has been recruited.<br>Appointed new Head of Information that starts at the beginning of April<br>Interim Head of Information re-developing plans and prioritising work<br>Assurance:<br>The key objective is to ensure all BAU work is being maintained i.e. statutory returns, adhocs and FOI's and support CQC inspection. Escalate to Exec level if any delays are likely<br>Continue to Access reports via the BIS application, new reports are being made available all the time<br>Continue to report progress, risks and issues through finance and project board meetings<br>Recruited 4 Information analysts as part of business case who are supporting with timely statutory reporting and key Trust workstreams including maternity, theatres, delayed discharges, urgent care.<br>Business Intelligence Development Roadmap produced and priorities will be agreed with key Execs to ensure prioritisation and Trust focused workstreams.<br>Recruited to a Band 8a Business Intelligence Manager, who commenced with the Trust on 03/09/2018.<br>Recruited to a Band 2 Data Quality Clerk, who commenced with the Trust on 20/08/2018.<br>BI Manager commenced and work on the new Emergency Care Flow Dashboard has started in collaboration with an external supplier. This will provide automated, timely, current performance data for urgent care operational staff, CBU leads and Executives to monitor service demands and track adverse variances with a view to deploying measures to improve services accordingly. Data Quality checks on patient demographics and completeness and timely discharge letters continue with real time daily routines to ensure letters stranded in interfaces are submitted timely.<br>The new ED patient flow dashboard has been developed which will support urgent care with monitoring urgent care patient flow and provide the means to respond in real time for some indicators. Currently awaiting the provision of a robust enough server to deploy the pilot dashboard for use prior to final adjustments and deployment.<br>Following recruitment of additional staff, the Department has now got the capacity to respond to demands for focussed analytics. Information Analysts have been aligned to CBUs and are now attending CBU Meetings to support with analysis and reporting.<br>The Department are to deploy the ED Flow Dashboard which will have current performance and live data streams to provide control room like intelligence by the end of April.<br>The work on the BI Road Map will continue to provide the prioritised dashboard and insight reports including Ward Dashboards.<br>ED Flow Dashboard live pilot commenced providing increased visibility. | | |  | |

# Board Assurance Framework

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| **Assurance Gaps:** | Provision of real time information for key operational areas<br>New models of reporting are underway but there is a need for wider Business Intelligence across the Trust and until that is deployed this risk cannot be reduced. |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Continue to work with the Business and clinical teams to help manage expectations and ensure work is prioritised around key objectives (BAU, CQC, etc) and then by the high priority datasets | Continue to work with the Business and clinical teams to help manage expectations | Continue to work with the Business and clinical teams to help manage expectations | Foster, Karen | 31/12/2018 | 02/08/2018 |
| Establish new information reporting structure lead by the new Head of Information starts | Establish new information reporting structure lead by the new Head of Information starts | Establish new information reporting structure lead by the new Head of Information starts | Foster, Karen | 29/09/2017 | 29/09/2017 |
| Develop interactive Business Intelligence system for end users for self-service to reduce demand for routine information enquiries | interactive Business Intelligence system | interactive Business Intelligence system | Foster, Karen | 30/09/2019 | |

# Board Assurance Framework

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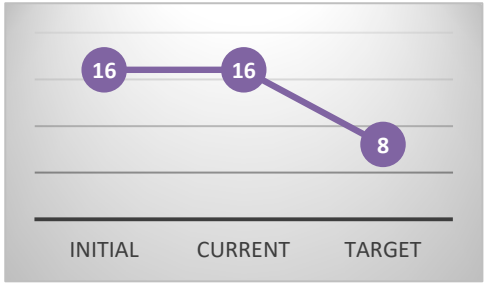
|---|---|---|---|---|---|
| **Risk ID:** | 224 | **Executive Lead:** | Evans, Chris | **Rating** | |
| **Strategic Objective:** | Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience. | | | | |
| **Risk Description:** | Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience. | | | **Initial:** | 16 (4x4) |
| | | | | **Current:** | 16 (4x4) |
| | | | | **Target:** | 8 (4x2) |
| **Assurance Details:** | Trust Bed Meeting 2 hourly from 08:00 to 18:00<br>Systemwide relationships including social care, community, mental health and CCGs<br>Discharge Lounge/Patient Flow Team<br>Red to Green - Discharge Planning<br>ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing Controller<br>Red Cross and Chloe Care Transport<br>FAU/Hub operational from June 2018 - Now operating 5 days per week.<br>Discharge Lounge opened 26th November 2018<br>Full ED business case approved for Q4 re: vision for ED Footprint creating assessment capacity.<br>System actions agreed supporting the Winter Plan<br>Warrington Together Board have asked for focussed work to take forward outputs from the Venn Work<br>Regular monitored at the Mid Mersey A&E Board<br>Long Length of Stay Collaborative in association with ECIST / NHSI. Bespoke approach for the Trust in embedding and sustaining LLoS review. To commence May 19 through until September 19.<br>Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. Co-location of teams approved in April 19. This will support harmonisation of pathways and increase integrated working between health and social care.<br>Co-location of teams to take place in May 2019 (Kendrick Wing)<br>Urgent Care Improvement Committee to commence form May/June 2019 focussing on 5 priorities:<br>1. CQC Actions<br>2. Acute Medicine<br>3. Assessment Capacity/Environment<br>4. Decision to admit<br>5. Collective decision making<br>The Committee will report to the Quality Assurance Committee and Exec Team<br>New ED 'at a glance' dashboard gone live – supports organisational visibility and proactive response from specialties.<br>Participating as a pilot site for recording of Same Day Emergency Care (SDEC) in association with NHSi & NHSE | | |  | |
| **Assurance Gaps:** | - fully embedding actions associated with system wide capacity & demand review undertaken by Venn Consulting<br>Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. | | | | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| A Weekend Bed Meeting following the Discharge Ward Rounds to support Flow in the ED | Weekend Bed Meetings | Discuss with Trust SMT | Liversedge, Tom | 29/03/2019 | 10/06/2018 |
| Discharge Lounge available 24/7 to enhance Flow in the Hospital to aid Flow and Patient Journey in ED | Discharge Lounge | Discuss with Trust SMT | Palin, Bradley | 30/11/2018 | 26/11/2018 |
| RN is available on each Shift to Nurse Patients in the ED Escalation Area | RN Cover for Escalation Areas | ED off duty to be checked and Escalation procedure followed to ensure Staffing level matches demand | Smith, Rachel | 27/07/2018 | 15/05/2018 |
| Frailty Unit to assess up to Max 50 | Frailty Unit | To discuss with SMT | Liversedge, Tom | 29/06/2018 | 10/06/2018 |

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| Patients weekly Mon - Fri 09:00 to 17:00 - has the potential to relieve pressure on the ED | | | | | |
| Discharged Lounge to be renovated. | Discharge Lounge | Discharge lounge approved for renovation; estimated date of completion is December 2018. | Liversedge, Tom | 12/12/2018 | 26/11/2018 |

# Board Assurance Framework

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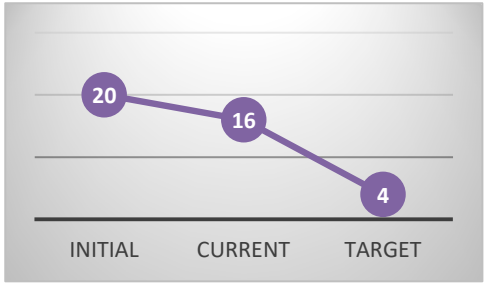
|---|---|---|---|---|---|
| **Risk ID:** | 125 | **Executive Lead:** | Evans, Chris | **Rating** | |
| **Strategic Objective:** | Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience. | | | | |
| **Risk Description:** | Failure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

# Board Assurance Framework

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| **Assurance Gaps:** | -Remaining generator sets are approaching the end of their useful life and spare parts are difficult to obtain and without investment for replacement there is a risk of loss of HV resilience for the Trust.<br>- Main power to Trust Main IT Network Room equipment is checked and serviced but it is now obsolete hence spare parts are no longer available. If the unit fails and there is a power outage there will be a 15 second gap between loss of power and the emergency generator starting up and restoring power during which time sensitive equipment may be damaged resulting in significant business interruption. |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy | Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy | Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy | Wright, Ian | 31/05/2019 | |
| Participate in Halton Healthy Hospitals strategy | Participate in Halton Healthy Hospitals strategy | Participate in Halton Healthy Hospitals strategy | Gardner, Mrs Lucy | 31/12/2018 | 30/04/2018 |
| Review of the Health & Safety risks aligned to estates and facilities to be undertaken | Health & Safety risks aligned to estates and facilities | Health & Safety risks aligned to estates and facilities | Wardley, Darren | 31/07/2017 | 31/07/2017 |
| Review the governance/meetings structure regarding Estates | Review the governance/meetings structure regarding Estates | Review the governance/meetings structure regarding Estates | Wardley, Darren | 29/09/2017 | 29/09/2017 |
| Obtain quotation from supplier in relation to the main power equipment with a view to an order being placed and installation completed | Obtain quotation from supplier in relation to the main power equipment with a view to an order being placed and installation completed | Paperwork and permits required for the ITU replacement. Once that is complete, we are going to take 2 of the racks from that UPS which are still ok and install them in the IT server room UPS to ensure this risk is also completed and addressed. By the time we have the plates manufactured to cover the holes from the 2no. missing UPS racks, the spare racks from the ITU UPS will be ready. Therefore we plan to wait until the end of May for the ITU UPS to be completed. | Wright, Ian | 31.05.2019 | |

