Trust Board Meeting
Part 1 (held in Public)

Wednesday 4 October 2023
10.00am -12.30pm
Trust Conference Room Warrington/Via MS Teams

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 4 October 2023, 10.00am – 12.30pm
Trust Conference Room, Warrington/Via MS Teams

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/23/10/109	**10:00**	Engagement Story – A Child's Healing Journey	***To Note***	**Presentation**	Ali Kennah, Deputy Chief Nurse/Jill Tomlinson, Matron Child Health
BM/23/10/110	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***		Steve McGuirk Chair
BM/23/10/111	**10:17**	Minutes and Action Log of the previous meeting held on **2nd August 2023**	***For decision***	***Minutes***	Steve McGuirk Chair
BM/23/10/112	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Steve McGuirk Chair
BM/23/10/113	**10:25**	Chief Executive's Report (Inc CQC update)	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/23/10/114	**10:35**	Chair's Report	***For info/update***	***Report & Verbal***	Steve McGuirk Chair
BM/23/10/115	**10:45**	Board Assurance Framework	***For approval***	***Report***	John Culshaw, Company Secretary
Strategic aim:	QUALITY		PEOPLE		SUSTAINABILITY
BM/23/10/116	**10:50**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a)		**Quality Dashboard**	***For assurance***	***Report & Presentation***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO; Zoe Harris, Director of Operations & Performance; Paul Fitzsimmons, Exec Medical Director
(b)		**Including** Assurance Reports Quality and Assurance Committee (QAC) 08.08.23/12.09.23			Cliff Richards, Committee Chair
(c)		**People Dashboard** **Including** Assurance Reports Strategic People Committee (SPC) 16.08.23/20.09.23	***For assurance***	***Report & Presentation***	Michelle Cloney, Chief People Officer Julie Jarman, Committee Chair

(d)		**Sustainability Dashboard Including** Assurance Reports Finance and Sustainability Committee (FSC) 23.08.23/27.09.23	***For assurance***	***Report & Presentation***	Jane Hurst, Chief Finance Officer John Somers, Committee Chair
(e)		Assurance Report Audit Committee (AC) 17.08.23	***To note for assurance***	***Report***	Mike O'Connor, Committee Chair
(f)		Charitable Funds Committee Assurance Report (CFC) 07.09.23	***To note for assurance***	***Report***	Steve McGuirk, Chair
Strategic aim:	QUALITY				
BM/23/10/117	**11:10**	Maternity Update including. i Ockenden Review Updates ii Maternity Incentive – 5-year update including Saving Babies Lives Care Bundle (SBLCB) iii Perinatal Mortality Review Tool - Quarterly Report – Q1 2023/24 iv Monthly Maternity & Neonatal Quality Update	***To note for assurance***	***Report***	Ailsa Gaskill-Jones, Director of Midwifery
BM/23/10/118	**11:25**	Moving to Outstanding (M2O) Update Report - Q1	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/10/119	**11:35**	Fragile Clinical Services Update	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO/Paul Fitzsimmons Executive Medical Director/Dan Moore Chief Operating Officer
Strategic aim:	PEOPLE				
BM/23/10/120	**11:45**	GMC Appraisal and Revalidation and Medical Governance	***To note for assurance***	**Paper**	Paul Fitzsimmons Executive Medical Director
BM/23/10/121	**11:55**	Freedom To Speak Up – Guardian Bi-annual Report	***To note for assurance***	**Paper**	Jane Hurst, Freedom to Speak Up Guardian

Strategic aim:	SUSTAINABILITY				
BM/23/10/122	**12:05**	EPRR Assurance Letter/Statement of Compliance	***To note for assurance***	**Paper**	Zoe Harris, Director of Operations & Performance
BM/23/10/123	**12:15**	Bi-monthly Strategy Programme Highlight Report	***To note for assurance***	**Paper**	Lucy Gardner Director of Strategy & Partnership

Governance					
BM/23/10/124	**12:25**	Audit Committee Annual Report	***For approval***	**Paper**	Mike O'Connor Non-Executive Director

<u>SUPPLEMENTARY PAPERS for noting</u> (see <u>Supplementary</u> Pack)

To Note For Assurance					
BM/23/10/125	Learning from Experience Summary Report – Q1	Quality Assurance Committee Date: 08.08.23 Ref: QAC/23/08/176 Outcome: Noted	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/10/126	Nurse Staffing Bi-annual Report	Quality Assurance Committee Date: 08.08.23 Ref: QAC/23/08/177 Outcome: Noted	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/10/127	Learning from Deaths Quarterly Report – Q1	Quality Assurance Committee Date: 12.09.23 Ref: QAC/23/09/193 Outcome: Noted	***To note for assurance***	**Paper**	Paul Fitzsimmons Executive Medical Director
BM/23/10/128	Director of Infection Prevention & Control Quarterly Report – Q1	Quality Assurance Committee Date: 08/08.23 Ref: QAC/23/08/174 Outcome: Noted	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/10/129	Digital Strategy Group Update Report	Finance & Sustainability Committee Date: 27.09.23 Ref: FSC/23/09/125 Outcome: Noted	***To note for assurance***	**Paper**	Paul Fitzsimmons Executive Medical Director
BM/23/10/130	RTT Validation Assurance Report	Finance & Sustainability Committee Date: 27.09.23 Ref: FSC/23/09/126 Outcome: Noted	***To note for assurance***	**Paper**	Zoe Harris, Director of Operations & Performance
Closing					

BM/23/10/131	**12:30**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/23/10/132		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting - 6 December 2023, Trust Conference Room , Burtonwood Wing, WHH					

A Child’s Healing Journey

Jill Tomlinson, Matron Child Health
Ali Kennah, Deputy Chief Nurse

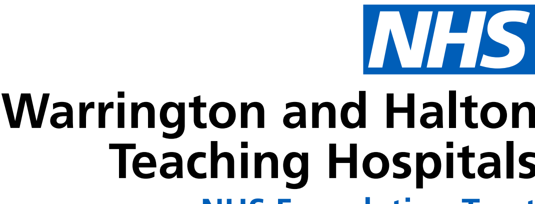
Background

In June 2023, a young child was admitted to our paediatric ward.

Due to severe neglect and unknown trauma the child and their sibling had suffered, they had been removed from their parents in May 2023. Therefore, there was no family support and they had been in the care system ever since.

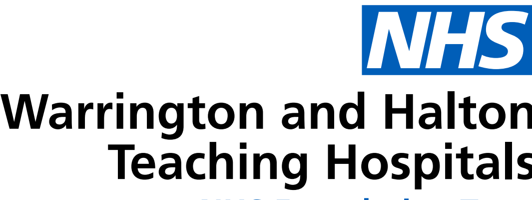
One of the children was admitted to WHH and stayed for a total of 9 weeks in our care.

The admission followed a Child and Adolescent Mental Health Service (CAMHS) assessment, where concerns were raised for physical and mental health.



Building trust

- The child slept outside on the bench the first night
  - Progressing to sleeping in the doorway and then a makeshift safe sleeping area
- The child presented in their clothing which they had worn for 2 weeks prior to admission
  - Staff purchased bespoke clothing and encouraged them to complete activities of daily living
  - Staff took clothes home and washed them
  - The child refused to remove coat throughout their stay
- The child was doubly incontinent
  - Staff built up self-confidence and worth to return to an independent toileting routine



Building trust

- The child refused to eat

  - Staff purchased preferred food and encouraged them to make their own food to reduce anxieties

  - Encouraged to go out to the shops and park in the electric ride on car

- The child was non-verbal for a week

  - Staff spending time, introducing play therapy and building trust they started to communicate with team and the shop staff

Therapy Dog

A therapy dog also came to the ward to encourage the patient to communicate with the nursing and medical team when they were first admitted.

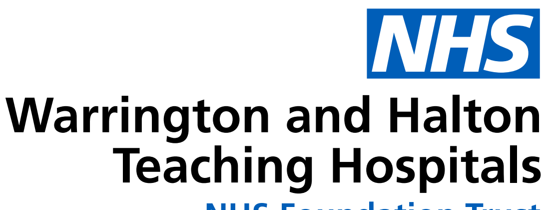
Otis the therapy dog, was extremely well received and made a visit to other patients and staff on the ward.

Acknowledgement of a special day

The patient deserved to have the opportunity to celebrate their forthcoming birthday. This was going to be after discharge, but the staff wanted to show them how important and deserving they are.

Multi agency working

- Robust escalation processes internally and support provided from senior nursing team and executive team to keep the child safe
- Appropriate completion of relevant paperwork and risk assessments completed, legal advice sought when required
- Effective collaboration and engagement with external agencies, attendance ensured at all meetings, executive attendance if required
- Regular support and advice provided by WHH Safeguarding Team
- Regular debriefs undertaken to support ward staff and ensure appropriate dissemination of information
- Daily meetings held to discuss progress and increase in safety huddles
- Support offered to staff by Health and Wellbeing Team



Feedback

Letter of thanks received from the Local Authority:

*I am the service leader at ********* social care. I have responsibility for ***** as *** is a looked after child. *** has been a patient and bought *** to hospital as they were extremely concerned about their presentation and emotional wellbeing. I wanted to thank the ward, staff team and ward managers for the care and support that they have provided to ***** and how fantastic the staff have worked with us as a local authority. They have provided excellent care to *** that has made a significant difference. Their support and understanding of the situation and how they have worked with ***** has been amazing. They have gone above and beyond every single day for **** and have placed them at the centre. This has also made a significant difference to how as an authority we have been able to support *****, how to identify and find the right placement and to plan the transition from hospital to new placement.*

Feedback

*Just some examples are - staff spending their breaks with ****, washing her clothes, having a birthday party, taking them to the park and giving time and space to feel safe and build trust.*

*I have been in similar situations with other hospitals when a child has been an inpatient and been medically fit for discharge when we have not had an appropriate placement. I have not experienced the same level of understanding, flexibility and child focussed planning as I have experienced from the team at B11. Their approach and commitment to **** has made a huge difference for **** which I am sure will stay with them into adulthood and has greatly assisted the local authority.*

Questions

Conflicts of Interest

At any meeting where the subject matter leads a participant to believe that there could be a conflict of interest, this interest must be declared at the earliest convenient point in the meeting. This relates to their personal circumstances or anyone that they are of at the meeting.

- Chairs should begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s) on completion of a Declaration of Interest Form.
- The Vice Chair (or other non-conflicted member) should Chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[1] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 2 August 2023 Trust Conference Room – Warrington & MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Simon Constable (SC)	Chief Executive
Andrea McGee (AM)	Chief Finance Officer & Deputy Chief Executive
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
Michelle Cloney (MC)	Chief People Officer
Dan Moore (DM)	Chief Operating Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Apologies	
Jan O'Driscoll (JO'D)	Partner Non-Executive Director
Dave Thompson (DT)	Associate Non-Executive Director
Adrian Carridice-Davids (ACD)	Associate Non-Executive Director
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Kate Henry (KH)	Director of Communications & Engagement
Ailsa Gaskill-Jones	Director of Midwifery
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Kirsty Pine (KP)	Associate Director of Clinical Research
Lisa Cheng (LC)	Head of Research Development & Innovation
Layla Alani (LA)	Director of Governance & Deputy Chief Nurse
Emily Kelso (EK)	Corporate Governance & Membership Manager **(minute taking)**
Observing	
Norman Holding	Lead Governor
Janet Parker	Associate Director of Finance - Strategy

Agenda Ref	Agenda Item
BM/23/08/78	**Engagement story – The Impact Research Had on Me** The presentation was introduced by LA, who handed over to LC Head of Research Development & Innovation and KP Associate Director of Clinical Research.

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The Trust Board received a video presentation detailing patient Bethany's story, around her participation in a clinical trial, it was noted that Bethany was one of the first global patients to be recruited to a clinical trial for non-responsive patients with Ulcerative Colitis, the trial had been a success, resulting in improvements to her physical and mental health and wellbeing. Bethany expressed her gratitude to research staff for enabling her clinical trial journey to be such a positive patient experience.

LC highlighted some of the key achievements of the Halton Clinical Research Unit to date along with details of research and development success factors, and the growing reputation for the Halton unit on a national level.

Details of the financial position of the unit were provided, which were positive in all areas.

Detail on next steps and looking forward were provided, these included:

- Securing pipelines for commercial studies
- Principle investigator (PI) growth
- Academic research
- Increasing awareness and community staff engagement

It was noted that the WHH team had won the Research Delivery Team of the Year Award, at the North West Coast Research & Innovation Awards 2023.

SMcG commented on the great success of the unit to date, and the positive impact it was already having on patients.

JS further commented that this was a great news story, particularly the impressive statistics in relation to growth and financial sustainability.

It was noted that the ambition was for the Trust to become a University Hospital, however that this was a 10-year plan and further growth would be necessary along with recruitment of additional clinical academics. LA commented that with the right infrastructure and investment the Trust would be capable of achieving the status.

The Trust Board discussed and noted the Engagement story and congratulated the team on their continued success.

BM/23/08/79 **Welcome, apologies and declarations of interest.**

The Chair welcomed the Trust Board, guests, and observers to the meeting, and noted the apologies received (as detailed above). There were no Declarations of Interest.

SC confirmed that the meeting was the final Trust Board meeting for

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	AMcG, who would be leaving the Trust to take on an external role. Thanks was expressed on behalf on the Trust Board for her commitment to WHH during her time as Chief Finance Officer & Deputy Chief Executive. It was noted that the Shadow Board meeting had been cancelled due to Industrial Action, hence updates would not be provided during the meeting. It was also noted, though, that some observers from the programme were present at the meeting. It was further noted that Leadership Observation visits had taken place prior to the meeting and observations would be utilised by Board members to triangulate information presented and discussed within agenda items. **The Trust Board noted the welcome, apologies and declarations.**
BM/23/08/80	**Minutes and action log from the previous meeting held on 7 June 2023.** The minutes of the meeting held on 7th June 2023 were agreed as an accurate record with one minor amendment to item BM/23/06/58, KSJ would provide the amendments following the meeting. The Action Log was reviewed, completed actions were noted, there were no outstanding/ongoing actions. **The Trust Board approved the minutes of the meeting held on 7th June 2023 and noted the Action Log.**
BM/23/08/81	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/23/08/82	**Chief Executive's Report** SC introduced the paper, which was taken as read. The following key points were taken from the questions raised and Trust Board discussions: The Board discussed the impact of Industrial action, agreeing this was an unprecedented time for the NHS, SMcG expressed his appreciation for the commitment of Executive colleagues and their teams to ensure staff and patient safety were maintained throughout periods of IA. SC confirmed his appreciation for the commitment of staff. SC added that the University Hospital status discussed in agenda item BM/23/08/78, would take time. It was explained that Halton research team had an opportunity in the early stages of the pandemic which had been strategically utilised and since then the team had gone from strength to strength. It was noted that by sharing the story and collaborating with system partners notably LUHFT the Trust would be able to further utilise opportunities, in addition further

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	provider collaboration and ICB support would be crucial for sustaining growth. **The Trust Board noted the Chief Executive's Report.**
BM/23/08/83	**Chair's Report** SMcG introduced the report, which was taken as read, the following key points were highlighted: - Partner Governor– Kuldeep Dhillon was awarded the British Empire Medal (BEM) in the Kings Birthday Honours in June along with his wife in recognition of the difference they have made to the wellbeing of their local community over the past four decades. - Covid Public Enquiries –The independent public inquiry set up to examine the UK's response to and impact of the Covid-19 pandemic and learn lessons for the future, it was noted that the enquires had begun and were moving forward at a good pace. - A new partner Governor had joined the Trust – Cllr Chris Loftus representing Halton Borough Council. **The Trust Board noted the Chair's Report.**
BM/23/08/84	**Board Assurance Framework (BAF)** JC presented the BAF update and highlighted the following proposed updates since the last Board meeting: • No new risks had been added • It was being proposed to increase the rating of risk #1757 (Effectively plan for and manage Industrial Action) from 16 to 20 • There had been no changes to the descriptions of any of the risks. • No risks had been closed or de-escalated SMcG queried the controls and assurance commentary for risk 224 which stated that Lillycross care facility had closed, and additional capacity had opened in Statham Manor, Grapenhall Manor and Oak Meadow. DM confirmed the space lost at Lillycross had been filled on time and to plan by the other facilities, leaving no gaps. SMcG commented on the positive improvement in sickness rates as detailed within the commentary for risk 1134. It was noted that the rolling 12-month sickness absence rate was 6% as at May 2023 and was showing an improving trajectory. **The Trust Board discussed and noted the report and supported the increase in the scoring of risk 1757 from 16 to 20.**
BM/23/08/85	**Integrated Performance Report** SC introduced the agenda item which provided a summary of the Trust performance, it was highlighted that the report would be taken as read with

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key highlights by Executive Leads and any questions on the report content from Non-Executive Directors.

SMcG commented on the improved format of the report which provided clarity on those areas of a concerning nature, requiring focus and those exceeding targets, it was further noted that the deep dives being received at Committee level were in line with those areas being reported as requiring focus. It was further highlighted that the report triangulated well to the paper on fragile services item BM/23/08/88.

Access & Performance (DM)

Quality of Care (KSJ)

CR commented on the timing issues around reporting into the Quality Assurance Committee, meaning that on months where Trust Board meetings took place the Board received the data prior to the Committee, hence assurance reporting up to Board on performance was a month in arrears.

JD queried the improving position for falls, it was asked if the Trust were looking at this data over time and recognising the improvements. KSJ responded that reporting did not always celebrate the improvements, examples were given of deep dive presentation at Quality Assurance Committee i.e., Sepsis which looked into the data behind the IPR and identified those actions that were leading to improvements in the figures presented in the IPR report. It was agreed the IPR was a snapshot and refining would be ongoing.

It was also noted that communications channels had been firmed up with Arbury Court to quality and safety of patients being care for at WHH, and utilisation of correct pathways, the Committee would continue to receive progress reports until full assurance was obtained.

People (Workforce) (MC)
MC highlighted the improved trajectory in long term sickness absence and the refreshed Supporting Attendance Policy focusing on bringing staff back to work when they were fit and well along with bespoke intervention to prevent long term sickness. It was noted that work was ongoing with CR the Trusts Health and Wellbeing Guardian to ensure evaluations were robust.

Finance & Sustainability (AMcG)
AMcG highlighted several areas for noting which included risks around:

- CIP Delivery - the Trust had delivered a CIP of £1.8m against a target of £1.8m. The full year CIP target was £17.9m of which £13.8m has been identified.
- Cost pressures – the Trust was unable to fund circa £8m cost

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- pressures and has put in a process to oversee mitigation plans and risk management.
- A&E staffing pressures.
- Additional capacity open due to the levels of no criteria to reside patients.
- Cost of Industrial Action.

JJ commented on the improved position in relation to agency use/spend, however the Trust was still not hitting target.

JS thanked the Executive Team for their openness and transparency in relation to finance and performance, and highlighted the following key points from the committee's discussions:

- Activity pressures and excess costs in A&E, were out of the Trusts control, and that to be sustainable a long-term solution was required with system and national support.
- The requirements as detailed in the Richard Barker and Graham Urwin letters – posed risks to the Trust and careful planning around deliverability would be crucial.
- The vulnerability of the Emergency Department was recognised, and a Deep Dive presentation had been scheduled for the Committee.

DM provided reassurance that an ED Improvement Group had been formed including Executives (KSJ, PF & DM) with meetings to start in August. There had been good clinical engagement from the ED Team. The group would focus on occupancy and performance.

It was noted that because the Trust was in Tier 1, it was afforded the most resource at a national level to help drive improvements, which was welcomed. It was also noted that the first meeting with the National Team was to take place this week.

SC commented that being in Tier 1 did not mean the Trust was viewed as a failing, instead it recognised the impact of the social care and local demographics including the aging population on the performance of the Trust. SMcG indicated that it was important to be open and transparent about the ED challenges (part of the reason for the involvement of the Lead Governor in the Mock CQC Inspection from which the concerns had arises). Accordingly, Exec colleagues would make a presentation on ED issues to the next Council of Governors (COG).

Audit Committee

MOC thanked the Trust accounts and team for their work on the accounts which had received an unqualified opinion by the Trusts external auditors Grant Thornton. It was further noted that the WHH Annual Report and Accounts for the 2022/23 financial year was successfully laid before parliament on the week commencing 3rd July 2023, a reflection of the Trust's hard work and commitment to meeting the deadline.

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	SMcG confirmed that the Annual Report and Accounts would be presented at the next COG and then Annual Members Meeting which had been scheduled for Wednesday the 4th October 2023 at 3:30pm following the Trust Board meeting. **The Trust Board discussed and noted the report**
BM/23/08/86	**Maternity Update** SMcG introduced Ailsa Gaskill-Jones, Director of Midwifery, who would be attending Trust Board meetings going forward to present maternity papers and to ensure that there was a 'maternity voice' at the Board going forward. It was further explained that this was in response to recommendations arising from recent reports into midwifery/ maternity crises and, consequently, should be welcomed and seen as a positive development. However, concern was also expressed at the risk of confusion about who was providing the *maternity voice,* not least as previous reviews have resulted in a NED Maternity Champion (JD), as well as a local Maternity Voices Partnership (MVP) (with an externally appointed Chair who is not a Board Member/ Director), alongside the Executive responsibilities of relevant Directors and the Assurance role of the relevant committees. While all these national recommendations were important and well-intended, there was a risk of ambiguity of responsibility and accountability with a range of entities providing the maternity voice so and it was going to be important that it was explicitly clear who was responsible for what. AGJ introduced the papers and provided the following updates: **1. Ockenden** The report provided an update in relation to Ockenden recommendations for the end of January, highlighting: The WHH Ockenden update as of 31st May 2023 was: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 95.76% compliant and is on trajectory to be 100% compliant by 31st December 2023. • **Ockenden 2**: WHH is 73.97% compliant (previously 69.86% at the end of April 2023) and is on trajectory to be 100% compliant by 30th November 2023. The remaining actions were morning at pace, key examples were noted as; the Fail-safe clerk position had been recruited to and a start date was to be confirmed • It was highlighted that Ockenden 2 did not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023. SMcG queried if there were and concerns around the delivery of the action plan or any key actions to highlight. AGJ responded that triage had been picked up by the CQC mock inspection, along with workforce issues, however improvements could be evidenced. It was noted that detail around

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these improvements would be presented to Board in November within the 3-year Delivery Plan, which had been published in March 2023 and had a more general focus on Quality whereas Ockenden was task focused.

KSJ added that a success story was that maternity triage was now achieving the standard, it was expected that the improvement trajectory would continue. It was further noted that staffing would always be a challenge, it was expected the Trust would reach establishment of 8 medical staff, and whilst there were still staffing risks plans were in place to improve the position.

KSJ confirmed a Maternity plus other chosen services CQC inspection would likely take place within the coming 2 -3 months. SC added that both Liverpool Woman's and Manchester had had adverse CQC feedback around safety.

JD commented that there was good progress being made and that positive news stories were being circulated to maternity staff through weekly updates by AGJ. JD agreed that progress had been made around triage and recruitment and that staff were being reassured of this progress.

SMcG asked whether a maternity focussed Leadership Observational visit could be scheduled for October Board Meeting, in order to extend the Board's contact and express thanks to the Maternity Team. KSJ confirmed that a number of Board Members including Non-Executive Director/ Maternity Champion JD were well sighted on the Maternity Unit but that additional visits would be welcomed.

CR added that the reports were consistent with the information being received at Committees, providing assurance that appropriate scrutiny was in place for maternity performance.

2. Maternity Incentive Scheme Year 5 Overview of Requirements

AGJ introduced the report explaining that NHS Resolution (NHSR) were operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by implementing 10 safety standards. It was noted that revised specifications for the requirements had been received and that further amendments were likely as more questions were put forward from providers. The Trust Board noted that Safety Action 9 would be completed at the October Quality Assurance Committee meeting.

JD queried the cost incentive associated with the scheme. It was confirmed each year the plan was to achieve and invest back into maternity services. It was noted that the Trust had historically achieved all targets set.

3. Avoiding Term Admissions into Neonatal units (ATAIN) Q4

AGJ explained that although the ATAIN rate for Q4 had not been met the,

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	the percentage of avoidable admissions had not risen, therefore is not suggestive of a deterioration in the standard of care. It was further noted that the mean for the year was 5.4% which was below both the regional North West Neonatal Operational Delivery Network target of 5.6% and national target of 6%. It was noted that a piece of work around culture was planned over the coming 6 months, part of which would include a maternity neonatal survey, which was a requirement of the Maternity Incentive Scheme. MOC sought clarity around the ATAIN objective to reduce the number of unexpected term admission of infants >37 weeks to the neonatal unit (NNU). AGJ confirmed that below 6% was the national target which took into account that some admissions would be unavoidable. It was further noted that the review of each admission enabled the Trust to drill down on where lessons could be learnt, and improvements made to take every measure to ensure term babies were able to stay with mums. **The Trust Board noted the updates in relation to Maternity, welcomed AGJ to the Board and noted the need for clarity about the various processes proposed to enable a Maternity Voice to be heard.**
BM/23/08/87	**Quality Strategy Update – Annual Report** KSJ introduced the report which sets out the Trust's key quality and priorities progress report for 2022-23 for the 9 priorities identified. The report detailed key achievements over the past year that had impacted upon the quality of care and standard of services delivered. The report provided details of the Q4 progress report 2022-23, identifying areas of improvement in the quality of services provided. These were noted within the Annual Quality Account 2022/2023. It was explained that the report was available online in the public domain via the Trust Board papers and would be published separately on the Trust website. **The Trust Board noted the annual report for assurance.**
BM/23/08/88	**Fragile Clinical Services Update** PF introduced the report which provided the Trust Board with an outline of the Trust's approach to identification and oversight of Fragile Clinical Services. Along with a high-level update on the services currently designated as fragile, these were: • Gynaecological surgery • Urology • Paediatric Ophthalmology • Ophthalmology – ARMD/Medical Retina • Orthopaedics – Fractured Neck of Femur

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	The following key points were taken from the paper and the Trust Board discussion: • the transparent and systematic line of sight from ward to Board for those services deemed as fragile, including details of governance and reporting requirements and procedures • The process for escalation and de-escalation of fragile services SMcG very much welcomed the specific focus on fragile services as it was important to be authentic and not gloss over some of the challenges being faced which are unprecedented. He further commented that the paper provided assurance on the Governance in place for Fragile Services at the Trust, noting that this had not been an external imposition, rather that it had been the Trust's decision to introduce the process, responding to the current climate including capacity, demand and staffing for particular services. CR agreed that the approach to an identification and oversight of fragile services enabled the Trust to spot deterioration early and highlight the issues, in order to drive a system approach to improvement. He commended the openness of the Medical Director with the new approach. AMcG commented that it was useful to see the approach to escalation de-escalation and the process would help to provide the appropriate corporate and financial support. SC added that the approach supported best practice in the well-led domain and provided assurance on the robust Governance processes for fragile services. It was further noted that although "fragile services" did not have a national definition, when benchmarked similar services that had been identified as "fragile" at WHH, were also under duress in other Trusts nationally, particularly those impacted by the pandemic. LC commented that the approach would help to drive collaboration conversations with others. **The Trust Board noted:** **- The newly introduced process for designation and oversight of Fragile Clinical Services** **- The current list of Fragile Services and associated high level progress updates** **- further updates would be provided at Quality Assurance Committee and Trust Board**
BM/23/08/89	**Patient Safety Incident Policy & Plan (PSIRF)** KSJ introduced the report explaining that the Patient Safety Incident Policy and plan both follow the national template set out by NHS England relating to the implementation of PSIRF.

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The Trust Board were informed that the policy covered all aspects of the PSIRF Framework. It was confirmed that following and extensive review of the clinical governance data the Trust's local priorities had been identified as:

- Potential for harm when there is a missed or delayed diagnosis of a cancer.
- Potential for harm when there is a delay in the identification, recognition and response to patient deterioration resulting in delayed escalation and treatment.
- Potential for harm when there is a delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)

KSJ confirmed that the policy was to be implemented in September. The Trust Board were informed that the core PSIRF implementation group would meet fortnightly, to assess progress against the project plan, and to keep abreast of communications and shared learning from the regional teams and that the Executive PSIRF oversight group currently meet weekly in order to support the progress and implementation requirements.

It was noted that the policy described the role of Patient Safety Partners, a role that would be recruited to within the Trust, to assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support to ensure PSPs have the essential tools and advice they need.

It was further noted that training for staff was progressing well, and that Non- Executive Directors CR and JD had taken part in a PSIRF Oversight and Responsibility Leadership Team session on the 31st of July with members of the Quality Assurance Committee. It was noted that a Board specific training session would be taking place at the Board Development Day 6th September.

KSJ confirmed that the plan was not set and could be changed as required, it was noted that a robust review of historical data had been undertaken to identify the priorities. It was noted that the Trainer who would lead on the Framework had confirmed that the 3 local priorities chosen were the best they had seen.

Each would be taken forward from September. It was further noted that there would still be a full review and Board level oversight of incidents that met Never Event criteria.

SMcG commented on the national template, agreeing that this had been a focus for a number of years and would support the Trust to improve. KSJ agreed that there had been an incredible amount of focus on patient safety particularly investigations of incidents and improving systems and

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	processes which was evidenced through patient outcomes. SMcG also observed that there was a need to ensure the PSIRF approach was aligned with the maternity approach discussed earlier. In a sense patient safety is an intrinsic dimension of the Maternity challenge, but adopting slightly different approaches to implementation reinforced the risk of 'initiative overload' and confusion or ambiguity. PF added that the framework represented a significant and improved shift, as in the past complex systems and those that did not intermesh, meant that large numbers of investigations would be undertaken for marginal gain for few patients. CR confirmed his support of the systematic framework particularly the change in the involvement of patients and families and would enable the Trust to focus on important issues and agreed with the importance of aligning programmes. AMcG commented that it was important to look at these priorities in the development of Trust's digital strategy, for example using Artificial Intelligence to detect cancers and using the strategy to prioritise investment and attract funds. MC informed the Board that future national staff surveys would have 4 specific questions around PSIRF and that the Trust would be looking at how to benchmark performance. **The Trust Board approved the Patient Safety Incident Policy & Plan**
BM/23/08/90	**Communications & Engagement Dashboard Q1 Update** KH introduced the report which provided details of the Q1 dashboard, the format of which had been refreshed to show not only the outputs of the Communications and Engagement Team, but to highlight the impact of key campaigns during the quarter. Highlights included: • Active Hospitals campaign • Children and Young People's Outpatients video • Where best next? campaign The dashboard provided examples of media releases issued during the quarter, plus engagement with social media, the Trust website and internal communication channels. KH highlighted the following activities: • The increased number of FOI requests in the quarter, which was a trend being experienced both regionally and nationally. • The pipeline work to update the Trust Website and Extranet, in order to move to more modern user-friendly platforms, specific reference was made to the current search function not being fit for purpose. • The increase in Experts by Experience. LG thanked Governors for

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	their involvement, confirming that outputs from the programme were evident. A specific example was given of the design of the new Breast Screening Unit. KSJ further commented that Experts by Experience would be utilised in the design of other new pathways. • The roll out of the new Trust branding, with a greater focus on accessibility SMcG commented on the success in the Disability Awareness event, thanking Governors and Non-Executive directors for their involvement. **The Trust Board noted the update.**
BM/23/08/91	**Working with People & Communities Strategy - Annual Report** KH introduced the report which provided an overview of the achievements and deliverables in the first year of the strategy, as well as providing an overview of the plans for the coming 12 months. It was noted that progress had been made in all four pillars of the strategy; however, there had been some areas where progress had not been at the anticipated pace. Objectives which had not been progressed as planned have been rolled over to the following year's work plan. It was further noted that that there had been good progress made since the appointment of the Trust Engagement and Involvement Officer it was explained this was a key role in service improvement and future design of Trust services through engagement. A summary of the outputs and outcomes against each objective within the four pillars was included in the report. It was noted that the development of an overarching Communications strategy would help to further drive progress on each of the pillars. The Trust Board discussed recruitment of Experts by Experience, and the importance of identifying their areas of expertise and ensuring diversity in the group. The Board also discussed the need to ensure the potential overlap between the role of Experts by Experience and existing governors needed to be managed and clear. LG added that there would be a requirement for more formal patient and public consultation in the future and that this would fall to the Trust to deliver, it was also noted that the Trust needed to be clear on requirements to consult or engage. The Board discussed the importance of addressing health inequalities and ensuring that all strategies were linked to the overall "Our Strategy 2023-25", which would be a focus for well-led reviews. **The Trust Board noted the progress made during the first year of the**

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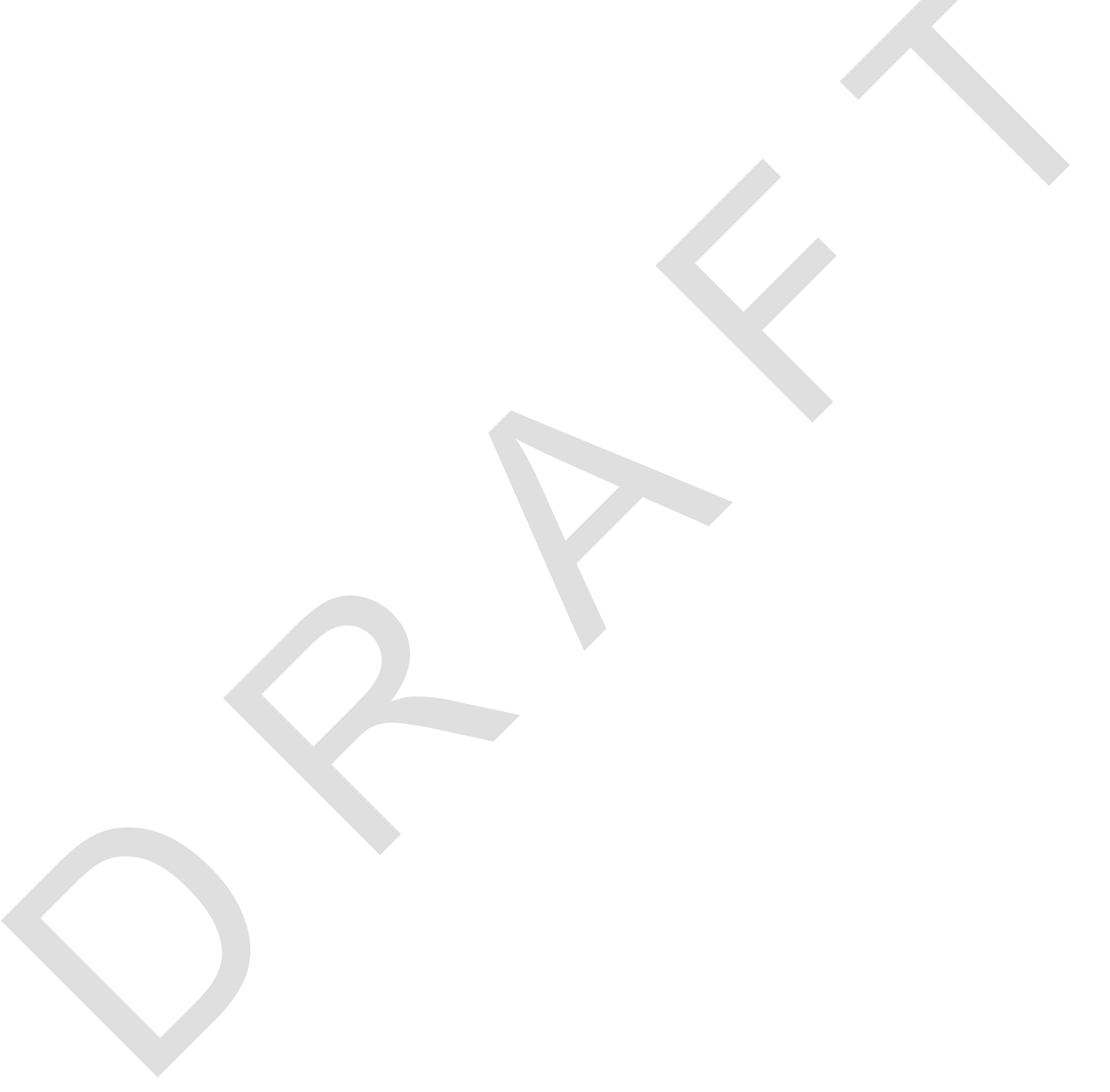
	Working with People and Communities Strategy 2022-25.
BM/23/08/92	**Quality Assurance Committee Annual Report** JC introduced the report which provided the Trust Board with assurance that The Committee had met their Terms of Reference and had gained assurance of the Trust's performance, throughout the reporting period. **The Trust Board noted and approved the Quality Assurance Committee Annual Report**
FOR APPROVAL	
BM/23/08/93	**Trust Organograms – Updated** JC introduced the paper detailing the updated Trust Organograms, it was explained that each of the Organograms had been approved by individual Executives and was being presented to the Trust Board for approval. KSJ asked the Board to note one additional update, the Director of Population Health and Inequalities who had been seconded to the Trust for 3 years. It was noted that this update would be made prior to the document being more widely circulated. **The Trust Board approved the Trust Organograms subject to the one amendment detailed above.**
SUPPLEMENTARY PAPERS	
BM/23/08/94	Annual Complaints Report
BM/23/08/95	Safeguarding Annual Report
BM/23/08/96	Infection Prevention and Control Board Assurance Framework Compliance – Bi-annual report
BM/23/08/97	DIPC Infection Control Annual Report
BM/23/08/98	Annual Health & Safety Report
BM/23/08/99	Risk Management Strategy Annual Report
BM/23/08/100	Digital Strategy Group Update Report
BM/23/08/101	Emergency Preparedness Annual Report
BM/23/08/102	Learning from Deaths Q4
BM/23/08/103	In-Patient Survey & Action Plan
BM/23/08/104	Perinatal Mortality Annual Report
BM/23/08/105	Patient Experience Bi-Annual Report
BM/23/08/106	Guardian of Safe Working – Annual Report
BM/23/08/107	**Review of the Meeting** The Trust Board agreed the meeting had been effective meeting with good discussions and challenge on items.
BM/23/08/108	**Any Other Business** **The meeting closed at 12:20pm**
The Date and Time of the next Trust Board Meeting is Wednesday 2nd October 2023	

Trust Conference Room, Warrington

Approved …………………………………………………………………………………

Dated ………………………………………….

Chair, Steve McGuirk



BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/23/10/111 (i)	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	4 October 2023

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/08/88	02.08.23	Fragile Clinical Services Update	To provide an update report at furture Board meetings	PF	From Oct 23	Ongoing	Updates to be provided going forward for those services classed as fragile **BM/23/10/119**	ongoing

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

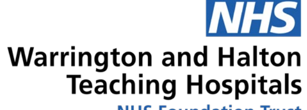
Minute ref	Meetin g date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/03/26	29.03.23	Chief Executives Report	Place-Based Partnership updates to be included in Bi-monthly strategy reports	Lucy Gardener	August 2023	October 2023	LG informed that Trust Board that PLACE and ICS development updates would be included in future reports from October 2023 On Agenda BM/23/10/122	

RAG Key

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



REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/113**				
SUBJECT:	**Chief Executive's Report**				
DATE OF MEETING:	4 October 2023				
AUTHOR(S):	Simon Constable, Chief Executive				
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.				✓
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.				✓
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.				✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**				
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***				
	1. Eliminate unlawful discrimination, harassment and other victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**	
				√	
	Further Information:				
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***	
				√	
	Further Information:				
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**	
				√	
	Further Information:				
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.				
PURPOSE: *(please select as appropriate)*	Information √	Approval	To note √	Decision	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.				
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable			
	Agenda Ref.				
	Date of meeting				
	Summary of Outcome				

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/23/10/113

1. BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 2nd August 2023, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 5 - August 2023. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

Our single most important operational performance challenge remains length of stay, and there has been some improvements in recent weeks and months, for both Warrington and Halton residents. Our total number of super-stranded patients with a length of stay greater than 21 days remains high at 120. However, the number of patients that do not meet the criteria to reside (NCTR) has come down to 102. These are similar figures to my last Board report in August. For Warrington Borough Council residents in hospital, this latter number is currently 56 (17.0%, just above the national average of 15%); for Halton Borough Council residents in hospital, it is 25 (22.9%). We are working with partners on improving these figures further, as well as working on own processes with regards to length of stay more generally.

The Trust continues to undertake an elective recovery programme although there has been continued disruption because of the impact of industrial action; the priority this year is now on the elimination of waiting lists longer than 65 weeks by the end of March 2024. Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality Assurance and the Finance & Sustainability Committees.

2.2 Senior Leadership Changes

After seven years as Chief Finance Officer, and more recently as Deputy Chief Executive, Andrea McGee, leaves the Trust on 30th September 2023 to embark on a new life in Gibraltar. I am delighted to announce that, following a competitive process which concluded on 21st September 2023 at Halton, and following ratification by our Nomination and Remuneration Committee, Jane Hurst has been appointed as our new Chief Finance Officer, effective from 1st October 2023.

Jane has been Deputy Chief Finance Officer and Freedom to Speak Up Guardian and will also continue to do the latter role as we appoint a successor over the coming weeks.

2.3 Cheshire & Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative Update

The CMAST Leadership Board met on 1st September 2023 and considered a number of important issues which included an update on specialised commissioning and programmes of work related to clinical leadership and Laboratory Information Management Systems (LIMS).

The issues discussed included:

• Specialised Commissioning: discussions included an update on a NW review of Women's and Children's Services in line with national standards and service specifications, and upcoming engagement on the emerging proposals with ICS partners through the autumn and spring. The programme of work currently has a targeted outcome by spring/summer 2024. The Board also received an update on the process of delegation of some functions to ICBs. In the NW a number of functions will be delegated to ICBs, some will be retained by NHSE, and a third category will be jointly discussed with all the NW ICBs in a shared forum. CMAST are represented by Alder Hey in these discussions.

• ICS Clinical Leadership. A request was made for Trusts to consider funding of clinical time for ICB Transformation Programme funding and bids. The Board recognised the need to engage with the ICB on this and to establish a more sustainable approach however the challenge for Trusts to deliver consistently more system contributions while also delivering heightened levels of efficiency was noted to be a challenge.

• A further update on the recommended system approach to Laboratory Information Management Systems (LIMS) and imminent delivery of an OBC for the 5 'host' Trust Boards (WHHT, WUHT, MWL, LUHFT and COCH) to support the next step in a consolidated C&M approach and the proposed delegation of the ITT process to CMAST.

• The Board noted the recent conclusion of the Lucy Letby trial and commended opportunities for future system learning.

• The Board also noted the development of a quarterly Cancer Alliance report for use by stakeholders.

The Board also received the following documents:
• C&M ICS Activity Summary Report
• C&M ICS Finance Report

The Board's next meeting will include Trust Chairs where business is expected to include a review of programme delivery - year to date.

2.4 The Lucy Letby Trial Verdict

In August we learned of the verdict in this trial. Lucy Letby committed appalling crimes that were an evil betrayal of the profound trust placed in her, and our thoughts are with all the families affected. The pain and anguish is something that few of us can imagine.

Like me, colleagues across the NHS have been shocked and sickened by her actions, which are beyond belief for staff working so hard to save lives and care for patients and their families. If you ever wanted a definition of the utmost vulnerability then surely premature and sick babies are it.

Now, an independent inquiry has been announced by the Department of Health and Social Care.

So much has already been strengthened since 2015/16. Implementation of Learning from Deaths, and the national roll-out of the medical examiner role has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner. Improving data quality has made it much easier to spot potential problems. There are now also specific reviews in the cases of babies, children and vulnerable adults that were not present then, in addition to medical examiner scrutiny.

In September, the new Patient Safety Incident Response Framework will represent a significant shift in the way we respond to patient safety incidents, with a much sharper focus on data, understanding how incidents happen, having a ‘just’ culture and changing our systems to make it harder for things to go wrong.

Continuing to be an environment where it is safe to speak up about concerns is vital and we see this in action at WHH through the work of the Freedom to Speak Up (FTSU) process, its Guardian and Champions – giving every member of staff open access to a confidential and independent route to raise concerns.

I would hope you would expect me, alongside the rest of the Trust Board, to ask the justifiable question of whether such a thing could ever happen in this organisation. It would be wholly wrong to dismiss such a suggestion, and that we would immediately reflect upon such a thing is, in many ways, at least one line of defence. We will continue to learn from others, alongside strengthening all the right things in terms of our culture and processes accordingly.

2.5 BMA Industrial Action

We continue to see industrial action by both hospital consultants and junior doctors across England, including, for the first time, an overlap of the two on the same day.

This represents industrial action in the NHS on a scale we have not seen previously, with new and different challenges to which to respond. Consultants are our most senior doctors with many other staff groups dependent upon consultant supervision in order to be able to carry out many aspects of their roles. Our treatments and procedures are listed under, and supervised by, consultants and it has been important in our planning to ensure we provide only those clinical activities where we are assured there will be sufficient consultant supervision and service delivery in each of our specialty areas.

However, thanks to colleagues from across the Trust working tirelessly to ensure that our patients remain safe and well cared for, we had robust plans in place with as much assurance as possible so that we could continue to maintain safe care.

Our plans during industrial action included:

- We provided, as a minimum, 'Christmas Day' consultant cover throughout, with additional cover as agreed with the BMA where required to ensure patient safety.
- Emergency and critical care cover was maintained throughout.
- Detailed plans were agreed in each Care Group to ensure sufficient consultant cover to keep our patients safe and deliver effective care.
- With elective care we prioritised patients with urgent, time sensitive conditions using the consultant cover we had available.
- All consultant sessions, clinical or not, were worked on site to ensure availability in case of an emergency.
- Any appointments or procedures that have been postponed due to industrial action have been rescheduled as soon as possible.

2.6 Unison Healthcare Support Worker Industrial Action

UNISON has balloted its WHH healthcare support worker members on the issue of retrospective pay banding and members have voted in favour of strike action.

Strike action at WHH will take place from 7am on Thursday 28th September to 8am on Saturday 30th September, with picket lines expected at both hospital sites. This action will involve band 2 healthcare assistants, midwifery support workers and theatre support workers.

This is unrelated to the ongoing national industrial action involving wider sections of the NHS workforce, although similar action has been taken at other NHS trusts over the issue of retrospective pay banding for band 2 healthcare support workers.

It follows a wider piece of work we have undertaken to look at the scope of all our healthcare support worker roles. This included a staff consultation on proposals to uplift the majority of band 2 healthcare support workers to band 3, which will come into effect from October 2023.

A separate issue was raised during the consultation period around retrospective pay banding for those staff who feel they have already been working at band 3 level. This is the issue on which UNISON balloted its healthcare support worker members.

As with all industrial action, we are putting plans in place to ensure patients remain safe in our care while essential members of our team are participating in industrial action. We have requested a number of derogations to support patient safety. We are committed to doing this in a way that respects the rights of our colleagues who wish to strike and complies with the legal requirements of employers during strike action.

Visiting arrangements will operate as normal and we will do what we can to support visiting outside of these hours, where possible.

As with all industrial action, a control room will be in operation throughout this period of industrial action to provide support and a central point of contact. We are also asking colleagues who are due to work from home on these strike days to come on-site to provide additional support, if needed.

Healthcare support workers in all areas of the Trust remain essential and much valued members of our team and we remain determined to do the right thing by them. Whilst this is regrettable, we remain committed to resolving the issue at the centre of this industrial action quickly and fairly.

2.7 *Patient Safety Incident Response Framework (PSIRF)*

1st September saw day one of the new Patient Safety Incident Response Framework (PSIRF).

The adoption of PSIRF will see a fundamental shift in the way that patient safety will be managed across any organisation providing NHS funded care. At WHH we have been working on PSIRF implementation for almost a year.

We will move away from the Serious Incident Framework and will be guided by our own developed PSIRF Policy and Plan.

Our Trust Board and the Cheshire & Merseyside Integrated Care Board (ICB) have approved our Policy and Plan and have supported the work that we have done so far in agreeing the WHH local priorities.

PSIRF aims to deliver 4 main objectives:

- Compassionate engagement and involvement of those affected by patient safety incidents; this includes patients, staff and families.
- The application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening the response system functioning and improvement.

Improvement work is an absolute must. The aim is to reduce avoidable patient harm and to build a safety culture where everyone feels 'psychologically safe' to raise concerns and to help us to improve our systems so that they keep patients safer.

Clearly, errors come in all shapes and sizes and not all cause harm, fortunately. Nor are they solely a hazard of the clinical environment. However, when they do happen we need to respond appropriately and proportionately. We then need to make sure we do all we can so that we do not repeat the same ones.

2.8 Sexual misconduct in the workplace

This month we have seen research reported widely that speaks of a culture of serious sexual misconduct in healthcare, particularly in surgery.

The research, carried out by the University of Exeter, the University of Surrey and the Working Party on Sexual Misconduct in Surgery, highlights that 90% of women and 81% of men had witnessed some form of sexual misconduct in the workplace.

Registered surgeons were invited to take part and over 1,400 did so anonymously, half of which were women. 63% of these women and 24% of men had been the target of sexual harassment from colleagues. 11% of women reported forced physical contact related to career opportunities. At least 11 incidents of rape were reported.

The stories of those affected are shocking; forced sexual contact, sexual abuse taking place during patient procedures, surgeons' careers being stalled when they have spoken up, sexual harassment, sexual assault and rape referred to as surgery's open secret.

I want to be clear that this type of behaviour will never be tolerated, at any level, at WHH.

Every one of us has the right to come to work to care for our patients and progress our careers without fear of any form of discrimination, harassment or coercion. Every one of us has an absolute responsibility in ensuring that this is, without exception, the reality for every person who works or receives care here.

I am equally clear in my responsibility as chief executive to make sure any concerns of this nature can be safely expressed and will be heard. Any claims of sexually inappropriate behaviour will be investigated, and the necessary action taken. This will happen free of any form of consequence for victims of sexually inappropriate behaviour who will always be supported and protected.

It is vital that people feel safe and confident in reporting what they have experienced and know with confidence that action will be taken. We have taken action in the past and will always take action in the future.

If we see or experience behaviour of this type, every one of us has a responsibility to speak up, irrespective of the severity of behaviour or the seniority of those involved – the standard of behaviour we walk past is the standard of behaviour we are willing to accept.

To be clear, sexualised 'banter', sexualised lewd language or invading personal space is never acceptable. Any unwanted physical contact that could be experienced as sexual is sexual assault and will be considered as such.

Inappropriate behaviour can be reported internally by contacting:

- A line manager or professional lead
- An educational or training lead
- A senior leader in the Care Group
- Our Freedom to Speak Up Guardian or Champions

In addition, the doors of every member of the Executive Team are always open to hear, in confidence, concerns of this nature.

We owe it to each other, and to future generations, to ensure that sexual misconduct is eradicated from the NHS. By speaking up and taking the action required at WHH we can make sure it never forms part of our culture here.

2.9 Maternity Services CQC Inspection

Within the last couple of weeks, we have had our core service inspection for maternity services by the CQC.

Very high-level feedback was shared during a meeting between us following the onsite inspection, pending a draft report that will be sent to us within the next few weeks or so. The feedback provided takes into consideration the actual onsite inspection itself, the interviews that have occurred over the subsequent days as well as the review of our data, the latter of which is still very much ongoing. The draft inspection report will be sent to us once the CQC have completed their due processes and we will have the opportunity to check the factual accuracy of the report.

Feedback was high level at this stage. It followed the usual, good practice, format of talking about the positives (there were lots of them) followed by potential areas for improvement.

Positive findings
• The teams were very welcoming, open to discussion and receptive to feedback, including leadership acting swiftly to any concerns raised.
• The environment was clean and well maintained; the new addition of the Triage area was particularly positive in terms of meeting the needs of women and ensuring effective implementation of a nationally recognised model for maternity triage.
• Positive work with at-risk groups by our continuity of care teams in particular the work done to set up clinics with the hotels housing asylum seekers, and the offer of care packages for those in most need (Team River).

Potential areas for improvement
• We need to provide further evidence that our management of bleeding following delivery of babies (post-partum haemorrhage, or PPH) is consistent with our own policy which is in turn consistent with nationally recognised guidelines. We know that we also need to show continuous improvement on the current variation which is already improving.
• We need to provide further evidence that enhanced maternity care provision is supported by appropriate staff training and competency to provide such care.
• We need to provide further evidence of how a baby is treated under the transitional care pathway and whether the current policy is being implemented in practice.

Thank you to everyone that has supported our maternity service in the last weeks and months in their preparation for this inspection. I know how grateful the team are, and how much all the support has meant to them. Equally, well done to the maternity team itself. We can be proud of the professionalism demonstrated and the service provided to women, babies and families.

This has been a massive team effort right the way across the organisation from clinical teams to support services. It was all calm and well organised with detailed knowledge evidenced at every level.

This is yet another tool we use to improve the quality of care we deliver for our patients and their families.

2.10 CT Scanning in the Emergency Department

Earlier this month I was really pleased to do the formal opening and 'ribbon cutting' of the new CT scanning suite in our Emergency Department.

Improved diagnostics for patients requiring emergency care is the latest in a line of improvements in our ED.

The new £1.9 million CT Department is directly accessed from ED to speed up the transfer of patients requiring urgent scans. The scanner is equipped with the latest technology and makes detailed CT imaging available to clinicians 24 hours-a-day, supporting them in making urgent and often life-saving diagnoses. All of the other things we have done recently on the ground floor of Appleton Wing, including the new Same Day Emergency Care Centre, has enabled us to reconfigure the department to accommodate the scanner and provide an improved environment for those undergoing urgent diagnostic scans.

Patients will also benefit from increased privacy as the department has been thoughtfully designed with a two-bed waiting bay with ambient and skylight ceiling lighting in the scanning area to help put them more at ease.

A computerised tomography (CT) scan uses X-rays to create detailed images of the inside of the body including many structures including internal organs, blood vessels and bones. They can be used to diagnose conditions including damage to bones, injuries to internal organs and problems with blood flow which may be present in patients experiencing trauma, stroke or some cancers.

When not required for emergency care, the scanner will be used to support the wider radiography and scanning requirements for patients receiving care elsewhere in the hospital.

It is another fantastic facility delivered by our Estates & Facilities team which has had responsibility for over £100m to 'make things happen' over both our hospitals over the last four years; you would never know you were in an older building. It looks and feels modern and state-of-the-art.

But this is more than about shiny buildings. It improves outcomes and efficiency; the early signs are excellent. For example, on Monday 4th September, radiology scanned 115 patients, 68 of which were done on the ED scanner which is an all-time record for CT - and 68 on one scanner is just showing how efficient it is. During the previous 4 weeks, the team have recorded 7 instances of scanning more than 100 patients in a day, something they had only done a few times since the first CT scanner was installed at Warrington in 1994.

The team has also done numerous trauma scans so far on the scanner and, despite still finding their feet, have done several of these within 12 minutes of receiving the request which was completely impossible before the ED scanner.

A lot of people have worked together to make this happen across radiology, ED and Estates & Facilities. All have once again demonstrated continued commitment to providing the best possible care for our patients despite high levels of demand for emergency care and the challenges presented by the physical limitations of some of our older buildings. The new CT scanner situated within the heart of our emergency care services will be a real boost to our capacity to carry out urgent diagnostic tests. Providing our emergency clinicians with timely information to make diagnoses or plan for the next phase of care and treatment will reduce any unnecessary waits in the department.

Thank you to everyone involved in delivering this project on time and on budget.

2.11 Flu and COVID-19 Vaccination Campaign 2023/24

The Occupational Health & Wellbeing Team have launched the flu and COVID-19 vaccination campaign for this year with a stand at the front of Warrington Hospital, next to the helpdesk from 8.30am to 3.30pm for staff to get their vaccinations.

The team will have a stationary stand over the coming weeks but will also be roving around the wards on both sites to support staff who cannot get to the stand. They will also be at Halton Hospital.

All staff are eligible for the flu vaccination this year. For the COVID-19 vaccination, we have followed the ‘Green Book’. This includes staff who are involved in direct clinical care or have potential ‘social contact’ with patients (but not necessarily be involved in direct clinical care) during the forthcoming winter. It was noted that the Trust’s successful ‘Helping Hands’ programme meant that at times of pressure and during industrial action, significant numbers of ‘back office’ staff undertook duties in a clinical setting and ‘social contact’ between ‘back office’ staff and patients in areas such as corridors, cafeterias and ward environments was frequent.

2.12 World Patient Safety Day

World Patient Safety Day (WPSD) is one of the World Health Organisation’s (WHO) global public health days and was established in 2019. This year, WPSD was observed on Sunday 17th September under the theme "Engaging patients for patient safety", in recognition of the crucial role patients, families and caregivers play in the safety of health care.

Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction, and health outcomes. By becoming active members of the health care team, patients can contribute to the safety of their care and that of the health care system.

Through the slogan “Elevate the voice of patients!”, WHO calls on all stakeholders to take necessary action to ensure that patients are involved in policy formulation, are represented in governance structures, are engaged in co-designing safety strategies, and are active partners in their own care. This can only be achieved by providing platforms and opportunities for diverse patients, families, and communities to raise their voice, concerns, expectations, and preferences to advance safety, patient centeredness, trustworthiness, and equity.

In the lead up to WPSD we worked with the National Patient Safety team at NHS England to make some videos with our Patient Safety Partners - Sue Barker and Gemma Luxton and Kimberley Salmon Jamieson, Chief Nurse and Deputy Chief Executive – to promote the work that we are doing to enable patient voices to be heard as part of our Patient Safety Incident Response (PSIRF) journey.

To achieve our goal to continuously improve our patient safety we took the opportunity to appoint additional Patient Safety Specialists (PSS) to join our two existing PSS - Dr Eshita Hassan, Associate Medical Director, and Ali Kennah, Deputy Chief Nurse. We now also have Emma Painter, Associate Chief of Nursing for Unplanned Care, Ailsa Gaskill Jones, Director of Midwifery, Debi Howard, Associate Director of Nursing, Lucy Parry, Lead nurse for Digestive Diseases, and Nicola Edmondson, Associate Director of Governance.

We held some online sessions with our Experts by Experience and members of the public to talk about the work we are doing to improve safety across WHH and to invite them to get involved. We had some great feedback and suggestions from participants and even had colleagues attend from other parts of the NHS to listen to the work we are doing.

We also launched some patient safety information which has been produced nationally to help patients to keep themselves safe whilst in hospital; this is now live on our website and will be part of patient letters when they are coming into hospital.

2.13 Halton Macmillan Delamere Centre 10th Birthday Celebrations

I was pleased to visit the Macmillan Delamere Cancer Information and Support Centre at Halton on 21st September to celebrate the Centre’s 10th Birthday. The event was a perfect opportunity to connect, celebrate, and show our appreciation for the ongoing support of the Macmillan Delamere Centre, and I was delighted to welcome the Mayor of Halton, Councillor Val Hill, and her consort Stan, alongside Debbie Monfared, Macmillan Integrated Cancer Information & Support Service Manager, and Kate Bailey, Deputy Manager. Such an important service is provided to patients and their families at some of the most difficult times in their lives through this centre. It was great to be able to meet patients, past and present, with staff and volunteers in such a nice positive environment.

2.14 Special Days/Weeks for professional groups

Since our last Board meeting in August 2023, several topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. These have included:

World Patient Safety Day: 17th September 2023
World Alzheimer's Month: September 2023

2.15 Local political leadership engagement

Since the last Board meeting, both the Chairman and I have continued regular communication and updates with our local political leadership, through the chief executives of both Warrington Borough Council and Halton Borough Council and the respective council leaders. I have also continued to be in regular communication with all four of our local Westminster MPs – Derek Twigg MP (Halton), Mike Amesbury MP (Weaver Vale), Charlotte Nichols MP (Warrington North) and Andy Carter MP (Warrington South). I have been updating them on the WHH situation, both in terms of current operational pressures as well as other significant issues; similarly, they have raised issues on behalf of their constituents. All of our senior stakeholders are active participants and members of our New Hospitals Strategic Oversight Group.

2.16 Employee Recognition

Our *You Made a Difference Awards* are in their third year of operation. Nominations are reviewed and awards are made by a multi-professional panel.

You Made A Difference Award (June 2023): Paediatric/Anaesthetic Emergency Team

This was a truly multi-professional team made up of individuals from different 'home' teams. The team demonstrated some extraordinary professionalism, dedication and excellent teamwork from collaborative working of anaesthetic, paediatric and physio colleagues on Ward B11 earlier in the summer. They tried to save the life of a very sick baby with very complex and serious health conditions, who deteriorated acutely.

You Made A Difference Award (July 2023): Halton Radiology Team

This award was made in recognition of amazing teamwork, quick thinking and the excellent care provided to a patient, who whilst attending their routine scanning appointment at Halton Hospital went into cardiac arrest after being injected with a contrast. The way the team sprang into action to support this patient in these extremely rare circumstances, embracing the rapidly changing situation all whilst communicating with PACU and the paramedics, quite literally saved this patient's life.

Despite all the odds of an out of Critical Care/Emergency Department survival rate of 7-8%, this patient arrived at Warrington Emergency Department conscious and talking. This is a credit to thier skill, professionalism and excellent teamwork.

You Made A Difference Award (August 2023): Debra Cunliffe

Debra Cunliffe, Housekeeper – NICU, was successfully nominated by a colleague for the support provided to them starting in a new role. Nothing was ever too much trouble for Debra and she was always there for help, advice and with a smile. Her positive attitude really did make a difference.

The winners of my own award since my last Board report have also been the following:

Chief Executive Award (September 2023): Dr Graham Barton

I was very pleased to recognise the work of Dr Barton in our Mortality Review Group following his retirement from the Trust as a consultant geriatrician in 2016.

Chief Executive Award (September 2023): Tony Weetman

This award was made for the outstanding contribution from volunteer, Tony Weetman, made to patients and their families, supporting learning across the organisation. Tony has worked in the complaints and PALS team for 7 years and is an extremely valued member of our team. He has supported communications between patients and families when at their most vulnerable and has delivered this in a kind, compassionate and professional manner. He has supported change in the complaints process over the last few years, which we know has resulted in greater efficiency and high quality responses, through both PALS and complaints directly affecting both patient care and experience.

