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Warrington and Halton Hospitals NHS Foundation Trust

# WHH Council of Governors

**Tuesday 13 August 2019**
**3:30pm – 5:30pm**
**Trust Conference Room**
**WARRINGTON HOSPITAL**

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NHS Warrington and Halton Hospitals NHS Foundation Trust

# COUNCIL OF GOVERNORS
## TUESDAY 13 August 2019, 3.30pm-5.30pm
## Trust Conference Room, Warrington Hospital

| AGENDA ITEM COG/19/05/XX | TIME PER ITEM | AGENDA ITEM | OBJECTIVE/DESIRED OUTCOME | PROCESS | PRESENTER | |
|---|---|---|---|---|---|---|
| | | | Choose an item. | Choose an item. | | |
| COG/19/08/ 36 | 3.30pm | Refreshed Primary Care Strategy<br>Marie Ann Hunter Primary Care Senior Commissioner and Melanie Alsop, Service Development Manager | | PPT | Warrington CCG | |
| **FORMAL BUSINESS** | | | | | | |
| COG/19/08/ 37 | 3.45pm | Welcome and Opening Comments<br>• Apologies; Declarations of Interest | | | Chairman | |
| COG/19/08/ 38 PAGE 4 | | Minutes of meeting held 16 May 2019 | ***For decision*** | ***Minutes*** | Chairman | |
| COG/19/08/ 39 PAGE 8 | | Matters arising/action log | ***For assurance*** | ***Action log*** | Chairman | |
| **GOVERNOR BUSINESS** | | | | | | |
| COG/19/08/ 40 | 3.50pm | Lead Governor Update | ***For info/update*** | ***Verbal*** | Lead Governor | |
| COG/19/08/ 41 PAGE 10 | 3.55pm | Items requested by Governors<br>- UTC<br>- Bridgewater Collaboration ***To follow***<br>- Outpatient Appointment process<br>- Car Parking (verbal update) | ***For info/update*** | ***Briefing notes +Q&A*** | | |
| COG/19/08/ 42 PAGE 13 | 4.05pm | Reports from<br>(a) GEG 7.08.2019<br>(b) Governors QiC 25.07.2019<br>(c) Board Committee Observations, Trust Board/SPC/CFC/Audit/FSC/QAC | ***For info/update*** | ***Verbal + Briefings*** | Chair of GEG + Chair of QiC & Board Committee Observers | |
| COG/19/08/ 43 | 4.15pm | Update on Elections | ***For info/update*** | ***Verbal*** | Head of Corporatre Affairs | |
| COG/19/08/ 44 | 4.20pm | Annual Appraisal of Trust Chairman<br>***Chairman to leave to room** | ***For decision*** | ***Verbal*** | Lead Governor | |
| COG/19/08/ 45 | | Proposal to uplift Chair & Non Executive Director Remuneration for 2019/20<br>***Non-Exec Directors to leave the room** | ***For decision*** | ***Briefing paper (to be tabled)*** | Lead Governor | |
| **TRUST BUSINESS** | | | | | | |
| COG/19/08/ 46 | 4.35pm | Chief Executives Report | ***For info/update*** | ***Verbal*** | Chief Executive | |
| COG/19/08/ 47 | 4.45pm | Chairmans Briefing | ***For info/update*** | ***Verbal*** | Chairman | |
| COG/19/08/ 48 PAGE 17 | 4.50pm | i) 2019-20 Annual Report + Accounts including Quality Account Report *(sent under separate cover)*<br>(ii) Auditors letter (attached) | ***To note*** | ***Report*** | **Michael Green** External Auditors | |
| COG/19/08/ 49 PAGE 32 | 5.00pm | Quality Strategy Update | ***To note*** | ***Report*** | Dir Integrated Governance + Quality | |
| COG/19/08/ 50 PAGE 54 | | Complaints Report | ***For info/update*** | ***Report*** | Dir Integrated Governance + Quality | |
| COG/19/08/ 51 PAGE 67 | 5.05pm | Engagement Dashboard | ***For assurance*** | ***Report*** | DCE + Fundraising | |
| **GOVERNANCE** | | | | | | |
| COG/19/08/ 52 | | Governor Traning + Develpoment MIAA as available | ***For discussion*** | ***Verbal*** | Head of Corporate Affairs | |
| COG/19/08/ 53 PAGE 74 | | Amendment to the Constitution (Change to the Trust name) | ***For assurance*** | ***Briefing paper*** | DCE + Fundraising | |

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| ITEMS FOR APPROVAL | | | | | | |
|---|---|---|---|---|---|---|
| COG/19/08/ 54 PAGE 77 | 5.15pm | Compliance Trust Provider Licence (Bi-annual report) | ***For approval*** | ***Report*** | Head of Corporate Affairs | |
| COG/19/08/ 55 PAGE 78 | | Council of Governors Terms of Reference | ***For Approval*** | ***Report*** | Head of Corporate Affairs | |
| COG/19/08/ 56 PAGE 85 | | Audit Committee Chair's Annual Report | ***To note*** | ***Report*** | I Jones | |
| **Closing** | **5.25pm** | | | | | |

***Schedule of 2018-19 dates attached for information***

**Next Meeting Date will be on Thursday 14 November 2019, 3.00pm-5.00pm, Lecture Theatre, HALTON ED. CENTRE**

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**COUNCIL OF GOVERNORS**
**Minutes of the Meeting held on Thursday 16 May 2019**
**3.30pm to 6.00pm, Trust Conference Room, Warrington**

**Present:**

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| Steve McGuirk (SMcG) | Chairman (Chair) |
| Mel Pickup (MP) | Chief Executive |
| Mark Ashton (MA) | Staff Governor |
| Terry Atherton (TA) | Non-Executive Director |
| Keith Bland (KB) | Public Governor |
| Paul Bradshaw (PB) | Public Governor |
| Norman Holding (NM) | Public Governor & Lead Governor |
| Colin Jenkins (CJ) | Public Governor |
| Alison Kinross (AK) | Public Governor |
| Anne Robinson (AR) | Public Governor |
| Nick Stafford (NS) | Public Governor |
| Peter Lloyd Jones (PLJ) | Partner Governor, Halton Borough Council |
| Anita Wainwright (AW) | Non-Executive Director |
| Professor John Williams (JW) | Partner Governor, University of Chester |

**In Attendance:**

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| Lucy Gardner (LG) | Director of Transformation |
| Andrea McGee (AMcG) | Director of Finance + Commercial Development |
| Pat McLaren (PMcL) | Director of Community Engagement + Fundraising |
| John Culshaw (JC) | Head of Corporate Affairs |
| Julie Burke (JB) | Secretary to Trust Board (Minutes) |
| Carl Marsh | Chief Commissioner, Warrington CC |
| Julia Harvey | Senior Commissioning Manager, Warrington CCG |

**Apologies:**

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| Margaret Bamforth (MB) | Non-Executive Director |
| Erin Dawber (ED) | Public Governor |
| Victoria Harte (VH) | Partner Governor, Warrington + Vale Royal College |
| Ian Jones (IJ) | Non-Executive Director |
| Colin McKenzie (CMcK) | Public Governor |
| Linda Mills (LM) | Public Governor |
| Louise Spence (LS) | Staff Governor |

| COG/19/05/17 | **WRAG Update** | |
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| | The Chairman welcomed CCG colleagues, Governors, and Non-Executive Directors.<br><br>C Marsh provided an overview of the background to Referral Gateway, referral schemes, processes and criteria and improvement measures that had been put in place over the last 12-18 months including:<br>- There is now national criteria for clinical based assessments which have been moved into contractual agreements with the Trust.<br>- Clinical thresholds for treatment through the Gateway.<br>- If someone does not meet criteria, eg cataracts, there is a process in place for treatment to be undertaken and funded.<br>- 60k elective referrals had been processed through the Referral Gateway supported by a new IT platform with a single referral form.<br>- Referral Handling Centre handles all referrals. Choice of where treatment can be offered is at this point. Whilst acknowledging this is patient choice, CM explained that aspiration is for WHH to be the local place of choice and this is being reinforced with primary care | |

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| | colleagues to give some guidance at the point of referral.<br>- Peer support to review clinical pathways, 50 of the pathways had been subject to clinical reviews with GPwSI and Consultants.<br>- Call Centre moved from Greater Manchester to Mid Lancs CSU.<br>- Referral activity for the last 8 months; 43% to WHH, 28% community provider, 7% returned to referring practitioner, 4% to Spire, 3% to StHKHT, 2% Manchester and low volume to other providers equating to 20% not at WHH through Patient Choice.<br>- Strengthening of process and referrals is a priority through the C&M Collaborative Sustainability Group, led by CM and C Evans to make WHH local place of choice for patients.<br>- Data to be analysed to look at reasons why different provider chosen, main reasons, practicality, locality, waiting times.<br><br>• **The Chairman thanked Carl and Julia for their update and invited them to attend a future CoG in 6 months time to provide a further update.** | |
| **COG/19/05/ 18** | **Welcome, Apologies & Introductions** | |
| | Apologies – noted above. There were no declarations of interest in relation to the agenda items for the meeting. | |
| **COG/19/05/ 19** | **Minutes of meeting held 14 February 2019 and Extraordinary Meeting held 11 April 2019** | |
| | Date to be amended to read 14 February 2019 and add A Wainwright to attendees. With this amendment, the minutes of the meeting held on 14 February 2019 and 11 April 2019, were approved as a true and accurate record. | |
| **COG/19/05/ 20** | **Matters arising/action log** | |
| | Action log noted, remaining items were covered on today's agenda. | |
| **COG/19/05/ 21** | **Lead Governor Update** | |
| | NH provided an update on pertinent matters since the last CoG:<br>- Colleagues were thanked for their support during the Well Led inspection.<br>- Patient and Public Participation + Involvement Strategy approved at Trust Board in March.<br>- NH attended Governor Focus Conference in London, main topics of discussion included Healthwatch, BME and Well Led, presentations and information to be circulated.<br>- Attended Regional Lead Governor Annual forum, main topics of discussion included NHS 10 Year Plan, data protection, communication networks and Governor Engagement with CCGs.<br>- From discussions with other Governors on the day, NH observed that Governor communication and dialogue at WHH is far advanced when compared to other Trusts.<br>- All encouraged to attend the informal joint meeting with Bridgewater Governors on 5 June at Bridgewater HQ. | |
| **COG/19/05/ 22** | **Items requested by Governors** | |
| | UTC - 4 organisations shortlisted, 2 NHS Providers and 2 Private providers. Notification anticipated 7-10 June 2019.<br>Shuttle Bus – extended to 31 October 2019 with no change to the service provided.<br>CQC Update. The CEO provided an overview of information that had been provided during the recent Core Services, Use of Resources and Well Led Inspections which included close down of the CQC Recommendations/Action Plan of all 259 actions following the previous inspection, population health needs, finance and performance information and measures in place to arrest the financial challenges. Examples provided of where financial and quality investment had been made, collaborative working with partners across a number of areas and 'Proud' examples from staff across the Trust.<br>The Trust had received positive feedback, in particular one team ethos across both sites, process for lessons learned sharing and risk management, improvement in complaints | |

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| | handling, LiA, whilst recognising the financial challenges faced by the Trust and the wider health and social care economy. Draft report anticipate mid-June.<br><br>Halton Healthy New Town . LG provided an overview of the current site at Halton and services provided including NW Borough services.<br>A Feasibility Study had been undertaken to understand the funding challenge and all financial requirements, total development cost £124.3m, Hospital Facility Cost £80.5m with a funding gap of £79.4m. Site and space utilisation is being reviewed, including other organisations, looking at where current floor space could be re-provided for potential income generation and where space is not currently being utilised which would support reducing the funding gap to circa £45.5m-£46.9m.<br>Next steps will include progressing discussions with stakeholders and partners and a commercial masterplan to enable wider stakeholder engagement, anticipated July.<br>The local authority proposals for East Lane House Development to include hotel, housing and supported accommodation for older people. | |
| **COG/19/05/23** | **Annual Appraisal of Non-Executive Directors** | |
| | SMcG reported that annual appraisals for NEDs had been completed. | |
| **COG/19/05/24** | **Reports from GEG and Governors QiC** | |
| | GEG - KB provided an update on key matters being progressed through the QiC<br>- Welcome screens installed, new reception area, Quality Improvement Training undertaken, proposed that all Governors undertake this training as part of Induction. Received Engagement Dashboard; governor promotional material being finalised; discussions to explore change of day /timing for the GEG meeting.<br>QiC - last meeting cancelled. New dates to be circulated. Governor Observation visits undertaken including to ICU and CC. Conversation café undertaken in ED, walk through arranged with COO to address issues raised. | |
| **COG/19/05/25** | **Chief Executives Report** | |
| | Refer to CQC update above. It was agreed information IPR not to be included in future papers and this information is reported to a number of Committees with Governor attendance. | |
| **COG/19/05/26** | **Chairman's briefing** | |
| | The Chairman explained that discussions are progressing at pace with Bridgewater to agree future collaborative working arrangements.<br>The Chairman had meet with the new Chair of Warrington CCG and plans to meet with the new Leader of Warrington Council. | |
| **COG/19/05/27** | **Trust Operational Plan** | |
| | The Director of Finance + Commercial Development provided a high level summary of the Operational Plan<br>- The Trust has accepted the control total set by NHSI of breakeven which means the Trust can access additional funding of £17.9m through Marginal Rate Emergency Tariff (MRET), Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF). The Finance + Sustainability Committee and Trust Board had approved breakeven Control Total acknowledging an element of risk to deliver CIP and other cost pressures and no plans to add to the current level of loans.<br>- The additional funding of £17.9m will be paid quarterly.<br>• **The Council of Governors noted the report.** | |
| **COG/19/05/28** | **Engagement Dashboard** | |
| | The DCE presented the recent social media, engagement, press activity which is reviewed and monitored through the GEG. The dashboard included the annual complaints date highlighting the triangulation of information across the Trust to inform the dashboard.<br>• **The Council of Governors noted the report.** | |

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| COG/19/05/ 29 | **Proposal to change the Trust's name** | |
| | The DCE provided an update on progress to date, explaining the background and journey following approval at CoG in April 2017. The University of Chester had supported incorporation of 'University' status in WHH name.<br>January 2019 NHSI unable to guide re: 'University' status but deemed 'Teaching' acceptable.<br>February 2019, review of membership requirements to join University Hospitals Association which has more criteria which will need to be defined to ensure WHH meeting all 'University' Trust criteria.<br>The Executive Medical Director is reviewing criteria in the University Hospitals Association requirements.<br>Short to medium proposals include commence name change to Teaching Hospitals ASAP.<br>Further updates to CoG as process progresses<br>• **The CoG supported the short to medium term plan. Paper to August CoG.** | |
| COG/19/05/ 30 | **Strategy Delivery Update Bi-Annual Report** | |
| | LG provided an overview of progress on the governance and delivery of the Trust's strategic objectives.<br>End of Q3 2018-19 the Trust is on track to deliver the outcome/KPI over the 3 year period on 17 indicators and ahead of plan on 29 indicators. There is 1 indicator which is not rated at this stage, internal promotion in WHH, plans in place to develop measurable.<br>ESCH - Next strategic submission at the end of the month with more detail on how to implement ESCH on 1 site. Details of consultation events will be shared when confirmed.<br>Governors invited to attend first design event for Warrington Hospital to discuss what services could be provided in a new hospital setting including all partner organisations and other stakeholders.<br>• **The CoG noted the report.** | |
| COG/19/05/ 31 | **My-Choice Progress Report** | |
| | The Director of Finance + Commercial Development provided an update regarding development of My Choice service. The service had gone live in September 2018 providing alternative choices for treatment, no longer available and funded by the NHS. There had been 397 visits to the Trust Web Site to view My Choice. Next steps and plans are to convert this interest into bookings, led by the Commercial Development Group to explore all commercial opportunities with continued emphasis on close working with GP colleagues.<br>• **The Council of Governors noted the report.** | |
| COG/19/05/ 32 | **CoG Cycle of Business** | |
| | **The CoG approved the 2019-20 CoG Cycle of Business.** | |
| COG/19/05/ 33 | **Amendment to the Constitution (CiC)** | |
| | JC explained the proposed amendments to the Constitution to allow the appointment of Committees in Common and Joint Committees with other NHS organisations which will support facilitation of collaborative working with BCH and other NHS organisations.<br>• **The CoG approved amendment to the Trust's Constitution.** | |
| COG/19/02/ 15 | **Governor Training and Development MIAA** | |
| | No updates to report. | |
| | Date and time of next meeting **Thursday 15 August 2019, 4.00pm-6.00pm, Trust Conference Room, WARRINGTON HOSPITAL,** Post meeting note, rescheduled to 13 August 2019 | |

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# COUNCIL OF GOVERNORS ACTION LOG

| AGENDA REFERENCE | CoG/19/08/39 | SUBJECT: | COUNCIL OF GOVERNORS ACTION LOG | DATE OF MEETING | 13 August 2019 |
|---|---|---|---|---|---|

## 1. ACTIONS ON AGENDA

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress report | RAG Status |
|---|---|---|---|---|---|---|---|---|
| **COG/19/02/12** | **14.02.2019** | **Governor Effectiveness Survey** | High level summary to next CoG. | **HCA** | **13.08.2019** | | 16.05.2019. Deferred to August meeting | |
| **COG/19/05/29** | **16.05.2019** | **Change of Trust Name** | Progress report and next steps | **DCE + Fundraising** | **13.08.2019** | | | |

## 2. ROLLING TRACKER OF OUTSTANDING ACTIONS

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress report | RAG Status |
|---|---|---|---|---|---|---|---|---|
| **COG/18/08/37** | **16.08.2018** | **Governors** | Car Parking – Walk-through on sites by Governors to be arranged prior to changes to current arrangements | **HCA/Ass Director Estates +Facilities** | | | 6.02.2019. Financial model to be agreed to ensure value for money. 16.05.2019. Discussions progressing. 02.08.2019. Update to be provided on 13 August 2019. | |
| **COG/18/11/56** | **15.11.2018** | **Lead Governor Update** | Date of visit to CoCH to be circulated | **HCA** | | | 6.02.2019. Awaiting confirmation from CoCH. 16.05.2019 . On-going discussion to agree date. | |
| **COG/19/02/14** | **14.02.2019** | **WRES Update** | Options for FTSU BME Champion to attend CoG as a 'Partner' or 'Staff' Governor. | **HCA** | | | 18.07.2019 Discussions ongoing. | |
| **COG/19/05/17** | **16.05.2019** | **WRAG presentation** | Further session to planned for 6 months | **WCCG** | **CoG 14.11.2019** | | | |

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## 3. ACTIONS CLOSED SINCE LAST MEETING

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress report | RAG Status |
|---|---|---|---|---|---|---|---|---|
| **COG/18/11/60** | **15.11.2018** | **CEO Report** | Date of next Patient Safety Summit TBC. | **Executive Medical Director** | | | 15.02.2019. Date TBC, anticipated September 2019. 17.05.2019. Date confirmed 21.6.2019 | |
| **COG/19/05/24** | **16.05.2019** | **QiC update** | Quality Improvement Training to be arranged for all Governors as part of Induction. | **HCA** | | **17.07.2019** | Will be included in Governor Induction | |
| **COG/19/02/01** | **14.02.2019** | **Lead Governor Update** | Arrangements for Safeguarding Training to be confirmed | **HCA** | | **02.08.2019** | 28.02.2019. Safeguarding Team progressing access to E-Learning with HR Dept. 2.07.2019 . Bookletbeing finalised to include Children's safeguarding. 02.08.2019 Circulated to Governors | |

**RAG Key**

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

**Council of Governors Briefing notes 13 August 2019**

**Halton UTC contracts**

**Could you let me know if these existing contracts are time limited, or otherwise have a termination clause?**

*This service sits within the main Warrington CCC led contract that runs 1st April 2019 to 31st March 2020. The contract only has funding included for 6 months 1st April 2019 – 30th September 2019 in anticipation of a new provider contract being awarded following the CCG procurement exercise, which would have seen a new contract awarded to the successful provider from 1st October 2019.*

*The Trust has now asked the CCG to vary in another 6 months funding for the UTC in Halton 1st October 2019 – 31st March 2020 whilst the CCG decides their next steps re a second procurement exercise.*

**Could you also let me know the recent tender terms and conditions for staffing numbers, qualifications of staff, and pay and conditions?**

*There were tender terms specified, other than all relevant staff would have TUPE rights and their current pay and conditions would be protected for a period as per Employment Law*

**I assume opening hours were specified. Were locations specified?**

*Opening hours were not specified but the centre was to be open at least 12 hours per day.*

*Locations of Runcorn and Widnes were specified but not sites.*

**Ophthalmology**

***Are there any plans in place to review / improve the Appointments Process?***
***From personal experience this year (Ophthalmology) , there appears to be room for efficiency improvements and financial savings. I have had all appointment cancelled / changed at least once. In January appointment changed twice which involved 5 letters and 5 texts. This month appointment for September cancelled and moved to October, when I queried if that meant both appointments (two appointment 30 minutes between, with different wording, sent in two letters on the same day) I was told ignore the second appoint that was an error and given the one appointment for October.***
***This example to me shows that patients will get frustrated and have a bad impression of the hospital even before they get there.***

Last year, as part of a quality initiative, an Ophthalmology multi-professional/multi-disciplinary Clinical Microsystem Group was put together to review service provision for emergency patients. The Group concluded mid-July and a number of recommendations were made. One of the recommendations is around outpatient provision and the need to introduce additional capacity for urgent/emergency patients. This is in acknowledgment that the demand for urgent clinic capacity often impinges on our elective routine patients resulting in appointment cancellations. As such an emergency clinic rota is currently being trialled for a period of 8 weeks after which time the impact and benefits will be assessed.

We have also recently experienced two separate episodes of long-term and unexpected clinician illness that has affected our glaucoma patients' clinic appointments. Although the absences were not concurrent they have nevertheless impacted on our clinic capacity and whilst we have tried to keep the cancellations to a minimum there has been an unavoidable need to move patients' appointments between existing clinics to ensure patients are seen within appropriate timescales. However we are pleased to confirm that since beginning of July we have been back to running at full capacity and as such we have already seen a reduction in the number of patient cancellations. Further, we have recruited a Clinical Fellow in Glaucoma who will be joining us in September. We would expect this additional resource to alleviate current pressures and clear the small ensuing backlog of appointments by October.

In addition to the glaucoma clinical fellow we have an international medical trainee due to start week commencing 5th August, and we are also out to recruitment for a locum ophthalmologist.