# Board Assurance Framework

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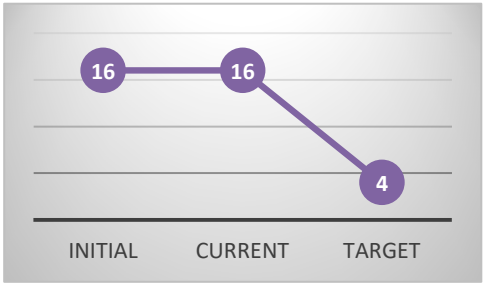
|---|---|---|---|---|---|
| **Risk ID:** | 701 | **Executive Lead:** | Evans, Chris | **Rating** | |
| **Strategic Objective:** | Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services. | | | | |
| **Risk Description:** | Failure to provide continuity of services caused by the scheduled March 2019 EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost. | | | **Initial:** | 16 (4x4) |
| | | | | **Current:** | 16 (4x4) |
| | | | | **Target:** | 4 (2x2) |
| **Assurance Details:** | Standard agenda item on the Trust wide Event Planning Group.<br>Brexit Sub Group has been established with key leads for the 7 key areas of activity outlined in the DHSC operational readiness guidance.<br>A readiness tracker has been produced and is being monitored by the Brexit Working Group.<br>The Procurement department completed the national self-assessment contract review tool and continues to review suppliers which are out of the national scope.<br>Service level business continuity plans continue to be refreshed.<br>The IT department have reviewed all the Trust key IT systems and none have been identified as having a touch point in the EU.<br>Nationally a 6 week stockpile of goods will be maintained.<br>Daily SitReps are being submitted to the DHSC.<br>May 2019 - the Government has agreed an EU Exit extension to the 31st October 2019. If the Withdrawal Agreement is ratified earlier the UK will leave the EU earlier, but it would be with a deal. All reporting has been stood down and the planning that had been in place will be adapted to support the extension. A debrief session has taken place to capture lessons learnt and has been shared with the regional EU exit team and will be used to support our preparations closer to the leave date. | | |  | |
| **Assurance Gaps:** | Continued national uncertainty on the terms of the EU exit and the date when this will be.<br>Trusts being requested not to stock pile supplies.<br>Risk to Supply BAU/CIP whilst resources are redirected to complete national work.<br>National concern on shortages of radiopharmaceuticals and blood products.<br>Potential price increases to supplies. | | | | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Supplies department to complete self-assessment tool in order to ascertain suppliers who have a point of contact in the EU. | Supplies department to complete self-assessment tool | Contact supplies to triage and if necessary complete a deep dive. | Steve Barrow | 30/11/2018 | 30/11/2018 |
| The Trust needs to identify any data flows that may be at risk if we leave the EU with a no deal exit. | Data control flows | Information Asset owners to complete a flow mapping template that has been produced by the Information Governance manager. | Phillip James | 31/05/2019 | |
| All corporate and clinical business units should have an up to date business continuity plan. | Services to review and update business continuity plans | Review and update service BCP's. | Emma Blackwell | 28/03/2019 | 10/04/2019 |

# Board Assurance Framework

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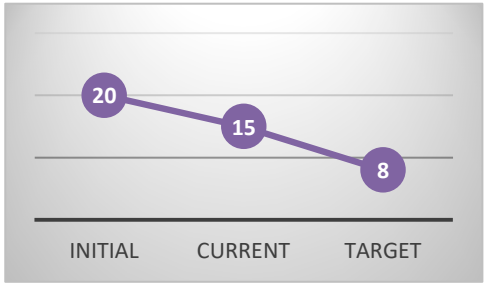
|---|---|---|---|---|---|
| **Risk ID:** | 145 | **Executive Lead:** | Pickup, Mel | **Rating** | |
| **Strategic Objective:** | Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services. | | | | |
| **Risk Description:** | Influence within Cheshire & Merseyside<br>a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.<br>b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. | | | **Initial:**<br>**Current:**<br>**Target:** | 20 (5x4)<br>15 (5x3)<br>8 (4x2) |
| **Assurance Details:** | Members of the board have secured lead roles on a range of programmes within the LDS and STP.<br>The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed.<br>We are developing plans, with partners, to establish Accountable Care Organisations in both Halton and Warrington.<br>We have developed an engagement strategy in partnership with our Governing Council<br>We have established a community-wide newsletter Your Hospitals<br>Assurance:<br>Evidenced by lead roles in STP and LDS.<br>No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the STP.<br>The Trust has developed effective clinical networking and integrated partnership arrangements:<br>The Trust is successfully leading and co-ordinating the delivery of new integrated care pathways for the frail elderly with partners from primary and social care, the voluntary sector, 5 Boroughs NHSFT and Bridgewater Community NHSFT.<br>The Trauma and Orthopaedic service has developed excellent links with the Walton Centre and the Royal Liverpool for complex spinal patients.<br>Monitoring engagement by stakeholders (attendance at events, membership survey)<br>Reports and Feedback from Healthwatch<br>'What Matters to Me' conversation cafes held across both sites in partnership with patient experience committee and governors. Will also include WHH volunteers, WHH careers and WHH charity<br>- Memorandum of Understanding and work plan with Bridgewater Community Healthcare NHS FT approved.<br>- Working in partnership with GP Federation in Halton on relation to improving joint clinical pathways.<br>- Council and CCG in both Warrington & Halton supportive of development of new hospitals.<br>- Agreement of sustainability contract with Warrington CCG.<br>- Work plan agreed with StHK<br>- Shared a presentation demonstrating Halton Hospital's suitability to host the Eastern Sector Cancer Hub with Clatterbridge and other stakeholders. This forms part of the formal decision making process on the location of the hub<br>- Two more GP engagement events planned.<br>- Regular Strategy updates are provided to the Council of Governors.<br>- GP Engagement event held, including engagement on clinical strategy<br>- Clinical strategy engagement held with Trust Board<br>- Submitted bid to provide UTCs in Runcorn & Widnes<br>- Halton Healthy New Town programme formally reports to One Halton Board<br>- Commissioned financial feasibility assessment for Halton Healthy New Town following unsuccessful bid to NHSE<br>- Clinical Strategy approved by Trust Board<br>- CBU specialty level strategies complete and incorporated in business plans<br>- Successful in One Public Estate revenue funding bid for Halton | | |  | |

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| | - Initial talks held with Elective Care STP Lead in relation to the suitability of Halton as a potential Elective Care Hub<br>Trust has met with Cheshire & Merseyside leads for Women's and Children's review to demonstrate strength of local Women's and Children's services and help inform outcomes of regional review.<br>NHSE supportive of draft strategy for breast screening. | |
| **Assurance Gaps:** | Our CQC rating may impact our ability to influence<br>Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress.<br>Limitations of the size of the catchment area.<br>Risk to Women's and Children's future provision due to Cheshire & Merseyside led review. | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Ensure WHH are in a strong position to influence the agenda | Influencing the agenda | CEO to ensure that she continues in her role as STP Chair to ensure that we can have an influence in the agenda | Pickup, Mel | 31/03/2019 | 31.12.2019 |
| Ensure evidence is provided to support strategic development and decision making. | Development of Trust Strategy document aligned to Trust planning priorities and | Development of Trust Strategy document aligned to Trust planning and priorities | Gardner, Mrs Lucy | 30/06/2018 | 30/06/2018 |
| Re-establish 'Board Talk' stakeholder newsletter | Re-establish 'Board Talk' stakeholder newsletter | Re-establish 'Board Talk' stakeholder newsletter | McLaren, Patricia | 31/05/2017 | 31/05/2017 |
| Create more opportunities for stakeholder engagement at our hospitals | Create more opportunities for stakeholder engagement at our hospitals | Create more opportunities for stakeholder engagement at our hospitals | Ryan, Candice | 30/06/2017 | 31/05/2017 |
| Revisit the Your Hospitals newsletter/membership communications to ensure optimised | Revisit the Your Hospitals newsletter/membership communications to ensure optimised | Revisit the Your Hospitals newsletter/membership communications to ensure optimised | Ryan, Candice | 31/05/2017 | 31/05/2017 |
| Establish clinician-led GP engagement opportunities | Establish clinician-led GP engagement opportunities | Establish clinician-led GP engagement opportunities | Crowe, Dr Alex | 31/12/2018 | 10/07/2018 |
| Ensure clinical strategies in place for all specialties. | Ensure clinical strategies in place for all specialties | Ensure clinical strategies in place for all specialties. | Crowe, Dr Alex | 30/11/2018 | 14/12/2018 |
| Establish formal partnership with Bridgewater.<br>Establish formal partnership with St Helen's and Knowsley. | Formalise partnerships with other local organisations | Signed memorandums of understanding and agreed workplans. | Gardner, Mrs Lucy | 30/11/2018 | 30/11/2018 |

# Board Assurance Framework

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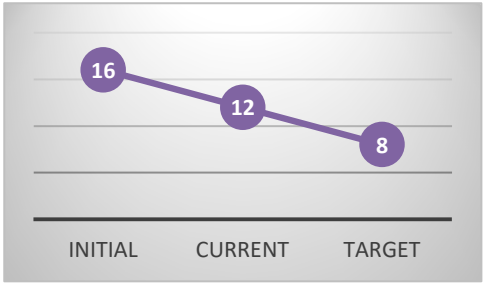
|---|---|---|---|---|---|
| **Risk ID:** | 123 | **Executive Lead:** | Constable, Simon | **Rating** | |
| **Strategic Objective:** | Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience. | | | | |
| **Risk Description:** | Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences. | | | **Initial:** | 16 (4x4) |
| | | | | **Current:** | 12 (3x4) |
| | | | | **Target:** | 8 (4x2) |
| **Assurance Details:** | Controls:<br>Discharge summary performance, both the 95% and 7 day standard, is now monitored through an electronic dashboard, and is overseen by the monthly Clinical Operational Board (and also Finance and Sustainability Committee).<br>Performance is managed at ward level, with an escalation protocol through the Clinical Business Unit and division.<br>Discharge Policy and processes in place to support staff<br>Training provided to staff, including junior doctors on induction, on Lorenzo<br>Assurance:<br>The current performance shows that we meet the 95% target for sending discharge summaries within seven days, whilst recognizing that improvement needs to continue to improve regarding sending discharge summaries within 24 hours. Current performance is 88% within 24 hours.<br>Sample audit work undertaken with regard to the backlog to date (June 23rd 2017) has not revealed that a patient has been harmed<br>A review of incidents and complaint information in the timeframe of the backlog has not identified that a patient has come to harm or that a patients has complained<br>E-Discharge Task and Finish Group has been set up to oversee a review of the Trust's E-Discharge policies and processes, to ensure that they are robust and that there is effective clinical review and escalation processes in place. The Task & Finish group reports to the Patient Safety & Clinical Effectiveness Sub Committee.<br>Discharge audit at service level undertaken as part of audit programme | | |  | |
| **Assurance Gaps:** | Discharge Summary Audit to be completed and actions embedded | | | | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Ensure an audit programme reviewing the quality of discharge summaries is established across the Trust | audit programme reviewing the quality of discharge summaries | audit programme reviewing the quality of discharge summaries | Crowe, Dr Alex | 10/05/2019 | |
| Ensure an update report of improvement is presented to Trust Patient Safety & Effectiveness Sub Committee | update report of improvement is presented | update report of improvement is presented | Crowe, Dr Alex | 30/11/2017 | 30/11/2017 |
| Ensure a daily report tracking discharge summary performance is established and sent out to Clinical Directors | discharge summary performance daily report | discharge summary performance daily report | Crowe, Dr Alex | 30/06/2017 | 30/06/2017 |
| Establish a Task and Finish Group, reporting to Digital Optimisation Group, to support taking the work of discharge summaries forward | Establish a Task and Finish Group | Establish a Task and Finish Group | Crowe, Dr Alex | 31/07/2017 | 31/07/2017 |
| Ensure that a review of policy, procedures and training for discharge summaries is undertaken to ensure that they are fit for purpose | Review of policy, procedures and training for discharge summaries | review of policy, procedures and training for discharge summaries | Crowe, Dr Alex | 10/05/2019 | |

