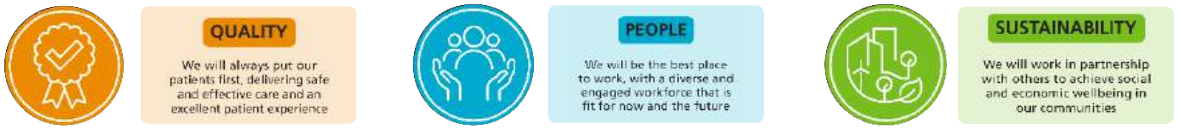
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting
Part 1 (held in Public)

Wednesday 7 August 2024
10.00am -12.30pm
Halton Education Centre, Halton Hospital/MS Teams

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 7 August 2024, 10.00am – 12.30pm
Lecture Theatre, Halton Education Centre

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/24/08/56	**10:00**	Engagement Story – How my cancer diagnosis was communicated My story by Bernadette Davies-Harwood (to be presented on the day)	***To note***	**Presentation /Video**	Chief Nurse
BM/24/08/57	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/24/08/58	**10:17**	Minutes and Action Log of the previous meeting held on **5 June 2024**	***For approval***	***Minutes***	Chair
BM/24/08/59	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/24/08/60	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/24/08/61	**10:30**	Chair's Report	***For info/update***	***Verbal***	Chair
BM/24/08/62	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:					
BM/24/08/63 **(a)** **(b)**	**10:40**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
		Quality Dashboard **Including** Assurance Reports Quality and Assurance Committee 11.06.24/09.07.24	***For assurance***	***Report & Presentation***	Chief Nurse, Chief Operating Officer & Deputy Chief Executive, Exec Medical Director Cliff Richards, Committee Chair
		People Dashboard **Including** Assurance Reports Strategic People Committee 19.06.24/17.07.24	***For assurance***	***Report & Presentation***	Chief People Officer Julie Jarman, Committee Chair
		Sustainability Dashboard	***For assurance***	***Report & Presentation***	Chief Finance Officer

(c)		**Including** Assurance Reports Finance and Sustainability Committee 26.06.24/24.07.24			John Somers, Committee Chair
(d)		Audit Committee Assurance Report 20.06.24	***For assurance***	***Report & Presentation***	Mike O'Connor – Senior Independent Director
Strategic aim:					
BM/24/08/64	**11:05**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/24/08/65	**11:15**	Maternity & Neonatal Update Summary Report to cover: • Ockenden • Maternity Incentive Scheme including Saving Babies Lives Care Bundle • Maternity Quality & Safety Review (April & May) • Birth Trauma Position • Transitional Care Q4 20234/24 • ATAIN Q4 2023/24	***To note for assurance***	***Report***	Director of Midwifery
BM/24/08/66	**11.25**	Compliance Q4 Update	***To note for assurance***	***Report***	Chief Nurse
BM/24/08/67		Mortuary Update – Response to Fuller Report	***To note for assurance***	***Report***	Chief Nurse
Strategic aim:					
BM/24/08/68	**11:50**	Communications & Engagement Dashboard Q1	***To note for assurance***	**Report**	Director of Communications & Engagement
BM/24/08/69	**11:55**	Guardian of Safeworking Annual Report	***To note for assurance***	**Report**	Executive Medical Director
BM/24/08/70		Health Inequalities *(from action log)*	***To note for assurance***	**Report**	Director of Strategy & Partnerships
Strategic Aim					

BM/24/08/71	**12:10**	EPRR Report	***To note for assurance***	**Report**	Chief Operating Officer & Deputy Chief Executive
BM/24/08/72	**12.15**	Strategy Programme Highlight Report	***To note for assurance***	**Report**	Director of Strategy & Partnerships
BM/24/08/73		Strategy Bi-Annual Delivery Report	***To note for assurance***	**Report**	Director of Strategy & Partnerships

Governance					
BM/24/08/74	**12.25**	Trust Organograms	***For approval***	**Report**	Company Secretary
BM/24/08/75		Fit and Proper Persons Test – Annual Report on Board Members	***For assurance***	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/24/08/76	Committee Chairs Annual Reports i Finance & Sustainability Committee ii Quality Assurance Committee	Finance & Sustainability Committee Date: 24.07.24 Ref: FSC/24/07/82 Quality Assurance Committee Date: 09.07.24 Ref: QAC/24/07/85	***To note for assurance***	**Report**	Non-Executive Directors/Chairs of Committees
BM/24/08/77	Director of Infection Prevention & Control Annual Report	Quality Assurance Committee Date: 09.07.24 Ref: QAC/24/07/77 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/08/78	Infection Prevention & Control Board Assurance	Quality Assurance Committee Date: 09.07.24 Ref: QAC/24/07/78 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/08/79	Safeguarding Annual Report	Quality Assurance Committee Date: 11.06.24 Ref: QAC/24/06/58 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/08/80	Safe Nurse Staffing Bi-Annual Report	Quality Assurance Committee *(Extraordinary)* Date: 16.07.24 Ref: QAC/24/07/96 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/24/08/81	Quality Strategy Update	Quality Assurance Committee Date: 11.06.24 Ref: QAC/24/06/60	***To note for assurance***	**Report**	Chief Nurse

BM/24/08/82	Risk Management Strategy & Annual Report	Quality Assurance Committee Date: 16.07.24 Ref: QAC/24/07/XX	***To note for assurance***	**Report**	Chief Nurse
BM/24/08/83	Health & Safety Report	Quality Assurance Committee Date: 16.07.24 Ref: QAC/24/07/98	***To note for assurance***	**Report**	Chief Nurse
BM/24/08/84	Complaints Annual Report	Quality Assurance Committee Date: 16.07.24 Ref: QAC/24/07/100	***To note for assurance***	**Report**	Chief Nurse
BM/24/08/85	Learning from Deaths	Quality Assurance Committee Date: 11.06.24 Ref: QAC/24/06/59	***To note for assurance***	**Report**	Executive Medical Director
BM/24/08/86	Medicines Management Annual Report	Quality Assurance Committee Date: 11.06.24 Ref: QAC/24/06/55	***To note for assurance***	**Report**	Executive Medical Director
BM/24/08/87	Controlled Drugs Annual Report	Quality Assurance Committee Date: 11.06.24 Ref: QAC/24/06/56	***To note for assurance***	**Report**	Executive Medical Director
BM/24/08/88	Digital Strategy Group Update	Finance & Sustainability Committee Date: 24.07.24 Ref: FSC/24/07/81 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
Closing					
BM/24/08/89	**12:30**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/24/08/90		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting – 2 October 2024, Trust Conference Room, WHH					

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 5 June 2024 Halton Education Centre & Via 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
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Simon Constable (SC)	Chief Executive
Ali Kennah (AK)	Chief Nurse
Jane Hurst (JH)	Chief Finance Officer
Dan Moore (DM)	Chief Operating Officer
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Jan O'Driscoll (JO'D)	Partner Non-Executive Director
Apologies	
In Attendance	
Lucy Gardner (LG)	Director of Strategy and Partnerships
Kate Henry (KH)	Director of Communications & Engagement
Ailsa Gaskill-Jones (AGJ)	Director of Midwifery
Claire Grice (CG)	Head of Patient Experience, Equality, Diversity & Inclusion (*in attendance for Agenda Item BM/24/06/028)*
Claire Grainger (CGr)	Patients' daughter (*in attendance for Agenda Item BM/24/06/028)*
Yasmin Habib (YH)	Lead Nurse for Urgent and Emergency Care (*in attendance for Agenda Item BM/24/06/028)*
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Emily Kelso	Corporate Governance & Membership Manager **(minute taking)**
Observing	
Norman Holding	Lead Governor

Agenda Ref	Agenda Item
BM/24/06/028	**Engagement Story Emergency Department Experience** The Trust Board received the patient story presented by CG and the patient's daughter CGr. The story detailed the journey of that patient through the WHH Emergency Department. CGr explained the initial triage conversation and consultations by doctors during the first stages of her ED visit, which were both informative and well

structured, following which the patient was allocated a bed in the ED department. However, due to capacity and demand issues this bed was located on a busy corridor. CGr then provided details of the crowded corridors and the level of shock at her encounter – which she described as feeling like a 'war zone' in the sense of the number and acuity of patients on the corridors. Despite the obvious pressures she noted how staff remained kind and friendly.

A video was also shared with the Board which was the patient describing the visit from her own perspective, she described feeling scared and vulnerable.

YH introduced herself and thanked the patient and their family for sharing their story and working with the Trust to learn lessons and develop action plans to improve.

A number of actions were detailed, these included:

- The intentions to reduce corridor care
- The introduction of allocated examination rooms for patients on corridors to ensure privacy and dignity during examinations
- The revised linen delivery programme to ensure shortages were not experienced. Teams had been educated on locations of linen stock in ED and how to replenish out of hours if required.
- An observations machine dedicated to each corridor.
- The plan to introduce signs on corridors detailing the names nurse, to ensure patients were informed of their allocated contact
- Development of a leaflet for patents in ED explaining the situation around corridor beds and signposting important information to increase their understanding.
- Isolation area for patients in ED with low immune, including 7 isolation cubicles, utilised following medical review.
- Nutrition and Hydration 2 – 3 hourly drink and snack round in addition to meal service

SMcG commented on the difficulties in corridor care, noting that corridor care was not something the Trust wanted, however it was necessary to meet demands. It was noted that the department was seeing 3-4 times more patients than that for which it was designed. He also commented on the importance of better communications so as to prepare patients better for the reality of corridor care (even though it was undesirable I was a reality for the foreseeable future) and the reality of long waits and difficult circumstances. Authentic communications were vital to avoid a level of surprise and this needed some thought.

CR queried whether in real time there was anyone available for the patient/her family to talk to. CGr responded that there may have been however they were not sure who and felt that they did not want to distract busy staff. It was agreed that a named nurse would have helped, an action which was detailed in the presentation.

	SMcG thanked CGr for joining the Board meeting to share her mother's story, the Board reflected on the pressure on the ED and its staff. It was noted that safe staffing was in place at a ratio of 1:5, however the unavoidable use of corridor created an environment which had negative impacts on patient experience. The board were assured of the communications with the patient and her family since the event and also of the actions in place to make improvements. The Board reflected on observational visits, AK explained that outputs from Governor observational visits along with leadership observational visits were now being reported through the Patent Experience Sub Committee and could be bought to QAC for triangulation. The Board further discussed the timing of Leadership Observational Visits prior to board not being ideal particularly forward staff. It was agreed this would be reviewed, and revised timings would be communicated to Board members prior to the August Board meeting. **The Trust Board;** **1. Discussed and noted the Engagement story.** **2. Agreed that an action from to review communications approach re preparation of patients for implications of corridor care with YH/AK would be taken by KH**
BM/24/06/029	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, invited presenters and observers to the meeting, no apologies were noted, and there were no declarations of interest made. SMcG referred to the recent successful recruitment process to appoint the new Chief Executive for the Trust to replace Simon Constable. A press release had been issued confirming that Nikhil Khashu had been successfully appointed to the position following a competitive recruitment process. A start date was yet to be confirmed. SMcG also reminded everyone that as a general election had been called the convention of purdah was now in place. **The Trust Board noted the welcome to the meeting**
BM/24/06/030	**Minutes and Action Log from the previous meeting held on 2 April 2024** The minutes of the meeting held on 2 April 2024 were agreed as an accurate record, with two minor amendments. 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 2 April 2024 and noted the Action Log.
BM/24/06/031	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/24/06/032	**Chief Executive's Report** SC introduced the paper, which was taken as read and welcomed any questions. SMcG commented on the news around the internal appointment of Eshita Hassan as Deputy Medical Director, who would start the position following Anne Robinson's retirement, SMcG further expressed his thanks on behalf of the Trust Board to Anne for her hard work and dedication to the Trust its staff and patients. JS queried the structure of the CMAST project team and whether any resource could be called upon to support the Trust in its integration work. SC responded that this was not the role of CMAST, instead its focus was on sharing ideas and best practice to support and enable organisations to make improvements. The governance of CMAST and reporting structure was explained, along with the benefits of efficiency at scale, shared systems and processes to drive savings. PF provided an explanation of capped and uncapped theatre utilisation, at the request of the Board. PF further explained that it was not typically complex procedures which caused delays but rather high-volume low complexity procedures, where delays were more frequent. Given this it was difficult to compare WHH with specialist trusts. LG further explained that uncapped was not funded, and had impacts on staffing costs, it was more financially beneficial for capped theatre utilisation to be as high as possible. **The Trust Board noted the Chief Executive's Report**
BM/24/06/033	**Chair's Report** SMcG introduced the report, which was taken as read, no further questions were raised by Board members. **The Trust Board noted the Chair's Report**
BM/24/06/034	**Board Assurance Framework (BAF)** JC introduced the report which provided the Board with an update on each of the strategic risks. The key highlights from the report, were as follows: • No new risks had been added; • The rating of one risk (#1134) had been reduced. • The description of one risk (#1757) had been updated • No risks have been closed or de-escalated;

	• There had been no changes to the risk appetites of any of the risks JC explained the work taking place around the corporate risk register and departmental risk registers through the Risk Review Group to improve strategic risk reporting up into the BAF. **The Trust Board discussed and approved the changes and updates to the Strategic Risk Register**
BM/24/04/008	**Integrated Performance Report** SC introduced the agenda item which provided a summary of the Trust performance, and the report was taken as read. SC further explained the revised approach to presentation of the report to Trust Board, the Executive team had been asked to present a summary slide to cover each of the 7 indicators within the IPR that were both failing and had special cause variation of a concerning nature. These were: **Quality:** **1. Healthcare Acquired Infections (Klebsiella)** AK explained the nature of Klebsiella infections a UTI/hepatobiliary. It was noted that an Audit of the UTI pathway was in progress and work around educating staff on catheter management was taking place, furthermore a hepatobiliary audit had been completed. It was explained that the Trust was not flagged as a high outlier however work was being undertaken with Bolton hospital to learn best practice given their high performance. A deep dive had been presented to QAC in April and progress would be reported into the committee to provide assurance around agreed actions. **2. VTE Assessment** AK explained that VTE assessment performance currently 93.3% (target >95%). It was explained that the deterioration had been driven by 3 key factors; EAU becoming an admitted area for patients, Delays to medical assessment in ED, Bypassing of VTE forcing function in clerking documentation by surgical specialities. AK further explained the recovery plan which included a deep dive, speciality level reporting to be shared with care groups and engagement with surgical teams regarding use of forms rather than notes in EPR. **3. Mixed Sex Accommodation Breaches (Non ITU Only)** AK explained the position and highlighted that there was a nil return for non ITU Mixed Sex Accommodation (MSA) breach, it was highlighted that the biggest driver for beaches was issues in patient flow notably no criteria to reside patients. The metric was being closely monitored and managed at bed oversight meetings. MOC queried the accommodation provisions for non-binary patients, SC responded this is a historic KPI and NHSE was looking to amend the constitution that would change reporting requirements and modernise.

4. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis

AK explained that the largest driver was ED crowding, it was explained that Introduction of Manchester Triage would hasten the triage process and highlight high risk patients. It was further explained that the Medical Director and Chief Nurse were to meet with the sepsis lead in June to; agree implementation plan for NICE NG15, develop pathway and reporting standards for NG51 and AoRMC, furthermore the current governance and reporting pathway was detailed. Slide 6 provided further sources of assurance to the Board.

Access and Performance:

5. RTT - Number of patients waiting 65+ weeks

DM explained the current position with the Trust sitting 136 behind plan. High areas of risk were Gynaecology, medium risk areas were Urology and Trauma and Orthopaedics, and low area of risk was Ear Nore and Throat, the mitigations in place were described for each. A table was shared identifying the Trusts C&M benchmarked position as 8/12. It was noted that this was an improving position from 23/24 when the Trust was routinely the worst performing (12th). DM explained that improvements were attributable to investments in additional activity and improvements in efficiency over the last 6 months

Finance

6. 61. Capped Theatre Utilisation

PF explained that the capped theatre utilisation for April sat at 68.8%, improvements were in place with indicative data for May 74.1% (it was noted this data was yet to be validated). The changes contributing to improved performance were described including a new approach to scheduling launched, interim scheduling software introduced, data quality exercise completed. In addition, the Theatres Improvement Programme was underway. Details of the reporting and governance process were shared.

7. Cost Improvement Programme (recurrent forecast) – In year performance to date

JH explained that only 9% of the CIP delivered in April was recurrent. Where recurrent CIP had not been realised efforts were made to deliver from non-recurrent savings. It was further noted that a detailed review of other recurrent schemes had taken place by the Executive Team. A further £6.3m has been identified and a review on these plans was arranged for 13 June 2024.

JS commented that FSC had not been assured on either the delivery or governance around the CIP as noted in the committee assurance report. SC responded that the Executive Team were required to respond accordingly and to provide assurance to NED colleagues, it was noted that tough decisions would be likely.

	SMcG made particular mention of the approach taken to the IPR at this Board. The Exec Summary had drawn especial attention to the 7 PIs above as failing and being concerning from the special cause perspective. Exec Directors' providing a particular focus and presentations on these specific matters was exactly the kind of approach to strategic performance management that the Board had been trying to achieve and evolve for some time. He encouraged Exec colleagues to reflect on this and to mirror for future board meetings. **Additional Note** AK informed the board of a regulation 28 issued from coroner, the case was heard in court on the 23 May. AK provided detail around the incidental x-ray findings not noted on the report. The Trust was planning to respond with a challenge letter, which would be going to the Executive Team meeting for approval 6 June 2024. PF further explained the complications in listing all incidental findings, which had the potential for reducing productivity and increased the risk of key findings being missed due to volume of information. **The Trust Board:** **1. Approved the cash support of up to £10.373m from NHSE for Q2** **2. Noted the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.** **3. Noted the contents of the report.**
Quality	
BM/24/04/009	**Fragile Clinical Services Update** PF introduced the report which provided the Board with a high-level overview of services currently identified as being Fragile. The following key highlights were taken from the report: • **Paediatric ophthalmology** had been stepped down from Fragile Services Oversight at PSCESC meeting in May. The Board were reassured that oversight of remaining low risk actions (implementation of Retinopathy of Prematurity camera screening) were to be maintained by CBU and Care Group. • **Stroke Services** had been escalated to Fragile Service status following presentation to the April PSCESC meeting. Issues identified with the pathway included the number of direct Acute Stroke admissions to the Warrington site (which is not commissioned to provide an Acute Stroke Service) and delays in repatriation from Whiston to the Warrington site. No harm had been identified. A demand and capacity exercise was underway, engagement with Whiston service was also underway and in addition a Deep Dive with plan was to be presented to QAC. • **Urology** - Surveillance cystoscopy position had improved (>75% reduction from peak). • **Gynaecological Surgery** remains fragile; however progress was being made, no new harms had been identified since the last report. • **Orthopaedics Fractured NOF** - Significant improvement across majority of performance indicators – performance at or close to national average in these domains

	• **ENT** – no harm had been reported to date, MIAA had audited the service, the only gap identified was in time to theatres. SMcG queried the impact AI was having. PF confirmed the benefits of using AI in urology were evident in being able to identify renal stones more productively than manual reviews. **The Trust Board noted the current list of Fragile Services and associated high level progress updates**
BM/24/06/037	**In patient Survey** AK introduced the report explaining that the National Inpatient Survey had been an annual requirement since 2002 by the CQC. The National Inpatient Survey results were published by CQC in September 2023. AK highlighted the WHH overall response rate of 29% compared to a national average response rate of 40% and confirmed that work around improving the repose rate for future years was a focus. It was noted that the Trust had seen decline in 2 individual questions compared to the WHH 2021 survey, however these were not seen as statistically lower than other Trusts. These were: • Did you get enough help to eat your meals? • Do you think the hospital staff did everything they could do to help your pain? Actions to improve these areas feature in the 2022 Inpatient Survey Action Plan and remain on target these would be monitored via Patient Experience Sub Committee quarterly. SMcG highlighted the comment under; *where patient experience could be improved, specifically hospital food quality* and sought assurance around the timescales for the new kitchen estates project, DM confirmed work was to be completed by Q3. **The Board of Directors noted the contents of the report.**
BM/24/04/010	**Maternity Update** AGJ introduced the new format, now including a summary paper as requested at the April Board meeting, which provided an overview of the required Maternity papers for oversight by the Trust Board. The following key points were highlighted: • The improvement in workforce measures related to retention and vacancy rate was being sustained • A process of reviewing all outstanding PDRs was underway with a trajectory to meet the trust target by the end of May 2024. • As reported to QAC in April, the results of the NHS Maternity Services Survey 2023 had been received and an internal plan was being produced and would be reporting throuhg QAC • A Maternity Safety Champion Walkaround took place on 12 March 2024 with a focus on the maternity ward and Neonatal Unit. Feedback from

	staff was both constructive and positive, environment remained a challenge due to the aging estate. • The maternity triage Task & Finish group would continue to work with the team to optimise the service and continue to improve performance. Audit of timeliness of medical review was being completed for the period Jan-March 2024 to support further improvements • An ongoing QI programme of work was in place for post-partum haemorrhages which would be reported into QAC from June, more timely regional data was awaited. • WHH stillbirth rate for Q4 2023/24 was 8.50 per 1000 births. The WHH annual Mean stillbirth rate (2023/24) is 2.71 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 was 4.1/1000 births. • In relation to Ockenden: ○ **Ockenden Part 1a**: WHH is 100% compliant. ○ **Ockenden 1b**: WHH is 100% compliant. ○ **Ockenden 2**: WHH is 98.55% compliant. The remaining one amber action is on track to be completed by 30 June 2024. SC commented that the summary report provided the Trust Board with good assurance on the work being undertaken in maternity services, and, together with the recent Maternity Services CQC rating of Good, provided evidence on the quality of care being provided at the Trust. SMcG also commended AGJ on a very clear and comprehensive overview. CR commented around the recent media attention around birth trauma, AGJ confirmed that the topic would be presented as a Hot Topic to QAC in June. The following papers were included, as an appendix to the summary report: • Maternity Quality & Safety update February 2024 • Maternity Quality & Safety update March 2024 • Maternity Incentive Scheme Year 5 and 6 • PMRT Annual Review • PMRT Q4 2023/24 • Maternity Self-Assessment biannual review • Ockenden position • Midwifery Safe Staffing Q4 2023/24 **The Trust Board discussed and noted the maternity reports as per national recommendations**
BM/24/04/039	**Maternity Review of 2023/24 Progress Report** JD introduced the presentation which had been developed to provide the Board with assurance from the NED Maternity Safety Champion around the work undertaken across Maternity throughout the year. The presentation was formatted to provide detail of the drivers, along with the completed activity to improve performance. The areas covered were: • Workforce recruitment & retention

	• Workforce development including workforce outcomes. • Personalised care • Care pathways. • Bereavement care • Neonatal care • Clinical governance JD commented that the information around activities completed triangulated well when visiting the Maternity units during the scheduled Maternity Safety Champion walkabouts, the examples noted were the developments in triage and Nest, along with the improved morale amongst maternity staff. JD further commented on the additional work to be completed with the end goal being a reduction in incidents, complaints, and harm. **The Trust Board noted the content of the presntation**
People	
BM/24/06/040	**Health and Wellbeing Guardian Annual Report** MC introduced the paper which provided the Trust board with an overview of the activity undertaken in 2023-24 to provide assurance against the national Health and Wellbeing Guardian principles and refreshed responsibilities. Furthermore, the report detailed how the organisation was supporting the health and wellbeing of the workforce, with plans for enhancement of the offers into 2024-25. MC highlighted that when wellbeing guardian role had been reviewed in 2023 and from Q3 2023-24, the Wellbeing Guardian role evolved to be a 'Health and Wellbeing Guardian'. In addition, the nine principles were replaced with a set of responsibilities which were detailed within the report. CR confirmed his position as the Trust's Health and Wellbeing Guardian and described the significant shift in the role from what felt like operational responsibility to one assurance seeking. CR commented further around the work required around health inequalities and how that would be a particular focus during the integration work with Bridgewater. LG confirmed that a report around health inequalities would be presented to the Trust Board in August. **The Trust Board noted the update provided on the progress of activity aligned to both the Wellbeing Guardian principles and the refreshed Health and Wellbeing Guardian responsibilities**
BM/24/06/041	**Gender Pay Gap Annual Report** MC introduced the report which presented the findings of the Gender Pay Gap for the financial year 2023/24. It was explained that The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 required all public sector organisations with over 250 employees to report and publish their Gender Pay Gap on their website on an annual basis. The following key points were highlighted from the report: • The reports reference to bonus payments were in relation to clinical excellence awards. It was noted that the 2023/24 consultant pay deal

	incorporated local clinical excellence awards. What was retained was the national clinical excellence awards, which were traditionally more received by those identified as male. It was explained that the 2023/24 report would be impacted by the national deal. PF explained that typically the report had always been skewed by a predominantly male consultant workforce, however this trend was likely to change given that female medical students now outweighed males 3:1 and given this trend future years would see this gap closing. JJ commented on woman being supported internally by the Trust to develop professionally and achieve promotions, including supporting part time and flexible working for those with parental and carer responsibilities. **The Trust Board noted the analysis, data and action plan**
Sustainability	
BM/24/06/042	**Estates Strategy** DM introduced the report which detailed the final version of the WHH Estates Strategy for approval by the Trust Board. It was noted that associated changes had been made to the strategy following presentation to the Board at the Board Development Day. DM reiterated the discussion that had taken place at the June FSC meeting, where the committee agreed the strategy needed to be adaptable in order to include progression on integration work with Bridgewater, it was agreed that updates would be reported into FSC, and the strategy would be adapted accordingly. **The Trust Board approved the 2024-2029 Estate Strategy**
Governance	
BM/24/06/043	**Declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence** JC introduced the paper explaining that NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. **The Trust Board noted the compliance with NHS Conditions G6 and CoS7 and approved the self-certification**
BM/24/06/044	**Updates to the WHH Constitution** JC introduced the report explaining that following approval at the Council of Governor meeting (16 May 2024) the Trust Board were being recommended to approve the amendments to the constitution as set out in the paper. **The Trust Board approved the amendments to the Constitution as**

	outlined in the paper to support:
	• **The Public Constituency – minimum number of members required, 50 per constituency.**
	• **Code of Governance updates, in regard to:**
	  ○ **Non-NHS income**
	  ○ **Significant transactions**

Supplementary Papers	
BM/24/06/045	Strategic People Committee - Chairs Annual Report
BM/24/06/046	Patient Experience Strategy Annual Report
BM/24/06/047	Infection Prevention & Control Q4 Update
BM/24/06/048	Learning From Experience Summary Report Q4
BM/24/06/049	Violence Reduction Strategy
BM/24/06/050	Guardian Of Safe Working Report Q3
BM/24/06/051	Guardian Of Safe Working Report Q4
BM/24/06/052	EPPR Compliance Update following Dec 2023 Report
BM/24/06/053	Digital Strategy Group Update
BM/24/06/054	**Review of the Meeting** SMcG reflected on the meeting, noting the meeting had contained good discussion, specifically around the BAF risks at the start of the meeting and the assurance received on maternity services. He also reminded everyone again to reflect on the approach taken to the IPR and the particular focus and presentations on these specific matters of concern as being exactly the kind of approach to strategic performance management that the Board had been trying to achieve and evolve for some time. He again encouraged Exec colleagues to reflect on this and to mirror for future board meetings. **The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items**
BM/24/06/055	**Any Other Business** No further business was raised. **Meeting ended at 12:27pm**
The Date and Time of the next Trust Board Meeting is Wednesday 7 August 2024, Education Centre, Halton Hospital.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD
ACTION LOG

AGENDA REFERENCE	BM/24/08/58	SUBJECT:	ACTION LOG	DATE OF MEETING	7 August 2024

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
N/A	N/A	Health Inequalities	To be presented to Trust Board	LG	August 2024	August 2024	Agenda Item BM/24/08/70	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/24/06/28	5.6.24	Engagement Story	KH to review communications approach re preparation of patients for implications of corridor care with YH/ AK	**KH/AK**	**August 2024**			

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/060**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	7 August 2024			
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 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)*	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/24/08/60

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 5 June 2024, 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 3 - June 2024. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

The Trust continues to undertake an elective recovery programme; the priority this year has been on the elimination of waiting lists longer than 65 weeks by the end of September 2024. Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality Assurance and the Finance & Sustainability Committees.

2.2 Leadership Changes

This is my final Board Report as chief executive at WHH. As previously reported, I will be leaving WHH at the end of August to join University Hospitals of North Midlands NHS Trust as their chief executive.

Nikhil Khashu has been appointed as my successor. He commences in post on 1 November 2024, on a two-year secondment from NHS England's Northwest regional team, where he has been Director of Finance since April 2022. More recently, Nik has been working nationally as NHS England's Deputy Chief Finance Officer. His previous experience includes executive director roles at provider organisations Calderstones and St Helens and Knowsley Teaching Hospitals.

The handover process has already started. Interim arrangements will be confirmed by the Nomination & Remuneration Committee following its meeting on 7 August 2024.

2.3 C&M Acute and Specialist Trust (CMAST) Provider Collaborative Update

The most recent CMAST update for Boards is attached as Appendix 2.

2.4 Urgent & Emergency Care System Improvement Programme

As a Trust we are committed to tackling the problems faced by overcrowding and people spending too long in our Emergency Department, as well as the challenges in discharging patients from hospital in a timely manner.

The Urgent and Emergency Care System Improvement Programme (UECSIP) has been established with partners across Warrington and Halton Places to drive improvements identified by the recent diagnostic work undertaken at the Trust by the external agency Newton.

The programme is being delivered by key partners across Warrington and Halton including ourselves and Bridgewater, along with Warrington Borough Council and Halton Borough Council. Carl Marsh, Warrington Place Director, is the Senior Responsible Officer (SRO) and Lucy Gardner, WHH Director of Strategy and Partnerships, is Programme Director.

The aim of the programme is to improve the quality of care delivered to patients using our urgent and emergency services. A number of specific objectives have been agreed which are expected to:

- eliminate corridor care over the course of 2024-25.
- improve 4-hour and 12-hour Emergency Department (ED) performance targets.
- reduce the number of patients in hospital with No Criteria to Reside (NCTR).
- reduce the length of stay (LoS) for patients.
- ensure that residents are supported in the right place in the community.
- obtain end-to-end system visibility of performance and patient position.

A number of workstreams have now been established with joint representation from our partner organisations:

- Admission and attendance avoidance – SROs: Dan Moore and Sarah Brennan
- Pre-NCTR (LoS) – SRO: Dan Moore
- NCTR (LoS) – SROs: Sarah Haworth and Stephanie Haddock
- Optimising intermediate care – SROs: Damian Nolan and Caroline Williams
- System visibility – SROs: Carl Marsh and Anthony Leo

The programme will report through the respective organisations' governance structures and to the Integrated Care Board Recovery Committee.

We know that lots of people have been working hard to resolve some of these big challenges, over several years, and some good progress has been made, although this has clearly not been enough. We are now working with, and alongside, those teams and individuals to ensure that there is no duplication and that together we can accelerate the actions which will make the biggest difference, both quickly and sustainably, to our patients.

2.5 IT Outage – Friday 19 July 2024

On Friday 19 July 2024 there was an IT outage which caused widespread disruption across the world, understood to be the result of two separate software updates applied early on Friday morning (approximately 5am BST).

The first update was to an anti-virus product Crowdstrike, which is used around the world. It is not used on any WHH hosted or provided systems, but it is used by the cloud hosting platform for Lorenzo.

The second update was a configuration change applied by Microsoft, to their Azure public cloud hosting platform. WHH uses systems that are hosted on this platform, including our 365 desktop solutions (MS Teams, Sharepoint) and the national NHSmail platform.

We stood up our Incident Control Room immediately as part of our well-rehearsed business continuity response.

Fixes were confirmed and initiated for both issues, but it did take time to flow through systems, but by the late afternoon we started to see light at the end of the tunnel.

It was disruptive, but not as disruptive as it could have been and we were not as affected as other organisations, NHS or otherwise.

Our digital and operational teams responded calmly and magnificently as ever and kept things going with confidence.

2.6 New Induction of Labour Unit

I am delighted that, earlier this month, we opened the new Induction of Labour Unit in Croft Wing.

This has been something on the 'to-do' list for a while, for a variety of reasons (not least of which patient and staff feedback), and we have finally got there.

The new unit has been relocated from Ward C23 to a larger, upgraded space within the Birth Suite itself.

It will enhance the experience and comfort for women on the induction of labour pathway. For anyone who has been through this will know how it can be a very anxious time.

The new unit includes: two induction bays, two bed spaces, improved bath and shower facilities, ensuite facilities for each bay as well as kitchen facilities for patients and birthing partners, alongside reclining chairs for comfort.

All of this has been done against a backdrop of improved patient safety and experience.

2.7 NHS Anti-Racist Framework

WHH has been awarded the bronze status as one of only four trusts in the Northwest region for the NHS Black, Asian, and Minority Ethnic Assembly Anti-Racist Framework. This achievement is a starting point for us in reflecting our dedication to fostering an inclusive culture for all.

This is not to say we have always got it right, nor have we finished. What this does say is that there is still more work to be done but we are starting on the right path.

Fully embedding anti-racist practices within our Trust is an ongoing journey that we all have a responsibility to support. We are committed to continuing this vital work in partnership with all. All voices are crucial in this process, and we are eager to hear ideas and experiences.

This milestone was achieved through the efforts of our workforce, led by our Multi-Ethnic Staff Network as well as our Culture and Inclusion Team, supported of course by our wider workforce with all roles and specialities.

The assembly recognised our commitment to programmes such as 'Your Future Your Way', the wonderful work of our clinical teams in aiming to remove barriers, reduce inequalities in access and our work around equality analysis and the impact this has on our communities and each other. For example, this year we are reporting some of our best data for the Workforce Race Equality Standard, where we are removing the disparity for staff being appointed from interview, no matter our race. This is a significant shift from previous years.

At WHH our workforce represents over 82 nationalities, a vast variety of different cultures, experiences and ways of life.

2.8 Supported Internship Programme

Since September of last year, we have been hosting a group of students from Warrington Vale Royal College on a Supported Internship Programme. The programme is run in collaboration with a charity (DFN Project Search), the local council, the college, and the Trust.

The programme serves as a transition from education to employment by enabling the students to develop employability skills. The students are enrolled at college; however, they have been based on site for the full academic year. They attend a taught session for the first hour of the day and a reflection session for the last hour. The four hours in between are spent on placement where the students develop skills such as communication, teamwork, and following instruction, amongst others. The students have been placed in non-clinical roles including portering, domestics, human resources, procurement, charity and finance.

They have successfully navigated their way through the programme, which for some has been challenging at times. Their tenacity, resilience and commitment has been evident for all to see as they have come into work every day dedicated to fulfilling their duties, supporting their team, and promoting the Trust values.

Our interns have now completed their time with us and graduated from the programme. This programme is essential in improving the life chances and independence of these young people. Some of them have already secured paid employment, with two of them having gained employment with us here at WHH.

2.9 Quality Academy Showcase

On 4 July we held our annual Quality Academy Showcase with 114 people coming together from across the Trust, our Governors, Experts by Experience, and external partners to share and celebrate the achievements of our staff in their work to improve quality, focusing on the theme of healthcare inequalities and patient and public involvement.

The event was expertly hosted by Professor Thara Raj, Director of Population Health and Inequalities, as we were guided through the programme of events for the day, including thought provoking keynote speakers, oral and poster presentations from our staff and a series of exciting breakout sessions.

Healthcare inequalities was chosen as the theme for the day, and it was clear from our expert keynote speakers Olly Benson (NHS England) and David Buck (The King's Fund), that by addressing what this means for the local population we serve we can, and we will, improve the quality of care that we provide, for all.

Thank you to all staff that delivered presentations and submitted posters for the event. The standard of work was very high, and judges had a tough job to pick the prizes awarded for our poster submissions on display during the event.

Poster presentation prizes were awarded as follows:

- **The People's Choice**
  Breast cancers identified from family history recall.
  Dr. Huma Irshad, Denise Bond and Mr. A. Farooq
- **First Place Poster Prize**
  Warrington and Halton Teaching Hospitals improving the uptake of BCG vaccination among eligible infants.

Claire Darling, Pauline Murphy, Tildy Ashcroft, Julie Langley, Rachel Crone, Donna Abbott, Jo Harvey, Jacqui Richards, Dr Gopalakrishna, Dr Satish Hulikere, Jo Houseman, Rose Murphy, Jill Cook

- **Second Place Poster Prize**
  Intensive care flashcard training – A quality improvement project at Warrington Hospital.
  Dr Henry Graham-Rack, Dr Michelle Riska, Dr Tim Furniss.
- **Highly Commended**
  Mouthcare matters: Taking mouthcare seriously.
  Claerwen Snell and Louise Spence – Highly Specialist Speech and Language Therapists.
- **Highly Commended**
  WHH inpatient ward productivity dashboard.
  Dr Phyu P Wai, Claire Leather through support of WHH QI improvement, WHH Data Analytics team, Ward A8 and Unplanned Care.

The showcase is an annual event, and it is always inspiring to see and hear about the great work happening. There are many more examples of outstanding work to improve quality across the Trust, our local partners and communities every day. The take home message from this event was that everyone should have a voice in the care they provide and receive, and the Quality Academy Team are here to support, to take forward ideas for quality improvement, clinical audit, research, and evidence-based practice, to ensure our voices heard, represented and acted upon, in every part of the work we do.

2.10 Annual Report and Accounts 2023-2024

As a Foundation Trust in the NHS, it is set out within legislation that our Annual Report and Accounts have to be submitted to Parliament every year. Those for 2023-2024 were laid before Parliament on 29 July 2024. Thank you to everybody involved who have made this possible.

Our Annual Members' Meeting is scheduled for 4 October 2024.

2.11 Runcorn Health and Education Hub

The Runcorn Health and Education Hub is one of eight "Towns Fund" projects being created in Runcorn as part of the Reconnecting Runcorn Programme. This new, integrated health and education facility is designed to help people look after themselves, reconnect with their local communities and live happily, healthily, and independently for longer. It will provide access to higher education and skills courses to help create the next generation of health and care workforce once it opens in 2025.

The hub is a collaborative system-wide project delivered by five core partners: Halton Borough Council, Warrington and Halton Teaching Hospitals, Bridgewater Community Healthcare, Mersey Care, and Riverside College.

The current Runcorn library will be refurbished to become the hub, with a service model focused on children, young people, families, and people living with long-term conditions. We are at an exciting milestone in the project, with the plans about to be signed-off.

Room layouts and technical drawings are just the start of bringing a building to life. Making sure that the building works and service users are supported to use it is a vital part of the design process. A crucial part of developing this programme has been engaging with colleagues, service providers, service users and patients to gather input and feedback.

Feedback on the plans for the hub and the designs have been overwhelmingly positive. There is much excitement around having a new facility in Runcorn town centre as a place to attend scheduled appointments, but also to drop-in for advice or spend time after an appointment.

Some feedback has already been addressed through the architectural and design team and the rest will be reflected when we come to the end of the build and commissioning the building. Our engagement is on-going, and we'll be checking-back in with a 'you said, we did' and to seek feedback as the programme progresses.

2.12 Special Days/Weeks for professional groups

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

- National Healthcare Estates and Facilities Day: 19 June 2024
- Pride Month: June 2024
- South Asian Heritage Month: 18 July – 17 August 2024
- Disability Pride Month: July 2024

2.13 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 our local Westminster MPs, through regular meetings but also when 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.

2.14 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 (May 2024): Erin O'Sullivan

I was delighted to go to Pharmacy and genuinely surprise Erin O'Sullivan (Pharmacy Technician) as the winner of the Trust's May 2024 *You Made a Difference Award*.

Erin went above and beyond whilst supporting a patient with some difficulties with their medication upon discharge, and it was immediately recognised and appreciated by a colleague.

The patient was "*beyond grateful"* with the help and support Erin provided, and her work was a great example of an act of kindness, consideration and making a positive contribution to a patient's experience at a challenging time. It's a great example because it's the sort of thing that goes on across the Trust around the clock, throughout the year.

The nomination stated that "*you truly are an asset to Team WHH*" and they were "*touched by what you have done for that patient, and what longer term impact that will have on them*".

You Made A Difference Award (June 2024): Colette Toynton

Colette Toynton, ENT Secretary, was the winner of the Trust's June 2024 You Made a Difference Award. Colette was nominated for her hard work and dedication, and in particular her amazing work over the past five months, demonstrating leadership skills, resilience and an ability to manage in some very stressful situations. It was lovely to read about "*a contagious personality, will do anything to help anyone, always going the extra mile*" and a "*very caring individual who is lovely with any patient you have contact with.*"

The recipients of my own Chief Executive's Award have also been as follows:

Chief Executive's Award (May 2024): Jill Malkin, Domestic Assistant

Jill has worked for the Trust for over 20 years and is described as a "proactive, get it done lady, who takes pride in her work. *She is dedicated, helpful, supportive, nothing is too much trouble, everything is organised the residents love her…Because she just quietly gets on with her work with the minimal of fuss even dealing with things that were not her responsibility."*

Chief Executive's Award (May 2024): Ward B18

Amongst many compliments I have received about the care on B18 this one stood out to me - from very grateful parents following the very sad death of their son earlier this year.

"I would like to therefore bring your attention to the care that he received whilst in your hospital, and in particular to the wonderful and dedicated staff of ward B18. My wife and I would like you to know how important your nursing staff and doctors are to the hospital, (they are the NHS.) Whilst in their care not only did all of them give him the best care, but also went above and beyond to give the whole family their care and support as well. We find it fitting in circumstances like this that all the staff are fully recognised for their dedication and compassion, which is sometimes overlooked, as people are quick to complain but not to commend. We would like for you to pass on our heartfelt gratitude for everything they have done, and for their commitment and dedication for this we will be always truly grateful, at a very difficult time."

Chief Executive's Award (May 2024): Communications & Engagement Team

I made this award in recognition of all the extra hard work that went into the delivery of the second highly successful Thank You Awards Ceremony at the Concorde Arena this year. It is a big event that takes a lot of organising in order to make everyone feel appreciated. The team have worked together to make sure this happens.

Chief Executive's Award (July 2024): Ward C20

I was delighted to make this presentation to the ward following receipt of a number of family and patient compliments over the last few months. The team on the Ward C20 consistently demonstrate our values on a daily basis and it it very much recognised by patients and their families.

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

I have also specifically and personally recognised the contribution of the following colleagues:

- Lefteris Zabatis, Senior Strategic Project Manager - Strategy & Partnerships
- Sharon Preston, Sister - Ward B4
- Maureen Steele, Medical Secretary - Women's & Children's Health

- Michelle Smith, Lead Allied Health Professional - Clinical Support Services
- Suzanne Miller, Staff Nurse, Outpatients Department - Halton Hospital
- Emily Clarke, Transfer of Care Nurse - Integrated Medicine & Community
- Katie Wilson, Pharmacy Technician - Clinical Support Services
- Diane Clare, Receptionist - Outpatients
- Michelle Annett, Healthcare Assistant - Ward B11
- Matthew Jones, Advanced Physiotherapist - Urgent & Emergency Care
- Sheelagh Simon, Staff Nurse - Ward A5 Elective
- Carole Daly, Paediatric Respiratory Nurse Specialist - Women's & Children's Health
- MRI Team, Halton Hospital
- Carole Baker, Volunteer - WHH Charity
- Sally Dudley, Ward Manager - Ward A5 Elective
- Suzanne Quick, Lead Chaplain
- Janet Parker, Deputy Chief Finance Officer
- Jo Smillie, Physiotherapist - Clinical Support Services
- Caroline Martin, Midwife - Women's & Children's Health
- Alex Ingram & Team, Ward Manager - Intensive Care Unit
- Alice Forkgen, Associate Director of Finance
- Zetta Edwards, Learning Disability & Autism Nurse - Safeguarding
- Lee Hudson, Porter - SDEC Urgent & Emergency Care
- Dr Neil Bailey, Consultant Physician - Acute Medicine

2.15 Signed under Seal

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

- IT Data Environmental & Expansion Works Scheme

3 MEETINGS ATTENDED

The following is a summary of key external stakeholder meetings I have attended in June and July 2024 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 & Halton System Executive Oversight Group (Weekly)

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 3 (June 2024)
Appendix 2: CMAST Board Update (July 2024)

Appendix 1 - CEO Dashboard Month 3 – June 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	85.94%	
RTT 18 Weeks	92.00%	59.91%	
RTT 65+ Weeks	0	1930	
A&E % patients seen within 4 hours	> 75.00%	66.25%	
A&E % waiting longer than 12 hours	< 2.00%	18.93%	
Cancer 28 Day Faster Diagnostic Standard	75.00%	61.20%	
Cancer 62 Day Wait	85.00%	79.40%	No SPC
Ambulance Handovers within 60 mins	100%	89.84%	
Discharge Summaries 24 hours	95.00%	90.58%	
Cancelled Operations – 28 days	0	2	
Super Stranded Patients	Trajectory	137	No SPC
Uncapped Theatre Utilisation	85.00%	80.30%	
Capped Theatre Utilisation	85.00%	74.00%	

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	11	
Sepsis Screening Emergency	90.00%	74.00%	
Sepsis Screening Inpatients	90.00%	80.00%	
Sepsis Antibiotics Emergency	90.00%	78.00%	
Sepsis Antibiotics Inpatient	90.00%	96.00%	
Inpatient Falls	20.00% reduction	28	
VTE	95.49%	94.16%	
Pressure Ulcers	10.00% reduction	10	
Medication Reconciliation (24 hrs)	80.00%	32.00%	
Complaints over 6 months	0	0	
Healthcare Infections - MRSA	0	1 YTD	
Healthcare Infections - MSSA	N/A	11 YTD	No SPC
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	29 YTD	
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	26 YTD	
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	11 YTD	
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	0 YTD	
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	3.60%	
MUST nutritional assessment completion	85%	63.64%	

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (£m)	-£3.22	-£3.95	No SPC
Capital Spend (£m)	£2.92	£2.77	
Cash Balance (£m)	£1.73	£5.87	No SPC
Better Practice Payment Code (£m)	95%	91%	
CIP In Year Delivered (£m)	£1.94	£1.93	
CIP Forecast (Recurrent) (£m)	£1.94	£1.83	
Agency Ceiling	Less than 3.7%	1.70%	

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.59%	
Retention	85.00%	87.04%	
Core/Mandatory Training	85.00%	89.84%	
PDR Compliance	85.00%	77.65%	

Strategy

- Between mid-March and the end of June, there were 2,500 attendances at the Warrington Living Well Hub. Around 60% of these were people “dropping in” to the hub, and the remainder were people with a booked appointment.
- Over 41,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since phase 1 opened in May 2023.
- Funding has been secured to implement a new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City). A project team is being established and the aim is to begin taking referrals from the autumn 2024.
- The Patient Engagement Portal went live on the 12th of June 2024. This enables the Trust to digitally send outpatient appointments, appointment reminders and for patients to request or reschedule appointments through the NHS App.
- Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. Workstreams have been established with representatives from both organisations and delivery plans are being developed. Stakeholder communication is being developed.
- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly.

CMAST Leadership Board
Update to Boards July

CMAST Leadership Board met on 5th July. The Board discussed three substantive items as follows:

A discussion, led by the ICB, on the recently announced Investigation and Intervention process initiated by NHSE which identifies a number of systems that will receive closer scrutiny in the short term linked to the size and scope of their deficit. C&M is working to identify a preferred supplier to work with on this and is keen to access those with familiarity of the patch and who are able to provide a consistent and dedicated team. Transparency, disclosure and focussed effort on 'sticky' areas were felt to be the key to delivering as positive an outcome as possible for the ICS.

A draft case for change for Women's Services in Liverpool was presented to the group with opportunity for Q&A and exploration of any related system challenges and interdependencies.

Finally the Board was provided with the underpinning detail of the Efficiency at Scale Programme which explored more fully its wider system contribution, connections and detailed deliverables to date – including significant cost savings over and above existing Trust's cost improvement plans.

Updates were also received on the following areas:

- Process of review and update for the CMAST Joint Working Agreement
- System financial report
- System performance update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/062**			
SUBJECT:	**Board Assurance Framework**			
DATE OF MEETING:	7 August 2024			
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; • The target ratings of four risks have been updated • There have been no changes to the descriptions of any of the risks			

	• No risks have been closed or de-escalated; • There have changes to the risk appetites of two of the risks		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to discuss and 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	Board Assurance Framework	AGENDA REF:	BM/24/08/062

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. Each risk is also monitored in an appropriate Committee/ Group and linked to the Trust's strategic objectives

Risk appetites for each of the risks have been supported by the appropriate monitoring Committees/ Executive Leads and are highlighted in appendix 1

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

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New Risks

Since the last meeting, no new risks have been added.

2.2 Amendment to Risk Ratings

Since the last meeting, a Deep Dive of the risks monitored by the Quality Assurance Committee and the Finance & Sustainability Committee were presented and discussed at the respective Committees at which the existing risk ratings, descriptions, and appetites of risks were reviewed. Consideration if any additional or new risks should be added also took place

As a result of the deep dive and discussions, it was agreed to amend the target risk scores of **four** risks.

Risk #134

It was agreed to increase the target score of this risk from **10** (Likelihood 5 x Consequence 2) to **12** (Likelihood 4 x Consequence 3) to better align with the agreed **Open** risk appetite, and to reflect the effort to decrease the likelihood of the risk transpiring.

ID	Risk description	Previous target rating	New target rating	Executive Lead
134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make	10 (L5xC2)	12 (L4xC3)	Jane Hurst

	decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			

Risk #1114

It is agreed to reduce the target score from **8** (Likelihood 2 x Consequence 4) to **5** (Likelihood 1 x Consequence 5)

The agreement to reduce the target score was a result of the recent successful Synnovis ransomware cyber-attack at several London Trusts and the subsequent increased threat of cyber-attack. Furthermore, the reduced target score aligns with the agreed **'minimal'** risk appetite applied to this risk.

ID	Risk description	Previous target rating	New target rating	Executive Lead
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.	8 (2x4)	5 (1x5)	Paul Fitzsimmons

Risk #1898

It was agreed to increase the target score from **4** (Likelihood 1 x Consequence 3) to 9 (Likelihood 3 x Consequence 3)

The recommendation to increase the target score is based on alignment with the agreed risk appetite of **'seek'**

ID	Risk description	Previous target rating	New target rating	Executive Lead
1898	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.	4 (1x4)	9 (3x3)	Lucy Gardner

Risk #115

It is agreed to reduce the target score from **12** (Likelihood 4 x Consequence 3) to **8** (Likelihood 2 x Consequence 4)

ID	Risk description	Previous target rating	New target rating	Executive Lead
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.	12 (4x3)	8 (2x4)	Lucy Gardner

2.3 Amendments to descriptions

Since the last meeting there have been no changes 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 Risk Appetite

Since the last meeting and following the Deep Dive discussion at the Quality Assurance Committee, the risk appetite of two risks (#224 & #1215) were updated.

Risk #224 – The risk appetite was amended from 'cautious' to 'open' as it more accurately reflected the actions taken and controls in place to improve the position, such as the introduction of the LLP and boarding.

Risk #1215 – The risk appetite was amended from 'minimal' to 'open', due to the willingness to consider all potential delivery options while also providing an acceptable level of reward.

2.6 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 and failure to achieve constitutional standards and financial plans.	<u>Assurances</u> • CDC phase 3 including CT & MRI due to open in spring 2025	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
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> • Fortnightly CEO led improvement meeting (inc finance & improvement) in place • CDC phase 1 & 2 complete. Phase 3 to be completed by 31st March 2025 • Revenue plans 2024/25 approved by the Trust Board in June 2024 • 2023/24 position was in line with original plans and with the reported likely forecast throughout the year • Tightening controls of non-pay expenditure with executive review of catalogue spend and review cease option to purchase some items • Executive Review of CIP gap and unfunded cost pressures. • Review of non-recurrent CIP and move to recurrent if possible • Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65 & 52 Week recovery. <u>Assurances</u> • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • We have allocated CIP targets for 2024/25 including additional 2% reduction on non-clinical staffing • Final 2024/25 Operational Plan has been submitted in June 2024 <u>Gaps</u> • Additional capacity remained open in quarter 1 closed in June 2024 (but remains in MSK)	20	No impact on risk rating
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>Assurance:</u> • Mandate met for Junior Doctors Industrial Action • Junior Doctors Committee has announced further strike dates; full walkout from 7am 27th June – 7am on 2nd July 2024 <u>Gaps in Assurances & Controls</u> Previous increasing fatigue amongst the Consultant and SAS doctor body is	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		resulting in these doctors being increasingly reluctant to undertake additional extra contractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. This is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics		
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: Registered Nurse turnover has decreased from 17.34% in January 2023 to 11.5 % in June 2024 • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.89% in June 2024 • Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy • Cost avoidance of £1.937,358m from agency managed service contract started August 2022 • Reduction in agency spend of £660,377 since April 2023.	16	No impact on risk rating
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.	<u>Controls</u> • New Phishing exercise by NHS England has been arranged for 24/25 <u>Gaps in Controls</u> • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network	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	<u>Gaps in Controls</u> • Further assurance required regarding state of readiness for implementation	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	and possible risk to patient safety			
1898	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.	<u>Assurances</u> • Development of business cases for initial phases of Estates Strategy drafted • Estates strategy refreshed and approved • Regular oversight meetings with partners, to support profile of need for investment, re-established	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	<u>Assurances</u> • Funding identified in the 2024/25 Capital Plan to Support refurbishment of another patient lift on the Warrington Site to improve operational efficiency • Plan to undertake roof repairs to pathology are included in the backlog maintenance plan for 2024/25 and are set to be completed by year end.	15	No impact on risk rating
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, 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.	<u>Controls</u> • Trust Estates priorities now also reflected in the ICB infrastructure plan • Joint Executive team meetings & programme of collaboration established with Bridgewater Community Healthcare NHS FT <u>Assurances</u> • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside. Endoscopy Hub due to open in August 2024 • CDC phase 3 including CT & MRI due to open in spring 2025	12	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update 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 5.63% as at May 2024 and is showing an improving variation. This is a slight month on month increase since the lowest sickness absence rate reported in December 2023 (5.56%) since April 2020. Target remains 4.2%. <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 2.81% % in May 2024. **Turnover and Attraction** Turnover in May 2024 was below target at 12.27% and is showing an improving variation. Turnover of permanent staff in May 2024 was 11.35% which was below Trust target. Target is 13%. The Trust's May-24 vacancy rate is 9.64%, and is showing an improving variation, demonstrating the Trust is attracting staff to work within its workforce. Target is 9%. <u>Assurances</u> • As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. May 2024 staff in post is 4,215 FTE. • Staff completing apprenticeships is above target at 3.7%, target is 2.3% **Temporary Staffing & Agency Spend** Bank and Agency reliance in May 2024 was 14.07% . Target is 9%. Bank reliance continues to increase and is 12.20% and agency reliance continues to decrease to 3.3%. <u>Controls</u> • The Resourcing Task and Finish group worked with staff group leads to	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this has enabled the organisation to develop plans to improve the effectiveness of workforce deployment. <u>Assurances</u> Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives and an options appraisal put forward.		

5 RECOMMENDATIONS

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

Appendix 1

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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; 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 have patients waiting more than 12 hours in the department from time of arrival	1	20 (L5xC4)	8 (L2xC4)	Open	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 (L4xC5)	6 (L3xC2)	Open	Quality Assurance Committee
134	Jane Hurst	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 (L5xC4)	10 (L5xC2)	Open	Finance & Sustainability Committee
1757	Michelle Cloney/Paul Fitzsimmons	If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.	2	20 (L5xC4)	8 (L4xC2)	Cautious	Strategic People Committee
2001	Paul Fitzsimmons	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.	1	20 (L5xC4)	6 (L2 xC3)	Minimal	Quality Assurance Committee
115	Ali Kennah	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	16 (L4xC4)	8 (L2xC4)	Minimal	Quality Assurance 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 (L4xC4)	5 (1x5)	Minimal	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 (L4xC4)	8 (L2xC4)	Cautious	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 (L4xC4)	9 (3x3)	Seek	Finance & Sustainability Committee
125	Daniel Moore	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	1	15 (L3xC5)	10 (L2xC5)	Open	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 (L3xC4)	8 (L4xC2)	Open	Executive Management Team
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	12 (L3xC4)	8 (L2xC4)	Open	Strategic People 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.

<u>Quality</u>

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

General Risk Appetite Principles

Methods of controlling risks must be balanced. The Trust may accept some high risks either because of the cost of controlling them, or to deliver innovation or use resources creatively when this may achieve substantial benefit.

As a general principle the Trust has a low tolerance for, and will therefore seek to control, all risks which have the potential to:

- Expose patients, staff, visitors and other stakeholders to harm
- Compromise the Trust's ability to deliver operational services
- Adversely impact the reputation of the Trust
- Have severe financial consequences which may impact on the Trust's future viability
- Cause non-compliance with law and regulation.

Risk appetite definitions for levels of risk appetite are set out in table 1, below.

These have been adopted from the Good Governance Institute's Risk Appetite for NHS Organisations Matrix2. (overleaf)

None	Avoidance of risk is a key organisational objective.
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.
Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

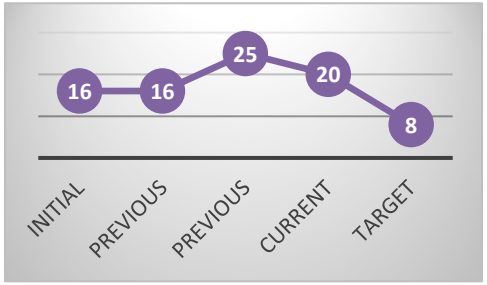
Board Assurance Framework

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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; 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 have patients waiting more than 12 hours in the department from time of arrival			**Initial:**	16(L4xC4)
				Current:	20(L5xC4)
				Target:	8 (L2 xC4)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
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 became 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. This became operational in April 24. • 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 • Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy.				

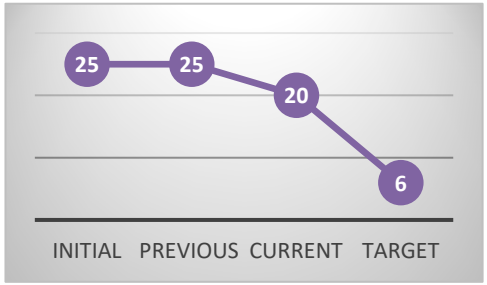
	• Introduction of the new Manchester Triage Process that went live on 14th April 2024. The aim is to support reduced overcrowding in ED and improve clinical quality and patient experience • Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2024/25 to support flow and urgent care • The Performance Improvement & Oversight Group has been establishes in place of the ED Improvement Gorup and is the oversight group for the performance of the Urgent & Emergency Care System Improvement Group • The Performance Improvement & Oversight Group reports to the Finance & Sustainability Committee **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 opened 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. • Continuous flow commenced on 8th October 2023 and is planned for a full roll out in medicine by the end of November 2023 • Triage and streaming test of change commenced in November 2023 – This is to improve productivity and utilisation of assessment areas to support lowering ED occupancy. • Transition to type 5 SDEC reporting went live on 1st November 2023. This will support improvements in streaming and data to allow the organisation to plan access and flow more robustly. • Reconfiguration of the ED footprint took place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12 hour time in department as referenced in the Tier 1 urgent care metrics. • Funding agreed to progress with the co-location of Minors with SDEC capital works. 12 week programme of work commenced in October 2023 and became operational in April 2024. This will improve utilisation and flows away from the main ED in to Minors assessment areas. • As part of being in tier 1 urgent care, the Trust and wider system were supported by Newton to undertake a place diagnostic on capacity and demand. The outcome has instigated a project to help improve flow, reduce attendances and thus lower bed occupancy. • Urgent & Emergency Care System Improvement Group established in May 2024. The aim of the Group is to deliver the opportunities identified by the Newton work. It covers 5 workstreams with system partners to improve urgent care performance and eradicate corridor care. This programme of work feeds in to the ICB Urgent Care programme of work. • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. This would constitute phase 3 and onwards of the ED footprint following the building of Same Day Emergency Care Centre (SDEC)	

	• Update nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor	
Assurance Gaps:	**Gaps in Controls** • Ongoing industrial action across a number of staffing groups including junior medical staff. **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.	Bowman, Karen	31/03/2025 (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	Bowman, Karen	31/03/2025 (ongoing)	
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

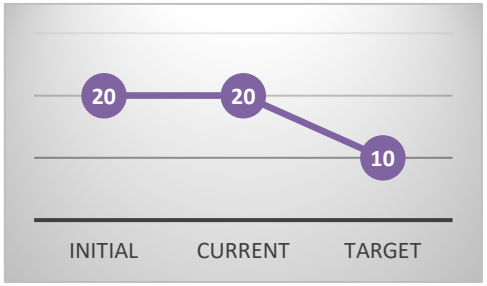
Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not have sufficient capacity (theatres, outpatients, 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 (L5xC5)
				Current:	20 (L4xC5)
				Target:	6 (L3xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Assurance Details:	**Controls** • 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. • 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. Became operational by April 24. • 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 Reservice 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 • 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 expanded in 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 commenced in May 2023 to improve data quality of the Trust waiting lists • New theatre day case unit opened on 1st April 2024 in CSTM as part of the first phase of national TIF investment **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 • The Trust has been confirmed as the 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 2023 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. • Additional ENT Locum supported to help target ENT specialty long waiters. Thie will specifically help treat 78 and 65 week waiters before the end of March 2024 • Regional funding secured to support reduction in the echocardiogram waiting list. This is with third party providers and commenced on 1st November 2023. • The Trust Board supported £4.6m for third party providers to treat all 78 & 65 waiters by the end of September 2024 & significantly reduce 52 week waiters. • Improvement & Productivity Group established from May 2024 supported by the appointment of a Head of Improvement. This Group will oversee improvements in productivity and utilisation of current services i.e. Theatres and Out Patients. • CDC phase 3 including CT & MRI due to open in spring 2025	
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	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	134	**Executive Lead:**	Hurst, Jane	**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 (L5xC4)
				Current:	20 (L5xC4)
				Target:	10 (L5xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Assurance Details:	**Controls** •Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Planning Group (CPG) oversee financial planning • Fortnightly CEO led improvement meeting (inc finance & improvement) in place • 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 2023 • Revised approach to GIRFT/ improvement/ CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced. • Appointed GIRFT Finance Lead and 5 PAs allocated. • Appointed Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High Level 5 year plan presented to the Finance & Sustainability Committee in April 2024 • CDC phase 1 & 2 complete. Phase 3 to be completed by 31st March 2025 • Capital Plans for 2024/25 approved by the Trust Board in March 2024. • Revenue plans 2024/25 approved by the Trust Board in June 2024 • Introduced system of escalation where there are risks to CIP delivery • 2023/24 position was in line with original plans and with the reported likely forecast throughout the year • 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. • In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance & sustainability Committee • Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023 • Tightening controls of non-pay expenditure with executive review of catalogue spend and review cease option to purchase some items • NHSE have approved (March 2024) Cash support c£7m & Q1 – Enhanced controls regarding pay and non-pay expenditure must be adhered to and are part of the controls outlined above. • Enhanced ECF meetings in place with Chief Executive sign off, with ICS & Bridgewater attendance • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Executive Review of CIP gap and unfunded cost pressures. • Review of non-recurrent CIP and move to recurrent if possible				

	• Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65 & 52 Week recovery. **Assurances** • Achieved ICS control total in 2022/23 • Subject to Audit 23/24 the control total was exceeded by the stretch target set by the ICS. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 Capital Plan (subject to audit) • 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. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge is to keep agency to below the 3.2% ceiling and reduce bank. • C&M ICS have indicated that there should be a 2% reduction in staffing in the 2024/25 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • We have allocated CIP targets for 2024/25 including additional 2% reduction on non-clinical staffing • 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. • Key financial controls review 2023/24 received substantial assurance for general ledgers and high assurance for accounts receivable and treasury management. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • Final 2024/25 Operational Plan has been submitted in June 2024 • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements • Draft 2023/24 Accounts submitted on time	
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP, and high risk schemes, 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. • Risk of unforeseen costs and under delivery of activity and income due to further Industrial action / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • 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 • Additional capacity remained open in quarter 1 closed in June 2024 (but remains in MSK) • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Industrial action uses management capacity to plan for safety which places CIP/GIRFT improvement programme at high risk as capacity/focus is diverted • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Output of review undertaken of CIP, cost pressures and benefits realisation to be monitored via the Committee structure	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane	31.03.2025	
Review of 2024/25 CIP / GIRFT / Improvement plans	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane; Fitzsimmons Paul, Gardner, Lucy; Moore, Dan	31.03.2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.			**Initial:**	16 (L4 xC4)
				Current:	20 (L5 xC4)
				Target:	8 (L4 xC2)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				

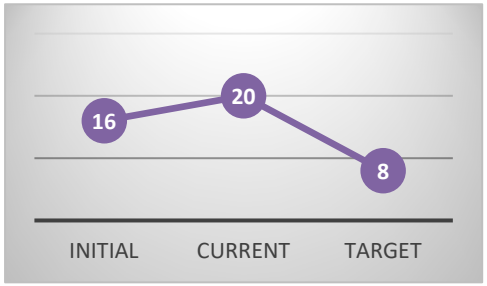
Control & Assurance Details:

Controls

- Trust policies updated in relation to industrial action
- Trust approach to industrial action established following implementation of IA Task and Finish group.
- 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 where applicable.
- Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA.
- IA Task and Finish group completed organisational preparedness for industrial action policies and procedures ratified and FAQ documents created and published and updated regularly.
- Executive Medical Director led check and challenge meetings for periods of industrial action to prepare and mitigate risk.
- Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.
- Following national guidance available for Consultant IA
- Recruiting Junior Doctors to WHH bank following legal challenge meaning collaborative bank cannot be utilised during IA.
- Trust proposal for split pot LCEA's with eligibility criteria to go to Board 07/02/24 which is the reflective approach of the proposed pay deal.
- Regular briefing sessions held in person and virtually for senior leaders and staff r.e. outcome of Band 2 HCA Acas collective conciliation agreement and subsequent process required to implement the agreement.
- Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.
- Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, Practice Educator Facilitator and a member of the HR Business Partnering team.

Assurance

- Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.
- 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 have published letter 13/07/23 r.e. the process for requesting derogations. No derogations been required thus far.
- 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.
- NHS England letter 03/10/23 to BMA welcoming pause to any further industrial action dates reiterating concerns formally re Christmas Day cover and patient safety concerns.
- B2 HCA IA stood down following successful Acas collective conciliation agreement.
- BMA SAS doctors mandate for industrial action on hold whilst a ballot is underway on a government pay offer dates of the ballot to be confirmed by the BMA.

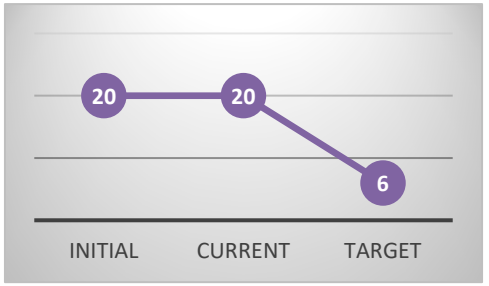


	• On 5th April 2024 following weeks of voting the consultants committee accepted the latest Government offer on pay for consultants in England. 83% of eligible BMA consultant members voted 83% with a (62% turnout). The effective date for the new pay structure will be 1 March 2024. • Mandate met for Junior Doctors Industrial Action • Junior Doctors Committee has announced further strike dates; full walkout from 7am 27th June – 7am on 2nd July 2024	
Assurance Gaps:	• Medical IA is based on nationally negotiated Terms and Conditions which are outside of the influence and control of the Trust. • 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 for Junior Doctors • 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. Also, Collaborative banks cannot be utilised. • Previous increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extra contractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. This is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics	

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	Ongoing New Jr Dr IA Dates; 7am 27th June to 7am on 2nd July 2024	
Check and challenge meetings to commence for Consultant Industrial Action	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Fitzsimmons, Paul	Ongoing New Jr Dr IA Dates; 7am 27th June to 7am on 2nd July 2024	
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	Ongoing whilst national disputes continue	
Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Laura Hilton	31/12/24	
Consistency panel meetings established to review and consider Band 2 HCA banding review claims.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Ali Kennah	31/12/24	

Board Assurance Framework

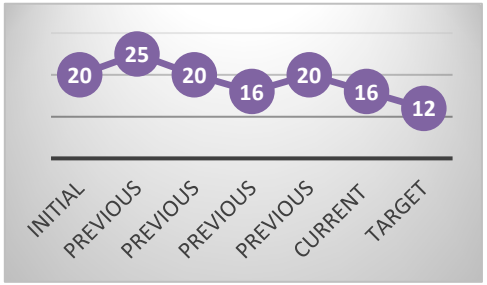
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	2001	**Executive Lead:**	Fitzsimmons, Paul	**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 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.			**Initial:**	20 (L5 xC4)
				Current:	20 (L5xC4)
				Target:	6 (L2 xC3)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	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 particular 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 • Stroke Services • ENT Surgery **Controls** • Formal process in place for identification and designation of Fragile Services • Focussed additional support to Fragile service from senior Medical, Nursing and Operational leadership teams • Appropriate prioritisation of Fragile Service Revenue and Capital Requests **Assurances** • Monthly oversight through standardised Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC) • Escalation to Quality Assurance Committee via PSCESC escalation reports • Bi-monthly Fragile Services report to Trust Board				
Assurance Gaps:	•Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bedbase) •Ongoing industrial action •Increasing demand				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

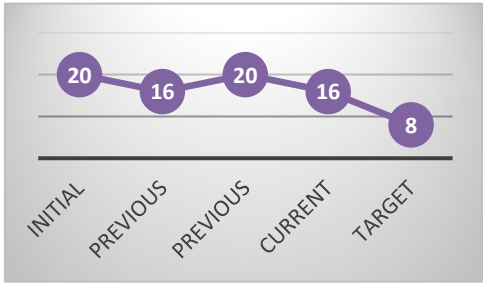
Risk ID:	115	**Executive Lead:**	Kennah, Ali	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial:** 20 (L5xC4) **Current:** 16 (L4xC4) **Target:** 12 (L4xC3)
Risk Appetite	**Minimal** – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.			
Assurance Details:	**Controls** • 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG) • Weekly ERostering KPI sign off meetings in place. • 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 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. • Agency reduction plan in place • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team • Local recruitment in place targeting ED and Endoscopy who have had recent investment / establishment increases. • Open advert for RN / HCSW recruitment • Quarterly recruitment events in place • Sickness absence being manged in line with Trust policy. **Assurances** • Increase in registered nursing establishment in the Emergency Department, January 2024 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 11.5 % in June 2024 • Overall CHPPD sustained improvement at national standard of 8.1 in Q1 • No requirement for staffing incentive scheme YTD • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.89% in June 2024 • Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy m • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. • Cost avoidance of £1.937,358m from agency managed service contract started August 2022 • Reduction in agency spend of £660,377 since April 2023. • International Nurse recruitment: Final cohort (11 staff) in post, pause for WHH in programme, pastoral care and retention is focus. • 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, 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. • 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. • Increased cohort of CSWDs for 2024 • The number of wards achieving 90% fill rate increased to 21 in June 2024 from 17 in December 2023	
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 – Beds were opened in escalation areas 187 times in April 2024 • Increased request to provide enhanced care. • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients. • Continued escalation during winter of ward A10 and intermittent escalation of Cardiac Catheter lab • Partially funded revenue requests • Time to post when recruiting new staff. • 11% increase in red flags in April due to enhanced care demand / escalation- 90 red flags raised during April 2024 due to accelerated discharge process. • 99 Menal Health Carer shifts were requested in April 2024 – highlighting increasing numbers of mantal Health patients attending the Trust	

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	19/10/24	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**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 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.			**Initial:**	20 (L5xC4)
				Current:	16 (L4xC4)
				Target:	8 (L2xC4)
Risk Appetite	**Minimal** – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Assurance:** • [DSPT Standard(s): 1.3.5] & 1.3.6] Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • [DSPT Standard(s): 1.3.5] & 1.3.6] Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • [DSPT Standard(s): 9.4.5] Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England'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 • [DSPT Standard(s): 7.1.4] Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) • Outcome of the third Phishing exercise by NHS England, communications have been sent out to staff members who entered details for awareness. **Controls:** • [DSPT Standard(s): 1.3.5, 7.1.2. 7.1.3, 7.2.1, 7.2.2 & 7.3.2] **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. • [DSPT Standard(s): 9.5.1] **Digital Change Management** regime including including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation 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 • [DSPT Standard(s): 8.3.1, 8.3.2, 8.3.3] 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.				

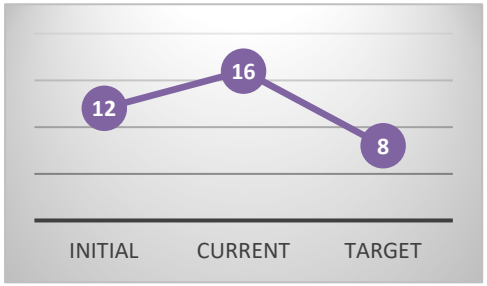
	• [DSPT Standard(s): 7.3.4] Secondary secure backup at Halton Data Centre • [DSPT Standard(s): 9.6.5] Remote devices no longer bypassing the web proxy • New Phishing exercise by NHS England has been arranged for 24/25 • [DSPT Standard(s): 8.4.1, 9.6.6] Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • [DSPT Standard(s): 4.5.3] MFA active on new starters for NHSMail • [DSPT Standard(s): 8.1.4 & 8.4.2] Funding provided for MUSE migration	
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” • [DSPT Standard(s): 4.2.3 & 4.4.1] No dedicated logging tool to pull all key logs together and provide useable alerts. • [DSPT Standard(s): 8.3.6] Lack of process to check antivirus/MDE alerts in console. MIAA to review processes and tools • [DSPT Standard(s): 4.4.2] Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • [DSPT Standard(s): 8.1.4 & 8.4.2] Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • [DSPT Standard(s): 8.1.2] Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • [DSPT Standard(s): 4.5.3] MFA on limited number of systems • [DSPT Standard(s): 8.3.4] 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 • [DSPT Standard(s): 8.1.4] Version 7 of Clinisys Ice is end of life • [DSPT Standard(s): 9.3.8] Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • [DSPT Standard(s): 4.1.2] No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts • [DSPT Standard(s): 7.3.4 & 7.3.5] Backup storage being end of life and out of support • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network.	

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	Migrate all 2003 and 2008 servers to 2016.	Clinical Audit Manager has confirmed the full migration of their clinical documents. Head of Employment Services has asked for an extension regarding some HR elements of the ECF process needs migration. It was agreed at Digital SLT to extend the shutdown of the Hub servers until the end of July 24. *** The SIRO has agreed to extend the switch off of the 2008 servers due to continuing work of migrating data.	Deacon, Stephen	30/09/24	

decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).		Draft communications are ready to be sent out announcing the shutdown to the HUB. This will be sent out by the Senior Information Risk Officer (SIRO)			
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	Update to the 2012 EOL project: Endoscopy Server Not on schedule due to the need to merging of patient records is required to migrate the last of the records. CBU speaking to HD Clinical, as if anything goes wrong merging the patient records would cause a clinical risk. Moving scheduled date to end of August as Digital Services need to know the outcome of the meeting between CBU and HD Clinical.	Waterfield, Tracie	30/08/24	
Multifactor authorisation (MFA) review of Trust critical systems	Multifactor authorisation (MFA) review of Trust critical systems as data has shown that majority of cyber attacks can be prevented within 20 minutes of the initial attack starting with MFA compared to organisations who don't use MFA.	Create a document that details the Trust's critical systems and contact the vendors to inquire whether they have Multi-Factor Authentication (MFA) and, if not, where it is on their roadmap.	Deacon, Stephen	31/03/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

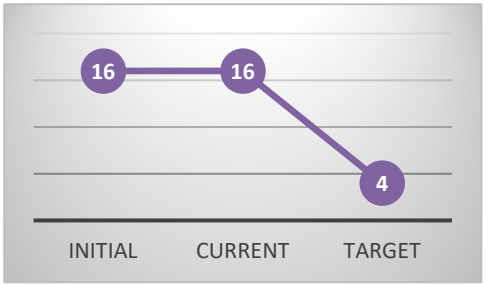
Risk ID:	1372	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 3: We will…Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust is unable to procure a new Electronic Patient Record then 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			**Initial:**	12 (L3 xC4)
				Current:	16 (L4xC4)
				Target:	8 (L2 xC4)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
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 • Trust approval of updated OBC includes extension of Lorenzo contract to enact option to retain to Nov 26 if required due to previous delays in EPR program • NHSE Electronic Patient Record Investment Board (EPRIB) has confirmed approval of the EPR Outline Business Case (OBC) • EPR project group has oversight on state of readiness for deployment and associated risks **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				
Assurance Gaps:	**Gaps In Assurance:** • ICS strategic approach to delivering managed convergence through open procurement remains unclear • Further assurance required regarding state of readiness for implementation • Complexity of coterminus LIMS implentation presents an emerging risk which requires a mitigating plan **Gaps In Controls:** • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Delay to implementation could push implementation date past Lorenzo contract and Lorenzo sunsetting date • Phasing of frontline Digitisation Funding with funding availability not matching the timing of forecast expenditure • Deficit in programme year 3 • Further assurance required regarding state of readiness for implementation				

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 FDIB leadership fully sighted and remain supportive of procurement approach including Tender format	Ongoing engagement with ICS and NHSE FDIB leadership	Fitzsimmons, Paul	01/04/2024	
Develop plan to manage risk posed by coterminous LIMS implementation	To ensure the Trust has a plan to ensure is in a position to deploy EPR and LIMS over similar timeframes	Plan to mitigate for potential coterminous implementation of LIMS	Poulter, Tom	01/08/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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:**	16 (L4xC4)
				Current:	16 (L4xC4)
				Target:	9 (L3 xC3)
Risk Appetite	**Seek** - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).				

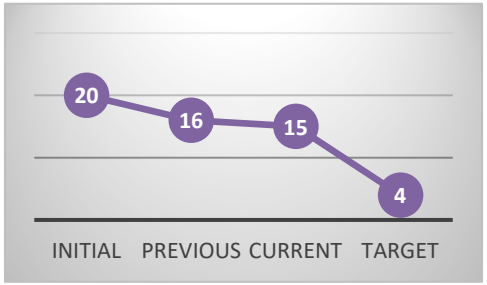
Control & Assurance Details	**Controls**
	• Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
	• Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have been carried out
	• Estates strategy incorporating options and enablers for new hospitals plans complete
	• 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,
	  ○ Additional theatre ward and endoscopy capacity at Halton
	  ○ Community Hubs in Runcorn and Warrington
	• Development of business cases for initial phases of Estates Strategy drafted
	• Estates strategy refreshed and approved
	• Regular oversight meetings with partners, to support profile of need for investment, re-established
	• Developing scope for work required to create phased new hospital plan for the Warrington site
					

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. • Requirement to secure funding to complete the development of the phased new hospital plan				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan.	Lucy Gardner	October 2024	October 2024

Board Assurance Framework

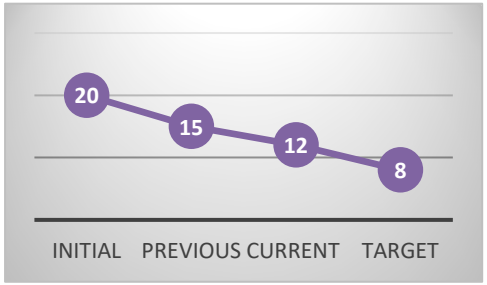
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns			**Initial:**	20 (L5xC4)
				Current:	15 (L3xC5)
				Target:	10 (L2xC5)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Assurance Details:	**Controls:** Annual capital funding is allocated to mandated and statutory estates projects The estates team operate a Planned Maintenance Program (PPM) The estates team operate a 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 Estate strategy 2024-2029 which addresses several backlog issues to reduce future costs and to develop both the Warrington and Halton sites with available capital funding **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 PLACE assessment with subsequent action plan Capital Planning Group – determine how the trust capital is spent 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 Operational and Safety groups linked to Health Technical Memorandum (HTM) that identify compliance issues and put in place actions to reduce any resultant risk Complete formal RAAC survey undertaken across whole estate. Small extension building identified as having RAAC present. Confirmation from NHSE of funding to take the necessary remedial action to eradicate RAAC on the small extension Following an environmental health inspection, upgrades to the Warrington kitchen facilities have been supported. Establishment of the Tactical Estates Group (TEG), reporting to the Capital Planning Group, to help support efficient decision making relating to estate allocation. Associate Director of Estates & Facilities and Director of Strategy & Partnerships represents the Trust on ICB Estates meetings from an operational and strategic perspective Funding identified in the 2024/25 Capital Plan to Support refurbishment of another patient lift on the Warrington Site to improve operational efficiency Plan to undertake roof repairs to pathology are included in the backlog maintenance plan for 2024/25 and are set to be completed by year end.				
Assurance Gaps:	Limited capital funding to address backlog Estates staffing - as maintenance (reactive and planned) increase due to limited backlog funding or new national standards, staff are asked to do more, with less and the estates maintenance team is currently under resourced 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	30/06/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 (L5xC4) **Current** 12 (L3xC4) **Target** 8 (L4xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.			
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.			
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. • 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 are refreshed annunallly • 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. • Refreshed programme for pathology collaboration shared by the Cheshire & Mersey Pathology Network. The first phase is to develop an outline business case for the hub model expected by the end of October 2024. • 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. • Health & Wellbeing Hub (Living Well Hub) opened in March 2024 • 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.			

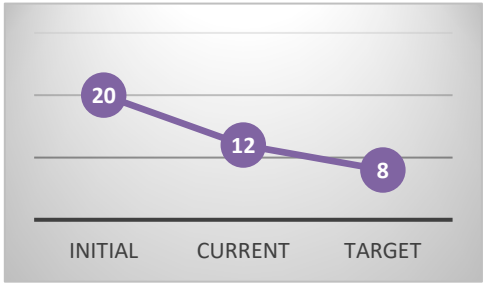
	• Funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Both reviews have been completed. • Formal partnerships developed with key educational partners to enable tailored education & training and research 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. • Trust Estates priorities now also reflected in the ICB infrastructure plan • Adaptive Reserve Fund created with Warrington Place partners • Discussions with neighbouring Trust to accelerate collaboration taking place • Joint Executive team meetings & programme of collaboration established with Bridgewater Community Healthcare NHS FT **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. • 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. • National funding secured for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside. Draft business case approved by the Trust Board in June 2024. • Detailed work commenced, supported by external consultants, to help address no criteria to reside & enable admission avoidance. • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside. Endoscopy Hub due to open in August 2024 • CDC phase 2 including ultrasound, spirometry, sleep studies, audiology & phlebotomy opened in Halton Health Hub in December 2023 • CDC phase 3 including CT & MRI due to open in spring 2025	
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 & Lucy Gardner	30/04/2025	
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Interim arrangements to support delivery given lack of available funding	Lucy Gardner & Dan Moore	30/04/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	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			**Initial:**	20 (L4xC5)
				Current:	12 (L3xC4)
				Target:	8 (L2xC4)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				



Control & Assurance Details:

Sickness Absence

The rolling 12-month sickness absence rate is 5.63% as at May 2024 and is showing an improving variation. This is a slight month on month increase since the lowest sickness absence rate reported in December 2023 (5.56%) since April 2020. Target remains 4.2%.

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.

•Focused welcome back conversation recording and internal audit

•Following an MIAA Audit, the HR team have worked with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers.

•Sickness absence, turnover and attraction workstreams have been reviewed in line with the Richard Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been considered.

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 2.81% % in May 2024.

•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 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. Well attended by staff.

•As a result of the sickness absence data analysis undertaken by the People Health and Wellbeing Group, OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within the last 12 months who have experienced an absence of depression/stress/anxiety, and are undertaking a deep dive to explore the split between work related and personal stress and any targeted interventions required.

Turnover and Attraction

Turnover in May 2024 was below target at 12.27% and is showing an improving variation. Turnover of permanent staff in May 2024 was 11.35% which was below Trust target. Target is 13%.

	Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving. The Trust's May-24 vacancy rate is 9.64%, and is showing an improving variation, demonstrating the Trust is attracting staff to work within its workforce. Target is 9%. **Controls** •Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review. •Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process. •Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work •Grief and Menopause cafes implemented to support individuals •Social media accounts have been created to support recruitment attraction across a number of social media platforms •Financial wellbeing resources have been implemented 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. Pilots commence January 2024 •HR are working with pilot areas to review their approach to rostering and the impact on agile/flexible working to support a reduction in turnover. To support with attraction, the Trust has adopted a coordinated approach to recruitment which has included: • International recruitment • Enhanced HCA recruitment events • Investment in TRAC (Recruitment system) • Enhanced Student Nurse recruitment • Enhanced wellbeing benefits package (financial and mental) • Improvements in agile/flexible working • Enhanced retirement support/offers Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention. **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 8.78% (May-24) 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. •As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. May 2024 staff in post is 4,215 FTE. •Staff completing apprenticeships is above target at 3.7%, target is 2.3% **Temporary Staffing and Agency spend** Bank and Agency reliance in May 2024 was 14.07% . Target is 9%. Bank reliance continues to increase and is 12.20% and agency reliance continues to decrease to 3.3%.	

	Controls •The increase in bank reliance is being driven by the Trusts industrial action response and as part of a plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. •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 •The Resourcing Task and Finish group worked with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this has enabled the organisation to develop plans to improve the effectiveness of workforce deployment. **Assurances** •Compliance against our processes and rate cards is 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. •Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives and an options appraisal put forward.	
Assurance Gaps:	• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating special cause variation of a concerning nature. • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend. • Lack of assurance regarding industrial action ending which impacts bank and agency utilisation. • Exit interview completion rates are low, currently reviewing process to improve completion rates.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
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	31.03.2025	
Embed an agile and flexible working culture within all WHH Teams – linked to WHH Culture Plan	As part of the WHH Culture Plan, 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	Carl Roberts	31.03.2025	

		– thus enabling further oversight of requests			
Review of Exit Interview Process to Support Improvement of Completion Rates	As part of the Delve OD programme within the People Directorate there is a further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine future actions to address exit interview compliance.	Laura Hilton	31.12.2024	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/08/63 I**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer and 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. **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. **#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.	

<table>
<tr><td></td><td>#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>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>
Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<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></td><td></td><td></td><td>√</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></td><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></td><td></td><td></td><td>√</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table>
</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>
The Trust has 75 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance. Table 1 sets out the “Assurance” and “Variation” of all indicators, of these, there are <u>4 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

Quality:
• 5.Healthcare Acquired Infections (CDI) (NEW)
• 10. VTE Assessment
Access and Performance:
• 41. Ambulance Handovers within 15 minutes (NEW)
• 61. Uncapped Theatre Utilisation

In Month 1 there were 8 failing and declining indicators, however 6 of these indicators now have normal variation or are no longer consistently failing, so have been removed from the top category since the Month 1 2024/25 IPR. These indicators are included below:
</td></tr>
</table>

	• *7. Healthcare Acquired Infections (Klebsiella)* • *22. Mixed Sex Accommodation Breaches (Non ITU Only)** • *25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis* • *34. RTT - Number of patients waiting 65+ weeks* • *39. Cancer 14 Days* • *74. Cost Improvement Programme (recurrent forecast) – In year performance to date* At Month 3 the plan was a £11.4m deficit. The actual deficit was £12.1m with the overspend being due to the impact of Industrial Action with cost and loss of income totalling £0.7m.		
PURPOSE: ***(please select as appropriate)***	Approval √	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 2. Approve the new Access and Performance KPI 3. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee	
	Agenda Ref.	FSC/24/07/79	
	Date of meeting	24/07/2024	
	Summary of Outcome	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/24/04/008

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 75 Integrated Performance Dashboard (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 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** **Quality** 5. Healthcare Acquired Infections (CDI) ***(29 YTD - 36 target)*** ⬇ 10. VTE Assessment ***(94.16% - 95% target)*** **A&P** 41. Ambulance Handovers within 15 minutes ***(32.7% - 65% target)*** ⬇ 61. Uncapped Theatre Utilisation ***(73.4% - 80% target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 13. Medication Safety - Reconciliation within 24 hours 22. Mixed Sex Accommodation Breaches (ITU Only) ⬆ 23. Sepsis - % screening for all emergency patients 24. Sepsis - % screening for all inpatients 27. Ward Moves between 10pm and 6am 31. MUST nutritional assessment completion 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis **A&P** 35. A&E Wait Times - % patients waiting under 4 hours 36. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 42. Ambulance Handovers within 30 minutes 43. Ambulance Handovers within 60 minutes 44. Discharge Summaries - % sent within 24hrs 62. Capped Theatre Utilisation **Finance** 72. Better Payment Practice Code	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 21. Friends and Family (ED and UCC) 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis ⬆ **A&P** 32. Diagnostic Waiting Times 6 Weeks 33. Referral to treatment Open Pathways ⬆ 34. RTT - Number of patients waiting 52+ weeks ⬆ **Workforce** 63. Supporting Attendance 66. Bank and Agency Reliance 68. PDR	**CONSISTENTLY FAILING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **A&P** 1.Incidents ⬇ 38. 28 Day Faster Cancer Diagnosis Standard ⬇	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 6. Healthcare Acquired Infections (Ecoli) 7. Healthcare Acquired Infections (Klebsiella) ⬆ 8. Healthcare Acquired Infections (PA) 12. Pressure Ulcers ⬆ 28. Acute Kidney Injury ⬇ 29. Maternity Postpartum Haemorrhage **A&P** 47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation **Finance** 73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** 11. Inpatient Falls & harm levels 15. Staffing Care Hours per patient day (CHPPD) **A&P** 45. Discharge Summaries - Number NOT sent in 7 days ⬆ 55. Elective Outpatient Activity **Finance** 71. Capital Programme 74. Cost Improvement Programme (recurrent forecast) – In year performance to date ⬆	**INCONSISTENTLY PASSING TARGET & NO SPC**

	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** 3. Healthcare Acquired Infections (MSSA)⬇	**Quality** 2. Duty of Candour (serious incidents) 19. Complaints 20. Friends and Family (Inpatients & Day cases) **A&P** 46. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 48. Urgent Operations Cancelled for 2nd Time	**Quality** 14. Staffing - Average Fill Rate 18. NICE Compliance **A&P** 56. Patients seen in the Fracture Clinic within 72 hours ⬆ **Workforce** 64. Retention 65. Turnover 67. Core/Mandatory Training **Finance** 75. Agency Ceiling	
	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** 3. Healthcare Acquired Infections (MSSA) 30. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 37. Average time in department ED 49. Super Stranded Patients 50. No Criteria to Reside (NCTR) 57. Type 5 attendances 59. % Patients discharged to their usual place of residence	**Quality** 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks ⬆ 16. Mortality ratio – HSMR 17. Mortality ratio - SHMI **A&P** 58. Reduction in Outpatient Follow Ups ⬆	**A&P** 39. Cancer 31 Days First Treatment 40. Cancer 62 Days First Treatment 51. Elective Recovery Activity (Grouped SPCs) 52. Elective Recovery Diagnostic Activity 56. % patients referred to long COVID service not assessed within 15 weeks 60. Virtual Appointments **Finance** 69. Trust Financial Position (£m) 70. Cash Balance (£m)

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**

⬆ **Improved category from previous IPR**
⬇ **Declined category from previous IPR**

2.2 New IPR Indicators

Prior to 2020, both WHH and St Helens and Knowsley Teaching Hospitals NHS Trust (STHK), now Mersey and West Lancashire Teaching Hospitals NHS Trust, benefitted from a 50% split of the WWIC, now known as UTC (Widnes Urgent Care Centre), Type 3 activity. This was displayed in our performance reports as including WWIC and excluding position. In 2019/20 we were notified of changes to the commissioning of Widnes UTC so that it fully came under STHK.

As such, it was understood that Type 3 activity would no longer be split between WHH and STHK, but instead fully benefit STHK. However, following recent conversations with the regional planning team, it has been uncovered that because of the pandemic, the commissioning changes didn't happen. As such, it has been confirmed that WHH's 4-hour position is to still benefit from the Widnes UTC 50% split. This gives WHH's "All Type 4 hour" position is to still a c5% positive increase. Now this has been confirmed, we have re-formatted the 4-hour performance reports to show an including and excluding Widnes UTC position.

Table 2 provides details of new Access and Performance Indicators.

Table 2: New Access and Performance Indicators

Proposed KPI	Proposed measures/target	Rationale
4-hour performance <u>including</u> Walton Walk-in Centre (WWIC)	A&E and walk-in centre waiting times including WWIC – % patients waiting under 4 hours from arrival to admission, transfer or discharge. To be included in addition to *35. 4-hour performance <u>excluding</u> WWIC*. **Target:** 75%	It has been agreed to monitor the 4-hour position with <u>including</u> WWIC as part of this year's annual planning round. This will enable the Trust Board to closely monitor 4-hour performance including WWIC as well as the 4-hour performance <u>excluding</u> WWI.

Following changes to the contract, Trust Board are asked to include the measurement of 4-hour performance including Walton Walk-in Centre (WWIC). Following approval, these amendments will be reflected in the August 2024 IPR.

If the proposed changes are all approved, the total number of indicators within Access and Performance on the Trust IPR will **increase by 1 indicator, from 30 indicators to 31 indicators**.

2.3 IPR Update

A breakdown of the current 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**.

2.4 Financial Update

The Income Statement for June 2024 is attached in **Appendix 5**.

Cheshire & Merseyside ICS has set the Trust a control total of £27.8m deficit (including a £3m integration stretch target). There are several risks to the achievement of the planned £27.8m deficit. The key risks are as follows:

- CIP delivery.
- Cost pressures – there was an overspend of £1.6m year to date at month 3. If cost pressures continue to overspend at the same rate, then the Trust will have an overspend of £4.8m. An enhanced monitoring process is in place to mitigate these cost pressures where possible.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR), activity delivered is under plan resulting in loss of income.
- Utilisation of additional capacity due to the levels of no criteria to reside patients.
- Ongoing industrial action – indications are that there is no additional funding available to mitigate this.

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

Given the overall financial position of Cheshire and Merseyside ICS as reported for month 2, NHS England has assessed the system as being at high risk of overspending against the plan submitted for the year and hence not meeting the system statutory requirement to breakeven. Therefore, the system has agreed with NHS England that we will engage external support to urgently review the financial position of WHH and Warrington and Halton Place.

This will focus on actions that can be taken to immediately reduce the rate of expenditure and to ensure that the financial plan for the year is delivered. This proactive support will cover controls over areas such as workforce and will also look carefully at our efficiency plans to make sure that they are deliverable, or to take action where this is not the case.