We have been experiencing issues with our outpatient letters that are not exclusive to WHH. Unfortunately we and the majority of NHS Trusts are experiencing integration issues with the National booking system eRS (electronic referral system) and ePR (electronic patient record), some of which impact on patient letters. Due to current technical limitations we unable to print one letter to a patient communicating a change to an appointment and the new appointment date. As such we have been sending both a separate cancellation and a separate new appointment letter. We have escalated this to our ePR provider who are currently working on a fix (and expect to have a fix in place ahead of other providers) but due to spiralling postal costs we are introducing a manual workaround that will enable us to send one letter to a patient thus reducing postal costs. We understand the workaround is ready to be launched and we are awaiting confirmation of a go-live date.

We are also part-way through another review of our outpatient letters which will focus on the content of the patient letters ensuring the information contained within the letter is relevant to the specialty or condition for which the patient is attending.

We have sub-contracted our text services to a third party supplier, Healthcare Communications, who are widely used by NHS Trusts. Two text reminders are sent to patients at seven day and two day intervals prior to patient appointments. As Ophthalmology appointments are often complex and require multi-disciplinary professional input quite often two separate clinic appointments are made with the appropriate professionals. We realise that can be frustrating for patients and we will speak to our suppliers to determine if there is a logic that can be added to the system to prevent multiple texts.

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| **AGENDA REFERENCE:** | **COG/19/08/42** |
| **COMMITTEE ATTENDED** | **Public Board**<br>**Private Board** |
| **DATE OF MEETING:** | 29/05/19 and 31/07/19 |
| **AUTHOR(S):** | Norman Holding – Lead Governor |
| | |
| **GOVERNOR COMMENTS** | I attended the Public Board and Private Board meetings held at the Warrington site on the dates above. The meetings were attended by all the NED's in post (Cliff Richard attending the 31/07/19 meeting).<br><br>**Public Boards**<br>There were no general public in attendance at either of the Public Boards. These meeting were opened with a Patients Story (positive or negative)<br>All NED's presented their committee Key Issues reports and contributed to the reports presented by Executive Board members. Changes were made at the July meeting to the way reports are presented and this contributed to a more effective meeting ensuring that things are not repeated by Exec's and NED's. The meetings were controlled well and concluded within the time scales but allowing debate on all agenda items. NED's actively challenged item's for approval to gain assurance that the best solutions were being delivered, requesting further information when necessary.<br><br>**Private Board**<br>At the Private Board NED's were fully involved and challenged to a great depth the issues and items on the Agendas. Sensitive / important items were given the time needed to interrogate in-depth the details that were presented. Discussions were open and everybody's view were listened to. The meetings were chaired well, the Chair allowing time for all to contribute and them giving an overview of the discussions and agreed outcomes. |

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| **AGENDA REFERENCE:** | **COG/19/08/42** |
| **COMMITTEE ATTENDED** | **Strategic People Committee** |
| **DATE OF MEETING:** | 24/07/19 |
| **AUTHOR(S):** | Colin Jenkins |
| | |
| **GOVERNOR COMMENTS** | This is a sub-committee that meets every two months with a huge agenda and I believe that the work of the HR dept, it's staff and this committee should not be under valued. All of our staff are fundamental to our success and the plethora of strands to the health, safety and welfare of all our people is the underpinning driver for the department.<br>Some of the key issues that were discussed were:<br>• A national initiative to recruit 40,000 additional nurses over the next 5 years<br>• Equality, Diversity and Inclusion Strategy - updates<br>• Workforce Race Equality Standard<br>• Work around the merger with Bridgewater<br>• The development of an agreed rate card and a collaborative bank for temporary staff<br>• A thorough nationwide review of all people practices following the tragic death of a nurse at a London NHS Trust who tragically took his own life between his dismissal and appeal<br>• A national review of the pension scheme. More staff have been affected by the recent changes which is having a direct impact on employee behaviour which in turn impacts on our performance and service delivery. I believe this is a potential hand grenade, not just for us, but for all people at work and their employers<br>• A constant drive to improve employee relations/people practices through physical and mental health support initiatives<br>• Facility time for trade union representatives appears to be providing value for money in terms of the hours spent and the associated costs. A high percentage of facility time implies there are problems. Ours appears to be quite low, a reflection of the work done by the HR team and departmental managers to maintain good and effective working relationships<br>• Junior Doctor contracts, working conditions, facilities and development and career progression opportunities (training). E-rostering system should help improved management of their hours with a view to encouraging them to take Time Off |

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| | In Lieu rather than compensatory payments where extra duties are worked.<br>• Nursing and midwifery are also engaged in an exercise with recruitment and retention at the core. This will assist the ward targets which in turn will reduce costs for bank and temporary staff.<br>There's a significant amount of topics/subjects not mentioned here and in the interests of minimising the amount of written reports the governors read, feedback into the format of report back the committee would prefer is welcomed. |

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| **AGENDA REFERENCE:** | **COG/19/08/42** |
| **COMMITTEE ATTENDED** | **Charitable Funds** |
| **DATE OF MEETING:** | Quarterly |
| **AUTHOR(S):** | Alison Kinross |
| **GOVERNOR COMMENTS** | I have been the elected Governor representative for the observation of the CF Committee since April 2017.<br>During this time it has been a very informative and interesting experience to see the varied requests which are presented for funding.<br>The purpose of Charitable Funds is to provide items which enhance and provide for patients over and above those provided for by the NHS.<br>The structure of the Committee has evolved during the past 2 years and become more formal in both attendees and Agenda.<br>My observations:<br>• More communication/education is needed before cases are brought to the Committee for consideration. This has been and is an ongoing observation which occurs many times. The process for applying to the Charity for funding does not seem to be widely available to all Departments.<br>Some cases are presented very unprepared with little knowledge of the bid process or what/why the applicant/Dept is asking for. Some presentations are poorly completed and the person presenting knows little about the subject. Others are very well prepared and the bid process fully understood. If an applicant is presenting to Committee I would expect them to be fully briefed on the process and why they are seeking funding from CF.<br>• I recently observed a bid declined, without I felt, due consideration and understanding.<br>In my experience of Grant Funding and many Community Projects involving 3rd parties where matched funding has been promised or applied for. Perhaps the way in which such bids are presented rather than requesting a huge total which is flatly declined a target of matched funding sums for each smaller phase of the project could be set which would be more achievable rather than refusing the bid.<br><br>Generally a well balanced discussion occurs between all members of the Committee considering the merits of each case in detail. A fair decision is made managing the Legacies and Fundraising Schemes.<br>Individual departmental Staff are invited to attend as relevant for the bids being presented.<br>A good mix of NEDS and EDS attend the Committee with Ian Jones as Chair awaiting the appointment of Cliff Richards to replace Jean-Noel Ezingeard the exiting Chair.<br>Thank you for inviting the Governors to attend and observe. |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

**Council of Governors**

| | | | | |
|---|---|---|---|---|
| **AGENDA REFERENCE:** | **COG/19/08/48** | | | |
| **SUBJECT:** | **Annual Audit Letter** | | | |
| **DATE OF MEETING:** | 13 August 2019 | | | |
| **ACTION REQUIRED** | **For noting** | | | |
| **AUTHOR(S):** | Gareth Winstanley, Grant Thornton Audit Manager | | | |
| **EXECUTIVE SPONSOR** | Choose an item. | | | |
| | | | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | | | |
| | Choose an item. | | | |
| | Choose an item. | | | |
| **EXECUTIVE SUMMARY** | The Annual Audit Letter summarises the audit work that has been completed during 2018/19 and highlights the key messages arising from our audit of the 2018/19 and the deadlines achieved. | | | |
| **PURPOSE**: *(please select as appropriate* | Information | Approval | **To note √** | Decision |
| **RECOMMENDATIONS** | To note the report. | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committee** | **Audit Committee** | | |
| | **Agenda Ref.** | AC/19/08/64 | | |
| | **Date of meeting** | 1 August 2019 | | |
| | **Summary of Outcome** | Noted | | |
| **NEXT STEPS:** *State whether this report needs to be referred to at another meeting or requires additional monitoring* | **N/a** | | | |
| | **None** | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED: (if relevant)** | Choose an item. | | | |

Grant Thornton

# The Annual Audit Letter for Warrington and Halton Hospital NHS Foundation Trust

**Year ended 31 March 2019**

**26 June 2019**

# Contents

**Your key Grant Thornton team members are:**

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# Executive Summary

## Purpose

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Warrington and Halton Hospitals NHS Foundation Trust (the Trust) for the year ended 31 March 2019.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this Letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit Committee as those charged with governance in our Audit Findings Report on 21st May 2019.

## Respective responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the National Health Service Act 2006 (the Act). Our key responsibilities are to:

- give an opinion on the Trust financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust financial statements, we comply with International Standards on Auditing (UK) (ISAs) and other guidance issued by the NAO.

## Our work

| | |
|---|---|
| **Materiality** | We determined materiality for the audit of the Trust's financial statements to be £4.312m, which is 1.75% of the Trust's gross operating expenditure. |
| **Financial Statements opinion** | We gave an unqualified opinion on the Trust's financial statements on 28th May 2019.<br><br>We included a material uncertainty paragraph in our report on the Trust's financial statements to draw attention to the note which explains the basis on which the Trust has determined that it is still a going concern.<br><br>This does not affect our opinion that the statements give a true and fair view of the Trust's financial position and its income and expenditure for the year. |
| **NHS Group consolidation template (WGA)** | We also reported on the consistency of the financial statements consolidation template provided to NHS England with the audited financial statements. We concluded that these were consistent. |
| **Use of statutory powers** | We did not identify any matters which required us to exercise our additional statutory powers. |

# Executive Summary

| | |
|---|---|
| **Value for Money arrangements** | Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:<br>• The Trust strengthened its financial reporting arrangements during the year but these remain to be tested over a full financial cycle and as such the Trust is unable to demonstrate that it has a sustainable budget with sufficient capacity to absorb emerging cost pressures.<br>• For the year ended 31 March 2019, the Trust achieved its control total set by NHS Improvement (NHSI) and delivered a retained deficit of £16 million which increased the cumulative deficit to £52.6 million. The Trust delivered £5.6 million of its planned £7 million Cost Improvement Plan (CIP) target for 2018/19. In addition the Trust has recently been notified, that it will receive additional Provider Sustainability Funding of £227,000.<br>• For 2019/20, the Trust has agreed to deliver a break even control total based on receiving £17.9 million of external non-recurrent funding comprising of £4.9m Provider Sustainability Funding, £12m Financial Recovery Funding and £1m Marginal Rate Emergency Tariff Funding to deliver a break-even position.<br>This matter identifies weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures.<br>We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for the issue raised above. We therefore qualified our value for money conclusion in our audit report to the Directors of the Trust on 28th May 2019. |
| **Quality Report** | We completed a review of the Trust's Quality Report and issued our report on this on 28th May 2019. We concluded that the Quality Report and the indicators we reviewed were prepared in line with the NHS foundation trust annual reporting manual and supporting guidance. |
| **Certificate** | We certified that we have completed the audit of the financial statements of Warrington and Halton Hospitals NHS Foundation Trust in accordance with the requirements of the Code of Audit Practice on 28th May 2019. |

## Working with the Trust

During the year we have delivered a number of successful outcomes with you:

- An effective audit – we delivered an effective audit with you in May enabling the Trust to meet the NHS deadline for submitting audited financial statements.
- Sharing our insight – we provided regular Audit Committee updates during the year, including best practice identified from our work with NHS entities across the country. We also shared our thought leadership reports with you.
- Providing training – we provided training on matters related to the financial accounts and annual report.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by Trust officers.

# Audit of the Financial Statements

## Our audit approach

### Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for the audit of the Trust's financial statements to be £4.312m, which is 1.75% of the Trust's gross operating expenditure. We used this benchmark as, in our view, users of the Trust's financial statements are most interested in where the Trust has spent its revenue in the year.

We also set a lower level of specific materiality of for senior officer remuneration.

We set a lower threshold of £0.215m, above which we reported errors to the Audit Committee in our Audit Findings Report.

### The scope of our audit

Our audit involves obtaining sufficient evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:

- the accounting policies are appropriate, have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the financial statements included in the Annual Report on which we gave our opinion.

We carry out our audit in accordance with ISAs (UK) and the NAO Code of Audit Practice. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

# Audit of the Financial Statements

## Key Audit Matters

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Improper revenue recognition**<br>Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. In this environment, we have considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue.<br>We rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be income from:<br>• Block contract income element of patient care revenues<br>• Education and training income.<br>We did not deem it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue.<br>We therefore identified the occurrence and accuracy of these income streams of the Trust and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement. | **Auditor commentary**<br>We:<br>• evaluated the Trust's accounting policy for recognition income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2018/19;<br>• updated our understanding of the Trust's system for accounting for income from patient care activities and other operating revenue, and evaluated the design of the associated controls;<br>**Patient Care Income**<br>• using the DHSC mismatch report, we investigated unmatched revenue and receivable balances over the NAO £300,000 threshold, corroborating the unmatched balances used by the Trust to supporting evidence;<br>• we agreed, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners;<br>**Other Operating Revenue**<br>• we agreed, on a sample basis, income and year end receivables from other operating to invoices and cash payment or other supporting evidence;<br>• agreed Provider Sustainability Fund (PSF) income recognised to NHS Improvement (NHSI) notifications. | Our audit work did not identified any issues in respect of revenue recognition. |

# Audit of the Financial Statements

## Key Audit Matters

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Management override of controls**<br>Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. The Trust faces external pressures to meet agreed targets, and this could potentially place management under undue pressure in terms of how they report performance.<br>We therefore identified management override of control, in particular journals, management estimates and transactions outside the course of business as a significant risk. | **Auditor commentary**<br>We:<br>• evaluated the design effectiveness of management controls over journals;<br>• analysed the journals listing and determine the criteria for selecting high risk unusual journals;<br>• tested unusual journals made during the year and after the draft accounts stage for appropriateness and corroboration; and<br>• gained an understanding of the accounting estimates and critical judgements applied made by management and consider their reasonableness. | Our audit work has not identified any issues in respect of management override of controls |
| **Valuation of land and buildings**<br>The Trust revalues its land and buildings on a five-yearly basis to ensure the carrying value in the Trust financial statements is not materially different from current value at the financial statements date. In the intervening years, such as 2018/19, the Trust requests a desktop valuation from its valuation expert. This valuation represents a significant estimate by management in the financial statements.<br>We therefore identified valuation of land and buildings as a significant risk. | **Auditor commentary**<br>We:<br>• evaluated management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work;<br>• evaluated the competence, capabilities and objectivity of the valuation expert;<br>• wrote to the valuer to confirm the basis on which the valuation was carried out;<br>• challenged the information and assumptions used by the valuer to assess completeness and consistency with our understanding; and<br>• tested revaluations made during the year to see if they had been input correctly into the Trust's asset register. | Our audit work has not identified any significant issues in relation to the risk identified |

# Audit of the Financial Statements

## Key Audit Matters

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Going Concern**<br>As auditors, under ISA (UK) 570, we are required to:<br>• "obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements, and<br>• to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern" (ISA (UK) 570).<br>The Trust continued to face significant financial challenges and forecast a deficit position for 2018/19 and the requirement for cash support to help pay its expenses.<br>We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk requiring special audit consideration. | **Auditor commentary**<br>The Trust incurred a £16m financial deficit in delivering its services in 2018/19. The cumulative deficit position on retained earnings is now £52.6 million and the Statement of Financial Position shows negative net current assets and liabilities of £26.7 million.<br>On 22 May 2019 the Department of Health and Social Care (DHSC) wrote to Trusts providing confirmation of its commitment that NHS providers should remain financially viable. The letter is a welcome confirmation of the government's and department's commitment that NHS providers should remain financially viable.<br>The letter is written on a sector wide basis and makes reference to a five year settlement. However, in terms of assurance, auditing standards set us a higher threshold in that assurances need to be specific to individual Trusts and specifically cover the period of 12 months from our audit report date (i.e. to June 2020).<br>The Trust's Operational Plan for 2019/20 is based upon a break-even position having received appropriate support. However, the Trust is due to repay loan principal of £22.1m to the Department of Health and Social Care during 2019/20. The plan anticipates, in line with previous experience, that the repayment terms of these loans will be extended and that these cash payments will not be required during 2019/20. The Trust has not had specific confirmations from DHSC on this. Whilst our experience would be that extensions tend to be granted without a formal confirmation there remains uncertainty.<br>Given the factors identified, we were of the view that these matters gave rise to a material uncertainty relating to the Trust's ability to continue as a going concern. The Trust has recognised this in note 1.2 to the financial statements and this material uncertainty is also referred to in the audit report. | Given the factors identified, we were of the view that these matters gave rise to a material uncertainty relating to the Trust's ability to continue as a going concern. The Trust has recognised this in note 1.2 to the financial statements and this material uncertainty is also referred to in the audit report. |

# Audit of the Financial Statements

### Audit opinion
We gave an unqualified opinion on the Trust's financial statements on 28th May 2019.

### Preparation of the financial statements
The Trust presented us with draft financial statements in accordance with the national deadline, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

### Issues arising from the audit of the financial statements
We reported the key issues from our audit to the Trust's Audit Committee on 22nd May 2019.

### Annual Report, including the Annual Governance Statement
We are also required to review the Trust's Annual Report, including the Annual Governance Statement.

### Whole of Government Accounts (WGA)
We issued a group return to the National Audit Office in respect of Whole of Government Accounts, which did not identify any issues for the group auditor to consider.

### Other statutory powers
We are also required to refer certain matters to the Secretary of State under schedule 10 (6) of the NHS Act 2006. We did not exercise our powers.

### Certificate of closure of the audit
We certified that we have completed the audit of the financial statements of Warrington and Halton Hospital NHS Foundation Trust in accordance with the requirements of the Code of Audit Practice on 28th May 2019.

# Value for Money conclusion

## Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2017 which specified the criterion for auditors to evaluate:

*In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.*

## Key findings

Our first step in carrying out our work was to perform a risk assessment and identify the risks where we concentrated our work.

The risks we identified and the work we performed are set out overleaf.

As part of our Audit Findings report agreed with the Trust in May 2019, we agreed recommendations to address our findings.

## Overall Value for Money conclusion

We are satisfied that, in all significant respects, except for the matter we identified on page 12, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2019.

# Value for Money conclusion

## Value for Money Risks

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Financial sustainability**<br><br>The Trust's financial plan for 2018/19 showed that the Trust's control total is a deficit of £16.881m and a cost improvement programme target of £7m. If the Trust hits its control total and national operational performance targets it will receive £4.942m Provider Sustainability Funding. As at month 7 the Trust has £2.7m of unidentified CIP schemes.<br><br>We will review the in year financial performance against the Trust's control total and cost improvement programme target, assessing whether the monitoring arrangements keep Board Members fully informed of the financial performance throughout the year. We will also review how the Trust manages the risk of non delivery. | During 2018/19 the Trust stabilised its financial position having achieved its control total set by NHSI and delivering a retained deficit of £16 million, which included a £1.1m charge for impairments and a cumulative deficit to £52.6m. The deficit after excluding the impairment charge is £14.9m including Provider Sustainability Funding monies. The £14.9m deficit is £2.0m better than the £16.9m control total. This is a significant achievement given the continued financial pressures affecting the sector. In addition the Trust has recently been notified, that it will receive additional Provider Sustainability Funding of £227,000.<br><br>For the period ending 31 March 2019 cash support of £16.9m has been drawn down in line with plan. The total Cost Improvement Plan (CIPs) target for 2018/19 was £7m. The Trust made good progress in the year delivering 80% of its target and achieved CIP savings of £5.6m.<br><br>Going forward for 2019/20 the Trust has agreed a control total offer of NIL (i.e. breakeven) after the receipt of external support of £17.9m comprised of £4.9m Provider Sustainability Funding, £12.0m Financial Recovery Funding and £1.0m Marginal Rate Emergency Tariff Funding. The CIPs target going forward (2019/20) is £7.5m, which represents approximately 2.9% of the Trust's cost base, which is ambitious, especially given the challenges the Trust encountered in 2018/19, however as at the end of April 2019 the Trust had identified CIP schemes worth £4.2m.<br><br>During the year we noted that the Trust had strengthened its reporting arrangements. In particular, enhanced service line reporting and improved dashboard reporting of financial information had been introduced, as well as the formation of a Finance Resources Group to monitor and manage financial performance including finance and procurement dashboards brings together clinicians, management and finance staff to review assess and monitor the financial performance of divisions throughout the year. The enhancing of these arrangements has allowed the Trust to be more proactive and responsive to areas of high spend or underperformance.<br><br>The Trust's Integrated Performance Dashboard Reports provide management and NED's with the in year financial reporting position of the Trust. These are presented and summarised at every Trust Board meeting and at each Finance and Sustainability Committee meeting. Review of the reports shows them to be comprehensive and produced one month in arrears demonstrating that they are timely and up to date.<br><br>They provide a clear analysis of the progress against the financial plan at income and expenditure levels, whilst also highlighting cost improvement programme (CIPs) performance, capital programme and cash management information including cash flow forecasts and aged debtor and creditor information. The level of detail is sufficient to allow members of the committee to be fully briefed on the current financial position of the Trust. | The Trust bettered its deficit control total in 2018-19 but being in deficit has meant that the cumulative deficit continues to increase. There remains a significant challenge ahead for 2019-20 with support of £17.9m (approximately 7.5% of expenditure) being required after the delivery of £7m of CIP (including the additional efficiency requirement up to 0.5% required by Trusts in deficit). The Trust's enhanced arrangements came into place during the financial period and place it in an improved position going into 2019-20 but remain to be tested over a full financial cycle such that it is able to demonstrate that it has a sustainable budget with sufficient capacity to absorb emerging cost pressures.<br><br>On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in AGN -07 we gave a qualified 'except for' conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. |

# Quality Report

## The Quality Report

The Quality Report is an annual report to the public from an NHS Foundation Trust about the quality of services it delivers. It allows Foundation Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

## Scope of work

We carry out an independent assurance engagement on the Trust's Quality Report, following NHS Improvement (NHSI) guidance issued in February 2019. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Report is not prepared in line with the criteria specified in the NHS foundation trust annual reporting manual and supporting guidance;
- the Quality Report is not consistent with other information, as specified in the NHSI guidance; and
- the indicators in the Quality Report where we have carried out testing are not compiled in line with the NHS foundation trust annual reporting manual and supporting guidance and do not meet expected dimensions of data quality.

## Quality Report Indicator testing

We tested the following indicators:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer to discharge
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- Summary Hospital-level Mortality Indicator (SHMI).

For each indicator tested, we considered the processes used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to underlying Trust data. We then tested a sample of cases included in the indicator to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the defined indicator definition.

## Key messages

- We confirmed that the Quality Report had been prepared in line with the requirements of the NHS foundation trust annual reporting manual and supporting guidance.
- We confirmed that the Quality Report was consistent with the sources specified in the NHSI Guidance.
- We confirmed that the commentary on indicators in the Quality Report was consistent with the reported outcomes.
- Based on the results of our procedures, nothing came to our attention that caused us to believe that the indicators we tested were not reasonably stated in all material respects.