Appreciation of WHH staff from patients, family, visitors and colleagues

I have also specifically recognised the work of the following colleagues:

- Nicola Cliffe, Registered Nurse Associate (A8) - Integrated Medicine & Community
- Stuart Whitlow, Waiting List Coordinator (Endoscopy) - Digestive Diseases
- Hilary Stennings, Associate Director - Clinical Support Services
- Patricia Harper, Domestic Assistant - Estates and Facilities
- Janette Richardson, Breast Screening Programme Manager - Clinical Support Services
- Patricia Stevens, Domestic Assistant - Estates and Facilities
- Dr Mohammad Qaffaf, Consultant Physician (FAU)Integrated Medicine & Community
- Damian Jolkowicz, Physician Associate (Emergency Medicine) - Urgent & Emergency Care
- Arun Sukumaran Nair Geetha, Staff Nurse (Emergency Department) - Urgent & Emergency Care
- Natalie Crosby, Associate Chief Nurse - Planned Care
- Kirsty Pine, Associate Director - Research & Development
- Lisa Cheng, Head of Research, Development & Innovation
- Luke Foster, Physician Associate (Emergency Medicine) - Urgent & Emergency Care
- Jill Tomlinson & Ward B11 Team, Paediatrics, Women's & Children's Health
- Dr James Williamson, Consultant & Lead Medical Examiner
- Rebecca Tunstall Burgess, Medical Examiner Officer
- Dave Wood, Fire Safety Advisor - Estates and Facilities
- Ian Wright, Associate Director - Estates and Facilities
- Linda Doherty, Specialist Nurse - Urgent & Emergency Care
- Matthew Jones, Advanced Physiotherapist - Clinical Support Services
- Helen Kirk, Physiotherapy Receptionist - Clinical Support Services

- Kate Lears, Physiotherapy Receptionist - Clinical Support Services
- Christine Mulholland, Domestic Assistant - Estates and Facilities
- Susan McDonough, Diabetes Nurse Specialist - Medical Care
- Debbie Monfared, Macmillan Integrated Cancer Service Manager
- Kate Bailey, Deputy Macmillan Integrated Cancer Service Manager

2.17 Signed under Seal

Since the last Trust Board meeting, the following items have been signed under seal:

- Warrington Induction of Labour project phase one

3. MEETINGS ATTENDED

The following is a summary of key external stakeholder meetings I have attended in August 2023 and September 2023 since the last Trust Board Meeting.

- NHSE NW Region System Leadership (Monthly)
- C&M Provider Collaboration CEO Group (Monthly)
- C&M Acute and Specialist Trust (CMAST) Leadership Board (Monthly)
- C&M Acute and Specialist Trust (CMAST) Programme SROs (Monthly)
- CMAST Clinical Pathways Programme (Various)
- Steven Broomhead, Chief Executive, Warrington Borough Council
- Stephen Young, Chief Executive, Halton Borough Council
- Carl Marsh, ICB Place Director (Warrington)
- Anthony Leo, ICB Place Director (Halton)
- Warrington Wider System Sustainability Group (Monthly)
- Clinical Research Network Northwest Coast Partnership Group Meeting (Quarterly)

4. RECOMMENDATIONS

The Board is asked to note the content of this report.

5. APPENDICES

Appendix 1: CEO Dashboard – Month 5 (August 2023)

Appendix 1 - CEO Dashboard Month 5 – August 2023

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	74.95%	F
RTT 18 Weeks	92.00%	50.51%	F
RTT 65+ Weeks	0	515	F
A&E % patients seen within 4 hours	75.00%	69.17%	F
A&E % waiting longer than 12 hours	< 2.00%	22.78%	F
Cancer 14 Days	93.00%	68.98%	F
Breast Symptomatic 14 days	93.00%	51.79%	F
Cancer 28 Day Faster Diagnostic Standard	75.00%	75.47%	?
Cancer 62 Days Urgent	85.00%	61.11%	F
Ambulance Handovers within 60 mins	100%	86.26%	F
Discharge Summaries 24 hours	95.00%	89.85%	F
Cancelled Operations – 28 days	0	3	?
Super Stranded Patients	Trajectory	135	No SPC
Theatre Utilisation	85.00%	86.00%	?
Day cases	85.00%	88.62%	P

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	0	P
Sepsis Screening Emergency	90.00%	56.00%	F
Sepsis Screening Inpatients	90.00%	68.00%	F
Sepsis Antibiotics Emergency	90.00%	58.00%	F
Sepsis Antibiotics Inpatient	90.00%	88.00%	?
Inpatient Falls	20.00% reduction	28	P
VTE	95.49%	93.86%	?
Pressure Ulcers	10.00% reduction	9	?
Medication Reconciliation (24 hrs)	80.00%	39.00%	F
Complaints over 6 months	0	0	P
Healthcare Infections - MRSA	N/A	0 YTD	P
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	13 YTD	?
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	35 YTD	?
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	5 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	2 YTD	?
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	3.84%	No SPC
Maternity 3rd and 4th Degree tears	Less than 1.85%	0.82%	No SPC
Maternity Pregnancy Bookings before 10 weeks	75%	55%	F
Maternity Pregnancy Bookings before 13 weeks	90%	84%	F
MUST nutritional assessment completion	85%	63%	F

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (culm)	-£1.55m	-£1.54m	No SPC
Capital Spend	£10.37m	£4.58m	F
Cash Balance	£21.54m	£22.11m	P
Better Practice Payment Code (culm)	95%	93%	F
CIP In Year Delivered (culm)	£4.18m	£4.18m	P
CIP Forecast (Recurrent)	£4.18m	£2.00m	F
Agency Ceiling	Less than 3.7%	3.2%	F

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.70%	F
Retention	85.00%	85.51%	F
Core/Mandatory Training	85.00%	90.07%	?
PDR Compliance	79.00%	75.04%	F

Strategy

Strategy

- **Community Diagnostic Centre (CDC)** – Phase 1, including respiratory, ultrasound and phlebotomy, is complete and over 8,000 patients have now accessed diagnostics from the newly refurbished area in Nightingale.
- **New hospitals and strategic estates** – New hospitals estate remains a priority for the Trust, despite not receiving funding in the latest national funding round. Options are being discussed to continue with the plans for the Halton site (i.e. an extension of CSTM, which is supported by phase 3 of the CDC) and to explore the possibility of a phased rebuild for Warrington hospital. In all options provision of services in the community where appropriate, e.g. via our new and planned community hubs, remains a priority.
- **Our Halton Health Hub** - in Runcorn Shopping City, was recently shortlisted for a national Government property award.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/10/114**	
SUBJECT:	**Chair's Report**	
DATE OF MEETING:	4 October 2023	
AUTHOR(S):	Steve McGuirk, Chair	
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to draw attention to matters that the Chair believes are of particular significance to the Board of Directors and not covered elsewhere on the Board agenda.
	
	This update draws attention to:
	• General Trust Update
	  ○ CT Scanning in ED
	  ○ CQC Maternity Inspection
	• WHH Meetings and Events Attended
	  ○ International Nurse Midwife and AHP Celebration Event
	  ○ Board Development Day
	  ○ Long Service Awards

<table>
<tr><td></td><td colspan="4">

- Industrial Action
- System Working & National Updates/Events
  - CMAT Update
  - CMAST Chairs Meeting
  - ICS Update
  - NHS Workforce Conference
- Council of Governors & Members Update
  - Governor Workshop
  - Governor Elections
  - Annual Members Meeting
  - Governor Observation Visits

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<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
✓</td><td>Approval</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to:

I. To note the matters being brough to the attention of the Board.
II. To make any comments or ask any questions arising from the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chair's Report	AGENDA REF:	BM/23/10/114

1. BACKGROUND/CONTEXT

This report highlights activity and strategic issues that, in the opinion of the Chair should be drawn to the attention of the Board, but ate not necessarily covered e4lsewhere on the agenda, as well as seeking to represent the point of view of the Council of Governors at the Board level.

2. MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

Date	Location	Meeting
8 September	Village Hotel Warrington	International Recruitment Celebration
13 September	The Innovation Centre, Sci Tech Park Daresbury Halton	Giving presentation for The Innovation Centre to nominate choose a Charity for the next two years
13 September	Warrington & Vale Royal College	Governors Workshop
19 September	MS Teams	NHS Workforce Conference
20 September	MS Teams	CMAST Chairs Meeting
27 September	MS Teams	Leadership Advisory Board
29 September	Park Royal Hotel Warrington	Long Service Awards

3. KEY ISSUES TO DRAW TO THE BOARD'S ATTENTION

3.1 General Update

CT Scanning in ED

On Thursday 7th September a formal opening and 'ribbon cutting' of the new CT scanning suite in our Emergency Department took place. Improved diagnostics for patients requiring emergency care is the latest in a line of improvements in our ED.

The new £1.9 million CT Department is directly accessed from ED to speed up the transfer of patients requiring urgent scans. The scanner is equipped with the latest technology and makes detailed CT imaging available to clinicians 24 hours-a-day, supporting them in making urgent and often life-saving diagnoses.

CQC Inspection Maternity Services

On Thursday 14th September we welcomed the inspection team from the Care Quality Commission (CQC) as part of the national maternity inspection programme. Initial

feedback was presented a few days after the inspection and elsewhere on the agenda is a paper that outlines what was said. The full report is anticipated within 50 days and, of course, will be in the public domain.

It is worth making the point, though, that, as far as we understand, we were the first Trust to have a regulatory inspection of Maternity Services following the conviction of Lucy Letby at a neighbouring trust, the Countess of Chester. And, while inspections of this nature always add a degree of pressure for staff - who want to be able to demonstrate the good job they do – it would be naïve to pretend the Letby case aspect did anything other than add an extra layer of pressure on this occasion. As indicated, the final report will be in the public domain in a few weeks and the early feedback elsewhere today. But on behalf of the Board, I would nevertheless want to express thanks and appreciation to the whole team for their efforts to make this inspection the best possible – bearing in mind it also occurred in the middle of a major period of industrial action.

3.2 WHH Meetings and Events Attended

International Nurse Midwife and AHP Celebration Event – 8th September 2023

This event was held at the Village Hotel and was a fantastic celebration of the diversity of nursing, midwifery and AHP staff at WHH. The Chief nurse welcomed all attendees to the event, following which staff members were then invited to share their stories. This was followed by entertainment music, lunch, and an engagement event. There were also various stalls available including Wellbeing and Occ Health support facilities, Trust staff networks, Union representatives, NHS Professionals, Professional Nurse Advocates and community engagement.

Board Development Day – 6th September 2023

Members of the Board (including the Lead Governor) undertook an important development/ learning day. Non-Executive directors also undertook a mandatory training module on Patient Safety Essentials in line with the new Patient Safety Incident Response Framework (PSIRF), and covered:

- The human, organisational and financial costs of patient safety
- The benefits of a framework for governance in patient safety
- Understanding the need for proactive safety management and a focus on risk in addition to past harm
- Key factors in leadership for patient safety
- The harmful effects of safety incidents on staff at all levels

Other agenda items included the New Hospital & Estates Strategy, Provider Relationships, Digital Strategy, Financial Recovery Plan, Elective Revocvery Plan and Early reflections on the Lucy Letby Case.

Long Service Awards - 29th September 2023
It was a pleasure to attend our annual, long Service Awards Lunch at the Park Royal Hotel, Stretton. This is always an uplifting event and celebrates hundreds of years of public service when aggregated across all the recipients. There were in fact people who had completed forty years' service in the NHS - a phenomenal achievement.

3.3 Industrial Action

For the first time industrial action saw junior doctors and hospital consultants striking at the same time. The industrial action encompassed 96 hours of continuous strikes, starting with consultants striking from 07:00 on Tuesday, 19 September to 07:00 on Thursday, 21 September and junior doctors striking from 07:00 on Wednesday 20 September to 07:00 on Saturday 23 September. This meant both groups took strike action together on Wednesday, 20 September.

NHS Trusts across Cheshire and Merseyside were severely impacted by these strikes, and the public were advised that significant service disruption is highly likely.

This issue is now every much a political football and it is fair to say that a hardening of attitudes is observable. It would be wrong to comment much beyond this, save to encourage all parties to return to the negotiating table with a shared spirit of compromise because the impact on patients and care is extremely worrying.

3.4 System Working & National Updates

CMAST Update
The latest CMAST briefing is attached to the Chief Executive's Briefing.

CMAST Chairs Meeting – 20th September 2023
The CMAST Chairs Meeting was facilitated MS Teams, and predominantly focused on the implications of the publication of the Long Term Workforce Plan for Cheshire and Merseyside.

NHS Workforce Conference - 19th September 2023

This meeting was for NHS leaders to listen to the latest policy updates and practical case studies from across the NHS. Previous and continued areas of conversation included Diversity and Inclusion, Culture Change, Staff Recruitment and Retention, Technology and Leadership Development.

Key learning points from the conference were:

Workforce planning: focusing on improving workforce planning in order to ensure that it has the right number and mix of staff to meet the needs of patients.

Recruitment and retention: challenges in recruiting and retaining staff, particularly in certain specialties and geographic areas. As a result, it is implementing initiatives to

improve recruitment and retention, such as offering flexible working arrangements and training programs.

Training and development: investing in training and development for its staff, in order to upskill and reskill the workforce and ensure that it has the knowledge and skills needed to meet the changing needs of patients.

Diversity and inclusion: working to increase diversity and inclusion in its workforce, in order to better reflect the diverse populations, it serves and to create a more inclusive and welcoming workplace.

Workforce engagement: focusing on improving workforce engagement, in order to create a more positive and supportive working environment and to improve the retention and satisfaction of staff.

3.5 Council of Governors & Members Update

Governor Workshop - 13th of September

This workshop was held on the at Warrington and Vale Royal College and was arranged following the receipt of a new addendum to Governors Statutory duties. A paper on this presented at the Council of Governors Meeting – 10th August 2023.

The purpose of the Workshop was to aid Governors in their understanding of new Governance and regulatory requirements, the topics that were covered at the workshop were:

- New Governance & Regulatory Requirements including Addendum to Statutory Duties, Code of Governance for NHS Provider Trusts, Guidance on Good Governance & Collaboration and NHS Provider License
- Local Constituencies/Communications with Trust Members
- Member Database Refresh/Recruitment
- The WHH Membership Strategy which had been drafted and the final version is to be presented for approval at the Council of Governors Meeting – 9th November 2023.

Governor Elections 2023

Governor elections are currently taking place, we have the following governor vacancies:

Public: Rest of England - 2 vacancies

Public: Warrington North - 1 vacancy

Public: Warrington South - 2 vacancies

Staff: Clinical Scientists or Allied Health Professionals - 1 vacancy

Staff: Support - 1 vacancy

More information about Governor elections can be found:

Governor Elections Website

The deadline for completed nomination forms is 5pm on Wednesday 11 October 2023.

Governors have developed a video, to provide some insight into the role of and NHS Governor. The video can be viewed through YouTube using the link below:

WHH Governor Video

Annual Members' Meeting

This year our Annual Members' meeting will be taking place on Wednesday 4 October 2023, 3.30pm to 4.30pm, in the Post Graduate Centre at Warrington Hospital. The meeting enables the board of directors to present the annual report and accounts, provide feedback on how the trust performed over the last year and the challenges and financial plan for the year ahead.

During the event Paul Wood, former Super League, Warrington Wolves and England player will be sharing insights from his mental health and wellbeing work with Warrington and Halton Teaching Hospitals, in partnership with Rugby League Cares.

This is also an opportunity for members who are contemplating becoming a governor to come and speak to our current governors to find out more about the role. Governors will be onsite at the Post Graduate centre from 2.30pm to chat to members. Tea, coffee, and biscuits will be available.

Governor Observation Visits

Since the last board meeting Governors have taken part in the following observational visits:

- Urgent Care, Halton – 24 August 2023
- Paediatrics Wards B11 – 12 and the Paediatrics Assessment Unit (PAU) – 20 September 2023

4. RECOMMENDATIONS

The Trust Board is asked to:

i. To note the matters being brough to the attention of the Board.
ii. To make any comments or ask any questions arising from the report.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/115**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	4th October 2023	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***		
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at the relevant Board Committees. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • No new risks have been added; however, it is proposed to add one new risk.

	• There have been no changes to the ratings of any of the risks; • There have been no changes to the descriptions of any of the risks; • No risks have been closed or de-escalated; Notable updates to existing risks are also included in the paper.			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee		
	Agenda Ref.	Multiple		
	Date of meeting	Multiple		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	BM/23/10/115	AGENDA REF:	BM/23/10/115

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

The latest Board Assurance Framework (BAF) is included as Appendix 1.

2. KEY ELEMENTS

2.1 New Risks

Following discussion at the Patient Safety & Clinical Effectiveness Sub-Committee, Quality Assurance Committee and the Risk Review Group, it is proposed to add a new risk (detailed below) in relation to services within the Trust that are defined as being fragile. It is proposed to add the risk at a rating of 20.

The Trust defines a Fragile Service for inclusion in its oversight program as 'A Service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with reference to patient safety and risk of harm'.

Current services included in the Fragile Services Oversight program are:

- Gynaecology
- Urology
- Orthopaedics – Fractured Neck of Femur
- Ophthalmology - Age Related Macular Degeneration
- Ophthalmology – Paediatric Ophthalmology

ID	Risk description	Rating	Executive Lead
TBC	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	20 (5 x 4)	Paul Fitzsimmons

2.2 Amendment to Risk Ratings

Since the last meeting, there have been no changes to the ratings of any of the risks.

2.3 Amendments to descriptions

Since the last meeting there have been no updates to the descriptions of any of the risks.

2.4 De-escalation of Risks

Since the last meeting, no risks have been closed or de-escalated.

2.5 Existing Risks - Updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm, failure to achieve constitutional standards and financial plans.	<u>Assurances</u> • Executive Team support for additional use of independent sector to treat all outpatients in 65 week wait cohort by 31st October 2023 in line with the NHS England letter dated 4th August 2023.	20	No impact on risk rating
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	<u>Assurances</u> • Nursing: 10 newly qualified staff nurses are due to commence in ED in October 2023 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 12.95% in August 2023. Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.54% in August 2023 • Maternity: Retention rates continuing to follow a positive trajectory. Turnover for all permanent staff has decreased from 29.49% in August 2022 to 14.81% in July 2023 (Reduction of 14.68%) for registered staff this figure has reduced from 30.15% in August 2022 to 16.82% in July 2023 (reduction of 13.33%) • Maternity: Vacancy rate for registered staff has reduced from a peak of 23.25% in June 2022 to 14.74% at the end of July 2023 • Cost avoidance from agency managed service of 928k since April 2022	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Reduction in agency spend of 238K since April 2023. This has been enabled by the introduction of padlock and golden keys systems which can only be removed by the Senior Nursing Team. This controls the cascade of shifts to lower cost and higher cost agencies respectively. • Reduction in agency hourly rate of £11.12 per hour since April 2022 • Revenue requests for ED have been approved which supports increased staffing establishment to provide corridor care 24/7. • International Nurse recruitment: cohort 13, 13 staff have been allocated to clinical areas and are progressing through induction in September 2023. Cohort 14, 11 staff arrive in the UK in September 2023. The Trust does not currently have plans for future cohorts. There will continue to be a focus on pastoral support and retention. • Leaver data is closely monitored and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner • A7, A8 and A9 uplift in healthcare support workers for night shifts has been approved to support the provision of enhanced care • Roster approval for Christmas and New Year periods has been brought forward. They will be ready to review end October 2023 • Re-launch of what was the Safe Staffing Group, now the Nurse Staffing and Clinical Outcomes Group to provide a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk Gaps • Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Winter pressures planning and potential escalation of A10, B4 and Cardiac Catheter Lab • 75% vacancy rate for Band 6 Pharmacists August 2023; 56% Band 7 • Time to post when recruiting new staff • Ensuring safe staffing in response to doctor and healthcare support worker strikes		
134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	<u>Controls</u> • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • ICS Expenditure Control Group established. Terms of Reference drafted and the initial meeting will take place on 1st October 20123 <u>Gaps</u> • New 65 week target will require investment of circa £1m	20	No impact on risk rating
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 5.9% as at June 2023 and is showing an improving variation. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. <u>Assurances</u> • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.6% in June2023. • Current annual welcome back conversation compliance is 88% in June 2023 • Sickness absence, turnover and attraction workstreams have been reviewed in line with the Richard	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been **Turnover and Attraction** Turnover in June 2023 was 13.86% compared to 14% in May 2023. Turnover of permanent staff in June 2023 was 12.85% which was below Trust target. Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving. <u>Controls</u> • A dedicated area to supporting Agile/Flexible working is available on the extranet, and a cultural change plan is in development which will encompass the Trust's approach to agile and flexible working. <u>Assurances</u> • The responses to Exit Interviews are positive, only 16% of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions. **Temporary Staffing & Agency Spend** Bank and Agency reliance in June 2023 was 16.59% compared to 17% in May 2023. Reasons for the variation can be attributed to industrial action and continuing sickness absence, turnover and additional capacity. <u>Controls</u> • The Resourcing Task and Finish group are developing robust processes to support compliance with national guidelines/standards for using temporary workers. All staff groups/CBUs will be monitored against these standards. Compliance is to be reported within the Medical and		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Nursing/AHP Workforce Groups and to FSC. A dashboard is being developed that will summarise workforce related intelligence to inform decision making regarding vacancies and temporary staffing. This will evolve to support the CBUs/staff groups to understand compliance gaps with national standards. <u>Assurance Gaps</u> Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally.		
1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	<u>Assurances</u> • Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA • Executive led IA operational task and finish group in place for each Strike with an exec led check and challenge session prior to each strike to ensure strike rosters allow safe staffing • Participation in ICB IA Clinical Cell calls <u>Assurance:</u> • Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of Industrial Action • Junior Doctors in England have announced a new 4-day walkout in August after the latest round of Government pay talks broke down. The strike will take place between 07:00 on Friday 11th August and 07:00 on Tuesday 15th August. Consultants in England have announced a further period of industrial action which will take place between 0700 on Thursday the 24th August and 0700 on the 26th August, Consultant staffing will be based on a 'Christmas Day' service level during this period. Planning meetings commenced and will continue. Rest facilities available throughout strike action period. Control room to be set up. Additional skills training to be set up. Junior Doctors who choose to work will report to the control room.	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Controlled and calm response for Junior Doctors 5-day walkout in July and the 48-hour consultant strike action on 20 - 21 July 2023 • AfC pay agreement implemented in June 2023 pay. Back pay for 22/23 and 5% uplift for 23/24 • RCN ballot that closed on the 23/06/23 did not meet the mandate therefore no further planned RCN IA at present time. Society of Radiographers did not meet their mandate at WHH. • BMA Junior Doctors re-ballot to commence 19/06/23 - 31/08/23 as current ballot mandate runs out at the end of August. • National guidance available for Consultant IA • BMA have published letter 13/07/23 r.e. the process for requesting derogations. • Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of Industrial Action • Long term NHS Workforce plan published 30/06/23 to address gaps in workforce. • Trust mitigated the need for derogations to services for Consultant IA held in July 2023 • Recruiting Junior Doctors to WHH bank <u>Gaps in Assurances & Controls</u> • Currently 2 ballots in progress, Junior Doctors BMA and Unison Band 2 Health Care Support workers. • Lack of clarity from the ICB regarding mutual aid • Lack of MOU from ICB • Lack of clarity from BMA process for requesting derogations • No further updates on national position regarding talks with Trade Unions specifically the BMA • Consultant IA likely to have significant operational and financial impact on the Trust. • BMA derogations process means unlikely to get derogations signed off for critical services. • High court ruling on 13/07/23 that employers can no longer use agency staff to fill in for striking workers for industrial action from 10/08/23. The		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Secretary of State for Business and Trade has 7 days to appeal this high court decision. Also, Collaborative banks cannot be utilised. • Junior Doctors in England have announced a new 4-day walkout in August after the latest round of Government pay talks broke down. The strike will take place between 07:00 on Friday 11th August and 07:00 on Tuesday 15th August. This timing of this Strike action increases the risk of impact on patient care: • The timing of the strike to predominantly impact on out of hours periods significantly increases the risk of elective care requiring rescheduling due to the need to shift consultant medical resource into out of hours periods, often associated with a requirement for compensatory rest – further impacting on availability for elective activity. • Increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extracontractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. • The above is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics • This junior doctor strike occurs during peak consultant annual leave period – whilst rostering rules maintain safe staffing levels throughout annual leave, these do not control for the requirement to cover junior doctor strike gaps at short notice. • Consultants in England have announced a further period of industrial action which will take place between 0700 on Thursday the 24th August and 0700 on the 26th August, Consultant staffing will be based on a 'Christmas Day' service level during this period. The timing and nature of this strike increase the risk of a direct impact on patient care: • The timing of the Strike, immediately preceding a bank holiday weekend (when Creamfields is held), along with the BMA position on derogations, increases the risk of the strike impacting		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		access to time critical elective interventions. • Uncertainty whether further IA will be national or regional approach and potential impact for different unions.		
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	Controls • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched Gaps in Assurance • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24) • No funding for MUSE system migration	16	No impact on risk rating
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	Assurance • Updated OBC following departure from partnership procurement has received Trust Board approval and an ICB letter of support Gaps in Assurance • NHSE sign off for revised OBC remains outstanding	16	No impact on risk rating
125	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	Assurances • New CT and MR scanner replacement to be undertaken in 2023/24 • Approval received to replace Computer Aided Facilities Management System	15	No impact on risk rating
1846	If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient	Assurances • Work to achieve UKAS IQIPS accreditation has commenced.	12	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	experience and reputational damage			

3. RECOMMENDATIONS

The Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.

Appendix 1

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.	1	20 (5x4)	8 (2x4)	TBC	Quality Assurance Committee
1215	Daniel Moore	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (4x5)	6 (3x2)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
134	Andrea McGee	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1757	Michelle Cloney/Paul Fitzsimmons	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	2	20 (5x4)	8 (4x2)	TBC	Strategic People Committee

1114	Paul Fitzsimmons	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1372	Paul Fitzsimmons	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1898	Lucy Gardner	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	3	16 (4x4)	4 (1x4)	TBC	Finance & Sustainability Committee
125	Daniel Moore	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	1	15 (3x5)	10 (2 x 5)	TBC	Executive Management Team
145	Simon Constable	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (3x4)	8 (4x2)	TBC	Executive Management Team
1846	Kimberley Salmon-Jamieson	If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage	1	12 (4x3)	4 (1x4)	TBC	Quality Assurance Committee

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future
Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.

Risk Appetite Statement

WHH is an ambitious organisation – ambitious for its patients, its workforce and for the communities it serves.

Our goal is to provide high quality care that put patients first, is both safe and effective and delivers an excellent patient experience. Alongside this, we aim to be the best place to work, with a diverse and engaged workforce, fit for now and the future. Together with our partners in the health and social care system, we will design our services to be fit for purpose, more integrated in order to achieve social and economic wellbeing in our communities.

The NHS unquestionably faces unprecedented economic and operational challenges, but these challenges are magnified at a local level by additional demographic factors, as well as specific WHH issues. The latter includes, for example, an aging estate on both our hospital sites. Achieving our goals, whilst meeting these challenges, will require significant change as well as extensive collaboration with partners across the NHS family and across the wider, public and third sectors. This degree of change brings significant opportunity but, correspondingly, it requires us to take more risk. Thus, we must endeavour to strike the best balance between the two.

Accordingly, we will continue to be guided by our risk management policy in order to understand and control risk. We will continue to develop our corporate risk register to monitor significant operational risks. We will also continue to apply our board assurance framework to monitor strategic risks and ensure that the risks we take are consistent with the risk appetite set by the Board.

Our risk appetite, therefore, represents a collective agreement, understanding and decision by the Board about the level of risk that we are prepared to accept, after balancing the potential opportunities and threats any given situation presents.

To ensure clarity, we have broken down our approach to expressing our risk appetite into the five main types of risk facing the majority of NHS provider organisations within our own context and terminology: namely, quality; financial and operational sustainability; regulation; people; and reputation.

Quality

Providing the best care and treatment we can is our purpose. We will actively avoid risks to the quality of clinical services and will take a cautious and balanced approach. Where innovation may improve quality of care we will however be more open to risk. When making significant decisions

about our services, we will assess and record any risks affecting safety, patient experience and clinical effectiveness, and apply the necessary control measures. The impact of changes on quality will be monitored continuously and reported using both quantitative data and qualitative intelligence.

People

We aim to provide a supportive and inclusive culture and working environment, in which both individuals and teams can thrive. We recruit, develop and train current as well as future staff. To achieve our goals in respect of quality services and financial sustainability we will need to take significant decisions about services that will affect our people and may impact their working arrangements. We are therefore open to risk where we can demonstrate longer-term benefits to patients from our decisions. In arriving at those decisions, we will engage with our staff to shape our proposals, in order to maximise the positive impact on patient care and mitigate any potential adverse impact on staff.

Financial and Operational Sustainability

We aim to be a highly productive organisation that consistently delivers on all our constitutional performance standards whilst demonstrating public value for money with integrity and probity. We aim to continuously improve and innovate in the best interests of our patients, staff and communities. We are therefore open to seek out risk through innovative approaches, subject to appropriate procedures and controls.

Regulation

Our first aim is to provide safe and effective patient care, alongside an efficient use of resources. We use our regulated status to provide assurance of the quality of the services that we provide, the environment that we operate within and our efficiency. Our regulatory environment assists us in promoting outstanding patient care, working in collaboration with health and social care partners. We are therefore open to this risk.

Reputation

We are an outward-looking organisation and are determined to contribute fully to partnership working within our system and beyond - for example, with other health and social care organisations, local authorities, education partners, and the voluntary, community and faith sectors. Involvement of patients and the public is important to us, and we proactively include them and their representatives as part of our decision-making processes. We are open to reputational risk in that we may take decisions which may attract challenge when we can clearly demonstrate that they will achieve at least the same, if not better, outcomes for our patients, workforce, and the communities we serve

Board Assurance Framework

Risk ID:	224	Executive Lead:	Moore, Daniel	Rating	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety			Initial: Current: Target:	16(4x4) 20(5x4) 8 (2 x 4)
Assurance Details:	**Controls** • Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day • Discharge Lounge/Patient Flow Team/Silver Command • ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing • Private Ambulance Transport to complement patient providers in and out of hours • FAU/Hub operational operating 5 days per week. • Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. • Increase IMC provided by the system such as the opening of the additional bedded capacity • Increase IMC at home • Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. • Same Day Emergency Care Centre (SDEC) completed July 2022. • Upgrade to Minor's resulting in Oxygen points in all cubicles • Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients • ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. • Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. • Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings • Additional Senior Manager on call support a weekends • Senior Dr at Triage Function • Ward A10 opened as winter escalation capacity funded by the ICB. • Plans being progressed to procure and install a new CT scanner co-located in the main body of the ED department. This will support increases urgent care pathway efficiency in the ED. This is set to be operational in September 2023. • Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients. • Plans to co-locate ED Minors in the SDEC building to enhance patient pathways. The capital project is now agreed and set to be operational in April 23. • Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter • Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E • Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside • Work plan to reduce super stranded and no criteria to reside in 2023/24 is being finalised by the System Sustainability Group • Executive led ED Improvement Group established chaired by the Chief Operating Officer with Chief Nurse & Medical Director as co-chairs			INITIAL 16 PREVIOUS 16 PREVIOUS 25 CURRENT 20 TARGET 8	

	Assurances • Systemwide relationships including social care, community, mental health and CCGs • System actions agreed supporting the Winter Plan • Redeveloped ED 'at a glance' dashboard • Trust implemented NHS 111 allowing for directly bookable ED appointments • Integrated discharge Team in place • Respiratory Ambulatory Care Facility agreed by CCG • Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved • Reinstated CAU 24/7 • Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 • Same Day Emergency Care Centre (SDEC) opened July 2022 • Plans to reduce length of stay for criteria to reside patients using SAFER methodology. This will form part of the GIRFT programme for 2023/24 • Following closure of the Lilycross facility at the end of May 2023, additional capacity has opening in Statham Manor, Grapenhall Manor and Oak Meadow. This replacement capacity is open and operational. • As a result of national urgent care tiering (Warrington placed in Tier 1), the Trust will be working with ECIST to support a service improvement programme. • New CT Scanner located in ED went live in August 2023.	
Assurance Gaps:	**Gaps in Controls** • Staffing pressure created in part as a result of COVID-19 Global pandemic. • Ongoing industrial action across a number of staffing groups including junior medical staff, nursing and consultants. **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/10/2023 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	31/10/2023 (ongoing)	

Board Assurance Framework

Risk ID:	1215	Executive Lead:	Dan Moore	Rating	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			Initial:	25 (5x5)
				Current:	20 (4x5)
				Target:	6 (3x2)

INITIAL 25 · PREVIOUS 25 · CURRENT 20 · TARGET 6

Assurance Details:

Controls

- Clinical Services Oversight Group (CSOG) established
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Reconfigured of ED to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance.
- Plans to create a co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Due to be operational by April 23.
- Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted.
- Waiting lists are reviewed through the Performance Review Group Weekly
- Workforce is continually reviewed to ensure that all wards and teams are staffed safely.
- Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery
- The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures.
- Capacity identified and being utilised with appropriate independent sector providers
- To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive Reserve programme of work.
- Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity
- Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward A5 on the Warrington site.
- Weekly theatre scheduling to ensure listing of patients in line with national guidance.
- Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
- Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks
- Continue to ensure urgent cancers are prioritised in line with national guidance
- Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends.
- Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients
- Use of Insourcing via 18 Weeks (NHS approved contractors) commenced in January 2023 to support 78-week target. Following approval by Execs. There are further plans to expand Insourcing to Maxfax and Gynae by the end of Q4 2022/23.
- Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24
- Digital Validation commencing in May 2023 to improve data quality of the Trust waiting lists

	Assurances • All elective patients have been clinically reviewed and categorised in line with national guidance. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery. • Same Day Emergency Care Centre (SDEC) opened in August 2022 • Bioquell Pods in ED live and operational • Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee. • Additional ultrasound contract awarded and commenced in January 2022 • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Regular meetings and communication with the ICB and primary care GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems. This is being progressed with the support of the estates and capital planning team. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • GIRFT/Efficiency programme to increase theatre productivity and utilisation • New theatre day case and endoscopy facilities due to be complete at Halton site by end of 2023/24. This is as a result of national Targeted Investment Fund (TIF) in support of restoration and recovery. • The Trust has bid to become a regional diagnostic hub to support the reduction of local and system waiting lists. • New CT and MR scanner replacement to be undertaken in 2023/24 • CDC phase 1 gone live in July 20023 which will increase capacity for diagnostic pathways • Executive Team support for additional use of independent sector to treat all outpatients in 65 week wait cohort by 31st October 2023 in line with the NHS England letter dated 4th August 2023.	
Controls & Assurance Gaps:	• Capacity challenge with social workers to keep on top of demand and necessary patient assessments. • Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • Limited bed base within A5 elective footprint • Ongoing industrial action across a number of staffing groups including junior medical staff, nursing and consultants.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/10/2023	

Board Assurance Framework

Risk ID:	115	Executive Lead:	Salmon-Jamieson, Kimberley
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.		
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.		

Rating	
Initial:	20 (5x4)
Current:	20 (5x4)
Target:	12 (4x3)

INITIAL 20, PREVIOUS 25, PREVIOUS 20, PREVIOUS 16, CURRENT 20, TARGET 12

Assurance Details:

Controls

- 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG)
- Progress against recruitment to fill Trust vacancies monitored by Associate Chief nurses and Deputy Chief Nurse at WRG, areas of concern escalated to Chief Nurse, Deputy Chief Executive and local actions plans in place with additional support from Executive Team
- Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity
- Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels
- Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency request via agreed Agency Managed Service
- Staff numbers and skill mix recorded daily on Gold Command report for transparency of clinical decision making
- Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust
- Workforce plan in place, includes agency reduction plan
- Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team

Assurances

- Nursing: 10 newly qualified staff nurses are due to commence in ED in October 2023
- Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 12.95% in August 2023. Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.54% in August 2023
- Maternity: Retention rates continuing to follow a positive trajectory. Turnover for all permanent staff has decreased from 29.49% in August 2022 to 14.81% in July 2023 (Reduction of 14.68%) for registered staff this figure has reduced from 30.15% in August 2022 to 16.82% in July 2023 (reduction of 13.33%)
- Maternity: Vacancy rate for registered staff has reduced from a peak of 23.25% in June 2022 to 14.74% at the end of July 2023
- Cost avoidance from agency managed service of 928k since April 2022
- Reduction in agency spend of 238K since April 2023. This has been enabled by the introduction of padlock and golden keys systems which can only be removed by the Senior Nursing Team. This controls the cascade of shifts to lower cost and higher cost agencies respectively.
- Reduction in agency hourly rate of £11.12 per hour since April 2022
- Revenue requests for ED have been approved which supports increased staffing establishment to provide corridor care 24/7.
- International Nurse recruitment: cohort 13, 13 staff have been allocated to clinical areas and are progressing through induction in September 2023. Cohort 14, 11 staff arrive in the UK in September 2023. The Trust does not currently have plans for future cohorts. There will continue to be a focus on pastoral support and retention.
- Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead

	• Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly • Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends this is a full day shift • Rolling recruitment for RN and HCA posts, 2- 4 weekly interviews • Leaver data is closely monitored and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner • Retention – Internal Transfer process in place for staff • A7, A8 and A9 uplift in healthcare support workers for night shifts has been approved to support the provision of enhanced care • Roster approval for Christmas and New Year periods has been brought forward. They will be ready to review end October 2023 • Re-launch of what was the Safe Staffing Group, now the Nurse Staffing and Clinical Outcomes Group to provide a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk	
Assurance Gaps:	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours • Winter pressures planning and potential escalation of A10, B4 and Cardiac Catheter Lab • Partially funded revenue requests • 75% vacancy rate for Band 6 Pharmacists August 2023; 56% Band 7 • Time to post when recruiting new staff • Ensuring safe staffing in response to doctor and healthcare support worker strikes	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • Domestic and international nursing recruitment • Position and plans for staff retention. • Planning for the future – succession planning and staff development. • 6/12 establishment reviews. • Triangulation of staffing position alongside patient safety measures.	Kennah, Ali	31/08/2023	

Board Assurance Framework

Risk ID:	134	Executive Lead:	McGee, Andrea	Rating	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			Initial:	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)
Assurance Details:	**Controls** •Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning •Fortnightly review at Finance Executive Team Meeting of CIP/GIRFT, activity, cost pressure and agency spend • Procurement/tender waiver training in place • TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years) • Latest guidance from MIAA Counter Fraud Team circulated • Counter Fraud campaign took place for national anti-fraud week in November 2022 • Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced. • Appointed GIRFT Finance Lead and 3 Clinical Leads • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • CDC phase 2 application approved for £4.5m capital over three years • Capital & Revenue Plans for 2023/24 approved by the Trust Board in March 2023 & updated and approved by the Trust Board in May 2023 • Introduced system of escalation where there are risks to CIP delivery • Reviewed of all aspects of 2023/24 operational plan resulting in an improved finance forecast • New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified. • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance & sustainability Committee • Supporting Cheshire & Merseyside ICS with development of 3 year financial strategy and recovery plan due to be in place in September 2023 **Assurances** • Achieved ICS control total in 2022/23 • Delivered 2022/23 Capital Plan • Unqualified audit opinion (2022/23) • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Capital is reported monthly to F&SC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations.			INITIAL 20 CURRENT 20 TARGET 10	

	• C&M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding (circa 1%). Overall, no change in WTE plan, however there is a plan to reduce agency and bank and increase substantive staffing. • HFMA self-assessment completed and audited. • All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed. • We have allocated CIP targets under an approved new methodology for 2023/24 • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • ICS Expenditure Control Group established. Terms of Reference drafted and the initial meeting will take place on 1st October 20123	
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) • Risk of unforeseen costs and under delivery of activity and income due to further COVID-19 / Flu surge / Industrial action • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Introduction of protocol for changing forecast outturn with the potential impact of restricting financial freedoms and access to capital. • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Not all cost pressures have been funded in plan for 2023/24 • Risk to financial freedoms as the Trust has a deficit plan • Sufficient cash available based on operational plan however, deterioration from plan represents a risk to cash • Industrial action uses management capacity to plan for safety which places CIP/GIRFT programme at high risk as capacity/focus is diverted • New 65 week target will require investment of circa £1m	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Monitor operational activity delivered under PbR as per plan			Moore, Dan	30.03.2024	
Ensure additional capacity is closed in line with operational plan			Moore, Dan	30.03.2024	
Supporting Cheshire & Merseyside ICS with development of 3 year financial strategy and recovery plan	Participate in workstreams to develop plan	Participate in workstreams to develop plan	McGee, Andrea	30.09.2023	

Board Assurance Framework

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk ID:	1134	Executive Lead:	Cloney, Michelle
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.		
Risk Description:	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff		

Rating	
Initial:	20 (4x5)
Current:	20 (4x5)
Target:	8 (4x2)

20 20 8
INITIAL CURRENT TARGET

Control & Assurance Details:

Sickness Absence
The rolling 12-month sickness absence rate is 5.9% as at June 2023 and is showing an improving variation. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter.

Controls
•New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023.
•Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers.
•Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported.
•Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management.
•People Health and Wellbeing Group. The group have focused on understanding the Trust's absence reasons and reducing the volume of absences recorded as 'unknown'.
•Supporting Attendance Month - roadshows, drop-in sessions, comms and events to showcase the Trust's commitment to Supporting Attendance
•Focused welcome back conversation recording and internal audit

Assurance
•The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub.
•The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.6% in June2023.
•Pilot took place in maternity services where WBC compliance improved from 20% to 85% and is now cited as a best practice case study by NHSE
•Pro-active health interventions being offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate
•Current annual welcome back conversation compliance is 88% in June 2023
•Sickness absence, turnover and attraction workstreams have been reviewed inline with the Richard Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been

Turnover and Attraction
Turnover in June 2023 was 13.86% compared to 14.% in May 2023. Turnover of permanent staff in June 2023 was 12.85%which was below Trust target.
Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving.

Controls

<table>
<tr><td></td><td colspan="4">•Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted action. This information is available on the Trust Workforce Information Dashboard.
•Rugby League Cares have been supporting WHH since July 2021
•Grief and Menopause cafes
•Social media accounts have been created to support recruitment attraction across a number of social media platforms
•Financial wellbeing resources have been implmented to support the workforce and retention including Wagestream
• A dedicated area to supporting Agile/Flexible working is available on the extranet, and a cultural change plan is in development which will encompass the Trust's approach to agile and flexible working.

Assurances
•The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH.
•As a result of analysis of exit interviews, a theme identified was working hours and flexible working. Pharmacy are working towards changes to working hours, which have been raised as a factor by leavers and potential joiners as a barrier.
The responses to Exit Interviews are positive, only 16% of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions.

Temporary Staffing & Agency spend

Bank and Agency reliance in June 2023 was 16.59% compared to 17% in May 2023. Reasons for the variation can be attributed to industrial action and continuing sickness absence, turnover and additional capacity.

Controls
•The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are:
o ECF process for non-clinical vacancies approval
o ECF process for bank and agency temporary staffing pay spend approval
o Medical Rate Escalations approved by Medical Director
• The Resourcing Task and Finish group are developing robust processes to support compliance with national guidelines/standards for using temporary workers. All staff groups/CBUs will be monitored against these standards. Compliance is to be reported within the Medical and Nursing/AHP Workforce Groups and to FSC. A dashboard is being developed that will summarise workforce related intelligence to inform decision making regarding vacancies and temporary staffing. This will evolve to support the CBUs/staff groups to understand compliance gaps with national standards.

Assurances
•Compliance against our processes and rate cards monitored through the Finance and Sustainability Committee
•To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings is in development. Streamlining the approval process to replace the ECF will ensure better oversight of the use of Temporary Staffing within the Medical and Dental Staff group.</td><td colspan="2"></td></tr>
<tr><td>Assurance Gaps:</td><td colspan="6">• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally.
• Turnover continuing to be above target but is showing an improving variance to meet target.
• Agency spend above the 3.4% target, factors influencing this will be monitored within the new approach developed by the Resourcing working group
• Compliance with NHSE Agency Rate card very low, to be measured within the new approach developed by the Resourcing working group
• Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend</td></tr>
<tr><th>Recommendation</th><th colspan="2">Action Description</th><th>Actions Required</th><th>Responsible Officer</th><th>Deadline Date</th><th>Completion Date</th></tr>
</table>

Developing an approach to measuring and monitoring factors influencing temporary staffing spend	Through the Resourcing working group establish a process of developing an approach to measuring and monitoring factors influencing temporary staffing spend	The Resourcing working group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: • Agency controls best practice • Rostering compliance • Rate card compliance • Establishment Control compliance (or an alternative approach) • Unplanned absences • Recruitment activity System will ensure the factors are reported to FSC and Workforce Review Groups	Carl Roberts	31.08.2023	
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including wellbeing days, cardiac clinics, smoking cessation.	• Analysis of areas with high sickness absence to develop targeted interventions • Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff	Laura Hilton	31.03.2024	
Embed an agile and flexible working culture within all WHH Teams	Through engagement, development and refined processes, support WHH leaders to embrace agile and flexible working.	• Engage with Senior Leaders to establish support for an agile and flexible working culture within all WHH Teams • Develop a campaign to promote WHH as an agile working/flexible employer • Development of WHH Leaders to enable them to support their teams to work in an agile/flexible way • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2024	

Board Assurance Framework

Risk ID:	1757	Executive Lead:	Cloney, Michelle/Paul Fitzsimmons	Rating	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future. Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety			Initial: Current: Target:	16 (4 x 4) ↑20 (5 x 4) 8 (4 x 2)
Control & Assurance Details:	**Controls** •Weekly IA Task and Finish group established from 28th October 2022 requiring representatives from across all departments to attend to plan for IA. • Derogation list for required services drafted for review as required with Staff Side once notification of strike received. •Weekly meetings with Staff Side established to manage partner relationships. •Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible. • Executive led IA Operational Task and Finish group in place for each period of IA with an Executive led check and challenge session to ensure strike rosters support safe staffing. •IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH. • Participation in ICB IA Clinical Cell calls • IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH. • Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA **Assurance** • Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice. • Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action. • Junior Doctors in England have announced a new 4-day walkout in August after the latest round of Government pay talks broke down. The strike will take place between 07:00 on Friday 11th August and 07:00 on Tuesday 15th August. Consultants in England have announced a further period of industrial action which will take place between 0700 on Thursday the 24th August and 0700 on the 26th August, Consultant staffing will be based on a 'Christmas Day' service level during this period. Planning meetings commenced and will continue. Rest facilities available throughout strike action period. Control room to be set up. Additional skills training to be set up. Junior Doctors who choose to work will report to the control room. • Controlled and calm response for Junior Doctors 5-day walkout in July and the 48-hour consultant strike action on 20 - 21 July 2023 • AfC pay agreement implemented in June 2023 pay. Back pay for 22/23 and 5% uplift for 23/24 • RCN ballot that closed on the 23/06/23 did not meet the mandate therefore no further planned RCN IA at present time. Society of Radiographers did not meet their mandate at WHH. • BMA Junior Doctors re-ballot to commence 19/06/23 - 31/08/23 as current ballot mandate runs out at the end of August. • National guidance available for Consultant IA • BMA have published letter 13/07/23 r.e. the process for requesting derogations. • Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of Industrial Action • Long term NHS Workforce plan published 30/06/23 to address gaps in workforce. • Trust mitigated the need for derogations to services for Consultant IA held in July 2023 • Recruiting Junior Doctors to WHH bank			Chart: INITIAL 16, CURRENT 20, TARGET 8	
Assurance Gaps:	• Currently 2 ballots in progress, Junior Doctors BMA and Unison Band 2 Health Care Support workers. • Lack of clarity from the ICB regarding mutual aid • Lack of MOU from ICB • Lack of clarity from BMA process for requesting derogations				

	• No further updates on national position regarding talks with Trade Unions specifically the BMA • Consultant IA likely to have significant operational and financial impact on the Trust. • BMA derogations process means unlikely to get derogations signed off for critical services. • High court ruling on 13/07/23 that employers can no longer use agency staff to fill in for striking workers for industrial action from 10/08/23. The Secretary of State for Business and Trade has 7 days to appeal this high court decision. Also, Collaborative banks cannot be utilised. • Junior Doctors in England have announced a new 4-day walkout in August after the latest round of Government pay talks broke down. The strike will take place between 07:00 on Friday 11th August and 07:00 on Tuesday 15th August. This timing of this Strike action increases the risk of impact on patient care: • The timing of the strike to predominantly impact on out of hours periods significantly increases the risk of elective care requiring rescheduling due to the need to shift consultant medical resource into out of hours periods, often associated with a requirement for compensatory rest – further impacting on availability for elective activity. • Increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extracontractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. • The above is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics • This junior doctor strike occurs during peak consultant annual leave period – whilst rostering rules maintain safe staffing levels throughout annual leave, these do not control for the requirement to cover junior doctor strike gaps at short notice. • Consultants in England have announced a further period of industrial action which will take place between 0700 on Thursday the 24th August and 0700 on the 26th August, Consultant staffing will be based on a 'Christmas Day' service level during this period. The timing and nature of this strike increase the risk of a direct impact on patient care: • The timing of the Strike, immediately preceding a bank holiday weekend (when Creamfields is held), along with the BMA position on derogations, increases the risk of the strike impacting access to time critical elective interventions • Uncertainty whether further IA will be national or regional approach and potential impact for different unions.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Check and challenge meetings to commence for Junior Doctor Industrial Action	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Fitzsimmons, Paul	10/08/2023	
Weekly Industrial Action Update to Execs	Executive Management Team to receive weekly updates on Industrial Action	Executive Management Team to receive weekly updates on Industrial Action	Hilton, Laura	30/11/2023 (ongoing)	
Participate in regional ICB Workforce Industrial Action preparedness group	Participate in regional ICB Workforce Industrial Action preparedness group	Attending and participating in regional ICB Workforce Industrial Action preparedness group	Hilton, Laura	30/11/2023 (ongoing)	

Board Assurance Framework

<table>
<tr><td>Risk ID:</td><td>1114</td><td>Executive Lead:</td><td>Fitzsimmons, Paul</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective:</td><td colspan="3">Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.</td></tr>
<tr><td rowspan="3">Risk Description:</td><td colspan="3" rowspan="3">If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.</td><td>Initial:</td><td>20 (5x4)</td></tr>
<tr><td>Current:</td><td>16 (4x4)</td></tr>
<tr><td>Target:</td><td>8 (2x4)</td></tr>
<tr><td>Assurance Details:</td><td colspan="3">Assurance:
• Risks for Cyber on risk register in line of national requirements of the DSPT & NHS Digital
• Digital Governance Structure including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures).
• Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee.
• Trust benchmarking activities including Use of Resources reviews (Model Hospital).
• ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live.
• Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee.
• Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital
• WHHT return for assurance re cyber security to NHS England

Controls:
• Digital Operations Governance including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard.
• Active membership of the Sustainability Transformation Partnership Cyber Group.
• Digital Change Management regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.
• Trust Data Quality Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting EPR Training regime for new starters including doctor's rotation and annual mandatory training.
• External NHS England approved Cyber Training for the Trust Exec Board
• The use of automatic patching software to rollout security updates to devices.
• Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links.
• Secondary secure backup at Halton Data Centre
• Remote devices no longer bypassing the web proxy
• Active Directory password set to expire again (covid working from home-related).
• Fully recruit to the Digital Service restructure Phase 1 restructure
• Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness.</td><td colspan="2">20 16 20 16 8
INITIAL PREVIOUS PREVIOUS CURRENT TARGET</td></tr>
</table>

	• Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched	
Assurance Gaps:	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) • Using SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security).. • No controls in place for Bluetooth connectivity. Would be difficult to implement. • Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • MFA on limited number of systems • Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • Version 7 of Clinisys Ice is end of life • No funding for MUSE system migration	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).	Migrate all 2003 and 2008 servers to 2016.	The data from SharePoint will be migrated by the end of October, allowing to plan for the last 2 2008 Windows Servers to be decommissioned.	Deacon, Stephen	31/10/2023	
Cisco Upgrade	Cisco upgrade to replace aging network equipment	Install and configure equipment (Part of the Halton network equipment to be installed). Core and Nexus switches are installed, however, the Access switches are to be installed.	Waterfield, Tracie	30/09/2023	

Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommsion Server 2012 servers	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to the latest Windows Server operating system or decommission them. Critical systems include e-Outcome, Data Warehouse, Clinisys ICE & MUSE	Waterfield, Tracie	31/10/2023	
Upgrade and enable DLP to enable USB read-only. Disabled as its is crashing desktops, needs the ePO agent on the server to be upgraded.	Upgrade and enable DLP	Decide whether to upgrade and enable DLP or move to a different product to provide the read-only protection.	Waterfield, Tracie	30/09/2023	

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Fitzsimmons, Paul
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.		
Risk Description:	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety		

Rating	
Initial:	12 (3 x 4)
Current:	16 (4 x 4)
Target:	8 (2 x 4)

Assurance Details:

Assurance:
- Clear reporting line from EPR Project Group via escalation/assurance route through Digital Strategy Group, FSC and Trust Board)
- Regular, documented conference calls with the ICS and NHSE – external partners supportive of managed convergence relaunch.
- Updated OBC following departure from partnership procurement has received Trust Board approval and an ICB letter of support

Controls:
- Business case approved and contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR
- Trust financial modelling in OBC includes 5-year Lorenzo costs
- ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance.
- Senior Programme Manager assigned
- Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs
- Identification of further realistic cash releasing benefits

INITIAL 12 – CURRENT 16 – TARGET 8

Assurance Gaps:

Gaps In Assurance:
- NHSE sign off for revised OBC remains outstanding
- ICS strategic approach to delivering managed convergence through open procurement remains unclear

Gaps In Controls:
- Lorenzo is at end of life and is unlikely to see significant future development or enhancements
- Phasing of frontline Digitisation Funding with funding availability not matching the timing of forecast expenditure
- Deficit in programme year 3
- Delays in launch due to abandoned partnership procurement process mean a business case may be required to extend Lorenzo contract to enact option to retain to Nov 26

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure ICS and NHSE Digital leadership sighted and supportive of procurement approach	Ensure ICS and NHSE Digital leadership fully sighted and remain supportive of procurement approach following departure from partnership procurement model	Ongoing engagement with ICS and NHSE Digital leadership	Fitzsimmons, Paul	02/08/23	02/08/23 – ICS Letter of support recieved

Board Assurance Framework

Risk ID:	1898	**Executive Lead:**	Gardner, Lucy	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communit				
Risk Description:	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.			**Initial:** **Current:** **Target:**	16 (4x4) 16 (4x4) 4 (1 x 4)
Control & Assurance Details	**Controls** • Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance • Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have been carried out • Estates strategy refresh planned to incorporate options and enablers for new hospitals plans • External funding sought to enable estates developments which support delivery of new hospitals plans and estates strategy • All partners, including MPs, Councils, Education Providers, Place Partners and ICB supportive of our new hospitals plans • Financial and economic cases for new hospitals being updated and funding options explored **Assurances** • DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside ICS to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M. • Funding secured to deliver community diagnostics centre, TIF and endoscopy expansion			Chart: INITIAL 16, CURRENT 16, TARGET 4	
Assurance Gaps:	• Confirmation received that the Trust was unsuccessful in securing funding via HIP phase 3. Future rolling programme of funding has been indicated ; however, the details are currently unclear.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Simon Constable and Lucy Gardner	Bi-monthly and as required.	Bi-monthly
Develop refreshed Estates Strategy	Ensure options for new hospitals and short/medium terms estates developments are reflected in Estates Strategy	• Executive Team strategy session to inform estates strategy. • Board Development Session • Partner Session	Gardner, Lucy Moore, Dan	31.10.2023	

Board Assurance Framework

Risk ID:	125	Executive Lead:	Moore, Dan	Rating	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns			Initial: Current: Target:	20 (5x4) 15 (3x5) 10 (2 x 5)
Assurance Details:	**Controls:** Annual capital funding is allocated to business critical, mandated and statutory estates projects Planned Maintenance Program Reactive maintenance process Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments **Assurance:** Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Non funded capital schemes are risk rated and monitoired through the above group Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment with subsequent action plan Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks Cleanliness monitoring identifies estates issues that are addressed through the estates building officer Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations Mechanical Craftsperson and Electrician business case approved providing stability of workforce and retention of skills In September 2022 it has been confirmed that phase 1 of the CDC & the Targeted Investment Fund (TIF) for delivery of elective recovery at the Halton site have both been approved. The capital builds in these cases will substantially increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity New CT and MR scanner replacement to be undertaken in 2023/24 Approval received to replace Computer Aided Facilities Management System Updated Estates Strategy in development and draft to be prsented to the Trust Board in September 2023 Second stage of digital fire alarm upgrade (Kendrick Wing) planned for 2024/25 Capital plan			INITIAL 20, PREVIOUS 16, CURRENT 15, TARGET 4	
Assurance Gaps:	Limited capital funding to address backlog Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM) Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	31/03/2024	
Develop estates maintenance compliance monitoring tools	Integrate performance and compliance into0 routing estates maintenance operations	Head of compliance and performance in post in April 2022 and will develop initiatives, processes and protocols to drive estates maintenance performance and in turn improve compliance against recommended guidelines and internal KPIs	Ian Wright	02/10/2023	
Develop new estates strategy	Update Estates Strategy	Complete strategy update for approval	Ian Wright	04/10/2023	

Board Assurance Framework

Risk ID:	145	Executive Lead:	Constable, Simon	Rating	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.			Initial	20 (5x4)
				Current	12 (3x4)
				Target	8 (4x2)
Risk Description:	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.			20 – 15 – 12 – 8 INITIAL, PREVIOUS, CURRENT, TARGET	
Assurance Details:	**Controls** • The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • The Trust has developed effective clinical networking and integrated partnership arrangements. • The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. • Council and PLACE Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level have been refreshed • Breast Centre of Excellence opened. Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved. • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside has been approved. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. • Revised plans for CDC approved by Trust Board and national diagnostics team. • Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington Town Centre. Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. Health & Social Care Academy opened. - Full Business Case for the Health & Wellbeing Hub approved by the Government. Contractors appointed to commence the capital works for Health & Wellbeing Hub. • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 approved by the Trust Board. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside. • Consistent Trust representation within Cheshire & Merseyside ICS. WHH CEO appointed as lead for Clinical Pathways within C&M and the Trust is playing an active role within the Cheshire & Merseyside Acute & Specialist Trust (CMAST) provider collaborative.				

	• Trust representation on place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Both reviews have been completed. • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities. • Director of Strategy & Partnerships co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Adaptive Reserve Fund created with Warrington PLACE partners • Discussions with neighbouring Trusts to accelerate collaboration taking place **Assurances** • Regular Strategy updates are provided to the Council of Governors & Trust Board • Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services. Halton Health Hub in Shopping City opened in November 2022. • Full refresh of the Trust 5-year strategy complete • In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. • Pace of pathology collaboration no longer poses a such significant risk to service delivery for WHH as challenges within histopathology are being addressed via mutual aid and recruitment.	
Assurance Gaps:	• Self assessments of both Warrington & Halton place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is established (stage 3 of 4). There is a requirement to further develop as places to ensure both boroughs can benefit from potential future autonomy. • Trust's capacity to deliver significant number of capital projects	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/10/2023	
Ensure sufficient capacity to deliver increased number of capital projects	Undertake Gap Analysis of requirements vs resource	Address any gaps identified	Lucy Gardner & Dan Moore	31/08/2023	

Board Assurance Framework

Risk ID:	1846	Executive Lead:	Salmon-Jamieson, Kimberley	Rating	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage			Initial:	16 (4x4)
				Current:	12 (4x4)
				Target:	4 (1 x 4)
Assurance Details:	**Controls** • Allocation of the Patient Safety Project Director to lead the incident response. • Appointment of an audiology Patient Safety Project Review Manager to prepare a comprehensive service review document and a whole project timeline. • The Trust is ensuring that for any babies who require testing, that this is carried out safely and in line with national best practice. This includes on site oversight provided by audiologists from an IQIPS accredited audiology service, for each ABR undertaken. • Allocation of technical support to maintain and effective waiting list and ongoing patient management tracking functionally. • Operational support to action service change requirements. • Audiology services to participate in Cheshire and Mersey Peer Review process to ensure oversight and consistency of ABR results • Auditory brain stem testing is carried out with commissioner support, with a contract variation in place. **Assurances** • WHH is working with Rochdale (Northern Care Alliance NHS Group) on the continuation of the ABR pathway and WHH staff training. • Work to achieve UKAS IQIPS accreditation has commenced.			INITIAL 16, PREVIOUS 16, CURRENT 12, TARGET 4	
Assurance Gaps:	**Gaps in Controls** The Trust is currently not providing unsupervised auditory brain stem testing for new born babies.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Full investigation to be carried out.	A programme of works to be set out to enable the Trust to carry out a complete and concise investigation of ABR testing since 2018.	An incident cell has been formed to oversee the actions required identified as part of the review. This requires the management of multiple stakeholders across local, regional and national bodies. In addition, there is the requirement to undertake a due diligence exercise for each baby who has had an ABR review since the beginning of 2018 up until 2/02/23.	Deborah Carter	31/08/2023	
Service review to be undertaken	A full service review to be undertaken of the audiology service.	A full service review to be undertaken of the audiology service.	Deborah Carter	31/08/2023	
To establish if any harm has been caused as a result of the issues identified in the incident	To undertake a full review of each individual identified	Clinical MDT established to review all cases	Deborah Carter	30/09/2023	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/10/116**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	4 October 2023	
AUTHOR(S):	Marie Garnett – Head of Contracts, Performance and Commercial Development Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker - Associate Director of Finance - Strategy	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.	

<table>
<tr><td></td><td colspan="4">#134 If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton.
#1134 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff</td></tr>
<tr><td rowspan="7">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A
√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A
√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A
√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="4">The Trust has 82 IPR indicators which have been placed into the following categories based on SPC/Making Data Count "Assurance" and "Variation" principles and performance over the last 7 months. Table 1 sets out the "Assurance" and "Variation" of all indicators, of these, there are <u>7 indicators that are both failing and are a variation concern</u>, these are:

Quality
• Medication Safety Reconciliation within 24 hours
Access and Performance
• Referral to treatment Open Pathways
• A&E Waiting Times – over 12 hour wait
• Cancer 62 Days Urgent</td></tr>
</table>

	Workforce • Bank and Agency Reliance ***Finance*** • Capital Programme • Cost Improvement Programme (recurrent forecast) At Month 5 the plan is a £9.2m deficit, however the actual deficit was £11.6m with the overspend being due in the main to Industrial Action (IA) costs, activity delivered under plan and additional capacity in A&E. The position includes an additional £0.5m income relating to April to August 2023 following a reduction in the ERF target of 2% to support the impact of IA in April 2023. A further £0.7m has been assumed in anticipation of further ERF adjustments relating to IA in June to August 2023 (as per discussion with ICS but not yet confirmed). A coding catch up of £0.6m has also been assumed for month 5. This presents risk in the reported position of £1.3m.

PURPOSE: ***(please select as appropriate)***	Information	Approval √	To note √	Decision

RECOMMENDATION:	The Trust Board is asked to: 1. Note the reduction in the oversubscribed capital programme and the associated deferral of schemes to 2024/25 as supported and approved by the Finance and Sustainability Committee. 2. Note the capital request supported by the Finance and Sustainability Committee. 3. Support the KPI amendments as outlined in this paper. 4. Note the contents of this report.

PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee
	Agenda Ref.	FSC/23/09/116
	Date of meeting	27/09/2023
	Summary of Outcome	Noted of the KPI amendments outlined. Reduction in oversubscription of capital programme and associated deferral of schemes to 2024/25. Changes to the capital contingency supported and approved.

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/23/10/116

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 82 IPR indicators have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count.

Appendix 1 details "Making Data Count" icons and data in relation to Statistical Process Control (SPC).

The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance and Sustainability

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

Table 1 contains the number of IPR indicators in each Making Data Count "Assurance" and "Variation" category.