The support will be expected to show rapid results and should be in place for around 8 weeks. Any decisions to reduce spending will be subject to routine governance and oversight, to make sure that service delivery, quality and patient safety are not adversely impacted.

Cash

The cash balance at the end of June is £5.9m, of which, £3.6m is related to capital creditors. Given the current cash position and the planned deficit for 2024/25 the Trust is in receipt of cash support. A request for £4.508m was submitted for June 2024 however, only £3m was approved. In addition, a request for July cash support has been submitted and approved for £5.145m.

CIP

At 30 June 2024, the Trust has delivered a CIP of £1.9m against a target of £1.9m (£11k off plan). It should be noted that the delivery year to date has been mainly achieved from central items and reduction in non-clinical posts. The full year CIP target is £19.4m of which £17.5m has been identified (90%). The current level of identified recurrent CIP is £16.6m. There is still significant risk in delivery of the CIP planned schemes.

Capital Programme

The Trust total capital funding consists of £7.63m CDEL (Capital Departmental Expenditure Limit) and £15.49m external funding, a total of £23.12m. The Trust also has £1.84m CDEL associated with lease expenditure (IFRS16).

The Trust year to date capital spend at month 3 is £2.77m which is £0.05m over the Trust plan of £2.72m.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 3		**133**
Proposed changes in month		
VAT Recovered		3
Capital scheme paperwork not completed & no longer required - to be returned to contingency		
Hysteroscopy Equipment	29	
TCU Equipment	70	
Sub Total		99
Requests supported at CPG 12 July 2024		
KOK Fees for Nurse Call 65537 and Roads and Paths scheme 61663 under accrual from 2023/24	- 7	
Airvo 3 Portable Humidified Nasal Cannula Oxygen device	- 11	
Sub Total		- 18
Contingency as at end of month 3		**217**

The Trust Board is asked to note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.

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
- Quality & Assurance Committee
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
2. Approve the new Access and Performance KPI
3. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*
- Consistently fails the target*

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	QUALITY	Plan/Target	Actual	Period	Variation	Actual	Period	
1	Incidents	0	11	Jun-24	H	0	May-24	?
2	Duty of Candour (serious incidents)	100.00%	100.00%	Jun-24		100.00%	May-24	P
3	Healthcare Acquired Infections (MRSA)	0	1	Jun-24	H	0	May-24	P
4	Healthcare Acquired Infections (MSSA)	No threshold set	2	Jun-24		4	May-24	No SPC
5	Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	11	Jun-24	H	7	May-24	F
6	Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	9	Jun-24		8	May-24	?
7	Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	1	Jun-24		4	May-24	?
8	Healthcare Acquired Infections (PA)	Less than 2 - annual	0	Jun-24		0	May-24	?
9	Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	0	Jun-24	L	0	May-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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10	VTE Assessment	95.00% (quarterly position)	94.16%	Jun-24		93.78%	May-24	
11	Inpatient Falls & harm levels	20% or more decrease from previous year	28	Jun-24		31	May-24	
12	Pressure Ulcers	10% reduction	10	Jun-24		9	May-24	
13	Medication Safety Reconciliation within 24 hours	80.00%	32.00%	Jun-24		30.00%	May-24	
14	Staffing - Average Fill Rate	90.00%	97.77%	Jun-24		90.43%	May-24	
15	Staffing - Care Hours Per Patient Day (CHPPD)	7.9	7.4	Jun-24		7.8	May-24	
16	Mortality ratio - HSMR	No target set	87.72	Jun-24		86.58	May-24	No SPC
17	Mortality ratio - SHMI	No target set	92.68	Jun-24		93.21	May-24	No SPC
18	NICE Compliance	90.00%	93.31%	Jun-24		92.63%	May-24	
19	Complaints	Zero complaints open over 6 months old/in the backlog	0	Jun-24		0	May-24	
20	Friends and Family (Inpatients & Day cases)	95.00%	96.00%	Jun-24		98.00%	May-24	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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21	Friends and Family (ED and UCC)	87.00%	78.00%	Jun-24	H	75.00%	May-24	F
22	Mixed Sex Accommodation Breaches (ITU Only)	0	10	Jun-24		7	May-24	F
23	Sepsis - % screening for all emergency patients.	90.00%	74.00%	Jun-24		80.00%	May-24	F
24	Sepsis - % screening for all inpatients	90.00%	80.00%	Jun-24		64.00%	May-24	F
25	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	78.00%	Jun-24		72.00%	May-24	F
26	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	96.00%	Jun-24	H	80.00%	May-24	F
27	Ward Moves between 10:00pm and 06:00am, for patients with an alert	0	6	Jun-24		6	May-24	F
28	Acute Kidney Injury	Less than previous month	124	Jun-24		187	May-24	?
29	Maternity Postpartum Haemorrhage	3.70%	3.60%	Jun-24		4.20%	May-24	?
30	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	22%	Jun-24		23%	May-24	No SPC
31	MUST nutritional assessment completion	above > 85%	63.64%	Jun-24		59%	May-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
32	Diagnostic Waiting Times 6 Weeks	95.00%	85.94%	Jun-24	H	88.88%	May-24	F
33	Referral to treatment Open Pathways	92.00%	59.91%	Jun-24	H	59.47%	May-24	F
34	RTT - Number of patients waiting 52+ weeks	0	1930	Jun-24	L	2128	May-24	F
35	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	75%	66.25%	Jun-24		65%	May-24	F
36	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	18.93%	Jun-24		19.9%	May-24	F
37	Average time in department ED	No Target	362	Jun-24		379	May-24	No SPC
38	28 Day Faster Cancer Diagnosis Standard	75%	61.20%	May-24	L	75.10%	Apr-24	?
39	Cancer 31 Day Wait	96%	97.80%	May-24	No SPC	96.30%	Apr-24	No SPC
40	Cancer 62 Day Wait	85%	79.40%	May-24	No SPC	82.60%	Apr-24	No SPC
41	Ambulance Handovers within 15 minutes	65%	32.70%	Jun-24	L	31.31%	May-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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42	Ambulance Handovers within 30 minutes	95%	71.53%	Jun-24		65.30%	May-24	F
43	Ambulance Handovers within 60 minutes	100%	89.84%	Jun-24		83.96%	May-24	F
44	Discharge Summaries - % sent within 24hrs	95%	90.58%	Jun-24		90.24%	May-24	F
45	Discharge Summaries - Number NOT sent within 7 days	0	6	Jun-24	L	0	May-24	?
46	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%	0.00%	Jun-24		0.00%	May-24	P
47	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	2	Jun-24		1	May-24	?
48	Urgent Operations Cancelled for 2nd Time	0	0	Jun-24		0	May-24	P
49	Super Stranded Patients	Trajectory	137	Jun-24		123	May-24	No SPC
50	No Criteria to Reside (NCTR)	No Target set	151	Jun-24		158	May-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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51	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
52	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
53	Elective Outpatient Activity	104%	96%	Jun-24	H	96%	May-24	?
55	Patients seen in the Fracture Clinic within 72 hours	95%	96.70%	Jun-24	H	100%	May-24	P
56	% patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Jun-24	No SPC	0	May-24	No SPC
57	Type 5 attendances	No Target set	1899	Jun-24		2039	May-24	No SPC
58	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	96%	Jun-24	H	96%	May-24	No SPC
59	% Patients discharged to their usual place of residence	No Current Threshold	96%	Jun-24		96%	May-24	No SPC
60	Virtual Appointments	No Target set	15%	Jun-24	No SPC	12%	May-24	No SPC
61	Uncapped Theatre Utilisation	85%	80.30%	Jun-24	L	80%	May-24	F
62	Capped Theatre Utilisation	85%	74.00%	Jun-24		74%	May-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
63	Supporting Attendance	4.20%	5.59%	Jun-24		5.64%	May-24	
64	Retention	85.00%	87.04%	Jun-24		87.15%	May-24	
65	Turnover	Below 13%	12%	Jun-24		12%	May-24	
66	Bank and Agency Reliance	9% or Below	14.67%	Jun-24		14.80%	May-24	
67	Core/Mandatory Training	85.00%	89.84%	Jun-24		90.13%	May-24	
68	PDR	85.00%	77.65%	Jun-24		76.82%	May-24	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

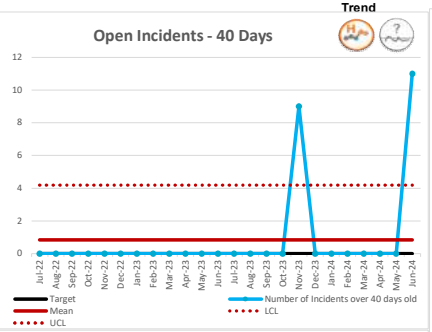
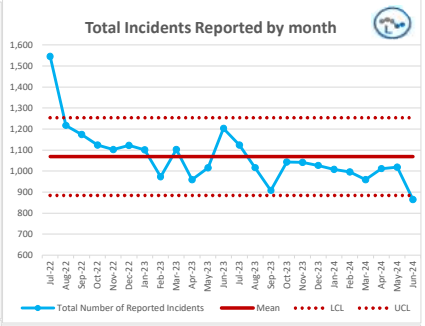
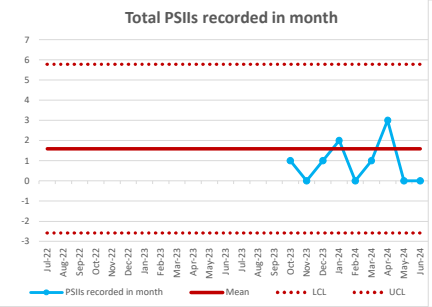
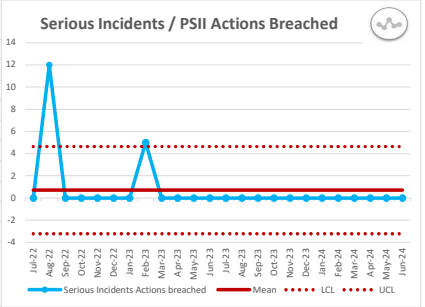
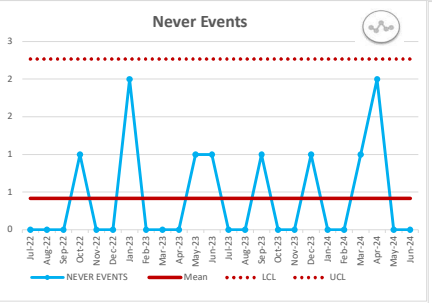
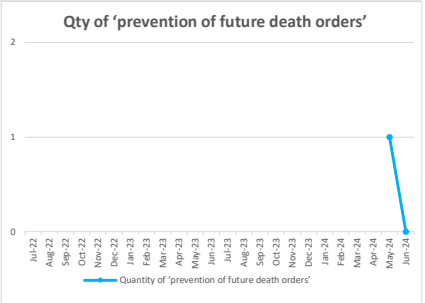
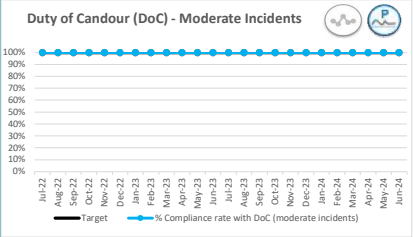
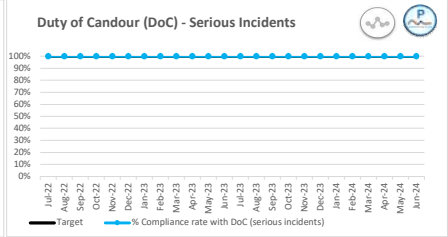
		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
69	Trust Financial Position (£m)	-£3.22	-£3.95	Jun-24	No SPC	-4.02	May-24	No SPC
70	Cash Balance (£m)	£1.73	£5.87	Jun-24	No SPC	5.92	May-24	No SPC
71	Capital Programme (£m)	£2.92	£2.77	Jun-24	H	£1.46	May-24	?
72	Better Payment Practice Code	95%	91%	Jun-24		92%	May-24	F
73	Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£1.94	£1.93	Jun-24		1.13	May-24	?
74	Cost Improvement Programme (recurrent) – In year performance to date (£m)	£1.94	£1.83	Jun-24	H	1.30	May-24	?
75	Agency Ceiling	Less than 3.7%	1.7%	Jun-24	L	2%	May-24	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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)?
1. Incidents (over 40 days) Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events	There were 11 incidents over 40 days old.	     	Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause variation of a concerning nature.	Incident reporting remains within range in month. There are 11 overdue 40-day incidents at the time of reporting due to operational pressures of clinical teams and ability to review and close low-level incidents. There were no PSIIs reported in June 2024 and no Never Events. There were no breached patient safety incident investigation actions at the time of reporting. 1 prevention of future deaths order has been received. This was received on 23 May 2024. A response from the Medical Director and Chief Nurse has been provided to HM Coroner on 19 July 2024. Actions have been identified to reduce the risk of further such harm.	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. 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. Datix system continues to alert at an additional lower threshold (30 days) to enable further support to be provided. Serious Incidents / PSII's Weekly monitoring continues with appropriate escalation to the CBU leads. The Trust moved to PSIRF on the 1st September 2023 where SIs will no longer be referenced. This is reflected using PSII terminology.
2. Duty of Candour (serious incidents)	The Trust achieved 100% for Duty of Candour in month.	 	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	There is no variance in Duty of Candour, the Trust remains 100% compliant. Compassionate Engagement data recording is in progress.	Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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)?
3. Healthcare Acquired Infections (MRSA) **Target: ZERO**	Healthcare Acquired Infections - MRSA	Healthcare Acquired Infections - MSSA	(MRSA) Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause variation of a concerning nature.		
4. Healthcare Acquired Infections (MSSA) **Target: Less than 32 - annual**					
5. Healthcare Acquired Infections (CDI) **Target: Less than 49 - annual**	Healthcare Acquired Infections - CDI	Healthcare Acquired Infections - ECOLI	(CDI) Assurance: The Trust consistently fails the target. (CDI) Variation: Common Cause (Normal) variation. (ECOLI) Assurance: The Trust inconsistently passes/fails the target. (ECOLI) Variation: Variation: Common Cause (Normal) variation.	HCAI Thresholds are not yet published Trust apportioned cases for Jun 24 MRSA: 1 case Following a MDT PSIRF review of patient, 2 potential sources identified, leg wound (also MRSA positive) or cannula site. Missed opportunity to swab the leg wound. Learning has been shared.	Revised reporting rule to include decision to admit (instead of admission date) which will result in additional cases being apportioned to acute Trusts MRSA: MSSA: Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with care of invasive devices. Revise patient safety investigation template to align with PSIRF. CDI: CDI prevention action plan in place. Brilliant Basics Action Plan co-produced with senior nursing team and project implementation plan devised. Communication strategy implemented which includes education across all hierarchies. Deep dive of 2023/24 cases and thematic analysis to identify any additional learning. Senior nursing leadership team IPC visits and spot checks. MDT review meetings are aligned to PSIRF, SIGHT mnemonic education will continue. ECOLI: Klebsiella: Pseudomonas aeruginosa: UTI audit in progress and results awaited. Plan to repeat catheter prevalence survey July 24. Revision and relaunch of the GNBSI Prevention Group, medical staff membership from both planned and unplanned care has been requested. Review of National Action Plan on tackling Antimicrobial Stewardship in progress.
6. Healthcare Acquired Infections (Ecoli) **Target: less than 72 - annual**					
7. Healthcare Acquired Infections (Klebsiella) **Target: Less than 25 - annual**	Healthcare Acquired Infections - Klebsiella	Healthcare Acquired Infections - PA	(K) Assurance: The Trust consistently fails the target (K) Variation: Special cause variation of a concerning nature. (PA) Assurance: The Trust inconsistently passes/fails the target. (PA) Variation: Common Cause (Normal) variation.	MSSA: 2 cases CDI: 11 cases ECOLI: 9 cases Klebsiella: 1 case Pseudomonas aeruginosa: 0 cases	
8. Healthcare Acquired Infections (PA) **Target: Less than 9 - annual**					
9. Healthcare Acquired Infections **COVID-19 Hospital Onset & Outbreaks (No Target)**	COVID-19 - Nosocomial	COVID-19 Outbreaks	Assurance: N/A - No target. Variation: Special cause variation of an improving nature		

Local thresholds have been set based on a 10% reduction from 2023/24.

MRSA cases YTD - annual threshold exceeded by 1

MSSA 11 cases YTD - no threshold set

CDI 29 cases YTD - annual threshold exceeded by 0

E. coli 26 cases YTD - annual threshold exceeded by 0

Klebsiella spp. 11 cases YTD - annual threshold exceeded by 0

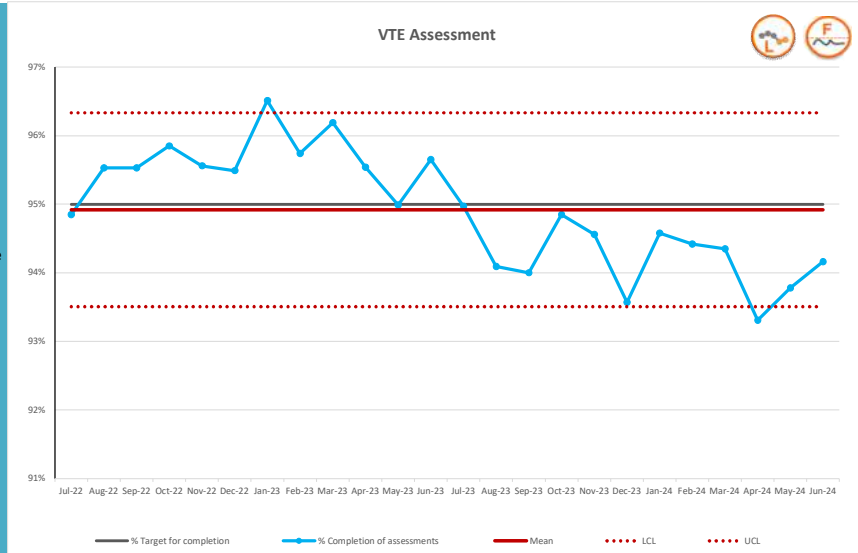
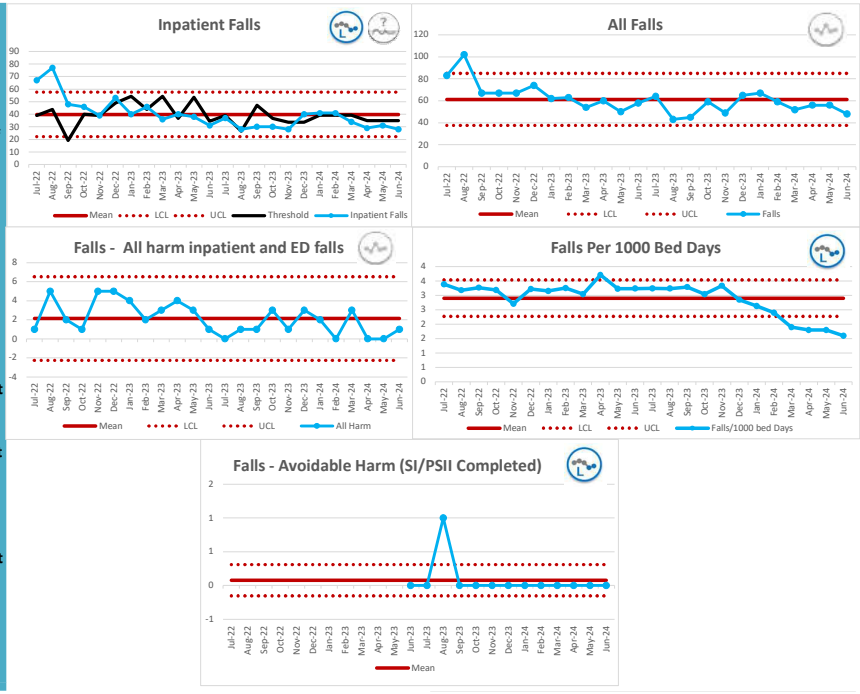
P. aeruginosa 0 cases YTD - annual threshold exceeded by 0

0 in month COVID-19 outbreak.

Covid-19:
5 day 8-14 cases probable healthcare associated cases in month.
7 day 15+ cases definite healthcare associated in month.

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)**	**The Trust did not achieve the required target at 94.16% for VTE assessments in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of a concerning nature**	**Performance target in June 2024 was below the threshold at 94.16%.** **It has been below the mandatory target since July 2023 in consecutive months to date.**	**Actions already taken to improve VTE RA compliance:** **GIRFT In-patient Ward productivity dashboard developed in house at WHH now includes VTE risk assessment data which can be drilled down at the ward level daily for data sharing purpose and for the ownership of this VTE RA data by front line clinicians to improve overall compliance. It has been launched trust wide in Early December 2023 after engagement with all relevant stakeholders.** **Further improvement actions in progress for VTE RA compliance:** **•Top 5 wards where highest VTE non-compliance data to be shared with CBU, matrons of these wards to improve overall trust compliance** **•C23 & EAU have been added to GIRFT In-patient Ward Productivity Dashboard for real-time VTE RA data sharing** **•Currently implementing SPC chart for reporting trend of non-compliance data at each ward level under each CBU in liaison with WHH data analytics team -end of June 2024** **•Development of VTE RA non-compliance data dashboard for reporting at trust/care group/CBU level for CBUs to monitor ward level performance and generating monthly report at the end of the month for all CBU governance meetings with VTE RA non-compliance data**
11. Inpatient Falls & harm levels **Target: decrease from 23/24 (418 Inpatient Falls in 2023/24)**	**48 total falls were reported in month. 28 of these were inpatient falls.** **There were 1 fall(s) in month with harm.** **There were 671 total falls in 2023/24. There have been 160 total falls YTD in 2024/25. We are expecting a 5% decrease in falls from last year.** **There were 418 inpatient falls in 2023/24. There have been 88 inpatient falls YTD in 2024/25. We are expecting a 16% decrease in falls from last year.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**During June 2024 there were a total of 28 inpatient falls which is within normal variation, and below the mean. There was one moderate harm fall which resulted in the patient having a # NOF.**	**The representative from Turun (falls alarm company) is continuing visits to all the ward areas to inspect current falls equipment, and is arranging to complete training with requesting areas.** **A survey regarding use of decaffeinated drinks is now complete. The results have been shared at the July 2024 Ward Managers Meeting.** **Falls prevention continues to be a focused theme of Patient Safety Improvement Nurse Walk Arounds. Falls are reviewed weekly at the Harm Free Care Meeting to identify and share lessons learned.**

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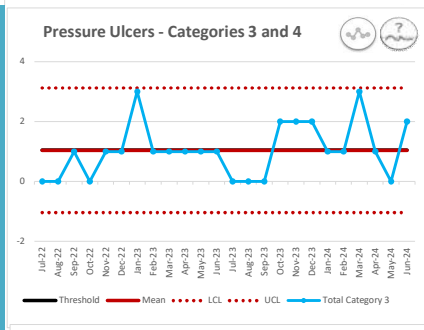
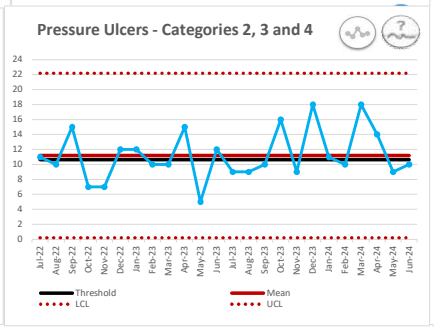
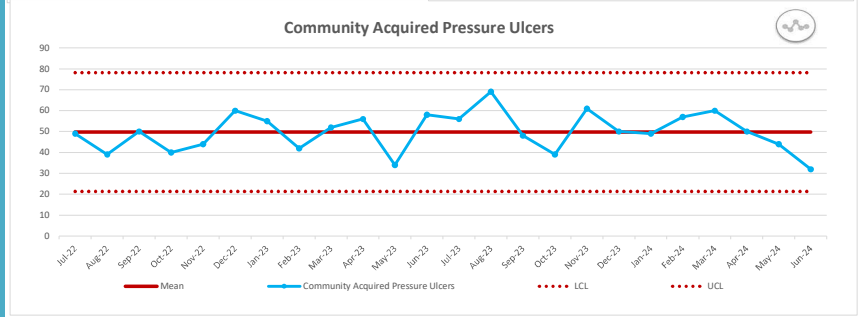
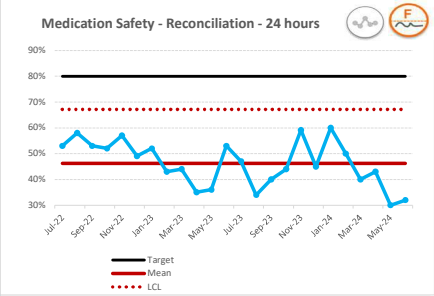
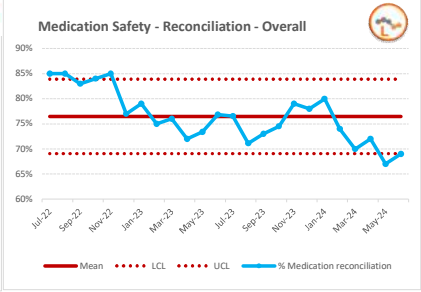
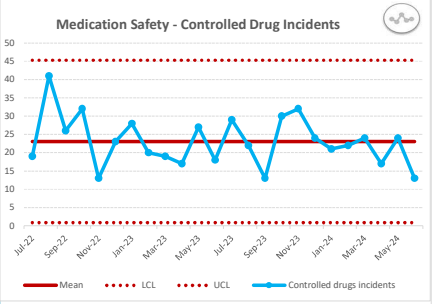
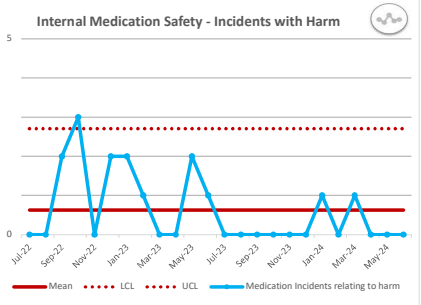
12. Pressure Ulcers (Category 2 and above) Target: 10% reduction based on 2023/24				
There were 8 hospital acquired category 2 pressure ulcers, 2 Category 3 pressure ulcers and 0 Category 4 ulcers in month. There were 32 community aquired pressure ulcers in month.	  	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	In June 2024, there were 8 category 2 pressure ulcers: B19 x 2, ITU x 2 (both device related, NIV mask and anchor fast), One on A2, A6, A8 and B12. There were also 2 pressure ulcers which were a minimum category 3, one on AMU and C21.	Actions to improve the position include: 1. After Action Reviews are taking place and lessons are shared with ward teams and via Operational Patient Safety Group. 2. Minimum category 3 and above will now have an MDT review completed. 3. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses. 4. A task and finish group continues. Actions from the group include: following a gap analysis of the Trust's current position against the Pressure Ulcer Recommendations and Clinical Pathway (Health Innovation Network, 2023), adding skin tone assessment to the skin assessment and incident form will be progressed; refresh of TVN referral criteria with Band 6/7 staff reviewing appropriateness of referrals before they are made, Test of Change in progress relating to NIV on ITU; review of photographic equipment that may support referrals, monitoring; review results of trial of a modified SKINN bundle; plan for relaunch of Tissue Viability Links/Champions, review of recording of Care Home information for community acquired pressure ulcers.
13. Medication Safety Reconciliation within 24 hours Target: 80%				
Medicines reconciliation was completed within 24 hours of admission for 32% of patients. 69% of patients had MR completed during inpatient stay. There were 13 controlled drug incidents. There was 0 medication harm incident reported in month.	   	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Medicines Reconciliation: Continued failure to achieve target, which is linked to ongoing vacancy factor in pharmacy establishment, resulting in some wards/areas having reduced/no pharmacy cover. Controlled drug incidents: there is no target for this metric. There were 13 controlled drug incidents in June 2024, with dispensing (n=4) and balance discrepancies/unaccounted for losses (n=3) the most commonly reported incident category. Two incidents related to TTOs being processed for St Rocco's Hospice and work is underway to agree a pathway for resolving prescribing issues relating to CDs on TTOs. Incidents causing harm: there is no target for this metric. While four incidents resulting in harm were reported in June 2024, all four occurred in an external site/ organisation but identified here and therefore have been excluded from our data shown.	Actions to improve performance against the medicines reconciliation target: Ongoing recruitment to vacancies - 11 pharmacists due to start between July and November 2024. Medicines reconciliation improvement action plan in place, overseen at Pharmacy Specialty Governance meeting. Actions include: reviewing pharmacy ED team prioritisation and deployment, piloting remote MR for elective surgical admissions, work with midwifery to embed midwife-led MR for low risk patients, deployment of BI dashboard to support prioritisation of pharmacy staff, data analysis to review themes and trends to identify process efficiencies. Medication/controlled drug incidents: all incidents are reviewed by a multiprofessional group and lessons learned are disseminated. Themes are identified and action plans developed through the medicines governance structure.

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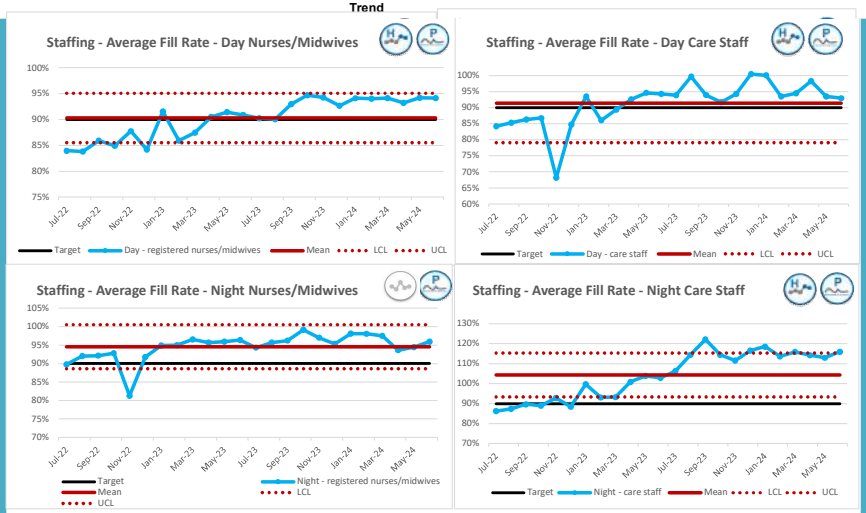
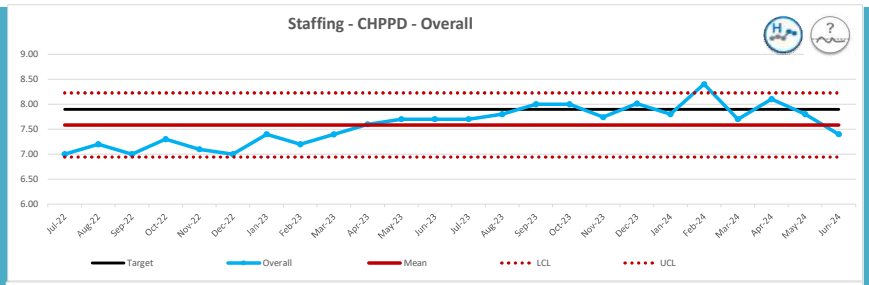
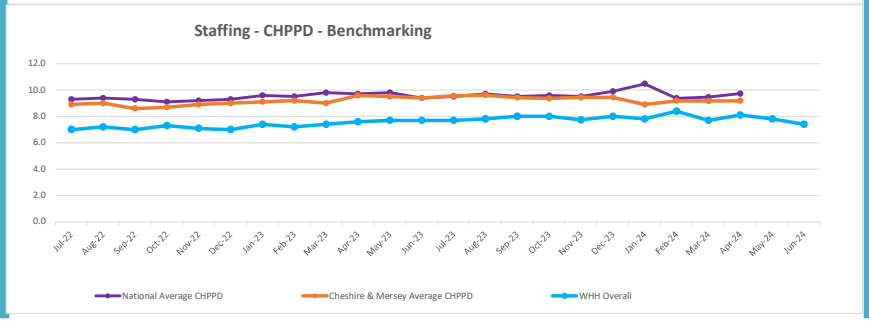
14. Staffing - Average Fill Rate **Target: 90%** **In month, the average staffing fill rates were:** **Day (Nurses/Midwife) 94.16%** **Day (Care Staff) 92.94%** **Night (Nurses/Midwife) 95.91%** **Night (Care Staff) 115.99%**		**Assurance: N/A Grouped Indicator** **Variation: N/A Grouped Indicator**	**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.** **The current percentage vacancy for June 2024 for registered staff is 12.02% against a Trust target of 9%. This is mainly due to AED increased establishment of 49.36 WTE. Specialist recruitment is taking place particularly for AED who have an outstanding vacancy of 40.0 WTE (Band 6 & Band 5) due to Trust investment with ongoing shortlisting and interviews. The Trust is currently supporting 44 students through the recruitment process who qualify this summer. The next Trust recruitment event is Oct 16 2024 with current ongoing recruitment taking place.** **The current percentage vacancy for unregistered staff for June 2024 is 11.54% against a Trust target of 9%. Monthly recruitment is taking place alongside specialist recruitment. The next scheduled interviews will take place on the 25th July in conjunction with NHSP with further interviews in August 2024.**
15. Staffing - Care Hours Per Patient Day (CHPPD) **Target: 7.9 CHPPD** **In month, the average CHPPD were:** **Nurse/Midwife: 4.2 hours** **Care Staff: 3.3 hours** **Overall: 7.4 hours**	 	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**The CHPPD for June 2024 is 7.4 which is a reduction from 7.8 in May and below the national target of 7.9.** **The overall CHPPD is affected by areas not meeting their planned hours e.g. due to absence and vacancy.**	**To ensure lower CHPPD figures are not impacting on care provision this data is triangulated with the Trust's harm profile and actions taken to ensure safe staffing throughout the Trust.** **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.**

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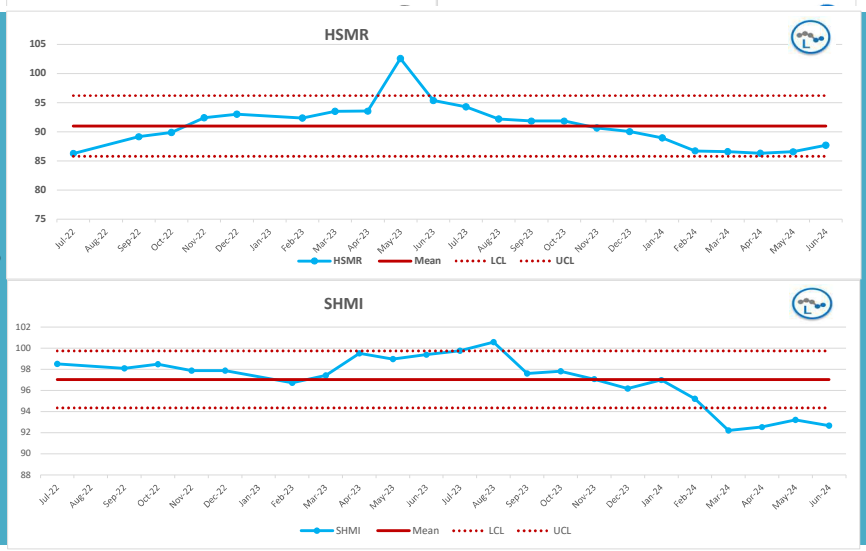
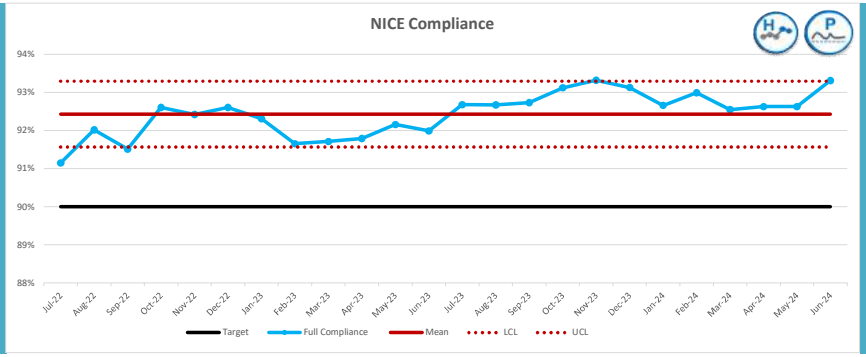
16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 87.72. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 92.68.		(HSMR) Assurance: NA - no target Variation: Special Cause Variation of an improving nature. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of an improving nature.	NHS Digital are making some changes to the definition of SHMI as from the publication due May 2024.These changes will also be reflected in HED, and any changes relevant to Warrington will be monitored and reviewed in future reports if appropriate. Key changes are: a) reintroduction of COVID activity from September 2021 onwards b) removal of activity from sites with 'hospice' in their title for trust level SHMI figures c) SHMI figures no longer to be published for certain sites (no change for Warrington) d) methodology for identifying primary and secondary diagnoses for spells with multiple episodes expanding to review all episodes, not just the first two e) activity with an invalid primary diagnosis moved to a separate diagnosis group.	Clinical Effectiveness Coordinator continues to liaise with the Safeguarding Team and Bereavement Services to ensure accurate Mortality data is captured on a regular basis. Going forward, the mortality diagnosis method for grouping will change. Instead of just reviewing the first 2 episodes in a spell, they are looking at all episodes in a spell, and selecting the first 'non – R' primary diagnosis, if there is one, or the primary diagnosis of the first episode if there isn't. The Charlson score will come from the first 'non – R code' primary diagnosis episode, not the first, going forward. R69X will have its own diagnostic group which will mean that uncoded data will have accurate representation and can be removed, if necessary, from reporting. The changes have been applied retrospectively to all data. If we want to see SHMI values based on the old methodology, it can be viewed in archived SHMI modules. It is hoped, that this will reflect in a reduction of R code deaths and also be able to show more clearly that "R69X" is coding backlog related.
18. NICE Compliance Target: 90%	The Trust achieved 93.31% in month.		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.	We currently have 619 pieces of NICE guidance where a total of 527 are' full compliance', 31 are 'agreed partial compliance', 37 are 'partial compliance' 21 are for information only and 3 are currently under review. Based on this we are 93.31% compliant with our NICE Guidance as a Trust. The Clinical Business Units' (CBU) are asked to review the partial compliance and when relevant actions have been completed the guidance is re-reviewed to determine our updated compliance against the relevant guidance. As a Trust we have consistently remained above the 90% compliance target.

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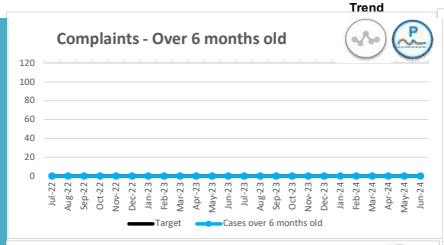
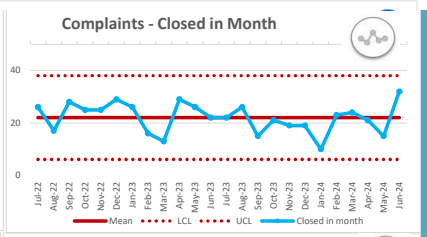
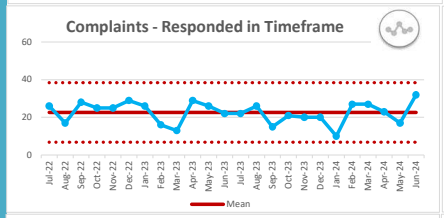
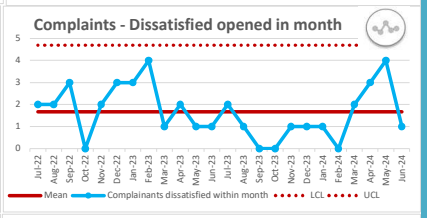
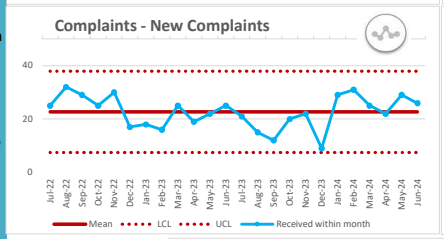
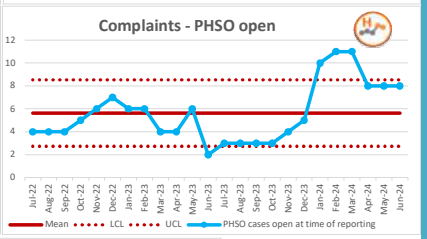
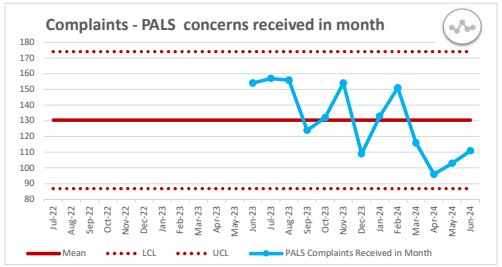
19. Complaints **Target: Zero complaints open over 6 months old/in the backlog**	**In month, 26 new complaints were received to the Trust which was a decrease of 3 from the previous month. There were 1 dissatisfied complaints received in month, which is a decrease from the previous month.** **4 PHSO cases were opened in January, these were not linked to a specific area or theme.**	      	**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. The Complaints Team continue to review their processes in order to maintain a quality service with a process mapping session rescheduled to take place with the new Deputy Director of Governance.**	**Complaints position of 66 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.**

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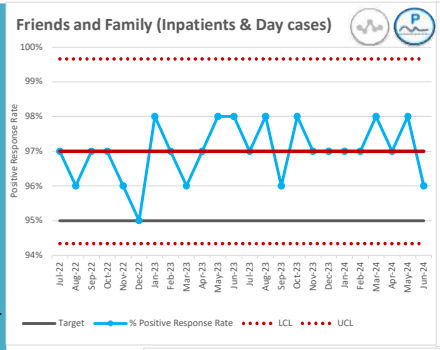
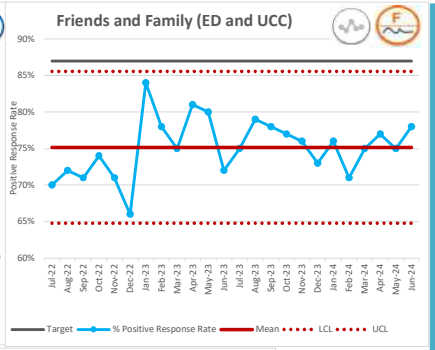
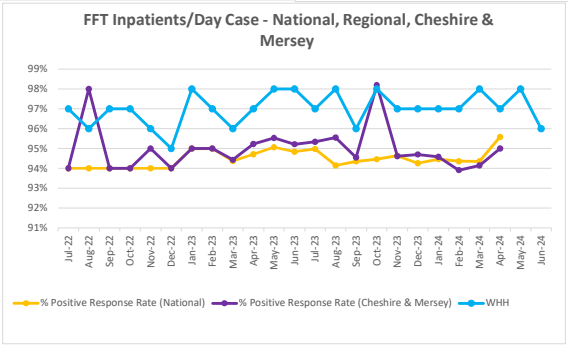
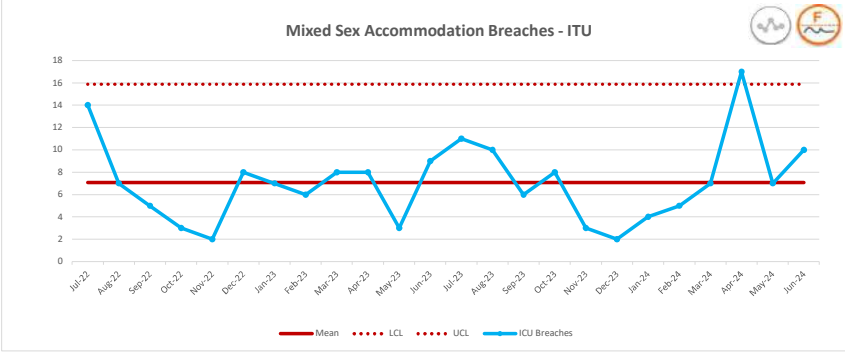
20. Friends and Family (Inpatients & Day cases) Target: 95% 21. Friends and Family (ED and UCC) Target: 87%	The Trust achieved 96% in month for Inpatient & Day case FFT and 78% for ED/UCC FFT. The most recent National average for FFT inpatients/Day Case was 95.58% and for C&M was 95%.	  	(IP/DC) Assurance: 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 96% positive recommendation rate in June 2024. ED/UCC - The Trust achieved 78% positive recommendation rate in June 2024.	All areas - Monitoring of themes, identify areas for improvement, share best practice at Patient Experience Sub-Committee - Patient Experience Team observations fed back to wards/department - QI projects e.g. use of QR codes and volunteers assisting throughout the wards and departments ED/UCC specific - Key themes for improvement include communication, waiting times, pain management and the environment. - Monitoring of care and comfort rounds - Visual communications to be prominent in areas - Mapping patient journeys to understand the support required at each touch point - Reviewing opportunities to involve volunteers in FFT completion within the department - Volunteers are assisting with drinks rounds - The UECSIP is to commence for 2024-2025, this work will address overcrowding, length of stay and discharge challenges
22. Mixed Sex Accommodation Breaches (ITU Only) Target: Zero	There were 0 mixed sex accommodation (MSA) incidents outside of the ITU in month. There were 10 MSA incidents within the ITU.		Assurance: The Trust consistently fails the target. Variation: Variation: Special Cause variation of a concerning nature.	There were 10 mixed sex accommodation breach reported in June 2024 in the Intensive Care Unit, an increase 3 from May 2024. These were due to the delayed discharge of level 1 patients. All delayed discharges are escalated to the Patient Flow Team and Tactical Manager of the day, and discussed at each bed meeting. 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.

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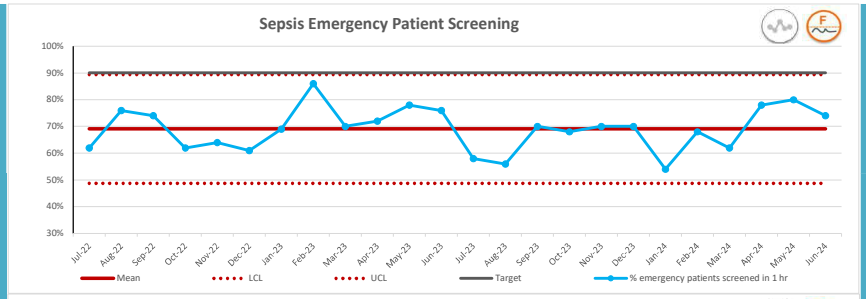
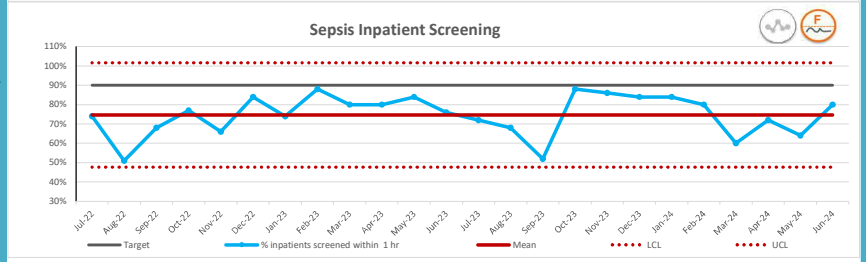
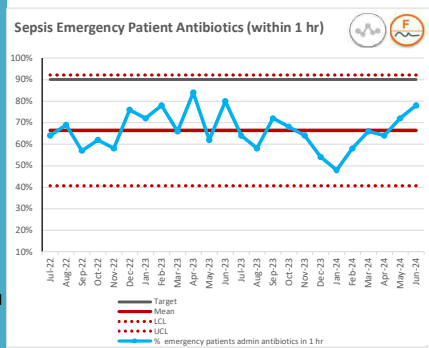
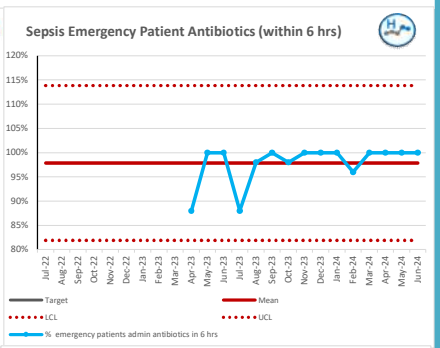
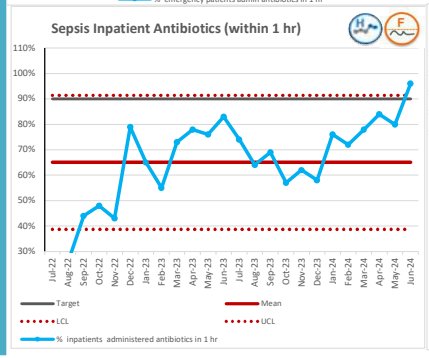
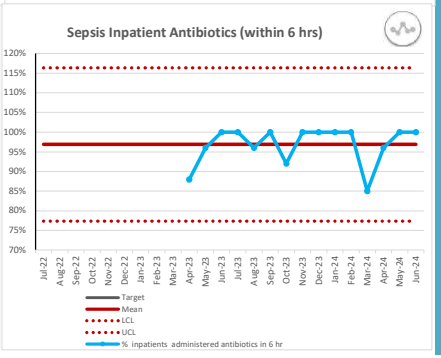
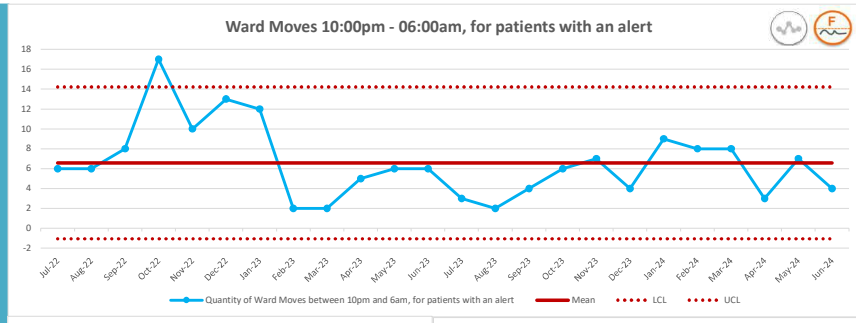
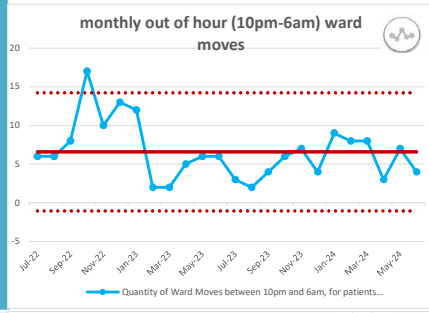
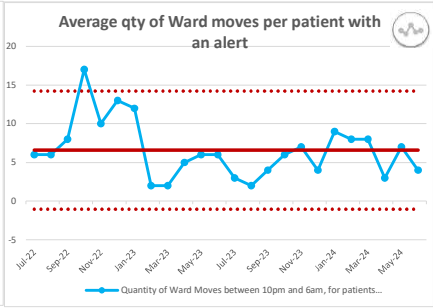
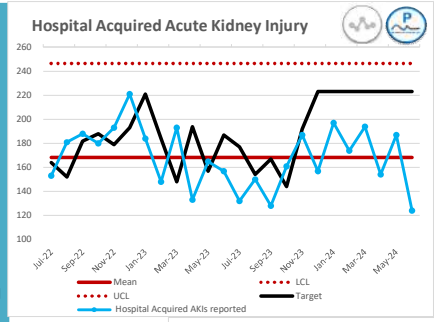
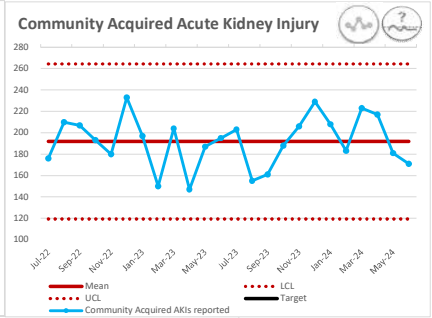
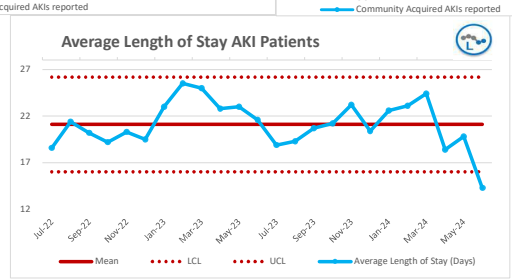
23. Sepsis - % screening for all emergency patients. Target: 90% 24. Sepsis - % screening for all inpatients Target: 90%	The Trust achieved: • 74% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 80% screening for all inpatients with suspected sepsis within 1 hour.	 	(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.	ED: The number of patients who are partially screened has improved with the absence of blood cultures a contributing factor Inpatients: there were 4 patients who had a partial screen. 2 were due to no lactate being taken, and 2 no blood cultures.	Sepsis management remains a focus on Safety Huddles and during the TWSB. ED continue to try and 'ring fence' beds for patients with suspected sepsis so they are not needing to be cared for on the corridor. Blood culture training figures continue to be a focus in Operational Patient Safety Group (OPSG) with training plans discussed by each CBU. Meetings are taking place in July regarding the NG51 guidance with the objective to roll out the new guidance with education and training for all staff
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: • 78% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made. • 96% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.	   	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common cause (normal) cause variation. (Inpatient) Assurance: The Trust consistently fails the target. Variation: Special cause variation of an improving nature.	In ED 45% of antibiotic delays were due to a delay in prescription. In ED there has been a 6% improvement between May 2024 and June 2024 in patients receiving antibiotics within the 1 hour timeframe.	NG51 updated at the end of January 2024, with initial discussions around the changes commenced. An action plan has been developed to ensure the role out of any new information is managed appropriately with the aim of rolling out the new sepsis guidance from September 2024. A Single Point Lesson to show nurses how to access the medication overview screen was shared Trust wide which will help them to identify the absence of antibiotic STAT prescription. A draft of the new teaching package has been devised and will be reviewed by the Trust Clinical Sepsis Lead during July.

Quality Improvement - Trust Position

Appendix 2

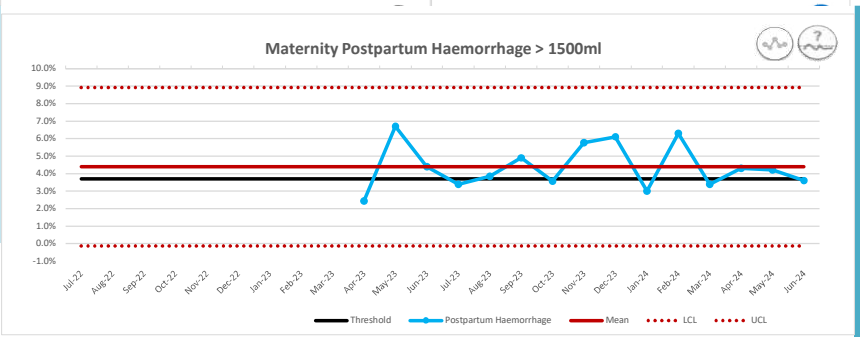
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Ward Moves between 10:00pm and 06:00am with a dementia, LD and/or Mental Health alert **No Target**	**There was a total of 4 ward moves in month between 10pm-6am for patients with an alert, compared to 6 in June 2023.**	  	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**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 Tactical Manager on call minimising non essential clinical patient moves.**	**The Tactical 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 needs to ensure no inappropriate moves have taken place. This notification is monitored by senior nurses who undertake a welfare check.**
28. Acute Kidney Injury **Target: Less than month in previous year**	**There were 124 acute kidney injuries reported in month compared to 187 last month.**	  	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**No Variation with LOS and HA-AKI with both being below the mean and HA-AKI below target.**	**Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient. Trust wide fluid balance audit actions have been agreed including amendments to the AKI e-learning package to strengthen fluid balance guidance, change to fluid balance guideline to more clearly define roles and responsibilities, increasing simulation opportunities related to fluid balance recording in HCA induction.** **Move towards a deteriorating patient bundle or reduce work and improve prevention and management.** **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.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission

Quality Improvement - Trust Position

Appendix 2

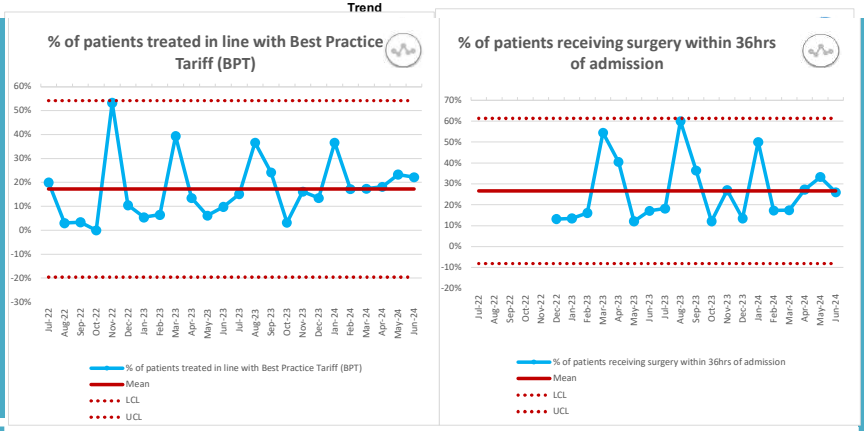
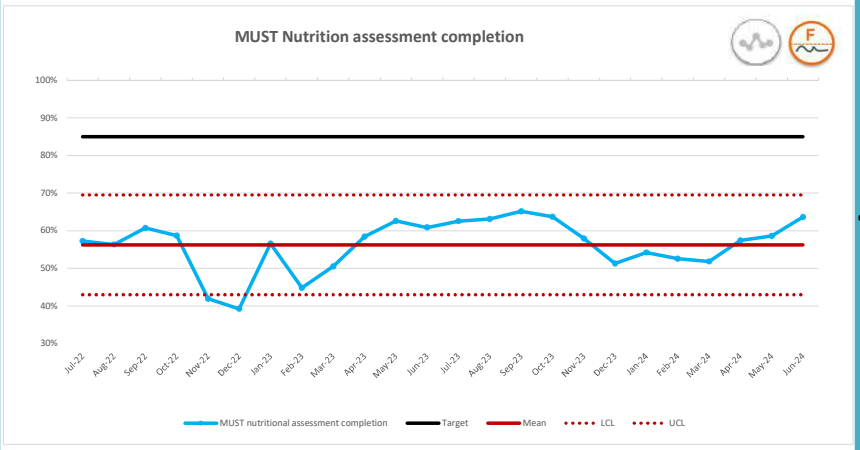
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml Threshold: < 3.7%	There were 3.6% Postpartum Haemorrhages >1500ml in month.		N/A - Not enough datapoints.	Rates for June have improved. QI work is ongoing but rates continue to fluctuate. The benchmark is based on historical regional data. The service is waiting for recent data to more accurately compare the service with other providers.	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 meets regularly to review patterns and themes from incidents of PPH >1500ml. In addition a PPH QI group has been established. This QI group is leading on the improvements identified as part of the previous audit. The PPH action plan is reported monthly to QAC alongside an SPC chart from June 2024.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission

Quality Improvement - Trust Position

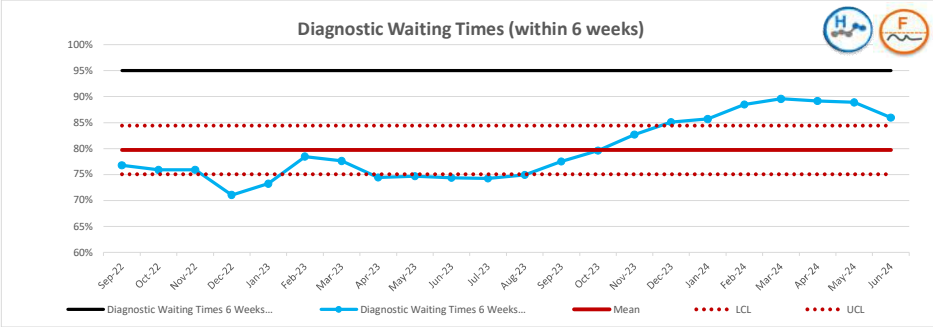
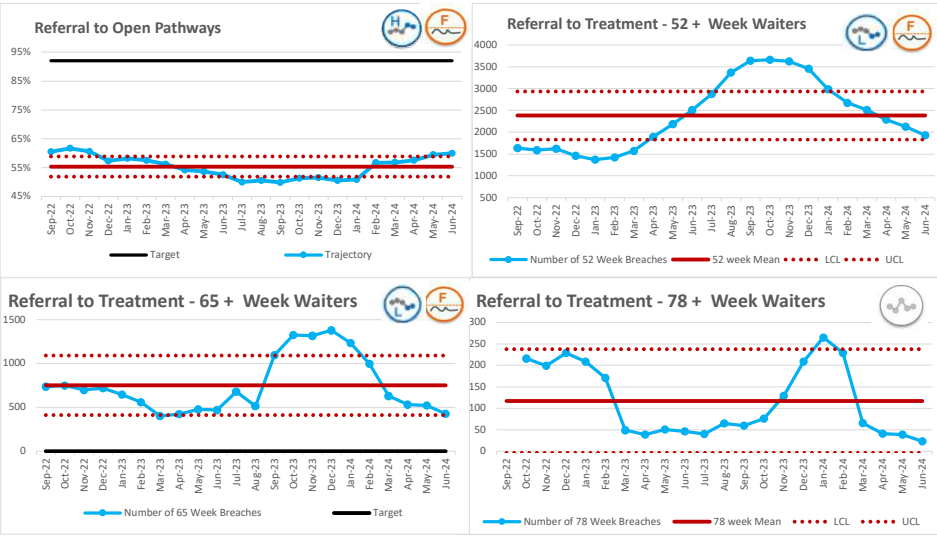
Appendix 2

	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)?
30. Fractured Neck of Femur **Target: Best Practice Tariff**	**23.33% of patients were treated in line with Best Practice Tariff (BPT) in May-24.**	 	**Variation: Common Cause (Normal) variation.**	**Overall average time to theatre improved in June by around 4 hours.** **Smaller patient cohort than previous month (38 vs 28).**	**Continue theatre improvement work to increase efficient performance of trauma lists.** **Further work with clinical leads for T&O and BPT, senior nursing and operational leads to interrogate action plan further to identify opportunities to sustain and build upon improvement.**
31. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 63.64% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**MUST compliance remains below Trust target in all 3 metrics on the LION Dashboard. This is due to delays in assessment on the ward.**	**Data reporting has been improved on LION dashboard with SPC charts added to help track compliance . These will be modified further to provide SPC charts for each ward area. All CBU's have access to the data and have been asked to provide an action plan to improve MUST compliance. HLBP has been introduced to all CBU's which will be submitted quarterly to the NF&HSG. An audit has been completed to review staffs understanding of the interventions that are recommended at ward level, when to refer to dieticians and documentation. The results of this audit are to be fed back at the ward managers meeting in March and actions to be agreed to improve. A Nutrition Nurse Specialist has been successfully appointed and will start in the Trust in April, subject to recruitment checks. This post will support the Trust to implement the complex nutrition MDT, set up SOP's to reduce admission for patients presenting in ED with blocked feeding tubes etc, and will develop long-term processes to ensure equal access and prompt review of patients with nutritional needs and support wards/units with training, whilst enforcing the need to screen patients on admission and every 7 days.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

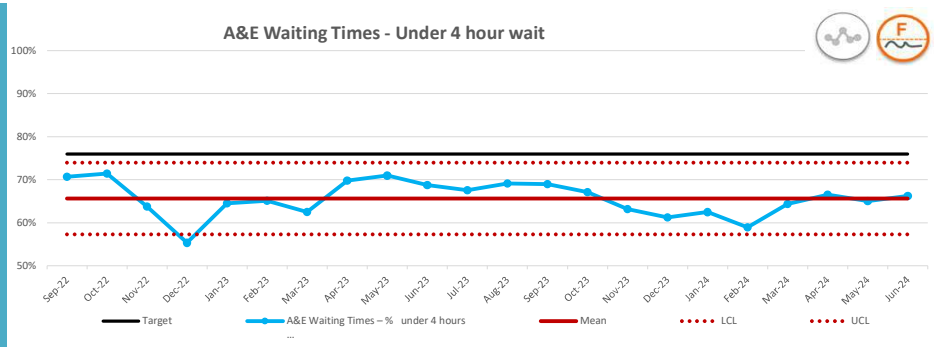
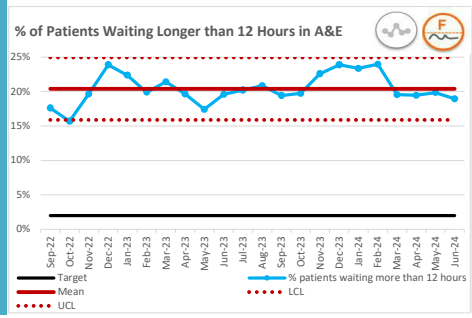
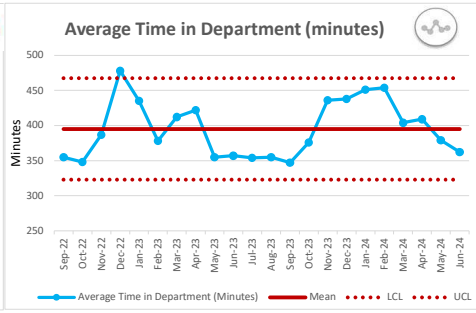
Key: Risk Register | System Oversight Framework | Care Quality Commission

	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. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 85.94% in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	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, recovery plans are in place for all modalities.
33. Referral to treatment Open Pathways Target: 92% 34. RTT - Number of patients waiting 52+ weeks Target: 0	The Trust achieved 59.91% in month. There were 1930, 52 week breaches, 23, 78 week breaches and 427, 65 week breaches.		(Open Pathways) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature. (52+) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	RTT performance - both 52 weeks and 65 weeks are off trajectory, with Gynae, T&O and Max Fac being major contributing specialties, 78 weeks remains challenged, however no capacity breaches were declared in June, mitigation plans through use of insourcing and mutual aid are supporting recovery plans.	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 2024/25 have been drawn up in line with current Operational Planning Guidance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

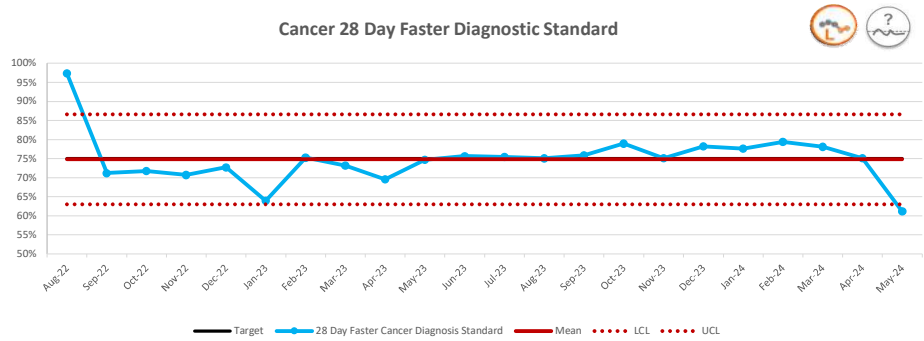
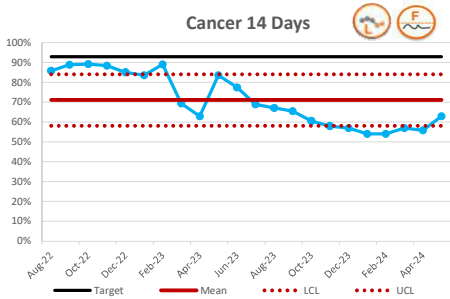
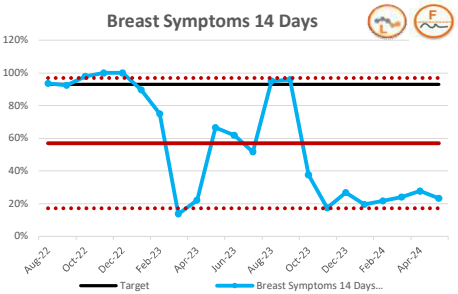
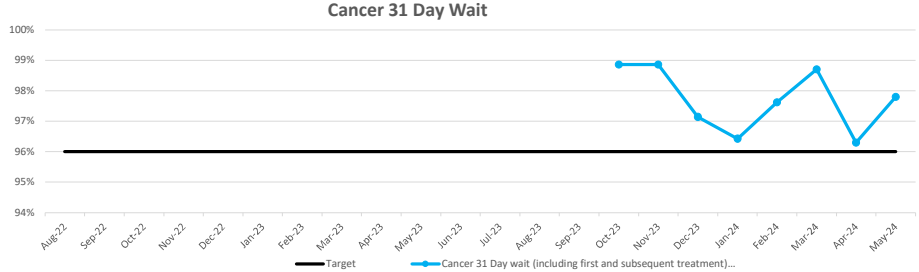
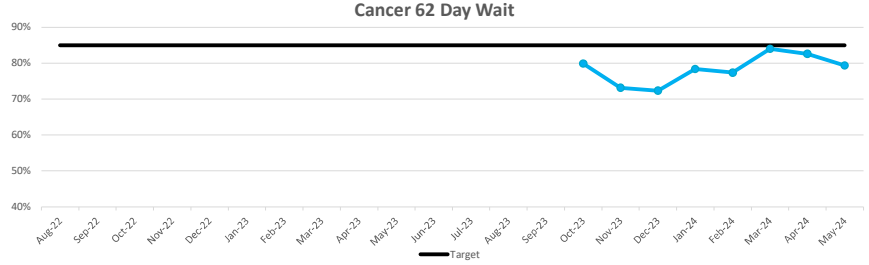
Key: Risk Register | System Oversight Framework | Care Quality Commission

	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)?
35.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 75%	The Trust achieved 66.25% excluding Widnes walk ins in month.		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. • A10 escalation beds closed on 7th June taking out 14 beds which negatively impacts on ED performance.
36. Average time in department ED No Target					
37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	18.93% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 362 minutes.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in 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 24/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 24/25 is set up to support improvement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

Key: Risk Register | System Oversight Framework | Care Quality Commission

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)?
38. 28 Day Faster Cancer Diagnosis Standard Target: 75% The Trust achieved 61.2% in month.	  	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	The Trust is currently meeting the 28 Day FDS. This remains challenging due to delays in some pathways including gynaecology and Breast that whilst now resolving may affect performance in forthcoming months. Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026 and an interim target of 77% by March 25.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG).
39. Cancer 31 Day wait Target: 96% The Trust achieved 97.8% in month for Cancer 31 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	The Trust achieved the 31 day target.	
40. Cancer 62 Day wait Target: 85% The Trust achieved 79.4% in month for Cancer 62 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	The 62-day referral to treatment target remains challenging but is seeing some improvement due to the combined standards. From the 1st October 2023 this standard will be combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85% there is a commitment to reach 70% by March 2025. The Trust is currently achieving this.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

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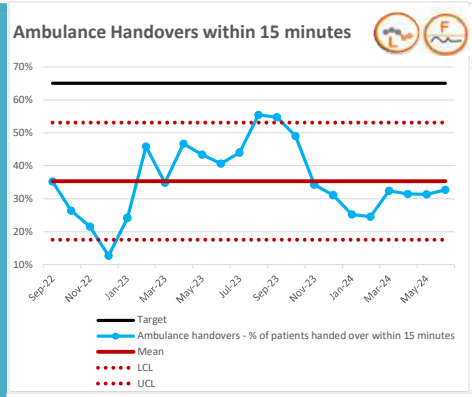
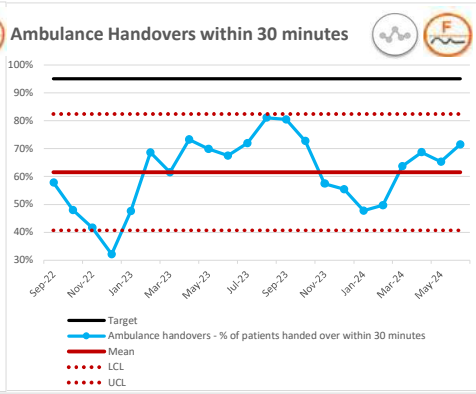
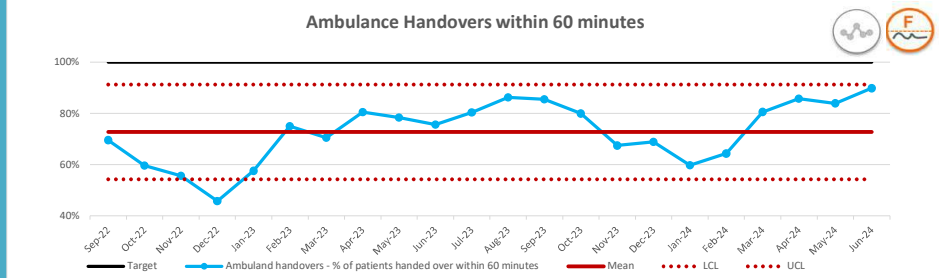
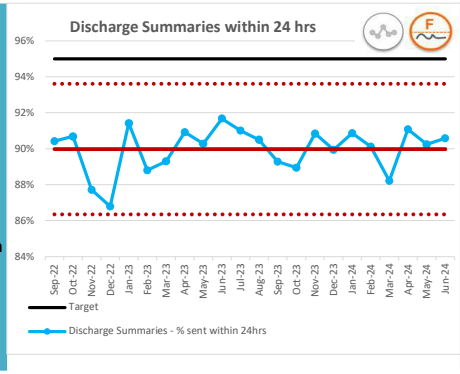
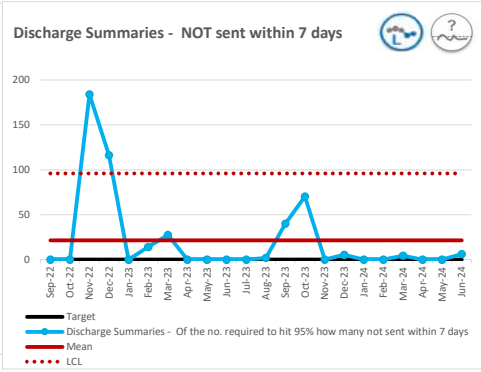
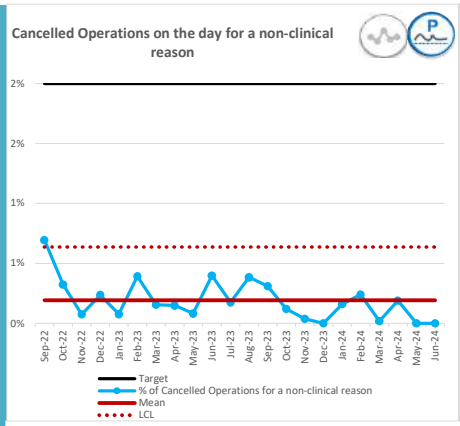
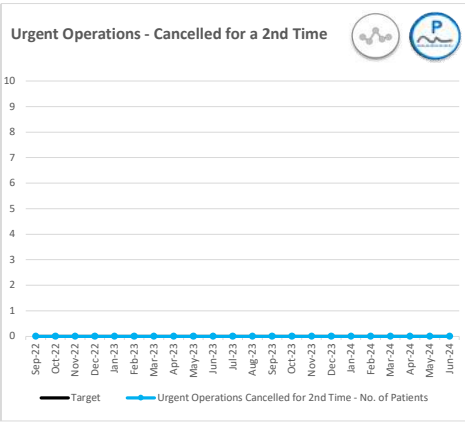
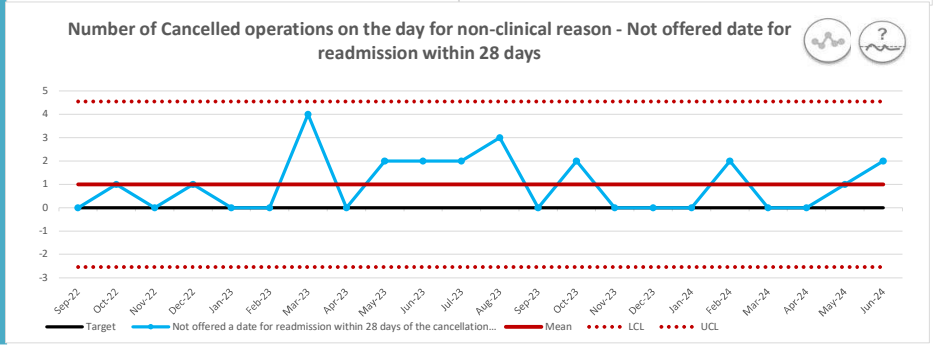
Key: Risk Register | System Oversight Framework | Care Quality Commission

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. Ambulance Handovers within 15 minutes Target: 65% 42. Ambulance Handovers within 30 minutes Target: 95% 43. Ambulance Handovers within 60 minutes Target: 100% **In month 32.7% of patients were handed over within 15 minutes, 71.53% were handed over within 30 minutes and 89.84% were handed over within 60 minutes.**	  	**(15) Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.** **(29) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(60) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Handover performance continues to be a priority, it has been challenged due to surges in demand and workforce constraints**	**The Trust will continue to work in partnership with NWAS to identify and implement improvements.**
44. Discharge Summaries - % sent within 24hrs Target: 95% 45. Discharge Summaries - Number NOT sent within 7 days Target: ZERO **The Trust achieved 90.58% in month for discharge summaries sent within 23 days, against the target of 95%.** **There were 6 discharge summaries in month not sent within 7 days, against the target of 0.**	 	**(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: There is special cause variation of an improving nature.**	**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.** **A deep dive is underway into the increase of discharge summaries not sent within 7 days.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

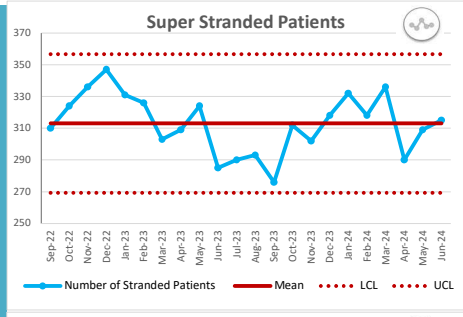
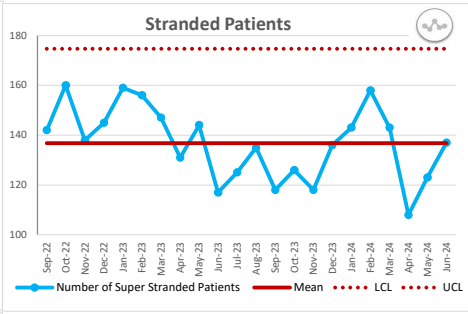
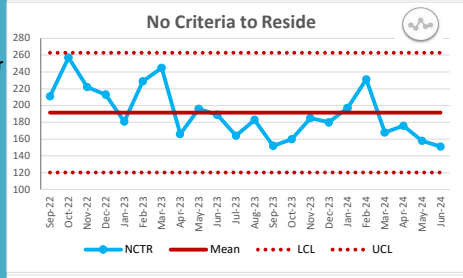
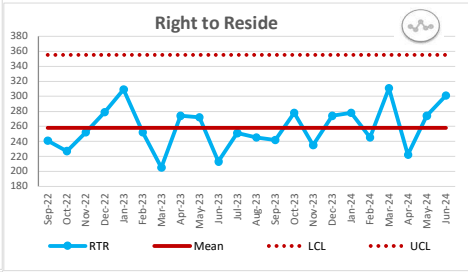
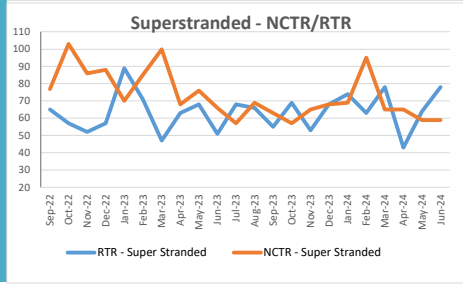
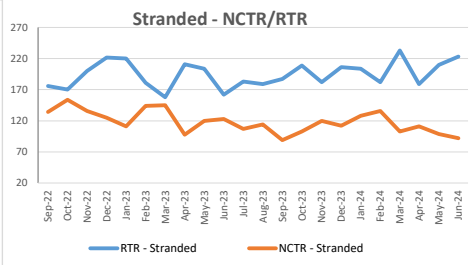
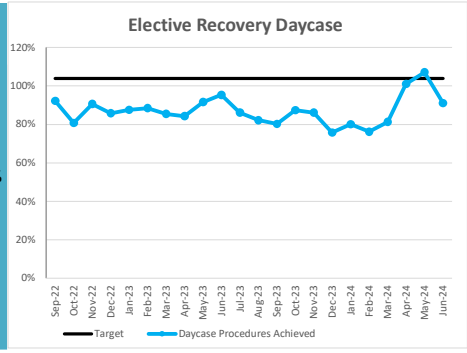
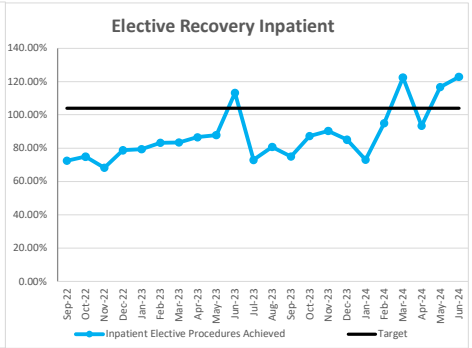
Key: Risk Register | System Oversight Framework | Care Quality Commission

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)?
46. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	Cancelled operations for a non-clinical reason was 0% in month. 2 cancelled operations were not offered a date for readmission within 28 days.		(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.		
47. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO			(Not offered 28 days) Assurance: The Trust inconsistently passes/fails the target.	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.
48. Urgent Operations Cancelled for 2nd Time			Variation: Common Cause (normal) variation. (Urgent Ops cancelled 2nd time) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.		