## Conclusion

As a result of this we issued an unqualified conclusion on the Trust's Quality Report on 28th May 2019.

# A. Reports issued and fees

We confirm below our final reports issued and fees charged for the audit and provision of non-audit services.

## Reports issued

| Report | Date issued |
|---|---|
| Audit Plan | 14 December 2018 |
| Audit Findings Report | 23 May 2019 |
| Annual Audit Letter | 24 June 2019 |

## Fees for non-audit services

| Service | Fees £ |
|---|---|
| Audit related services<br>- Quality Report | 6,000 |
| Non-Audit related services<br>- None | - |

## Fees

| | Planned £ | Actual fees £ | 2017/18 fees £ |
|---|---|---|---|
| Statutory audit including Quality Report | 46,200 | 46,200 | 46,200 |
| **Total fees** | **46,200** | **46,200** | **46,200** |

- The fees reconcile to the financial statements.
  - £56k
  - *Less* VAT - £10k
  - total fees per above - £46k

## Non - audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified.

- We have considered whether non-audit services might be perceived as a threat to our independence as the Trust's auditor and have ensured that appropriate safeguards are put in place.

The above non-audit services are consistent with the Trust's policy on the allotment of non-audit work to your auditor.

- The fees reconcile to the financial statements.
  - £7k
  - *Less* VAT - £1k
  - total fees per above - £6k

# Council of Governors

| | |
|---|---|
| **AGENDA REFERENCE:** | **COG/19/08/49** |
| **SUBJECT:** | **Quality Strategy update.** |
| **DATE OF MEETING:** | 13 August 2019 |
| **ACTION REQUIRED** | **Note** |
| **AUTHOR(S):** | Ursula Martin, Director of Integrated Governance & Quality.<br>Hayley McCaffrey, Head of Clinical Effectiveness & Quality |
| **EXECUTIVE SPONSOR** | Kimberley Salmon-Jamieson, Chief Nurse |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | All |
| **EXECUTIVE SUMMARY** | The purpose of this paper is to provide a summary of the following;<br>• Progress made in relation to the Trust Quality Strategy and the Quality Pledges detailed within the strategy.<br>• An assurance statement for each Quality Pledge outlined within the Trust Quality Strategy.<br>• Proposals for reviewing the Quality Strategy to ensure that it is still aligned to the Trust's current priorities and takes into account the Trust's 'Moving to Outstanding' agenda.<br><br>Updates have been received from the Clinical leads for each of the Quality Strategy pledges and assurance levels have been assigned using the following assurance structure; |

| **Level of Assurance** |
|---|
| **High -** There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed. |
| **Substantial -** There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. |
| **Moderate -** There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk. |
| **Limited -** There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk. |
| **No -** There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives. |

Assurance Statement: The Trust is advised that there is Moderate Assurance in relation to the work conducted to date in relation to implementation of the Trust Quality Strategy. The Trust is in the second year of implementing the Trust Quality Strategy and this represents good progress. Implementation of the Quality Strategy was a key component of the Trust's 'Getting to Good' programme and as we 'Move to Outstanding', review and embedding the Quality Strategy is a key enabler.

| | | | | |
|---|---|---|---|---|
| **PURPOSE**: *(please select as appropriate* | Information | Approval | To note<br>√ | Decision |
| **RECOMMENDATIONS** | We make the following recommendations;<br>▪ Recommend that the Trust review progress to date regarding implementation of the Trust Quality Strategy.<br>▪ The Quality Strategy needs to be reviewed and realigned to the Trust's revised priorities to help us move forwards on our journey to Outstanding. | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committee** Quality Assurance Committee | | | |
| | **Agenda Ref.** | | Quality Reporting | |
| | **Date of meeting** | | Quarterly basis | |
| | **Summary of Outcome** | | Assured regarding progress of implementation of the Trust Quality Strategy | |
| **NEXT STEPS:**<br>***State whether this report needs to be referred to at another meeting or requires additional monitoring*** | Choose an item. | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED: (if relevant)** | None | | | |

## 1. BACKGROUND/CONTEXT

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care. To support our overall aim we hosted a Quality Event in October 2017 with key stakeholders and staff that led to the development of the Trust Quality Strategy, which was launched in early 2018.

The Quality strategy was developed to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind, we use the following three priority domains: Patient safety, Clinical effectiveness and Patient experience.

For each priority domain we have a series of Quality Pledges and Quality Priorities; the progress of each priority is reported on a quarterly basis to the Trust's Quality Assurance Committee. Where possible we include performance indicators to measure and benchmark progress and they are reported on a monthly basis, via the Quality Dashboard to the Board of Directors.

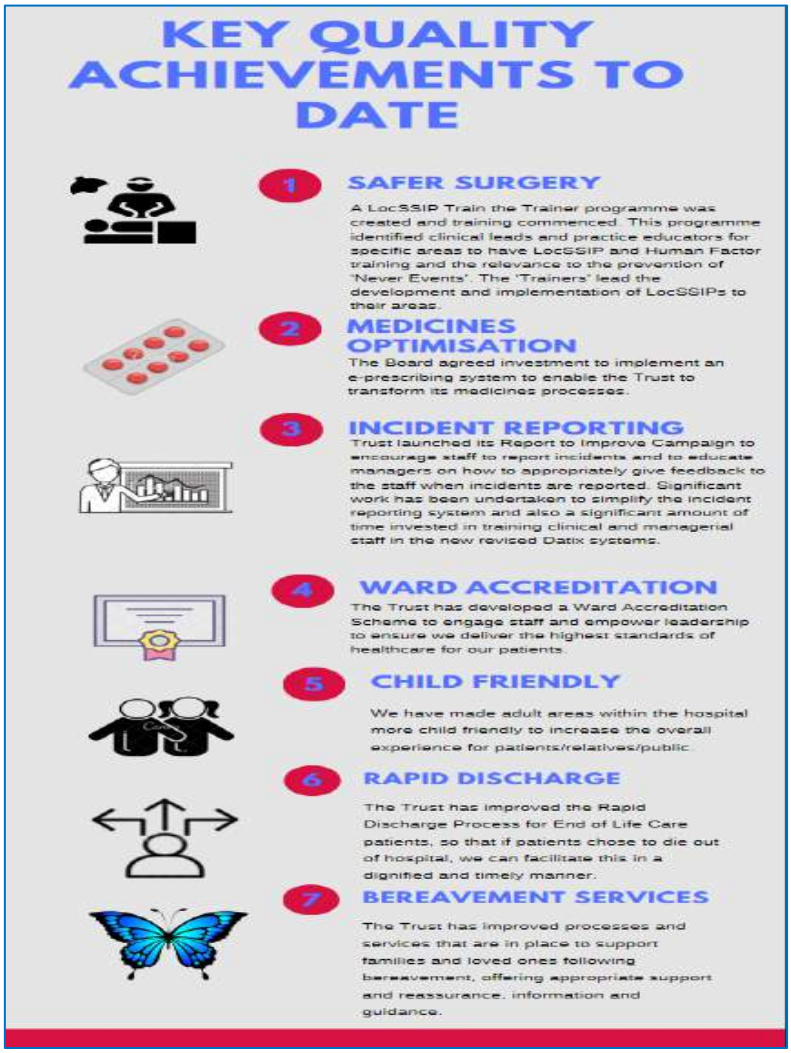
## 2. KEY ELEMENTS

### 2.1Key Achievements to date

The Quality Strategy uses the following measures of success;

- ✓ We will ensure that we minimise harm for patients
- ✓ We will have safe systems of work in place
- ✓ Every patient should have the opportunity to feedback about their experience and we promise to use this to improve care and services
- ✓ We will ensure partnership working and needs based care. We will simplify patient focused processes.
- ✓ We will communicate in line with our values
- ✓ We will ensure that we are providing care that is evidence based
- ✓ We will ensure that we are focused on outcomes for patients and that we are benchmarking/peer reviewing ourselves against the 'best in class'
- ✓ We will ensure that we foster a culture of Quality Improvement

With the above measures of success in mind, the following infographic details some of our key achievements from the Quality Priorities for 2018/19;



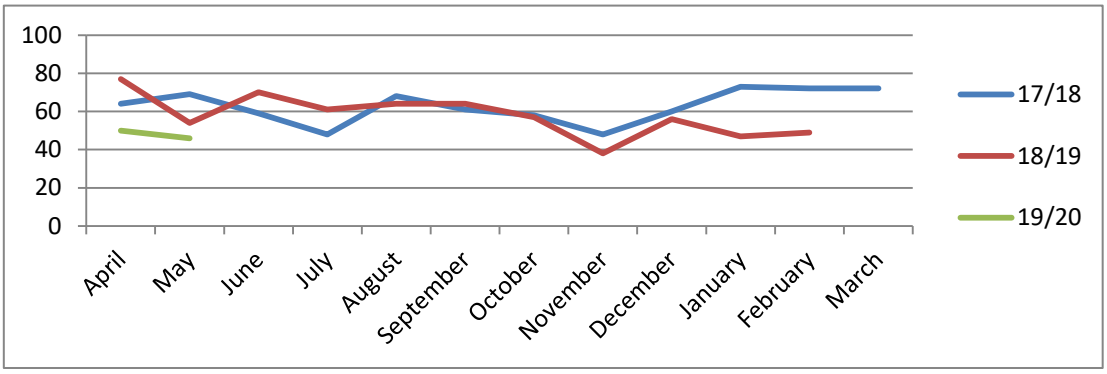

### 2.2 Assurance and Quality Pledge progress

The Quality Strategy contains Quality Pledges and the table below contains updates have been on each of the pledges and an assurance levels has been assigned;

| **Patient Safety Pledges** |
|---|
| **Pledge: A 20% reduction in falls for our patients who stay in hospital** |
| **Lead: Alison Kennah, Associate Chief Nurse - Patient Safety** |
| ***Assurance Level: Moderate*** |
| **Implementation Plan and progress to date:** |
| • Improvement collaborative supported by the Trust's Quality Academy commenced in May 2019 with innovation wards identified- aligned to high risk areas that report elevated incidents of falls.<br>• Falls prevention measures at ward level are assessed monthly for the ward quality metrics, action plans are completed where improvements are required.<br>• Weekly falls meetings continue to share learning.<br>• Any learning from inpatient falls is shared across the Trust through TWSB.<br>• Work programme created for the Quality Priority for 2019/20 to have a 10% reduction in the |

number of Serious Harm Falls.

- The graph below demonstrates comparison for Inpatient only falls 17/18, 18/19 and 19/20- the Trust did report a 20% reduction of inpatient falls in Quarter 1 of 2019/20. We will continue to monitor this to ensure this remains a sustained reduction;




**How progress is monitored and reported**

Trust Integrated Performance Report, Falls monthly steering group reporting to Patient Safety & Effectiveness Sub Committee (PSESC), CQUIN in 2019/20 regarding falls, Quality Committee oversight of quality strategy and high level briefing from PSESC.

**Pledge: 100% medicines reconciliation when patients come into hospital and promotion of safe prescribing and administration of medicines**

**Lead: Diane Matthew, Chief Pharmacist**

***Assurance Level: Limited***

**Implementation Plan and progress to date:**

- Medicines reconciliation (MR) within 24 hours of admission is a NICE recommendation for adult patients. The Trust's MR position for 18/19 was: MRtotal=68%; MR<24h=26%.
- Trust Board have invested in business case completed and Phase 1 approved for 3.5FTE pharmacists & 3.5FTE pharmacy technicians to implement a Pharmacy Seven Day Service, which will improve MR. Staff recruitment commenced January 2019 and is ongoing
- Phase 1 pilot & implementation to commence September 2019
- Ongoing data collection to allow business case review & assessment of progress (benefits realization)
- Business case review (review data for consideration of Phases 2 & 3) (Q3 2019/20)
- If approved, staff recruitment for Phase 2 (Q4 2019/20), Phase 3 (Q2 2020/21)
- Phase 2 implementation (Q2 2020/21), Phase 3 implementation (Q4 2020/21)

Aiming to achieve the following improvements:

- Phase 1: MRtotal: >75%; MR<24h: >40%
- Phase 2: MRtotal: >80%; MR<24h: >55%
- Phase 3: MRtotal: >85%; MR<24:= >70%

The Quality Priority for 2018/19 of 'Improving patient safety by decreasing prescribing errors and saving time and resource' has helped to underpin this pledge. To date the following work has been undertaken to

improve medicines optimization within the Trust;

- ✓ A programme approach regarding e- prescribing was developed. Awaiting an upgrade of Lorenzo to be installed that provided critical functionality. With the necessary delay in commencing EPMA implementation at Warrington it was agreed to focus work at the Halton site for 2018/19.
- ✓ Halton EPMA programme included initial staff engagement, equipment approval and Estates work and staff training. Intensive staff support was provided through go-live and 2 to 3 weeks after.
- ✓ EPMA is currently live on B1, B4 and CMTC Wards and in Halton and CMTC Theatres.
- ✓ The learning from these pilot implementations has been used to develop the roll out plan for Warrington. Subject to approval, this plan could achieve implementation of EPMA in surgical, gynaecological, Main Theatres and medical wards before August 2019 with remaining areas (Maternity, Maternity Theatres and Paediatric Wards) following from September.
- ✓ Medication order sets have been developed with anaesthetics and are in use for elective surgical and orthopaedic patients at Halton. These provide a more standardised approach to prescribing for the post-operative period. Oxygen and fluids are also being prescribed electronically.
- ✓ To date there is evidence of improved documentation of medication administration with far fewer instances of omitted medicines where a reason for omission has not been given. Since implementing EPMA on CMTC Ward, medicines reconciliation improvements have been seen with % completed increasing by 14%.

**How progress is monitored and reported**

Trust Integrated Performance Report, Medicines Governance group reporting to Patient Safety & Effectiveness Sub Committee (PSESC), Quality Committee oversight of quality strategy and high level briefing from PSESC.

**Pledge: A 10% reduction in Hospital Acquired Infections – particularly focusing on safe catheter care and implementation of the Trust's Urinary Tract Infection (UTI) pathway**

**Lead: Lesley McKay, Associate Director of Infection Control**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

- Weekly email circulated with up-to-date information on cases by location & monthly dashboard
- Internal GNBSI reduction action group set up which meets monthly
- Gram Negative Collaborative driver diagram and action plan have been developed with the Quality Academy with agreed tests of change. Focus of activity includes:-
  - i. Aim to reduce use of urinary catheters – daily challenge in place
  - ii. Improvements to care of urinary catheters – review of all urinary catheter policies required and introduction of competency assessments incorporating ANTT
  - iii. Patient Hand Hygiene Strategy
  - iv. Hydration Strategy
  - v. Report to Medical Cabinet
  - vi. Grand Round Presentation
  - vii. UTI Audit: More than a Wee Problem – Conducted and concluded in February 2019 with actions that have fed back to the Mortality Review Group, Medical and Surgical Audit

Meetings and a Grand Round for dissemination of learning.

viii. With regards to health care acquired infections (HCAI) during 2018/19, the Trust threshold was 0 cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and despite the continued focus on managing HCAI; the Trust reported 2 cases of MRSA bacteraemia. In relation to Clostridium difficile the Trust reported 27 hospital onset cases against the annual threshold of 26 cases. The CCG review panel consider the cases and have deemed that 18 of the 22 cases between Q1 and Q3 were not due to lapses in care. Cases from Q4 will be reviewed in May.

ix. The Trust also carefully monitors Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia and E. coli bacteraemia. The Trust reported 15 hospital onset cases of MSSA bacteraemia during the financial year. This is a decrease of 2 cases compared to the previous financial year. These cases are under review to identify any areas for care improvement. The Trust reported 46 hospital onset cases of E. coli bacteraemia. Partnership working is in place across the health economy and the Trust is working with community partners to progress the action plans. Work streams related to the reduction of healthcare acquired infections continue with oversight at Patient Safety Sub Committee and Quality Assurance Committee.

**How progress is monitored and reported**

Trust Integrated Performance Report, Meeting minutes and action log – to monitor progress. Actions not completed will be escalated to the Deputy Chief Nurse for discussion at 2:1 meetings with the Chief Nurse, Monthly Safety Thermometer urinary catheter data and quarterly prevalence surveys (scheduled for June: Sep; Dec & Mar).

**Pledge: 100% of patients having sepsis screening and being treated appropriately**

**Lead: Alison Kennah, Associate Chief Nurse - Patient Safety**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

- Have developed a weekly audit of patients in receipt of treatment for Sepsis, to ensure they receive the full bundle of care aligned to Sepsis 6.
- Blood culture training for wider nursing population has commenced.
- Antimicrobial ward rounds continue.
- Plan to embed the Sepsis Care Bundle pathway into the Trust electronic record keeping system.
- Recent purchase of new falls alarms and sensor equipment.
- The Trust are signing up to become involved in the Advancing Quality programme, run by AqUA, which supports Trusts to improve the reliability of their clinical practices and reduce variation in the care of patients with Sepsis. The Sepsis improvement network from AqUA supports delivery of the highest quality care to every Sepsis patient, every time across the region.

The Patient Safety team continued to train staff to screen and treat patients in relation to sepsis and through this we have seen screening rates increase to 100% in ED and 100% for inpatients by the end of Q4 from 100% and 98% in 2017/18 respectively, which saves valuable time in being able to diagnose and treat patients, which is key to reduction of mortality from sepsis.

| | Target | AED Screening 18/19 | Inpatient Screening 18/19 | AED Antibiotic Administered 18/19 | Inpatient Antibiotic Administered 18/19 | Antibiotic review 18/19 |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Q1 | 90.00% | 93% | 99% | 89% | 98% | 74% |
| Q2 | 90.00% | 100% | 91% | 89% | 95% | 73% |
| Q3 | 90.00% | 100% | 99% | 95% | 99% | 74% |
| Q4 | 90.00% | 100% | 100% | 100% | 99% | 87% |

**How progress is monitored and reported**

Quality Dashboard, Quarterly Sepsis Steering group reporting to Patient Safety & Effectiveness Sub Committee (PSESC), Quality Committee. The Trust is also about to re-commence Advancing Quality for Sepsis and Acute Kidney Injury, given that the CQUIN for sepsis is no longer in place.

**Pledge: 100% of patients to have a Venous Thromboembolism (VTE) assessment and to have appropriate treatment**

**Lead: Alison Kennah, Associate Chief Nurse - Patient Safety**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

- Updated Trust policy with streamlined cohort directive.
- Targeted training utilizing simulation.
- Updated Patient Information.
- Risk assessment documentation modification complete to include 16yr old and above.
- Root Cause Analysis process in place.
- The data will be integrated onto the Clinical Governance Dashboards for each specialty to review.
- There will be escalation processes in place and accountability for specialties to highlight any concerns in relation to VTE assessments in their areas.

**Venous Thromboembolism (VTE) – percentage of risk assessments undertaken**

| Year | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **2018/2019** | 95.76% | 95.02% | 95.03% | 95.58% |
| **2017/2018** | 95.18% | 95.88% | 95.24% | 95.62% |

The Trust has taken the following actions to improve this percentage, and so the quality of its services by updated the Lorenzo system to further support the established process for undertaking risk assessments, and the Trust consistently achieves over the 95% recommended standard for risk assessment completion, the data is collated corporately and incorporated into the Quality Dashboard for monthly review and monitoring by both the Quality Committee and Trust board. Trust policy has been updated to reflect changes to NICE guidance with associated amendments to patient information. Early identification of patient risk of VTE remains a high priority for the Trust.

To note – validation work is underway regarding Q4's figures which will report to Patient Safety & Effectiveness Sub Committee and Quality Committee.

**How progress is monitored and reported**

- Trust Integrated Performance Report, Specialty dashboards, Quarterly Thrombosis Group meeting reporting into Patient Safety & Effectiveness Sub Committee.

**Clinical Effectiveness Priorities**

**Pledge: Reduce DTOCs to no greater than 3%**

**Lead: Dan Moore, Deputy Chief Operating Officer**

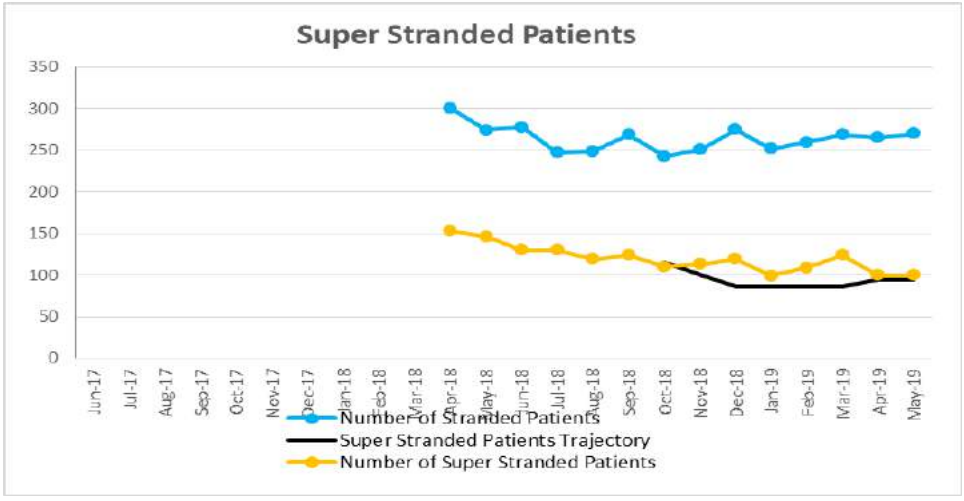
***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

- Super Stranded Patients – we have worked with our regulators to create an improvement trajectory which will see no more than 95 patients with a LoS over 21 days. Since September 2018 we have significantly improved our position from 160 patients to 120 with a LoS over 21 days and to a current position of approximately 100.
- Corporate flow meetings were established once a week but this has now increased to three times a week – this is in line with the NHSI Guide to reducing long hospital stays. These meetings are an MDT where we have a lead from social care, a lead medic and a lead AHP visiting the wards. Other staff groups are co-opted in where appropriate.
- Collaborative between NHSI and the Trust is currently underway – we are starting with 5 wards and looking to reduce LoS by 40%. This is a Quality Improvement (QI) collaborative and after 90 days an assessment will be made to see if this will be beneficial to roll out across the Trust.
- Integrated Discharge Team that are now collocated for easier working.
- Red to Green work being implemented across the Trust.
- Ward Round Accreditation being rolled out, working with Elliot Blanchard, to ensure that the Trust successful Ward Accreditation programme is extended to review medical related functions at ward level.

- ED Improvement Committee established which is reviewing the acute review of patients and also elements like time to speciality review etc.

The improvement is reduction of length of stay and super stranded patients is shown below.




**How progress is monitored and reported**

Trust Integrated Performance Dashboard, Quality dashboard, Specialty dashboards, Quality Committee,

Trust Operational Board, KPI Meeting.