# Board Assurance Framework

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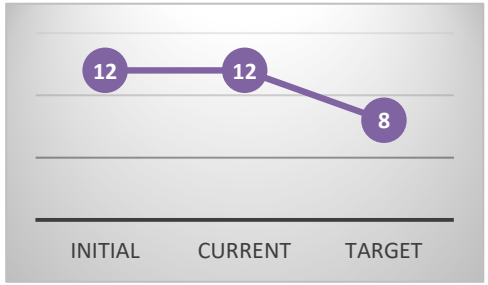
|---|---|---|---|---|---|
| **Risk ID:** | 143 | **Executive Lead:** | Deacon, Stephen | **Rating** | |
| **Strategic Objective:** | Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience. | | | | |
| **Risk Description:** | Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation | | | **Initial:** | 12 (4x3) |
| | | | | **Current:** | 12 (4x3) |
| | | | | **Target:** | 8 (4x2) |
| **Assurance Details:** | Firewall deployed to protect the network by filtering the traffic that is permitted in and out of the WHH network.<br>Blocking file extensions recommended by NHS Digital on WHH Fileshare areas. CareCert bulletins containing information security measures which need to be implemented are produced by NHS Digital and measures taken to implement their requirements are documented at IT Seniors meeting on a weekly basis.<br>Information Security Management System (ISMS) in use to protect WHH IT assets. The ISMS is based on the principles contained within the ISO27001 standard in use to control physical and network access and the controls required to protect said assets.<br>Daily backups and 4 hour replication to the Halton site which replicates data on the Halton site storage area network (SAN). Data loss in the event of a Cyber-attack would be minimised due to the replication of data.<br>Achievement of Cyber essentials certification and completion of the requisite network penetration testing. Certification to the Cyber Essentials standard has been recommended for all Trusts and compliance with its requirements can enhance protection against circa 80% of Cyber-attacks.<br>Removal of obsolete operating systems (eg Windows XP) and automatic patching of critical updates offered by Microsoft.<br>Removal of XP operating system across WHH continues and three tier patching regime is proposed<br>A robust patching regime has been implemented and automated using Solar Winds software which allows time to be spent on the complex areas for patching. Patching completion has increased to 96%.<br>17/4/19: Network Penetration Tests - MIAA have completed an external penetration testing of our network and we are awaiting the formal report. The Trust has also purchased software that will test any internal vulnerabilities on our servers. The server has been set up and software has been installed and the next steps are to do the server configuration. | | |  | |
| **Assurance Gaps:** | The version of Java cannot be updated due to the restrictions in place by NHS Digital for national systems including SBS and ESR. These systems require a certain version (which is many versions out-of-date) for them to work properly and remain supported by the NHS Digitals Service Desk.<br>Windows 7 support expires ends security updates for Windows 7 PC 14th Jan 2020. The Trust must move over to Windows 10 before then. All new devices are Windows 10 only and rebuilds or tech refresh is Windows 10 only. This is covered by IT Services BAU.<br>07/11/2018<br>Trust only has a handful of Windows XP in Radiology which are hardened which means their code cannot be altered by an attack, we are happy from a desktop point of view all Windows unsupported operating systems are now been cleared. We are working on migrating all desktops to Windows 10, removing Windows 7 and 8 from the desktops.<br>The cyber business case is in draft and Director of IT and Information at the Wirral has asked for feedback from the other two trusts. WHHT have feedback to Wirral.<br>04/01/2019 - The migration of the back ups have been delayed due to the Trust prioritising the domain controller migration other IT projects. All other actions have been reviewed and no further action.<br>04/01/2019 - SharedData and 12 SQL servers have been added, however, 6 of them are not truncating, will require resolving.<br>13/03/2019 - Medical devices need to be moved into medical VLAN 'bubble'. 17.04.2019 - This still incomplete due to the work required to move medical devices across to within the protection. This requires co-ordination between the operational teams in Pathology and Radiology, external suppliers and adequate IT resources all of which are impacting on the completion of this task<br>17/4/19 - The VLAN bubble work - This still incomplete due to the work required to move medical devices across to within the protection. This requires co-ordination between the operational teams in Pathology and Radiology, external suppliers and adequate IT resources all of which are impacting on the completion of this task.<br>17/4/19 - Encryption of backups – The encryption software has been switched however sense checks are to be undertaken before this can be completed. | | | | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
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| Ensure capital monies are available in 2018/19 for upgrade of vital security software and hardware | capital monies are available in 2018/19 for upgrade of vital security software and hardware | capital monies are available in 2018/19 for upgrade of vital security software and hardware | McGee, Andrea | 30/04/2018 | 27/04/2018 |
| Implement security 'bubble' around the | Implement security 'bubble' around the | Implement security 'bubble' around the | Caisley, Sue | 30/03/2018 | 05/09/2018 |

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| medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment – development of a plan | medical VLAN | medical VLAN | | | |
| Act on recommendations made in the Cyber essentials report to ensure improved cyber security. | Act on recommendations made in the Cyber essentials report to ensure improved cyber security. | Act on recommendations made in the Cyber essentials report to ensure improved cyber security.<br>04/01/2019<br>Reviewed, no further action<br>17/01/2019<br>Reviewed with other members of the STP Cyber Group internal server vulnerability scanning options. Nessus was the recommended option. The CIO has approved the purchase of the software and is on order. | Deacon, Stephen | 30/04/2020 | |
| Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan | Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan | Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan | Caisley, Sue | 30/03/2018 | 31/03/2017 |
| Ensure that Information Governance messages around safe use of IT assets are reiterated via corporate induction and training | Information Governance messages around safe use of IT assets | Information Governance messages around safe use of IT assets | Caisley, Sue | 31/12/2018 | 31/03/2017 |
| Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system – send out an alert to all staff on a regular basis and report quarterly to Information Governance and Corporate Records Sub-Committee | Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system | Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system | Caisley, Sue | 31/12/2018 | 05/09/2018 |
| NHS Digital issues CareCERT advisory bulletins to support the NHS in maintaining high standards of cyber security. Trusts are to confirm that they have acted on the most critical of these, where applicable to their IT infrastructure.<br><br>All Trusts give a template setting out 39 of the critical CareCERT advisories, all issued over the last three months after WannaCry, which have been deemed most critical in preventing successful | Complete actions on NHS England's CareCERT 39 | Download template and update it with current status and when all 39 CareCERTS are to be completed.<br><br>07/11/2018<br>All CareCERT's are now completed and sent back to NHS Enlgand. | Deacon, Stephen | 30/11/2018 | 07/11/2018 |

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| cyber-attacks. | | | | | |
| Several desktop devices still on Windows XP due to systems not compatible with Windows 7 onwards. IT working closely with the departments and third party supplies to ascertain a plan to migrate to Windows 7/Windows 10 | Removal of Unsupported Windows XP from Desktop Devices | 08/08/18<br>Supporting each department helping them to remove Windows XP from their areas replacing them with Windows 7 onwards, some systems will need upgrading or replacing dependant on funding (On-going)<br>04/09/2018<br>A report has been created for the IM&T Programme Board the following XP devices/systems using XP have been identified:<br>26/09/2018<br>Paper was presented to the IM&T Programme Board, discussions with Radiology has reduce the numbers further due to hardening of the XP Servers. | Whitfield, Simon | 26/10/2018 | 10/10/2018 |
| Move medical devices into VLAN bubble. This will involve participation of multiple 3rd parties and internal WHH staff. | Add medical devices to VLAN bubble | 04/01/2019<br>Network Manager has begun pre work on the VLAN protective bubble | Smith, Mr Philip | 31/03/2020 | |
| Additional network security (Phase 2) to replace aging hardware around web filtering and file blocking is required. | Additional network security | Submit capital form to capital meeting (Complete)<br>Obtain budget code (Complete)<br>Place order (Complete)<br>Install and configure (Complete)<br><br>04/09/18<br>Waiting on arrival of the ASA firewalls for remote access , but training required to utilise the product | Smith, Mr Philip | 31/12/2018 | 14/09/2018 |
| Review of security options with HSCN when upgrading our N3 link to HSCN. | Review security options with HSCN | Review of security options with HSCN when upgrading our N3 link to HSCN (Completed - Sticking with local security) | Smith, Mr Philip | 29/03/2019 | 14/06/2018 |
| Requiring to beef up our Cyber Security including patching for servers<br><br>This includes server security patches. | Implement robust server patching regime | 20/11/18<br>Automatic software has been purchased and will require a period of time to configure before we can automate majority of servers.<br>05/12/18<br>The Server Manager and Technical Specialist are meeting this week to start looking at looking at configuration the server. | Garnett, Joseph | 31/05/2019 | |

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| | | 04/01/2019<br>Reviewed, no further action | | | |
| There are 39 out of 150 outstand hidden shares that are accessible by specialist software to view contents of those shares. This includes e-outcome, these need to be secured. | E-outcome hidden share accessible to all users | 10/10/2018<br>We have been told this is no longer an issue, the IG Manager and IT Manager cannot access the area, but passing over the IT Specialist to double check as he raised the issue originally, however, waiting for him to return back from A/L | Deacon, Stephen | 19/10/2018 | 19/10/2018 |
| Part of the Cyber Essentials+ recommendations the Trust needs a corporate policy for IT logs retention | Corporate Policy for IT Logs Retention | Update the ISMS to contain the corporate policy for IT logs retention | Deacon, Stephen | 28/09/2018 | 26/09/2018 |
| 26/09/2018<br>Update the infrastructure for the ASA's (Remote Access Secure Token System). | Renew the ASA (Remote Access Secure Token System) | 26/09/2018<br>Update the hardware infrastructure for the ASA's (Remote Access Secure Token System.<br>The new hardware is in the department but requires configuration from the supplier (SoftCat) next week, currently waiting on an action plan. Once configured will be put through change control to replace the old hardware, however, there will be downtime for remote access (token based) , mainly suppler based, NHS guest Wi-Fi and staff Wi-Fi and IPAD users using VDI externally but will be minimal.<br>10/10/2018<br>ASA's are being replaced w/c 15/10/18 | Smith, Mr Philip | 19/10/2018 | 24/10/2018 |
| As part of the Windows 10 agreement from NHS Digital, ATP (Advance Threat Protection) across all our desktop devices before the end of December 2018 | Install Advance Threat Protection on all desktop PC's and laptops | Install ATP across the desktop estate | Whitfield, Simon | 31/12/2018 | 30/11/2018 |
| From the C&M Cyber Group:<br>To share those Cyber Essentials Plus questionnaires that were unsuccessful? As they may reveal common areas of improvement that we could work on together. | Provide the C&M Cyber Group with the answers from the CE+ | To send to the C&M Cyber Group the answers from the Cyber Essentials+ assessment. | Deacon, Stephen | 31/10/2018 | 10/10/2018 |
| Encrypt backup data to stop any successful cyber-attack from affecting the backup data | Encrypt backups | 03/12/18<br>The Data Domain is now configured and has been tested with one server. The Server Manager will perform a phased migration of all other servers. With the | Garnett, Joseph | 30/04/2019 | |