Key:
Risk Register
System Oversight Framework
Care Quality Commission

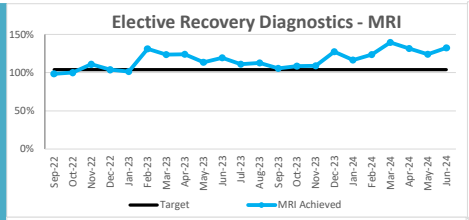
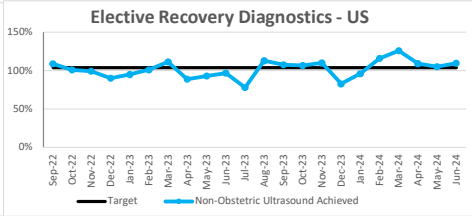
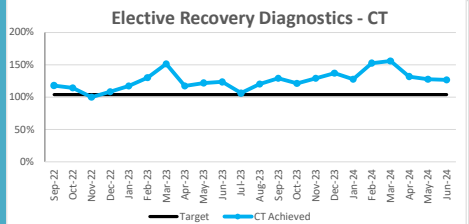
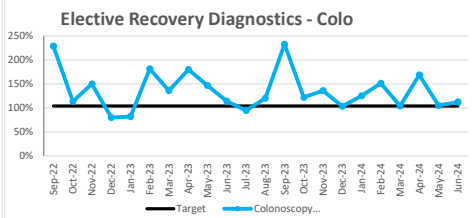
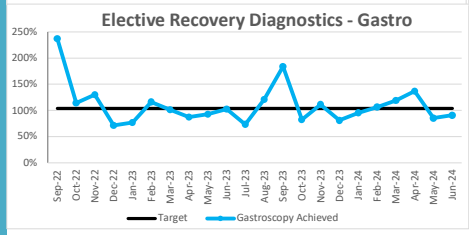
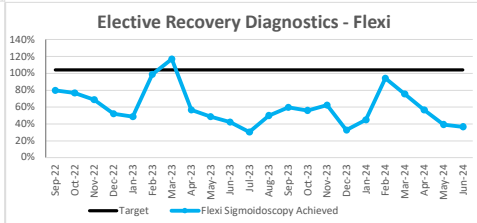
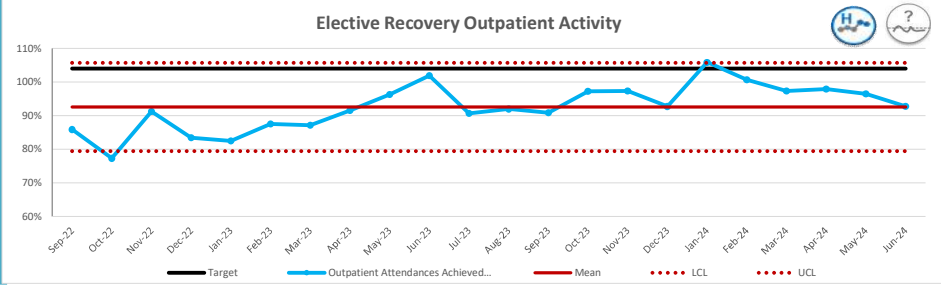
Access & Performance - Trust Position

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)?
49. Super Stranded Patients Target: Trajectory 50. No Criteria to Reside (NCTR) There were 315 stranded and 137 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	     	(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (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 has decreased and is largely been driven by patients with criteria to reside, daily MDT meetings review all non criteria to reside patients, the current numbers are reflective of seasonal variation	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
51. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20 In month, the Trust achieved the following % of activity against 2019. This included 91% of Daycase Procedures and 122.9% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Inpatient electives had a strong performing month a decrease in day cases was seen as a result of IA and a focus on clearing the complex longwaiters	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
System Oversight Framework
Care Quality Commission

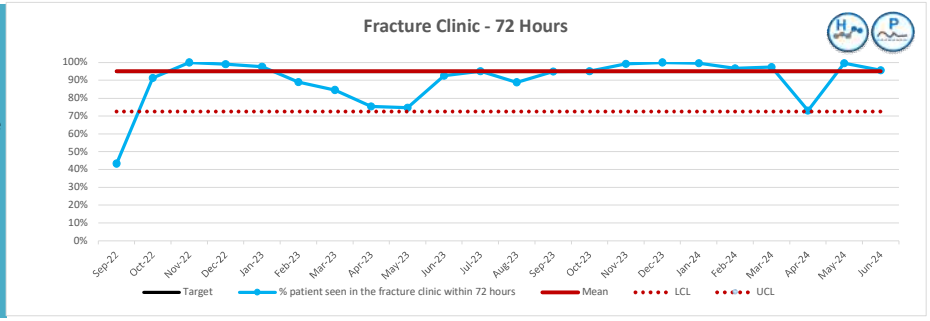
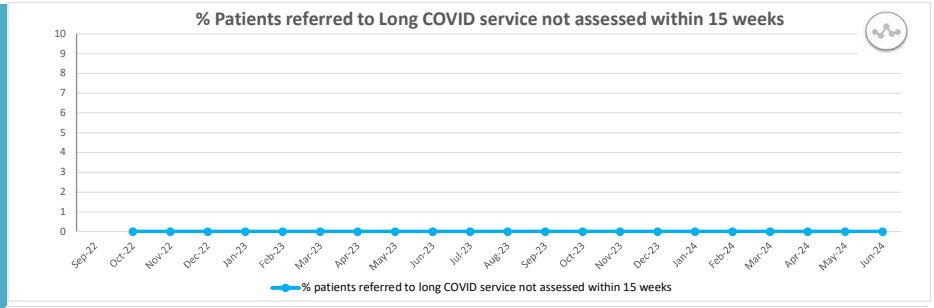
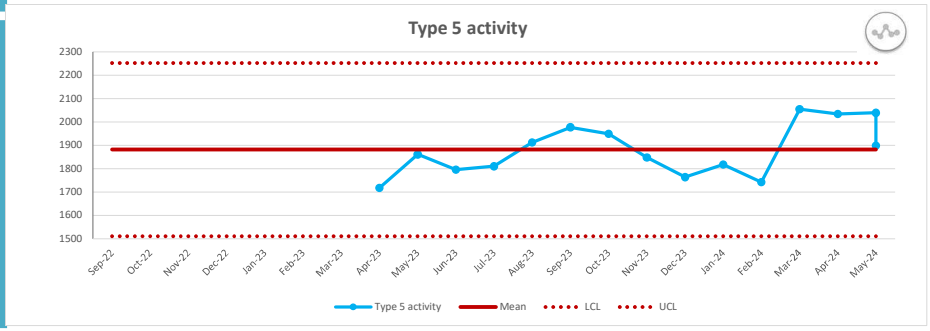
Access & Performance - Trust Position

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)?
53. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20				
In month, the Trust achieved the following % of activity against 2019. **This included:** **132.55% of MRI** **126.77% of CT** **109.85% of Non-Obstetric Ultrasound** **36.63% of Flexi Sigmoidoscopy** **112.32% of Colonoscopy** **90.84% of Gastroscopy**	     	**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.** **Underperformance in Flexi sig will be explored at the Performance Review Group.**
54. Elective Recovery Outpatient Activity Aggregate Target: 104%				
In month, the Trust achieved 92.8% of Outpatient activity against 2019.		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**The Trust continues to deliver Outpatient activity inline with operational planning guidance**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

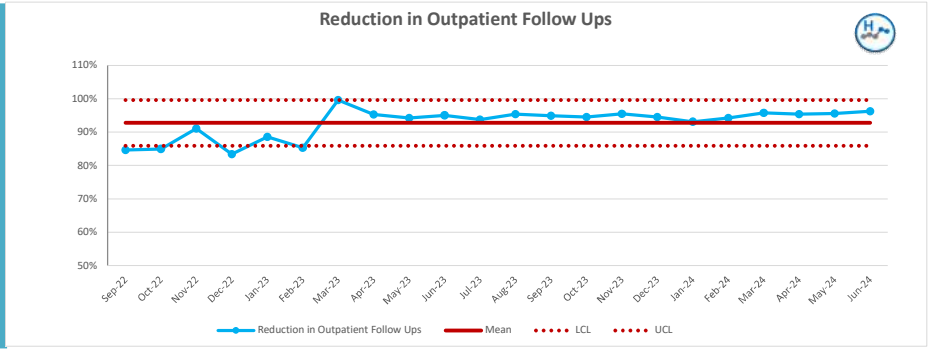
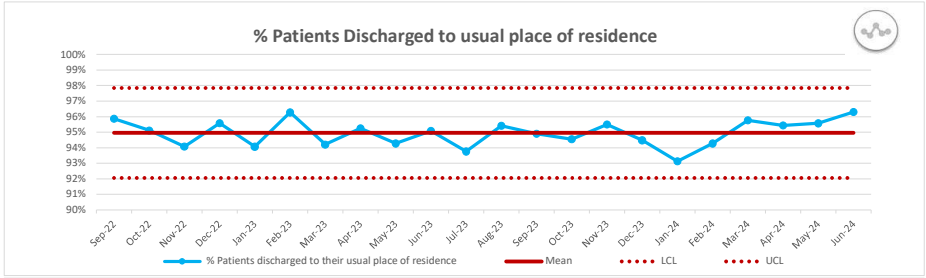
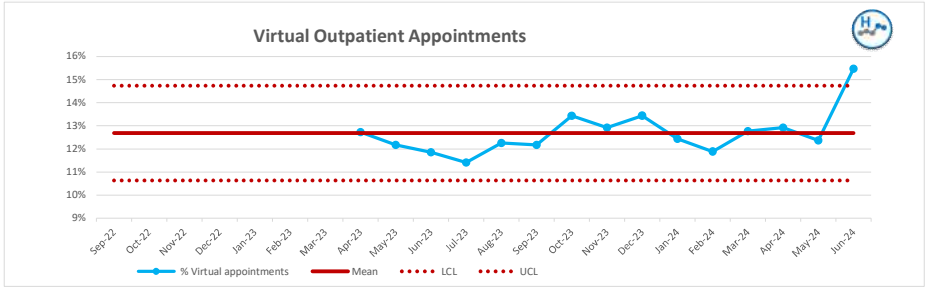
Key:
Risk Register
System Oversight Framework
Care Quality Commission

	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. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In monthly, the fracture clinic saw 95.7% of patients within 72 hours.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Good performance position is being sustained.	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.
56. % patients referred to long COVID service not assessed within 15 weeks	This month, the Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.		
57.Type 5 (previously SDEC) activity No Target	Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 189900 Type 5 Attendances.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.	As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

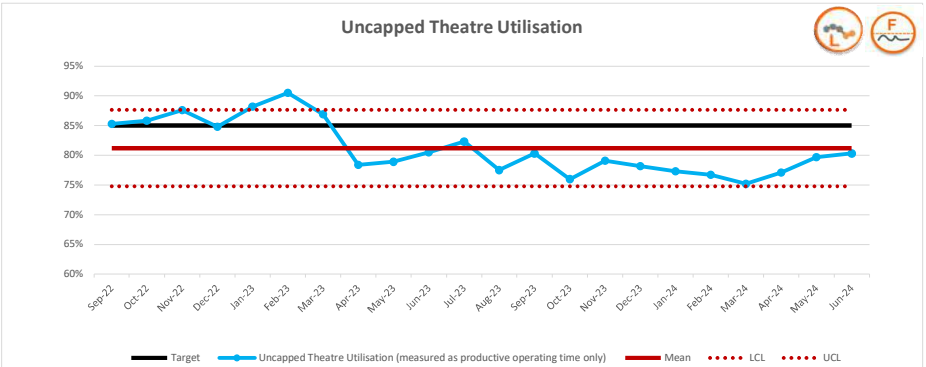
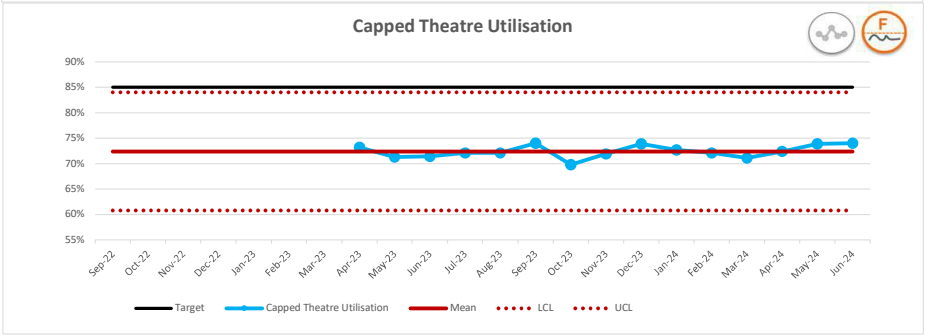
Key:
Risk Register
System Oversight Framework
Care Quality Commission

	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)?
58. 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 96.3% of 19/20 activity in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
59. % Patients discharged to their usual place of residence Target: No Current Threshold	**96.3% patients in month were discharged to their usual place of residence.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Common Cause (Normal) variation.**		
60. Virtual Appointments (figures have been derived using SUS logic to determine the contact type and clinics which need to be held F2F have been excluded)	**15.47% Virtual Outpatient appointments in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Risk Register
System Oversight Framework
Care Quality Commission

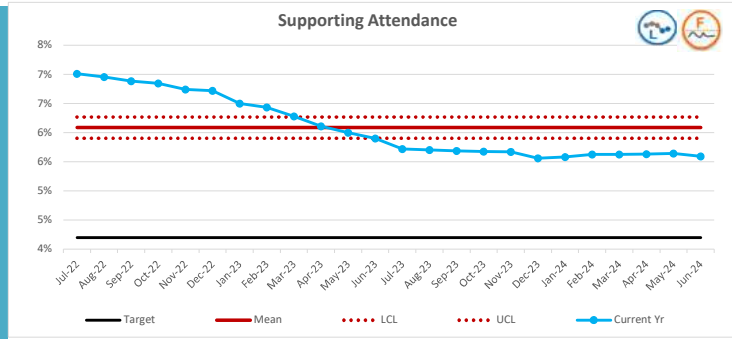
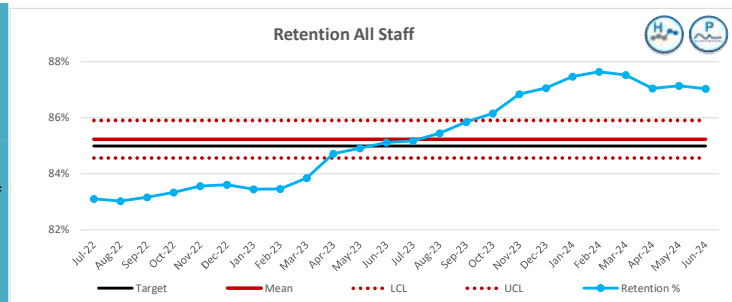
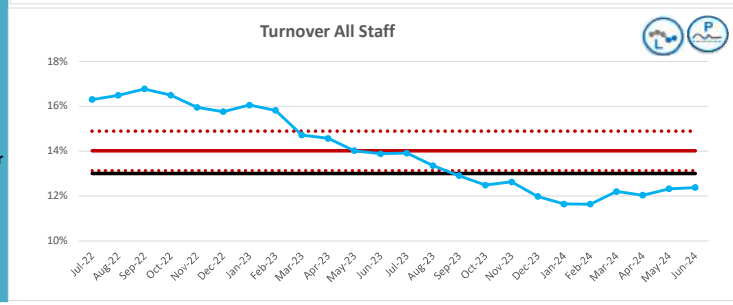
Access & Performance - Trust Position

	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)?
61. Uncapped Theatre Utilisation (measured as productive operating time only) Target: 85%	**80.3% Uncapped Theatre utilisation in month (measured as productive operating time only).** **74% Capped Theatre utilisation in month (measured as productive operating time only).**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: There is special cause variation of a concerning nature.**	**Theatre Utilisation remains a challenged area, a focus on late starts and improving productivity are key priorities for 24/25.** ***Please note, data in the IPR has been revised to reflect utilisation - previously a combined utilisation and productivity figure. As a result, figures are different from those previously reported in the IPR.**	**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.**
62. Capped Theatre Utilisation Target: 85%			**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**		**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.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

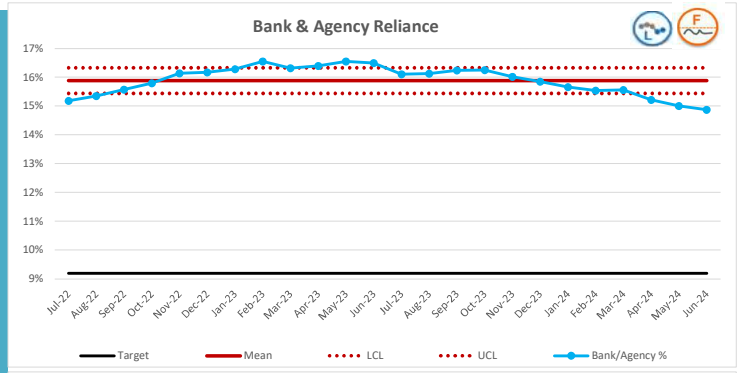
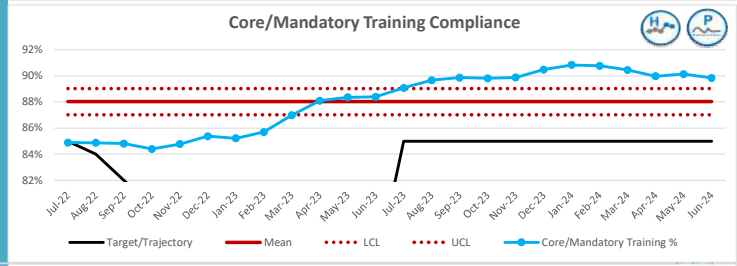
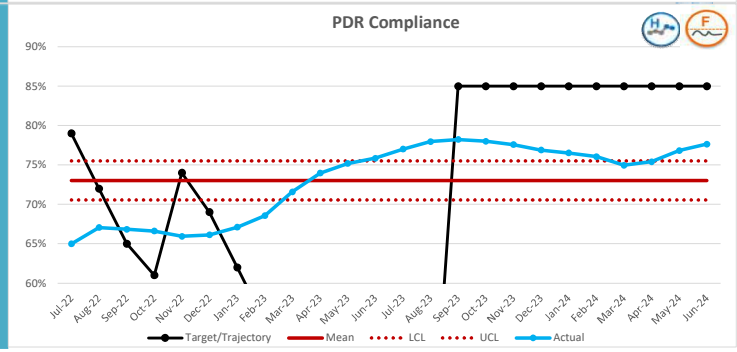
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
Trust Strategy
Risk Register

	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)?
63. Supporting Attendance Target: Below	The Trust's annualised sickness rate was 5.59%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence is showing an Improving Variation. The annualised sickness absence percentage in June 2024 was 5.59%, which is very similar to the previous 6 months. Reasons for the variation can be attributed to the reduction in long term sickness following implementation of the new Attendance Management policy and the People Health and Wellbeing Group being established.	Sickness absence levels remain below 2022/23 absence rates. The HRBP team are monitoring absence reason trends and supporting CBUs to understand this data, taking action to address individual absences and localised patterns where these are identified. The OH team have developed a referral pathway for members of staff with sleep issues, which can be detrimental and have an impact on an individual's health and wellbeing. The team are now fully trained in the national Sleep Ambassador programme. The OH team supported Men's Health Week by undertaking health MOTs and signposting to men's health services across Warrington and Halton.
64. Retention Target: 85%	The Trust's annualised retention of all staff was 87.04%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Annualised retention is showing an Improving Variation. Retention of all staff in June 2024 was above Trust target at 87.04%, a slight decrease from 87.1% in April 2024. Retention for permanent staff in June 2024 remains above Trust target at 89.5%.	Work/life balance, relocation, retirement and promotion are the main reasons people leave WHH. Improving flexible working continues to be a priority and is embedded into the We Are WHH Culture Plan. It is a key area of delivery for the Trust's nationally funded People Promise programme of work. The People Promise Manager is working with areas identified for piloting flexible working including team rostering. Improvements in turnover and retention are reflected in the overall increase in substantive workforce numbers, thus leading to a reduction in temporary staffing.
65. Turnover Target: Below 13%	The Trust's annualised turnover of all staff was 12.38%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in June 2024 was 12.38% compared to the Trust target of 13%. Turnover of permanent staff in June 2024 was better than the Trust target at 11.51%.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

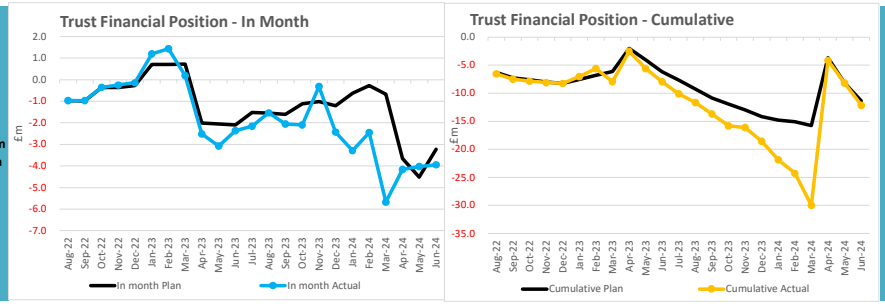
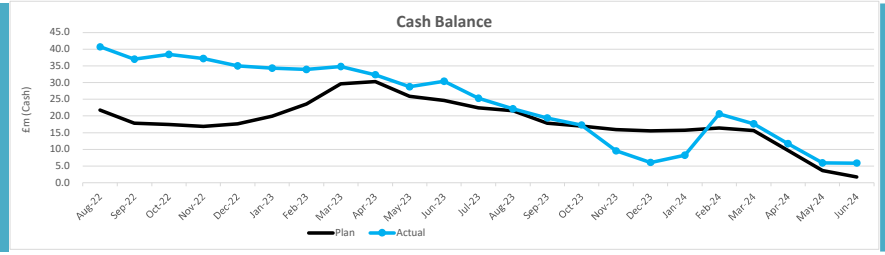
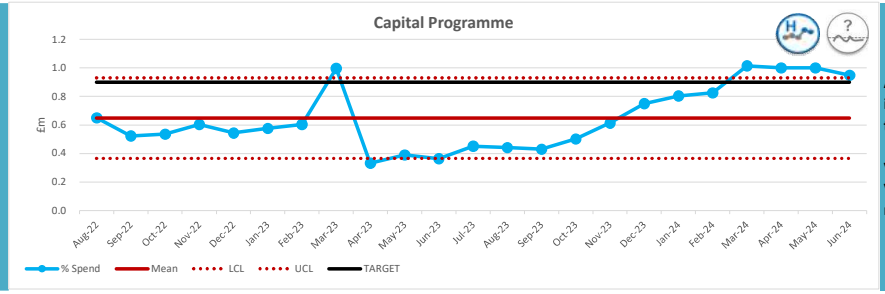
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
Trust Strategy
Risk Register

	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)?
66. Bank and Agency Reliance Target: 9% or Below	Annualised Bank and Agency Reliance was 14.67%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Bank and Agency reliance is showing an Improving Variation. Bank and Agency reliance in June 2024 was 14.67%, a slight improvement from April 2024 at 15%. Bank reliance in June 2024 is 12.4%, a slight increase from 12.2% in April 2024. Agency reliance continues to decrease and was 2.7% in June 2024 against a target of 3.2%.	The Resourcing Task and Finish group has shared with Staff Group leads findings relating to approaches to improve how effectively the Trust deploys it's workforce. The Trust is currently at the early stages of reviewing it's roster systems/capability and job planning system/process to ensure staff are effectively deployed. In addition, to supplement the refined Vacancy Request ECF process, a refined temporary staffing ECF process has been launched. Processes relating to approval of temporary staffing are being reviewed to ensure grip and control.
67. Core/ Mandatory Training Target: 85%	Core/Mandatory training compliance was 89.84% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Training is showing an Improving Variation. In June 2024, CSTF Mandatory Training compliance was 89.84%.	Care Groups report compliance at Operational People Committee with actions required to ensure targets are met. Further to the national CSTF review, there were only a few areas identified as a variation at WHH to the proposed national approach. These areas are being discussed with the national team to ensure the correct approach within legislative frameworks is applied.
68. PDR Target: 85%	Annualised PDR compliance was 77.65%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In June 2024, Appraisal compliance was 77.65%, an increase from 74.2% in April 2024. Currently Appraisal rates are below the trajectories but higher than 2022.	Care Groups and Corporate areas report their PDR compliance at OPC and have set trajectories to achieve 85% compliance by July 24. Unplanned Care have demonstrated a significant improvement in their appraisal compliance since April 2024 following a focus on ensuring appraisals are completed in a timely manner and recorded to ensure staff are supported and developed.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

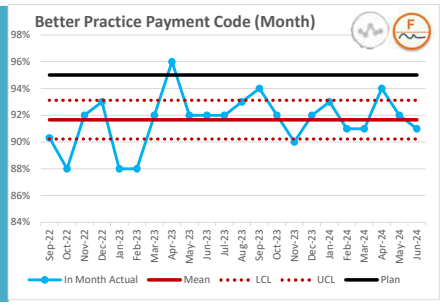
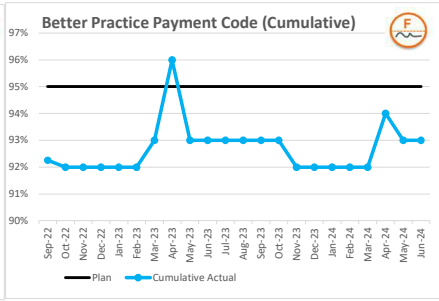
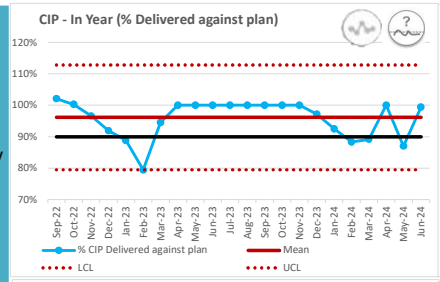
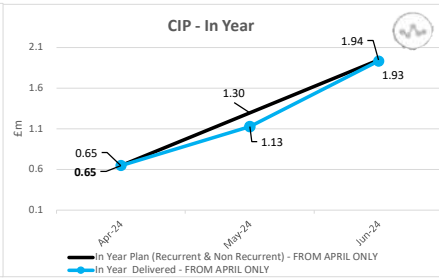
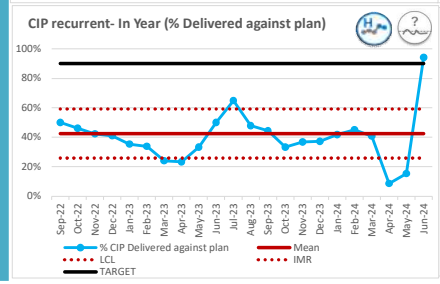
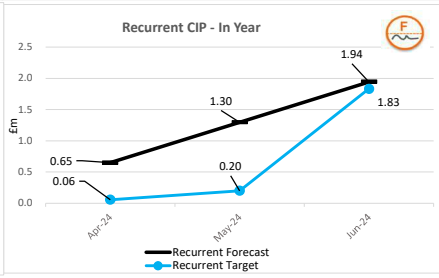
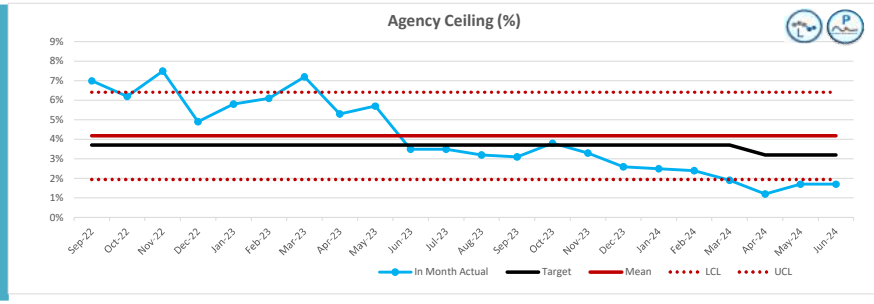
Key:
SOF System Oversight Framework
UoR Use of Resources Assessment
RR Risk Register
CQC Care Quality Commission
Trust Strategy

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)?
69. Trust Financial Position **Target: Plan** The Trust has recorded a deficit position of £12.1m at 30 June 2024 against a deficit plan of £11.4m.	 		The driver for the deficit being worse than plan is the impact of Industrial Action.	Seek funding to offset the impact of Industrial Action. In addtion, work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity to ensure delivery of the financial plan.
70. Cash Balance **Target: On or better than plan** UoR The cash balance at 30 June 2024 is £5.9m. RR134			The current cash balance is £5.9m which is £4.5m higher than the cash plan. This is due to the timing of receipt of income and payment of capital creditors. Of the £5.9m cash, £3.6m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A request for £4.5m was submitted for June 2024, however only £3m was approved. In addition, a request for July cash support has been submitted and approved for £5.145m.
71. Capital Programme **Target: On plan 90%-100%** UoR Capital expenditure at the end of month 3 is £2.8m against a plan of £2.9m.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	The annual Trust Capital Plan of £23.3m is oversubscribed by £0.2m against £23.1m of capital funding. Capital expenditure at month 3 is £0.1m ahead of the Trust internal plan of £2.7m at month 3.	All capital paperwork for approved capital schemes was required to be completed by the end of Q1 to ensure that the capital programme continues to spend in line with plan throughout the year. The majority of paperwork is now complete which will enable the Trust to spend in line with plan.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
- SOF System Oversight Framework
- UoR Use of Resources Assessment
- RR10 Risk Register
- CQC Care Quality Commission
- Trust Strategy

	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)?
72. Better Payment Practice Code Target: Cumulative performance 95%	Cumulative BPPC performance is 93% which is below the national target of 95%.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	Timely raising of requisitions, matching of purchase orders and approval of invoices enables invoices to be paid within the 30 day threshold for Better Payment Practice Code (BPPC). There are some occasions where this is not always possible which has led to the achievement of 93%.	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.
73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date Target: >90% plan delivered YTD	The month 3 CIP plan is £1.9m and £1.9m has been delivered, currently £11k off plan.	 	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	Although CIP is only £11k behind plan at month 3, it should be noted that this delivery has been mainly achieved from central items. At month 3 there is only 10% of the CIP target included in the plan as the annual CIP plan increases towards the end of the year.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. During Q1 futher plans have been identified circa £8m from executive review. Teams continute to identify further schemes to meet the 2024/25 CIP target.
74. Cost Improvement Programme (recurrent) – In year performance to date Target: Recurrent Forecast is more than 90% of annual target	£1.8m CIP has been delivered recurrently against the target of £1.9m.	 	Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	There is an increase in recurrent CIP delivery from previously reported following a detailed review of all non-recurrent schemes. Where recurrent CIP has not realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.	The Trust is continuing to identify recurrent CIP schemes for 2024/25. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT are being used.
75. Agency Ceiling Target: Agency spend should not exceed 3.2% of total pay (ICS target)	The Trust Agency spend in month is 1.7% against a target of 3.2%.		Assurance: The Trust consistently passes the target Variation: Special Cause Variation of an improving nature.	The agency ceiling has reduced from 3.7% in 2023/24 to 3.2% in 2024/25. Trust agency spend is still significantly below the target at 1.7%.	Agency spend continues to be monitored even though the target has been consistently achieved so that any actions can be taken if required. In addition, bank expenditure is now the focus of further scrutiny to control overall pay expenditure

Appendix 3 – Trust IPR Indicator Overview

Indicator	KPI	Detail	Target	Additional Context
Quality				
Incidents		Number of incidents reported in month.		Nationally incidents are no longer referred to as SIs. This has been replaced by PSIIs in accordance with the nationally mandated Patient Safety Incident Response Framework.
	1	Number of incidents open over 40 days.	0	
		Total PSIIs recorded in month.		
		Number of PSII Actions Breached.		
		Number of never events reported in month.		
		Number of 'prevention of future death' orders.		
Duty of Candour		Duty of Candor (DoC) – Moderate Incidents		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 must be done within 10 working days.
	2	Duty of Candor – Serious Incidents	100%	
Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)	**3**	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.	Reduction from previous year	
	4	MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.		
	5	Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.		
	6	Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.		
	7	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.		
	8	Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.		
Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks	**9**	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).		
VTE Assessment	**10**	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.	>= 95%	

Inpatient Falls & Harm Levels		Total number of falls which have occurred in month.		
		Falls per 1000 bed days in month.		
	11	Total number of inpatient falls which have occurred in month.	20% decrease from previous year	
		Levels of harm reported as a result of a fall in month.		
		Level of avoidable harm which has occurred in month.		
Pressure Ulcers		Pressure Ulcers (Categories 3 and 4)	10% reduction on previous year	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).
	12	Pressure Ulcers (Categories 2, 3 and 4)	10% reduction on previous year	
		Community Acquired Pressure Ulcers		
Medication Safety	**13**	Medication reconciliation within 24 hours.	>=80%	Overview of the current position in relation to medication, to include:
		Medication reconciliation throughout the inpatient stay.		
		Number of controlled drugs incidents.		
		Number medication incidents resulting in harm.		
Staffing Average Fill Levels	**14**	Staffing - Average Fill Rate - Day nurses/midwives		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.
		Staffing - Average Fill Rate - Day care staff		
		Staffing - Average Fill Rate - Night nurses/midwives		
		Staffing - Average Fill Rate - Night care staff		
Care Hours Per Patient Day (CHPPD)	**15**	Staffing - CHPPD Overall	>=7.9	Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
		Staffing - CHPPD Benchmarking		
HSMR Mortality Ratio	**16**	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.	Plan	

SHMI Mortality Ratio	**17**	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.	Plan	
NICE Compliance	**18**	Trust NICE compliance	90%	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.
Complaints		Number of complaints received in month.		
		Number of complaints received in timeframe		
		Number of dissatisfied complaints in month.		
		Total number of open complaints in month.		
	19	Total number of cases over 6 months old in month.	0	
		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.		
Friends and Family Test (Inpatient & Day Cases)	**20**	Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?	95%	
		National, Regional, Cheshire & Mersey positive response rates for Benchmarking		
Friends and Family (ED and UCC)	**21**	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?	87%	
Mixed Sex Accommodation Breaches (ITU)	**22**	Number of MSA Breaches in month (ITU).	0	Due to no Mixed Sex Accommodation breaches being recorded outside of ITU over the past 24 months, it will be more effective to monitor ITU breaches.
Sepsis	**23**	Sepsis Emergency Patient Screening	>=90%	To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if
	24	Sepsis Inpatient Screening	>=90%	
	25	Sepsis Emergency Patient Antibiotics (within 1hr)	>=90%	

		Sepsis Emergency Patient Antibiotics (within 6hrs)		necessary administered anti-biotics within 1 hour.
	26	Sepsis Inpatient Screening (within 1hr)	>=90%	
		Sepsis Inpatient Screening (within 6hrs)		
Ward Moves Between 10pm and 6am	**27**	Ward Moves 10:00pm - 06:00am, for patients with an alert		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.
		Monthly out of hour (10pm-6am) ward moves		
		Average qty of Ward moves per patient with an alert		
Acute Kidney Injury	**28**	Number of hospital acquired Acute Kidney Injuries (AKI) in month.	Less than month in previous year	
		Number of community acquired Acute Kidney Injuries (AKI) in month.		
		Average Length of Stay (LoS) of patients within a AKI.		
Postpartum Haemorrhage >1500ml	**29**	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard.	<3.7%	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.
Fractured Neck of Femur	**30**	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.
		% of patients receiving surgery within 36hrs of admission		
MUST nutritional assessment completion	**31**	MUST Nutrition assessment completion	>85%	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

Diagnostic Waiting Times – 6 weeks	**32**	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.	>95%	
RTT Open Pathways and 52 & 65 week waits	**33**	Referral to open pathways	>92%	The elective recovery plan was published in February 2022 and sets targets to reduce long waits for elective treatment – namely, to eliminate waits of over 104 weeks by July 2022, waits of over 78 weeks by April 2023, 65 week waits by March 2024, and 52 week waits by March 2025.
	34	Number of patients waiting over 52 weeks.	0	
		Number of patients waiting over 65 weeks.	0	
		Number of patients waiting over 78 weeks.	0	
4 hour A&E Target and ICS Trajectory	**35**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>75%	
Average Time in Department (ED)	**37**	How long on average a patient stays within the emergency department (ED).		
A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.	**36**	% of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.	<=2%	
Cancer 14 Days	**38**	Cancer 28 Day Faster Diagnostic Standard	>75%	All patients need to receive their first appointment for cancer within 14 days of urgent referral. 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. All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
		Cancer Appointment within 14 Days	>93%	
		Breast Symptoms appointment within 14 days	>93%	
Cancer 31 Day wait	**39**	Cancer 31 Day wait	>96%	All patients to receive treatment for cancer within 31 days of decision to treat.
Cancer 62 Day wait	**40**	Cancer 62 Day wait	>85%	All patients to receive treatment for cancer within 62 days of decision to treat.
Ambulance Handovers 15	**41**	% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).	>65%	
Ambulance Handovers 30–60 minutes	**42**	% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).	>95%	
Ambulance Handovers – more than 60 minutes	**43**	% of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).	100%	

Discharge Summaries – Sent within 24 hours	**44**	Discharge Summaries within 24 hrs	>95%	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.
Discharge Summaries – Not sent within 7 days	**45**	Discharge Summaries - NOT sent within 7 days	0	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.
Cancelled operations on the day for non-clinical reasons	**46**	% of operations cancelled on the day or after admission for non-clinical reasons.	<=2%	
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	**47**	Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	0	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.
Urgent Operations – Cancelled for a 2nd Time	**48**	Number of urgent operations which have been cancelled for a 2nd time.	0	
Super Stranded Patients		Stranded Patients are patients with a length of stay of 7 days or more.		
	49	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.		
No criteria to reside (NCTR)	**50**	Number of patients with no criteria to reside		
		Number of patients with right to reside		
		Superstranded - qty of NCTR vs CTR		
		Stranded - qty of NCTR vs CTR		
Elective Recovery Activity	**51**	% of Elective Activity (Inpatients)	month in previous year	
		% of Elective Activity (Day cases)	month in previous year	
Elective Recovery Diagnostics	**52**	% of Elective Diagnostic Activity - MRI	month in previous year	
		% of Elective Diagnostic Activity - Non-Obstetric Ultrasound	month in previous year	
		% of Elective Diagnostic Activity - CT scans	month in previous year	
		% of Elective Diagnostic Activity - Flexi Sigmoidoscopy	month in previous year	

		% of Elective Diagnostic Activity - Gastroscopy	month in previous year	
		% of Elective Diagnostic Activity - Colonoscopy	month in previous year	
Elective Recovery Outpatients	**53**	% of Elective Recovery Outpatient Activity	104%	
Fracture Clinic	**55**	Fracture Clinic - patients seen within 72 Hours	>95%	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
% Outpatient referred to long covid service within 15 weeks	**56**	% of Patients referred to Long COVID service not assessed within 15 weeks		
% of zero-day length of stay admissions (Type 5)	**57**	Type 5 activity		Following guidance from NHS Digital, since November 2023 we have been recording 'SDEC attendances' as a Type 5 A&E attendance instead, to include within ECDS. Type 5 attendances are for same day emergency care, they are not the same as an attendance at an Urgent Care Centre or Accident and Emergency department.
Reduction in Outpatient Follow Ups	**58**	% reduction in Outpatient follow ups compared to 19/20 activity.	<=75%	
% Patients discharged to their usual place of residence	**59**	% of patients who were discharged to their usual place of residence.		
Virtual Outpatient Appointments	**60**	Virtual Outpatient Appointments		
Theatre Utilisation (measured as productive operating time only)	**61**	Uncapped theatre utilisation	>85%	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.
	62	Capped theatre utilisation	>85%	

Workforce				
Supporting Attendance	**63**	the monthly sickness absence % with the Trust Target (4.2%) previous year.	<4.2%	
Retention	**64**	ention rate % over the last 12 months.	>85%	
Turnover	**65**	of the turnover % over the last 12 months.	<13%	
Bank & Agency Reliance	**66**	reliance on bank/agency staff.	<9%	
Core/Mandatory Training	**67**	of the Core/Mandatory Training Compliance, this includes:	>85%	Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and most recently, safeguarding
Performance & Development Review (PDR)	**68**	of the PDR compliance rate.	>85%	
Finance				
Trust Financial Position	**69**	Cumulative operating surplus or deficit compared to plan.	Plan	
		In month operating surplus or deficit compared to plan.	Plan	
Cash Balance	**70**	The cash balance at month end compared to plan.	Plan	
Capital Programme	**71**	Capital expenditure compared to plan.	Plan	
Better Payment Practice Code	**72**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	>95%	
Cost Improvement Programme – Plans in Progress in Year	**73**	Cost savings schemes in-year compared to plan.	>90% of annual target	
		CIP - In Year	plan	
Cost Improvement Programme – Recurrent	**74**	Cost savings schemes recurrent compared to plan.	>90% of annual target	
		Recurrent CIP - In Year	plan	
'Agency Ceiling'	**75**	At ICS level, agency spend should not exceed 3.7% of total pay.	>3.7%	

Appendix 4 - Statistical Process Control

1.0 What is SPC?

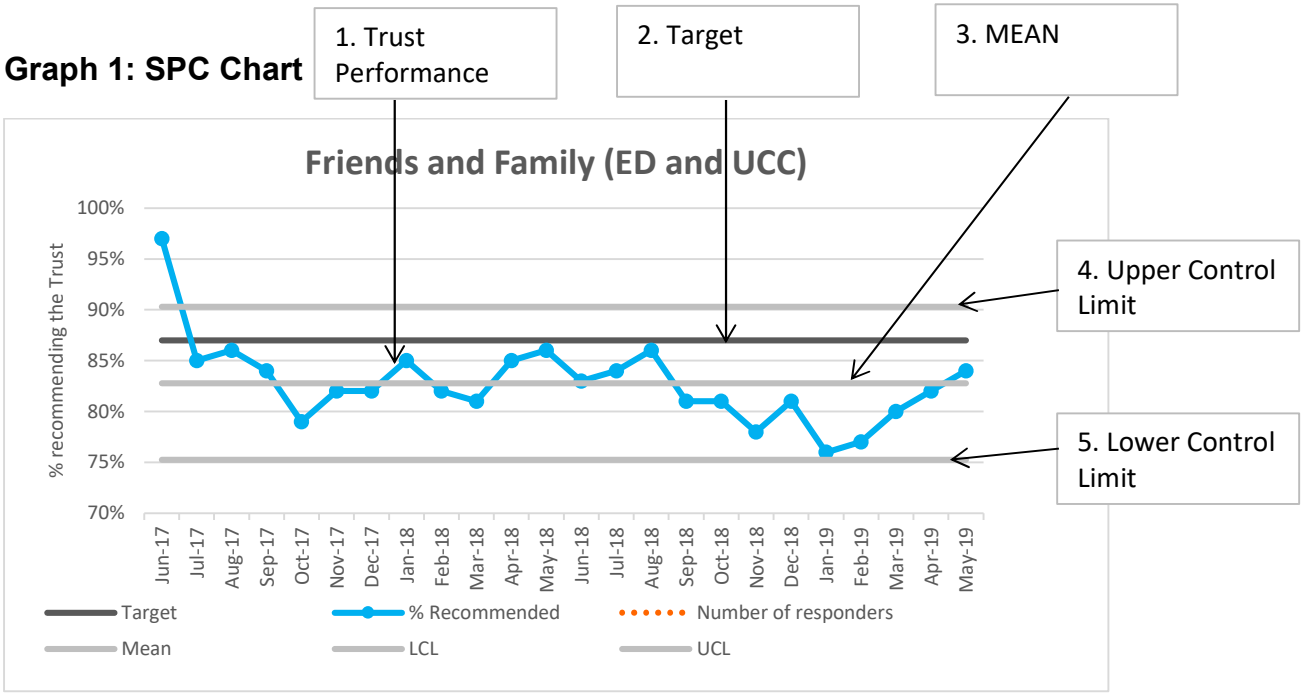
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

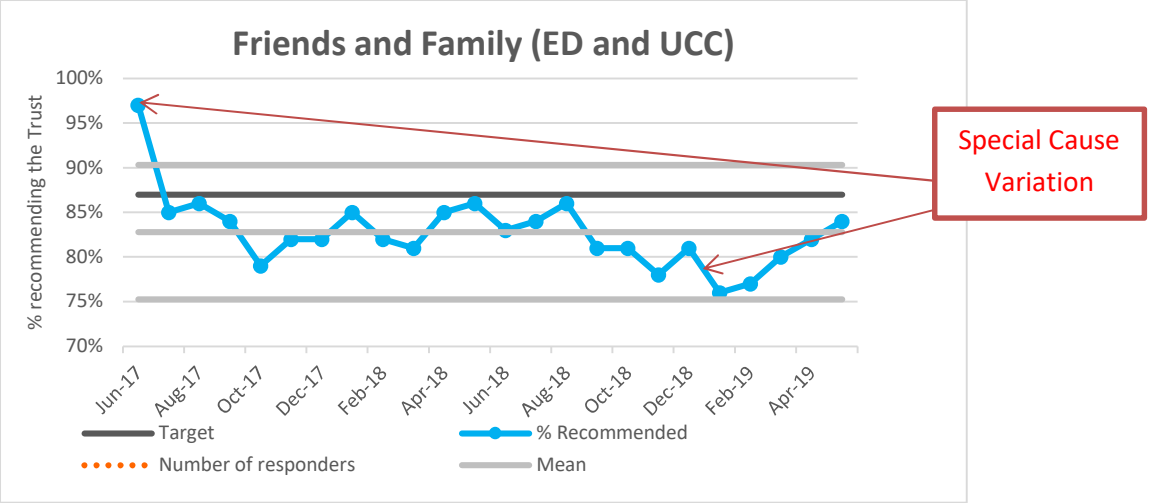


2.1 Interpreting a SPC Chart

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		
					
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 at 30th June 2024

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	**315,412**	**25,746**	**25,606**	**-140**	**77,560**	**77,566**	**6**
Non NHS Clinical Income							
Private Patients	8	1	0	-1	2	1	-1
Non NHS Overseas Patients	70	5	6	1	25	27	1
Other non protected	670	-49	160	208	109	318	209
Sub total	**748**	**-43**	**166**	**209**	**136**	**345**	**209**
Other Operating Income							
Training & Education	9,541	782	782	0	2,506	2,506	0
Donations and Grants	50	5	14	9	5	14	9
Miscellaneous Income	14,681	1,223	1,359	136	3,491	3,627	136
Sub total	**24,272**	**2,009**	**2,154**	**145**	**6,002**	**6,146**	**145**
Total Operating Income	**340,432**	**27,712**	**27,926**	**214**	**83,698**	**84,058**	**359**
Operating Expenses							
Employee Benefit Expenses	-255,572	-21,751	-22,575	-824	-66,883	-67,852	-969
Drugs	-21,934	-1,769	-1,649	121	-5,686	-5,566	121
Clinical Supplies and Services	-23,849	-1,853	-2,209	-356	-6,136	-6,493	-356
Non Clinical Supplies	-46,875	-3,880	-3,943	-63	-11,476	-11,540	-63
Depreciation and Amortisation	-15,843	-1,320	-1,320	0	-3,961	-3,961	0
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	**-364,073**	**-30,574**	**-31,696**	**-1,123**	**-94,143**	**-95,411**	**-1,268**
Operating Surplus / (Deficit)	**-23,641**	**-2,862**	**-3,770**	**-909**	**-10,445**	**-11,353**	**-908**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0
Interest Income	393	20	205	186	220	406	186
Interest Expenses	-147	-12	-10	2	-35	-32	2
PDC Dividends	-4,834	-398	-398	0	-1,254	-1,254	0
Total Non Operating Income and Expenses	**-4,588**	**-391**	**-203**	**188**	**-1,069**	**-881**	**188**
Surplus / (Deficit) - as per Accounts	**-28,229**	**-3,253**	**-3,973**	**-720**	**-11,514**	**-12,234**	**-720**
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	-50	-5	-14	-9	-5	-14	-9
Add Depreciation on Donated & Granted Assets	487	41	41	0	122	122	0
Total Adjustments to Financial Performance	**437**	**36**	**27**	**-9**	**117**	**108**	**-9**
Adjusted Surplus / (Deficit) as per NHSI Return	**-27,792**	**-3,217**	**-3,946**	**-729**	**-11,397**	**-12,126**	**-729**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/63 a i	Meeting	Trust Board	Date Of Meeting	7 August 2024

Date of Meeting	11 June 2024
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:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/06/49	**HOT TOPIC – BIRTH TRAUMA WHH POSITION**	The Committee received the Hot Topic in relation to the WHH position for birth trauma, following publication of national inquiry to investigate the reasons for birth trauma. Policy recommendations included in report published in May 2024. • 12 key recommendations from the report • 9 having implications for care delivery at WHH • Overview provided of each recommendation, including the WHH position/assurance and next steps for implementation Points of note include: • LMNS to confirm monitoring process • Harms not noted in the presentation • Increased support required for mental health Further updates to be provided	**Moderate:** **Further work required in relation to mental health provision and identifying harm**	**Substantial:** **Monthly reporting with Executive oversight through Quality Assurance Committee**	**QAC**

QAC/24/06/50	**DEEP DIVE – PROCEDURAL SAFETY STEERING GROUP NEVER EVENTS**	The Committee received an update in relation to never events declared in theatres. The following key challenges, risks and actions were highlighted: Never Events for WHH were listed with the incident, type definition, clinical and CBU area, patient harm, and the date of the incident. Themes include: • Wrong site surgery, • Wrong implant/prosthesis, • Retained foreign object post procedure • Misplaced nasogastric tube. The presentation included: • Deep Dive review of Theatre Never Events • Procedural Safety Work Programme outline • Building a safety culture • Lessons learnt from ICB Never Event Summit • PSIRF compassionate engagement, a system based proportionate response and supportive oversight The Committee agreed on the importance of ongoing monitoring and improvement in theatre safety assessing progress against recommendations from the safety day on a regular basis. Theatres added to Fragile Services	**Moderate:** **Sustained improvement required**	**Substantial:** **Monthly reporting with Executive oversight through PSCESC** **Escalation processes in place**	**PSCEC July 2024**

	PATIENT SAFETY AND CLINICAL EFFECTIVENESS SUB-COMMITTEE EXCEPTION REPORT	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the committee which included reporting on fragile services: **1. Opthalmology** **2. Gynaecology** **3. Fractured Neck of Femur** **4. ENT** Of the items escalated from the Sub-Committee, of particular note was: • Gynaecology waiting lists had seen no improvement with continued high demand – one stop clinics had been trialled at the weekends which had been successful • In relation to Fractured Neck of Femur (NOF) all areas were making progress with significant assurance from MIAA • ENT- a deteriorating workforce position. Continued work with the LLP/insourcing/outsourcing was taking place to manage waiting lists • Hyperacute stroke care was added to Fragile services of PSCESC in April 2024	**Moderate:** **Backlog in Gynaecology waiting lists** **ENT backlog**	**Substantial:** **Monthly reporting with Executive oversight through PSCESC** **Escalation processes in place** **Stroke added to Fragile Services**	**PSCEC July 2024**

The Committee also received the following items;

QAC/24/06/48	ED Improvement Programme
QAC/24/06/52	Quality Account (final)
QAC/24/06/53	Quality IPR Metrics
QAC/24/06/54	Patient Safety Clinical Effectiveness Sub Committee – Exception Report
QAC/24/06/55	Medicines Management Annual Report

QAC/24/06/56	Controlled Drugs Annual Report
QAC/24/06/57	Maternity Update
QAC/24/06/57	Safeguarding Annual Report Update
QAC/24/06/59	Learning from Deaths Q4 Report
QAC/24/06/60	Quality Strategy Annual Report
QAC/24/06/61	Quality Priorities Q4 Update
QAC/24/06/62	Nursing & Midwifery Strategy Update
QAC/24/06/63	Living Well Hub Arrangements

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

Governance Assurance: *Assurance in the internal controls in place*

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/63 a ii	Meeting	Trust Board	Date Of Meeting	7 August 2024

Date of Meeting	9 July 2024
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:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/24/07/74	**HOT TOPIC STROKE**	The Committee received the Hot Topic in relation to Stroke Services at WHH. The following key challenges, risks and actions were highlighted: • Criteria for treatment at WHH v treatment at MWL (Whiston) • 48 of 122 patients did not meet criteria (23/24) • Communication with Whiston ongoing • A review of any harm to be undertaken Points of note include: • NMWAS aware of pathway • Challenge with adherence to pathway • Need to understand hidden harms	**Moderate:** **Challenge with adherence to pathway**	**Substantial:** **Monthly reporting with Executive oversight through Quality Assurance Committee**	**PSCEC August 2024**

QAC/24/06/50	**DEEP DIVE – Board Assurance Framework (BAF)**	A Deep Dive presentation was provided in relation to the Board Assurance Framework (BAF),associated risk appetite and scoring for risks related to the Quality Assurance Committee (QAC) as part of a Trust wide review. The risks for which QAC is a monitoring committee were noted, and each risk was discussed individually to agree any amendments. The BAF risks below were discussed individually • Risk #224 • Risk #1215 • Risk #2001 • Risk #115 Points of note include: Discussion relating to the interpretation of "open" risk appetite, Committee in agreement with changes made	**High:** **Management of risk embedded within Exec and Trust Board**	**High:** **Monthly reporting with Executive oversight via Trust Sub-Committees and Trust Board**	**QAC Trust Board August 2024**
QAC/24/07/76	**Patient Safety and Clinical effectiveness Sub-Committee Exception Report**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the committee which included reporting on fragile services: **1. Urology** **2. Gynaecology** **3. ENT** Of the items escalated from the Sub-Committee, of particular note was:	**Moderate:** **ENT workforce remains fragile**	**Substantial:** **Monthly reporting with Executive oversight through PSCESC**	**PSCEC August 2024**

		• Gynaecology One Stop clinical Saturdays have been successful • Issues with blood tracking noted due to training – review underway • ENT workforce fragile, backlog improved due to outsourcing to LLP, discussion in relation to sustainable model across Merseyside		**Escalation processes in place**	
QAC/24/07/79	**Maternity Update**	The Committee received the monthly Maternity Update Reports, a key challenge to note is: • Induction of Labour (IOL) Data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well with regard to timeliness of induction of labour activity when compared to other local providers. Task and finish group in place to address with monthly reporting back to QAC	**Moderate:** **Continue to have challenge in delays to IOL**	**Substantial:** **Monthly reporting to Quality Assurance Committee and Bi-monthly Trust Board**	**QAC Trust Board August 2024**
QAC/24/07/84	**Strategy Position**	The Committee received a report which identified the enabling strategies due to be refreshed in 2024. Trust Strategy due to be updated in 2025 Committee agreed light touch refresh to: • Trust Strategy until integration with Bridgewater concluded. • 4 enabling strategies due for update in 2024 25 enabling strategies to be reviewed with a plan to reduce and replace with key supporting documents.	**High:** **Supports reduction in numbers of strtaegies**	**High:** **Reporting to QAC**	

The Committee also received the following items;

QAC/24/07/73	Patient Story – Dementia provision for patients with newly diagnosed Dementia at WHH
QAC/24/07/77	Infection Prevention & Control Annual Report
QAC/24/07/78	Infection Prevention & Control Board Assurance Framework
QAC/24/07/80	Dementia Strategy Annual Report
QAC/24/07/81	Arbury Court Update
QAC/24/07/82	ED Improvement Programme
QAC/24/07/83	Mortuary Enquiry Bi-Annual Update
QAC/24/07/85	Annual Chairs Committee Report to Trust Board
QAC/24/07/86	High Level Enquiries & External Assessment/Inspections

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

Governance Assurance: *Assurance in the internal controls in place*

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/63 b i	Meeting	Trust Board	Date Of Meeting	7 August 2024

Date of Meeting	Wednesday 19 June 2024
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	Delivery Assurance	Governance Assurance	Follow up/ Review date
SPC/24/06/41	Hot Topic – Integration with WHH & BCH – Workforce Implications	**Director of Strategy & Partnerships** The update was based on the following six deliverables: • **Workforce Principles** – being developed by both Chief People Officers. • **Legal Framework** – WHH and BCH Executive teams agreed to develop a joint legal framework, which enable further clarity on the legal process. • **Workforce Workstream** – short, medium and long-term priorities agreed between WHH and BCH executives. • **Vacancy Control Process (WHH & BCH)** – joint approach to recruitment. • **Communications with Workforce** – joint communications plan being developed to ensure consistency – routine and message. Exploring joint branding options.	The Committee received **substantial assurance** on the actions taken.	The Committee received **substantial assurance** on the governance processes.	TBC

		• **Impact on Morale** – the previous five deliverables will support managing the morale of the workforce during this process.			
SPC/24/06/45	WHH Workforce Equality, Diversity & Inclusion Strategy Annual Report	**Head of Culture and Inclusion** The update centred on the WHH People Promises. The approach to staff voice within the organisation has improved during 2023/24 with the development and support of new staff voice groups and networks. The relative likelihood of staff being appointed from shortlisting based on Race has improved to 0.97; Disability, has improved to 1.41, but work still to do. The Trust has been recognised by the Race Equality Lead for the North West BAME Assembly for its commitment to the framework and engagement with both patient and workforce members, and was included in their first annual report for work to address disproportionate bullying of Black, Asian and Minority Ethnic staff.	The Committee received **high assurance** on the actions taken.	The Committee received **substantial assurance** on the governance processes.	June 2025
SPC/24/06/47	Improving People Practices Annual Report	**Head of Human Resources** The update included level of activity, areas of risks, and wider actions to improve employee relations case management performance.	The Committee received **substantial assurance** relating to the actions taken.	The Committee received **substantial assurance** in terms of the governance processes.	June 2025

SPC/24/06/48	Hospital Volunteer Annual Report	**Associate Chief Nurse** The annual update included information related to new volunteer roles and engagement numbers. The report highlighted future actions focusing on targeted and inclusive engagement of volunteer. This will align to the Trusts approach as an anchor institution, by offering opportunities to disadvantaged young people	The Committee received **substantial assurance** on the actions undertaken.	The Committee received **substantial assurance** on the governance processes.	June 2025
SPC/24/06/50	Facilities Time Off Annual Report	**Head of Human Resources** The committee approved the report for publication on the website, in line with the 31/07/24 deadline.	The Committee received **high assurance** on the actions taken.	The Committee received **high assurance** on the governance processes.	June 2025

Other reports received by the committee.

- SPC/24/06/44 - Chief People Officer Report presented by Deputy Chief People Officer
- SPC/24/06/49 - Monthly Safe Staffing Report, presented by Associate Chief Nurse

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*

Governance Assurance: *Assurance in the internal controls in place*

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

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/63 b ii	Meeting	Trust Board	Date Of Meeting	7 August 2024

Date of Meeting	Wednesday 17 July 2024
Name of Meeting and 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	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPC/24/07/59	Deep Dive – Sexual Safety	The Committee received a Deep Dive on Sexual Safety following the Sexual Safety Charter being mandated as part of the Operational Planning Guidance 2024/25. The Committee were presented with the Trusts' results for sexual harassment questions from the Staff Survey results for 2023 which had been included for the first time. The Deep Dive included an update on the actions being taken to support the implementation of Sexual Safety requirements as well as actions to address the results from the Staff Survey. The Committee proposed a Trust Board development session to include Sexual Safety.	The Committee received **substantial assurance** on the actions taken.	The Committee received **substantial assurance** on the governance processes.	As required

SPC/24/07/60	Hot Topic – Physician Associates	The Committee received a presentation regarding Physician Associates (PAs) at WHH. The presentation detailed how PAs are deployed across the Trust and the roles they undertake. It also included an overview of the pastoral support provided to PAs at the Trust following the negative publications regarding the contributions of PAs by the BMA and in the media. An update on the proposed regulatory changes to the role of PAs including GMC registration from December 2024 was provided to the Committee. Following the NHSE Guidance 'Ensuring Safe and Effective Integration of Physician Associates into Departmental Multidisciplinary Teams Through Good Practice', a gap analysis is being undertaken and will be reported back to SPC. The Committee noted their support for PAs and the value the profession adds to providing safe patient care.	The Committee received **substantial assurance** on the actions taken.	The Committee received **substantial assurance** on the governance processes.	September 2024
SPC/24/07/62	Chief People Officer Report	The Committee received the report which detailed updates on industrial action, Anti-Racist Framework Bronze Award, People Promise Exemplar Programme and the Band 2 – 3 Healthcare Assistant Rebanding. The Committee noted the Trust's Anti-Racist Framework Bronze Award, one of only 4 Trusts in the North West with the framework now being presented nationally as best practice.	The Committee received **substantial assurance** on the actions undertaken.	The Committee received **substantial assurance** on the governance processes.	August 2024

SPC/24/07/63	Workforce Integrated Performance Report	The Committee received the report which detailed the Trust's performance for June 2024. The Committee noted data for Additional Clinical Support Services staff group (Health Care Assistants) showed concerns against target, the Chief Nurse provided assurance that a review has been undertaken and an action plan is in place to address. Following the Improving Working Lives national programme of work requiring Payroll KPIs to be reported to Trust Board, the Committee approved Payroll KPIs to be reported to SPC. The Committee noted the current high performance and plans to further expand KPI reporting to SPC.	The Committee received **substantial assurance** on the actions undertaken.	The Committee received **substantial assurance** on the governance processes.	September 2024
SPC/24/07/64	Monthly Safe Staffing Report (incl Q1 Red Flag Data)	The Committee received the report which provides an oversight of ward staffing data for May 2024. The Committee noted the 30-day Safer Nursing Care Tool (SNCT) data collection which took place in May 2024 with another data collection proposed in 6 months' time. The purpose of the data collection is to ensure appropriate staffing for patient acuity and dependency. The current analysis suggests an increase of staffing which the Committee was assured is currently being covered by temporary staff via bank or agency.	The Committee received **substantial assurance** on the actions undertaken.	The Committee received **moderate assurance** on the delivery of safe staffing due to the data analysis identifying additional staffing required.	August 2024
SPC/24/07/65	Nursing Bank Reduction Q1	The Committee received the presentation on actions taken to reduce temporary staffing in the nursing workforce.	The Committee received **high assurance** on the	The Committee received **substantial**	

		The Committee noted the positive impact on staff morale due to the decreasing usage of agency workers. The Committee were assured of high levels of grip and control and significant progress that had been made in reducing the usage of temporary workforce.	actions undertaken.	**assurance** on the governance processes.	

Other reports received by the Committee:

- SPC/24/07/61 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPC/24/07/66 – Guardian of Safe Working Annual Report
- SPC/24/07/67 – Operational People Committee Chairs Log
- SPC/24/07/68 – Workforce Review Group Chairs Log

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*
Governance Assurance: *Assurance in the internal controls in place*

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed
Substantial	There is a good system of internal control designed to meet the system objectives, and that the controls are generally being applied consistently
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No	There is an inadequate system of internal control as weaknesses in control, and/ or consistent non-compliance with controls should/ has resulted in failure to achieve the system 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*

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/XX	Meeting	Trust Board	Date Of Meeting	7 August 2024

Date of Meeting	26 June 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
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	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/06/49	**Hot Topic – CIP & Cost Pressures update**	The Committee received the presentation noting:- • Risk of delivering the resubmitted plan of £27.8m due to shortfall in CIP identification and cost pressures overspend • At month 2 £8.5m of £19.4m CIP target identified, gap of £10.9m needs to be bridged • Further work has identified a further £0.5m by CBUs / Corporate departments and £8.5m potential additional schemes • Latest position £17.5m plans compared to £19.4m target • Additional collaboration stretch target of £3m also to be delivered • Cost pressures forecast at circa £8m at month 1, reduced to £5m in month 2 forecast • Worst case scenario deficit £49.7m, work to date reduces this to £37.7m, £9.9m still to find to achieve £27.8m deficit	The Committee received **limited** assurance based on delivery of the plan	The Committee **noted** and discussed the presentation receiving **substantial** assurance around plans in place	
FSC/24/06/50	**Deep Dive – Strategic Risk incl BAF and Risk Register Report**	The Committee received the presentation noting:- • Limitation on risk scoring due to matrix therefore risk appetite introduced • Risk 134, scored at 20, target is 10 and risk appetite is open, proposed change likelihood to 4 and consequence of 3 therefore target of 12 due to integration and system working	The Committee received **substantial** assurance based on delivery of the review	The Committee **noted** and discussed the presentation receiving **high** assurance around review of BAF	

		• Risk 1114, scored at 16, target is 8 and risk appetite is minimal, proposed change likelihood to 1 and consequence 5 therefore target of 5 as impact would be significant • Risk 1372, scored at 16, target is 8 and risk appetite is cautious, no changes proposed • Risk 1898, scored at 16, target is 4 and risk appetite is open, proposed change likelihood 3 and consequence 3 therefore target of 9 due to current position			
FSC/24/06/51	**Corporate Performance Report**	The Committee received the report noting:- • ED Improvement group stood down, replaced by Productivity Improvement and UEC Improvement Groups • Widnes UTC type 3 activity to be 50% split between WHH and MWL, leads to a circa 5% positive increase in 4 hour performance • Time in department is showing a maintained position for third consecutive month • Tier 2 metrics, 78 weeks expectation was to be achieved by the end of June. Due to choice and complexity, 20-25 patients expected to remain at the end of June. Expected to be cleared by the end of August • Regional benchmarking, the Trust remains bottom of the table in relation to 78 week waiters. No longer bottom of the table for 65 and 52 week waiters (11 and 10 out of 12 respectively)	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** and discussed the presentation receiving **substantial** assurance around level of detail reported	**FSC July 2024**
FSC/24/06/53	**Monthly CIP & Productivity Improvement Update**	The Committee received the report noting:- • M2 CIP under plan by £0.2m, £1.1m achieved • Theatre Improvement – 73.9% utilisation which is an increase in month, theatre capacity increased from 70% to 90% of job planned sessions • UEC Improvement– risk of delivery due to corridor care • Outpatient Improvement – on trajectory to achieve metrics in year, biggest challenge is around new to follow up ratio. There is a focus on this by the leadership team to make improvements	The Committee received **limited** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **substantial** assurance around plans in place	**FSC July 2024**
FSC/24/06/55	**Pay Assurance Report**	The Committee received the report noting:-	The Committee received **substantial**	The Committee **noted** the report, receiving	**FSC July 2024**

		• ECFs are reducing with more challenge at local and Executives panels as well as behaviours changing throughout the Trust leading to fewer requests being put forward • Positive feedback from C&M and our ECF process has been shared more widely	assurance based on the controls around the new ECF process.	**substantial** assurance on the detailed workforce information.	
FSC/24/06/56	**Finance Report Month 2**	The Committee received a report noting:- • Month 2 actuals in line with revised plan, monitoring continues against original plan with the main drivers of the variance being nursing enhanced care and escalation, Urgent Treatment Centre GP and nursing due to acuity and CIP not delivered • Cash support of £4.5m requested in June however only £3m approved • £150m deficit for C&M expected to be cash backed, with the Trust expected to receive circa 60% of the deficit plan • The process and timetable associated with the National Cost Collection (NCC) which will be reported to Trust Board for approval • £109k off plan in relation to the ERF target which is an improvement from the position at month 2 in 2023/24 • Revenue requests supported by the Executive Team highlighted in the report • Risks around CIP delivery, cost pressures overspending and activity delivery up to the 104% income target	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance due to covering all areas required. The Committee supported the NCC to go to Board for approval.	**FSC July 2024**
FSC/24/06/58	**Capital Position Month 2**	The Committee received a presentation noting:- • M2 spend is in line with revised submitted plan with underspend phased over the remainder of the financial year • Movement in capital contingency was approved	The Committee received **substantial** assurance due to spend being in line with plan.	The Committee **noted** the presentation receiving **substantial** assurance and **approved** the contingency change	**FSC July 2024**

Items for noting

FSC/24/06/52 Recovery Update
FSC/24/06/54 Cost Pressures M2
FSC/24/06/57 EPCMS Outcome
FSC/24/06/58 Schemes over £500k
FSC/24/06/59 Digital Strategy Group Update

Assurance Key:

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Governance Assurance: *Assurance in the internal controls in place*

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/XX	Meeting	Trust Board	Date Of Meeting	7 August 2024

Date of Meeting	24 July 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
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	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/07/66	**Hot Topic – Recovery Update Q1**	The Committee received the presentation noting:- • 65 week wait position is 213 behind the service adjusted target. • There are a number of high risks specialities including Gynaecology, T&O and Max Fac • A number of specialities are coming online via the LLP and other providers during July and August. • T&O surgical hub - mutual aid is being accessed to reduce the waiting list. • Costs forecasted to reduce from £4.6m to £3.6m with the £1m saving included as part of CIP identification.	The Committee received **substantial** assurance based on delivery of the recovery plan	The Committee **noted** and discussed the presentation receiving **substantial** assurance around plans in place for recovery	**FSC August 2024**
FSC/24/07/67	**Deep Dive – Benefits Realisation – A&E**	The Committee received the presentation noting:- • Investment was made to meet the minimum safe staffing for the main ED footprint. • Continued work will reduce the use of corridor care however level of "no right to reside" impacting on this delivery. • Eliminating corridor care and the need to escalate areas within ED would release £0.5m. • External UEC improvement work across the system to eradicate corridor care.	The Committee received **moderate** assurance based on delivery of the review	The Committee **noted** and discussed the presentation receiving **substantial** assurance around the management of the staffing levels in ED	**FSC November 2024**

		• Positive impact on staff experience and retention – turnover reduced, reduction in agency usage, increased number of applicants for vacancies advertised			
FSC/24/07/68	**Corporate Performance Report**	The Committee received the report noting:- • Percentage of patients waiting over 12 hours remains a challenge but has started to stabilise. • Improved position in the C&M leaderboard position in relation to 65 week waits. • 4 hour performance excluding Widnes UTC 66.3% which is in line with projections • Endoscopy – delay in the opening of the Endoscopy Hub, some activity to commence in September and will become fully operational at the end of October 2024. • Outpatients – some DNA rates have increased, worse than trajectory mainly due to industrial action.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** and discussed the report receiving **substantial** assurance around level of detail reported	**FSC August 2024**
FSC/24/07/72	**Monthly CIP Update**	The Committee received the report noting: • Significant increase in the identified schemes from £8.5m to £17.5m and the recurrent position from £5.7m to £16.6m • Month 3 CIP position is £11k behind plan – however stepped increase in the plan in the later part of the year. • £1.9m unidentified CIP and £3m collaboration to be identified	The Committee received **moderate** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **substantial** assurance around plans in place	**FSC August 2024**
FSC/24/07/73	**Monthly Productivity Improvement Update – inc UEC**	The Committee received the report noting:- UEC • Due to the need to use corridor care, there is a risk to delivering the UEC improvement targets. • Waterfall for each piece of work for the ICS to be brought back to FSC Outpatients • DNAs gone up in month. Issues have been identified and change process in place. Theatres • Improved theatre capacity and job plans • Negative impact from Industrial action	The Committee received **limited** assurance on the delivery of the improvement savings	The Committee **noted** and discussed the report receiving **substantial** assurance of the plans in place	**FSC August 2024**

		Savings on Outpatients and Theatres won't be realised until the Trust achieves 104% of 2019/20 activity			
FSC/24/07/74	**Cost pressures M3**	The Committee received the report noting:- • Cost pressures have continued, the majority relating to nursing and medical requirements • Forecast overspend has reduced from £5.0m in month 2 to £4.8m • Peer review by the Executive Team is now in place with an aim to reduce cost pressures further	The Committee received **limited** assurance based on the continued overspend on cost pressures	The Committee **noted** and discussed the report receiving **substantial** assurance of the ongoing review	**FSC August 2024**
FSC/24/07/75	**Pay assurance report**	The Committee received the report noting:- • The ECF process is continuously being developed and improved. All CIP targets are now reported rather than just the scheme associated with the 2% reduction in non-clinical workforce • A new process has been introduced by the ICS where Band 8D and above roles requiring approval by the ICS	The Committee received **substantial** assurance based on the controls around the new ECF process.	The Committee **noted** the report, receiving **substantial** assurance on the detailed workforce information.	**FSC August 2024**
FSC/24/07/77	**Revenue Request - Radiology WLI and Outsourcing**	The Committee received the revenue request noting:- • The virement of budget non recurrently to support the costs of Radiology WLIs and outsourcing. • Part of the budget is ringfenced and the other part will be funded via Radiographer vacancies and vacancies across other Clinical Support Services (Therapies and Pharmacy)	The Committee received **substantial** assurance on the revenue request	The Committee **noted** the revenue request receiving **substantial** assurance and **supported** the revenue request	**Trust Board August 2024**
FSC/24/07/79	**Monthly Finance position – month 3**	The Committee received the report noting:- • £12.1m deficit with an adverse variance to plan of £0.7m which is the impact of Industrial Action (IA). Indications are that there will be no additional funding for this. • Risks around cost pressures overspends, under delivery of CIP, risk of activity delivery to achieve the 104% income target and the impact of IA • Revenue requests supported by the Executive Team highlighted in the report • NHS England have commissioned external support from PwC to review a number of ICSs nationally. The review has commenced to identify actions which can be taken to immediately reduce the rate	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance and **approved** the CPG Terms of Reference	**FSC August 2024**

		of expenditure and to ensure that the financial plan for the year is delivered • Approval of the CPG Terms of Reference.			
FSC/24/07/80	**Capital Position Month 3**	The Committee received the report noting:- • M3 capital spend is in line with plan • Movement in capital contingency was approved	The Committee received **substantial** assurance due to spend being in line with plan.	The Committee **noted** the presentation receiving **substantial** assurance and **approved** the contingency changes	**FSC August 2024**

Items for noting

FSC/24/07/69 Costing Update Q4
FSC/24/07/70 Access and Performance KPIs in the IPR - supported
FSC/24/07/71 CPG annual report
FSC/24/07/76 Emergency Preparedness Annual Report & Annual Assurance Letter Statement of Compliance
FSC/24/07/78 Patient Access Policy
FSC/24/07/80 Schemes over £500k
FSC/24/07/81 Digital Strategy Group Update
FSC/24/07/82 Committee Chairs Annual Report to the Trust Board - supported

Assurance Key:

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/08/063 (d)	Meeting	Trust Board	Date Of Meeting	7 August 2024

Date of Meeting	20 June 2024
Name of Meeting & Chair	Audit Committee (YEAR END), Chaired by Mike O'Connor
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	Delivery Assurance	Governance Assurance	Follow up/ Review date
AC/24/06/32 & AC/24/06/33	**External Auditor's Findings Report 2023/24 & Annual Report**	The Committee received the report, which summarised the key findings and other matters arising from the statutory audit of the Trust and the preparation of the Trust's financial statements for the year ended 31 March 2024 for those charged with governance. It was highlighted that There was one area outstanding in relation to pensions and the remuneration report, The committee also received the Auditor's Annual Report for the year ended 31st March 2024 - The Committee received and discussed the report which highlighted two recommendations	**Substantial** – The Committee received substantial assurance; pending the receipt of the outstanding information.	**Substantial** – it was evidenced that the Trust had substantial Governance systems and processes in place	Receipt of the Auditors final opinion, for inclusion in the 2022/23 Annual Report submission.
AC/24/06/34	**Annual Report**	The Committee received final audited version of the WHH Annual Report & Accounts for 2023/24	**High –** the Committee approved the Annual Report to be laid before Parliament	***High* -** the Committee received high assurance on the completion of the Annual Report	**Annual Members Meeting**

AC/24/06/35	**Quality Account**	The Committee received report, it was explained that In line with legal requirements, Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce and publish their Quality Accounts for the 2023/24 by 30 June 2024.	**High –** the Committee approved the Quality Account for publication on the Trust's website	***High*** **-** the Committee received high assurance on the completion of the Quality Account	**n/a**
AC/24/06/36	**Final Audited Accounts & Financial Statements**	The committee received the Accounts & Financial Statements, and it was noted that the Audit had not yet concluded. The Committee were advised of the amendments made since the presentation of the draft versions in April 2024. The Committee agreed that should there be any additional changes that do not impact on the draft audit opinion, the Audit Committee would be asked to support approval of any further amendments on the committee's behalf by the Chair of the Audit Committee and disclosed to the committee by email.	**Substantial** – the Committee approved the Annual Accounts pending any significant findings.	***High*** **-** the Committee received high assurance on the completion of the Annual Accounts	**Annual Members Meeting**

Other agenda items:
AC/24/06/37 - Licence Annual Return
AC/24/06/38 – Fit & Proper Persons Test Annual Report

Assurance Key:
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Governance Assurance: *Assurance in the internal controls in place*

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/64**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
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)*	**#2001** 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. **#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 and failure to achieve constitutional standards. **#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	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:

	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:			

<table>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="3">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:
• Stroke
• Urology
• Gynaecological surgery
• Orthopaedics – Fractured Neck of Femur
• ENT

Services entering Fragile Services oversight since last report:
• Theatres (procedural safety)</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
√</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to:

• Note the current list of Fragile Services, associated clinical risk and high-level progress updates
• Note emerging risk posed by growing high risk follow up patient backlogs
• Note a deteriorating position with regards to ENT medical Staffing
• Receive further Fragile Service Oversight reports</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/24/06/xx

1. BACKGROUND/CONTEXT

Following recognition of a need for a systematic oversight mechanism for Fragile Services the oversight 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 particular 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

Theatres (Procedural Safety)

- Increased incidence of procedural never events in last 18 months
- After initial interventions, actions and reporting via PSCESC and QAC oversight of improvement to be managed through Fragile Services program
- No Never Events for last 3 months
- 26% reduction in all-cause procedural incidents in may and June
- Completed actions
    - Procedural Safety Steering Group (PSSG) was established to monitor and triangulate all aspects of procedural safety (for Theatres and non-theatre procedural areas)
    - 9/11 recommended actions completed from action plan formulated after theatres safety day and external review of procedural safety
    - Safe Surgery Audit standards refined and improved with a 5-fold increase in daily sample size
    - Band 7 theatre staff have undertaken Human Factors training
    - Safety simulation exercises have been undertaken on both sites
    - SAFE stops / suture magnets / action cards fully implemented
    - NATSSIPs2 infographics cascaded to all governance leads for presentation

- Ongoing improvement plan actions
    - 2 actions from external review of theatres safety day in progress - MIAA external audit & formation of theatre culture working group (dependent on ARHQ AQUA results)
    - ARHQ AQUA results received and to be discussed with Planned Care Tri and next PSSG (to be fed back to PSCESC Aug 2024)
    - Human Factors training for wider theatres and surgical team
    - Swabsafe trays are being trialled
    - Incivility behavioural data is available and will be a focus for Theatre Safety Culture/ Theatre Civility work

3. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- P2 waits have decreased significantly in month, which is the first such reduction that has been seen in P2 waiters
- 5 in year incidents of moderate/severe harm identified which have been subject to appropriate investigation and Duty of Candour has been discharged. 1 low harm incident identified since last report.
- Emerging risk posed by growing high risk follow up patient backlog
- Transperineal Biopsy position (>60% reduction) and Surveillance cystoscopy position (>75% reduction from peak) very significantly improved from peak
- Significant volume of high risk patients confirmed by AI list validation
- Ongoing risk of harm remains given P2/Stone and surveillance cystoscopy backlogs
- Service exceeding clinical activity targets (>105% of 19/20 activity)
- Completed Actions
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved and actioned
    - 3 Middle Grade doctors commenced in post – 2 require additional training before full effect will be felt
    - Locum consultants commenced in post April 2024
    - successful transfer of cystoscopy into UIU
- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site
    - PCNL Stone patients transferred to Chester
    - Ongoing harm review process
- Ongoing improvement plan actions:
    - Plan to reintroduce PCNL at Warrington site as IR radiologist now in post – meeting with Chester August 2024 to agree repatriation to WHH

    - Plan to divert some weekend P3 outsourcing capacity to deliver P2 activity in week
    - Specialist nurse delivered cystoscopy training plan now confirmed – training May (2 colleagues - completed) and September (2 colleagues) followed by 3 months direct supervision – may need some staggering to avoid an excessive loss of core capacity to training lists
    - UIU increasing cystoscopy case numbers per list.
    - Theatres demand and capacity review
    - Follow up backlog plan to be presented to executive team and QAC August 2024

Gynaecological Surgery

- Demand and capacity mismatch – driven predominantly by workforce issues with some initial diagnostic equipment pressures (hysteroscopes – now resolved)
- 6 incidents of moderate harm identified in year due to delays which have been subject to appropriate investigation and Duty of Candour has been discharged. No new harms identified since previous report.
- New patient waiting list numbers remain high and static – demand related
- Emerging risk posed by growing high risk follow up patient backlog
- Service has recovered its Cancer 2WW position – no breaches since December - Dedicated 2WW / CFT clinic continues to mitigate for risk
- Increasing numbers of juniors undertaking Less Than Fulltime Training (LTFT) and with restricted duties is increasingly a workforce challenge
- Completed Actions
    - Full complement of hysteroscopes now purchased and in service.
    - Gynaecological surgery capacity supported by approved elective c-section revenue request.
    - Full consultant job plan review completed informed by demand and capacity exercise.
    - Full compliment of consultant staff to be in post by end of August
    - Successful trial of one stop long waiter clinics in WLI / Outsourced capacity
- Current mitigations
    - Insourcing and WLI as appropriate/available
    - AI aided Harm Review process in place
    - Daily 2WW performance tracker in place
- Ongoing improvement plan actions:
    - Follow up backlog plan to be presented to executive team and QAC August 2024
    - Triage/Advice and Guidance workstream
    - Develop junior doctor gap mitigation plan
    - Further development of Halton HVLC and Complex patient ‘Superweeks’/’Superlists’
    - Incorporate 1-stop clinics into core capacity in consultant job plans

Orthopaedics – Fractured Neck of Femur

- Demand and capacity mismatch – driven predominantly by increased demand and insufficient theatre capacity for Trauma workload
- Significant improvement across majority of performance indicators – performance at or close to national average in these domains
- Prompt surgery is the remaining significant challenge
- Some risk orthogeriatrician review performance given recent leavers in geriatrics
- 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 lists utilising bank locum consultant
- Ongoing improvement plan actions:
  - Focused improvement plan to deliver 'prompt surgery' – revenue request in development to support extended trauma caapcity
  - Development of escalation SOP to ensure that prolonged delays to theatre are escalated and managed appropriately triggered by wait time, rather than numbers waiting
  - Develop plan for sustaining orthogeriatric cover with changes in Geriatric medicine staffing

Ear Nose and Throat Surgery

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- Significant medical staffing challenges – deteriorating position
- ENT currently has the Trust's largest backlog
- No harm reported to date
- Additional capacity via LLP is supporting the reduction of patients awaiting 1st OPD appointment within the 65 week waiting cohort
- New OP waiting list has reduced significantly in month from >3500 to <1650.
- FU OP waiting lists remain a challenge
- High risk FU patients continue to be prioritised
- Completed Actions
  - Task and finish group established
  - Enrolled in phase one of GIRFT Further Faster program
  - NHS Locum recruited and has commenced in post
  - Additional ENT stacker and scope procured for Warrington site
- Current mitigations
  - Outsourced sessions funded and underway
  - AI aided Harm Review process in place
  - 2 Trust F2 doctors to commence in post August 2024
- Ongoing improvement plan actions:
  - ENT Medical staffing review and intensive support plan

- Strategic conversation with MWL and LUHFT regarding a sustainable ENT model for Mid Mersey
- GIRFT Further, Faster baseline assessment and action plan outstanding
- Incorporate Triage and clinical waiting list validation into job plans
- Develop Local Anaesthesia biopsy service

Stroke Services

- The Stroke pathway escalated to fragile service oversight in April 2024 due to concerns regarding:
  - Direct admissions of Acute Stroke patients to the Warrington site which is not commissioned or provisioned to provide Acute Stroke care
  - Delays in repatriation of post-acute phase Stroke patients from the Whiston to Warrington site

- No harm has been identified with no 'missed' thrombolysis patients, however impact on long-term outcomes from delayed access to acute stroke care is challenging to identify and quantify
- Improved position with only 1 patient deviating from the transfer pathway in June
- Monthly MDT meetings now underway with MWL to review direct admissions and live audit and education program in place
- WHH remains committed to repatriating 1 rehab patient from MWL each weekday with a length of stay reduction program to deliver the bed capacity required to do this reliabl

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

None

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note the escalation of Theatres (Procedural Safety) into the Fragile Services oversight program
- Note emerging risk posed by growing high risk follow up patient backlogs – plan to be presented to executive team and QAC August 2024
- Note the deteriorating position with regards to ENT Medical Staffing
- Receive further Fragile Service Oversight reports

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/65**	
SUBJECT:	Maternity & Neonatal Update	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
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.	X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***	**#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 and failure to achieve constitutional standards and financial plans. **#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	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	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 and improving safety and outcomes for this cohort.			

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="3">This paper provides an overview of activity, performance and quality within the maternity and neonatal services.

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.

This paper also provides a summary in relation to the following reports for oversight and discussion:

• June Maternity Quality & Safety update – appendix 1
• July Maternity Quality & Safety update – appendix 2
• Maternity Incentive Scheme Year 5 and 6 – appendix 3
• All-Party Parliamentary Group report on Birth Trauma– appendix 4
• Transitional Care Q4 2023/24 – appendix 5
• ATAIN Q4 2023/24 – appendix 6
• Ockenden position – appendix 7</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
√</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to note the contents of this report ..</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QAC/24/06/57
QAC/24/07/79</td></tr>
<tr><td>Date of meeting</td><td colspan="2">11th June 2024
9th July 2024</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update Summary Report	AGENDA REF	BM/24/08/65

1. BACKGROUND/CONTEXT

This paper provides an overview of activity, performance and quality within the Maternity and Neonatal Services.

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.

This paper provides a summary in relation to the following for oversight and discussion:

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- ATAIN Q4 2023/24 – appendix 6
- Ockenden position – appendix 7

All papers have been shared and discussed at the appropriate committee meeting.

2. QUALITY & SAFETY METRICS

A review of Quality & Safety within the Maternity and Neonatal services is shared with Quality Assurance Committee (QAC) each month across a range of key themes and areas of national and local focus. These detailed reports are included in appendices 1 and 2.

2.1 Patient Safety Events

In April and May 2024 themes from patient safety events were as follows:

- Admission of term babies admitted to Neonatal Unit
- PPH >1500ml
- PPH >1000ml
- Postnatal readmission

All patient safety events have received an internal review to identify urgent learning. Further details of the cases, learning identified and plans to improve are included in the detailed reports.

2.2 Workforce metrics

Work remains ongoing across the maternity and neonatal teams to improve and sustain compliance with mandatory training and completion of staff appraisals. At the end of May compliance for mandatory training across maternity and child health colleagues is above the At the end of May compliance for Trust mandatory training across maternity and child health

colleagues is 88.83% for Trust mandatory training (including safeguarding training), 87.10% for role specific training. This includes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge but improving. Rates in May (including those with a long term absence) for maternity and child health services is 79.39%, an improved position from April 2024 when the rates was 77.81%. An action plan remains in place.

Compliance with maternity specific training is excellent.

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	97.6%	96.7%	92%	96.1%	53.2%
Obstetric Consultants	100%	100%	88.9%	n/a	n/a
Other Obstetric	100%	100%	90.9	n/a	n/a
Obs Anaesthetic Consultants	96%	n/a		n/a	n/a
Maternity Support Workers	95.8%	n/a		n/a	16.6%

*new training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track

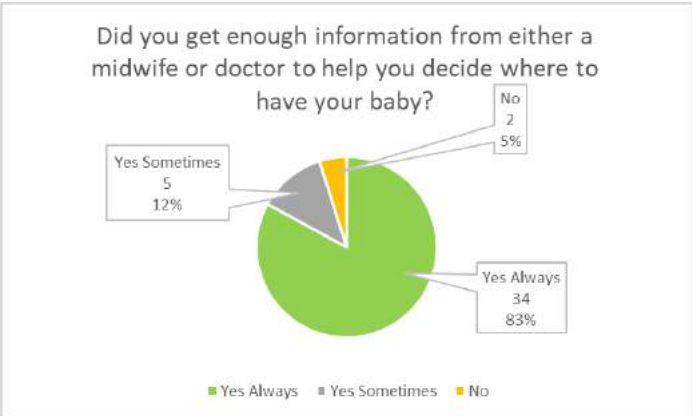
Turnover for maternity and child health staff (permanent staff) has increased to 10.49% but remains below the Trust target. Turnover has remained below the Trust target of 13% since December 2023.

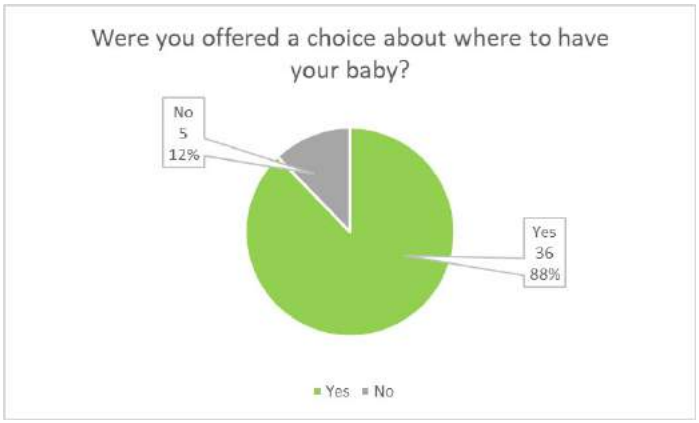
The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 5.2% in April 2024. At the end of May 2024, the vacancy rate for registered midwives was 2.15% a continued improvement from the position in March and April 2024.

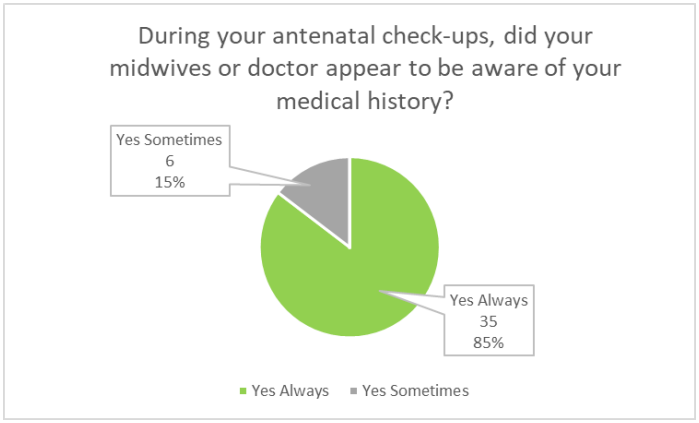
2.3 Service User Feedback

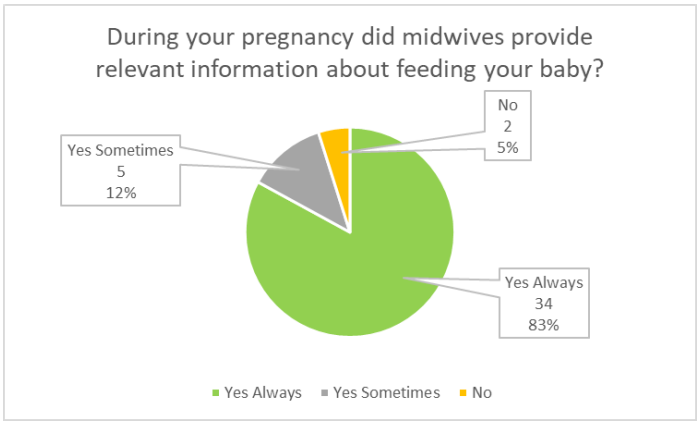
As reported to Trust Board in June, the results of the NHS Maternity Services Survey 2023 have been received.

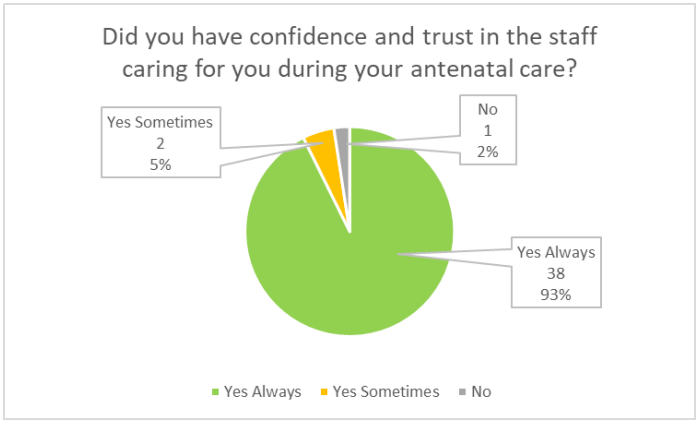
To further explore the findings of the report, a hotspot audit of experience was completed to ascertain current position in relation to those areas of concern. 41 anonymous responses were received and outcomes are detailed below:

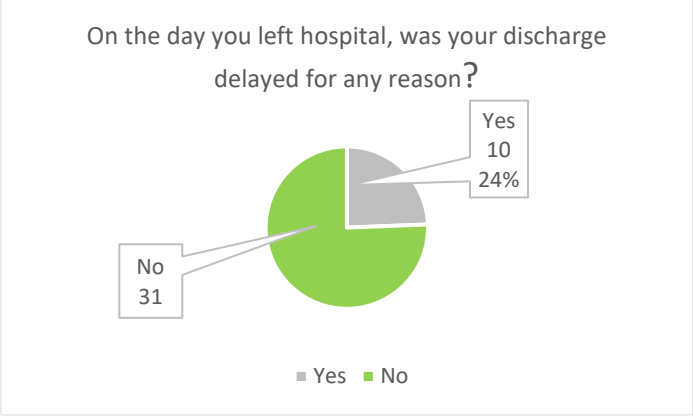



Were you offered a choice about where to have your baby?
No
5
12%
Yes
36
88%
Yes
No


During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?
Yes Sometimes
6
15%
Yes Always
35
85%
Yes Always
Yes Sometimes


During your pregnancy did midwives provide relevant information about feeding your baby?
No
2
5%
Yes Sometimes
5
12%
Yes Always
34
83%
Yes Always
Yes Sometimes
No


Did you have confidence and trust in the staff caring for you during your antenatal care?
Yes Sometimes
2
5%
No
1
2%
Yes Always
38
93%
Yes Always
Yes Sometimes
No



The feedback from the hotspot questionnaires has been considered alongside a more detailed review of the survey, from which a number of priorities have been identified. These priorities also reflect the wider national maternity agenda.

Priority	Justification
Effective discharge processes from the maternity ward including improved processes around take-home medication and timely medical review	Deteriorating position and remains an issue following hotspot survey
Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby	Deteriorating position, hotspot survey shows 12% of women were not offered a choice and personalised care is nationally a key area for improvement
Ensuring those who have care are involved in decisions about their care including decisions to be induced	Reduced position, 2023 v 2022 and personalised care is nationally a key area for improvement
Provision of relevant information about feeding baby during the antenatal period	Deteriorating position, remains an issue in hotspot survey, links with wider population health partnership workstreams
Explore why respondents did not have confidence and trust in the staff providing care during labour and birth	No improvement in position over time
Measures implemented to ensure relevant/appropriate information or explanations provided in the postnatal period	Deteriorating position and no improvement over time

In collaboration with the Maternity and Neonatal Voices Partnership, a CQC Maternity Survey action plan has been developed. This action plan has been approved by Quality Assurance Committee and submitted to the Local Neonatal and Maternity System (LMNS) for external assurance.

The maternity service has recently responded to two PALS concerns regarding the experience of families within the induction of labour pathway. This correlates both with learning from debriefs where experience of IOL has been noted as an area for improvement and the findings of the most recent CQC maternity survey. A task and finish group is in place and will report monthly to Quality Assurance Committee.

Individual feedback from families is included in the detail of the reports submitted to Quality Assurance Committee.

2.4 Staff feedback

Trust Board will be aware the maternity and neonatal service have been undertaking the NHSE Perinatal Cultural Leadership Programme (PCLP). As part of this a SCORE Cultural Survey has been completed.

Details results were received in March 2024 and were shared with Quality Assurance Committee in June 2024. Further exploration of the results have subsequently taken place via a series of “cultural conversations”.

In total eight cultural conversations were held with representation from all matenrity and neonatal teams and representation across all roles.

The insights/feedback from these sessions were shared with the Quadrumvirate in a further feedback session with three key aspirations agreed:

1. Focus on kindness through building relationships, trust and understanding each others roles, responsibilities and pressures which will also support shared decision making.

2. Increase collaboration through improved teamwork across teams and specialisms.

3. Increase communication to gather ideas, help staff rise to the challenge, deal with change and foster inter role relationships.

These aspirations will now form the basis for a PCLP action plan which will be shared with Quality Assurance Committee in August 2024.

A Maternity Safety Champion Walkaround took place on 11th June 2024 with a focus on Birth Suite including the new induction of labour facility.

Feedback from Birth Suite staff was both constructive and positive. The team acknowledged the unit had experienced some difficult times in the relatively recent past (“last couple of years”) but noted the unit feels much better, staff articulated their “love” for working in the unit and at WHH. The team also noted they feel very supported by the leadership team (Matrons etc) and by the medical staff. They shared their pride in working as part of a great

team within which everyone pulls together to support each other and the families who choose to birth at WHH.

Individual feedback from a colleague is included in the detail of the July report to Quality Assurance Committee (appendix 2).

2.5 Maternity Triage

In May 2024 590 triage attendances were recorded on the BadgerNet patient record system. This reflects the continued increase in Triage attendance since the beginning of 2024:

Triage attendances Dec 23 - May 24		
Month	**Attendances**	**Ave per day**
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0

In May 2024, 92% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes. 98% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes.

A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require a reduced investment of £278,645. This paper has been presented to the Trust Executive Team who have requested further information. An updated paper has been drafted and is under review.

To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour (IOL) pathways. The audit of timeliness of medical review in Maternity Triage was reported to Trust Board in June and identified some challenges. The audit was presented to the Women's Health audit meeting in June 2024. The following key actions were agreed:

- Share Birmingham Symptom Specific Obstetric Triage System (BSOTS) presentation with all doctors on call
- Explore potential for having separate doctors covering Triage and Antenatal Day Unit (ANDU) during the day – suggestion of two registrars if possible
- Plan for handover times to prevent delay in doctor's review if required in Triage/ANDU
- Identify if additional IT hardware required to expedite the review process

- Reaudit to be undertaken to include the times when delays are occurring to establish any themes

Whilst these actions are implemented, the Triage Team are aware of the importance of timely escalation of delays via both the red flag system and maternity bleep holder to ensure the continued safety of the service.

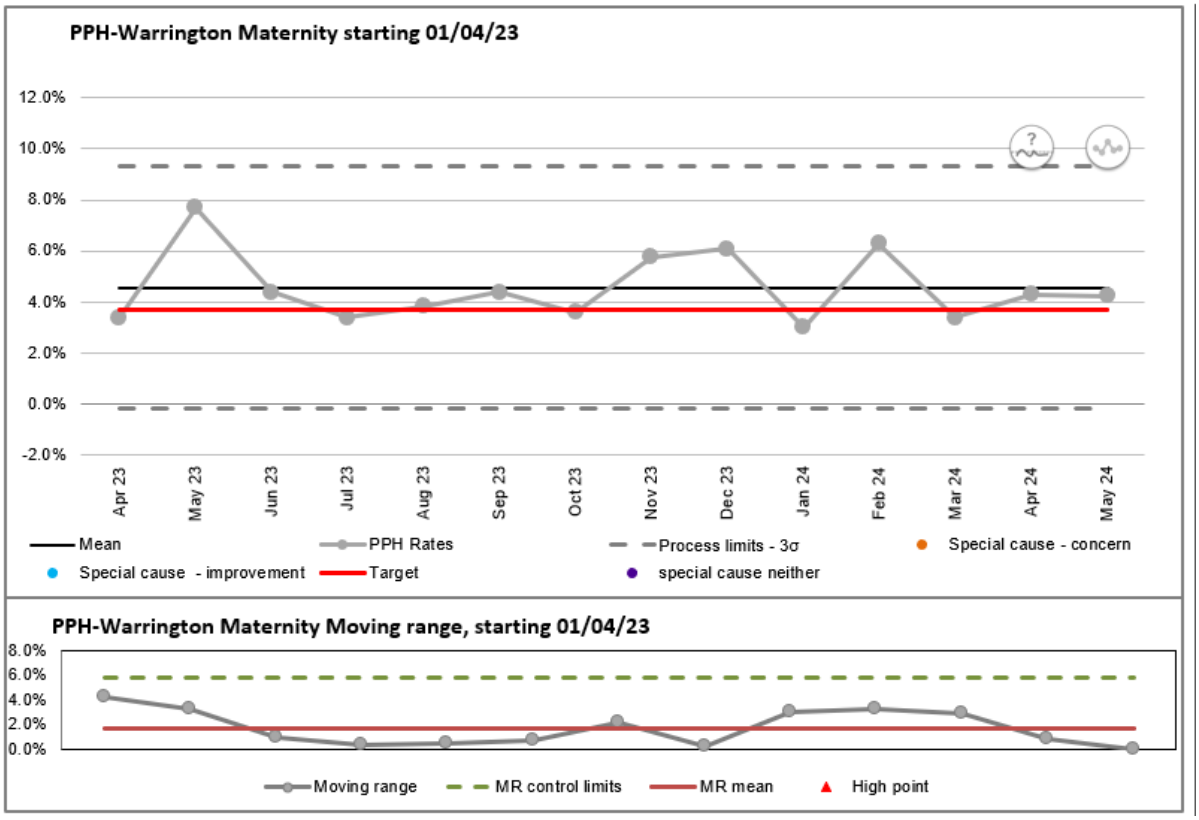
The Triage Task & Finish group will continue to work with the team to optimise the service and improve performance.

2.6 Post-partum haemorrhage

All cases of PPH ≥1500mls are reviewed via the MDT Intrapartum Review Group to ensure any urgent learning is enacted and fed into the PPH QI project. There were six cases of PPH ≥1500ml in May 2024. From June 2024, rates of PPH ≥1500ml have been reported to QAC via SPC chart.

The SPC chart shows no trend at present, the chart shows rates for May 2024 at 4.25% which is above the target of 3.7% (agreed based on historical regional data).

The PPH action plan is shared as part of CBU governance processes and monthly to QAC.



2.7 Induction of Labour

The position of the maternity service in relation to induction of labour (IOL) pathways and particularly the number of IOL delays compared to other local providers has been noted. As a result, the IOL position is now reported monthly to QAC.

May data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers:

- The data below reports the **total number of delays by week by Provider** from **1st to 31st May**

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total	% of Total
29/04/2024	2			9	3	4	1	19	19.00%
06/05/2024		6	1	0	5	1	3	16	16.00%
13/05/2024	2		6	1	3	8	12	32	32.00%
20/05/2024	2		7	2	3	5	1	20	20.00%
27/05/2024	1				4	7	1	13	13.00%
Grand Total	7	6	14	12	18	25	18	100	100.00%
% of Total	7.00%	6.00%	14.00%	12.00%	18.00%	25.00%	18.00%	100.00%	

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 31st May**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	31	127	60	48	128	83	71	548
Total Delayed	7	6	14	12	18	25	18	100
% of Total	22.58%	4.72%	23.33%	25.00%	14.06%	30.12%	25.35%	18.25%

The IOL task and finish group have taken IOL delays as a key area of focus and an action plan is being developed to improve IOL pathways and the experience of families.

2.8 Complaints

Eight complaints were received in the CBU in April and May 2024, three of which were related to care within the maternity and neonatal services.

Specialty	Description	Complaint Opened
Maternity	Traumatic birth 8 years ago for which the complainant had a debrief meeting at the time. Has since read a CQC report which has raised 2 questions - complainant would like further clarification on these questions.	13/05/24 (reopened complaint)
Maternity	Patient was discharged with retained products which required the patient to be re-admitted to hospital to have it surgically removed. Patient also has concerns relating to the consultants' attitude and refusal to investigate concerns raised by the midwife.	15/05/24

Maternity	Patient attended Maternity Triage due to reduced fetal movements at 37 +6. Felt dismissed by the Consultant. Following USS the following day, patient attended to triage again and was admitted for emergency c-section. Baby was found to have cord wrapped around neck 4 times and patient feels this could have been a different outcome had she not gone back to triage/pushed for USS	28/05/24

2.9 Coroner regulation 28 Enquiries

No Regulation 28 enquiries have been received

3. MATERNITY INCENTIVE SCHEME (MIS)

Successful achievement of all 10 Safety Actions for MIS Year 5 was published on 10 April 2024.

Guidance for the launch of MIS Year 6 was received on 2 April 2024. Meetings have been held with Leads for all 10 Safety Actions to review the required specifications for each action. Progress will be monitored on a monthly basis with leads and support will be available from the senior leadership team as and when required.

A quarterly MIS check-in point meeting took place on 31 May 2024. The LMNS were assured by our progress to date against the MIS Year 6 requirements. The LMNS also reviewed progress against Saving Babies Lives Care Bundle v3 (SBLCBv.3).

Following the latest quarterly meeting on 31st May 2024, the LMNS was assured that WHH is on track with completion of all elements of this safety action. Further evidence has now been uploaded to the external portal. The LMNS will assess this evidence again prior to the quarterly check-in meeting in September 2024.Where full compliance has not yet been achieved, robust action plans are in place. As part of their assurance role, the LMNS are assessing overall compliance against the measures alongside evidence of sustainable improvement. The LMNS were assured by the service's plans and progress to date.

Trusts are required to complete their MIS Year 6 Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2025.

4. ALL-PARTY PARLIAMENTARY GROUP REPORT ON BIRTH TRAUMA

A report by The All-Party Parliamentary Group (APPG) on Birth Trauma was published in May 2024. An overview of the report was presented as a Hot Topic to Quality Assurance Committee in June 2024. This is included in full as appendix 4.

In summary, the APPG identified a number of concerns/areas for improvement, many of which reflected the findings of other national reports/inquiries into maternity care. In particular:

- Care that lacked compassion

- Women not being listened to and being denied basic needs such as pain relief
- Women felt they were subjected to interventions they had not consented to
- Women feeling they had not been given enough information to make decisions during birth
- Poor post-natal care
- Significant short term and long-term impact of birth trauma on women and partners and lack of access to appropriate support
- Lack of high quality follow up care for women who had experienced a birth injury
- Women from marginalised groups, particularly those from minority ethnic groups, appeared to experience particularly poor care

The report included 12 key recommendations, 9 of which will have implications for care delivery at WHH. A proportion of the recommendations will require further national guidance prior to implementation. There is also a suggestion some of the recommendations will be supported via the LMNS.

A gap analysis has been completed comparing WHH practice against the new recommendations. This has identified a good position albeit with further progress required. In particular WHH are already doing some excellent work with regard to perinatal pelvic health pathways, the post-natal debrief and birth reflections offer and collaborative work with partner organisations with regard to support for families in relation to mental health.

An action plan to meet all recommendations from the APPG has been drafted and will be presented to Quality Assurance Committee in August 2024 for approval.

5. Q4 2023-24 TRANSITIONAL CARE

The Q4 2023/24 Transitional Care Audit was presented to Quality Assurance Committee in June 2024 and is included as appendix 5.

During Q4, 13 babies met the criteria for TC. An audit of these cases has identified the following:

Admitted direct to TC	4
Appropriately received NNU care and stepped down to TC when well enough	5
Allocated to PEEP for 30 pathway	2
Did not received TC	2

Of the 13 babies who met the criteria in Q4, four babies were admitted straight to TC from birth indicating an improvement from Q3 when no babies received TC straight from birth.