**Pledge: Reduce readmissions within 30 days for patients >65 to no greater than 12.5%**

**Lead: Dan Moore, Deputy Chief Operating Officer**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

Working with performance we will establish baseline data for 2018/19 and then review the current position. This data is currently monitored for all patients and relates to readmissions within 30 days. The new data capture which is currently being produced will capture >65 specifically.

**How progress is monitored and reported**

Quality dashboard, Specialty dashboards, Quality Committee

**Pledge: Understanding variance in clinical outcome measures across all specialities, measure and agree improvements**

**Lead: Mark Halliwell, Associate Medical Director for Clinical Effectiveness, Gary Sutton, Quality Academy Manager, Hayley McCaffrey, Head of Clinical Effectiveness**

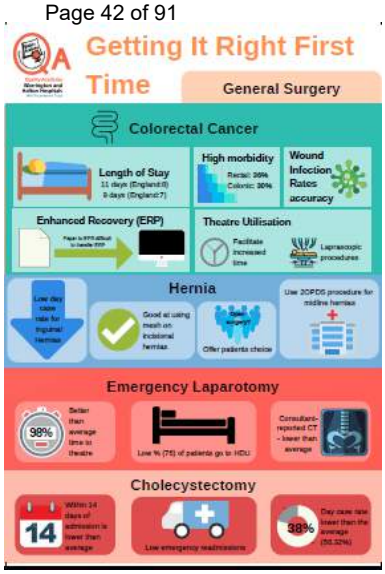
***Assurance Level: Moderate***

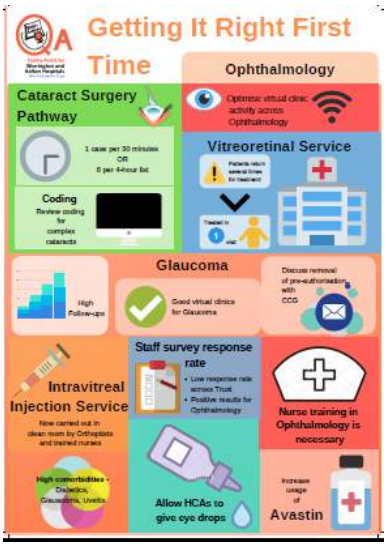
**Implementation Plan and progress to date:**

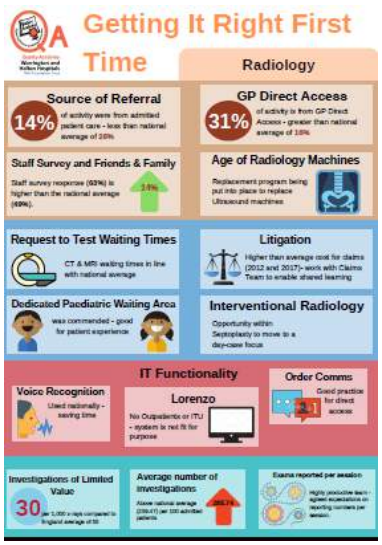
Getting It Right First Time (GIRFT) is a national programme designed to reduce variations in care within the NHS. Overseen by NHS Improvement, it combines data analysis within specialities and treatments alongside professional knowledge of senior clinicians to examine current practice and how it can be improved. Its underlying principle is to provide patients with timely and effective investigations, treatment and outcomes irrespective of where and who delivers that care. The programme aims to identify approaches from across the NHS that have demonstrated improvement in outcomes and patient experience without the need for radical change or investment.

**GIRFT Deep Dive Specialty Updates**

To date, the following specialties have had an initial visit from the national GIRFT Team to discuss their data. Each specialty receives a briefing and an infographic regarding their report and work with the Quality Academy to develop a Quality Improvement Plan:




| Specialty | Positive / Negative Variance |
|---|---|
| Urology | **Positive Variance -** Excellent performance with the coding of patients.<br>**Negative Variance -** High new to follow up ratio with 3,000 excess appointments in the system.<br>Some emergency admissions are not coming under Urology Consultants on EPR.<br>Consultant management of the acute patient should be driven by Consultants.<br>Streamline the urinary retention pathway to reduce the difference between admission with retention to admission for surgery.<br>Nesbit's procedure for Peyronie's disease has low volumes – consider links with a tertiary centre.<br>Ureteric stone patients should have a Ureteroscopy rather than a temporising stent. |
| Ophthalmology | **Positive Variance -** Good F&F response rate for ophthalmology.<br>Issue with patients lost to follow up due to a change in IT system. But now the system is established and a failsafe was put into place. Now feeling assured that with the failsafe in place, no patients should ever be lost to follow-up.<br>Intravitreal Injection Service - Injections were being carried out in theatre and were being coded as day cases. However, they are all now being carried out in a clean room. Given by orthoptists and trained nurses.<br>Meeting the demand by developing HCPs with expanded roles.<br>Nurse and orthoptist injectors.<br>Innovative glaucoma virtual clinics.<br>**Negative Variance -** Optimising Cataract Surgery Patient Pathway:<br>Theatre lists have an increased number of cases per cataract list; 1 case per 30 minutes or 8 patients per 4-hour list.<br>Review/audit coding for complex cataracts.<br>Developing your HCP staff.<br>Continue to train & develop the multi-disciplinary team3) IT infrastructure review to optimise VC potential.<br>An IT platform which allows collation of diagnostics & clinical data from several different sources would be useful.<br>Coding practices to be reviewed to ensure accuracy. Some of the reported |

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| | clinical activity did not feel in line with your views therefore, we recommend audits to review your coding practices could be useful. For example: complex cataracts and tubes.<br>Review your ECLO post and make changes to ensure it becomes a designated role in future.<br>Review and identify your staff training needs – provision of good training will help you retain your staff and reduce turnover.<br>Discuss the training needs of your community optoms with the CCGs in order to improve the provision of minor eye care in the community.<br>Recommend a Medisoft audit to highlight the good cataract service being provided and make a case for not requesting pre-authorisation for cataract cases.<br>Work with CCGs to get funding in order to develop referral refinement. |
| Trauma & Orthopaedics | **Positive Variance** - Revision surgery is now done by 5 surgeons who undertake the surgery regularly. Highest volume 17 followed by 9 and three do less than 5.<br>On average 3 joints or equivalent on all day list but try to do 4.<br>Capacity for growth.<br>Quick anaesthetic throughput in theatres.<br>LOS since 2013 is improving for hip and knees.<br>They have physiotherapists at weekends.<br>Waiting times 92% across whole of T&O.<br>The attendees stated they are not an outlier in the NJR for deep infection for hip and knee – from April 2016/March 2017 their infection rate was 0.99% for hip and knee.<br>They have regular meetings to discuss litigation.<br>The Trust has an excellent ortho-geriatrician. They have one in place 5 days a week: ½ one in elderly care and ½ acute medicine.<br>PROMS – good on knees but not quite so good for hips.<br>PROMS compliance 79% for hips, 91% for knees.<br>**Negative Variance** - Best practice tariff was good at 74/76% but has reduced because of beds and nursing staff.<br>The Trust must participate in the audit for deep infection.<br>Review low volume surgeons undertaking complex work – have interdepartmental policy.<br>Cemented hip replacements for patients over 70 years.<br>Huge opportunity with split elective working to increase productivity and compete to repatriate work from AQP. |
| Obstetrics & Gynaecology | **Positive Variance -** Very good Friends & Family Test recommendation rate from postnatal community.<br>Very good admitted and non-admitted RTT.<br>Low rate of spontaneous labours result in emergency caesarean sections in multips.<br>High rate of women who VBAC after having a previous caesarean section.<br>Estimated cost of claims per birth and per gynae admission are low (in bottom five for gynae admissions in the country).<br>**Negative Variance** - Friends & Family Test - 21% response rate compared to |

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|---|---|
| | England average of 24%.<br>Low recommendation rate for intrapartum care (bottom 10% of the country).<br>Gynaecology new to follow-up ratio 2.11 which is third highest in the country and is almost double the England average of 1.11.<br>The number of vaginal repairs recorded on HES (63) is lower than the number recorded on the BSUG database.<br>Vaginal repairs are not performed as day-case and Trust has the longest length of stay in the country.<br>Large number of hysteroscopies being recorded - appear to be more than would be anticipated for a Trust of this size.<br>Endometrial ablations have never been audited.<br>Induction of labour rate is above England average and length of stay is around the average.<br>Higher than average pre-labour caesarean sections for primips - 2% above England average of 3%. |
| ENT | **Positive Variance** - 2.3 Specialty level - referral to treatment times for ENT - 95% of non-admitted pathways are waiting less than 18 weeks for treatment in comparison to the average of 88.1%, with the average weeks waiting being 7.7 weeks. 64% of admitted pathways are waiting less than 18 weeks for treatment in comparison to the average of 63.9%, with the average weeks waiting being 14.8 weeks. Overtime non-admitted pathways are consistently above average, currently working on capacity and demand, good results within ENT and do not put extra capacity on as not required.<br>3.2 Day surgery rates – British Association of Day Surgery (BADS): PAEDIATRIC - Achieving high day case rates within paediatric for all procedures and exceeding BADS targets consistently. Achieving good day case rates for tonsillectomy consistently across all age bands.<br>5.1 Elective Spells with HRG for planned procedure not carried out -Overall 5% which is the national picture, good figures here, dedicated pre assessment which is generic. Pre op is on the ward and carried out a few week ahead of the surgery.<br>12.1 Adult rhinology – functional endoscopic sinus surgery (FESS) and functional endoscopic nasal surgery (FENS) -96% are being captured with FESS/FENS, all work is carried out endoscopically.<br>14.1 Summary ENT outpatient activity – total (adult + paediatrics). No non-consultants led activity, this will be different now with aural care nurse. New to follow up rates are low at 1 to 0.90, see more patients at consultant level, no clinics run by SHOs. Ethos to only bring back if necessary. 60% of new referrals are seen once and then discharged.<br>16.5 Litigation – number and estimated cost for ENT specialty -1 claim in the 5 year period in ENT, low cost for this claim at £2k, good reflection on governance and department.<br>**Negative Variance -** Non-elective spells with no dominant procedure . Rates are slightly higher than the average at 57%, first grade on call can be trainees with little experience.<br>Non-elective readmission rates for tonsillectomy procedures. Readmission rates for paediatrics are high at 14.9% in comparison to the average of 9.4%. |

| | |
|---|---|
| | NHS England cancer waiting times metrics. Slightly below the national average at 94.2% of suspected cancers being seen within 2 weeks. |
| General Surgery | **Positive Variance -** SSI bundle in place, led by sepsis nurses.<br>Good coding quality.<br>Participating in Cardiff-led stoma audit, CLOSE-IT.<br>Emergency laparotomy : Time to theatre: 98%, which is better than average.<br>**Negative Variance -** Colorectal Cancer - Median length of stay is longer than national average: 11 days for rectal resection (England: 8), and 9 days for colonic resection (England: 7).<br>Majority of inguinal hernias are done as open, which was felt to be accurate and not a coding issue. NICE guidance say that patients should be offered a choice, which does not look that this is the case.<br>Day case rate is very low for inguinal hernias.<br>Cholecystectomy within 14 days of admission for acute pancreatitis is low at around 17%; higher (around 23%) for admission for acute cholecystitis or biliary pain. This is due to low consultant numbers, and logistical issues for getting MRCP in time. |
| Emergency Medicine | **Positive Variance -** Basic GIRFT EM case IT Script Time - 3 minutes 43 seconds (Lorenzo) England rate - 4 minute.<br>Staff Turnover rate - 1.6% England rate - 19.5%.<br>**Negative Variance -** Staff sickness absence rates - 6.4%. England rate - 4.4%.<br>Friends & Family Test - Recommend the service - 84.3%. England rate - 88.3%.<br>Acute admissions admitted via A&E with a 0 length of stay - 16.0% England rate - 6.8%.<br>Admitted Patient Breach Rate (APBR) - 46%.<br>Aggregated Patient Delay (APD) - 393 hours. England rate - 401.5 hours.<br>Discharge/Admit/Transfer (DAT) 4 hour performance - 85%.<br>Discharge/Admit/Transfer (DAT) 4 hour performance - Target 95%.<br>A&E attendances per non-consultant doctor - 5,185. A&E attendances per non-consultant doctor. England rate - 3,333.<br>Acute admissions via A&E - 84.7% - ideally 66%.<br>% of patients admitted from ED - 39.5% - England rate – 30%.<br>Proportion of attendances arriving by ambulance - 0.33%- England rate - 15.29%. |
| Hospital Dentistry | **Negative Variance -** Surgical Removal of Impacted Tooth (including wisdom teeth) . The trust performed a lower number of surgical removals of impacted tooth procedures compared to non-impacted so these might be instead performed in a tier 2 setting. However, this is counter intuitive and should be checked.<br>Orthodontics for non-interdisciplinary patients. The trust recorded that 29% of patients had not had an orthodontic appliance removed which is better than the England mean but is probably inaccurate. The trust should ensure that they code the removal of an appliance.<br>52% of simple extractions are on patients aged between 10-15 and 34% are 16-18 year olds. The average age for simple extraction is recorded as 14 which is seven years older than the England average. This might be if the patient is having a surgical exposure and having a simple extraction at the same time. |
| Radiology | **Positive Variance -** There is good team working across all staff groups, with |

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| | 'Listening into action' and 'What matters to you' schemes.<br>MDT's are monitored well with a process to allow for workforce planning if the number of patients is to be increased.<br>There is good practice with patient information, on what to expect when being referred from the GP for a scan.<br>There is a low vacancy rate across both medical and non-medical staff.<br>The GMC training survey results are excellent in the top 10% nationally with 100% overall satisfaction, registrars come back to work for the Trust as Consultants.<br>The department have order comms in place for direct access.<br><br>The (PACS) team are based within the department; with a robust out of hour's process if there are any issues.<br>The waiting lists are monitored daily and reporting is fairly allocated based on expertise and availability.<br>There is good control of investigations of limited clinical value, with low numbers across all of the investigations.<br>The team are highly productive and flexible; they use expectations for the number of reports in a session actively. It is suggested that this is the reason why there are no consultant vacancies.<br>There is cohesive and dedicated Paediatric team with support from Alder Hey, there is also a dedicated paediatric waiting area.<br>**Negative Variance -** The Diagnostic Imaging Dataset (DID) data highlights that a low 14% of referrals were for admitted patient care with the national average being 26%, 31% of activity was from GP Direct Access which is much higher than the national average of 16%.<br>Consultant Direct Clinical Care (DCC) per GA bed is slightly higher than the England average of 9.33 at 11.38.<br>A lot of equipment has passed the recommended replacement time, including DEXA, CT and MRI. The CT and MRI have very high throughput, meaning there is a clinical risk if the scanner goes down.<br>The number of overall investigations per 100 admitted patients, are slightly above the national average of 259.47 at 285.74; with the numbers of MRI, U/S and fluoroscopy being in the higher 25% nationally. The number of litigation claims between 2012 and 2017 were high, with a higher than average estimated cost of £3,242,600. |
| Diabetes | **Positive Variance -** The Trust have a hospital policy/guideline for good hypo/hyper glycaemic control in place which is best practice.<br>The Trust have and do offer weekend Diabetes Inpatient Specialist Nursing service resulting in very good discharge rates at the weekend.<br>The Trust's Day case rates are very good with very low conversion and readmission rates.<br>The Trust does have an orthotist as part of the Foot Care Team, and this is gold standard for the foot care service.<br>**Negative Variance -** The Trust should consider proper planning for the Type 1 service including the pump service and new technologies such as CGM/flash glucose monitoring. They currently offer a mixed service and they do not have an established Type 1 Service.<br>A dedicated Psychologist is also required for the T1DM service and therefore should also be considered in the overview of the Type 1 diabetes service<br>The transition & young adult clinics does need a Psychologist, and the volume |

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|---|---|
| | will increase with time.<br>Although there is an established foot service in the Trust, there is need for the MDFT to have regular meetings and create a clearer pathway for the foot service.<br>The department should work with primary care, pre-op assessment and anaesthetic colleagues create a more structured peri-operative clinical pathway in line with the NCEPOD guidance.<br>The Trust needs to keep an eye on the metrics shown in NaDIA Audits when comparing data for 2010-2014 with 2015-2017 for patients with Type 1 that develop DKA during in-hospital admission as this is on the increase.<br>Insulin prescription errors have been on the increase in the last 7 years and the Trust needs to curb this as patients are at risk. |
| Paediatric General Surgery / Urology | **Negative Variance -** Non Elective Surgery - no regional policy on appendix pathway means there is a lack of consistency in antibiotic policy that will influence LOS/readmission rates.<br><br>Roll out Abdominal Pain care pathway; named paediatrician to share responsibility of care with surgeons.<br><br>All cause 30 day readmissions rates following circumcision seem high at 9%.<br><br>Stop umbilical hernia operations in children under the age of 3 years 30% of umbilical hernia operations were on Children under 3 years. |

**How progress is monitored and reported**

Regular meetings with the Specialty and GIRFT Regional Implementation Manager. Actions plans are in place for all of the above, particularly where there is negative variance and this is reported to Patient Safety and Effectiveness Sub-Committee. This is also discussed at Trust CBU Performance meetings on a quarterly basis

**Pledge: Number of Quality Improvement Projects successfully completed**

**Lead: Ursula Martin, Director of Integrated Governance & Quality and Gary Sutton, Quality Academy Manager**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

Quality Improvement has had a significant increase in profile across the Trust in the last 2 years, with improvement programmes, such as Ward Accreditation and the work aligned to the Getting to Good, Moving to Outstanding action plan. Since the establishment of the Quality Academy in June 2018, we have started applying more rigorous Quality Improvement methodology, and the following Quality Improvement work is currently ongoing.

- The Quality Academy launched the Falls Collaborative in May 2019 with the following innovation wards: A1, A4, A7, A9 and B19. There will be two further Learning Sessions held over the summer/autumn where staff will come together and share successes in tests of change, key issues and lessons learnt. All successful tests of change will be implemented Trust wide by an agreed Falls Prevention Change Package.

- In addition the Trust Pressure Ulcer Collaborative commenced in June 2019, with the following innovation wards: A1, A7, A8, A9, B3 and B19. Again Learning Sessions and tests of change being implemented, with a Pressure Ulcers Change Package being the desired outcome of this Quality Improvement work.
- Maternity services are currently involved in an Improvement Collaborative with the Innovation Agency entitled Improving Maternal and Neonatal Safety. The aim of this is to improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England. This is reported through the Trust's patient Safety & Effectiveness Sub Committee.
- The Trust is about to launch the Gram Negative Reduction Quality Improvement Collaborative, which is to support the Trust's quality priority to reduce healthcare associated Gram Negative Bloodstream Infections by 50% by March 2021. Their focus is upon three aspects: Prevention of infection, Improvement of detection of cases on admission and education.
- In collaboration with the Innovation Agency the Trust is participating in the Emergency Laparotomy Quality Improvement which aims to support Trusts with the implementation of a care bundle. The Innovation Agency has made a set of Resources, such as an ELC run-chart maker, available to demonstrate improvement and we also intend to distribute a comparative dashboard showing adherence to the ELC care bundle and patient outcome measures on a quarterly basis. Hospital teams participating in the programme can then use this data to improve quality of care and patient outcomes on an ongoing basis.
- The Trust was one of the first in the country to implement NEWS2, which was an improvement project is increase staff awareness of deterioration. This was a Trustwide improvement project, which was implemented and continues to be monitored at Quality Committee.
- Following on from Ward Accreditation, the Trust is working with Elliot Blanchard to roll out Ward Round Accreditation, to ensure that there are clear standards for medical related functions at ward level.
- Microsystems are a method to provide practitioners with ongoing support and coaching to enable improvements within a pathway or process. The Ophthalmology microsystem is the first one of its kind within the Trust and it is looking at making improvement to the Emergency Eye clinic. The Microsystem has standardised and improved the triage of patients to the clinic and also increased its capacity without the requirement of further investment from the Trust. Initially, prior to the microsystem the CBU were preparing a business case for two extra Consultants to meet the clinic's demand.

The Trust is currently reviewing its Quality Improvement capacity within the Trust and delivering a training programme Trustwide. This is a key component of the Trust's Moving to Outstanding agenda and, whilst it is recognized that progress has been significant, there is further embedding of this culture and skillset within the Trust required.

**How progress is monitored and reported**

Progress is monitored via a programme of ward walkarounds offering support and guidance alongside measuring progress. Quality Academy Board which meets on a quarterly basis and reports to Trust Quality Assurance Committee.

**Pledge: Increase number of staff with quality improvement training via Quality Academy**

**Lead: Mark Halliwell, Associate Medical Director for Clinical Effectiveness and Gary Sutton, Quality Academy Manager**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

Ongoing training programme established within the Trust with the following compliance

| Training Level | Numbers trained **From Jan 19 – to date** | Delivery Mechanism |
|---|---|---|
| QI Foundation | **1,450 staff trained to date** | These numbers relate to new staff to the Trust who have received Foundation QI during Trust Induction. They also include staff have received training via a number of drop in sessions within Women's & Child Health CBU, Preceptorship training sessions, Dietician & SALT training session, Governance & Quality Academy training session, Infection Control training session, Ophthalmology staff, drop in sessions, Junior Doctors – ad hoc, AHPs – ad hoc, Lead Nurses. These sessions have been provided to support staff that have started to work on or are about to embark on a number of improvement initiatives within their CBU's/roles. |
| QI Practitioner | **30 staff trained to date** | These staff have been trained to QI Practitioner level via a "Clinical Microsystem", which is a specific QI project within a team/department or Specialty . This project was within Ophthalmology and looked at their WEEP clinic. Staff received formal teaching on The Model for Improvement, Lean Methodology, RCA, process mapping, Microsystems coaching, PDSA Cycles, Measurement, Reliability Science and Human Factors, Failure Modes & Effects analysis. |

**How progress is monitored and reported**

Quality Academy Board which meets on a quarterly basis and reports to Quality Assurance Committee.

**Patient Experience Priorities**

**Pledge: Increase in Friends and Family Test scores to ensure all specialties meet or exceed national benchmarks**

**Lead: Trish Richardson, Head of Patient Experience**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

- There are no "national benchmarks" for the FFT but we have set internal set ones for UEC and Inpatients/day cases.
- Current FFT data cannot be split by specialty and the denominator varies between Trusts.
- Volunteers gather the returns and we can target specific areas.
- Patient Experience Strategy will be reviewed in July 2019 and this will look to develop how we monitor FFT scores.
- The Trust has in place an FFT contract in order to improve the process and increase the response rate e.g. text services.
- The ratings are published on both NHS Choices and in the Open and Honest publication which is published on the NHS England Trust websites.