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|---|---|---|---|---|---|
| | | speed being faster we are able to look at changing/when how the backups are performed.<br>04/01/2019<br>The Trust prioritised the Domain Controller migration over other IT projects<br>04/01/2019<br>SharedData and 12 SQL servers have been added, however, 6 of them are not truncating, will require resolving.<br>10/01/2019<br>18 servers have been migrated to the new backup system. The 6 SQL servers issues with truncation of their logs has also been resolved.<br>15/03/2019<br>Server manager to ascertain how to implement encryption on data domain | | | |
| Support for Windows Server 2003 has now ceased and as a consequence, Microsoft no longer provide security updates or technical support for this operating system. Consequently, any server or system reliant on Windows Server 2003 presents a cyber-security risk to the Trust.<br><br>We either need to migrate or decommission the unsupported Windows Server 2003 to Windows 2016 (Latest server operating system) | Review Server 2003 servers | 24/10/2018<br>Obtained a list of servers using Server 2003 and provide a report to the next Digital Board. Currently, the Trust still has 20 servers which use Windows Server 2003, however today we have been able to decommission 1 of the servers already.<br>20/11/18<br>The paper was discussed at the digital board. Estates are migrating the rest of the users to the cloud for Resman system and one more can be shutdown.<br>04/01/2019<br>Reviewed, no further action<br>15/03/2019<br>17 2003 servers left to complete | Garnett, Joseph | 31/12/2019 | |
| Wirral are the lead for the STP Cyber Group. They required to create a business case which covers a programme of work with a number of project areas which together will provide joint and collective assurance on the work around cyber security for the Health and Care Partnership. | WHHT to help Wirral create the STP Cyber Business Case | 07/11/2018<br>The cyber business case is in draft and Director of IT and Information at the Wirral has asked for feedback from the other two trusts. WHHT have feedback to Wirral.<br>20/11/18<br>Final draft has been sent out for comment. | Deacon, Stephen | 31/05/2019 | |

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|---|---|---|---|---|---|
| The strands of work include support for joint work on:<br>- Cyber Essentials Plus accreditation<br>- Strategy and Policy Development<br>- Training and skills development<br>- Business Continuity Planning<br>- Procurement and Vendor relations<br><br>The creation of the business case is restricted to a limited number of Trusts within the STP to ensure we are able to meet the deadline.<br><br>WHHT along with Mid-Cheshire and Wirral are the only Trusts involved with the business case, allowing WHHT to be at the forefront of cyber security. | | 03/01/2019<br>Reviewed, no further action<br><br>01/02/19<br>Reviewed, no further action<br><br>05/03/19<br>Reviewed, no further action | | | |

# Board Assurance Framework

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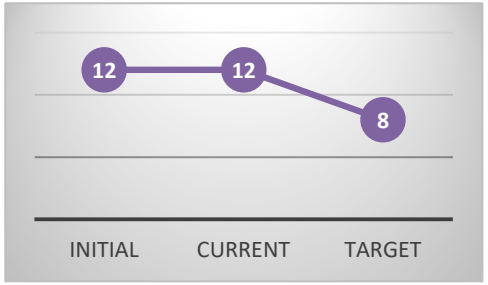
|---|---|---|---|---|---|
| **Risk ID:** | 414 | **Executive Lead:** | James, Phill | **Rating** | |
| **Strategic Objective:** | Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services. | | | | |
| **Risk Description:** | Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches. | | | **Initial:** | 12 (4x3) |
| | | | | **Current:** | 12 (4x3) |
| | | | | **Target:** | 8 (4x2) |
| **Assurance Details:** | • Data Security and Protection Toolkit Returns (NHS Digital)<br>• MIAA Annual Data Security and Protection Toolkit Assurance Audit (significant assurance in 2018)<br>• Cyber Essentials Plus Certification Audits<br>• MIAA Cyber Security baseline<br>• Firewall Health Check<br>• Reporting to Information Governance and Corporate Records Sub-Committee and Quality Committee<br>• MIAA GDPR Readiness assessment<br>Information Governance Manager now reports to IT Services Manager for support & guidance and cross-cover, which reduces the risk of single point dependency.<br>A draft re-structure that includes an Information Security Manager has been produced and will be presented to the newly appointed CIO in due course.<br>Audits on wards underway to establish whether IG best practice is in place<br>Options for improving security of access to Lorenzo other than smartcards, which will include deploying VDI Trustwide (currently in ED Department) will be formulated and submitted to the Digital Optimisation Group and Digital Board for consideration regards costs vs risks and benefits in advance of NHS Digital deploying any security solutions in the future.<br>Follow up audit on IG compliance across all wards and clinical areas to be undertaken by the IG<br>•Follow up audit on IG compliance completed across all wards. Reports provided to Ward Managers and CQC G2G meetings. Key messages disseminated at Safety Huddle and 'You Didn't Think Privacy' unannounced mini-audit initiative launched.<br>New IM&T Department structure developed. The increase in support for IG and Information Security has been recognised. | | |  | |
| **Assurance Gaps:** | • Full compliance with EU NIS Directove<br>•Ongoing audit of information governance and application of IG controls in the general environment including storage of records and training requirements<br>• Embedding of best practice following IG Ward audits<br>• Delivery of unmet assertions on Data Protection Security Toolkit<br>• Ensure business as usual patching cycle<br>• Maintain adherence to IG Policy & Procedures in ward/clinical areas<br>• Maintenance of an effective asset register and information flow mapping | | | | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| IT operational restructure in order to provide information governance support to deal with the burgeoning IG/Cyber Security agenda | IT Dept restructure to increase sources targeted at Information Governance | IT Manager to draft IT operational services restructure<br><br>CIO is reviewing structure of department and resources committed to IG/Information Security | Deacon, Stephen | 30/09/19 | |

# Board Assurance Framework

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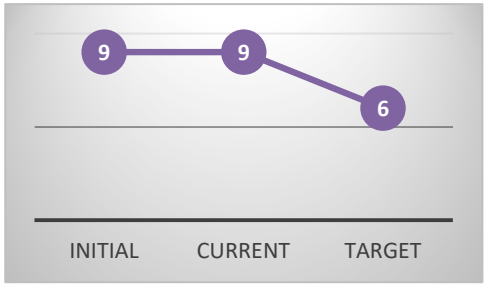
|---|---|---|---|---|---|
| **Risk ID:** | 695 | **Executive Lead:** | Salmon-Jamieson, Kimberley | **Rating** | |
| **Strategic Objective:** | Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience. | | | | |
| **Risk Description:** | Failure to keep the national invasive cancer audit up to date to comply with NHS Cervical screening programme standards; which caused a backlog of cervical screening reviews which resulted in a non-compliance with the cervical screening specification 2018/2019. | | | **Initial:** | 9 (3x3) |
| | | | | **Current:** | 9 (3x3) |
| | | | | **Target:** | 6 (2x3) |
| **Assurance Details:** | Trust has now implemented NHS Cervical Screening Guidance in NHSCSP Publication 28 (1) and Disclosure of audit results in cancer screening best practice (2)<br>i. There is now a ratified policy in place I /12/18 so we are now compliant<br>ii. The Recommendation from SQAS to implement policy for audit and disclosure has now been implemented.<br>Patients diagnosed with cervical cancer will be informed of the audit and offered disclosure from December 2018<br>iii. The Recommendation from SQAS to review screening histories of patients diagnosed with cervical cancer at the Trust from April 2013 to date and discussed at Colposcopy MDT if indicated. This is in progress.<br>Briefing paper and action was plan presented for Patient Safety & Clinical Effectiveness 30/10/18 and will be monitored by this committee.<br>A final report has been received by WHH and the commissioner on the 22nd January 2019. A comprehensive action plan is in development and will be available within 4 weeks of receiving the final report,<br>Developed and returned action plan to SQAS on 22nd February 2019<br>SQAS agreed to work with the Trust to complete the action plan within 12 months.<br>Monitored monthly in Patient Safety & Clinical Effectiveness Sub-Committee<br>The audit of all women diagnosed between 2013 and 2018 is in progress and ongoing. | | |  | |
| **Assurance Gaps:** | Any patients diagnosed with cervical cancer prior to 2018 have not been informed of the audit. Based on the audit details a discussion will be taken at Colposcopy MDT meeting. Patients who require disclosure or possible duty of candour will need sensitive and skilled consultation.<br>The current gap in assurance is the unknown results of all of the audit as it is still in progress with a completion date set by SQAS of November 2019. | | | | |

| Recommendation | Action Description | Actions Required | Responsible Officer | Deadline Date | Completion Date |
|---|---|---|---|---|---|
| Draft policy for National Invasive Cervical Cancer Audit<br>Draft policy for Disclosure of results for National Invasive Cervical Cancer | Policy for National Invasive Cervical Cancer Audit | Requires ratification and implementation | Cooper, Tracey | 31/12/2018 | 27/12/2018 |
| Identify unit numbers/NHS numbers for backlog of patients (approx. 100 -120)<br>Lists of cervical cancer patients in timescale requested from Pathology manager and Cancer Services to ensure all patients captured | Identify backlog of patients | Lists of cervical cancer patients in timescale requested from Pathology manager and Cancer Services to ensure all patients captured<br>Using standard proforma in draft policy systematically review cervical screening histories of above cohort of patients<br><br>Refer complete reviews to a MDT meeting as required. (Patients diagnosed with cervical cancer who have not engaged or defaulted from the programme can be excluded) | Cooper, Tracey | 08/11/2019 | |

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|---|---|---|---|---|---|
| | | Cases where the care or treatment after discussion at MDT is potentially a serious incident the case will be discussed with SQAS as per Managing Screening Incidents guidance. | | | |
| Undertake a review of identified patients cervical screening history | Identify time and staff to undertake review of screening history | Identify time and clinical staff to undertake cervical screening history reviews | Cooper, Tracey | 31/01/2019 | 04/02/2019 |
| MDT will confirm if disclosure would not be appropriate (i.e. if patient has died or is terminally ill and routine disclosure) but otherwise patients will be offered the option of disclosure by a letter explaining the background to the national audit. Draft letter to be drawn up | MDT confirm when disclosure would not be appropriate | Any patient requesting disclosure or duty of candour will have the option for results in a meeting with the Lead Colposcopist/Lead Colposcopy Nurse/ and with clinical input form Cytology/Histopathology if required | Rauf, Ambreen | 31/12/2018 | 28/12/2018 |
| Disseminate NHS guidance for cervical smear takers re training, updates; responsibilities to the patient and screening programme through Cervical Screening Management Meeting once established in 2019 | Disseminate NHS guidance for cervical smear takers re training, updates; responsibilities to the patient and screening programme through Cervical Screening Management Meeting once established in 2019 | Implement a PHE e-learning package as part of the Trust's mandatory training and monitoring of compliance<br><br>Gynaecology and GUM managers to ensure a rolling register of all smear takers in their area including trainees<br><br>Undertake audit of smear takers inadequate rates; rejection rates<br><br>Undertake audit of cervical screening failsafe systems once in place | Rauf, Ambreen | 31/03/2019 | 27/03/2019 |