The other 9 babies who met the broad TC criteria in Q4 required some level of respiratory support and were initially provided with care via NNU. However, two babies did not receive TC when this was indicated. These were babies not stepped down to TC due to short term sickness and high acuity on the Neonatal Unit. The babies were not stepped down and remained on the NNU.

As part of the audit, good practice has been identified as follows

- Improvement seen in the early recognition of babies who can step down to TC

- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers
- Sharing of audit outcomes across the MDT with both midwifery and neonatal teams to ensure learning is communicated.
- All Band 6 and 7 Neonatal Nurses are able to access the SafeCare system to raise red flags when unable to provide TC care, as part of TC action plan this will be mirrored across the maternity service.
- NNU Ward Manager continues to deliver training at MAMU (Maternity Mandatory Updates).
- Band 6 TC Midwifery champion in place, attending TC training and attends working group (protected time each month)
- Review of TC Criteria completed, disseminated to all staff and displayed in all areas
- Review of Enhanced Care criteria completed, disseminated to all staff and displayed in all areas
- Revisited and redesigned the TC Audit. This is now lead by Lead Nurse and NNU Manager. Audit information is reported to QAC
- "Think TC" Boards in each clinical area – to remind staff of TC admission criteria. Includes updates re progress with TC project

To further enhance the TC offer, an action plan is in place which reflect the key recommendations of the audit:

- Continue to offer targeted support to staff with learning in relation to step down on babies to TC, due to improvements being seen from this method
- Focussed learning from TC review to be included on Neonatal Natter and OWL
- Regular review of TC actions to ensure timely completion
- Staffing – Continue to ensure that Neonatal staff are allocated to TC Care babies. SBAR created as interim measure for hourly rounding if NNU staff are unable to remain on Ward C23. Monitored via Datix and red flag process.
- TC review group to be established, (similar to ATAIN) to review and discuss cases and monitor actions/progress against the action plan
- Updated TC guideline completed and progressing through Trust governance processes.
- TC Bay on C23 to be created – project lead in place. Will be commenced following IOL move to Birth Suite
- TC Review Group to work in collaboration with ATAIN group to share learning and optimise WHH ability to avoid unnecessary separation of mother and baby.
- Work underway to develop business case for sustainable staffing model, including benchmarking against other providers
- Outstanding actions from action plan;
    - Ongoing TC audit which will be reported through Quality Assurance Committee and to Trust Board.
    - Policy review and staffing model to be completed

The Transitional Care action plan is monitored via Women's Health and CBU Governance.

6. ATAIN Q4 2023/24

The Q4 2023/24 Avoiding Term Admission into Neonatal Unit (ATAIN) review was presented to Quality Assurance Committee in June 2024 and is included as appendix 6.

The Q4 ATAIN rate is 6.99%, which is above both the national and NWNODN targets of 6% and 5.6% respectively and is an increase of 1.5% on the last quarter. All term admissions in Q4 were reviewed and learning from these cases shared and used to inform the ATAIN action plan.

Over 50% (23) of term admissions were respiratory-related, i.e. required admission or additional observations due to signs of respiratory distress which includes grunting and low oxygen saturation (SATs or oxygen requirement). Only 6 of these cases were deemed avoidable if care had been optimal. This correlates with the findings of the Q4 Transitional Care Audit referenced in section 5.

The 23 respiratory-related admissions comprised of the below:

- 15 cases with Transient Tachypnoea of the Neonate (TTN) – only 1 case was deemed an avoidable admission as caesarean section delivery should have been performed more urgently based on the clinical situation.
- 7 babies had Respiratory Distress Syndrome (RDS)
- 1 baby had Choanal Atresia

WHH Oct 2022 – Mar 2024	Number of Term Admissions	Outcome of ATAIN review		
		Avoidable Admissions	Unavoidable Admissions	% avoidable
Q3 Oct – Dec 2022	33	5	28	15.2%
Q4 Jan – Mar 2023	43	7	32	16.3%
Q1 Apr – Jun 2023	37	7	29	18.9%
Q2 Jul – Sep 2023	41	11	30	26.8%
Q3 Oct – Dec 2023	34	12	22	35.2%
Q4 Jan – Mar 2024	41	13	28	31.7%

Reasons for categorising term admissions as avoidable included:

- Caesarean section should have been performed more urgently
- Caesarean section undertaken too early and not in line with documented patient symptoms & cessation contractions.
- Poor management in intrapartum care of baby
- Hypoglycaemia pathway not followed.

As part of ATAIN reviews, good practice has been identified as follows:

- Impact of Peep for 30 QI project
- Excellent documentation from Obstetric Consultant & Midwives
- Paediatrics requested and attended within 2 minutes of request

- Appropriate escalation points from midwives at all of the right points
- Appropriate involvement of safeguarding legal team – supported informed decisions being made.
- Appropriate escalations from midwives when escalating concerns around query sepsis.

The ATAIN action plan is in place and monitored via Women's Health and CBU Governance.

7. OCKENDEN RECOMMENDATIONS UPDATE

The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates.

WHH has 3 Ockenden action plans: Ockenden Part 1a, developed 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 May 2024 is:

- **Ockenden Part 1a**: WHH is 100% compliant.
- **Ockenden 1b**: WHH is 100% compliant.
- **Ockenden 2**: WHH is 98.55% compliant. The remaining one amber action is in progress and will be completed by 31 August 2024.

8. MONITORING/REPORTING ROUTES

The contents of this report are reported via the Women's Health Governance meeting. Items for escalation are monitored at W&C CBU Governance meeting monthly.

9. ASSURANCE COMMITTEE

The contents of this report has previously been noted and discussed at Quality Assurance Committees on 11th June 2024 and 9th July 2024.

10. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/65 - Appendix 1**	
SUBJECT:	**Maternity Update – Ockenden Report**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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:

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:

The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the Ockenden recommendations are to ensure safer care for this cohort. Achieving the principles of Ockenden will have a positive impact on this group.

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 Quality Assurance Committee (QAC) oversight of the update with regards to Ockenden recommendations, and the report will also be noted at Trust Board.

	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 May 2024 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 100% compliant. • **Ockenden 2**: WHH is 98.55% compliant. The remaining one amber action is in progress.		
PURPOSE: ***(please select as appropriate)***	**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/24/07/79i	
	Date of meeting	9 July 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF	BM/24/08/65 Appendix 1

1. BACKGROUND/CONTEXT

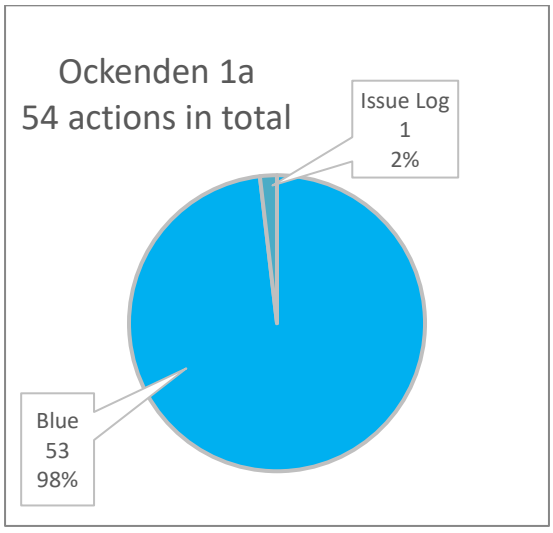
1.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report·

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

1.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

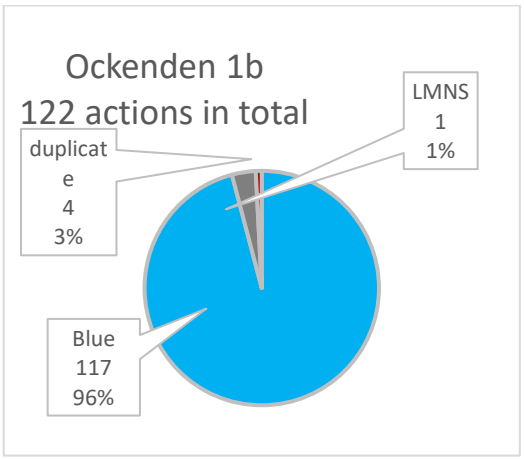
No change from previous month.

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

1.1.3 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

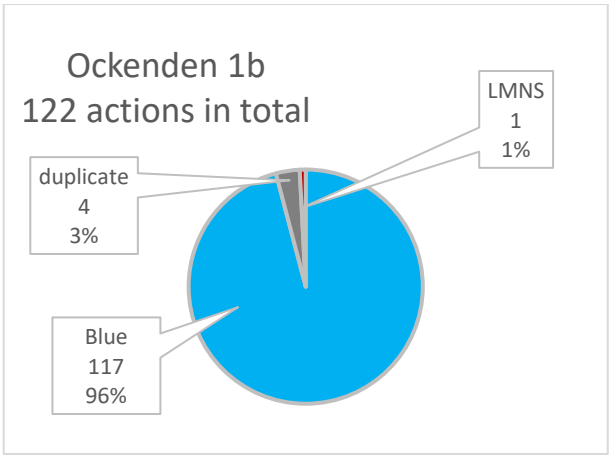
0 Outstanding Actions (previously 1)

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

1.1.4 WHH Compliance with Ockenden 2 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

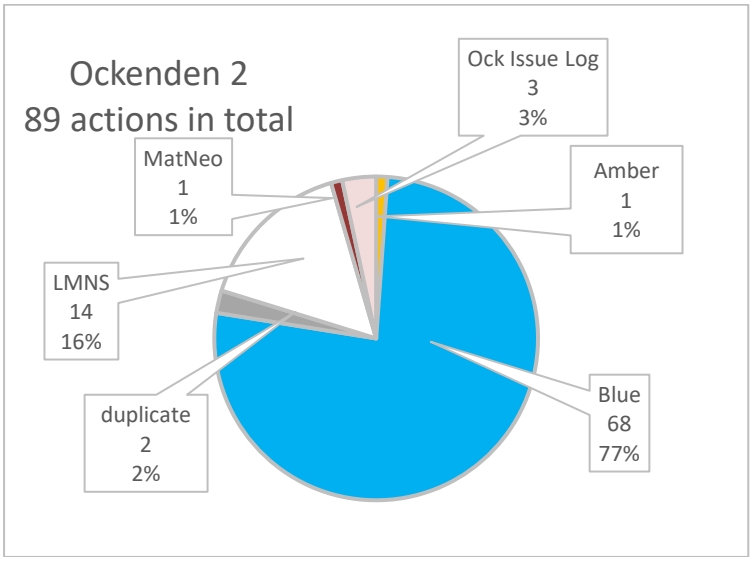


Update

0 Outstanding Actions (previously 1)

Excluding the 1 LMNS and 4 duplicate actions, Ockenden Part 1b action plan is 100% compliant.

Chart 3: WHH Ockenden 2 Compliance



1 Outstanding Action (previously 1)

1 Amber Action

Excluding the following 20 actions from the initial 89:

- 14 LMNS
- 2 duplicate actions
- 4 (including 1 MatNeo) transferred to an Ockenden Issues Log. These actions require further monitoring and some analysis of audit, and it was agreed to close on the A/P and transfer to an Ockenden Issues Log so that they remain under scrutiny.

The Ockenden 2 action plan is 98.55% compliant (68/69) at 31 May 2024 (no change from previously reported).

WHH Risks for Escalation

- None

a. Ockenden Summary

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

- Ockenden 1a Action Plan is 100% compliant.
- Ockenden 1b Action Plan is 100% compliant.
- Ockenden 2 Action Plan is 98.55% compliant.

One Ockenden action remains outstanding. This relates to a gap analysis of leadership roles amongst Specialist Midwives and Obstetric Consultants and the implementation of a workforce planning strategy. This work is underway in collaboration with colleagues from the People Directorate. The workforce planning

strategy will be shared with the Quadrumvirate and via Women's Health Governance in August 2024 for approval prior to this action being formally closed.

Four actions have been transferred to an Issues Log for continued monitoring.

2. 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 and Trust Board.

3. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 9th July 2024.

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/65 – Appendix 2**			
SUBJECT:	**Maternity Incentive Scheme Year 6 Update**			
DATE OF MEETING:	7 August 2024			
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah Chief Nurse			
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:***			
	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: The paper relates to care of /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 and year 6 will have a positive impact on this group.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and			

	brain injuries from the 2010 rate by 50% before the end of 2025. NHSR is now operating Year six of the Clinical Negligence Scheme for Trusts (CNST) MIS following publication of guidance on 2 April 2024. Conditions of eligibility for payment under the Scheme are set out in the guidance and a completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025. A quarterly MIS check-in point meeting took place on 31 May 2024 with the LMNS who were assured by our progress to date with both the ongoing action plans in relation to Saving Babies Lives care Bundle v3 (SBLCBv.3) and MIS Year 6.		
PURPOSE: ***(please select as appropriate)***	**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/24/07/79ii	
	Date of meeting	9 July 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Incentive Scheme Year 6 Update	AGENDA REF	BM/24/08/65 – Appendix 2

1. BACKGROUND/CONTEXT

NHS Resolution has now commenced year six of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2024. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2025.

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

2. CURRENT POSITION

2.1 Overall position

Successful achievement of all 10 Safety Actions for MIS Year 5 was published on 10 April 2024.

Guidance for the launch of MIS Year 6 was received on 2 April 2024. Meetings have been held with Leads for all 10 Safety Actions to review the required specifications for each action. Progress will be monitored on a monthly basis with leads and support will be available from the senior leadership team as and when required.

A meeting to launch MIS Year 6 was held on 29 April 2024, and a quarterly MIS check-in point meeting took place on 31 May 2024. The LMNS were assured by our progress to date.

2.2 Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the SBLCBv.3.

Following the latest quarterly meeting on 31st May 2024, LMNS is assured that WHH is on track with completion of all elements of this safety action and has assessed the 6 elements as follows:

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	40%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	25%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Not implemented	0%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Not implemented	0%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	4%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Not implemented	0%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	14%	Partially implemented	94%	CNST Met

Further evidence has now been uploaded to the external portal in line with the deadline of 7 June 2024 to demonstrate progress towards completion of all elements of SBLCBv.3. LMNS will assess this evidence again prior to the quarterly check-in meeting in September 2024.

Where full compliance has not yet been achieved, robust action plans are in place. As part of their assurance role, the LMNS are assessing overall compliance against the measures alongside evidence of sustainable improvement. The LMNS were assured by our plans and progress to date.

3. MONITORING/REPORTING ROUTES

Progress with the remaining aspect of MIS Year 5 (SBLCBv3), and MIS Year 6 is shared and discussed at CBU Governance meetings.

The content of this report was shared at Women's Health Governance in July 2024.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 9 July 2024.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/65 Appendix 3 i**	
SUBJECT:	Monthly Maternity & Neonatal Quality Update – April 2024	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
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:

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	√		

Further Information:

	Yes	No	N/A
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	√		

Further Information:

	Yes	No	N/A
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 and improving safety and outcomes for this cohort.

EXECUTIVE SUMMARY ***(KEY ISSUES):***

This paper provides an update in relation to maternity and neonatal quality and provides Quality Assurance Committee (QAC) with oversight of key matters to provide assurance to the Board on maternity and neonatal safety and quality issues. This information will be reported monthly to Quality Assurance Committee and Trust Board.

In particular:

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

There were three moderate harm events in April 2024. Two cases were within the maternity and neonatal services. Appropriate safety reviews have been completed and learning shared.
There was one severe harm event. This was not in the maternity or neonatal service. This case was a gynaecology case related to a patient lost to follow up. An ISR has been completed and a further MDT review of the case is planned.
Themes from maternity/neonatology patient safety events in March are as follows:

- Admission of term babies admitted to Neonatal Unit
- PPH >1500ml
- PPH >1000ml
- Postnatal readmission

A cluster review of all cases explored via the PMRT process where maternal diabetes was identified as a factor in the case has been completed. Some additional learning has been identified by the cluster review and will feed into the diabetes in pregnancy QI project.
At the end of April compliance for mandatory training across maternity and child health colleagues is 87.78% for Trust mandatory training (including safeguarding training), 87.79% for role specific training. Compliance with PDR completion remains a challenge but improving. Rates in April (including those with a long term absence) for maternity and child health services is 77.81%, an improved position from March 2024 when the rates was 71.38%.

Compliance with maternity specific mandatory training is excellent.

In collaboration with the Maternity and Neonatal Voices Partnership a CQC Maternity Survey action plan has been developed. This is included in Appendix 2 for approval.
Detailed results from the NHSE Perinatal Cultural Leadership Programme (PCLP) SCORE Cultural Survey has been received and explored with the team via a series of ‘Cultural Conversations.’ The insights/feedback from these conversations were shared with the Quad in a

	further feedback session with three key aspirations agreed: 1. Focus on kindness through building relationships, trust and understanding each others roles, responsibilities and pressures which will also support shared decision making. 2. Increase collaboration through improved teamwork across teams and specialisms. 3. Increase communication to gather ideas, help staff rise to the challenge, deal with change and foster inter role relationships. These aspirations will now form the basis for a PCLP action plan which is being drafted. Once agreed, this action plan will come to QAC for oversight. In April 2024 95% of attenders to Maternity Triage were seen within 15 minutes of arrival (best practice guidance), and 99% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Work is ongoing to ensure a sustainable staffing model for Maternity Triage. Two complaints were received in the CBU in March 2024. Neither related to care in the maternity and neonatal services. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**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/24/06/57iii	
	Date of meeting	11 June 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update	AGENDA REF	BM/24/08/65 Appendix 3 i

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the month April 2024.

The paper provides Quality Assurance Committee (QAC) 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 6 *(Safety action 9: Can you demonstrate that there is clear oversight 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

Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU in April 2024:

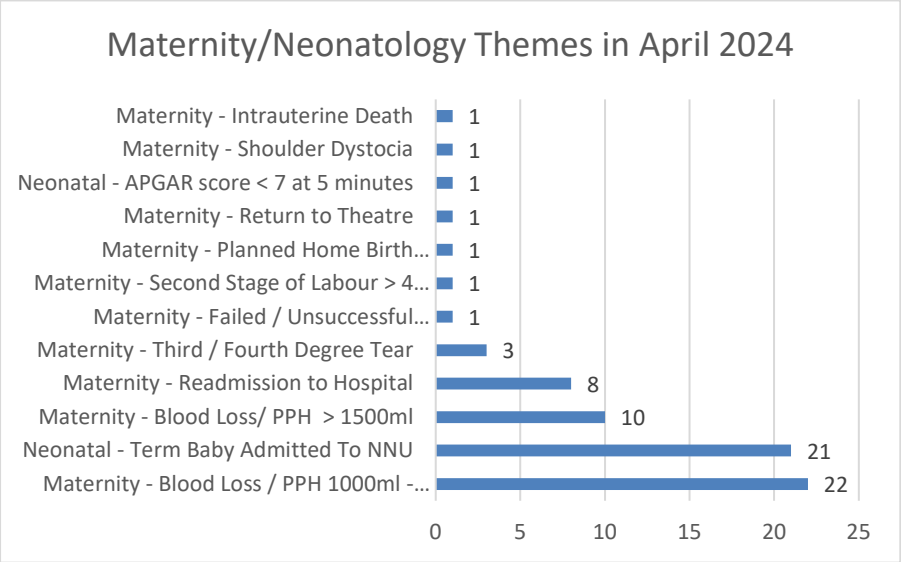
Severity	Mar 24	April 24
1 – No Harm	101	83
2 – Low Harm	23	52
3 – Moderate Harm	2	3
4 – Severe Harm	1	1
5 – Fatal	0	0
Total	127	139

There were three moderate harm events in April 2024. Two cases were within the maternity and neonatal services. One case related to a women who had undergone an initially uncomplicated caesarean but whose clinical picture deteriorated following transfer to the maternity ward. The woman was transferred back to Birth Suite where further assessments were completed including a bedside ultrasound. A further deterioration in the clinical picture was noted therefore the decision was made to transfer to maternity theatre. A peritoneal haematoma was identified and repaired. An ISR was completed and urgent learning identified. Actions from the ISR have been implemented and completed.

The second case was a 4th degree tear following vaginal birth. The case has been reviewed. There were no concerns regarding care from the review.

There was one severe harm event within the CBU. This was a gynaecological case related to a patient lost to follow up who has a new diagnosis of cancer. This case has had an ISR and will undergo an MDT review within the PSIRF framework.

Themes from maternity/neonatology patient safety events in April are detailed in the below:



There were 22 PPH >1000ml reported. This is a significant increase from March, however further exploration has highlighted not all these cases occurred in April. 12 cases were identified as part of a triangulation of BadgerNet and Datix data which had not been reported via Datix at the time of the event and were therefore reported retrospectively.

10 cases of PPH >1000ml occurred in April 2024. These cases have all been reviewed locally utilising the standardised proforma. No themes were identified.

The same disparity in numbers applies to term babies admitted to NNU. 16 cases occurred in April 2024 (not 21 as stated in the graph). Term babies being admitted to Neonatal Unit (NNU) is the most frequent patient safety event. All cases of term admission are reviewed via ATAIN which reports quarterly to QAC.

A reminder has been sent to all staff of those patient safety events which should be reported via Datix and the importance of timely reporting.

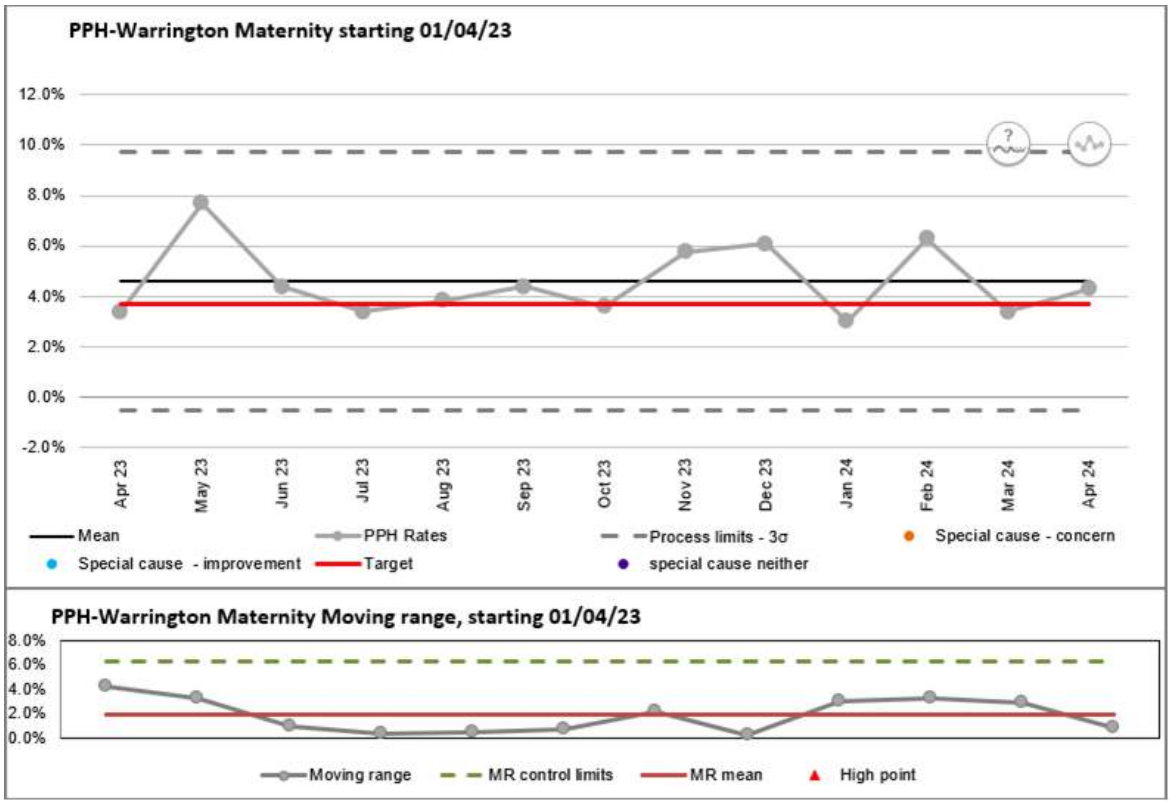
Eight postnatal readmissions were reported in April 2024. A new process for the review of postnatal readmissions was introduced in April 2024. All cases are reviewed by the Maternity Matron for antenatal & postnatal care, the Maternity Ward

manager and the CBU Governance lead using a specific readmission proforma to ascertain if the readmission was avoidable. Provisional data suggests, of the readmissions, one was deemed unavoidable as an earlier tissue viability review could have prevented a second postnatal readmission.

A quarterly cluster review of readmissions is also planned albeit it appears to date, the majority of these readmissions are unavoidable, i.e. PN wound infection but with appropriate post operative care, advice, timely antibiotics etc.

PPH >1500ml is another key theme. The SPC chart for PPH ≥1500mls shows no trend at present, the chart shows WHH mean rates at 4.85% which is above the target of 3.7% (based on historical regional data). QAC will be aware work around PPH is a current QI project within the maternity service. The PPH action plan is attached for information in Appendix 1. All cases of PPH ≥1500mls are reviewed via the MDT Intrapartum Review Group (IRG) to ensure any urgent learning is enacted as well as feeding into the PPH QI project.

The LMNS have also been contacted to ascertain whether more recent comparator data is available.



As referenced at previous Quality Assurance Committees two thematic (cluster) reviews have recently been instigated. The purpose of these two cluster reviews is to ensure the service has captured all learning from the events, as well as any wider system issues and themes which may not be identified when cases are reviewed in isolation.

The first cluster review explored all cases reviewed via the PMRT process where maternal diabetes was identified as a factor in the case. There were four cases within this cluster. Much of the learning identified as part of the cluster review was learning already identified via the ISR or PMRT review process. However the cluster review did identify some similarities in the history of the baby's mother:

- All women had pre-existing diabetes prior to pregnancy (rather than diagnosed in pregnancy).
- In all cases the mother had other health conditions in addition to the pregnancy (either related or unrelated to the diabetes).
- In all cases the mother had undergone a non-maternity inpatient stay in an acute setting during pregnancy either related to her diabetes or other non-pregnancy medical condition.
- In all cases there were challenges for the woman with accessing/maintaining compliance with the diabetes in pregnancy pathway.
- In all cases there appears to be a lack of a holistic approach from the midwifery team leading to a lack of a coordinated approach to care delivery.

This learning has been shared with the team leading the diabetes in pregnancy quality improvement project with some suggested actions. These will form part of the action plan which is being formulated..

The second analysis will review all cases referred to MNSI in 2023. In total there are seven cases within this cluster (all relating to babies transferred to another provider for cooling). This review is underway and the findings will be shared to August Quality Assurance Committee and via CBU governance processes.

3. WORKFORCE METRICS & MEASURES

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

At the end of April compliance for mandatory training across maternity and child health colleagues is 87.78% for Trust mandatory training (including safeguarding training), 87.79% for role specific training. This includes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge but improving. Rates in April (including those with a long term absence) for maternity and child health services is 77.81%, an improved position from March 2024 when the rates was 71.38%. An action plan remains in place.

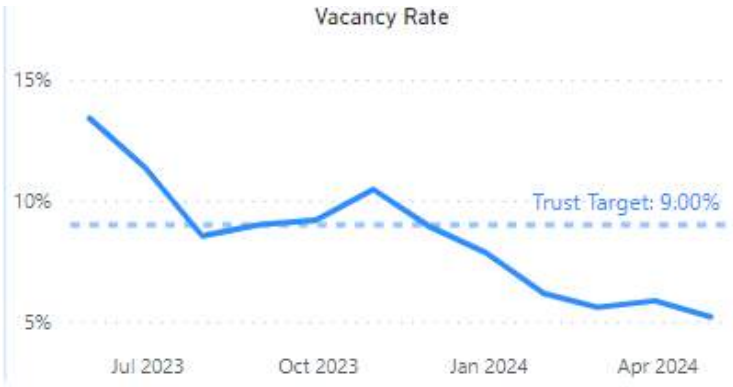
Compliance with maternity specific training is excellent:

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	97.6%	96.7%	92.8%	96.1%	53.2%
Obstetric Consultants	100%	100%	88.9%*	n/a	n/a
Other Obstetric	100%	100%	90.9	n/a	n/a
Obs Anaesthetic Consultants	96%	n/a		n/a	n/a
Maternity Support Workers	95.8%	n/a		n/a	21.7%

*new training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track

Turnover for maternity and child health staff (permanent staff) has reduced to 9.94% and remains below the Trust target. Turnover has remained below the Trust target of 13% since December 2023. This is illustrated in the graph below:

The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 5.2% in April 2024. This is illustrated in the graph below:



At the end of April 2024, the vacancy rate for registered midwives was 4.01% an improvement from the position in March 2024.

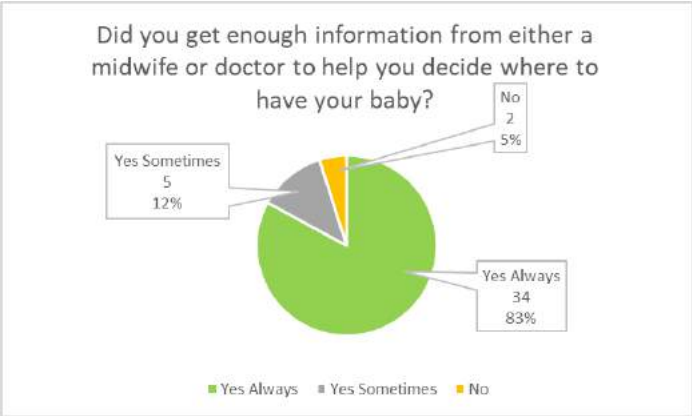
4. SERVICE USER FEEDBACK

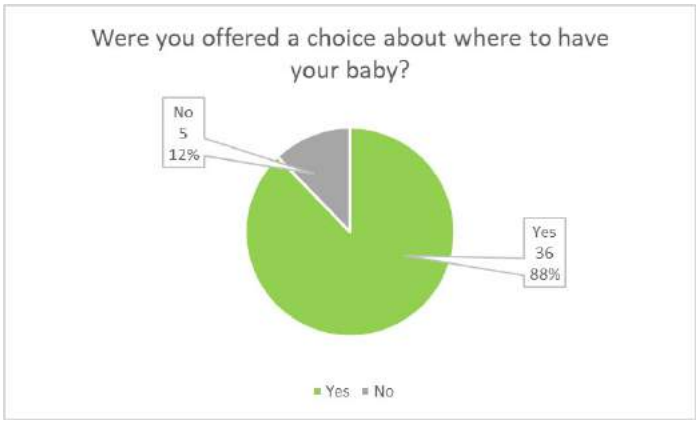
As reported to QAC in April, the results of the NHS Maternity Services Survey 2023 have been received.

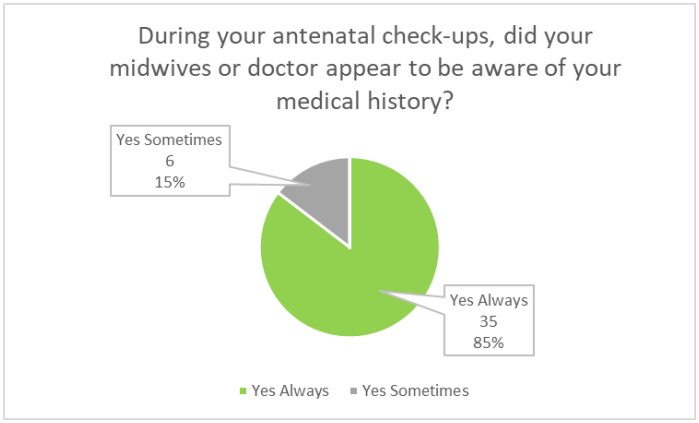
To further explore the findings of the report a hotspot audit of experience was completed to ascertain current position in relation to those areas of concern, specifically:

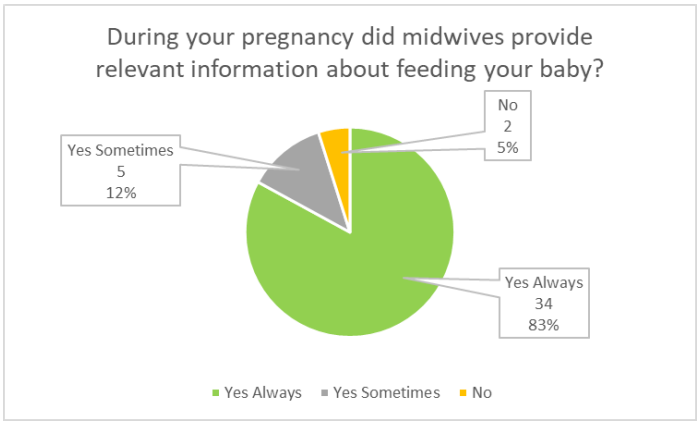
- Were you offered a choice about where to have your baby?
- Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
- During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?
- During your pregnancy did midwives provide relevant information about feeding your baby?
- Did you have confidence and trust in the staff caring for you during your antenatal care?
- On the day you left hospital, was your discharge delayed for any reason? (recognising the changes and service improvements within the maternity service since February 2023)

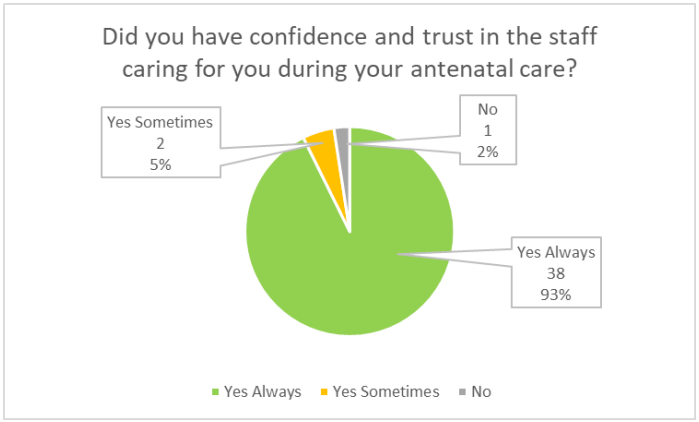
41 anonymous responses were received and outcomes are detailed below:

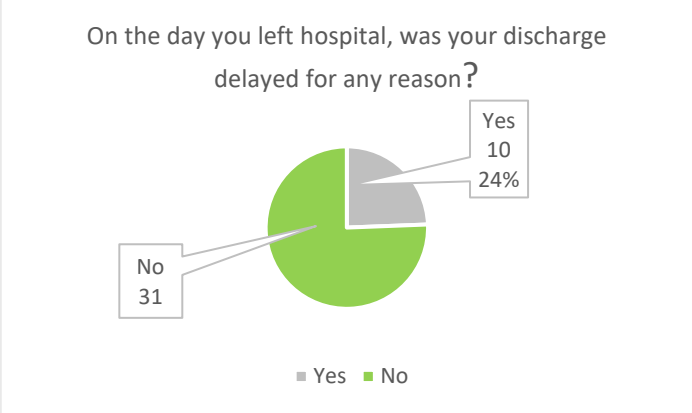



Were you offered a choice about where to have your baby?
No
5
12%
Yes
36
88%
Yes
No


During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?
Yes Sometimes
6
15%
Yes Always
35
85%
Yes Always
Yes Sometimes


During your pregnancy did midwives provide relevant information about feeding your baby?
No
2
5%
Yes Sometimes
5
12%
Yes Always
34
83%
Yes Always
Yes Sometimes
No


Did you have confidence and trust in the staff caring for you during your antenatal care?
Yes Sometimes
2
5%
No
1
2%
Yes Always
38
93%
Yes Always
Yes Sometimes
No



The feedback from the hotspot questionnaires has been considered alongside a more detailed review of the survey, from which a number of priorities have been identified. These priorities also reflect the wider national maternity agenda.

Priority	Justification
Effective discharge processes from the maternity ward including improved processes around take-home medication and timely medical review	Deteriorating position and remains an issue following hotspot survey
Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby	Deteriorating position, hotspot survey shows 12% of women were not offered a choice and personalised care is nationally a key area for improvement
Ensuring those who have care are involved in decisions about their care including decisions to be induced	Reduced position, 2023 v 2022 and personalised care is nationally a key area for improvement
Provision of relevant information about feeding baby during the antenatal period	Deteriorating position, remains an issue in hotspot survey, links with wider population health partnership workstreams
Explore why respondents did not have confidence and trust in the staff providing care during labour and birth	No improvement in position over time
Measures implemented to ensure relevant/appropriate information or explanations provided in the postnatal period	Deteriorating position and no improvement over time

In collaboration with the Maternity and Neonatal Voices Partnership a CQC Maternity Survey action plan has been developed. This is included in Appendix 2 for approval. Once the action plan has been approved by Quality Assurance Committee it will be submitted to the LMNS for external assurance in prior to their deadline of 30th June 2024.

5. STAFF FEEDBACK

Members of QAC will be aware the maternity and neonatal service have been undertaking the NHSE Perinatal Cultural Leadership Programme (PCLP). As part of this a SCORE Cultural Survey has been completed.

Details results were received in March 2024 and shared with the CBU Quadrumivirate ('Quad'). The detailed results are included in Appendix 3. An externally facilitated session was then completed to explore the detailed findings and to identify areas for further exploration with the maternity and neonatal team via a series of "cultural conversations".

It was agreed the following areas would be expolored:

1. Burnout – why do others seem burnt out? What can we do to address burn out? What is working and more can be done? How can we improve work/life balance?

2. Teamwork – who is in your team? What are the challenges? How can communication be improved – cross departments, between specialties? What would be the best methods? How do you wish to receive positive feedback, what would you like to see in terms of time and availability of leaders?

3. Emotional Recovery/Resilience – what can we do to improve mood, recovering from setbacks and a more positive outlook? What can you personally do?

4. Decision Making – what would this ideally look like? What solutions/ideas do you suggest that would increase your influence on decisions? Are they going straight to leaders and leap frogging their supervisors? What would improve first level leadership?

In total eight cultural conversations were held with representation from all matenrity and neonatal teams and representation across all roles.

The insights/feedback from these sessions were shared with the Quad in a further feedback session with three key aspirations agreed:

1. Focus on kindness through building relationships, trust and understanding each others roles, responsibilities and pressures which will also support shared decision making.

2. Increase collaboration through improved teamwork across teams and specialisms.

3. Increase communication to gather ideas, help staff rise to the challenge, deal with change and foster inter role relationships.

These aspirations will now form the basis for a PCLP action plan which is being drafted. Once agreed, this action plan will come to QAC for oversight.

6. MATERNITY TRIAGE

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

Current performance

- In April 2024 576 triage attendances were recorded on the BadgerNet patient record system.
- 21.2% attendees were seen immediately on arrival.
- The longest wait recorded for initial review was 32 minutes.
- 95% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes and an improved position from January-March 2024.
- 99% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes.
- 1% of attendees were categorised as red on arrival. Appropriate ongoing care was provided in all cases.
- 22% of attendees were categorised orange on arrival, this is on a par with March 2024 and an increase from January and February, 18% and 17.7% respectively.

Activity in place to support a safe service

- A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require a reduced investment of £278,645. This paper has been presented to Executive Board who have requested further information. An updated paper is being prepared and will be submitted in early June.
- To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour (IOL) pathways.

Most recent data from the LMNS (provided below) suggest WHH does not perform well with regard to timeliness of IOL activity when compared to other local providers:

- The data below reports the **total number of delays by week by Provider** from **1st to 30th April.**

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total	% of Total
01/04/2024	3	4			9	14	4	34	29.57%
08/04/2024		2			3	10	5	20	17.39%
15/04/2024		14	3	1	2	9	13	42	36.52%
22/04/2024		1	1	1	6		9	18	15.65%
29/04/2024					0	1		1	0.87%
Grand Total	3	21	4	2	20	34	31	115	100.00%
% of Total	2.61%	18.26%	3.48%	1.74%	17.39%	29.57%	26.96%	100.00%	

The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 30th April**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	32	126	45	49	127	62	75	516
Total Delayed	3	21	4	2	20	34	31	115
% of Total	9.38%	16.67%	8.89%	4.08%	15.75%	54.84%	41.33%	22.29%

When reasons for delay in IOL are explored, it almost always relates to safe staffing. A deep dive is already underway to further review all workforce and acuity related data and metrics to understand why there continue to be staffing challenges within the maternity service despite the significant improvement in vacancy rates amongst registered colleagues. The IOL task and finish group have also been asked to explore other contributory factors in more detail and will report into QAC via this monthly report moving forward.

Initial learning has identified this is multi-faceted albeit, prioritising safe staffing of Maternity Triage is a feature. The deep dive will report to a future QAC and Strategic People Committee.

The audit of timeliness of medical review in Maternity Triage was reported to QAC in April and identified some challenges. Initially this audit was to be presented to Joint Maternity, Obstetrics, Gynaecology and Children's Health Clinical Audit meeting on the 10th May 2024. This was deferred and will instead be discussed at the next Women's Health audit meeting. In the interim the Triage team are aware of the importance of timely escalation of delays via both the red flag system and maternity bleep holder to ensure the continued safety of the service.

Next Steps (January – June 2024)

- Maternity Triage task and finish group in place.
- Shift leader for triage to be identified from next roster to support oversight and effective escalation processes
- Action plan to improve timeliness of medical reviews to be agreed and implemented.

- Implementation of new staffing model
- Telephone triage to be moved from the clinical triage area, this will be dependent on the new staffing model being implemented.
- Telephone system to be upgraded

The Triage Task & Finish group will continue to work with the team to optimise the service and continue to improve performance.

7. COMPLAINTS

Two complaints were received in the CBU in April 2024, these did not relate to care within the maternity and neonatal services.

8. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

9. MONITORING/REPORTING ROUTES

The monthly review of matters relating 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 11th June 2024.

11. RECOMMENDATIONS

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

Appendix One – PPH QI Project Action Plan

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Action	Owner	Progress Report	RAG
Action- 25.10.23			
Register as QI	CH/AC	Complete- 8.11.23	
Monthly Audit	CH/CB/AC	Not yet set up need to benchmark. KF to link in with MG ahead of next meeting 15.11.23- MG and KF are meeting to finalise audit dataset. Information from the team has been sent ready to finalise the audit and to link in with QI team 22.11.23- Dataset now complete	
PPH Guideline	KF/RA	Updated now circulating and out for comments ahead of governance-22.11.23- CBU on Friday 20.12.23- Now on Hub	
Cluster review/ identifying themes/ IPGR	LD/CH/AC	Ongoing	
To invite a member of the QI team to the group	MG	Complete 8.11.23	
To liaise with KJ for digital proforma update	KF	Complete 8.11.23	
Actions - 8.11.23			
Walk through of PPH- Room/theatre	AC/CH/VM/SD	15.11.23- Update- Amelia to set up with QI team next week. 20.12.23- Unable to set date with QI team- To meet in the new year 27.2.24- Walk through of PPH in room to theatre complete. OI team will send an updated presentation of next steps	
PPH Simulation in theatre	AC/JF	15.11.23-carried over to next meeting 20.12.23- Awaiting date from RC. 27.2.24 PPH SIM stepped down this week due to acuity on the ward. Re-booked for next week 13.3.24-PPH Simulation stepped down due to ward acuity to re-book 27.3.34-Meeting stepped down. PEF has re-booked SIM beginning of April- 24.4.24- PPH SIM will be completed before the next meeting. 26.4.24-Sim complete	
Process mapping support from QI team at next meeting	VM/SD	15.11.23- Unable to map until data set/audit finalised 31.1.24- 1st process map complete	
To share learning from most recent thematic review- Documentation/recognition of loss in theatre	CB/CH/	To include in all safety briefs. 15.11.23- Safety brief will be updated at the end of the month	

Actions - 15.11.23			
KF to ensure that PPH guideline has been re-circulated with added comments	KF		
KF to set meetings to Bi-weekly	KF		
Actions- 22.11.23			
Data Analysis MDT meeting TBA	KF/MG/CH/AC	**20.12.23 Data analysis has now been sent to AK/CB to present at QAC in January. Currently data analysis is in progress.**	
Actions- 20.12.23			
KJ- To include on Badger newsletter an issue that was raised in Prompt. PPH proforma completion will save even if baby not yet admitted.	KJ	**To include in newsletter**	
AC- To ensure theatre algorithm of recognition escalation is in view of staff	AC		
KF- To liaise with RA/CB as to surgeon responsibility of escalating loss.	KF	**No reply from e-mail- for update next week- 13.3.34 - Update from CB - Part of the ongoing QI - recognition.**	
Actions-31.1.24			
AC to invite team to theatre SIM next wed	AC	**28.2.24 -SIM not completed due to ward acuity- Team where invited.**	
Next PPH group meeting to process map another walk through- Kim to book the croft	KF	**28.2.24- Walk through complete**	
Actions- 28.2.24			
Process mapping of walk through (completed today)- Book croft for next meeting	KF/QI	**13.3.24-Process mapping now complete for elective c-section**	
Actions-13.3.24			
Walk through of PPH- Room/theatre (completed)- Process mapping in croft for next meeting	QI Team	**Process mapping at next meeting. 27.3.24- Meeting stepped down due to acuity and no availability of a Consultant Obstetrician. 10.4.24- Process mapping completed. completed the process mapping process and are now due to pull the themes from these and begin the Fishbone diagram process to start the problem analysis component at next meeting- 15.5.24**	
Actions-10.4.24			
PPH SIM to be completed this month	QI Team	SIM Completed by team - 26.4.24-See report.	
Action-15.5.24			
Fishbone analysis	QI Team	Started. Awaiting updated slide dec from QI team-E-mail re-sent 3.6.24	
Actions- 3.6.24			
KF now part of the regional team to develop a regional PPH guideline	KF	24.5.24- Had a discussion with regional team- Andrew Weeks Consultant Obstetrician leading. Local guidelines shared	

Appendix Two – CQC Maternity Survey action plan

CQC MATERNITY SURVEY PUBLISHED MARCH 2024

RAG	
Red	not compliant
Amber	partial compliance - work underway
Green	Full compliance - evidence not yet received
Blue	Full compliance - evidence received

No	Recommendation	Action Required	Lead	Name	Initial due date
CQC001a	Effective discharge processes from the maternity ward including improved processes around take-home medication and timely medical review	Qualitative explanation via MNVP partners of experience of discharge from the ward in the last 6 months - Dec23-May24	MNVP Chair	L Welch	31/08/2024
CQC001b	Effective discharge processes from the maternity ward including improved processes around take-home medication and timely medical review	Speak to Engagement and Involvement Officer, to link with Patients by Experience and request if possible for them to provide focus groups to explore reasons for delayed discharge.	Consultant Midwife	S Nuttie	31/08/2024
CQC001d	Effective discharge processes from the maternity ward including improved processes around take-home medication and timely medical review	Review of maternity red flags to: *quantify the number of delayed discharge due to a delay in medical review *identify issue causing delayed medical review *agree further actions to reduce delays	Antenatal and Postnatal Services Matron	S Emery	31/07/2024

CQC002a	*Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby. *Ensuring those who have care are involved in decisions about their care including decisions to be induced	Provide data from BadgerNet relating to Personalised Care Plans for births over a 4 month period, Jan-April 24	Compliance & Improvement Manager	M Armstrong	30/06/2024
CQC002b	*Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby. *Ensuring those who have care are involved in decisions about their care including decisions to be induced	Undertake a survey to understand disparity between CQC Survey response and BadgerNet data and agree next steps for improvement measures.	MNVP Chair	L Welch	31/08/2024
CQC002c	*Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby. *Ensuring those who have care are involved in decisions about their care including decisions to be induced	Parent education implemented end of March 2024 and all women offered sessions from 34/40. *Ensure the last session of antenatal education includes a tour of the maternity unit and different birth settings: -MLC rooms on birth suite -Nest -Labour rooms on birth suite -IOL suite	Antenatal and Postnatal Services Matron	S Emery	31/07/2024

CQC002d	*Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby. *Ensuring those who have care are involved in decisions about their care including decisions to be induced	Parent education implemented end of March 2024 and all women offered sessions from 34/40. *Evaluate the parent education programme 3 months from commencement July 2024 and October 2024 from feedback questionnaires and identify areas for improvement.	Antenatal and Postnatal Services Matron	S Emery	30/11/2024
CQC002e	*Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby. *Ensuring those who have care are involved in decisions about their care including decisions to be induced	Senior Midwifery team to attend medical Senior Staff meeting to present triangulated findings from complaints, PALS, debrief and patient safety events in relation to consent, communication and involvement in decision making	Intrapartum Matron	Kim Farrell	30/09/2024
CQC002f	*Implementation of further measures to ensure all women/families are aware of birth options and have been supported in discussions about where to have their baby. *Ensuring those who have care are involved in decisions about their care including decisions to be induced	Develop conversation support cards (i.e.. VBAC, Prev PPH, IOL) to be used as tools to support discussions around birth choices, to empower midwives to promote informed choice and individualised birth planning.	Consultant Midwife	S Nuttie	31/01/2025
CQC003a	Provision of relevant information about feeding baby during the antenatal period	Review antenatal information about feeding baby (include Infant Feeding Specialist Midwife) and explore options to make improvements e.g. Add feeding slides to the Parent Education slides, signposting women so they are aware who to contact for further information.	Antenatal and Postnatal Services Matron	S Emery	31/07/2024

CQC003b	Provision of relevant information about feeding baby during the antenatal period	Contact Elle Gregson, Health Improvement Specialist, Halton Borough Council, for feedback and ideas to make improvements.	Antenatal and Postnatal Services Matron	S Emery	30/06/2024
CQC004a	Explore why respondents did not have confidence and trust in the staff providing care during labour and birth	Undertake a Hotspot survey to identify and understand the reasons for not having confidence and trust in the staff providing care during labour and birth.	Consultant Midwife	S Nuttie	31/08/2024
CQC005a	Measures implemented to ensure relevant/appropriate information or explanations provided in the postnatal period	Work with MNVP Chair to develop a Circle of Care toolkit to ensure women and families understand everyone who is involved in looking after their care - using same language as BadgerNet.	Consultant Midwife	S Nuttie	31/12/2024
CQC005b	Measures implemented to ensure relevant/appropriate information or explanations provided in the postnatal period	*Establish a Workstream with the health visiting team in relation to family hubs and the 'best start for life'. *Develop an offer of care from pre-conception to two years old – to include all services offered and how to access *Members of this workstream to ensure information and signposting of services is shared and women in the postnatal period.	Antenatal and Postnatal Services Matron	S Emery	31/08/2024
CQC005c	Measures implemented to ensure relevant/appropriate information or explanations provided in the postnatal period	Work with partners to develop pathways and consistent signposting for fathers to secondary support services e.g. fatherhood institute or Dads Matters	Consultant Midwife	S Nuttie	31/03/2025

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/65 3 ii**	
SUBJECT:	Monthly Maternity & Neonatal Quality Update - May 2024	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
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:

	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 and improving safety and outcomes for this cohort.			

EXECUTIVE SUMMARY ***(KEY ISSUES):***

This paper provides an update in relation to maternity and neonatal quality and provides Quality Assurance Committee (QAC) with oversight of key matters to provide assurance to the Board on maternity and neonatal safety and quality issues. This information will be reported monthly to Quality Assurance Committee and Trust Board.

In particular:

- Harm Incidents
- Workforce Metrics including training compliance
- Service user feedback

	• Staff feedback • Complaints • Coroner Regulation 28 position There were no moderate, severe or fatal harm events in May 2024. Themes from maternity/neonatology patient safety events in May are as follows: • Admission of term babies admitted to Neonatal Unit • PPH >1000ml • Postnatal readmission At the end of May compliance for Trust mandatory training across maternity and child health colleagues is 88.83% for Trust mandatory training (including safeguarding training), 87.10% for role specific training. Compliance with PDR completion is improving. A Maternity Safety Champion Walkaround took place on 11th June 2024 with a focus on Birth Suite including the new induction of labour facility. Feedback was positive with no concerns to escalate. Individual feedback from families is included. In May 92% of attenders to Maternity Triage were seen within 15 minutes of arrival (best practice guidance). 98% of attenders were seen within less than 30 minutes of arrival (NICE guidance). For both measures the service is meeting agreed KPIs. Work is ongoing to ensure a sustainable staffing model for Maternity Triage. May data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well with regard to timeliness of induction of labour (IOL) activity when compared to other local providers. A task and finish group is in place which will focus on IOL delays alongside wider work in relation to experience of IOL pathways. Six complaints were received in the CBU in May 2024. Three related to care in the maternity and neonatal services. No Regulation 28 enquiries have been received.

PURPOSE: ***(please select as appropriate)***	**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/24/07/79 iii	
	Date of meeting	9 July 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update - May 2024	AGENDA REF	BM/24/08/65 Appendix 3 ii

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the month May 2024.

The paper provides Quality Assurance Committee (QAC) 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 6 *(Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?)* alongside emerging local and regional matters.

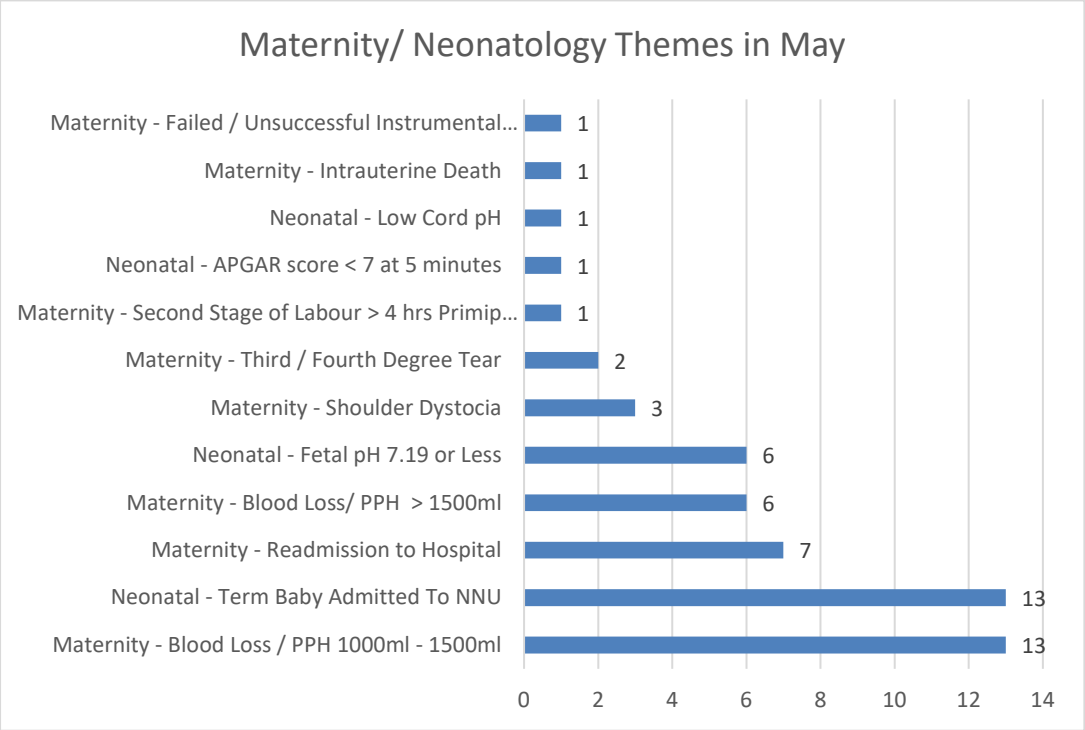
2. HARM INCIDENTS

Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU in May 2024:

Severity	April 24	May 24
1 – No Harm	83	102
2 – Low Harm	52	39
3 – Moderate Harm	3	0
4 – Severe Harm	1	0
5 – Fatal	0	0
Total	139	141

There were no moderate or severe harm events in May 2024.

Themes from maternity/neonatology patient safety events in May are detailed in the below:



There were 13 post-partum haemorrhage (PPH) >1000ml -1500ml reported. These cases have all been reviewed locally utilising the standardised proforma.

Work in relation to reduction of PPH is a key WHH workstream, with reduction in PPH ≥1500ml a formal QI project. The QI project team is progressing well through the 5 Essentials of Continuous Quality Improvement and the recommended methodology. Process mapping for emergent and elective caesarean sections and vaginal delivery have been completed, as has an incident 'walk and talk' through, with waste analysis completed as a result.

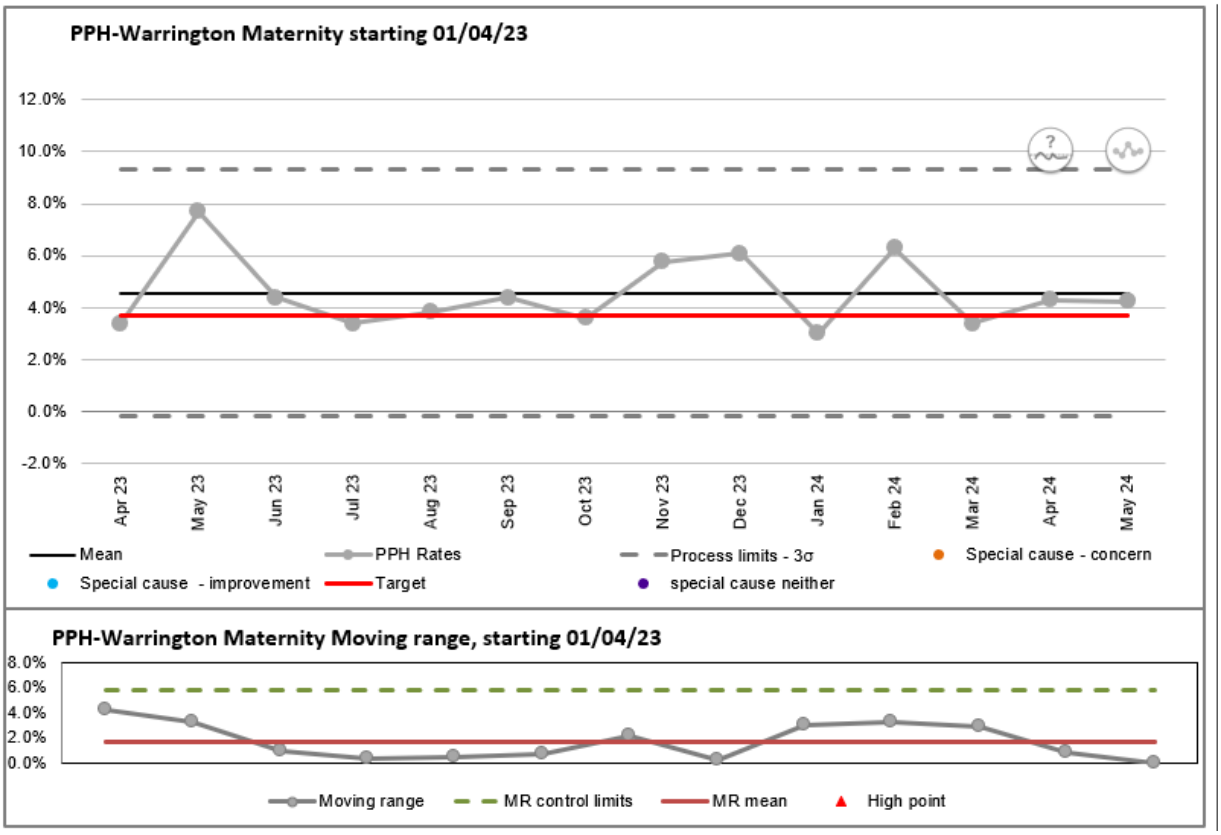
Work is ongoing with the fishbone analysis and a family of measures have been agreed. The data collection plan will be constructed in the next group meeting.

Alongside the QI project, all cases of PPH ≥1500mls are reviewed via the MDT Intrapartum Review Group (IRG). Learning identified as part of the local review of PPH 1000mls-1500mls reflects the learning identified through the more formal IRG process

There were six cases of PPH ≥1500ml in May 2024. The SPC chart for PPH ≥1500mls shows no trend at present, the chart shows rates for May 2024 at 4.25% which is above the target of 3.7% (based on historical regional data).

13 term babies were admitted to the neonatal unit (NNU). This is a reduction from April when there were 16 cases. All cases of term admission are reviewed via ATAIN which reports quarterly to QAC.

Seven postnatal readmissions were reported in May 2024. As presented to June QAC a new process for the review of postnatal readmissions was introduced in April 2024 to ensure all learning and areas for improvement are identified. A quarterly cluster review of readmissions is underway and will report to August QAC.



3. WORKFORCE METRICS & MEASURES

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

At the end of May compliance for Trust mandatory training across maternity and child health colleagues is 88.83% for Trust mandatory training (including safeguarding training), 87.10% for role specific training. This includes staff who are currently absent from work on a long term basis.

Compliance with PDR completion remains a challenge but improving. Rates in May (including those with a long term absence) for maternity and child health services is 79.39%, an improved position from April 2024 when the rates was 77.81%. An action plan remains in place.

Compliance with maternity specific training is excellent:

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	97.6%	96.7%	92%	96.1%	53.2%
Obstetric Consultants	100%	100%	88.9%	n/a	n/a
Other Obstetric	100%	100%	90.9	n/a	n/a
Obs Anaesthetic Consultants	96%	n/a		n/a	n/a
Maternity Support Workers	95.8%	n/a		n/a	16.6%

*new training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track

Turnover for maternity and child health staff (permanent staff) has increased to 10.49% and remains below the Trust target. Turnover has remained below the Trust target of 13% since December 2023. This is illustrated in the graph below:

The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 5.2% in April 2024. This is illustrated in the graph below:

At the end of May 2024, the vacancy rate for registered midwives was 2.15% a continued improvement from the position in March and April 2024.

4. SERVICE USER FEEDBACK

The maternity service has recently responded to two PALS concerns regarding the experience of families within the induction of labour pathway. This correlates both with learning from debriefs where experience of IOL has been noted as an area for improvement and the findings of the most recent CQC maternity survey. This learning alongside the PALS feedback will inform the work of the IOL task and finish group referenced in section 7.

Individual feedback from families has been received as follows:

"Good morning, I am the husband of Charlotte, one of the patients of your midwives who recently last week was discharged, I just wanted to thank CM specifically and the midwives for their help they gave us. My wife has been struggling after her C-section and I have been the primary carer of her and our now 3 children, I work in the Royal Navy based in Portsmouth and was being recalled on Sunday, but due to the effort of CM and the evidence she gave of Charlotte's wound infection and her inability to manage by herself I was able to liaise with Royal Navy welfare and get the time off I needed which without Caroline would not have been possible. I cannot recommend her professionalism and compassion enough. Thank you so much Caroline."

"I am emailing you to say a very heartfelt thank you to you and the team who cared for Jess and her partner, my stepson in April of this year. Your team were wonderful. I am under no illusion of the effort, commitment, and dedication of those who were involved. DG did on call after working and stayed with Jess till after she birthed Mabel. LD also stayed beyond her shift to support Jess too. LL undertook all of Jess's antenatal care and postnatal care once she moved to Warrington and was manager of the day when Jess went into labour, LL's care and support was invaluable. The ward staff on C23 were excellent too. All of this contributed to a very positive experience and outcome which is all anyone ever wants. It was a superb team effort. The kindness and care given to my family was exceptional and I will be forever grateful. Thank you are two small words, however as I write this, they mean a great deal."

5. STAFF FEEDBACK

A Maternity Safety Champion Walkaround took place on 11th June 2024 with a focus on Birth Suite including the new induction of labour facility.

Feedback from Birth Suite staff was both constructive and positive. The team acknowledged the unit had experienced some difficult times in the relatively recent past ("last couple of years") but noted the unit feels much better, staff articulated their "love" for working in the unit and at WHH. The team also noted they feel very supported by the leadership team (Matrons etc) and by the medical staff. They shared their pride in working as part of a great team within which everyone pulls together to support each other and the families who choose to birth at WHH.

Individual feedback from Team River midwife:

"As you are all aware, I have been involved in the very complex case for a lady at Arbury Court. The last few months have been challenging to say the least, however yesterday all our hard work paid off.

The robust birth plan that was in place went without a hitch and was thanks to the amazing support received from our team, including ST and AC. Working closely with the staff at Arbury Court, we were able to put a birth plan in place that ensured the safety of our patient, her baby and all staff involved in her care.

I honestly cannot thank everyone enough for their support. Yesterday I was able to fulfil my role as "birth partner" which enabled me to support KJ spending precious time with her baby and make memories, which I'm sure will help in her recovery journey.

Everyone involved in her care demonstrated kindness and compassion. The theatre team were brilliant, patient and understanding, which all contributed to a positive birth experience.

I'm off on annual leave but had to say a massive thankyou to everyone involved, including my amazing Team River, Birth Suite, Obstetrics, Sonographers - EVERYONE !

I am very proud to be part of our team 💙"

6. MATERNITY TRIAGE

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

Current performance

In May 2024 590 triage attendances were recorded on the BadgerNet patient record system. This reflects the continued increase in Triage attendance since the beginning of 2024:

Triage attendances Dec 23 - May 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0

- 12.2% attendees were seen immediately on arrival.
- The longest wait recorded for initial review was 65 minutes, this was due to high acuity

- 92% of attenders were seen within 15 minutes of arrival (best practice guidance), this is beyond the KPI of 90% review within 15 minutes.
- 98% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes.
- 0.4% of attendees were categorised as red on arrival. Appropriate ongoing care was provided in all cases.
- 16.5% of attendees were categorised orange on arrival, this is a reduction from previous months.

Activity in place to support a safe service

- A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Following the implementation of a number of other measures, an updated staffing model has been prepared which would require a reduced investment of £278,645. This paper has been presented to Executive Board who have requested further information. An updated paper has been drafted and is under review.
- To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour (IOL) pathways.

The audit of timeliness of medical review in Maternity Triage was reported to QAC in April and identified some challenges. The audit was presented to the Women's Health audit meeting in June 2024. The following key actions were agreed:

- Share BSOTS presentation with all doctors on call
- Explore potential for having separate doctors covering Triage and Antenatal Day Unit (ANDU) during the day – suggestion of two registrars if possible
- Plan for handover times to prevent delay in doctor's review if required in Triage/ANDU
- Identify if additional IT hardware required to expedite the review process
- Reaudit to be undertaken to include the times when delays are occurring to establish any themes

Whilst these actions are implemented, the Triage team are aware of the importance of timely escalation of delays via both the red flag system and maternity bleep holder to ensure the continued safety of the service.

The Triage Task & Finish group will continue to work with the team to optimise the service and improve performance.

7. INDUCTION OF LABOUR

At April QAC the position of the maternity service in relation to induction of labour (IOL) pathways and particularly the number of IOL delays was noted. As a result, it was agreed the IOL position would be reported monthly to QAC to ensure appropriate oversight.

May data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers:

- The data below reports the **total number of delays by week by Provider** from **1st to 31st May**

Week Commencing	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total	% of Total
29/04/2024	2			9	3	4	1	19	19.00%
06/05/2024		6	1	0	5	1	3	16	16.00%
13/05/2024	2		6	1	3	8	12	32	32.00%
20/05/2024	2		7	2	3	5	1	20	20.00%
27/05/2024	1				4	7	1	13	13.00%
Grand Total	7	6	14	12	18	25	18	100	100.00%
% of Total	7.00%	6.00%	14.00%	12.00%	18.00%	25.00%	18.00%	100.00%	

- The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 31st May**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	31	127	60	48	128	83	71	548
Total Delayed	7	6	14	12	18	25	18	100
% of Total	22.58%	4.72%	23.33%	25.00%	14.06%	30.12%	25.35%	18.25%

The IOL task and finish group have taken IOL delays as a key area of focus and an action plan is being developed to improve IOL pathways and the experience of families.

8. COMPLAINTS

Six complaints were received in the CBU in May 2024. Three complaints related to care within the maternity and neonatal services as follows:

Specialty	Description	Complaint Opened	Current Stage
Maternity	Traumatic birth 8 years ago for which the complainant had a debrief meeting at the time. Has since read a CQC report which has raised 2 questions - complainant would like further clarification on these questions.	13/05/24 (reopened complaint)	In DRAFT
Maternity	Patient was discharged with retained products which required the patient to be re-admitted to hospital to have it surgically removed. Patient also has concerns relating to the consultants' attitude and refusal to investigate concerns raised by the midwife.	15/05/24	In progress

Maternity	Patient attended Maternity Triage due to reduced fetal movements at 37 +6. Felt dismissed by the Consultant. Following USS the following day, patient attended to triage again and was admitted for emergency c-section. Baby was found to have cord wrapped around neck 4 times and patient feels this could have been a different outcome had she not gone back to triage/pushed for USS	28/05/24	In progress

9. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

10. MONITORING/REPORTING ROUTES

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

11. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committees on 9th July 2024.

12. RECOMMENDATIONS

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

Appendix One – PPH QI Project Action Plan

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Action	Owner	Progress Report	RAG
Action- 25.10.23			
Register as QI	CH/AC	Complete- 8.11.23	
Monthly Audit	CH/CB/AC	Not yet set up need to benchmark. KF to link in with MG ahead of next meeting 15.11.23- MG and KF are meeting to finalise audit dataset. Information from the team has been sent ready to finalise the audit and to link in with QI team 22.11.23- Dataset now complete	
PPH Guideline	KF/RA	Updated now circulating and out for comments ahead of governance-22.11.23- CBU on Friday 20.12.23- Now on Hub	
Cluster review/ identifying themes/ IPGR	LD/CH/AC	Ongoing	
To invite a member of the QI team to the group	MG	Complete 8.11.23	
To liaise with KJ for digital proforma update	KF	Complete 8.11.23	
Actions - 8.11.23			
Walk through of PPH- Room/theatre	AC/CH/VM/ SD	15.11.23- Update- Amelia to set up with QI team next week. 20.12.23- Unable to set date with QI team- To meet in the new year 27.2.24- Walk through of PPH in room to theatre complete. OI team will send an updated presentation of next steps	
PPH Simulation in theatre	AC/JF	15.11.23-carried over to next meeting 20.12.23- Awaiting date from RC. 27.2.24 PPH SIM stepped down this week due to acuity on the ward. Re-booked for next week 13.3.24-PPH Simulation stepped down due to ward acuity to re-book 27.3.34-Meeting stepped down. PEF has re-booked SIM beginning of April- 24.4.24- PPH SIM will be completed before the next meeting. 26.4.24-Sim complete	
Process mapping support from QI team at next meeting	VM/SD	15.11.23- Unable to map until data set/audit finalised 31.1.24- 1st process map complete	
To share learning from most recent thematic review- Documentation/recognition of loss in theatre	CB/CH/	To include in all safety briefs. 15.11.23- Safety brief will be updated at the end of the month	

Actions - 15.11.23			
KF to ensure that PPH guideline has been re-circulated with added comments	KF		
KF to set meetings to Bi-weekly	KF		
Actions- 22.11.23			
Data Analysis MDT meeting TBA	KF/MG/CH/AC	20.12.23 Data analysis has now been sent to AK/CB to present at QAC in January. Currently data analysis is in progress.	
Actions- 20.12.23			
KJ- To include on Badger newsletter an issue that was raised in Prompt. PPH proforma completion will save even if baby not yet admitted.	KJ	To include in newsletter	
AC- To ensure theatre algorithm of recognition escalation is in view of staff	AC		
KF- To liaise with RA/CB as to surgeon responsibility of escalating loss.	KF	No reply from e-mail- for update next week- 13.3.34 - Update from CB - Part of the ongoing QI - recognition.	
Actions-31.1.24			
AC to invite team to theatre SIM next wed	AC	28.2.24 -SIM not completed due to ward acuity- Team where invited.	
Next PPH group meeting to process map another walk through- Kim to book the croft	KF	28.2.24- Walk through complete	
Actions- 28.2.24			
Process mapping of walk through (completed today)- Book croft for next meeting	KF/QI	13.3.24-Process mapping now complete for elective c-section	
Actions-13.3.24			
Walk through of PPH- Room/theatre (completed)- Process mapping in croft for next meeting	QI Team	Process mapping at next meeting. 27.3.24- Meeting stepped down due to acuity and no availability of a Consultant Obstetrician. 10.4.24- Process mapping completed. completed the process mapping process and are now due to pull the themes from these and begin the Fishbone diagram process to start the problem analysis component at next meeting- 15.5.24	
Actions-10.4.24			
PPH SIM to be completed this month	QI Team	SIM Completed by team - 26.4.24-See report.	
Action-15.5.24			
Fishbone analysis	QI Team	Started. Awaiting updated slide dec from QI team-E-mail re-sent 3.6.24. 12.6.24- Fishbone analysis now complete.	
Actions- 3.6.24			
KF now part of the regional team to develop a regional PPH guideline	KF	24.5.24- Had a discussion with regional team - Andrew Weeks Consultant Obstetrician leading. Local guidelines shared	

Actions-26.6.24			
KF to update meetings to weekly as per governance oversight.	KF	Completed	
To plan a meeting to discuss a data collection plan.	ALL	Arranged for next meeting	
CH to send the raw data to Sarah Delooze for review	CH	Sent during meeting	
SD to compile SPC charts for all necessary measures and distribute so that decisions can be made re. the current problem and aim statements.	SD		
SD to complete and circulate the fishbone diagram	SD		
Gantt chart to be compiled for all actions until now	SJ		

QUALITY ASSURANCE COMMITTEE

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

HOT TOPIC : Listen to Mums: Ending the Postcode Lottery on Perinatal Care - A report by The All-Party Parliamentary Group on Birth Trauma - WHH position
11.06.2024

Ailsa Gaskill-Jones –

Director of Midwifery

National findings

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Report published 13th May 2024
- First national inquiry in the UK Parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma
- Findings:
  - Care that lacked compassion
  - Women not being listened to and being denied basic needs such as pain relief
  - Women felt they were subjected to interventions they had not consented to
  - Women feeling they had not been given enough information to make decisions during birth
  - Poor post-natal care
  - Significant short term and long-term impact of birth trauma on women and partners and lack of access to appropriate support
  - Lack of high quality follow up care for women who had experienced a birth injury
  - Women from marginalised groups, particularly those from minority ethnic groups, appeared to experience particularly poor care

Report outcomes

Warrington and Halton Teaching Hospitals NHS Foundation Trust

12 key recommendations, some for providers across primary and secondary care, some for NHSE, some for the government.

9 of the 12 recommendations have implications for care delivery at WHH (marked with *).

Focus:

- Recruitment and retention of maternity staff (across all specialities)*
- Improved access to specialist maternal mental health services*
- Improvements to the six week post birth GP appointment
- Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth*
- National standard for post birth services (e.g. birth reflections process)*
- Better education for women around birth choices*
- Respect mothers' choices about giving birth and access to pain relief and keep mothers together with their baby as much as possible*
- Support for fathers*
- Better continuity of care and improved communication between primary and secondary health care pathways*
- Extend the time limit for medical negligence litigation
- Commit to tackling inequalities in maternity care among ethnic minorities*
- NIHR to commission research on the economic impact of birth trauma and injuries

WHH position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation	WHH position/assurance	Next steps
Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services	➢ WHH good position re recruitment and retention ➢ Vacancy rate for medical and midwifery colleagues low	➢ Sustain improved position through ongoing workforce and culture workstreams ➢ New Birth rate+ assessment scheduled for January 2025 ➢ Await national guidance re any change to safe levels of staffing
Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth	➢ WHH have completed RCOG OASI training for the first care bundle ➢ OASI included as part of mandatory maternity training	➢ Await updated national guidance
Maternity units to adopt the recommendations of the consensus statement on instrumental birth due to be published this year	➢ Awaiting consensus statement	➢ Dr Arya involved in national rollout of the consensus statement form MASIC about the risks of assisted vaginal birth. ➢ National guidance due 2024/25. Will be shared with women when approved

WHH position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation	WHH position/assurance	Next steps
Oversee the national rollout of standardised post birth services, such as birth reflections, to give all mothers a safe space to speak about their experiences in childbirth	➢ Consultant led monthly debrief clinic in place for those who have had a complex outcome ➢ All women who birth at WHH are eligible for a birth reflection appointment. Service is led by the Consultant Midwife and is supported by specialist and senior midwives across the maternity service	➢ Await the RCOG workforce report which will confirm if any further changes to job planned sessions are required e.g. postnatal lead ➢ Birth reflections survey underway – aim is to collect feedback and demographic data to review who is accessing this service. This data will highlight if we need to make changes to better meet the needs of the local population ➢ Maternity team exploring options for a bespoke physical space to deliver birth reflection and rainbow service
Ensure better education for women on birth choices. All NHS Trusts should offer antenatal classes. At the 34-week appointment, discuss with women their options during birth, including the risk factors relating to instrumental and caesarean birth	➢ Antenatal classes recommenced March 2024 for Warrington and Halton families ➢ Delivered by community teams to support continuity of care agenda ➢ Risk in pregnancy discussed at each antenatal appointment and documented BadgerNet ➢ Designated appointment with named midwife in place at around 36 week gestation to discuss birth choices	➢ Antenatal classes for ‘out of area’ women to be implemented Summer 2024 ➢ Content of antenatal education to be reviewed to ensure opportunity to discuss risks and birth planning

WHH position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation	WHH position	Next steps
Respect mothers' choices about giving birth and access to pain relief and keep mothers together with their baby as much as possible	➢ A recurring theme from birth reflections is that women felt the rationale for decision making could have been communicated better by the medical team ➢ Of 76 birth reflections completed since Sept 2023, no cases where lack of pain relief, not listening or lack of consent notes as an issue	➢ Learning from women's experience (as shared as part of birth reflections feedback) to be discussed at July MDT ➢ Action regarding communication with women included as part of MNVP workplan for 2024/25 ➢ Ongoing projects regarding transitional care pathways and ATAIN in place
Provide support for fathers and ensure nominated birth partner is continuously informed and updated during labour and post-delivery	➢ Birth partners encouraged to attend birth reflections process ➢ Of 76 birth reflections completed since Sept 2023, two cases where fathers have expressed difficulty of experience. Did not relate to not being kept informed. ➢ Where birth partner expresses trauma, pathways are in place via Parents in Mind, Dads Matters and GP led mental health support	➢ To further develop support pathways for birth partners ➢ Working closely with community partners to enhance existing offer for Dads ➢ Piece of work to be completed to ensure effective processes for maintain good communication with birth partners during labour and post birth

WHH position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation	WHH position	Next steps
Offer mental health screening to partners after birth. This could be in the form of one or two questions from a health professional	➢ At primary post-natal visit both parents asked how are you feeling? and ICON message promoted ➢ Referral pathways for partners in place via the local authority, talking therapies and Dads Matters ➢ Birthing women are offered debrief appts following difficult experiences, partners are encouraged to attend ➢ Partners made aware signs of declining mental health and crisis numbers on BadgerNet at discharge	➢ WHH reps to attend fatherhood champion training ➢ Paternal mental health will be included in future education to staff following completion of this training
Provide better continuity of care and digitise mother's health records to improve communication between primary and secondary health care pathways. This should include the integration of different IT systems to ensure notes are always shared	➢ Automated discharge notification process in place via BadgerNet to provide information to health visiting and GP	➢ Further improvement to communication pathways to be included as part of ongoing Better Birth workstream between maternity services and 0-19 services. ➢ Project will include enhancing communication processes with primary care partners

WHH position

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Recommendation	WHH position	Next steps
Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery	➢ MDT Pathways in place to support perinatal mental health across the spectrum of need including access to and referral pathways via external services ➢ Team River provide continuity of care to those with history of poor mental health throughout the pregnancy continuum ➢ Specialist Midwife – Perinatal Mental Health in place supporting holistic care planning	➢ To continue to develop pathways and ensure WHH engaging with external offer
Provide mandatory training on trauma-informed care	➢ Not currently in place	➢ Likely to be an LMNS/regional led offer ➢ Other WHH led training options have been explored – would require financial investment ➢ Halton Borough Council have offered to support with funding for training of key midwives ➢ Potential option to then develop a bespoke in-house session to be incorporated within the existing mandatory perinatal mental health teaching

WHH position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation	WHH position	Next steps
Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women	➢ Equality & Equity action plan in place and ongoing ➢ Team River have developed specific resources for non-English speaking women. ➢ Team River can now provide antenatal education classes to families who do not speak English as a first language. ➢ Team River have also launched a Health Flashcard document which contains key words and phrases next to an image. These visual aids are to be used alongside trust approved translation services ➢ 3.0wte Enhanced Maternity Support Workers in post to support with signposting and provide additional support to families with higher level of need	➢ To continue with Equality & Equity Action Plan
Introduce specialist midwives for young parents who understand the intersection with other vulnerabilities, such as deprivation or care experience	➢ Team River are an enhanced continuity team that provide continuity of carer to vulnerable women and families, includes young parents. ➢ Bespoke antenatal education delivered for these women. Band 3 MSW recruited to signpost women to support that is available to them, i.e. Koala, financial support, infant feeding etc. ➢ Excellent collaborative working between WHH and the Family Nurse Partnership to support young families	➢ To continue with existing workstreams ➢ To work with MNVP to capture voices of young parents

WHH position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation	WHH position	Next steps
Maternity units to implement NHS England's Perinatal Pelvic Health service specification	➢ PPHS pathway in place including access to advice and support in antenatal and postnatal periods via specialist midwifery and physiotherapy input ➢ PN birth reflections/debriefs for women in place via Specialist RM - Pelvic Health for those who have experienced a 3rd/4th degree tear ➢ Pelvic health is included within parent education classes and is part of mandatory training for staff on MAMU3	➢ Further training for staff ➢ Creation of further resources appropriate for service users ➢ To continue with ongoing work to streamline pathways across physiotherapy and midwifery ➢ Introduction of a a single point of access MDT post-natal perineal clinic for those who have experienced perineal trauma
Launch a national NHS-wide campaign to publicise the importance for Black and Asian women of taking Vitamin D during pregnancy	➢ Vitamin D recommended as part of routine antenatal care ➢ Vitamin D supplementation captured as a part of the SBL element 2 data, however currently not broken down into ethnicity.	➢ Engage effectively with national campaign ➢ Ensure subsequent audits capture compliance, broken down by ethnicity, to ensure robust actions can be developed if issues arise

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Any questions

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/65 – Appendix 5**	
SUBJECT:	**2023-2024 Quarter 4 Transitional Care (TC) Report**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah – Chief Nurse	
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:

	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. Achieving the principles within ATAIN will have a positive impact on this group.

EXECUTIVE SUMMARY ***(KEY ISSUES):***

The paper provides an overview of babies who required Transitional Care (TC) in the period January 2024 -March 2024.

An audit of babies who received TC within Q4 2023/24 has been undertaken and results of this will be described within this paper along with any identified learning.
Key points to note:

	• Following the recent CQC inspection of Maternity Services at WHH, a full review of the current Transitional Care (TC) Model has taken place. • A Task and Finish group was created with representatives from both maternity and neonatal services and is led by the Lead Nurse for Paediatrics & Gynaecological Services and the Deputy Director of Midwifery. • A robust action plan has been developed. • The Transitional Care Action Plan is monitored via WCH Governance and the Neonatal Oversight Meeting. • A quality improvement project continues in order to further enhance our transitional care offering, which will reduce term admissions and separation of mothers and babies.		
PURPOSE: ***(please select as appropriate)***	**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/24/06/57v	
	Date of meeting	11th June 2024	
	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	2023/2024 Quarter 4 Transitional Care (TC) Report)	AGENDA REF	BM/24/08/65 – Appendix 5

1. BACKGROUND/CONTEXT

"Neonatal transitional care (NTC) is additional to normal care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals" (BAPM 2017).

Transitional Care (TC) is embedded in the Maternity Incentive Scheme, Year 6, Safety Action 3. Transitional Care is not always a physical location but a pathway involving more frequent observations and coordinated care between the neonatal and midwifery team. TC is for babies who need a little more nursing care and monitoring and is provided by the team on the Neonatal Unit, Birth Suite and Postnatal Ward.

The aim of TC is to keep parents and babies together in a neonatal transitional care setting and to support the resident birthing parent as primary care provider for their babies more than normal newborn care. The pathway provides additional support for small and/or late preterm babies and their families to facilitate a smooth transition to discharge baby home and prevent neonatal admission.

Following the recent CQC inspection of Maternity Services at WHH, a review of the current transitional care model has taken place, from this a Task and Finish group has been created and a robust action plan developed. Alongside this, an audit of babies who received TC within Q4 2023/24 has been undertaken and results of this will be described within this paper.

2. KEY ELEMENTS

2.1 WHH Transitional Care Position

The findings of this report have been collated from a review of all babies who met the criteria for TC during the Q4 reporting period from 1st January 2024 to 31st March 2024.

Each case has been reviewed utilising the BadgerNet and Lorenzo database system to ensure any learning is identified and shared in a timely manner.

WHH Transitional Care Criteria

- Gestational Age 34+0 to 35+6 weeks
- Birth Weight of >1.6kg to <2.0kg

Any baby requiring one or more of the following:

- Infants requiring intravenous antibiotics with risk factors
- Additional support with feeding via nasogastric tube
- Haemolytic disease requiring phototherapy and assessment of serum bilirubin 4-6 hourly
- Infants with Neonatal Abstinence Syndrome requiring medication on a weaning regime and on regular observations (4 hourly or more frequently)
- Babies requiring observations more frequently than four hourly
- Management of hypoglycaemia to be controlled with a minimum of two hourly feeding

2.2 Summary of Babies who met the Transitional Care Criteria

During Q4, 13 babies met the criteria for TC. An audit of these cases has identified the following:

Admitted direct to TC	4
Appropriately received NNU care and stepped down to TC when well enough	5
Allocated to PEEP for 30 pathway	2
Did not received TC	2

Of the 13 babies who met the criteria in Q4, four babies were admitted straight to TC from birth indicating an improvement from Q4 when no babies received TC straight from birth. In Q3 four babies had met the criteria for TC from birth but this was not received due to NNU staffing capacity.

The other 9 babies who met the broad TC criteria in Q4 required some level of respiratory support and were initially provided with care via NNU. Of these:

- Five babies were then appropriately stepped down to TC when clinically indicated.
- Two were term, therefore followed the PEEP for 30 pathway. This pathway is part of a QI project the Neonatal team are undertaking whereby babies who at 30 mins post birth are still requiring respiratory support, will come to NNU and be commenced on vapotherm with NO formal admission for the first hour. To establish if they can be weaned quickly. If successful the baby will then go back to mum on with a TC plan to establishing feeding and for closer observations.
- The remaining two babies did not receive TC. This was due to short term sickness and high acuity on the Neonatal Unit. The babies were not stepped down to TC as planned and remained on the NNU.

Reasons for admission to the NNU are highlighted in the table below, it is to be noted that significant improvements have been seen this quarter due to continuous education and collaboration between the midwifery and Neonatal services;

	Reason baby admitted to NNU from delivery	Actions to reduce occurrence
1	Babies requiring respiratory support	• Audit undertaken to review length of time baby required respiratory support, noted to be appropriate care and required admission, noticeable improvement from Q2 and Q3, ANNPs undertaking QI project (PEEP for 30), in order to reduce term admissions to the NNU.

2.3 Good Practice:

- Improvement seen in the early recognition of babies who can step down to TC
- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers
- Sharing of audit outcomes across the MDT with both midwifery and neonatal teams to ensure learning is communicated.
- All Band 6 and 7 Neonatal Nurses are able to access the SafeCare system to raise red flags when unable to provide TC care, as part of TC action plan this will be mirrored across the maternity service.
- NNU Ward Manager continues to deliver training at MAMU (Maternity Mandatory Updates).
- Band 6 TC Midwifery champion in place, attending TC training and attends working group (protected time each month)
- Review of TC Criteria completed, disseminated to all staff and displayed in all areas
- Review of Enhanced Care criteria completed, disseminated to all staff and displayed in all areas
- Revisited and redesigned the TC Audit. This is now lead by Lead Nurse and NNU Manager. Audit information is reported to QAC
- “Think TC” Boards in each clinical area – to remind staff of TC admission criteria. Includes updates re progress with TC project

2.4 Recommendations:

- Continue to offer targeted support to staff with learning in relation to step down on babies to TC, due to improvements being seen from this method
- Focussed learning from TC review to be included on Neonatal Natter and OWL

- Regular review of TC actions to ensure timely completion
- Staffing – Continue to ensure that Neonatal staff are allocated to TC Care babies. SBAR created as interim measure for hourly rounding if NNU staff are unable to remain on Ward C23. Monitored via Datix and red flag process.
- TC review group to be established, (similar to ATAIN) to review and discuss cases and monitor actions/progress against the action plan
- Updated TC guideline completed and progressing through Trust governance processes.
- TC Bay on C23 to be created – project lead in place. Will be commenced following IOL move to Birth Suite
- TC Review Group to work in collaboration with ATAIN group to share learning and optimise WHH ability to avoid unnecessary separation of mother and baby.
- Work underway to develop business case for sustainable staffing model, including benchmarking against other providers
- Outstanding actions from action plan;
    - Ongoing TC audit which will be reported through this committee
    - Policy review and staffing model to be completed

3. MONITORING/REPORTING ROUTES

The TC action plan is monitored at both the Women's and Children's Clinical Business Unit Governance Meeting and Neonatal Oversight meeting which take place monthly, prior to reporting to the Quality Assurance Committee. This report will be shared at both meetings during June 2024.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 11 June 2024.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/65 – Appendix 6**	
SUBJECT:	**2023-2024 Quarter 4 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah – Chief Nurse	
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:

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	√		

Further Information:

	Yes	No	N/A
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	√		

Further Information:

	Yes	No	N/A
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. Achieving the principles within ATAIN will have a positive impact on this group.

EXECUTIVE SUMMARY ***(KEY ISSUES):***

- Q4 2023/24 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 6.99%, which is above both the national and NWNODN targets of 6% and 5.6% respectively and is an increase of 1.5% on the last quarter.

	• All term admissions in Q4 were reviewed and learning from these cases informs the ATAIN action plan. • The ATAIN action plan is monitored via WCH Governance. • A quality improvement project is currently underway to put in place a further enhanced transitional care offering, which will reduce term admissions and separation of mothers and babies.		
PURPOSE: ***(please select as appropriate)***	**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/24/06/57ii	
	Date of meeting	11th 2024	
	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	2023-2024 Quarter 4 Avoiding Term Admission into Neonatal Unit (ATAIN) Report	AGENDA REF	BM/24/08/65 – Appendix 6

1. BACKGROUND/CONTEXT

NHS Resolution is operating a sixth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to continue to support the delivery of safer maternity care.

The ATAIN objective is to reduce the number of unexpected term admission of infants ≥37+0 weeks gestation to the neonatal unit (NNU). The national ambition is to ensure that term admission rates are below 6% of live births. North West Neonatal Operational Delivery Network (NWNODN) has set a separate target of 5.6% for term admissions to neonatal units. This initiative is to keep mothers and babies together as much as possible and avoids separating them at the crucial time after birth.

This paper describes the current position of Warrington and Halton Teaching Hospital (WHH) against Safety Action 3 of MIS Year 6 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 6 specify the ATAIN action plan should be shared with Trust Board, Local Maternity and Neonatal System (LMNS), and Integrated Care System (ICS) quality surveillance meetings.

2. KEY ELEMENTS

WHH ATAIN position

The findings of this report have been collated from the review of all cases of term babies that were admitted to the Neonatal Unit (NNU) during the Q4 reporting period from 1st January 2024 to 31st March 2024.

Each case is reviewed by a multidisciplinary team (MDT) of Obstetrician, Neonatologist, Midwives, Neonatal Nurse and Operational Management. The ATAIN Group meet fortnightly to ensure any learning is captured in a timely manner but with capacity to increase frequency where indicated.

Maternity Incentive Scheme (MIS) specification directs providers to report the ATAIN data to the Trust Board on a quarterly basis. However, when reviewing the quarter data, it is important to review the data over a longer time period due to the small number of babies involved.

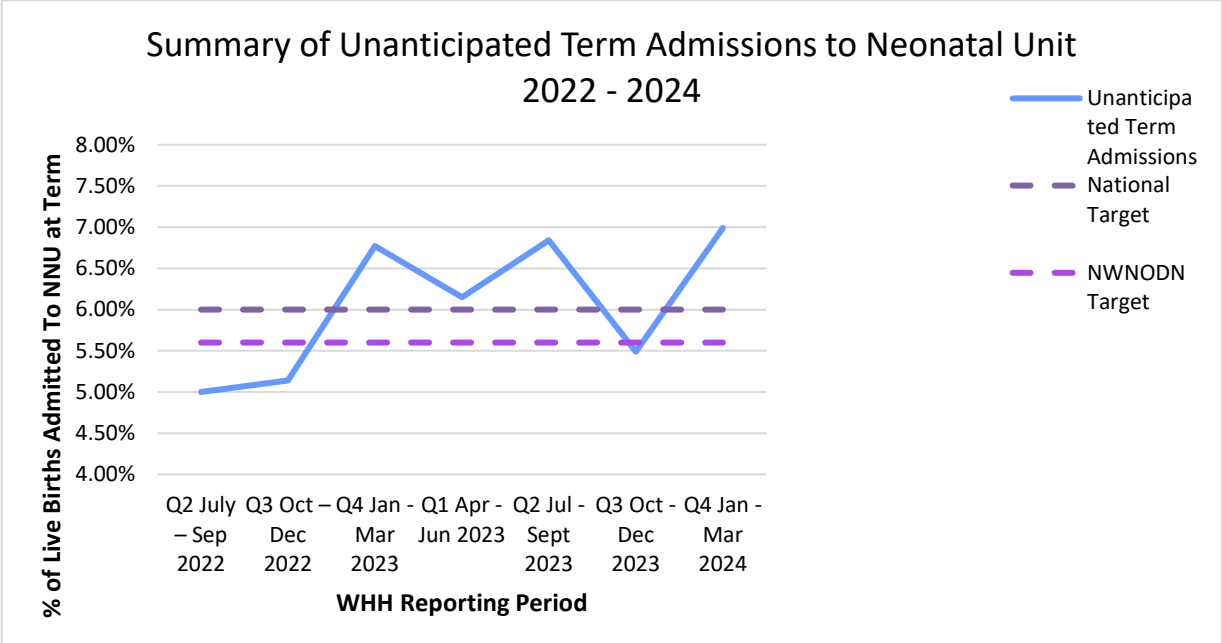
Summary of unexpected term admissions to NNU

The Q4 ATAIN Rate was 6.99%. Out of the 41 term admissions, 3 did not require review as part of the ATAIN process as the babies were well and admitted for social reasons, having explored all other available options for care. If these three admissions were not included, this would bring the ATAIN rate for Q4 down further, to 6.48%.

The overall ATAIN rate was higher than the national and NWNODN targets with an increase of 1.5% on last quarter. This reflects a deterioration in the term admission rates to NNU in comparison to last quarter; however the focus and drive on QI projects and individual case learning has still been an effective strategy in improving care and this will be continued.