Table 1: KPIs by Assurance and Variation Categories

	Special Variation of a Concerning Nature	Common Cause Variation	Special Variation of an Improving Nature	No SPC/Not Enough Datapoints/NA
Consistently Fails the Target (based on the last 7 months)	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & NO SPC**
	Quality 13. Medication Safety - Reconciliation within 24 hours **(39% - *80% target*)** **A&P** 35. Referral to treatment Open Pathways - **(50.5% - *92% target*)** 37. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge **(22.8% - *2% target*)** 45. Cancer 62 Days Urgent **(61.1% - *85% target*)** **Workforce** 71. Bank and Agency Reliance **(15.9% - *9% target*)** **Finance** 77. Capital Programme **(£4.58m – *£10.57m target*)** 80. Cost Improvement Programme (recurrent forecast) – In year performance to date **(£2m - *£4.28m target*)**	**Quality** 23. Sepsis - % screening for all emergency patients. 24. Sepsis - % screening for all inpatients 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis – 33. MUST nutritional assessment completion **A&P** 34. Diagnostic Waiting Times 6 Weeks 37. A&E Wait Times - % patients waiting under 4 hours 39. Cancer 14 Days 40. Breast Symptoms 14 Days 47. Ambulance Handovers within 15 minutes 50. Discharge Summaries - % sent within 24hrs **Finance** 78. Better Payment Practice Code	**Quality** 15. Staffing Care Hours per patient day (CHPPD) 21. Friends and Family (ED and UCC) 31a. Maternity Pregnancy Bookings before 10 weeks 31b. Maternity Pregnancy Bookings before 13 weeks **A&P** 48. Ambulance Handovers within 30 minutes 49. Ambulance Handovers within 60 minutes 67. RTT - Number of patients waiting 65+ weeks **Workforce** 68. Supporting Attendance 69. Retention 70. Turnover 73. Safeguarding Training 74. PDR	**Quality** **A&P** 58. Elective Outpatient Activity **Finance** 81. Agency Ceiling
Inconsistently Passes/Fails the Target	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & NO SPC**
	Quality 10. VTE Assessment	**Quality** 5. Healthcare Acquired Infections (CDI) 6. Healthcare Acquired Infections (Ecoli) 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 12. Pressure Ulcers 28. Acute Kidney Injury **A&P** 41. 28 Day Faster Cancer Diagnosis Standard 42. Cancer 31 Days First Treatment 51. Discharge Summaries - Number NOT sent in 7 days 59. Patients seen in the Fracture Clinic within 72 hours	**Quality** 14. Staffing - Average Fill Rate 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis **A&P** 53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation 65. Theatre Utilisation (measured as productive operating time only)	

	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE	CONSISTENTLY PASSING TARGET & NO SPC
Consistently Passes the Target (based on the last 7 months)		**Quality** 1.Incidents 2. Duty of Candour (serious incidents) 19. Complaints 20. Friends and Family (Inpatients & Day cases) 22. Mixed Sex Accommodation Breaches (Non ITU Only) **A&P** 43. Cancer 31 Days Subsequent Surgery 44. Cancer 31 Days Subsequent Drug 46. Cancer 62 Days Screening 52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 54. Urgent Operations Cancelled for 2nd Time 66. Day case (measured as an aggregate of total cases) **Finance** 79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	**Quality** 3.Healthcare Acquired Infections (MRSA) 11. Inpatient Falls & harm levels 18. NICE Compliance **Workforce** 72.Core/Mandatory Training	**Finance** 76. Cash Balance (£m)
	NO ASSURANCE SPC & DECLINING PERFORMANCE	**NO ASSURANCE SPC & VARYING PERFORMANCE**	**NO ASSURANCE SPC & IMPROVING PERFORMANCE**	**NO ASSURANCE SPC & NO SPC**
No SPC/Not Enough Datapoints/Not Applicable	**Quality** 16. Mortality ratio – HSMR	**Quality** 4. Healthcare Acquired Infections (MSSA) 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks 17. Mortality ratio - SHMI 32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 38. Average time in department ED 55. Super Stranded Patients 62. Reduction in Outpatient Follow Ups 64. % Patients discharged to their usual place of residence	**A&P** 61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	**Quality** 27. Ward Moves between 10pm and 6am 29. Maternity Postpartum Haemorrhage 30. Maternity 3rd and 4th Degree tears **A&P** 56. Elective Recovery Activity (Grouped SPCs) 57. Elective Recovery Diagnostic Activity 60. % patients referred to long COVID service not assessed within 15 weeks **Finance** 75. Trust Financial Position (£m)

Key:

Areas requiring focus – areas are failing to meet the target and declining in performance

Areas exceeding the target and continuously maintaining/improving performance

Areas of a concerning nature due to either:

- **indicators not meeting (failing) their set target**
- **declining nature of the performance**

Following a national consultation, NHSE have introduced changes to Cancer KPIs, as set out in **Table 2**. Changes are required to take place from 1st October 2023, which will be reflected in the December 2023 IPR due to the nature of cancer data and the timeline by which it is reported.

Table 2: Updated Access and Performance Indicators

<table>
<tr><th>Current KPI</th><th>Proposed KPI</th><th>Proposed Change</th><th>Rationale</th></tr>
<tr><td>42. Cancer 31 Days First Treatment
Target: 96%</td><td rowspan="3">42. Cancer 31 Day wait
Target: 96%</td><td rowspan="3">All patients to receive treatment for cancer within 31 days of decision to treat including first and subsequent treatment.

A combined indicator will replace all current 31 Day KPIs, including first treatments (42) subsequent surgery (43) and subsequent drug (44)

The new indicator (42) will include first and subsequent treatment.

The revised combined target will be 96%.</td><td rowspan="5">Following a national consultation, the government has agreed that from 1st of October the existing Cancer Waiting Times Standards will be rationalised into three core measures:
• The 28 Day Faster Diagnosis Standard (Indicator 41)
• One headline referral to treatment standard
• One headline 31 day decision to treatment standard</td></tr>
<tr><td>43. Cancer 31 Days Subsequent Surgery
Target: 94%</td></tr>
<tr><td>44. Cancer 31 Days Subsequent Drug
Target: 98%</td></tr>
<tr><td>45. Cancer 62 Days Urgent
Target: 85%</td><td rowspan="2">43. Cancer 62 Day wait
Target: 85%</td><td rowspan="2">All patients to receive treatment for cancer within 62 days of a referral, including urgent, screening and consultant upgrades.

A combined indicator will replace all separate 62 Day KPIs, including urgent (45) and screening (46).

The new indicator (43) will include urgent, screening and consultant upgrades.

The revised combined target is 85%, with a commitment to achieve 70% by March 2024.</td></tr>
<tr><td>46. Cancer 62 Days Screening
Target: 90%</td></tr>
</table>

The impact of these changes is a reduction in the total number of indicators within Access and Performance indicators in the Trust IPR from 32 29.

A breakdown of the performance against targets can be found in **Appendix 2**.

Descriptions of each KPI are available in **Appendix 3**. Further detail around interpretation of Statistical Process Control (SPC) charts and “Making Data Count” icons can be found in **Appendix 4**.

The Income Statement for August 2023 is attached in **Appendix 5**.

The Trust has agreed a control total of £15.7m deficit with Cheshire & Merseyside ICS. There are several risks to the achievement of the planned £15.7m deficit. The key risks are as follows:

- CIP delivery.
- Cost pressures – the Trust was unable to fund circa £8m cost pressures and has put in a process to oversee mitigation plans and risk management.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR) - An additional £0.5m income is included in the position which relates to the period April to August 2023. This follows a reduction in the ERF target of 2% to support the impact of IA in April 2023. A further £0.7m has been assumed in anticipation of further ERF adjustments relating to IA in June to August 2023 (as per discussion with ICS but not yet confirmed).
- A&E staffing pressures.
- Additional capacity open due to the levels of no criteria to reside patients.
- Cost of Industrial Action.

These risks also present a challenge to future sustainability if they are not addressed.

Cash

The cash balance at the end of August is £22.1m. The cash flow forecast demonstrates sufficient cash levels for the year provided the Trust delivers the plan.

CIP

At 31 August 2023, the Trust has delivered a CIP of £4.2m against a target of £4.2m. The full year CIP target is £17.9m of which £15.1m has been identified (84%). The current level of recurrent CIP is £9.1m which is an increase from £6.8m last month, however, further work is required to increase recurrent CIP levels.

Capital Programme

The Trust’s capital programme was oversubscribed by £1.5m at the beginning of the financial year. A review has been undertaken to determine schemes no longer required (£0.1m) and schemes to be deferred to 2024/25 (£0.7m) therefore reducing the amount oversubscribed to £0.7m. This movement was supported by FSC. The schemes to be deferred are the pharmacy aseptic service (£0.2m), the Doctors Mess (£0.14m), part of the Catering Upgrade (£0.35m) and Ward B3 Bathroom (£0.03m).

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 5		**184**
Proposed changes in month		
Emergency request		
Histology Cassette Printer	- 24	
Novasure FR Controller	- 18	
Sub Total		- 42
VAT rebate		33
2022/23 Year End Accruals Released		
61638 - Cisco Refresh Phase 2	7	
61648 - Network Diagnostics	2	
61712 - Pintuition Breast Tags	7	
Various - Accruals will not be fulfilled	6	
Sub Total		22
Requests approved at FSC 27/09/23		
Increase budget of ED Minors following tender results	- 151	
Reduce budget of Induction of Labour following tender results	88	
		- 63
Contingency as at end of month 5		**134**

The Trust Board is asked to:

- Note the reduction in the oversubscribed capital programme and the associated deferral of schemes to 2024/25 as supported and approved by the Finance and Sustainability Committee.
- Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.

Financial Recovery

As a deficit Trust, the ICS has requested a recovery plan to take the organisation to financial sustainability by the end of 2025/26. A plan is being developed which will need to be supported with sufficient resources in order to deliver a £22m financial improvement over this period.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPIs that are underperforming are managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee

- Quality & Assurance Committee
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the reduction in the oversubscribed capital programme and the associated deferral of schemes to 2024/25 as supported and approved by the Finance and Sustainability Committee.
2. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
3. Support the KPI amendments as outlined in this paper.
4. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Appendix 1

Key: Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

Consistently passes the target*

Inconsistently passes and fail the target*

F Consistently fails the target*

*based on the last 6 datapoints/months

	QUALITY	Latest				Previous		Assurance
		Plan/Target	Actual	Period	Variation	Actual	Period	
1	1. Incidents	0	0	Aug-23		0	Jul-23	P
2	2. Duty of Candour (serious incidents)	100.00%	100.00%	Aug-23		100.00%	Jul-23	P
3	3. Healthcare Acquired Infections (MRSA)	0	0	Aug-23	L	0	Jul-23	P
4	4. Healthcare Acquired Infections (MSSA)	No target set	1	Aug-23		4	Jul-23	No SPC
5	5. Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	4	Aug-23		5	Jul-23	?
6	6. Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	8	Aug-23		5	Jul-23	?
7	7. Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	2	Aug-23		0	Jul-23	?
8	8. Healthcare Acquired Infections (PA)	Less than 2 - annual	0	Aug-23		0	Jul-23	?
9	9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	2	Aug-23		0	Jul-23	No SPC
10	10. VTE Assessment	95.00% (quarterly position)	93.86%	Aug-23	L	94.90%	Jul-23	?
11	11. Inpatient Falls & harm levels	20% or more decrease from previous year	28	Aug-23	L	37	Jul-23	P

Statistical Process Control - Assurance & Variation

Appendix 1

Key: **Special Cause Variation of a improving nature.** **Consistently passes the target***

Common Cause (Normal Variation). **Inconsistently passes and fail the target***

Special Cause Variation of a concerning nature. **Consistently fails the target***

***based on the last 6 datapoints/months**

	Measure	Target	Value	Month	Variation	Value	Month	Assurance
12	12. Pressure Ulcers	10% reduction	9	Aug-23		9	Jul-23	?
13	13. Medication Safety Reconciliation within 24 hours	80.00%	39.00%	Aug-23	L	48.00%	Jul-23	F
14	14. Staffing - Average Fill Rate	90.00%	97.77%	Aug-23	H	90.43%	Jul-23	?
15	15. Staffing - Care Hours Per Patient Day (CHPPD)	7.9	7.8	Aug-23	H	7.7	Jul-23	F
16	16. Mortality ratio - HSMR	No target set	92.20	Aug-23	H	94.30	Jul-23	No SPC
17	17. Mortality ratio - SHMI	No target set	100.57	Aug-23		99.76	Jul-23	No SPC
18	18. NICE Compliance	90.00%	92.67%	Aug-23	H	92.68%	Jul-23	P
19	19. Complaints	Zero complaints open over 6 months old/in the backlog	0	Aug-23		0	Jul-23	P
20	20. Friends and Family (Inpatients & Day cases)	95.00%	98.00%	Aug-23		97.00%	Jul-23	P
21	21. Friends and Family (ED and UCC)	87.00%	79.00%	Aug-23	H	75.00%	Jul-23	F
22	22. Mixed Sex Accommodation Breaches (Non ITU Only)	0	0	Aug-23		0	Jul-23	P
23	23. Sepsis - % screening for all emergency patients.	90.00%	56.00%	Aug-23		58.00%	Jul-23	F

Statistical Process Control - Assurance & Variation

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*based on the last 6 datapoints/months

24	24. Sepsis - % screening for all inpatients	90.00%	68.00%	Aug-23		72.00%	Jul-23	F
25	25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	58.00%	Aug-23		64.00%	Jul-23	F
26	26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90%	88.00%	Aug-23	H	100.00%	Jul-23	?
27	27. Ward Moves between 10:00pm and 06:00am	0	38	Aug-23	No SPC	38	Jul-23	No SPC
28	28. Acute Kidney Injury	Less than previous month	167	Aug-23		154	Jul-23	?
29	29. Maternity Postpartum Haemorrhage	3.70%	3.84%	Aug-23	No SPC	3.40%	Jul-23	No SPC
30	30. Maternity 3rd and 4th Degree tears	<1.85%	0.82%	Aug-23	No SPC	2.40%	Jul-23	No SPC
31a	31a. Maternity Pregnancy Bookings before 10 weeks	10-week Target: >75%	55%	Aug-23	H	51%	Jul-23	F
32b	31b. Maternity Pregnancy Bookings before 13 weeks	13-week Target: >90%	84%	Aug-23	H	82%	Jul-23	F
32	32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	10%	Jun-23		14%	Apr-23	No SPC
33	33. MUST nutritional assessment completion	above > 85%	62.72%	Aug-23		62%	Jul-23	F

Statistical Process Control - Assurance & Variation

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	ACCESS & PERFORMANCE	Latest Plan/Target	Latest Actual	Latest Period	Latest Variation	Previous Actual	Previous Period	Assurance
34	34. Diagnostic Waiting Times 6 Weeks	95.00%	74.95%	Aug-23		74.24%	Jul-23	
35	35. Referral to treatment Open Pathways	92.00%	50.51%	Aug-23		49.96%	Jul-23	
36	36. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	75%	69.17%	Aug-23		68%	Jul-23	
37	37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	22.78%	Aug-23		22.2%	Jul-23	
38	38. Average time in department ED	No Target	356	Aug-23		354	Jul-23	No SPC
39	39. Cancer 14 Days	93%	68.98%	Jul-23		77.43%	Jun-23	
40	40. Breast Symptoms 14 Days	93%	51.79%	Jul-23		61.90%	Jun-23	
41	41. 28 Day Faster Cancer Diagnosis Standard	75%	75.47%	Jul-23		75.67%	Jun-23	
42	42. Cancer 31 Days First Treatment	96%	98.59%	Jul-23		97.80%	Jun-23	
43	43. Cancer 31 Days Subsequent Surgery	94%	100.00%	Jul-23		100.00%	Jun-23	
44	44. Cancer 31 Days Subsequent Drug	98%	100.00%	Jul-23		100.00%	Jun-23	

Statistical Process Control - Assurance & Variation

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*based on the last 6 datapoints/months

45	45. Cancer 62 Days Urgent	85%	61.11%	Jul-23	L	70.87%	Jun-23	F
46	46. Cancer 62 Days Screening	90%	75.00%	Jul-23		85.71%	Jun-23	P
47	47. Ambulance Handovers within 15 minutes	65%	55.40%	Aug-23		43.97%	Jun-23	F
48	48. Ambulance Handovers within 30 minutes	95%	81.10%	Aug-23	H	72.02%	Jun-23	F
49	49. Ambulance Handovers within 60 minutes	100%	86.26%	Aug-23	H	80.43%	Jul-23	F
50	50. Discharge Summaries - % sent within 24hrs	95%	89.85%	Aug-23		90.69%	Jul-23	F
51	51. Discharge Summaries - Number NOT sent within 7 days	0	29	Aug-23		0	Jul-23	?
52	52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	0.30%	Aug-23		0.18%	Jul-23	P
53	53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	3	Aug-23	L	2	Jul-23	?
54	54. Urgent Operations Cancelled for 2nd Time	0	0	Aug-23		0	Jul-23	P
55	55. Super Stranded Patients	Trajectory	135	Aug-23		125	Jul-23	No SPC
56	56. Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC

Statistical Process Control - Assurance & Variation

Appendix 1

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***based on the last 6 datapoints/months**

57	57. Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
58	58. Elective Outpatient Activity	85%	87%	Aug-23	No SPC	79%	Jul-23	F
59	59. Patients seen in the Fracture Clinic within 72 hours	95%	88.90%	Aug-23		95%	Jul-23	?
60	60. % patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Aug-23	No SPC	0	Jul-23	No SPC
61	61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	No Target set	90%	Aug-23	H	92%	Jul-23	No SPC
62	62. Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	87%	Aug-23		79%	Jun-23	No SPC
64	64. % Patients discharged to their usual place of residence	No Current Threshold	95%	Aug-23		94%	Jul-23	No SPC
65	65. Theatre Utilisation (measured as productive operating time only)	85%	86.00%	Aug-23	H	88%	Jul-23	?
66	66. Day case (measured as an aggregate of total cases)	85%	88.62%	Aug-23		87%	Jul-23	P
67	67. RTT - Number of patients waiting 65+ weeks	0	515	Aug-23	L	680	Jul-23	F

Statistical Process Control - Assurance & Variation

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	WORKFORCE	Plan/Target	Actual	Period	Variation	Actual	Period	
68	68. Supporting Attendance	4.20%	5.70%	Aug-23	L	5.72%	Jul-23	F
69	69. Retention	86.00%	85.51%	Aug-23	H	85.22%	Jul-23	F
70	70. Turnover	Below 13%	13%	Aug-23	L	14%	Jul-23	F
71	71. Bank and Agency Reliance	9% or Below	15.90%	Aug-23	H	15.88%	Jul-23	F
72	72.Core/Mandatory Training	85.00%	90.07%	Aug-23	H	89.51%	Jul-23	P
73	73. Safeguarding Training	Trajectory	83.96%	Aug-23	H	83.44%	Jul-23	F
74	74. PDR	85.00%	75.04%	Aug-23	H	74.95%	Jul-23	F

Statistical Process Control - Assurance & Variation

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	FINANCE & SUSTAINABILTY	Latest				Previous		Assurance
		Plan/Target	Actual	Period	Variation	Actual	Period	
75	75. Trust Financial Position (£m)	-£1.55	-£1.54	Aug-23	No SPC	-2.15	Jul-23	No SPC
76	76. Cash Balance (£m)	£21.54	£22.11	Aug-23	No SPC	25.28	Jul-23	P
77	77. Capital Programme (£m)	£10.37	£4.58	Aug-23	L	£3.77	Jul-23	F
78	78. Better Payment Practice Code	95%	93%	Aug-23		92%	Jul-23	F
79	79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£4.18	£4.18	Aug-23		2.98	Jul-23	P
80	80. Cost Improvement Programme (recurrent forecast) – In year performance to date (£m)	£4.18	£2.00	Aug-23	L	2.98	Jul-23	F
81	81. Agency Ceiling	Less than 3.7%	3.2%	Aug-23	No SPC	4%	Jul-23	F

Key:
Risk Register
System Oversight Framework

Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
34. Diagnostic Waiting Times 6 Weeks Target: 95%	SOF CQC The Trust achieved 74.95% in month. RR1215 RR1125	Diagnostic Waiting Times (within 6 weeks)	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.	A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies.
35. Referral to treatment Open Pathways Target: 92% 67. RTT - Number of patients waiting 65+ weeks Target: 0	SOF CQC The Trust achieved 50.51% in month. There were 3372, 52 week breaches, 65, 78 week breaches and 515, 104 week breaches in . RR1125 RR1215	Referral to Open Pathways Referral to Treatment - 52 + Week Waiters Referral to Treatment - 65 + Week Waiters Referral to Treatment - 78 + Week Waiters	Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature. Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	RTT performance - 52, 65, 78 week wait performance in the reporting period was worse than the operational as a result of cancellations due to industrial action.	Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre. • Restoration and recovery plans for 2023/24 have been drawn up in line with Operational Planning Guidance.

Key:
Risk Register

System Oversight Framework

Care Quality Commission

Access & Performance - Trust Position

Indicator	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
36.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 75% 37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	CQC The Trust achieved 69.17% excluding Widnes walk ins in month. RR774	A&E Waiting Times - Under 4 hour wait	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow. • System resource investment in order to support Pathway 1 discharges. • Additional beds remain open on the Halton site to support bed capacity and flow.
38. Average time in department ED No Target	22.78% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 356 minutes.	% of Patients Waiting Longer than 12 Hours in A&E; Average Time in Department (minutes)	Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature.	12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED.	The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 23/24 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 23/24 is to be set up to support improvement.
39. Cancer 14 Days Target: 93% 40. Breast Symptoms 14 Days Target: 93%	SOF CQC The Trust achieved 68.98% in November 2022 for Cancer 14 days and 51.79% in month for Breast Symptomatic. RR1125	Cancer 14 Days; Breast Symptoms 14 Days	(C14) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation. (Breast) Assurance: The Trust inconsistently fails the target. Variation: Common Cause (normal) variation.	The 2ww standard and Breast Symptoms have seen a drop in performance through March and April due to the continued high levels of referrals coupled with reduced staffing within radiology to support the new patient clinics. There has also been disruption caused by IA.	The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard. Performance against this standard is monitored via the Performance Review Group (PRG). Targeted capacity and demand work has been initiated for the Breast service.

Key:
Risk Register
SOF System Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
41. 28 Day Faster Cancer Diagnosis Standard. Target: 75%. SOF. The Trust achieved 75.47% in month.	Cancer 28 Day Faster Diagnostic Standard	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	This indicator is impacted by continued high volumes of referrals into General Surgery creating pressures on 2 week wait capacity. Short term additional capacity continues to be put in place.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG)
42. Cancer 31 Days First Treatment. Target: 96%. 43. Cancer 31 Days Subsequent Surgery. Target: 94%. 44. Cancer 31 Days Subsequent Drug. Target: 98%. SOF, CQC, RR1125. The Trust achieved 98.59% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in month.	Cancer 31 Days First Treatment; Cancer 31 Days Subsequent Surgery; Cancer 31 Days Subsequent Drug	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation. (Surgery) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation. (Drugs) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The 62 day and 31 day targets have both been affected by a number of longer waiting kidney patients and some breast breaches due to the 2ww issues causing overall longer pathways in this group who do not normally breach. This has remained an issue for April but is now resolving and will be reflected in May's performance.	Capacity is being reviewed in line with clinical service restoration plans.
45. Cancer 62 Days Urgent. Target: 85%. 46. Cancer 62 Days Screening. Target: 90%. SOF, CQC, RR1125. The Trust achieved 61.11% for Cancer 62 Day Urgent and 75% for Cancer 62 Day Screening in month.	Cancer 62 Days Urgent; Cancer 62 Days Screening	(Urgent) Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature. (Screening) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	The 62 day urgent target was not achieved in this reporting period, this was a decrease to previous months. The key factors driving this drop are the Urology and CR pathways which have capacity constrains due to workforce pressures, a recovery plan is in place. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

Access & Performance - Trust Position

Metric	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
47. Ambulance Handovers within 15 minutes Target: 65% 48. Ambulance Handovers within 30 minutes Target: 95% 49. Ambulance Handovers within 60 minutes Target: 100%	In month 55.4% of patients were handed over within 15 minutes, 81.1% were handed over within 30 minutes and 86.26% were handed over within 60 minutes. SOF	Ambulance Handovers within 15 minutes Ambulance Handovers within 30 minutes Ambulance Handovers within 60 minutes	(15) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (30) Assurance: The Trust consistently fails the target. Variation: Special cause variation of an improving nature. (60) Assurance: The Trust consistently fails the target. Variation: Special cause variation of an improving nature.	Handover performance has improved as a result of modest improvement in No Criteria to Reside patients and the reduction in the impact of winter. Additonal staffing to support the offloading of Ambulances has also been used in this period.	The Trust will continue to work in partnership with NWAS to identify and implement improvements.
50. Discharge Summaries - % sent within 24hrs Target: 95% 51. Discharge Summaries - Number NOT sent within 7 days Target: ZERO	The Trust achieved 89.97% in month. There was 1 discharge summary not sent within 23 days required to meet the 95.00% threshold.	Discharge Summaries Discharge Summaries - NOT sent within 7 days	(24 hrs) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (7 Days) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.	The Performance Review Group (PRG) continues to monitor this standard to support improvements.

System Oversight Framework

Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Cancelled Operations on the day for a non-clinical reason Target: Less than 2% 53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO 54. Urgent Operations Cancelled for 2nd Time	CQC Cancelled operations data validation for month is in progress.	Cancelled Operations on the day for a non-clinical reason Urgent Operations - Cancelled for a 2nd Time Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation. (Not offered 28 days) ently passes the target. Variation: Common Cause (normal) variation. (Urgent Ops cancelled 2nd time) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	Compliance against this standard remains below the monitored threshold of 2.00% (positive).	Recovery of elective activity continues to be monitored via Performance review group.

Key:
Risk Register

System Oversight Framework

Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Super Stranded Patients Target: Trajectory	There were 293 stranded and 135 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	Super Stranded Patients; Stranded Patients; Null Criteria to Reside; Right to Reside; Superstranded - NCTR/RTR; Stranded - NCTR/RTR	(SS) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (SS) Assurance: N/A Trajectory Not Agreed. Variation: There is special cause variation of a concerning nature. (NCTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (RTR) Assurance: N/A Trajectory Not Agreed Variation: Common Cause (normal) variation.	The number of Super Stranded patients continues to remain higher than trajectory as a result of the community and Local Authority discharge delays, and a increase in complex patients with both physical and mental health care needs.	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.
56. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	SOF RR1125 In month, the Trust achieved the following % of activity against 2019. This included 83% of Daycase Procedures and 82.05% of Inpatient Elective Procedures.	Elective Recovery Daycase; Elective Recovery Inpatient	N/A - Grouped indicator.	Inpatient activity for the reporting period is below the Trajectory but is inline with the Month 1 plan when the cancellations for Industrial Action is taken into account.	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiatvie and Insourcing methods to undertake additional activity is being undertaken.

Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
57. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	SOF RR1125 In month, the Trust achieved the following % of activity against 2019. This included: 111.2% of MRI 106.24% of CT 77.94% of Non-Obstetric Ultrasound 30.48% of Flexi Sigmoidoscopy 94.9% of Colonoscopy 73.55% of Gastroscopy	Elective Recovery Diagnostics - MRI; Elective Recovery Diagnostics - US; Elective Recovery Diagnostics - CT; Elective Recovery Diagnostics - Colo; Elective Recovery Diagnostics - Gastro; Elective Recovery Diagnostics - Flexi	N/A - Grouped indicator.	Recovery trajectories Radiological specialties and Endoscopy are in line with recovery trajectories. Challenges remain in Cardiorespiratory services.	The Trust continues to restore clinical services in line with the national operating guidance. Additional insourcing support for Echo is being progressed to help reduce waiting times.
58. Elective Recovery Outpatient Activity Aggregate Target: 104%	SOF RR1125 In month, the Trust achieved 89.12% of Outpatient activity against 2019.	Elective Recovery Outpatient Activity	Assurance: The Trust consistently fails the target.	The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative servcies such as patient initiated follow. Activity is impacted by Industrial Action.	The Trust continues to restore clinical services in line with the national operating guidance.

Key:
Risk Register
System Oversight Framework

Care Quality Commission

Access & Performance - Trust Position

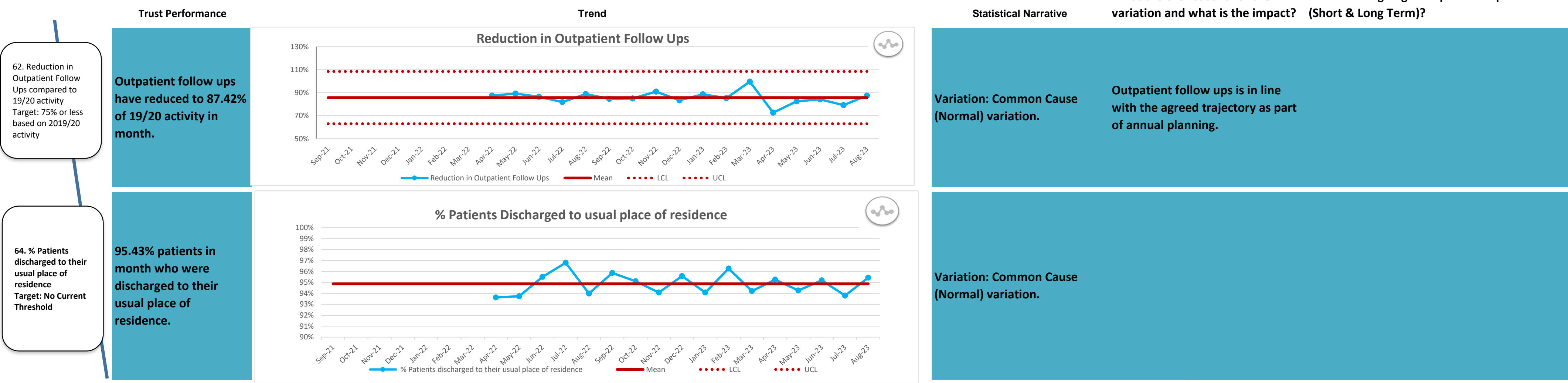
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
59. Patients seen in the Fracture Clinic within 72 hours Target: 95%	The Dashboard data for this indicator is no longer reflective since the commencement of eTrauma.	Fracture Clinic - 72 Hours	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	Issue of non-compliance addressed in-month.	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.
60. % patients referred to long COVID service not assessed within 15 weeks	The Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks for .	% Patients referred to Long COVID service not assessed within 15 weeks	N/A - Not enough datapoints.		
61. 59. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	89.76% of SDEC Emergency Admissions had a zero day length of stay.	SDEC - % of Zero Length of Stay Admissions	Variation: Special Cause Variation of an improving nature	As SDEC becomes more establised the service is maturing and an increase in zero day admissions is seen.	

Key:
Risk Register

System Oversight Framework

Care Quality Commission

Access & Performance - Trust Position



	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
62. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 87.42% of 19/20 activity in month.**	Reduction in Outpatient Follow Ups	**Variation: Common Cause (Normal) variation.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
64. % Patients discharged to their usual place of residence Target: No Current Threshold	**95.43% patients in month who were discharged to their usual place of residence.**	% Patients Discharged to usual place of residence	**Variation: Common Cause (Normal) variation.**		

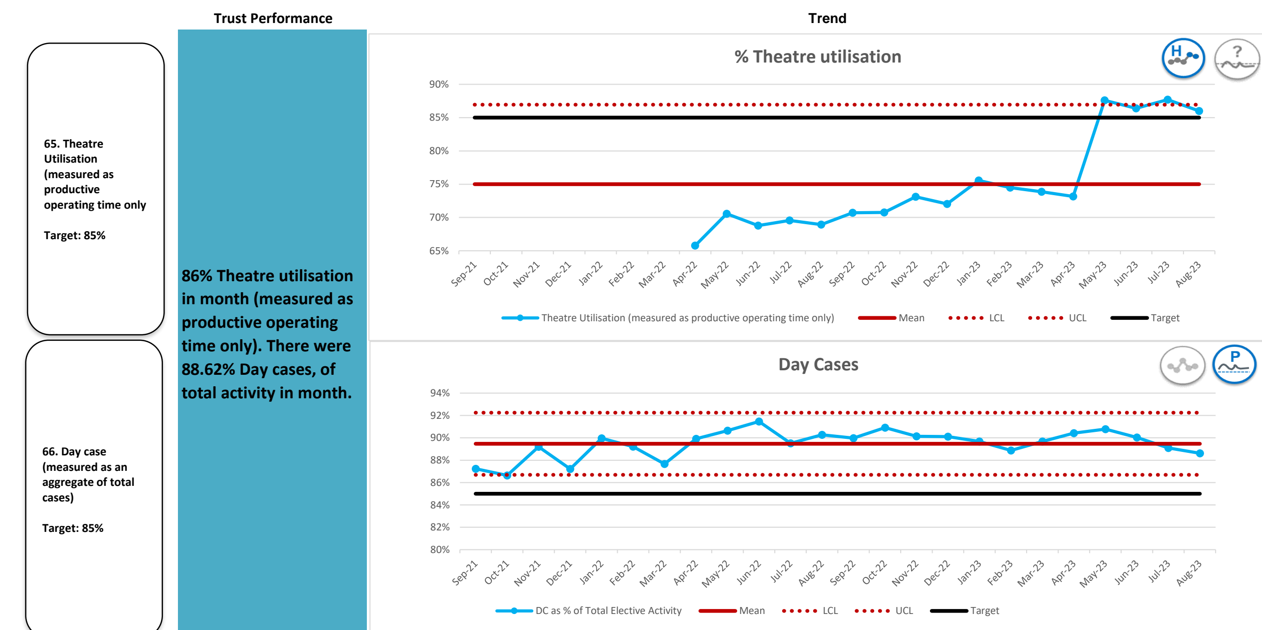
Key:

Risk Register

System Oversight Framework

Care Quality Commission

Access & Performance - Trust Position



	Trust Performance	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
65. Theatre Utilisation (measured as productive operating time only Target: 85%	86% Theatre utilisation in month (measured as productive operating time only). There were 88.62% Day cases, of total activity in month.	Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature.	Theatre Utilisation has improved, but has been steadily increasing since Apr 22 with the participation in the regional Theatre improvement programme. The performance is as a result of some utilisation improvement and changes in recording - this is in the process of being validated.	The Planned Care Transformation Group is focussed on increased utilisation, with a key area of priority of Late Starts in line with the Model Hospital data. Relaunch of late start program is 11th September, following agreement with Planned Care Clinical Directors.
66. Day case (measured as an aggregate of total cases) Target: 85%		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Daycase rates have been higher in 2023/24 with majority hitting the target.	The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates. Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.

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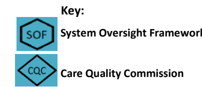

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events	SOF CQC There were 0 incidents over 40 days old.	Open Incidents - 40 Days; Total Incidents Reported; Incidents Reported By Month; Serious Incidents & Never Events; Serious Incidents Actions Breached	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	Incident reporting remains within range with little variance across the Trust. The number of open incidents has increased outside of normal control limits for the past two months. There are no overdue 40-day incidents. There were 3 Serious Incidents reported in August 2023. A decrease of 2 when compared to July 2023. There were 0 breached serious incident actions in August 2023.	**Incident Reporting** A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Each CBU is supported by a designated member of the Governance Team to ensure consistency. A systems review is being undertaken to further understand the position in relation to open incidents. This has been impacted by staffing deficits within the Governance Team. **Number of incidents within 40 days** Weekly CBU monitoring supports timely escalation to the Associate Director of Governance, thus ensuring the position of zero incidents over 40 days continues to be maintained. **Serious Incidents** Weekly monitoring continues with appropriate escalation to the CBU leads. The Trust will move to PSIRF on the 1st September 2023 where SIs will no longer be referenced. This will be reflected using PSII terminology.
2. Duty of Candour (serious incidents) Target: 100%	CQC The Trust achieved 100% for Duty of Candour in month.	Duty of Candour (DoC) - Moderate Incidents; Duty of Candour (DoC) - Serious Incidents	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There is no variance, the Trust remains 100% compliant.	Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.

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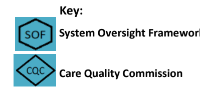
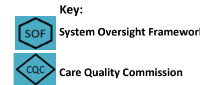


Quality Improvement - Trust Position

Appendix 2

Trust Performance		Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO 4. Healthcare Acquired Infections (MSSA) Target: No set Target 5. Healthcare Acquired Infections (CDI) Target: Less than 36 -annual 6. Healthcare Acquired Infections (Ecoli) Target: less than 54 - annual 7. Healthcare Acquired Infections (Klebsiella) Target: Less than 18 - annual 8. Healthcare Acquired Infections (PA) Target: Less than 2 - annual	SOF CQC S MRSA 0 cases over threshold MSSA 11 cases YTD - no threshold set CDI 13 cases YTD, annual threshold exceeded by 0 cases E. coli 35 cases YTD (0 case(s) over the annual threshold) Klebsiella spp. 5 cases YTD (0 cases over the annual threshold) P. aeruginosa 2 cases YTD (0 cases over the annual threshold)	Healthcare Acquired Infections - MRSA Healthcare Acquired Infections - MSSA Healthcare Acquired Infections - CDI Healthcare Acquired Infections - ECOLI Healthcare Acquired Infections - Klebsiella Healthcare Acquired Infections - PA	(MRSA) Assurance: The Trust consistently passes the target. (MRSA) Variation: Special Cause Variation of an improving nature. (CDI) Assurance: N/A Annual Target (CDI) Variation: Common Cause (Normal) variation. (ECOLI) Assurance: N/A Annual Target (ECOLI) Variation: Common Cause (Normal) variation. (K) Assurance: N/A Annual Target (K) Variation: Common Cause (Normal) variation. (PA) Assurance: N/A Annual Target (PA) Variation: Common Cause (Normal) variation.	MRSA: Nil returns for Apr - Aug. MSSA: 1 Trust apportioned case: unknown source. CDI: 4 Trust apportioned cases in Aug - remain within annual trajectory. ECOLI: Klebsiella: Mainly UTI associated, followed by hepatobiliary source cases for all GNBSI cases. Pseudomonas aeruginosa: 2 Trust apportioned cases FYD - annual threshold reached. Covid-19: 2 outbreaks reported in Aug.	MRSA: MSSA: Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with care of invasive devices. Revise investigation template to align with PSIRF. CDI: CDI prevention action plan in place. RCA investigations & review meetings will continue, approach will be aligned to PSIRF, SIGHT mnemonic education will continue, review of approach to auditing hand hygiene with NHSE, 3 HCA C. difficile study days in September. ECOLI: Klebsiella: Pseudomonas aeruginosa: Audit of hepatobiliary cases has commenced, revise investigation of hospital onset GNBSI cases - aligning approach to PSIRF, review urinary catheter use and protocol for nurse led removal, focus support on wards with higher UTI associated cases. The GNBSI Prevention Group has been reconvened. Covid-19: Close liaison with operational teams for patient placement. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients, staff and visitors. The national requirements to report Covid-19 outbreaks remains in place.
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No	2 in month COVID-19 outbreak. Covid-19: 6 day 8-14 cases probable healthcare associated cases YTD 14 day 15+ cases definite healthcare associated YTD	COVID-19 - Nosocomial COVID-19 Outbreaks	Assurance: N/A - No target. Variation: Common Cause (Normal) variation.		



Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. VTE Assessment Target: 95% (quarterly position)	SOF S The Trust did not achieve the required target at 93.86% for VTE assessments in month.	VTE Assessment (chart: % Target for completion, % Completion of assessments, Mean, LCL, UCL; Sep-21 to Aug-23)	Assurance: The Trust inconsistently passes/fails the target. Variation: Special cause variation of a concerning nature	Performance target did not meet threshold for August 2023 - impacted by the new medical staff rotation.	VTE Data sharing Further work with the corporate information team to develop a BI dashboard of VTE RA data at every ward level to improve overall compliance. This was endorsed by PSCESC as an one of the improvement plans based on VTE report. Education and training To continue to raise awareness of the need for VTE completion at new August intake induction and with the every changeover of junior doctors 4 months placement. Improvement plan To gather feedback from all CBUs on how to improve future CBU VTE risk assessment compliance.
11. Inpatient Falls & harm levels Target: 20% or more decrease from 21/22 (590 Inpatient Falls in	CQC S 43 total falls were reported in month. 28 of these were inpatient falls. There has been a 48.84% decrease in Trust falls from the previous month, and a 32.14% decrease inpatient falls. There has been an increase of 59 of Trust wide fall compared with same period last year. There was 1 falls in month with harm	Inpatient Falls (Mean, LCL, UCL, Target, Inpatient Falls); All Falls (Mean, LCL, UCL, Falls); Falls - All Harm (Mean, LCL, UCL, All Harm); Falls Per 1000 Bed Days (Mean, LCL, UCL, Falls/1000 bed Days); Falls - Avoidable Harm (Mean); Sep-21 to Aug-23	Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	Contributing factors to inpatient falls include: inconsistency in the use of falls alarms and the requirement for enhanced care support with staffing challenges.	Falls risk alerts have been added to Lorenzo and this process will be monitored to ensure embedded. Learning continues to be shared at Harm Free Care Meetings. The daily Trust-wide Safety Brief has been relaunched facilitating face to face discussion including inpatient falls within the preceding 24 hours. Falls awareness week is to be held during September for which plans are in place to support learning.

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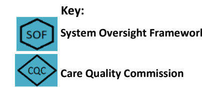
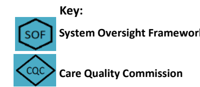


Quality Improvement - Trust Position

Appendix 2

Trust Performance		Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Pressure Ulcers Target: 10% reduction based on 91 in 2021/22	CQC There were 9 hospital acquired category 2 pressure ulcers and 0 Category 3 pressure ulcer in month. There were 69 community aquired pressure ulcers in month.	Pressure Ulcers - Category 2; Pressure Ulcers - Category 3; Pressure Ulcers - Category 4; Community Acquired Pressure Ulcers	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Contributory factors to the development of category 2 pressure ulcers including delay to transfer time to pressure relieving mattress, inconsistent repositioning in ED and medical devices (TED stockings and oxygen tubing).	Actions to improve the position include: 1. After Action Reviews have commenced and lessons are shared with ward teams and via Operational Patient Safety Group. 2. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses. 3. Following the pilot of Repose wedges to aid pressure relief on two wards, the wedges are now available to order by all wards. 4. A mattress audit with the provider company is due to take place in September 2023 to ensure that mattress remain fit for purpose. 5. The Tissue Viability Nursing (TVN) Team continue to have an increased presence in the Emergency Department. 6. The QI Team are supporting Matrons to monitor the sustainability of the change package. 7. Tissue viability training for preceptorship nurses and international nurses. 8. Nursing staff regularly shadow the TVN Team to gain experience in pressure ulcer prevention and management.
13. Medication Safety Reconciliation within 24 hours Target: 80%	Medicines reconciliation was completed within 24 hours of admission for 39% of patients. 72% of patients had MR completed during inpatient stay. There were 22 controlled drug incidents. There was 0 medication harm incident reported in month.	Medication Safety - Reconciliation - 24 hours; Medication Safety - Reconciliation - Overall; Medication Safety - Controlled Drug Incidents; Medication Safety - Incidents with Harm	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Medicines reconciliation: performance continues to be adversely impacted by the current pharmacist vacancy rate. Controlled drug incidents: there is no target for this metric. The most common type of incident relating to controlled drugs related to documentation, but no specific themes were identified. Incidents causing harm: there is no target for this metric, and no incidents involving medicines causing harm were reported in August 2023.	Medicines reconciliation: 1. Ongoing recruitment - 2wte band 6 pharmacists started September 2023, 1wte starting in October 2023 and 2wte starting in January 2023. No new starters at band 7/8a level (except internal promotions) 2. Continued use of bank and agency pharmacists to support gaps in the establishment. 3. 2wte band 5 technicians recruited to work in ED, will support with medicines reconciliation of patients with DTA. Controlled drug incidents: Monthly self-assessments and quarterly CD audits are undertaken. Themes identified and addressed with specific action plans. Support given to areas with poor compliance. Incidents with harm: All medication incidents reviewed by pharmacy, clinical and governance teams and lessons learned shared.



Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 90.05% Day (Care Staff) 99.65% Night (Nurses/Midwife) 95.7% Night (Care Staff) 114.38% RR115 RR1108	Staffing - Average Fill Rate - Day Nurses/Midwives; Staffing - Average Fill Rate - Day Care Staff; Staffing - Average Fill Rate - Night Nurses/Midwives; Staffing - Average Fill Rate - Night Care Staff	Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	Additional beds in use across the Trust due to increased demand in AED, in addition to acuity and a large number of super stranded patients and escalated beds open.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse. RN vacancy is currently 138.86 and once all appointed staff are in post the Trust will be approximately 20 RN over recruited to support with winter pressures and off set expected turnover. This includes international nurse cohort 14 which equates to 11 international nurses joining the Trust in October 2023. Additional resource is available to support recruitment until October 2023 to reduce time to post. HCSW vacancy is currently 31 with more interviews taking place on the 19th September 2023 with the aim to appoint to the remaining vacancy.
15. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	In month, the average CHPPD were: Nurse/Midwife: 4.3 hours Care Staff: 3.6 hours Overall: 7.8 hours	Staffing - CHPPD - Overall; Staffing - CHPPD - by Staff Group; Staffing - CHPPD - Benchmarking	Assurance: The Trust consistently fails to hit the target. Variation: Common Cause variation of an improving nature.	The CHPPD August increased to 7.8 overall which is a continued improving trajectory.	Staffing is reviewed twice daily by the Senior Nursing Team to maintain safety and work is ongoing to reduce agency usage, recruit to posts and migrate regular agency workers to NHSP. There are clear processes for escalation to ensure staffing is based upon acuity to ensure patient safety.

Quality Improvement - Trust Position

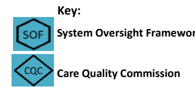
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 92.2. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 100.57.	HSMR chart (Sep-21 to Aug-23; HSMR, Mean, LCL, UCL) SHMI chart (Sep-21 to Aug-23; SHMI, Mean, LCL, UCL)	Assurance: NA - no target Variation: Special Cause Variation of a concerning nature.	Both SHMI and HSMR are both within range.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. UTI is noted as a new trend which has been identified and will be monitored via the IPR with further reviews undertaken as necessary.
18. NICE Compliance Target: 90%	The Trust achieved 92.67% in month.	NICE Compliance chart (Sep-21 to Aug-23; Target, Full Compliance, Mean, LCL, UCL)	Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Performance against the target of 90% continues to be sustained.	The Clinical Effectiveness Manager continues to work closely with the CBUs with focus upon partial compliance and those 'under review' to ensure timeliness of progress and completion.

Quality Improvement - Trust Position

Appendix 2

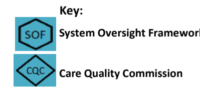
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Complaints Target: Zero complaints open over 6 months old/in the backlog.	In month, 15 new complaints were received to the Trust which was a decrease of 6 from the previous month. There were 1 dissatisified complaints received in month, which is a decrease from the previous month.	Complaints - Over 6 months old; Complaints - Closed in Month; Complaints - Responded in Timeframe; Complaints - Open 1st Response; Complaints - Received in Month; Complaints - PHSO; Complaints - PALS concern	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The Trust continues to sustain performance in the timely completion of complaints. There continues to be no complaints over 6 months old.	Positive complaints position of 36 open complaints. All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the clinical teams. All CBUs have a designated complaints case handler to ensure consistency.



Quality Improvement - Trust Position

Appendix 2

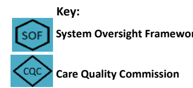
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) Target: 95% 21. Friends and Family (ED and UCC) Target: 87% The Trust achieved 98% in month for Inpatient & Day case FFT and 79% for ED/UCC FFT. The most recent National average for FFT was 94.84% and for C&M was 95.22%.	Friends and Family (Inpatients & Day cases); Friends and Family (ED and UCC); FFT Inpatients/Day Case - National, Regional, Cheshire & Mersey	(IP/DC) Assurance: The Trust consistently passes the target. (IP/DC) Variation: Common Cause (Normal) variation. (ED/UCC) Assurance: The Trust consistently fails the target. (ED/UCC) Variation: Special cause variation of an improving nature.	Inpatient/Day Case - The Trust achieved 98% positive recommendation rate in August 2023. The departmental teams continue to maintain a positive response rate by monitoring feedback regularly. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients. ED/UCC - The Trust achieved 79% positive feedback in Friends and Family Test results in August 2023. The Patient Experience and Inclusion team and the ED/UCC senior nursing team continue to focus on the environment and communication, both written and verbal.	Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis supporting continuous improvement. Impact noted includes waiting times for which operational plans are in place, monitored through appropriate committees.
22. Mixed Sex Accommodation Breaches (Non ITU Only) Target: Zero There were 0 mixed sex accommodation incidents outside of the ITU in month. There were 10 MSA incidents within the ITU.	Mixed Sex Accommodation Breaches - Non ICU; Mixed Sex Accommodation Breaches - ICU	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There were 10 mixed sex accommodation breach reported in August 2023 in the Intensive Care Unit. There were zero breaches within any other ward area.	Work is underway in the Unplanned Care Group in relation to ongoing patient flow to ensure the prioritisation of patients from ITU into the general bed base. Patients requiring step down from ITU are a standing agenda item at each bed meeting. A contributing factor to these breaches are the high number of super-stranded patients within the Trust bed base.



Quality Improvement - Trust Position

Appendix 2

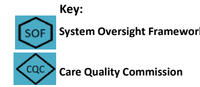
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. Target: 90% 24. Sepsis - % screening for all inpatients. Target: 90%	The Trust achieved: • 56% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 68% screening for all inpatients with suspected sepsis within 1 hour.	Sepsis Emergency Patient Screening Sepsis Inpatient Screening	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (Inpatient) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	A reduction in screening for both inpatient and ED is a result of incomplete blood culture sampling, compounded by a high number of patients in ED.	Quality Improvement support is in place to drive improvements across the Trust. There are four workstreams with a focus for improvement: ED, In-patient, Paediatrics and Maternity. Sepsis management remains a focus on Safety Huddles. A study day has been established for World Sepsis Day on the 13 September 2023 which will be open to all staff. A QR code has been attached to the poster this event to support staff to book onto blood cultures training. The Aqua Advancing Quality Sepsis Collaborative will be taking place on 09 September with representatives from PSIN and QI attending. All patients who do not receive assessment and treatment within the 1 hour timeframe are reviewed with no harm recorded.
25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag. Target: 90% 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis. Target: 90%	The Trust achieved: • 58% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made. • 88% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.	Sepsis Emergency Patient Antibiotics (within 1 hr) Sepsis Emergency Patient Antibiotics (within 6 hrs) Sepsis Inpatient Antibiotics (within 1 hr) Sepsis Inpatient Antibiotics (within 6 hrs)	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (Inpatient) Assurance: The Trust consistently fails the target. Variation: Special cause variation of a concerning nature.	A decrease in the administration of antibiotics within 1 hour for patients within ED compounded by the increased numbers within the department. The inpatients compliance is noted to be just below the threshold at 88%. For both inpatient and patients within ED, over 90% receive antibiotic administration within 6 hours. All patients were reviewed with no harm was noted.	The importance of prescribing antibiotics in a timely manner continues to be a focus for improvement. A comprehensive review of the prescribing process for antibiotics will be undertaken with the Chief Pharmacist, Medical Director, Trust Medical Lead for Sepsis and Emergency Department staff, to determine whether a more efficient solution can be introduced.



Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Ward Moves between 10:00pm and 06:00am No Target	There was a total of 38 ward moves between 10pm-6am in month, compared to 95 in 2022.	Ward Moves 10:00pm - 06:00am	N/A - Monthly/ Annual Comparison.	The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and the Senior Manager on call minimising non essential clinical patient moves.	The Senior Manager on call (SMOC) and Patient Flow Team work together to minimise the movement of patients across the Trust after 10pm. Automatic notifications are applied for patients who have a learning disability or mental health need to ensure that health needs are met in a timely and safe manner. This notification is monitored by senior nurses who undertake a welfare check.
28. Acute Kidney Injury Target: Less than previous month	There were 167 acute kidney injuries reported in month.	Acute Kidney Injury; Average Length of Stay AKI Patients	Variation: Common Cause (Normal) variation.	There has been a significant decrease in the length of stay for patients with AKI's. An increase of incidents of Hospital Acquired AKI's is seen in month.	Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient . Staff survey undertaken to understand 'barriers to completion' and suggested E-learning / ward-based teaching package to be developed. Ward based further AKI education as part of the AKI role. Drive to increase the AKI bundle to improve practice and utilise the AKI clinics each week to reduce the 30-day readmission rate.



Key:
SOF System Oversight Framework
CQC Care Quality Commission

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml Threshold: < 3.7%	There were 3.84% Postpartum Haemorrhages >1500ml in month.	Maternity Postpartum Haemorrhage > 1500ml (chart)	N/A - Not enough datapoints.	Rates for August are slightly above the benchmark which marks a slight increase 0.44% from July. However, this remains an improved position from May and June 2023. A deep dive was presented to QAC in May and learning has been captured in an action plan is nearing completion. One aspect of the action plan was the introduction of an new medication regime for those undergoing caesarean section. This improvement measure has been audited and has had a positive impact. A full audit of PPH >1500mls March 2023 - August 2023 is underway via Intrapartum Incident Review Group.	A retrospective audit of PPH will commence in September 2023 to assess the impact of the action plan and any additional learning since its implementation. PPH >1500mls will continue to be reviewed on an individual basis via governance processes but will also be subject to additional review through the Intrapartum Incident Review Group which will meet regularly to review patterns and themes from incidents of PPH >1500ml. All PPH >1500mls continue to be reviewed via governance processes.
30. Maternity 3rd and 4th Degree tears Threshold: <1.85%	There were 0.82% 3rd and 4th Degree tears in month.	Maternity 3rd and 4th Degree tears (chart)	N/A - Not enough datapoints.	Incidence of 3rd & 4th degree tears is below the benchmark in August, this is consistent with the performance March-June 2023 and in improvement from July 2023. All 3rd & 4th degree tears are reviewed via governance processes and the learning from these reviews is then shared. No significant factors have been identified.	Incidence of 3rd & 4th degree tears continue to be reviewed via governance processes and the learning from these reviews is then shared. In view of the increased rates this will be included for further review and discussions at the next Women's Health Governance meeting.+DX50
31. Maternity Pregnancy Bookings before 10 weeks and 13 weeks 10-week Target: >75% 13-week Target: >90%	54.6% bookings before 10 weeks and 84.4% bookings before 13 weeks.	Maternity Bookings before 10 weeks (chart); Maternity Bookings before 13 weeks (chart)	(10 weeks) Assurance: The Trust consistently fails the target. (10 weeks) Variation: Special cause variation of an improving nature. (13 weeks) Assurance: The Trust consistently fails the target. (13 weeks) Variation: Special cause variation of an improving nature.	An action plan is in place to improve timeliness of bookings and there had been improvement over the last 12 months. For both booking measures performance has continued to improve and is nearing that of local provider best averages (58.9% for bookings <10 weeks and 87.9% for bookings <13 weeks). Work will continue to meet the stretch target to achieve best practice results.	An action plan is in place to improve timeliness of bookings and there had been significant improvement following implementation of this particularly in relation to bookings <10 weeks. This work will continue with booking performance monitored on a weekly basis .

Key:
System Oversight Framework
Care Quality Commission

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
32. Fractured Neck of Femur Target: Best Practice Tariff	36.7% of patients were treated in line with Best Practice Tariff (BPT) in Aug-23.	% of patients treated in line with Best Practice Tariff (BPT) % of patients receiving surgery within 36hrs of admission	Variation: Common Cause (Normal) variation.	There is a significant improvement in patients receiving surgery within 36hrs.	Work continues with regards to improving capacity to aid performance of 'Prompt surgery', this includes a review of theatre availability for trauma, scheduling of an additional list, as is possible, productivity monitoring and a review of the delivery of the Trauma Consultant on Call rota'.
33. MUST nutritional assessment completion Target: above 85%	MUST Nutrition assessment completion was 62.72% in month.	MUST Nutrition assessment completion	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	The performance in completion of MUST is noted at 62.72%, this is an improving trajectory month on month.	Local QI projects and dashboards are in place. SPC charts for each ward to be added to dashboard to aid data interpretation have been made available. Ward-based interventions are to be re-launched. Collaboration with QI team to analyse audit data and formulate Trust wide Quality improvement project. Compliance is monitored by monthly Nutrition, Food & Hydration Steering Group.

Workforce - Trust Position

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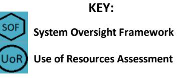
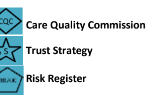
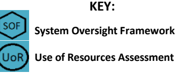
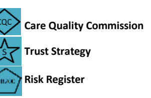




	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
68. Supporting Attendance Target: Below 4.2%	UoR SOF S The Trust's sickness absence rate was 5.7% in month.	Supporting Attendance (chart: Target, Current Yr, Mean, LCL, UCL; Sep-21 to Aug-23)	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence showing an Improving Variation. The annualised sickness absence percentage in August 2023 was 5.7%, a decrease from 5.9% in June 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter.	August 2023 annualised absence is the lowest annual absence rate since April 2020. Following an MIAA Audit, the HR team are working with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. The OH and Wellbeing team meet with HR to triangulate data to support bespoke interventions including supporting areas where there are outbreaks of infections to minimise impact to absence and implementing targeted, proactive health prevention programmes of work to address high patterns of absence e.g. MSK in Estates.
69. Retention Target: 85%	UoR RR1108 RR1134 Retention of all staff was 85.51% in month.	Retention All Staff (chart: Target, Retention %, Mean, LCL, UCL; Sep-22 to Aug-23)	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Retention showing an Improving Variation. Retention of all staff in August 2023 was above target at 85.5%, an increase from 85.2% in June 2023. Retention for permanent staff remains above Trust target in August 2023 at 88.16%.	Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving. HR are working with targeted areas including Maternity to review their approach to flexible working to support the reduction in turnover. The Trust continues to review the benefits and support offered to the workforce, including financial wellbeing and are further developing our physical wellbeing offers. There has been a focus on improving Staff Voice through listening events and robust follow up communications of actions taken as a result.
70. Turnover Target: Below 13%	S CQC SOF UoR Turnover of all staff was 13.35% in month.	Turnover All Staff (chart: Sep-21 to Aug-23)	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Turnover is showing an Improving Variation. Turnover in August 2023 was 13.35%, a decrease from 13.86% in June 2023. Turnover of permanent staff in June 2023 was 12.34% which is below Trust target.	

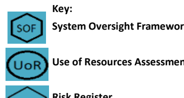
Workforce - Trust Position

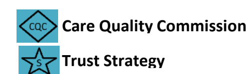




	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
71. Bank and Agency Reliance Target: 9% or Below	UoR Bank and Agency Reliance was 15.9% in month.	Bank & Agency Reliance	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Bank and Agency reliance is showing a Concerning Variation. Bank and Agency reliance in August 2023 was 15.9%, a decrease from 16.59% in June 2023.	The Resourcing Task and Finish group has developed a benchmarking framework using the five stages of Workforce Deployment. The framework is based on national guidelines/best practice that will enable the Trust to identify areas where workforce deployment mirrors best practice and areas where improvements are required. A change in legislation now means agency workers can no longer be booked to cover gaps due to industrial action. The Workforce Deployment framework focuses on ensuring bank workers have the opportunity to fill any gaps and only securing agency workers as a last resort, for short periods, with clear mitigation plans in place.
72.Core/Mandatory Training Target: 85%	UoR CQC Core/Mandatory training compliance was 90.07% in month.	Core/Mandatory Training Compliance	Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Training (exclusive of Safeguarding) is showing an Improving Variation. In August 2023, CSTF Mandatory Training compliance was 90.1%, excluding Safeguarding Training (Children's and Adults); Safeguarding (Children's and Adults) compliance was 84%.	Compliance continues to be supported by the continual review of training at the Mandatory and Role Specific Training Panel and the offer of face to face training. Care Groups report compliance at Operational People Committee with actions required to ensure targets are met. Changes have been made in terms of accessibility of Safeguarding training which has resulted in a slight increase in compliance.
73. Safeguarding Training Target: Trajectory	Safeguarding Training compliance was 83.96% in month.	Safeguarding Training	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.		
74. PDR Target: 85%	S CQC PDR compliance was 75.04% in month. SPC - there is evidence of special cause variation for PDR compliance.	PDR Compliance	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In August 2023, Appraisal compliance was 75%, an increase from 74.31% in June 2023. Currently Appraisal rates are below the trajectories but higher than 2022.	New streamlined paperwork is due to be launched responding to workforce feedback to simplify the approach to support achievement of target. The implementation of Pay Step Progression has contributed to improving trajectories for PDRs across the organisation. There is a current review of how Medical PDRs are recorded and reported, with an increase to overall PDR compliance expected upon completion of the review.

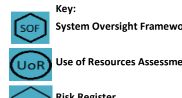
Finance and Sustainability - Trust Position

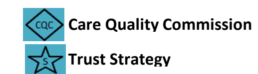




Trust Performance		Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
75. Trust Financial Position Target: Plan	The Trust has recorded a deficit position of £11.65m at 31 August 2023 against a plan of £9.2m. The position includes £0.5m additional income relating to a reduction of the ERF target to compensate for the impact of Industrial Action as well as a further assumed £0.7m as advised by C&M ICS.	Trust Financial Position - In Month; Trust Financial Position - Cumulative	Assurance: The Trust inconsistently passes/fails the target.	The main drivers for the deficit being worse than plan are Industrial Action (IA) costs, activity delivered under plan and the cost of additional capacity in A&E.	The Trust is forecasting delivery of the forecast £15.7m deficit, however there are significant risks to achieving this plan.
76. Cash Balance Target: On or better than plan	UoR The cash balance as at 31 August 2023 is £22.11m. RR134	Cash Balance	Assurance: The Trust consistently passes the target.	The current cash balance is £22.11m which is £0.6m better than the cash plan. In the main this relates to timing differences in the payment of trade and capital creditors and the timing of debtor receipts.	
77. Capital Programme Target: On plan 90%-100%	UoR Capital expenditureat the end of month 5 is £4.58m against a plan of £10.37m.	Capital Programme	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Annual Trust capital plan of £24.7m is £0.7m oversubscribed against £24m of capital funding. The monthly profile of the Trust plan has been updated to be more reflective of the expected position. With the updated profile, £7.1m was expected to be spent by 31 August 2023 giving a variance of £2.52m.	The underspend year to date is mainly due to the timing of externally funded schemes. In particular, the plan for TIF is £7.5m and for CDC is £3.3m which were profiled in 12ths whilst waiting for a detailed plan from cost advisors. There was also a subsequent delay due to additional funding requests. The majority of TIF and CDC expenditure is now expected in months 7 to 12.