# Board Assurance Framework

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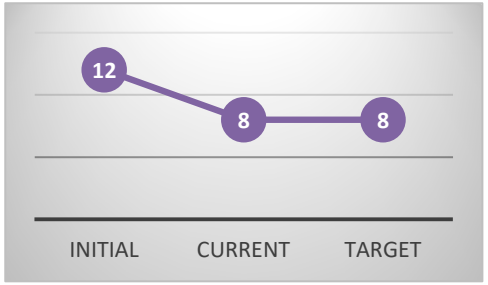
|---|---|---|---|---|---|
| **Risk ID:** | 241 | **Executive Lead:** | Constable, Simon | **Rating** | |
| **Strategic Objective:** | Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future. | | | | |
| **Risk Description:** | Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation. | | | **Initial:** | 12 (4x3) |
| | | | | **Current:** | 8 (4x2) |
| | | | | **Target:** | 8 (4x2) |
| **Assurance Details:** | Regular monthly meetings taking place with HENW involving The Deanery. An agreed action plan has commenced and is progressing.<br>Regular weekly journal/ educational meetings on Mondays co-ordinated by a clinical fellow.<br>Trust Locum Consultants have been approved as educational supervisors and are providing educational supervision to the ST3s in geriatric medicine.<br>Appointment of a Chief Registrar; popular interest by doctors for future Chief Registrar appointments.<br>Recruited to Medical Utilisation Manager Role.<br>Trust wide work stream for rota management.<br>Clinical Director to ensure that all trainees attend their mandatory training.<br>Working on getting more bank doctors, rather than agency.<br>Establishment of Medical Trainees Experience Improvement Group.<br>Deputy Medical Director to have Director of Medical Education portfolio.<br>Improving Medical Staffing and processes across key medical wards.<br>Senior management presence at Medical handover to review any safety issues, escalated to Trust Wide Safety Brief.<br>Weekly Medical Educational Huddle.<br>Business Case currently being developed to support the recruitment of substantive consultant physicians.<br>High level briefing paper submitted to QAC (7.5.19).<br>Trust wide work stream for rota management.<br>Clinic attendance for trainees to ensure they can be released from wards to attend – record log in place and escalation process if not occurring. Subsequent plans to improve training available clinics.<br>3 substantive consultant appointments in Acute Medicine, 1 consultant in Care of the Elderly who is also Clinical Director for Integrated Medical and Social Care CBU.<br>Ward Round Accreditation quality improvement work stream.<br>Access for trainees to Quality Academy and Quality Improvement work streams.<br>Fortnightly Medical Education newsletter | | |  | |
| **Assurance Gaps:** | Recruitment of substantive consultant physicians ongoing | | | | |

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

# Finance and Sustainability Cycle of Business 2019-2020

| | | | 2019 | | | | | | | | 2020 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Exec Lead** | **17.4.19** | **22.5.19** | **19.6.19** | **24.7.19** | **21.8.19** | **18.9.19** | **23.10.19** | **20.11.19** | **18.12.19** | **Jan** | **Feb** | **Mar** |
| **INTRODUCTION & ADMINISTRATION** | | | | | | | | | | | | | |
| Apologies for Absence | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |
| Declarations of Interest | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |
| Minutes of the Last Meeting | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |
| Matters Arising + Action Log | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |
| Rolling attendance log + cycle of business | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |
| **GOVERNANCE & COMPLIANCE** | | | | | | | | | | | | | |
| Committee Terms of Reference | **EMD/HCA** | | | | | | | | | | | | X |
| Committee Cycle of Business | **EMD/HCA** | | | | | | | | | | | | X |
| Committee Chair's Annual Report to Board | **Chair** | X | | | | | | | | | | | |
| Pay Assurance Dashboard + Harmonisation Report + Pay Spend and Review Group Mins | **Dir HR+OD** | X | X | X | X | X | X | X | X | X | X | X | X |
| NHSI Checklist quarterly report | **Dir HR+OD** | X | | | X | | | X | | | X | | |
| Risk Register | **HCA** | X | X | X | X | X | X | X | X | X | X | X | X |
| PAF Review and Refresh of Trust KPIs | **DoF** | | | | | | | | | | | | X |
| **PERFORMANCE** | | | | | | | | | | | | | |
| Corporate Performance Report (incl efficiency, productivity, utilisation, LOS, DNAs ) | **COO** | X | X | X | X | X | X | X | X | X | X | X | X |
| **FINANCIAL ASSURANCE** | | | | | | | | | | | | | |
| Monthly Finance report, + Capital Planning Group Finance + Resources Group Minutes and escalation log Commissioner Contract minutes | **DoF&CD** | X | X | X | X | X | X | X | X | X | X | X | X |
| Combined Financial Position | **DoF+CD** | | | | X | | | X | | | X | | |
| Monthly Cost Pressure Report | **Dof+CD** | X | X | X | X | X | X | X | X | X | X | X | X |
| **INVESTMENT** | | | | | | | | | | | | | |
| Annual Capital Programme | **DoF&CD** | | | | | | | | | | | X | |
| **PLANNING** | | | | | | | | | | | | | |
| Operational Plan & Budgets | **DoF&CD** | | | | | | | | | | | | X |
| Service Line Reporting Quarterly Report | **DoF&CD** | | X | | X | | | | X | | | X | |
| Reference Cost Report | **DoF&CD** | | | | X | | | | | X | | | |
| **CLOSING** | | | | | | | | | | | | | |
| Key issues to the Board | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |
| Any Other Business | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |
| Next Meeting Date & Time | **Chair** | X | X | X | X | X | X | X | X | X | X | X | X |

# Finance and Sustainability Cycle of Business 2019-2020

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

## DRAFT PUBLIC TRUST BOARD – CYCLE OF BUSINESS JANUARY 2019-MARCH 2020

| | | JAN 2019 | MARCH 2019 | MAY 2019 | MAY | JULY 2019 | SEPT 2019 | NOV 2019 | JAN 2020 | MARCH 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| | OWNER | | | YEAR END | | | | | | |
| **Patient or staff story (30 Mins)** | | X | X | | X | X | X | X | X | X |
| **OPENING BUSINESS** | | | | | | | | | | |
| Chairman's Opening Remarks, Welcome, Apologies & Declarations | **CHAIR** | X | X | X | X | X | X | X | X | X |
| Minutes of Previous Meeting & Action Log | **CHAIR** | X | X | X | X | X | X | X | X | X |
| Chief Executive's Report (incl CQC Steering Group Report) | **CEO** | X | X | X | X | X | X | X | X | X |
| Chairman's Report (Inc CoG Report) | **CHAIR** | X | X | X | X | X | X | X | X | X |
| **QPS ASSURANCE** | | | | | | | | | | |
| Integrated Performance Dashboard incl Monthly Nurse staffing report | **Execs** | X | X | X | X | X | X | X | X | X |
| Spinal Services update | **Exec MD** | X | X | | X | X | X | X | X | X |
| PAF/ Review and refresh of Trust Integrated KPIs (April prior to formal signing in May) | **DoF** | | X | X | | | | | | |
| **QUALITY** | | | | | | | | | | |
| Annual Complaints Report | **CN** | | | | | X | | | | |
| Learning From Experience Summary Report | **CN** | | X Q3 | | XQ4 | | XQ1 | XQ2 | | XQ3 |
| Annual Health & Safety Report | **CN** | | | | | | X | | | |
| DIPC Report Annual | **CN** | | | | | X | | | | |
| DIPC Quarterly Report | **CN** | | XQ3 | | XQ4 | | XQ1 | XQ2 | | XQ3 |
| Safeguarding Annual Report | **CN** | | | | | X | | | | |
| QCQ Action Plan Update | **CN** | X | X | | **X** | **X** | **X** | **X** | **X** | **X** |
| Quarterly Mortality Review report | **Exec MD** | | XQ3 | | XQ4 | | XQ1 | XQ2 | | XQ3 |
| Medicines Management Annual Report | **Exec MD** | | | | X | | | | | |
| Annual SIRO Report | **DIM+T** | | | | X | | | | | |
| Quality Strategy | **CH** | | | | X | | | | | |
| **PEOPLE** | | | | | | | | | | |
| NHS Staff Opinion Survey | **HRD** | | | | X | | | | | |
| Nurse Staffing Bi-Annual report | **CN** | Def to Mar ~~¥~~ | X | | | X | | | X | |
| GMC Re-validation Annual Report | **Exec MD** | | | | | | X | | | |
| Engagement Dashboard 6 month Report | **DCE** | | X | | | | | X | | |
| Engagement Dashboard Year End Report | **DCE** | | | | X | | | | | |

| | | JAN 2019 | MARCH 2019 | MAY 2019 | MAY | JULY 2019 | SEPT 2019 | NOV 2019 | JAN 2020 | MARCH 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| | OWNER | | | YEAR END | | | | | | |
| Guardian of Safe Working Quarterly Report | **Guardian** | X Q3 | | | X Q4 | | X Q1 | X Q2 | | |
| Freedom To Speak Up – Guardian Bi-annual Report (Jane Hurst) | **CN** | X | | | | | X | | | |
| Hospital Volunteer Annual Report | **CN** | | X May 2020 | | | | | | | X |
| Patient and Public Participation + Involvement Strategy | **DCE+F** | | X May 2020 | | | | | | | X |
| **SUSTAINABILITY** | | | | | | | | | | |
| Operational Plan & Budgets Approval | **DoF** | | X | | | | | X | | |
| Capital Programme | **DoF** | | X | | | | | | | |
| Emergency Preparedness Annual Report | **COO** | | | | | | X | | | |
| ¼ ly Progress on Carter Rep Recommendations + Use of Resource Asmt | **DoF** | X | | | X | X | | X | | X |
| **KEY ISSUES FROM COMMITTEE CHAIRS** | | | | | | | | | | |
| Audit Committee | **Chair** | | X | | X | X | | X | | X |
| Quality Assurance Committee | **Chair** | X | X | | X | X | X | X | X | X |
| Finance & Sustainability Committee | **Chair** | X | X | | X | X | X | X | X | X |
| Strategic People Committee | **Chair** | X | X | | X | X | X | X | X | X |
| **YEAR END** | | | | | | | | | | |
| Annual Report & Accounts Sign Off (inc Quality Account) | **DoF/CN** | | | X | | | | | | |
| Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors | **Exec MD/HCA** | | | X | | | | | | |
| **GOVERNANCE** | | | | | | | | | | |
| Strategic Risk & BAF Update | **HCA** | X | X | | X | X | X | X | X | X |
| Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs) | **DoF** | | X | | | | | | | |
| Risk Management Strategy | **CN** | | | | | X | | | | |
| WHH Charity Annual Report | **DCE** | | | | | | | X | | |
| Board Annual Cycle of Business | **EMD/HCA** | | X | | | | | | | |
| Board Sub-Committee ToRs + Cycle of Business Ratification | **EMD/HCA** | | AC, QAC, SPC | | FSC+~~TOB~~ | COG | CFC | | | |
| **Committee Chairs Annual Reports:** | | | | | | | | | | |
| Quality Assurance Committee Annual Report | **Chair** | | | | | X | | | | |

| | | JAN 2019 | MARCH 2019 | MAY 2019 | MAY | JULY 2019 | SEPT 2019 | NOV 2019 | JAN 2020 | MARCH 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| | OWNER | | | YEAR END | | | | | | |
| Finance & Sustainability Committee Annual Report | **Chair** | | | | X | | | | | |
| Audit Committee Annual Report | **Chair** | | | | X | | | | | |
| Strategic People Committee | **Chair** | | X | | | | | | | |
| **CLOSING BUSINESS** | | | | | | | | | | |
| Any other business & Date of next meeting | **Chair** | X | X | | X | X | X | X | X | X |