WHH Reporting Period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	National target 6%	NWNODN Target 5.6%
Q2 Jul – Sept 2022	682	34	4.98%		
Q3 Oct – Dec 2022	642	33	5.14%		
Q4 Jan – Mar 2023	635	43	6.77%		
Q1 Apr – Jun 2023	602	37	6.15%		
Q2 Jul – Sept 2023	599	41	6.84%		
Q3 Oct – Dec 2023	619	34	5.49%		
Q4 Jan – Mar 2024	586	41	6.99%		

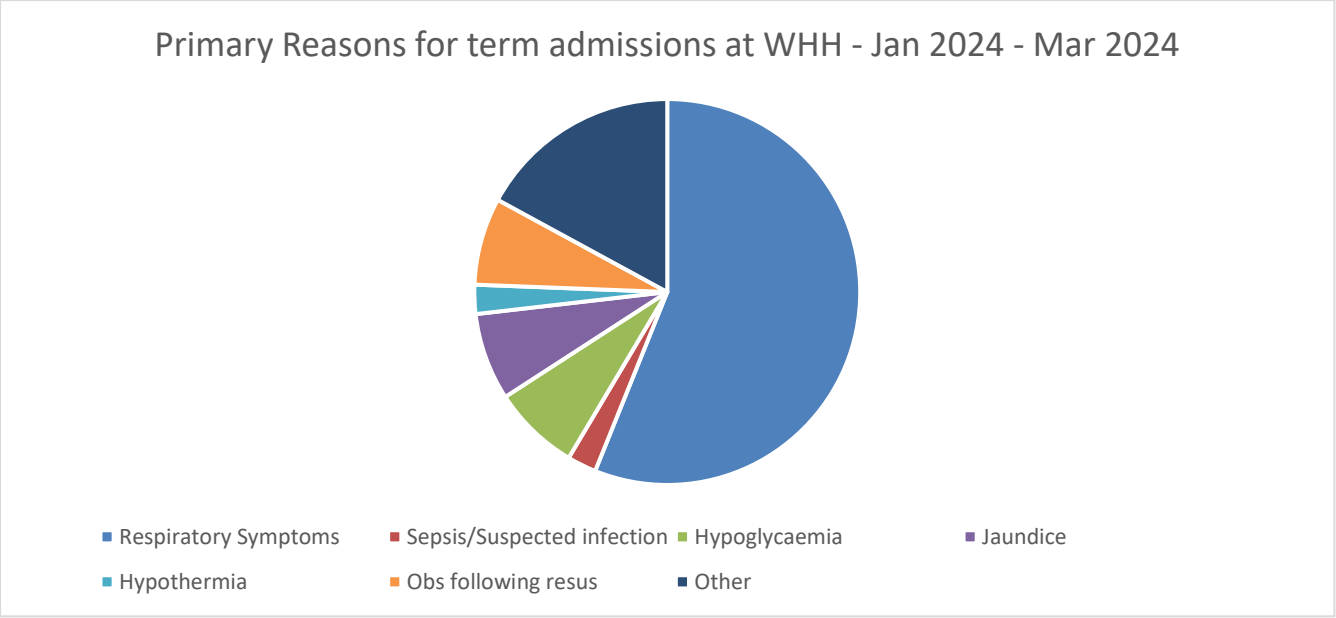
Below is a summary of unanticipated Term admissions to Neonatal Unit from July 2022 – March 2024.



Reasons for term admissions
(recorded on BadgerNet by ATAIN admission criteria)

WHH Number Live Births 2022-2023		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions
Q4 Jan-Mar 2023	635	43	6.77%	19	47.5%	3	7.5%	4	10%	2	5%	1	2.5%
Q1 Apr-Jun 2023	602	37	6.15%	26	70.3%	1	2.7%	1	2.7%	0	0%	3	8.1%
Q2 Jul-Sep 2023	599	41	6.84%	26	63.4%	1	2.4%	0	0%	3	7.3%	2	4.9%
Q3 Oct-Dec 2023	619	34	5.49%	17	50%	0	0%	3	8.8%	2	5.9%	2	5.9%
Q4 Jan-Mar 2024	586	41	6.99%	23	56%	1	2.4%	3	7.3%	3	7.3	1	2.4%

Below is a table of Primary reasons for term admissions at WHH; Jan 2024 – Mar 2024.



Over 50% (23) of term admissions were respiratory-related, i.e. required admission or additional observations due to signs of respiratory distress which includes grunting and low oxygen saturation (SATs or oxygen requirement). Only 6 of these cases were deemed avoidable if care had been optimal.

The 23 respiratory-related admissions comprised of the below:

- 15 cases with Transient Tachypnoea of the Neonate (TTN) – only 1 case was deemed an avoidable admission as caesarean section delivery should have been performed more urgently based on the clinical situation.
- 7 babies had Respiratory Distress Syndrome (RDS)
- 1 baby had Chonal Atresia

Themes and Learning: Outcomes of ATAIN review

WHH Oct 2022 - Mar 2024	Number of Term Admissions	Outcome of ATAIN review		
		Avoidable Admissions	Unavoidable Admissions	% avoidable
Q3 Oct – Dec 2022	33	5	28	15.2%
Q4 Jan – Mar 2023	43	7	32	16.3%
Q1 Apr – Jun 2023	37	7	29	18.9%
Q2 Jul – Sep 2023	41	11	30	26.8%
Q3 Oct – Dec 2023	34	12	22	35.2%
Q4 Jan – Mar 2024	41	13	28	31.7%

Reasons for categorising term admissions as avoidable included:

- Caesarean section should have been performed more urgently
- Caesarean section undertaken too early and not in line with documented patient symptoms & cessation contractions.
- Poor management in intrapartum care of baby
- Hypoglycaemia pathway not followed.

Good Practice:

- 30 minutes of peep
- Excellent documentation from Obstetric Consultant & Midwives
- Paediatrics requested and attended within 2 minutes of request
- Appropriate escalation points from midwives at all of the right points
- Appropriate involvement of safeguarding legal team – supported informed decisions being made.
- Appropriate escalations from midwives when escalating concerns around query sepsis.

Learning Points/Themes/Actions:

- Audit taking place with regards to elective caesarean sections taking place before 39 weeks gestation with no medical indication or for maternal request.
- Earlier detection of deterioration of babies on Birth Suite and Postnatal Ward so earlier intervention can be instigated, potentially avoiding admission to NNU.

Individualised learning and facilitated reflection has taken place for specific intrapartum and postpartum care issues as appropriate with the support of colleagues/supervisors.

A quality improvement project is currently underway to put in place a robust and consistent transitional care offering, which will reduce term admissions and separation of mothers and babies, which will include ensuring clarity for neonatal doctors and ANNP regarding the suitable criteria for transitional care.

Recommendations:

- Continuation of targeted support for staff as required from cases requiring individualised learning.
- Continue regular ATAIN meetings to discuss cases and actions/progress with involvement from the wider team.
- Shared learning from ATAIN to continue to be disseminated to all midwifery, paediatric, neonatal and obstetric staff.
- Regular review of ATAIN actions to ensure timely completion.
- Implementation of a quarterly cluster review process to provide a further deep dive and exploration of themes.
- Senior midwifery review of all babies to be facilitated on Birth Suite and C23 in order to support early identification of deteriorating babies to allow actions to prevent admission.

3. MONITORING/REPORTING ROUTES

The ATAIN 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 was shared at the Women's and Children's Clinical Business Unit Governance meeting in June 2024.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 11th June 2024.

5. RECOMMENDATIONS

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

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ATAIN ACTION PLAN

	Action	Owner	Next Review Date	Target Completion Date	Update	RAG
2	Warm care bundle to be adapted for theatre environment. For consideration: facilitation of skin-to-skin in theatre, removal of weighing scales from theatre	Maternity Theatre Coordinator / Birth Suite Manager / Infant Feeding Co-ordinator	29/09/2023	Completed	Skin-to-skin in theatre has been facilitated and has been added to the theatre safety huddle. Decision made to continue weighing babies in theatre as no cases of admission have been due to hypothermia in theatre. This will continue to be under review Wool blankets are in use	
3	Appointment of fetal monitoring lead consultant and fetal monitoring lead midwife as per Ockenden requirements.	Associate Clinical Director / CBU Manager / Director of Midwifery	29/09/23	Completed	29/2/24: Fetal monitoring lead midwife appointment (secondment) and in post New Consultant recruitment made to Fetal Monitoring Lead post – expected to commence July 2024 (Associate CD continuing to fulfil role until that time)	
4	Audit to take place of all elective caesarean sections to ascertain how many were performed <39/40 with no medical indication.	Maternity Theatres Co-ordinator	30/04/24	Ongoing	29/2/24 Commenced as part of the wider ATAIN audit (see action below). 4/6/24 – Learning from this Audit to be reviewed and shared with action log	
5	Audit to take place of all aspects of ATAIN parameters (asphyxia, temperature, jaundice, hypoglycaemia and respiration).	Birth Suite Manager, C23 Manager, Maternity Theatres Co-ordinator	30/04/24	Ongoing	4/6/24 – Commenced with input from the wider midwifery management team. Data to be reviewed every 3 months to observe any themes.	
6	Improve compliance on Birth Suite to ensure hourly peer reviews of CTG's – this work is currently ongoing and in January we saw a considerable improvement.	Birth Suite Manager	30/04/24	Ongoing	4/6/24: QI project is ongoing. Compliance had exceeded 90% and continues to be audited monthly. Co-ordinators now peer review every other CTG to ensure oversight and an escalation process is being	

		Audit and Assurance Midwife			implemented at present to ensure staff are aware of who to escalate to and when.	
7	Implement 30-minute review by Co-Ordinators for all admissions on Birth Suite – they were informed of this at the last meeting, and this will be audited as part of the overall ATAIN audit	Birth Suite Manager	30/04/2024	Ongoing	4/6/24 Audit to be commenced from July 2024 as part of monthly ATAIN review.	
8	NEWTT audit every month to ensure compliance with neonatal observations	Ward Managers	30/04/2024	Ongoing	To be implemented in July 2024.	
9	Development of Transitional Care offering to further reduce term admissions and separation of mothers and babies.	Clinical Director	31/03/2024	Ongoing	4/6/2024: TC service has now been implemented however business cases are being developed to increase staffing establishment. MDT meeting held 22/09/2023 to plan funding/staffing/logistics for this. 29/2/24: TC is being provided, but need update as to whether this is consistently staffed yet. 01/03/24: Commenced TC working group. Admission criteria has been simplified and disseminated. Plan made to cover the service 24hrs from NNU and postnatal ward staff. Admissions are being audited and business plan being developed for long term sustainability. All babies admitted to NNU are being audited to see if they could have been cared for on TC to identify any areas of improvement to increase TC offering.	
10	Recommend senior midwifery review of all babies on Birth Suite before transfer to Ward area in order to identify signs of early deterioration to address before admission required	LW	30/04/24	Ongoing		
11	QI project to give 30 min PEEP in theatre prior to admission to NNU to reduce admission rate	Neonatal CD, ANNPs	1/3/24	Ongoing	QI Project of 30 min of peep is going well and proving to be effective.	

12	Quarterly fresh eyes review group to be established to complete thematic reviews of ATAIN ensure actions are implemented and share learning and good practice	Assistant CBU Manager, Governance Lead & Maternity Matron	04/06/2024	Ongoing	First meeting to be held 3rd week in June.	

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/66**	
SUBJECT:	**Care Quality Commission (CQC) Compliance Update Report Q4**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Ali Kennah, Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; 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 have patients waiting more than 12 hours in the department from time of arrival **#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 and failure to achieve constitutional standards and financial plans. **#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 **#1757** If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services. **#2001** 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. **#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. **#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	

<table>
<tr><td></td><td>reduction in operational productivity, reporting functionality and possible risk to patient safety
#1898 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.
#125 If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities 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, 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.
#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>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>
Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<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>
</table>
</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td>The report included the Q4 Items reported to the Quality Assurance Committee Meeting held on 24 May 2024 which are summarised below:

• Maternity Update
• Warrington Living Well Hub</td></tr>
</table>

	• Compliance Group & Mock Inspection Programme • Care Quality Commission (CQC) Engagement and Risk Meeting – January 2024 and April 2024 • Single Assessment Framework From 2024/25 Q1 this report will be extended to provide oversight of wider regulatory compliance and inspections e.g. Health and Safety, Health Technical Memorandums (HTMs). These will be noted within the report whist scrutiny will continue via the relevant sub committees.		
PURPOSE: ***(please select as appropriate)***	**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.	June 24	
	Date of meeting	7 August 2024	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Compliance Update (Q4 2023/24)	AGENDA REF	BM/24/08/66

1. BACKGROUND/CONTEXT

- The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.
- Their role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.
- The CQC monitor, inspect and regulate services and publish findings. Where poor care is found, the CQC have powers to act.
- Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) continues to make sure it provides people with safe, effective, caring, and responsive services and that it is 'Well- Led', in line with the CQC standards.

2. KEY ELEMENTS

Q4 Items reported to the Quality Assurance Committee Meeting held on 24 May 2024 are summarised below:

- Maternity Update
- Warrington Living Well Hub
- Compliance Group & Mock Inspection Programme
- Care Quality Commission (CQC) Engagement and Risk Meeting – January 2024 and April 2024
- Single Assessment Framework

From 2024/25 Q1 this report will be extended to provide oversight of wider regulatory compliance and inspections e.g. Health and Safety, Health Technical Memorandums (HTMs). These will be noted within the report whist scrutiny will continue via the relevant sub committees.

3. MATERNITY UPDATE

A CQC Maternity Inspection was undertaken on 14 September 2023. The factual accuracy concluded, and the final report was published on 17 January 2024.

No 'Must Do's' were identified and the service maintained its 'Good' rating.

There were 5 'Should Do's' identified (listed below). An action plan in relation to these points has been developed. This action plan is managed and overseen by the Care Group; any risks are escalated to the Quality Assurance Committee.

1. The service should continue to improve training compliance rates for all staff in all relevant areas.
2. The service should ensure all policies and procedures are in place and reflect current evidence based best practice and are fit for purpose.
3. The service should ensure that electronic patient records are integrated as far as is possible to avoid the risk of missed information.
4. The service should continue to develop, communicate, and embed the transitional care provision.
5. The service should ensure that all staff complete regular simulation training/skills and drills training, such as regular pool evacuation and abduction drills.

The national review of Maternity Services has concluded. Assessments of Maternity Services will now form part of the new CQC Single Assessment Framework (SAF).

4. WARRINGTON LIVING WELL HUB

This service was successfully registered by the Trust with the CQC on 27 February 2024.

All new services are assessed to check they are likely to be safe, effective, caring, responsive, and well-led.

As several different providers (circa 30 services) use the Hub, registration could have been time consuming and problematical, however, the process ran very smoothly and to time with the CQC.

5. COMPLIANCE GROUP AND MOCK ASSESSMENT PROGRAMME

- The Compliance Working Group met on 15 May 2024 to decide on terms of reference/agenda/work plan including membership of the Trust's future Quality, Compliance Oversight Group (QCOG). It was agreed the new group will review quality and compliance information collected and manage any required programmes for improvement.
- The Executive Led QCOG Meetings have been scheduled to take place on monthly basis, reporting to QAC.
- Quality statement gap analysis has commenced in Q1 (24/25) with Care Groups/services.
- Gap analysis will highlight areas of good practice/innovation as well as areas for improvement.
- Following the assessment of core services against the new Single Assessment Framework (SAF), a revised schedule of mock assessments will be presented at the August Quality Compliance Oversight Group (QCOG) for approval. The order of mock assessments will be prioritised based on risk. A

Mock CQC inspection of the Emergency Department was undertaken in June 2024.

6. CQC ENGAGEMENT AND RISK MEETING – JANUARY 2024 & APRIL 2024

The CQC visited the Trust on 29 January 2024. Three core services were identified, and the CQC requested additional assurance.

- Urgent and Emergency Care
- Surgery
- Medicine

Following this meeting, the CQC wrote to the Trust on 11 March 2024 requesting further information regarding these service areas. The information was sent to the CQC before the due deadline of 28 March 2024.

The CQC advised that such reviews can trigger a service inspection. However, the CQC confirmed that with the submission of the further information, no service inspection would be taking place at this time.

The CQC visited the Trust again on 23 April 2024. Key points from the meeting were as follows:

- The meeting was an opportunity for the CQC to gather information and for WHH Team to ask questions on future CQC arrangements.
- WHH provided updates regarding Never Events, Sepsis, Electronic Patient Records (EPR), Freedom to Speak Up (FTSU), press and publicity re: Reinforced Autoclaved Aerated Concrete (RAAC), pest control and coroner's inquests, as well as highlighting areas of good practice.
- Visits took place to B12 and B18 along with Children's Outpatients. The CQC were shown the virtual tour video of Children's Outpatients, which was well received.
- The Trust has not had a well-led review for 4 years, therefore may expect one soon. This would likely be linked to at least one service review and not a standalone review.
- The CQC provider portal – the system to obtain requests and provide information is still not operational. The date for this has not yet been released.
- Alison Kennah, Chief Nurse has been successfully registered with the CQC as the Responsible Officer for the Trust's services.
- The CQC were interested in the work undertaken to improve Urgent and Emergency Care Services and have requested that the next meeting focus on RTT and elective performance.
- Future CQC Engagement Meetings are to be scheduled every 6 to 8 weeks.
- The CQC also requested that arrangements are made for their officers to observe one of the Trust's private and public Board of Directors Meetings.

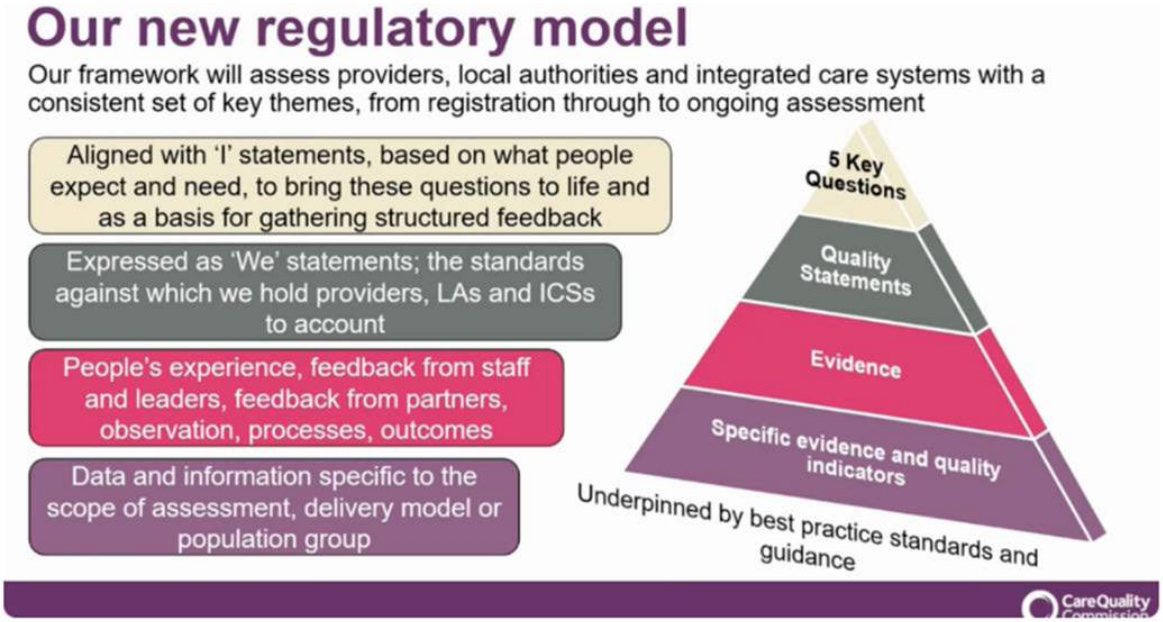
- The Trust Team in attendance concluded the Engagement Meeting was a positive experience. A further meeting is scheduled for 6 August 2024.

7. CQC – NEW SINGLE ASSESSMENT FRAMEWORK

The CQC undertook a presentation and workshop on 26 March 2024 to advise on the following.

- The CQC's new strategy
- New CQC working arrangements.
- The new single assessment framework

The new regulatory model is highlighted below.



CQC New Regulatory Model

In summary, the 5 domains remain: referred to as 'key questions' (safe, effective, caring, responsive, well-led)

There will be 34 quality statements assessed against 6 evidential categories. These are.

1. People's experiences.
2. Feedback from staff/leaders.
3. Feedback from partners.
4. Observations of care.
5. Outcomes of care.
6. Processes.

The Moving to Outstanding Group (to be renamed Quality Compliance Oversight Group Meeting is to be re-introduced and re-focussed to manage the CQC's new

Single Assessment Framework and other regulatory requirements. e.g. HSE, Royal Colleges etc.

An updated 'Guide to inspections' booklet is being produced for staff which will detail all the essential information required for the new Single Assessment Framework.

8. CQC ENQUIRIES

There were 6 enquiries logged during Q4 (2023/24) of which 3 were completed and closed. The remaining 3 relate to longer investigations being processed using the Patient Safety Incident Response Framework (PSIRF). When the Patient Safety Incident Investigation (PSII) reports have been completed, these will be forwarded to the CQC with a view to closing these enquiries.

9. RECOMMENDATIONS

The Trust Board is asked to note the contents of this report.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Mortuary Compliance against Fuller Inquiry Recommendations

Trust Board
7 August 2024

Ali Kennah- Chief Nurse

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Fuller Inquiry

Background

- Inquiry to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries at Maidstone and Tunbridge Wells NHS Trust and why they went unnoticed
- Sir Jonathan Michael – appointed Chair of the Independent Inquiry with phase 1 of the inquiry released in November 2023

National regulatory framework and its effectiveness - Phase 2 review of the Inquiry:

- Procedures
- Practices
- Security and dignity of the deceased

WHH Position: Mortuary status

Warrington and Halton Teaching Hospitals NHS Foundation Trust

HTA inspection May 2022, licence maintained. Compliant with recommendations.

WHH Gap Analysis and Inquiry Recommendations

WHH gap analysis of the 17 recommendations, update June 24:

- **0 x areas of non-compliance**
- **17 x full compliance**

It should be noted that these are recommendations and are not currently mandated by the HTA in order for our licence to be maintained.

WHH will take these recommendations forward as best practice standards.

Further reports will be provided bi-annually to the Health and Safety committee Quality Assurance Committee ahead of Trust Board.

Recommendations Identified Following Inquiry

Warrington and Halton Teaching Hospitals

Recommendation Number	Recommendation Descriptor	Assurance	Compliance

1	Ensure that all non mortuary staff and contractors both internal and external are always accompanied by another staff member	Mortuary staff present Monday to Friday 8am – 5pm
		
		• Out of Hours access to mortuary is held by:
		  • Porters
		  • Security team
		
		Required for safe and timely transfer of the deceased.
		
		2 people must swipe in and out (additional measure introduced- to be audited monthly).
			Achieved

2	The Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.	Monthly audit undertaken by Head of Security (CCTV). To be included in bi-annual Patient Safety Clinical Effectiveness Sub Committee and Quality Assurance Committee report.	Achieved
3	The Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements	Compliant with Trust policy: DBS completed ahead employment.	DBS recheck options under discussion

Recommendation Number	Recommendation Descriptor	Assurance	Compliance
4	The Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.	Qualifications are on record and have been checked. Accountability evidenced within Trust management structure.	Achieved
5	The role of Mortuary Manager should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.	Full time dedicated role in place. Banding review underway following benchmark as part gap analysis (band 6 vs band 7)	Rebanding underway
6	The Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.	Policies reviewed and updated: • Mortuary Viewing • Out of Hours Access • Release of Deceased	**June update:** Policy approved and live in the intranet since April 24.
7	The Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.	• Access is routinely monitored • Internal CCTV monitoring monthly • Audit of policies to be reported to Clinical Support Services Governance Meeting and Patient Safety Clinical Effectiveness Sub Committee ahead of Quality Assurance Committee	Achieved

Recommendation Number	Recommendation Descriptor	Assurance	Compliance
8	The Trust should treat security as a corporate not a local departmental responsibility.	Security corporately form part of Estates and Facilities.	Achieved
9	The Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.	Cameras in place with the exception of the Postmortem room -this is not a HTA requirement and considered to be inappropriate due to dignity considerations.	Achieved
10	The Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.	Monthly review of footage as per previous process. Now to be reviewed alongside additional requirement for **both** parties to use swipe card access. Bi-annual report to Patient Safety Clinical Effectiveness Sub Committee and Quality Assurance Committee.	Swipe card access monitored. Report to go to PSCEC
11	The Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary	Not currently a requirement from HTA. The latest report is not shared with external stakeholders. Details are available on the HTA website. Further review and recommendations to be made in Phase 2 of the enquiry.	Partial
12	The local council should examine their contractual arrangements with Trusts to ensure that they are effective in protecting the safety and dignity of the deceased.	Further review and recommendations to follow in phase 2 of the inquiry.	Local Council communicate with us and there are plans to review the contract

Recommendation Number	Recommendation Descriptor	Assurance	Compliance
13	The Trust must not rely on reassurance rather than assurance in monitoring its processes. The Board must review it's governance structures and function in light of this.	• Incident review process in place via datix. • To be specifically discussed at Clinical Support Services Governance meeting. • To form part of bi-annual report from Head of Security to Patient Safety and Clinical Effectiveness Sub Committee ahead of Quality Assurance Committee and Trust Board.	**June update:** Mortuary minutes included in HLBP from CSS.
14	The Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the **Designated Individual** is actively involved in reporting to the Board and is supported in this	Designated Individual to provide content of report for Trust Board	DI will complete report. Report will be presented by Chief Nurse
15	The Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the **Designated Individual**. The Act will be subject to review in Phase 2 of the Inquiry's work.	• Compliant with HTA regulations • Designated Individual in place supporting Trust Board report	DI in place
16	The Chief Nurse should be made explicitly responsible for assuring the Warrington & Halton Teaching Hospitals NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.	• Incident review process • Bi-monthly incident report Patient Safety and Clinical Effectiveness • Bi-annual report Trust Board	Achieved
17	The Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.	• No incident themes identified • Actions completed in accordance with previous HTA inspection	Achieved

Next Steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Associate Director Clinical Support Services to oversee compliance with recommendations.
- Bi-annual report to be introduced Patient Safety Clinical Effectiveness Sub Committee ahead of Quality Assurance Committee and Trust Board – cycle of business to be agreed.
- Await further instruction following phase 2 analysis.
- Designated individual to attend Trust Board bi-annually as stipulated.
- Chief Nurse will be Accountable Officer for security and dignity of the deceased as stipulated.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/68**			
SUBJECT:	**Communications and Engagement Dashboard Q1 24_25**			
DATE OF MEETING:	7 August 2024			
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement			
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):				
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):*	The report contains updates on communications and engagement activity during quarter 1 of 2024-25 and incorporates quarterly reporting on the Working with People and Communities Strategy. The report consists of: • Communications and Engagement Team updates • Overview of Q1 activity (April to June 2024) • Updates on Experts by Experience involvement • Key campaigns and highlights during Q1 • Working with People and Communities Strategy Q1 update			

	• Details of the current plan for engagement events during the forthcoming year		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update report on communications and engagement activity during Q4.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.	N/A	
	Date of meeting	N/A	
	Summary of Outcome	N/A	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD
7 August 2024

Communications and Engagement Update Quarter 1 2024-25 (April to June)

Kate Henry, Director of Communications and Engagement

Our role within WHH

The Communications and Engagement Team remit covers:

- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including – content development for trust's corporate social media channels and updates to the website
- Identity, branding and design
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information

During the Q1 period (April to June 2024) the Communications and Engagement Team…

- processed and allocated **75** communications 'Job Requests' for design, film, photography and communications campaign support
- prepared/issued a total of **8** media statements
- Issued **9** media releases
- handled **21** enquiries from local, regional and national print and broadcast media

- With effect from 1 April 2024 Freedom of Information requests and the enquiries inbox are no longer managed by the Communications and Engagement Team.

Q1 activity and achievements overview

- Delivered the annual WHH Thank You Awards and associated internal and external communications
- Working with Informatics Merseyside to scope and develop a new intranet and website – to be delivered summer 2024
- Working with Pulse Outdoor advertising to secure advertising income from digital screens and static poster panels located on both sites
- Working with Cheshire and Merseyside Endoscopy Transformation Programme including communications and an opening event for the new Endoscopy Hub in Nightingale Building
- Supporting plans for an opening of the new day case unit and theatre at Captain Sir Tom Moore as part of £9.3m TIF funding
- Produced communications for the Pharmacy First campaign to make it relevant for our local population
- Re-written the Production of Patient Information (PINFO) Policy to include a process for patient information in video/animation format and to improve clarity around the process for clinical sign-off of information
- Through dedicated chasing we have reduced the number of expired PINFO leaflets to just under 200 - the lowest level in two years. Since January, 174 leaflets have been created or reviewed by the team and a significant number have been archived. In total there are 607 PINFO leaflets and five videos currently in circulation.

Details of other communications and engagement activity is included in the highlights section of this update

Media

The Trust issued 9 **proactive** media releases/statements during Q1 including:

Maternity initiative shortlisted for the HSJ Patient Safety Awards
Read the release

New chief executive announced for hospital trust
Read the release

First phase of £9.2m theatre re-development opens at Halton Hospital
Read the release

Hospital radio volunteer celebrates 50 years of service
Read the release

Media activity during the quarter was impacted by the restrictions on activity during pre-election periods for local elections held in our boroughs and the general election.

Engagement, involvement and insight

During Q1 (April to June 2024) we recruited 18 Experts by Experience (EbyEs)

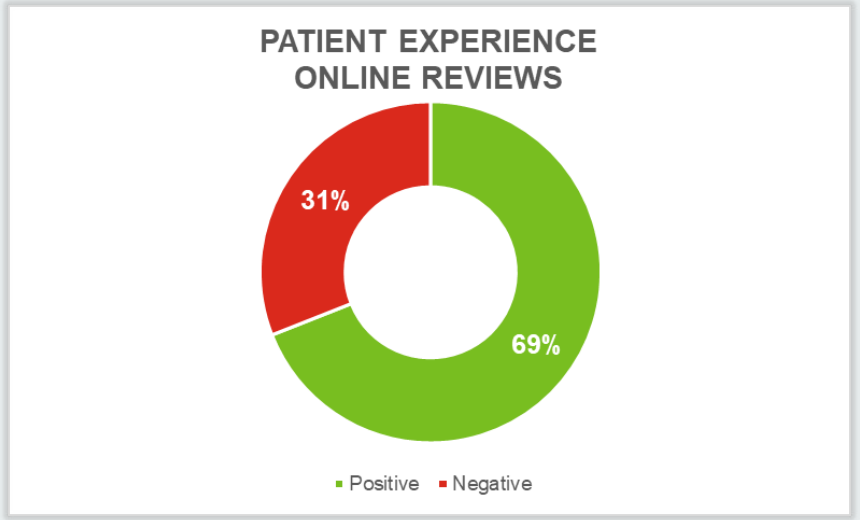
We received requests for engagement support for the following projects:

- PEP user feedback survey
- Ongoing redevelopment of WHH website
- Dementia and Delirium Steering Group
- Pathology annual user survey
- Children's Ward (B11) multi-sensory equipment
- Corporate Induction - compassionate care

PEP EbyE engagement feedback

"EbyEs have been a vital part of the PEP Project Team, from procurement to feature development, system testing, communications and content (wording of messages and accessibility).
Their experience has been invaluable as it's great to understand the issues faced by patients which drive the project, and for them to be included all the way through to ensure we don't 'miss the mark'!"

Elaine Czarnecki-Wilson, EPR Project Manager - Digital Services



A total of 71 online reviews from patients rating their WHH experience were published in Q1.

Sources of data:

- NHS Choices
- Google reviews
- I want great care

Experts by Experience (EbyE) projects

Project Name	Overview	No of EbyEs	Outcomes
Pathology survey (phlebotomy and specimen collection)	Request for EbyE participation within the annual pathology user survey	36	• 20 EbyEs recruited for Pathology Focus Group • Department signage changed in response to feedback
d/Deaf focus group	Request for EbyEs to share care and experience of d/Deaf needs as an inpatient or outpatient	1	• 1 EbyE recruited to join d/Deaf Focus Group • Patient Experience and Inclusion Team to host meetings and develop WHH offer
WHH website engagement	Request for EbyE involvement in online session to discuss templates and content mapping	8	• 7 EbyEs participated in an online web development session on 01/05/2024 • 1 EbyE supported with one-to-one session (reasonable adjustments) • Further online demos and testing due August 2024 prior to September go-live
Children's Ward (B11) sensory equipment	Request for EbyE involvement in procurement of sensory equipment for children's multi-sensory room	3	• 3 EbyEs recruited (one of whom informed development of Warrington Play and Sensory Centre) • Feedback on equipment types, design and sensory aspects shared with project leads • Site visits planned (TBC)

EbyE projects (continued)

Project Name	Overview	No of EbyEs	Outcomes
Corporate induction	Request for EbyE feedback of compassion in care at WHH, to inform corporate induction	2	• 2 anonymised stories shared with project lead (one positive, one negative) • Training updated to include EbyE feedback • Finalised presentation content to be shared with EbyEs involved
Runcorn Health and Education Hub workshop	Online EbyE session to discuss design and accessibility of Runcorn Health and Education Hub	6	• 6 EbyEs joined an online workshop with the Strategy Team to query and discuss design and layout • 1 EbyE supported with one-to-one session (reasonable adjustments) • Strategy Team engagement scheduled with Warrington Maternity and Neonatal Voices Partnership, Halton VCFSE network, Warrington Staying Connected

Campaigns shared with EbyEs: 6

- DHSC - NHS Constitution 10-year review
- WBC Healthy Weight Declaration Strategy
- Active Warrington Strategy Consultation
- WHH Pathway to Research
- WBC Warrington Carers Strategy
- Living Well programme

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key campaigns / highlights from Q1

WHH Thank You Awards

Annual staff awards ceremony held at the Concorde Conference Centre, Manchester Airport, on Friday 10 May

- 285 guests (including sponsors) in attendance
- 17 sponsors secured, raising £34,800 (inc VAT)
- Internal communications shared via Team Brief, The Week and GMWHH messages
- Individual communications issued to ticket holders and nominees
- Social media content shared pre/during/post event
- Media releases produced included:
  - Annual Thank You Awards ceremony honours staff stars and health heroes
  - Outstanding Achievement Award winner: Dr Anne Robinson

Patient Engagement Portal (PEP) launch

Communications support provided for the launch of the portal.

A range of internal communications were issued to staff and external communications including videos, media and website updates with the following outcomes:

Warrington Guardian online campaign

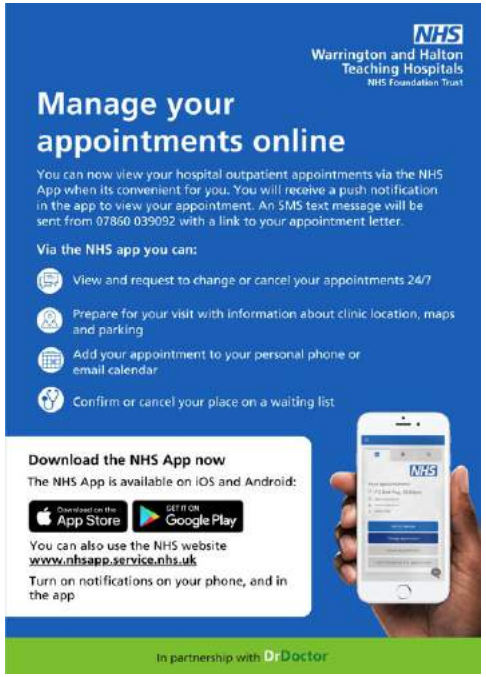
- 66,555 impressions
- 454 clicks
- 183 hours viewed

Warrington Worldwide

- Banner advert online achieved almost 190,000 views
- 10,000 magazines with full page advert distributed

Social advertising

- Total reach: 115,958
- Total clicks: 134
- Average CPC: 0.84p
- CTR: 0.11%



Communications support for digital projects provided through additional resource contracted by the Trust.

CSTM day unit and theatre opening

On 3 April the Communications and Engagement Team supported an event to mark the official opening of the new day unit and theatre at CSTM.

The event included a tour of the unit, which hosts 10 new day case pods, a state-of-the-art laminar flow theatre and a new treatment room for low complexity surgery. Communications included:

- invitations to key stakeholders
- GMMWH message for staff and updates in Team Brief
- media release promoting the facility

Further communications activity is planned to support the development of a £5m dedicated Endoscopy Hub (due for completion summer 2024) and an £8m purpose-built diagnostics centre (scheduled to open in 2025).

Forget Me Not celebration

On 13 May communications and engagement support was provided for the 10-year anniversary of the Forget Me Not Unit, a facility that continues to lead the way in providing the best quality care for people living with dementia.

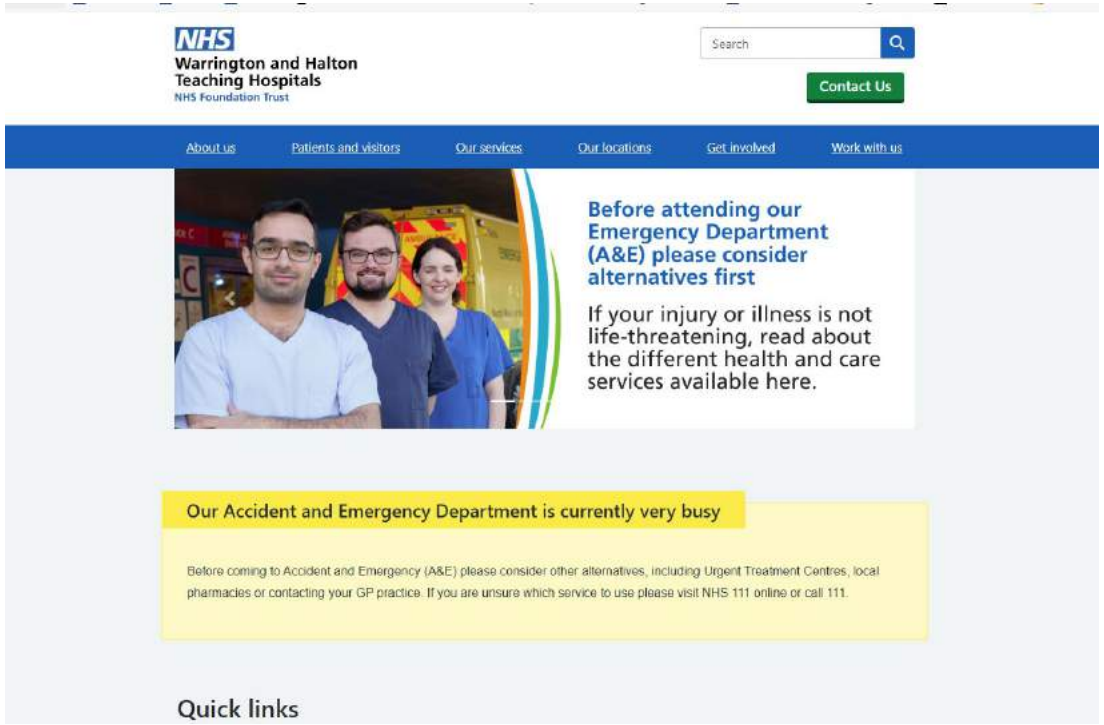
Activity included:

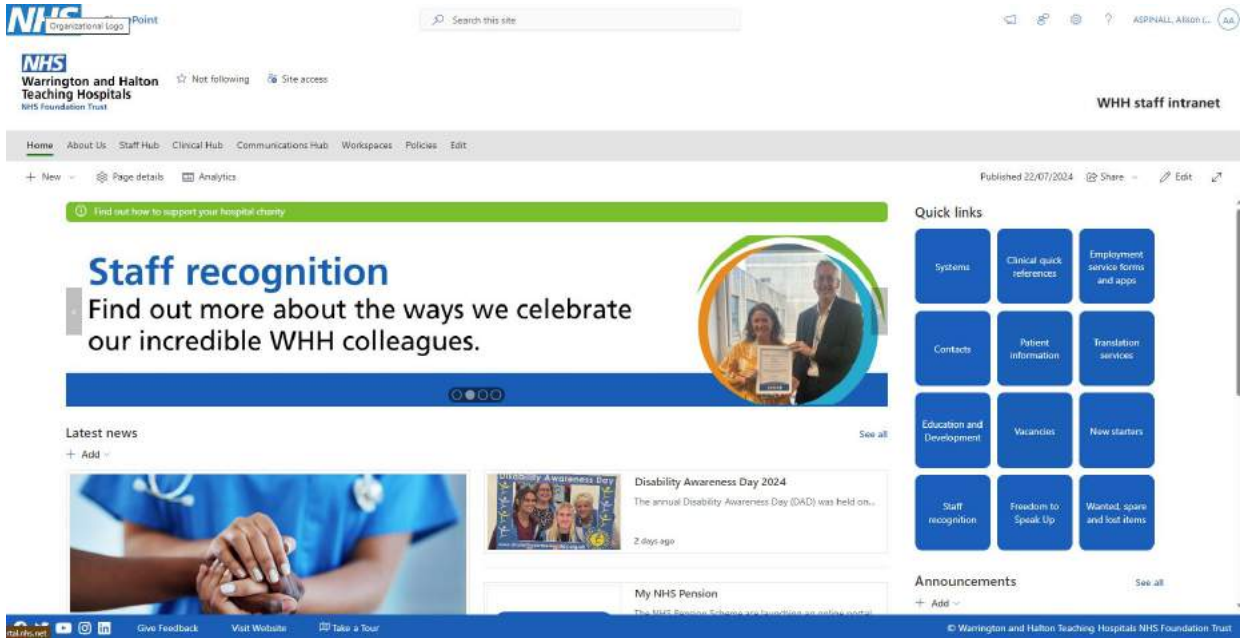
- coordination of opening event invitations to stakeholders
- GMWHH message for staff and updates in Team Brief
- media release to celebrate the event and successes of the past 10 years
- assisting the Forget Me Not Team with pre-event planning and running order

The Forget Me Not Unit is a key partner in providing dementia support at the new Living Well Hub in Warrington town centre. Significant ongoing communications input will promote the Hub and timetable to encourage access for Warrington residents and those most in need of Dementia support.

Website and intranet sites in development

The team has been working on two significant projects to redevelop the Trust website and intranet – with expected go live dates in August.





Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy
Q1 update

Pillar 1: Co-production in Service Change/ Development

Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• 18 Experts by Experience recruited during 24/25. • 146 Experts by Experience total (cumulatively to date). • Continuing to work with WHH colleagues to identify opportunities to involve EbyEs from the outset of projects (#StartwithPeople). • Hosted 4 stands at community events to promote EbyE recruitment.	• Ongoing
2. Support EbyE recruitment and retention	• 7 EbyE Projects delivered in 24/25 (plus 2 extended projects – website redevelopment and PEP). • 11 further EbyE projects pending (NHSE Criteria Led Discharge, Hospital Entertainment System, Paediatric Virtual Wards, Respiratory Therapies, Food tasting, Bereavement QI Project, SG/Child Protection medicals QI Project, palliative care leaflet, Audiology service changes, review of Maternity areas to support Neurodivergent patients/families, health inequalities). • 66 EbyEs (currently) participating in Q1 projects.	• Ongoing
3. Enhance our programme for involvement	• Annual involvement timetable for Awareness Days and Events informs engagement plan – dependent on team availability (see slide 18). • Discussions with Estates and Strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement or advocacy representation.	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• EbyE Refresher training session held 06/06/2024 • Inclusion of EbyE engagement from beginning of significant projects e.g. Runcorn Health and Education Hub (ongoing), WHH website redevelopment (ongoing) and Trust-wide work e.g. Clinical Audit, Quality Improvement	• Ongoing
5. Ensure representation to support Place-Based integrated care delivery	• Warrington and Halton Peoples Voice meetings no longer take place – but we will link governors and Experts by Experience in with any engagement/co-production opportunities • Use our resources to support wider place-based initiatives and to access insight from our communities and advocacy/equality groups.	• Ongoing

Pillar 2: Accessible Information Standard (AIS)

Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Patient Letters	• The Patient Engagement Portal (PEP) in partnership with DrDoctor was launched on 12/06/2024. Experts by Experience involved in PEP procurement exercise, testing, implementation and feedback stages. Patients can manage appointments, fill out forms, receive notifications or update details for waiting lists. The PEP will support; reduction of DNAs, online amendments of appointments and access to information in different formats/languages. • Work has commenced on a tendering exercise for a new Electronic Patient Record (EPR) system to succeed the current system, Lorenzo.	• 2024-25
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• All updated content being compared against accessible content checklist to ensure it is up to date and accessible. • New website (and intranet) - Communications and Engagement Team are working with NHS Informatics Merseyside on both projects, with accessibility and ease of navigation remaining a key priority. Engagement with Experts by Experience 01/05/2024 (demo due August 2024) is informing the structure/content of the public-facing site. To be launched August/September 2024.	• Ongoing
3. Accessible content creation	• BadgerNet (Maternity) development – app is available in nine languages with 216 alternative language leaflets/videos. Team River's parent education sessions available in 8 languages. Cue cards (common words) available in 15 languages (digital and easy read). Acute event information (including caesarean section, ventouse and labour care) now available in 8 languages.	• Ongoing
5. Patient Information	• A revised version of the Production of Patient Information Policy is in final stages of development and is being shared for feedback. This version references more clearly the process for clinical sign off and requests for patient information in video formats. • Awaiting completion of digital system changes to launch Communications Passport – see update on EPR above.	• Ongoing
7. Signage/Wayfinding	• Initial Wayfinding T&F Group (Estates, Patient Experience and Inclusion, Communications and Engagement and Clinical Governance) held 10/06/2024. Next meeting 29/07/2024	• Ongoing

Pillar 3: Reducing Health Inequalities

Using WHH engagement and understanding health inequalities to geographical areas of Warrington North, Warrington South, Widnes and Runcorn

1. Strengthen WHH engagement programme	• Continue to work with collective WHH teams (Patient Experience and Inclusion, Workforce EDI, Membership and Governance, Children/Young People, Dementia, Staff Health and Wellbeing team, charity, volunteers, chaplaincy, catering/estates, ward/service reps) to set/link events calendars and activities for 2024/25 and 25/26. • Event meetings, co-hosted by Engagement and Involvement/Patient Experience, to collectively discuss and agree 24/25 engagement to be re-started in Q2.	• Ongoing
2. Provide opportunities for governors to engage in their communities	• Promotion and encouragement of governor event engagement opportunities i.e. speaking with visitors about the constituencies they represent, showcasing their roles, sharing info, collecting details of visitors interested in becoming a WHH Foundation Trust Member. Events undertaken were: ✓ International Clinical Trials Day 2024 ✓ Warrington Pride ✓ Warrington Armed Forces Day ✓ NIHR Clinical research bus outreach	• Ongoing
3. Support Place Based activity and other key local events	• Link governors and Experts by Experience members with opportunities for engagement and co-production in local health and care systems. • Warrington Living Well Hub promo messages and drop ins to be shared continually throughout 24/25. • CSTM day unit and theatre opened (April 2024). • CSTM Endoscopy Hub (due completion Summer 2024). • Diagnostics centre (scheduled opening 2025).	• Ongoing

Pillar 4: Anchor Institution/Building Social Value

Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Use WHH communication channels to increase engagement with the voluntary and third sector and raise awareness of key health improvement and economic wellbeing initiatives. • Inclusion of Apprenticeship information and promotional materials in Trust and community engagement events (i.e. Armed Forces Day, Disability Awareness Day, International Clinical Trials Day, Warrington Mela). • Ongoing sharing of '350 Careers, One NHS, Your Future' booklet and online link to information. • WHH stakeholder newsletter (monthly from 10/06/2024) shared with BWCH, Mersey Care, NWAS, M&W Lancs, LAs, C&M ICB, CMAST, NHSE, CQC, Healthwatch, PCNs, VCFSE and MPs.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer in order to enhance the aspirations and life chances of local people. • Inclusion of volunteering information and promotional materials in Trust and community engagement events (Armed Forces Day, International Clinical Trials Day, Warrington Pride, NIHR clinical research outreach). • Level of engagement with social media and websites. • Further Nurse Recruitment events planned for 24/25.	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Cherry Tree Courtyard hub – providing internal communications support for this project and working with People Directorate to ensure this facility is available to support patient/community engagement where appropriate. • Work with charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at Patient Experience Sub Committee (PESC) and Patient Equality, Diversity and Inclusion Sub-Committee (PEDISC). • Charity stakeholder and staff newsletters created and shared monthly.	• Ongoing

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Upcoming engagement events

Upcoming engagement events: 2024

Date	Event	Time	Venue	Event purpose
29 Aug 24	Endoscopy Hub Opening	9.30am to 11am	CSTM, Earls Way, Palacefields, Runcorn WA7 2HH	Official opening of WHH's Endoscopy Hub, part of Cheshire and Merseyside's Endoscopy Transformation Programme.
15 Sept 24	Warrington Mela	11am to 5pm	Queen's Garden, Palmyra Square, Warrington, WA1 1JN	Annual partnership event supporting cultural diversity and community inclusion within Warrington.
24 Sept 24	WHH Staff Culture and Inclusion Conference	9.30am to 4.30pm	Post Grad Centre Warrington	Trust conference to promote and discuss WHH's staff culture approach inc Culture Corners, Culture Champions, Staff Voice Forum and staff networks.
2 Oct 24	Annual Members' Meeting	3.30pm to 5pm	Post Grad Centre Warrington	Trust-led annual membership event, bringing together Foundation Trust Members, Governors, Directors and the Chair.

Dates for your diary

- International Clinical Trials Day 2025 – 20 May 2025
- Disability Awareness Day - 13 July 2025

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/69**	
SUBJECT:	**Guardian of Safe Working Annual Report**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Rachel Wallis, Guardian of Safe Working Hourse	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
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	✓ ✓
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; 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 have patients waiting more than 12 hours in the department from time of arrival **#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 and failure to achieve constitutional standards and financial plans. **#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 **#1757** If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services. **#2001** 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. **#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	

<table>
<tr><td></td><td>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 its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety
#1898 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.
#125 If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities 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, 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.
#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>**LINK TO PUBLIC SECTOR EQUALITY DUTIES**</td><td>***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***
<table>
<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</td><td>**Yes**
✓</td><td>**No**
✓</td><td>***N/A***
✓</td></tr>
</table></td></tr>
</table>

	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	**Yes**	**No**	**N/A**
		✓	✓	✓
	Further Information:			

EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Guardian of Safe Working is required to report annually to the Strategic People Committee on exception reporting activity, and financial implications. Unlike previous years, the level of reporting has now stabilised to pre-pandemic levels and is consistent with that experienced by other trusts in the region. The annual report is attached. Key areas include: • Positive culture changes surrounding exception reporting and sign off • New GoSW team • Fines levied by the Guardian of Safe Working • Immediate Safety concerns (ISC) and processes • Training post fill and vacant slots • Themes over the 12 month period - Trauma and Orthopaedics (T&O) - Obstetrics and Gynaecology (O&G) General Medicine		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision** ✓
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	SPC/24/07/66	
	Date of meeting	17 July 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Annual Report of Guardian of Safe Working Hours March 2023 – April 2024	AGENDA REF	BM/24/08/69

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers. The GSW is also part of a national GSW network facilitated by a WhatsApp group to provide support and ensure consistency of approach across trusts in England and Wales.

Most junior doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible.

2. KEY ELEMENTS

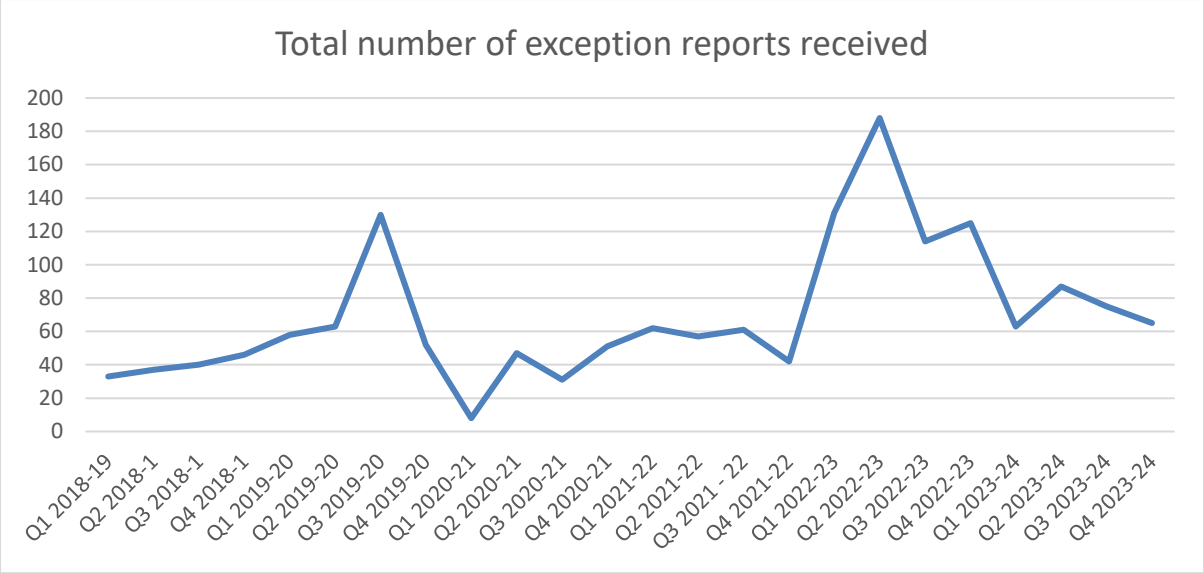
High level data

Number of doctors including training and trust grade (total): 374
Number of doctors in training on 2016 TCS (total): 270

Exception Reporting

A total of 290 exception reports were submitted during the period covered by this report, which is significantly less than the 558 submitted in the previous 12 months.

Chart 1 below illustrates the fall in exception reporting year on year



Decreasing Numbers of Exception Reports

Over the preceding 12 months the previous GSW worked to promote increased understanding and education regarding the need for exception reporting to support positive evidence-based change. This was reflected in the higher number of reports submitted compared to pre-pandemic levels. The increasing number of exception reports in 2022-2023 was viewed as a positive change. Subsequently the workforce and activity within the Trust has become more settled and action taken over the year has resulted in a reduced incidence of exception reporting in line with national trends. During the junior doctors' induction programme in August 2023 a concerted effort was made to increase awareness and understanding of the exception reporting process. This will be repeated in 2024 August induction by the current GSW in order to continue the progress made. Educational sessions have also been held with educational supervisors. It is hoped that if junior doctors feel empowered to report 'minor' concerns then there will be fewer barriers to reporting when significant concerns arise. The GSW will be present at the 2024 induction meetings and will continue to educate regarding the importance of exception reporting.

Fines Levied

The safeguards around working hours of doctors and dentists in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured. The GSW reviews all exception reports and identifies where a breach has occurred which results in a financial penalty as per TCS. During June to December 2023, the post of GSW was vacant for approximately 6 months, however fines have been identified and issued retrospectively where appropriate. There have been £2426.89 of fines levied by the GSW during the period covered by this report (see chart 2).

Chart 2 – Fines levied by the GSW during 2023-2024.

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Date Fine issued by GOSW	Total fine levied by GOSW	Proportion of fine paid to GOSW	Proportion of fine paid to Dr	Breach	CBU	Dept	Penalty rate	Comment
05/08/2023 - 7/8/2023	100.78	62.99	37.79	Max shift lengh	Surgical Specialities	T&O	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
01/09/2023	67.52	42.2	25.31	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
02/09/2023	85.66	53.54	32.12	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
03/09/2023	50.39	31.5	18.9	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
08/09/2023	173.34	108.33	65.01	Max shift lengh	Digestive diseases	Gen Surgery	ST7	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
25/09/2023	151.17	94.49	56.69	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
26/09/2023	50.39	31.5	18.9	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
27/09/2023	151.17	94.49	56.69	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
28/09/2023	100.78	62.99	37.79	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
05/10/2023	58.34	36.47	21.87	Max shift lengh	Digestive diseases	Gen Surgery	F1	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW

06/10/2023	21.77	13.61	8.16	Max shift lengh	Digestive diseases	Gen Surgery	F1	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
07/10/2023-8/10/2023	50.39	31.5	18.9	Max shift lengh	Surgical Specialities	T&O	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
01/11/2023	100.78	62.99	37.79	Max shift lengh	Surgical Specialities	T&O	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
11/12/2023	125.98	78.74	47.24	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
12/12/2023	125.98	78.74	47.24	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
13/12/2023	151.17	94.49	56.69	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
14/12/2023	125.98	78.74	47.24	Max shift lengh	Digestive diseases	Gen Surgery	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
29/12/2023	43.54	27.22	16.32	Max shift lengh	Surgical Specialities	T&O	F1	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
23/01/2024	100.78	62.99	37.79	Max shift lengh	Surgical Specialities	T&O	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
12/02/2024	43.54	27.22	16.32	Max shift lengh	Surgical Specialities	T&O	F1	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
06/03/2024	151.17	94.49	56.69	Max shift lengh	Women & Childrens	O&G	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
07/03/2024	151.17	94.49	56.69	Max shift lengh	Women & Childrens	O&G	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
18/03/2024	201.56	125.98	75.58	Max shift lengh	Women & Childrens	O&G	F2	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW

01/04/2024	43.54	27.22	16.32	Max shift lengh	Surgical Specialities	T&O	F1	Proportion of the total fine(x1.5) paid to Dr, the remainder is paid to GOSW
TOTAL	**2426.89**	**1516.92**	**910.04**					

For some breaches a proportion of the fine is paid to the individual doctor, the GSW is responsible for the remaining balance, which must be used to benefit the education, training and working environment of the trainees. The GSW should devise allocation of funds in collaboration with the JDF.
During 2023-2024 the JDF and GSW determined a plan to purchase coffee machines for doctors in training and these were subsequently purchased with consumables at a cost of …. The remainder of the balance of funds will continue to be allocated to replace consumables until spent unless a decision is made at a future JDF to reallocate funds to an alternative project.

Date	Item	Monies out	Monies In	Balance
				£5,005.13
Sep-23	Sept 23 - Coffee Machines and consumables	£1,968.50		£3,036.63
Jan-24	Coffee Machine consumables	£1,412.50		£1,624.13
Jun-24	Fines from GOSW		£1,516.92	£3,141.05

Immediate Safety Concerns
Immediate safety concern (ISC) ERs were submitted on 5 occasions during the period covered by this report. Two were reviewed by the GSW and not thought to have been any safety concern and therefore downgraded. Of the remaining ISC reports the majority were reports understaffing and concern regarding levels of support available to the junior doctor. All ISCs were escalated appropriately, reviewed, and remedial action implemented to mitigate the risk. Junior doctors reporting the ISCs were given appropriate support by educational supervisors and the GSW. There is a clear process for escalation of ISCs. The GSW is assured that processes are in place to ensure any issues highlighted as an ISC are acted on quickly and diligently.

Themes for April 2023 – March 2024

New GSW and Medical Workforce Administrator
The GSW post was vacant for a period between June and December 2023 with the new GSW coming into post in December 2023. Additionally, the previous medical trainees workforce administrator resigned and a new MWTA was appointed. This led to a backlog in exception reports and the application of fines for regulatory breaches. The majority of this work has now been resolved with plans to resolve remaining exceptions.

T&O
In the preceding 12 months 25% of all exception reports were submitted by T&O doctors, which is down from 30% in 2022-23 but still significantly higher than other specialties when the number of doctors in training as a proportion of the total is taken into consideration. However, over the course of the year positive improvements have been made as a result of a comprehensive action plan developed via a series of meetings facilitated by the GSW. Reporting in Q4 continued a downward trend with 14 exception reports submitted compared with 24 in Q3. Work within the T&O department, supported by Senior Management and the GSW is ongoing and will continue to be monitored via the exception reporting system however the position is significantly improved compared to 2023.

O&G
During Q4 there were a significant number of exception reports in O&G with 13 being submitted across all grades all relating to hours of work. It is recognised that previously there have been very few exception reports submitted by doctors in O&G. The GSW met with the CL and manager to review the issue. Following this the clinical team met with the doctors to explore the issues and have identified several issues in the way of working which were negatively impacting on the ability of doctors to complete their work and handover within their normal hours of work. Measures have been put into place to address this, which will be reviewed in the near future to determine their impact. A work schedule review is planned as the next stage should the planned measures not result in significant improvement.

General Medicine
In Q4 there were a number of exception reports relating to General Medicine and in particular the Foundation Y1 (FY1) trainees (15 in total) which was an increase on Quarter 3 (12). These related to hours worked but are felt to represent an increase in the intensity of workload on specific wards. The GSW has spoken with the clinical leads for the respective areas and has participated in a medical staffing review for the medical wards to optimise distribution of both training and non-training grades of doctors in light of current activity.

Overall Post Fill Rate and Vacant Slots
During academic year August 2023 to July 2024 the Trust carried a significant number of underfilled rotations, especially with regard to the GP training programme (GPSTs) which for a number of years has been undersubscribed across the region. In addition, there has been a trend nationally of an increase in flexible working patterns for doctors in training with many undertaking a less than full time rota at 60-80% of full time hours. This has led to a shortfall in medical staffing. The trust has actively engaged in the recruitment of Specialty Doctors and Locally Employed Doctors to minimise the effect on patient care. For August 2024 to July 2025 we are anticipating an greater fill of training posts as below:

Role	2023-2024	2024-2025
FY1	39	42
FY2	36	39
IMT1	11	11
IMT2	1	0
IMT3	2	4
GPST	16	27
GPST+	4	2
ST	73	86

Summary

- Number of exception reports raised = 290
- Number of work schedule reviews that have taken place = 10
- ERs flagged as immediate safety concerns = 5
- Fines that were levied by the Guardian = 7

Exception Reports (ER) over past quarter	
Reference period of report	01/04/23 - 31/03/24
Total number of exception reports received	290
Number relating to immediate patient safety issues	2
Number relating to hours of working	260
Number relating to pattern of work	13
Number relating to educational opportunities	10
Number relating to service support available to the doctor	7
***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*	

This year has seen a maintenance of standards in the sign off of exception reports which is again due to efforts made during the induction programme, ongoing updates at the JDF and regular reminders sent via the Medical Trainee Workforce administrator.

Due to the period of vacancy in the post of GSW and the commencement in post of both GSW and Medical Trainee Workforce Administrator there was a backlog of exception reports in December. However, the backlog has been cleared, demonstrating an obvious improvement in resolution of those reports. The GSW and Medical Trainees Workforce Administrator will continue to monitor outstanding exception reports and encourage continued engagement from both trainees and educational supervisors.

In addition to this, all JDF meeting have been well attended and there has been strong engagement between Junior Doctors' Representatives, the MEM, DME and GSW.

3. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	125
Total number of overtime payments	101
Total number of work schedule reviews	10
Total number of reports resulting in no action	28
Total number of organisation changes	2
Compensation	0
Unresolved	52
Total number of resolutions	**266**
Total resolved exceptions	**267**

Note :
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

4. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate.
4. The Junior Doctor needs to indicate their “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

The GSW will be provided with timely data reports to support this role in the coming year, with reference to improvement in response times for ERs.

5. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours’ Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the Trust’s Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust’s Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

6. TIMELINES

SPC – GSW - Quarterly Reports, Safe Working Hours Junior Doctors in Training

- Q1 Apr – Jun; Submitted Sept 2023
- Q2 Jul – Sept; Submitted Nov 2023
- Q3 Oct – Dec; Submitted Jan 2024
- Q4 Jan – Mar; Submitted May 2024
- GSW – Annual Report, Safe Working Hours Junior Doctors in Training – Submitted July 2024

Trust Board – GSW – Annual Report Reports, Safe Working Hours Junior Doctors in Training

- 12-month review period Apr 2023 – Mar 2024 – Submitted August 2024

7. ASSURANCE COMMITTEE (IF RELEVANT)

Strategic People Committee – Quarterly submission & Annual Submission, prior to Trust Board
Trust Board – Annual Submissions

8. RECOMMENDATIONS

The Trust Board is asked to consider the contents of the report for formal submission, following assurance made at the Strategic People Committee. The GSW will continue to monitor all exception reports to ensure the Trust is compliant with the 2016 Junior Doctor Contract Terms and Conditions and to ensure any persistent issues in departments that arise are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours.

9. ASSURANCE COMMITTEE

10. RECOMMENDATIONS

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/70**	
SUBJECT:	**Trust work to address health inequalities**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Viviane Risk, strategic project manager; Adam Harrison-Moran, Head of Culture and Inclusion; Tracy Fennell, Deputy Chief Nurse; Hayley Heard, Deputy Director of Strategy and 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:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		√		
	Further Information: It is recognised that work to address health inequalities is subsequently aligned with inclusive cultures. There are programmes in this paper, particularly through engagement which support the elimination of discrimination and harassment in healthcare settings.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		√		
	Further Information:			

<table>
<tr><td rowspan="3"></td><td colspan="4">This paper recognises the importance of health inequalities in access and experience. Therefore, by continuing work to reduce health inequalities this will have a significant impact on access for patients, service users and also prospective staff in the future.</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:
As per notes 1 and 2, this paper outlines the importance of recognising available data to make tangible improvements. Therefore, in doing so, this will aim to create a culture whereby relations between protected groups improves through equitable outcomes and experience.</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">NHS England set out five key priority areas for addressing health inequalities within the 2021/22 Priorities and Operational Planning Guidance[1]. In response to this, the Trust began a scheme of work to formalise and structure the approach to addressing health inequalities aligned with our role as an anchor institution.

Further to this a statement was published in 2023 which sets out how relevant NHS bodies should exercise their powers to collect, analyse and publish information on health inequalities, including how this should be used to address health inequalities. This is a core element of the National Healthcare Inequalities Improvement Programme[2].

The Trust Board has the responsibility for ensuring that they work in partnership to create inclusive cultures and report progress to the relevant bodies.

This paper sets out an overview of the Trust's work to address health inequalities, provides examples of impact and describes the next steps to ensuring that the Trust is continuing the commitment to address health inequalities.</td></tr>
</table>

[1] NHS England, 2021/22 priorities and operational planning guidance: Implementation guidance - https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

[2] NHS England, National healthcare inequalities improvement programme - https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the work to address health inequalities and the requirement to formally report through the annual reporting process. The Trust Board is asked to support the next steps and associated governance.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	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 TRUST BOARD

SUBJECT	Trust work to address health inequalities	AGENDA REF	BM/24/08/70

1. BACKGROUND/CONTEXT

On 25 March 2021 NHS England set out five key priority areas for addressing health inequalities within the 2021/22 Priorities and Operational Planning Guidance[3], to support recovery following the COVID-19 pandemic. In response to this, the Trust began a scheme of work to formalise and structure the approach to addressing health inequalities aligned with our role as an anchor institution.

Further to this a statement was published in November 2023 which sets out how relevant NHS bodies should exercise their powers to collect, analyse and publish information on health inequalities, including how this should be used to address health inequalities. This is a core element of the National Healthcare Inequalities Improvement Programme[4]. A copy of the Trust Healthcare Inequalities action plan can be found as Appendix One with the statement for 2023/24 found as Appendix Two.

Specifically for the Trust workforce, the NHS Equality, Diversity and Inclusion Improvement Plan[5], published in 2023 sets out a requirement for organisations to "develop and implement an improvement plan to address health inequalities within the workforce" by March 2025. This is reported through the Workforce Equality, Diversity and Inclusion Strategy updates to Strategic People Committee on a bi-annual basis.

The Trust Board has the responsibility for ensuring that they work in partnership with its patients, communities and workforce to create inclusive cultures. Part of the annual public sector equality duty reporting, through the Equality Delivery System, reviews 'inclusive leadership' which scores Board members involvement, understanding and commitment to equality and health inequalities from 'developing' to 'excelling'.

Overall, this paper sets out to provide an overview of the Trust's work on addressing health inequalities, examples of impact and next steps, ensuring that the Trust is continuing the commitment to addressing health inequalities.

[3] NHS England, 2021/22 priorities and operational planning guidance: Implementation guidance - https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf
[4] NHS England, National healthcare inequalities improvement programme - https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/
[5] NHS England, National equality, diversity and inclusion improvement plan - https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/

2. KEY ELEMENTS

2.1. Work to address health inequalities

In 2021 work began to formalise and structure work around the Trust's role as an anchor institution. The work included:

- clarifying definitions and terminology
- gathering and analysing the baseline data
- identifying potential areas of focus
- detailing existing initiatives/work addressing anchor objectives, and gaps and next steps.

Information and data sources included the use of joint strategic needs assessments for Warrington and Halton, nationally published Public Health Outcomes Framework data and the national social value measurement framework. The information was collated and shared for discussion including at the Trust Board, Executive Team, Local Authority Health and Wellbeing Boards, and the Council of Governors.

A set of principles defining the Trust's anchor institution approach were agreed, as outlined in Figure One:

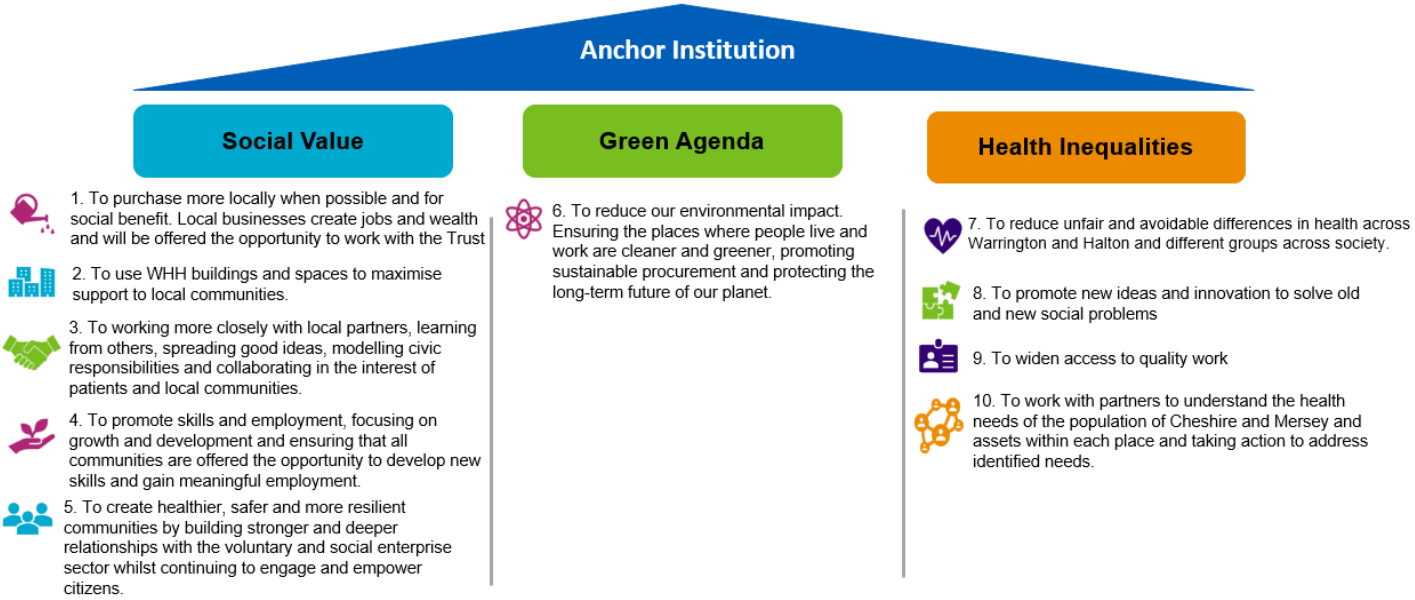

Figure One: Anchor Institution Principles

Following the COVID-19 pandemic through the restoration of services, NHS England published guidance which set out eight urgent actions for tackling health inequalities. This was later refined to five key priority areas which underpin the work of the National Healthcare Inequalities Improvement Programme. The five priority areas remain in place as per the 2024/25 operational planning guidance and NHS standard contract. They are:

1. restoring NHS services inclusively
2. mitigating against digital exclusion
3. ensuring datasets are complete and timely
4. accelerating preventative programmes
5. strengthening leadership and accountability.

The actions outlined in the 2021/22 guidance were initially reported through the Trust Board Assurance Framework, under risk 1235. Following which there was investment into the

Patient Experience and Inclusion function, a Board-level sponsor was appointed as the executive lead for health inequalities and strengthened governance arrangements were put in place. It is noted that the primary focus of the five priorities is for patients and the public. The Trust is however committed through its Workforce Equality, Diversity and Inclusion Strategy 2022-2025 to address the health inequalities of its workforce.

Section 2.1.1 to 2.1.5 outline some examples of the work undertaken and/or currently being delivered by the Trust in addressing health inequalities aligned to the five priorities.

2.1.1. Restoring NHS services inclusively

Priority one focuses on using data and local evidence to plan the inclusive restoration of services, addressing pre-existing disparities in access, experience, and outcomes that were exacerbated by the COVID-19 pandemic, particularly in areas of diverse ethnicity and deprivation. Examples include:

Living Well Hub

Opened in March 2024, The Health and Wellbeing Hub (known as the Living Well hub) was 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 is 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.

External accreditations and charter marks

The Trust has a variety of external accreditations and charter marks, they support the Trust in ensuring that that best practice is implemented through the lens of equality, diversity and inclusion as well as addressing health inequalities.

Navajo Charter Mark

The Navajo Merseyside & Cheshire LGBTQ+ Charter Mark is an equality mark sponsored by In-Trust Merseyside and supported by the LGBTIQA+ Community networks across Merseyside. To achieve the status members from across the Trust supported the process with interviews, evidence etc to ensure we were successful. The award is supported by an action plan, providing evidence for 2023-25 to sustain and improve standards for people from the LGBTQ+ community.

Stonewall Diversity Champion

The Stonewall Diversity Champion accreditation is a supportive mechanism in ensuring that the Trust implements policies, processes and procedures which are inclusive in practice and support the reducing in inequalities experienced by groups. Although specifically an LGBTQ+ accreditation, it focuses on intersectionality and ensuring that all WHH processes are inclusive for all.

NHS Rainbow Badge Scheme – Phase 2

The Rainbow Badge Scheme is an external accreditation in place by NHS England by which the Trust received the ‘bronze’ award. This marker supports the Trust in identifying opportunities to improve the experience of LGBTQ+ patients and the workforce. Additionally, this delves into the experiences of patients, ensuring services consider the needs of all patients and address inequalities in access and experience.

Disability Confident Leader Status

The Disability Confident Leader status is a symbol which supports the Trust in securing, retaining and developing disabled staff who are skilled and have the support they need to complete their work. The status is specifically important recognising the local population and disability employment gap in the UK. Additionally, 83% of those with a disability acquire this during working age, therefore the status is intertwined through employment processes. For example, the launch of the Trust Workplace Passport which is a tool to empower staff with a disability, long-term health condition or neurodiversity to talk about their condition and any adjustments they need in work.

NHS Veteran Friendly and Employer Recognition Scheme (Silver)

The Trust is recognised as veterans friendly for its patients, communities and workforce. This is externally achieved through the Veterans Friendly accreditation and NHS Employer Recognition Scheme, where the Trust has achieved the silver status.

With a general population of around 1,095,100 in Cheshire, it is estimated that around 130,634 (12%) are from the armed forces community. During work on the Trust’s re-accreditation in 2023, the Veterans Covenant Healthcare Alliance (VCHA) noted that the Trust had been developing its original offer; of particular note the Trust had an Armed Forces Advocate post for two years, a strong Armed Forces Veterans Staff Network, which has helped inform developments for patients from the Armed Forces Community, and good levels of staff awareness. This included commendations on the Trust’s commitment to the Step into Health programme, particularly the varied support through all levels of military and community service. This work is continued through the Culture and Inclusion function.

Anti-Racist Framework

The North West Anti-Racist Framework has been developed by the North West BAME Assembly and provides a framework for all NHS organisations to work towards the ambition of becoming actively anti-racist organisations. It provides guidance to implement actions quickly and the steps needed to reduce the inequalities that exist across the workforce and to become intentionally anti-racist as an organisation.

The framework has three levels of achievement (bronze, silver and gold). Each level enables organisations to make incremental improvements whilst taking consistent action to support anti-racist practices within the organisation. Figure Two illustrates the bronze level of accreditation and achievement which signifies that an organisation has taken initial steps to become intentionally anti-racist.

Key Drivers	Direct Deliverables	Supporting Actions
Leading from the front	The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.

Figure Two: Anti-Racist Framework Bronze Accreditation Overview

WHH has been awarded the bronze status on 28th June 2024 by the North West BAME Assembly for its commitment to ensuring that the organisation progresses actions in a meaningful manner. This recognises the work to create the culture and conditions where the organisation takes action to becoming unapologetically anti-racist.

Specifically linked to health inequalities, the Trust has embedded the Equality Delivery System Domain 1 to address, identify and share best practice in association with health inequalities within services. In 2023/24 this was completed with Maternity, Long Covid and the Chaplaincy and Spiritual Care Service. Of note, work focused on Team River's inclusive practices were commended as outstanding by the assessors.

Staff Networks

The Trust has five staff networks, they are: Multi-Ethnic Staff Network, Progress LGBTQ+ Network, Disability Awareness Network, Women's Staff Network, Armed Forces and Veteran's Community Network

The networks are a key voice in decision making and influencing of strategic direction. In doing so the Trust can ensure that the voice of a wider range of stakeholders is key to policy design and service improvement through equality analysis. In addition, an executive director sponsors each network, this ensures that the voice of the organisation feeds into strategic direction and design.

On an annual basis, the work of the staff networks is reported through the Equality, Diversity and Inclusion Annual Report – this can be found here:
https://whh.nhs.uk/download_file/view/2944/227

Health Education England Health Ambassador Initiative

WHH joined the HEE Health Ambassador initiative in a bid to connect with school children of all ages to talk about the breadth of roles available in the NHS. The initiative aims to inspire young people to consider a future career in the NHS. WHH NHS Ambassadors take part in activities such as speed networking, mock interviews, open days, careers marketplace, workplace visits, career days and many more, alongside interactive virtual sessions to connect with young people online.

Clinical service improvements

- Maternity Teams - Lunar, Sunlight and River – supporting people across the Warrington and Halton region, including vulnerable and complex cases.
- Elective recovery including a new theatre, endoscopy unit and community diagnostic centres on our Halton site, where the population typically experiences the highest levels of deprivation.
- Halton Health Hub (opened Dec 2022)
- Runcorn Health & Education Hub (due to open late Summer 2025)

2.1.2. Mitigating against digital exclusion

Priority two focuses on ensuring face-to-face care for patients unable to use remote services, improving data collection on consultation types by protected characteristics and health inclusion groups, and assessing the impact of digital consultations on patient access.

Examples include:

- Digital inclusion cafes, previously supported by Warrington Voluntary Action and banking groups.
- Implementation of the Patient Engagement Portal with robust communications and engagement, a significant step in the journey to be a digital first Trust, using technology and data to improve the lives of patients and staff
- Where safe and appropriate encouraging and embedding a patient-initiated follow-up process (PIFU) in outpatient settings.
- Working with Experts by Experience to incorporate a wide range of views in digital first approaches, ensuring that digital inclusion is at the forefront of any change.

2.1.3. Ensuring datasets are complete and timely

Priority three focuses on improving the collection and recording of equality and diversity information, specifically ‘ethnicity’ data across all NHS settings.

Examples include:

- Mandated recording of ethnicity data at urgent and emergency care admissions.
- The recording of ethnicity to be a mandated field for all patients accessing the Trust, including elective inpatient admissions and outpatient appointments.
- Commenced the development of equality, diversity and inclusion dashboards, which include the monitoring of protected characteristics.
- Ensured that protected characteristic data fields, including ethnicity, are a key component to the procurement of the new electronic patient record system.

2.1.4. Accelerating preventative programmes

Priority four focuses on accelerating preventative programmes and proactive health management for groups at greatest risk of poorer health outcomes.

Examples include:

- **Halton Health and Wellbeing** – The Trust Director of Strategy and Partnerships co-chairs the Wider Determinants workstream within the One Halton place-based partnership. The workstream aims to address factors affecting the overall health and wellbeing of Halton residents focussing on economic regeneration, (violent) crime reduction, workforce and education, living conditions, adopting a Marmot[6] approach.
- **Supported Internship Programme** – Working with Warrington Vale Royal College and Project Search, WHH have established a Supported Internship Scheme to support the recruitment of young people with a learning disability, autism spectrum condition or both, to placements across roles at WHH. The aim of the project is to support the students to develop work-based skills so they can go onto apply and secure future employment either with WHH or in the local community. This project concluded in June 2023 with the second cohort due to commence in September 2024. This programme reports through the Workforce Equality, Diversity and Inclusion Strategy updates to Strategic People Committee.
- **Active Hospitals** – Implementing the "ready, dress, go!" programme and national re-conditioning games. Encouraging patients to move more and to be active, to prevent the serious risks of hospital associated deconditioning.
- **Smart Heart schools programme**
- **Tobacco Dependency** – The work of the Alcohol Care Team and the Trust's tackling tobacco dependency programme for acute inpatients and within maternity services.
- **The High Intensity Users service** which provides 12 weeks of one-to-one support connecting people who frequently attend Emergency Department to appropriate community support.
- **Prevention Pledge** – The Trust was an early adopter of the prevention pledge[7] across Cheshire and Merseyside, recognising how the community continues to experience widespread preventable illness and inequalities in health.

2.1.5. Strengthening leadership and accountability

Priority five focuses on ensuring that NHS organisations have a named executive board-level lead for tackling health inequalities. Additionally, it highlights the importance of board members receiving training to tackle health inequalities.

Examples include:

- Appointment of the Director of Strategy and Partnerships as the named executive board-level lead for health inequalities.
- The Chief Nurse is the executive lead for the patient and service users' equality, diversity and inclusion agenda.

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[6] Institute of Health Equity – The Marmot Review, 10 Years On: https://www.health.org.uk/sites/default/files/2020-03/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_executive%20summary_web.pdf

[7] NHS Cheshire and Merseyside – Prevention pledge: https://www.cheshireandmerseyside.nhs.uk/about/sustainability/nhs-prevention-pledge/

- The Chief People Officer is the executive lead for the workforce equality, diversity and inclusion agenda.
- Tackling health inequalities embedded within Trust strategic priorities for 2023 to 2026.
- Appointment to the role of Director of Population Health and Inequalities.
- Signed-up to the Cheshire and Merseyside Anchor Institution Charter.
- Recipient of the Cheshire and Merseyside Social Value Award.
- Introduction of Equality and Health Inequalities Impact Assessments – to ensure alignment with existing Trust processes, embedding health inequalities as part of business-as-usual activity, there has been a review of the equality analysis process as a Trust. This now requires leaders and decision-makers to review the need to complete a Health Equity Assessment Tool (HEAT) within the existing Equality Impact Assessment process.
- Ensuring health inequalities is a key agenda item for all – the focus of the Trust Quality Academy Summit on 4 July 2024 was reducing health inequalities and patient and public involvement. This highlighted the importance of this agenda in achieving exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes.

2.2. Next Steps

Addressing health inequalities continues to be a core component of the Trust, both as an anchor institution and as a key strategic aim. The Trust utilises the guidance published by NHS England which outlines the five key priorities, as well as the Schedule 2N reducing health inequalities action plan, found as Appendix One.

To ensure that we are effectively addressing health inequalities in all that we do whilst effectively incorporating and reflecting regional and national guidance, a number of actions are being taken at WHH aligned to the five key priorities. They include:

- **Priority 1:** Restore NHS services inclusively:
  - use the CORE20Plus5 framework for children and young people and adults to complete a gap analysis to tackle healthcare inequalities.
- **Priority 2:** Mitigate against digital exclusion:
  - carry out data collection to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups.
- **Priority 3:** Ensure datasets are complete and timely:
  - ensure the new Electronic Patient Record and Patient Engagement Portal captures the right data to monitor health inequalities develop health inequalities dashboards.
- **Priority 4:** Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes:
  - review progress against the commitments outlined in the NHS Prevention Pledge and refresh the tracker for 2024/25.
- **Priority 5:** Strengthen leadership and accountability delivery:
  - carry out a self-assessment of the Trust's approach to tackling health inequalities to identify and address gaps.

Ensuring that the work of the Trust is monitored for assurance with lessons learnt shared, a Health Inequalities Focus Group has been established. This group will:

- provide advice and guidance on how to further embed considerations of health inequalities.
- ensure that the right data is used to tackle health inequalities.
- support and equip staff across the Trust to address health inequalities.
- collate published guidance and ensure that the Trust is addressing actions and requirements using the five NHS priorities for tackling healthcare inequalities post pandemic.
- undertake a mapping exercise to collate requirements across all published guidance, ensuring the Trust is compliant with regards to addressing health inequalities.

Recognising that workstreams to reduce health inequalities are integral to the Trust strategic objectives, the Health Inequalities Focus Group will report as required to the Patient Experience and Inclusion Sub-Committee and Workforce Inclusion and Culture Sub-Committee, providing assurance to Quality Assurance Committee and to the Strategic People Committee on matters relating to workforce health inequalities, as appropriate. This is demonstrated in Figure Three.

Figure Three: Health Inequalities Focus Group Governance

With the expansion of the equality impact assessment process to include consideration of how a project, policy or service change impacts on health inequalities, the tool will ensure health inequalities are considered when designing or re-designing a service or pathway. The revised process was formerly ratified on 24 July 2024 for implementation from August 2024.

Additionally, the workforce elements of the NHS equality, diversity and inclusion (EDI) improvement plan will be reported through the Strategic People Committee and outlined within the Trust Annual Equality, Diversity and Inclusion Report for 2024/25. This includes the use of the Workforce Race and Disability Equality Standards, mandated reporting such as pay gaps and Domain Two of the Equality Delivery System.

2.3. NHS England Statement on Information on Health Inequalities

In November 2023 NHS England published a statement setting out the monitoring and reporting responsibilities of NHS bodies (ICBs, Trusts and Foundation Trusts) to identify and act on health inequalities. The full statement is available online, but in brief the three aims of the statement are:

- Understanding healthcare needs,
- Understanding health access, experience, and outcomes,
- Publishing information on health inequalities.

Understanding healthcare needs

ICBs should be able to understand:

- The demographic profile of people living in the local area served, including the size and geographical distribution of more disadvantaged groups.
- Healthcare needs of the population, particularly among people living in more deprived places or who are from more disadvantaged social groups.
- Wider social, environmental and economic factors that affect health and wellbeing underpin health inequalities.

Understanding health access, experience and outcomes

- NHS bodies should collect, analyse and publish the information on health inequalities contained in the table in the appendices of the statement.
- Data should include information on NHS services commissioned to other providers.
- In addition, collect and analyse other information as required for national monitoring, or considered relevant for local populations or priorities.

Publishing information of health inequalities

- Publish information on the health inequalities set out in the appendix. This can be within or alongside annual reports.
- Trusts and foundation trusts should publish information at a trust level. Where a trust works with more than one ICB, if and how data is to be included will need to be discussed.
- Reports should be in an accessible format, distilling the key messages and explaining the data.
- NHS bodies should describe how they intend to respond to inequalities and make progress.

Within or alongside annual reports NHS bodies must publish reports on the health inequalities domains and indicators set out in Appendix One of the statement, summarising the inequalities revealed and how the information has been used to guide action. Other information on health inequalities relevant to local populations or priorities can be reported where appropriate.

Information should be used by services and boards to inform service improvement and reductions in healthcare inequalities. This should be through:

- Strategy development
- Policy options review
- Resource allocation

- Service design
- Commissioning and delivery decisions
- Service evaluations

Knowledge and information that is not included in this statement but is available can and should be used to inform action.

Review and analysis of the data sets was undertaken and reported within the 2023/24 Trust Annual Report. The section from the annual report is included as Appendix Two.

3. RECOMMENDATIONS

The Trust Board is asked to note the work to address health inequalities and the requirement to formally report through the annual reporting process. The Trust Board is asked to support the next steps and associated governance.

4. Appendices

Appendix 1 - Schedule 2N reducing health inequalities action plan for inclusion in NHS Trust contracts 2024/25

SCHEDULE 2 – THE SERVICES

A. Health Inequalities Action Plan

Schedule 2N sets out specific actions which the Provider will take, aimed at reducing inequalities in access to, experience of and outcomes from care and treatment, with specific relation to the Services.

Ref	Schedule Requirements	Description	Method of Measurement	Rationale for inclusion	Escalation	Resources
2N-1	**Trust to contribute to NHSE North West Healthcare Public Health Systems Quarterly Oversight Update.**	Trust to provide updates on the following reporting requirements: **Healthcare Inequalities** Adult Core20Plus5 Children & Young People Core20Plus5 Anchors Inclusion Health Strategic Priorities Restoring NHS services inclusively- inclusive recovery Mitigating against digital exclusion Ensuring datasets are complete & timely Accelerating prevention programmes	Quarterly Submission to CHAMPS public health collaborative	Supports completion of 2N-2 Opportunity to share success/ developments/ good practice	Non-submission followed up by ICB Director of Population Health. In accordance with Contract Management GC9.	NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people NHS England Equality and Health Inequalities Hub. Equality and Health Inequalities Hub: Data and insight. Health Inequalities Improvement Dashboard (HIID);

		Strengthening leadership & accountability **National Initiatives** Core20Plus5 Ambassadors Connectors InHIP **NHS LTP** **Prevention Programme** Alcohol Care Teams Tobacco Treatment Dependency Programme Digital Weight Management Programme				NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion A national framework for NHS – action on inclusion health. Healthcare Inequalities Improvement Programme - FutureNHS Collaboration Platform
2N-2	**Health Inequalities Statement**	Trusts have a legal duty to include in their annual reports a review of the extent to which they have exercised their functions consistently with NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006).	Publication of annual report.	Section 13SA NHS Service Act 2006 Opportunity to share success/ developments/ good practice.	In accordance with relevant legislation.	NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)
2N-3	**Adoption of the NHS Prevention Pledge**	14 core commitments, covering key themes including: - Promoting workforce development, workplace health & wellbeing - Promoting healthier lifestyles for	Progress update to CQPG/CQRM as identified by meeting workplan. (In line with	Cheshire and Merseyside Health and Care Partnership (HCP) Strategic Objective	Contract/Quality to revise agreed timescale for progress update to CQRM/CQPG in accordance with trust internal	NHS Prevention Pledge - NHS Cheshire and Merseyside

		patients/visitors & making every contact count - Using Marmot principles to address health inequalities & working with partners at Place - Signing up to C&M Concordat for Better Mental Health - Embedding prevention in governance structures	updates to Trust Board).	Opportunity to share success/ developments/ good practice	governance, followed by NHS Standard Contract General Conditions.	
2N-4	**Sign up to Cheshire and Merseyside Social Value Charter**	The vision for Social Value across Cheshire and Merseyside is that everyone recognises their contribution to Social Value, including the changes it can bring about to reduce avoidable inequalities and improve health and wellbeing. The Charter sets out key principles and values in terms of how we embed Social Value within our organisations.	Progress update to CQPG/CQRM as identified by meeting workplan.	HCP Strategic Objective Opportunity to share success/ developments/ good practice	Contract/Quality lead to revise agreed timescale for progress update to CQRM/CQPG in accordance with trust internal governance, followed by NHS Standard Contract General Conditions.	social-value-charter.pdf (cheshireandmerseyside.nhs.uk)
2N-5	**Achievement of Social Value Award**	A quality mark which is centred on providing evidence against and making a pledge for one or all of the 4 themes - Innovation, Economic, Social and Environment - the Social Value Award aims to help organisations to recognise the impact that they are making in their community through their social value, deliver social value, and recognises the	Progress update to CQPG/CQRM as identified by meeting workplan.	HCP Strategic Objective Opportunity to share success/ developments/ good practice	Contract/Quality lead to revise agreed timescale for progress update to CQRM/CQPG in accordance with trust internal governance, followed by NHS Standard Contract General Conditions.	Social Value Award - NHS Cheshire and Merseyside

		organisation as an 'Anchor Institution.				
2N-6	**Sign up to the Anchor Institute Framework**	Based on the 5 recognised anchor pillars, the Anchor Framework has a set of priorities and principles that organisations are asked to commit to deliver - providing opportunity, real living wage and achieving net zero.	Progress update to CQPG/CQRM as identified by meeting workplan.	HCP Strategic Objective Opportunity to share success/ developments/ good practice	Contract/Quality lead to revise agreed timescale for progress update to CQRM/CQPG in accordance with trust internal governance, followed by NHS Standard Contract General Conditions.	Anchor Institution Framework - NHS Cheshire and Merseyside
2N-7	**Implement the North West Black, Asian and Minority Ethnic Assembly Framework**	The aim of the framework is to support all North West NHS organisations to become anti-racist by encouraging the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Its five key principles are: • Prioritise anti-racism • Understand lived experiences • Grow inclusive leaders • Act to tackle inequalities • Review progress regularly	Progress update to CQPG/CQRM as identified by meeting workplan.	HCP Strategic Objective Opportunity to share success/ developments/ good practice	Contract/Quality lead to revise agreed timescale for progress update to CQRM/CQPG in accordance with trust internal governance, followed by NHS Standard Contract General Conditions.	The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf (england.nhs.uk) NHS leadership competency framework for board members

2.4 How equality of service delivery to different groups has been promoted through the organisation

As a public sector organisation, all NHS Trusts are required to demonstrate how they meet the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010.

The Trust ensures it provides equality of access to its patients, workforce and members of the public. It is committed to furthering equality, diversity, inclusion and human rights, and works in partnership with a variety of external partners and advocacy groups. This allows for a greater understanding of the local population, their health needs and any barriers to accessing health care, which enable the Trust to better address potential health inequalities across the boroughs that we serve. At Warrington and Halton Teaching Hospitals (WHH), adherence to the Public Sector Specific Equality Duties are demonstrated through the production of the Workforce Equality Analysis Report and the Equality Duty Assurance Report which is published annually on the Trust website.

In addition to the Equality Act 2010 and Human Rights Act 1998, the Armed Forces Act 2021 further enshrines the Armed Forces Covenant into law to help prevent service personnel and veterans being disadvantaged when accessing public services.

The Act introduces a duty to have 'due regard' to the principles of the Armed Forces Covenant, as follows:

- The unique obligations of, and sacrifices made by, the armed forces
- The principle that it is desirable to remove disadvantages arising for service people from membership, or former membership, of the armed forces
- The principle that special provision for service people may be justified by the effects on such people of membership, or former membership, of the armed forces

WHH considers the element of 'due regard' associated with the Armed Forces Act 2021 in its equality analysis and considerations process. Progress and achievements against the Armed Forces Act 2021 are reported through the Equality Duty Assurance Report annually to demonstrate progress against the Act and its duties.