Finance and Sustainability - Trust Position





Trust Performance		Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
78. Better Payment Practice Code Target: Cumulative performance 95%	UoR The Better Payment Practice Code performance based on volume for NHS is 79% and non-NHS is 93%. The Better Payment Practice Code performance based on value for NHS is 84% and non-NHS is 91%.	Better Practice Payment Code (Month); Better Practice Payment Code (Cumulative)	Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	Cumulative performance is 93.00% which is below the national target of 95.00%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments. Waiver training has also been rolled out across the Trust which will also speed up the PO approval process.
79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date Target: >90% plan delivered YTD	UoR The month 5 CIP plan is £4.2m and £4.2m has been delivered.	CIP - In Year (% Delivered against plan); CIP - In Year	Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	84% of savings have been identified for 2023/24 which is £15.1m of the £17.9m target.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT programme with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust. The plan for 2023/24 continues to be developed for the £17.9m target.
80. Cost Improvement Programme (recurrent forecast) – In year performance to date Target: Recurrent Forecast is more than 90% of annual target	£2m CIP has been delivered recurrently against the target of £4.2m.	CIP recurrent- In Year (% Delivered against plan); Recurrent CIP - Forecast	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	The Trust is working to identify additional recurrent CIP for 2023/24. A key driver will be GIRFT efficiencies throughout the Trust. Of the £15.1m identified, £9.1m is recurrent, an increase from £6.8m last month.	The Trust is in the process of identifying additional recurrent CIP schemes for 2023/24. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.
81. Agency Ceiling Target: Agency spend should not exceed 3.7% of total pay (ICS target)	UoR The Trust Agency spend in month is 3.2% against a target of 3.7%	Agency Ceiling (%)	Assurance: The Trust inconsistently passes/fails the target.	The Trust Agency spend is below the agency ceiling due to moving agency staff onto the bank.	The Resourcing Task and Finish group has been established to develop a system/process to report on factors influencing temporary staffing spend such as: - Agency controls best practice - Rostering compliance - Rate card compliance - Establishment Control compliance (or an alternative approach) - Unplanned absences - Recruitment activity

Appendix 3 – Trust IPR Indicator Overview

	Indicator	Detail
	Quality	
1.	**Incidents**	• Number of incidents reported in month. • Number of incidents open over 20 days and 40 days. • Number of serious incidents reported in month. • Number of serious incidents where actions have breached the timescale. • Number of never events reported in month.
2.	**Duty of Candour**	• Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where the Trust contacts the patient or their family to advise of the incident; this has to be done within 10 working days.
3. **4.** **5.** **6.** **7.**	**Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)**	• Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. • MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin. • Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. • Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. • Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis. • Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.
9.	**Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks**	• Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. • Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
10.	**VTE Assessment**	• Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month, however this indicator is reported quarterly.
11.	**Inpatient Falls & Harm Levels**	• Total number of falls which have occurred in month. • Falls per 1000 bed days in month. • Total number of inpatient falls which have occurred in month. • Levels of harm reported as a result of a fall in month. • Level of avoidable harm which has occurred in month.
12.	**Pressure Ulcers**	• Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).

13.	**Medication Safety**	Overview of the current position in relation to medication, to include: • Medication reconciliation within 24 hours. • Medication reconciliation throughout the inpatient stay. • Number of controlled drugs incidents. • Number medication incidents resulting in harm.
14.	**Staffing Average Fill Levels**	• Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
15.	**Care Hours Per Patient Day (CHPPD)**	• Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
16.	**HSMR Mortality Ratio**	• Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
17.	**SHMI Mortality Ratio**	• Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
18.	**NICE Compliance**	• The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. This indicator monitors Trust compliance against NICE guidance.
19.	**Complaints**	Overall review of the current complaints position including; • Number of complaints received in month. • Number of dissatisfied complaints in month. • Total number of open complaints in month. • Total number of cases over 6 months old in month. • Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month. • Number of complaints responded to within timeframe in month. • Number of PALS complaints received and closed in month.
20.	**Friends and Family Test (Inpatient & Day Cases)**	• Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
21.	**Friends and Family (ED and UCC)**	• Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
22.	**Mixed Sex Accommodation Breaches (Non-ITU)**	• Number of MSA Breaches in month (outside of ITU).
23. **24.** **25.** **26.**	**Sepsis**	• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.

27.	**Ward Moves Between 10pm and 6am**	• Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
28.	**Acute Kidney Injury**	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.
29.	Postpartum Haemorrhage >1500ml	• To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard. • PPH>1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH>1500mls when compared to the North West Coast Maternity Dashboard.
30.	3rd and 4th Degree tears	• To monitor rates of 3rd & 4th degree tears against North West Coast Regional Dashboard. • WHH are not currently an outlier for 3rd & 4th degree when compared to the North West Coast Maternity Dashboard, but 3rd and 4th degree tears are a significant outcome with the potential for long term impact of women's health and wellbeing.
31.	3rd and 4th Degree tears	• To monitor pregnancy bookings met within the 10 and 13 week target. • Timeliness of pregnancy booking is a key performance indicator. • WHH is currently an outlier for bookings before 10 weeks when compared to the North West Coast Maternity Dashboard. • WHH is also currently an outlier for bookings before 13 weeks gestation when compared to the North West Coast Maternity Dashboard
32.	Fractured Neck of Femur	• The % of patients treated in line with Best Practice Tariff (BPT). • The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database (nhfd.co.uk)). • Shorter time to theatres significantly reduces risk of mortality and improves pain.
33.	*MUST nutritional assessment completion*	• To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE) • In hospital, disease-related malnutrition has been shown to result in increased wound infections, chest infections and pressure ulcers; increased length of admission; increased numbers of re-admissions; and increased overall morbidity
	Access & Performance	
34.	**Diagnostic Waiting Times – 6 weeks**	• All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.

35. 67.	**RTT Open Pathways and 52 & 65 week waits**	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
36.	**Four hour A&E Target and ICS Trajectory**	• All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.
37.	**A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.**	• % of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.
38.	**Average Time in Department (ED)**	• How long on average a patient stays within the emergency department (ED).
39.	**Cancer 14 Days**	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
40.	**Breast Symptoms – 14 Days**	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
41.	**Cancer – 28 Day Faster Diagnostic Standard**	• All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.
42.	**Cancer 31 Days - First Treatment**	• All patients to receive first treatment for cancer within 31 days of decision to treat.
43.	**Cancer 31 Days - Subsequent Surgery**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery.
44.	**Cancer 31 Days - Subsequent Drug**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments.
45.	**Cancer 62 Days - Urgent**	• All patients to receive first treatment for cancer within 62 days of an urgent referral.
46.	**Cancer 62 Days – Screening**	• All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers.
47.	**Ambulance Handovers 15**	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
48.	**Ambulance Handovers 30 – 60 minutes**	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
49.	**Ambulance Handovers – more than 60 minutes**	• % of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).
50.	**Discharge Summaries – Sent within 24 hours**	• The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
51.	**Discharge Summaries – Not sent within 7 days**	• If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
52.	**Cancelled operations on the day for non-clinical reasons**	• % of operations cancelled on the day or after admission for non-clinical reasons.
53.	**Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days**	• All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
54.	**Urgent Operations – Cancelled for a 2nd Time**	• Number of urgent operations which have been cancelled for a 2nd time.

55.	**Super Stranded Patients**	• Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
56.	**Elective Recovery Activity**	• % of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20.
57.	**Elective Recovery Diagnostics**	• % of Diagnostic Activity against the same period in 2019/20.
58.	**Elective Recovery Outpatients**	• % of Outpatient Activity against the same period in 2019/20.
59.	**Fracture Clinic**	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
60.	**% Outpatient referred to long covid service within 15 weeks**	•
61.	**% of zero-day length of stay admissions (SDEC)**	• % of zero length of stay admission (SDEC).
62.	**Reduction in Outpatient Follow Ups**	• % reduction of Outpatient follow ups compared to 19/20 activity.
63.	**COVID-19 Recovery Cancer First Treatment**	• % of people who received their first treatment for cancer compared to the equivalent month in 19/20.
64.	**% Patients discharged to their usual place of residence**	• % of patients who were discharged to their usual place of residence.
65.	**Theatre Utilisation (measured as productive operating time only)**	• Increase productivity and meet the 85% day case and 85% theatre utilisation expectations using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings. • Aim is to support providers and systems to maximise the effectiveness and throughput of their surgical theatres through improvements across the surgical elective pathway. As part of the High-Volume Low Complexity (HVLC) programme, GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time utilisation by 2024/25.
66.	**Day case (measured as an aggregate of total cases)**	
	Workforce	
68.	**Supporting Attendance**	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
69.	**Retention**	Staff retention rate % over the last 12 months.
70.	**Turnover**	A review of the turnover % over the last 12 months.
71.	**Bank & Agency Reliance**	The Trust reliance on bank/agency staff.
72.	**Core/Mandatory Training**	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
73.	**Safeguarding Training**	A summary of safeguarding training compliance.
74.	**Performance & Development Review (PDR)**	A summary of the PDR compliance rate.
	Finance	
75.	**Trust Financial Position**	The Trust operating surplus or deficit compared to plan.
76.	**Cash Balance**	The cash balance at month end compared to plan.

77.	**Capital Programme**	Capital expenditure compared to plan.
78.	**Better Payment Practice Code**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
79.	**Cost Improvement Programme – Plans in Progress in Year**	Cost savings schemes in-year compared to plan.
80.	**Cost Improvement Programme – Recurrent)**	Cost savings schemes recurrent compared to plan.
81.	**'Agency Ceiling'**	At ICS level, agency spend should not exceed 3.7% of total pay. The Trust ceiling is still to be confirmed.

Appendix 4 - Statistical Process Control

1.0 What is SPC?

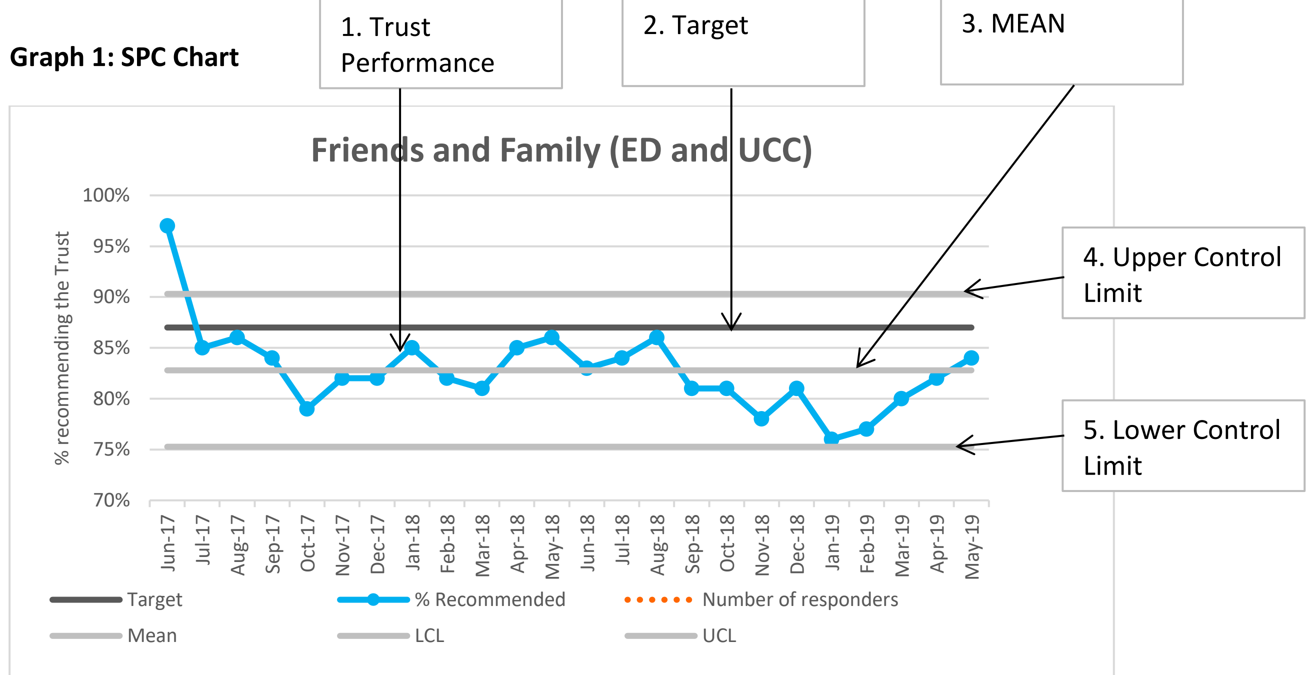
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes and both common cause (normal) and special cause (unexpected) variation.

2.0 SPC Charts

In addition to the process/metric being measured, SPC charts on the IPR have 3 additional lines.

- Mean – is the average of all the data points on the graph. This is used a basis for determining statistically significant trends or patterns.
- Upper Control Limit – the upper limit that any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.
- Lower Control Limit – the lower limit than any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.

Graph 1: SPC Chart

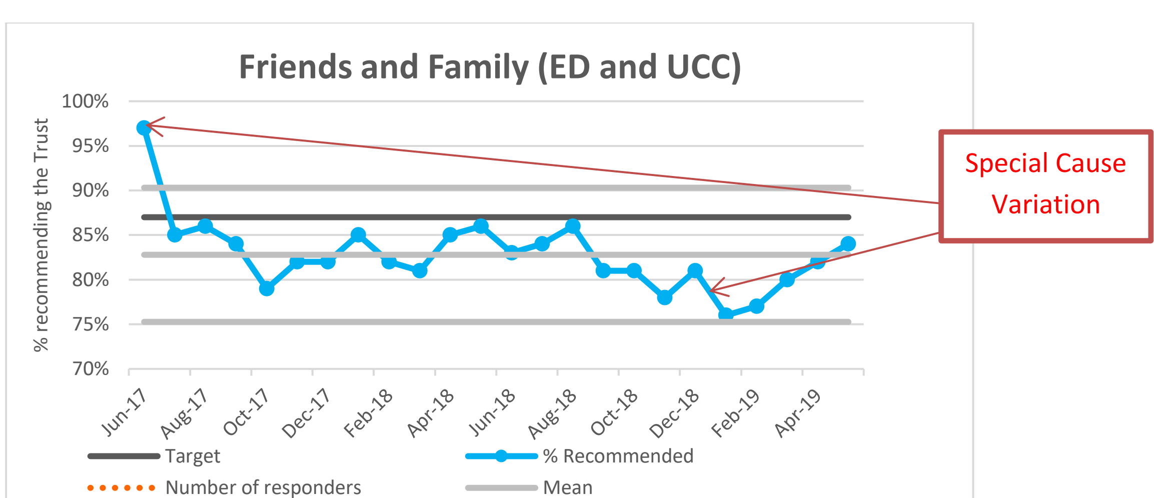


2.1 Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, this means that there is special cause variation present and that the process is not in control and requires investigation. Please note that breaching a rule does not necessarily mean the process needs to be changed immediately, but it does need to be investigated to understand the reasons for the variation.

1. All data points should be within the upper and lower control limits.
2. No more than 6 consecutive data points are above or below the mean line.
3. There are more than 5 consecutive points either increasing or decreasing.

Graph 2: Outlining Special Cause Variation



In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

For high targets (e.g. above 90%) if the upper control limit is below the target, it's unlikely the Trust will achieve the target using the current process.

For low targets (e.g. below 10%) if the lower control total is above the target, it's unlikely the Trust will achieve the target using the current process.

For the purposes of the Trust IPR, the RAG ratings (Red, Amber, Green) will be maintained to understand the Trusts current performance against the outlined targets. SPC should be considered side by side with the RAG rating as it is possible for a process to be within control but not meeting the target.

3.0 Making Data Count Assurance & Variation Icons

For 2022/23 the Trust has introduced the “Making Data Count” variation and assurance icons. These can be found in Appendix 2. Each indicator (where relevant) has been given one of the three assurance icons and one of the five variation icons which is based solely on the data and the SPC rules. Ideally the assurance icon should be blue “P” icon which notes the indicator is consistently passing its target over the last 6 months. Again, ideally the variation icon should be either the grey “common cause variation” icon or a blue “H” or “L” icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

Assurance			Variation		
?	P	F		H L	H L
Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

3.1 Business Rules

- Where there are not enough data points for an SPC chart, the target is based on a cumulative position (e.g. an annual target) or SPC is not appropriate, a “No SPC” icon is utilised as outlined below.

- Assurance icons are based on the last 6 months. E.g. if the Trust has consistently passed a target in the last 6 months the blue “P” icon will be used.
- The Variation icon is based on the last data point. If the last data point means that the one of the SPC rules described in section 2.1 of this appendix is broken, the appropriate coloured “H” or “L” icons will be used to indicate special cause variation. The variation is common cause, the grey common cause variation icon will be used.

Warrington & Halton Teaching Hospitals NHS Foundation Trust **Appendix 5**

Income Statement as at 31 August 2023

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income	**308,681**	**26,371**	**26,200**	**-170**	**127,953**	**127,023**	**-930**
Non NHS Clinical Income							
Private Patients	8	1	1	1	3	5	2
Non NHS Overseas Patients	60	5	12	7	25	30	5
Other non protected	728	61	-22	-83	303	216	-87
Sub total	**796**	**66**	**-9**	**-75**	**332**	**252**	**-80**
Other Operating Income							
Training & Education	9,093	758	807	49	3,789	4,110	321
Donations and Grants	2,095	349	230	-119	1,746	827	-919
Miscellaneous Income	14,620	1,217	1,731	514	6,085	7,898	1,813
Sub total	**25,808**	**2,324**	**2,768**	**444**	**11,620**	**12,835**	**1,215**
Total Operating Income	**335,285**	**28,761**	**28,959**	**198**	**139,904**	**140,109**	**205**
Operating Expenses							
Employee Benefit Expenses	-248,897	-21,548	-21,871	-323	-105,404	-107,536	-2,132
Drugs	-20,191	-1,692	-1,879	-187	-8,517	-8,413	104
Clinical Supplies and Services	-22,298	-1,904	-1,981	-77	-9,638	-10,451	-812
Non Clinical Supplies	-38,398	-3,237	-3,104	132	-16,203	-17,451	-1,248
Depreciation and Amortisation	-14,278	-1,170	-1,137	33	-5,810	-5,618	192
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-344,062**	**-29,551**	**-29,972**	**-421**	**-145,572**	**-149,469**	**-3,897**
Operating Surplus / (Deficit)	**-8,777**	**-790**	**-1,013**	**-223**	**-5,667**	**-9,360**	**-3,693**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	44	44
Interest Income	518	35	133	98	428	708	280
Interest Expenses	-191	-16	-9	7	-80	-45	35
PDC Dividends	-5,679	-473	-473	0	-2,365	-2,365	0
Total Non Operating Income and Expenses	**-5,352**	**-454**	**-348**	**106**	**-2,017**	**-1,658**	**359**
Surplus / (Deficit) - as per Accounts	**-14,129**	**-1,244**	**-1,361**	**-118**	**-7,684**	**-11,018**	**-3,334**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	-2,095	-349	-230	119	-1,746	-827	919
Add Depreciation on Donated & Granted Assets	475	40	51	11	198	198	0
Total Adjustments to Financial Performance	**-1,620**	**-310**	**-179**	**130**	**-1,548**	**-629**	**919**
Adjusted Surplus / (Deficit) as per NHSI Return	**-15,748**	**-1,553**	**-1,540**	**13**	**-9,232**	**-11,647**	**-2,415**

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116a (i)	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	8 August 2023
Name of Meeting & Chair	Quality Assurance Committee – Chaired by Cliff Richards
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/08/164	**Patient Story – Health and Home**	The Committee received a presentation on the Healthy and Home service, in place to reduce length of stay and support patients by fully embedding the Voluntary, Community & Social Enterprise (VCSE) Sector in the hospital discharge process.	The Committee received **moderate assurance** on the service and the progress to date, it was agreed that further data in relation to bed days would be provided.	
QAC/23/08/165	**Hot Topic – Mental Health**	The Committee received a presentation which provided details on the Trusts mental health/gap analysis, highlighting the increasing demand in mental health, and increased acuity of patients. The presentation detailed the increased demand for health services and referrals from the WHH team to Core 24, to 65% in the last five years. It was agreed that a monthly update would be provided to the Committee whilst work was continuing.	The Committee received **moderate assurance** and noted the next steps.	**QAC September 2023 and monthly ongoing**
QAC/23/08/166	**Deep Dive - Urology**	The Committee received the presentation on Urology services, which set out the background on demand and capacity along with patient safety, quality, and risk.	The Committee received **moderate assurance**	**QAC September 2023** *(Response*

		The Committee received details of the Urology action plan to support timeliness and mitigate patient harm. The Committee supported ongoing monthly oversight of performance and delivery of plan in Fragile Services section of the Patient Safety and Clinical Effectiveness Sub Committee.	and noted the action plan to address concerns.	*to questions raised)*
QAC/23/08/168	**Digital Strategy 2023-2025**	The Digital Strategy was presented in summary, prior to presenting to Trust Board Development for approval - 6 October 2023. The Committee received assurance that the new Digital Strategy provided a continued focus on replacing Lorenzo with a new EPR system and refreshing the Trusts technology infrastructure, along with a wide range of other digital programmes, including patient-facing solutions and quality and safety developments.	The committee received **moderate assurance** on the ongoing development of the digital governance and policy frameworks and endorsed the Digital Strategy for Trust Board approval	
QAC/23/08/171	**Paediatric Audiology Incident Update**	The Committee received an update on the progress to date, The highlights from the presentation were: • The ongoing monitoring of remaining children to determine where possible if any harm has occurred. • Maintaining the relationship with NCA until team competency sign off achieved then move to C&M peer review for all ABR results. • The incident status had been de-escalated • A final report on the incident was in development	The committee received **moderate assurance** on the progress to date, bi-monthly updates would continue	

The Committee also received the following items;
QAC/23/08/166 – Board Assurance Framework & Risk Register
QAC/23/08/168 – Patient Safety & Clinical Effectiveness Sub-Committee Exception Report

QAC/23/08/170 – Maternity Update – including; Ockenden, PMRT, NHSE Three Year Delivery Plan, Saving Babies Lives Care Bundle and Maternity & Neonatal Update
QAC/23/08/172 – Move to Outstanding
QAC/23/08/173 – Management of Patients with Sepsis
QAC/23/08/174 – Infection Prevention and Control Report Q1
QAC/23/08/176 - Learning from Experience Report 1
QAC/23/08/177 – 6 Monthly Safe Staffing Report
QAC/23/08/178 - IG Corporate Records
QAC/23/08/179 - Committee Effectiveness Review Update Action/Improvement Plan

Assurance Key:

(Green)	**High Assurance -** can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed. **Substantial Assurance -** can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
(Amber)	**Moderate Assurance -** can be given that 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 of the organisation's objectives at risk.
(Red)	**Limited Assurance** - can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk. **No Assurance -** can be given that 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 organisation's objectives

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116a (ii)	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	12 September 2023
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/09/186	**Hot Topic – ED Improvement**	The Committee received a presentation in relation ED Improvement which included 4-hour performance data, regulation breaches in relation not overcrowding, key improvement actions following visit from ECIST. There was discussion around patient harm in relation to ED waits, it was agreed that further profiling would be undertaken and reported back to the committee.	The Committee received **moderate assurance** in ED improvement.	**Updates to be provided to the next meeting 10.10.23**
QAC/23/09/187	**Deep Dive – Gynaecologica l Surgery (*Fragile Services*)**	A presentation was received which provided the background in relation to demand and capacity and patient safety, quality and risk. In regard to 2 week wait capacity issues it was noted that three themes were identified to be the causation, these were – Workforce, Equipment and Demand. It was noted that progress had been made and the next steps to improve further were highlighted.	The Committee received **moderate assurance** on the position and the continuing work on the gynaecology action plan.	
QAC/23/09/190	**Maternity Update**	The Committee received the Maternity Update reports:	The Committee received **moderate assurance** on	

		i. Ockenden The committee were reassured that full review of all actions was planned to ensure the service remains on track to meet the internally set timelines., with the outcomes to be reported into the committee. ii. Maternity Incentive Scheme (MIS) including Saving Babies Live Care Bundle (SBLCB) iii. Maternity Neonatal Quality Review It was noted that these reports would be presented in full to the Board, by the Director of midwifery on the 4th October 20023.	updates in relation to the areas of Ockenden, MIS, and Maternity Neonatal Quality Review.	
QAC/23/09/196	**Mental Health**	The Committee received an update in relation to Mental Health, which had been requested as a monthly agenda item going forward. The presentation provided progress on the action plan since the last meeting and the details on ongoing actions. The Committee would continue to receive monthly updates.	The Committee received **moderate assurance** on the progress to date.	To be presented monthly. Next update 10.10.23
QAC/23/09/197	**High Level Enquiries**	Two high level enquiries were noted, both in relation to letters from the HSE. • Letter received 8 August 2023 in relation to maintenance of two autoclaves. • Letter received 8 September in relation to streamlining processes in Pathology. Both areas of concern were being addressed and response letters would be sent within the required timeframe.	The Committee received **substantial assurance** on the progress on each of the high-level enquiries.	

The Committee also received the following items;
QAC/23/09/188 - Patient Experience Strategy 2023-25
QAC/23/09/189 – Patient Safety Clinical Effectiveness Sub-Committee Exception Report
QAC/23/09/191 – Quarterly Transitional Care Audit
QAC/23/09/192 – Liberty Protection Safeguarding (LPS) Update
QAC/23/09/193 – Learning from Deaths Report Q1
QAC/23/09/195 – Quality Priorities Q1

Assurance Key:

(Green)	**High Assurance -** can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed. **Substantial Assurance -** can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
(Amber)	**Moderate Assurance -** can be given that 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 of the organisation's objectives at risk.
(Red)	**Limited Assurance** - can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk. **No Assurance -** can be given that 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 organisation's objectives

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116c i	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	16 August 2023
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/08/108	**Deep Dive – International Nursing**	The Committee received a presentation on the Recruitment of Overseas Nurses, ongoing since November 2020. 222 Nurses recruited, across 21 countries, making up 40% of our Band 5 Nursing Workforce. Current pause on further international recruitment, whilst the Trust concentrates on the retention of these Nurses, which will include a focus on the North West BAME Assembly anti-racist framework and the development of our internally educated colleagues.	The Committee received moderate assurance recognising there was now a required focus on retention	Progress against improving retention will be received at a future SPC
SPC/23/08/109	**Hot Topic – ICS Assurance (Workforce)**	The Committee received a presentation on the Workforce Related Controls within the Richard Barker Letter, received in Jun-23. The committee received assurance that the Trust already has processes in place in response to the Workforce	**The Committee received substantial assurance, recognising the existing processes will continue to be refined.**	**N/A**

		Related Controls. The Trust has taken the opportunity to review and refine the existing processes.		
SPC/23/08/110	**Chief People Officer Report**	The committee discussed the recent industrial action by the Junior Doctors and future plans for Junior Doctors and Consultants. The related risk rating has recently been increased, reflecting the increasing impact on our leadership teams to continually plan.	The Committee received moderate assurance, that the plans in place will continue to mitigate.	Planning progress will continue to be monitored within the industrial action group and report to SPC
SPC/23/08/111	**Workforce Race Equality Standard (WRES)**	The committee received the Trusts Workforce Race Equality Standard (WRES), which sets out agreed actions to ensure employees from black and minority ethnic (BME) backgrounds have equality of access to career opportunities and receive fair treatment in the workplace. The requirements of the Trust include: • The data collation and reporting to the national WRES team which was completed on 31 May 2023 • Analysis of findings to be completed with an action plan for improvement developed by 31 October 2023 • Publication of the Trust action plan by 31 October 2023 The report summarised the data analysis against the 9 metrics, which we used to formulate the Trust wide action plan for improvement. The committee were requested to note the content of the report and approve the action plan.	The Committee received substantial assurance that the action plan reflected the content of the report..	Progress against the action plan will be received at a future SPC

SPC/23/08/112	**Workforce Disability Equality Standard (WDES)**	The committee received the Trusts Workforce Disability Equality Standard (WDES) report which the Trust is required to complete on an annual basis. The report set out agreed metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The requirements of the Trust include: • The data collation and reporting to the national WDES team which was completed on 31 May 2023 • Analysis of findings to be completed with an action plan for improvement developed by 31 October 2023 • Publication of the Trust action plan by 31 October 2023 The report summarised the data analysis against the 10 metrics, which we used to formulate the Trust wide action plan for improvement. The committee were requested to note the content of the report and approve the action plan.		
SPC/23/09/128	Workforce IPR	The Committee noted the report and received good assurance, identifying the improving Workforce IPR.	The Committee received substantial assurance.	November 2023
SPC/23/09/129	People Strategy Update	The Committee noted the report and assurances provided. The Committee highlighted that a number of items from the Strategy have previously been updated to the Committee.	The Committee received substantial assurance.	Bi-Annual Submission

The Committee also received:

Matters to Note for Assurance
SPC/23/09/130 – Freedom to Speak Up Bi-Annual Report

SPC/23/09/131 – Monthly Safer Staffing Report
SPC/23/09/132 – GMC National Trainee Survey

Sub Committee Chairs Logs
SPC/23/09/133 – Workforce Review Group
SPC/23/09/134 – Operational People Committee

Assurance Key:

(green)	**High Assurance** - can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed. **Substantial Assurance** - can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
(amber)	**Moderate Assurance** - can be given that 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 of the organisation's objectives at risk.
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BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116c (ii)	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	20 September 2023
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/09/123	Deep Dive – Widening Participation	The Committee received a presentation regarding the various Widening Participation initiatives in place across the organisation. There was a particular focus on Apprenticeships, Step into Health and Supported Internships. The initiatives were well received by the Committee with further evidence requested regarding the impact of such initiatives.	The Committee received moderate assurance with further details regarding impact of the initiatives to be provided at a future Committee.	November 2023
SPC/23/09/124	Hot Topic – Changes to the Pension Scheme	The Committee received a presentation regarding changes to the NHS Pension Scheme from 1st October 2023 with particular focus on the option for 'drawdown' by staff. The Committee noted the current risk regarding lack of clarity of application of the process nationally, and potential impact to the organisation if staff are able to access the scheme without organisation approval.	The Committee received moderate assurance with further clarity from the national NHS Pensions team required regarding the process.	January 2024

SPC/23/09/125	Chief People Officer Report	The Committee noted the paper which provided updates relating to - Industrial Action; Lucy Letby – People Directorate Response; Medical and Dental National Pay Award; Flu and COVID Update; Annual Staff Survey Update; National Workforce Disability Equality Standard Report and NHS Armed Forces Friendly Accreditation. The Committee noted the risk presented by industrial action and all the additional administration capacity and resources required to support planning for days of strike action.	The Committee received moderate assurance, noting the continued risk of industrial action.	October 2023
SPC/23/09/126	GMC Revalidation Annual Report	The Committee received the report which provides assurances that the system for medical appraisal and the processes for monitoring completion for GMC revalidation are robust. The Committee approved the report.	The Committee received substantial assurance and approved the report.	Annual submission
SPC/23/09/127	Workforce Brief	The Committee received an update on the letter sent by NHS England following the Lucy Letby trial and the 5 areas for review. The Committee also received an update on Transforming People Services nationally and regionally. The Committee sought clarification on the programme of work linking to the CMAST Efficiencies at Scale Board.	The Committee received moderate assurance with further clarity from the regional team regarding links to CMAST required.	October 2023
SPC/23/09/128	Workforce IPR	The Committee noted the report and received good assurance, identifying the improving Workforce IPR.	The Committee received substantial assurance.	November 2023
SPC/23/09/129	People Strategy Update	The Committee noted the report and assurances provided. The Committee highlighted that a number of items from the Strategy have previously been updated to the Committee.	The Committee received substantial assurance.	Bi-Annual Submission

The Committee also received:

Matters to Note for Assurance
SPC/23/09/130 – Freedom to Speak Up Bi-Annual Report
SPC/23/09/131 – Monthly Safer Staffing Report
SPC/23/09/132 – GMC National Trainee Survey

Sub Committee Chairs Logs
SPC/23/09/133 – Workforce Review Group
SPC/23/09/134 – Operational People Committee

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BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116d(i)	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	23 August 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/08/86	**BAF & Risk**	No changes to previous month.	The Committee **noted** the report	**FSC September 2023**
FSC/23/08/87	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance dipped slightly on last month to 67.46% • Closure of A10 and the bay in B4 has impacted on activity • Reduction in no criteria to reside • Continuing to see improvements in ambulance handover • Use of discharge lounge has helped with flow • Draft Esist report has been received. Final Esist report expected for next month • ED improvement group meet weekly with unplanned care group – work programme – improving quality and performance against national metrics • RTT performance – 51.07% - in line with the trajectory • Cancer – 2 week wait still remains a challenge. Yesterday – no patients waiting for over 14 days	The Committee **noted** the report receiving **moderate** assurance	**FSC September 2023**

		• DNA rates – text reminder service – further work to establish full usage by all services. Industrial action has impacted on DNA rates. PRG are reviewing the full impact of IA on DNA • Elective waiting list reduction – H2 plan for elective recovery for 72 weeks and 65 weeks waiters – expected to be reported back next month. Will be working this up as part of the finance recovery work. • Need to explore models for recovery activity.		
FSC/23/08/88	**Pay Assurance Report**	The Committee received the report noting:- • The medical resourcing group pilot has led to the convergence of agency to bank staff – 9 moved from agency to bank – now fast track that as a way of going forward in other areas. • Establishment control programme – outlined at Execs – review the good practice and amending the panel to include Chief People Officer, Chief Finance Officer and Medical Director.	The Committee **noted** and discussed the report, receiving **good** assurance	**FSC September 2023**
FSC/23/08/89	**Monthly CIP report**	The Committee received the report noting:- • CIP overview at month 4, the £3m target year to date was achieved • £0.8m is recurrent – more to do to identify recurrently • CIP gets increasingly challenging each quarter as the target increases • Gap of £3.5m and therefore need to do more to identify further schemes, however, moving in the right direction. • Big challenge in delivering GIRFT due to industrial action.	The Committee **noted** and discussed the report, receiving **moderate** assurance	**FSC September 2023**
FSC/23/08/90	**Cost Pressures**	The Committee received the report noting:- • Challenge of unfunded cost pressures with £3.5m year to date of which £1.1 are new emerging pressures. • All Exec Directors are aware of the cost pressures in their areas. Focus on the cost pressures and how to manage and reduce as this is a significant financial risk to the Trust. A review of the ED nursing pressure is being undertaken, and a report will be presented to FSC in September	The Committee **noted** and discussed the report, receiving **moderate** assurance	**FSC September 2023**

FSC/23/08/91	**Digital Strategy**	The Committee received a report and presentation noting:- • Two year digital strategy has been developed and is aligned to the digital goals within the corporate strategy and the ICS digital strategy. • Priorities have been identified over the next two years including replacement of EPR, infrastructure replacement and other new developments such as patient facing technology. • External capital and revenue funding has been secured for the next 2 years priorities. Internal capital funding for 2023/24 has been agreed with proposed funding for 2024/25 to be agreed aligned to the Trust's capital funding process. • A request to approve the new Digital Strategy 2023-2025 for presentation to and formal approval from Trust Board in September 2023	The Committee noted the presentation and the paper receiving **good** assurance. The Committee **supported and recommended** the digital strategy be presented to the Trust Board in September	**Trust Board September 2023**
FSC/23/08/92	**Finance Report**	The Committee received a report noting:- • The month 4 position is off plan by £2.4m with a deficit £10.1m • Two main drivers of the position - £1.5m Industrial Action expenditure and ED nursing pressures • Activity not being delivered fully – Deep dive on elective planned for September FSC • Reduction in agency spend but more spend on bank, good progress with agency reduction noted • Revenue requests supported by the Executive Team are highlighted in the report • Capital is behind Trust plan £1.4m, the majority is on external schemes. • Approval of capital funding for tow truck £8k, expansion of medical retina service £18k and further work to Pharmacy Robot scheme £32k were requested from the Committee. • ICS letter – around grip and control, operational performance, workforce and finance. Discussed the requirements in various committees and letter to GU has been sent as response. A financial recovery plan is being developed, and the draft plan will be presented to Trust Board in September for discussion and	The Committee discussed and noted the paper receiving **moderate** assurance. The Committee **approved** the capital requests.	**FSC September 2023**

		• following feedback and further work a second draft will be presented to September FSC. • A best, worst and likely scenario has been included as an assessment of the level of risk for the Trust – risk of CIP and £2.5m, £7m pressures that couldn't be turned off at the start of the year and further emerging pressures. It is not clear whether there will be any funding to support the costs of industrial action. Potential of not achieving the activity plan and therefore not receive the planned level of income.		
FSC/23/08/93	**Endoscopy Business Case**	The Committee received a report noting:- The business case has been approved by the Trust Board in August and submitted to FSC for noting.	The Committee **noted** and discussed the report, receiving **good** assurance	
FSC/23/08/95	**Capital Position**	The Committee received a presentation noting:- • Additional capital secured in May for enabling works 4 NOUS rooms and in June for CDC – MOUs have been signed • Under spend on capital year to date, changes to profile for CDC are one of the reasons for this • Managing the oversubscription of £1.5m – request for Pharmacy Aseptic services and Drs Mess to be deferred to 2024/25. This reduces the oversubscription by £0.34m Schemes >£500k • Catering tendering will be concluded by end of August 2023 • MRI & CT Scanner are still on track • ED CT scanner has been installed and project is complete • Induction of Labour – Phase 1 has been completed, phase 2 tender is due to complete in September • Warrington robot is completed, Halton further works required • Network refresh phase 3 – on track • Warrington Town Deal – slight delay for full opening to January 2024 due to delivery of lift • CDC – Full progress on the scheme and the impact of revenue will be brought back to the next FSC **TIF Update** –	The Committee **noted** the presentation, **approved** the changes to the capital contingency and **approved** the schemes to be deferred to 2024/25 The Committee **approved** option 1 for TIF on the basis	**FSC September 2023**

		• The current forecast position would require an additional £4m (worst case). Final costs are expected in the next 3 weeks. 3 options were presented setting out options to reduce costs. The committee supported option 1, the full scheme on the basis that when the final costs are available, the overall capital programme is examined, and the other reduced options are introduced should there be insufficient Trust capital • Strategic and operational capital schemes will be modelled and led by Alice Forkgen & Janet Parker and will be brought to the next FSC meeting.	there are clearly identified mitigations to manage the project within capital funds available	**Trust Board September 2023**
FSC/23/08/96	**Benefits Realisation Q1 Update**	The Committee received the report noting:- • 13 revenue requests were due • 10 have been returned and completed.	The Committee **noted** the report, receiving **good** assurance	**FSC November 2023**
FSC/23/08/97	**Digital Strategy Group Update**	• The Committee received the report noting:- • • Cyber attack which was managed with quick resolution • As a test, a phishing email was sent out to test if staff would open the email / open the link / enter details – to the findings will be presented to the Audit Committee and the team will continue to work with Counter Fraud colleagues on raising awareness campaigns and training plans. • National initiative for electronic bed management solution. In the process of scoping out a delivery plan and will keep the Committee updated with progress in due course.	The Committee **noted** the report, receiving **good** assurance	

Assurance Key:

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BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116d (ii)	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	27 September 2023
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/09/106	**Hot Topic – ED Performance**	The Committee received the report noting:- • The Trust has been notified it is in Tier 1. • Operational Planning guidance – 76% required by March 2024 • ECIST visit resulted in 20 comments / recommendations across 6 areas, plan in place to drive improvements • CQC Regulatory breach re: ED staffing, investment into nursing and medical staffing • All workstreams are aiming to improve on the 12 hour performance • There is a risk posed by the increase in mental health patients with additional need for 1-1 care • Update to be brought as part of business as usual through Corporate Performance Report along with key dates of delivery, expecting improvement by December 2023	The Committee **noted** the report receiving **limited** assurance	**FSC October 2023**
FSC/23/09/107	**Deep Dive – Activity – Main areas of Underperformance / Planned**	The Committee received the report noting:- • Planned Care YTD Month 5 activity performance presented, delivering 91.21% against plan • Underperformance mainly in General Surgery, T&O, Ophthalmology and Gynaecology • Main drivers of underperformance are industrial action, medical vacancies, changes to baseline activity and sickness	The Committee **noted** the report receiving **limited** assurance	

	Care & Elective Recovery	• If all factors remain the same, projecting delivery of 92.6% of planned activity • Risks highlighted around continued IA, availability of resources and workforce to deliver		
FSC/23/09/108	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance improved slightly on last month to 69.7% • Continuing to see improvements in ambulance handover • RTT performance – 50.51% which is behind trajectory • Cancer targets met in month • From 1 October the Trust is moving to Tier 2 from Tier 1 for Elective	The Committee **noted** the report receiving **moderate** assurance	**FSC October 2023**
FSC/23/09/109	**Winter Plan**	The Committee received the report noting:- • Started planning in August 2023 following receipt of guidance, no issues noted	The Committee **noted** and discussed the report, receiving **good** assurance	**FSC October 2023**
FSC/23/09/110	**Pay Assurance Report**	The Committee received the report noting:- • Outlier re: compliance with NHSI rates for nursing and HCA agency. Compliant with local CAMs contract, however contract higher than the NHSI rate. The rates are coming down and a trajectory is being developed to bring in line with NHS I rates, more detail to come to October Committee.	The Committee **noted** and discussed the report, receiving **good** assurance	**FSC October 2023**
FSC/23/09/111	**Monthly CIP report & GIRFT**	The Committee received the report noting:- • CIP overview at month 5, the £4.2m target year to date was achieved (£2m is recurrent) • Forecast £9.1m recurrent, increase of £2.3m from last month • Gap of £2.8m and therefore need to do more to identify further schemes, however, moving in the right direction. • Significant risk around cash releasing efficiencies as 103.8% activity needs to be delivered in order to realise savings • Big challenge in delivering GIRFT due to industrial action. • Deep dive next month on delivery of CIP in Clinical Support Services • Additional project transformation capacity may be required	The Committee **noted** and discussed the report, receiving **limited** assurance	**FSC October 2023**

FSC/23/09/112	**Cost Pressures**	The Committee received the report noting:- • Challenge of unfunded cost pressures with £5.2m year to date of which £1.5 are new emerging pressures. • Many unfunded cost pressures have now stopped, • All pressures continue to be monitored • Total overspend of £4m, £1.1m relating to ED staffing. Remaining £2.9m pressures are offset with underspends across budgets. • Further review to be undertaken to determine if budget realignment is required	The Committee **noted** and discussed the report, receiving **moderate** assurance	**FSC October 2023**
FSC/23/09/113	**Warrington Town Deal – Draft Collaboration Agreement**	The Committee received the report noting:- • Original business case for the Living Well Hub, included ongoing annual revenue costs of £350k shared between 4 partners once central funding exhausted, expected to begin from June 2025 • Legally binding Collaboration Agreement is in place to legally commit the four partners to the ongoing costs, required to be signed by January 2023 by each CEO	The Committee **noted** and discussed the report, receiving **good** assurance	**Trust Board October 2023**
FSC/23/09/115	**Finance Report**	The Committee received a report noting:- • The month 5 ytd position is off plan by £2.4m with a deficit £11.6m • On plan in month due to an income adjustment in relation to IA, as agreed with the ICS, however this is a potential risk • Activity target is not being achieved • Reduction in agency spend (4.2% ytd) with last 3 months below 3.7% target • CIP delivered against plan, £4.2m ytd, noting back profiled plan • Revenue requests supported by the Executive Team are highlighted in the report • Capital is behind Trust plan £2.5m, the majority is on external schemes. • Reduction in oversubscription against the capital programme from £1.1m to £0.7m • Risks highlighted around ED staffing, IA and lack of associated funding, CIP achievement and no provision for potential backpay for Band 2 to Band 3	The Committee discussed and noted the paper receiving **moderate** assurance. The Committee **approved** the capital requests.	**FSC October 2023**

		• A best, worst and likely scenario has been included as an assessment of the level of risk for the Trust at a very high level, more detail to follow next month		
FSC/23/09/116	**Amendment to Cancer Metrics**	The Committee received a report noting:- • Nationally mandated changes for cancer targets, 1 combined 31 day wait target and 1 combined 62 day wait target to be reflected in IPR	The Committee **noted** the report and **supported** the change to the metrics for approval at Trust Board.	**Trust Board October 2023**
FSC/23/09/117	**Recovery Plan** • **Finance** • **Operational**	The Committee received a report about the Finance Recovery Plan noting:- • Additional guidance received from ICS and changes to recovery plan since Trust Board presentation • Medium term plan changed to 3 year plan with 2023/24 as the first year therefore financial sustainability required by 2025/26 • No new cost pressures to be included, £1m included for resourcing of the recovery plan • GIRFT reduced to offset the reduction in cost pressures as reduced investment will impact on deliverability • Non-recurrent £6m funding included to reconcile between the underlying position to the reported position • Potential capital and revenue investment would increase the deliverability of the plan • Deliverability is a risk, however GIRFT plans are in place, non-recurrent income and additional investment have been included to request support from the ICS The Committee received a report about the Operational Recovery Plan noting:- • At 15 September 2023, 4,496 patients remain undated, guidance received that all patients to be given an appointment by 31 October • Use of the Independent sector to give patients a first appointment at a cost of £266k for first outpatient appointment with ASET and Spire, £155k for the continuation of their care	The Committee **noted** the reports and **supported** the recovery plans for approval at Trust Board.	**Trust Board October 2023** **Trust Board October 2023 and FSC November 2023**

		• Executive Team supported use of ASET and Spire to undertake first outpatient appointment noting if follow up not undertaken by same organisation this would lead to a negative patient experience • Not all patients would be seen via this route with 1,670 patients remaining undated and therefore the 31 October target would not be met • Supported the total investment of £484k for patients to receive their full patient journey through ASET and Spire or WHH Waiting List • Update to be provided to FSC in November 2023		
FSC/23/09/118	**Revenue Request - Radiology WLI**	The Committee received a revenue request noting:- • Two approvals at Executive Team, one for June to August 2023 (£657k) and one for September to November 2023 (£691k) • Radiology has been undertaking WLIs for a number of years, allowing ability to flex to demand • Expenditure will be funded from vacancies elsewhere in the Care Group. This has been reported to FSC and Board as the additional spend is above plan and the vacancies could have added to the CIP delivery • Concerns around the Care Groups CIP delivery, therefore a deep dive will be presented next month on the delivery of CIP in Clinical Support Services	The Committee **supported** the revenue request for approval at Trust Board.	**Trust Board October 2023**
FSC/23/09/121	**Capital Position**	The Committee received a presentation noting:- • YTD spend is £4.58m, underspend against plan mainly due to externally funded schemes • Oversubscription reduced from £1.1m to £0.7m in month, two schemes deferred to 2024/25 and some schemes no longer required • Strategic capital reviewed across 2023/24 and 2024/25 • Based on current estimates, if the Endoscopy Hub bid is approved there will be enough funding in total, however too much funding in 2023/24 and not enough in 2024/25 • Conversations externally about transferring funding to a later year • Work also ongoing internally to bring 2024/25 mandated and business critical schemes into 2023/24, to be brought to the next Committee	The Committee **noted** the presentation, **approved** the changes to the capital contingency and **approved** the schemes to be deferred to 2024/25	**FSC October 2023**

		• ED minors and Induction of Labour – ED minors £160k budget compared to costs received of £311k (£151k increase) Induction of Labour £886k budget compared to costs received of £798k (£88k decrease). Agreed to fund ED minors via decrease in Induction of Labour and the remainder from contingency (£63k)	The Committee **noted** the presentation, **approved** the changes to the capital contingency to fund ED minors	
FSC/23/09/122	**Costing Update**	The Committee received the report noting:- • NCC timeline for 2022/23 data submission • Benchmarking for 2021/22, at a very granular level, however supports that the Trust is reviewing the right areas as part of the GIRFT programme • Q1 PLICS triangulates with GIRFT data	The Committee **noted** the report, receiving **good** assurance	**FSC December 2023**

Items for noting

FSC/23/09/114 Private Patient Update in relation to pause
FSC/23/09/119 BAF & Risk Register
FSC/23/09/120 LIMS Business Case (ICS/C&M Pathology Transformation)
FSC/23/09/127 Committee Effectiveness Review Update on Actions / Improvement Plan
FSC/23/09/126 Digital Strategy Group Update
FSC/23/09/125 RTT Validation Assurance Report
FSC/23/09/124 Implementation of recommendations from Runcorn Shopping City review
FSC/23/09/123 CDC Activity Reforecast and Costs

Assurance Key:

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BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116e	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	17 August 2023
Name of Meeting & Chair	Audit Committee – Chaired by Mike O'Connor
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
AC/23/08/55	**Committee Assurance Update**	Committee Assurance updates were received from the Chair's of the relevant Committees and provided assurance of the level and appropriateness of discussions taking place.	The Committee received **substantial assurance** on the governance around committee assurance.	
AC/23/08/56	**Progress Report on Internal Audit Follow-Up Actions**	The report provided an update which highlighted one overdue management action, which was partially complete. It was agreed that the extension in relation to BadgerNet partially complete action would be reviewed.	The Committee received **partial assurance** on the progress of actions	
AC/23/08/57	**Internal Audit Follow Up Report**	The report provided a position statement on those recommendations past their original review date. The Committee received assurance that all recommendations had been implemented, with one recommendation in relation to Badgernet as partially implemented, and subject to further follow up.	The Committee revived **partial assurance** on the progress of actions	

AC/23/08/58	**Internal Audit Progress Report**	The Committee received the report which provided progress on outcomes of reviews completed since the last Audit Committee meeting. It was noted that 3 reports had been issued since the last meeting and 4 reviews were in progress.	The Committee revived **partial assurance** on the progress of actions	
AC/23/08/59	**MIAA Mortuary Report**	The Committee received an update in relation to the Mortuary project. The Committee agreed that going forward additional expertise and knowledge would be sourced for future projects.	The Committee revived **partial assurance**, agreeing the need for outsourcing specialist knowledge in future.	
AC/23/08/64	**Fit and Proper Person Policy**	The Committee received and approved the Fit and Proper Person policy. It was noted that the policy would undergo an update by 30 September 2023 following receipt of the new NHS England Fit and Proper Persons Test Framework published on 2 August 2023.	The Committee received **substantial assurance** on the process to develop the Trusts Fit and Proper Person Policy. The policy was approved.	
AC/23/08/69	**Committee Chair's Annual Report**	The Committee received the report which provided assurance that the Committee had met its Terms of Reference and had gained adequate assurance through the reporting period.	The Committee received **substantial assurance** that the Committee had met its Terms of Reference.	

The Committee also received the following items;

AC/23/08/54 - Board Assurance Framework (BAF)
AC/23/08/60 – External Audit Update
AC/23/08/61– Anti-Fraud Progress Report
AC/23/08/62– Review Losses & Special Payments Q1 2023/24
AC/23/08/63 – Review of Quotation & Tender Waivers Q1 2023/24
AC/23/08/65 – Risk Management Annual Report
AC/23/08/66 – On Call & Overtime Annual Report Update
AC/23/08/67 – NW Skills Development Network Bi-Annual Update
AC/23/08/68 – ICON Programme Bi-Annual Update

Assurance Key:

	High Assurance - can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed. **Substantial Assurance** - can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
	Moderate Assurance - can be given that 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 of the organisation's objectives at risk.
	Limited Assurance - can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk. **No Assurance** - can be given that 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 organisation's objectives

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/23/10/116f	MEETING	Trust Board	DATE OF MEETING	4 October 2023

Date of Meeting	7 September 2023
Name of Meeting & Chair	Charitable Funds Committee, Chaired by Steve McGuirk
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
CFC/23/09/38	Fundraising Report & Quarterly Work Plan	The report provided an update in relation to national context and progress aligned to the Charity's three-year strategy. It was noted that a 12-month project had commenced following NHS Charities Together development grant funding to review the Charity's approach to marketing and fundraising. This was seen to be a positive development for the Charity.	The Committee received **substantial assurance** that work was ongoing and further updates would be provided as required.	**December 2023 meeting**
CFC/23/09/39	Draft Annual Impact Report	The draft Annual Impact Report was shared with the Committee to review and for comment. The report highlighted some of the key achievements of the Charity, along with its successes during 2022/23.	The Committee received **substantial assurance** and noted the contents of the report.	**Final report to be presented to the December 2023 meeting**
CFC/23/09/41	Bid Applications	The Committee was asked to approve one bid application for a spend of £8,788.36 for the construction of a new multi-function sensory room in the children's ward. This is part of the Charity's Making Waves children's appeal.	The Committee received **substantial assurance** and approved the bid application.	
CFC/23/09/43	Charity Commission	The Committee received the report detailing the Charity's position against the six principles that trustees should	The Committee received **substantial assurance**	

	Fundraising Checklist	follow to help meet their responsibility for their charity's fundraising.	on the Charity's position against the checklist.	
CFC/23/09/44	Charitable Funds Governing Document	The Committee received, which set out the requirements of the committee and the review of the Governing Document yearly to assure itself it is supporting the discharge of its duties prior to presenting to the Trust Board.	The Committee received **substantial assurance** and approved the Charitable Funds Governing Document	

Additional agenda items presented included.
CFC/23/09/40 – Finance Report as at 30 June 2023
CFC/23/09/42 – Annual Report & Accounts 2022/23
CFC/23/09/45 – Risk Management Statement
CFC/23/09/46 – Risk Register

Assurance Key:

(green)	**High Assurance** - can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed. **Substantial Assurance** - can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
(amber)	**Moderate Assurance** - can be given that 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 of the organisation's objectives at risk.
(red)	**Limited Assurance** - can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk. **No Assurance** - can be given that 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 organisation's objectives

Note: *Please fill the Recommendation / Assurance/mandate to receiving body column with the correct colour and state the Committees' level of assurance i.e. No Assurance, Limited Assurance, Moderate Assurance, Substantial Assurance or High Assurance*

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/117i**
SUBJECT:	**Maternity Update – Ockenden Report**
DATE OF MEETING:	4 October 2023
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. — X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

Equality duty	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	√		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			√
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			√
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of Ockenden is to ensure safer care for this cohort.			

EXECUTIVE SUMMARY *(KEY ISSUES):*	The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates. This paper provides the Board with an update with regards to Ockenden recommendations.

	In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update as of 31st July 2023 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 95.76% compliant and is on trajectory to be 100% compliant by 31st December 2023. • **Ockenden 2**: WHH is 75.34% compliant Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023. This is a static position from end of June 2023 due to challenges in arranging triumvirate sign off of completed actions during August. Triumvirate sign off meetings are scheduled to review all July and August actions. In addition, a full review of all actions is planned to ensure the service remains on track to meet the internally set timelines of November and December 2023 for completion of all remaining actions. The outcome of this review will be reported to October Quality Assurance Committee.

PURPOSE: ***(please select as appropriate)***	Information √	Approval	To note √	Decision

RECOMMENDATION:	The Trust Board is asked to receive and discuss this report as per Ockenden recommendations.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/23/09/190/i
	Date of meeting	12th September 2023
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF	BM/23/10/117i

1. BACKGROUND/CONTEXT

The report will update the Trust Board of the Ockenden report position. Each element of the Ockenden action plans have been presented using pie charts to aid visualisation and tracking of all actions. The following key describes the colour coding of each chart:

RAG

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring
LMNS	LMNS action
Duplicate	Action duplicated/combined with another action
BN Issue Log	Transferred to BN Issues Log

2. KEY ELEMENTS

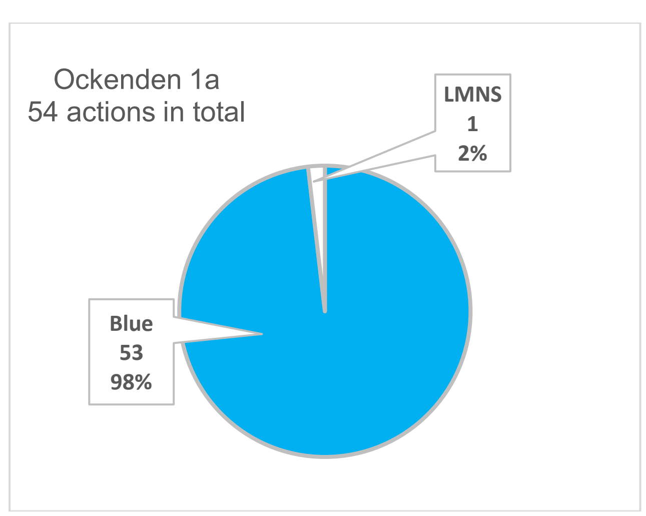
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report.

The initial Ockenden Report (December 2020) presented the findings of an inquiry into maternity care at Shrewsbury and Telford NHS Trust following a letter from families raising concerns about significant harm and deaths of neonates and mothers. Following this, 7 Immediate and Essential Actions were recommended to improve safety within maternity services and improve the experience of women and families.

1. Enhanced Safety
2. Listening to Women and their Families
3. Staff Training and Working Together
4. Managing Complex Pregnancies
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well Being
7. Informed Choice

2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

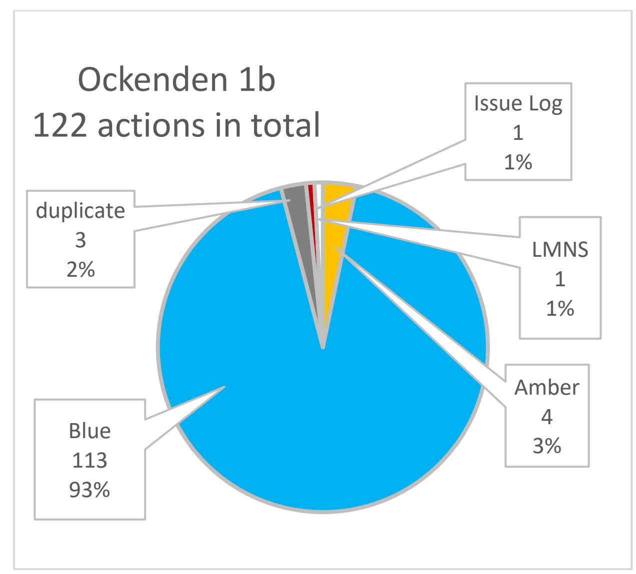
No change from previous month.

Excluding the LMNS action, Ockenden Part 1a action plan is 100% compliant. This action plan closed following agreement at Moving to Outstanding.

2.1.3 WHH Compliance with Ockenden 1b Report

Following the initial Ockenden 7 IEA's recommendations, all maternity providers submitted their evidence of compliance to the national maternity team. Ockenden 1b was actioned following feedback of the initial evidence submitted.

Chart 2: WHH Ockenden 1b Compliance



Update

4 Amber (no change): -
On track to move to green by end Dec 2023

113 Blue (no change)

1 – Action not for WHH

3 Duplicate – actions combined as refer to appointment of 11th Consultant who will take on the role of Lead Obstetrician in Fetal Surveillance

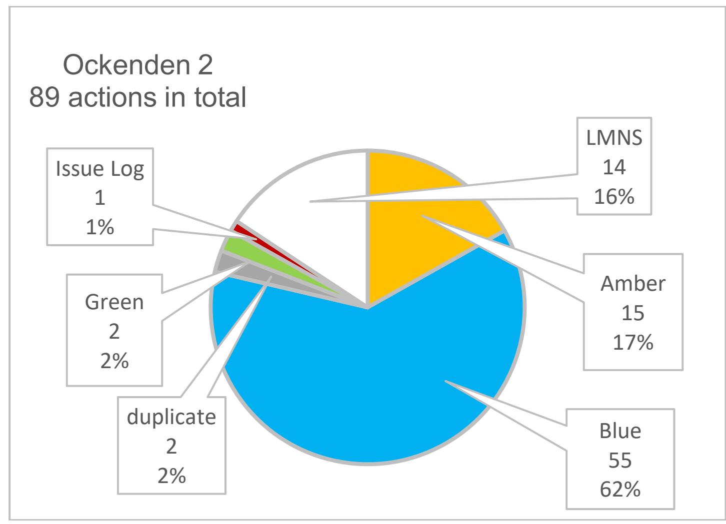
1 Action transferred to a BadgerNet Specific Issue Log (no change)

Excluding the 1 LMNS and 3 duplicate actions, Ockenden Part 1b action plan is currently 95.76% compliant (no change from previous month), with a trajectory to be 100% compliant by 30th December 2023.

2.1.4 WHH Compliance with Ockenden 2 Report

Ockenden 2 was launched on 30th March 2022 and reported on the care provided to 1862 families examined during the investigation and identified internal and external factors that may have contributed to failings in care.

Chart 3: WHH Ockenden 2 Compliance



Update

15 Amber (previously 16)

On track to move to green by end September 2023

2 Green (no change)
On track to move to blue by end July 2023

55 Blue (previously 54)

14 – Actions not for WHH (no change)

2 – Actions duplicated (combined) as refer to appointment of 11th Consultant who will take on the role of Lead Obstetrician in Fetal Surveillance

1 action has been transferred to a BadgerNet Specific Issue Log.

- Excluding the 14 LMNS and 2 duplicate actions, Ockenden 2 action plan is 75.34% compliant (previously 73.97%).
- Trajectory for completion of this action plan is 30 November 2023.

a. WHH Risks for Escalation

Ockenden Part 2 identifies the introduction of specific roles within the maternity workforce: -

- The Lead Obstetrician in Fetal Surveillance role will be included in a new Consultant post. Funding has been identified for this new post and recruitment will commence. Meeting this recommendation will be dependent upon successful recruitment and anticipated recruitment is six months.
- Within the Ockenden report additional supernumerary clinical skills facilitators are recommended. Work is ongoing to identify how to meet this requirement within existing establishments.

b. Ockenden Summary

Ockenden recommends Trust Boards have oversight of the implementation of Ockenden IEAs. This paper provides the QAC of WHH current Ockenden position:

- There has been no change in compliance form June 2023 due to challenge sin arranging triumvirate sign off of completed actions in August 2023.
- Ockenden 1a is 100% compliant.
- 95.76% compliant with a trajectory to be 100% compliant by 30th December 2023.
- Ockenden 2 action plan is 75.34% compliant Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30 November 2023.
- A full fresh eyes review of all actions is planned to ensure the service remains on track to meet the internally set timelines of November and December 2023 for completion of all remaining actions. The outcome of this review will be reported to October Quality Assurance Committee.

3. MONITORING/REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This Report will be shared at the Women's and Children's Clinical Business Unit Governance Meeting on 26th September 2023.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 12th September 2023.

5. RECOMMENDATIONS

The Trust Board is requested to note the findings of this paper for information.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/117ii**
SUBJECT:	**Maternity Incentive Scheme Year 5**
DATE OF MEETING:	4 October 2023
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

Equality duty	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	√		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	√		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			√
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the maternity incentive scheme is to ensure safer care for this cohort. Achieving the principles of MIS year 5 will have a positive impact on this group.			

EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Resolution (NHSR) is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by implementing 10 safety standards. Revised specifications and timelines have been released in July 2023 and advised Trusts must submit the completed Board

	declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024. This paper will update the Trust Board of the current position and trajectory of the 10 safety actions as recommended by NHSR. • **Safety Action 1** WHH is on track to be 100% compliant in all elements of Perinatal Mortality Review Tool (PMRT) following submission of Q1 PMRT report on 8 August 2023. • **Safety Action 2** WHH is on track to submit Maternity Services Data Set (MSDS) to the required standard. • **Safety Action 3** WHH is on track to demonstrate 100% compliance with transitional care services in place to minimise separation of mothers and their babies. • **Safety Action 4** WHH is on track to be 100% compliant for all medical and neonatal staffing specifications. • **Safety Action 5** WHH is on track to be 100% compliant in all elements of Maternity staffing specifications. • **Safety Action 6** WHH is on track to deliver all elements of Saving Babies Lives Version 3 (SBLV3) • **Safety Action 7** WHH is on track to complete all Maternity Voice Partnership (MVP) specifications. • **Safety Action 8** WHH is on track to meet multi professional Core Competency Framework training standards. • **Safety Action 9** WHH is on track to be 100% compliant for providing Board assurance for maternity and neonatal safety and quality issues. • **Safety Action 10** WHH is on track to be 100% compliant with all requirements related to Healthcare Safety Investigation Bureau (HSIB) reporting and investigations and NHS Resolution Early Notification Scheme MIS Year 5 actions are on track to be compliant by the required timeframes and submission of the completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024

PURPOSE: ***(please select as appropriate)***	Information √	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/23/09/190/ii

	Date of meeting	12th September 2023
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Incentive Scheme Year 5 Update	AGENDA REF	BM/23/10/117ii

1. BACKGROUND/CONTEXT

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care by implementing 10 safety standards.

Trusts that can demonstrate all 10 safety standards will recover 10% of their CNST contribution and receive a share of unallocated funds.

Initial specifications and timelines were released in May 2023 followed by a revised version of the document in July 2023. Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024.

In preparation of the submission deadline a monthly update report will be provided. This paper will update the Board of the current Warrington and Halton position for the month of July 2023.

2. KEY ELEMENTS

The Women's and Children's Clinical Business Unit (W&C CBU) triumvirate has undertaken a benchmarking exercise and met with each Maternity Incentive Scheme (MIS) Action Lead to monitor progress of each safety action and specifications as stipulated in the MIS Year 5 Guidance relaunched in May 2023 and revised in July 2023.

2.1 MIS 10 Safety Standards and Warrington and Halton Teaching Hospital (WHH) position:

- Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

WHH is on track to remain compliant with all specifications of SA2.

The W&C CBU present quarterly PMRT reports to QAC which are shared with the Trust Board. Quarter 1 (Q1.) was presented in August 2023 and Quarter 2 (Q2.) will be presented to QAC in November 2023. Each PMRT review is required to meet all MIS Standards in terms of reporting timelines, multi-disciplinary review and Duty of Candour.

- Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

  WHH is on track to complete all SA2 specifications within specified timeframes.

- Safety action 3: Can you demonstrate that you have transitional care (TC) services in place to minimise separation of mothers and their babies?

  WHH is on track to remain 100% compliant with SA3.

  Transitional Care quarterly reports are submitted to QAC, and updates are included in to the quarterly Maternity Trust Board Report.

- Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

  There is a new focus on locum workforce and rest periods for doctors working non-resident on-call out of hours.

  WHH is on track to remain compliant with all specifications of SA4.

- Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

  WHH is on track to remain 100% compliant with MIS SA5 specifications.

  Maternity staffing is reviewed by Workforce Review meeting monthly. Maternity staffing is also included in the Trust bi-annual Safe Staffing Report.

- Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

  → Element 1: Reducing smoking in pregnancy (existing element)
    - WHH is on track to remain compliant with Element 1.
    - Project underway to implement Cheshire and Merseyside Tobacco Treatment Dependency (TTD) Pathway.
    - Additional data is now required, and work is ongoing to ensure all required data is collected. Action plans will be developed following completion of gap analysis.
    - A guideline review group is being developed to review guidelines and ensure alignment with SBLCBv3.

→ Element 2: Fetal Growth: Risk assessment, surveillance and management (existing element)

- WHH is on track to remain compliant with Element 2.
- Additional data is now required, and work is ongoing to ensure all required data is collected. Action plans will be developed following completion of gap analysis.
- A guideline review group is being developed to review guidelines and ensure alignment with SBLCBv3.

→ Element 3: Raising awareness of reduced fetal movement (existing element)

- WHH is on track to remain compliant with Element 3.
- Work is ongoing to capture the additional data required and review existing guidelines.

→ Element 4: Effective fetal monitoring (existing element)

- Fetal monitoring training compliance for July is 97%, 100% and 80% for midwives, doctors and NHSP/agency midwives respectively.
- Fetal monitoring competency assessment compliance for July is 86%, 76% and 80% for midwives, doctors and NHSP/agency midwives respectively.
- Monthly monitoring of CTG Reviews and Fresh Eyes has seen a reduction in compliance following a retrospective audit. Action Plan has commenced in July, re-audit planned to review the data for August to drive targeted quality improvement if required.

	Apr 23	**May 23**	**Jun 23**	**Jul 23**
CTG Reviews	75%	70%	50%	65%
Peer Reviews	20%	35%	30%	30%

- A recruitment campaign to replace the Specialist Midwife - Fetal Surveillance Midwife was completed. However, no applications were received. The midwifery leadership team are considering other options with regard to this post. In the interim, fetal surveillance training will be provided by a local maternity provider.
- Recruitment for a Lead Obstetrician for Fetal Surveillance has commenced.

→ Element 5: Reducing preterm births and optimising perinatal care (existing element)
  - WHH is on track to remain compliant with Element 5.
  - A pre-term birth / perinatal optimisation Midwife Lead is required. Funding for this post is to be finalised. A job specification is being drafted to ensure recruitment can commence as soon as funding is agreed.
  - There is ongoing work to support data collection and review relevant guidelines to ensure compliance and alignment with SBLCBv3.

→ Element 6: Management of pre-existing Diabetes in Pregnancy (new element)
  - WHH is on track to be compliant with Element 6.
  - Data reported to National Pregnancy in Diabetes (NPID) by medical team and diabetes specialist nurse.
  - Joint medical clinic weekly with specialist nurse input and endocrinologist input.
  - Recruitment of a diabetes specialist midwife is required. Funding for this post is to be finalised. A job specification is being drafted to ensure recruitment can commence as soon as funding is agreed.
  - Diabetes Dietician to be allocated to clinic.

→ Monitoring of compliance with Saving Babies' Lives Care Bundle Version 3
  - A national Implementation Tool has been made available on the Maternity Transformation Programme's Future NHS platform. The tool supports providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory.
  - The implementation tool is now live and the team are now able to view the evidence requirements to demonstrate compliance and provide assurance.
  - The CBU have commenced populating this tool to confirm the ongoing current position. The tool once populated will provide a percentage of compliance and this will be shared as part of future reporting to Quality Assurance Committee.

- Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users?

  WHH is on track to be 100% compliant in all specifications of SA7.

- Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

    1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.
    2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.
    3. The plan is developed based on the "How to" Guide developed by NHS England.

    - Work is ongoing to ensure additional requirements regarding service user involvement in developing and delivering training is included in the design of training provision.
    - Learning from local findings and incidents is utilised to inform training provision, evidence to support this is being collated.
    - Training compliance is monitored monthly via CBU Governance meetings, and the month Quality & safety paper presented to Quality Assurance Committee.

  WHH is on track to meet training standards of SA8.

- Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

  Significant additional reporting is required to provide assurance to the Board on maternity and quality issues in line with the Perinatal Quality Surveillance Model and to reflect local learning as a result of patient safety incidents.

  - Harm Incidents
  - Workforce Metrics including training compliance
  - Service user feedback
  - Staff feedback
  - Complaints
  - Coroner Regulation 28 position

  This is reported to Quality Assurance Committee on a monthly basis as part of the Maternity & Neonatal Quality Update.

  There is also a requirement for Board Safety Champions to be involved on the NHSE Perinatal Culture and leadership programme. This work is underway at WHH.

  WHH is on track to be compliant with all requirements of SA9.

- Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

  WHH is on track to remain 100% compliant with SA10 HSIB specification.

2.2 Summary

WHH is on track to be 100% compliant with MIS Year 5 Safety Standards within specified timeframes and submission of the completed Board declaration form to NHS Resolution by 12 noon on Thursday 1 February 2024.

3. MONITORING/REPORTING ROUTES

MIS safety actions are monitored at W&C CBU Governance meeting monthly.

4. ASSURANCE COMMITTEE

The content of this repot has previously been noted and discussed at Quality Assurance Committee on 12th September 2023.

5. RECOMMENDATIONS

The Trust Board is requested to note the findings of this paper for information.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/117iii**
SUBJECT:	**Quarter 1 2023-24 Perinatal Mortality Review/Audit**
DATE OF MEETING:	4 October 2023
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

Equality duty	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	√		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	√		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			√
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the PMRT review model is to ensure safer care for this cohort.			

EXECUTIVE SUMMARY *(KEY ISSUES):*	The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025. The Perinatal Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales. NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action

	One of the Maternity Incentive Scheme (Year 5) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports. This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 1 (Q1.) PMRT report for the period covering 01/04/2023 – 30/06/2023. During Q1, WHH reported four babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): **Three Stillbirth:** • One baby born at 30+4 weeks (HL). • One baby born at 29+4 weeks (SW). • One baby born at 36+5 weeks (ET). **One Early Neonatal Death:** • One baby born at 38+5 weeks (SB). The key findings, learning, good practice, and action plan for these cases will be reported in the Quarter 2 2023/24 QAC following a PMRT review panel for each case. WHH stillbirth rate for Q1 2023/24 was 1.65 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.04 per 1000 births. The MBRRACE-UK national stillbirth rate for 2021 is 4.2/1000 births. WHH Neonatal mortality rate during Q1 2023/2024 was 1.66 per 1000 live births. The MBRRACE-UK national rate is 1.64/1000 live births. During Q1, WHH undertook four PMRT review panels. Parental perspective of the care they received were sought in all cases. The panels reviewed: **Two late fetal losses:** • Twins born at 22+5 weeks **One stillbirth:** • One baby born at 31+4 weeks **One early neonatal death:** • One live baby born at 22+6 weeks In three of the cases (two pregnancies), issues with care of the mother and baby up to the point that the baby was confirmed to have died were identified which may have made a difference to the outcome for the baby.

	In one case, issues with care of the mother and baby up to the point that the baby was confirmed to have died were identified which would have made no difference to the outcome for the baby. In one case, issues with care of the mother following confirmation of the death of her baby were identified that would have made no difference to the outcome for the mother. In two of the cases, there were no issues identified with the care of the mother following confirmation of the death of her baby. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee. Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.

PURPOSE: ***(please select as appropriate)***	Information √	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report ..			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/23/08/170/ii
	Date of meeting	8th August 2023
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quarter 1 2023-24 Perinatal Mortality Review/Audit	AGENDA REF	BM/23/10/117 iii

1. BACKGROUND/CONTEXT

The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025. The Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) -UK confidential enquiries, reported that 60-80% of term perinatal deaths might have been prevented and recommends Trusts should undertake robust reviews and develop lessons learned to reduce the rate of stillbirth.

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 5 standards and recommended each maternity service audits all babies born stillborn and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

This quarterly report includes details of all WHH perinatal deaths reviewed and action plans implemented. This report presents WHH Quarter 1 PMRT audit data for 2023/2024 and highlights good practice and lessons learned during the mortality reviews. Q1 covers the reporting period from 01/04/2023 to 30/06/2023.

Definitions:

- **Perinatal mortality** refers to the number of stillbirths and early neonatal deaths in the first week of life.
- **Late Fetal Loss** is when a baby is born between 22+0 weeks and 23+6-weeks' gestation showing no signs of life.
- **Stillbirth** is when a baby is born showing no signs of life after 24+0 weeks of pregnancy.
- **Early Neonatal death** occurs when a baby is born after 20+0 weeks gestation or weighs 400grams or more and lives but dies within 7 days of being born.
- **Neonatal Mortality Rate** refers to the number of babies which have died within the first 28 days of life.
- **Perinatal Mortality Review Tool (PMRT)** is a national standardised approach to systematically review circumstances and care leading up to and surrounding each stillbirth and neonatal death. The review should incorporate a multidisciplinary approach which includes communication with parents on their experience of care provided and any questions they may have. Following the review, a grading of care is provided by the multidisciplinary review team.

2. KEY ELEMENTS

The Perinatal Review Tool has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland, and Wales. This paper has extracted the key findings of the report for information and noting.

During Q1 reporting period four cases were reported to MBRRACE-UK:

Three Stillbirths:

- One baby born at 30+4 weeks. Their death was notified to MBRRACE, and surveillance is completed. The PMRT review panel for this case is scheduled for 31st July 2023 and will be included in the Q2 2023/24 Perinatal Mortality Review Audit report to QAC.
- One baby born at 29+4 weeks. Their death was notified to MBRRACE, and surveillance is completed. The PMRT review panel for this case is scheduled for 31st July 2023 and will be included in the Q2 2023/24 Perinatal Mortality Review Audit report to QAC.
- One baby born at 36+5 weeks. Their death was notified to MBRRACE, and surveillance is completed. The PMRT review panel for this case is scheduled for 31st July 2023 and will be included in the Q2 2023/24 Perinatal Mortality Review Audit report to QAC.

One Neonatal Death:

- One baby born at 38+5 weeks. Their death was notified to MBRRACE, and surveillance completed within the specified timescale. On advice from MBRRACE, there is no scheduled PMRT review panel for this case whilst awaiting the coroner report.

2.1 Quarter 4. WHH Stillbirth Rate:

- WHH Q1 stillbirth rate for 2023/2024 1.65 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2021 is 4.2/1000 births.
- WHH had no intrapartum stillbirths.
- WHH had no term stillbirths (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH current annual stillbirth rate for Q1-Q4 2022/23 is 2.03 per 1000 births. The MBRRACE-UK national rate is 3.51 per 1000 births.

Table 1: WHH Stillbirth Data Over 12-month Period:

Metric	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	12-month total
Number of live births	577	641	633	603	2454
Total number of stillbirths >24 weeks	1	2	1	1	5
Total Stillbirth Rate >24 weeks (per 1000 births)	**3.59**	**3.11**	**1.58**	**1.65**	**2.03**
Number of intrapartum still birth rate	**0**	**0**	**0**	**0**	**0**
Number of stillbirths >37 weeks	**1**	**1**	**0**	**0**	**2**

2.2 Q3. WHH Neonatal Mortality Rate:

There was one early neonatal death reported in Q1 2023/2024.

WHH Neonatal mortality rate during Q1 2023/2024 was 1.66 per 1000 live births. The key findings, learning, good practice, and action plan for this case will be reported following a PMRT review panel which will be scheduled once the coroner report is received.

2.3 Quarter 1 PMRT Review Panel Key Findings

Synopsis of Findings

Twins, born at 22+5 weeks gestation were a late fetal loss. The cause of death identified at post-mortem was twin-to-twin transfusion syndrome.

One baby born at 31+4 weeks gestation was a stillbirth. The cause of death agreed was uterine rupture.

One baby born at 22+6 weeks gestation was an early neonatal death. The cause of death agreed was extreme prematurity (AR).

Surveillance Findings:

- Two babies were of a singleton pregnancy.
  Two babies were from a twin pregnancy.

- One woman was aged between 30-34.
  Two women were aged between 35-38.

- Two women were identified as white ethnicity.
  One woman was identified as Pakistani ethnicity.

- Two women spoke English as their first language.

  One woman was described as non-English speaking.

- None of the women had any communication problems as a consequence of learning difficulties/hearing problems.

- One woman was of a healthy BMI between 18.5 - 24.9.
  One woman had an increased BMI between 25 - 29.9.
  One woman had a BMI of greater than 30 (associated with an increased risk of complications in pregnancy.)

- All women were non-smokers and had a carbon monoxide (CO) level below 3 parts per million (PPM).

- In one case the woman booked late at 13+2 weeks gestation.

- In all cases there were no issues identified with the care provided in relation to safeguarding.

2.4 PMRT Grading of Care

Each PMRT review panel consists of senior obstetric, midwifery, bereavement, and governance representation from WHH and external peer review members from another maternity provider within Cheshire and Mersey Local Maternity System. Parental perspective is also included as part of the PMRT review and contributes to the grading of care.

The PMRT review concludes with each panel member reporting if, in their professional opinion, the care given up to the point where the baby was confirmed as having died and or care provided following the birth of the baby could have made a difference.

During Q1 one PMRT stillbirth review panel and two late fetal loss review panels took place. Parental perspective of the care they received were sought in all cases.

In three of the cases, issues with care of the mother and baby up to the point that the baby was confirmed to have died were identified which may have made a difference to the outcome for the baby.

In one case, issues with care of the mother following confirmation of the death of her baby were identified that would have made no difference to the outcome for the mother.

In two of the cases, there were no issues identified with the care of the mother following confirmation of the death of her baby. An action plan has been implemented (Table 7).

An action plan has been implemented (Table 7).

PMRT grading	**Care provided to the mother up to the point that her baby was confirmed as having died**	**Care provided to the mother following confirmation of the death of her baby**
PMRT grade A The review group concluded that there were no issues with care identified	-	2
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	-	1
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	3 (includes one set of twins)	-
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	-	-
Not Graded	-	-
Total Cases	Three cases	Three cases

During Q1 one neonatal death PMRT review panel took place. Parental perspective of the care they received was sought.

In this case issues with care up to the point of birth of the baby were identified that would have made no difference to the outcome for the baby. Issues with care from the birth up to the death of the baby were also identified which would have made no difference to the outcome for the baby. No issues were identified with care provided to the mother following confirmation of the death of her baby.

Table 4: Q1 WHH Grading of Care Following Neonatal Death

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby from birth to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A The review group concluded that there were no issues with care identified	-	-	1
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	1	1	-
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	-	-	-
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome	-	-	-
Not Graded	-	-	-
Total cases	One case	One case	One case

2.5 Q1. WHH PMRT Panel Attendance

There have been four PMRT panel reviews in Q1 which were attended by multidisciplinary internal and external panel members.

Table 5: Q1 WHH PMRT Panel Attendance

	Number of participants involved in PMRT reviews. Total number of reviews from 01/04/2023 – 30/06/2023 = 4		
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	3	1	4
Admin/Clerical	3	1	4
Bereavement Midwife	3	1	4
External Rep	3	1	4
Management Team	0	0	0
Midwife	3	1	4
Neonatal Nurse	n/a	0	0
Neonatologist/Paediatrician	n/a	1	1
Obstetrician	3	1	4
Other	3	1	4
Governance Manager	0	0	0
Safety Champion	0	0	0

2.6 Maternity Incentive Scheme Year 5 Compliance

WHH is currently on track to be 100% compliant in all elements of Perinatal Mortality Review Tool (PMRT) in line with the requirements of Maternity Incentive Scheme Year 5.

Table 6: PMRT MIS Safety Action 10 Compliance

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
Standard Required		**Compliant Y/N**
a)	All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	On track
b)	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	On track
c)	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months	On track
d)	Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	On track

2.7 Learning and Good Practice

- The four cases have been notified and surveillance completed within the required timescale.
- Antenatal care was graded C at three of the PMRT panel meetings, which included feedback from the parents. This relates to two pregnancies. In one case there was a misidentification of the chorionicity of the pregnancy. The other case relates to a woman discharged home where further review may have been indicated. Learning from both cases forms part of the PMRT Action Plan (Table 7).
- Postnatal care was graded A all of the PMRT panel meetings, which included feedback from the parents.
- Parental involvement was sought in all cases as part of PMRT panel review.
- The review panel agreed that bereavement care should be graded by the parents and a pathway for this will be developed.

Action Plan Summary
All actions identified following PMRT reviews are recorded in full on the Datix incident reporting system and monitored through Women's and Children's Governance Meetings.
There were five actions recorded from the Q1 2023/24 PMRT review panels and one action remains in progress:

Table 7: PMRT Action Plan

Action	Lead	Start date	Due Date	RAG rating
Chorionicity of multiple pregnancy to be verified by two sonographers and reviewed by the multiple pregnancy obstetric lead.	Sue Thilwind, Obstetric Ultrasound Lead	28.02.23	26.05.23	28.02.23
Guideline for Missed Appointments to include a prompt/flowchart to support action required/decision making to ensure appropriate escalation when women do not attend appointments in maternity.	Leanne Lawrenson, Antenatal Services and Continuity Manager	26.05.23	31.07.23	03.07.23
Develop a pathway to request for all parents to provide the grading of care for bereavement for the PMRT review panel at WHH	Lisa Davies, Governance Quality Lead Midwife	26.05.23	01.09.23	
Women who present to maternity triage with a high-risk pregnancy must have a decision to discharge discussed with ST3 doctor or above.	Rita Arya, Consultant Obstetrician and Gynaecologist	26.05.23	31.07.23	
All cervical length images to be reviewed for assurance purposes	Rita Arya, Consultant Obstetrician and Gynaecologist	26.05.23	31.07.23	

2.8 Summary

WHH Q1 PMRT audit recorded four babies reported to MBRRACE that were born between 01/04/2023 and 30/06/2023.

- One baby born at 30+4 weeks
- One baby born at 29+4 weeks
- One baby born at 36+5 weeks
- One baby born at 38+5 weeks).

The key findings, learning, good practice, and action plan for three of these cases will be reported in the Quarter 2 2023/24 QAC report following the PMRT review panels due to be held on 31st July 2023. The fourth case is awaiting coroner's report, prior to review.

- WHH stillbirth rate for Q1 2023/24 was 1.65 per 1000 births. WHH annual Mean stillbirth rate is 2.04 per 1000 births which is below the 2021 MBRRACE-UK national rate 4.2 per 1000 births.
- WHH Neonatal mortality rate during Q1 2023/2024 was 1.66 per 1000 live births. This includes one baby who was born at 38+5 weeks.
- Four PMRT review panels were held in Q1 which were attended by multidisciplinary internal and external panel members. PMRT reviews are all graded as either A B C or D as per outcome incurred.
- Parental perspective of the care they received were sought in all cases.
- In three of the cases there were issues with care of the mother and baby up to the point that the baby was born which may have made a difference to the outcome for the baby.
- In one of the cases there were issues with the care of the mother and baby up to the point where the baby was born that would have made no difference to the outcome for the baby.
- In one case issues were identified with care up to the point that the baby was confirmed to have died which would have made no difference to the outcome.
- Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee and there is one outstanding Q1 PMRT action in progress.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards are being met.

3. MONITORING/REPORTING ROUTES

PMRT actions are monitored at W&C CBU Governance meeting monthly.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 8th August 2023.

5. RECOMMENDATIONS

The Trust Board is requested to note the findings of this paper for information.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/117/iv**
SUBJECT:	Monthly Maternity & Neonatal Quality Update
DATE OF MEETING:	4th October 2023
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. — X SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

Equality duty	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	√		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	√		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			√
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the PMRT review model are to ensure safer care for this cohort.			

EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update in relation to maternity and neonatal quality for June and July 2023. The paper provides oversight of key national safety and quality issues in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 (Safety

	action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues). This information is reported monthly to Quality Assurance Committee. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Complaints • Coroner Regulation 28 position This paper will also provide an overview of emerging regional/local issues as appropriate. including: • Maternity Triage • Compliance with PDRs In June and July there was three moderate harm incidents. There were no major or catastrophic harm events Work remains ongoing across the maternity and neonatal teams to improve and maintain compliance with mandatory training and completion of staff appraisals. Mandatory training across maternity and child health colleagues was above 80% and showing an improving trajectory. However these measures remain slightly short of the trust target of 85%. Compliance with PDR completion also reflects an improving picture. Current compliance is 75.73%. This remains below the trust target of 85%. Completion of mandatory training and PDRs is monitored weekly. Workforce measures related to retention and vacancy rate remain much improved. The Maternity Voices Partnership (MVP) chair has completed an informal visit to maternity triage following its relocation. Feedback was positive, commenting particularly on calm and compassionate staff providing care. Further feedback is being collated and will be

	shared alongside the formal feedback from the 15 steps challenge completed on 9th June 2023. A Maternity Safety Champion Walkarounds took place on 8 August 2023 and a clinical leaders walkaround on 31st August 2023. Feedback from these was positive and no concerns were raised by staff. A project to relocate maternity triage commenced in early 2023. The relocation took place on 16th August 2023. The Triage Task & Finish group continues to provide oversight of the relocation project and will work with the wider team to optimise the service. Service user feedback is being collated following the relocation. This will be shared to Quality Assurance Committee in October. In July 2023 94% of attenders to maternity triage were seen within 15 minutes of arrival (best practice guidance), 98.2% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is within the KPI standards. 2.1% of attendees were categorised as red on initial assessment. All were immediately transferred to birth suite for 1:1 care and 100% of attenders received immediate ongoing care There were ten complaints received across the CBU in June and July 2023. Four of these complaints related to care within the Maternity and Neonatal Services. One complainant has raised concerns related to birth experience and care from the medical team. One complainant has raised concerns across the antenatal, intrapartum and post natal pathways. A further complaint relates to care and treatment in the early postnatal period. The investigation into all these complaints is ongoing and meetings have been scheduled with the famillies. The fourth complaint relates to the lack of communication of swab results following attendance at maternity triage. This complaint has been closed and learning shared with the team. Following an increase in complaints within maternity in the last 12 months a deep dive of complaints has been completed. The deep dive reviewed complaints for the

<table>
<tr><td></td><td colspan="4">period April 2022-July 2023. The top three themes identifed as part of the deep dive were clinical care, consent/communication (a feature in 30% of cases) and staff behaviour (a feature in 20% of cases).

All complaints are investigated via robust governance processes and learning shared at an individual and service level. In light of the findings of the deep dive a number of measures will be implemented. Further information regarding this is included in the body of the paper.

No Regulation 28 enquiries have been received.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information √</td><td>Approval</td><td>To note √</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to note the contents of this report ..</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Quality Assurance Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3">QAC/23/08/170/vi
QAC/23/09/190/iii</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="3">8th August 2023
12th September 2023</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="3">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">Choose an item.</td></tr>
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REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update	AGENDA REF:	BM/23/10/117/iv

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the months of June and July 2023.

The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 *(Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues)* alongside emerging local and regional matters.

2. HARM INCIDENTS

There were 177 incidents reported across the CBU in June 2023 which is an increase of 20% from the 141 incidents in May 2023.

Below shows a breakdown of incidents reported and investigations declared in June 2023:

Severity	May 2023	Jun 2023
1 – Negligible / None	119	155
2 – Minor	20	20
3 – Moderate	2	2
4 – Major	0	0
5 – Catastrophic	0	0
Total	141	177

In June there were 5 Initial Safety Reviews undertaken and 4 Rapid Incident Reviews within the CBU. There were two moderate harm incidents, both in Maternity. One has been declared an HSIB Investigation, 1 has been declared a Cluster Review. There were no major or catastrophic harm events

The HSIB investigation relates to a baby born requiring respiratory resuscitation which once admitted to the Neonatal Unit (NNU) began to show signs of seizure activity. As a result, the baby was transferred out to Liverpool Women's Hospital. The baby is now well and awaiting MRI scan. HSIB accepted the referral based on parental concerns around care.

All incidents meeting HSIB referral criteria are reviewed locally through MDT (rapid incident review) and any immediate actions identified and agreed. These are assigned on Datix and completed whilst we await the HSIB review. We will continue this approach with the introduction of PSIRF

The second case relates to a baby which slipped off the bed and fell to the floor on Ward C23. Initial suggestion is Mum fell asleep holding the baby. The baby was taken to NNU for observation and subsequently underwent a CT scan which showed a cranial fracture. The baby is now fully recovered and at home. This was the third incident of this type in the in 2023. This case is being reviewed as a cluster review. In the interim, a rapid review was undertaken, and immediate safety actions have been implemented as follows:

- SBAR handover documentation between clinical areas (for woman/birthing person) to include a postnatal medication review
- Safety alert sent out the same day to remind staff of the importance of curtains around the bed areas being kept open unless privacy required to improve oversight. In addition, staff were asked to ensure parents were aware of the importance of placing baby back in cot and in calling for help if they felt tired or needed support.

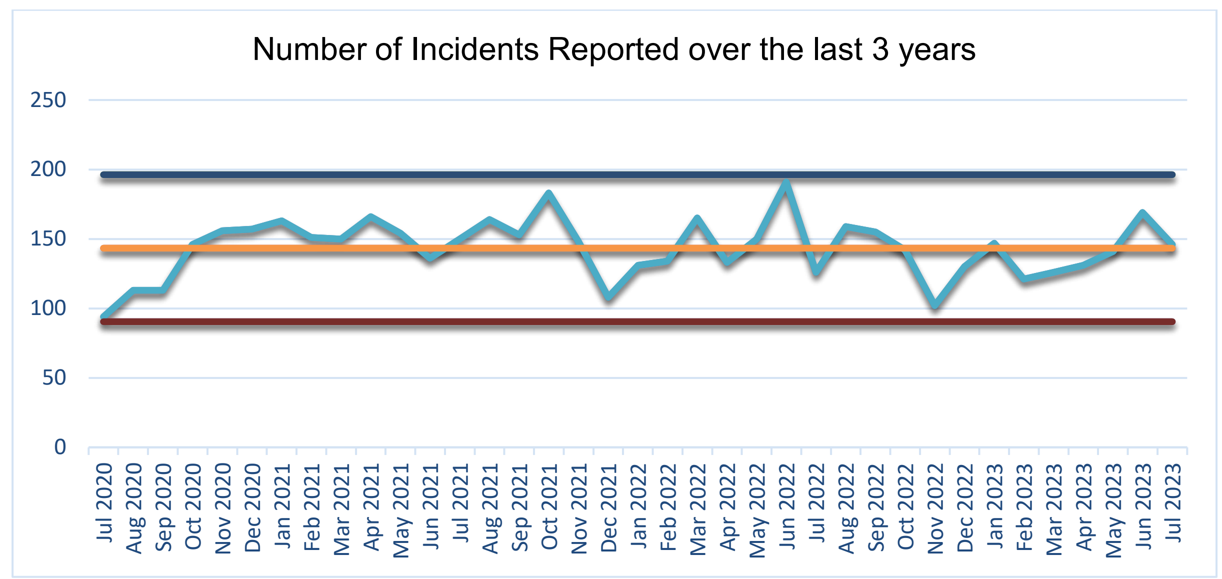
In addition to the above incidents with moderate harm, a Serious Investigation has been declared for a maternity service divert which took place on 31st May 2023 (reported 1st June 2023). This was a no harm incident but due to the significance of such events will be fully investigated and learning collated and shared.

To provide further assurance around cases of potential harm due to Hypoxic-ischaemic encephalopathy (HIE) and working with the CBU Governance lead we have reviewed the number of cases referred to HSIB in 2023 (to date) compared to 2022. In 2022 four cases were referred to HSIB due to potential HIE. Of these cases, one was rejected by HSIB as no concerns. Three were investigated via HSIB resulting in 11 recommendations which have formed action plans monitored via Datix.

In 2023 (January to June) there have been four cases referred to HSIB, three due to potential harm due to HIE. Of these, one was rejected due to no concerns from HSIB, the Trust or the family. Two have been taken forward for investigation by HSIB, those investigations are ongoing. The fourth case related to a neonatal death rather than HIE. HSIB have rejected this case due to lack of parental engagement, but this case will be investigated via the coroner's service. The family are engaging with the coroner's service. This case will be reviewed by the trust via PMRT processes; however, this process has been paused at present following advice from MBRRACE UK who recommended the trust wait until the coroner's report is complete.

To ensure the service continues to identify themes and learn from all cases of potential HIE we will conduct a cluster review of all HSIB recommendations for 2022-2023 once the two most recent cases are published.

There were 146 incidents reported in July 2023 which is a decrease of 17% from the 177 incidents in June 2023.



Below shows a breakdown of incidents reported and investigations declared in July 2023:

Severity	Jun 2023	Jul 2023
1 – Negligible / None	155	115
2 – Minor	20	30
3 – Moderate	2	1
4 – Major	0	0
5 – Catastrophic	0	0
Total	177	146

There were no major or catastrophic harm events in July 2023. There was one moderate harm incident.

There were seven Initial Safety Reviews undertaken, of which two have been declared as Comprehensive Investigations, two have been reported to MBRRACE and will be reviewed via the PMRT process, one case has been declared an After-Action Review.

The two Comprehensive Investigations relate to diverts of the maternity service.

The After-Action Review relates to a complaint regarding care of a women with previous gestational diabetes. The investigation is currently underway.

The two PMRT cases relate to two stillbirths, one at 32+5 weeks gestation (the moderate harm incident detailed above) and one at 30+1 gestation. Both will be

reviewed via the PMRT process and reported via the quarterly PMRT report to a future Quality Assurance Committee

3. WORKFORCE METRICS

Work remains ongoing across the maternity and neonatal teams to improve compliance with mandatory training and completion of staff appraisals.

At the end of July 2023 compliance for mandatory training across maternity and child health colleagues was above 80% and showing an improving trajectory. However, these measures remain slightly short of the trust target of 85%. Line managers are proactively managing this, and considerable work has been completed during August particularly in relation to Safeguarding training.

Compliance with PDR completion also reflects an improving picture. Current compliance is 75.73%. This remains below the trust target of 85%. Completion of PDRs is monitored weekly.

Compliance with key maternity specific mandatory training MAMU2 (which relates to CTG competence) and Prompt (multidisciplinary team skills drill training) remains good, however at present WHH are not meeting the Maternity Incentive Scheme Year 5 target of 90% compliance.

Compliance for MAMU2 at end of July 2023:

Staff Group	Fetal Surveillance training	Fetal Surveillance competencies
Midwives	97%	86%
Medical staff	100%	76%
Agency staff	80%	80%

An action plan is in place to continue to improve MAMU2 compliance and competence with additional training dates scheduled.

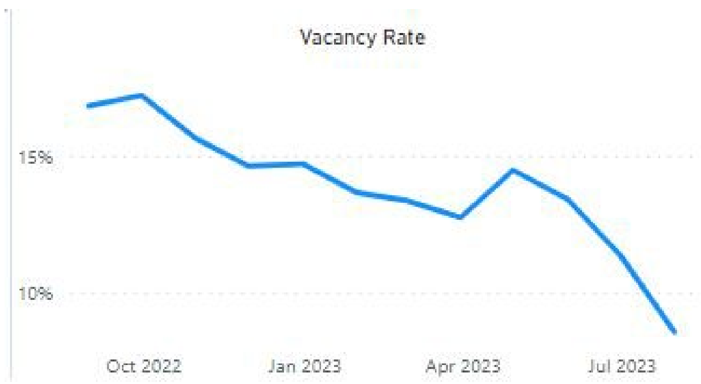
Compliance with Prompt training at the end of July 2023 was 78.8%, this is below the target of 90%. This reduction in compliance is as a result of the cancellation of the July Prompt day due to unavailability of trainers and inability to support MDT training due to medical industrial action. To support compliance an additional virtual PROMPT took place in August. Prompt will resume face to face from 4th September with increased allocation to improve compliance.

Improvement has been noted in a number of other workforce measures, in particular in relation to staff recruitment and retention which is key to the provision to a safe and quality service. This is reported in detail to Strategic People Committee.

However, of particular note:

- Turnover for maternity and child health staff has shown a slight increase from 11.74% in June 2023 to 12.31%. This will be monitored closely to ensure this does not mark the beginning of a trend; however, the position remains much improved from September 2022.

- The vacancy rate for maternity and child health staff has reduced from a peak of 17.23%% in September 2022 to 8.54% in July 2023. This is an improvement of 2.82% from June 2023. This improvement excludes those in the recruitment pipeline.



4. SERVICE USER FEEDBACK

A Maternity Voices Partnership (MVP) led 15 Steps Challenge of all maternity and neonatal areas was completed on 9th June 2023. Formal feedback is being collated by the MVP chair and will be shared with Quality Assurance Committee. In the meantime, informal feedback received following the visit has been positive. The volunteers were excited about the changes the service has planned to the maternity estate and having visited all clinical areas left feeling assured staff were warm, caring and calm.

The service has also received individual feedback regarding care experience from a number of families. This is shared for information in appendix one.

The Maternity Voices Partnership (MVP) chair has also completed an informal visit to maternity triage following its relocation. Feedback was positive, commenting particularly on calm and compassionate staff providing care

The service has also received individual feedback regarding care experience from a number of families. This is shared for information in appendices one and two.

5. STAFF FEEDBACK

Feedback has been received from the midwifery team with regard to the staffing and pathways related to induction of labour (IOL) This feedback has been acknowledged with the team via the Director of Midwifery weekly update and a number of measures implemented to support resolution of the concerns raised. This includes the trialling of an additional ward midwife overnight to provide resilience to the induction bay at times of high acuity, reinstatement of the IOL task and finish group and measures to support escalation of concerns. These will be interim measures whilst we await the phase 2 estate works which will resolve many of the concerns raised.

The Freedom to Speak up Guardian has completed walkarounds of the unit during June. This has been to raise the profile of Freedom to Speak Up processes and to listen to any worries or concerns. No significant concerns have been highlighted as part of these walkarounds. Some local issues were highlighted, and these are being addressed with the relevant line manager.

A Maternity Safety Champion Walkarounds took place on 8 August 2023. No concerns or issues were raised by staff as part of those walkarounds. A clinical leaders walkaround took place in the maternity service on 31st August 2023. Feedback was positive. The team visited both Birth Suite and ward C23, and noted a very welcoming, clean, tidy environment in both areas. Conversations with the maternity team focused on how staff escalate and whether the team are aware of the Freedom to Speak up process. On both fronts the visiting team were assured by the staff they met.

Some further individual staff feedback from a Midwife currently completing her preceptorship is included in appendix two.

6. MATERNITY TRIAGE

The maternity triage service is included within this paper in light of significant regional and national scrutiny of maternity triage services.

In addition, WHH maternity triage was noted as a red flag area as part of the maternity mock CQC inspection held in March 2023. This was due to its location and inability of staff to maintain oversight of those attending for care.

A project to relocate maternity triage commenced in early 2023. The relocation took place on 16th August 2023. This provides a new purposeful space with its own entrance and four clinical rooms. This provides additional privacy to those attending alongside a fit for purpose waiting area. The new location also provides clinical staff with good oversight of those waiting to be seen, a key issue highlighted in March.

The Triage Task & Finish group will continue to work with the team to optimise the service. Service user feedback is being collected following the relocation. This will be collated and shared to Quality Assurance Committee in October.

Current performance

- In July 2023 617 Maternity Triage attendances were recorded in the BadgerNet patient record system.
- The shortest wait in July was 0 minutes.
- The longest wait for initial review was 90 minutes, this was a woman requiring postnatal readmission who had not been noted as arriving. This was a known issue related to the previous location of maternity triage which is resolved by the project to relocate the triage service.
- 94% of attenders were seen within 15 minutes of arrival (best practice guidance)
- 98.2% of attenders were seen within less than 30 minutes of arrival (NICE guidance)
- 2.1% of attendees were categorised as red on initial assessment.
- All were seen within 15 minutes for initial assessment

- All were immediately transferred to birth suite for 1:1 care and 100% of attenders received immediate ongoing care

Activity in place to support a safe service

- An audit of peak activity times has been completed and a potential staffing model has been agreed. To meet the ambition of this staffing model, there will be the requirement for new and/or redeployment of staffing resource. The Midwifery leadership team will be meeting further to agree next steps and a proposal brought forward.
- The new maternity triage location includes two phone lines. This provides additional phone capacity and will be further developed as part of the wider trust project related to telephone systems.

Next Steps

- Maternity triage task and finish group in place.
- Ongoing monthly audit of triage delays in place and monitored through CBU Governance meetings. Themes and trends will be identified, and actions incorporated into the maternity triage action plan.
- Phone system to be upgraded

7. COMPLAINTS

There were 10 complaints received across the CBU in June and July 2023. Four of these complaints related to care within the Maternity and Neonatal Services.

One complainant has raised concerns across the antenatal, intrapartum and post natal pathways, inclusing poor communication, delay in pain relief and lack of support with infant feeding.The investigation into this case is ongoing but is on schedule for completion within prescribed timescales, learning gained from the case will be shared following completion of the investigation process.

The second complaint relates to the lack of communication of swab results following attendance at maternity triage. This complaint has been closed and learning shared with the team.

One complainant has raised concerns related to birth experience and care from the medical team. The investigation into this case is ongoing and a meeting is scheduled with the family for later in September.

The second complaint relates to care and treatment in the early postnatal period. In this case the mother has concerns the documentation relating to the care episode is inaccurate. The investigation into this case has commenced and a meeting with the family is scheduled for October.

Following an increase in complaints within maternity in the last 12 months a deep dive of complaints has been completed. The deep dive reviewed complaints for the period

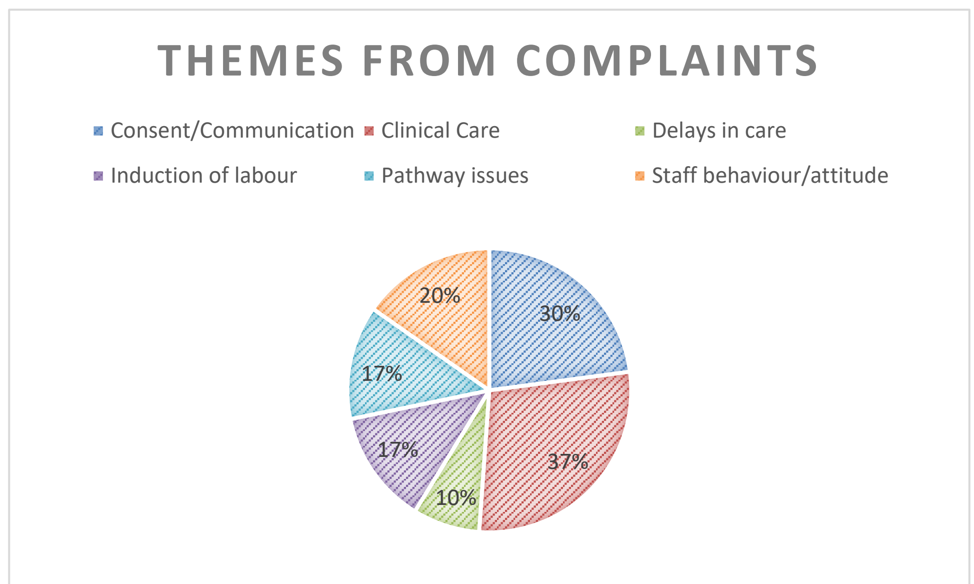
April 2022-July 2023 and was reported to Quality Assurance Committee in September 2023.

During this period 30 complaints were received in maternity, an average of almost two per month.The maternity total equated to 48.39% of all CBU complaints.

The deep dive explored when within the pregnancy continuum the complaint related, and where within the maternity service concerns had been highlighted. The reason for the complaints were also reviewed and two key “reason” themes identified for each complaint.

The majority of maternity complaints related to the antenatal and intrapartum periods (93.3%). In total there were six key themes across the complaints as follows:

- Consent/Communication
- Clinical Care
- Delays in care
- Induction of labour
- Pathway issues
- Staff behaviour/attitude



The top three themes identifed as part of the deep dive were clinical care (a feature in 37% of cases), consent/communication (a feature in 30% of cases) and staff behaviour (a feature in 20% of cases). Those cases categorised as clinical care were muti faceted in their detail, no specific themes/patterns were identified beyond those within the top six themes.

All complaints are investigated via robust governance processes and learning shared at an individual and service level. However, in light of the findings of the deep dive the following measures will be implemented.

- Consultant Midwife led multidisciplinary working group to be established to focus on issues in relation to consent and communication. This group will work with staff, the Maternity Voices Partnership and women/birthing people to explore how matters of consent are discussed and to ensure we embed a positive communication culture across the services.
- Additional anyalysis of data to identify any further themes in relation to individual development needs regarding communication and staff behaviour in care provision to be completed.
- Project to implement a Maternity and Neonatal Score Survey to commence week of 4th September as part of the maternity and neonatal service participation in the NHSE Perinatal Culture and Leadership Programme Programme. The Score culture survey will provide a cultural overview of the service. As part of this, trusts will also be assigned independent external debriefing support at site level to assist the sense checking/socialisation of survey results and to facilitate work on the development of local plans to support cultural shift.
- Quarterly review of themes from complaints to commence with effect from Q2 2023-2024. Learning will feed into service activity and will be reported via CBU governance meetings and to Quality Assurance Committee and Trust Board via the regular Maternity & Neonatal Quality Update.

8. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

9. MONITORING/REPORTING ROUTES

The monthly review of matters eating to quality and safety are reported via Women's Health Governance meeting. Items for escalation are monitored at W&C CBU Governance meeting monthly.

10. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committees on 8th August 2023 and 12th September 2023.

11. RECOMMENDATIONS

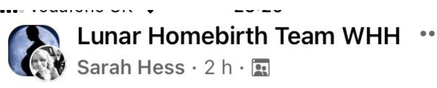
The Trust Board is requested to note the findings of this paper for information.

Appendix One – Service User Feedback - June

Feedback from Laura Bailey:

"I just wanted to send a little note to pass on my gratitude to each and every member of staff I have had the pleasure of meeting during my pregnancy and delivery!! My Continuity of Carer midwife Becky has been outstanding and seeing her at every appointment has been incredibly reassuring, she is simply lovely and so very helpful always answering any (daft) questions I may have! The acute staff on Induction, C23 and Birth Suite have been wonderful, so very supportive during an uncertain time. They are so very professional but make you feel so cared for and at ease. I particularly want to thank the 5 midwives that supported me during my labour, Alison, Lilly, Debbie, Pippa, and Amy. I'm so happy to hear that our baby girl was Lilly's 25 delivery working towards her becoming a qualified midwife in September, Lilly was incredible and talked me through everything - I will never look at a packet of polos the same way ever again! The midwifery team have been outstanding and I'm incredibly proud to work for WHH and to know that the staff that cared for me are my colleagues. They go to work with smiles on their faces every day, working through a long shift and literally keep women standing at the most special but uncertain time of having a baby! You are all wonderful and do an amazing job, thank you for keeping me and my baby girl so safe and cared for."

Feedback from women under the care of Team Lunar (Homebirth)



Introducing Jude Francis Paul Berrington, who joined us on 4th July at 7.57am, weighing in at 9lb 6 💙
George and I can't thank the wonderful team enough for all they've done for us. From Natalie making the change to a home birth happen for us quite late on in pregnancy (in no time at all), to Sarah, Natalie and Nicole being by our sides to guide both of us through a long labour and staying with us as plans had to change and we had to transfer to hospital.
I'm so grateful for Natalie and Sarah being in the room for the last stage of Jude's birth to support us, meaning George could feel confident the right decisions were being made on Jude's and my behalf.
While the little man had other plans and didn't end up being born at home, these strong women made sure it was still the best experience possible and I felt so empowered having them around me and literally holding my hand when I needed it.
The breastfeeding support I received has also been absolutely invaluable and set us off on a great journey - thank you Sarah and Natalie!
These women will forever be such an important part of Jude's story and I'm so pleased he is a Lunar baby 💙

Hey lovely Lunar Goddesses 🌙
I just wanted to firstly say such a massive and heartfelt thank you to the gorgeous Luna Team for making me feel to confident and lovely throughout my pregnancy and although we didn't get the full, beautiful home birth we'd planned, we still got to experience some of it before transferring in where we gave birth to our angelic rainbow of hope Miss Gracie Rai Cooke born 6th July at 4.15pm weighing a perfect 7lbs.
My gorgeous midwife Natalie kept me calm and helped me through the change in our plan which was extremely emotional for us and although it might not have been our gorgeous home birth plan, it was the plan that got our little cherub to us safely and soundly so it was the perfect plan in the end.
Honestly Team Lunar, you are the best and we are so lucky to have been with you on this magical journey. Thank you especially to gorgeous midwife Natalie Starkey you' Earth Angel 😇 🌸🌈

Appendix Two – Staff & Service User Feedback - July

Feedback from RM Alanya Tunstall

“I just wanted to send a nice email just to give Amy Morris a bit of recognition and a pat on the back! I have experienced two shoulder dystocia’s in my last two shifts, one on Tuesday which I was the second midwife for and one today which I was the first midwife, and Amy was there to assist in both of them. my arrived very quickly from triage, took a lead role in both situations and managed both emergencies amazingly. She was very confident in handling manoeuvres and remained calm the whole time and also took the time to check on me afterwards. I'm very grateful to that she was there to assist on both days, and I just wanted to let you know that she is a fabulous, skilled and experienced midwife who I think deserves some positive feedback and recognition!

I also would like to thank everyone else who was present during both emergencies as everyone worked quickly and effectively as a team. Jo Lumsden and Denise Nunnerley in particular were a massive support and were also quick to act and confident in performing manoeuvres and giving direction and Rachel Crone who was quick to declare the emergency for the first shoulder dystocia and continued to support the woman and her family throughout. Some days as a band 5 can feel overwhelming but I've felt so supported by all staff the past few days and it's reassuring to know you have a lovely team that always have your back if you need it!

Feedback from KB:

“I have recently been under the care of women and children's. I am currently an A&E nurse myself and the care I received was that first class I felt you needed to be aware.

I was cared for with such dignity, respect and compassion by ALL staff members involved in my care. Nothing was too much to ask and nothing was too much trouble for anybody. I was expecting a natural birth with my second baby, but things didn't go to plan so ended up having a c section.. I was very nervous and frightened as I had never stepped foot in a theatre as a patient before but my midwife (Charlotte Mahoney and her student midwife) where what I can only describe as exceptional. Everything was absolutely incredible in terms of communicating to me, explaining to me, and giving me the aftercare, I needed afterwards. I would like to thank specifically; Charlotte Mahoney (MW), Joanna H (MW) Summer (StM), Dr Will (anaesthetics), Dr Raju, Einir (MW), Jazmine (StM), Helen Cummins (MSW).”

Feedback received regarding care on Neonatal Unit

26 Aug ·

Myself and becky would like to say a massive thank you to the amazing staff at Warrington neonatal unit for the care and love they showed reggie while he spent 47 days in neonatal unit amazing so glad he's home thank you 😊 ❤️ 💙 ❤️ ☺️

TRUST BOARD
WEDNESDAY 4th OCTOBER 2023

Moving to Outstanding, Q1

Kimberley Salmon Jamieson, Chief Nurse/ Deputy Chief Executive

CQC Single Assessment Framework

Rationale for Change:

- Focused approach
- Better understand delivery of care as a system

- **What is different?**
  - Key Lines of Enquiry – Quality Statements
    - "We statements"- provider perspective
    - "I statements" – service user perspective
- **Six categories of evidence**

People Experience	Feedback from Staff and Leaders	Observations of Care	Feedback from Partners	Processes	Outcomes of Care

- Risk based approach – data driven
- CQC framework training in place at WHH provided by HLTHGroup
- Commenced April 2023
  - 100 staff trained
  - Training provided at Board Development session

CQC Position and Enquiries

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Likely inspection Maternity by September 2023
- Likely ED inspection – increase in CQC enquiries requested
- Review of Moving to Outstanding meeting – align to single assessment framework
- Executive led engagement sessions completed in Maternity
- Executive led engagement sessions to be completed in ED
- Enquiries received - table below.
    - Majority in ED and Maternity = request for incident investigation reports / complaints. Other enquiries relate to care provision.

Area	Number
Urgent and Emergency Care	8
Surgery	1
Maternity	4
Medical Care	3
Clinical Support Services	1
Digestive Diseases	2
Whistleblowing enquiries received and closed, supported by FTSU walkrounds	

WHH Mock Inspection Programme: Core Services

Date Inspection Undertaken/ Planned	Area	Re-inspection
4th April 2022	Urgent and Emergency Care	22 June 2023
2nd March 2022 9th March 2022	Surgery	July 2023
31st March 2023	Maternity	TBC
22nd June 2023	Urgent and Emergency Care	TBC
Mock Inspections Planned		
September 2023	Surgery Medical Care	Delayed due to formal CQC maternity inspection
October 2023	Medical Care	
November 2023	End of Life	
December 2023	Critical Care	
January 2024	Outpatients	
February 2024	Children's Services	

Maternity CQC Inspection Progress

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust - Maternity Dashboard

Safe: Number of Bookings by 9 Weeks + 6 Days; Number of Bookings by 12 Weeks + 6 Days; Sepsis; PPH >1500ml; Transfer to ITU; 3rd & 4th degree tear (all); 3rd & 4th degree tear (Spontaneous Vaginal); 3rd & 4th degree tear (Instrumental)

Effective: Location of Birth; Type of Birth; Type of Birth (Other); C-Section by Grade; Induction of Labour Rates; Neonatal Readmissions within 14 days

Caring: Births (Babies Born); Complaints; Incidents - In Month; Incidents - 5 Catastrophic; % Apgar <7 at 5 Mins; Maternity Readmissions within 14 Days; Maternity Readmissions within 28 Days

Responsive: % Bookings by 9 weeks + 6 days; % Bookings by 12 weeks + 6 days; General Anaesthetic at Caesarean Section; C-Section - Cat 1 decision to delivery % within 30 minutes; C-Section - Cat 2 decision to delivery % within 30 - 75 minutes; Babies born at other location (including home) midwife NOT present

Well Led: Mandatory Training; PDR; Starters/Leavers; Sickness; Vacancy Rate; Midwife to Birth Ratio

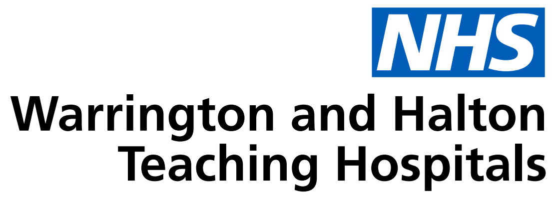
- Internal dashboard - live
- Shared at CBU governance
- Areas for awareness:

a) Pregnancy Booking completed <10 weeks –trajectory for improvement in place –on track

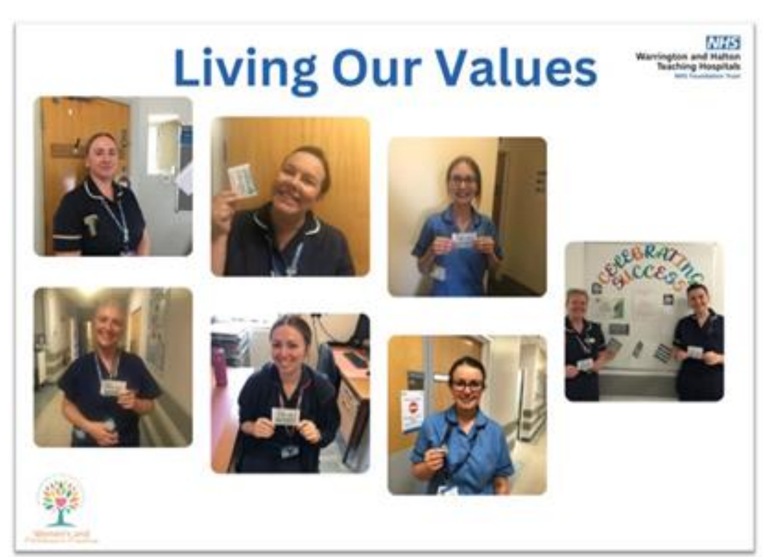
b) Pregnancy Bookings completed <13 weeks –trajectory for improvement in place –on track

a) Post-partum haemorrhage >1500mls

Maternity Improvements and Next Steps



Improvements Identified
Neonatal Unit awarded Green at FiCare accreditation visit 20/7/2023
Identification of small for gestation babies - detection rates above national average
Significant reduction in repeat newborn blood spot screening
Optimisation of BadgerNet EPR supporting outstanding care



Next Steps

- Relocation of Maternity triage August 2023
- Relocation of Induction of Labour services
- Implementation of learning from NHSE Perinatal Cultural & Leadership Programme
- Continued population health workstream activity

Urgent and Emergency Care

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Mock Inspection undertaken 22 June 2023
- Detailed action plan in place – progress tracked weekly through Executive led meeting
- Action plan includes work to be undertaken by estates
- Priority plan in place – includes regulatory risks from 2019
- Triage also area of focus

Crowding in the emergency department must be reduced so that patients do not have to wait on trolleys in corridors **Regulation 12(2)(b)**
Patients whose clinical condition is at risk of deterioration Regulation 12(2)(a)(b)
Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons to ensure patient safety. To include all professional groups. Regulation 18 (1)
Ensure that systems and processes are in place and effective to assess, monitor and drive improvements in the quality and safety of services provided. Regulation 17

- Mock inspection Urgent Care Centre (Halton) and Frailty Unit (Warrington) August 2023

Formal Maternity Inspection 14th September 2023

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- High Level Feedback following inspection:
  - Areas for Improvement Improvements

Staff articulation of Enhanced Care	Staff articulation of Transitional Care

Areas of Good Practice Identified

Positive culture across units	Positive experience reported from women/birthing people

- No specific risks or concerns were escalated by the CQC inspection team on the day of inspection
- Letter received from the CQC on 22nd September 2023, detailing the following as **significant concerns**
  - Enhanced Care
  - Transitional Care
  - Postpartum haemorrhage rates
- Additional evidence was submitted at the request of CQC within timeframe
- Further meeting held with CQC on 29th September 2023 to discuss content of the Trust letter of response which has been submitted.
- 5 whistle blowing entries received during the inspection period.

Additional Areas of Focus M20

Fragile Services

- Audiology
- Urology
- Gynaecology
- Fractured Neck of Femur
- Opthalmology

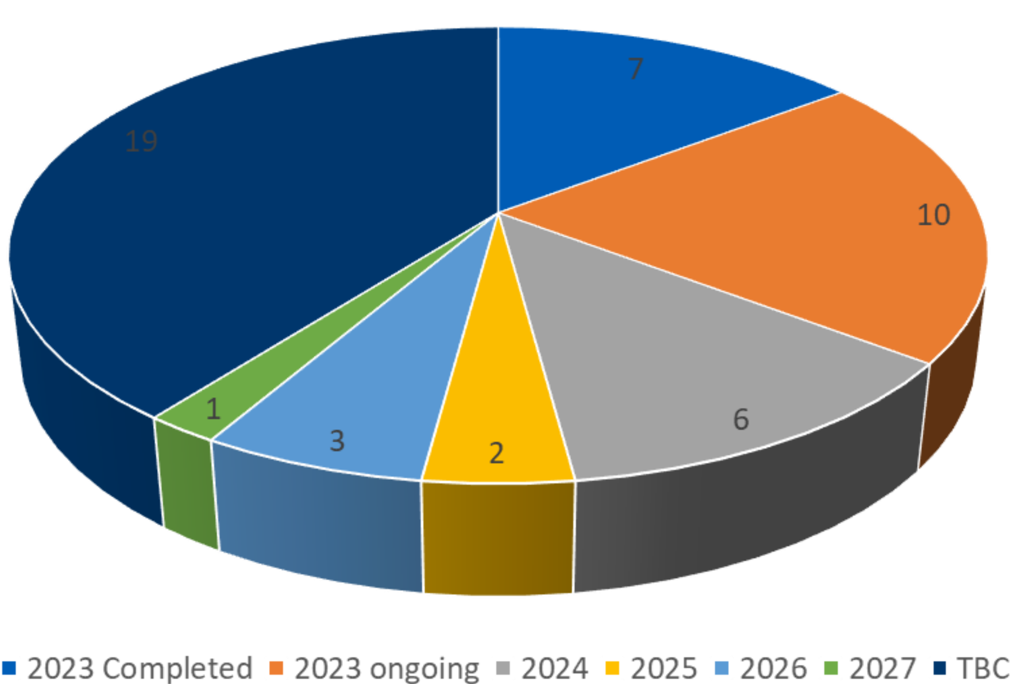
Medicines management

- Staffing deficits
- Medicines reconciliation
- Omission of medicines
- Meeting oversight structure under review

- Monitored at Quality Assurance Committee and Patient Safety and Clinical Effectiveness Sub Committee
- Medicines management also monitored as part of Integrated Performance Report

Accreditation and Peer Review Position Statement

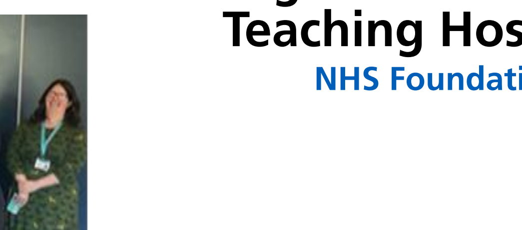
46 Accreditations & Reviews



Scheduled assessments for the remainder of 2023

Department	Accreditation/Review
Estates & Facilities	• Environmental Health Officer • PLACE • Estates Survey
Pathology	• ISO15189 UKAS Medical Laboratories(9563) • ISO15189 UKAS Medical Laboratories(9561) • ISO15189 UKAS Medical Laboratories(9560)
Workforce Equality Diversity & Inclusion	• Stonewall Diversity Champions • NHS Rainbow Badges • Veterans Covenant Healthcare Alliance • Anti-Racist Framework

Good News Stories



Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

North West Coast: Research and Innovation Awards. Research Delivery Team of the Year.

Your Future Your Way –Shortlisted for Excellence in Organisational Development.

Active Hospital shortlisted for award from HSJ

Introduction of ED CT scanner.

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="4">BM/23/10/119</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Fragile Clinical Services</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="4">4 October 2023</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="4">Paul Fitzsimmons, Executive Medical Director</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="4">Paul Fitzsimmons, Executive Medical Director</td></tr>
<tr><td rowspan="3">LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="3">SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.</td><td>√</td></tr>
<tr><td colspan="3">SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future</td><td></td></tr>
<tr><td colspan="3">SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.</td><td></td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):

(Please DELETE as appropriate)</td><td colspan="4">#1215 If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards.
#115 If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.
#1134 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff
, reduced patient experience and reputational damage</td></tr>
<tr><td rowspan="10">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td rowspan="2">1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="2">2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="2">3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table>

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">This paper aims to provide assurance with regards to the Trust’s oversight of Fragile Clinical Services.

A high-level update is provided on the services currently designated as fragile:
Gynaecological surgery
Urology
Paediatric Ophthalmology
Orthopaedics – Fractured Neck of Femur</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
√</td><td>Approval</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">Trust board is asked to:
- Note the current list of Fragile Services and associated high level progress updates
- Note the de-escalation of Ophthalmology – ARMD from fragile service oversight
- Receive further Fragile Services reports</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="3"></td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="3"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/23/10/119

1. BACKGROUND/CONTEXT

Following recognition of a need for a systematic oversight mechanism for Fragile Services the oversight of these services via PSCESC has been trialled from March 2023. Following iterative development, a formal process for oversight of Fragile Services has been incorporated into the PSCESC Agenda reporting to QAC since July 2023.

For the purposes of the Fragile Services Oversight program the Trust defines a Fragile Service as: 'A service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with reference to patient safety and risk of harm'.

This report aims to provide a high-level overview of services currently identified as being Fragile.

2. SERVICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

None

3. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Gynaecological Surgery

- Demand and capacity issues – driven predominantly by workforce issues with some diagnostic equipment pressures (hysteroscopes – now resolved)
- 4 incidents of moderate harm identified (Jan – Sept 23) which have been subject to appropriate investigation and Duty of Candour has been discharged. No new harm identified since previous report to board.
- Service has recovered its 2WW position – monitored daily.
- Completed Actions
  - Full compliment of hysteroscopes now purchased and in service.
  - Gynaecological surgery capacity supported by approved elective c-section revenue request.
- Current mitigations
  - Insourcing and WLI as appropriate/available
  - Waiting list validation process underway
  - Daily 2WW performance tracker in place
- Ongoing improvement plan actions:
  - Consultant posts to advert – interviews 12/10/23
  - Triage/Advice and Guidance workstream
  - Individual job plan reviews informed by demand/capacity exercise

Urology

- Demand and capacity issues – driven predominantly by workforce issues and increased demand.
- 2 incidents of moderate/severe harm identified which have been subject to appropriate investigation and Duty of Candour has been discharged. No new harm identified since previous report to board.
- Ongoing risk of harm remains given P2 and surveillance cystoscopy backlogs.
- Service exceeding clinical activity targets (109% of 19/20 activity in August 2023)
- Completed Actions
    - Revenue requests approved for additional medical staff
    - Increased endoscopy cystoscopy capacity by 40/week
    - 30 WLI sessions approved
- Current mitigations
    - Robust stent register process in place
    - Hot stone list implemented at Warrington site
    - Short term increase in capacity through WLI sessions
- Ongoing improvement plan actions:
    - Mutual aid request to C&M Hub and WWL
    - Insourcing proposal in development
    - 3 Middle grade and 1 consultant post out to advert

Ophthalmology - Paediatric Ophthalmology

- Demand and capacity issues – driven predominantly by workforce issues
- Significant consultant workforce issues
- No harm identified to date
- Current mitigations:
    - Monthly review of all high risk and 17 week plus patients
    - Regular interim orthoptic/optometry review if potential risk to sight
    - Re-prioritisation as clinically indicated by patient level risk
    - Agreement with Specialist Trust to support undated patients on operative waiting list
    - Agreement with specialist Trust to accept paediatric emergencies and any patients deemed at risk of sight loss requiring surgery
    - Additional activity from external consultant as available
- Ongoing improvement plan actions:
    - Recruitment – 2 consultant posts out to advert
    - Further negotiation with Specialist Trust underway regarding mutual aid for listed and dated patients
    - Capital request in development for Retinal Screening Camera to increase capacity for Retinopathy of Prematurity screening

Orthopaedics – Fractured Neck of Femur

- Demand and capacity issues – driven predominantly by increased demand, increased pressures on bed base and insufficient theatre capacity for Trauma workload
- Significant improvement in month across majority of performance indicators
- Prompt surgery remains a significant challenge
- Current mitigations:
  - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
  - Additional orthogertiatrican and orthogeriatric fellow in post
  - Additional ad hoc fractured neck of femur list utilising bank locum consultant
- Ongoing improvement plan actions:
  - Focused improvement plan to deliver 'prompt surgery'
  - Agreement of ringfencing process to allow direct admission to specialist ward

4. FRAGILE SERVICES DE-ESCALATED FROM OVERSIGHT SINCE LAST BOARD

Ophthalmology - AMD/Medical Retina

- Demand and capacity issues – driven predominantly by increased demand.
- 2 cases of moderate harm identified March 2023 - subject to appropriate investigation and Duty of Candour, no subsequent identified harm due to mitigating actions.
- Current mitigations have allowed the service to provide assurance that there has been no shortfall in capacity for the last quarter.
- Medium- and long-term sustainability plan now in delivery phase with successful recruitment to meet increased demand.
- Recommendation to step de-escalate from Fragile Service Oversight to Performance Review Group Oversight supported at PSCESC September 2023.

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services and associated high level progress updates
- Note the progress made in Ophthalmology AMD/Medical Retina allowing de-escalation from Fragile Services Oversight
- Receive further Fragile Services Oversight reports

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/10/120**
SUBJECT:	2022-2023 Annual Submission to NHS England North West Appraisal and Revalidation and Medical Governance
DATE OF MEETING:	4 October 2023
AUTHOR(S):	Anne Robinson, Deputy Medical Director
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#1114** If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with

<table>
<tr><td></td><td colspan="4">its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety
#1757 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff
#125 If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns
#145 If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.
#1579 If the North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the Trust may not be able to transfer patients with time critical urgent care needs to specialist units which may result in patient harm</td></tr>
<tr><td rowspan="10">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td rowspan="2">1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="2">2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="2">3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="4">This report provides assurances to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust.

Doctors who practise medicine in the UK must be registered and hold a licence to practise Both registration and licensing are delivered by the GMC.</td></tr>
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<tr><td></td><td colspan="4">Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All doctors have a legal obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practise

Most licensed doctors are supported with their appraisal and revalidation through connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes a recommendation to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most, or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details'.

The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Anne Robinson.

The responsible officer must:
1. Make sure doctors have access to appraisal systems and processes for collecting and holding information
2. Make a recommendation to the GMC every five years, indicating whether the doctor is up to date, fit to practise and should be revalidated.

The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that a doctor must present. Doctors at WHHFT collate their supporting information using SARD - a web-based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval
√</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to approve the 2022-2023 Annual Submission to NHS England North West Appraisal and Revalidation and Medical Governance</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Strategic People Committee</td></tr>
</table>

	Agenda Ref.	SPC/23/09/126
	Date of meeting	20 September 2023
	Summary of Outcome	The Strategic People Committee supported the report for approval at Trust Board on 4 October 2023.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

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Introduction:

The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Warrington and Halton Teaching Hospitals NHS Foundation Trust
What type of services does your organisation provide?	NHS

	Name	Contact Information
Responsible Officer	Dr Anne Robinson	Anne.robinson9@nhs.net
Executive Medical Director	Dr Paul Fitzsimmons	paul.fitzsimmons1@nhs.net
Medical Appraisal Lead	Dr Hilary Furniss	hilary.furniss@nhs.net
Appraisal and Revalidation Manager	Mrs Kate Davidson	kate.davidson4@nhs.net
Additional Useful Contacts	Miss Paula Harris	paula.harris6@nhs.net
	Mrs Andrea Stazicker	andrea.stazicker@nhs.net

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Not Applicable

If yes, who is this with?

Organisation: **Please describe arrangements for Responsible Officer to report to the Board: NA** **Date of last RO report to the Board:** **Action for next year:**

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	308
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	244
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	46 (includes appraisal meetings not due within that time frame, new to the Trust, new to the NHS/UK, and long term sickness, maternity, sabbatical)
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	18 (includes some late appraisals following transition to new appraisal and revalidation system and several inactive Bank doctors who had left but not appeared on a leavers report)
Total number of appraisers as at 31 March 2023?	73

*A missed appraisal is an appraisal that is not completed, and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	41
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	36
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	5

Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	0

Section 3: Medical Governance Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	1
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	0
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	0
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	0

Organisational Policies

List your policies to support medical appraisal and revalidation	Implementation date	Review date
Medical Appraisal Policy to support GMC Revalidation 2023	01/08/2019	31/05/25 (being reviewed currently to update re SARD)
Appraisal and Revalidation Group (ARG) ToR	01/02/2022	18/07/2023
Revalidation Policy	01/08/2015	01/08/2023
Medical Workforce 360 Multisource Feedback Assessment SOP	01/08/2023	31/07/2025
Medical Workforce New Starter for Medical Appraisal and Revalidation Purposes	01/07/2022	01/07/2025
SARD SOP	01/07/2023	01/07/2026
Information Requests to WHH Responsible Officer SOP	12/01/2015	01/08/2023

List your policies to support MHPS and managing concerns	Implementation date	Review date
Resolving Workplace Issues	01.12.2021	30.11.2024
MHPS	30.09.2022	30.09.2023
Disciplinary	01.07.2021	30.06.2024
Supporting Performance Improvement	01.12.2021	30.11.2024
Supporting Attendance	03.04.2023	02.04.2026

Other relevant policies	Implementation date	Review date
Equality, Diversity, and Inclusion	01.08.2022	31.05.2025
Conflict of Interest	01.05.2023	01.05.2025
Annual leave for medical and dental staff	30.11.2022	30.10.2024

How do you socialise your policies?
Policies are displayed on the Trust Extranet and links are embedded in the SARD platform. Some policies (i.e., supporting attendance) are supported by training or awareness workshops. Some policies have intranet resource pages i.e., job planning. Any updated policies are highlighted in weekly staff bulletin and link provided to Trust extranet

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes Dr Anne Robinson continues as Responsible Officer (RO) RO Training completed in September 2021 RO attends the North West Higher Level Responsible Officers Network (NWHLRO) update on a quarterly basis supported by AMD and Revalidation Lead.
Action for next year (1 April 2023 – 31 March 2024). Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes The Responsible Officer is supported by: a. An Associate Medical Director (AMD) – Dr Hilary Furniss (3 PAs) b. A Revalidation Lead, Andrea Stazicker – 80% WTE c. A Medical Workforce Development Administrator - Paula Harris 1 WTE d. Medical Education Manager - Kate Davidson, who manages the Revalidation Lead and Medical Workforce Development Administrator in addition to duties in Medical Education. e. Band 3 clerical support – Sosanna Thomas 1 WTE to facilitate cross-cover and support and avert single points of failure in working practices. The Trust currently provides SARD an on-line platform for the management of all doctors' annual appraisals including 360-degree MSF in every 5 year cycle to support the necessary colleague and patient feedback for revalidation The Trust's appraisers are remunerated 0.125PAs per 4 appraisees or 0.25 for more than 4. The Trust supports appraisers with initial training, refresher training and 2 update forums annually
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? Connections to, and removals from, the Designated Body are managed by the Revalidation Lead. Lists of connected doctors and revalidation dates are shared and stored in electronic format in a secure area of the Trust server, which is accessible to ARG members, and updated monthly. The Appraisal and Revalidation group have reviewed and developed policies relating to medical staffing as per actions: • Annual review of Revalidation Policy and Medical Appraisal Policy complete • SOP for Medical Workforce New Starter for Medical Appraisal and Revalidation -to facilitate improved information sharing between the two departments -to support correct and prompt recognition and assignment of doctors, in particular locum doctors. • SARD SOP
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024).

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review?

The RO and AMD have links to the NWHLRO network. They attend NWHLRO forums supported by the Revalidation Lead to keep up-to-date and discuss topical issues, comparing regional practises, and ensuring standard practices are observed.

National changes to appraisal and revalidation from the GMC and NHSE are communicated electronically to the RO and disseminated to the ARG Team.
ELA from GMC – meet quarterly and communicates changes. ELA has also attended an Appraiser Forum update meeting in 2022, with positive feedback

All ARG policies have been reviewed 2022-23 due to a change of online appraisal platform. During COVID peer reviews were deferred however the Trust is planning to undertake a peer review late 2023- early 2024 and LUHFT and have been approached and agreed to support. We will also be discussing with other Trusts.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes
The Trust employs locum, bank and short-term placement doctors to fill operational gaps in rotas. This can present some challenges in maintaining oversight of their appraisal and revalidation needs. Some of the junior doctors are unaware of the requirements for appraisal and revalidation but since last year, we have continued to make progress in identifying and contacting these doctors earlier, finding out their previous appraisal history, and planning their appraisals ahead. This has resulted in a more effective system.
Many trainees take years out of training and work variable hours in the Trust in a variety of named posts, (including 'Trust Grade', 'Trust Bank Doctor', 'LAS', 'Clinical Fellow', 'FY3', 'FY4' etc') and locum in all of these grades. They take these posts in pursuit of increased flexibility, freedom from the structure of a training programme, no exams and to have less rigid and shorter hours.
The Appraisal & Revalidation Group receive monthly updates of new starters, leavers, doctors on periods of prolonged leave. A 'change of assignment' category was added in 2021, which aims to identify more accurately the exact capacity in which doctors are employed, for example change from temporary to permanent contract.

The Trust also employs oral surgeons who also work in dental practices, or Trusts, but are supported with study leave allowance, and learning opportunities. They are not subject to GMC revalidation, but the Trust supports their appraisal, mandatory training and CPD to maintain their

recognition by the General Dental Council. Governance information is received and reviewed from their other employers.

The Trust's Physician Associates appraisals follow a similar process to the medical appraisal process in readiness for when they are regulated by the GMC. They have their own separate online appraisal system (from the same provider), which is tailored to better suit their needs.

The International Training Fellows (ITFs) are a group of doctors who also fulfil appraisal and revalidation. There is a designated ITF administrator. The team contact these employees to ensure they are aware of the requirements for A&R, provide contact details, appraisal guidance document, and contacting ITFs with relevant information.

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

Early identification of this group of doctors together with the allocation of an appraiser help support their appraisal and revalidation. These doctors are encouraged to attend any Trust development opportunities e.g., teaching, governance meetings, training, quality improvement opportunities and audit sessions. They are given access to the appraisal and revalidation team who explain the requirements for revalidation and how to use the appraisal documentation.

Emails are used to disseminate information to new doctors, both general and individual.

One to one meetings (either face to face, vis Teams or by telephone) are arranged as required to help tailor the process for individuals.
There is ongoing doctors' development project work to provide introductory information on availability of CPD, development courses, appraisal and revalidation.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes

The Trust has migrated onto a new online platform which incorporates the MAG 2022 model.

Support was provided to all Doctors during the migration process which included,

- Weekly emails including reminders and comprehensive instructions for each step.
- Data checking to ensure all Doctors had taken the steps outlined and individual tailored support where potential gaps were identified.
- Regular accessible training sessions, including drop in options with varying times and days.
- Link provided to You Tube video recording of training session
- Agenda item at appraiser forums, and Medical Cabinet (Senior Medical Leaders forum held bi-weekly)
- Back up information storage solution to maintain NHS retention schedule and support colleagues.

All doctors are annually offered an appraisal, which reviews supporting evidence and reflection on • Quality improvement, • Continuing education, • Feedback from colleagues and patients, • Compliments, • Serious incidents, complaints and claims A WHH Appraisal Preparation crib-sheet is provided and updated annually to outline requirements, particularly on focussing the appraisal, quality not quantity, and presenting evidence at the meeting rather than uploading. The Trust Governance Dept provides information on serious incidents, complaints and claims and this is uploaded to appraisal folders for reflection. An Independent Sector Checklist and/or Letter of Good Standing is expected for all work external to WHH. All appraisees and appraisers receive individual feedback and guidance regarding their appraisal.
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

No
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

- Migration onto a new online platform which incorporates MAG 2022, and 360 MSF feedback into one system
- Review of processes for non-responders
- Review of the appraisal policy and related policies and SOPS
- Annual new appraiser training
- Annual refresher appraiser training
- Review of processes and update of Standard Operating systems (SOPs) in conjunction with the new online appraisal, revalidation and 360 MSF system

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

- Peer review with 2/3 neighbouring Trusts
- Doctors' development portfolio- The RO, AMD for A&R and the Medical Education Manager are working with the Trust's organisational development team to summarise the development opportunities that are available to doctors on joining the Trust. It is anticipated to be complete by the end of September 2023.
- Appraiser and Appraisee Q&A
- Survey of appraisers and appraisees regarding new platform to facilitate any further customisation of the platform.
- Development of appraiser QA database to track training and refresher course and forum attendance, their ASPAT (Appraisal Summary And PDP Audit Tool – NHS England) scores and of completing appraisal summaries after meetings. This will be used to provide evidence for the AMD to use in feeding back to individuals and to maintain standards.

5.5 How do you train your appraisers?

A new appraiser course and appraiser refresher course are offered annually, with hybrid options run by MIAD Healthcare. Both group and individual sessions are made available to all.

Medical appraisers in the Trust are offered 2 hybrid appraiser forums annually, to be updated on developments and to exchange views.

All appraisers were provided with the amalgamated feedback scores and comments from their appraisees following their appraisal meetings. These are collated in the on-line platform and sent to appraisers by email.

Since 2020-21, the AMD adds a quality assurance score on appraisal summaries.

For the first time, in autumn 2021 appraisers were informed of PROGRESS scores on their appraisal summaries, alongside the Trust range of scores and mean score for comparison.

Discussion was offered to any appraisers requesting further feedback, and to those who persistently scored below average. During the year an improvement in summaries and in scores has been noted, with a rise in the Trust's overall average score from 15-16 out of a maximum of 20.

This will now be an annual process supported by our new online platform, which allows appraisees to provide electronic feedback regarding their appraisers and for the AMD to use ASPAT for scoring appraisal summaries. This information is then fed back to the appraisers and can be discussed on individual basis to maintain appraisal standards.
The AMD is available for one-to-one advice for appraisers for individual problems or issues.

Quarterly feedback to Medical Cabinet re Appraisal and Revalidation issues.

5.6 How do you Quality Assure your appraisers?

The ARG team have continued to track appraisal completion and collate completion data. Overdue appraisals are reported to CBU Clinical Directors or Clinical Leads, and Business Managers, to encourage timely completion.

Doctors completing their appraisal make an evaluation, score within the online system on their appraiser and the organisation of the process. Appraisers receive this feedback. General themes are fed back to appraisers during forum meetings.

Appraiser performance QA reports and scores are shared with them, as detailed above, for reflection and discussion, and to drive improvement.
A new database of appraisers has been set up to track training and refresher course and forum attendance, their ASPAT scores and timeliness of completing appraisal summaries after meetings. This will be used to provide evidence for the AMD to use in feeding back to individuals and to maintain standards. One to one meetings will be arranged with outlying appraisers and plans made to support and improve standards, if required. Persistently poorly performing appraisers may be removed from the appraiser list.

5.7 How are your Quality Assurance findings reported to the board?

Appraiser QA reports are to be included in the High-Level Briefing paper from the Appraisal and Revalidation Group which is provided to Operational People Committee (OPC) quarterly in line with the meeting schedule and feeds into Board. Appraiser QA process also included in the Annual Appraisal and Revalidation and Medical Governance submission which is shared in the ARG Annual SPC report and then subsequently to Board following approval. Annual Board presentation in September/October.

5.8 What was the most common reason for deferral of revalidation?

The deferral reasons were equally split between the five doctors deferred.

1 x lack of appraisal activity, 1 x incomplete 360° Multi-Source Feedback and the remaining 3 doctors were deferred for both lack of appraisal activity and incomplete 360° MSF.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

All colleagues are treated on an individual basis with particular circumstances considered when entering into discussions. Regular reminders are sent out via the SARD electronic platform, and one to one meetings are offered to support confidential discussions and create personal support plans to provide the best opportunity to engage with the process.

The Trust prioritises shared understanding of the objectives behind appraisal ensuring the exercise is meaningful and achieves intended outcomes bringing continued professional development to the forefront.

If, following the offer of support mechanisms above, engagement continues to be an ongoing concern, a face to face appointment is schedule with the RO in line with the escalation process.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

Regular contact is maintained between the appraisal and revalidation group and the Governance department.

The governance department supply information on request.

- Three reports for annual appraisal documentation relating to any serious events in which the doctor has been named in the appraisal review period. Ongoing claims are reported and any complaints which remain unresolved. Reflection on each area is expected in appraisal documentation and should be covered in appraisal discussion.
- Reports to inform the Revalidation Panels in supporting revalidation recommendations, which contain all serious incidents and ongoing claims
- Ad-hoc reports to inform governance requests on individual doctors.

To help monitor case management across the organisation the Trust has the following in place:

- Regular triangulation meetings attended by the Medical Director, RO, senior representatives of Human Resources, Governance department, and the AMD for Appraisal and Revalidation. No decisions about case management are made at these meetings. They are used to discuss progress on investigations and open or emerging cases or issues. No notes of these meetings are kept but the tracker (referred to below) is updated with the current position.
- A tracker in the form of an excel spread sheet which gives brief details of 'live' matters being considered and their current status. This is used to keep track of progress and for reporting at Revalidation Decision Making panels. Access to the tracker is on a restricted basis.
- Regular progress reports on all Employee Relations cases [anonymous basis], are made to the Operational and Strategic People Committees. These committees are held bi-monthly, and the regular reports are presented at each meeting.

  If alerts are raised by colleagues or via National database audits – these are actioned accordingly

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

Regular progress reports on all Employee Relations cases [anonymous basis], are made to the Operational and Strategic People Committees. These committees are held bi-monthly, and the regular reports are presented at each meeting. Equality information is analysed and where numbers allow this data is reported, where case numbers fall below 6 and data is not sufficiently able to be anonymised, this is monitored outside of formal reporting.

6.3 How do you ensure that any concerns are managed with compassion?

The Trust values include kindness and senior leaders are trained in compassionate leadership. Principles of just and learning culture are embedded into the formal process documents.

Training which is inclusive of just and learning culture awareness is provided to those with a formal role within Trust employee relations and specifically MHPS processes.

Compassionate leadership training is available to all Trust management staff. The training included a recent lecture on compassionate leadership at the Trust Quality Academy meeting by Professor West.

All concerns are taken seriously and, following investigation, results fed back to those who have raised concerns.

The Trust has an ongoing compassionate leadership program externally facilitated and available across the working including for all levels of medical staff.

All those nominated for undertaking a role within formal employee relations processes are trained to undertake the role for which they are appointed.

The Trust employee relations policies include measures in support of just and learning culture including minimum use of suspension, regular suspension reviews, timeline requirements for review to ensure case delays are minimised and managed. Clear responsibilities for communication. Options for welfare referrals to occupational health where required by any stakeholder within employee relations processes.

Support for all case roles including hearing chairs, case managements and investigation officers by qualified HR professionals,

6.4 How do you Quality Assure your system for responding to concerns?

Medical Triangulation meetings are conducted on a monthly basis chaired by the Medical Director and attended by the Trust RO; these are supported by HR Business Partners.

Case oversight meetings are conducted on a monthly basis by the Trust Chief People Officer.

Lesson learned processes are conducted on a regular basis for employee relations case management processes, including case management for medical staff groups.

Formal reporting that is inclusive of quality measures such as timeline to resolution, case patterns/ themes and outcome are presented to the strategic people committee on a bi-annual basis.
A process of regular case debriefs, and lesson learn processes are undertaken for review of formal case management.

6.5 How if this Quality Assurance information reported to the board?

Feedback is included within employee relations reports presented to both the operational people committee and strategic people committee in anonymised formats.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

There is a recognised process for sharing information between Responsible Officers (RO) via a Medical Practice Information Transfer form (MPIT) which is provided by NHS England.

This is the way in which we request information for new starters to WHH from their previous employer's RO and is also the way in which we respond to requests we receive to provide information regarding doctors who have previously worked at WHH.

However, the MPIT process is not restricted to when doctors change employers and we use this process to share information of note about a doctor as and when the need arises. An example of this would be when a doctor works at WHH as well as an independent healthcare provider and there is information of note which our RO needs to share.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The Trust has a robust process for undertaking equality impact assessments for all policy developments these are subject to scrutiny by the ratification committee and reviewed on a cycle of at least every three years.

This process includes a review of protected characteristics, socioeconomic factors, health inequalities and the Armed Forces and Military Veterans community. This ensures that there is no

negative / adverse impact on the grounds of a protected characteristics. In addition, this highlights opportunities for positive impact to ensure processes are free from bias and discrimination.

A quality assurance process is completed by the Workforce Equality, Diversity and Inclusion Team.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

Introduction of SARD to the Trust- a much more user-friendly electronic platform which has 360 MSF feedback as an integral part of the documentation

– Governance reports cannot be amended or removed from the SARD documentation by individuals.

- SARD also includes the ability to quality assure appraisers of the quality of their appraisals

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

- Further development and utilisation of the appraiser QA database to track training and refresher course and forum attendance, their ASPAT scores and timeliness of completing appraisal summaries after meetings. This will be used to provide evidence for the AMD to use in feeding back to individuals and to maintain standards.
- Development of an electronic portfolio of available opportunities to allow discussion /challenge at appraisals - The Trust has reviewed its Doctors development package and opportunities including the most effective format and timeframe to target this discussion. Work is ongoing into creation of a portfolio of offerings to be specifically targeted at new Doctors starting at the Trust but available and proactively shared with our existing Doctors also. This will be compiled of information pertaining to their ongoing development including, Appraisal and Revalidation, Leadership, Group specific Training, and available posts including education faculty opportunities. We hope this will prove a supportive resource which improves our recruitment and retention as a Trust who proactively develops our workforce.
- Introduce peer review with neighbouring Trusts LUHFT and other Trusts have been approached and agreed to support.
- Introduction of the new Patient Safety and Incident Response Framework into the Trust from 1/9/23, will see much more of a focus on system-based learning from incidents with more time spent on the quality improvement work. One would expect this change to slowly be reflected in the appraisal documentation.
- Scheduled review of the MHPS policy and procedure, this will include review of the associated equality impact assessment.

The GMC have just released updated 'Good Medical Practice standards' which in addition to the existing standards, include new focus on behaviours and culture. They will be introduced into the Trust in Jan 2024, and we will work to ensure the standards are embedded into the Trust and included in appraisal documentation.

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

The system for ensuring pre-employment checks including qualifications and professional registrations are undertaken for fixed term/permanent doctors is completed via the Trust employment services team. In order that professional/clinical staff can fulfil their role, the vast majority are required to be registered with their regulatory body before they can practice. This is a contractual requirement, and it is an explicit term in the contract of employment. It is the responsibility of the Employment Services team prior to commencement to check the Alert Letter File which identifies professional staff who may have action pending against them and with the relevant regulatory body, usually via their website, that they are appropriately registered. Prior to commencement, the Employment Services team will check that the individual is included on the relevant professional register of the regulatory body using their unique on-line service. Details of the confirmation are entered onto the ESR system. The Trust has a separate Professional Clinical Registration Policy which contains further details. Locum, bank and agency staff require the same employment checks as those undertaken for permanent staff. Warrington and Halton Hospitals NHS Foundation Trust use approved agencies established under the 'Buying Solutions Framework Agreement'. Pre-employment checks form part of the Agreement and all agencies on the framework undertake all pre-employment checks for temporary staff they employ and only supply staff who comply with the terms of the Agreement. Buying Solutions regularly audit, via a rolling programme, these agencies and this evidence is provided to the Supplies Department as part of the Agreement. This information is maintained and available for reference via the Trust Recruitment and Selection Policy

Do you collate EDI data around recruitment and /or concerns information?

Yes
If yes, how do you use this information? The organisation collates equality and diversity information as part of the recruitment process. This is collected voluntarily by candidates at the application stage and then a further opportunity is offered at the pre-employment stage. During employment, individuals are able to self-declare their equality and diversity information at any stage. This information is reported on as part of the Trust Workforce Equality and Diversity Monitoring Report and Workforce Race and Workforce Disability Equality Standards reporting. This information is then used to develop action plans for improvement to ensure that there is no disproportionate impact on recruitment processes based on a protected characteristic.

This information is available via the Equality, Diversity and Human Rights section on the Trust website: https://whh.nhs.uk/about-us/corporate-publications-and-statutory-information/equality-diversity-and-human-rights

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

Section 2 Appraisal and Revalidation data – With the introduction of the new SARD system accurate data on appraisal and revalidation will be readily available at any point in time and as required.
Section 3 Organisational Policies – In 2023 all policies have been reviewed to coincide with the introduction of the new SARD system. In some cases, this was not in line with the review period documented but was required to reflect the changes to systems and processes. There has also been the introduction of some additional SOPs to clarify SARD related processes and responsibilities.
Section 4 General Information - The board / executive management team can confirm that Dr Robinson will continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings. Staffing is reviewed and responsibilities clarified in line with any changes to processes. **Section 4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained -** Connections to, and removals from, the Designated Body are managed by the Revalidation Lead in line with the revised policies and SOPs. **Section 4.4 Peer review -** During COVID peer reviews were deferred however the Trust is planning to undertake a peer review late 2023- early 2024 and LUHFT have been approached and agreed to support along with other Trusts. **Section 4.5 and 4.6 Locum or Short term placement Doctors** - There a process in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation are supported. Specific processes and additional supportive measures have also been identified and developed for other target groups including, dental and oral surgeons, Physician Associates and International Training Fellows.
Section 5 Appraisal Information - The Trust has successfully migrated onto a new online platform SARD which incorporates the MAG 2022 model. **Section 5.3 Good Practice and Improvements April 2022-23–** • Migration onto a new online platform which incorporates MAG 2022, and 360 MSF feedback into one system • Review of processes for non-responders

- Review of the appraisal policy and related policies and SOPS
- Annual new appraiser training
- Annual refresher appraiser training
- Review of processes and update of Standard Operating systems (SOPs) in conjunction with the new online appraisal, revalidation and 360 MSF system

Section 5.4 Plans for future improvements/changes April 2023-24 -

- Peer review with 2/3 neighbouring Trusts
- Doctors' development portfolio- The RO, AMD for A&R and the Medical Education Manager are working with the Trust's organisational development team to summarise the development opportunities that are available to doctors on joining the Trust. It is anticipated to be complete by the end of September 2023.
- Appraiser and Appraisee Q&A
- Survey of appraisers and appraisees regarding new platform to facilitate any further customisation of the platform.
- Development of appraiser QA database to track training and refresher course and forum attendance, their ASPAT (Appraisal Summary And PDP Audit Tool – NHS England) scores and of completing appraisal summaries after meetings. This will be used to provide evidence for the AMD to use in feeding back to individuals and to maintain standards

Section 5.5 Training for Appraisers –

- Training is provided annually for new appraisers and refresher training for existing appraisers.
- Appraiser forums are hosted twice a year with feedback to appraisers.

Section 5.6 and 5.7 QA of Appraisers –

- SARD allows appraisees to feedback regarding their appraiser and for the AMD to score appraisal summaries and PDPs documented by appraisers through the ASPAT process.
- A new appraiser database for QA purposes is being developed and overseen by the AMD and RO allowing feedback to individuals.
- Appraiser QA reports are to be included in the High-Level briefing papers provided to OPC from the appraisal and revalidation group.

Section 5.8 and 5.9 engagement –

- Regular reminders are sent out via the SARD electronic platform, and one to one meetings are offered to provide support.

Section 6 Medical Governance –

- Individual governance reports of incidents, complaints and claims are included in the supportive information for discussion and reflection at appraisal.
- Triangulation meetings occur monthly attended by the Medical Director, RO, senior representatives of Human Resources, Governance department, and the AMD for Appraisal and Revalidation to discuss individual cases.

- Regular progress reports on all Employee Relations cases [anonymous basis], are made to the Operational and Strategic People Committees
- There is a recognised process for sharing information between Responsible Officers (RO) via a Medical Practice Information Transfer form (MPIT) which is provided by NHS England.

Section 6.8 Medical Governance good practice –
Introduction of SARD to the Trust- a much more user-friendly electronic platform which has 360 MSF feedback as an integral part of the documentation.

- Governance reports cannot be amended or removed from the SARD documentation by individuals.
- SARD also includes the ability to quality assure appraisers of the quality of their appraisals

Section 6.9 Medical Governance Plans for improvement –

- Appraiser QA database
- Development of an electronic portfolio of available opportunities to allow discussion /challenge at appraisals
- Introduce peer review with neighbouring Trusts
- Introduction of the new Patient Safety and Incident Response Framework
- Scheduled review of the MHPS policy and procedure, this will include review of the associated equality impact assessment.

Section 7 Employment Checks - The system for ensuring pre-employment checks including qualifications and professional registrations are undertaken for fixed term/permanent doctors is completed via the Trust employment services team.

Section 9: Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body.

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ……………………………………………………………….

Name: ………………………………………………………………………………………………

Role: ……………………………………………………………………………………………..

Date: ……………………………………………………………………………………………..

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/121**	
SUBJECT:	**Freedom to Speak Up**	
DATE OF MEETING:	4 October 2023	
AUTHOR(S):	Jane Hurst, Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#1757** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#125** If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	

<table>
<tr><td rowspan="9">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td rowspan="2">1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td>✓</td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="2">2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td>✓</td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes
✓</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="4">During 2022/23 the Freedom to Speak Up (FTSU) team managed 42 disclosures (compared to 20 in 2021/22). The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD to support individuals and teams to resolve the issues that are highlighted. In the first quarter of 2023/24 there has been 6 disclosures (compared to 17 in 2021/22).

The FTSU team continues to engage with medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to make them aware of FTSU.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
✓</td><td>Approval</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to note to progress on FTSU</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Strategic People Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="3">20 September 2023</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="3">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/23/10/121

1. BACKGROUND/CONTEXT

During 2022/23 the FTSU team managed 42 disclosures (compared to 20 in 2021/22). The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD to support individuals and teams to resolve the issues that are highlighted.

In the first quarter of 2023/24 there has been 6 disclosures (compared to 17 in 2021/22). The FTSU team continues to engage with medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to make them aware of FTSU.

2. KEY ELEMENTS

Table 1 sets out the number of disclosures for the last 2 years and Q1 of 2023/24:

Table 1 Number of disclosures

	2021/22	2022/23	2023/24
Quarter 1	4	17	6
Quarter 2	8	5	TBC
Quarter 3	6	13	TBC
Quarter 4	2	7	TBC
Total	**20**	**42**	**6**

Table 2 sets out how cases are grouped:

Table 2 Types of disclosures

	2021/22 Q1 – Q4	2022/23 Q1 – Q4	2023/24 Q1
Behaviour, culture and relationships	15	31	5
Process	2	3	1
Patient safety	1	5	
Staff levels / patient care	2	2	
Communication		1	
Total	**20**	**42**	**6**

There have been no patient safety concerns raised in quarter 1. Any patient safety issues are escalated immediately to the Chief Nurse & Deputy Chief Executive.

The Freedom to Speak up Guardian (FTSUG) and Champions continue to present at events across the Trust, in particular to the rotational doctors, preceptorship staff and international nurses. October is National FTSU month, the theme is removing barriers to speaking up. We will be raising awareness of FTSU through Safety Huddle, Good Morning WHH, ward visits and stalls at both Warrington 6th October and Halton 12th October.

The Trust Board received an interactive training session on FTSU at the May Trust Board development day, with a follow up session in July on the reflective tool which incorporated the Trust Board's input from the May session.

The FTSU guardian has undertaken the national refresher training and the champions have been asked to complete the Electronic Staff Record (ESR) FTSU training.

3. MEASUREMENT / EVALUATION

In 2022/23 FTSU guardians nationally handled over 25,000 cases; a record number which highlights how valued guardians are as a route to speaking up.

The national team has published its survey of FTSU guardians (**Appendix 1**). The survey highlighting 84% of guardians who responded said that their organisation is working to tackle the barriers to speaking up. However, there is a sharp decline in their perceptions overall that the speaking up culture is improving.

Just over half (54%) said they had enough time to carry out their FTSU guardian role. In addition to supporting workers who speak up, guardians also need time for the proactive part of their role, identifying and tackling barriers to speaking up; yet 48% spent the majority of their time responding to workers, a reflection on the increased number of cases being raised to guardians.

As a Trust it has been recognised that the FTSU guardian role needs more dedicated time and has been advertised for expression of interest as a two day a week role.

The Speak Up data from Q1 2023/24 is now available to view on the National Guardians Office - NGOwebsite. 6,673 speak up cases were raised with guardians in Q1 2023/24 according to the figures reported to the NGO; a similar number of cases reported compared to the previous quarter (6,759 cases) and a 21.5% increase compared to the same quarter last year.

Just under two-fifths of cases (37.5%) included an element of inappropriate behaviours and attitudes (other than bullying and harassment) and almost a third of cases (31.3%) included an element of worker safety or wellbeing. Almost 1 in every 25 cases reported to guardians are from workers indicating that they have suffered detriment after speaking up.

It should be noted that as the Trust reviews the findings from the Lucy Letby case the role FTSU plays in the Trust will be considered and amended as appropriate.

4. LESSONS LEARNT

In 2022/23 the Trust saw an increase in disclosures post pandemic with a return to normal, but with the added pressure of recovery and ongoing fatigue from the pandemic. The data shows that there is an increase in disclosures in Q3 after the FTSU month when staff are reminded about FTSU, which supports the decision to increase the allocated time of the guardian. This will enable more engagement with staff across the Trust.

It was clear in the FTSU Board sessions that the Board members want to ensure the Trust has a speak up culture and the FTSU is a part of that.

5. RECOMMENDATIONS

The Trust Board is asked to note the progress of Freedom To Speak Up.

LISTENING TO GUARDIANS

Freedom to Speak Up Guardian Survey 2023

July 2023

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About us

The National Guardian’s Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC’s report “The Freedom to Speak Up” (2015).

Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The National Guardian’s Office leads, trains and supports a network of Freedom to Speak Up guardians in England and conducts speaking up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector.

There are over a thousand guardians in NHS and independent sector organisations, national bodies and elsewhere that ensure workers can speak up about any issues impacting on their ability to do their job.

Freedom to Speak Up guardians

Freedom to Speak Up guardians support workers to speak up and work within their organisation to tackle barriers to speaking up.

NHS trusts and providers of NHS care subject to the NHS standard contract must appoint a Freedom to Speak Up Guardian and follow the National Guardian's Office's (NGO) guidance on speaking up. Other organisations have also introduced the Freedom to Speak Up Guardian role.

Acknowledgements

Thank you to all the Freedom to Speak Up guardians who participated in this survey. We are grateful for their commitment to improvement and generosity of time. Their feedback provides valuable insights into the speaking up landscape across England's healthcare system.

We also thank Picker Institute Europe for their expertise and support in running the survey.

Foreword

Since the National Guardian's Office first survey of guardians in 2017, the Freedom to Speak Up network has grown significantly. From 200 guardians, mainly in NHS trusts, there are now over 1,000 guardians working across healthcare, including primary medical services, hospices, the independent sector, and national bodies. This growth signifies the increasing recognition of the importance of Freedom to Speak Up for all organisations who want to do their best for colleagues and for people using services.

The survey takes a temperature check of the speaking up culture within organisations as perceived by Freedom to Speak Up guardians. Through their role of listening to workers and speaking truth to power, guardians have a unique insight into the health of the Speak Up culture in their organisations.

This temperature check serves as an early warning sign of cultural issues in the sector. Our report looking at the results can serve as a tool for improvement by highlighting areas of concern that impact upon worker wellbeing, retention, and ultimately, the quality and safety of care and services.

Freedom to Speak Up culture

In previous years, a consistent majority of guardians who responded - ranging from 82 per cent in 2018 to 73 per cent in 2021 - believed that the Freedom to Speak Up culture in healthcare was improving. But this year's survey reveals for the first time that those who think there has been an improvement are in the minority (45%).

While the majority of responding guardians still hold a positive view of the culture within their own organisations, there has been a decline in the number of guardians who perceive improvement internally over the past year. Over three quarters of the Freedom to Speak Up guardians who responded (78%) said speaking up was taken seriously in their organisations, but this figure was down six percentage points compared to results in 2020.

This decline in perceptions concerns me, as it should all leaders, whether they are providers, regulators, or government. So much work has been undertaken since the Freedom to Speak Up Review[1], but I fear that in this atmosphere of huge challenge for the sector, we are not always hearing what matters, and what can help us improve – the voices of our people.

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[1] http://freedomtospeakup.org.uk/the-report/

Taking action

It takes time to build trust. These results show that nurturing a Speak Up culture is a long-game. It is positive to note that 84 per cent of respondents said their organisation was taking action to tackle barriers to speaking up, a nine percentage point increase compared to the previous surveys results, and three-quarters of respondents said retaliation as a result of speaking up was not tolerated.

But, speaking up can only be seen as worthwhile if listening up and following up takes place. That is why I am concerned that Freedom to Speak Up guardians' responses reflect those of the National Staff Survey: that a sense that speaking up for too many may seem futile and is fast becoming the most significant barrier to making speaking up business as usual.

Almost two-thirds of respondents (66%) identified the concern that nothing will be done was a barrier to workers in their organisation speaking up. This is an eight percentage point increase compared to responses to the previous survey (58%) and puts feelings of futility on a par with the fear of detriment as the main barrier to speaking up.

As one Guardian said: *"… it is hard in conversations with those who speak up about safe staffing levels as there isn't the available staff and whilst short term fixes are generally found the bigger long-term issue is not addressed and… Speaking Up feels futile."*

Freedom to Speak Up Guardian wellbeing

This is having an impact on the wellbeing of guardians, who as a result are feeling that they are not always meeting the needs of the workforce. While the overwhelming majority feel valued by workers, there was a seven-percentage point fall in those who thought they were meeting their needs, down from 72 per cent in 2021/22 to 65 per cent in 2022/23. Some of the cases which guardians hear are complex and emotional; people may be feeling angry and distressed. Sometimes there are complex mental health issues involved, feelings of suicide, experiences of sexual harassment. Forty-four per cent said that the role had reduced their health and wellbeing, so clinical supervision and adequate support is essential.

For guardians to fulfil their role effectively, meaningful support from leaders is vital. This means not only providing them with the necessary time and resources, but also ensuring that they are supported emotionally and with sufficient training, including the time to keep up to date with their mandatory training from the National Guardian's Office.

As the Freedom to Speak Up Guardian network develops, we are seeing an increased professionalisation in the role. Encouragingly, there are positive movements in terms of increased investment in terms of time and banding, but we would like to see this considered more consistently across the sector.

Despite these challenges, eight out of ten guardians who responded said they would recommend the role to a friend or colleague. In the words of one Freedom to Speak Up Guardian: *“I feel satisfied that I am helping others, especially when they have no one else to turn to. The job can be difficult and draining sometimes but knowing that people can come to us for support makes it worthwhile.”*

To me, this underlines the qualities of those who step up to undertake this important, but often isolating role – their openness to listen to all workers and their resilience in speaking truth to power in the most challenging of circumstances.

In order to reap the benefits which speaking up can bring, it is vital that it is welcomed as a tool for improvement. Yet Freedom to Speak Up guardians are reporting a decline in how valued they feel by managers and senior leaders, which is now at a four-year low.

This response from one guardian highlights the impact of these systemic issues: *“Staff in the NHS and healthcare are on the brink of crash and burn. Depression, anxiety, stress and burnout are at their highest levels. Staff are scared to raise concerns and ignored when they do. Managers feel that as the guardian is in post they don't have to do anything. Senior leaders are the same. If I challenge I am shot down and belittled, I have no fight left in me. I can’t do any more.”*

This is painful to read, and as the National Guardian, I too am raising my voice to call for urgent action to be taken to focus on the wellbeing of the workforce. Our report highlights the need for continuous attention to nurturing a speak up culture. This responsibility falls on everyone, requiring each conversation and action to contribute to fostering an environment where speaking up is highly valued and heard. It cannot be solely reliant on the efforts of Freedom to Speak Up guardians. Their role alone cannot drive the transformation of the speaking up culture in healthcare. It is only by us all making this our own personal responsibility, that we can make speaking up business as usual.

Dr Jayne Chidgey-Clark

National Guardian for the NHS

Key findings

Speak up culture

- Forty-five per cent of respondents said that there had been an improvement in the speaking up culture in the healthcare sector over the last 12 months. Over a quarter (26%) said the speak up culture in healthcare had deteriorated. This was a sharp decline compared to previous years when most respondents consistently reported improvements in the speaking up culture in the healthcare sector (73% 2021, 80% 2020).
- Fifty-nine per cent of respondents said the speaking up culture in their organisation had improved over the last 12 months. Twelve per cent said it had deteriorated. In comparison, three quarters of respondents in the previous survey said the culture in their organisation had improved in the preceding 12 months.
- Almost three-quarters of respondents (74%) said that senior leaders supported workers to speak up, a three-percentage point decrease compared to the results of the previous survey (71%, 2021).
- Over half of respondents (51%) said managers supported workers to speak up. Fifteen per cent disagreed.
- Sixty-nine per cent of respondents said that speaking up was used in their organisation to identify learning and make improvements. Sixty-seven per cent agreed that there was assurance about the speaking up culture and arrangements, and a plan to improve it.

Barriers to speaking up

- Fifty-one per cent of respondents said workers in their organisation felt safe to speak up about anything that concerned them.
- Three-quarters of respondents (75%) said that disadvantageous and/or demeaning treatment as a result of speaking up was not tolerated in their organisation. Nonetheless, most respondents (66%) perceived the fear of detriment as having a noticeable or very strong impact as a barrier to workers in their organisation speaking up.
- Two-thirds of respondents (67%) identified futility (i.e. the concern that nothing will be done) as being a 'noticeable' or 'very strong' barrier to workers in their organisation speaking up. This was an eight percentage point increase compared to responses to the previous survey (58% 2021).
- Eighty-four per cent of respondents said their organisation was taking action to tackle barriers to speaking up, a nine percentage point increase compared to the previous survey's results (75%, 2021).

- Two thirds (66%) of respondents described the actions taken to tackle barriers as somewhat or very effective, down 14 percentage points since the results of the previous survey (80%, 2021).

Freedom to Speak Up Guardian role

- 78% said they would recommend the role to a friend
- Forty-four per cent (44%) of respondents stated that the role had reduced their health and wellbeing, either somewhat or greatly. This is a decrease of five percentage points compared to the results of the previous survey, (49%).
- Three-quarters (74%) of respondents felt valued by senior leaders, down nine percentage points (83% 2021). Two-thirds felt valued by managers, down six percentage points (72% 2021).
- Ninety-six per cent of respondents felt valued by the individuals who came to them for support and 85 per cent felt valued by workers in their organisations more generally. However, there was a seven percentage point fall in those who thought they were meeting the needs of workers in their organisation, down from 72 per cent in 2021 to 65 per cent in 2023.
- Seven out of ten (70%) respondents had some ring-fenced time to carry out their role (66% 2021, 70% 2020). Among those supporting NHS trusts, that figure rose to 84 per cent.
- A quarter of the respondents had more than four days per week of ring-fenced time. Among those supporting NHS trusts, 40 per cent had more than four days per week to carry out their role, an increase of 14 percentage points since the 2021 survey.

Section 1: About this survey

For the last six years, we have annually surveyed Freedom to Speak Up guardians in order to gain insight into the implementation of the Freedom to Speak Up guardian role and how this could be improved.

Respondents' feedback has helped us assess developments since the launch of the Freedom to Speak Up guardian role and identify and prioritise improvements that we may need to make to support the Freedom to Speak Up network.

This report focuses on Freedom to Speak Up guardians' answers to the 2023 Freedom to Speak Up Guardian survey.

Please see here for reports from our previous surveys.

In response to feedback from Freedom to Speak Up guardians, we moved the 2022 survey from September – October to January – February 2023. We invited 950 Freedom to Speak Up guardians to participate in the survey, which was open from 12 January to 9 February 2022. Almost 40 per cent (39%, or 368 guardians) of those invited took part in the survey.

All survey questions were voluntary, and so the number of responses to each question varied. Results are shown as a percentage of the total number of responses to each question.

Please see here for the Freedom to Speak Up Guardian Survey 2023 Question List.

The reference sheets containing the results for these sections of the report are available here

All references in this report to Freedom to Speak Up guardians refer to Freedom to Speak Up guardians registered and trained by the National Guardian's Office.

Our survey included questions to gather respondents' perspectives on our support and offers for Freedom to Speak Up guardians. We will share these results with the guardians later this year.

Among Freedom to Speak Up guardians, a minority (45%) provide support to NHS trusts. The majority of Freedom to Speak Up guardians support other types of organisations, such as independent healthcare providers and primary medical services. However, despite this distribution, the voices of these non-NHS trust Freedom to Speak Up guardians remained underrepresented in our survey, with the majority of respondents (58%) supporting NHS trusts.

Freedom to Speak Up Guardians supporting primary medical services (PMS)[2]

Fourteen per cent of Freedom to Speak Up guardians trained and registered with the National Guardian's Office support primary medical services (PMS). In comparison, Freedom to Speak Up guardians that support PMS accounted for five per cent of those participating in our survey.

Even where guardians are in place in primary medical services, levels of speaking up to them remains low.

The updated national Freedom to Speak Up policy and updated Freedom to Speak Up guide and improvement tool apply to primary care, secondary care and more widely in health and care systems. The National Guardian's Office and NHS England have also issued information clarifying the expectations of integrated care boards (ICBs) and integrated care systems (ICSs)[3] in relation to Freedom to Speak Up.

Building on our work exploring the introduction of the Freedom to Speak Up Guardian role in Primary Care and Integrated Settings[4], the National Guardian's Office and NHS England have been working with Freedom to Speak Up guardians and a group of ICBs to better understand the successes and practical challenges of Freedom to Speak Up in primary care with a view to creating a menu of support for organisations and integrated care systems.

Based on this work, we plan to share further information by 31 March 2024 about the precise expectations of ICBs in regard to Freedom to Speak Up for primary care workers and across their system.

Most Freedom to Speak Up guardians support organisations regulated by England's health and social care regulator, the Care Quality Commission (CQC). The CQC gives one of four ratings to services: outstanding, good, requires improvement, and inadequate.

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[2] Primary medical services includes general practice, community pharmacy, dental, and optometry (eye health) services

[3] https://www.england.nhs.uk/ourwork/freedom-to-speak-up/integrated-care-boards-integrated-care-systems-and-freedom-to-speak-up/

[4] https://nationalguardian.org.uk/2021/06/03/exploring-freedom-to-speak-up-in-primary-care-and-integrated-settings/

Half of respondents (50%) supported organisations rated good or outstanding overall by the CQC - see figure 1.[5]

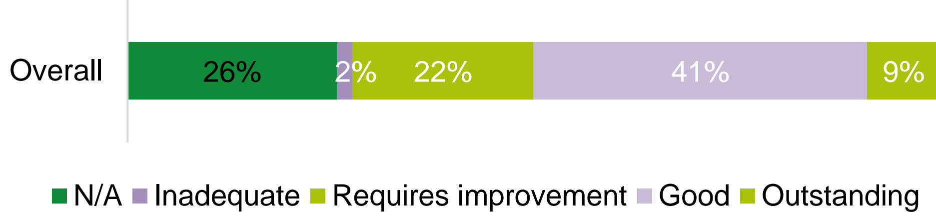

Figure 1. Responses by CQC Ratings

Forty-six per cent of respondents supported organisations with fewer than 5,000 workers, whereas 14 per cent supported 'large' organisations with more than 10,000 workers – see figure 2.

We did not have data for organisation size for 10 per cent of respondents.

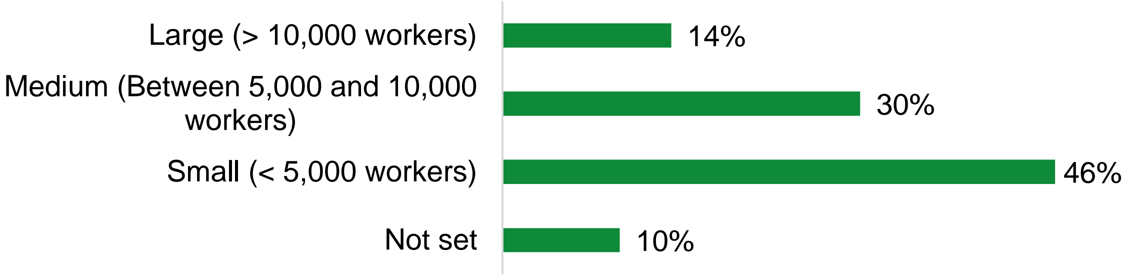

Figure 2. Responses by size of organisation

Respondents included Freedom to Speak Up guardians from organisations based in all regions, as well as multi-regional or national organisations.

[5] Figures with response options selected by fewer than five respondents have been suppressed to protect participants' anonymity.

Section 2: Speak Up culture and arrangements

A healthy speaking up culture is characterised by an environment where everybody feels safe, supported, and empowered to raise concerns, share ideas, and contribute to the improvement of the organisation.

We asked respondents to share their views as to whether and how the speak up culture in the healthcare sector and in their organisation specifically had changed in the preceding 12 months.

In previous years, a consistent majority of respondents said that the speaking up culture in the healthcare sector had improved – ranging from a high of 82 per cent in 2018 to 73 per cent in 2021. For the first time, respondents who reported an improvement in the speak up culture in the healthcare sector were in the minority – see figure 3.

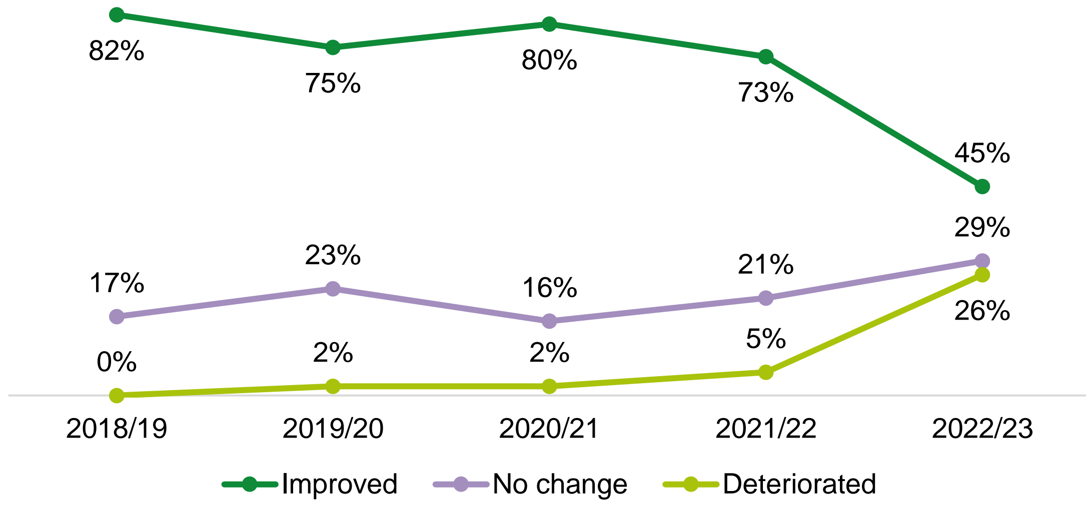

Figure 3. Freedom to Speak Up culture has improved in the last 12 months in the healthcare sector

Forty-five per cent of respondents said the Freedom to Speak Up culture in healthcare had improved in the last 12 months. Over a quarter (26%) said it had worsened.

Figure 4 (below) demonstrates a similar decline in the percentage of respondents who reported an improvement in the Freedom to Speak Up culture of their own organisation over the past 12 months. Fifty-nine per cent of respondents said the culture had improved, down from 75 per cent in 2021. Twelve per cent said it had deteriorated, up from five per cent in 2021.

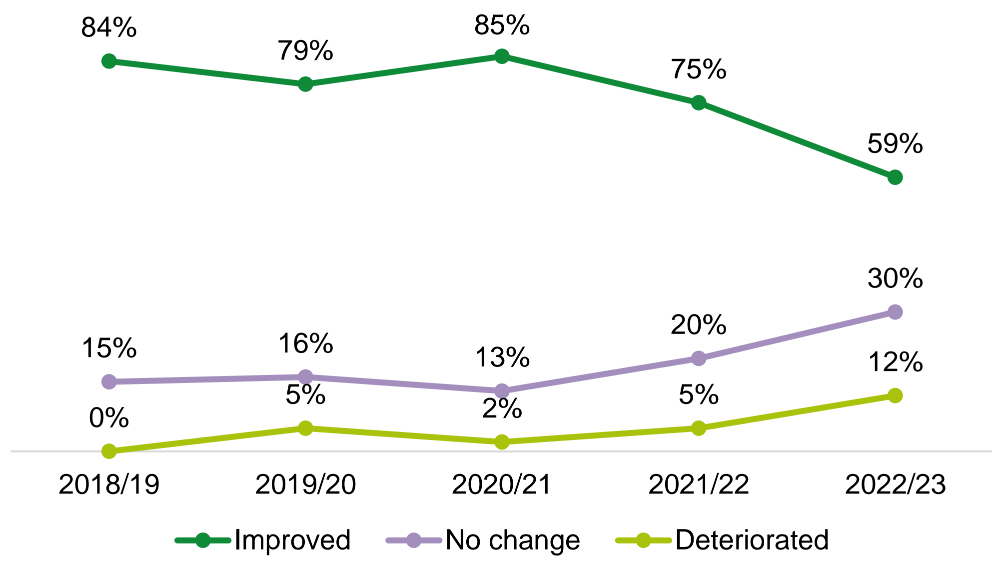

Figure 4: Freedom to Speak Up culture has improved in the last 12 months in my organisation

More encouragingly, two-thirds (66%) of respondents said their organisation had a positive culture of speaking up which is an increase of seven percentage points from 2021 – see figure 5.

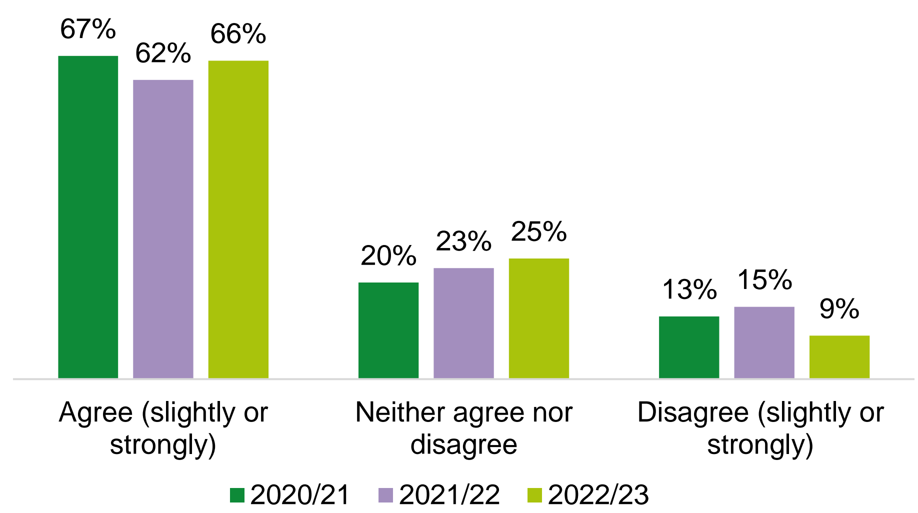

Figure 5: Organisation has a positive culture of speaking up

While most respondents (78%) said speaking up was taken seriously in the organisations they were supporting, this figure was down six percentage points compared to results in 2020 – see figure 6.

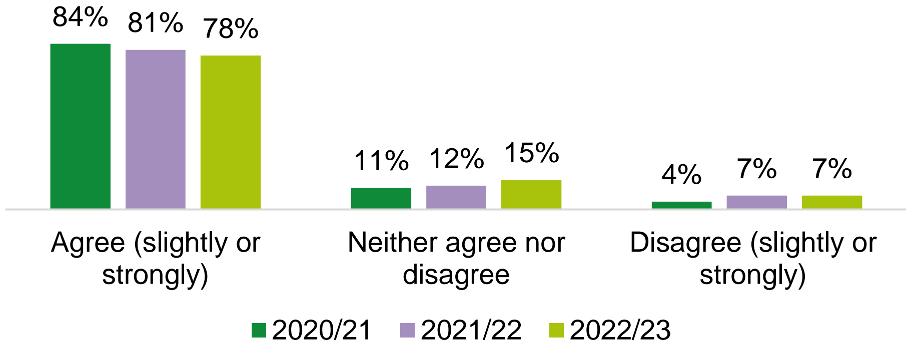

Figure 6: Speaking up is taken seriously in the organisation I support

Respondents shared their perception of the various aspects of speaking up culture and arrangements in their organisations, which we have grouped thematically as:

1. Knowledge, ability and the feeling of safety
2. Listening and acting
3. Learning and improving

Knowledge, ability and the feeling of safety

In a healthy Speak Up culture, workers need to know how to speak up, be given the means to do so and feel safe to voice their views.

Knowledge

When we asked respondents about the extent to which not knowing how to speak up acted as a barrier for workers in their organisation, four in five (80%) stated that it had very little or no impact – see figure 7. This suggests that respondents generally believed that workers in their organisation possessed the knowledge of how to speak up.

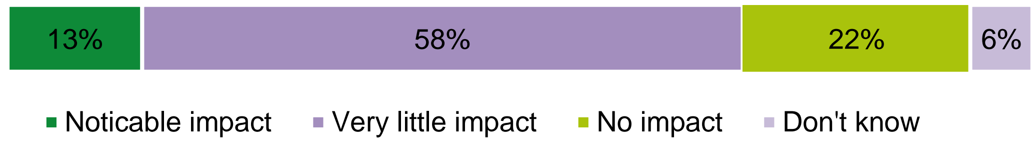

Figure 7: Not knowing how to speak up as a barrier (2022/23)

Ability

Workers also need to have the means to be able to speak up. What this looks like will depend on the individual organisation; for example, some workers may not have access to a computer in an otherwise computer-centric organisation, others may be excluded due to shift-patterns.

Almost two-thirds (65%) of respondents perceived this as having little or no impact as a barrier to speaking up for workers in their organisation – see figure 8.

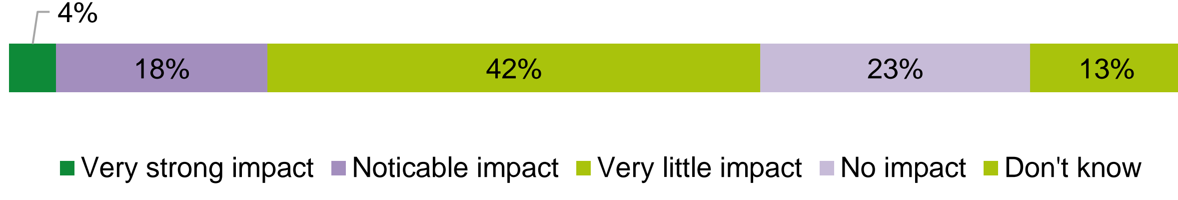

Figure 8: Working arrangements as a barrier (2022/23)

Feeling safe

In comparison to their responses regarding the knowledge and means of workers in their organisation to speak up, a reduced percentage of respondents – 51 per cent - indicated agreement when asked about whether workers felt *safe* to speak up about anything that concerned them in their organisation – see figure 9[6]

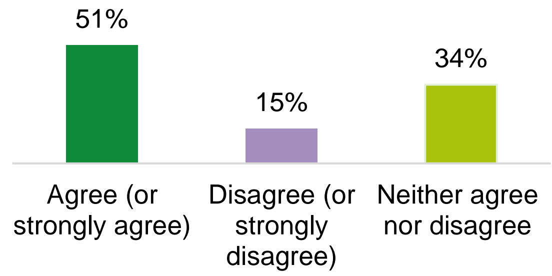

Figure 9. Workers feel able to speak up about anything that concerns them (2022/23)

Being able to speak up without suffering detriment – without any disadvantageous or demeaning treatment resulting from speaking up - is vital to the feeling of safety.[7]

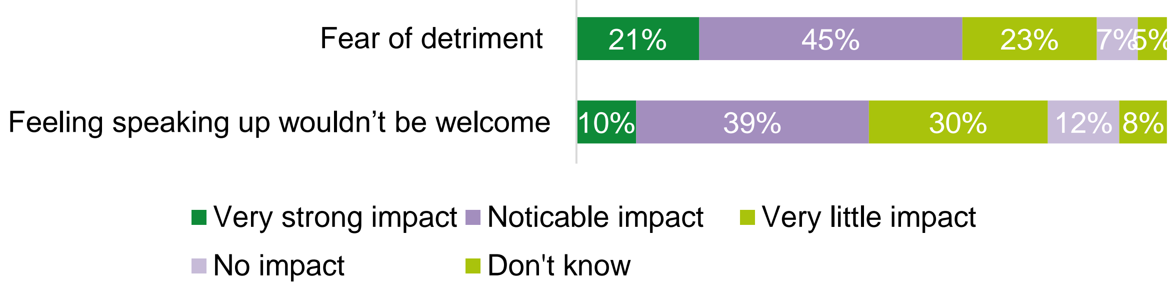

Figure 10. To what degree do the following act as barriers to speaking up for workers in your organisation? (2022/23)

Three-quarters of respondents (75%) said that disadvantageous and/or demeaning treatment as a result of speaking up was not tolerated in their organisation. Despite this, two-thirds of respondents (66%) perceived the fear of detriment as having a noticeable or very strong impact as a barrier to workers in their organisation speaking up. Almost half of respondents (49%) thought that feeling that speaking up

[6] When we asked about respondents' views on whether workers in their organisations felt safe to speak up about any concerns, it was explicitly clarified that this included workers who faced barriers to speaking up due to their protected characteristics.