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NHS Warrington and Halton Hospitals NHS Foundation Trust

## AUDIT COMMITTEE – CYCLE OF BUSINESS FEBRUARY 2019-MARCH 2020

| | | FEB 2019 | APRIL 2019 | MAY 2019 | AUG 2019 | NOV 2019 | FEB 2020 |
|---|---|---|---|---|---|---|---|
| | **OWNER** | | | YEAR END | | | |
| **STANDING ITEMS** | | | | | | | |
| • Welcome, apologies, declarations of interest, cycle of business | **CHAIR** | X | X | X | X | X | X |
| • Review Minutes and Action Log | **CHAIR** | X | X | | X | X | X |
| • Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually | **CHAIR** | X | | | X | | |
| • Review rolling attendance log | **CHAIR** | X | X | | X | X | X |
| • Approve Chair's key issue report items for escalation (post meeting) | **CHAIR** | X | X | | X | X | X |
| • Meeting effectiveness - bi-annual review | **CHAIR** | | | | | X (rep Feb) | X |
| • Meeting effectiveness - annual review | **CHAIR** | | X (rep Aug) | | X | | |
| **QPS ASSURANCE** | | | | | | | |
| • Update from Chairs of F&S, Q&A (inc Clinical Audit) & CFC | **TA/MB/ JNE** | X | X | | X | X | X |
| • Changes or Updates to BAF | **HCA** | X | X | | X | X | X |
| • Annual Review of BAF | **HCA** | | | | | X | |
| **DEEP DIVE REVIEWS** | | | | | | | |
| • Rolling programme of progress review of the Trust's principle key risks | **AS RQD** | | | | | | |
| • Commission and receive ANY additional scrutiny projects | **AS RQD** | | | | | | |
| **FINANCE** | | | | | | | |
| • Review Losses & Special Payments | **DoF + Comm Dvpmt** | X | X | | X | X | X |
| • Review Quotation and Tender Waivers of Standing Financial Instructions | **DoF + Comm Dvpmt** | X | X | | X | X | X |
| • Going Concern Report | **DoF + Comm Dvpmt** | | X | | | | |
| • Progress report on internal audit follow-up actions | **DoF + Comm Dvpmt** | X | X | | X | X | X |
| **INTERNAL AUDIT** | | | | | | | |
| • Internal Audit Plan & Fees | **MIAA** | X | | | | | |
| • Internal Audit Progress Report | **MIAA** | X | X | | X | X | X |
| • Internal Audit Progress Report on follow-up actions | **MIAA** | X | | | X | X | X |
| • Head of Internal Audit Opinion | **MIAA** | | X | | | | |
| • Internal Audit Charter Annual Report | **MIAA** | | X | | | | |
| • Insight Report | **MIAA** | X | X | | X | X | X |
| **EXTERNAL AUDIT** | | | | | | | |
| • External Audit Plan & Fees | **GT** | X | | | | | |
| • Report and Updates from External Audit | **GT** | X | X | | X | X | X |
| • Annual Audit Letter (AC following year-end Audit Cttee) | **GT** | | | | X | | |

| | | FEB 2019 | APRIL 2019 | MAY 2019 | AUG 2019 | NOV 2019 | FEB 2020 |
|---|---|---|---|---|---|---|---|
| | **OWNER** | | | YEAR END | | | |
| • Renewal/Refresh of External Audit Contract (at term) | **GT/AMcG/JC** | | | | | | |
| **COUNTER FRAUD** | | | | | | | |
| • **DRAFT** Annual Counter Fraud Plan | **MIAA** | X | | | | | |
| • **FINAL** Annual Counter Fraud Plan | **MIAA** | | X | | | | |
| • Counter Fraud Progress Updates | **MIAA** | X | | | X | X | X |
| • Annual Counter Fraud Annual Report | **MIAA** | | X | | | | |
| **QPS GOVERNANCE AND COMPLIANCE** | | | | | | | |
| • Annual report and accounts timetable and plans | **DoF + Comm Dvpmt** | X | | | | | |
| • **Draft** Annual Governance Statement | **HCA** | | X | | | | |
| • **Draft** Annual Report | **CEO** | | X | | | | |
| • **Draft** unaudited Accounts & Financial Statements | **DoF + Comm Dvpmt** | | X | | | | |
| • Annual Report | **CEO** | | | X | | | |
| • Quality Account | **D Integ Gov+ Quality** | | | X | | | |
| • **Draft** Annual accounts accounting policies | **DoF + Comm Dvpmt** | X | | | | | |
| • **FINAL** and Audited Accounts & Financial Statements | **DoF + Comm Dvpmt** | | | X | | | |
| • Head of External Audit Opinion Statement | **GT** | | | X | | | |
| • Head of Internal Audit Opinion Statement | **MIAA** | | X | | | | |
| • Review other reports and policies as appropriate – eg changes to standing orders – as arise, Freedom to Speak Up | **ALL** | | | | | | |
| • Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors | **HCA** | | | X | | | |
| • Code of Governance Compliance Declaration – eg changes as required | **HCA** ***(AS RQD)*** | | | | | | |
| • Review of Trust Registers (eg Conflicts of Interest) | **HCA** | | | | X | | |
| • Terms of Reference x 2 years | **HCA** | | | | | | X |
| • Cycle of Business | **HCA** | X | | | | | |
| • On-Call, Call-Out, Overtime Annual Report | **HRD+OD** | | | | X | | |
| **EFFECTIVENESS** | | | | | | | |
| • Committee Objective Setting | **ALL** | | X | | | | |
| • Committee Chairs Annual Report for Board & Council of Governors | **CHAIR** | | | X | | | |

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NHS Warrington and Halton Hospitals NHS Foundation Trust

# *Work Plan 2018 - 2020*

| STRATEGIC PEOPLE COMMITTEE (SPC) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Topic** | **Lead** | **September 2018** | **November 2018** | **January 2019** | **March 2019** | **May 2019** | **July 2019** | **September 2019** | **November 2019** | **January 2020** | **March 2020** |
| **Apologies for Absence** | Chair | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Declarations of Interest** | Chair | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Minutes of the last meeting** | Chair | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Matters Arising** | Chair | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Action Log** | Chair | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Terms of Reference** | Chair | √ | | | √ | | | | | | √ |
| **Annual Cycle of Business** | Chair | √ | | | √ | | | | | | √ |
| **Committee Chairs Annual report to Trust Board** | Chair | | | | √ | | | | | | √ |
| **Annual Effectiveness Committee Survey** | Chair | | | | √ after March SPC | √ outcomes of survey | | | | | √ after March SPC |
| | | | | | | | | | | | |
| **Director of HR & OD report** | Director HR & OD | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **BAF & Risk Register – Staff** | Head of HR Strategic Projects | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **WHH People Strategy Report +Strategic Projects (People)** | Deputy Director HR & OD | | | | √ | | √ | | √ | | √ |
| **CQC – Getting to Good, Moving to Outstanding - Staff** | Director HR & OD | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **HENW/GMC Annual Reports:**<br>• **GMC Patient Survey Response Report**<br>• **HENW Local Education Provider (LEP) Report**<br>• **HENW Monitoring Visit (Annual Assessment Visit)**<br>• **GMC National Trainee Survey** | Executive Medical Director + Deputy CEO | | <br>√<br>√<br>√<br>√ | | | | | | <br>√<br>√<br>√<br>√ | | |
| **Medical Appraisal + GMC Revalidation Annual Report** | Executive Medical Director + Deputy CEO | √ | | | | | | √ | | | |
| **Policies and Procedures Report** (as required) | Head of HR Strategic Projects | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Employee Relations Report** | Deputy Director HR & OD | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **National Staff Opinion Survey** | Deputy Director HR & OD | | | | | √ | | | | | |
| **Freedom to Speak Up** | Chief Nurse | √ | | | | √ | | | | √ | |
| **Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training** | Medical Director | | √ | | √ | | √ | | √ | | √ |
| **Equality and Diversity – Strategy Update** | Deputy Director HR & OD | | √ | | | √ Def to July | √ | | √ | | |
| **Equality and Diversity – Regulated Reports (as required)** | Deputy Director HR & OD | | | | | | | | | | |
| • **Equality Duty Assurance Report (EDAR) PSED Standard (for sign off)** | | | | √ | | | | | | √ | |
| • **Workforce Equality Assurance Report (WEAR) PSED Standard (for sign off)** | | | | √ | | | | | | | |
| • **Equality Delivery System 2 (EDS2) – within OPC Chairs Log** | | | | | √ | | | | | | |
| • **Gender Pay Report – – within OPC Chairs Log** | | | | | √ | | | | | | |
| • **Workforce Race Equality Standard (WRES) – within OPC Chairs Log** | | √ | | | | | √ | | | | |
| • **Workforce Disability Equality Standard (WDES) - within OPC Chairs Log** | | | | | | | | √ | | | |
| **Facilities Time Off Annual Report** | Head of HR Strategic Projects | | | | | | √ | | | | |
| **VIP + Celebrity Visits Policy Annual Report** | Director of Community Engagement | | | | √ | | | | | | √ |
| **Engagement and Recognition Annual Report** | Director HR & OD | | | | √ | | | | | | √ |
| **Trust Board Monthly Staffing Report – Key Issues Report** | Chief Nurse | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| | | | | | | | | | | | |
| **Operational People Committee** | Director HR & OD | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Premium Pay Spend + Review Sub Committee** | Deputy Director HR & OD / Head of Workforce Transformation | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |

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# Quality Assurance Committee Cycle of Business 2019-2020

| Item | Lead | 9.01.2019 | 5.03.2019 | 7.05.2019 | 2.07.2019 | 3.09.2019 | 5.11.2019 | 7.01.2020 | 3.03.2020 |
|---|---|---|---|---|---|---|---|---|---|
| **SAFETY** | | | | | | | | | |
| Bi-monthly Maternity Update and Maternity Safety Champion report | Head of Midwifery + Safety Champion Lead Governance Lead Obstetrics/ Obstetrics Safety Champion Lead | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Deep Dive Reviews **AS RQD** | Chief Nurse/ Director Integrated Governance and Quality | EoL | ~~Consent def to Mar~~ E+MD | Consent | TBC | TBC | TBC | TBC | TBC |
| SI Lessons Learning Audit quarterly report | Director Integ Governance + Quality | | ✓Q3 | ✓Q4 | | ✓Q1 | ✓Q2 | | |
| Safeguarding (Bi-Annual Report) | Deputy Chief Nurse | Def to Mar ~~✓~~ | ✓ | | | | ✓ | | |
| Safeguarding Committee (Annual Report) | Deputy Chief Nurse | | | | ✓ | | | | |
| Medicines Management/Controlled Drugs Annual Report | Medical Director | | | ✓ | | | | | |
| Learning from Experience Report | Director Integ Governance + Quality | | ✓Q3 | ✓Q4 | | ✓Q1 | ✓Q2 | | ✓Q3 |
| 6 monthly staffing report | Chief Nurse | Def to Mar ~~✓~~ | ✓ | | | ✓ | | | |
| DIPC Infection Control (1/4 ly) | Chief Nurse | | ✓Q3 | ✓Q4 | | ✓Q1 | ✓Q2 | | ✓Q3 |
| DIPC Infection Control Annual Report | Chief Nurse | | | | ✓ | | | | |
| Health and Safety Annual Report | Head of Safety + Risk | | | | ✓ | | | | |
| Infection Control Sub Committee **High Level Briefing** | Chief Nurse | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patient Safety + Clinical Effectiveness Sub Cttee **High Level Briefing** | Medical Director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Safeguarding Committee **High Level Briefing** | Deputy Chief Nurse | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Health and Safety Sub Committee **High Level Briefing** | Director Integ Governance + Quality | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **CLINICAL EFFECTIVENESS** | | | | | | | | | |
| Clinical Forward Audit Plan | Director Integ Governance + Quality | Def to Mar ~~✓~~ | ✓ | | | | | | ✓ |
| Mortality Review Quarterly report | Medical Director | | ✓Q3 | ✓Q4 | | ✓Q1 | ✓Q2 | | ✓Q3 |
| Clinical Audit Quarterly report | Director Integ Governance + Quality | | ✓Q3 | ✓Q4 | | ✓Q1 | ✓Q2 | | ✓Q3 |
| Clinical Audit Annual Report | Director Integ Governance + Quality | | | | ✓ | | | | |
| **PATIENT EXPERIENCE** | | | | | | | | | |
| Complaints Annual Report | Director Integ Governance + Quality | | | ✓ | | | | | |
| Complaints Quality Assurance Group **High Level Briefing** | Director Integ Governance + Quality | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patient Experience Sub Committee **High Level Briefing** | Deputy Chief Nurse | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| End of Life Steering Group **High Level Briefing** | Deputy Chief Nurse | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dementia Strategy Annual Review | Deputy Chief Nurse | | ✓ | | | | | | ✓ |
| Dementia Strategy quarterly (wef August 2018) | Deputy Chief Nurse | | ✓Q3 | ✓Q4 | | ✓Q1 | ✓Q2 | | ✓Q3 |
| **COMPLIANCE & OVERSIGHT** | | | | | | | | | |

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NHS Warrington and Halton Hospitals NHS Foundation Trust

| Item | Lead | 9.01.2019 | 5.03.2019 | 7.05.2019 | 2.07.2019 | 3.09.2019 | 5.11.2019 | 7.01.2020 | 3.03.2020 |
|---|---|---|---|---|---|---|---|---|---|
| Quality Dashboard | Chief Nurse/Medical Director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Quality Priorities 2019-20 | Director Integ Governance + Quality | | ✓ | | | | | | ✓ |
| Quarterly Quality Report | Director Integ Governance + Quality | | ✓Q3 | ✓Q4 | | ✓Q1 | ✓Q2 | | ✓Q3 |
| Quality Strategy | Director Integ Governance + Quality | | | ✓ | | | | | |
| Strategic Risk Register and Board Assurance Framework | Head of Corporate Affairs | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Risk Review Group **High Level Briefing** | Director Integ Governance + Quality | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Risk Management Strategy Annual Review | Director Integ Governance + Quality | | | ✓ | | | | | |
| Quality Impact Assessment Report for CIP plans | Director of Finance + Comm Development | ✓ | | ✓Q4 | | ✓Q1 | ✓Q2 | ✓Q3 | |
| Review and Refresh of Trust KPIs | Director of Finance + Comm Development | | ✓ | | | | | | ✓ |
| GDPR Readiness action plan report | Deputy Director IM&T | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| R&D quarterly report (wef May 2018 to March 2019) | Director Integ Governance + Quality | | ✓Q3 | | | | | | |
| Information Governance and Corporate Records Group | Deputy Director IM&T | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Getting to Good Steering Group **High Level Briefing** | Chief Nurse | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| High Level Enquires (when notified) | Director Integ Governance + Quality | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Summary (assurances and risks to escalate to Board) as required | Chair | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Terms of Reference / Cycle of Business | Chair/Head of Corporate Affairs | ✓ | | | | | | | |
| Monitoring of Committee Attendance | Chair | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Committee Effectiveness Review | Head of Corporate Affairs | ✓ | | | | | | ✓ | |
| Committee Chair's Annual Report to the Board | Chair | | | | ✓ | | | | |

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# FINANCE & SUSTAINABILITY COMMITTEE
# TERMS OF REFERENCE

## 1. PURPOSE

The Finance and Sustainability Committee ("the Committee") is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance and strategic & business development.

## 2. AUTHORITY

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

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

## 3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.

The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

## 4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

**Finance and performance**

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the Monitor Provider Licence (under the auspices of NHS Improvement).
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- To provide overview and scrutiny to the development of the medium and long term financial models (MTFM and LTFM).

- To ensure the MTFM and LTFM is designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the MTFM and LTFM is provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- To review the performance indicators relevant to the remit of the Committee.
- Consider any relevant risks within the Board Assurance Framework and corporate level Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Key Issues Report.
- To monitor compliance with NHSI requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee

**Strategy, planning and development**

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £500k or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.

## 5. MEMBERSHIP

The Committee shall be composed of not less than two (2) independent Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

## 6. CORE ATTENDEES

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Director of Finance & Commercial Development
- Chief Operating Officer
- Chief Nurse

- Executive Medical Director and Deputy Chief Executive
- Director of HR and Organisational Development
- Deputy Director of Finance Strategy
- Head of Corporate Affairs

Other Directors including the Chief Executive or staff members may also be invited/expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

## 7. QUORUM

A quorum shall be two (2) members. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

## 8. FREQUENCY OF MEETINGS

Meetings shall be held on a monthly basis.

## 9. REPORTING GROUPS

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting;
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have;
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

- Capital Planning Group
- Finance and Resources Group
- Pay Spend and Review Committee, including reports on premium pay spend

## 10. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

## 11. REVIEW / EFFECTIVENESS

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

**Date: March 2019**

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

## TERMS OF REFERENCE REVISION TRACKER

| | |
|---|---|
| **Name of Committee:** | Finance and Sustainability Committee |
| **Version:** | V5 |
| **Implementation Date:** | March 2019 |
| **Review Date:** | March 2020 |
| **Approved by:** | Finance + Sustainability Committee |
| **Approval Date:** | 20 March 2019 |

| **REVISIONS** | | | |
|---|---|---|---|
| **Date** | **Section** | **Reason on Change** | **Approved** |
| **22 March 2017** | **3 – Reporting arrangements** | - There is no requirement to circulate Committee minutes unless specifically requested to the Trust Board, rather the Chair's key issues report will highlight points of note in the public forum. | |
| **22nd March 2017** | **4. Duties and Responsibilities** | - To recognise NHS Improvement as an umbrella organisation with oversight of Monitor-imposed regulation or enforcement | |
| **22 March 2017** | **6 - Attendance** | - Change of Core Membership to Core Attendees to distinguish between membership (non-executive – required for quoracy) and those invited to attend – not included in quoracy.<br>- Changes to core attendees to include, Chief Nurse, Medical Director, Director of HR&OD, Deputy Director of Finance | |
| **22 March 2017** | **9. Reporting Groups** | Two groups removed:<br>- The Business Planning sub Committee (strategic).<br>- Strategic & Annual Planning Steering Group.<br>One Group added:<br>- Pay Spend and Review Committee minutes to reporting groups. | |
| **22 March 2017** | **10 Administrative Arrangements** | - Due to change in administrative support to the Committee<br>- Agreement with the Chair and Director of Finance to amend the timescale for circulating papers | |
| **18th October 2017** | **4. Duties and responsibilities**<br><br>**6. Core attendees**<br><br>**9. Reporting Groups** | - Delete items relating to Estates and IM&T<br><br>- Delete Director of IM&T | |

| | | | |
|---|---|---|---|
| | | Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records | |
| **22nd November 2017** | **Section 4 Duties and Responsibilities**<br><br>**Section 9 Reporting Groups** | - To monitor compliance with NHSI requirements relating to pay policies<br>- To review and monitor the Trust's overall pay bill<br>- To monitor all elements of the Board Assurance Framework that relate to the work of this Committee<br><br>To include: reports on premium pay spend | |
| **21st March 2018** | **Core Attendees** | Addition of Medical Director | |
| **19th September 2018** | **Core Attendees** | Remove Director of Transformation | |
| **20 March 2019** | **Section 6: Core Attendees** | Remove Medical Director<br>Add Head of Corporate Affairs | |
| **20 March 2019** | **Section9: Reporting** | Add Financial Resources Group<br>Remove Out Patient Turnaround<br>Remove ICIC | |

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

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Warrington and Halton Hospitals NHS Foundation Trust

# TERMS OF REFERENCE

# QUALITY ASSURANCE COMMITTEE

## 1. PURPOSE

The purpose of the Quality Assurance Committee (the Committee) is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety.
The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks are managed appropriately in line with professional and regulatory standards.

## 2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly

## 3. QUORUM

Quorum shall be seven members, of which at least two should be Non-Executive Directors.

## 4. MEMBERSHIP

The Committee shall be composed of two Non-Executive Directors, one of whom shall be appointed by the Board to be Chair of the Committee

**Core Members**

- Chief Executive
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- Director of Integrated Governance and Quality
- Director of Finance + Commercial Development
- Deputy Chief Nurse
- Deputy Medical Director, Director of Medical Education, Clinical Chief Information Officer
- Director of Strategy
- Director of HR and Organisational Development
- Chief Information Officer
- Head of Corporate Affairs
- Chief Pharmacist
- Associate Medical Director – Patient Safety
- Associate Medical Director – Clinical Effectiveness
- Associate Medical Director – Strategy
- Associate Chief Nurse - Quality+Safety



Date: V3 January 2019
Approved: 8 January 2019
Review date 12 months from approval

- Associate Chief Nurse – Clinical Effectiveness
- Associate Chief Nurse – Patient Experience
- Associate Chief Nurse/Associate DIPC
- Head of Midwifery/Midwifery Safety Champion Lead + Governance Lead

**Attendees**

- Obstetrics/Obstetrics Safety Champion Lead ~~Audit and Governance Lead for Women's Health~~

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

## 5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of people external to the Trust, with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

## 6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.
- The Chair of the Committee will provide a written key issues report to the Board bi-monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented to the ~~at the May~~ Board meeting on its work and performance in the preceding year.