In April 2022 the Trust, in line with the specific duties of the Public Sector Equality Duty, reviewed and refreshed its equality objectives. Part of this review included the formation of two new strategies:

- Workforce Equality, Diversity and Inclusion Strategy 2022-2025
- Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022-2025

The two strategies provide an approach to delivering on the expectations of the Public Sector Equality Duty and Armed Forces Act 2021 whilst supporting the delivery of the Trust's commitment to being an inclusive employer and outstanding place to receive healthcare. The contents of the strategies were informed by national reports, regulated reporting such as the Workforce Equality Standards and known health inequality data to ensure they delivered meaningful impact.

The Workforce Equality, Diversity and Inclusion Strategy 2022-2025 sets out the Trust's commitment to be the best place to work, creating a culture of belonging for all. The Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy 2022-2025 was designed with our patients and communities at its centre, acknowledging the role WHH plays in ensuring our hospitals are accessible and that our services address health inequalities in our community.

The Workforce Equality, Diversity and Inclusion Sub Committee and the Patient Equality, Diversity and Inclusion Sub Committee are chaired by the Chief People Officer and Deputy Chief Nurse, respectively. Both committees in turn ensure oversight of the equality, diversity and inclusion agenda via respective Board committees with escalations reported to the Board of Directors as required. The sub-committees have internal and external stakeholder membership, with active involvement from patient representatives, staff networks and members of third sector bodies.

The Trust complies with the Equality Delivery System (EDS) reporting, which is in place for both patients and service users and workforce. The Trust participated in the pilot for the refreshed EDS 2022 framework which was completed in the 2022/23 financial year. EDS grading is completed on an annual basis is graded in collaboration with community partners, key stakeholders and the wider public. This is published annually and is available on the Trust website.

A commitment to undertaking equality analysis ensures that our policies, strategies, functions and any services we deliver endeavour not to lead to an unfavourable effect on different people. Equality analysis also helps to identify any positive action we can take to promote equality of opportunity and access for our patients, workforce and communities.

Equality Impact Assessments (EIA) are used as a tool for Warrington and Halton Teaching Hospitals (WHH) to evidence that it is paying 'due regard' to the general aims of the Public Sector Equality Duty, Armed Forces Act 2021 and Human Rights Act 1998.

In 2022-2023 the Trust refreshed its EIA process to adopt a two-stage EIA process ensuring that EIAs are meaningful and enable the organisation to actively eliminate discrimination, harassment, and victimisation, foster good relations between people who share a protected characteristic and those who don't and advance equality of opportunity between all. The updated process also puts ownership on the authors requirement to identify both positive and negative impacts with learnings shared widely.

The Trust also ensures that due regard is given to other vulnerable groups where evidence shows potential barriers to healthcare or where health inequalities are known, such as, but not limited to:

- Carers
- Deprived communities
- Armed Forces and Military Veterans

The Trust is confident in securing the views of its patients, their families and our workforce and this is evidenced by the following:

- Trust Friends and Family Test scores – inpatients, Emergency Department, maternity and outpatients
- National Patient Survey results
- Patient feedback reported through Patient Experience and Inclusion Team and local community partners and Healthwatch
- National NHS Staff Survey – completed on an annual basis
- National People Pulse Surveys – completed on a quarterly basis

Scores and data collated from the Friends and Family Test, survey results and subsequent action plans and key themes identified through engagement with the public and community partners are reported monthly to the Patient Experience Sub-Committee. The Trust assesses feedback from the Friends and Family Test and national sby protected characteristic to review if there are any disproportionate impact on patients' experience.

Learnings from patient feedback and results are presented to the Patient Experience Sub-Committee and are used in patient stories, enabling continued learning across the Trust.

Data and qualitative information collated from the National NHS Staff Survey and People Pulse Surveys are reported to the Operational People Committee and Workforce Equality, Diversity and Inclusion Sub-Committee to monitor findings and subsequent action plan progress. This includes breaking down the results by protected characteristic to identify any disproportionate impacts, this is supported by the Trust Staff Networks of which there are four:

1. Multi-Ethnic Staff Network
2. PROGRESS Staff Network – supporting the LGBTQIA+ Community
3. Disability Awareness Network
4. Armed Forces and Military Veterans Community Staff Network

Armed Forces and Veterans Community Staff Network

Multi-Ethnic Staff Network

Progress LGBTQ+ Network

Disability Awareness Network

The Trust in 2022/23 was successfully recognised for its work in the equality, diversity and inclusion agenda. This included the attainment of three equality related accreditations in addition to those already achieved:

1. **Disability Confident Leader** (Level 3) – part of the UK Government Scheme recognising our commitment to supporting people living with a disability or long-term health condition to access and thrive in work
2. **In-Trust Cheshire and Merseyside Navajo Charter Mark** for the LGBTQIA+ community. This accreditation recognises the commitment WHH continues to make to improve the experience and health outcomes of the LGBTQIA+ community – both for our patients and our workforce
3. **Stonewall Diversity Champions Accreditation** – this accreditation recognises our commitment to continue to improve our policies, procedures and workstreams to positively impact on the LGBTQIA+ community

The Trust in 2022/23 also made a commitment to strive to achieve the NHS North West Anti-Racist Organisation Framework Accreditation – highlighting that WHH is an inclusive organisation with zero tolerance to any form of discrimination, harassment and victimisation.

Performance report: health inequalities

In November 2023 NHS England published a statement setting out the monitoring and reporting responsibilities of NHS bodies (ICBs, Trusts and Foundation Trusts) to identify and act on health inequalities.

The three aims of the statement are:

- understanding healthcare needs
- understanding health access, experience, and outcomes
- publishing information on health inequalities

Indicators and associated data sources are specified with the statement, and are aligned to the five healthcare inequalities priorities and the Core20PLUS5 approach. Analysis of the data for each indicator the Trust is required to report on is detailed below.

Context – Trust catchment population

Census 2021 data – key statistics:

Halton

- **Population of 128,478**
- **White is the stated ethnicity for 96.5% of the population**
- **Ranked 31st most income-deprived of all 316 local authorities in England**
- **35/79 neighbourhoods among the 20% most income-deprived in England; 12 were in the 20% least income-deprived neighbourhoods**
- **Ranked in the bottom 20% of local authorities in England for health in 2021**
- **Female healthy life expectancy is 58, male healthy life expectancy is 61.4**

Warrington

- **Population of 210,974**
- **White is the stated ethnicity for 93.5% of the population**
- **Ranked 153rd most income-deprived of all 316 local authorities in England**
- **22/127 neighbourhoods among the 20% most income-deprived in England. 40 were in the 20% least income-deprived neighbourhoods**
- **Ranked around average among local authority areas in England for health in 2021**
- **Female healthy life expectancy is 64.8, male healthy life expectancy is 64.6**

The above is a snapshot of available statistics but shows that the Trust catchment is one of two halves. The Halton population is considerably more deprived and healthy life expectancy is worse than that of Warrington residents by 6.8 years for females and 3.2 years for males.

Summary analysis of required indicators set out in the statement

Due to the reporting timetable of the Trust, only 11 months of data has been provided from April 2023 to March 2024. Data for the pre-pandemic period has been provided for April 2018 to March 2019. Below is a summary of the analysis for each indicator, work being undertaken to address health inequalities and a gap analysis. In line with the guidance in the statement, a separate detailed report is to be published alongside the annual report.

The statement sets out that the data for each indicator should be analysed by deprivation, age, sex and ethnicity.

Elective activity vs pre-pandemic levels for under 18s and over 18s

Analysis of the specified data sets shows that elective admissions for under 18s totalled 691 in 2023/24 vs 1064 in the pre-pandemic comparison period. For adults this is 25,516 and 28,136 respectively.

While overall elective admissions figures are lower following the pandemic, the data suggests that for both periods the proportion of elective admissions from the most deprived quintile is consistent for both adults and children. In fact, for under 18s the proportion of elective admissions from the most deprived quintile is higher than for adults, at just over 34% vs 27%, for both periods. In both age categories and for both periods' elective admissions from the most deprived quintile represents the highest proportion.

By age group, adults aged 50 and over accounted for 74.7% of all elective admissions in 2018/19. In 2023/24, this increased to 77.8%. This is consistent with the ageing population of the Trust's catchment. For under 18s, admissions for the 10 to 14 age bracket remained consistently the highest proportion both pre and post-pandemic at 29%. Since the pandemic, there was an increase in elective admissions for 14 to 17-year-olds of 4.5% and a drop for under 1s of 4.5%.

By gender the figures remain consistent for under 18s with an even split, with a 1.3% variance between the reporting periods. For adults, the data suggests a 1.8% increase in elective admissions for males, and the same percentage decrease for females.

White British is the most common stated ethnicity for both reporting periods for both adults and children, reflecting the stated ethnicities of our catchment populations.

Emergency admissions for under 18s

In 2023/24 there were 2,685 emergency admissions for under 18s. The highest proportion of emergency admissions were from the most deprived quintile at 34.4%. By age group, the highest proportion of admissions is for under 1-year-olds at 29.1% and this is closely followed by 1 to 4-year-olds at 28.2%. However, versus the pre-pandemic period the proportion of emergency admissions for under 1s decreased by 6.5%. The 2023/24 period also shows a small change in proportions of admissions for 5 to 9, 10 to 14 and 14 to 17-year-olds, increasing by approximately 2% against 2018/19. By sex the proportions are almost evenly split at 48.4% for female and 51.5% for males.

As with elective admissions, White British stated ethnicity is overwhelmingly the highest proportion of emergency admissions at 75.5%. This is reflective of the overall ethnic breakdown of our catchment populations across Halton and Warrington.

Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions, not number of teeth extracted)

Due to the very low numbers within the data for this indicator, they have not been included due to concerns around data de-anonymisation.

Smoking cessation

The Trust established a new tackling tobacco dependency service in July 2023. It is operating across our acute inpatient settings. The service includes behavioural advice and provision of smoking cessation aids, including nicotine replacement therapy (NRT).

The maternity service also provides in-house smoking cessation support.

The majority of our patients who smoke live in the most deprived areas of our Trust catchment population and we work closely with our community smoking cessation services to target support within the hospital and in the community. The in-house service makes onward referrals to community pharmacy or local authority smoking cessation services where appropriate.

Work to address health inequalities

The Trust has been actively working to address health inequalities across our populations since 2021. The Trust has formalised its approach to improving health inequalities as part of its focus as an anchor institution, and has an agreed set of principles in place:

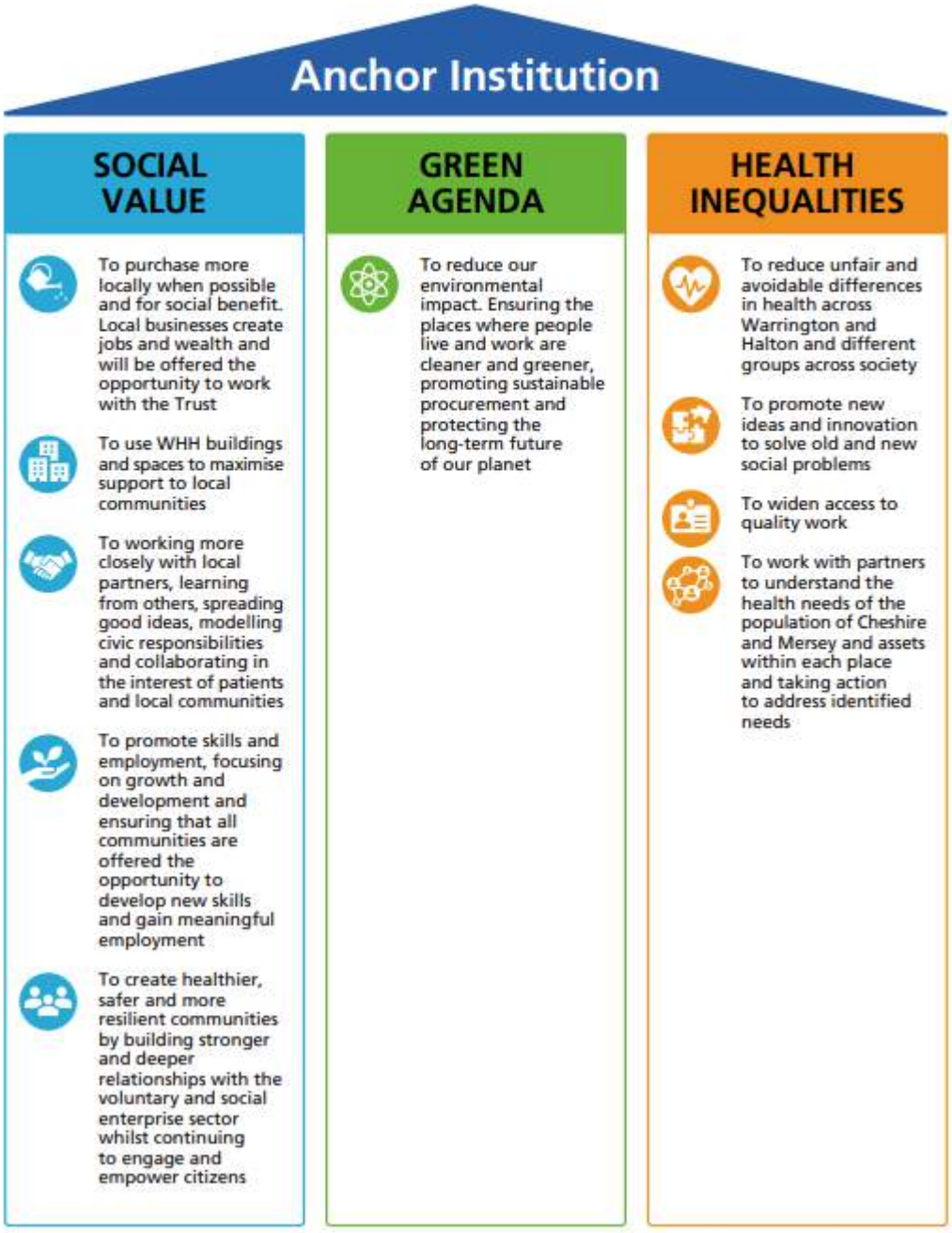


Figure 1. Anchor Institution principles

The Trust serves a population which experiences considerable health inequalities. Tackling health inequalities is a key component of the Trust's strategy and it is using the following NHS framework to systematically tackle health inequalities which includes:

- Influencing multi-agency action to address social determinants of health
- Using our influence as an anchor institution
- Tackling inequalities in healthcare provision

Influencing multi-agency action to address social determinants of health

The Trust is part of the Cheshire and Merseyside All Together Fairer steering group, which is working across nine local authority areas towards becoming a Marmot community to tackle health inequalities.

As an active member of the local Health and Wellbeing Boards and the Integrated Care Partnership local Place Partnership Boards, the Trust is contributing its expertise and resources to tackle health inequalities. Two examples are given below, one from Halton and one from Warrington.

One Halton

The Trust is co-chair of the Wider Determinants workstream, making up the five priority work streams of the One Halton place-based partnership. Workplans are in development which will then be adopted as part of the One Halton workplan for 2024-25.

The workstream aims to address factors affecting the overall health and wellbeing of Halton residents focusing on:

- **Economic regeneration**
- **(Violent) crime reduction, with a focus on domestic abuse**
- **Education, workforce and education**
- **Living conditions**
- **Adopting a Marmot approach**

Warrington Living Well Hub

Opened in March 2024, the Living Well hub is designed to target and address health inequalities in Warrington by providing a range of services focused 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 is a space where providers from across mental and physical health, social care and the third sector come together to deliver integrated services, support, and learn from one another for the collective benefit of the local population. The Trust led this multi agency project which has been a key part of the town's regeneration plans.

Using our influence as an anchor institution

The Trust has been an early adopter of the NHS Cheshire and Merseyside Prevention Pledge and has embedded its approach to tackling health inequalities within its principles as an anchor institution.

Tackling inequalities in healthcare provision

The Trust has delivered or is undertaking a significant amount of work to address health inequalities, including but not limited to:

- Maternity teams Lunar, Sunlight and River
- Elective recovery including a new theatre, endoscopy unit and community diagnostic centres
- Active Hospitals – ready, dress go! And national re-conditioning games
- Smart Heart schools programme
- The work of the Alcohol Care Team
- A new in-house tackling tobacco dependency programme for acute inpatients to compliment the already established smoking cessation team within maternity services
- The High Intensity Users service which provides 12 weeks of one-to-one support connecting people who frequently attend Emergency Department to appropriate community support
- The appointment of a Director of Population Health and Inequalities
- Halton Health Hub (opened Dec 2022)
- Digital inclusion cafes, supported by Warrington VCA and banking groups
- Regular wellness sessions for patients, visitors and staff to offer blood pressure checks, atrial fibrillation checks and smoking cessation advice

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/71**
SUBJECT:	**Emergency Preparedness Annual Report (EPRR) & Annual Assurance Letter Statement of Compliance**
DATE OF MEETING:	7 August 2024
AUTHOR(S):	Rachel Clint, Head of Emergency Preparedness, Resilience and Response
EXECUTIVE DIRECTOR SPONSOR:	Dan Moore, Chief Operating Officer & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE	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)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; 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 have patients waiting more than 12 hours in the department from time of arrival **#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 and failure to achieve constitutional standards and financial plans. **#1757** If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services. **#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.

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:			
		Yes	**No**	**N/A**

	3. Foster good relations between people who share a protected characteristic and those who do not			
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report will:- • Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust. • Outline the work that has been undertaken in the area during the past 12 months. • Describe the trust response to incidents which have occurred during 2023-24. Summarise the planned work streams and priorities for the year ahead.			
PURPOSE: *(please select as appropriate)*	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability Committee		
	Agenda Ref.	FSC/24/07/76		
	Date of meeting	24 July 2024		
	Summary of Outcome	The report was noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO TRUST BOARD

SUBJECT	Emergency Preparedness Annual Report (EPRR) & Annual Assurance Letter Statement of Compliance	AGENDA REF	BM/24/08/71

1. BACKGROUND/CONTEXT

All NHS organisations are required to deliver their legal duties and responsibilities for Emergency Preparedness, Resilience and Response (EPRR) set out in The Civil Contingencies Act 2004. As a Category 1 responder under the Act, the trust has a duty to develop robust plans to prepare and respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

Over recent years the EPRR world has seen both significant disruption and major change – from EU Exit to the COVID-19 pandemic, to recent instances of industrial action. The demands of Accountable Emergency Officers (AEOs), EPRR Professionals and Boards in ensuring robust, resilient systems for patients and communities has never been greater.

Like most NHS organisations, WHH has had our resilience tested on several occasions over the last year, most notably in the form of the operational pressures associated with winter, but also through the occurrences of industrial action. The Trust continues to engage with the ICB and system partners to collaborate on the responses to significant events such as industrial action and winter pressures.

The trust plans and procedures, along with the commitment of WHH staff, have enabled WHH to manage incidents in a professional manner which has helped to minimise disruption to patient care.

In 2023, NHS England adapted the method of assessing providers self-assessments in relation to the Core Standards for EPRR. This involved a rigorous assessment of Trust policies and plans, and subsequently highlighted the requirement for a total refresh of the EPRR domain.

2. PURPOSE

The purpose of the annual report is to: -

- Provide an overview of the emergency preparedness arrangements within Warrington and Halton Teaching Hospitals
- Outline the work that has been undertaken in emergency planning during the past 12 months
- Describe the trust response to incidents which have occurred during 2023-24.
- Summarise the planned work streams and priorities for the year ahead
- Outline the continuous improvement work streams to support WHH compliance with Core Standards for EPRR

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Emergency Preparedness Structure

The Trust has an Emergency Preparedness, Resilience and Response (EPRR) policy in place which outlines the approach to the principles of risk assessment, multi-agency co-operation, emergency planning, sharing information and communicating with public. In addition, key plans such as the Incident Response Plan, the overarching Trust Business Continuity Plan and Major Incident Plan underpin the plans outlining how critical services will continue to be provided in the event of a disruptive incident.

Lead Officers

- Dan Moore- Chief Operating Officer and Deputy Chief Executive is the designated Accountable Emergency Officer with responsibility for Emergency Planning within the Trust
- The Lead Director is currently supported by Rachel Clint, Head of Emergency Preparedness (EPRR Manager)
- In the absence of the AEO, The Director of Operations and Performance deputises and would fulfil the role of the Strategic Commander in their absence
- John Somers is the Non-Executive Director with responsibility for Emergency Planning, all Non-Executive Directors have a responsibility for understanding and knowledge of the EPRR function
- Trust Board are updated on significant matters associated with EPRR

Committee Structure

To discharge our responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the trust's Committee structure.

The Event Planning Group (EPG), chaired by the Chief Operating Officer and Deputy Chief Executive, is charged with the responsibility of overseeing the development of emergency preparedness arrangements within the Trust. The group meets monthly and its membership includes senior managers from Planned Care, Unplanned Care and Clinical Support Services, there is clinical attendance and appropriate representation from corporate services.

In addition to Emergency Preparedness matters the role of the EPG is to anticipate and plan for forthcoming events which are likely to prevent a challenge to our services and resources and to develop co-ordinated plans. Minutes of the Group's meetings are produced, and high-level briefing reports are provided to the Finance and Sustainability Committee and to the Strategic Executive Oversight Group as appropriate. There are bi-annual updates shared with the Board.

EPRR External Structure:

The NHS England Area Team has lead responsibility for co-ordinating a local health response to an emergency. A Cheshire, Halton and Warrington Local Health Resilience Partnership (LHRP) exist to deliver National EPRR strategy in the context of local risks, this partnership is coordinated by the Cheshire and Merseyside Integrated Care Board (ICB).

The LHRP brings together the health sector organisations involved in emergency preparedness and strengthen cross-agency working. The quarterly Strategic LHRP meetings are attended by The Chief Operating Officer or Deputy. The Head of EPRR attends the Tactical LHRP and task group meetings. This structure has recently evolved following the establishment of the Integrated Care Board in July 2022, with this structure becoming embedded into standard practice.

4. MEASUREMENTS/EVALUATIONS

Training

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. In 2023-24 there have been more opportunities to engage teams in training exercises and this programme will continue with some routine training along with standalone tabletop exercises.

Tactical Manager on-call training has been enhanced through the delivery of bi-annual events to on-call managers, with thematic focus areas based on the needs of trainees. This training also supports the portfolio and CPD of Tactical Commanders.

National Occupational Standards were introduced by NHSE in 2022 for Strategic and Tactical Managers. All Executive's and Tactical Managers have been invited to attend the rolling training programme and are required to maintain evidence of their training standards. The EPRR Lead has also attended train the trainer sessions. A Training Needs Analysis and Exercise Schedule has been established for until 2026.

Assurance Process

The Trust is required to undertake an annual self-assessment against the NHS England Core Standards for EPRR. The full assurance exercise was last undertaken in September 2023. The annual self-assessment process provided by NHSE was refreshed for 2023 with some revised and more specific areas of consideration, along with increased scrutiny. The Trust self-assessment was submitted as 'substantial compliance'. There was a deep dive assessing training and exercising.

The overall outcomes of the 2023 assurance cycle suggested WHHFT was fully compliant with 3 of the Core Standards for EPRR, and partially compliant with 59. There were no standards assessed as non-compliant. These outcomes were significantly different to the Trust's self-assessment, granting an overall compliance score of 5% and a non-compliant outcome in the 2022-2023 cycle of core assurance. Table 1 below details the outcomes and Table 2 the thresholds for assurance ratings.

Table 1 – 2022-2023 Core Assurance Self-Assessment and Outcomes

Domain	Total Applicable Standards	Fully Compliant			Partially Compliant			Non Compliant		
		SA	1st	2nd	SA	1st	2nd	SA	1st	2nd
Governance	6	6	0	1	0	6	5	0	0	0
Duty to Risk Assess	2	2	0	0	0	2	2	0	0	0
Duty to Maintain plans	11	10	0	0	1	11	11	0	0	0
Command and control	2	2	0	0	0	2	2	0	0	0
Training and Exercising	4	3	0	0	1	4	4	0	0	0
Response	7	6	0	0	1	7	7	0	0	0
Warning and informing	4	4	0	0	0	4	4	0	0	0
Cooperation	4	4	1	2	0	3	2	0	0	0
Business Continuity	10	8	0	0	2	10	10	0	0	0
Hazmat / CBRN	12	12	0	0	0	12	12	0	0	0
Totals	**62**	**57**	**1**	**3**	**5**	**61**	**59**	**0**	**0**	**0**

Table 2 – Assurance Rating Thresholds

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 Standards.

In the wake of lessons identified from recent incidents and a number of public inquiries, there has been a refreshed assurance framework requiring robust governance, proactive planning and tried and tested plans. This will ultimately improve resilience across the system.

In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process as a pilot. This involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment. This model required commissioners and providers of NHS commissioned care to submit evidence which went through a formal review and subsequent check and challenge, whereby supplementary evidence against any challenges could be uploaded before finalising the assurance position. The experience in the Midlands demonstrated a significant gap between self-assessments and the evidential reviews.

The model was implemented for the North East & Yorkshire and North West regions for the 2023 cycle. Similar outcomes were noted to the Midlands and the Cheshire and Merseyside Integrated Care Board have proactively supported opportunities to collaboratively address common themes and areas of improvement, as well as sharing good practice.

It is recognised that the changes in the EPRR Core Assurance process has come at a very difficult time for EPRR professionals across organisations, it is important to note that his does not signal a material change or deterioration in preparedness but should be considered as a more rigorous baseline in which to improve plans for preparedness, response and recovery.

The Trust's substantive Head of EPRR returned from a period of maternity leave in February 2024. In response to the outcomes of the 2023 process, a robust action plan was devised to refresh all EPRR plans and policies, including a training and exercise plan. It was also identified that there were some gaps in the Trust's documentation, meaning a series of new policies and guidelines have formed part of the action plan to9 move to fully compliant. In Q4 2023-2024 and Q1 2024-2025, a significant amount of work has been completed to refresh the EPRR programme and this will continue in the months ahead. The Strategic Executive Oversight Group and the Finance and Sustainability Committee have been appraised of the progress made in the EPRR workstream. The documentation that has been developed or refreshed is outlined later in this document.

The Core Assurance letter was received on 16th July 2024, somewhat later than in recent years. The process for 2024-2025 is unchanged, with a review set to occur for 2025-2026. The Trust awaits confirmation of the local submission process. It is likely the Trust self-assessment will be submitted to FSC in September prior to submission to public Board.

Incidents, Exercises & Learning

During 2023-24 the following significant incidents and exercises occurred:

Creamfields (24th- 27th August 2023)

The Creamfields Music Festival occurred in Daresbury in August 2023.

The August Bank Holiday weekend has historically been a busy period for the Trust. Fluctuations in demand associated with bank holiday periods exist, but the August Bank holiday weekend also coincides with the staging of the Creamfields Music Festival (CF) in Daresbury, of which Warrington Hospital is the primary receiving hospital for the event.

Creamfields 2022 was held between Thursday 24th August and Monday 27th August. A series of planning meetings with external organisations and partners took place, along with internal Bank Holiday weekend planning meetings.

Events Medical Service (EMS) was once again appointed as the main provider of healthcare on site and worked in partnership with NWAS. As far as possible, it was planned that patients would be treated on site or referred direct to admitting specialities. Predictions for attendances, admissions, discharges and occupancy were shared based upon the past 6-week trends, alongside previous Bank Holiday and Creamfields Festival weekend activity. Historically most activity associated with the festival occurs on the Saturday and the Sunday when the festival reaches a peak of circa 70000 attendees.

As the local receiving Trust to the festival, it was imperative for robust plans to be in place in advance of the event to ensure the capacity for safe, patient-focused care across the Bank Holiday period and in the days that followed.

Representatives from clinical, nursing and operational teams met with the event organisers and medical team twice in advance of the festival weekend. There were monthly preparation updates through the Event Pkanning Group and the Creamfields operational order and medical plans shared with senior operational and clinical colleagues. A bank holiday handover meeting took place on Friday 25th August. The Creamfields Event Team invited the Trust to attend two daily Silver Command meetings at 10.00am and 19.00pm across the 4-day festival. The aim of these meeting was to coordinate any items to escalate or plans for mutual aid if required.

A full event debrief took place after the event. It was agreed that learning from previous years festivals had been embedded and there were minimal impacts on services at WHHFT during the festival weekend.

Public Health Commander Training (June 2022 – onwards)

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 (CCA), the Civil Contingencies Act 2004 (Contingency Planning Regulations) 2005, the NHS Act 2006 and the Health and Care Act 2022.

This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

The day-to-day management of people and patients in the NHS is subject to legal frameworks, duty of care, candour and moral obligation. This does not change when responding to an incident; however, these events can lead to greater public and legal scrutiny. If staff are planning for or responding to an incident, they need to have the tools and skills to do so in line with their assigned NHS command and/or incident response role.

The minimum national occupational standards that health commanders, managers and staff responding to incidents as part of an incident management team and other staff involved in EPRR must achieve to be competent and effectively undertake their roles. All staff with a command role in incident management must maintain continual professional development (CPD), maintaining personal development portfolios (PDPs) in accordance with NHS Core Standards for EPRR.

As part of the revised EPRR Framework in June 2022, the minimal occupational standards were introduced and all Strategic and Tactical managers are expected to attend this every three years. Participation from WHH Strategic and Tactical managers has been very encouraging to date, with further opportunities identified for 2024, ensuring new personnel have access to the training too. 76% of Tactical Commanders have attended the POHC course, and all Strategic Commanders have attended or are booked on to training within the coming months.

Communications Exercises

There was an NHS England planned no-notice Comms exercise scheduled for May 2024. This exercise was aborted when relevant processes were not followed with the ICB.

Exercise Hedwig was carried out by the ICB on Friday 30th June 2023. This was aimed to test ICB call out processes at no notice. It was identified that the correct use of terminology for commanders was not understood by WHHFT Switchboard with the request to speak to the Tactical Commander being directed to the Site Manager. This has been addressed through training with Switchboard personnel.

Exercise Calliope is an ICB led no notice exercise that will take place on Thursday 29th August 2024 from 10:00hrs. Each Trust within Cheshire and Merseyside will make their own arrangements for monitoring of this exercise, as the notification and cascade reaches their Trust. The exercise will begin with an NHS Cheshire and Merseyside on-call Tactical Commander relaying a METHANE message as they would do per a real-life incident, using their call out list. Each Trust contacted will then activate their call out list and follow their internal notification and cascade processes.

Exercise Toto was an internal communication exercise, carried out on 19th June 2024. This was to test the new system (Dr Doctor) in place and to identify any learning to improve the trust resilience. Several items were raised and are expected to be addressed through the participation in Exercise Calliope and a subsequent internal exercise.

Wider Training Opportunities

Utilising contributions from acute and community providers, Cheshire and Merseyside ICB plan to deliver MACA (Military Awareness) training, Legal training and Accountable Emergency Officer training in 2024. This will assist the Trust's Strategic Commanders in their compliance with the National and Minimal Occupational Standards for EPRR.

Decontamination and CBRNe Training

The Trust has agreed to host NWAS train the trainer courses in August 2024, this will assist the resilience of our responses to CBRNe incidents and support the development of the Trust's CBRNE and HAZMAT Plans.

Industrial Action (November 2022 – ongoing)

The EPRR Manager has been working collaboratively with the Executive Medical Director and the Associate Chief People Officer to coordinate the management of periods of industrial action directly and indirectly affecting WHH. An Industrial Action Task and Finish Group runs when there is notice of forthcoming action. Key stakeholders across Care Groups and Corporate Services participate to develop mitigation plans and Tactical response plans for the dates of industrial action. The EPRR Manager continues to engage with the ICB and participate in exercises and debriefs to support further planning.

Tactical Commander (formerly SMOC) Training (April 2024, October 2024)

Bi-annual Tactical Commander training has been delivered ensuring both experienced and newer members of the senior operational management team are confident with trust plans and out of hour arrangements. An accompanying Tactical Commander handbook is frequently updated and acts as a guide to support the role and gives an overview of a number of significant documents that may require access at pace. The trust On-Call Guidelines have also been updated.

Planned IT and Telephony Downtime (ongoing)

There have been a number of instances of IT and Telephony downtimes. A robust operational management plan has been developed to ensure all wards and departments are aware of the details of each period of downtime, the mitigation, actions, service impact and recovery from the downtime. A series of preparatory meetings have enabled thorough planning ahead of scheduled downtime and in the last year there have been no service impacts as a consequence of the installation of appropriate updates to systems. SOPs were developed in Summer 2022 to support preparation for planned IT infrastructure downtimes, these were refreshed in February 2024.

Business Continuity

There has been a refresh of the Trust's Business Continuity processes, this incudes promoting the important of Business Impact Analyses, exercising BCPs locally and auditing the departmental Business Continuity Plans (BCPs). The Finance and Sustainability Committee, along with the Board, are asked to review and support the Trust's business continuity processes and overarching policy. The refreshed Trust Business Continuity Plan is available in Appendix 1.

Wider events / disruptions

Several events with potential implications on the Trust have been monitored. These include:

- Measles
- National cybersecurity issues
- OPEL 4 – owed to operational pressures over winter, WHH declared OPEL 4 on multiple occasions in 2023-2024

Work undertaken in 2023/24

The following policies were created or refreshed and updated to reflect local and national developments during 2023-2024:

- Trust Escalation Plan
- Full Capacity Plan
- Adverse Weather Plan
- On-call Guidelines
- Tactical Commander Handbook
- Site Manager Handbook
- Internal Winter Plan
- System Winter Plan
- Bank Holiday Plans
- Major Incident Plan
- Incident Response Plan
- Trust Debrief Guidelines
- SitRep Guidelines
- Incident Coordination Centre SOP
- EPRR Policy

- Trust Business Continuity Plan
- Countermeasures Plan

Engagement has continued with the following external groups:

- Cheshire Health Resilience Partnership
- System Partners (Cheshire and Merseyside ICB, Warrington Borough Council, Halton Borough Council, Bridgewater)
- Close liaison has been maintained with partner agencies in planning for local mass gathering events i.e., Creamfields festival. Member of Creamfields Safety Advisory Group and liaison with NWAS

Single Point of Contact

The EPRR Manager has continued to act as the trusts Single Point of Contact (SPOC). This includes the monitoring, storing and cascading of national and local guidelines.

Learning and Lessons Identified

Learning from incidents and events is tracked through Event Planning Group on a lessons identified tracker. Following on from an incident or exercise a debrief or exercise report details the learning, with an action plan to embed learning into policy reviews or to practice. Further information of this process is defined in the WHH Debrief Guidelines.

5. TRAJECTORIES/OBJECTIVES AGREED

Work programme for 2024/25

In 2023-24 the core focus has been to refresh the emergency planning portfolio and embedding the new ways of working within the ICB structure.

For 2024-2025, the focus will include reviewing outcomes in line with the Core Assurance Framework and testing a number of WHH emergency plans. EPRR in an ongoing cycle of planning, training, testing and improving. Although debrief activities have been carried out, it is prudent to continue to capture the learning through response and recovery to enable effective winter preparation for 2024-2025. This will include collaboration with key stakeholders involved in the responses, raising staff awareness, testing plans and identifying any areas for improvement.

The Board has previously expressed satisfaction with the Trust's EPRR resource. A benchmarking exercise carried out in April 2024 indicates that WHH does not have the same level of resource as neighbouring trusts, or some trusts of a similar scale. With the changing requirements in EPRR it will be prudent to review the EPRR structure in the year ahead.

In addition to resource, EPRR has historically not had a budget allocated. Despite this, annual servicing of PRPS Suits and the decontamination shelter takes place, utilising the UEC budget to cover costs incurred. There is the need to invest in training for instance for loggists and debrief trained personnel, as well as the requirement to offer training so commanders are up to date with the skills and education required as part

of the minimal occupational standards. Furthermore, it is imperative that all incident control rooms are appropriately equipped with logbooks, tabards and such, this will require some funding to maintain the Trusts compliance with the EPRR Framework (2022).

The Head of EPRR has started to collaborate with partners to review all emergency plans and policies considering the future integration plans with Bridgewater Community Trust. The integration will require significant input with the likelihood of the need to complete another complete refresh of all EPRR documents and to increase the training programme to meet the requirements of the EPRR Framework 2022. A number of priorities have been identified to address integration in the short, medium and long term, some of these are listed below:

- Develop a structure for the single delivery of EPRR and AEO functionality
- Refresh all policies and plans with consideration of different ways of working across acute and community settings
- Develop training and plans to amalgamate the on-call systems and processes
- Work in collaboration with Estates, Digital Services and Operational Managers to ensure resilience across Place
- Establish integrated on-call, business continuity and incident response arrangements.

In support of and in addition to the above, the following work plans will be undertaken:

- Continue to deliver training to key staff in Emergency Preparedness and Incident Management through Tactical Commander training, Strategic Commander training, Operational (Site) Manager training and ad-hoc events
- Continue to encourage and support opportunities for Strategic and Tactical on-call managers to attend the Public Health Commander training to ensure minimal occupational standards are met
- Test the Trust Major Incident plan ensuring wider stakeholder input
- Continue to develop Trustwide CBRN plans to complement the plans in UEC
- Embed learning from 2023-2024 to support planning for winter pressures
- Continue as a full and active member of the Local Health Resilience Planning Group
- Update plans and procedures in line with any new National guidance
- EPRR education within care groups and the workforce to enhance resilience
- Review the Corporate Business Continuity Plan, embed the audit process and request all areas exercise their plans
- Monitor the lessons learned from other local, regional and national incidents

6. MONITORING/REPORTING ROUTES

The ICB led LHRP meets quarterly and is attended by the Trust Emergency Planning Lead; the outcomes are fed into the Trusts Event Planning Group meeting. The Strategic LHRP meets quarterly and is attended by the AEO. Wider participation occurs with ICB task and finish groups, of which the Head of EPRR attends.

The Event Planning Group meets monthly and reports updates through the Finance and Sustainability Committee and Strategic Executive Oversight Group meetings.

For any incidents or wide-scale events, Tactical Response meetings are established on an ad-hoc basis and follow the above reporting routes.

7. TIMELINES

This report is presented annually to the Finance and Sustainability Committee and the to the Trust Board. The Core Assurance submission will take place in September 2024. The Finance and Sustainability Committee and the Trust Board will be appraised of the assessment and the outcomes.

8. ASSURANCE COMMITTEE

The EPRR Manager escalates issues to the Event Planning Group. This subgroup continues to escalate changes through Finance and Suitability Committee, and to the weekly Strategic Executive Oversight Group meetings.

9. RECOMMENDATIONS

The Trust Board is asked to note the significant work and achievements undertaken during 2023-24 and the planned work programme for 2024-25 in support of improvements in EPRR and the Trusts objectives.

To:
- Integrated care boards:
  - accountable emergency officers
  - EPRR leads
- Trusts:
  - accountable emergency officers
  - EPRR leads
- NHS England regions:
  - regional directors
  - regional chief operating officers
  - regional deputy directors of EPRR
- Local health resilience partnership co-chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

15 July 2024

Dear colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2024/25

During 2023/24, the NHS managed a year of disruptive incidents and events that threatened our ability to deliver core services to our populations. Once again the NHS rose to these challenges, and for that I thank you. The hard work and dedication of EPRR staff, accountable emergency officers (AEOs) and colleagues across the NHS has been vital to ensuring that services have remained resilient, patients and the public have received the care and information they needed, and staff were supported to work through challenging circumstances.

As always, it is critical that we learn from each incident so that we can improve our response arrangements, and that we annually benchmark our work against a common set of standards. I am therefore asking you to undertake the EPRR annual assurance process set out below before Friday 27 December 2024.

2024/25 EPRR annual assurance process

This year's process will remain largely unchanged from 2023/24. The process must promote inclusive, open and transparent dialogue; be supportive and encouraging; and enable the

sharing of good practice and continual improvement. The following familiar actions are required as part of this year's assurance process:

- All NHS funded organisations should undertake a self-assessment against the organisation-relevant NHS core standards for EPRR (attached). The compliance level for each standard is defined as:
  - Fully compliant: fully compliant with the core standard.
  - Partially compliant: not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
  - Non-compliant: not compliant with the core standard. Compliance will not be reached within the next 12 months.
- All NHS funded organisations should generate an overall EPRR assurance rating using the following:
  - Fully: the organisation is fully compliant against 100% of the relevant NHS EPRR core standards
  - Substantial: the organisation is fully compliant against 89-99% of the relevant NHS EPRR core standards
  - Partial: the organisation is fully compliant against 77-88% of the relevant NHS EPRR core standards
  - Non-compliant: the organisation is fully compliant up to 76% of the relevant NHS EPRR core standards
- The outcome should then be presented and discussed at a public board meeting prior to submission and published in the annual report within the organisation's own regulatory reporting requirements. For organisations which do not hold public boards, the outcome should be reported as part of a public statement of readiness and preparedness activities and published in the relevant annual report.
- Integrated care boards (ICBs) are to work with their commissioned organisations and local health resilience partnership (LHRP) partners to agree the process in which commissioners and LHRP partners gain confidence with each organisation's overall EPRR assurance rating.
- NHS England regional deputy directors of EPRR and their teams will work with ICBs to agree a process to obtain the organisation EPRR assurance ratings for all commissioners and providers from within their geography.
- NHS regional chief operating officers will submit the assurance ratings for each organisation in their region and a description of their regional process before Friday 27 December 2024.

2024/25 deep dive

Each year, alongside the annual assurance process, a ‘deep dive’ is conducted to gain valuable additional insight into a specific area. Following recent incidents and common health risks raised as part of last year’s annual assurance process, the 2024/25 EPRR annual deep dive will focus on responses to cyber security and IT related incidents.

The deep dive questions are applicable to those organisations indicated within the EPRR self-assessment tool.

Please note that compliance ratings against individual deep dive questions do not contribute to the overall organisational EPRR assurance rating.

The outcome of the deep dive will be used to identify areas of good practice and further development and as in previous years it is expected that organisations will use their self-assessment to guide the development of local arrangements.

Future EPRR assurance

We are currently reviewing the EPRR assurance process to ensure that it continues to develop and support continual improvement. The NHS core standards for EPRR will continue to be reviewed and updated every 3 years. To give reassurance, each new updated set of standards will be published no less than 12 months ahead of them being used for assurance purposes.

The reviewed process will see changes from 2025/26 which will include:

- ensuring ICBs are empowered and supported to take the lead with regards to local delivery of the EPRR agenda (in line with the NHS England operating framework, seeking further opportunities to embed new ways of working in all our activities)
  - this includes ICBs being responsible for gaining the NHS EPRR assurance compliance rating from their providers of NHS funded care, under the terms of the NHS Standard Contract
- NHS England developing its relationship with related regulatory bodies to share and secure a common understanding regarding assurance outcomes, ensuring that compliance is achieved through a single mechanism
  - these organisations include the Care Quality Commission and the Health and Safety Executive
- identifying any unconditional compliance requirements of the NHS core standards for EPRR
- NHS England annually self-assessing its EPRR compliance as a single organisation, including all relevant departments and regions

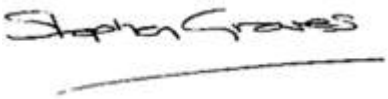
- evaluating options for a digital solution to facilitate delivery of the overall assurance process

I will write to you in more detail to outline our intentions regarding the delivery and supporting activities and ensure your engagement in this work.

If you have any queries about this year's EPRR assurance process, please contact your ICB EPRR leads or regional deputy director of EPRR.

Once again, I sincerely thank you for your continued commitment to NHS preparedness and response, to maintain or enhance services for our communities.

Yours sincerely,



Stephen Groves

Director of NHS Resilience (National)

NHS England

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trustwide Business Continuity Plan

Lead executive	Chief Operating Officer		
Author's details	Rachel Clint, Head of Emergency Preparedness, Resilience and Response		
Type of document	Policy		
Target audience	Trustwide		
Document purpose	To ensure arrangements are in place to manage any disruption to business continuity within the organisation. This plan should be used to guide business continuity planning within departments and services.		
Ratification meeting	Finance and Sustainability Committee		
Approval meeting	Event Planning Group		
Implementation date	Friday, 07 June 2024	Review date	24 May 2025
WHH documents to be read in conjunction with			
Major Incident Plan Incident Response Plan Local Business Continuity Plans Trust Debrief Guidance and Template Business Impact Assessment tool			
Document change history			
Version	4.00		
What is different?	New format Refreshed due to revised EPRR Framework 2022 Complete revision of overarching BCP in line with EPRR Core Assurance Framework, and ISO22301		
Appendices/electronic forms	Appendix 1: Incident Severity Rating Guide Appendix 2: Incident Declaration Flowchart Appendix 3: Priority Services Appendix 4: Business Impact Assessment and METHANE report Appendix 5: Business Continuity Command and Control Team Appendix 6: Business Continuity Action Cards Appendix 7: Business Continuity Exercise Guidance Appendix 8: Key Contact list		
What is the impact of change?	Updated arrangements based on learning from events in recent years		
Training requirements	Awareness of trust wide and departmental business continuity plans		
Keywords	Business Continuity, Major Incident, Critical Incident, Response		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Taxonomy	Type	Policy category non-clinical	Policy category clinical
	Non-Clinical	Operational	Choose an item.

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
4.0	April 2024	Head of EPRR	Current	Refresh and re draft of the Business Continuity Plan, utilizing the Business Continuity toolkit, EPRR Framework (2022) and Core Standards for EPRR

Record of Changes made			
Section Number	**Page Number**	**Change/s made**	**Reason for Change**
Version 1 (Current)			

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1. Flowchart of process

Business Continuity Disruption Identified

(for example: loss of workforce, communications, buildings, equipment, digital service, utilities, supply chain)

↓

Obtain further information using the Business Impact Assessment form (Appendix 7)

Refer to local Business Continuity Plan for contingency arrangements and actions to be taken.

Inform the Tactical Manager of the Day / Tactical Commander out-of-hours

↓

If the disruption begins to affect other critical areas and requires greater coordination and support, refer to the Trust Business Continuity Plan and Incident Response Plan for the activation of the Incident Control Centre and subsequent responses.

The Tactical Commander will determine the response required based on the incident severity level.

2. Executive Summary

2.0 Introduction

Under the Civil Contingencies Act (CCA) 2004 Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHHFT) has a requirement is to ensure that robust arrangements are put in place to manage disruptions to business continuity within the organisation.

The NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) 2022 provides a minimum standard which NHS Trusts must meet. All NHS organisations and providers of NHS funded care must develop, maintain, and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301.

For the NHS, incidents are defined as:

Business Continuity Incident – an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

Critical Incident – any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.
A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

There is an expectation that services will continue to operate even in the event of a serious disruption or in the face of extreme weather.

In order to deliver this expectation, it is important that we are able to anticipate what may present a threat to the smooth running of our services, put measures in place to reduce the risk of occurrence and develop effective contingency plans should those threats be realised.

At Warrington and Halton Teaching Hospitals we have had our resilience tested on a number of occasions over the past few years when responding to incidents such as a pandemic, fires, floods, telecommunication failures and severe weather. We have an excellent track record of managing such incidents in a professional and effective way which has allowed us to maintain our critical services throughout and restore normal working as quickly as possible.

Whilst it is impossible to predict every kind of conceivable incident which might threaten the continuity of the Trust's services, it is possible to set out basic plans which can be implemented to cover a wide range of scenarios.

This plan focusses on the common scenarios that often impact NHS organisations:

- Skilled Staff Shortages
- Loss of Electricity Supply
- Loss of Water
- Loss of Heating
- Loss of Medical Gases
- Loss of Essential Equipment
- Loss of IT Network
- Loss of Telephones
- Loss of Bleep System
- Loss of Critical Supplier

Business continuity planning also involves consideration of the short- and long-term impacts of climate change on WHHFT. The Trust Green Plan and Green Planning working group includes multiple stakeholders across services and directorates and serves the purpose of planning for the likely implications of climate change, and considering the adaptations required to continue to serve the local population in line with the Trusts strategic aims. The Adverse Weather Plans (Heatwave and Cold Weather Plans) also offer continuity planning during short term periods of adverse weather conditions.

Business continuity planning at WHHFT involves the consideration of national, regional and local risks. The Cheshire Community Risk Register provides information on the biggest emergencies that could happen to Cheshire, together with a risk likelihood and potential impact assessment. There are 9 risks identified as the top risks for the Cheshire area:

• Pandemic flu

• Flooding

• Severe weather

• Loss of critical network infrastructure

• Animal diseases

• Environmental incidents

• Industrial incidents

• Transport incidents

• Terrorist threats

For the some of the risks identified, there are specific trust wide incident response plans, such as the Adverse Weather Plans and Pandemic Flu Plan. These plans should be read in conjunction with the Incident Response Plan. Some of the wider responses to risks such as terrorist threats would be led by the police and therefore the trust will take direction from outside agencies when it is appropriate to do so and use the Trust's Incident Response Plan / Major Incident Plan as directed by Tactical and Strategic Commanders. Local risks are managed on the Trust's risk register and are reviewed through the Risk Review Group. The local risk register also identifies areas for services to consider in the review and development of their business continuity plans.

Business Continuity Management (BCM) is the process adopted by the Trust to identify its key services and the potential hazards and threats, both internal and external, which threaten those services.

All clinical and corporate services are expected to develop, review and test their Business Continuity Plans on an annual basis. Business Continuity Plans are audited by senior managers beyond the department on an annual basis to ensure they continue to be appropriate and consider the changing

landscapes in the NHS and the wider world. Business Impact Assessments are carried out when reviewing business continuity plans (Appendix 2).

Contractors and external suppliers are expected to provide business continuity plans to ensure resilience in supply chain and delivery of services. Details of this are held within local BCPs.

Business continuity continues to develop at WHHFT, the Trust have adopted plans to promote business continuity in line with Business Continuity Week (in May) and will promote themes through the Event Planning Group, Trust wide communications and the Emergency planning area on the extranet.

3. Purpose and scope

3.0 Purpose

Business Continuity Management (BCM) provides a framework for building organisational resilience. Fundamentally it aims to establish a pro-active culture at all levels within the organisation to manage the risks to the smooth running of services and provide a quick and effective response to a disruption.

The Civil Contingencies Act 2004 has placed a requirement on all NHS Trusts, as Category 1 responders under the Act, to have comprehensive Business Continuity Plans (BCPs) in place at all levels of the organisation. Business Continuity Plans are a key component of the Trust's BCM strategy which enables the Trust to; -

- To identify those critical services which, if interrupted for any reason, would have the greatest impact upon the Trust, the health economy and the wellbeing of the community.
- To identify, prioritise and reduce the risks to the continuity of these critical services
- To develop plans which enable the Trust to maintain its core services during a disruption and return to normal working in the shortest time possible.

All business activity is subject to disruptions, such as fire, floods, technology failure, loss or disruption of utilities, terrorism and loss of staff for various reasons. Business Continuity Management provides the capability to react swiftly to operational disruptions whilst protecting safety and health.

The Business Continuity Management Framework developed by NHS England (2013), recommends that NHS organisations should consider the following critical business functions when developing arrangements for business continuity, including restoration and recovery. They are; -

- Human Resources
- Buildings and Equipment
- Utilities
- Communications
- Information Technology
- Service capacity
- Supply chains and outsourced services

A Glossary of Terms relating to Business Continuity Management is provided later in this policy.

The purpose of the Trust Business Continuity Plan is; -

- To set out how the Trust will meet its' statutory and non-statutory obligations regarding Business Continuity Management (BCM) arrangements.
- To provide guidance on escalation procedures and the Trust BCM structure.
- To identify the critical activities of the Trust and the resources needed to support them. This will be achieved by conducting a Business Impact Analysis (BIA) at both strategic and operational levels.
- To ensure that Business Continuity Plans are in place at all appropriate levels of the Trust in order to ensure continuity of critical functions in the event of a disruption.
- Specify the roles and responsibilities for BCM within the Trust.
- To provide a framework for efficient liaison between the Strategic (Gold), Tactical (Silver) and Operational (Bronze) Business Continuity Management Teams.

- To ensure that Business Continuity Plans are monitored and reviewed at planned intervals and when significant changes occur.

The Business Continuity Management (BCM) arrangements within the Trust will align with the International Organisation Standard (ISO) for Business Continuity – ISO 22301, issued in 2012.

3.1 Aim

The aim of the business continuity plan is to provide the Trust with a framework for preparedness, response, and recovery to business continuity incidents; embedding risk reduction strategies to ensure that the Trust is prepared and coordinated to respond to a disruptive event and restore key activities as soon as possible.

3.2 Objectives

The objectives of the Business Continuity Plan are to:

- Provide a consistent approach to business continuity planning and response;
- Outline appropriate processes for response and recovery to a business continuity incident

The procedures and processes specified in the plan are applicable to all services provided by the Trust. It should be read in conjunction with the Major Incident Plan and other appropriate Emergency Plans.

The Continuity Plans has been developed alongside the Trust Incident Response Plan and Major Incident Plan (which details arrangements for the Trust's response to Civil Emergencies) to ensure that they can both be implemented at the same time should it be necessary to do so.

4. Duties and Responsibilities

Role	Responsibilities
Chief Executive	The Chief Executive has overall responsibility for the strategic and operational management of the Trust, including ensuring that robust arrangements are in place for business continuity.
Accountable Emergency Officer (AEO) and Deputy AEO Delegated Executive Lead	The Chief Operating Officer has overall responsibility for ensuring that the Trust meets the requirements of the Civil Contingencies Act 2004 and that an effective system of Emergency Preparedness is in place throughout the Trust. Ensuring that the Trust, and any providers that the Trust commission, have robust business continuity planning arrangements in place which reflect the standards set out in the Framework for Health Services Resilience (PAS 2015) and ISO 22301.
Tactical Managers (Associate Directors and Senior Managers of Departments)	Associate Operational Directors will ensure that: • Business Continuity Plans are developed and maintained for all the critical services managed by their area, (based upon accurate Business Impact Analysis) in line with ISO 22301. • Their staff and all relevant external partners are aware of those plans. The plans are regularly and properly tested.
Head of EPRR	The Head of EPRR will co-ordinate the development, implementation and maintenance of Business Continuity Plans and will provide advice and guidance to managers and staff across the Trust.
Senior Information Risk Owner	The Senior Information Risk Officer will ensure that a business continuity strategy is in place for all critical information assets and critical processes; including those provided under service contract or agreement by third parties. Information security elements will be considered and reviewed in business continuity plans.
All Staff	Staff will familiarise themselves with and adhere to all relevant business continuity plans within their service area and undertake appropriate training relevant to their role. In addition, the following group will be pivotal to the Emergency Planning and Business Continuity Management structure; -
The Event Planning Group	The Event Planning Group will be responsible for delivering the national and local Emergency Planning/Civil Contingencies Agenda to minimise

	the risk to Trust patients, staff and business from an untoward/catastrophic event. The Group will approve plans prior to formal ratification by the appropriate committee.

5. Policy Details

5.1 Objectives of department business continuity plans

Department Business Continuity Plans identify the critical service areas within each department. They provide the framework for operational level response and recovery, detailing the actions to be taken to continue or recover delivery of the services within identified timescales. These are prioritised as follows:

- Priority 1 A service that needs to be restored within 1 hour
- Priority 2 A service that needs to be restored within 24 hours
- Priority 3 A service needing to be restored within 3 days
- Priority 4 A service that can be suspended for up to 7 days
- Priority 5 A service that can be suspended for more than 7 days

They provide the framework for the operational response to and recovery from issues that may arise and include:

- Key Contact and Stakeholder Information
- Contingency Arrangements for Identified Single Points of Failure
- Contingency Arrangements for Loss of Access to Sites or Buildings
- Contingency Arrangements for Loss of Access Routes
- Contingency Arrangements for Loss of Critical Equipment
- Contingency Arrangements for Loss of Critical IT Systems and / or Documents

- Contingency Arrangements for Loss of Electrical Power
- Contingency Arrangements for Loss of Mains Gas
- Contingency Arrangements for Loss of Mains Water
- Contingency Arrangements for Loss of Staff
- Contingency Arrangements for Loss of Steam
- Contingency Arrangements for Loss of Telecommunications
- Contingency Arrangements for Supply Chain Disruption
- Contingency Arrangements for Surge in Demand for Care/Service

The BCM arrangements within the Trust will align with the International Organisation Standard (ISO) for Business Continuity – ISO 22301, issued in 2012.

Table 1 and diagram below shows the ISO 22301 'Plan, Do, Check, Act' (PDCA) cycle, as applied to the BCM processes.

Table 1: Explanation of PDCA Model

Plan (Establish)	Establish business continuity policy, objectives, targets, controls, processes and procedures relevant to improving business continuity in order to deliver results that align with the organisations overall policies and objectives.
Do (Implement and operate)	Implement and operate the business continuity policy, controls, processes and procedures. Undertake Business Impact Analysis (BIA)
Check (Monitor and review)	Monitor and review performance against business continuity policy and objectives, report the results to management for review and determine and authorise actions for remediation and improvement.
Act (Maintain and improve)	Maintain and improve the Business Continuity Management Systems (BCMS) by taking corrective action, based on the results of management review and reappraising the scope of the BCMS and business continuity policy and objectives. Debrief when appropriate.

(Source: Smartsheet, IS0 22301, PDCA Cycle)

When dealing with any disruption, the Trust has a responsibility to:

- Maintain a safe and secure environment for the assessment and treatment of patients.
- Maintain a safe and secure environment for staff that will ensure the health, safety and welfare of staff including appropriate arrangements for the professional and personal indemnification of staff.
- Restore critical services with minimum disruption to patient, staff and stakeholder safety.
- Provide a clinical response including provisions of general support and specific / specialist health care to those impacted by the disruption including casualties, victims and responders.
- Liaise with the Local Health Resilience Partnership and other external health economy partners to reduce the impact of the disruption across the region.
- Provide appropriate support to any designated receiving hospital or other neighboring service that is substantially affected.
- Maintain communications with relatives and friends of existing patients and those resulting from the incident, the Casualty Bureau, the local community, the media and VIPs.

5.2 Business Impact Assessment

The Business Impact Analysis (BIA) is the first step towards developing a business continuity plan. It identifies, via a logical process; -

- The core services which are critical to achieving the objectives of the organisation
- The services which they in turn rely on
- The main threats to the loss or disruption to those services in a prioritised format
- The potential consequences to the organisation
- The measures which will be taken to mitigate the risk

Through this process critical activities can be determined and timeframes for recovery can be assigned for each activity.

Any issues identified as being a risk to the continuity of services that the Trust provides must be registered on the Corporate Risk Register as should intended courses of action for mitigation.

A BIA has been completed for the Trust as the foundation for this business continuity plan which demonstrates how we can respond effectively to an incident which is likely to cause a disruption to the smooth running of our services.

5.3 Health and Safety

An incident of any kind should not be regarded as justification for relaxing safety measures and / or the requirements of the Health & Safety at Work Act 1974 and any other relevant safety regulations which are still to be observed.

Where Trust employees are involved at or near the scene of an incident, the Trust Health & Safety Advisors may also be in attendance to advise and supervise the general working conditions of those in the area.

Any accidents involving injury to Trust staff or contractors assisting in an incident must be reported through normal procedures and the employee's manager notified. If the Incident Control Centre is in operation and the injury is of a significant nature the Incident Control Commander should be notified immediately.

In addition to the above:

- Only appropriately trained personnel will be expected to participate in the response to an emergency incident.
- It is the responsibility of Service Managers to ensure that appropriate breaks are taken, suitable shift patterns are worked and that the changeover of staff is co-ordinated appropriately.
- The Trust will have due regard to the potential impact that an incident can have on its personnel. Staff counselling services will be available in appropriate circumstances. All managers should ensure that staff are made aware of support that may be provided through the Trust's HR and Occupational Health department.

5.4 Activation of the Plan

If the scale of disruption warrants the activation of the Incident Control Centre the Accountable Emergency Officer will make the necessary arrangements for activation. The Trust Conference room, Warrington site has been identified as the primary Incident Control Centre. This will allow greater space for the management of any incident. A secondary location has been identified within the ITU handover room, Burtonwood Wing, should the primary Incident Control Centre not be available. Should the nature of the incident dictate that neither of these locations is suitable, the A&E Seminar room will be utilised as a back-up.

5.5 Co-ordinated Management of a Disruption

Some disruptions may not warrant the activation of the Incident Control Centre. However co-ordinated management of the disruption needs to be considered. The principles of command and control must still be applied and the use of a loggist considered. The scale of the disruption should be assessed using the guide at Appendix 1 and escalated as per Appendix 2.

5.6 Command and Control

Decisions on the activation of management levels to command and control any incident should be guided by flexibility, functional requirements and two broad principles. First, the principle of subsidiarity should be applied (i.e. decisions should be taken at the lowest appropriate level, with co-ordination at the highest necessary level). Secondly, that it is better to activate a Strategic level of co-ordination on a precautionary basis and then stand it down, than be forced to activate it belatedly under the pressure of events.

5.7 Level of Response to Disruption

The management of the response to a disruption will normally be undertaken at one or more of three ascending levels:

- Operational Incident Management Team

These are the staff involved at the scene of an incident, for example, CBU Managers, Senior Nursing Staff, Service Managers etc, and implement the tactical decisions made at operational level. They are responsible for the response to, and recovery from, any disruption within their Service / CBU.

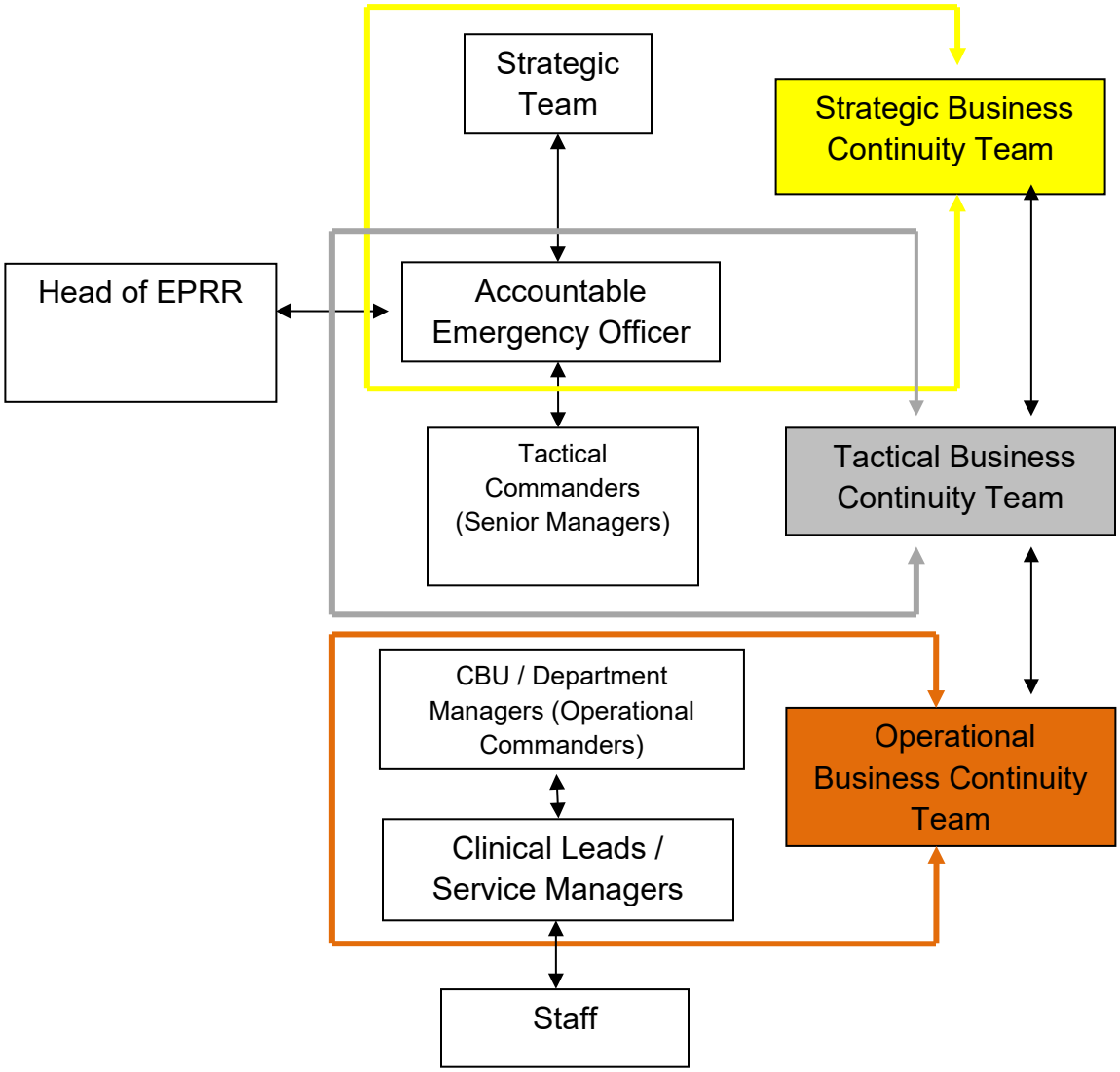
- Tactical Incident Management Team

This includes Associate Operational Directors or deputies, along with Tactical Commanders at WHHFT. This may be activated in response to any disruption which affects the normal business of the Trust. They co-ordinate resources, stop services if required and sanction the necessary expenditure and liaise with external partners as appropriate. These managers are usually based in the Incident Control Centre. They should provide the Strategic Team with tactical advice and regular updates.

- Strategic Incident Management Team

This includes the Chief Executive, Deputy Chief Executive and Executive Board Members. They provide strategic support and direction throughout the disruption and recovery process, giving direction to the Tactical Team. An essential role of the Strategic Team is to face outward to stakeholders and liaise with external partners as appropriate. They are not based in the Incident Control Centre, but at a strategic location in the Executive Meeting Room and should convene on a regular basis.

5.8 Incident / Disruption Management Structure



5.9 Incident Severity Rating Guidance

The Incident Severity Rating Guidance table at Appendix 1 provides a rating for the severity of the disruption anticipated and potential impact. It should be used when communicating incidents in line with the incident escalation chart at Appendix 2. The information and descriptors contained within the table are not exhaustive. Each incident should be assessed against the impact experienced

5.10 Service Priorities

The Business Impact Analysis process carried out by the service managers and approved by senior managers, identifies priority services and key stakeholders including internal and external customers and suppliers. It seeks to identify critical functions through accurate impact assessment.

5.11 Priority Ratings

The designated priority levels for Trust services are as follows:

- Priority 1 A critical service that needs to be restored within 1 hour
- Priority 2 A critical service that needs to be restored within 24 hours
- Priority 3 A service needing to be restored within 3 days
- Priority 4 A service that can be suspended for up to 7 days
- Priority 5 A service that can be suspended for more than 7 days

Staffing, premises, equipment and information needs have already been considered for each Priority 1 and 2 function of each service area. It is envisaged that Priority 3, 4 and 5 functions will be considered at the time of disruption.

NB: One of the first considerations following a disruption will be to assess the services disrupted and the order of priority they should be restored given the nature and scale of the disruption.

Some services may not appear to be Priority 1 or 2, however included in the assessment scoring is the support provided by those teams in the event of a civil emergency or service disruption. They may also be providing a service to other high priority functions.

For ease of reference the services are listed in Appendix 3.

5.12 Incident Response

Anyone notified of a disruption should make contact with the Service manager/Manager of the Day or Out of Hours the Senior Manager on-call if:

- More than one service is affected
- Where special arrangements such as temporary suspension of services or relocation is required
- A disruption has the potential to impact on the Trusts response to a civil emergency.

An initial reporting template is available in appendix 4. Appendix 5 details the Incident Response Command and Control Team. Appendix 6 displays the action cards for the key players in a business continuity incident.

5.13 Actions by the Tactical Commander (Tactical Manager of the Day / Senior Manager on-call)

The Tactical Commander will ascertain what is required and arrange for assistance to be given by other Trust services as appropriate.

5.14 Escalation

To ensure the response to any disruption is controlled and appropriate, senior personnel must be notified without delay. Escalation should be done in accordance with the Incident Escalation Chart (appendix 2).

5.15 Tactical Business Continuity Team

At the earliest opportunity, an initial meeting should be arranged with senior representatives from the affected Care Group/Department as indicated below, along with representation from supporting functions as appropriate. This will determine the response to the incident and management of and recovery from the disruption. Appendix 6 outlines the role sin responding to the Business Continuity incident, these should be considered in the event of a moderate business continuity incident or critical incident.

- Communications
- Corporate Services
- Estates and Facilities Management
- Human Resources
- Digital Services
- Pharmacy
- Supplies
- Loggist

The following issues should be included on the agenda for the meeting as appropriate:

- Patient safety
- Service priorities and recovery
- Medicines Management
- Supplies
- Alternative accommodation
- Staff/Patient/Public information
- Legal obligations and financial implications
- Response to major incidents
- Recovery

Consideration must be given to the relief in post of those individuals forming part of any response at all levels.

5.16 Support Functions

Apart from the responsibilities in ensuring Care Groups can continue to run their own services there are some cross cutting functions and services that will be required to provide a supporting role in the event of a disruption. The reallocation of resources to support those of a higher priority may be required. Priority of services and recovery time objectives are given at appendix 3.

5.17 Recording of Incidents and Preservation of Documents

The possibility of legal proceedings after any incident must be borne in mind and the recording data and collection of information should be designed to assist in preparing the subsequent report on the action taken by the Trust.

For this reason, staff should ensure that their principal actions are recorded in a legible format. It is important that staff log details of all messages that are passed verbally by radio or telephone and any emails or letters collated and stored appropriately. At the conclusion of the incident all information should be passed to the Accountable Emergency Officer for collation and storage.

A comprehensive log of all actions taken during a disruption should be made. This will form the basis of any subsequent inquiry into the disruption and should be treated as a legal document. A Business Impact Assessment is attached at Appendix 4. Log sheets should be forwarded to whh.controlroom@nhs.net

In the event that a Strategic or Tactical Business Continuity Team is convened, a Loggist should be utilised to ensure accurate record of events are kept.

The accurate recording of events will contribute significantly to the enhancement of resilience within the Trust. Learning from previous incidents, (both internal and external) is widely regarded as an integral component of organisational learning and recognised as part of the incident management cycle.

5.18 Administration

In the event of a disruption, departmental administration teams will:

- Provide administrative support to the Incident Management Teams (Strategic and Tactical)
- Provide administrative support to other specific groups set up to manage the response to a business disruption as directed.
- Provide administrative support to Care Groups / Departments experiencing high levels of demand for services.

5.19 Switchboard

Switchboard may receive a high volume of calls from patients or the public concerned about services or any other query relating to the disruption. This may include relatives enquiring after the safety of staff and media enquiries.

In the event of a disruption the Switchboard will:

- Provide internal communication support to the Tactical Business Continuity Team ensuring that information is cascaded as directed.
- Provide a point of contact for public advice and support as directed by the Communications Team.
- Direct all media calls to the Communications Team.

5.20 Communications Team

In the event of a disruption:

- Ensure information is made available to patients (where appropriate), staff, the public and the media, liaising with partners as appropriate

- Activate the Trust Incident Communications Plan as appropriate in line with the Cheshire and Merseyside Resilience Forum Media Protocol in an Emergency (latest edition)
- Provide appropriate support for CBU's/Departments during a disruption.

Any information released to media and public by the Trust will need to be:

- Timely
- Detailed
- Accurate and appropriate
- Shared with, and on occasions cleared by partners

Use of the Trust Website and social media will be a critical means of helping operational staff and will also help meet the demands from the media, as accurate and detailed information about the disruption and changes to services can be quickly made available to the media and the wider public. This web content can support employee dealing with a disruption by helping save time spent answering telephone calls, and by ensuring accurate information is clearly stated and easily accessible to everyone that needs it.

It is critical that the Communications Team is notified at the earliest opportunity after a disruption is first reported.
The Communications Team will also notify partner agencies as appropriate.

5.21 Press and Media Management

Under no circumstances should members of the media be allowed access to any other part of the Main Hospital Building

Press facilities will be set up under the supervision of the Director of Communications.

Filming or photographing will only take place with the permission and knowledge of the Media Liaison Officer.

The Strategic Incident Management Team must agree briefings, including any advice from Public Health England considered relevant. These must be coordinated with the media officers of all other organisations involved in managing the incident. The Police must co-ordinate the Trust's media response when this is appropriate to the incident being managed.

Patients' consent must always be sought for release of details, participation and interviews and for the taking of photographs.

Interviews will be authorised by the Chief Executive or Deputy. The Strategic Incident Management Team will detail spokespeople acting on behalf of the Trust.

5.22 Advice to Public

Until the procedures established through the Cheshire & Merseyside Resilience Forum "Media Protocol During an Emergency" have been activated, any calls received by the Trust regarding health concerns relating to an emergency should in the first instance be referred to NHS England.

Arrangements to provide health advice will be put in place by the Director of Public Health England (PHE). This advice may be sourced through a Scientific and Technical Advisory Cell (STAC) once established through the Strategic Co-Ordination Group (SCG). Advice on technical issues, including technical aspects of health, will be provided to the SCG by the STAC. This will normally be co-located with the SCG, and will comprise representation from NHS England, PHE, NWAS, and clinical experts in the fields of toxicology, microbiology, infectious diseases, etc., and other experts as required.

5.23 Counselling

Some disruptions, no matter how large or small, may have an emotional impact on staff. Throughout the disruption, and as part of the de-briefing process, managers should ensure that all staff are made aware of support that may be provided through the Trust's People Strategy and staff counseling service.

5.24 Estates and Facilities Management

Where infrastructure is affected, Estates and Facilities will ensure that the working environment is safe, secure and comfortable for patients, staff and visitors.

In the event of a disruption Estates and Facilities (and those responsible for the management of infrastructure) will:

- Maintain liaison with emergency services at the site if necessary
- Advise on the safety of buildings and structures and the protection and repair
- Provide plans of buildings
- Control salvage activities of assets
- Provide information regarding building and asset loss for insurance purposes

- Assist in the identification of alternative facilities as required
- Ensure that should disruption be experienced due to utility failure, alternate supplies will be sourced.

5.25 Finance Department and Expenditure

The Finance Department will:

- Monitor expenditure across the Trust
- Provide advice and assistance in relation to expenditure, insurance and procurement
- Provide, where necessary, an emergency expenditure code
- Provide support and information regarding insurance
- Liaise with loss adjusters
- Co-ordinate the procurement and replenishment of supplies.

The Director of Finance, in liaison with the Tactical Business Continuity Management Team will authorise expenditure while adhering to Trust financial regulations. Individual members may authorise transactions that fall within their respective levels of authority.

Accurate records must be maintained of all decisions taken and costs incurred to enable any appropriate claims to be made and a clear audit trail established. All records should be forwarded to the Accountable Emergency Officer.

5.26 Health & Safety Department

In the event of a disruption:

- Provide health & safety advice
- Attend the scene of a disruption to assist and supervise general health & safety arrangements

5.27 People Directorate

In the event of a disruption:

- Provide corporate information, support and assistance to the affected Care Group/Departments
- Ensure welfare support is available
- Assist in co-ordinating the re-allocation of staff resources

5.28 Digital Services

In the event of a disruption:

- Assess incident severity and damage to ICT facilities
- Provide technical support and assistance to the affected services
- Provide a recovery strategy and timetable, which is dependent upon the extent of damage and critical infrastructure/systems affected. This will be done in order of priority
- Assess and provide information regarding losses for insurance purposes

5.29 Governance Services

In the event of a disruption:

- Ensure that the Trust complies with any legal requirements
- Provide advice and assistance in relation to legal requirements

5.30 Pharmacy

Following the initial contact an initial assessment will be made and the Pharmacy team will provide a Pharmacy service appropriate for the immediate emergency situation thereafter monitoring what further services / actions and staffing / resources are required.

5.31 Procurement Services

The Procurement Services team will act to ensure Supply Resilience is met as set out in set out in Department of Health, Standards of Procurement, Standard 1.4.

Where a disruption necessitates the need for specialised purchasing of contractors, equipment and / or agency staff the Procurement Services team will provide the necessary assistance.

5.32 Mutual Aid

It is the prerogative of the Chief Executive to sanction any request for support from outside the Trust to meet any special demand or to give reciprocal aid.

Mutual aid would normally only be required where the resources of the Trust were proving inadequate to deal with the emergency or the delivery of essential day to day services were compromised.

5.33 Key Contacts and Stakeholders

Details of Key Contacts and Stakeholders can be found in the relevant CBU/Departmental Business Continuity Plans.

5.34 Dependents and Dependencies

Details of Dependents and Dependencies are documented in CBU / Departmental Business Continuity Plans.

5.35 Stand Down and Recovery Procedures

Once the disruption has been brought under control it is essential that clear instructions are given to all services and staff that they should stand down operations. A significant / major disruption may involve all Services and it is possible that some Services will be required to stand down prior to others. As a rough guide, the process of standing down should occur when it is sufficient to resume the recovery as part of normal activities.

5.36 Situation Reporting

Dependant on the nature of the incident, there will be a requirement for affected areas/staff to receive regular updates from the Incident Management Team. The timetable or 'battle rhythm' for SitReps may changes as the incident takes effect and will vary as the impact varies

5.37 Recovery

All plans should include information on how services will return to normal following a disruption. Recovery will vary dependent upon the type and duration of the disruption and the service(s) affected. Consideration must be given the welfare of staff. The following issues should be considered during recovery:

- Staff
  - Accumulation of leave
  - Time in lieu
  - Exhaustion and low morale
  - Managing expectations

- What steps are in place now for the eventuality of losing key staff within key Services
  - Succession planning
  - Transfer of staff knowledge/skills – work related or other skills

- Facilities
  - Return of facilities to “normal use”
  - Prioritisation and co-ordination across the division
  - Who, when and how?

- IT Systems
  - Extra inputting of information/data if a service reverted to a paper based system or alternative IT method during a disruption e.g. pre designed templates or log sheets

- Equipment/supplies
  - Shortage of key components/spare parts
  - Lack of key equipment
  - Low or minimal supplies of consumables
  - Rationing, co-ordination and sharing

- Medicines Management
  - Review of medicines safety and security arrangements
  - Ongoing review of rotas throughout the period to ensure appropriate allocation of Pharmacy staffing resources
  - Allocation or replenishment of medicines stocks
  - Removal of medicines stocks from de-escalated areas

- Which services should be re-introduced first?
  - How would you decide?
  - Who would you need to consult?
  - What is the mechanism for this?

- How and when will targets be re-introduced?
  - How would you decide?
  - Who would you need to consult?
  - What is the mechanism for this?

- How would you communicate your plan to re-introduce services with your stakeholders?
  - Staff
  - Patients
  - Visitors
  - The Public
  - Independent providers

  - Partner agencies
  - Contractors
  - Governing bodies

- If there are a large number of fatalities as a result of the disruption, what actions will be taken to provide support and counselling for the bereaved in your division/service?

- The capture of lessons learned during the disruption?

5.38 Formal De-brief

Within 48 hours of staff being informed to 'stand-down' by the Incident Management Team, a structured de-brief should take place involving the Strategic Business Continuity Team and appropriate senior hospital staff. Services should also ensure that structured debriefs are held in order to identify any lessons learned which will can be utilised to improve resilience. The meeting must be documented and the findings presented to the Event Planning committee. Records must be held on file.

5.39 Staff Support

As a part of the de-briefing process, managers should ensure that all staff are made aware of support that may be provided through the Trust's Staff Strategy and staff counselling service.

5.40 Reporting of Events to External Agencies

The Trust must notify the Co-ordinating Commissioner as soon as is reasonably practicable and in any event no later than 5 operational working days following the activation of the business continuity plan.

5.41 Overview of Trust Business Continuity Plans

The development of comprehensive business continuity plans will cover a number of possible eventualities. For example a plan for loss of staff may be used to cover losses due to high sickness absence, transport difficulties due to severe weather or fuel shortages, or slightly longer absences due to pandemic flu etc. Similarly a plan for loss or denial of premises may be used to recover from incidents such as fire, flood, structural damage etc. if the outcome is the same. Business Continuity Plans have been developed for key areas identified in the Emergency Planning Guidance across the Trust, as well as for pandemic flu, severe weather and fuel shortage.

5.42 Workforce

The most important asset to an organisation is its workforce. Any significant or prolonged loss of staff therefore presents a significant risk to the Trust. The response to loss of staff will depend on the nature of the incident. For example, a short term but high impact loss incurred by severe weather, industrial action, or transport problems will require a different response to a 'rising tide' incident such as pandemic flu or ongoing recruitment difficulties where the impact will be felt over a longer period of time.

Service level business continuity plans detail contingency arrangements for loss of staff by service based on a 10% - 30% reduction.

Plans for short term loss of staff include agreement of mutual aid from other departments or neighbouring Trusts, temporary outsourcing of work, working from home with IT support in the event of adverse weather conditions, and introducing flexible working patterns to enable staff to respond to peaks in workload.

The response to loss of staff will depend upon the nature of the incident. E.g. a short term but high impact loss incurred by severe weather, industrial action, transport problems will require a different response to a 'rising tide' incident such as pandemic flu or recruitment difficulties where the impact will be felt for a longer period of time. Some measures which could be incorporate within the plan include; -

- Working from home with IT support
- Explore mutual aid from other Trusts or internal departments
- Maintain a list of staff with additional skills who can be redeployed to support critical functions
- Develop a training plan which is aimed at widening the skills and knowledge base of staff to provide more scope for cross-cover during emergencies
- Identify which non-critical services can be suspended if necessary, during an incident, e.g. as identified in pandemic flu plans
- Suspend new requests for annual leave and attendance at training events
- Introduce flexible working practices to enable staff to respond to peaks in workload
- Temporary outsourcing of work to other Trusts or organisations

5.43 Communications

The telecommunications system represents one of the key business functions of the Trust and loss of this function will have immediate repercussions on our core services.

A telecommunications business continuity plan has been developed which identifies the Disaster Recovery arrangements which will be implemented in the event of a system failure. In the event of a failure on the Warrington site three main contingency arrangements will be activated; -

- The system will be diverted to a back-up switchboard facility at Halton Hospital.
- Analogue 'red' back up telephones in key areas of the Trust including all ward and clinical areas, will continue to operate independently from the main switchboard.
- A supply of hand held radios and mobile telephones will be made available for other key areas without a means of communication.

Full details of the plans for dealing with major failures of the telephony system are set out in the Telecommunications business continuity plan.

5.44 Buildings

In the event that any Trust premises are unavailable or inaccessible for an extended period of time, e.g. to due to fire, flood, structural damage etc, alternative accommodation will be sought to house all business critical services. All services, as part of their business continuity arrangements, have identified critical services, staff and equipment in their department and have defined minimum office amenities requirement in order to continue to deliver essential services.

If a business continuity incident is declared which results in a denial of premises, the incident control team will be assembled and will determine priorities for use of accommodation using local service business continuity plans as a guide. Critical business functions identified in the BIA will take priority in the allocation of accommodation and this may involve the displacement of non-critical functions, or functions that can be re-sited with little impact. The Associate Director of Estates & Facilities will form part of the control team in such circumstances.

Alternative premises identified in business continuity plans include the use of accommodation at Halton Hospital, the Cheshire and Merseyside Treatment Centre and non-critical accommodation such as education centres, committee rooms, seminar rooms, common rooms, IT training rooms, accommodation at other local Trusts, or premises used by third party organisations.

Other contingency plans for temporary loss of premises include the use of alternative premises owned by other organisations as part of a reciprocal arrangement, arrangements which involve moving the workload but not the staff, e.g. outsourcing work, or the use of specialist organisations to provide short term accommodation.

In some cases where safety of staff cannot be guaranteed, it may be necessary to ask staff to work from home for a limited period of time until the immediate crisis can be resolved. In such

circumstances, local business continuity plans will identify which key staff need to remain on site to occupy the limited alternative accommodation available, and other staff may work from home but remain productive via use of e-mail, internet and telephone contact.

5.45 Equipment:

Faults on specialist equipment may lead to a total failure of the item or affect some of its functionality and represent a significant threat to the Trust's ability to undertake its core functions. Business continuity plans at service level include contingency arrangements for loss of critical equipment.

Vital equipment which may have serious consequences for patient safety in the event of a failure will be prioritised when devising business continuity plans, as will any Single Points of Failure (SPoF).

5.46 Information Management Technology:

Information and information management systems are vitally important assets to the Trust and their continuity is vital to the smooth day to day running of critical business functions. A major failure of IT systems represents a significant risk for the Trust and it is important therefore that all of the necessary steps are taken to ensure that they are protected at all times to ensure their ongoing continuity.

An IT Infrastructure Service Business Continuity Plan (BCP) has been developed to maintain vital IT services providing access to essential Trust IT systems during a business continuity incident. The Plan includes detailed risk descriptions of key IT systems managed by the Trust including a Disaster Recovery Plan which identifies the steps which will be taken to recover critical functions in the event of a system failure. The Disaster Recovery Plan outlines Recovery Time Objectives for each loss of function and the priorities for recovery in the event of a phased return to normal working.

Additionally, service level business continuity plans outline the procedures which will be implemented by Departments who are affected by loss of IT. These measures will include: -

- Retain a supply of vital paper documents and pro-formas to enable records to be maintained and basic services to continue
- Invoke Mutual IT recovery strategies with other Trusts
- Utilise remote access for access to basic IT services
- Ensure information is backed up at all times
- Geographical spread of technology so that the likelihood of disruption to all areas is minimised
- In some cases it may be necessary to relocate key staff to an alternative site or to work from home for a temporary period in the event of a lengthy disruption.
- Process for uploading paper information onto the electronic systems after the incident

5.47 Utilities

The Estates Department have produced Recovery Plans for the loss of key utilities which outline the immediate action to be taken to restore critical services. The plans include an assessment of the criticality of each utility and a Recovery Time Objective.

Service level plans identify the impact on individual services as a result of various utility failures, e.g. loss of power, fuel, water, heating, medical gases, air conditioning, etc. and the actions that will be implemented in the event of a failure. These actions will include: -

- Identify vulnerable patients to prioritise care and monitor with increased frequency
- Assess the need for patient transfer or ambulance diversion procedures
- Assess the need to cancel elective surgery
- Identify infection control risks
- Assess the requirement to bring in extra staff to assist with an emergency situation
- Apply restricted visiting arrangements
- Implement increased security presence
- Maintain an inventory of vital equipment with Uninterrupted Power Supply (UPS)
- Activate evacuation plan if necessary
- Identify equipment which can be used in an emergency such as portable heaters, air conditioning units, torches, portable suction machines etc.

5.48 Supply Chain

The Trust relies on the products and services of other organisations to be able to deliver services to its patients. The failure of a key supplier represents a significant risk to the Trust. A business continuity plan has been developed to protect the Trust against the worst effects of supplier failure and is referenced in this document.

In addition, as part of their Business Impact Analysis, services have identified external dependencies and the measures they have taken by way of mitigation.

The NHS Supply Chain has developed a Business Continuity Plan to demonstrate their resilience in the event of a disruption. For example, in the event of a national fuel crisis, the NHS Supply Chain has developed contingency plans involving the immediate isolation of enough fuel to last for approximately three weeks. A summarised version of this document can be found in the Business Continuity Plan of the Trust's Supplies Division, along with contact details of all Suppliers to the Trust.

Other business continuity plans have been developed to take account of specific risks; - the maintenance of an inventory of core supplies which support critical functions, arrangements with NHS Supply Chain and third parties to deliver critical stock at short notice, the production of a specific business continuity plan in response to the potential impact of a loss of the decontamination of medical equipment service provided by Synergy Ltd.

5.49 Pandemic Flu

In addition to the loss of critical business functions, it is also necessary to develop plans to take account of specific incidents which pose a major threat to the day-to-day business of the Trust. The potential impact of pandemic flu on both the Trust and the community at large poses such a threat and therefore requires a planned response in the event of an outbreak.

The business continuity plan for pandemic flu provides a framework for the development and implementation of the Trust's response to an outbreak of pandemic influenza.

5.50 Severe Weather

The effects of climate change present particular challenges to the smooth running of services provided by the NHS. In response to this, the Trust has developed plans in response to both a heatwave and severe winter weather in collaboration with our local health partners. Alerting procedures are in place through critical months and reports are provided by the Met Office during periods of severe weather.

The plans outline the actions which will be taken at incremental stages of a weather system which is likely to cause some disruption to services. They also include plans to respond to communication issues, loss of staff, transport difficulties, access to services, surges in demand and support services. A multi-agency approach is taken to support winter preparedness and detailed winter plans are developed in conjunction with the wider healthcare system.

5.51 Fuel

A national Emergency Fuel Plan has been developed in order to maximise the supply and use of fuel in the event of a disruption, e.g. industrial action, severe weather, supply failure etc. The main purpose of the plan is to mitigate potential problems associated with a national fuel disruption which may disrupt the NHS in England's core business functions.

The plan will be activated by the NHS England Area Team and the ICB in conjunction with the Cheshire Resilience Forum.

5.52 Training

As part of the process of embedding a BCM culture within the Trust, business continuity should be an important consideration for Managers when considering the training and development needs of staff.

The Civil Contingencies Act 2004 requires Category 1 responders to ensure that staff that are expected to take part in a response to an emergency are adequately trained.

The Trust should aim to exercise and test the business continuity arrangements alongside partner NHS organisations. Lessons learnt and post exercise reports will be shared with all interested parties.

5.53 Validation and Testing

Exercise programmes provide demonstrable evidence of a business continuity and incident management competence and capability. Business Continuity Plans cannot be considered to be robust until they have been validated by exercise and review. Appendix 7 sets out the considerations for business continuity exercises.

The Trust has developed an exercise programme in conjunction with the Cheshire Local Health Resilience Partnership and ICB, along with other external agencies with the aim of ensuring that Business Continuity Plans will work as anticipated when required. This consists of multi-agency events, discussion based exercises, table top exercises or independent audit. The Trust's emergency planning programme has responsibility for exercising emergency plans in a live event every 3 years, table top annually and communications every 6 months.

Service level continuity plans will be fully reviewed on an annual basis or more frequently where significant changes in service, legislation or the business environment have taken place. Testing will be programmed and conducted in a way which does not put essential business functions at risk. Departmental business continuity plans should be tested annually during live or planned exercises.

5.54 Audit

NHS England and the Department for Health and Social Care require assurance that NHS Trusts have in place a robust business continuity plan. As part of this assurance process, an annual audit of the Trust's business continuity arrangements takes place. This is currently managed by senior managers who are not assigned to the department, and supported by the Head of EPRR.

Recommendations arising from the audit will be reported to the Event Planning Group and a plan to action the recommendations will be developed by the Head of EPRR. The Head of Operational Programmes and Recovery currently supports the audit process.

5.55 Review

Business Continuity Management is a cyclical process and associated plans will be living documents that will change and grow as incidents occur and risks are re-assessed. All business continuity plans will therefore be reviewed and updated on annual basis to meet the requirements of Category 1 responders under Civil Contingencies Act. The review may be undertaken sooner in the event of any significant operational, legislative or environmental change.

6. Document monitoring

This document will be reviewed annually, and this will take place through the Event Planning Group. Departmental BCPs will be reviewed as part of the annual audit process.

Departmental BCPs are reviewed annually through internal governance meetings, and are subsequently shared with the Head of EPRR for ratification through the Event Planning Group. Local BCPs will be audited as part of an annual cycle, there is a separate business continuity audit document in place to capture such reviews.

The Trust Business Continuity Plan is ratified through the Finance and Sustainability Committee (FSC). This document will be presented and approved by the Board on an annual basis, aligned with the annual report for EPRR.

7. Glossary of Terms

The following definitions provide additional guidance to the terms used in the main body of the policy:-

Activation: The implementation of business continuity procedures, activities and plans in response to a Business Continuity Emergency, Event, Incident and/or Crisis. *(Business Continuity Institute Good Practice Guidelines).*

Business Continuity: The strategic and tactical ability of the organisation to plan for and respond to incidents and business disruptions in order to continue business operations at an acceptable pre-defined level. *(British Standard for Business Continuity BS25999).*

Business Continuity Incident: An incident which threatens to disrupt the day to day business operations of an organisation. *(British Standard for Business Continuity BS25999).*

Business Continuity Management: A management process that helps to manage the risks to the smooth running of an organisation or delivery of a service, ensuring that it can operate to the extent required in the event of a disruption. *(Civil Contingencies Act 2004).*

Business Continuity Management Policy: A policy which sets out an organisation's aims principles and approach to BCM, what and how it will be delivered, key roles and responsibilities and how BCM will be governed. *(Business Continuity Institute Good Practice Guidelines).*

Business Continuity Management System: That part of the overall management system that establishes, implements, operates, monitors, reviews, maintains and improves business continuity. *(British Standard for Business Continuity BS25999).*

Business Continuity Plan: A documented set of procedures and information intended to deliver continuity of critical functions in the event of a disruption. *(Civil Contingencies Act 2004).*

Business Impact Analysis: A method of assessing the impacts that might result from an incident and the levels of resources and time required for recovery. *(British Standard for Business Continuity BS25999).*

Civil Emergency: An event or situation which threatens serious damage to human welfare or security in the UK. *(Civil Contingencies Act 2004).*

Critical Activities: Those activities which have to be performed in order to deliver the key products and services which enable an organisation to meet its' most important and time-sensitive objectives. *(British Standard for Business Continuity BS25999).*

Critical Activities: Those activities which would have the greatest impact in the shortest period of time and which need to be recovered most quickly could be termed 'critical activities'. *(Association of Local Risk Managers 2007).*

Critical Function: A service or operation, the continuity of which a Category 1 responder needs to ensure, in order to meet its business objectives. *(Civil Contingencies Act 2004).*

Emergency Planning: The development and maintenance of agreed procedures to prevent, reduce, mitigate and take other actions necessary in the event of a civil emergency. *(British Standard for Business Continuity BS25999).*

Exercise: An activity in which business continuity plan(s) is rehearsed in part or in whole to ensure that the plan(s) contains the appropriate information and produces the desired result when put into effect. *(British Standard for Business Continuity BS25999).*

Incident Management Plan: A clearly defined and documented plan of action for use at the time of an incident, typically covering the key personnel, resources, services and actions needed to implement the incident management process. *(British Standard for Business Continuity BS25999).*

Local Resilience Forums: An umbrella organisation that brings together all organisations that have a duty to co-operate under the Civil Contingencies Act 2004, and others who would be involved in the response to an emergency. The purpose is to ensure that preparation for emergencies is carried out in a co-ordinated and effective way. *(Civil Contingencies Act 2004).*

Major Incident: Any occurrence that presents a serious health threat to the health of the community, disruption to the service or causes such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations. *(NHS Emergency Planning Guidance 2005).*

Maximum Tolerable Period of Disruption (MTPD): The duration after which an organisation's viability will be irrevocably threatened if product and service delivery cannot be resumed. *(British Standard for Business Continuity BS 25999).*

Recovery Time Objective (RTO): Identifies the time by which critical functions and/or their dependencies must be recovered. *(Civil Contingencies Act 2004).*

Resilience: The ability of an organisation to absorb the impact of a business interruption, disruption and/or loss and continue to provide a minimum acceptable level of service. *(Business Continuity Institute Good Practice Guidelines).*

Risk Assessment: The overall process of risk identification, analysis and evaluation. *(British Standard for Business Continuity BS 25999).*

Risk Management: The process of measuring or assessing risk, and then developing strategies to manage the risk and reduce the risk of occurrence. *(Institute of Risk Management)*

Single Point of Failure: The only source of a service, activity and/or process whose failure would lead to the total failure of a mission critical activity and/or dependency. *(British Standard for Business Continuity BS 25999).*

Stakeholders: Those with a vested interest in the organisations' achievements. E.g. employees, customers, suppliers, partners, investors, insurers, owners, governors, regulators, media, outsourced services. *(British Standard for Business Continuity BS 25999).*

Vital Record: Computerised or paper record which is considered to be essential to the continuation of the business following an incident. *(British Standards Institute Good Practice Guidelines).*

8. Associated documents

NHS Emergency Preparedness Resilience and Response Framework 2022

Good Practice Guidelines, 2018 Edition, The global guide to good practice in business continuity Civil Contingencies Act 2004 (CCA 2004)

The NHS Act 2006

The Health and Care Act 2022

NHS Standard Contract

The NHS Constitution

NHS Core Standards for Emergency Preparedness, Resilience and Response

Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (MOS)

9. Sources/references

ISO 22301:2019 Security and resilience – Business continuity management systems ISO 22301:2019(en), Security and resilience — Business continuity management systems — Requirements

10. Training needs analysis

Staff role	Training requirement	Frequency	Training delivery method
Strategic Commanders	Emergency preparedness	Annual	• Induction training for new starters • On-Call training for Executive Directors • Media emergency training • Supplementary training will be provided in response to any new developments, legislation etc. on an ad hoc basis. • Familiarity with Trust wide Business Continuity Plan, Incident Response Plan and Major incident plan
Tactical Commanders	Emergency preparedness	Bi-annual	• Induction training for new starters • On-Call training for tactical Commanders • Supplementary training will be provided in response to any new developments, legislation etc. on an ad hoc basis. • Familiarity with Trust wide Business Continuity Plan, Incident Response Plan and Major incident plan
Senior Managers	Emergency preparedness	Annual	• Business continuity awareness • Understanding of the Business Impact Assessment process • Supplementary training will be provided in response to any new developments, legislation etc. on an ad hoc basis
All Trust staff	Emergency preparedness	Annual	• Familiarity with business continuity plans in their working area

If training is required, please consider the following: who needs the training (and how often); who will deliver it and how will they do this (e.g. duration/ location); what are the objectives it will meet and how will you assess learner competence; how quickly do staff need to be trained and do we have the resources to deliver this; are there any funding implications; where will completion of this training be recorded (and who will do this).