**Friends and Family scores 2017/2018 and 2018/2019**

| | Inpatient 2017/18 | Inpatient 2018/19 | A&E 2017/18 | A&E 2018/19 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Apr | 97% | 94% | 97% | 85% |
| May | 97% | 94% | 93% | 86% |
| Jun | 97% | 95% | 97% | 83% |
| Jul | 95% | 95% | 85% | 84% |
| Aug | 95% | 97% | 86% | 86% |
| Sept | 94% | 96% | 84% | 81% |
| Oct | 95% | 94% | 79% | 81% |
| Nov | 94% | 94% | 82% | 78% |
| Dec | 95% | 96% | 82% | 81% |
| Jan | 90% | 94% | 85% | 76% |
| Feb | 95% | 94% | 82% | 77% |
| Mar | 94% | 96% | 81% | 80% |

**How progress is monitored and reported**

Trust Integrated Performance Report, Patient Experience Committee reporting into Quality Committee

**Pledge: Improve across all indicators in the inpatients survey**

**Lead: John Goodenough, Deputy Chief Nurse**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

- The annual National Inpatient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC, who use the information as part of the Hospital Intelligent Monitoring.
- The 2018 Inpatient survey was undertaken by Quality Health, on behalf of the Trust and covers all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal Medicine, Stroke and Respiratory Medicine.
- 1250 patients were randomly selected during an inpatient stay in July 2018 and 41% responded compared to a response rate of 35% last year.
- The NHS in patient survey provides the Trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.
- Areas of focus for improvement have been recommended as the hospital ward, where the highest concentrations of the scores in the bottom 20% were found. The Ward Accreditation Scheme within the Trust will help to improve this rating as the aim is to engage staff and empower leadership to ensure we deliver the highest standards of healthcare for our patients.
- The Trust have taken the following actions in response to the personal needs of our patients;
    - #EndPJParalysis
    - Morning Movers
    - Always Events Pilot
    - Bedside Booklet
    - Reducing noise at night through their "*Have a good night*" scheme.
    - Developed an alert system for patients living with a Learning Disability/Dementia accessing outpatient services to ensure we are providing adequate support at appointments.

- Customer Care Strategy.
- Finger foods for patients living with dementia are now provided by our catering services.
- Maternity acupuncture has been offered at Warrington for the last 3 years. The Clinic runs every Saturday in the Antenatal Clinic (ANC).

**How progress is monitored and reported**

Patient Experience Committee reporting into Quality Committee

**Pledge: 10% reduction in formal complaints**

**Lead: Ursula Martin, Director of Integrated Governance & Quality and Joanne O'Neill-Brown, Head of Complaints, PALS and Claims**

***Assurance Level: Moderate***

**Implementation Plan and progress to date:**

The Trust has agreed this as a Quality Account Priority for 2019/20.

A Quality Improvement scoping exercise has been undertaken within the Complaints team to review bottle necks in the process.

A CBU focus group is being held in July 2019, along with structured interviews with complainants. This will enable the Trust to review issues from all aspects of complaints handling to ensure any amendments to the process can be made.

The Trust has agreed a trajectory for improvement and will be targeting those CBUs/specialties where timeliness has been an issue.

In 2018/19 the Trust improved the timeliness of complaints from 26.7% in Q1 2017/18 to 52% in Q4 2018/19 when the Trust implemented the Complaints Handling improvement plan.

Work will be undertaken now to build on this improvement to reach at least 90% of complaints being responded to within timeframes.

**How progress will be monitored and reported**

Trust Integrated Performance Report, Complaints Quality Assurance Group reporting into Quality Assurance Committee.

### 2.3 Moving from Good to Outstanding

We will continue to use our existing quality domains as measures of quality; Patient Safety, Clinical Effectiveness and Patient Experience.

The quality domains have been in use since the publication of Lord Darzi's report, *High Quality Care For All* in 2008 and they underpin not only the Quality Strategy, but many other strategies across the Trust.

We have made significant progress in relation to Quality and the implementation of the Quality Strategy as demonstrated within this report but it is now time to pause and to focus on the move from Good to Outstanding.

A review of the current Quality Strategy is needed to ensure that our priorities and pledges are still appropriate and to look to see if we are measuring quality in line with the CQCs Key Lines of Enquiry (KLOEs). The KLOEs are the subsets of the 'five key questions' that the CQC asks of every health and social care organisation that they inspect. These key questions are:


The Trust maintains its commitment to delivering high quality services by monitoring effectiveness and studying outcomes. We will continue to be open and transparent, publishing progress against our quality priorities at public Board meetings and multiple staff forums. We are in the process of further refining the monthly Quality dashboard so that it aligns the Trust's performance and the Trust Quality priorities.

Moving forwards, we want to improve the way we present and share data by using more sophisticated data analysis methods including statistical control charts. By improving the ways we display data it will make it easier for staff, from the ward to the Board, to understand where we are making improvements and where we need to increase our efforts. Continual measurement will also help us ensure that any improvements we do see are sustainable in the long term.

External benchmarking, such as the CQC's monthly Insight reports will also play an important role in the way we measure the quality of our care. Our aim is to get to 'Outstanding' provider and benchmarking like the Insight report will assist us in monitoring our performance and detecting any deterioration that needs to be addressed.

We will also continue to produce an annual Quality Account which will be our way of demonstrating to the public the progress we have made against our quality priorities each year and what we plan to improve in the succeeding year.

## 3. CONCLUSION

The Quality Strategy was developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be.

As demonstrated in this report, we have made progress across the board in relation to the Quality Pledges that were formed in early 2018. However, the Trust has made significant progress in relation to Quality within the organisation and now that the focus is to move to Outstanding, we feel that this is the time to revisit the Quality Strategy to align it to our refined priorities.

To summarise we make the following recommendations and assurance statement;

| |
|---|
| Assurance Statement: The Trust are advised that there is Moderate Assurance in relation to the work conducted to date in relation to implementation of the Trust Quality Strategy. The Trust is in the second year of implementing the Trust Quality Strategy and this represents good progress. Implementation of the Quality Strategy was a key component of the Trust's 'Getting to Good' programme and as we 'Move to Outstanding', review and embedding the Quality Strategy is a key enabler. |

- Recommend that the Trust review progress to date regarding implementation of the Trust Quality Strategy.
- The Quality Strategy needs to be reviewed and realigned to the Trust's revised priorities to help us move forwards on our journey to Outstanding.

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## Council of Governors

| | |
|---|---|
| **AGENDA REFERENCE:** | **COG/19/08/50** |
| **SUBJECT:** | **Annual Complaints Report** |
| **DATE OF MEETING:** | 13 August 2019 |
| **ACTION REQUIRED** | **Receive for information** |
| **AUTHOR(S):** | Ursula Martin, Director of Integrated Governance and Quality. Joanne O'Neill-Brown, Head of Complaints, Claims and PALS |
| **EXECUTIVE SPONSOR** | Kimberley Salmon-Jamieson, Chief Nurse |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | All |
| | Choose an item. |
| | Choose an item. |
| **EXECUTIVE SUMMARY** | The Trust has a statutory requirement to produce an annual complaints report. This is reviewed by the Trust External Auditors as part of the Trust's Quality Account audit, and this annual report was reviewed and found to be in keeping with the requirements for the Trust.<br><br>This report was also received by the Trust Quality Assurance Committee at May 2019's meeting, where the following was discussed. This report is also being discussed at the Trust Board of Directors in July 2019, as this is a statutory requirement.<br><br>The Trust has continued with the improvement plan to increase the timeliness of responding to concerns. As a result the overall performance for Complaints and PALS received 2018/19 has improved. This will continue to be a priority for the year 2019/20 and it is a quality priority that we increase timeliness so that at least 90% of our complaints are responded to within the timeframes that we stipulate in our Complaints Handling policy.<br>• 455 complaints were received during the reporting period, a decrease of 1 from 2017/18.<br>• 441 complaints were closed during the reporting period of which 97 were Upheld, 178 were Partially Upheld, and 129 were Not Upheld.<br>• 8 complaints were found on review to be Serious Incidents –which is a decrease from the previous year (15). There was a discussion at Quality Assurance Committee regarding that this was an indication of our Serious Incident and Learning from Deaths protocols being more embedded. |

| | |
|---|---|
| | • 67 complaints were open at the time of reporting, with 29 in backlog i.e. breached timeframes against Trust policy<br>• 4 PHSO cases are currently being investigated; and<br>• 1195 PALS cases have been received.<br>These figures are correct on the date of reporting 30/4/19.<br><br>Assurance around the complaints process is continuously sought via the monthly Complaints Quality Assurance Group, which is chaired by the Trust Chairman, and scrutiny at Quality Assurance Group. Executive scrutiny is also in place on a weekly basis by the Chief Nurse and Director of Integrated Governance & Quality. |
| | Assurance Statement – The Trust has continued to implement the improvement plan developed in 2017 to ensure complaints handling was in line with best practice. In the Trust's latest CQC inspection informal feedback from the inspectors was that they could see the vast improvements (at the point of writing this report, the Trust awaits formal feedback). We will continue with the improvement plan, focusing on timeliness of responses, as well as quality, for all of our patients and public who raise formal or informal concerns, as well as embedding of lessons learned from the valuable feedback that PALS and complaints offer us. |

| | | | | |
|---|---|---|---|---|
| **PURPOSE**: *(please select as appropriate* | Information | Approval | To note √ | Decision |
| **RECOMMENDATIONS** | | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committee** Quality Assurance Committee | | | |
| | **Agenda Ref.** | | QAC/19/05/88 Complaints Annual Report | |
| | **Date of meeting** | | 7th May 2019 | |
| | **Summary of Outcome** | | Received and approved as an accurate record | |
| **NEXT STEPS:** *State whether this report needs to be referred to at another meeting or requires additional monitoring* | **None** | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED: (if relevant)** | None | | | |

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| SUBJECT | Annual Complaints Report | AGENDA REF | COG/19/07/50 |
|---|---|---|---|

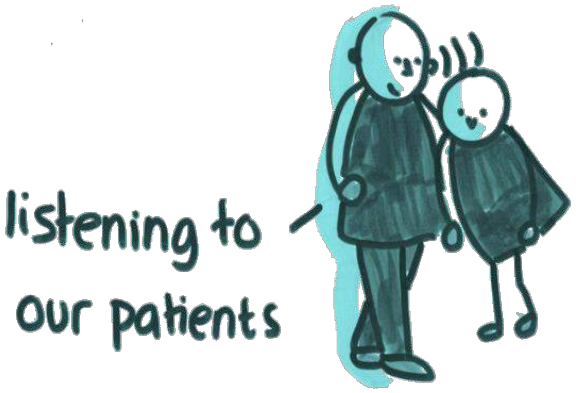
## 1. BACKGROUND/CONTEXT

The purpose of the annual complaints report is to satisfy the requirements of the NHS complaints procedure in England, effective from 1 April 2009, and to analyse and identify trends in the occurrence of complaints. The report is prepared annually, and analyses the activity relating to 'formal' complaints data received in the period covering the past financial year.

Warrington and Halton Hospitals NHS Foundation Trust is committed to providing high standards of patient centred care. The Trust encourages a culture that seeks and then uses peoples' experience of care to improve quality and welcomes feedback from the people who use our services.

The Trust recognises that there are times when its actions do not meet the expectations of those that use our services. When that happens, the Trust has a policy which sets out the procedure to make sure that we listen and respond to complaints and concerns from patients, their relatives and carers and that complaints are properly investigated and monitored.

The Trust understands that by listening to people about their experiences of our services, staff can learn new ways to improve, and prevent the same issues from happening in the future. By seeking, monitoring and acting upon feedback, we are able to make improvements in areas that patients, their relatives and carers say matter most to them.




Effective complaints handling is a cornerstone of the patient experience and the Trust aims at all times to provide local resolutions to complaints and takes all complaints seriously. By listening and responding to complaints we aim to remedy the situation as quickly as possible and ensure that the individual is satisfied with the response they receive. The learning from complaints is used to improve services for the people who use them as well as for the staff working in them.

In accordance with the NHS complaints procedure, the annual complaints report is made available to the public. It is publishable as part of the Freedom of Information Act publication scheme.

The following key principles must be applied:

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties;
- High standards of conduct are expected from all staff at all times to ensure that service users/representatives will be treated respectfully, courteously and sympathetically;
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise);
- All patients and their families will be advised how they can raise a concern or make a formal complaint via information leaflets available on all wards and clinical service units and the internet;
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint;
- As far as possible, people who make complaints will be involved in decisions about how their complaints are handled and considered;
- The Trust will aim to resolve complaints within the Trust as part of local resolution (first stage of the national complaints procedure), wherever possible;
- Complainants receive a meaningful apology when appropriate;
- The Trust will identify appropriate learning and implement change as the result of a complaint where appropriate;
- The Trust will co-operate with other organisations when a complaint involves other outside organisations;
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint.

## 2. KEY ELEMENTS

Following a review undertaken in April 2017 into the complaints function at the Trust, the Trust invested significantly in an improvement plan to ensure:

- The backlog of complaints in the Trust was reduced,
- The timeliness of responses to complainants improved,
- A new policy and a new process was developed on how the Trust deals with complaints, to ensure it was more person centred,
- Training was provided to staff to ensure they were trained on the Trust's new complainants policies and processes and on good complaints handling,
- A Quality Assurance Group led by the Trust Chairman was developed to review the quality of our complaints responses and to promote accountability of leading the complaints agenda at senior management level within the clinical services,

- An improvement in how the Trust responds to PALS concerns,
- To reduce the number of dissatisfied complainants and PHSO referrals,
- Improve the system (Datix) used to log complaints, to make it more accessible and create an environment of visible data, and
- Improve the lesson learning from complaints and compliance of actions arising through audits.

This plan was implemented and successes in 2018/19 have included:

- The significant backlog of complaints, particularly those complaints that were over six months old, being cleared;
- The timeliness of complaints has improved from 26.7% in Q1 2017/18 to 52% in Q4 2018/19 when the Trust implemented the improvement plan. However, the Trust has now set a target, as part of the Trust's Quality Account priorities in 2019/20 to significantly improve the timeliness of complaints response and meet the Trust target of 90%;
- The Trust Quality Assurance Group has continued to meet since being established in July 2017. Led by the Trust Chairman, the Complaints Quality Assurance Group has now had all Clinical Business Unit (CBU) leads come to present a complaint and discuss their processes for complaints handling and learning;
- The Trust renovated the PALS offices in 2018/19, to ensure the environment to support patients and the public was more appropriate;
- Timeliness of responsiveness to PALS concerns has improved to 4 days in March 2018/19, compared to 12 days in March 2018.
- The Trust has further invested in the Datix system in 2018/19 and complaints/PALS data is now available in the governance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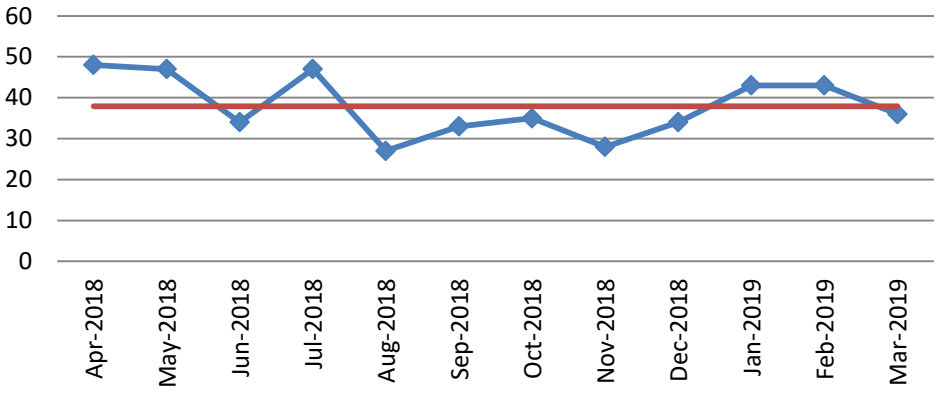
### 2.1 Complaints received

The Trust uses complaints to listen, learn and improve our services from the feedback given by the service users.
455 complaints were received during the reporting period, a decrease of 1 from 2017/2018 (456). The graph below details the amount of complaints opened over time:

**Complaints by First received (Month and Year)**




| | Apr-2018 | May-2018 | Jun-2018 | Jul-2018 | Aug-2018 | Sep-2018 | Oct-2018 | Nov-2018 | Dec-2018 | Jan-2019 | Feb-2019 | Mar-2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Data | 48 | 47 | 34 | 47 | 27 | 33 | 35 | 28 | 34 | 43 | 43 | 36 |
| Average | 38 | 38 | 38 | 38 | 38 | 38 | 38 | 38 | 38 | 38 | 38 | 38 |

### 2.2 Complaint themes

Formal complaints can be received for a variety of reasons. The following tables shows the primary subjects of complaints opened during this reporting period:

| Theme | No. |
|---|---|
| Clinical treatment | 214 |
| Attitude and behaviour | 66 |
| Communication (oral) | 53 |
| Admissions / transfers / discharge procedure | 25 |
| Premises | 16 |
| Personal records | 14 |
| Communication (written) | 13 |
| Date for appointment | 13 |
| Patient privacy / dignity | 7 |
| Patient property / expenses | 7 |
| Test results | 6 |
| Outpatient and other clinics | 6 |
| Date of admission / attendance | 4 |
| Failure to follow agreed procedures | 4 |
| Competence | 2 |
| Bed shortages | 2 |
| Shortage / availability | 1 |

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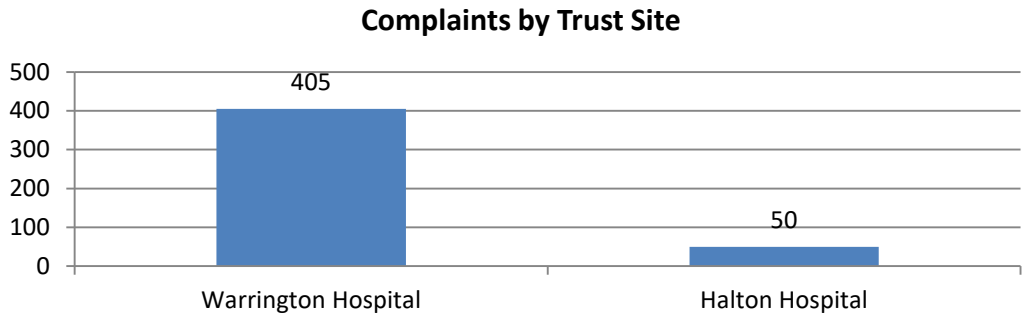
| Theme | No. |
|---|---|
| Catering | 1 |
| Consent to treatment | 1 |
| **Totals:** | **455** |

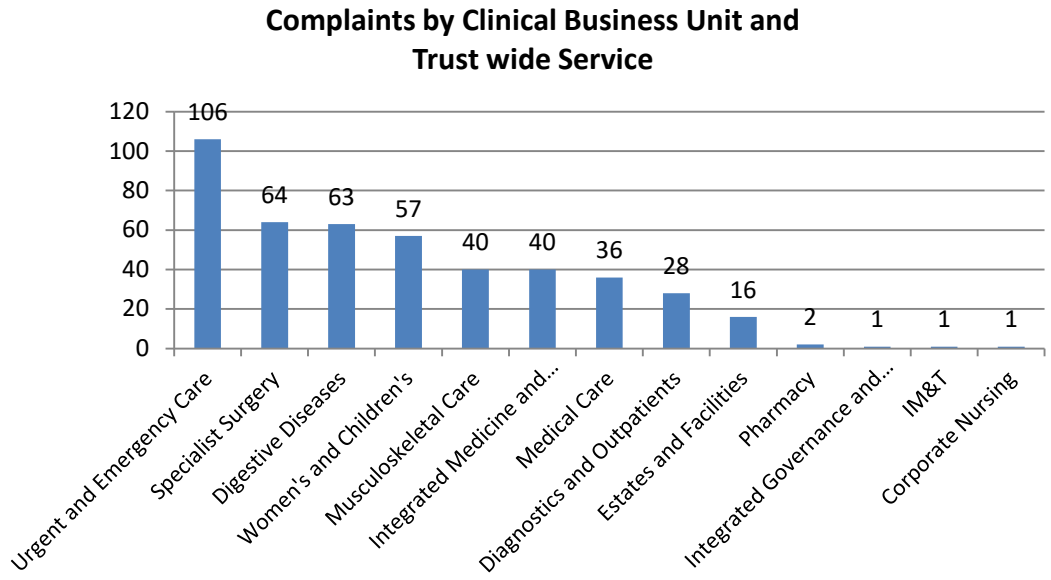
The most common cause for people to complain was that elements of their clinical treatment did not meet their expectations.

### 2.1 Complaints received by Locations/Service

The graph below details which Site complaints have been attributed to:




The following graph details the 455 complaints received by the Trust in the reporting period by Clinical Business Unit and Trust wide service:




Urgent and Emergency Care received the most complaints followed by Specialist Surgery. This is in line with the pressures seen national in the Urgent and Emergency Care Sector. The rise in Specialist Surgery complaints is due to a vacant post within the Trust which led to delays in providing Urology services including stent removals, which resulted in concerns from patients.