The sub committees listed below are required to submit high level briefing papers to the Committee:

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience Sub-Committee
- Health, Safety & Risk Sub-Committee
- Information Governance and Corporate Records Sub Committee
- Safeguarding Sub Committee
- Risk Review Group
- Complaints Quality Assurance Group
- Research and Development Sub Committee
- Infection Prevention and Control Sub Committee
- End of Life Steering Group
- Divisional Governance
- Medicines Governance

## 7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Oversee the development and implementation of the Trust's strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;
- Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring that there is scrutiny and oversight of the strategic risk register and Board Assurance Framework, prior to approval at the Board of Directors and that there is appropriate liaison with the Audit Committee, to ensure internal audit resources within the Trust are aligned appropriately to risk;
- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board or the Committee, particularly "Serious Incidents Requiring Investigation" and how well any recommended actions have been implemented;
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board;
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory and contractual requirements;
- Ensure there is a process in place regarding assessing and monitoring the impact on quality from Trust transformation and efficiency plans;
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated;
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations;
- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust;
- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately and escalated when off track;
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit and assessments are communicated appropriately and changes in practice are facilitated;
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;

- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.
- Ensure that the Trust has effective communication channels in place for ward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) and risk management (Annual Governance Statement) reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;
- To inform the Board where it has significant concerns about:
  - Standards of care in the Trust
  - Or where it considers any service (or part of) to be unsafe

## 8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected
Members unable to attend must send a deputy who is able to make decisions on their behalf.
Other Executive Directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Committee may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Committee if they are unable to attend and who will attend as their deputy.

## 9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee the Agenda and Papers will be sent out 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Tuesday preceding the Quality and Assurance Committee.

Papers are to be submitted in the following format:

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

## 10. REVIEW / EFFECTIVENESS

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

The Cycle of Business will be reviewed by the Committee every 12 months.

## TERMS OF REFERENCE REVISION TRACKER

| | |
|---|---|
| **Name of Committee:** | Quality Assurance Committee |
| **Version:** | V3 |
| **Implementation Date:** | January 2019 |
| **Review Date:** | 8 January 2020 |
| **Approved by:** | Quality Assurance Committee |
| **Approval Date:** | 8 January 2019 |

**REVISIONS**

| Date | Section | Reason on Change | Approved |
|---|---|---|---|
| 6 December 2016 | 5 - Membership | Revised to include Non-Executive Directors to be amended to read **two**<br><br>Core Attendees – to read **Core Members**<br>Delete Divisional Operational Directors from the Core Membership<br>**ADD Transformation Director**<br>**ADD - Co-Opted Members from the Workforce Sub Group.** The Quality Committee to receive minutes from the WSG and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters in relation to staffing, quality and safety.<br>Quorum – change from 10 **to maximum of 7, to include 1 Executive Director, 1 Non-Executive Director and 1 representative from each Division.** | QAC 6.12.2016 |
| | 10 – Administrative Arrangements | The Committee will be supported by the Secretary to the Trust Board. | QAC 7.2.17 |
| 10 January 2017 | 5 - Membership | Membership further reviewed to include<br>Head of Midwifery and Associate Director Infection Control + Prevention. | QAC 7.2.17 |
| 7 February 2017 | 5 – Membership | Delete Director of IM&T | QAC 7.2.17 |
| 02 January 2018 | 4 – Membership | Delete Chief Pharmacist, Chiefs of Service, Surgery, Women's & Children | QAC 09.01.2018 |

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| | | and Acute Care Services, Associate Directors of Nursing, Associate Director of Infection Control. | |
| 02 January 2018 | 2 – Frequency of Meetings | Meetings to move from monthly to bi-monthly | QAC 09.01.2018 |
| 02 January 2018 | 6 – Reporting | Removal of Infection Control Committee, medicines management, Inclusion of Risk Review Group, Complaints Quality Assurance Group, Research and Development Sub Committee and Safeguarding Committee, | QAC 09.01.2018 |
| 04 May 2018 | 4 – Membership | Add Audit and Governance Lead for Women's Health | QAC 03.08.2018 |
| 08.01.2019 | 4 – Membership | **Add** CEO DoF + Commercial Development Chief Pharmacist **Replace Deputy HRD with** Director of HR + OD **Replace Deputy DoIM&T with** Chief Information Officer Change in titles of Director of Strategy, Associate Medical Directors and Associate Chief Nurses **Move** Audit and Governance Lead for Women's Health to attendee section | QAC 08.02.2019 |
| 08.01.2019 | 6 – Reporting | **Add** Infection Prevention + Control SC End of Life Steering Group Divisional Governance Medicines Governance | QAC 08.02.2019 |
| 08.01.2019 | 10– Review/Effectiveness | **Add** Cycle of business reviewed annually | QAC 08.02.2019 |
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| **TERMS OF REFERENCE OBSOLETE** | | |
|---|---|---|
| **Date** | **Reason** | **Approved by:** |
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We are WHH

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

# TERMS OF REFERENCE
# STRATEGIC PEOPLE COMMITTEE

## 1. PURPOSE

The Strategic People Committee is accountable to the Trust Board and will maintain a strategic overview of the Trusts human resources and organisational development arrangements with a view to ensuring that these are designed to provide a positive working environment for colleagues, and that the Trust has in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high quality care.

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture, quality improvement and collaborative leadership development:
  - Key Lines of Enquiry (KLOE)1: Leadership, capacity, capability to deliver high quality sustainable care
  - Key Lines of Enquiry (KLOE)3: Culture of high quality sustainable care
  - Key Lines of Enquiry (KLOE)7: Are people who use services, public, staff and external partners engaged and involved to support high quality sustainable services.
  - Key Lines of Enquiry (KLOE)8: Robust systems and processes for learning, continuous improvement and innovation
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future, and
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, and

The Committee will oversee strategic actions to enable the trust to deliver the WHH Strategy and specifically the People Strategic Objectives. In addition the Committee will provide assurance to Trust Board that the Strategic People Objectives will support our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

The Committee will provide assurance to the Trust Board on the management of risks related to our people.

## 2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

## 3. MEMBERSHIP

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of HR & OD
- Deputy Director HR & OD

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Approved: SPC 20 March 2019
Review Date: March committee meeting each year

- Chief Operating Officer
- Medical Director
- Chief Nurse
- Director of Strategy
- Director Finance & Commercial Development
- Director of Community Engagement
- Head of HR Strategic Projects

In attendance for specific agenda items scheduled in SPC annual workplan:

- Head of Education Development & Wellbeing
- Head of Medical Staffing and Education
- Head of HR Business Partners
- Head of Workforce Transformation

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Strategic People Committee may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members Trust email account.

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

## 4. QUORUM

Quorum shall be two NEDs, Director of HR & OD or Deputy Director HR & OD - plus 3 Executive Directors or their deputies.

## 5. AUTHORITY

The Strategic People Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Strategic People Committee. The Strategic Committee may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee.

## 6. REPORTING

**Governance**

The Strategic People Committee will have the following reporting responsibilities:

A Chairs Key Issues Report will be formally recorded and circulated to the Trust Board of items discussed. The Chair of the Strategic People Committee shall draw to the attention of the Trust Board any issues that require disclosure to it, or require a decision or escalation.

The Strategic People Committee will report to the Trust Board annually on its work and performance in the preceding year.

## 7. DUTIES & RESPONSIBILITIES

**Duties – decision making:**

- To provide overview and scrutiny in areas of workforce performance referred to the Strategic People Committee by the Trust Board
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board.
- To provide overview and scrutiny to the development of the People Strategy
- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided
- To receive, agree and monitor progress on the People Strategy through receipt of exception reports and updates
- To ensure that the Trust attracts and retains our workforce using the principles of Model Employer to become the employer of choice.
- To ratify employment policies and procedures on behalf of the Trust
- To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust
- To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience.

**Duties – advisory:**

- Consider any relevant 'people' risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Strategic People Committee, as part of the reporting requirements,
- To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients.

**Duties – monitoring:**

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the performance indicators relevant to the remit of the Strategic People Committee
- To report any areas of significant concern to the Trust Board as appropriate via the Chair Key Issues Report.
- To receive a report on Employee Relations Cases in respect of numbers, workforce demographics, emerging themes, lessons learned and in particular those cases where suspension/exclusion is involved

**Duties of members:**

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

**Sub-Committees (Groups):**

- Operational People Committee
- Premium Pay Spend and Review Group

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Review Date: March committee meeting each year

Each Sub-Committee will submit a Chair Key Issues Report detailing any items of escalation or items requiring decision or action rather than minutes.

## 8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a deputy who is able to make decisions on their behalf.

## 9. ADMINISTRATIVE ARRANGEMENTS

The Strategic People Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business (workplan) will be established

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

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / HR & OD Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair of the Committee.

## 10. REVIEW / EFFECTIVENESS

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

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

# TERMS OF REFERENCE REVISION TRACKER

| | |
|---|---|
| **Name of Committee:** | STRATEGIC PEOPLE COMMITTEE |
| **Version:** | V5 |
| **Implementation Date:** | March 2019 |
| **Review Date:** | March 2020 |
| **Approved by:** | Draft v3 approved by TRUST BOARD (July 2018)<br>Draft v4 – to be presented to September TRUST BOARD<br>Draft v5 - to be presented to May 2019 Trust Board |
| **Approval Date:** | 19 September 2018 – SPC<br>V4 approved 26 September 2018 – Trust Board<br>V5 approved 20 March 2019 – SPC |

**REVISIONS**

| Date | Section | Reason on Change | Approved |
|---|---|---|---|
| May 2018 | Draft TORs v1 | | Amendments – AW / MC |
| June 2018 | Draft TORs v2 | | Amendments – AW / MC |
| July 2018 | Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval | | Amendments – AW / MC |
| July 2018 | Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees | | Amendments – AW / MC |
| September 2018 | 1. **Purpose** – clarification on Well Led KLOEs to be reported to SPC and further confirmation of role of SPC as an assurance committee<br>2. **Membership** – Written approval by quorate membership rather than full membership<br>3. **Duties & Responsibilities** – Section on Decision Making. Clarity on SPC role | | Amendments agreed by members of the Strategic People Committee 19 September 2018<br>Approved Trust Board (September 2018) |

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Approved: SPC 20 March 2019
Review Date: March committee meeting each year

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| | to assure actions taken to recruit and retain our workforce<br>Section on Monitoring. Scope of Employee Relations Case Report clarified and to be included in workplan<br>4. **Subcommittees** – to include Triangulation Group | | |
| **20 March 2019** | **Section 3 – Membership** | Updated attendee titles | |
| **20 March 2019** | **Section 7 – Duties + Responsibilities** | Triangulation Group removed | |

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