Please refer to Trust Procedural Document Control Policy for support on how to complete this section and who to contact.

Appendix 1: Incident Severity Rating Guide

Localised Disruption / incident	**One or more of the following apply** ▪ The incident is not serious or widespread and is unlikely to affect business operations to a significant degree ▪ No significant impact on patient or staff safety ▪ No significant impact on performance or finance ▪ The incident can be dealt with and closed by relevant managers ▪ No significant media or political interest

Incident managed within the affected areas

Where the initial impact assessment grades the situation as a localised minor incident, the affected management team should deal with this using localised contingency arrangements. Where this incident has the potential to impact on Patient Flow the Patient Flow Team must be notified. Where this incident has the potential to spill over into the evening / weekend the Tactical Commander along with the Site Manager and Matron should be notified and informed of the contingency arrangements in place through bed meetings, weekend handover or weekend site meetings.

Minor Disruption / Incident	**One or more of the following apply** ▪ Limited impact on patient and staff safety ▪ Incident expected to be fully resolved and closed within 24 hours ▪ Limited but some impact on service delivery in critical areas ▪ One or a number of local contingency plans activated ▪ Incident still expected to be managed through localised contingency arrangements ▪ Limited financial / performance impact ▪ Limited Governance issues ▪ Possible public/media/political interest

Incident managed using local contingency arrangements.

Where the initial impact assessment grades the situation as a minor disruption, the incident should be managed by the Operational Commanders affected in their CBU/ Department. The Operational Commanders will escalate where necessary and inform the Tactical Commander (Manager of the Day) if appropriate. Where this incident has the potential to impact on Patient Flow the Patient Flow Team must be notified. Where the incident spills over (or has the potential to) into the evening / weekend, the relevant Tactical Commander/Site Manager/Matron should be informed for information regarding the contingency arrangements in place.

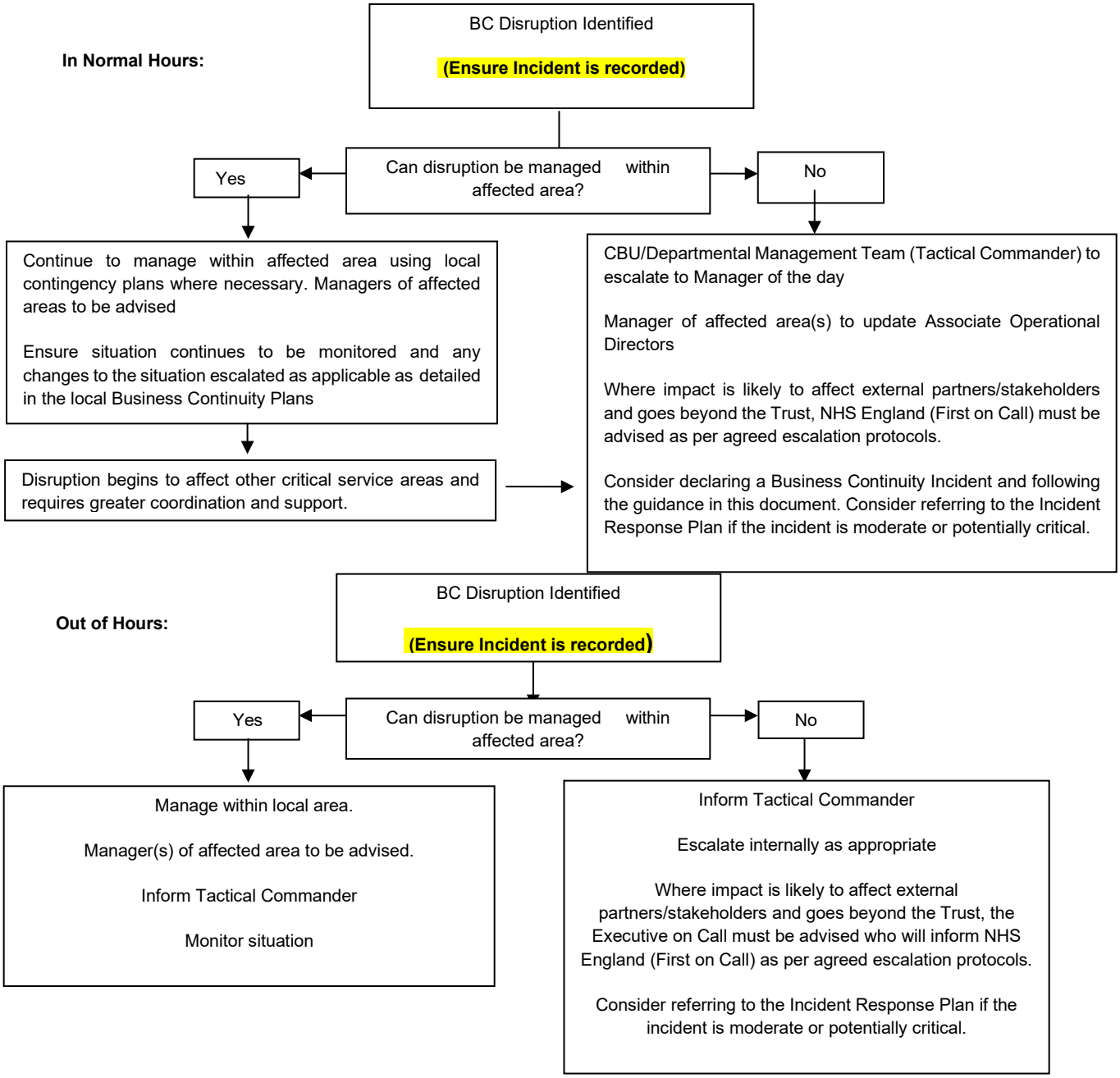
Significant Disruption / Incident	**One or more of the following apply** ▪ Disruption to a number of critical services likely to last for more than 1 working day ▪ Significant impact on patients and staff ▪ Access to one or more sites denied where critical services are carried out for more than 24 hours ▪ Suspension of a number of services required ▪ Access to systems denied and incident expected to last more than 1 working day and therefore impacting on operational service delivery ▪ A number of critical services seeking to activate service level contingency plans thus requiring overall management ▪ Significant impacts on finances and performance ▪ Significant Governance issues ▪ Possible public/media/political interest
Numerous contingency plans activated thus requiring effective management by calling together of a specific multi directorate team Where the initial impact assessment grades the situation as significant the incident will need to be formally managed to ensure resources and activities are effectively coordinated. The Operational Commanders (CBU Managers) and Tactical Commanders (Associate Directors) of the affected areas will consider the activation of an Incident management team. It may also be necessary to inform the NHS England First On-Call. The Integrated Care Board (ICB) will be informed when it is appropriate to do so.	
Major Disruption / Incident	**One or more of the following apply** ▪ Incident expected to impact on critical services for more than 48 hours ▪ Widespread disruption, loss of a major or multi-occupancy site ▪ Major impact on patient and staff safety ▪ Wide-scale incident in a geographical area affecting multiple critical services ▪ Significant disruption to business activities ▪ Local contingency plans inadequate to deal with incident ▪ Response requires strategic coordination and assistance from other health economy partners
Widespread incident requiring overall strategic management	

Where the Initial impact assessment grades the situation as major disruption the incident will need to be formally managed to ensure resources and activities are effectively coordinated. The Strategic Commander (AEO in hours), to agree the composition of a Strategic Incident Management Team.

The term Major Incident should not be used lightly or confused with a Major Incident that sets out the Trusts response to an external Trauma type mass casualty incident. The Command and Control principles adopted by the Trust for all types of incident remain the same.

Please refer to the Major incident Plan.

Appendix 2: Incident Declaration Flowchart



Appendix 3: Priority Services

- Priority 1 A service that needs to be restored within 1 hour
- Priority 2 A service that needs to be restored within 24 hours
- Priority 3 A service needing to be restored within 3 days
- Priority 4 A service that can be suspended for up to 7 days
- Priority 5 A service that can be suspended for more than 7 days

Individual departmental BCPs identify the priority services.

UNPLANNED CARE

PRIORITY ONE SERVICES

Service **Care Group / CBU**
Unplanned Care / Medical Care / Urgent and Emergency Care / Integrated Medicine and Community
Critical Care / Acute Care Team / Telemetry / Accident and Emergency /Runcorn Urgent Care/ Patient Flow Team/ Ambulatory Care/ Same Day Emergency Care (SDEC)/ EAU/ Ward AMU / Ward A2/ Ward A3 /Ward A7/ Ward A8/ Ward A9 /Ward A10 / Ward B12/ Ward B14/ Ward B18/ Ward B19/ Ward C21/ Ward K25/ Diagnostics – ECHO and Sleep where capacity issues have already been identified and service need to be maintained to support patient safety / Cardiology Services /Respiratory services/ Acute Diabetes and Endocrine/ Discharge team/ Elderly Care Medical and General Medicine Team / Stroke Specialist Nurses

PRIORITY TWO SERVICES

Service **Care Group / CBU**
Unplanned Care / Medical Care / Urgent and Emergency Care / Integrated Medicine and Community
Diabetes Specialist Nurses / Diabetes Medical Teams/ Cardio-Respiratory Specialist Nurses / Diabetes Obstetrics/ Virtual Wards Palliative Care Medical Team/ Frailty Assessment Unit

PRIORITY 3 SERVICES

Service **Care Group / CBU**
Unplanned Care / Medical Care / Urgent and Emergency Care / Integrated Medicine and Community
Diabetes Administration Team / Invasive Angiography/ Elderly Care Administrative Team / Palliative Care Administrative team/ Palliative Care Specialist Nurses

PRIORITY FOUR SERVICES

Service **Care Group / CBU**
Unplanned Care / Medical Care / Urgent and Emergency Care / Integrated Medicine and Community
Sexual Health – Out Patients Department / GUM and HIV Management Team

PLANNED CARE

PRIORITY ONE SERVICES

Service **Planned Care** Digestive Diseases / Specialist Surgery including Cancer Services / Women and Childrens
Warrington Emergency Theatres / Warrington Theatres Recovery/ On-Call Surgical team/ On-Call GI Bleed Team/ On-Call Anaesthetic Team/ On-Call ENT Team/ On-Call Urology Team/ On-Call T&O/ On-Call Ophthalmology/ Cancer / 2WW, P2, any patient .78 weeks on an open pathway, clinically high priority patient/ Trauma Theatre/ Endoscopy/ Ward A4/ Ward A5 Gastro / Ward A5 Elective/ Ward A6/ CSTM – Ward/ PACU/ Ward B3/ Ward B4/ Ward B10/ Ward B11/ Ward C20/ Ward C23/ Ward – Neonatal Unit/ Birth Suite/ Maternity Theatres/ EPAU/ GAU/ PAU on B11/ Specialist Nurses –Cancer / Paeds/ T&O – Trauma Coordinators

PRIORITY TWO SERVICES

Service **Planned Care** Digestive Diseases / Specialist Surgery including Cancer Services / Women and Childrens
Pain Service / PIU/ Pre-Op service/ Maxillofacial Service/ Orthopaedics/ Fracture clinic/ Planned Care Outpatients/ Cancer MDT/ Pediatric Out Patients/ Community and Antenatal Care Maternity services/ Child Safeguarding Services/ Colposcopy/ Antenatal Clinic

PRIORITY THREE SERVICES

Service **Planned Care** Digestive Diseases / Specialist Surgery including Cancer Services / Women and Childrens
Routine Out Patients / Audiology Diagnostics/ Hearing Aid Services/ ENT Diagnostic Services/ Out Patients Services Administration

PRIORITY FOUR SERVICES

Service **Planned Care** Digestive Diseases / Specialist Surgery including Cancer Services / Women and Childrens/

Tinnitus Therapy Service / The NEST

PRIORITY FIVE SERVICES

Service
Planned Care
Digestive Diseases / Specialist Surgery including Cancer Services / Women and Childrens
Breast Prosthetic Service / Macmillian Information Centre/ New Born Hearing Screening/ ENT Administration

CLINICAL SUPPORT SERVICES

PRIORITY ONE SERVICES

Service **Clinical Support Services** Diagnostics / Outpatients / Therapies
Main X-Ray / A&E X-Ray /Infection Prevention and control – Clinical Advice / Pharmacy / Biochemistry Lab/ Haematology Lab / Phlebotomists / Microbiology Lab/ Radiology Services for inpatients – CT Scans, MRI, Ultrasound / Therapy – respiratory/ Therapy – RRT/ Therapy – neuro rehab/ Therapy - Acute Medicine & Elderly Care / Cancer, P2, Long Waiters (>78 weeks); 2 week waiters, clinically high priority Out Patient services / Non-Elective Pacing/ PAC's Office

PRIORITY TWO SERVICES

Service **Clinical Support Services** Diagnostics / Outpatients / Therapies
Non-Elective Coronary Angiography / Interventional Radiology/ Trauma and Orthopaedic Out Patients / Medical Records Mortuary Services/ Long COVID Clinic Team / COVID Vaccination Service/ Therapy – Inpatients/ OT /Therapy – Inpatients Physiotherapy / Therapy – Inpatients/ Speech and Language/ Therapy – Inpatients/ Dietetics/ Plaster Room/ Therapy - Orthotics

PRIORITY THREE SERVICES

Service **Clinical Support Services** Diagnostics / Outpatients / Therapies
Non-Urgent Out Patients / Therapy Out Patients: MSK Routine / Therapy Out Patients: OT Routine / Therapy Out Patients: SLT Routine / Therapy Out Patients: Dietetics Routine / Therapy – Halton Intermediate Care & Frailty Service

PRIORITY FOUR SERVICES

Service **Clinical Support Services** Diagnostics / Outpatients / Therapies
Therapies – Pulmonary / Therapies – Cardiac / Therapies Neuro Rehab / Therapy – Community Services: OT / Therapy – Community Services: Physiotherapy / Therapy – Community Services: SLT / Therapy – Community Services: Dietetics

ESTATES & FACILITIES

PRIORITY ONE SERVICES

Service **Corporate** **Estates & Facilities**
Domestic clinical areas / Patient Catering / Clinical Waste Management / Security – Deceased Patient Transfer /Urgent and Emergency Reactive Estates Maintenance / Medical Engineering Reactive Maintenance/ Switchboard/ Linen/ Security - ALL

PRIORITY TWO SERVICES

Service **Corporate** **Estates & Facilities**
Domestic Waste Management /Medical Devices/ Porters

PRIORITY THREE SERVICES

Service **Corporate** **Estates & Facilities**
Non-Urgent and Planned Preventative Maintenance / Non-Urgent Postal Services / Non-Clinical Cleans

PRIORITY FIVE SERVICES

Service **Corporate** **Estates & Facilities**
Ground Maintenance Equipment Porters Staff Catering

CORPORATE SERVICES

PRIORITY ONE SERVICES

Corporate Services
Executive Team / Incident Response Team / CBU Managers Tactical On-Call Manager / General Manager of the day Executive Deputies & Associate Directors – Strategic Commanders

PRIORITY TWO SERVICES

Corporate Services
Assistant CBU Managers / Nurse Bank Team/ Medical Bank Team / Communications/ Digital Services/ Supplies and materials management

PRIORITY THREE SERVICES

Corporate Services
Occupational Health Service / Mental Health & Wellbeing Team/HR Business Partnering team /Recruitment Team/ Medical Bank & Agency Team/ Workforce Information Team/ Finance Team/ Procurement Team/ Clinical Coding Team Commercial Development Team/ Business Intelligence Team/ Corporate Governance Team, including Executive Pas / Corporate Nursing Teams: Patient Experience/ Corporate Nursing Teams: Veterans & Armed Forces Patient Lead/ Clinical Education Nursing Teams/ Clinical Governance Team – PALS/ Clinical Governance Team –Complaints/ Clinical Governance Team – H&S/ Clinical Governance Team –Safeguarding (Children and Adults)/ Clinical Governance Team – Legal/ Quality Academy Team/ Strategy & Partnership Team/ Marketing and Engagement Team/ Medical Education Centre/ Clinical Governance: Libraries & Knowledge Management Services/ Medical Directors Team/ Workforce Equality, Diversity and Inclusion Team/ Payroll

PRIORITY FOUR SERVICES

Corporate Services
Staff Engagement Team / Organisational Development/ Learning and Development/ Pensions

Appendix 4: Business Impact Assessment and METHANE report

Complete the following Impact Assessment when a disruption is reported/or is already occurring and will affect the Service being delivered. Once completed, use to make an assessment of priorities and to assist in the service recovery and then forward to person/team identified in your service areas BCP for escalation (i.e. Associate Director/ Tactical Commander) Complete the following Impact Assessment when a disruption is reported/or is already occurring and will affect the Service being delivered. Once completed, use to make an assessment of priorities and to assist in the service recovery and then forward to person/team identified in your service areas BCP for escalation (i.e. Associate Director/ Tactical Commander).

This form can also be used to consider business continuity planning within a department.

Service Delivery Team/Department/Ward	
Service Delivery/Department/Ward Manager	
Contact Details of Service/Department/Ward Manager	
Person reporting the incident (Name and Details)	

Date of Disruption Occurring	**Time of Disruption**	**Date Disruption Reported**	**Time Disruption Reported**

(MAXIMUM PERIOD OF TOLERABLE DISRUPTION (MPTD)

ESSENTIAL Activities	**HIGH PRIORITY Activities**	**MEDIUM PRIORITY Activities**	**LOW PRIORITY Activities**

P1 Services MPToD: None Permissible	P2 Services MPToD: 24hrs	P3 Services MPToD: 48hrs	P4 & P5 Services MPToD: 72hrs+
Activities which cannot tolerate any disruption. If activities are not resumed immediately it may result in the loss of life, significantly impact patient outcomes, significant impact on other NHS services	Activities which can tolerate very short periods of disruption. If activities are not resumed within 24hrs patient care may be compromised, infrastructure may be lost and/or may result in significant loss of revenue.	disruption between 24hr & 48hr. If service / functions are not resumed in this time frame it may result in deterioration in patient(s) condition, infrastructure or significant loss of revenue.	Activities that could be delayed for 72 hours or more *but are required* in order to return to normal operation conditions and alleviate further disruption to normal conditions.

Confirm the nature and scale of the disruption	
Are there any casualties or significant injuries	
Are the Emergency Services required **- Has 999 been called** **- Are they in attendance now** **- When are they expected**	**YES** **NO**
What resources are affected	**STAFF:** **BUILDINGS:** **ICT/TELEPHONES/BLEEPS:** **UTILITIES:** **OTHER:**
Mutual Aid Request required? **Eg: patient transfers/ambulance divert**	**YES** **NO** **DETAILS:**

Media interest expected/received (please give details)	
How long is the disruption estimated to last?	
What assistance is required by other trust teams?	

Time Scale	**Estimated Impact on Service**
First 24 Hours	
First 3 Days	
First 7 Days	
Over 7 Days	

Please determine incident severity rating below and include rationale for your decision:

SEVERITY RATING	
1 – Low level incident (Business Continuity Minor Disruption)	
2 – Moderate level incident (Business Continuity Moderate Disruption)	
3 – Significant level incident (Critical Incident)	
4 – Extreme level incident	

Internal Activation Triggers

Incident Level	Description
1 – Low level incident	This level would consist of routine issues which can be dealt with within **business as usual (BAU)** measures and will not impact upon any critical activities/services. i.e. Leaks, spills, generic maintenance issues... **One or more of the following apply:** • Limited impact on patient and staff safety • Incident expected to be fully resolved and closed within 24 hours • Limited but some impact on service delivery in critical areas • One or a number of local contingency plans activated

	• Incident still expected to be managed through localised contingency arrangements • limited financial/performance impact • limited governance issues • possible public/media/political interest

Incident managed using local contingency arrangements:
Where the initial business/service impact assessment grades the situation as a minor disruption, the incident should be managed by the department within the localised BCP. The Managers will escalate where necessary. Where the incident has the potential to impact on Patient Flow this must be escalated to the Tactical Manager of the Day.

Where this incident has the potential to spill over into the evening / weekend the Tactical Manager on-call should be notified and informed of the contingency arrangements in place.

2 – Moderate level incident	This level would consist of loss of **non-critical activities/services** due to a minor disruption or incident which is not expected to last more than **the Recovery Time Objective (RTO)** and will not impact on critical activities/services i.e. Local flooding, local IT failure, telecoms disruption, localised infection disease outbreak. …. • Disruption to a number of critical services likely to last for more than 1 working day • Moderate impact on patients and staff • Access to one or more sites denied where critical services are carried out for more than 24 hours • Suspension of a number of services required • Access to systems denied and incident expected to last more than 1 working day and therefore impacting on operational service delivery • A number of critical services seeking to activate service level contingency plans thus requiring overall management • Impacts on finances and performance • Governance issues • Possible public/media/political interest

Numerous contingency plans activated thus requiring effective management by calling together of a specific multi directorate team

Where the initial impact assessment grades the situation as a level 2 disruption, it will need to be formally managed to ensure resources and activities are effectively coordinated. An Incident Management Team should be set up and during working hours, the Chief Operating Officer (Accountable Emergency Officer) or their deputy will decide on its composition.

Out of hours, the Tactical Manager On Call Manager must be informed first, who in turn will notify the Strategic Manager on call and the team composition agreed. **Out of hours, the Tactical On Call Manager must attend site during a moderate business continuity incident.** It may also be necessary to inform the ICB on call managers and the Strategic Commander on call will make this decision.

3 – Significant level incident (Critical Incident)	This level would consist of loss of **critical activities/services** due to a disruption or incident which has a potential to last more than the **Recovery Time Objective (RTO)** but will need the coordination of a senior manager. i.e. Utility failure, damage to site, restricted access to site, partial loss of key suppliers…… • Incident expected to impact on critical services for 8-48 hours • Widespread disruption, loss of a major or multi-occupancy site including, • Major impact on patient and staff safety • Wide-scale incident in a geographical area affecting multiple critical services • Significant disruption to business activities • Local contingency plans inadequate to deal with incident • Outside interest causing major disruption to the smooth running of the hospital (e.g. significant press intrusion, protests at the hospital, protester with a weapon on roof of hospital, hostage situation) • Response requires strategic coordination and assistance from other health economy partners
Widespread incident requiring senior strategic management: Where there is significant disruption, the incident will need to be formally managed to ensure resources and activities are effectively coordinated. In hours, the AEO/Chief Operating Officer and Tactical Manager of the Day must be notified. **The AEO/COO** (or their deputy) **can make the decision to declare a Critical Incident.** **Out of hours, the Tactical On Call Manager must attend site during a critical incident and if required, request on site support from Strategic on call Manager.** The Chief Operating Officer (Accountable Emergency Officer) or the Strategic Commander on call**,** will discuss with the Tactical Commander and authorise for Switchboard to trigger the 'Communication Cascade' to be activated and will activate the internal command and control structure. The STRATEGIC Commander must notify the ICB on call that the Trust has declared a critical incident.	
4 – Extreme level incident	Loss of **critical activities/services** due to a disruption or incident which is expected to **last more than the RTO and may cause risk to patient and staff safety** i.e. Fire on a ward resulting in evacuation, Severe weather conditions causing damage to site and access issues, complete prolonged IT or Utility failure, External Major incident • Widespread or prolonged disruption expected to impact on Trust services.

	• Permanent loss of core service or facility. • Wide-scale incident in a geographical area affecting multiple services (eg incident with large number of casualties or Cyber-attack). • Response requires strategic coordination and assistance from other health economy partners. • Critical incident that is expected to have a significant impact on critical services for more than 48 hours.

Widespread incident requiring overall strategic command and control management.

Where the business/service area Initial impact assessment grades the situation as major disruption the incident will need to be formally managed to ensure resources and activities are effectively coordinated.

The AEO/COO (Strategic on Call out of hours) will activate Strategic Command.

AEO/COO (Strategic on Call out of hours) escalates to Cheshire and Merseyside ICB first on call and considers national escalation to co-ordinate the response.

The STRATEGIC Commander will also consider if the situation warrants a major incident to be declared. **Please note that a major incident should only be declared in a severe event or situation with a range of significant impacts**, **which requires special arrangements to be implemented by one or more emergency responder organisations** e.g. major rail/road crash, major hospital power failure requiring evacuation etc.
A major incident is:

a) beyond the scope of normal operations or business-as-usual;
b) likely to involve serious harm, damage or risk to human life or welfare, essential services, the environment or to the security of the UK;
c) a situation where the severity of impacts associated with a major incident are likely to constrain or complicate the ability of emergency responders to manage the incident;
d) likely to require a multi-agency response, rather than just a single agency response, which may include multi-agency support to a primary responding agency

Warrington and Halton Teaching Hospitals NHS Foundation Trust

METHANE - INCIDENT NOTIFICATION FORM

Name of Caller:	
Originating Organisation:	
Emergency Service Incident Number:	
Date and Time of Call:	
Contact Number: (Mobile and Landline)	
Major Incident:	**DECLARED / STANDBY** *(Circle)*
Exact location: (Grid Reference, directions etc)	
Type of incident: (Rail, chemical etc)	
Hazards: (Present and potential)	
Access: (Direction of approach/egress)	
Number of casualties: (Number, severity and type)	
Emergency Services activated and responding: (Present and required) ☐ Police ☐ Fire ☐ Ambulance	
Support Requested:	
Number of persons displaced, evacuated or at risk:	

Organisations affected or likely to be: (Is more than one organisation affected? List those effected)	
What Infrastructure affected:	
Completed by (Signature)	
Completed by (Print Name)	

Appendix 5: Business Continuity Command and Control Team

Role	Office Hours	Out of Hours
Strategic Commander	Chief Operating Officer (Accountable Emergency Officer) or nominated deputy	Strategic Commander (Exec-on-call
Tactical Commander	Tactical Manager of the Day, or appropriate member of the senior leadership team nominated by Strategic Commander	Tactical Manager (SMOC)
Medical Coordinator	Medical Director	Senior Consultant
Executive Nurse	Chief Nurse/Deputy Chief Nurse	Matron
Department Leads (areas affected)	Head of Department/Deputy	On Call lead (if available)
Estates	Estates Manager	Estates on-call
Technical Support:		
Loggist	Loggist	Loggist – refer to Loggist list
Communications Team	Head of Communications	Communications on Call / Media Trained Strategic Commander

Appendix 6: Business Continuity Action Cards

STRATEGIC COMMANDER - BUSINESS CONTINUITY ACTION CARD	
Office Hours	**Out of Hours**
Chief Operating Officer (Accountable Emergency Officer or Deputy)	Strategic Commander (Exec-on-call)
Responsibilities:	
• To take strategic command of the business continuity response for the Trust upon alert • Notify the ICB (0845 124 9802) if a moderate business continuity incident is likely to cause disruption to services and if a critical incident is declared – see Incident Response Plan • Notify NHS England Tactical Commander via the NWAS Health Control Desk on 0345 113 0099 if a moderate business continuity incident or critical incident causing disruption to services is declared	
Action Card and Log Sheet:	**Time**
• Start a log of decisions made. During office hours, appoint a decision Loggist. It is important that the options available to you, the decision made and the reason why that decision was made is recorded. Legally, decisions should be recorded in a numbered hard back and in black pen, signed, dated, and timed.	
• Confirm who is acting as 'Trust Tactical Commander. Tactical Commander will coordinate the response to the incident.	
Operational Actions:	
• Attend Tactical Incident Command Room (Trust Conference Room) and meet the Tactical Commander there.	
• Call a Business Continuity (BC) Incident Management Meeting in the Trust Conference Room	
• Set the 'strategic aim' for responding to the incident with the Tactical Commander and Tactical Management Team. Normally, to 'reduce harm and save life'. The Strategic Aim should be referenced at the start of each incident meeting.	

• Discuss the incident with the teams and consider initial actions required. Instruct the Tactical Commander to liaise with local tactical managers to investigate the effects of the incidents on essential and critical areas and report to the Trust Conference Room at a given time.	
• Confirm the Business Continuity Incident Severity Level (minor/moderate/critical) and arrange for this to be communicated to staff as required. If a critical incident is declared, follow the Incident Response Plan	
• If a moderate business continuity or if a critical incident is declared, notify: - ICB on (0845 124 9802) - NHS England 1st On Call Manager via the NWAS Health Control Desk on 0345 113 0099	
• Communicate as necessary to staff	
• Once the initial response plan is in place, identify any staff that can assist you in the Trust strategic response. Move yourself and your 'Strategic Response Team' to the Strategic Incident Meeting Room (Executive Team Meeting Room). Strategically direct the Business Continuity response. Key people to form the Strategic Incident Response Team are Medical Director, Chief Nurse// Executive Directors including Director of Finance, Director of Communications, however, this is dependent on the nature of the incident.	
• Agree the 'battle rhythm' for situation reporting and command team meetings i.e., do you want to attend each Tactical Meeting, or do you want to receive regular situation reports from the Tactical Commander. It would be useful to attend first incident response meeting while incident response systems are being established	
• Hold strategic meetings as required with your strategic team. Send everyone out of the strategic command room to complete their actions, unless you need anyone to stay with you for a reason and agree the time, they need to return for the next incident meeting. This will avoid the command room becoming overcrowded and noisy. Do you need your Loggist to stay with you to record further decisions made?	
• If the incident is likely to last more than one day, ask an appropriate officer to produce a 24/7 Business Continuity Strategic Commander rota and a general Strategic on call rota to avoid burn out.	

Stand Down:	
• When the incident is stood down, communicate this to staff and to the ICB/NHS England.	
• Immediately hold a hot debrief and manage any recovery and return to normality required. Then organise a formal debrief within four weeks of the incident occurring.	

MEDICAL DIRECTOR - BUSINESS CONTINUITY ACTION CARD	
Office Hours:	**Out of Hours**
Medical Director	Senior Consultant

Responsibilities:

- The title 'Medical Coordinator' is intended to cover all specialties (medicine, surgery, neuro etc.) to coordinate the response by medical staff as a whole
- Activation of medical staff
- Liaison with Strategic Commander to provide advice on medical aspects of the response to the Business Continuity Incident, if applicable

Action Card and Log Sheet	**Time**
• Upon alert by the Strategic Commander, discuss the situation with them	
• Start your log of decisions made. It is important that the options available to you, the decision made and the reason why that decision was made is recorded. Legally, decisions should be recorded in a numbered hard back and in black pen, signed, dated, and timed.	
• Report to the Trust Conference Room for a briefing by the Strategic Commander	

Operational Actions:

• Provide advice to the Strategic Commander with respect to the medical aspects of the response	
• In liaison with the Strategic Commander, decide whether some or all of the following steps should be taken: - Repatriation	

- Call in additional medical staff - Cancel elective surgery and clinics - Transfer medical and/or nursing staff from St Helens and other departments	
• Brief members of senior medical staff as they arrive and direct them to the areas where they are required	
• Communicate with medical teams from other Trusts to inform them of the current situation and expected development of the Business Continuity Incidents	
• As the situation develops and resolves, reinstate services as appropriate	
Stand Down:	
• When the incident has been stood down, attend 'hot debrief' and attend the formal debrief which will be organised within four weeks of the incident occurring.	

CHIEF NURSE - BUSINESS CONTINUITY ACTION CARD	
Office Hours	**Out of Hours**
Chief Nurse	Unavailable Matron acts as senior Nursing representative
Responsibilities:	
• To consider nursing impact of incident and advise on strategic response • Activation of Deputy Director of Nursing, Associate Chief Nurses, Matrons, and nursing staff as required • Liaison with Strategic Commander to provide advice on nursing aspects of the response to the business continuity incident, if applicable, to maintain patient safety, staff safety and minimise risk.	
Action Card and Log Sheet	**Time**
• Upon alert by the Strategic Commander, discuss the situation with her/him	
• Start your log of decisions made. It is important that the options available to you, the decision made and the reason why that decision was made is recorded. Legally, decisions should be recorded in a numbered hard back and in black pen, signed, dated, and timed.	
• Report to the Incident Meeting Room for a briefing by the Strategic Commander	
Operational Actions:	
• Provide advice to the Strategic Commander with respect to the nursing aspects of the response	
• Liaise with Deputy Director of Nursing, Associate Chief Nurses, Matrons, and nursing staff to co-ordinate the response and actions required by nursing staff, offering direction and support as required.	
• Communicate with nursing teams from other Trusts to inform them of the current situation and expected development	
• As the situation develops and resolves, reinstate services as appropriate	
Stand Down:	

• When the incident has been stood down, attend 'hot debrief' and attend the formal debrief which will be organised within four weeks of the incident occurring.	

COMMUNICATIONS LEAD - BUSINESS CONTINUITY ACTION CARD	
Office Hours:	**Out of Hours**
Communications Team	Media Trained Strategic Commander
Responsibilities:	
• Lead the communications response to an incident and if applicable, the media response	
Action Card and Log Sheet	**Time**
• Receive a briefing from the Strategic Commander	
• Start your log of decisions made. It is important that the options available to you, the decision made and the reason why that decision was made is recorded. Legally, decisions should be recorded in a numbered hard back and in black pen, signed, dated, and timed.	
Operational Actions:	
• Take advice from members of the Business Continuity Incident team on the details and extent of the problem. If appropriate, remind all staff of the Trust policy re talking to the media and use of social media	
• Provide updates on the situation to staff, partner agencies and the public as appropriate or available via: - E-mail - Intranet - Website - Telephone - Fax	
• For incidents that affect the geographical area and therefore lots of agencies and/or incidents that are likely to be very protracted, liaise closely with Strategic Command Communications Cell and obtain help and support via the ICB if required	

• Upon stand down, attend the hot debrief led by the Strategic Commander.	
• Assist in the broadcast of the stand down	
Stand Down:	
• When the incident is stood down, attend the immediate hot debrief, to report any lessons learned and then attend the formal debrief meeting which will be organised within four weeks of the incident.	

TACTICAL COMMANDER - BUSINESS CONTINUITY ACTION CARD	
Office Hours:	**Out of Hours**
Tactical Manager of the Day or member of the SMOC rota as agreed by AEO (COO) / Deputy	Tactical Commander (SMOC)
Responsibilities:	
• Activate the Business Continuity Plan as directed by the Strategic Commander • Investigate and assess the extent of the problem and complete the Business Continuity Incident data sheet • Direct managers to operate contingency plans • Obtain situation reports from wards, areas, and functions (other tactical managers) • Support Strategic Commander with stand down arrangements	
Action Card and Log Sheet	
• Start a log of decisions made. It is important that the options available to you and the decision made is recorded. Legally, decisions should be recorded in a numbered hard back and in black pen, signed, dated, and timed.	
• Attend Tactical Incident Command Room (Trust Conference Room) and meet Strategic Commander. Notify other members of the Operational management team to respond within the hospital while you attend the incident command room.	
Operational Actions:	
• Discuss the situation with the Strategic Commander who will set the 'strategic aim' for responding to the incident. Normally, 'to reduce harm and save life'. The strategic aim should be referenced at the start of each incident meeting.	
• Hold an incident meeting and consider initial actions required. Make contact with all wards, areas and function managers establishing and noting which are affected, how much and what contingency measures are being used.	
• Local managers to investigate the effects of the incident on essential and critical areas and report to the Trust Conference Room	

• The Strategic Commander will confirm the Business Continuity Incident Severity Level (minor/ moderate/critical) and arrange for this to be communicated to staff as required. If a critical incident is declared, follow Critical Incident Plan.
• Once the initial response plan is in place, the Strategic Commander will leave the Tactical Command Room and set up a strategic incident response team. Agree the 'battle rhythm' for reporting to the Strategic Commander i.e., via regular situation reports or will Strategic Commander attend each formal incident meeting?
• Communicate as necessary to staff
• Consider activation of an emergency preparedness cost centre finance code to record spending
• Continue to hold incident response meetings as required. Invite persons present to leave the Tactical command room to complete their actions, unless you need anyone to stay with you for a reason. Agree a time they need to return for the next incident meeting. This will avoid the command room becoming overcrowded.
• If incident is likely to last more than one day, ask a member of the Tactical Command Team to produce a 24/7 Critical Incident Tactical Commander rota and a shadow SMOC rota to avoid burn out.
• Ensure that all key intelligence and decisions are transmitted immediately to all relevant personnel and departments
Stand Down:
• When the business continuity incident can be stood down by the Strategic Commander, attend the immediate 'hot debrief' meeting to report any lessons learned and attend the formal debrief meeting which will be organised by the Strategic Commander within four weeks.

SITE MANAGER- BUSINESS CONTINUITY ACTION CARD	
Office Hours:	**Out of Hours**
Senior Nursing Representative	Site Manger
Responsibilities:	
• To support site including staffing and patient flow during the business continuity incident	
Action Card and Log Sheet	**Time**
• On notification of the business continuity incident, attend the incident meeting room as requested and receive a briefing	
• Start a log of decisions made. It is important that the options available to you and the decision made is recorded. Legally, decisions should be recorded in a numbered hard back and in black pen, signed, dated, and timed.	
Operational Actions:	
• Provide ward, staffing and patient flow support as required.	
• If required, inform other Divisional staff to liaise with ward staff to clear the wards as directed	
• Provide support as requested by Tactical Commander	
Stand Down:	

• When business continuity incident is stood down, attend the immediate 'hot debrief' to report any lessons learned and attend the formal debrief meeting as requested.	

ESATATES / FACILITIES MANAGER - BUSINESS CONTINUITY ACTION CARD	
Office Hours	**Out of Hours**
Senior Estates / Facilities Manager	OOH Estates

Responsibilities:	
• Coordination of facilities staff e.g., Portering, security, domestics, catering, and linen • Provide advice on facilities management aspects of response to Trust Tactical Commander as required	
Action Card and Log Sheet:	**Time**
• Start your log of decisions made. It is important that the options available to you, the decision made and the reason why that decision was made is recorded. Legally, decisions should be recorded in a numbered hard back book and in black pen, signed, dated, and timed.	
• Attend the Trust Conference Room to receive a briefing from the Tactical Commander	
Operational Actions:	
• Organise department teams and ensure staff are alerted to details of the incident	
• Deploy staff and services where required as advised by the Tactical Commander or where you identify a need	
• Keep in contact with Tactical Commander and attend incident command room to provide regular updates as required	
Stand Down:	
• On incident stand down, attend the hot debrief and the formal debrief within four weeks of the incident occurring.	

Appendix 7: Business Continuity Exercise

Business Continuity Exercising

Introduction

Exercises can expose vulnerabilities in an organisation's structure, initiate processes needed to strengthen both internal and external communication and can help improve management decision making during an incident. They are also used to assess and identify gaps in competencies and further training, that is required for your staff. Exercising is also used to measure effectiveness of plans, as well as highlighting areas for improvement.

Your service or department should test their Business Continuity Plans on an annual basis.

In the event of a disruptive incident, it is essential that the organisation has the ability to stand up an effective response. In order to achieve this outcome, the organisation will need to have trained people with the right set of skills and the ability to communicate with stakeholders (internal and external) in a timely and consistent manner. The information (intelligence) needs to be managed effectively to ensure, that decisions are made with the most up-to-date information available. Equally, the decision-making process needs to be defined, agreed, and understood, this is critical when collaborating with operational partners. Exercises can be designed to incorporate some or all of these elements, ensuring that the training conducted has been understood and can be implemented.

The Exercise Program

An exercise program would:

- Identify the impacts on operational disruption
- Exercise the effects or impact of disruption
- Change and update the plan as outlined in the report's action plan
- Demonstrate the effectiveness of your incident plan to deal with the disruption
- Help develop an incident plan if no planning exists
- Promote an organisational wide approach to business continuity

When you are planning to deliver an exercise consider:

- Which plan(s) is being tested?

• Who is participating in the exercise?
• What are the weak points of the plan?
• What risks are highlighted for the plan(s) in question?
• When was the last time this plan was tested?
• When was the last time these people were tested?
• How exposed do you want the delegates to feel?
• How are you going to capture learning?
• How will you ensure the delegates are open to learning and taking responsibility for actions identified during the testing?
• What facilities do you have in the room?
• How long can you reasonably book the delegates for?
• How many times do you need to rehearse this plan per year?

Please consult the Head of EPRR to identify training exercises if required whh.controlroom@nhs.net

Post Exercise

A debrief should be carried out using the Trust Standard Debrief Template and Guidance for information.

Appendix 8: Key Contacts

Informing/Activating NHS England Strategic/Tactical Command Merseyside:

If the internal business continuity incident develops into a Major Incident, the Trust's Strategic Commander **must inform and activate NHS England Strategic Command. This will automatically** release regional resources and ensure activation of the Merseyside Major Incident Commander Structure.

For initial activation, call the 24-hour **NWAS Health Desk on 0345 113 0099. Ask to speak to the NHS England Area Team Strategic or Tactical Commander for Merseyside.**

Useful Contact Numbers

NHS Providers	
Organisation	Contact
Bridgewater Community Trust	01925 664000
Countess of Chester Hospital	01244 365 000
NW Boroughs Healthcare	01925 664000
Liverpool University Hospitals Foundation Trust	0151 706 2000
Mersey and West Lancashire Teaching Hospitals	0151 426 1600
Wrightington, Wigan and Leigh Hospital	01942 244000

Utilities	Contact
United Utilities	03450 509485 (24hr control room) 0771 388 7302 (ICC Response Manager)
SP Energy Networks	0845 272 2424 0845 273 4444
National Grid (electricity)	0151 339 2721 (office hours) 0800 404090 (out of hours)
National Grid (gas)	0845 835 1111 (enquiry line) 0800 917 2414 (emergency line)
BT National Emergency Link Line	08457 555 999
Local Authorities	Contact
Warrington Borough Council	01925 444400
Halton Council	0303 3334300
Blue Light/Military/Transport	
Merseyside Police	0151 709 6010 (24 hr contact)
Cheshire Police	01606 362 270 (Force Incident Manager)
North West Ambulance Service	ROCC 0345 113 00 99 regionalhc@nwas.nhs.uk 0345 113 0099 Duty Control Manager
Merseyside Fire and Rescue	0151 296 4000 (24 hours)
Cheshire Fire and Rescue	01925 460 852 (out of hours)
British Transport Police	0800 405040 (24 hr contact line) 0121 254 8906 (24 hr emergency only line)

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

NHS England Cheshire and Merseyside	
Office hours	Out of hours
0345 113 00 99	
(back up 0151261 42000)	
System Control Centre (C&M)	
SCC@cheshireandmerseyside.nhs.uk	

ICB – Cheshire & Merseyside
0845 124 9802
eprr@cheshireandmerseyside@nhs.uk

UKHSA	
Office hours	Out of hours
0344 225 1295	0345 113 00 99

NWAS	WMAS
#6181 / 0151 261 4321 **ROCC 0345 113 00 99** **(inc OOH)**	0345 425 0050

Mental Health Crisis Lines	
Halton/St Helens/ Warrington/ Knowsley	**Greater Manchester Mental Health Crisis Lines for Manchester, Bolton, Salford & Trafford**
01925 275309 0800 051 1508	01204 483071 0800 953 0285
Sefton	**Wigan**
0151 330 7332	01942 636305 0800 051 3252

Internal Extensions

WHH ED Control room	01925 662708
WHH Switchboard (emergency phone)	01925 662343
WHH Patient Flow	01925 662876
WHH Gold Control room (Trust Conference Room	01925 665047 01925 662707

Medical Examiner Office:

Rebecca Tunstall MEO	Contact via Switch for questions or queries
James Williamson ME	As Above

Equality Impact Assessment

1. **This section asks you to consider a few questions relating to your policy, process, procedure or decision.**

Initial screening	Yes	No
1.1. Does your policy affect people (Patients/Workforce/Public)?	X	☐
1.2. Does the policy affect one or more group of people in a different way to another?	☐	X
1.3. Does the policy offer opportunity to promote equality?	☐	X

1.4. Does your policy impact positively, negatively or neutrally on any of the below characteristics/groups?
If yes, please indicate how and which type (positive or negative) in the 'Barriers/Impact' section:
Neutral impact is where there will be no change in actual/potential impact on this protected group.

Initial assessment	Scale	Barriers/impact
Age	Neutral	
Disability - learning disabilities/difficulties, physical/hidden disability, sensory impairment and mental health problems	Neutral	
Gender reassignment	Neutral	
Race	Neutral	
Religion or belief	Neutral	
Sex	Neutral	
Sexual orientation including lesbian, gay and bisexual people	Neutral	
Marriage and civil partnership – including same sex relationships	Neutral	
Pregnancy and maternity/paternity	Neutral	
Carers	Neutral	
Social factors - deprivation, homelessness, education etc.	Neutral	
Armed forces and military veterans	Neutral	

1.5.	Is the impact of the policy likely to be negative?	☐ **Yes**	X **No**

1.6.	If yes, please summarise if the impact can be avoided or are there any alternatives?	

1.7.	Does your policy support positive action for underrepresented groups.	☐ **Yes** ☐ **No** X **N/A**

If you have answered no and neutral to all of the questions in section 1 then a full Equality Impact Assessment is not required. Where you have answered yes, please move to section 3.

2. Does your policy support the general aims of the Public Sector Equality Duty (Equality Act 2010)?

Yes X **No ☐**	**1.** Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by or under the Equality Act 2010 **2.** Advance equality of opportunity and remove disadvantages between those who share a protected characteristic and those who do not **3.** Foster good relations between people who share a protected characteristic and those who do not

3. Please assess your proposals analysis equality reference scale:

☐	**High –** This policy shows a **high degree of negative or positive** impact to one or more protected characteristics or one or more general aims of the Equality Act 2010 or Armed Forces Act 2021 (where rationale cannot be justified)
☐	**Medium –** This policy shows a **medium degree of impact** (positive or negative) to one or more protected characteristic.
X	**Low –** This policy **does not have any impact to any protected characteristic** or general aim of the Equality Act 2010 or Armed Forces Act 2021.

If your analysis has scored **high**, then a full Equality Impact Assessment should be completed (Stage 2). This can be found here. If your analysis has scored **low or medium** when considering the evidence detailed above, then a full Equality Impact Assessment may not be required.

If you require any support, please contact the Equality, Diversity and Inclusion Team at whh.equalityimpactassessments@nhs.net

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/72**			
SUBJECT:	**Strategy Programme Highlight Report**			
DATE OF MEETING:	7 August 2024			
AUTHOR(S):	Megan Wainwright, Strategy Project and Team support officer			
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, 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.			
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):*	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)***	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note this 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.	

Strategy Update
May - June 2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Section 1 - Key Messages	
Slide 2	Summary of key developments this reporting period

Section 2 - Stakeholder Engagement	
Slide 3-4	Summary of key stakeholders engaged during the reporting period

Section 3 - Key Strategic Projects

Page	Project	Strategy Lead	Status
Slide 5-6	Living Well Hub in Warrington	Stephen Bennett/Caroline Lane	
Slide 7-8	Runcorn Town Deal	Carl Mackie/Viviane Risk	
Slide 9-10	Community Diagnostic Centre	Stephen Bennett/Lefteris Zabatis	
Slide 11-12	New Hospitals Programme and strategic estates	Carl Mackie/Viviane Risk	

Section 4 - Other Trust Strategic Updates	
Slide 13-15	Summary of other Trust strategy related updates

Section 5 - Place-based Strategic Updates	
Slide 16	Summary of strategic updates from local places (Warrington and Halton)

Section 6 - Cheshire and Merseyside Strategic Updates	
Slide 17	Summary of strategic updates from Cheshire and Merseyside

Key Messages

- Between mid-March and the end of June, there were 2,500 attendances at the Warrington Living Well Hub. Around 60% of these were people “dropping in” to the hub, and the remainder were people with a booked appointment.

- Over 41,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since phase 1 opened in May 2023.

- Funding has been secured to implement a new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City). A project team is being established and the aim is to begin taking referrals from the autumn 2024.

- The Patient Engagement Portal went live on the 12th of June 2024. This enables the Trust to digitally send outpatient appointments, appointment reminders and for patients to request or reschedule appointments through the NHS App.

- Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. Workstreams have been established with representatives from both organisations and delivery plans are being developed. Stakeholder communication is being developed.

- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly.

Stakeholder and engagement overview

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Asia Bibi	Associate Chief Operating Officer, Alder Hey	Paediatric surgical hub development
Cathy Morgan	Director of Secondary Prevention, Dept of Health and Social Care	Living Well Hub and the wider Living Well programme
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Halton Place Estates
Andrew Furber	Regional Director of Public Health (North West), Dept. of Health and Social Care	Living Well Hub and the wider Living Well programme
Ian Triplow	CDC Programme Director, Cheshire & Merseyside	Community Diagnostic Centre
Paula Worthington	Director of Education and SEND, Warrington Borough Council	Living Well programme and Virtual Hub
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme and Virtual Hub
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities
Gill O'Hare	Service Development Manager, Adult Social Care, Warrington Borough Council	Development of Community Networks across Warrington and links to Living Well programme
Rob Cooper	Managing Director, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Dr Sangeetha Steevart	General Practitioner, Clinical Director, Warrington Place	Living Well Hub and women's health
Steve Cullen	CEO, Warrington Citizen's Advice Bureau	VCFSE connections as part of Living Well programme
Wesley Rourke	Operational Director, Economy, Enterprise and Property	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Tracey Cole	Diagnostic Programme Director C&M	CDC, pathology collaboration
Nikki Stevenson	Chair Medical Directors Network, CMAST	C&M clinical strategy
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy
Linda Buckley	Managing Director, CMAST Provider Collaboration	CMAST

Stakeholder and engagement overview

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
Nick Armstrong	Estates, Cheshire and Merseyside ICB	Strategic estates planning, Warrington
Paul Mullane	Director of Development and Sales, Halton Housing	Estates Planning, Runcorn Town Deal
Ian Lewis	Operations Manager, Northwest Region, Get Set for Skills, DWP	Runcorn employment project, Halton Health Hub
Leigh Thompson	Director of Strategic Partnerships, Mersey Care	Living Well Hub, Runcorn Health and education Hub, One Halton delivery plan
Tim McPhee	Associate Director Integration, Transformation and Partnerships, Mersey Care	Living Well Hub, Runcorn Health and education Hub, One Halton delivery plan
Damian Cooke	Principal Regeneration Officer	Runcorn Health and Education Hub
Adam Hindhaugh	Early Help Transformation Lead – Family Hubs Programme, Halton Borough Council	Runcorn Health and Education Hub
Ben Holmes	Acting Assistant Director – Education, Children's Services Directorate, Halton Borough Council	Runcorn Health and Education Hub
Adam McClure	Senior Programme Manager, Cheshire and Merseyside Diagnostic Programme	Pathology Collaboration
Neil Haslam	Clinical Lead, Cheshire and Merseyside Endoscopy Network	Intelligent Liver Function Testing
Mary Murphy	Principle, Riverside College and Cronton College	Runcorn Health and Education Hub
Zoe Fearon	Director of Childrens services, Halton Borough Council	Runcorn Health and Education Hub

Living well hub in Warrington- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

WHH has led 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 (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 is 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.

What does this mean for WHH?

Delivery of WHH services, including midwifery, cardiac rehabilitation and physiotherapy from a convenient and accessible town centre location. Working alongside key partners including Bridgewater, Mersey Care, Warrington Borough Council and the Voluntary, Charity and Social Enterprise organisations to support the prevention agenda.

Progress since last report

- Over 2,500 attendances between mid-March and the end of June.
- 60:40 split in terms of drop-in attendances to booked appointments.
- Flooding incident caused the facility to close for two days in early May. Subsequent investigations identified the likely cause of the issue and work has been completed to mitigate the risk of recurrence. Remedial work to flooring and some partition walls is being costed with support from WHH procurement team.
- 2 bids submitted to the national HSJ awards about the project (shortlisting takes place in August 2024).
- Discussions with national and regional Directors from Dept of Health and Social Care have created some wider interest in the project.

Living well hub in Warrington- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Implementation of ongoing project governance arrangements	September 2024

Contact details

Caroline Lane - Strategic Project Manager
caroline.lane10@nhs.net

Runcorn town deal-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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.

What does this mean for WHH?

- Delivery of WHH services, including maternity, respiratory, and phlebotomy, from a convenient and accessible town centre location.
- Opportunity to work with local further education college to provide education and training tailored to jobs in health and care, helping to reduce our vacancies.
- Opportunities to further integrate services with other providers across health, care and wellbeing.

Progress since last report

- Tender documents currently being drafted with an aim to begin the formal procurement process later in July.
- Further technical engagement with all elements of the deigns to ensure a robust, flexible and clinically appropriate environment for partners to deliver services from is created.
- Workshop undertaken to agree the core principles of the collaboration agreement, which will formalise working arrangements between partners moving forwards. Following comments, this will be drafted into a legally binding document to support delivery of the project by all partners.

Runcorn town deal- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	**Looking after our people** ✓	**Working in partnership**✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
RIBA Stage 4 designs approved	July 24
Procurement process for lead contractor commencement	July 24
Lead contractor procured	Oct 24

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-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 covers three phases:
  - Phase 1 (now complete) saw the development of a range of diagnostic services within the Nightingale Building at Halton.
  - Phase 2 (now complete) saw a range of diagnostic services established within the Halton Health Hub at Runcorn Shopping City.
  - Phase 3 will see the development of a new build extension to the CSTM building on the Halton site to accommodate additional CT and MRI services.

What does this mean for WHH?

- Additional capacity to undertake diagnostic testing for patients of Halton and Warrington, and the wider Cheshire and Merseyside region.
- New estate at Halton General Hospital and at the Halton Health Hub in Runcorn Shopping City, which supports new hospitals plans and the estates strategy.

Progress since last report

- Over 41,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1+2) since Phase 1 went live in May 2023.
- Enabling works package completed for phase 3
- Contract price for the phase 3 full works package was received and contract fully signed
- Completion of the project is planned for March 2025.
- Commencement of clinical activity in phase 3 is planned for end of March 2025.
- Funding has been secured to implement a new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City).

Community diagnostic centre- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	Looking after our people	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	Working responsibly
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Commencement of CDC facility construction phase 3	July 24
Services within new build CDC (phase 3) to commence	Mar 25

Contact details

Lefteris Zabatis - Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New hospitals and strategic estates planning- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- Development of new WHH hospital estate and infrastructure.
- Within Warrington, this is the development of a new hospital, either on the current site or elsewhere in the town.
- Within Halton this is the redevelopment of the Halton Hospital site, including extending Captain Sir Tom Moore to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

What does this mean for WHH?

- Delivery of Trust services from modern, accessible and safe environments.
- Opportunities to develop service provision in appropriate clinical settings and expand opportunities to work with local partners or in external locations.

Progress since last report

- The contents of the refreshed Trust Estates Strategy has been ratified by the WHH Trust Board. This will be published over the next reporting period.
- The estates programme, including intentions for strategic estates projects has been submitted to Cheshire and Merseyside ICB. This describes the Trust's capital investment intentions across the next 10 years, should capital become available.
- The New Hospitals Strategic Oversight Group met in May 2024. Partners from across the system, including local councillors, who have all reaffirmed their commitment to progressing our case for new hospitals across Warrington and Halton.

New hospitals and strategic estates planning- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Commissioning of updated new hospital plan including phased opportunities for investment	August 24

Contact details

Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Other Trust strategic updates

C&M Endoscopy Hub at Nightingale Building, Halton

- Currently in construction in Nightingale Building for additional endoscopy rooms and a decontamination unit
- The WHH Project Team are working closely with developers around areas in the department requiring further attention. Specific examples include fire stopping and the communications room.
- Operational teams are continuing to work on plans around delivery of activity whilst construction works are taking place.

Theatre 3 at Nightingale Building, Halton

- Currently in RIBA design stage 4. Designs will be approved in July 2024 and construction works will commence in September 2024.

Upgrade to Ward B2 at Nightingale Building, Halton

- Plans were approved by key stakeholders
- The WHH Project Team working with procurement colleagues to appoint a construction company.

Other Trust strategic updates

Digital Projects

Electronic Patient Care Management System (EPCMS)

Following detailed procurement evaluation and demonstrations, outcome of the procurement exercise is being finalised. Supplier contract finalisation is planned for early August, subject to ICB endorsement.

Patient Engagement Portal (PEP)

The Patient Engagement Portal went live on the 12th of June 2024. This enables the Trust to digitally send patient outpatient appointments and appointment reminders and allows patients to request rescheduling of appointments through the NHS App.

We have already seen benefits and excellent patient feedback:

- 122K New Appointment Notifications sent
- 50K First SMS Reminders sent
- 45K Second SMS Reminders sent
- 27K Booking Confirmation – 42% via the NHS App, 58% SMS
- 47K Letters uploaded digitally with 45% viewed preventing a paper letter being sent
- 2.2K Requests to reschedule / cancel appointments
- 15% Increase in NHS App Sign Up

I'm fairly digitally competent, I found the whole process really simple. I think even people with basic skills of using a smart phone would find it simple to use. It's so useful to

"I received my text and viewed my letter seamlessly. I can look at the details in the NHS App anytime which is so much easier than trying to find a letter."

Warrington Together

WHH continue to work with the ICS in finalising the shared to care business case proposal. The ICS has appointed a Programme Lead and will be attending the next Warrington Digital Enabling Group in August to outline plans and next steps.

Digital Transformation Roadmap

This roadmap outlines all the projects that support our Digital Transformation

NHS
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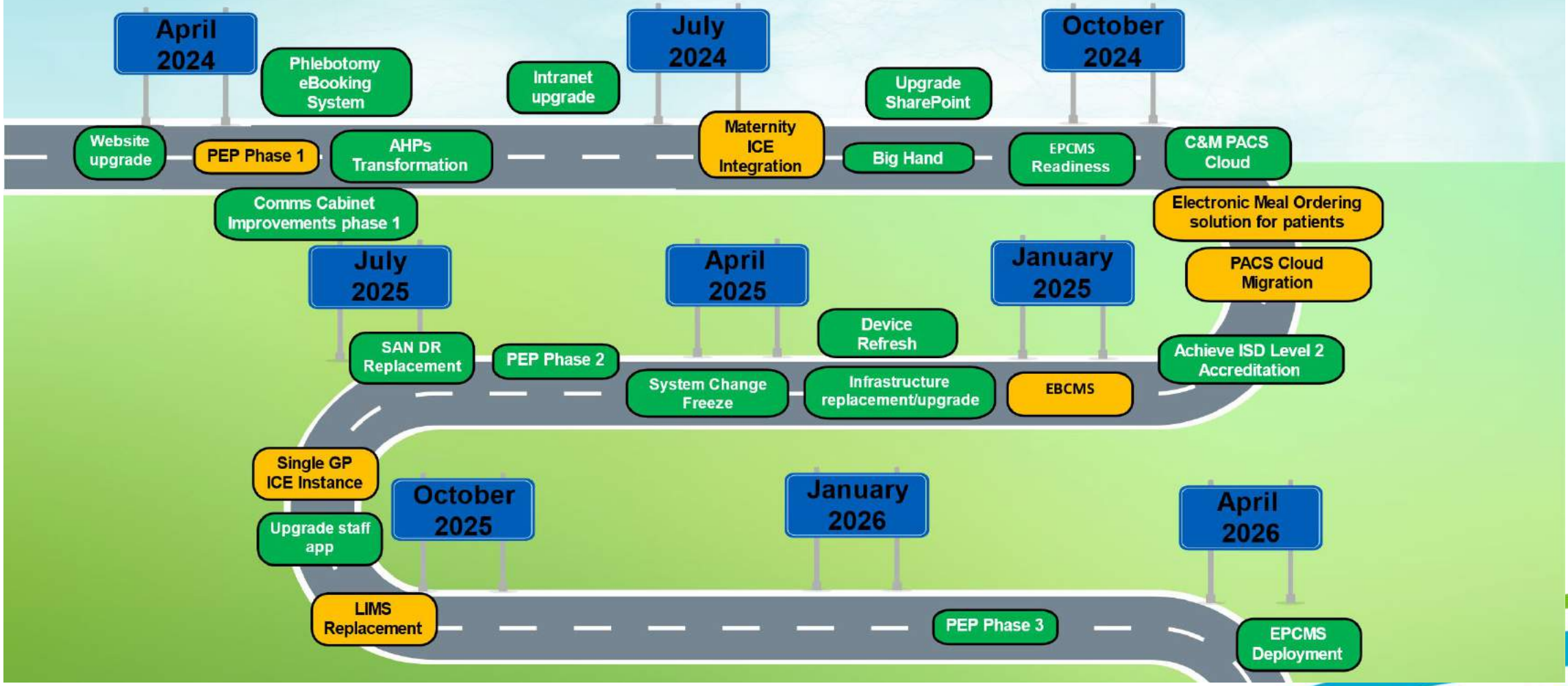

Place based strategic updates

Urgent and Emergency Care System Improvement

- A programme has been established to drive system improvement in urgent and emergency care. The programme has established workstreams in response to the diagnostic work undertaken by Newton and will deliver system improvement in partnership with Bridgewater, Warrington Borough Council and Halton Borough Council. This work will report into the ICB recovery committee, and updates will be issued separately.

Warrington and Halton Integration

- Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital NHS Trust to make best use of our resources and improve care for our patients.
- Teams from both organisations are involved in developing workstream plans for:
    - Clinical and operational services
    - Workforce
    - Communication and engagement
    - Finance
    - Corporate services
    - Estates
    - Digital services
- Regular joint executive meetings are being held a Board-to-Board meeting is planned.

Warrington

- Agreement has been secured to progress the procurement and development of a new digital health and wellbeing hub for Warrington. WHH will lead on the project on behalf of wider place partners. The project will form a key part of the wider Living Well (prevention and early intervention) programme across Warrington.
- A first draft of the Cheshire & Merseyside ICS Infrastructure Strategy has been issued to stakeholders for comment, ahead of a final submission to NHS England in July.

Halton

- Delivery plans for each specialist area of the Wider Determinants of Health group are being developed and priority areas for focus will be identified in August.
- A delivery group for Senior Responsible Officers tasked with delivering the Health and Well Being Strategy has been established to ensure delivery at pace.

Cheshire and Merseyside strategic updates

Laboratory Information Management System (LIMS)

- The Full Business Case for a unified LIMS across 5 healthcare organisations was approved by the Trust Board in June 2024. The procurement process continues with contracts for the preferred LIMS supplier due to be signed towards the end of August 2024.

Pathology collaboration

- The pathology hub delivery group (East) has been established and a potential Target Operating Model described. A workshop to shape the target operating model was held on the 30th May where options for the configuration of pathology services across the region were considered. Work continues to describe the benefits and costs of each option and an outline Business Case is in development. The OBC is expected to be presented to Trust Board in October 2024.

Paediatric surgery

- The pilot of Alder Hey @ Warrington continues with paediatric theatre lists being delivered by Alder Hey surgeons in Warrington. Further collaboration with Alder Hey is being discussed and a joint project team is being established with a visit to the Halton Hospital site planned in August.

C&M Infrastructure Plan

- The Trust has received the draft NHS C&M Infrastructure Plan which highlights the Halton Health Hub and the Living Well Hub as good practice exemplars across the region. The final submission to NHS England is due in July 2024.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/73**	
SUBJECT:	**Strategy Bi-Annual Delivery Report**	
DATE OF MEETING:	7 August 2024	
AUTHOR(S):	Carl Mackie, Halton Healthy New Town and Strategy Manager;	
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, 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.	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	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):*	In May 2023 Trust Board ratified governance and reporting arrangements for the updated Trust Strategy 2023-25. It was agreed that reporting against the delivery of the Strategy would be standardised, including a bi-annual update of progress against the priorities within each of the strategic aims (Q, P, S) to the appropriate Board committee.

	There are a total of 62 strategic priorities within the refreshed 2023-25 Trust Strategy. These are broken down and monitored as below: There are 23 strategic priorities against the 4 objectives within the Quality aim of the Trust strategy. These are reported twice yearly through Quality Assurance Committee. H2 KPIs were reported to QAC on 11th June 2024 as per the Final Quality Account 2023-24. There are 24 strategic priorities against the 4 objectives within the People aim of the Trust strategy. These are reported twice yearly through Strategic People Committee. H2 KPIs were reported to SPC on 17th April 2024 as per the WHH People Strategy Annual Report. There are 15 strategic priorities against the 4 objectives within the Sustainability aim of the Trust strategy. These are reported twice yearly through Finance and Sustainability Committee. H2 KPIs were reported to FSC on 22nd May 2024 as per the Sustainability Strategic Priorities Bi-Annual Report . As of this report, the Trust is on target to meet 37 priorities, 20 are behind expectations with mitigations and programmes in place to bring back in line with expectations, and 4 are behind expectations with limited or no mitigations. 1 priority is not yet rated.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note progress of the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee; Strategic People Committee; Finance and Sustainability Committee	
	Agenda Ref.	Various	
	Date of meeting	Various as described	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests		

REPORT TO TRUST BOARD

SUBJECT	Strategy Bi-Annual Delivery Report	AGENDA REF	BM/24/08/73

1. BACKGROUND/CONTEXT

In March 2023, Trust Board approved a refresh of the Trust Strategy, which included a set of 12 strategic objectives underpinned by high level priorities. A summary of the refreshed Strategy is below.

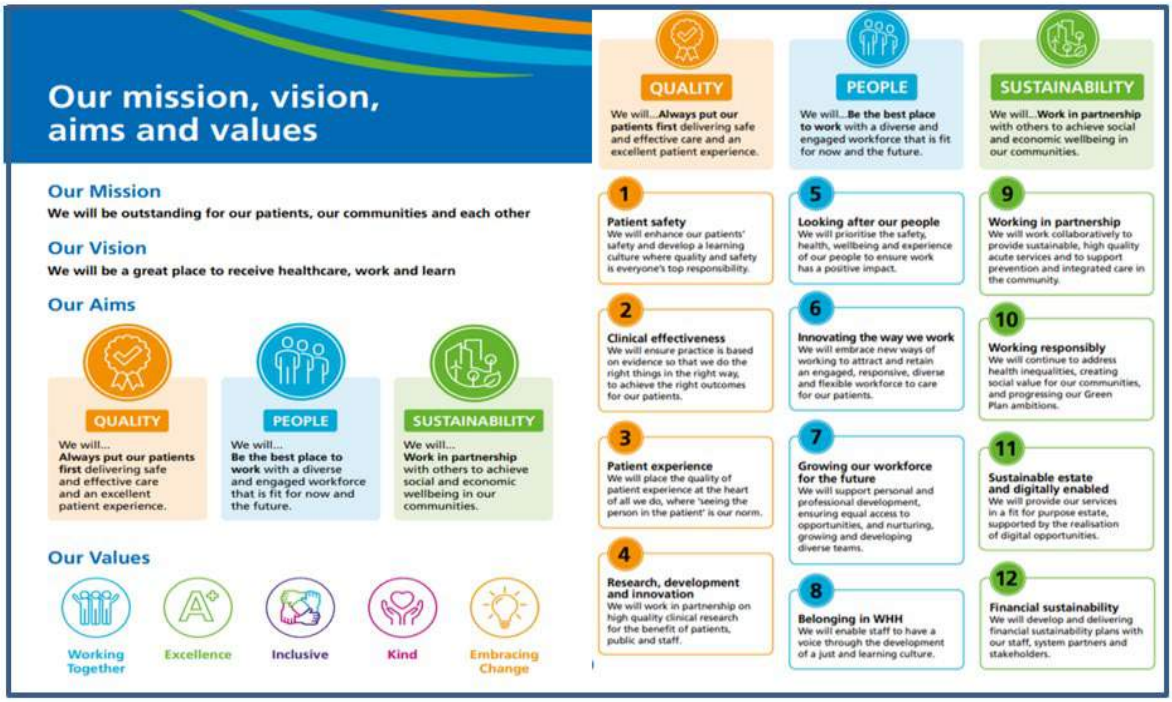

Figure 1: Summary of Trust Strategy 2023-25

In May 2023, Trust Board ratified the governance and reporting arrangements for the updated Trust strategy. This included the alignment of reporting across all aims of the strategy, and the approval of KPIs and / or Measures of Success aligned to each strategic priority.

As part of the alignment of reporting it was agreed that progress on the delivery of the strategy would be reported twice yearly, with the measures of success/KPIs relating specifically to Quality aims being monitored via Quality Assurance Committee, People aims being monitored via Strategic People Committee, and Sustainability aims being monitored via Finance and Sustainability Committee.

The refreshed Objectives, related Measures of Success / KPIs and associated baselines are described within the relevant appendix for each aim.

2. KEY ELEMENTS

The updated position for H2 2023/24 can be found in the table below. There are no metric changes from those previously set out as per the H1 update shared in November 2023.

An update on progress of the Strategic Priorities for the Quality aims was reported to QAC on 11th June 2024 as per the Final Quality Account 2023-24. Metrics are derived from this update and from the relevant Integrated Performance Report to Board (June 2024).

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
1. Patient Safety: We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.	1.1 We will reduce avoidable harm and patient deterioration with a focus on Covid-19 elective recovery.	Delivery of 104% of pre-pandemic activity by the end of 2023/24.	85.07%	97.45%	104%		The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.
		Potential Harm review panel will continue to undertake reviews where harm is suspected following a delay to treatment – feeding into wider governance processes					
	1.2 We will implement actions to deliver new standards required as a result of national reviews in Maternity care/provision, ensuring learning is acted upon.	Progress against action plans - Ockenden 1b:	94.91%	100.00%	100% compliant by 31 March 2024		
		- Ockenden 2:	68.53%	100.00%	100% compliant by 31 March 2024		
		Change in practice as a result of learning being acted upon, evidenced through monthly tracking of improvements and impact of actions with triumvirate.					
	1.3 We will enhance timely patient recovery through therapy led initiatives, including work around	Reduction in the number of patients who develop pressure ulcers.	15	18	9		A number of areas have been highlighted that contribute to the development of pressure ulcers including mattress provision, use of medical devices, and documentation.
		Patients participating in active movement and cognitive stimulation on the wards.					

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
	deconditioning and rehabilitation.	Annual reduction in the number of inpatient falls & harm levels. Based on 590 falls in 2021/22	545 (2022/23)	415 (2023/24)	20% annual reduction (436)		The Trust continues to report large numbers of patients admitted with pressure ulcers from the community. (April – 50). The First Pressure Ulcer Task and Finish Group was held in May 2024. A themed analysis was reviewed identifying a number of areas of focus. Following the meeting a 12 month work plan has been produced that will focus on pressure ulcer prevention and Tissue Viability Care.
	1.4 We will improve recognition and response to deteriorating patients.	Clinical deterioration is recognised and escalated in accordance with NEWS2 parameters, evidenced by recording of and response to NEWS2 score for unplanned critical care admissions (CQUIN)	56%	60%	Min 10% Max 30%		NEWS2: Compliance with CQUIN baseline above upper threshold. The CQI Team supported the Trust's Sepsis Improvement Group as part of a wider quality priority to improve the recognition and response to deteriorating patients. The group identified different needs and challenges in different clinical areas which led to the establishment of five task and finish sub-groups: • Inpatients • ED • Maternity • Paediatric inpatients • Paediatric ED Following the release of a new national sepsis screening tool, the Sepsis
		20% improvement in response to patients who trigger a clinical review on NEWS2.	63%	78.0%	75.6% correct escalation for NEWS 5-6		
		Time to medical review and coordination of treatment	19%		33% of patients seen within 60 minutes		
		Sepsis - % screening for all emergency within 1 hour	72%	62%	90%		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
		Sepsis - % screening for all inpatients within 1 hour	80%	60%	90%		Improvement Group will decide on how the tool is to be implemented, which will determine the work plan progression in 2024/ 2025. Sepsis data continues to be regularly reviewed using SPC statistical process control) charts to monitor progress.
		Sepsis - % patients within an emergency setting receive antibiotics administered within 1hour of diagnosis	84%	66%	90%		
		Sepsis - % patients within an inpatient setting receive antibiotics administered within 1hour of diagnosis	88%	75%	90%		
	1.5 We will reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)	Reduction in the number of patients who develop pressure ulcers.	1 (Category 3 and 4)	3 (Category 3 and 4)	0		Actions to improve the position include: The First Pressure Ulcer Task and Finish Group was held in May 2024. A themed analysis was reviewed identifying a number of areas of focus. Following the meeting a 12 month work plan has been produced that will focus on pressure ulcer prevention and Tissue Viability vCare. Priority Actions include. •Mapping of community pressure ulcers to inform system wide pressure ulcer prevention. •Relaunch of SSKIN bundle across all areas. •Test of change on Respiratory ward and ITU regarding device related pressure ulcers •Review of TED stockings • Explore documentation challenges. •Review availability of Repose wedges across the Trust • Review ED trolley matrasses exploring alternative options. • Development of Education in Practice Programme
	1.6 We will continue to evidence a culture of quality, safety and	Evidenced through the use of incident reporting, learning, risk management and					Patient Safety Syllabus Training is available to staff via the ESR platform and is mandated for staff who have been

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
	learning aligned to the National Patient Safety Framework.	triangulation of clinical governance. Evidenced through richer learning via new investigation methods including cluster reviews.					assessed as part of the Training Needs Assessment. Compliance is monitored weekly is currently 90.9% for level 1, 74.5% for level 2 and 89.4% for senior leaders, targeted messages have been sent to key individuals to increase compliance. • Human factors training has been delivered to senior leads particularly targeted at those who will undertake learning responses (2 sessions), further sessions have been scoped. Both the Women, Children's and Theatre leadership are looking to provide bespoke training for their teams. • We have increased the number of Patient Safety Specialists within the organisation from 2 to 7, these are all currently undertaking the level 3 and 4 Patient Safety Training Syllabus with Loughborough University. Once completed this will be evaluated to understand the opportunities for wider sharing of the learning. • HSSIB level 2 training is now open again for enrolment and the link has been shared across the trust. • LFPSE and PSIRF went live on 1st September. • Monitoring of trends and themes in Weekly Safety Summit Meetings. The TOR will be reviewed in Q4.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
2. Clinical effectiveness: We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.	2.1 We will continue to utilise and evidence best clinical practice through the evidencing of compliance with guidance, such as the National Institute for Clinical Effectiveness.	NICE compliance	91.65%	92.67%	90%		• The Trust's performance as of September 2023 in relation to NICE compliance is 92.67%, which is over the 90% target for compliance. • There are currently 582 pieces of NICE Guidance applicable to the Trust on the NICE database. • Of those, 39 are partially compliant which has decreased by 1. The Clinical Effectiveness Manager has sent reminders for all partial compliance action plans. • There are currently 2 NICE guidelines under review and awaiting confirmation of compliance from the leads of which 1 is overdue. • 1 guideline is overdue, a task and finish group has been created to ensure completion of the assessment.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
	2.2 We will continue to embed a positive risk management culture from ward to board.	Flexibility in risk appetite is recognised, this will be informed by the management of risk registers at service level, corporately and through the Board Assurance Framework.					The Risk Management Strategy provides a framework for managing risk across the Trust. The Strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust. Local risk registers are monitored and maintained locally within the Clinical Business Units (CBU) which enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the Corporate Risk Register and Strategic Risk Register where required. The Trust employs a number of systems to ensure that risk management is embedded within the organisation including business planning, performance management frameworks and clinical information systems. Regular reports are also available to the various committees responsible for aspects of risk management. There are corporate policies and procedures in place to support risk management, covering the management of incidents, risk assessment and consent and general risk management arrangements. Risk appetite levels will

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but a greater appetite for opportunity risks such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation. Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board. Risk appetites are determined by the Trust Board. The Trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience Committee. Partners and Governors are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management. The Trust has a Board Assurance Framework in place which is reviewed by the Board of Directors and includes: the identification of the key risks to the achievement of the Trust strategic objectives and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation.

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							The Board Assurance Framework is reviewed by the Board of Directors at each of their meetings and the Audit Committee, and bi-monthly by the Board Committees, which provides additional challenge and scrutiny of the risks identified.
	2.3 We will recover core services and improve productivity in line with	% of plans on track to deliver annual operational improvement trajectories	0	51%	100%		A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
	targets set in the NHS Long-term 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, recovery plans are in place for all modalities
	2.4 We will improve a culture of quality, safety and learning through the consistent application of LOCSIPs, achieving >90% compliance in documentation and observational audits.	Implementation and audit of LOCSIP safety standards, with focus on non theatre areas. 90% compliance to be achieved in the following areas for 23/24 • Endoscopy • Cardiac Catheter Lab • Ophthalmology • Paediatric • Gynaecology • Neonatal • Breast Screening • Interventional radiology • ITU • B18	N/A - areas currently measured as high, medium or low instead of a percentage baseline.		90%		• Annual observational audit of all non-Theatre has commenced in January 2024. The results are to be presented and monitored at PSSG. • Focus on Theatre Safety Culture with review of actions relating to Never Events. Theatre safety day took place on 8 December 2023 and was successful, resulting in several recommendations. An action log is being produced by the Procedural Safety Steering Group (PSSG) and progress will be reported through to PSCESC. • A re-audit of pleural procedures including LocSSIPs is underway. The results will be presented at PSSG. • Repeat observational LocSSIPs audits in all other non-Theatre areas. Individual area leads to undertake with oversight provided by the Deputy Associate Medical Director. These audits have commenced in January 2024. • The Deputy Associate Medical Director and Clinical Effectiveness to chair Procedural safety steering group (PSSG). • Safe surgery audit and recommendations from Theatre safety day shared widely with actions monitored through PSSG.
		Audit of WHO checklist effectiveness with evidence of effective operative and a focus upon theatre culture.					
		Systemisation of safety improvement, evidenced through robust system controls and incident response processes.					

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
	2.5 We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.	Increase the percentage of patients that receive a diagnostic test across all reportable diagnostic services within 6 weeks to 95%.	74.40%	89.57%	95%		Increase the percentage of patients that receive a diagnostic test across all reportable diagnostic services within 6 weeks to 95%. Overall status currently amber. Currently not at 95% across all diagnostics, ongoing plans and workstreams are in place to continue to work towards achieving this target. • Radiology status is consistently green and is compliant with 95% target. • Endoscopy, Cystoscopy, Sleep Studies, Echo's status is Amber (approx. 2,500 patients waiting above 6 weeks) and there are action plans in place in order to achieve the targets. • DMO1 is monitored weekly at PRG and is a Trust performance measure. • Live data is shared, and plans discussed at PRG which is chaired by the Director of Operations or Chief Operating Officer. • Trajectories and current performance, including workstreams and any mitigation plans are monitored via the Unplanned Care Transformation Board. Improved access to Elective Care through reduced waiting times and improve theatre productivity to 85%. • Overall status amber. Currently not at 85% utilisation (capped theatre time), plans and workstreams in place to achieve target by March 2025 across all specialties. • Current metric 67.3% against 85% target (March 2024). Improve ED waiting times so that no less
		Improved access to Elective Care through reduced waiting times - eliminating 65+ week waits by March 2024	376	628	0		
		Improved access to Elective Care through improved theatre productivity to 85%.	90%	67%	85%		
		Improve ED waiting times so that no less than 76% of patients are seen within 4 hours	69.80%	64.40%	76%		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							than 76% of patients are seen within 4 hours. • Overall status is currently amber. Currently not at 76% target, plans and workstreams were in place to aim to achieve target. This will be an ongoing target into 2024/25.
	2.6 We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework).	Increase QI capability and capacity to 10% (400) for QI Foundation and 2.5% (100) for QI Practitioner programmes.	Foundation 6.3% (252)	388	10%		The management of quality improvement projects and systems to disseminate evidence of learning and improvement has undergone a period of evaluation and redevelopment this financial year. The CQI team hold a central record of QIPs (Quality Improvement Projects), however, it is important to note this is not an accurate representation of all WHH QI work as the system relies on staff registering through the central database. The development of an internal quality management system is a long-term aim and would be required to fully meet the requirements of this objective. To improve our position and as part of the ongoing work to develop a QI culture, the following summary will demonstrate the progress in this objective and highlight opportunities to further develop our quality management systems into the next financial year: New systems developed this financial year: • Impact statements added to QIP registration database to collect learning
			Practitioner 0.6% (23)	89			
		Achieve 80% Quality Improvement assessment score in line with CQC requirements.		92%	80%		
		Evidence learning and improvement through Quality Improvement Projects and assurance of actions					

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							proactively. • M2O pieces written and shared to highlight improvement work. • Developed a standard project progress and assessment criteria based on the IHI (Institute for Healthcare Improvement) Standard Assessment Scale to assess the quality of completed projects and will use this to inform further guidance on completing and reporting projects. • Launch of a quick reference guide, a WHH Essentials of CQI vision and QIP SOP. • The QIP SOP outlines a more robust system of identifying projects that have not progressed or have been completed and escalation through the governance system. • QI agenda items on care group/ CBU Governance Meetings following a series of engagement activity. • Database of QIPs now sent monthly to Governance Mangers to cross reference against governance actions. Further engagement underway to establish and standardise where info will be shared/ reported. • Development of shared learning forum. The aim of the forum is to provide an opportunity for WHH colleagues, partners and people with lived experience of our services to share and learn from a wide range of quality and safety related initiatives, improvement and innovation projects, patient and staff feedback, to celebrate outstanding practice and learn from excellence. • Development of the QIPC (Quality Improvement Practitioner Community) to

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							network, share and learn from improvement projects. • Operational patient safety group reporting redesigned to include SPC charts where appropriate and improve the system to identify and report on related local QI work. Next steps and opportunities for improvement: • Develop standardised system for sharing learning from QIPs and recognise success via certification and presentations. • Further develop clear channels of reporting/ communication through governance systems. • Continue to develop links with clinical audit and contribute to share-point update to automate some QIP communication functions, freeing up capacity of central team. Improvement Action Plan: • CQI team to continue delivery of training, review capacity and demand for training and to implement the forward plan for 24/25 (capability and capacity building plan, presented to QASC and signed off by execs March 2023). • Annual review of CQC evidence matrix with Head of Compliance/ ADQ/ Head of CQI to refresh and update as required. • If required by the CQC, ad hoc review of the assessment score and update to be completed by the Head of Compliance/ ADQ/ Head of CQI. • CQI team to continue work on development of internal QI management

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							system into 24/25 as part of team objectives/ work plan
3. Patient experience: We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the	3.1 We will empower patients to be active participants in their care, giving consistent information, listening and discussing next steps in their care.	A reduction in both PALS and complaints in relation to communication as a key theme.	9.4% (Complaints with a primary theme of communication)	5.50%	> 9.4%		
			22.75% (PALS with a primary theme of communication)	25.40%	> 22.75		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
patient' is our norm.	3.2 We will ensure an inclusive communications method for each patient, taking into account their personal circumstances, using clear and easy to understand language.	Evidenced through improved use of interpreters for both people of whom English is not their first language and British sign language users					Continuing monthly d/Deaf awareness training sessions, running until March 2024, open to all Trust colleagues. • Including the d/Deaf Community in EDS Engagement Events to reflect on services provided. • Initiation of visual alert on patient paper notes and patient bedside to highlight communication support required. • Focused meetings and ward visits to ensure compliance with the interpretation policy. • Monthly meeting with Patient Experience and Inclusion, Deputy Chief Nurse and Deaf Advocacy Groups and contracted Interpretation Service
	3.3 We will create first and lasting impressions which contribute towards a positive experience of care.	Monitored by: - Ward accreditation - Leadership observations - Patient experience walk round - Governors walk rounds. - Feedback received at Patient experience sub committee					
	3.4 We will improve patient experience for those with mental health attendance.	Training package to be developed specific to the care of mental health patients in an acute trust with evidence of evaluation.					A Training Needs Analysis has been completed and this has identified that different staff groups have differing training needs. The three main themes for training relates to the: 1) Provision of mental health observations/enhanced care 2) The legal requirements for detaining or caring for someone who is detained under the Mental Health Act

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		All staff in the Emergency Department to be compliant with the training package and trajectories in place for compliance across all wards.	0	As per comments	100%		3) Mental Health conditions – the symptoms and treatment pathways • In respect to point 1 - The Trusts Enhanced Care Policy has recently been updated. • Training has been delivered on the provision of enhanced care, including mental health observations to the HCAs who work in the emergency department. • Evaluation of the feedback of this training is underway and it is planned that this training will be rolled out to the nurses and doctors in ED. • This training will then be further evaluated with feedback from the nursing and doctor professional groups, before a planned roll out across other wards and departments. •A Mental Health Act Policy has been written and implemented within the Trust. The Trust solicitors and the Mersey Care Mental Health Law Team have been approached to develop and implement a training package which specifically focuses on the legal requirements of the Mental Health Act. Additionally, a training session has been delivered to Senior Nursing Teams across the organisation to increase their awareness and knowledge of the Mental Health Act. • In respect to point 3 - a training package and dates are being organised for ED staff to attend training dates following a programme of work delivered by Core 24. The delivery of this training will be via two mechanisms – the mental health team will work alongside WHH nursing teams for one hour and then a one-hour drop-in session will follow. This
		Ensure consistency in the assessment of patients with mental health needs, evidenced through the 1-hour time to review standard where clinically appropriate.	KPIs of Core 24 service being reviewed.	Mental Health service provided by Core 24, hosted by Mersey Care	100% where clinically appropriate		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							will be delivered every two weeks. After a three-month period, this training package and delivery method will be evaluated and amended based on feedback. • Awareness raising relating to patients cared for at Arbury Court has been undertaken, to support learning for patients with very complex mental health needs – this has been shared at Medical Cabinet and Nursing and Midwifery Forum. • HCAs within the ED have received a training package during Q4, which has been received positively. • Amendments will be made as required, and a plan will be put in place for roll out across the Nursing and Medical Teams, firstly in ED and then other Trust areas.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
	3.5 We will reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods.	Patients with a learning disability are referred and reviewed by the Specialist Nurse/team to ensure that communication needs are met >90%.			90% of patients reviewed		Database developed to capture data and provide assurance. ICE notifications received and notification via data warehouse are used to identify both children and adults with a Learning Disability (LD), where communication will be picked up. Hospital communication booklet is available to support patients with LD and communication difficulties. Widgit and Widget health are available to support easy read material for communication aids. Flashcards are available on the learning disability/autism workspace for all Trust staff. Training sessions to be made available to support how to use the communication aids. Coordinating a LD awareness day that would look at supporting LD patients and how communication can support them to be involved in their care. Makaton subscription for signs within the hospital to support patients who have a LD and use this sign language to be more inclusive. Makaton sign and symbol of the week completed within the week bulletin every Friday. Makaton training by an External Makaton trainer held on a quarterly basis. Improvement Action Plan • Database and collection process confirm, and data collection commenced 1st October 2023, results are available when needed. • Training sessions for the usage of the
		Embed an alert system for patients, where English is not the first language including British Sign Language.		Embedded			
		Audit of patients requiring interpretation services as identified through the alert system and actions taken			90%		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							communication booklet, flashcards and widget health on track for June 2024, with communications at present. • Makaton sign and symbol of the week has been removed from the Monday safety brief and is now available in the circulated newsletter the 'the week'. Whilst this information remains available to trust staff – the visual example of the sign has been removed. • Makaton subscription for 2024 as been confirmed and working through support of signage within the hospital and for easy read material, target is June 2024.
	3.6 We will improve patient experience by the pilot of a patient/family 'access line' primarily for out of hours.	Evidence of Improved patient/ family experience through patient feedback. Feedback from staff to support focused learning and improvement.					The access line will now be considered as 'Call 4 Concern' in accordance with the national programme. This will provide: Supplementary support in the provision of a telephone line where service users,

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		Results from evaluation to support Trust wide implementation.					relatives and their carers can contact a senior member of staff, if they are concerned regarding a patient's clinical condition or notice a change in their clinical condition. They may also call if the Ward Team is not addressing the concern or feel that there are inconsistencies in how care is being given and require an immediate resolution. • This is not intended to replace local departmental/ward resolution, however, enable the provision of immediate supplementary support. • The Acute Care Team are responsible for the management of the phone line and are the point of contact. • Adult Intensive Care (ICU) patients who have stepped down to adult wards were the initial pilot group. • The pilot commenced on 29 January 2024. No calls were received during this phase of the pilot. 2 further ward areas were therefore added to the pilot in March 2024. • Information leaflets are being given to patients who are in the pilot areas. • If a Call 4 Concern is received about a patient, this is documented by the Acute Care Team on the Lorenzo CDC form, viewable through the medical charts option. A reason for referral drop down is used to track the reason for contact. This form captures: Date and time of review, summary of care, resuscitation status, airway, breathing circulation, disability, exposure, fluid balance, investigations, acute kidney injury (AKI) grade, sepsis suspected, plan of care, escalation plan,

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							when discussed with Intensive Care and capacity. • To date 1 call has been received, regarding a patient in the Emergency Department (ED). • The project team are preparing for a Trust wide roll out (of adult in patient areas) on June 3, 2024. Objective 2: • A Call for Concern Steering Group supported planning of the project, this included representation of experts by experience. • A communication plan had been enacted for the pilot and this is currently being refreshed ahead of the Trust wide roll out. Objective 3: Initial measures have been defined to understand improvements, these include: • Monitoring for reductions in the number of out of hour queries (PALS) received relating to clinical deterioration (quarterly). • Monitoring for a reduction in the number of clinical incidents reported relating to clinical deterioration (quarterly). • Auditing what concerns are raised out of hours, what was the action taken, were they standardised and was the issue resolved. • Quarterly review of qualitative feedback from questionnaire. • Work has been undertaken with informatics and has enabled the ability to extract CDC details out of Lorenzo, this will support analysis of data, when there

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							is sufficient data. Improvement outcomes. • Improved accessibility for patient to access senior staff out of hours and resolve concerns. • Improved patient experience and satisfaction. • Reduced number of complaints /PALS/ incidents linked to clinical deterioration. Improvement Action Plan. • Enact refreshed communication plan for Trust roll out. • Register an audit to enable evaluation of concerns raised out of hours, action taken and resolutions. • Further work with Informatics to understand data. • A record of the number of patients and time taken will continue to be recorded, this will then form the basis of an impact assessment for the Acute Care Team. • Ongoing evaluations via surveys and quantitative data reviews • The Trust have been selected to progress as an early adopter of Martha's Rule.
4. Research, Development	4.1 We will continue to create opportunities for	Increase Pathway to Research participants	8	241	250		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
and innovation: We will work in partnership on high quality clinical research for the benefit of patients, public and staff.	members of the public to gain access to clinical research trials contributing to the health of our population.	Increased awareness of research across the Trust, evidenced through annual research survey					
		Continue to operate as part of a wider research Board, embracing commercial, non-commercial and academic opportunities.					
	4.2 We will further develop and grow our research capability through the application and selection for clinical trials.	Commercial studies will achieve minimum income target (approx. £600k) to sustain Halton Clinical Research Unit infrastructure with additional funding to invest in capacity and capability building initiatives.	£0k	£539,532 available carry forward into 2024.25	£600k		On target with studies in pipeline
		Working in partnership with providers and across sectors.					
	4.3 We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.	Annual increase in 20% of Principal Investigators.	27	32	20% (+4 Principal Investigators)		
	4.4 We will grow the academic research portfolio supporting staff recruitment and retention.	Formal arrangement established with Higher Education Institutes e.g. Chester Medical School, Edge Hill Faculty of Health					Warrington and Halton Teaching Hospitals, NHS Trust has scoped opportunities to partner with Higher Education Institutions (HEIs), including Edge Hill, John Moore's and Chester Universities, and through the Applied Research Collaboration Northwest Coast, to develop the academic research portfolio. Collaborations of this nature will enhance opportunities for WHH staff and patients to co-produce research proposals which meet the needs of the local population and secure the
		Submission of relevant research grant applications.					
		Growth in workforce involvement in academic research.					

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar-24)	Target	RAG	Comments
							necessary funding to undertake that research.
	4.5 We will seek to expand our research offer seeking opportunities for further collaboration through the Halton Clinical Research Unit.	Established formal agreements with Clinical Research Organisations and commercial sponsors to identify relevant studies secure preferred site arrangements.					The RD&I Department is actively pursuing a strategic partnership with Sci-Tech Daresbury. Recognising the immense potential of this collaboration, a visit took place in January 2024 marking the commencement of efforts to cultivate a robust and mutually beneficial relationship. This strategic alliance holds the promise of unlocking new avenues for research innovation and growth, further positioning WHH at the forefront of healthcare advancement.
		Increase opportunity for further expansion in collaboration with other research partners.					
		Increased number of Participant Identification Centre agreements signed between Primary Care and Halton Clinical Research Unit	1		3		

An update on progress of the Strategic Priorities for the People aims was reported to SPC on 17th April 2024 as per the WHH People Strategy Annual Report.