[7] Disadvantageous and demeaning treatment due to speaking up may include being ostracised, given unfavourable shifts, overlooked for promotion, or moved from a team. It can be a deliberate act or a failure to act (i.e., an omission).

would not be welcome had a noticeable or very strong impact as a barrier – see figure 10, above. Respondents shared information about steps being taken to tackle detriment:

”Board development session on the "fear of speaking up and detriment" - a number of actions being put in place to afford more protection to staff, root out the areas where speaking up is not welcomed and identify problem areas.”

”Openly talking about zero tolerance of detriment.”

‘Case study which has been used to educate management the detrimental effects/barriers to speaking up of FY1[Junior doctor]’

‘Team meeting attendance explaining confidentiality and we will not tolerate adverse reactions to those who speak up’

Characteristics

Respondents shared their views as to the extent to which attitudes towards certain characteristics acted as a barrier to workers in their organisations speaking up – see figure 11.

- **Professional hierarchies:** This year a greater proportion of respondents said that attitudes to professional hierarchies were a barrier to speaking up.
- **Seniority:** Similar results as for professional hierarchies.
- **Protected characteristics:** Over a third (34%) of respondents said that attitudes towards protected characteristics have an impact on workers feeling able to speak up.

Figure 11: To what degree do the following act as barriers to speaking up for workers in your organisation? Attitudes towards...

Recording characteristics

Understanding the characteristics of the person speaking up can potentially shed light on barriers to speaking up. These may include 'protected characteristics' such as age, gender, ethnicity, or sexual orientation, as well as other factors like the person's contractual relationship (for example, students, agency workers, volunteers) or their work shift patterns (for example, night shift workers).

Collecting this information can help organisations understanding of the reach of the Freedom to Speak Up Guardian across the organisation and identify groups that may be using the Freedom to Speak Up Guardian route more or less frequently.

For the first time, we included a question in our survey regarding whether respondents record information about the protected characteristics of individuals who speak up to them, and if so, which characteristics they record.

Figure 12. Which of the following characteristics of the workers who speak up do you keep a record of? (2022/23)

Overall, respondents had varying approaches to collecting and recording worker characteristics, influenced by factors such as relevance, capacity, and appropriateness. At least half of the Freedom to Speak Up guardians who responded said they collected information on ethnicity (53%) and gender (50%), respectively. Forty-two per cent (42%) of respondents did not collect information on protected characteristics.

Several said they did not keep a record of these characteristics due to low number of cases, limited capacity, or the perceived lack of relevance. Some respondents mentioned not seeking or recording this information for every worker speaking up, focusing only on relevant characteristics related to the cases being raised and only recorded this information if it was shared or deemed appropriate. Certain characteristics, such as age, ethnicity, or sexual orientation, were not always asked for, especially if the worker was distressed.

Some Freedom to Speak Up guardians who responded mentioned that there were challenges in collating the data and keeping records of these characteristics.

Where information was captured, some reported that this was volunteered or disclosed during initial discussions with a worker speaking up. Many respondents asked workers to provide information on their characteristics through feedback forms or satisfaction surveys but acknowledged that not everyone provided this information. Some mentioned future plans to collect information from other sources, such as the Electronic Staff Record (ESR).

Recording Cases and Reporting Data: Guidance for Freedom to Speak Up Guardians

In accordance with guidance from the National Guardian's Office (NGO), Freedom to Speak Up guardians are required to maintain records of all cases of speaking up that are raised with them. These records serve several purposes, including helping guardians keep a comprehensive track of the issues brought forward and the actions taken in response.

The NGO plans to conduct a review of its guidance in collaboration with Freedom to Speak Up guardians and other stakeholders this year (2023-24). This review aims to enhance the guidance and ensure its alignment with the evolving needs of a growing and diverse Freedom to Speak Up Guardian network as well as good practices in promoting a culture of speaking up.

Listening and acting

In previous surveys, we observed that smaller percentages of respondents had confidence in managers' support for various aspects of Freedom to Speak Up.[8] When workers need to voice their concerns or share important information, it is often their line managers who they first approach. It is therefore crucial that managers at all levels receive support and training to listen, take appropriate actions and use the received information for learning and improvement. Without this support, managers may respond poorly when employees do speak up, especially if the feedback feels personal or challenges their role.

[8] Freedom to Speak Up Guardian Survey 2020

Listening

Respondents shared their views of the support for workers to speak up among different groups in their organisation (figure 13).

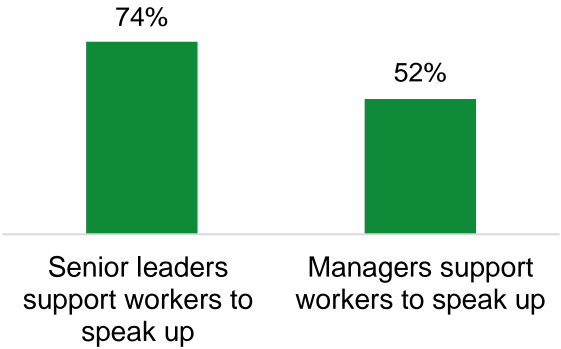

Figure 13: Percentage agreeing with the statements (2022/23)

Almost three-quarters of respondents (74%) thought that senior leaders supported workers to speak up, up three percentage points compared to the last survey (71%, 2021) – though there was a 13 percentage point drop in those who 'strongly agreed' that senior leaders supported workers to speak up – see figure 14, below.

Seven per cent of respondents said that senior leaders did not support workers to speak up. One in five (20%) neither agreed nor disagreed with the statement.

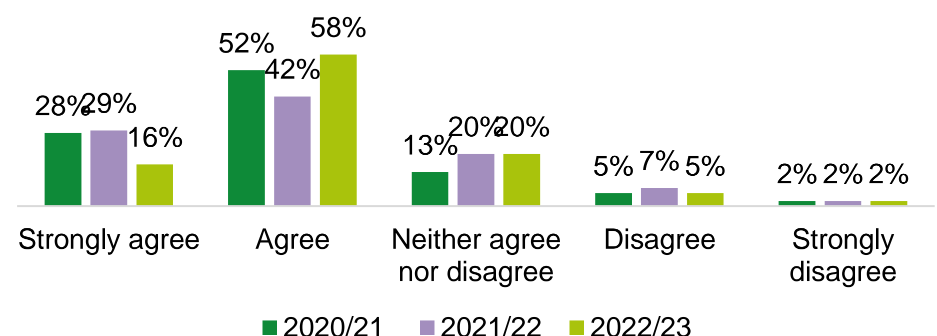

Figure 14:Senior leaders support workers to speak up

A smaller proportion (52%) of respondents said that managers supported workers to speak up – see figure 15, below. Fifteen per cent disagreed and the remaining 33 per cent neither agreed nor disagreed (figure 15).

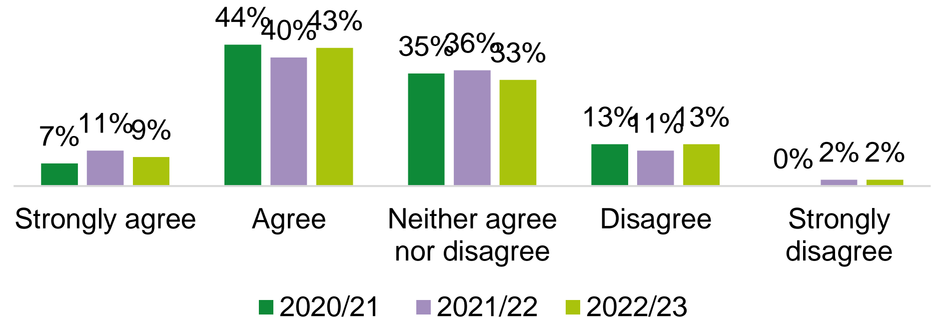

Figure 15: Managers support workers to speak up

Respondents also shared their views on the following aspects of the speaking up culture and arrangements in their organisation – see figure 16, below.

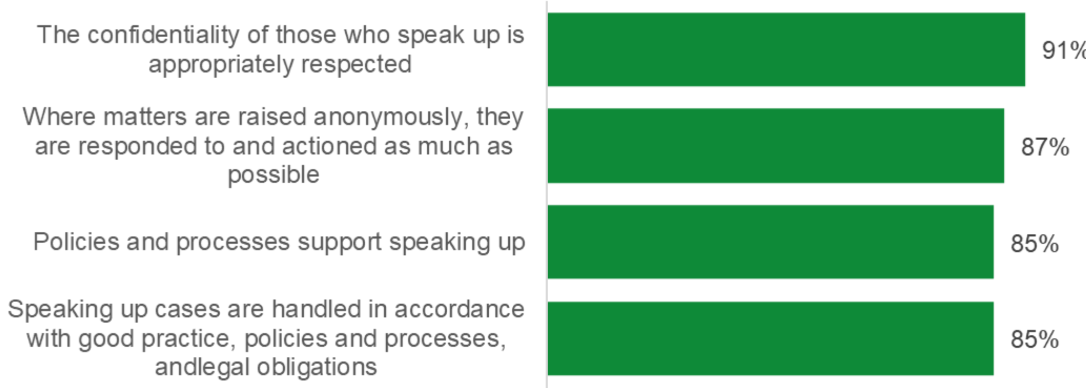

Figure 16: To what extent do you agree with the following statements - % agreed/strongly agreed (2022/23)

Most respondents (91%) said that the confidentiality of those who speak up was appropriately respected and 87 per cent said that matters raised anonymously were responded to and actioned as much as possible.[9]

'Putting minds at rest that there will be no reprisal if colleagues speak up. 100% confidentiality. No finger pointing or singling out. Allowing the culture to speak up is not frightening.'

Eighty-five per cent of respondents said that policies and processes supported speaking up. The same proportion said that cases were handled in accordance with good practice, policies and processes and legal obligations.

[9] Anonymous cases are those where the person speaking up is unwilling or feels unable to reveal their identity to you - you do not know who they are. Where someone speaks up confidentiality, they reveal their identity to someone on the condition that it will not be disclosed further without their consent (unless legally required to do so).

Acting

In this year's survey, there was a 10 percentage point increase in respondents identifying futility – the belief that appropriate action would not be taken if someone spoke up - as having a noticeable or very strong impact as a barrier. Two-thirds of respondents (67%) identified futility as having a noticeable or very strong impact.

Futility has surpassed fear of detriment (66%, 2023) as the barrier most often identified as having a noticeable or very strong impact on workers speaking up.

'… it is hard in conversations with those who speak up about safe staffing levels as there isn't the available staff and whilst short term fixes are generally found the bigger long-term issue is not addressed and… Speaking Up feels futile.'

Eighty-four per cent of respondents said their organisation was taking action to tackle barriers to speaking up, a nine percentage point increase since our previous survey (75%, 2021) – see figure 17.

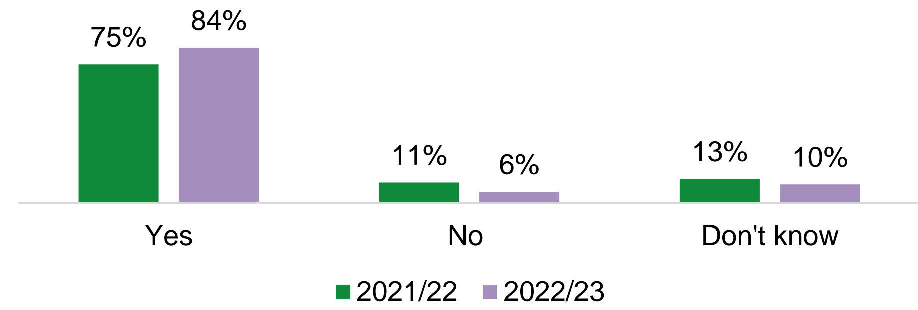

Figure 17: Are organisations taking action to tackle barriers?

Two-thirds (66%) of respondents who said their organisation was taking action to tackle barriers described the actions as somewhat or very effective – see figure 18, below.

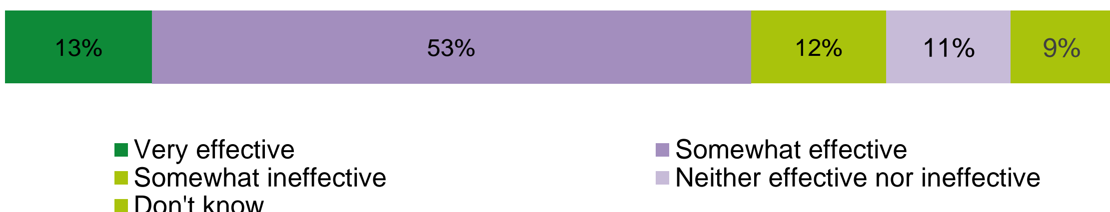

Figure 18. How effective are the actions to tackle barriers? (2022/23)

Learning and improvement

Establishing policies and processes to support speaking up may seem straightforward. However, for policies to translate into culture requires a growth mindset which seeks to foster psychological safety and promotes speaking up as a learning opportunity. By recognising and actively working to address barriers to speaking up, organisations can foster an environment where speaking up becomes a catalyst for positive change and continuous improvement.

Sixty-nine per cent of respondents said that speaking up was used in their organisation to identify learning and make improvements. Sixty-seven per cent agreed that there was assurance about the speaking up culture and arrangements, and a plan to improve it (figure 19).

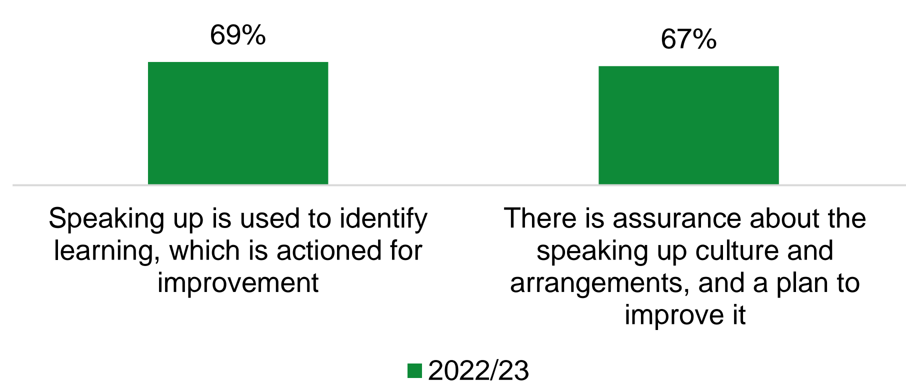

Figure 19: % agreeing/strongly agreeing with the statement

'There is a significant lack of engagement and action from the areas of the organisation that need to be responsive and supportive. They need to be open to learn and improve, as well as to address issues that are impacting people within the workplace otherwise the Freedom to Speak Up role cannot achieve its objectives, and nothing changes for the individuals affected and involved within the organisation. It is very frustrating as a Guardian that we are also being ignored and not heard or supported as a result of this.'

Speaking up is a gift; it is a gift of information which can lead to learning and improvement. The benefits of Freedom to Speak Up can only be realised if leaders and board members are inquisitive about what is presented to them and are keen to embrace the learning which listening to those who speak up can bring.

By seeking assurance about the speaking up culture, leaders can identify areas for growth and develop strategies to address any concerns or challenges. This proactive approach could contribute to positive changes and realise the benefits which listening to workers can bring.

Recommendations

Our findings indicate that, while Freedom to Speak Up guardians reported feeling most workers know how to speak up, there are actual or perceived barriers to them doing so. Respondents identified factors such as a feeling of futility and fear of retaliation as key obstacles affecting workers' ability to speak up. These findings align with the 2022 NHS Staff Survey outcomes, as detailed in our recent report looking at the Freedom to Speak Up (Raising Concerns) sub-score.[10]

Freedom to Speak Up guardians responding to our survey also reported lower levels of agreement regarding managerial support for Freedom to Speak Up, with just over half (52%) saying that managers support workers to speak up. Less than 70% agreed with the statement that there was assurance about the speaking up culture and arrangements in their organisation, including plans for improvement. This is a responsibility for senior leaders, and a governance duty for boards.

The deterioration of confidence noted in both this survey and the NHS Staff Survey, underscores the need for improved understanding of the benefits of speaking up and the responsibilities as leaders of those in management positions.

Our Freedom to Speak Up eLearning[11], developed in association with Health Education England, is for all healthcare workers, managers and leaders to help them understand the vital role they play and the support available to encourage a healthy speaking up culture for the benefit of patients and workers.

In light of these findings, we recommend that leaders:

- **Mandate Speak Up training for all workers, prioritising those responsible for responding to colleagues' concerns.**
  This will equip managers with the necessary skills and knowledge to effectively listen and follow up when workers speak up. It is equally crucial that senior leaders lead by example and undertake this training themselves. To embed this training, discussions with those responsible for responding to workers' concerns should take place post-training to encourage reflection on the learnings and explore practical ways to apply these insights in their roles.
- Working with their Freedom to Speak Up guardians, they should **identify and initiate a plan to address barriers to speaking up** in their organisation, particularly the perception of futility and fear of retaliation.

[10] Fear and Futility: what does the staff survey tell us about speaking up in the NHS? - National Guardian's Office
[11] Training - National Guardian's Office

Section 3: Implementation

Freedom to Speak Up guardians provide an additional route to support workers to speak up, ensuring people are thanked, issues raised are responded to, and feedback given on the actions taken. They also work proactively to help identify and reduce barriers to speaking up, working in partnership with senior leaders to create a climate where speaking up, listening up and following up becomes business as usual.

Organisations determine how the role(s) will be implemented to meet the expectations of the universal job description[12] within the unique context of their organisation.

Appointment

All roles should be appointed based on fair and open competition, and the Freedom to Speak Up Guardian role is no exception. This allows for the appointment of the best candidates and makes it more likely that workers will have confidence in their Freedom to Speak Up Guardian, including their impartiality and ability to handle conflicts of interest.

Eighty-one per cent of respondents said they were appointed through fair and open competition, up three percentage points since 2021 (78%) – see figure 20.

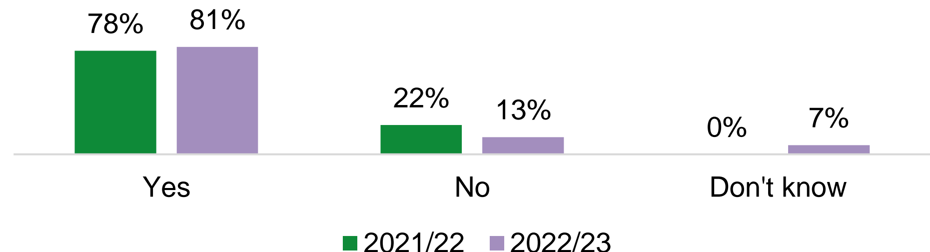

Figure 20. Were you appointed through open and fair competition?

There was a marked difference in responses when broken down by the type of organisation that the respondents supported:

- 92 per cent of respondents supporting NHS trusts stating that they were appointed through an open and fair competition.
- 65 per cent of those supporting other organisations said the same.

This variation is likely attributable to the fact that the guardian role was initially implemented within NHS trusts, resulting in a relatively more mature and embedded position within these organisations, including fair and open appointment of guardians.

[12] Freedom to Speak Up Guardian Job Description

We asked respondents who had not been appointed through fair and open competition to expand on their response. Most of the comments we received indicated that the respondents were individually approached and asked to take on the role. In some cases, this was because their pre-existing role was thought to be closely aligned with the Freedom to Speak Up Guardian role:

'I was directly selected to be Freedom to Speak Up Guardian as the company needed one - I was not given much choice in the matter either, nor offered any benefits for the additional work.'

'Agreed as part of my job description and due to the experience/length of service and how staff perceive me as a trusted confidante.'

Leaders should take proactive measures to ensure that people's protected characteristics, such as ethnicity, do not serve as barriers, either in reality or perception, to becoming a Freedom to Speak Up guardian. This means implementing a fair and open recruitment process with appropriate safeguards against bias. Leaders should consider broader cultural factors and address any potential barriers that may discourage people from applying or considering the role. (See figure 46 which illustrates the ethnic demographic of Freedom to Speak Up guardians who responded to this survey).

Models of Guardian provision

As the Freedom to Speak Up Guardian role has become more embedded within organisations, and leaders have examined the amount of time needed in order for the role to be effective, we have seen different models develop of guardian provision.

We sought information from respondents on these arrangements, including structures and job titles. Broadly, we identified three models based on respondents' feedback:

Model One: Many respondents were the sole guardian in their organisation, sometimes supported by a network of Freedom to Speak Up champions or ambassadors.

Some respondents expressed concerns about this model's impact on guardians' wellbeing, particularly in larger organisations.

Model Two: Some respondents were part of a team consisting of two or more guardians within their organisation. As with Model One, these networks were sometimes supported by a network of Freedom to Speak Up champions/ambassadors.

These guardians tended to share the same band/grade/seniority level and had the same job description. They might divide the workload, take responsibility for some geographical regions, and even share jobs.

Model Three: Some organisations had a 'lead' Guardian accompanied by one or more 'deputy' or 'associate' guardians. Although these terms were commonly used by respondents, there were variations, such as 'advisory' guardians. There were also instances where guardians were dedicated to specific services or specialisms.

The responsibilities and roles of lead guardians and their deputies/associates differed across organisations. In some organisations, there were three levels of guardian roles: lead > deputy > associate. As with model two, the Guardian team in model three tended to assign responsibility for, for example, particular geographical areas/sites to specific guardians.

In general, lead guardians (or equivalent) held more senior positions compared to their deputies/associates and had more dedicated time for the Guardian role. They also tended to be tasked with, among other things, strategic aspects of the role as well as reporting to the board (or equivalent). Nonetheless, there was no indication in respondents' feedback that 'lead guardians' - or others that were trained and registered with the National Guardian's Office - did not undertake the reactive aspects of the role, responding to workers speaking up to them.

Some respondents mentioned the existence of fixed-term contracts in the context of model two and three networks, which were periodically reviewed to assess their effectiveness. Both Model Two and Model Three networks included guardians with diverse professional backgrounds. This potential positive was also mentioned in the context of Freedom to Speak Up champion/ambassador networks (see Figure 23 below).

"Three of us cover what's needed between us. People approach who they prefer."

Across all models, administrative assistants were also mentioned as part of some local networks to facilitate the functioning of these teams.

Feedback indicated that many Freedom to Speak Up Guardian teams operated effectively, with meetings vital to communication and collaboration. However, insufficient protected time was mentioned as a hindrance to the effectiveness of these network, particularly for those in deputy/associate roles in model three networks.

Freedom to Speak Up Champions/Ambassadors

Several respondents mentioned difficulties around setting up an effective Freedom to Speak Up provision for organisations with complex structures (size, geographical spread etc.). A network of champions/ambassadors is one way of tackling this issue. The terms 'champion' and 'ambassador' are often used interchangeably to describe roles which are designed to raise awareness and promote the speaking up agenda.

Some organisations have a network of Freedom to Speak Up champions or ambassadors[13] who work alongside guardians to complement the work they do – see figure 21.

Some respondents told us that they were responsible for setting up and supporting their network.

Larger organisations (10,000+ workers) had more Freedom to Speak Up champions/ambassadors.

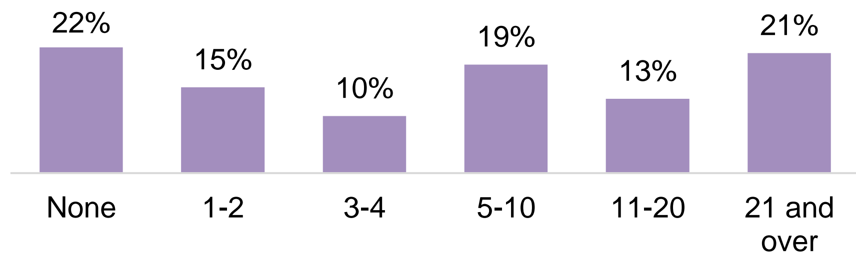

Figure 21: How many Freedom to Speak Up champions / ambassadors does the organisation(s) you support have? (2022/23)

Over a third of respondents (36%) from organisations with a network of Freedom to Speak Up champions/ambassadors said that the reach of this network was satisfactory. Twelve per cent thought that their reach was poor –see figure 22.

Figure 22: How would you rate reach across the organisation achieved through the local Freedom to Speak Up Champion network? (2022/23)

Another benefit of having a network of champions is improved representation of diverse groups. However, 20 per cent of respondents from organisations with champions described the representation of diverse groups amongst the champion network as poor or very poor – see figure 23.

Figure 23: How would you rate representation of diverse groups amongst the local Freedom to Speak Up Champion network? (2022/23)

[13] Developing Freedom to Speak Up Champion and Ambassador Networks (nationalguardian.org.uk)

Support from Leadership: trends and changes in perceptions

Freedom to Speak Up guardians cannot be effective in isolation and must have access to senior leaders and decision-makers in their organisations.

A lack of leadership support can undermine guardians' ability to do their job, including holding leadership to account to address barriers and escalate serious matters effectively. Lack of visible support can diminish the role in the eyes of workers, managers, and sometimes guardians themselves. In extreme cases, we have even heard of guardians feeling victimised for the effective performance of the expected job.

Compared to 2021, a similar proportion of respondents expressed feeling supported by their chief executive (or equivalent) and senior manager team (figure 24).

- The majority of respondents (86%) felt supported by their chief executive,
- Seventy-seven per cent felt supported by their senior management team more generally.

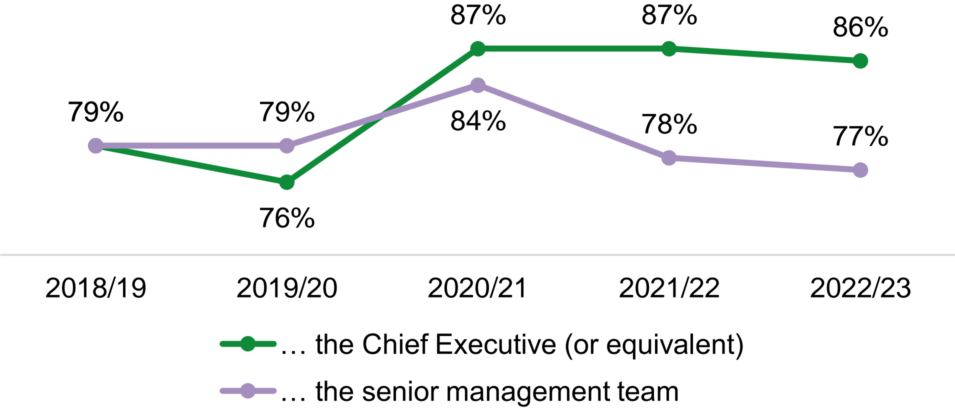

Figure 24. How far do you agree or disagree with the following statements: I am … - % agreed or strongly agreed

Eighty-one per cent of respondents believed they had access to the support they needed, which indicates a positive increase of four percentage points compared to the results in the previous survey (77%, 2021) – figure 25

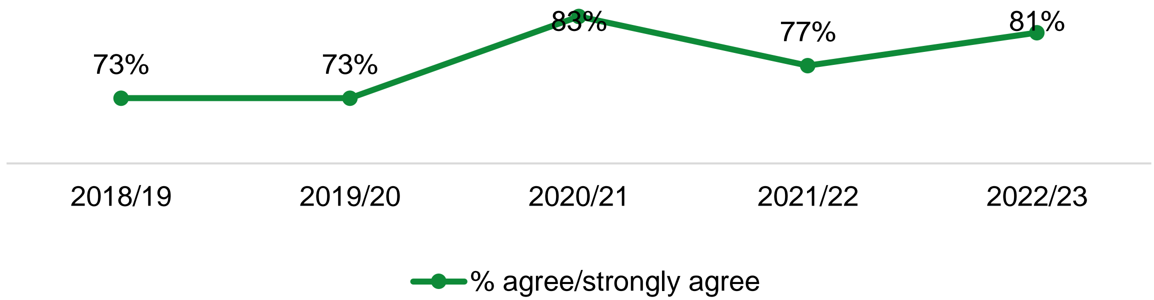

Figure 25. Has access to the support needed

The 2020 survey, conducted during the early stages of the COVID-19 pandemic, showed marked improvements in responses. There was an 11 percentage point increase in respondents who felt supported by their Chief Executive (87% in 2020, 76% in 2019). Since then, the percentage of respondents feeling supported by their Chief Executive has remained consistent. However, there has been a decline of seven percentage points in the number of respondents feeling supported by their senior management team, compared to its peak in 2020 - see figure 26.

It is concerning to note that a quarter of respondents did not agree with the statement: *The senior management team support me*. Likewise, while there has been a slight improvement in this year's results, it remains the case that nearly one in five respondents (19%) did not agree with the statement: *I have access to the support I need*. These findings highlight the need for further attention and improvement in these areas to ensure adequate support for all guardians.

This year's results indicate a marked decline in respondents feeling valued by their managers and senior leaders. Two-thirds (66%) felt valued by managers, showing a decrease of six percentage points compared to the results from the previous survey (72%, 2021). Similarly, just under three-quarters (74%) felt valued by senior leaders, representing a notable decline of 9 percentage points from the previous year (84%, 2021). These findings mark a four-year low in terms of feeling valued by managers and senior leaders (figure 26).

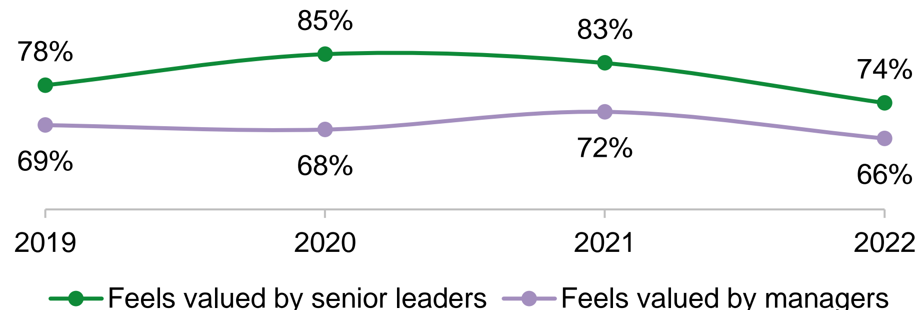

Figure 26. How far do you agree or disagree with the following statements: I feel valued by… - % agreed (strongly or otherwise)

The lower percentage of respondents feeling valued by managers compared with senior leaders aligns with other findings in this report. There may be specific challenges in supporting speaking up and Freedom to Speak Up guardians among this group of workers, which we touch on earlier in this report (see on page 13).

Access to organisational leadership: perspectives on direct engagement with chief executives, non-executives, and the board

When asked about their access to senior leadership, the majority of respondents said they had sufficient access, although there was a five percentage point decrease in those with access to the board (or equivalent).

- **Chief executives (or equivalent):** 92 per cent of respondents said they had direct access to their chief executive (or equivalent), down a percentage point since the previous survey (93% in 2021, 94% in 2020 and 91% in 2019 and 2018)
- **Non-executive director (or equivalent) who has speaking up as part of their portfolio:** 83 per cent of respondents said they had direct access to the non-executive director (or equivalent), up a percentage point year-on-year.
- **Board (or equivalent):** 78 per cent said they had sufficient access to the board (or equivalent), down five percentage points year-on-year (83%, 2021).

Section 4: Meeting the needs of workers

We asked participants how valued they felt by workers in general, and the individuals they support:

- An overwhelming 96 per cent of respondents felt valued by the individuals they support. This high level of feeling valued has remained consistent over the past four years (94% in 2019, 96% in 2020, 93% in 2021).
- 85 per cent of respondents felt valued by workers in general. A similar percentage of respondents felt the same in previous years (87%, 86% in 2020 and 86% in 2021).

However, in this year's survey, two-thirds (65%) of respondents reported that they were meeting the needs of workers in their organisation. This figure represents a seven percentage point decline (72%, 2021) – see figure 27.

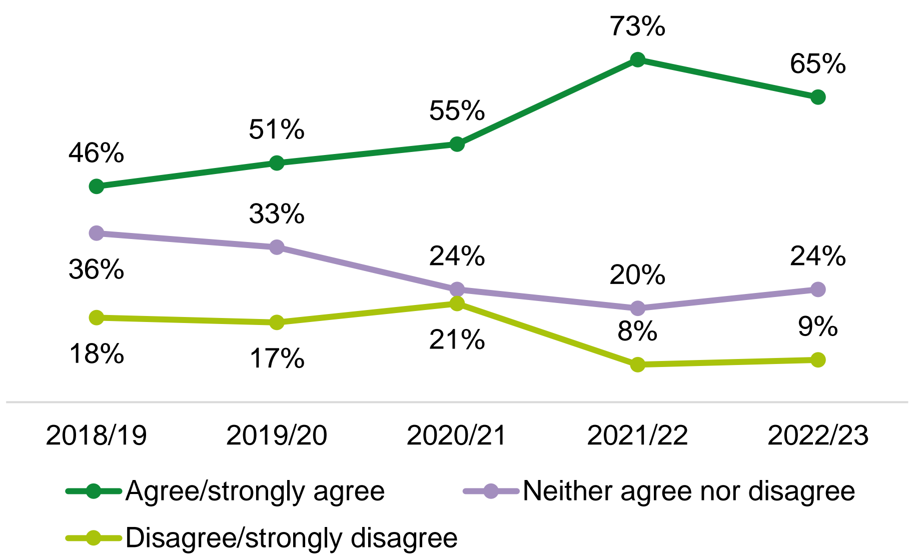

Figure 27. How far do you agree or disagree with the following statement? - I am confident that I am meeting the needs of workers

Protected time

In order to meet the needs of workers, Freedom to Speak Up guardians need protected time which is ring-fenced for their Freedom to Speak Up Guardian duties.

This is an aspect of arrangements that is included in the CQC's well-led inspection guidance. In addition, by the end of January 2024, the senior lead for Freedom to Speak Up in all NHS Trusts should have used the Freedom to Speak Up Reflection and Planning Tool to demonstrate to the senior leadership team, board or any oversight organisation the progress made in developing Freedom to Speak Up

arrangements and includes statements to help reflect on how much time a Guardian has to carry out their role.

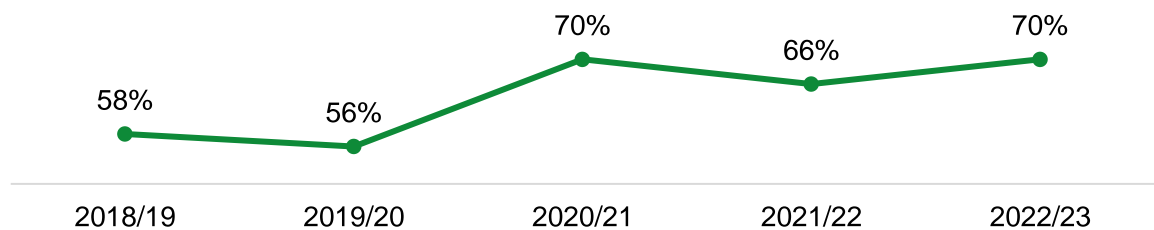

Figure 28: Proportion of Freedom to Speak Up guardians with ring-fenced time – change over time

Seventy per cent of respondents had protected time to fulfil their Freedom to Speak Up guardian role, marking a four percentage point year-on-year increase (66%, 2021) – see figure 28, above.

Over a third (34%) of respondents said they did not have another role. This figure has steadily increased over the years – in 2018, only 12 per cent of respondents did not have another role (figure 29).

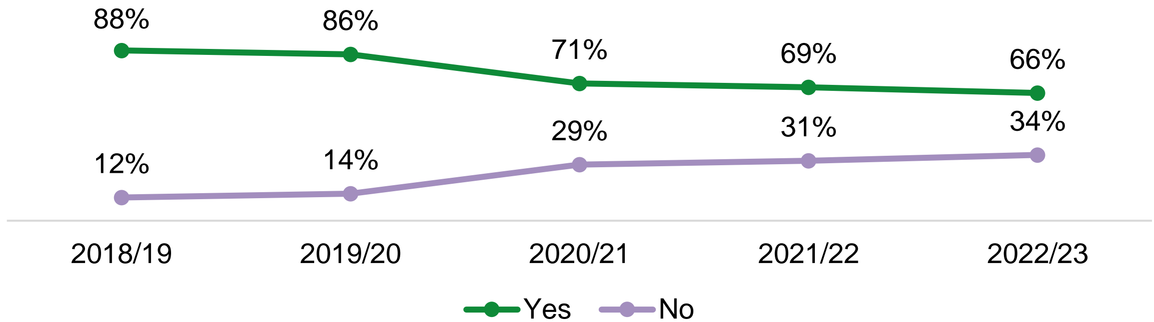

Figure 29: Do you have another role?

Dual roles can work effectively only where there is adequate protected time and resource to carry out the responsibilities of the role.

Amount of protected time

In this year's survey, we asked about the amount of protected (or ring-fenced) time, if any, allocated to respondents for fulfilling their Freedom to Speak Up role – see figure 30.

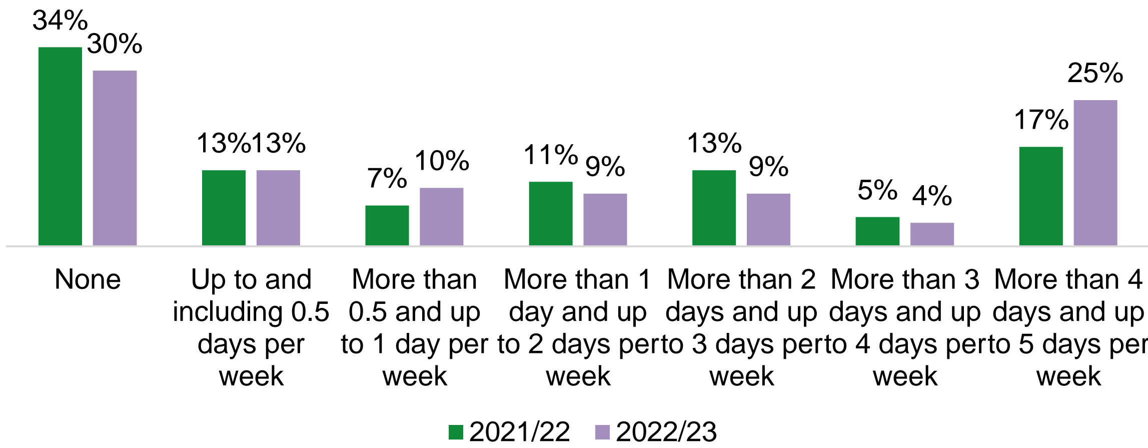

Figure 30: How much ring-fenced time is given to carry out the Freedom to Speak Up role?

Among respondents supporting NHS Trusts, 40 per cent had been allocated more than four days per week. This represents a notable increase of 14 percentage points since the 2021 survey. In comparison, a quarter of all respondents reported having more than four days per week allocated for this purpose.

Breakdown of the results revealed that there was little disparity between organisations with a single Freedom to Speak Up Guardian and those with multiple when it came to whether they had at least some protected time to fulfil their Freedom to Speak Up role.

Thirteen per cent of respondents told us that there had been an increase in their ring-fenced time over the last 12 months.

We asked respondents if they felt they have sufficient time to carry out their Freedom to Speak Up role (figure 31).

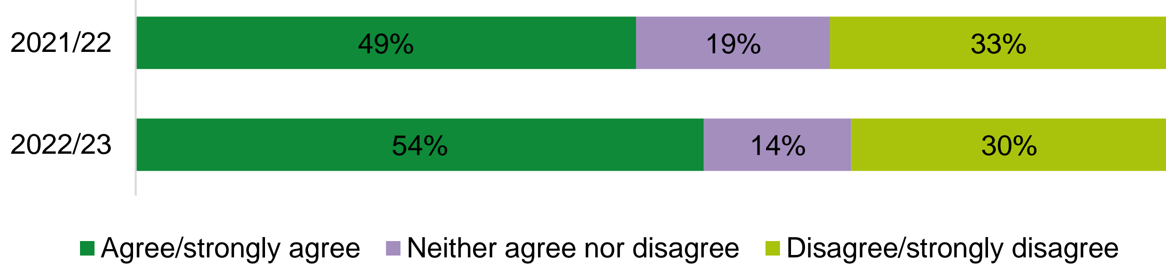

Figure 31: How far do you agree or disagree with the following statement? - I have sufficient time to carry out my Freedom to Speak Up responsibilities

The results indicate that 42 per cent of respondents agreed or strongly agreed with the statement, representing a five percentage point increase compared to the results of the previous survey. On the other hand, 30 per cent of respondents disagreed with

the statement and 14 per cent of respondents neither agreed nor disagreed with the statement.

Respondents who disagreed provided various insights on how the lack of time affects their ability to fulfil their role effectively. Common themes included:

- **Time constraints:** *"It is hard to make any significant culture improvements and maintain a visible presence when you are continuously reacting and responding/ following up on cases. It is even harder when your organisation has multiple sites across a wide geographical area. I personally feel that I am spread too thin to make any significant improvements/ changes."*
- **Impact on workload:** *"Affects wellbeing as own time can be eaten into. The quality and timeliness of the work itself can be affected also. There is much juggling of tasks between responsive and proactive work at all levels of the organisation and collaborative work needed."*.
- **Reactive versus proactive work:** *"As soon as you work on the proactive side of the role - you are left with doing the responsive part of the role in your own personal time. The Freedom to Speak Up guardian job description is a service offer and not a job description that is in any way workable for one individual."*
- **Work/life balance:** "*Even with increased time allotted, there is always a clash between my clinical role and my Guardian role. I am often staying late to speak with staff rather than being able to conduct during my core hours and feel that I am unable to be very proactive at all. I feel that at times, I spread myself too thinly and the variability makes it hard to plan."*
- **Lack of resources:** *"When there is less time for proactive work, the reach of our team/service is limited. Working in a large organisation requires sufficient Guardian resource to do this effectively and safely. The expectation of the Guardian role in relation to doing ALL tasks, is not ideal. Guardians could use their time more effectively if Trusts were encouraged to employ Guardian Teams and have capacity for admin support included in this.".*

Balance between reactive and proactive time

We asked how respondents allocated time between the 'reactive' and 'proactive' aspects of their Freedom to Speak Up Guardian role. Reactive aspects of the role include supporting workers who speak up to Freedom to Speak Up Guardians and proactive aspects include working within their organisation to tackle barriers to speaking up.

The findings revealed that 33 per cent of respondents reported an equal split, with 50

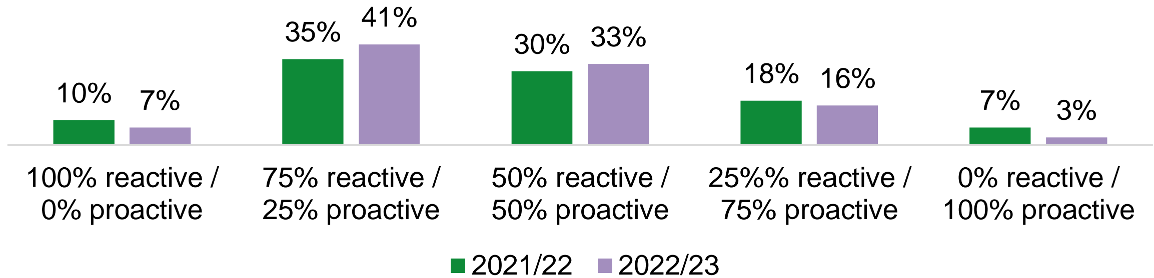

Figure 32. Approximately, what proportion of your time is spent on handling cases brought to you by workers (i.e. the 'reactive' part of the role) and what proportion is spent on other Freedom to Speak Up activities (e.g. compiling reports and promoting

per cent of their time dedicated to reactive tasks (such as supporting workers who speak up) and 50 per cent to proactive tasks (such as addressing barriers to speaking up within their organisation). This marks a three-percentage point increase compared to the previous survey's results (30%, 2021) –see figure 32 above.

Nearly half of the respondents (48%) predominantly spent their time on reactive activities, representing a three percentage point increase from the previous year. Conversely, 19 per cent allocated more time to proactive tasks, indicating a decrease of six percentage points from the prior year.

In addition, we asked whether guardians felt that the proportion of time allocated to reactive and proactive aspects of their role was suitable – see figure 33.

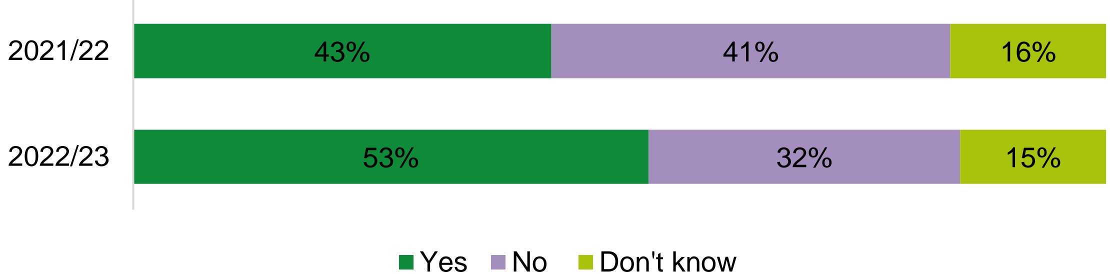

Figure 33. Does this proportion feel right for you?

Just over half of respondents (53%) indicated that the proportion felt right for them. This was a marked increase of 10 percentage points compared to the previous survey results (43%, 2021).

The rationale for the amount of protected time

Forty-two per cent of respondents stated that leaders in their organisations had demonstrated the rationale for the amount of protected time available. Over a quarter (26%) said they had not.

Many respondents mentioned using the National Guardian's Office and NHS England's self-reflection and planning tool[14] in order to determine the amount of protected time. Feedback from Freedom to Speak Up guardians was also mentioned, in conjunction with open and supportive discussions and negotiations with managers, senior leaders and/or the board. Reports from regulators of insufficient resources for Freedom to Speak Up guardians and the results from internal and external audits also led to an increase in time.

Data used to support the rationale for the amount of time included staff survey results and analysis of speaking up cases raised with the Freedom to Speak Up Guardian(s). This included the number and complexity of cases and number of cases where detriment was indicated.

Approaches to increase time for the Freedom to Speak Up Guardian role

Having undertaken the rationale exercise to determine the amount of time needed, approaches to increase the amount of time for the Freedom to Speak Up Guardian service included:

- Appointing additional guardians or increasing the working hours of existing guardians.
- Flexibility in working arrangements, such as compressed hours to accommodate individual preferences and those with dual roles.

In some organisations, part-time or deputy/associate guardians were appointed to ensure coverage throughout the working week.

Feedback from respondents in smaller organisations emphasised the significance of recognising the unique characteristics of each organisation and the need for a customised approach when allocating protected time to guardians:

> *"We are a very small organisation who have an open-door policy for their staff. I have two days a month ring fenced time which has proven over the last two years to be more than enough for me to carry out my... duties."*

Some respondents highlighted systemic challenges, such as staffing shortages, that impacted an organisation's ability to allocate dedicated time for the role.

> *"Unfortunately, with shortage of staffing at the moment, it is impossible to get time ring-fenced. So, this role, at present - until things improve - will be done in my own time. This, hopefully, will change this year and I will get ring-fenced time."*

[14] Freedom to Speak Up: A reflection and planning tool

The impact of insufficient protected time

The 30 per cent of respondents who disagreed or strongly disagreed with the statement, '*I am confident that I am meeting the needs of workers'*, described several ways that this impacts how effectively they can carry out their role. In some instances, Freedom to Speak Up guardians said that they did not have enough time to carry out the reactive side of the role.

> *"I have had to stop taking cases due to a heavy caseload, of complex cases which are not moving very quickly towards resolution despite a considerable effort from me to push these with the relevant areas of the organisation."*

However, the main impact described was a lack of time to carry out 'proactive' work, such as visiting teams across the organisation, attending inductions, creating promotional materials, sharing learning and improvements.

> *"It is impossible to be proactive as constantly fighting fires and managing cases."*

The Freedom to Speak Up guardian role is varied and requires a unique range of skills. Some respondents told us that the expectations on Freedom to Speak Up guardians are unrealistic and require skills outside the scope of the job description competencies.

There are also 'business as usual' tasks which guardians struggle to complete within their protected time (if any) such as general administration, data reporting and board reporting. Several respondents also said that they were involved in additional projects due to their role as a Freedom to Speak Up guardian, which adds to their workload and time commitments.

Comparing results from those with and without protected (ring-fenced) time

The table below provides a breakdown of protected (or ring-fenced) time results. To ensure a more meaningful comparison, the results only include respondents who are the sole guardian in their respective organisations – please see figure 34, below.

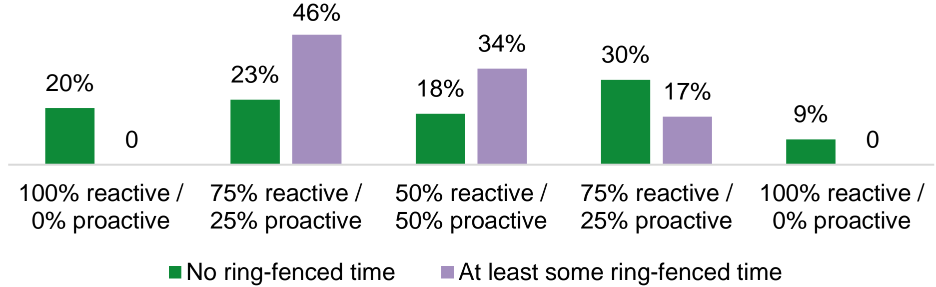

Figure 34. Approximately, what proportion of your time is spent on handling cases brought to you by workers and what proportion is spent on other Freedom to Speak Up

We have also provided a breakdown of responses to statements by respondents without ring-fenced time and those with at least some ring-fenced time. As above, to ensure a more meaningful comparison, the results only include respondents who are the sole guardian in their respective organisations – please see figure 35, below. The results highlight those respondents with at least some protected time have more of a balance between the reactive and proactive aspects of their role:

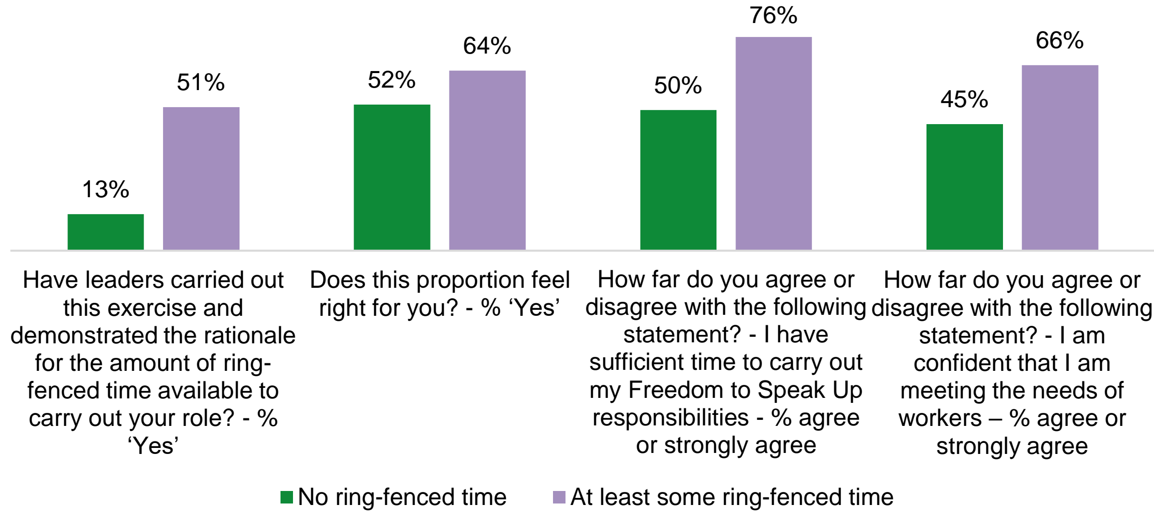

Figure 3535. % of respondents answering 'yes' or 'agree'/strongly agree' to the statements (2022/23)

- Among respondents with protected time, only 3 per cent reported focusing solely on either reactive or proactive elements of the role, whereas this percentage rose to 29 per cent for those without protected time.
- Over three-quarters (76%) of respondents with protected time agreed they had sufficient time to fulfil their Freedom to Speak Up responsibilities. In comparison, half (50%) of those without protected time said the same.
- Respondents with at least some ring-fenced time demonstrated a higher level of confidence in meeting the needs of workers. Almost two-thirds (66%) of

respondents with protected time agreed with this statement, while the agreement rate dropped to 45 per cent among those without.

Protected time and zero and nil data submissions

Freedom to Speak Up guardians are expected, on a quarterly basis, to submit anonymised data about the cases they have received to the National Guardian's Office:

- Respondents working for organisations that reported zero cases in the four quarters leading up to the survey had much less protected time compared to those working for organisations with at least one reported case during the same period.[15] In the former group, no guardians had more than one day per week of dedicated time –see figure 36, below.[16]
- Even less protected or dedicated time was allocated to Freedom to Speak Up guardians from organisations that did not provide any data, including zero cases, to the NGO during the same period.

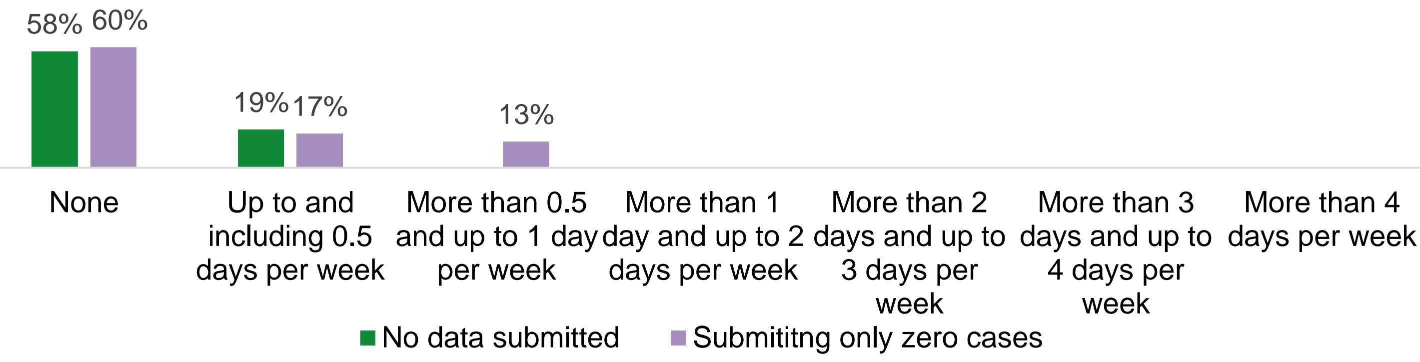

Figure 366: Ring-fenced time for guardians from organisations that submitted zero cases and organisations that did not submit data to the National Guardian's Office

Other resources

Freedom to Speak Up guardians must have access to the necessary resources to fulfil their role effectively.

We asked about respondents' access to resources, such as a budget for expenses and room availability for private meetings – see figure 37.

For each resource we inquired about, a majority of respondents indicated having

[15] Even if no cases were received during the reporting period, Freedom to Speak Up guardians are still required to report this as zero, in compliance with the NGO guidance.

[16] As part of the survey process, we shared certain participant information with the organisation responsible for conducting the survey. This information encompassed details such as names and contact information as well as compliance with data collection requests and, where applicable, regulatory ratings and national staff survey results. This meant we were able to carry out filtered analysis of the survey results based on these breakdowns - allowing for a more comprehensive analysis and interpretation of the collected data - while upholding the anonymity of the survey participants.

access to it. However, the proportions of these majorities varied. Compared to the results of the previous survey, there was an increase in the percentage of respondents who indicated having access to these resources.

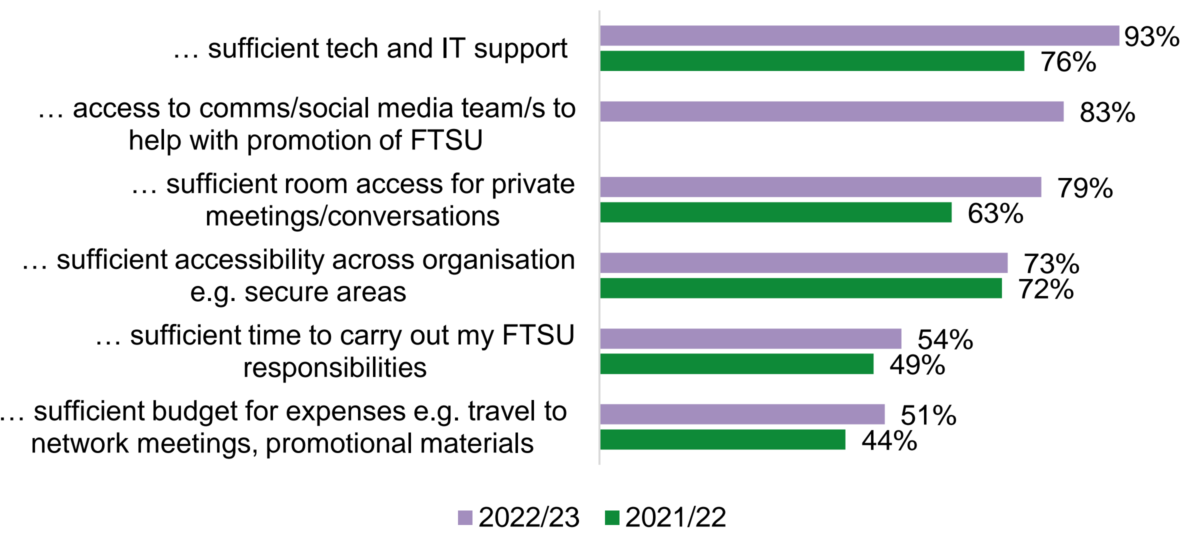

Figure 377: How far do you agree or disagree with the following statement? - I have... (% that agreed or strongly agreed)

For the first time, we also asked respondents whether they had access to communications and social media teams to assist in promoting Freedom to Speak Up. Eighty-three per cent (83%) of respondents said they had such access – while three per cent disagreed, indicating a relatively positive level of support in this area. However, for budget allocation for expenses, the results were less favourable. Just over a half of respondents (51%) indicated having sufficient budget, while 26 per cent did not.

We asked participants about why they identified these insufficient resources as problematic. Based on the responses, we have identified several key themes, including:

1. **Lack of budget:** Many respondents expressed concerns that this limited their ability to pay for promotional materials, training, events, and other essential resources. The absence of a dedicated budget hindered their capacity to deliver innovative and creative work and restricted their ability to promote their roles effectively.
   "During Freedom to Speak Up Month, I tried to promote Freedom to Speak Up as much as I could but... end up buying lots of things out of my own money… ."

2. **Administrative support:** Several respondents mentioned the need for administrative support to handle tasks such as diary management, room bookings, event coordination, and report analysis. The absence of this support resulted in time-consuming administrative tasks, limiting their capacity

to engage in their primary responsibilities and strategic activities.
"Admin support... in setting up meeting and following/chasing and liaise and setting up events and forums… this would give guardians time and head space to focus on the role and concerns (not feeling rushed and be able to be in the room and listen to the person) but also look at the bigger picture around themes/trends and the wider culture."

3. **Communications and publicity:** Many respondents expressed frustration with the lack of communication support and limited access to promotional materials. This meant they could not effectively promote Freedom to Speak Up and reach out to workers. Delays and limited support from their communications teams were also mentioned as challenges.

4. **Lack of private space:** The absence of private and confidential spaces to support workers was also mentioned as a problem by many respondents. Difficulties in finding suitable locations for sensitive conversations had a negative impact on their ability to offer a safe space for workers and provide timely support.
"Room and space availability for private and confidential discussions. This results in discussions being undertaken off site."

5. **IT and Technological Support:** Several respondents highlighted the lack of robust and secure digital systems for capturing caseload information and providing confidential channels for workers. The absence of adequate IT and technological support hindered their ability to handle and address concerns effectively and may potentially impact on confidentiality.
"Obtaining access to bits of data for the purpose of triangulation has likewise been hard to get due to the various platforms used, capacity of teams, silo working and access issues."

6. **Travel Expenses:** Some respondents mentioned the challenge of obtaining travel expenses reimbursement in a timely manner. The need to pay for travel, parking, and other related expenses upfront and wait for reimbursement placed financial pressure on them and affected their ability to allocate resources effectively.

Absence cover

Fifty-nine per cent of respondents said that their organisation had arrangements for absence cover (planned or unplanned) in order to ensure a continuous level of support for workers. Consideration was given to upholding confidentiality and NGO expectations when arranging cover for absences (see box below).

Set arrangements were more commonly reported, indicating established procedures for absence cover. But ad hoc arrangements were mentioned in some organisations, implying a more improvised approach to covering absences. Cover arrangements primarily focused on addressing the reactive aspects of the guardian role and

supporting workers in the absence of the guardian. Limited mention was made of covering the proactive elements.

The absence of cover arrangements could lead to increased workloads and challenges upon the Guardian's return, impacting their wellbeing. Workers were directed to policy documents, intranet resources, or other internal channels for reporting concerns during the Guardian's absence.

They type of cover varied:

- **Arrangements between/among guardians:** Many respondents were part of a team of two or more guardians, working together to provide coverage during leave periods. Guardians often alternated leave and provided support for each other within their team.
- **Arrangements with other colleagues:** Contingency arrangements involved collaboration with Freedom to Speak Up champions/ambassadors, executive and non-executive leads for speaking up, or other designated contacts. These colleagues were identified as alternative points of contact during the absence of the Guardian.

  Cross-organisational support/integration: Collaboration and cross-cover arrangements existed with some neighbouring organisations/those within the same integrated care system.

Guidance for Starting Out and Stepping Down

The National Guardian's Office has issued guidance for Freedom to Speak Up Guardians[17] on their roles, transitions, and responsibilities. The guidance covers the process of starting in the role, dealing with absences, and stepping down.
It clarifies how case data and ongoing cases are handled when a Guardian takes extended leave or transitions out of the role. The document also offers instructions for planned changes in Guardianship and how to handle unforeseen absences to maintain trust, worker support, and confidentiality.

Recommendations

Freedom to Speak Up guardians play a crucial role in providing an alternative channel for workers to voice their suggestions, concerns or any other matter. They also work in partnership throughout the organisation to foster an environment that normalises speaking up as an integral part of everyday work. They need adequate resources and support from the organisation in order to fulfil these responsibilities effectively.

The National Guardian's Office has consistently emphasised the need for such resources and organisational support. These matters are explored in the Freedom to

[17] https://nationalguardian.org.uk/wp-content/uploads/2023/06/2023-Starting-out-Stepping-Down-Guidance.pdf

speak up guidance and a Freedom to speak up reflection and planning tool we developed with NHS England and considered by the Care Quality Commission as part of their regulatory and inspection work.

Yet, our data reveals that many guardians report a lack of organisational support and limited access to necessary resources.