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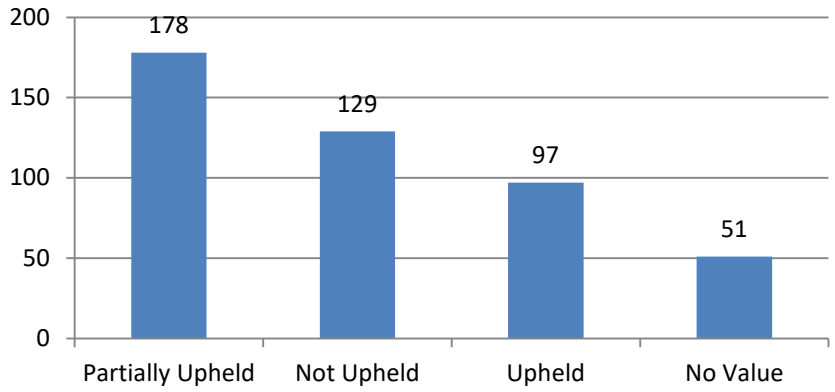
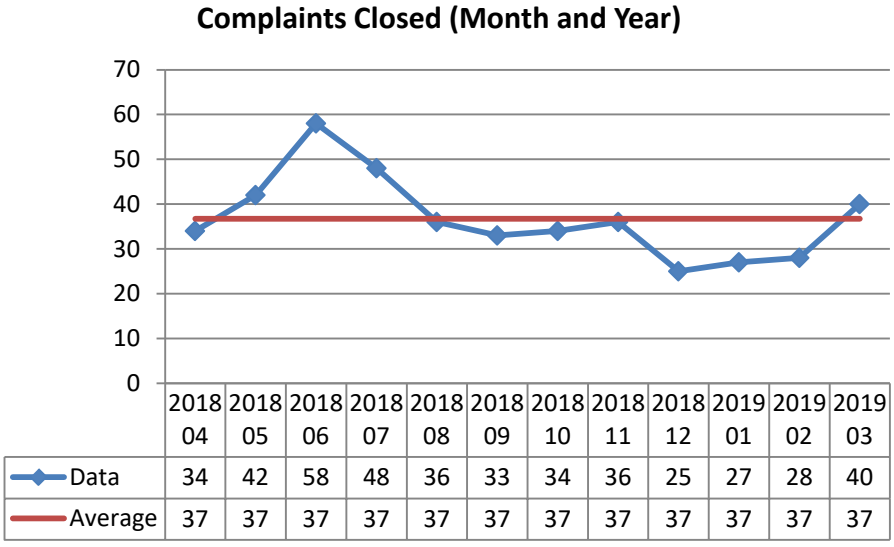
### 2.4 Complaints upheld

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". Those not yet concluded or those to which we have not yet received consent at the time of writing this report, are categorised as "No value". The graph below show the outcome of closed complaint during the reporting period:

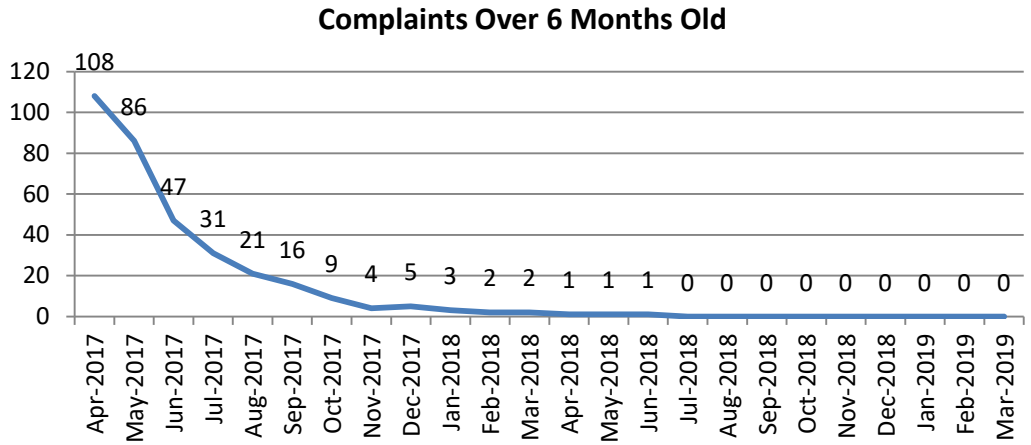



### 2.5 Complaints Resolved

In the reporting period the Trust closed 441 complaints. The graph below shows the closed complaints over time and a graph to show the significant reduction in the number of complaints open over 6 months:




| | 2018 04 | 2018 05 | 2018 06 | 2018 07 | 2018 08 | 2018 09 | 2018 10 | 2018 11 | 2018 12 | 2019 01 | 2019 02 | 2019 03 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Data | 34 | 42 | 58 | 48 | 36 | 33 | 34 | 36 | 25 | 27 | 28 | 40 |
| Average | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 |




In order to improve the experience of complainants, one of the major initiatives within the Complaints and PALS team has been to improve the timeliness of responses. The following table shows the timeliness of responding to complaints by each CBU in each quarter over the reporting period:

| CBU | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| **Medical Care** | 14% | 64% | 45% | 44% |
| **Digestive Diseases** | 63% | 53% | 50% | 67% |
| **Diagnostics** | 100% | 0% | | 100% |
| **Urgent and Emergency Care** | 60% | 70% | 53% | 45% |
| **Estates and Facilities** | 83% | 100% | 100% | 100% |
| **Integrated Governance and Quality** | | 100% | | |
| **IM&T** | | | | 100% |
| **Musculoskeletal Care** | 60% | 93% | 60% | 38% |
| **Diagnostics and Outpatients** | 100% | 100% | 88% | 67% |
| **Pharmacy** | | | | 0% |
| **Integrated Medicine and Community** | 14% | 27% | 44% | 56% |
| **Specialist Surgery** | 62% | 80% | 56% | 68% |
| **Women and Children's** | 50% | 75% | 75% | 27% |

There has been a consistent improvement in relation to Integrated Medicine and both Digestive Diseases and Specialist Surgery have started to see and an increase in timeliness during quarter four.

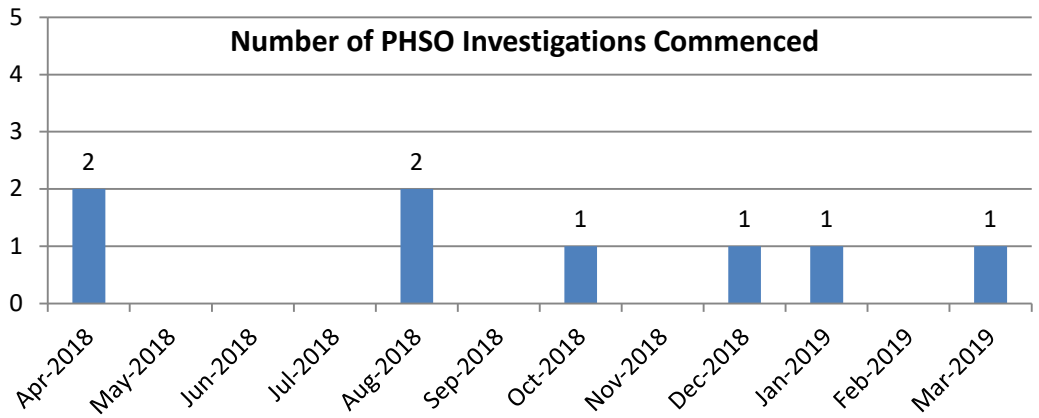
### 2.6 Referrals to Parliamentary Health Service Ombudsman

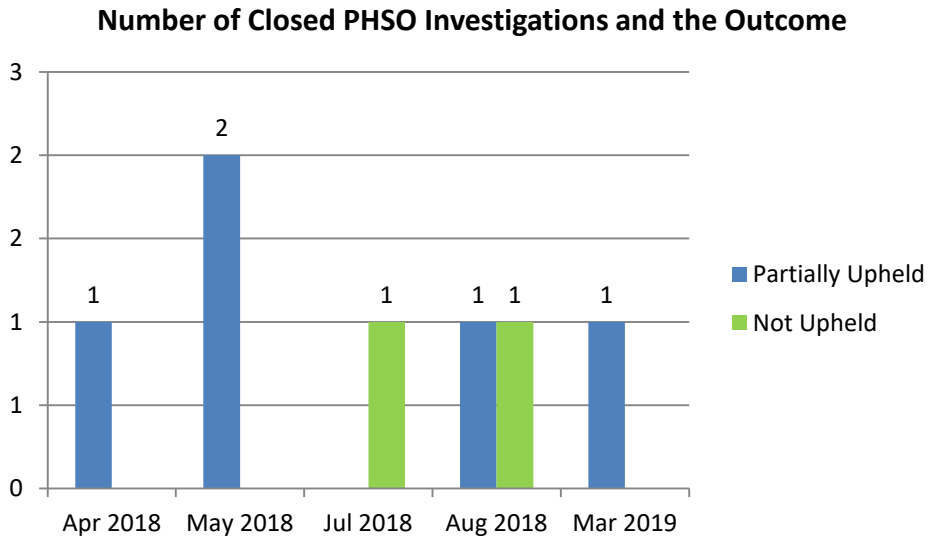
Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

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.

The following graph shows the amount of investigations the PHSO has commenced at the Trust over the period:

The graph below shows the PHSO grading and outcome following their final report over the period:



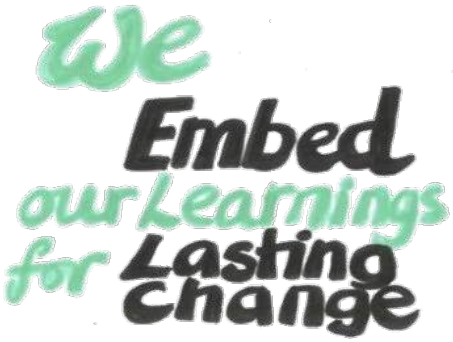



The PHSO has upheld four of the cases closed during this reporting period. Where cases were partially upheld the Trust acknowledged any failings identified and put in place actions to ensure improvements were completed as a result of the findings.

**2.7 Learning from Complaints**

It is paramount that the Trust continues to learn from complaints and that this is reflected in service improvements. Detailed below are some examples of how learning from complaints has led to changes:

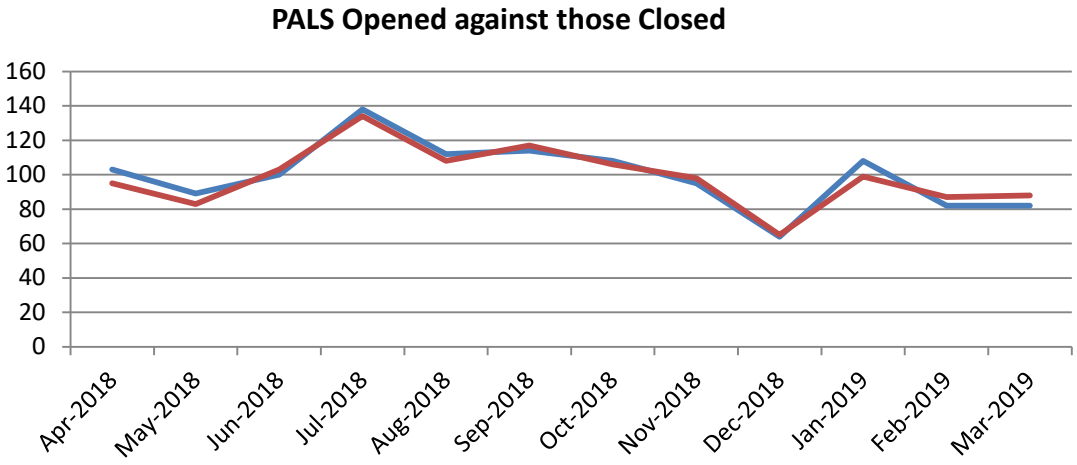
- Dementia awareness – The Emergency Department converted two cubicles in the majors area to make them "dementia friendly". The cubicles are located in a quieter area of the department and have been decorated in pastel colours and have a large clock that is recognised as being beneficial to dementia patients. The team also created a space within the Clinical Decisions Unit.
- Improved communication – The Ophthalmology Department are trialling the use of Volunteers at the Nurses Hub, to help communicate waiting times and respond to general enquiries from patients. Volunteers are there every Tuesday and Wednesday, and if successful, the plan would be to roll this out, and recruit more volunteers throughout the week.
- Listening to concerns – Medical Care implement a 'Matron Listening Surgery'. This is a new initiative which is designed to ensure that patients, visitors and staff can raise or share concerns for immediate discussion and investigation. Posters are displayed within each bay of the wards to promote this.
- Breastfeeding support – The Women and Children Department have introduced a lead focus group to provide breastfeeding support and advice to new mothers.



## 2.8 Patient Advice & Liaison Service (PALS)

In the reporting period, PALS received 1195 enquires, which is a decrease from 2017/18 (PALS received a total of 1397 enquiries). The decrease in PALS activity can be due to staff proactively responding to concerns at source on the wards and in clinical areas and resolving concerns without the need for any additional support or advice.

The graph below shows the PALS cases that have been opened against those that have been closed over the year:




| | Apr-2018 | May-2018 | Jun-2018 | Jul-2018 | Aug-2018 | Sep-2018 | Oct-2018 | Nov-2018 | Dec-2018 | Jan-2019 | Feb-2019 | Mar-2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Open | 103 | 89 | 100 | 138 | 112 | 114 | 108 | 95 | 64 | 108 | 82 | 82 |
| Closed | 95 | 83 | 103 | 134 | 108 | 117 | 106 | 98 | 65 | 99 | 87 | 88 |

The top 5 themes during this period were:

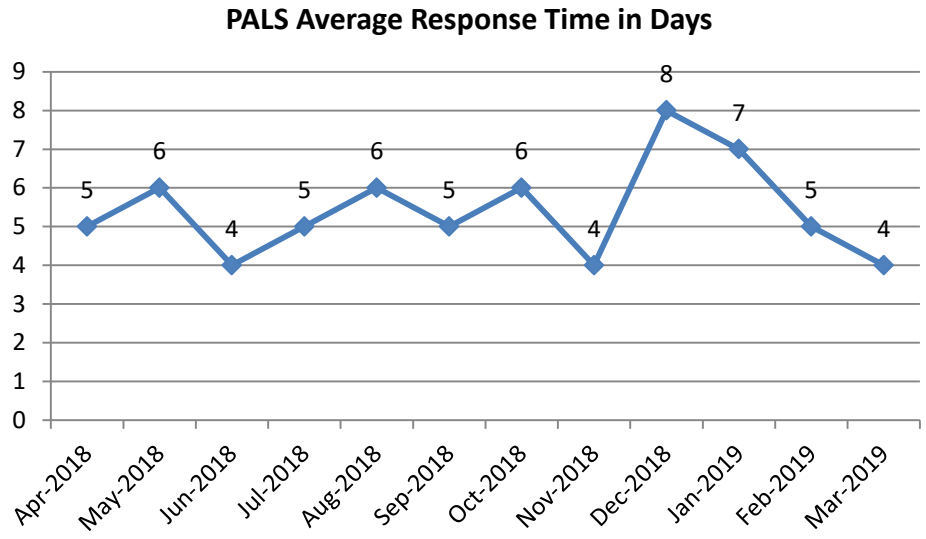
| | |
|---|---|
| **Clinical treatment** | 220 |
| **Date for appointment** | 217 |
| **Communication (written)** | 187 |
| **Communication (oral)** | 169 |
| **Premises** | 72 |

The top 5 reporting Departments were:

| | |
|---|---|
| **Specialist Surgery** | 195 |
| **Musculoskeletal Care** | 168 |
| **Urgent and Emergency Care** | 156 |
| **Digestive Diseases** | 155 |
| **Medical Care** | 133 |

The most common area for PALS concerns is Specialist Surgery which reflects the themes identified with complaints that is a result of the delays and cancellations of appointments within the Urology Service.

During the reporting period a total of 1195 PALS were opened and closed. The graph below shows the average response time in days per month of this opened and closed within the period:




The Trust will continue to ensure that the PALS team aim to resolve as many concerns as possible in a timely way, without the need for service users to make formal complaints if they would not choose to, therefore improving their experience.

## 3. CONCLUSION

The Trust implemented an improvement plan in April 2017 that has seen responsiveness improve from 26.7% in Q1 2017.18 to 52% in Q4 2018/19. During the next financial year, the Trust will continue to improve timeliness by implementing specific actions within CBUs. Improvement plans will be developed in conjunction with the Head of Complaints, Claims and PALS that will identify specific targeted actions where performance is below 90% that will be monitored through the Quality Assurance Group. Consideration should be given to each CBU presenting progress against their improvement plans as part of the rolling programme for the Quality Assurance Group.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

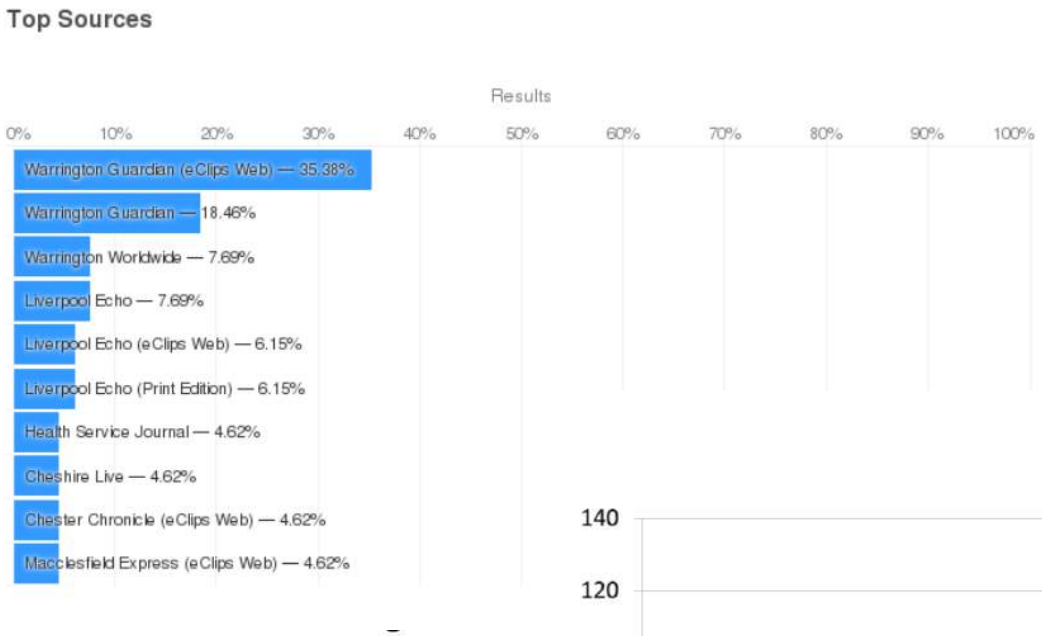
## Council of Governors

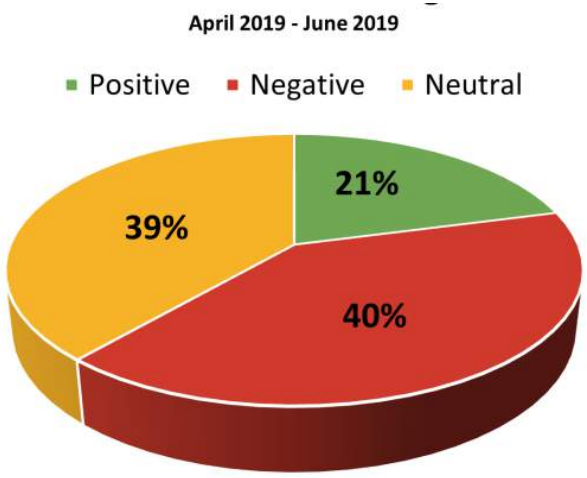
| | |
|---|---|
| **AGENDA REFERENCE:** | **COG/19/08/51** |
| **SUBJECT:** | **Trust Engagement Dashboard Q1 2019** |
| **DATE OF MEETING:** | 13 August 2019 |
| **ACTION REQUIRED** | **For Assurance** |
| **AUTHOR(S):** | Pat McLaren, Director Community Engagement |
| **EXECUTIVE SPONSOR** | Pat McLaren, Director of Community Engagement + Fundraising |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | All |
| **EXECUTIVE SUMMARY** | The Trust has launched its first patient and public participation and involvement strategy for 2019-21, a measure of the success of the deployment of this strategy is the attached Engagement Dashboard.<br><br>The Dashboard addresses:<br>- Level of success in managing the Trust's reputation in the media and across digital and social platforms<br>- Our engagement with patients, staff and public via our social media<br>- The Trust's website and levels engagement with this key platform<br>- Patient enquiries via our website<br>- Patient feedback on the independent platforms<br>- Engagement with the Trust through the Freedom of Information process.<br><br>In Quarter One our presence in the media was largely negative due to an unusual number of issues including:<br><br>• CQC focused inspection report of the Emergency Department<br>• The recalculation (unaudited) of NHS Digital's mortality data by Prof Brian Jarman claiming WHH is one of 33 Trusts with higher than normal mortality rates<br>• The Listeria outbreak in NHS hospitals (WHH NOT affected but named as one Trust receiving sandwiches from that supplier)<br>• The significant mis-reporting on the Trust's My Choice programme.<br><br>This negativity was not reflected in our social media presence, with Twitter followers continuing to climb steadily and now topping 10.8K. We also reached an average of 9k individuals on Facebook each month in Q1 with around 50% of all posts liked and shared. |

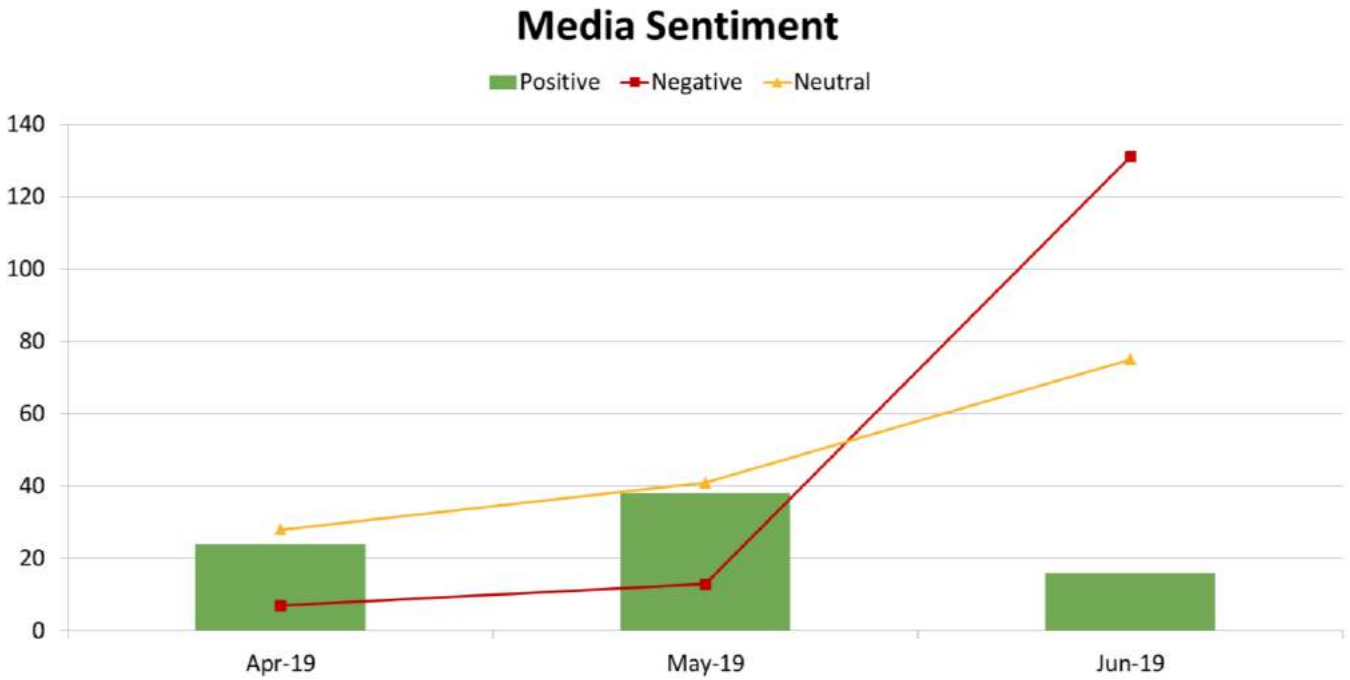
| | | | | |
|---|---|---|---|---|
| | On our website we doubled the amount of visitors in June – largely around the My Choice issue, with circa 50 K visitors in June alone. Most visitors continued to access the website by mobile phone with session duration slightly down to 1.19mins.<br><br>We received, and dealt with 666 patient enquiries through our website across a wide variety of topics, this is a significant increase on the same period last year where we received 506 enquiries. We use these topics to continue to refine our website content ensuring that patients have easy access to most of the information they seek.<br><br>Our patients continued to rate our care highly across a range of platforms including NHS Choices, I Want Great Care and Care Opinion. NHS Choices continues to be the 'Tripadvisor' of healthcare and where we maintain 4* rating for Warrington and 5* each for Halton and CMTC.<br><br>Finally, we are reporting on Freedom of Information activity for the first time as this is yet another engagement with patients/public and other stakeholders. The Communications Team normally handles circa 50 enquiries per month but there was a surge in May accounted for by potential supplier enquiries. | | | |
| **PURPOSE**: *(please select as appropriate* | Information<br>X | Approval | To note<br>X | Decision |
| **RECOMMENDATIONS** | That the Council of Governors receive the dashboard for assurance relating to the deployment of the PPP&I strategy. | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committee**<br>Choose an item. | Governors Engagement Group | | |
| | **Agenda Ref.** | GEG/19/08/ | | |
| | **Date of meeting** | 07/08/2019 | | |
| | **Summary of Outcome** | Present to CoG quarterly | | |
| **NEXT STEPS:**<br>***State whether this report needs to be referred to at another meeting or requires additional monitoring*** | **Submit to Trust Board** | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED: (if relevant)** | None | | | |