We recommend that senior leaders discuss these findings with their Freedom to Speak Up guardian(s). These discussions should encompass an evaluation of resources, including protected time, provided to the role. Leaders should consider various relevant factors outlined in the Freedom to Speak Up guidance from the National Guardian's Office and NHS England.[18]

The National Guardian's Office recommends that NHS England and the Care Quality Commission review their regulatory and supervisory processes to ensure they identify and address cases where organisations fail to implement and sustain the Freedom to Speak Up Guardian role in line with our guidance.

[18] https://nationalguardian.org.uk/wp-content/uploads/2022/06/B1245_ii_NHS-FTSU-Guide-eBook.pdf

Section 5: Wellbeing and support

Being a Freedom to Speak Up Guardian is a rewarding, challenging, and sometimes isolating role. Freedom to Speak Up guardians must have the support, time and resources from their organisation and understand and take advantage of the other available support offers depending on what is right for them. This includes the support from buddies, guardian networks and the National Guardian's Office.

Guardians are often approached by people in distress, wanting to speak up about the most serious of matters. However, respecting confidentiality means they can be holding a large amount of sensitive information, some of which they are not able to pass on. This can affect the health and wellbeing of guardians. So, it is essential that leaders recognise the need to engage regularly with their guardians to understand what tailored support can be offered.

Despite the stressful aspects of the role, nearly eight out of ten (78%) respondents expressed their likelihood, to recommend the Freedom to Speak Up guardian role to a friend or colleague. Conversely, 15 per cent of respondents indicated their unlikelihood to recommend the role – see figure 38.

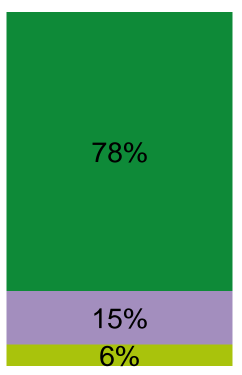

Figure 38: If a friend or colleague was seeking out a new role, how likely would you be to recommend a Freedom to Speak Up Guardian role to them? (2022/23)

Respondents shared their views on the impact of the Freedom to Speak Up Guardian role on their health and wellbeing - see figure 39.

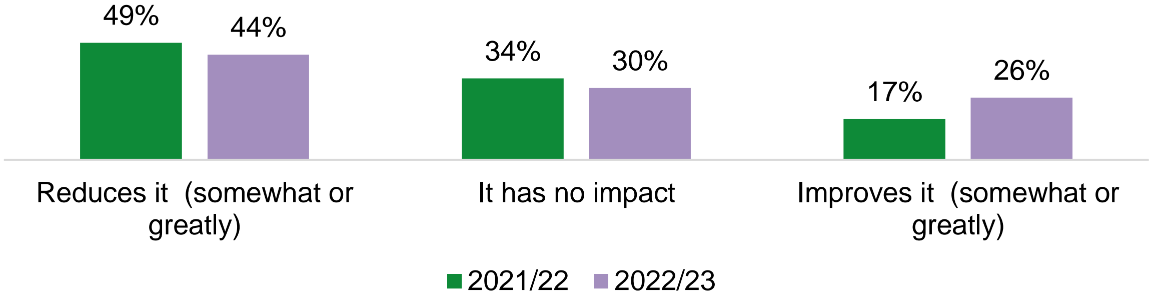

Figure 39: How do you feel your role as Freedom to Speak Up Guardian impacts on your emotional and psychological well-being?

Forty-four per cent (44%) of respondents stated that the role had reduced their health and wellbeing, either somewhat or greatly. This figure represents a decrease of five percentage points compared to the results of the previous survey, where the figure stood at 49 per cent.

A notable finding was that 26 per cent of the respondents reported an improvement in their health and wellbeing due to the Freedom to Speak Up Guardian role. This represents a notable increase of nine percentage points from the previous results (17%, 2021).

Three in ten respondents (30%) reported that the role had no impact on their health and wellbeing.

We asked respondents to elaborate on their answers. Overall, the messages express a mix of positive and negative experiences, emphasising the emotional toll the role can take, the importance of support, and the satisfaction of helping others.

We have grouped the key points that emerged from respondents' answers thematically:

1. **Emotional impact:** Hearing about workers' concerns and negative experiences can be emotionally draining and the role can be stressful and overwhelming at times. Dealing with distressing cases, such as suicide or abuse, affects mental health. The role can be lonely and isolating, with limited support from managers. Continuous exposure to difficult situations meant some felt vulnerable and that the role had had a negative impact on their wellbeing. The role may affect confidence or trigger personal circumstances.

2. Rewarding aspects: Guardians expressed feeling privileged to be in the role, and being able to help others and make a difference for workers. Positive feedback and knowing that workers feel supported and listened to is rewarding, especially when cases are successfully resolved. They enjoyed the variety and autonomy the role offers and being part of the network.

3. Challenges and frustrations: Some felt limited in the ability to effect change or address concerns due to organisational resistance. There was frustration with HR/people policies and slow resolution of concerns. There was mention that some people who spoke up had unrealistic expectations of immediate resolution. Inadequate support from the organisation left them feeling vulnerable in the role. Speaking truth to power and differences of opinion with leadership or managers was a challenge.

4. Support and wellbeing: Guardian shared how used self-care practices to prevent burnout, with a good support network and hobbies outside of work. Some felt valued and supported by their managers, with regular supervision and access to professional support (such as clinical psychologists). They appreciated the autonomy in managing one's schedule and participating in learning events.

We asked respondents whether their employer offered them health and wellbeing support (such as access to occupational health or other emotional and psychological support services):

- 89 per cent reported that support was available to them
- Out of this group, 23 per cent had actually used this support
- Of those who accessed the support, 76 per cent indicated that they found it helpful.

Regional and national networks

Freedom to Speak Up Guardians are expected, as part of the role, to join and participate in regional and national network meetings with other Freedom to Speak Up Guardians. These meetings seek to provide the following:

- Peer support and networking
- Sharing of learning, ideas, challenges, and successes in a confidential environment
- Being informed about and inputting into NGO plans
- Contributing to and furthering the Freedom to Speak Up agenda

We asked respondents how often they had attended networks meetings. Over half (58%) reported attending three or more regional or national Freedom to Speak Up guardian network meetings in the past 12 months, representing a notable increase of seven percentage points compared to the results from our previous survey (51%, 2021) – see figure 40.

Twenty-nine percent (29%) of respondents had attended one or two such meetings during the same period. Similar to the previous survey's findings, 13 per cent stated

that they had not attended any regional or national Freedom to Speak Up network meetings in the past 12 months.

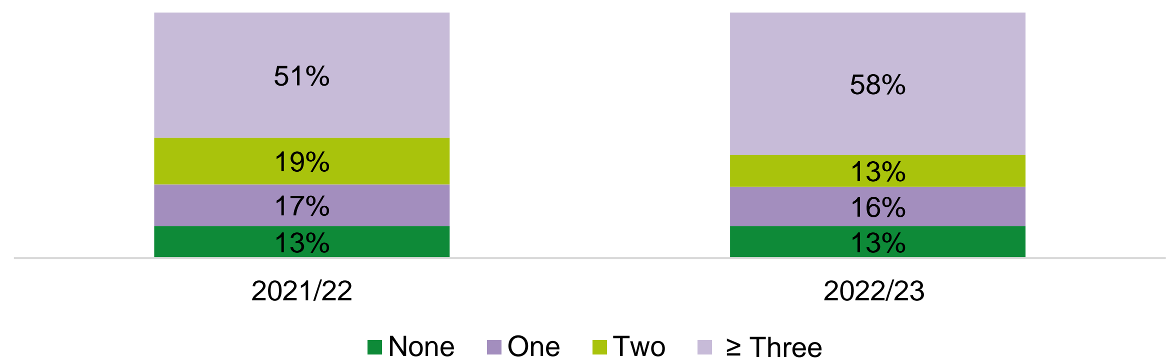

Figure 40: In the last 12 months, how many national and regional Freedom to Speak Up Guardian network meetings have you attended?

Common themes we identified among respondents' feedback were::

- Importance of support from within the organisation, including senior leaders and former guardians, to attend meetings
- Value of attending regional and national network meetings, as they provided opportunities for communication, collaboration, and sharing of good practices.

Following responses to the previous Freedom to Speak Up Guardian Survey, we are working in collaboration with the networks and their network chairs to ensure that networks meet the needs of all Freedom to Speak Up guardians. This includes clear network chair role expectations and fair and open recruitment of new network chairs and regular check-ins with network chairs. Post-meeting surveys of network members are now in place and feedback from the surveys will be used to monitor effectiveness of the networks.

Section 6: About the Freedom to Speak Up Guardian Network

Freedom to Speak Up guardians represent different professions, roles, levels of seniority and experience.

Length of time in role

In this year's survey, there was an increase in the percentage of respondents who had been in the guardian role for three or more years, with 36 per cent of participants falling into this category compared to 32 per cent in the previous survey.

Twenty-two percent of respondents had been serving as guardians for more than four years.[19] On the other hand, 28 per cent of the respondents were still in their first year as a guardian.

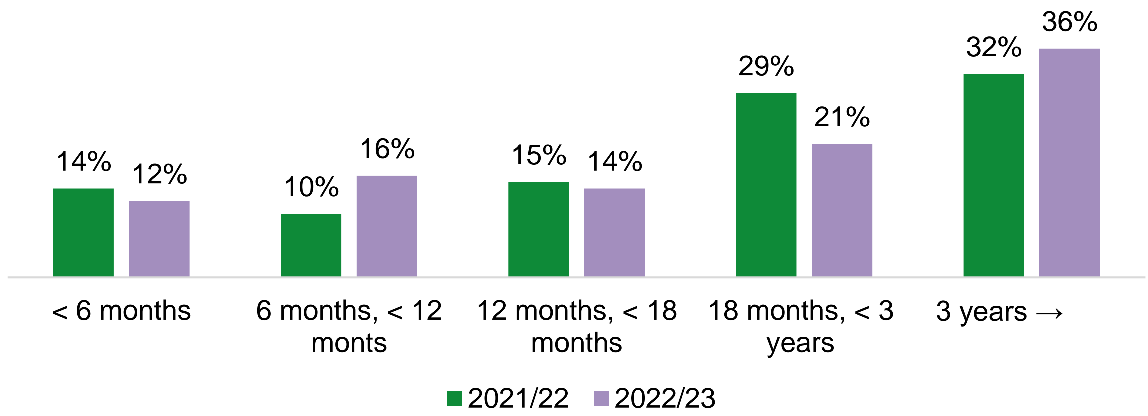

Figure 381: How long have you been in role?

Occupational group

Almost a fifth of respondents (19%) classified their role as sitting in the Central Functions / Corporate Services occupational group – see figure 42.

Contractual arrangements

Most respondents said that they were on permanent contracts (84%). There are also a small number of guardians who are employed by external suppliers, are bank workers or who carry out the role on a voluntary basis.

[19] Unlike previous years, our latest survey introduced a new response option, allowing participants to select 'four years or more' when indicating their tenure in the guardian role. Due to this change, the corresponding data for this category is not included in figure 41, as it cannot be compared directly to the previous year's survey.

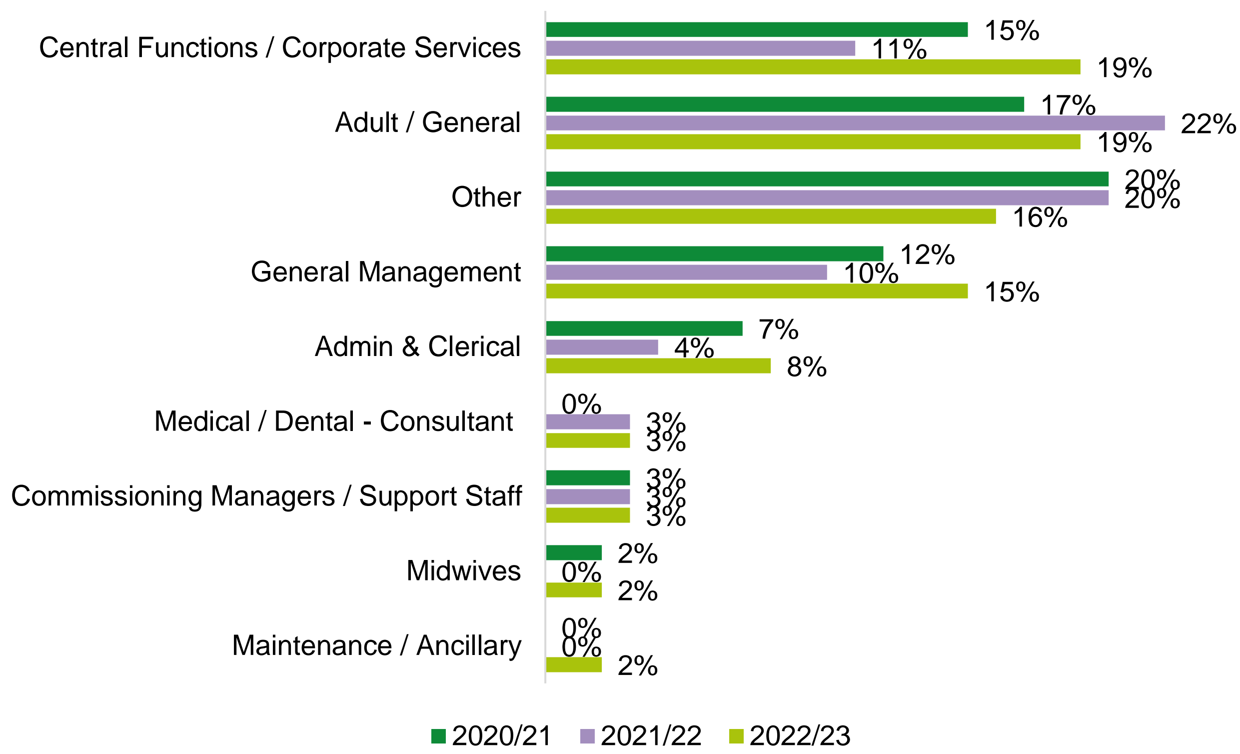

Figure 42: What is your occupational group?

Banding, grading and seniority

Sixty-three per cent of respondents were on the Agenda for Change (AfC) pay scale, which is the current NHS grading and pay system for NHS staff, except for doctors, dentists, apprentices and some senior managers.

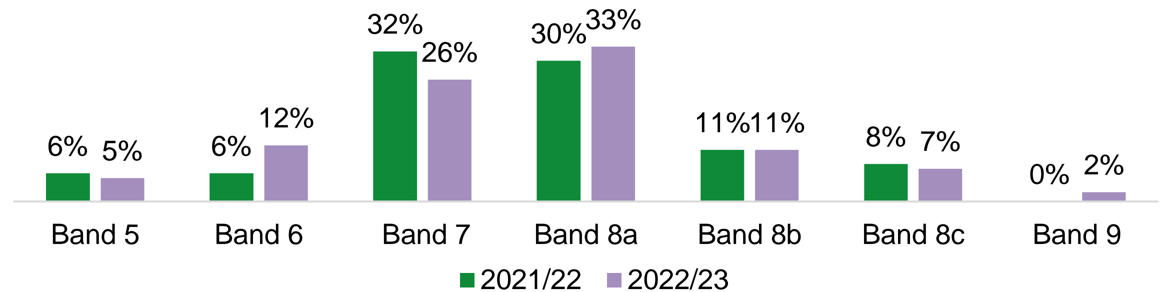

Figure 393: Agenda for Change banding

A notable change in the banding for respondents on Agenda for Change (AfC) pay scales was observed compared to the results in the previous survey. In 2021, the most common band for respondents was band 7, accounting for 32 per cent of respondents. However, in our most recent survey, the most popular band shifted to band 8a, with 33 per cent of respondents falling into this category – see figure 43.

There has been a seven percentage point decline in the proportion of respondents identifying themselves as 'very senior management' among those who are not on the Agenda for Change (AfC) banding (figure 44).

A number of respondents asked for standardised banding, clearer recruitment processes, and consistent monitoring to address issues of inconsistency and ensure fair treatment and effectiveness across the guardian role:

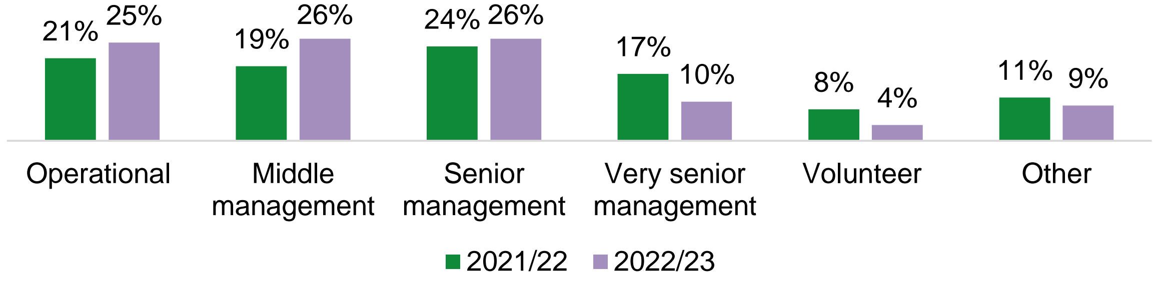

Figure 44: Non-Agenda for Change

Protected characteristics

Many Freedom to Speak Up guardians, including many of those that participated in our survey, support organisations other than NHS Trusts. Therefore, it is not possible to compare directly the collective demographics of participants to the NHS workforce. Nonetheless, in this section, we refer to figures on the composition of the NHS workforce to provide relative context on the representation of participants as a collective.

Gender

Over three-quarters of respondents (77%) identified as female, down three percentage points since the previous survey. Over a fifth of respondents (21%) identified as men – see figure 45.

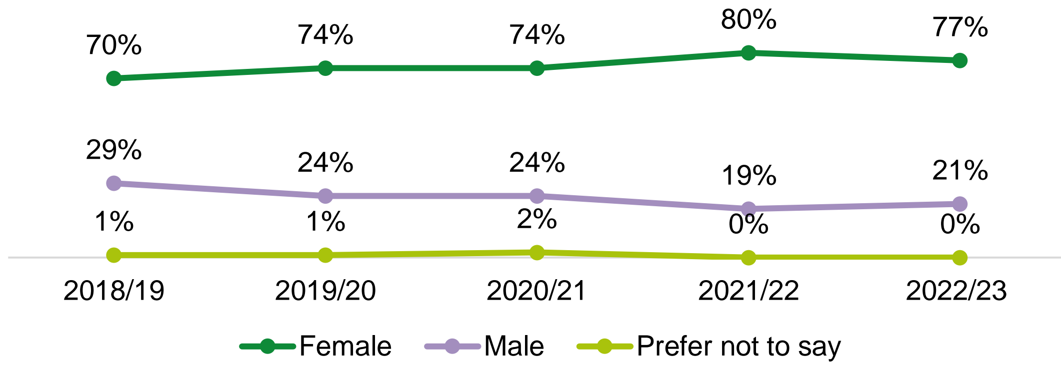

Figure 405: What of the following best describes you?

The NHS workforce is composed of 75 per cent female employees.[20] The gender representation within the guardian network, as reflected by the respondents in our survey, aligns with the broader workforce demographics.

The percentage of respondents identifying as female has shown a notable increase of seven percentage points since 2018 when it stood at 70 per cent. There has been a corresponding decrease in the percentage of respondents identifying as men, declining by eight percentage points since 2018.

Ethnic group or background

Eighty-five per cent of respondents identified as White in terms of their ethnic group or background.[21] Fifteen per cent were from other/minority ethnic backgrounds – see figure 46.

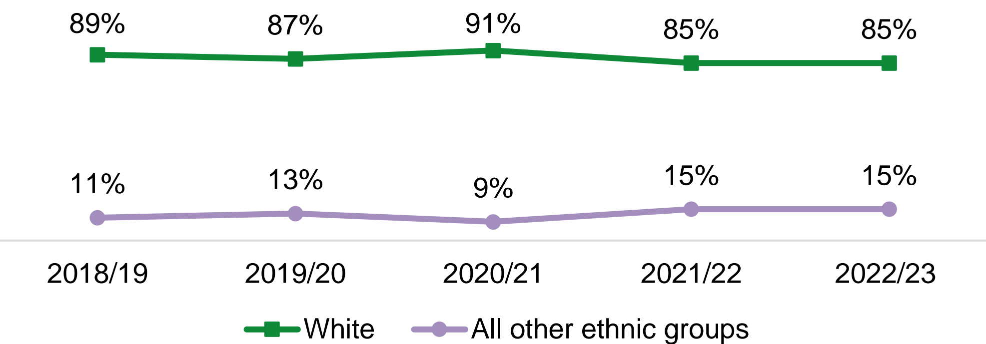

Figure 46: What is your ethnic group?

In comparison, 74 per cent of the NHS workforce identified as White.[22]

Since 2018, there has been a five percentage point increase in respondents from ethnic minority backgrounds, up from 10 per cent in 2018 to 15 per cent in 2023.

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[20] https://www.england.nhs.uk/2021/03/nhs-celebrates-the-vital-role-hundreds-of-thousands-of-women-have-played-in-the-pandemic/

[21] This encompasses the following subcategories: English / Welsh / Scottish / Northern Irish / British, Irish, Gypsy or Irish Traveller and Any other White background.

[22] NHS workforce - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk) (April 2023)

Age

Just over half of participants (53%) were aged between and including 51 and 65 years – see figure 47.There has been a notable shift in the age demographics of respondents over the past five years:

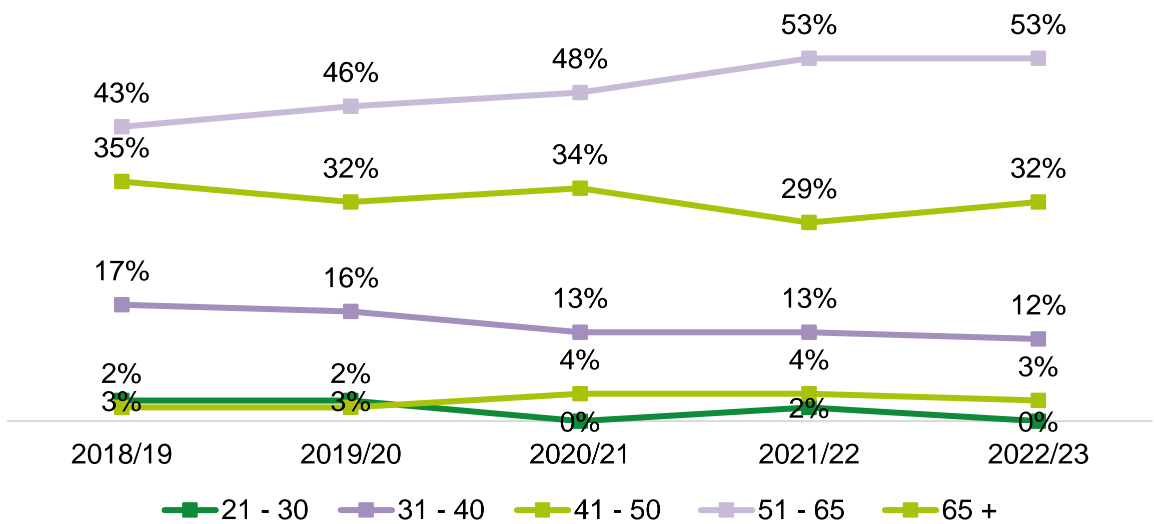


Figure 47: What is your age?

- In 2018, 43 per cent of respondents indicated that they fell within the 51 to 65 age range, representing a ten-percentage point increase compared to the current survey result (53%).
- The percentage of respondents aged between 21 and 40 has witnessed a decline over the same period. In 2018, this age group constituted 20 per cent of the respondents, which decreased to 12 per cent in the 2023 survey, reflecting an eight percentage point decrease.

Please see the reference sheet for a breakdown of respondents by other characteristics.[23]

Recommendations

Our findings indicate that in some respects, like ethnicity, the network is not necessarily representative of the wider workforce it serves. In 2018, 89 per cent of respondents identified as White, which stood at 85 per cent in 2023. In comparison, and though not directly comparable, among NHS staff whose ethnicity was known, 74 per cent were White.

There are likely several reasons contributing to this disparity. For example, appointments to the Freedom to Speak Up Guardian role are not always made through fair recruitment processes. Research has identified the so-called "snowy white peaks" of the NHS - that the workforce gets whiter as it becomes more senior - and we are aware of a shift upwards among respondents in terms of their

[23] Reference sheets available at https://nationalguardian.org.uk/wp-content/uploads/2023/07/20230629-Reference-sheet.docx

banding/seniority.[24] Likewise, the results suggest that the network may be getting older, and White colleagues are more prominent in older cohorts.

Also, some groups, such as ethnic minorities, face specific barriers to speaking up. It is reasonable to assume that people within such a group might also feel that the Freedom to Speak Up guardian role is itself not a career option available to them.

We commissioned research in 2021[25] which indicated that workers are more likely to feel confident to speak up to someone they believe will better understand their concerns and respond to them appropriately (for example, a worker experiencing racism at work). A Freedom to Speak Up Guardian - or anyone else for that matter - cannot be that person for all workers regarding every potential issue they may wish to raise. To address these concerns, two key actions must be prioritised:

1. Those responsible for responding to workers speaking up must receive effective training to listen with curiosity, empathy and be conscious of barriers to speaking up and their impact on marginalised groups.
2. Workers should have a variety of routes available for them to voice their concerns. Offering multiple avenues increases the likelihood of workers finding a suitable channel for them to speak up to.

It is essential to address the systemic discrimination and discriminatory hiring practices that may discourage people from applying or even considering the Freedom to Speak Up Guardian role. People's protected characteristics, including ethnicity, should not be a barrier to becoming a Freedom to Speak Up Guardian. Leaders must ensure a fair and open recruitment processes to support this.

[24]Kline, R (2014) The "snowy white peaks" of the NHS
The 2022 WRES data indicates that this is still the case https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/#wres-indicator-1
[25] Difference_Matters.pdf (nationalguardian.org.uk)

Section 7: Conclusion and Next Steps

Freedom to Speak Up guardians serve as a vital additional channel for workers to express their concerns and work with others to enhance the speaking up culture within their organisations. However, the effectiveness of this role is contingent upon its implementation and support. The Guardian function is just one aspect of the broader Freedom to Speak Up arrangements within each organisation, and just one part of a wider strategy for improving Speak Up culture and psychological safety.

Consistency of implementation of the Freedom to Speak Up Guardian role

Our findings demonstrate that an increasing percentage of respondents have protected time, indicating that the guardian role is becoming increasingly valued within many organisations. Nonetheless, the results also highlight that the Freedom to Speak Up Guardian role, along with Freedom to Speak Up arrangements in general, is not always implemented in line with expectations and good practice. Together with the NHS Staff Survey's identification of a deterioration in the confidence to speak up by healthcare workers, this underscores the need for healthcare leaders and regulators to take meaningful action in response to these findings.

A significant gap remains within the speaking up arrangements across healthcare. Many organisations still do not have a Freedom to Speak Up Guardian registered with and trained by the National Guardian’s Office.

Training for Freedom to Speak Up guardians

This report has highlighted the complexity of the Freedom to Speak Up Guardian role.

Freedom to Speak Up guardians are required to complete the National Guardian’s Office training in order to be placed on the National Guardian’s Office’s directory. The training is in two parts:

1. Foundation eLearning
2. A reflective conversation with a Freedom to Speak Up Guardian mentor

Successful completion of the Foundation e-learning module allows the Guardian to register on the National Guardian’s Office Directory and enables access to Guardian networks and important communications. Within three months of completion of the module, Freedom to Speak Up Guardians are expected to have had a reflective

conversation with a Freedom to Speak Up Guardian mentor. Those that have not may be removed from the NGO's Directory.

Some Freedom to Speak Up guardians had completed their Foundation training many years ago, and others had become guardians during the pandemic. To give the National Guardian's Office assurance that all guardians were trained to the same level of knowledge and understanding of the expectations of this unique and far-reaching role, in 2021/22 all Freedom to Speak Up guardians were asked to complete the newly devised Foundation eLearning modules. This served as Refresher Training for that year.

Annual Refresher training is now mandatory. From 2022/23, if guardians do not complete their annual refresher training by 30 November each year, they will be contacted to ensure they have the support they need to complete the eLearning. If following this support offer they still fail to meet this requirement, the National Guardian's Office will notify CQC and NHSE so that they are informed of the relevant organisation's non-compliance with our guidance.[26] The Freedom to Speak Up Guardian's details may also be removed from the NGO's Find My Guardian page, because we cannot be assured that they have the necessary training to carry out this important role.

Next steps

We will share our findings and recommendations with key stakeholders, including NHSE, CQC, and others, to inform their work in improving the speaking up culture and arrangements within healthcare organisations.

We will use the findings of this survey to inform our ongoing work supporting Freedom to Speak Up guardians and their organisations to make speaking up business as usual.

[26] This applies to organisations that come within CQC and/or NHS England's remits.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/10/122**	
SUBJECT:	EPRR Assurance Letter/Statement of Compliance	
DATE OF MEETING:	4 October 2023	
AUTHOR(S):	Daniel Moore, Chief Operating Officer	
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: *(Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): *(Please DELETE as appropriate)*	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1114** If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **#1579** If the North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the Trust may not be able to transfer patients with time critical urgent care	

<table>
<tr><td></td><td colspan="4">needs to specialist units which may result in patient harm</td></tr>
<tr><td rowspan="10">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td rowspan="2">1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="2">2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="2">3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="4">This report will:-
• Provide an overview of the Emergency preparedness, resilience and response (EPRR) annual assurance process for 2023-23
• Provide an overview of Warrington and Halton teaching Hospital’s compliance with the EPRR Core Standards
• Provide an overview of the deep dive into evacuation and shelter
• Outline a workplan to ensure the Trust continues to move towards full compliance whereby 100% of the NHS EPRR Core standards are met with full compliance</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note √</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to note the EPRR Annual Assurance submission</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3"></td></tr>
</table>

	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Emergency preparedness, resilience and response (EPRR) annual assurance 2023-24	AGENDA REF	BM/23/10/122

1. BACKGROUND/CONTEXT

The 2023 EPRR NHS England core assurance framework has been updated for 2023, along with the new EPRR Framework that came into effect last year.

The NHS core standards for EPRR cover 10 domains:
1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

Organisations, including acute trusts are asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each. The new process moves away from a completely self assessment and peer review model, to a one that also requires the upload of evidence to substantiate the self assessment. Evidence is to be uploaded to an online portal, locally and regionally peer reviewed / check and challenged and then submitted nationally. This is the first time the EPRR Core Standard process has been undertaken in this way.

Organisational assurance rating
The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. There are 62 standards applicable to acute trusts.

The compliance levels for organisations are defined as:

Assurance Rating Thresholds

- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Self-assessment takes place for each appropriate standard (for acute providers) standard using the following criteria:

Compliance level	Compliance definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Not compliant	Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.

Deep dive
The topic included in the deep dive for the 2023-24 assurance is EPRR responder training. The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating; these are reported separately.

Action to take/next steps

- All NHS organisations should undertake a self-assessment against the 2023 updated core standards (attached) relevant to their organisation. These should then be taken to a Public Board or, for organisations that do not hold public boards, be published in their annual report.
- The timetable for the review and challenge is set out in the the table below.

EPRR core standards check and challenge			October 2023
LHRP EPRR core standards assurance review / approval			November 2023
LHRP EPRR Core Standards Assurance Report to RHRP			November 2023

The final date for submission is Friday 29 September via an NHS England Share Point portal. The core standards review check and challenge will take place in October 2023. The final date for November 2023.

What has changed since 2022?

Repository
There is a requirement as part of this year's EPRR Assurance Process to provide evidence for each of the EPRR Core Standards that supports the organisations self-assessment submission and overall EPRR assurance rating. To facilitate this, NHS England have set up a repository within SharePoint to allow Trusts to upload their self-assessment, statement of compliance, EPRR Core Standards Evidence, Deep Dive Evidence and the 2022-2023 Action Plan.

Impact for the Trust Includes

1. Requirement to have hard copies of all standards e.g., ISO23001 / ISO23013 CCA2004 etc.
2. Business Continuity Management System for evidence-based audit.

3. All the additional Documents in the EPRR office for audit.
4. Review of Trusts Policies, Procedures, Documents, Working Groups within the organisation.
5. More Staff training at all levels within the organisation.
6. Additional trained and competent Commander's requirement for portfolio.
7. Use of external Training due to new competence requirements in the training needs analysis.

Work Plan / Action Plan
The Integrated Care Board & NHS England have sent the workplan for Trusts to follow and the Audit will be completed by them after the Trust have sent their Self-Assessment Document to the repository for examination.

2. KEY ELEMENTS

For 2022/2023, the EPRR Core Standards compliance level was self-assessed at Substantially Compliant with Warrington and Halton Teaching Hospitals rated as being fully compliant against 89-99% of the relevant NHS EPRR Core Standards.

The Trust employs 1.00 WTE EPRR Manager who has been on Maternity Leave since February 2023 and is due back in February 2024. The post has been covered by agency locums throughout despite a fixed term post being advertised. Whilst adequate qualified cover has been maintained throughout this period, this has slowed the pace of development of the EPRR work programme during 2022-23.

This year, considering the refreshed approach, the EPRR Core Standards compliance level was self-assessed at SUBSTANTIAL compliance once again and a summary of compliance levels is tabled below. Warrington and Halton Teaching Hospitals was rated as being fully compliant against 89-99% of the relevant NHS EPRR Core Standards (92% Fully compliant and 8% partially compliant). However, under the new evidence review approach this will be validated by external review and a compliance score officially given. Therefore this should be treated as a forecast at this stage. It should be also noted, that because this is the first year that evidence has been sought and marked against the criteria there are some unknowns the scoring approach and therefore the accuracy of the forecast could be low.

Appendix 1 includes the full template for the annual EPRR Core Assurance.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	7	6	1	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	8	2	0	1
Hazmat/CBRN	12	12	0	0	7
Total	**62**	**57**	**5**	**0**	**11**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	10	0	0	0
Total	**10**	**10**	**0**	**0**	**0**

Percentage Compliance	92%
Overall Assessment	Substantially Compliant

EPRR Core Standards

Overall the Trust is self-assessed as FULLY COMPLIANT in 57 out of 62 core standards. There are 5 Core standards with partial compliance. The deep dive indicates the Trust is fully compliant (100%) with Training. Again, this score could be lower once reviewed as being lower once the review of evidence has been completed.

The 5 Partially Compliant EPRR Core Standards in 2022/2023 are:
Decision Logging

- *To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure:*
- *1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy.*
- *2. Has 24-hour access to a trained loggist(s) to ensure support to the decision maker.*

Action plan

This was identified as a partially compliant standard in the 22/23 review. Further logging training is due to be scheduled in 23-24, with the incorporation of the role of loggist in specific administrative and clerical job descriptions. EPRR Manager will continue to identify appropriate colleagues and opportunities for loggist training. A

model to support 24-hour access to trained loggists must be developed and mutual aid via the ICB be considered. Some organisations have an on-call process in place. This is not currently funded at WHH.

Business Impact Analysis/Assessment (BIA)
The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).

The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme.

Documented process on how BIA will be conducted, including:
- the method to be used
- the frequency of review
- how the information will be used to inform planning
- how RA is used to support.

The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA:

- Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption.
- A consistent approach to performing the BIA should be used throughout the organisation.
- BIA method used should be robust enough to ensure the information is collected consistently and impartially.

Action plan
This again was identified as being partially compliant in last years assessment. Whilst a significant number of business continuity plans have been updated, there remain a number in process. As each of the remaining plans are updated then this process will support the activities associated with the Business Impact Analysis/Assessment (BIA).

EPRR Exercising and testing programme
In accordance with the minimum requirements in line with guidance the organsiation has an exercising and testing programme to safely test incident response arrangements

Exercise schedule
• Participation in COMAH site exercises for staff.

Action plan
Because of the temporary arrangements of the EPRR post holder this year the annual exercise has not taken place at the time of submitting the report. An exercise is being planned for November 2023 ahead of the operational pressures of Q4.

Exercising for specific high profile events, such as the Cream Fields festival have gone ahead this year.

BC audit
The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme;

- process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation
- Board papers
- Audit reports
- Remedial action plan that is agreed by top management.
- An independent business continuity management audit report.
- Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle.
- External audits should be undertaken in alignment with the organisations audit programme.

Action plan
This again was identified as being partially compliant in last years assessment. A joint approach with the Governance department will enable the BC audit to be aligned with the WHH audit programme. Additionally this is being put forward for the 24-25 MIAA work programme.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The EPRR workplan for 2023-2024 shows a timeline for training and reviews in order to support the progress towards full compliance across all EPRR Core standards. The workplan is attached as Appendix 1.

The workplan is monitored through the Event Planning Group who meet monthly, and updates are shared with the group as per the workplan.

Lead Officers

- Dan Moore - Chief Operating Officer is the designated Lead Executive Director with responsibility for Emergency Planning within the Trust.
- The Accountable Officer is currently supported by an agency locum, Alan Moore. Rachel Clint is the Trust substantive EPRR Manager who is currently on Maternity Leave until February 2024.

4. IMPACT ON QPS?

As identified in the outcomes of the assurance process.

5. MEASUREMENTS/EVALUATIONS

The NHS England Core Assurance document is attached and outlined in Appendix 1.

6. TRAJECTORIES/OBJECTIVES AGREED

To move towards being fully compliant across all NHS EPRR Core Standards.

7. MONITORING/REPORTING ROUTES

EPRR updates continue through the Event Planning Group and the Finance and Sustainability Committee and the Trust Board of Directors.

8. TIMELINES

This report is presented annually to the Board. The EPRR workplan details the monthly priorities identified by the EPRR Manager along with Local Health and Resilience Partners.

9. ASSURANCE COMMITTEE

Event Planning Group, held monthly.

10. RECOMMENDATIONS

The Board are asked to note the forecast EPRR Annual Assurance self-assessment rating at 'SUBSTANTIAL COMPLIANCE' and note the changes to this years process and that the self assessment will be certified once a review of the Trust submitted evidence is reviewed. The Board is also asked to support the workplan in moving towards full compliance with all 62 standards.

Appendix 1- Full assurance document

Appendix 2 – EPRR Workplan

Version Control
2.1 28/07/23

Please choose your organisation type: Acute Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	7	6	1	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	8	2	0	1
Hazmat/CBRN	12	12	0	0	7
Total	**62**	**57**	**5**	**0**	**11**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	10	0	0	0
Total	**10**	**10**	**0**	**0**	**0**

Interoperable Capabilities for NHS Ambulance Service Providers only

Interoperable Capabilities	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant
HART Capability	#REF!	#REF!	#REF!	#REF!
HART Human Resources	#REF!	#REF!	#REF!	#REF!
HART Administration	#REF!	#REF!	#REF!	#REF!
HART Response time standards	#REF!	#REF!	#REF!	#REF!
HART Logisitics	#REF!	#REF!	#REF!	#REF!
SORT Capability	#REF!	#REF!	#REF!	#REF!
SORT Human Resources	#REF!	#REF!	#REF!	#REF!
SORT Administration	#REF!	#REF!	#REF!	#REF!
SORT Response Times	#REF!	#REF!	#REF!	#REF!
MassCas Capability	#REF!	#REF!	#REF!	#REF!
MassCas Equipment	#REF!	#REF!	#REF!	#REF!
Gen C2	#REF!	#REF!	#REF!	#REF!
Resource C2	#REF!	#REF!	#REF!	#REF!
Decision Making C2	#REF!	#REF!	#REF!	#REF!
Recording Keeping C2	#REF!	#REF!	#REF!	#REF!
C2 Learning Lessons	#REF!	#REF!	#REF!	#REF!
Competence C2	#REF!	#REF!	#REF!	#REF!
JESIP	#REF!	#REF!	#REF!	#REF!
Total	**#REF!**	**#REF!**	**#REF!**	**#REF!**

Percentage Compliance	92%
Overall Assessment	Substantially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non Compliant' standards

EPRR Workplan

	Subject	2023-24											
		September	October	November	December	January	February	March	April	May	June	July	August
EPRR Plans and Policies	Fuel Plan (new following national guidance)	Complete											
	EPRR Policy (review and update)	Complete											
	Major Incident Plan (review and update)	Complete			Review								
	Evacuation Policy (review and update)				Review								
	Business Continuity Plan (review and update)	Complete	Review	Review									
	Escalation Plan (review and udpate)												Review
	Full Capacity Plan (operationalise)												Review
	CBRN Plan (review and update)	Review	Review					Review					
	Pandemic Flu Plan (update)		Review										
	Heatwave Plan (review and update)												Review
	Cold Weather Plan (review and update)				Review								
	Lockdown (review and update)			Review									
	Fuel Plan												
Event Planning	Produce Easter Plan							Review					
	Produce Early May Bank Holiday Plan								Review				
	Neighbourhood Weekender Event Planning									Review			
	Produce Spring Bank Holiday Plan									Review			
	Produce Creamfields/August Bank Holiday Plan												Review
	Winter Planning	Review	Review										
	Produce Christmas & New Year Plan			Review	Review								
Corporate	Review Terms of Event Planning Group								Review				
	Produce Annual EPRR Report											Review	
	On-Call Guidance (review and update)	Complete											
	Complete Assurance to NHSE re EPRR	Complete											
	Provide LHRP feedback	Complete									Complete		
EPRR Training	Refresher training for On-Call Execs and Mgrs			Scheduled						Scheduled			
	Refresher training Loggists						Review	Review					
	Medical Staffing Grand Round			Review									
	Acute Care Team Major Incident training / Site Mgr												Review
	Senior Nursing Team inc Ward Mgrs												Review
	Refresher training Theatres			Review									
	ED MAJAX and Decon training									Complete	Complete		
	Disaster Victim Identification					Review							
EPRR Exercising	Communications Exercise	Review						Review	Review				
	Decontamination EMERGO Exercise			Review				Review					
	Paediatric major incident table top exercise			Review									
	Whole System Pandemic Influenza exercise			Review									
	Evacuation Exercise			Review									
	Black Start Exercise			Review									
	Cyber attack			Review									
	CBU Business Continuity			Review									

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/10/123**		
SUBJECT:	**Bi-monthly Strategy Highlight Report**		
DATE OF MEETING:	4 October 2023		
AUTHOR(S):	Stephen Bennett, Head of Strategy & Partnerships		
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships		
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	√	
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	√	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	√	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.		
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***		

Equality duty	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			√
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	√		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not	√		
Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	The following Strategy Highlight Report provides a progress update on key strategic projects and initiatives that underpin a number of WHH's strategic (QPS) priorities.

PURPOSE: ***(please select as appropriate)***	Information √	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Bi-monthly Strategy Highlight Report	AGENDA REF	BM/23/10/123

1. BACKGROUND/CONTEXT

This report summarises the progress of key strategic projects and initiatives that underpin a number of WHH's strategic (QPS) priorities.

2. KEY ELEMENTS

The Strategy Highlight Report consists of the following elements:

- Key messages
- Stakeholder engagement log, which provides a snapshot of external stakeholder engagement over the 2-month period. It is not a comprehensive list of all stakeholders engaged and does not include the extensive stakeholder engagement via regular external meetings and forums.
- Individual strategic project updates.
- Other Trustwide updates that are pertinent to our Trust strategy.
- Place based strategic updates.
- Cheshire and Merseyside strategic updates.

The report is produced every two months, however, to bring in line with internal Committee dates and Trust Board, the most recent version (appended to this paper) reflects the status of the key strategic projects as at the end of September 2023 (three months).

3. MONITORING/REPORTING ROUTES

Strategy delivery is monitored via each of the committees of the Board via biannual strategy delivery reports for each of the aims, quality, people and sustainability. This bi-monthly qualitative report will be shared with the executive team, Trust Board and Council of Governors, as well as internal stakeholders across the organsiation.

4. RECOMMENDATIONS

It is recommended that the Trust Board note the report for information and assurance.

Strategy Update
July-September 2023

Section 1 - Key Messages			
Slide 2	Summary of key developments this reporting period		
Section 2 - Stakeholder Engagement			
Slide 3-4	Details of key stakeholders engaged during the reporting period		
Section 3 - Key Strategic Projects			
Page	**Project**	**Strategy Lead**	**Status**
Slide 5	Living Well Hub in Warrington	Stephen Bennett/Caroline Lane	
Slide 6	Runcorn Town Deal	Carl Mackie	
Slide 7	Community Diagnostic Centre	Stephen Bennett/Lefteris Zabatis	
Slide 8	New Hospitals Programme and strategic estates	Carl Mackie/Viviane Risk	
Section 4 - Other Trust Strategic Updates			
Slide 9	Summary of other Trust strategy-related updates		
Section 5 - Place-based Strategic Updates			
Slide 10	Summary of strategic updates from local places (Warrington and Halton)		
Section 6 - Cheshire and Merseyside Strategic Updates			
Slide 11	Summary of strategic updates from Cheshire and Merseyside		

Key Messages

- Community Diagnostic Centre (CDC) – Phase 1, including respiratory, ultrasound and phlebotomy, is complete and over 8000 patients have now accessed diagnostics from the newly refurbished area in Nightingale.

- New hospitals and strategic estates – New hospitals estate remains a priority for the Trust, despite not receiving funding in the latest national funding round. Options are being discussed to continue with the plans for the Halton site (i.e. an extension of CSTM, which is supported by phase 3 of the CDC) and to explore the possibility of a phased rebuild for Warrington hospital. In all options provision of services in the community where appropriate, e.g. via our new and planned community hubs, remains a priority.

- Our Halton Health Hub, in Runcorn Shopping City, was recently shortlisted for a national Government property award.

Stakeholder Engagement Overview

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Carl Marsh	Place Director – Warrington Place	New Warrington Health and Wellbeing Strategy and role of Health & Wellbeing Board
Dr Ted Adams	Medical Director, Bridgewater Community Healthcare	Living Well Hub contact and advocate for Bridgewater
Gareth Pugh	Assistant Director of Finance, Bridgewater Community Healthcare	Contribution and Collaboration agreement for Living Well Hub
David Mills	Deputy Medical Director, Bridgewater Community Healthcare	Contribution and Collaboration agreement for Living Well Hub
Ian Triplow	CDC Programme Director Cheshire & Merseyside	CDC activity reprofile
Lauren Sadler	Transformation and Change Lead – Warrington Together Partnership	Warrington Place programme development
Jamie Foster	Partner, Hill Dickinsons	Initial discussions with core partners in Living Well Hub project around Collaboration and Contribution Agreement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme across Warrington and Community-Led Support programme board
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities
Barry Geden	Commissioner, Warrington ICB	Mobilisation of Community Spirometry service in CDC
Dave Thompson MBE	CEO, Warrington Disability Partnership	Expert advice re: design of Living Well Hub and disability access
Alison Cullen	CEO, Warrington Voluntary Action	Involvement of voluntary and charity sector in Living Well programme, Living Well Hub and Talking Points
Dave Pearman	General Manager, Runcorn Shopping City	Active travel pilot
David Herne	Director of Public Health, Warrington Borough Council	JSNA Steering Group and Healthy Weight initiative under Warrington Together Staying Well programme
Laurence Pullan	Head of Communications, Warrington Borough Council	Development of communications plan for Living Well Hub
Warrington Falls Steering Group	Various members	Opportunity to develop falls prevention offer within Living Well Hub

Stakeholder Engagement Overview

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Linda Buckley	MD Provider Collaborative, Cheshire & Merseyside	Provider Collaborative leadership
Wesley Rourke	Operational Director, Economy, Enterprise and Property	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Wayne Longshaw	Integration Director, STHK	Service collaboration opportunities
Steve Park	Growth Director, Warrington Borough Council	Local plan, new hospitals, Estates planning
Sinead Clarke	Associate Medical Director for System Quality and Improvement C&M ICS	Addressing health inequalities
Rick Howell	Strategic Lead Commissioning, WBC	Contribution and Collaboration agreement for Living Well Hub
Amanda Ridge	Associate Director Transformation and Partnerships- Warrington	Regular catch up with place-based transformation lead
Pat McGuiness	Associate Director Strategic Partnerships	Mersey Care delivery of services from Living Well Hub
Nikki Stevenson	Chair Medical Directors Network, CMAST	C&M clinical strategy
Warrington Together Digital Enabling Group	Various Members	Virtual hub for Warrington Place
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy, Living Well Hub
Tony Leo	Place Director, Halton	Place development
Sam Scott	CEO, Halton Housing	Wider determinants of health, housing and health
UKSPF Local Partnership Group	Warrington Stakeholders, led by WBC	Allocation of UKSPF in Warrington
John Smith and Mark Swift	Liverpool City Region CA CEO, Wellbeing Enterprises	Active travel hub in Halton Health Hub

Living Well Hub in Warrington

Project overview

WHH is leading a major project to develop a system-wide Health and Wellbeing Hub in Warrington Town Centre. The project forms part of the Town Deal programme, which covers 7 different infrastructure projects across Warrington, funded as part of the Government's levelling up agenda. The Health & Wellbeing Hub (to be known as the Living Well hub) is designed to target and address health inequalities in Warrington by providing a range of services focussed on prevention and early intervention in a town centre location with proximity to the areas of the town with the highest levels of deprivation. The Hub will be a space where providers from across mental and physical health, social care and the third sector can come together to deliver integrated services, support and learn from one another for the collective benefit of the local population.

Progress since last report

- Building works have commenced on site with good progress being made and an anticipated practical completion date of mid-December.
- Engagement with the 4 key partners in the project continues (Warrington Borough Council, Mersey Care, Bridgewater and WHH). Moving towards agreeing the Collaboration and Contribution Agreement.
- Integration of the Living Well Hub with system-wide programmes of work continues. The refreshed Health and Wellbeing Strategy is to be called the Living Well Strategy and includes a focus on the Living Well Hub as an example of how we will deliver the Health and Wellbeing Strategy.
- A Comms and Engagement plan has been produced under Warrington Together to promote the project.
- Work continues to secure additional funding to support the ongoing revenue costs of the Hub from a central funding pot.

Latest Images/Links/ Further information

What is the new Living Well Hub that is coming to Warrington? | Warrington Guardian

Upcoming Key Milestones

Milestone	Date
Completion and signing of Collaboration and Contribution agreement between 4 core partners	Oct 23
Finalise timetable	Oct 23
Build work completed	Dec 23
Launch of Hub	Jan 24

Contact details

Caroline Lane
Strategic Project Manager
caroline.lane10@nhs.net

Runcorn Town Deal

Project overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long term conditions from a central location in Runcorn.

The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

Progress since last report

- Stage 3 plan signed off by all partner organisations at July Oversight Group.
- Planning application now in development.
- Creation of transport statement to support planning agreed by all partner organisations.
- Continued engagement with clinical and non-clinical teams to maximise design opportunities.

Latest Images/Links/ Further information

Upcoming Key Milestones

Milestone	Date
Planning Application Submitted	Oct 23
Ongoing revenue funding principles ratified	Oct 23
RIBA stage 4 documentation produced	Nov 23
Opening	Summer 25

Contact details

Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net
Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

Community Diagnostic Centre

Project overview

As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.

The final approved CDC Programme will cover three phases. Phase 1 (Completed) will develop a range of diagnostic services within the Nightingale Building at Halton. Phase 2 will see diagnostic services established within the Halton Health Hub at Runcorn Shopping City. Phase 3 will see the development of a small new build extension to the CSTM building on the Halton site to accommodate CT and MRI services.

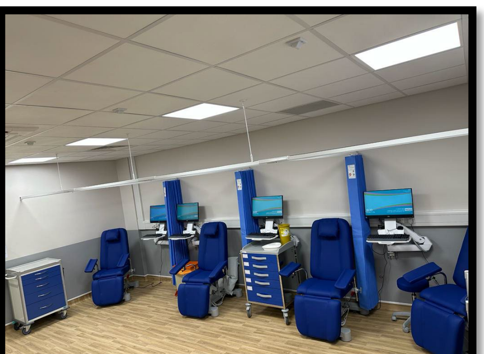
Progress since last report

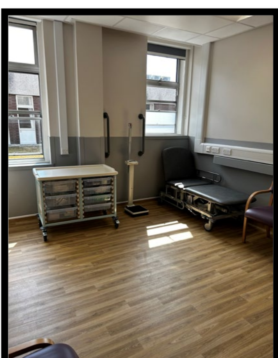
- **Phase 1** (Fast Track/Nightingale) has now been completed and handed over to the clinical services. Over 8,000 patients have been seen since opening.
- The **Phase 2** works (Shopping City) have commenced, and the project is scheduled to complete end of November 2023. Patient activity is expected to commence in early December 2023.
- The design process for **Phase 3** (New Build CDC) has started and sign off of the RIBA 3 stage (layout drawings) has been completed.
- All required clinical and non-clinical equipment for the operation of the CDC has been procured.
- Recruitment for the additional posts for the CDC operation has started.

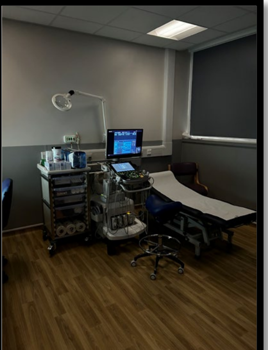
Upcoming Key Milestones

Milestone	Date
Final sign off of New Build CDC designs by Execs.	Oct 23
Planning Permission for New Build Received	Dec 23
Services within Halton Health Hub to commence	Dec 23
Services within new build CDC to commence	Sep 24

Latest Images/Links/ Further information







Contact details

Lefteris Zabatis
Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New Hospitals Programme

Project overview

- Development of new WHH hospital estate and infrastructure.
- Within Warrington, this is the development of a new hospital for Warrington, either on the current site or elsewhere in the town.
- Within Halton this is the redevelopment of the Halton Hospital site, including extending CSTM to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

Progress since last report

- Notification that Expression of Interest has not been approved by HM Government. Development of a Plan B to realise the Trust's new hospitals ambitions is now underway.
- Financial and economic models developed by PA Consulting have been shared with the Trust, allowing us to use work in development of Plan B.
- A review of the new hospital's governance arrangements is underway to ensure all enabling projects, such as the community hubs, are aligned to and governed as part of the new hospitals.
- A refresh is underway of the Trust's Estates Strategy, which will incorporate a refreshed new hospitals plan.

Latest Images/Links/ Further information

Upcoming Key Milestones

Milestone	Date
Estate Strategy Board discussion	Aug 23 (complete)
Strategy workshop with partners	Oct 23
Initial draft estates strategy for discussion.	Oct 23

Contact details

Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net
Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Other Trust strategic updates

Refreshed Trust Strategy

- Trust strategy refreshed for 2023-2025
- 12 objectives around 3 domains of Quality, People, and Sustainability
- Posters and other communications materials now deployed

Halton Health Hub Active Travel pilot scheme

- Wellbeing practitioner based in Halton Health Hub to encourage uptake of active travel opportunities
- Additional linkage to ongoing social prescribing and Health and Care system wayfinding across the borough
- Project in partnership with Liverpool City Region Combined Authority and Wellbeing Enterprises CIC
- Pilot to launch Autumn 2023

Targeted Investment Fund (TIF) Programme – Developing elective services on the Halton site

- Enabling works have been completed for the daycase unit and theatre 5 at CSTM. Main construction works have commenced.
- Preparation works underway for Endoscopy and TSSU in Nightingale.
- RIBA stage 4 for Theatre 3 in Nightingale.
- Initial Road Map for use of Theatres and Endoscopy has been shared with operational teams.

Place based strategic updates

Warrington

- Work has started around the development of the new Health & Wellbeing strategy for Warrington and an associated delivery plan. This will be underpinned by the refresh of the Joint Strategic Needs Assessment (JSNA), which helps identify clear areas of need based upon measured health outcomes and identified inequity in outcomes. WHH's plans for a new hospital are explicit in the refreshed strategy and the strategy is aligned to our refreshed WHH strategy.
- The Warrington Together programme of work is focused on delivery against 3 priority areas, Starting Well, Staying Well, Ageing Well.
- Warrington Borough Council are currently co-ordinating the development of a programme of investment from central Government to replace the previous European Regional Development Funds. The programme is called the UK Shared Prosperity Fund (UKSPF) and aims to target specific criteria from adult education to economic regeneration. The Trust is playing an active part in these discussions, including appropriate allocation of funds.
- A key programme of work to develop a Warrington wide estates strategy and delivery plan has commenced. Lucy Gardner is taking a lead role in this programme, alongside David Cooper, ICB finance.
- A Warrington Place workforce strategy has been developed, which includes key priorities for WHH, including recruitment and education and training.
- A review of urgent and emergency care on the day demand and capacity has commenced across Warrington, which aims to address some of the pressure on our ED department and on GP services.

Halton

- The One Halton programme of work is currently emerging, focused on delivery around 5 themes:
  - Starting Well
  - Living Well
  - Ageing Well
  - Wider Determinants
  - Integrated Hubs
- To date, Senior Responsible Officers have been appointed to lead each workstream, and an overarching delivery plan supported by expected outcomes and delivery metrics is currently in development. Lucy Gardner is joint SRO for the wider determinants theme, alongwith Sally Yeoman, CEO Halton and St Helen's VCA.

Cheshire and Merseyside strategic updates

C&M endoscopy
The Trust has submitted a business case to develop an endoscopy hub on our Halton hospital site.

C&M Clinical strategy
The ICB Medical Director has drafted a set of clinical strategy principles. A workshop took place in September, led by Nikki Stevenson and Lucy Gardner, for medical directors and strategy directors to contribute to and further develop the C&M clinical strategy.

C&M pathology
A business case in in development for a shared LIMs (Laboratory Information System) for C&M. National capital funding has been secured. Delivery is due to commence in March 2024.

C&M paediatrics
Paediatrics, including paediatrics elective recovery, has been identified as a priority within C&M. The Trust is in initial discussions with Alder Hey, including how we can support elective recovery, which may include increased paediatric surgical provision at WHH.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/10/124**
SUBJECT:	**Audit Committee Chairs Annual report 2022/23**
DATE OF MEETING:	4 October 2023
AUTHOR(S):	Mike O'Connor, Non-Executive Director & Audit Committee Chair
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate*)**	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. √ SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future √ SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities. √
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

Equality duty	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	√		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	√		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not	√		
Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	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. The overall Head of Internal Audit opinion for the period 1st April 2022 to 31st March 2023 provides **Substantial Assurance**. This provides assurance that there is good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

PURPOSE: ***(please select as appropriate)***	Information	Approval √	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the Audit Committee Chair's Annual Report 2022/23			
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee		
	Agenda Ref.	AC/23/08/69		
	Date of meeting	17 August 2023		
	Summary of Outcome	Supported for approval by Trust Board 4 October 2023		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Audit Committee Annual Report 2022-23	AGENDA REF:	BM/23/10/124

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 2022-31 March 2023.

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. During the year the Committee met five times. Non-Executive Michael O'Connor holds the position of Chair of the Audit Committee.

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by members of the Committee. The Chair of the Trust is not a member of the Audit Committee in line with best practice.

Member	Attendance (Actual v Max)
Michael O'Connor. Non-Executive Director	5/5
Cliff Richards, Non-Executive Director	5/5
Julie Jarman, Non-Executive Director	4/5
Jayne Downey, Non-Executive Director	4/5
John Somers, Non-Executive Director	2/2
Terry Atherton, Non-Executive Director	3/3

Regular attendees at the Committee Meetings were the Trust's external auditors Grant Thornton (External Auditors from January 2017), Mersey Internal Audit Agency (MIAA – Internal Audit and Counter-Fraud Services), the Chief Finance Officer & Deputy Chief Executive, the Director of Integrated Governance and Quality and the Company Secretary

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in August 2022 to ensure they continue to remain fit-for-purpose and will be reviewed again in August 2024.

Frequency of Meetings & Summary of Activity

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

High Assurance was provided in the following: Key Financial Controls (Accounts receivable and Accounts Payable)

Substantial Assurance was provided in the following: Waiting List Initiatives, Waiting List Managements, Payroll, Ockenden, Risk Management Core, Key Financial Controls (Treasury Management & General Ledger), Mortality (21/22) Data Security & Protection Toolkit (DSPT) submission (assessment against self-assessment)

Moderate Assurance was provided in the following: Data Security & Protection Toolkit (DSPT) submission (assessment against national Data Guardian Standards), Digital Systems (Clinical Safety)

Limited Assurance was provided in the following: Sepsis, Critical Applications (Badger Net Maternity)

There were no areas reported as providing no assurance.

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, approved the Trust's Risk Appetite Statement and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and at Committee meetings bi-monthly in year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board. Each strategic risk is allocated to a committee for focused oversight and scrutiny.

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 **Substantial 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 discussed with the Executive Team via the Chief Finance Officer & Deputy Chief Executive 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 regularly to the Committee by Internal Audit throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

An efficient and effective Assurance Framework is a fundamental component of good governance, providing a tool for Boards to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to organisational success.

The Assurance Framework Review concluded that the organisation's Assurance Framework is structured to meet the NHS requirements.

Opinion	
Structure	The organisation's AF is structured to meet the NHS requirements.
Risk Appetite	The organisation has recently developed a risk appetite statement, which has been used to support the Board tolerance of risk. Work is now ongoing to evidence a direct link within the AF to demonstrate how risk appetite has been used to inform the management of the AF.
Engagement	The AF is visibly used by the organisation.
Quality & Alignment	The AF clearly reflects the risks discussed by the Board.

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.

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 LLP commenced its initial three-year term as Auditors to the Trust in January 2017. The company then commenced a two-year term in October 2020, following a competitive procurement exercise and recommendation by the Council of Governors. The contract contained the option to extend for additional years and following support from the Audit Committee and approval by the Council of Governors, an extension up to 30th September 2024 was agreed.

During the year, the Auditors reported on the 2022–23 Financial Statements, 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 Trust and representatives of Grant Thornton have attended each Audit Committee meeting.

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. During 22/23 MIAA commenced investigations into four potential fraud issues, of which three cases were closed and one remains open. There were also two cases carried forward from the previous years of which one remains open, and one has been closed.

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.

With respect to the Internal Audit plan for 2022-23, 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 2023-24 Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

During 2022-23, alongside the Audit Committee, four main Board assurance committees were in place:

1. Quality Assurance Committee,
2. Finance & Sustainability Committee,
3. Strategic People Committee and

4. Clinical Recovery Oversight Committee. *(The Committee was a temporary Committee established in March 2021, during the COVID-19 pandemic and was accountable to the Board to ensure triangulation of matters detailed above under the purview of the Quality Assurance Committee and the Finance & Sustainability Committee; and ensuring that the organisational risks were managed appropriately in line with professional and regulatory standards. In March 2023, the Board agreed to disestablish the Committee and incorporate the above matters within the remit of the Quality Assurance Committee and Finance & Sustainability Committee as appropriate)*

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 Committee Assurance Report.

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in November 2022

The Committee will also assess its own performance during the year and will report to the Board of Directors in November 2022.

The Audit Committee acknowledges the significant amount of work carried out by the Quality Assurance Committee 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 a year which again proved to be unusually challenging. The pandemic continued to create significant unexpected pressures, and all concerned adapted to the situation in a highly professional manner to ensure that effective risk management and good governance were maintained throughout.

Mike O'Connor
Chair of Audit Committee
August 2022