# Media Sentiment:
## April 2019 – June 2019

Warrington and Halton Hospitals NHS Foundation Trust



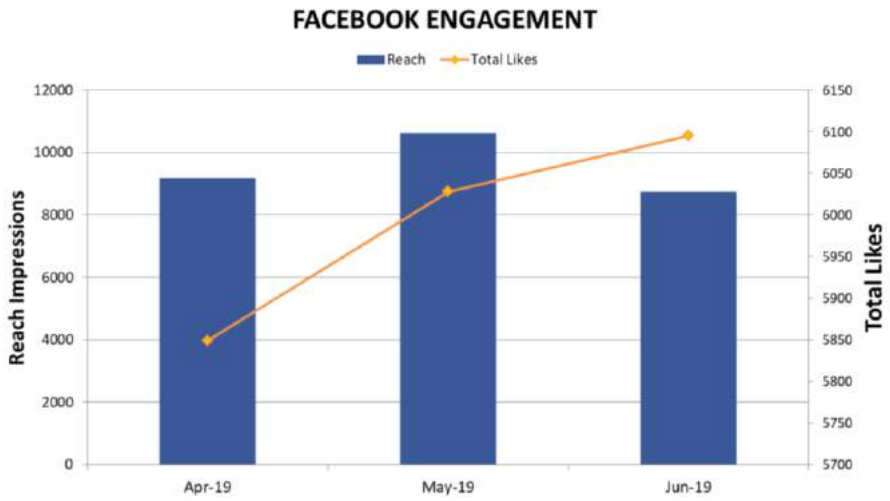
# Social Media:

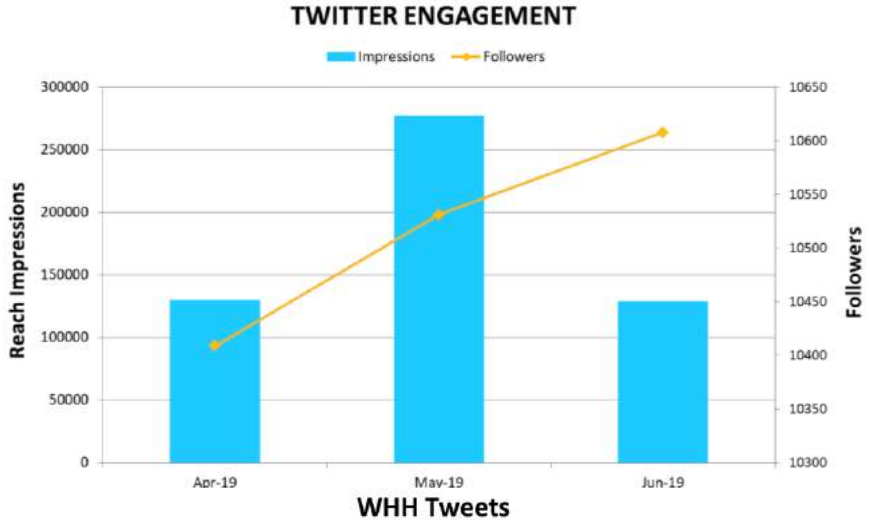

April 2019 – June 2019

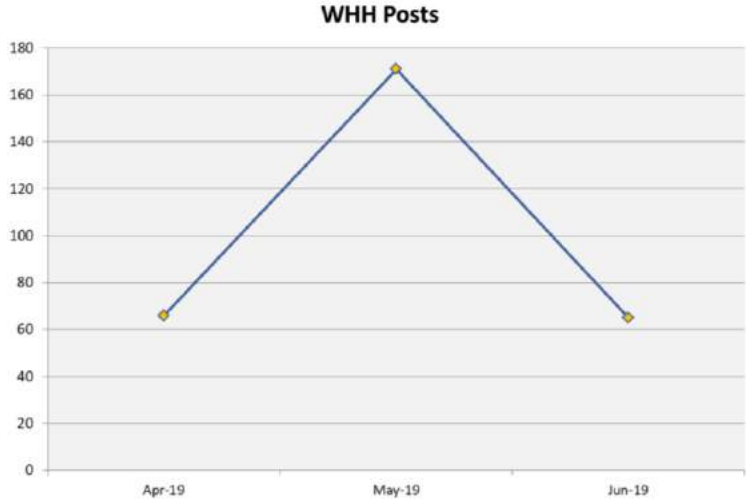
NHS
Warrington and Halton Hospitals
NHS Foundation Trust

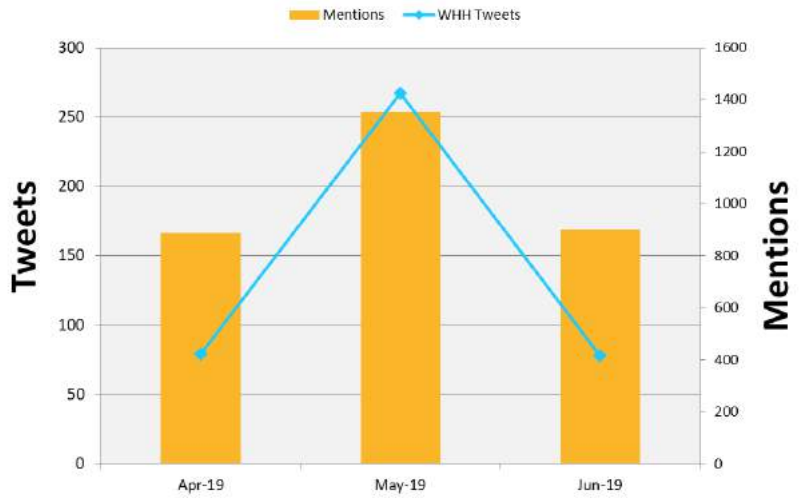
facebook

twitter



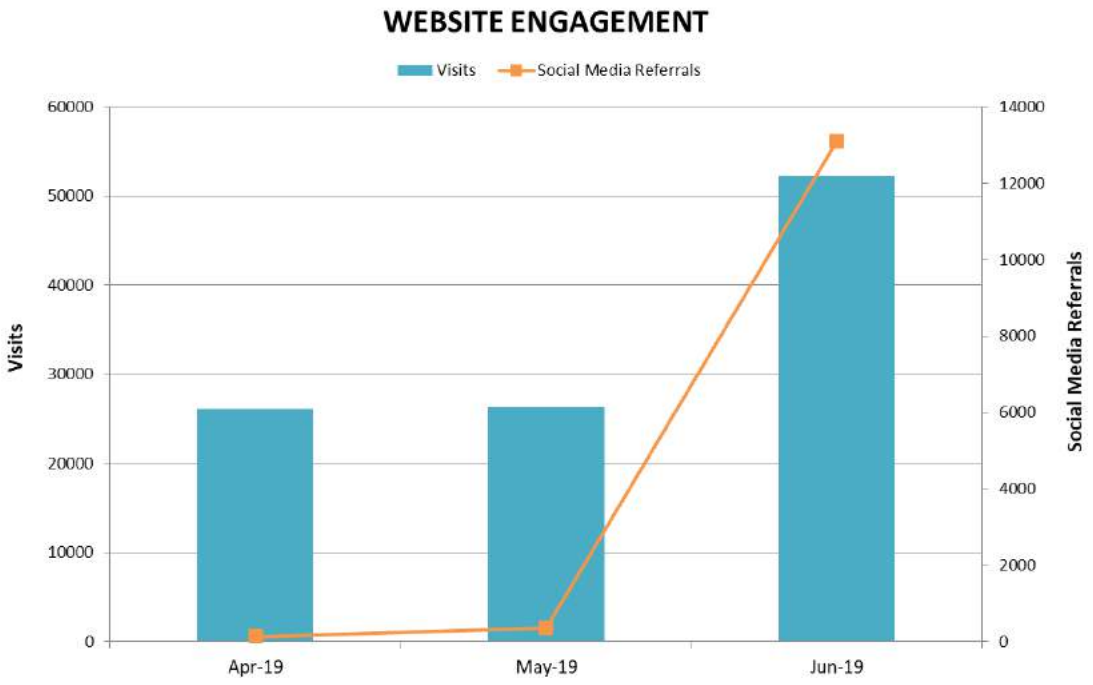



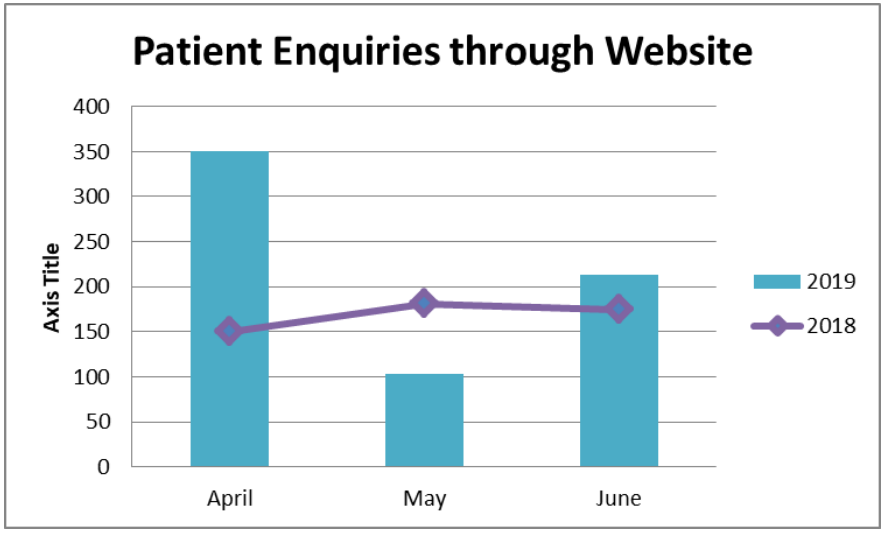



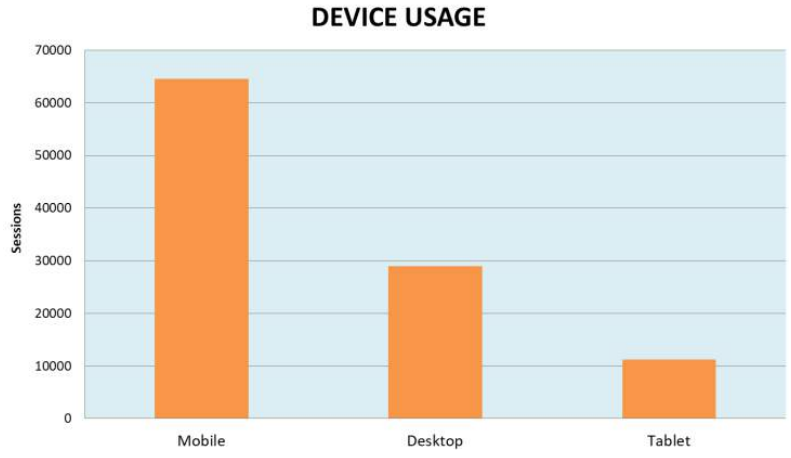
# WHH Website:

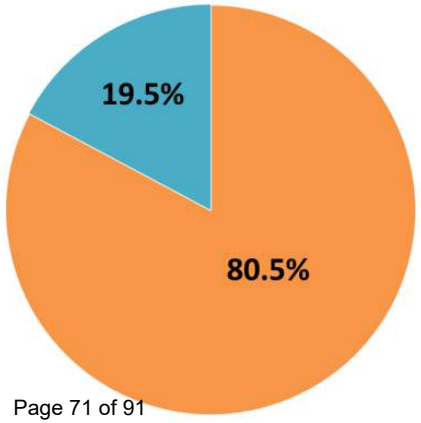

## April 2019 – June 2019

Warrington and Halton Hospitals NHS Foundation Trust



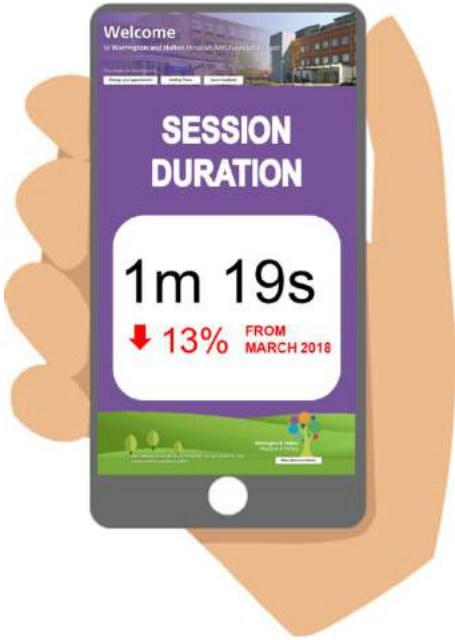





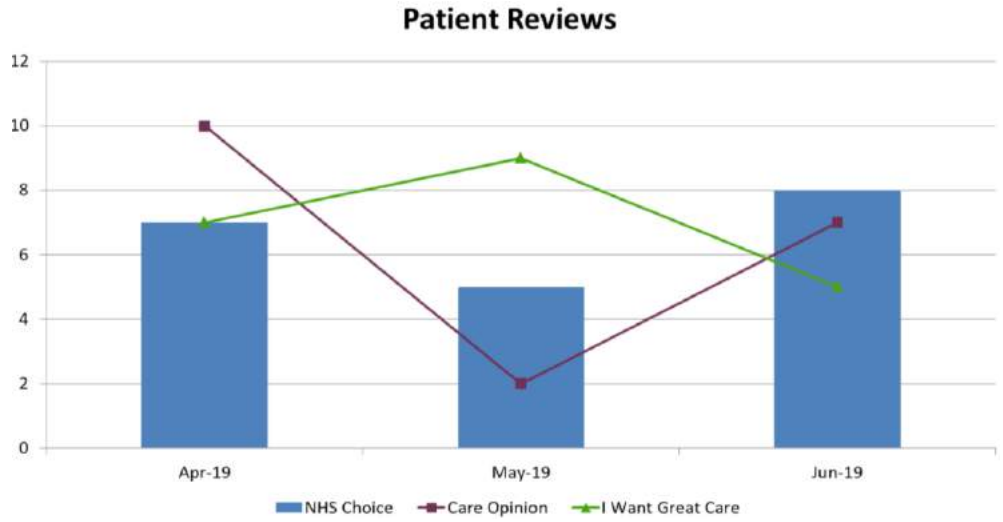

New visitors  Returing visitors

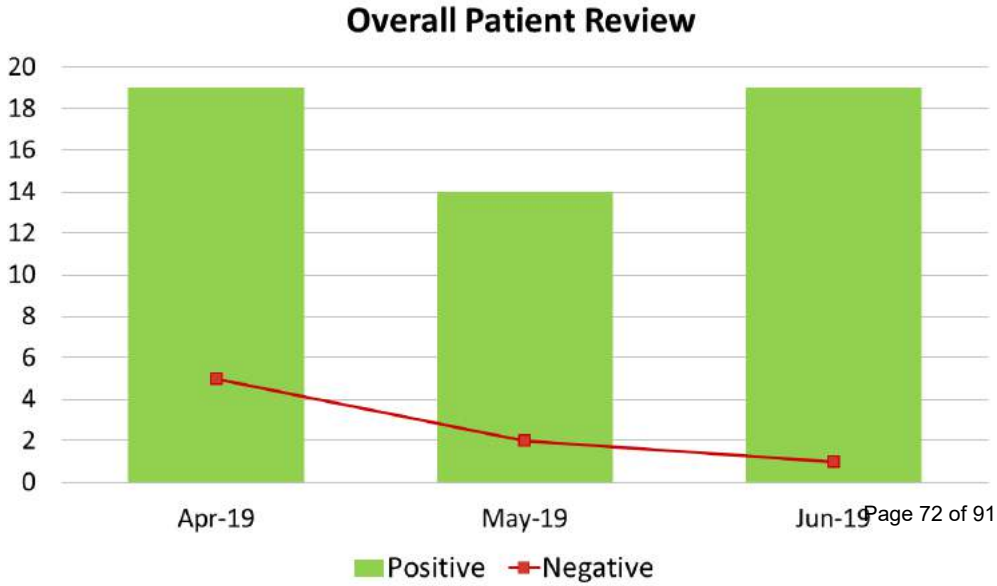


# Patient Experience:


## April 2019 – June 2019

Warrington and Halton Hospitals NHS Foundation Trust

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### Feedback Rating by NHS Choices

**4**
Average rating at Warrington

**5**
Average rating at Halton

**5**
Average rating at CMTC

### Feedback Rating by Care Opinion

**3.5**
Average rating at Warrington

**4**
Average rating at Halton

**4**
Average rating at CMTC

### Feedback Rating by iWantGreatCare

**5**
Average rating at Warrington

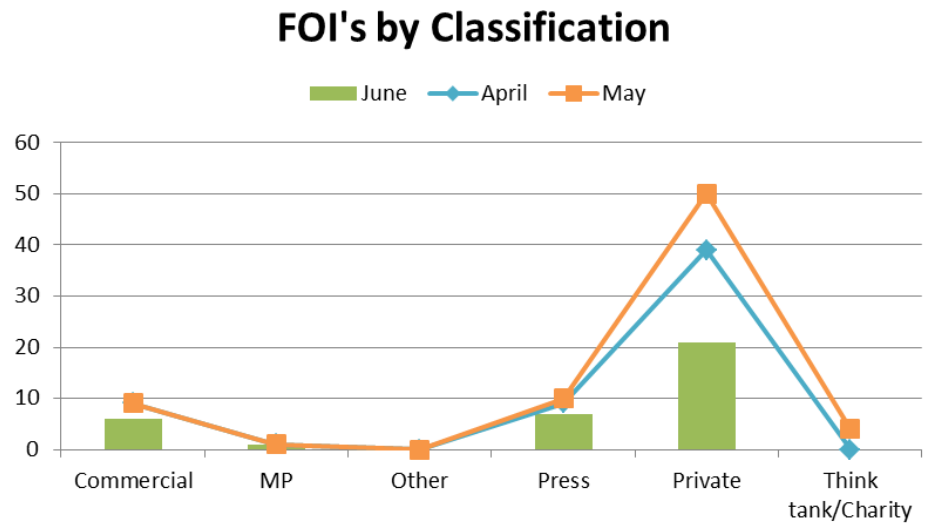
**5**
Average rating at Halton

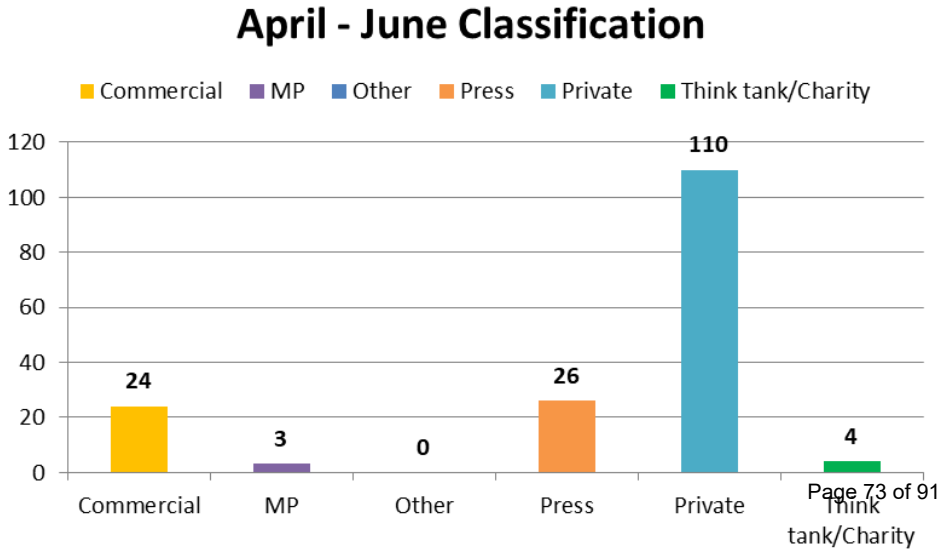
**5**
Average rating at CMTC

# Freedom of Information Requests:

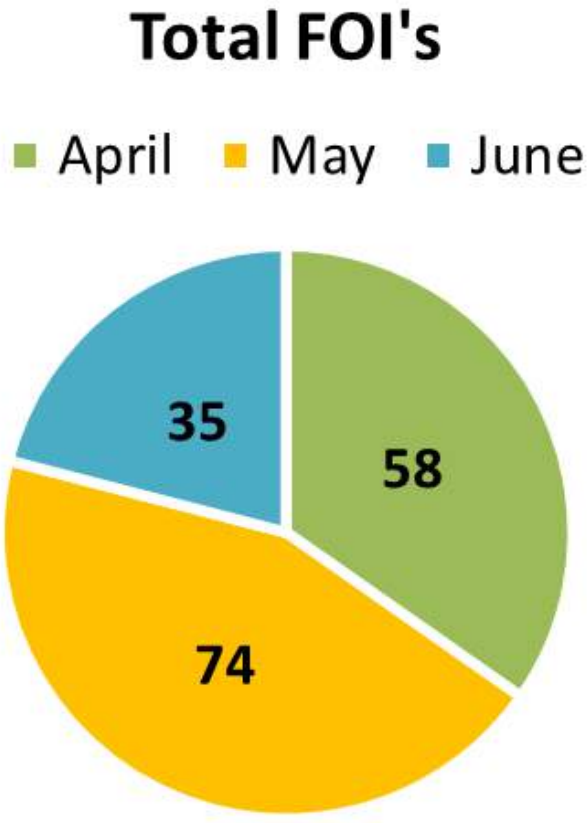
## April 2019 – June 2019

Warrington and Halton Hospitals NHS Foundation Trust




Total Freedom of Information request in Q1 is 167



We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

# Council of Governors

| | | | | |
|---|---|---|---|---|
| **AGENDA REFERENCE:** | **CoG /19/08/53** | | | |
| **SUBJECT:** | **Amendment to the Constitution** | | | |
| **DATE OF MEETING:** | 13 August 2019 | | | |
| **ACTION REQUIRED** | **For Approval** | | | |
| **AUTHOR(S):** | Patricia McLaren, Director Community Engagement | | | |
| | | | | |
| **EXECUTIVE SUMMARY** | The Trust's Constitution states:<br><br>*45. Amendment of the constitution*<br><br>*45.1. The Trust may make amendments to its constitution if:*<br>*45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and*<br>*45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.*<br><br>The paper proposes amendments to the all areas of the Constitution:<br>• Change to the Trust's Name – Recorded in section 1.1 'Name'<br>• Replacement of Warrington and Halton Hospitals NHS Foundation Trust with Warrington and Halton Teaching Hospitals NHS Foundation Trust - 10 occasions in document<br>• Replacement of branding | | | |
| **PURPOSE**: *(please select as appropriate* | Information | Approval ✓ | To note | Decision |
| **RECOMMENDATIONS** | That the Council of Governors approves the proposed amendment to the Trust's Constitution | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committee** | Governors Engagement Group | | |
| | **Agenda Ref.** | GEG 19/08/ | | |
| | **Date of meeting** | 7th August 2019 | | |
| | **Summary of Outcome** | Approved | | |
| **NEXT STEPS:**<br>***State whether this report needs to be referred to at another meeting or requires additional monitoring*** | **Submit to Trust Board** | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED: (if relevant)** | None | | | |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

| SUBJECT | Amendments to the Constitution | AGENDA REF | CoG /19/08/53 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

The Trust has been working on its status as a Teaching Hospital for the past two years, following initial approval from the Council of Governors to commence the process.

This process has now concluded and the final action, together with approaching NHS Identity, is to amend the Constitution to reflect the name change to Warrington and Halton Teaching Hospitals NHS Foundation Trust.

In order to make amendments, the Trust's Constitution states:

*45. Amendment of the constitution*

*45.1. The Trust may make amendments to its constitution if:*

*45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and*

*45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.*

The proposed amendments are set out below.

A full copy of the amended Constitution will be circulated once all name changes, and new branding, have been incorporated.

## 2. KEY ELEMENTS

The timeline for the change of status is set out below:

| Actions | Materials/Communications format | Timeline | Status | |
|---|---|---|---|---|
| Proposal to change Trust's name | • Trust Board approval<br>• CoG approval<br>• Board decision – option 1 and option 2 | | April 17<br>July 17<br>Feb 19 | |
| Branding | 1. Draft design for engagement<br>2. Application to NHS Identity team for new branding<br>3. Rebrand all digital platforms<br>4. Rebrand print items only as due for renewal/re-order<br>5. New signage main entrances | April 17<br><br><br>On completion | | |
| Support from the University of Chester | Letter from CEO MP requesting letter of support from Vice Chancellor | Received 20.11.18 | | |
| Press release | Name change – local/regional media | In draft | | |
| Change Constitution | Paper to CoG on 13.8.19 | Prepared | | |
| Stakeholder engagement | 1. Trust staff – Team Brief/all staff comms | | Staff - complete | |
| | | | Governor | Members |

| | | | |
|---|---|---|---|
| | 2. Governors and Members<br>3. University of Chester<br>4. Other academic partners<br>5. Commissioners<br>6. MPs<br>7. Warrington Together partners<br>8. One Halton partners<br>9. Healthwatch<br>10. NHSI regional team | Letter from CEO 5.8.19 | University of Chester<br>Academics<br>Commissioners<br>MPs elected members<br>WT and One Halton<br>Healthwatch<br>NHSI Regional Team |
| Formal notification of name change | 1. NHS Improvement national team<br>2. NHS England<br>3. NHS Digital<br>4. Care Quality Commission<br>5. NHS Choices<br>6. NHS Jobs<br>7. NHS Employers | Following Governor/Board approval of constitution change | |

## 3. ACTIONS AND RECOMMENDATIONS

The Council of Governors are asked to approve the proposed amendments to the Trust's Constitution prior to submission to the Trust Board for approval.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

## Council of Governors

| | | | | |
|---|---|---|---|---|
| **AGENDA REFERENCE:** | **COG/19/08/54** | | | |
| **SUBJECT:** | **Review the Trust's Compliance with its Licence 2018-19** | | | |
| **DATE OF MEETING:** | 13th August 2019 | | | |
| **ACTION REQUIRED** | **For assurance** | | | |
| **AUTHOR(S):** | John Culshaw, Head of Corporate Affairs | | | |
| **EXECUTIVE SPONSOR** | Mel Pickup, Chief Executive | | | |
| | | | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | | | |
| | Choose an item. | | | |
| | Choose an item. | | | |
| **EXECUTIVE SUMMARY** | This update details any changes to the various declarations of compliance with the Trust's Provider License.<br><br>Following review of the Trust's compliance with its License, the Trust continues to declare full compliance with all conditions. | | | |
| **PURPOSE:** *(please select as appropriate* | Information | Approval | **To note** ✓ | Decision |
| **RECOMMENDATIONS** | The Council of Governors is asked to note full compliance with all license conditions. | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committee** | Choose an item. | | |
| | **Agenda Ref.** | | | |
| | **Date of meeting** | | | |
| | **Summary of Outcome** | | | |
| **NEXT STEPS:**<br>***State whether this report needs to be referred to at another meeting or requires additional monitoring*** | **None** | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED: (if relevant)** | Choose an item. | | | |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

# Council of Governors

| | | | | |
|---|---|---|---|---|
| **AGENDA REFERENCE:** | **COG/19/08/55** | | | |
| **SUBJECT:** | **Council of Governors Terms of Reference** | | | |
| **DATE OF MEETING:** | 13th August 2019 | | | |
| **ACTION REQUIRED** | **Approval** | | | |
| **AUTHOR(S):** | John Culshaw, Head of Corporate Affairs | | | |
| **EXECUTIVE SPONSOR** | Mel Pickup, Chief Executive | | | |
| | | | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | | | |
| | Choose an item. | | | |
| | Choose an item. | | | |
| **EXECUTIVE SUMMARY** | The Council of Governors is asked to review to and approve the Committee Terms of Reference.<br><br>There have been no amendments to those previously approved by the Council of Governors in 2018. | | | |
| **PURPOSE**: *(please select as appropriate* | Information | Approval ✓ | To note | Decision |
| **RECOMMENDATIONS** | That the Council of Governors approves the Terms of Reference | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committee** Choose an item. | | | |
| | **Agenda Ref.** | | | |
| | **Date of meeting** | | | |
| | **Summary of Outcome** | | | |
| **NEXT STEPS:**<br>***State whether this report needs to be referred to at another meeting or requires additional monitoring*** | Choose an item. | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED: (if relevant)** | None | | | |

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

**TERMS OF REFERENCE OF THE COUNCIL OF GOVERNORS**

**COUNCIL OF GOVERNORS (COG)**

**Approved by the Council of Governors on 17 May 2018**

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

## Council of Governors - Terms of Reference

**1. PURPOSE**

The role of the Council of Governors is derived from Schedule 7 and other sections of the National Health Service Act 2006 as amended by the Health & Social Care Act 2012. This document should be read in conjunction with the act.

**2. GENERAL DUTIES**

The general duties of the Council of Governors are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Trust as a whole and the interests of the public

**3. STANDING**

The full meeting of the Council of Governors and its Nomination & Remuneration Committee are the bodies in which Governors have official standing. All other forums are advisory.

**4. MEMBERSHIP**

The composition of the membership of the Council of Governors is set out in the Constitution. The Chair of the Board of Directors is the Chair of the Council of Governors and presides over meetings of the Council of Governors. In the absence of the Chair, the Senior Independent Director will take the Chair.

5. **QUORUM**

The quorum for the Council of Governors is set out in the Constitution and states that 'No business shall be transacted at a meeting of the Council of Governors unless at least one third of all the members are present, at least five of which are elected Governors, are present.

If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of a declaration of a conflict of interest she/he will no longer count towards quorum.

**6. COUNCIL OF GOVERNORS COMMITTEES**

The Council of Governors will establish the following committees:

- Nomination & Remuneration Committee
- Quality in Care and Governors' Engagement Group
- Such other committees as may be required from time to time
- Task & Finish Working Groups as necessary

**7. THE ROLE OF THE COUNCIL OF GOVERNORS**

**Non-Executive Directors; Chief Executive and the Auditors**

- Approve the policies and procedures for the appointment and where necessary for the removal of the Chair of the Board of Directors and non-executive directors of the Trust Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve the appointment or removal of a Chair of the Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve the appointment or removal of a non-executive director on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve the policies and procedures for the annual appraisal of the Chair of the Board of Directors and non-executive directors of the Trust Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve changes to the remuneration, allowances and other terms of office for the Chair of the Board and other non-executive directors on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve or where appropriate, decline to approve the appointment of a proposed candidate as Chief Executive recommended by the non-executive directors
- Approve the criteria for appointing, re-appointing or removing the Auditor
- Approve the appointment or re-appointment and the terms of engagement of the Auditor on the recommendation of the Audit Committee

**Constitution and Compliance**

- Jointly approve with the Board of Directors amendments to the Constitution, subject to any changes in respect of the powers, duties or role of the Council of Governors being ratified at the next general meeting of members (at which a member of the Council of Governors needs to present the change.)
- Notify Monitor, via the Lead Governor, if the Council of Governors is concerned that the Trust is breaching its Licence if these concerns cannot be resolved at the local level.

**Governors**

- Approve the allocation of Governors to sub-groups of the Council of Governors, working groups and any joint working groups set up by the Board of Directors.
- Approve the appointment and the role of the Lead Governor.
- Receive quarterly reports from the Chairs of the Council of Governors sub-groups in the discharge of the sub-groups' duties
- Approve the removal from office of a Governor in accordance with procedure set out in the Constitution.
- Approve jointly with the Board of Directors the procedure for the resolution of disputes and concerns between the Board of Directors and the Council of Governors.

**Strategy, Planning, Reorganisations**

- Provide feedback on the development of the strategic direction of the Trust to the Board of Directors as appropriate.
- Contribute to the development of stakeholder strategies, including member engagement strategies.

- Act as a critical partner to the Board of Directors in the development of the forward plan.
- Where the forward plan contains a proposal that the Trust will carry on an activity other than the provision of goods and services for the purposes of the NHS in England, determine whether the proposal will interfere or not in the fulfilment by the Trust of its principal purpose (the provision of goods and services for the purposes of the health service in England). Notify the board of its determination.
  Approve or not approve increases to the proposed amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the trust.
- Approve or not approve proposals from the Board of Directors for mergers, acquisitions, separations and dissolutions. More than half of the total number of Governors needs to approve such a proposal.
- Approve or not approve proposals for significant transactions where defined in the Constitution or such other transactions as the Board may submit for the approval of Governors from time to time. Such transactions require the approval of more than half of Governors voting at a quorate meeting of the Council of Governors.

**Representing Members and the Public**

- Approve the membership engagement strategy.
- Contribute to members' and other stakeholders' understanding of the work of the trust in line with engagement and communication strategies.
- Seek the views of stakeholders, including members and the public and feedback relevant information to the Board of Directors or to individual managers within the Trust as appropriate.
- Act as ambassadors in order to raise the profile of the Trust's work with the public and other stakeholders.
- Promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy.
- Attend events during the year that facilitate contact between members, the public and Governors to promote Governor accountability
- Report to members each year on the performance of the Council of Governors.

**Holding the Non-Executive Directors to Account**

- The Council of Governors must hold the non-executive directors individually and collectively to account for the performance of the board. It must agree a process and dialogue with the board that will enable them to fulfil this duty.
- As part of this a good working relationship between the Board of Directors and Council of Governors is critical; it can be fostered by meeting regularly and with sufficient frequency to establish appropriate channels of communication and constructive challenge.

Some of the following may support this process and dialogue:

- Receive the agenda of the meetings of the Board of Directors before the meeting takes place.

- Be equipped by the trust with the skills and knowledge they require in their capacity as governors.
- Receive the annual report of the audit committee on the work, fees and performance of the auditor.
- Receive the annual report and accounts (including quality accounts).
- Receive the quarterly report of the board of directors on the performance of the foundation trust against agreed key financial, operational, quality and regulatory compliance indicators and stated objectives.
- Participate in opportunities to review services and environments such as PLACE inspections/quality reviews/ local activities and evaluation of user/carer experience.
- Receive and review quarterly assurance reports.
- Receive reports from the board on important sectoral or strategic issues.
- Use information obtained through the above sources to monitor performance and progress against the key milestones in the strategic and annual plans and to hold the non-executive directors to account for the performance of the board of directors.
- If considered necessary (as a last resort), in the fulfilment of this duty, obtain information about the Trust's performance or the directors' performance by requiring one or more directors to attend a Council of Governor meeting

## 8. COLLECTIVE EVALUATION OF PERFORMANCE

The Council of Governors will carry out an annual review of its effectiveness and efficiency in the discharge of its responsibilities and achievement of its objectives.

## 9. FREQUENCY OF MEETINGS

The Council of Governors will meet 4 times per year. Members are expected to attend all meetings of the Council and of committees of which they are a member, or give timely apologies if absence is unavoidable.

## 10. MINUTES

The Council of Governors will be supported by the Head of Corporate Affairs and the Secretary to the Trust Board who will agree the agenda with the Chair and produce all necessary papers. Minutes will be circulated promptly to all members as soon as reasonably practical.

## 11. REVIEW

The Council of Governors will review these Terms of Reference annually.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

## TERMS OF REFERENCE REVISION TRACKER

| | |
|---|---|
| **Name of Committee** | Council of Governors |
| **Version** | V3 |
| **Implementation Date** | |
| **Review Date** | 17 May 2018 |
| **Approved By** | Council Of Governors |
| | |

| **REVISION** | | | |
|---|---|---|---|
| **Date** | **Section** | **Reason for Change** | **Approved By** |
| 19.1.17 | 5 | Changes to section 5 for clarity on quorum – item as described in the Trust's Constitution | CoG 19.1.2017 |
| 19.1.17 | 6 | To include the named Committees established as Quality in Care and Governors Engagement Group | CoG 19.1.2017 |
| 19.1.17 | 10 | The Council of Governors will be supported by the Secretary to the Trust Board. | CoG 19.1.2017 |
| 17.05.18 | 9 | Changes to section 9 to provide clarity on the expectations relating to attendance. | CoG 17.5.2018 |
| 17.05.18 | 10 | The Council of Governors will also be supported by the Head of Corporate Affairs. | CoG 17.5.2018 |

| **TERMS OF REFERENCE OBSOLETE** | | |
|---|---|---|
| **Date** | **Reason** | **Approved By** |
| | | |

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Warrington and Halton Hospitals NHS Foundation Trust

**COUNCIL OF GOVERNORS**

| | | | | |
|---|---|---|---|---|
| **AGENDA REFERENCE:** | **COG/19/08/56** | | | |
| **SUBJECT:** | **Audit Committee Chairs Annual Report** | | | |
| **DATE OF MEETING:** | 13 August 2019 | | | |
| **AUTHOR(S):** | Ian Jones, Non-Executive Director & Chair of Audit Committee | | | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Mel Pickup, Chief Executive | | | |
| | | | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience | | | |
| | SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future | | | |
| | SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services | | | |
| | | | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This report seeks to deliver assurance to the Council of Governors that the Audit Committee has met their Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance. | | | |
| **PURPOSE: (please select as appropriate)** | Information | **Approval √** | To note | Decision |
| **RECOMMENDATION:** | To note and approve the Audit Committee Chair's Annual Report | | | |
| **PREVIOUSLY CONSIDERED BY** | **Committees Audit Committee + Trust Board** | | | |
| | 21 May 2019 – Audit Committee, Ref AC/19/05/53 – approved<br>29 May 2019 – Trust Board, Ref TB/19/05/53- approved | | | |
| **NEXT STEPS:** ***State whether this report needs to be referred to at another meeting or requires additional monitoring*** | **None** | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | | | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | | | |

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NHS Warrington and Halton Hospitals NHS Foundation Trust

**AUDIT COMMITTEE**

| | | | | |
|---|---|---|---|---|
| **AGENDA REFERENCE:** | **AC/19/05/53** | | | |
| **SUBJECT:** | **Audit Committee Chairs Annual Report 2018/19** | | | |
| **DATE OF MEETING:** | 21 May 2019 | | | |
| **AUTHOR(S):** | John Culshaw, Head of Corporate Affairs | | | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Ian Jones, Non-Executive Director, Committee Chair | | | |
| | | | | |
| **EXECUTIVE SUMMARY:** | This report seeks to deliver assurance to the Board and Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls. | | | |
| **PURPOSE: (please select as appropriate)** | Information | **Approval** ✓ | To note | **Decision** ✓ |
| **RECOMMENDATION:** | **The Committee reviews the document and ensure it meets its purpose.** | | | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable | | |
| | **Agenda Ref.** | | | |
| | **Date of meeting** | | | |
| | **Summary of Outcome** | | | |
| **NEXT STEPS:** *State whether this report needs to be referred to at another meeting or requires additional monitoring* | **Submit to Trust Board** | | | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Whole FOIA Exemption | | | |
| **FOIA EXEMPTIONS APPLIED:** *(if relevant)* | Section 22 – information intended for future publication | | | |

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Warrington and Halton Hospitals NHS Foundation Trust

## AUDIT COMMITTEE REPORT 2018-19

### The Committee

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and, where necessary, highlighting any areas of concern. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2018 - 31 March 2019.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda, and are in support of the achievement of the Trust's objectives.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of at least three Non-Executive Directors with a quorum of two. I have been the Chair of the Committee since 1st December 2014.

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by myself, the Chair of the Committee and the details of my biography can be found on page 22 (*of the Annual Report and Accounts*).

| Member | Attendance (Actual v Max) |
|---|---|
| Ian Jones, Non-Executive Director & Chair | 5/5 |
| Margaret Bamforth, Non-Executive Director | 5/5 |
| Terry Atherton, Non-Executive Director | 5/5 |
| Anita Wainwright, Non-Executive Director | 5/5 |
| Jean-Noel Ezingeard, Non-Executive Director | 3/5 |

Regular attendees at the Committee Meetings were Grant Thornton (External Auditors), Mersey Internal Audit Agency ("MIAA") (Internal Audit & Anti-Fraud Services), the Director of Finance & Commercial Development and the Director of Community Engagement & Corporate Affairs (Company Secretary Designate).

### Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in October 2018 to ensure they continue to remain fit-for-purpose.

**Frequency of Meetings & Summary of Activity**

The Committee met five times during the year. A summary of the activity covered at these meetings follows:

**Governance & Risk Management**

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and the Quality Assurance Committee on a bi-monthly basis. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Moderate Assurance** rating from the Head of Internal Audit (HOIA).

**Internal Audit Activities**

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Committee and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting. The assurance level for each audit completed during the year are listed below:

| Substantial Assurance | Moderate Assurance | Limited Assurance | Advisory Support and Guidance Provided to: |
|---|---|---|---|
| • Data Quality<br>• Combined Financial Systems<br>• Care and Comfort Round | • Data Protection & Security Toolkit<br>• Mental Capacity Act/Deprivation of Liberty<br>• Safeguarding<br>• 5 Steps to Safer Surgery<br>• Medical Locums | • Review of Servers<br>• Temporary Staffing – Non-Clinical<br>• Overtime Payments. | • Continued to support the Trust's own internal tracker for Internal Audit recommendations.<br>• CQC Action Plan<br>• Cyber Security<br>• GDPR Regulations<br>• Bank and Agency (Medical Locums) |

It was also confirmed that the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

Reports have been issued for discussion with management:

- CBU and Speciality Governance Review;
- Overtime Payments Review.

The Internal Audit reports include detailed recommendations to improve systems and address weaknesses identified. Based on these recommendations, actions are agreed with Line Management and the Audit Committee tracks the implementation of the agreed actions to ensure implementation within an appropriate timeframe.

An Assurance Framework opinion test against NHS best practice was undertaken and the standards were met.

**External Audit**

Grant Thornton commenced its 3-year term as Auditors to the Trust in January 2017 following a competitive procurement exercise and review and recommendation by the Council of Governors.

During the year the Auditors reported on the 2017-18 Financial Statements and Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

**Anti-Fraud Activity**

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy. The Audit Committee received regular progress reports from the AFS and also received an annual report. No significant cases or issues of Anti-Fraud took place or were identified during the year.

**Issues Carried Forward**

The Audit Committee will continue its work to ensure the overall system of internal controls and the assurance processes remain robust.

In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.

Whilst the outcomes of the Clinical Audit programme falls under the remit of the Quality Committee and are reported and challenged in that forum, this Committee will review its approach purely from an audit perspective and to obtain assurance of methodology and approach as well as its contribution to improving quality.

With respect to the Internal Audit plan for 2019-19, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the 2019-20 Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

During 2018-19, alongside the Audit Committee, three main Board assurance committees were in place: (1) Quality, (2) Finance & Sustainability and (3) Strategic People. All of these Committees were chaired by Non-Executive Directors and each Committee included at least two Non-Executive Directors. This structure gave strong visibility and focus at Non-Executive level on the key issues facing the Trust. The NEDs meet several times a year to assess a wide range of Trust issues including the appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

**Summary**

In year, the Committee has considered a wide range of issues in relation to financial statements, operations and compliance and has sought to gain assurance on each element by working closely with Internal Audit, the other Board Committees and key individuals across the Trust.

Throughout the reporting period, the Chair of the Committee reported in writing on the nature and outcomes of its work to the Board of Directors highlighting any area that should be brought to its attention through a Chair's Key Issues Report.

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in August 2019

The Committee has also assessed its own performance during the year and will report to the Board of Directors in January 2020.

The Audit Committee acknowledges the significant amount of work carried out by the Quality Committee, the Chief Nurse and Director of Integrated Quality and Governance in continuing to refresh and embed the Trust's governance and risk management systems.

I would also like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

**Ian Jones**
**Chair of Audit Committee**
**April 2019**

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NHS Warrington and Halton Hospitals NHS Foundation Trust

# Council of Governors

## DATES 2019-2020

## Meetings in theTCR, Warrington to be held 4.00pm-6.00pm

## Meetings at Halton Hospital to be held 3.00pm-5.00pm

| DATE OF MEETING | VENUE |
|---|---|
| **2019** | |
| Thursday 14 February 2019 | **Trust Conference Room Warrington** |
| Thursday 16 May 2019 | **Trust Conference Room, Warrington** |
| Thursday 15 August 2019 | **Trust Conference Room, Warrington** |
| Thursday 14 November 2019 | **Lecture Theatre, HALTON EDUCATION CENTRE** |
| **2020** | |
| Thursday 13 February 2020 | **Lecture Theatre, HALTON EDUCATION CENTRE** |