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.	5.1 We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.	Reduction in sickness absence	5.60%	5.45%	4.2% supporting attendance		Development of WHH Leaders to Support Staff's Health and Wellbeing - 50% implemented
	5.2 We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.	Improved Retention	83.36%	87.52%	86% retention		Embed the NHS Health and Wellbeing Cultural Framework - 100% implemented
	5.3 We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.	Reduction in bank and agency reliance	17.00%	15.86%	9% reliance		Develop Bespoke Health Promotion Programmes to Address Population Health Inequalities - 71% Implemented
	5.4 We will equip line managers to use person centred engagement practices which improve employee experience.	Reduced turnover	15.98%	12.20%	13%		Empower Managers to Enhance Employee Experience - 33% Implemented
	5.5 We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.	Reduction in vacancy rate	11.53%	9.03%	9%		Promote Employee Recognition and Appreciation Schemes - 50% Implemented
	5.6 We will consistently apply onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff.						Onboarding - Create a Great First Impression - 71% Implemented
6. Innovating the way we work: We will embrace new ways of working to attract and	6.1 We will develop strategic workforce plans which are reflective of current and future needs.	Reduction in Vacancy Rate	11.53%	9.03%	9%		Development of Workforce Plans - 78% Implemented
	6.2 We will participate in system wide workforce planning.	Reduced Staff Turnover	15.98%	12.20%	13%		System wide approach to Education that enables Fair and Equitable access - 75% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
retain an engaged, responsive, diverse and flexible workforce to care for our patients.	6.3 We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.	Improved Retention	83.36%	87.52%	86% retention		Embed Agile Working Principles - 50% Implemented
	6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.	Reduction in bank/agency reliance	17%	15.86%	9% reliance		Equip the Workforce to review Models of Care - 50%
	6.5 We will equip our workforce with the skills to shape and deliver effective and changing models of care.						Enhance the Digital Capability - 90% Implemented
	6.6 We will enhance digital capability, skills and leadership which embrace digitally enabled services.						Improve Attraction and Retention - 67% Implemented
7. Growing our workforce for the future: We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.	7.1 We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.	Improved mandatory training compliance	86.11%	90.44%	85% compliance for mandatory		WHH Leadership Development Programme - 100%
	7.2 We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans.	Improved role-specific training compliance	84.21%	88.63%	85% compliance for role specific training		Widen Participation in Development Programmes - 80% Implemented
	7.3 We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role	Reduction in Vacancy Rate	11.53%	9.03%	9%		Review Mandatory and Role Specific Training - 100% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
	specific training and leadership development.						
	7.4 We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.	Reduced Staff Turnover	15.98%	12.20%	13%		Scope for Growth Appraisal Implementation - 100% Implemented
	7.5 We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.	Improved Retention	83.36%	87.52%	86%		WHH Career Development - 50% Implemented
	7.6 We will equip Team leaders to use structured tools and techniques to develop effective team working within their Care Groups, across Care Groups and with the wider health and social care system.	Reduction in bank/agency reliance	17.00%	15.86%	9%		Team Development - 100% Implemented
		Improved appraisal compliance	64.24%	74.96%	79%		
8. Belonging in WHH: We will enable staff to have a voice through the development of a just and learning culture.	8.1 We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.	Reduction in Vacancy Rate	11.53%	9.03%	9%		Staff Able to Speak Up and Feel Heard - 67% Implemented
	8.2 We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.	Reduced Staff Turnover	15.98%	12.20%	13%		Create a culture of Psychological Safety - 0% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 23)	Target	RAG	Comments
	8.3 We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.	Improved Retention	83.36%	87.52%	86%		Compassionate Leadership - 60% Implemented
	8.4 We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.	Reduction in bank/agency reliance	17.00%	15.86%	9%		Access to Co-Created Resources to Assist in the Delivery of Compassionate and Inclusive People - 60% Implemented
	8.5 We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.	Reduction in sickness absence	5.60%	5.45%	4.20%		Adopt Principles of a Restorative and Just Culture - 0% Implemented
	8.6 We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.						Behavioural Framework Embedded for Each Trust Value which Promotes Civility, Kindness and Respect for all Staff - 100% Implemented

An update on progress of the Strategic Priorities for the Sustainability aims was reported to FSC on 22nd May 2024 as per the Sustainability Strategic Priorities Bi-Annual Report.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
9. Working in partnership: We will collaboratively work to provide sustainable, high quality acute services and to support prevention and integrated care in the community	9.1 We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.	RTT – Number of patients patient waiting 65+ weeks will be 0 by March 2024	478	628	0		RTT performance - 52 week waits have started to improve in line with the trajectory, 78 weeks and 65 remain challenged, mitigation plans through use of insourcing and mutual aid are supporting recovery plans. 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 2024/25 have been drawn up in line with current Operational Planning Guidance.
		Volume and Impact of collaborative projects being delivered with partners to reduce care backlogs to reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.					
	9.2 We will collaborate with primary care, community care, social care and all community partners, including the voluntary sector to support the provision of integrated care in the	Increased number of clinical appointments in off-site locations	82,636 (Total number of appointments, including DNAs & cancellations)	92,108 (11% increase)	5% increase		All projects on track or delivered as per individual plans. Trust embedded within a number of projects at place and region, including Prevention Pledge (ICB) and One Halton Wider Determinants of Health (Place) among others.
		Deliver Living Well Hub in 2023/24.					

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	community and prevention of ill health. It is proposed that this includes relocation of appropriate secondary care into the community, following the principle of right service, delivered in the right place to deliver excellent patient care and experience and to improve access and address health inequalities.	Deliver Runcorn Town Deal Hub by end of 2025/26.					
		Deliver phase 1 and 2 of new Community Diagnostic Centre in 2023/24.					
		Deliver phase 3 of new Community Diagnostic Centre in 2024/25.					
		Deliver breast screening reconfiguration at Bath Street by 2023/24.					
		Actively contribute to delivery of projects at place and regional level which seek to improve access and address health inequalities					
	9.3 We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts. This would be approached on a service by service basis to ensure the best outcomes for patients and our regional healthcare system.	Proactively review repatriation opportunities at service level.					Discussion of opportunities undertaken through strategic priority setting conversations. Opportunities including Paediatric Hub in partnership with Alder Hey in progress.
10. Working responsibly: We will continue	10.1 We will work in coordination with our system and place	Support both Warrington and					Trust embedded within Place and ICB governance to support place maturity. This includes leading on a number of

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.	partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.	Halton to develop place maturity.					workstreams within both One Halton and Warrington Together. Community spirometry services commenced delivery.
		Deliver our Core20PLUS5 objectives.					
		Deliver community spirometry services on behalf of Warrington and Halton.					
	10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.	Heat decarbonisation plan in place by end of 2023/24 for Halton and Warrington sites.					Requirements for production of HDCP identified but funding source for external expertise identified not yet secure. The Trust does not have dedicated sustainability resource, putting delivery of this priority at risk.
		Annual reduction in CO2 emissions	14,200tCO2e		5-10% reduction by 2025		
		Number of procedures/care pathways with carbon footprints calculated.	0	1	5		
	10.3 We will drive improved social value for our local population increasing the social and economic wellbeing in the communities we serve.	Maintain the number of local people employed by the Trust	77.00% (staff with a Warrington or Halton postcode)		77.00%		3 local jobs supported through the creation of the Warrington Living Well Hub
		Prioritise spend with local suppliers In Cheshire and Merseyside.					
		Jobs created as a result of projects.					

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
		Increased Town centre footfall as a result of enhancing service provision within community locations, with 70% of clients attending Halton Health hub, the Living Well Hub and the Runcorn Health and Education Hub reporting that the presence of the Hub has encouraged them to come to the Town Centre.			70%		
		Learning opportunities created and supported to support people into education and jobs					
	10.4 We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a	Staff-led initiatives/Quality Improvement projects incorporating sustainability.					Initiatives flagged by Theatre Team, ICU team and IPC team. Not yet formally registered with QI team. With leads to capture and record necessary information. Methodology for capturing information needed to calculate carbon/environmental impacts developed to ensure robust calculations and like-for-like comparisons.
		Green ambitions included within corporate paperwork (job descriptions, Trust induction etc)					

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	net zero National Health Service by 2045	Assessment criteria for environmental impact included in capital project proposals					
	10.5 We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care.	Delivery of prevention pledge action plan.					Prevention Pledge work ongoing. Case study submitted to NHS Cheshire and Mersey ICB on preventative opportunities created through the creation of the Living Well Hub.
11. Sustainable Estate and digitally enabled service models: We will provide our services in an estate that is fit for purpose, supported by the realisation of digital opportunities and aligned to the needs of our patients, staff and populations	11.1 We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.	Submit bids at all available opportunities.					The Trust's New Hospitals programme continues to explore options to deliver against the vision for new estate.
		Delivery of case of need communications plan.					
		Explore alternative funding options to deliver new hospitals and estates enablers.					
	11.2 We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and effective use of clinical space, whilst we work	Deliver TIF					All projects on track or delivered as per individual plans. Trust Estate Strategy due for ratification Q1 2024/25 Trust embedded within Place and ICB governance for strategic estate programmes.
		Deliver CDC					
		Deliver Living Well Hub					
		Deliver Runcorn Health & Education Hub.					
		Deliver Trust Capital Programme					

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	towards our realisation of our new hospitals.	Refresh Trust Estates Strategy and develop opportunities.					
		Work with partners at place and in C&M to maximise public sector estate utilisation.					

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	11.3 We will enhance our digital infrastructure to ensure it is reliable, modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.	WGLL Digital Maturity Assessment (DMA) - Smart Foundations.	DMA Overall 2.9	Smart Foundations – 3.6	Smart Foundations 4.6		• The IT replacement programme is a trust funded capital scheme across 2 years. 2024/25 is the second year of the programme, which is on track to deliver a complete replacement of the trust's wired and wireless local area network by the end of 2024/25. • A new high speed Digital Diagnostics IT network has been installed and configured. This advanced infrastructure solution has been implemented in preparation for migration to PACS cloud (December 2024) and a regional LIMS (2026/27 at WHH) • Subject to confirmation of NHSE funding for the national eBCMS programme, a Trust Board approved business case includes funding for Real Time Location Services (RTLS). RTLS will enable the trust's Wi-Fi network to be used for tracking people and equipment around the hospital site.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	11.4 We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised though Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.	Empowering Citizens		Empowering Citizens 1.10	Empowering Citizens 4.1		• The WHH Patient Engagement Platform (PEP) is due to go live on 10th June 2024. In conjunction with the NHS App, the PEP will allow all WHH patients to securely receive electronic correspondence from the hospital and to manage appointments easily online, reducing DNAs and telephone calls to Outpatients. • The initial scope at go live is for all appointment related correspondence and details to be available to all WHH patients who wish to register for using the App. Initially this will exclude Radiology Appointments, due to some technical integration challenges, but its anticipated this will be added to the live system within the first month after go live • Future phases of PEP include self-assessments, waiting list management, test results etc., to be planned and prioritised in line with wider trust requirements
12. Finance sustainability: We will act according to our duty to collaborate, by working with partners on	12.1 We will deliver the Trust's agreed financial plan.	Achievement of CIP programme	17.9m	CIP performance for 2023/24 was £16m against £17.9m target (£7.3m recurrent)	£17.9m		Although the CIP target was not fully achieved for the 2023/24 financial year it was the highest in year and recurrent delivery to date.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
shared financial objectives to achieve sustainability of the Trust and the wider Cheshire and Merseyside system.		Achievement of agreed financial plan	£15.7m deficit	£30m deficit subject to audit for the year ended 31 March 2024	£15.7m deficit		The Trust recorded a £30m deficit subject to audit. The main drivers of the deficit being off plan are the cost of corridor care in A&E, specialling, activity underperformance, B2 to B3, annual leave accrual, cost of industrial action and undelivered CIP. The Trust had a revised control total of £21.2m, however there has been a shortfall in industrial action funding, increase in B2 to B3 costs, annual leave accrual and partial achievement of the £5.3m stretch target. Therefore, the actual deficit is £30m
	12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.	Actively participate and contribute to the delivery of the ICS Procurement 34 Point Action Plan. Actively participate and contribute to the development of procurement within the ICS. Successful in leading on the introduction of a single Contract Management platform across the ICS.					The Trust is playing an active role in the development of the ICS procurement programme. Alison Parker is the Deputy Chief Procurement Officer. The Trust has now adopted Atamis, a centralised contract tender management system across the ICS to include trusts workplan's and contract registers. The C&M Procurement Community has developed a workplan to delivery increased savings and has appointed HealthTrust Europe to support Trusts in delivery of the workplan. There are also links with other ICS level networks to support collaboration (HR, IT, Estates etc.) A savings tracker has been developed to track savings a both Trust and ICS Level.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
							Governance has been developed and introduced for the management of projects. A Procurement Strategy is in draft.
	12.3 We will deliver value for money by ensuring efficient use of resources	Amber or Green rating achieved in the Value for Money assessment undertaken by the Trust's external auditors and reported in the Auditor's Annual Report	Amber	N/a – annual assessment next due June 2024	Amber or Green rating	N/a – annual assessment next due June 2024	N/a – annual assessment next due June 2024

3. MONITORING/REPORTING ROUTES

The monitoring and reporting route for the Trust Strategy is described in the diagram below:

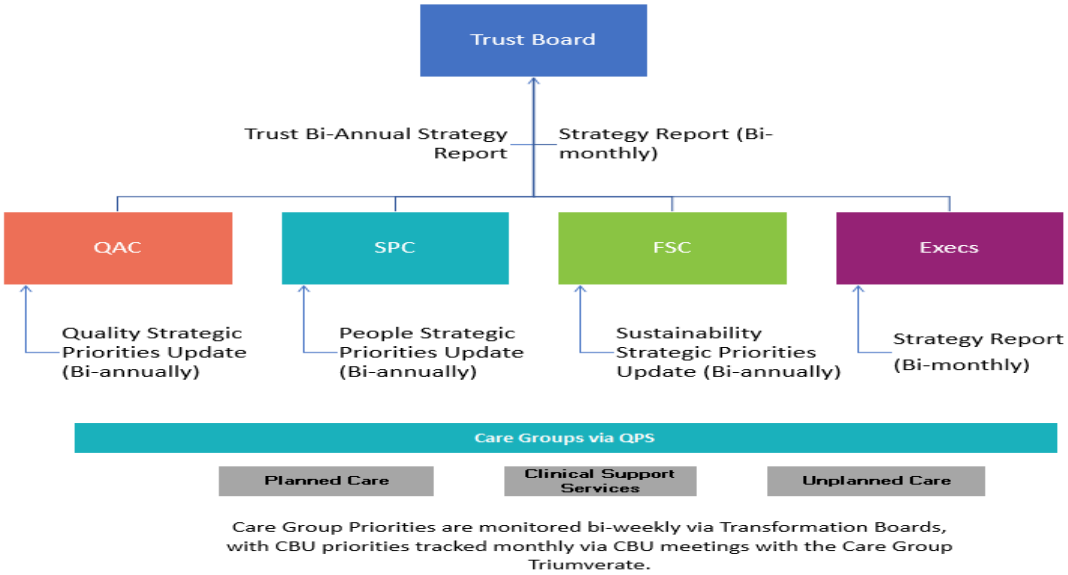


Figure 2: Monitoring and reporting arrangements for Trust Strategy 2023-25

4. TIMELINES

The strategy spans a two-year timeframe from 2023-25. The measures of success/KPIs will cover the duration of the strategy with bi-annual monitoring of delivery through each committee of the Board. The KPIs will be reviewed and refreshed as appropriate.

A further update on the H1 position 2024/25 will be presented to Board after October 2024.

5. ASSURANCE COMMITTEE

All as noted above.

6. RECOMMENDATIONS

The Trust Board is asked to note progress of the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/74**			
SUBJECT:	**Trust Organisation Chart**			
DATE OF MEETING:	7 August 2024			
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):*	The document provides the Trust Board with an overview of the organisation structure of the Trust			
PURPOSE: *(please select as appropriate)*	**Approval** ✓	**To note** ✓	**Decision** ✓	
RECOMMENDATION:	The Trust Board is asked to note the update organisation structure			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

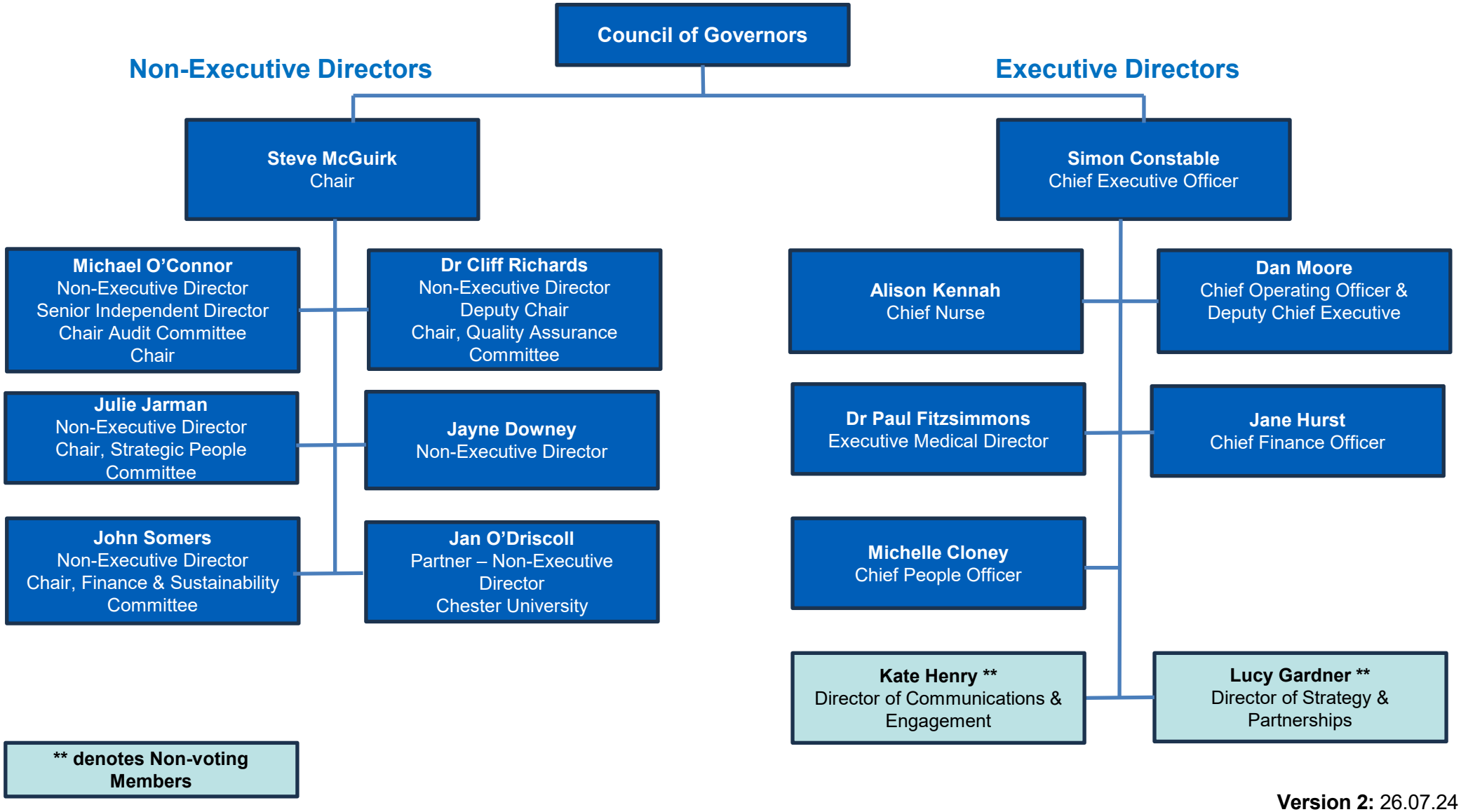
NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS FT

Organogram

Warrington and Halton Teaching Hospitals NHS Foundation Trust

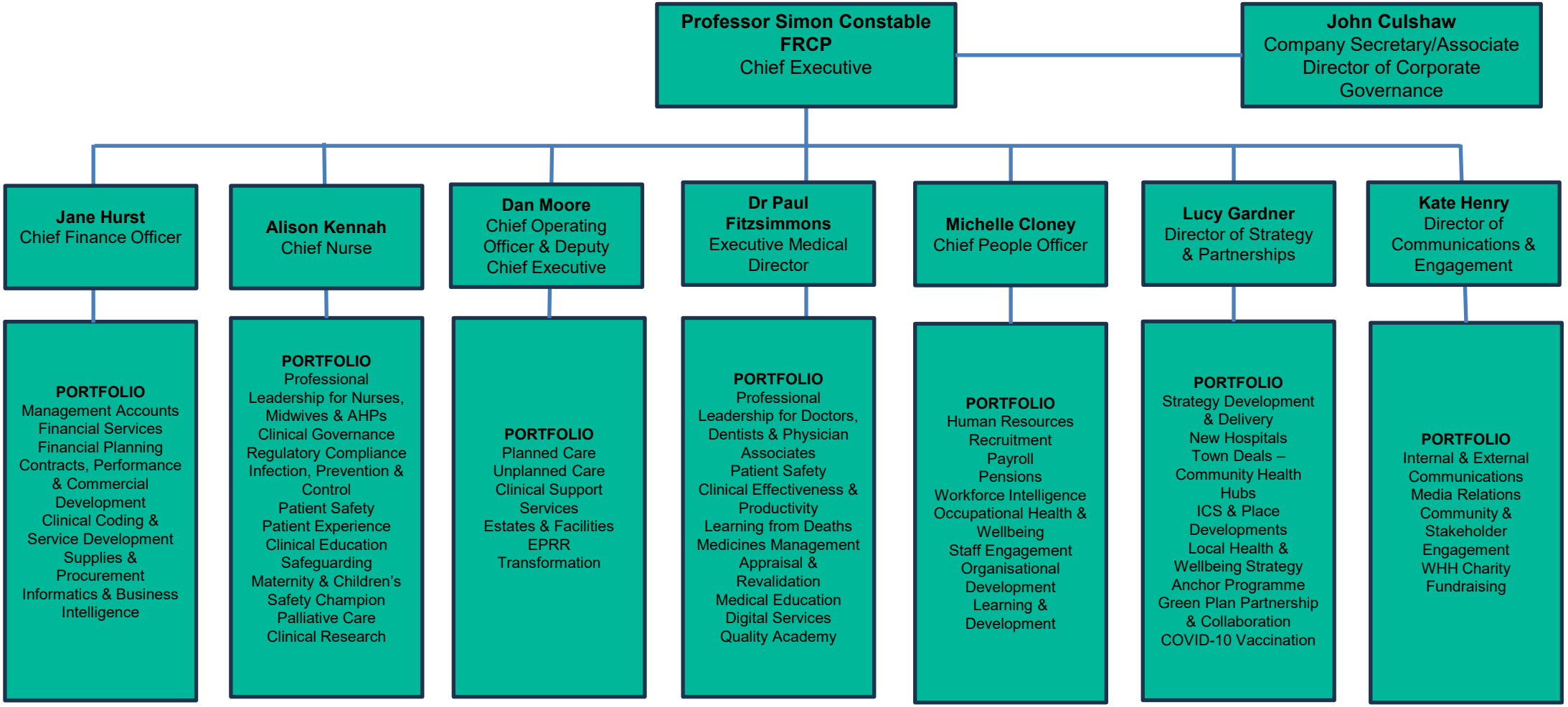
Trust Board



Version 2: 26.07.24

Warrington and Halton Teaching Hospitals NHS Foundation Trust

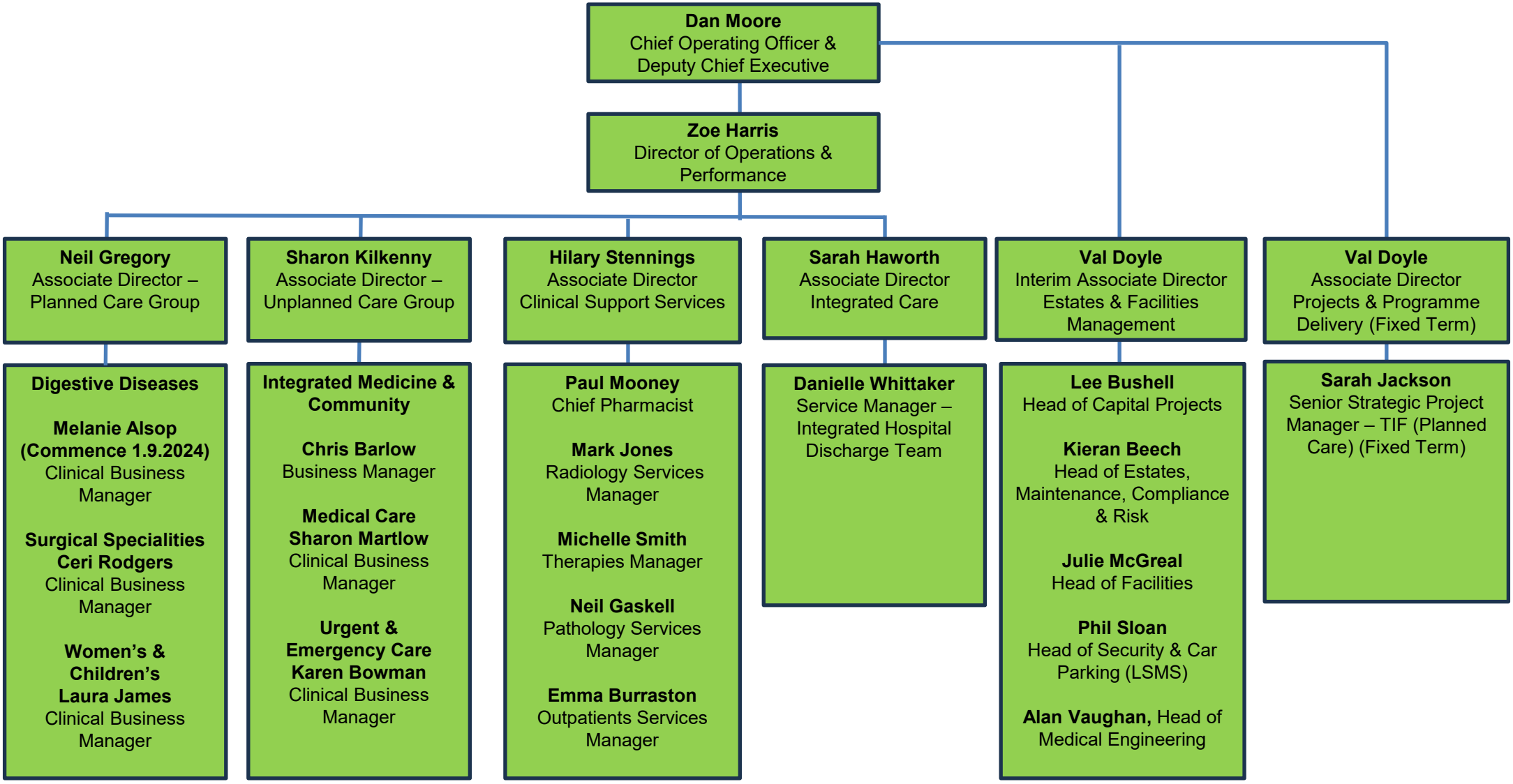
Executive Team



Version 1: 26.07.2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Operations



Version 5: 26.07.2024

Care Groups and Clinical Business Units

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Dan Moore
Chief Operating Officer & Deputy Chief Executive

Zoe Harris
Director of Operations & Performance

Planned Care Group

Neil Gregory
Associate Director

DIGESTIVE DISEASES (VACANT)
Clinical Director
Melanie Alsop
Clinical Business Manager
Lucy Parry
Lead Nurse

CLINICAL SERVICES
Gastroenterology
General Surgery
Upper Gastro-intestinal Surgery
Colorectal Surgery
Endoscopy
Anaethetics
Liaison Pain Management
Pre-Op Assessment
Ward A4
Ward A5 Gastro
Ward A5 Elective
Ward B4
Planned Investigations Unit
Theatres
Post Anaesthetic Care
CT Room

Anna Vondy
Associate Medical Director

SURGICAL SPECIALITIES (VACANT)
Clinical Director
Ceri Rodgers
Clinical Business Manager
Carol McEvoy
Lead Nurse

CLINICAL SERVICES
Gastroenterology
Trauma & Ortho
Ophthalmology
Urology
ENT
Audiology
Maxilofacial Surgery
Orthodontics
Ward A6
Ward B3
Captain Sir Tom Moore Ward

Sonia Griffin
Associate Chief Nurse

WOMEN & CHILDREN's HEALTH
Dr Satish Hulikere
Clinical Director
Laura James
Clinical Business Mngr
Ailsa Gaskill Jones
Director of Midwifery
Jill Tomlinson
Lead Nurse Women & Childrens Gynae

CLINICAL SERVICES
Midwifery
Obstetrics
Gynaecology/Assessment Unit
Colposcopy
Paediatrics
Neonatology/Neonatal ITU
Antenatal Day/Clinic
The Nest//Birth Suite
C23
Ward 20
Wards B10 & 11
Children's Outpatients

Unplanned Care Group

Sharon Kilkenny
Associate Director

MEDICAL CARE
Dr Laura Langton
Clinical Director
Sharon Martlow
Clinical Business Manager
Claudine Reynolds/Ellis Clarke, Lead Nurses

CLINICAL SERVICES
Critical Care Medicine
Cardiology
Respiratory Medicine
Cardio Respiratory Investigations
Diabetes & Endocrinology
Nephrology
Rheumatology
Neurology
Dermatology
Acute Care Team
Intensive Care Unit
Acute Cardiac Care A3
Acute Respiratory B18
Ward C21

Dr Mark Forest
Associate Medical Director

URGENT & EMERGENCY CARE
Dr Saagar Patel
Dr Adebole Adebowale
Associate Clinical Directors
Karen Bowman,
Clinical Business Manager
Yasmin Habib
Lead Nurse

CLINICAL SERVICES
Emergency Medicine
Acute Medicine Emergency Department
Same Day Emergency Care Unit
Runcorn urgent Treatment Centre
Acute Medical Unit A1
Ward A2
Patient Flow Team

Emma Hackett
Associate Chief Nurse

INTEGRATED MEDICINE & COMMUNITY
Pradeep Magapu
Clinical Director
Chris Barlow, Clinical Business Manager
Janey Pye, Lead Nurse

CLINICAL SERVICES
General Medicine
Care of the Elderly
Palliative Care
Frailty Assessment Unit Ward A7
Wards A8 & A9
Forget Me Not Unit B12
Stroke Unit B14
Ward B19 & K25
Discharge Suite
Integrated Discharge Team

Clinical Support Services

Dr Alison Davis, Clinical Director
Hilary Stennings
Associate Director
Nicola Milkns, Matron
Paul Mooney, Chief Pharmacist
Michelle Smith
Head of Therapies

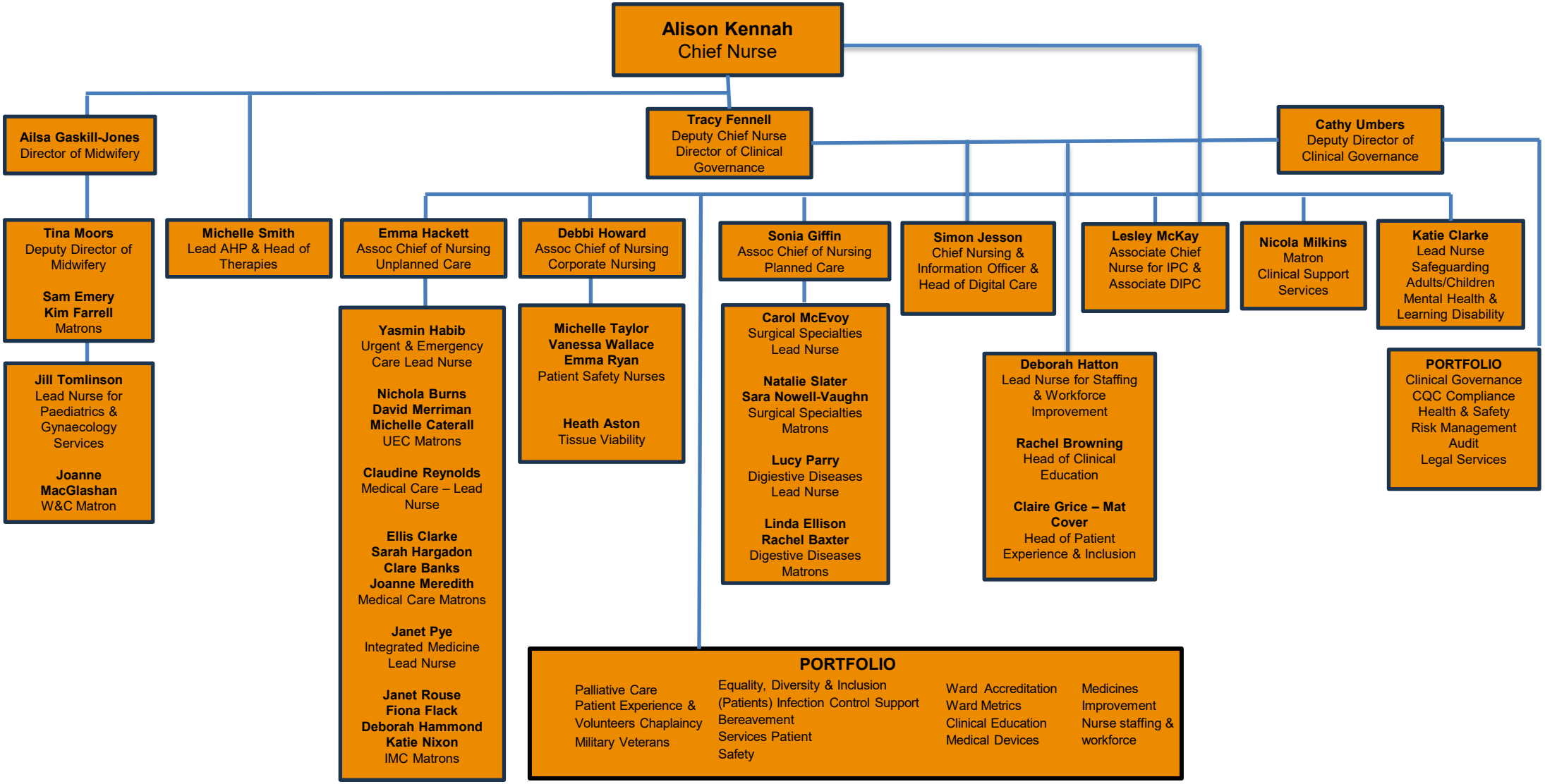
Mark Jones
Radiology Services Manager
Neil Gaskell
Pathology Services Manager
Lesley McKay
Associate Director, Infection, Prevention & Control (IPC)

CLINICAL SERVICES
Haematology
Microbiology
Clinical Chemistry
Imaging
Histopathology
Radiology
Breast Screening
Infection Prevention & Control
Outpatients
Pharmacy
Therapies

Version 4 : 26.07.2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

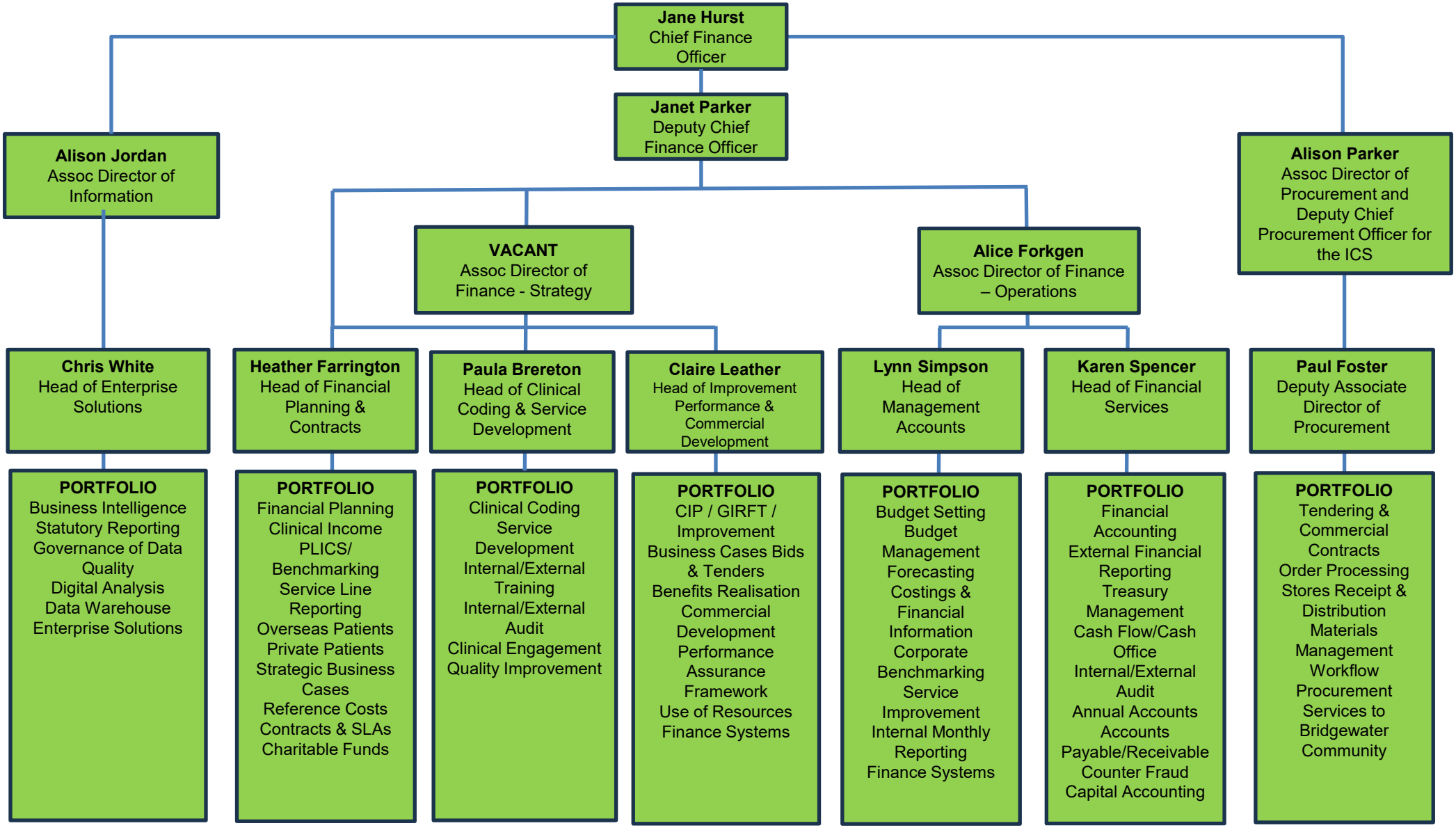
Nursing and Clinical Governance



Version 3: 26.07.24

Finance

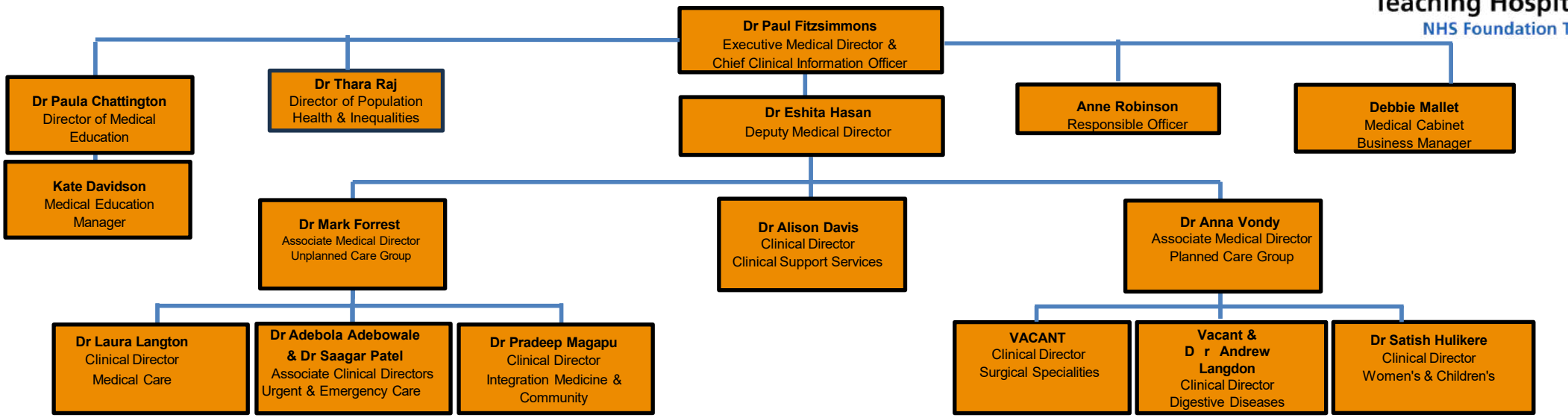
Warrington and Halton Teaching Hospitals NHS Foundation Trust



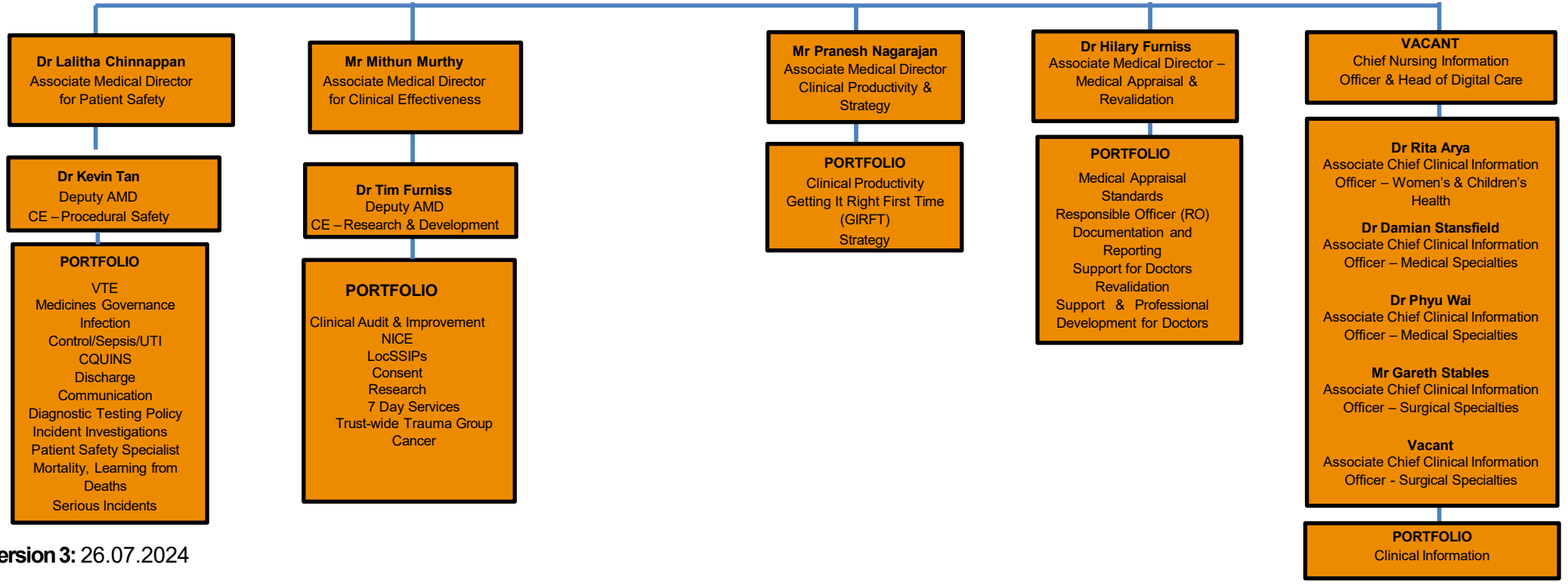
Version 6: 26.07.2024

Medical Cabinet

Warrington and Halton Teaching Hospitals NHS Foundation Trust



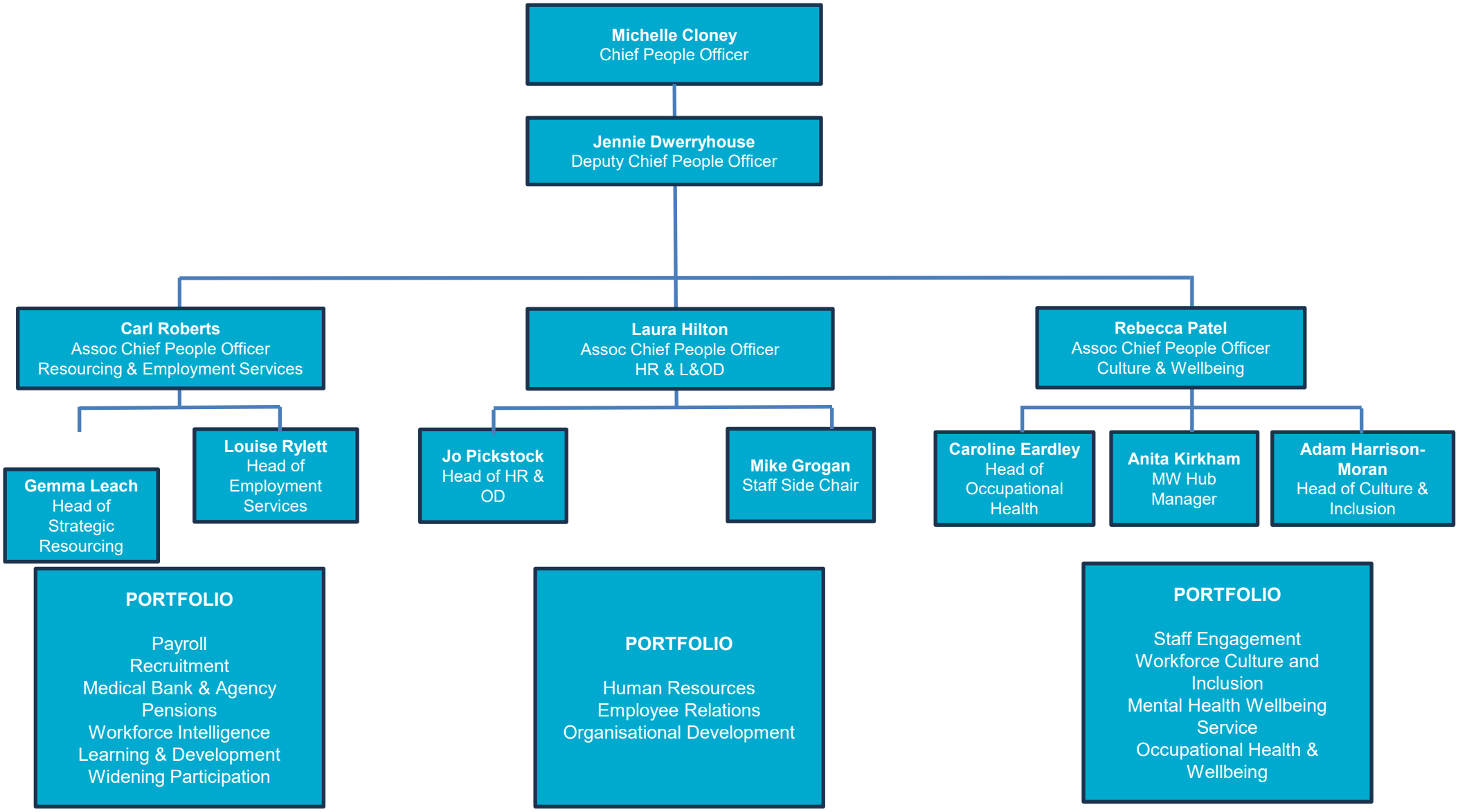
Portfolio Associate Medical Directors



Version 3: 26.07.2024

People

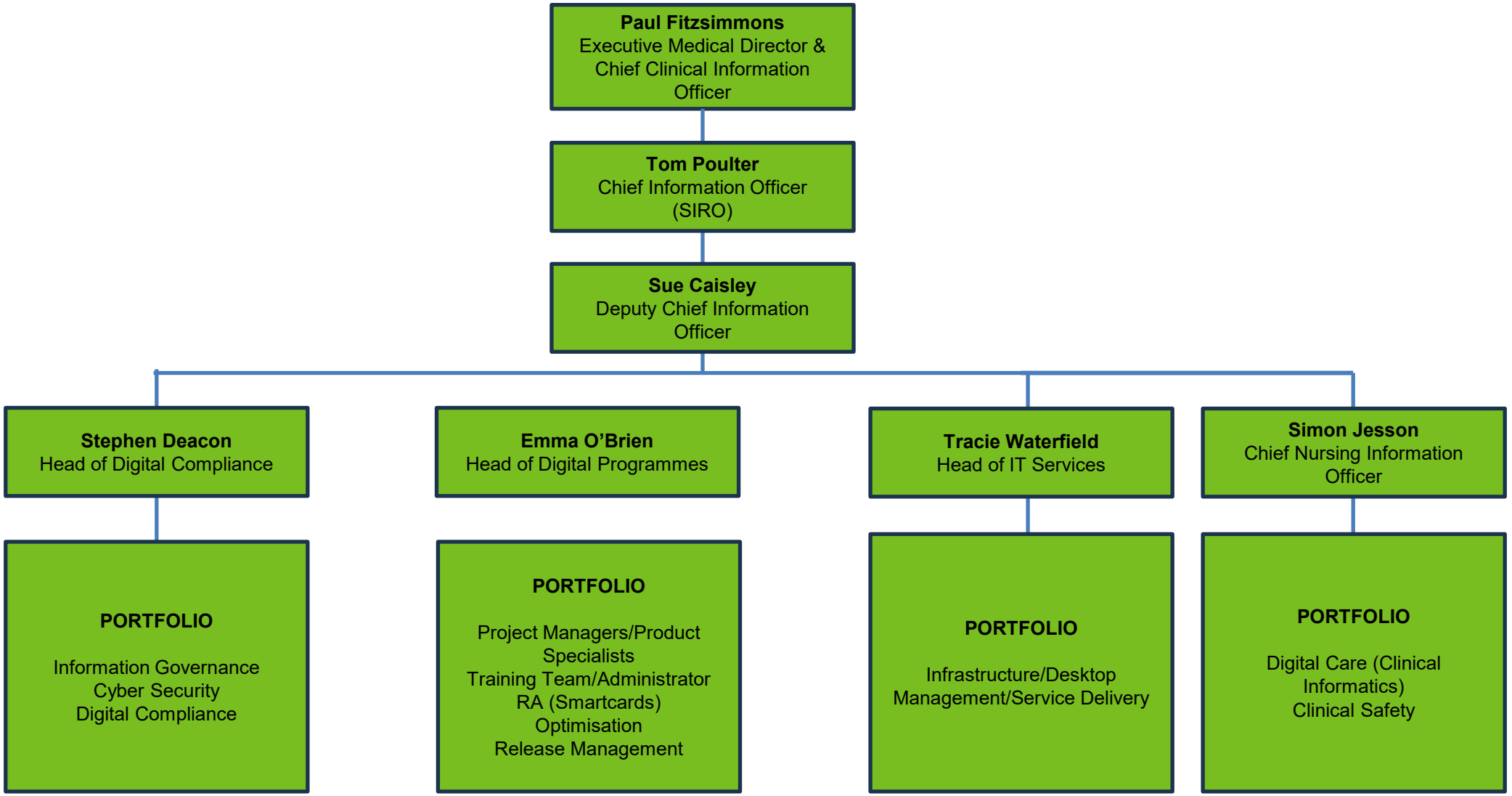
Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version 2: 26.07.2024

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

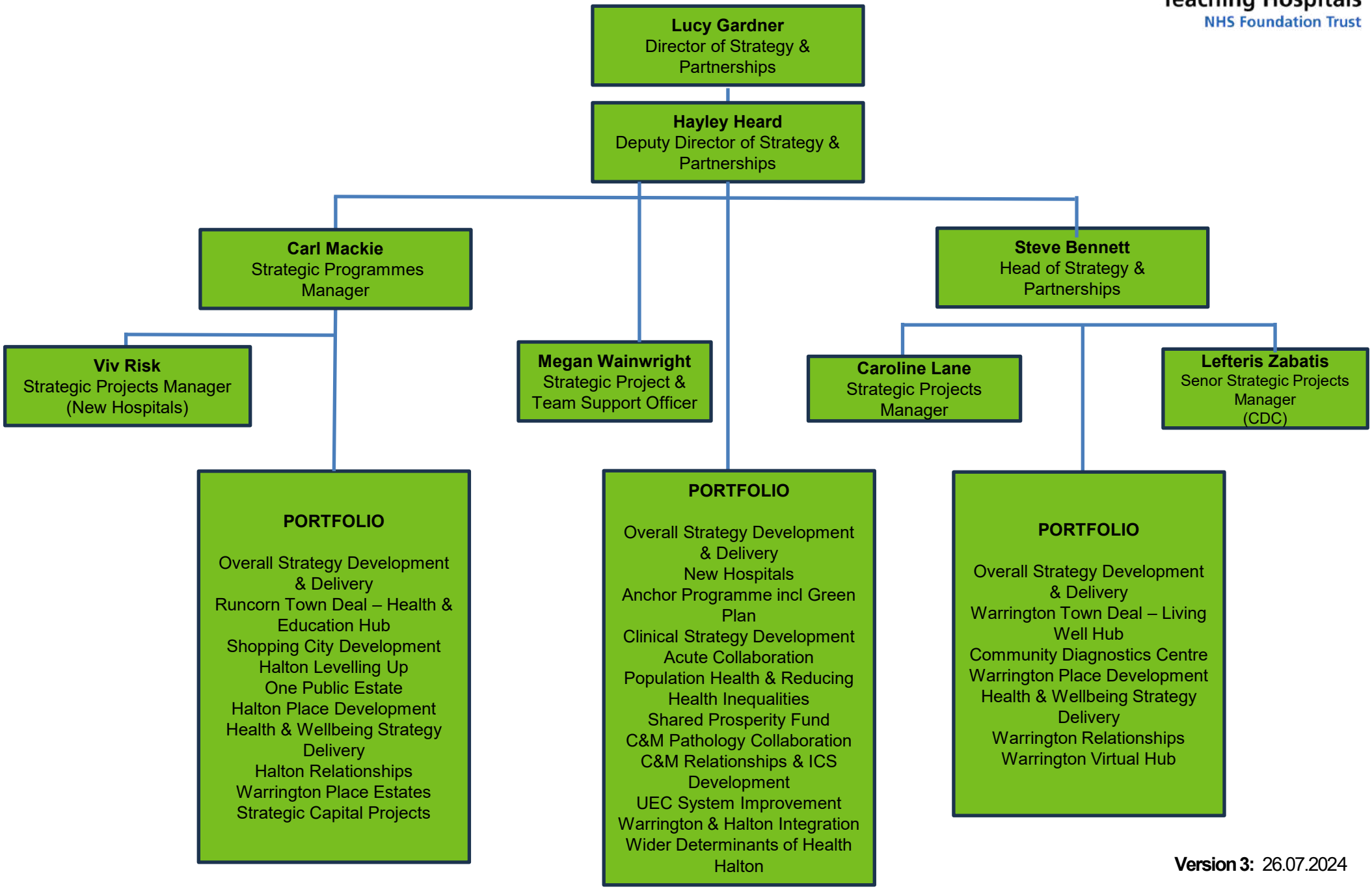
Digital Services



Version 2: 26.07.2024

Strategy and Partnerships

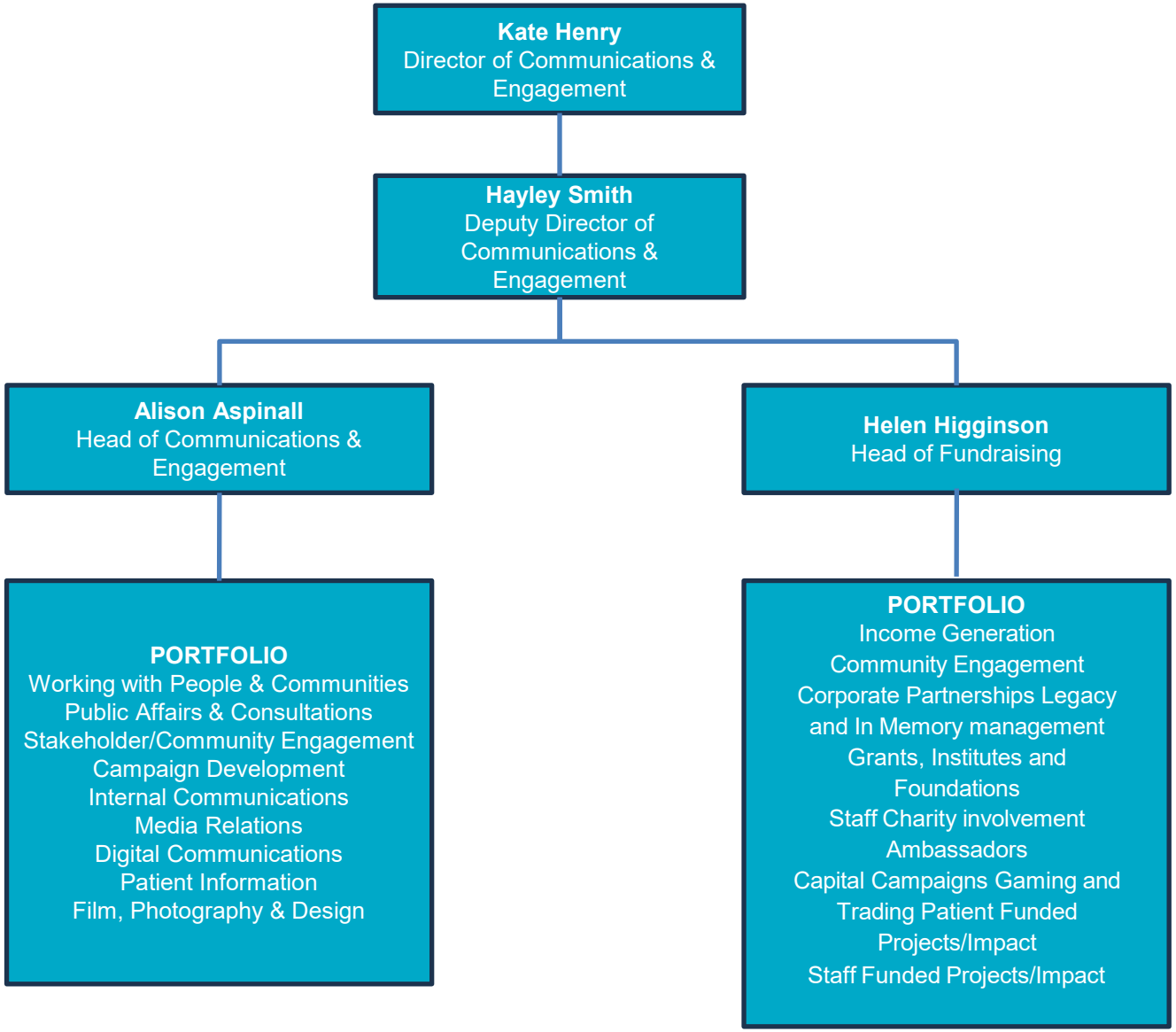
Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version 3: 26.07.2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

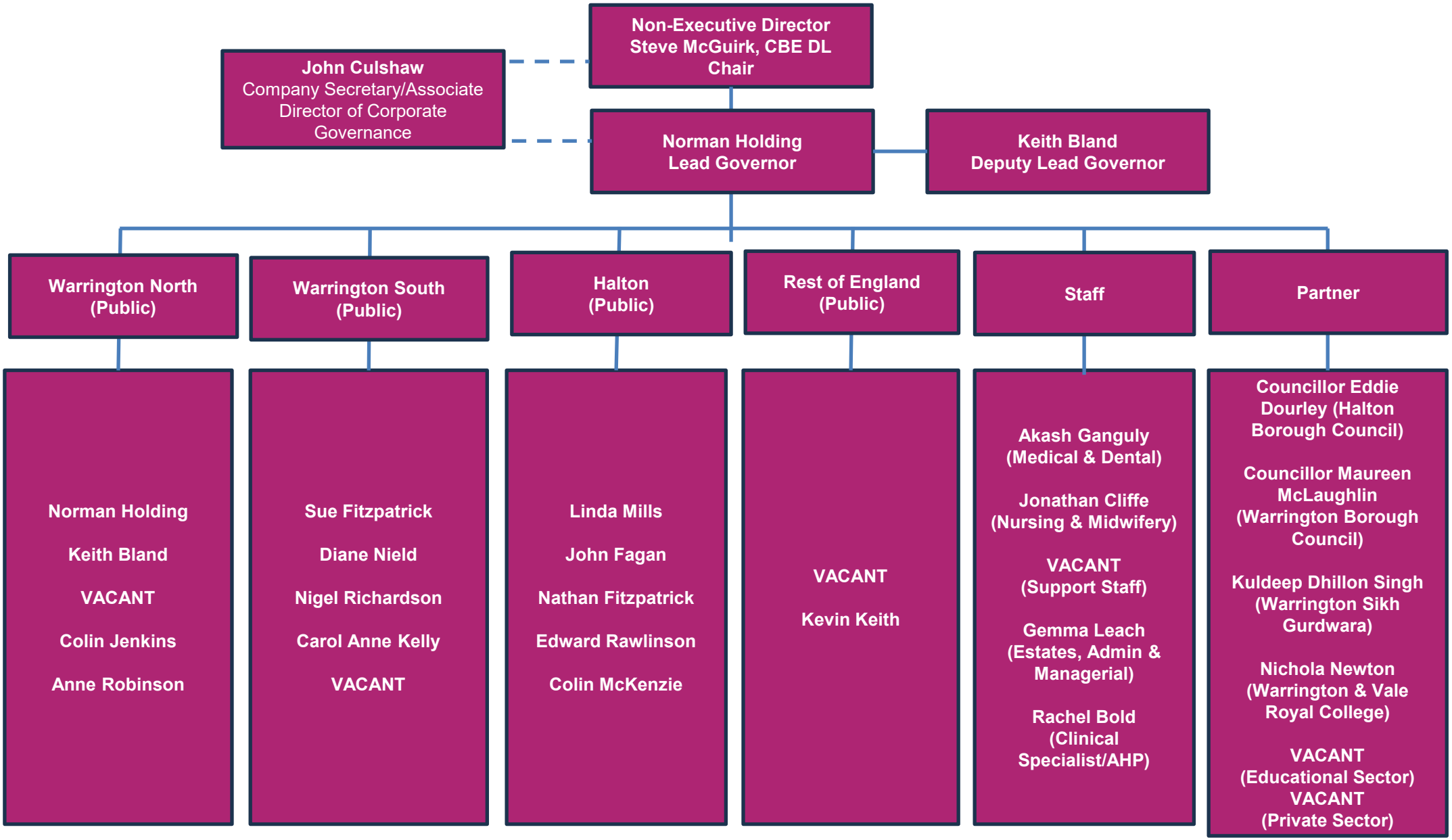
Communications and Engagement



Version 2: 26.07.2024

Governors

Warrington and Halton Teaching Hospitals NHS Foundation Trust



Version 2: 26.07.2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/08/75**			
SUBJECT:	**Fit and Proper Persons Test Annual Report**			
DATE OF MEETING:	7 August 2024			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair			
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)***	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):***	The new NHS England Fit and Proper Persons Test Framework came into effect 30 September 2023, following this the WHH Fit and Proper Persons Policy was updated to comply with the framework. The framework has introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.			

	The purpose of this paper is to provide assurance to the Trust Board that all directors remain fit and proper for their roles and that the required evidence as per the NHS England Fit and Proper Persons Test Framework is on track to be received in time to submit the Annual NHS FPPT report to the Regional Director NHS England, by the required deadline of 30 June 2024.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of the report for assurance purposes.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee	
	Agenda Ref.	AC/24/06/37	
	Date of meeting	20 June 2024	
	Summary of Outcome	The Audit Committee approved the Fit and Proper Persons Test Annual Report for submission to the Regional Director of NHS England.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Fit and Proper Persons Test Annual Report	AGENDA REF	BM/24/08/75

1. BACKGROUND/CONTEXT

The 'fit and proper persons' test set out in Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities)* Regulations 2014 (referred to as the 2014 Regulations) came into force on 27th November 2014 and aimed at making sure those individuals who have authority in organisations that deliver care, are responsible for the overall quality and safety of that care, and can be held accountable if standards of care do not meet legal requirements.

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations in the Kark Review, NHS England developed the Fit and Proper Person Framework for board members to strengthen/reinforce individual accountability and transparency for board members.

The framework has introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC. This FPPT Framework came into effect from 30 September 2023.

The WHH Fit and Proper Person Policy was reviewed and updated in line with the Fit and Proper Person Framework for board members, and approved by the policy review group in November 2023.

The FPPT is conducted on an individual board member basis, and in the annual submission to the NHS England regional director, the chair will provide the overall summary of the FPPT outcomes for the board.

FPPT data fields have been developed in ESR which enables the FPPT assessment elements to be recorded, along with some high-level detail where appropriate.

The purpose of this paper is to provide assurance to the Trust Board that all directors and their deputies remain fit and proper for their roles and that the required evidence along with the Annual NHS FPPT report is on track to be approved by the Trust Chair and submitted to the Regional Director NHS England, by the 30 June 2024 deadline.

2. KEY ELEMENTS

The annual FPPT for WHH Board members and their deputies has been undertaken in line with, the:

- Care Quality Commission (CQC) Fit and Proper Person Requirements (FPPR)
- NHS England Fit and Proper Person Framework
- WHH Fit and Proper Person Policy

Scope

The Fit and Proper Person Framework applies to the board members of NHS organisations. Within the framework the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments
- those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 201

The WHH Fit and Proper Person Policy specifies the scope as, all board appointments i.e., Executive and Non-Executive Directors. It also applies to those in a Deputy Director role, permanent, interim, and Associate NED positions, irrespective of their voting rights and in addition; the Company Secretary/Associate Director of Corporate Governance and the Freedom to Speak Up Guardian.

Pre-Employment Checks

To confirm that an individual is of good character, the Trust undertakes pre-employment checks as determined by the NHS employment standards[1]. These include:

- Employment history:*
- Board Member Reference A standardised board member reference process will be followed (as detailed in the NHSE Fit and proper Person Framework and using the Board member Reference Template
- qualification and professional registration checks (the original for inspection and verification)
- right to work check
- proof of identity
- an appropriate DBS check (on a case-by-case basis and if they have a role that falls within the DBS eligibility criteria). Including date DBS received.
- search of insolvency and bankruptcy register
- disqualified directors check
- Disqualification from being a charity trustee check.
- Social Media check
- Medical Clearance Dated (including confirmation of OHA)
- Employment tribunal judgement check
- Disciplinary findings – That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement relevant to FPPT, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.

[1] NHS Employers Employment Check Standards, the Rehabilitation of Offenders Act (1974), guidance issued from the Disclosure and Barring Service (DBS), statutory guidance for Regulated Activity and Home Office

- Self-attestation form signed
- Sign-off by chair/CEO.
- NHS FPPT letter of confirmation submitted to the Regional Director NHS England (Appendix Five)

* Fields marked with an asterisk (*) – do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

Annual Review of Existing Directors

In line with the Fit and Proper Person Framework, the Trust is required to regularly review the fitness of directors to ensure that they remain fit for the roles they are in. The following processes take place annually:

- An audit of the retained evidence of documentation required as listed above
- Verification of the documentation completed for the director appraisals.
- A completed Declaration of Interest form (via Civica Declare[2])
- Self-attestation form signed to be completed as part of annual appraisal
- Sign-off by chair/CEO.
- An Annual NHS FPPT report will be submitted to the Regional Director NHS England

Each director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Trust Chair or the Company Secretary.

The above checks are overseen by the Chief People Officer & Company Secretary/ Associate Director of Corporate Governance, evidence of the checks is documented on each of the individual's personal files and saved on ESR.

Reporting

The fit and proper person's requirements (FPPR) place the ultimate responsibility on the Chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria.

The Trust was required to submit an Annual NHS FPPT report to the Regional Director NHS England, by the 30 June 2024. This report was be signed by the Chair confirming all Board members satisfy the fit and proper person test requirements and that evidence has been retained on ESR. This was submitted follow approval by the Audit Committee on 20 June 2024.

3. CONCLUSION

The pre-employment checks and annual checks have been completed for each of the Trust Board members and those within the scope of the Fit and Proper persons policy, these checks have been overseen by the Chief People Officer & Company Secretary/Associate

[2] Civica Declare is the Trusts fully integrated end-to-end cloud governance software, enabling declarations of interest to be captured and published, Declarations are publicly available on the Trusts Website.

Director of Corporate Governance. Evidence of the checks has been documented on each of the individual's personal files and saved on ESR.

The Trust can confirm that all required checks were completed and an Annual NHS FPPT report to the Regional Director NHS England, by the 30 June 2024.

4. RECOMMENDATIONS

The Trust Board is asked to note:

i. the Fit and Proper Persons Test has been conducted in line with the NHS England Fit and Proper Person Framework
ii. the Trust has submitted the Annual NHS FPPT report to the Regional Director NHS England, by the required deadline of 30 June 2024 following approval by the Audit Committee on 20 June 2024.
iii. the WHH Fit and Proper Person Policy has been revised to include all requirements as set out in the NHS England Fit and Proper Person Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

	FSC/24/07/82			
SUBJECT:	**Committee Chairs Annual Report 2024/25**			
DATE OF MEETING:	27 July 2024			
ACTION REQUIRED:	**Approval**			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	John Somers, Non-Executive Director, Committee Chair			
LINK TO STRATEGIC OBJECTIVE	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.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Finance and Sustainability Committee that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: (please select as appropriate)	**Approval** √	**To note**	**Decision**	
RECOMMENDATION:	The Finance and Sustainability Committee is asked to support the report for formal approval at Trust Board on 7 August 2024.			
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***			

FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Committee Chairs Annual Report 2024/25	AGENDA REF	FSC/24/07/82

1. BACKGROUND/CONTEXT

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Finance and Sustainability Committee (FSC) Annual Report which covers the reporting period 1 April 2023 to 31 March 2024.

The Committee is responsible on behalf of the Board for reviewing financial and operational planning, digital, performance and strategic and business development.

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 primarily been composed of two Non-Executive Directors with a quorum of two (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence.

The Finance and Sustainability Committee attendance record is attached in Appendix 1.

Regular attendees at the Committee meetings are the Chief Finance Officer, Executive Medical Director, Chief Nurse, Chief People Officer, Chief Operating Officer & Deputy Chief Executive, Director of Strategy & Partnerships, Deputy Chief Finance Officer, Chief Information Officer and the Company Secretary & Associate Director of Corporate Governance. Furthermore, a Trust Governor observes each meeting and provides feedback to the Council of Governors on how the meeting was chaired, the extent of challenge and degree of assurance received.

2. COMMITTEE TERMS OF REFERENCE

The Committee's Terms of Reference were reviewed and approved by the Trust Board in April 2023 for the financial year 2023/24, to ensure they continue to remain fit for purpose with amendments approved to;

Section 4 – Duties & Responsibilities

- Updated reference to new Provider License
- Re-instated review of performance following dis-establishment of Clinical Recovery Oversight Committee
- Addition of oversight of annual operational plan
- Removal of duplicate responsibility
- Updated Committee Capital Spend limit
- Remove reference to MTFM and LTFM

Section 6 – Core Attendees

- Addition of Associate Director of Estates & Facilities Management

Section — Reporting Groups

- Update of Report Group titles

The Committee met face to face 12 times during the year, and a summary of the activity covered at these meetings are included in this report.

Deep Dives & Hot Topics

At each meeting, the Committee received either a 'Hot Topic' and/ or 'Deep Dive', dependent on issues raised. Hot Topics provided high level information that shared detailed information about a current topic that needed focussed attention and discussion by the Committee and relating to areas of national, local, partner or internal focus; new services, accreditation of services or items escalated from a sub-committees or other meetings. Deep Dives provided an in-depth review of a topic that had been escalated from sub-committees or other meeting, areas noted from other reports and wider triangulation, areas flagged by the CQC or items requested by the Trust Board.

Hot topics received included; activity, discharge co-ordinators, no criteria to reside, risk benefit of LLP, financial forecast, operational plan, budgets and digital key projects.

Examples of Deep Dives that have been presented as part of the assurance process include agency staffing reduction, planned care surgical specialties activity, DNAs, areas of underperformance planned/unplanned care, CIP delivery in unplanned care and elective recovery, CIP/GIRFT and review of elective recovery spend.

3. REPORTING

In terms of reporting to the Finance and Sustainability Committee, the following key reports were submitted in 2023/24.

Pay Assurance

The Pay Assurance reports set out an overview of the workforce FTE position across the Trust on a monthly basis throughout 2023/24 and provided information to the Finance and Sustainability Committee information on compliance with the processes in place to control pay spend, including;

- Establishment Control Process
- Estimated cost of absence
- Medical Bank Rate Card compliance
- Agency Rate Card compliance
- Temporary staffing booking lead times

It was reported that there were a number of drivers for the usage of temporary staff, however, overall, the percentage of temporary staff used had reduced.

Work had taken place with the Medical Resourcing Group to agree three top priorities per Care Group in order improve current effectiveness for workforce redeployment, and a dashboard developed to track progress of the priorities against a number of KPIs.

In relation to the Establishment Control Process, new control arrangements were put in place and all control requests required approval by Finance, Senior Manager and Human Resources.

The information provided within the report is reviewed within the Nursing/AHP and Medical Resourcing Groups.

Risk Monitoring & Assurance

The committee oversees and considers any relevant risks within the Board Assurance Framework (BAF) and Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Committee Assurance Report.

The BAF and corporate risks relevant to the Committee's remit were presented on a monthly basis with actions, mitigations and scoring discussed and amended as appropriate. During the year the committee assigned individual risk appetites to each of its strategic risks in line with the overall Trust Risk Appetite Statement. All recommended changes are presented to and approved by the Trust Board.

Throughout the year 2023/24, the Finance and Sustainability Committee monitored four risks on the Board Assurance Framework. At year end (31st March 2024), the following ratings and appetites were held by each of the five strategic risks monitored by the committee:

Risk Description	Current Rating	Risk Appetite
Risk 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	20 (L5xC4)	Open
Risk 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..	16 (L4xC4)	Minimal
Risk 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	16 (L4xC4)	Cautious
Risk 1898: 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.	16 (L4xC4)	Seek

Finance

Key financial headlines at 31 March 2024

The Trust recorded an adjusted deficit of £30m which was £14.3m away from the original £15.7m deficit plan (revised to £21.2m excluding industrial action). This adjusted deficit is the value which NHSE monitors the Trust against and was not achieved.

The annual capital programme was £31.2m and the actual spend for the year was £31.5m (including IFRS16), delivering an overspend of £0.3m.

The cash balance at the end of the year was £17.6m of which £11.1m related to capital creditors and which included £7.4m cash support. The cash balance will be utilised to manage the position in April and pay the capital creditors.

There were no failures in financial governance during the year.

The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report.

Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on a regular basis.

Capital has been monitored through the year via the Capital Planning Group and Finance and Sustainability Committee, with a particular focus on schemes over £0.5m. Over the past 12 months the Trust has continued to have regular meetings with the ICS where the financial position, forecast and capital have been discussed, reviewed and challenged.

Scheduled Agenda Items

- Corporate Performance Report
- Monthly CIP/GIRFT update
- Cost Pressures
- Pay Assurance Report
- Capital Position incl schemes over £500k
- Digital Strategy Group update

Additional reports received throughout 2023/24

- Industrial Action and PBR income relating to deficit position
- ED Staffing challenges
- ED Performance
- Non recurrent CIP
- CIP/GIRFT impact of industrial action
- Activity Performance in planned care and elective recovery
- Recovery Plan

Revenue Requests/Approvals

A number of revenue request approvals were sought during 2023/24 and these included;

- Maternity Phase I & II
- EPCMS
- ED Nursing
- Endoscopy
- Elective Recovery
- EDCMS
- Radiology WLI
- Local Clinical Excellence Awards
- Elective Restoration 2024/25

Digital

- Digital Strategy
- EPCMS
- £675k central funding allocation for Patient Engagement Platform (PEP)
- Cyber security incident
- New Digital policies produced
- EBCMS – Short Business Case timetable and £250k revenue funding in 2023/24
- EPCMS OBC was approved by NHE EPRIB on 13th October significant milestone achievement
- PEP – Procurement delays revised dates preferred supplier December 2023
- Cyber Security Funding for PACS
- Laboratory Information Management System (LIMS) the digital system that supports all pathology disciplines. Cheshire and Merseyside pathology network are undertaking procurement of a system-wide solution for this, working to tight timescales to deliver a revised 2023/24 capital allocation by the end of the financial year.
- Hot Topic – Digital Strategy and a major digital programmes update to become a 'Digital Trust'

Issues Carried Forward/Escalated

- Capital position
- Deficit position 2024/25
- CIP/GIRFT performance

4. SUMMARY

The Committee continues to encourage frank, open discussions between regular attendees to the meetings, and I would like to thank all attendees and members of the Committee for their responses, support and contributions during the year.

John Somers
Chair – Finance and Sustainability Committee, July 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/07/85**			
SUBJECT:	**Annual Chair's Report to the Committee**			
DATE OF MEETING:	9 July 2024			
ACTION REQUIRED:	To note			
AUTHOR(S):	Emily Kelso, Corporate Governance and Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Cliff Richards, Non-Executive Director/QAC Chair			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance to the Quality Assurance Committee that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Quality Assurance Committee is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***			
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Annual Chair's Report to the Committee	AGENDA RE	QAC/24/07/85

1. BACKGROUND/CONTEXT

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Quality Assurance Committee Annual Report which covers the reporting period 1 April 2023 - 31 March 2024.

The Quality Assurance Committee is accountable to the Board of Directors for providing oversight and assurance on all aspects of quality, including strategy, quality improvement, delivery, clinical risk management and clinical governance, clinical audit and the regulatory standards relevant to quality and safety. This includes assurance around relevant Health and Safety matters.

The Committee is accountable to the Board for ensuring that the Trust's Strategic Objective 2***: "We will ... Always put our patients first delivering safe and effective care and an excellent patient experience"*** is delivered.

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

2. KEY ELEMENTS

Terms of Reference

The Committee's Terms of Reference were reviewed during Quarter 4 of 2023/24, along with the Cycle of Business. This included a review of the membership, quoracy and duties and responsibilities of the Committee.

The approved terms of reference are attached as **Appendix 1** and the revised 2024-25 cycle of Business as **Appendix 2.**

Frequency of Meetings and Summary of Activity

Meetings continued to take place monthly throughout 2023/24 and subsequently the Committee met 12 times during the year. The Quality Committee attendance record is attached in **Appendix 3**.

Summary of Committee Activity throughout 2023/24

Engagement Stories

Given the time restraints of Committee meetings and the ever-increasing oversight required, agendas have become increasingly busy, as a result Engagement Stories have been presented less frequently than in previous years in the knowledge that the Trust Board also received engagement stories at each of its meetings. Whenever

possible, the Committee commenced meetings with an engagement story. Examples of such stories from 2023-24 include:

- Patient Safety Incident Response Framework “A Patients Perspective”
- Healthy and Home
- The Importance of Shared Care
- Recognising my Support Needs

Deep Dives & Hot Topics

At each meeting, the Committee received a ‘Hot Topic’ and ‘Deep Dive’ presentation. Hot Topics provided high level information that shared a story or a journey. Each relating to areas of national, local, partner or internal focus; new services, accreditation of services or items escalated from a sub-committees or other meetings. Deep Dives provided an in-depth review of a topic that had been escalated from sub-committees or other meeting, areas noted from other reports and wider triangulation, areas flagged by the CQC or items requested by the Trust Board.

Hot topics received included; age related macular degeneration - ophthalmology, intensive care unit length of stay, gastrointestinal bleed & 7 day working in gastroenterology, fragile services, mental health, emergency department improvement, cancer nurse specialist, the impact of industrial action – patient safety & quality, tracheostomies displaced – intensive therapy unit, emergency department incident profile & long waits, nutritional update.

Examples of Deep Dives that have been presented as part of the assurance process include: third- & fourth-degree tears, postpartum haemorrhage, ophthalmic never event, fractured neck of femur, urology, gynaecological surgery, medicines reconciliation, ear, nose and throat fragile services, never events thematic review and surveillance programmes backlogs position update.

Risk Monitoring and Assurance

The committee oversees the Trust’s Quality Strategic Risks on behalf of the Board and liaises with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework drives the internal audit plan on quality and safety issues and to provide the Audit Committee assurance regarding systems of internal control.

The Board Assurance (BAF) and corporate risks related to quality are presented to the committee on a bi-monthly basis with actions, mitigations and scoring discussed and amended as appropriate. During the year the committee assigned individual risk appetites to each of Its strategic risks in line with the overall Trust Risk Appetite Statement. All recommended changes are presented to and approved by the Trust Board.

Throughout the year 2023/24, the Quality Committee monitored five risks on the Board Assurance Framework. At year end (31st March 2024), the following ratings and appetites were held by each of the five strategic risks monitored by the committee:

Risk Description	Current Rating	Target Rating	Risk Appetite
Risk 224: If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; 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 have patients waiting more than 12 hours in the department from time of arrival	20 (L5xC4)	8 (L2xC4)	Cautious
Risk 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 and failure to achieve constitutional standards and financial plans.	20 (L4xC5)	6 (L3xC2)	Cautious
Risk 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	20 (L5xC4)	8 (L4xC2)	Cautious
Risk 2001: 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 (L5xC4)	6 (L2 xC3)	Minimal
Risk 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.	16 (L4xC4)	12 (L4xC3)	Minimal

Risks were presented on a monthly basis at the following Committees:

- Risk Review Group
- Finance and Sustainability Committee
- Strategic People Committee
- Quality Assurance Committee

The Risk Review Group continued to meet to ensure that there was scrutiny of the Corporate Risk Register and departmental, speciality and Clinical Business Unit risk registers, with appropriate escalation processes in place.

Strategy Development

The committee received regular updates in relation to the Strategic Quality Priorities for the Trust. In addition, updates of enabling quality strategies were provided e.g. Mortality reports, Violence Reduction Strategy, Dementia Strategy, Nursing and Midwifery Strategy, Digital Strategy, Palliative Care End of Life Strategy, Patient Experience Strategy.

Quality Integrated Performance Report / Dashboard

The committee has overseen an ongoing review of quality Key Performance Indicators, which are monitored through the Integrated Performance Dashboard. A report of the Quality Dashboard was received bi-monthly to review performance and to determine

assurance of mitigating actions as appropriate, in advance of presentation at Trust Board meetings.

The Trusts Integrated Performance Report (IPR) is reviewed at least annually in line with the Trust's Performance Assurance Framework (PAF) to ensure all indicators remain relevant and up to date.

At its March meeting, the committee approved several amendments to Quality Indicators on the Trust's IPR. No new indicators were added.

Investigations and Learning from Experience

The Committee receives a regular update to assure itself that investigations from patient safety incidents are being undertaken as per statutory and regulatory requirements. This also includes monitoring Duty of Candour.

The Committee receives a quarterly Learning from Experience Report which contains both quantitative and qualitative data analysis using information obtained from the Datix Risk Management System and other governance functions to triangulate the data and learning from incidents, complaints, claims, health and safety, clinical audit, compliance, quality improvement and research and development. The report provides summary of themes, trends and key findings that have influenced learning and actions to support and sustain improvement.

Reports following Incidents/Concerns

During the year the Committee received regular update reports on two issues/incidents. Regular reporting provided the Committee with updates on the progress against actions agreed and assurance that incidents were being managed effectively. These were:

- Paediatric Audiology Incident and Service Review
- Arbury Court

Scheduled Quality Assurance Agenda Items

The committee receives a number of regular reports to provide assurance on quality and safety matters, reports are presented by members of the Trust Executive Team, supported by subject matter experts, include:

- Quality Priorities – quarterly, providing progress against each of the annual priorities selected as part of the Quality Account.
- Infection prevention and control – quarterly reports
- Quality Improvement – biannual progress report
- Learning from Deaths – quarterly report

The Committee also received an exception report at each meeting from the Patient Safety & Clinical Effectiveness Sub-Committee. From July 2023, the report included updates on the services classed as 'fragile' to demonstrate clarity and focus. 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 particular reference to patient safety and risk of harm’.

Regulatory and Statutory monitoring

The committee continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year. This included monitoring of the post Care Quality Commission Inspection Action plan (also via the Moving to Outstanding now the Compliance Update agenda item) national audit activity, NICE guidance, national surveys, quality KPIs and complaints improvement.

The Quality Assurance Committee received, supported and approved a number of annual reports including, Patient Experience, Health & Safety, Medicines Management & Controlled Drugs, Safeguarding, Risk Management, Complaints, Infection Prevention & Control, Clinical Audit, Quality Strategy and Dementia Strategy.

Maternity Oversight

Following increased scrutiny and the requirement for oversight at Board level on key national maternity safety and quality issues and in line with the requirements of the Maternity Incentive Scheme - Safety Action 9*. The Director of Midwifery presents a number of reports concerning Quality & Safety within the Maternity and Neonatal services as scheduled in the Cycle of Business, these are:
Ockenden update

- Cheshire & Merseyside Perinatal Mortality Report (PMRT)
- Avoiding Term Admission into Neonatal Unit (ATAIN)
- Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)
- Maternity Self-Assessment Tool
- Maternity Strategy
- Maternity & Neonatal Quality Review Report (including Inpatient Maternity Survey)

Reports are also presented to the Trust board bi-monthly.

An item that will be carried forward into the 2024/25 Cycle of Business is the Post Partum Haemorrhage Audit.

**Maternity Incentive Scheme (MIS) - 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*

Issues Carried Forward

There are a number of issues which the Committee will carry forward into 2023-24.

- Fuller Mortuary Enquiry
- Medication Errors
- Theatre Safety Culture
- Stroke Services

- Sepsis
- Implementation of the Quality Priorities for the year.
- Monitoring of the requirements of the Ockenden Review
- PPH Audit

Summary

As the Chair of the Quality Assurance Committee I encourage honest and open discussion, so that areas of success can be celebrated, and areas of improvement escalated and actioned. To ensure that the patient voice is heard the meeting regularly commences with a patient/staff story. This has been a challenging year, and the Committee has had to adapt and adopt a flexible approach in order to maintain the necessary level of oversight needed during the continuing pandemic. Committee members have responded to this challenge and provided the assurance required as well as managing the demands resulting from the pandemic.
I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Dr Cliff Richards, Chair of Quality Assurance Committee

3. RECOMMENDATIONS

The Quality Assurance Committee is asked to note the report for onward reporting to the Trust Board.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/07/77**			
SUBJECT:	**Director of Infection Prevention and Control Annual Report**			
DATE OF MEETING:	9 July 2024			
ACTION REQUIRED:	To note and approve			
Author	Lesley McKay, Associate Chief Nurse for Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah Chief Nurse/Director of Infection Prevention + Control			
LINK TO STRATEGIC OBJECTIVE:	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.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2023 to March 2024 financial year. The Covid-19 pandemic continued to place demands on the Infection Prevention and Control Team (IPCT) and had an impact of achieving the annual work plan as activity was redirected in response to the pandemic and other emergent issues including measles. There were: - • 13 Covid-19 outbreaks • 166 Hospital onset/probable healthcare associated cases • 198 Hospital onset/definite healthcare associated cases			

	Total HCAI case numbers for 2023/24 are comparable with similar sized Trusts when benchmarked using UK Health Security Agency data. Totals for HCAIs were: - • 55 Clostridium difficile cases – 19 cases over threshold • 0 MRSA bacteraemia cases • 36 MSSA bacteraemia cases – no threshold • 81 E. coli bacteraemia cases – 27 cases over threshold • 28 Klebsiella bacteraemia cases – 10 cases over threshold • 11 P. aeruginosa bacteraemia cases – 9 cases over threshold HCAI prevention plans are in place to prevent healthcare associated infections. Gratitude is extended to all members of the IPCT for their hard work over the year. Collaboration and successful engagement with colleagues across the Trust have contributed to the successes detailed within this report. This report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.		
PURPOSE: (please select √ as appropriate)	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Quality Assurance Committee is asked to receive and note the report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Infection Control Sub-Committee	
	Agenda Ref.	ICSC/24/06/65	
	Date of meeting	20 June 2024	
	Summary of Outcome	Submit to Quality Assurance Committee	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control DIPC Annual Report	AGENDA REF	QAC/24/07/77

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1. BACKGROUND/CONTEXT

Executive Summary

Organisation

Warrington and Halton Teaching Hospitals NHS Foundation Trust, sits within the mid-Mersey region in the northwest of England, providing healthcare services to Warrington, Runcorn, Widnes, and surrounding areas. The Trust has 3 hospitals across two sites and circa 520 beds, with over 4,400 substantive staff.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. Good infection prevention and control practices are a fundamental part of this mission and vision.

Infection Prevention & Control Strategy and Annual Work Plan

The Infection Prevention and Control Strategy was launched in June 2022 with three objectives: -

- Prevention of healthcare associated infections
- Strengthening antimicrobial stewardship
- Commitment to cleanliness

The strategy was updated in 2023/24 to include a 4th objective: -

- Sustainability

The Infection Prevention and Control Team (IPCT) worked towards delivery of the annual work plan. The Covid-19 pandemic and national measles incident had an impact on completion of all elements as efforts were appropriately re-directed.

A robust annual work plan (Appendix 1) which is linked to the Infection Prevention and Control Strategy, has been devised for the 2024/25 financial year. The work plan includes attendance at other committee meetings to ensure integration of infection prevention and control across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice/policies; policy/guideline reviews and a programme of education and awareness raising events. An additional workstream has been created called Brilliant Basics in Infection Prevention and Control with a project implementation plan spanning the financial year. Quality Academy support will be provided to support the plan.

Covid-19 Pandemic

The Covid-19 pandemic continued to present challenges. Timely and integrated working took place between the infection prevention and control and operational teams to ensure safe patient placement to reduce the risk of Covid-19 transmission within the Trust. The Trust complied with recommendations for reporting outbreaks

of hospital onset cases, as detailed below, until guidance was provided to step down reporting: -

- 13 Covid-19 outbreaks
- 166 Hospital onset/probable healthcare associated cases
- 198 Hospital onset/definite healthcare associated cases

Code of Practice on Prevention of Healthcare Associated Infections

The Code of Practice on Prevention of Healthcare Associated Infections, which is linked to Regulation 12 of the Health and Social Care Act (2008), was updated in December 2022. The Trust is working towards full compliance with the 10 criterions. Revised assessment against the updated Code of Practice shows : -

- 7 are fully compliant
- 3 have minor non-compliances

These minor non-compliances relate to old estate i.e., lower number of side room facilities, and in a small number of areas, lower ratio of hand washing sinks to patient number than current guidance.

The annual Patient Led Assessment of the Care Environment (PLACE) occurred in November 2023 and achieved cleanliness scores above 99% for both sites.

Healthcare Associated Infections

NHS standard contracts include a quality requirement to minimise rates of C. difficile and Gram-negative bloodstream infections (GNBSI) to thresholds set by NHS England (NHSE). The approach to learning from HCAI events has been revised to align with the Patient Safety Incident Response Framework. Trust apportioned healthcare associated infection (HCAI) figures include hospital onset/healthcare associated (HOHA) and community onset/healthcare associated (COHA) cases. The Trust apportioned cases are detailed below: -

Table 1 HCAI Data and Trust Thresholds

Organism	Trust Apportioned (HOHA/COHA)	Total	Trust threshold
C. difficile	45 HOHA: 10 COHA	55	36
E. Coli bacteraemia	42 HOHA: 39 COHA	81	54
Klebsiella Spp. bacteraemia	12 HOHA: 16 COHA	28	18
MRSA bacteraemia	0 cases	0	Zero avoidable
MSSA bacteraemia	26 HOHA: 10 COHA	36	No threshold
P. aeruginosa bacteraemia	6 HOHA: 5 COHA	11	2

Actions in place to prevent C. difficile include; hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship. An in-depth action plan called Brilliant Basics in IPC and project plan will be launched in 2024 to drive improvements in infection control.

This report outlines the arrangements, activities, and achievements during the 2023/24 financial year. The report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.

Alison Kennah
Chief Nurse/Director of Infection Prevention and Control (DIPC)
June 2024

Acknowledgements

Lesley McKay	Associate Chief Nurse Infection Prevention and Control/Associate DIPC
Dr Zaman Qazzafi	Consultant Medical Microbiologist/ Infection Control Doctor/Deputy DIPC
Jacquline Ward	Lead Pharmacist in Antimicrobial Stewardship
Kate Rainbird	Interim Lead Pharmacist in Antimicrobial Stewardship
Faye Smale	Interim Lead Pharmacist in Antimicrobial Stewardship
Julie McGreal	Head of Facilities
Claudine Reynolds	Lead Nurse Medical Care CBU

2. KEY ELEMENTS

Description of Infection Control Arrangements

Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) is scheduled to meet fortnightly. Meeting frequency was affected as efforts were redirected to respond to the continued Covid-19 pandemic, increase in seasonal respiratory viruses and the national measles incident. The national increase in measles cases has been linked to low uptake of the measles, mumps, and rubella (MMR) vaccination. The IPC Team implemented actions for timely triage, isolation and testing of suspected cases, and worked with the Occupational Health and Wellbeing Department to review staff vaccination status and took action to promote vaccination.

The Infection Prevention and Control Team membership includes: -

- Consultant Medical Microbiologists: -
  - Dr Zaman Qazzafi (Deputy DIPC and Infection Control Doctor)
  - Dr Toong Chin
  - Dr Janet Purcell (0.6 WTE) – extended leave

- Associate Chief Nurse for Infection Prevention and Control: -
  - Lesley McKay (Associate DIPC)

- Infection Prevention and Control Matron
  - Carol Baskett (from June 2023)

- Infection Prevention and Control Nurses Band 7: -
  - Aalifha Mariadhas Margret
  - Louise Bale
  - Jessical Ford

- Infection Prevention and Control Nurses Band 6: -
  - Shaiby Coot (from June 2023)

- Lead Pharmacist in Antimicrobial Stewardship
  - Jacquline Ward (extended leave)
  - Kate Rainbird (interim until February 2024)
  - Faye Smale (interim from January 2024)

- Infection Control Administrator: -
  - Amanda Mayor-Hughes

- Operational Estates Manager

- Kieran Beech

Infection Control Sub-Committee

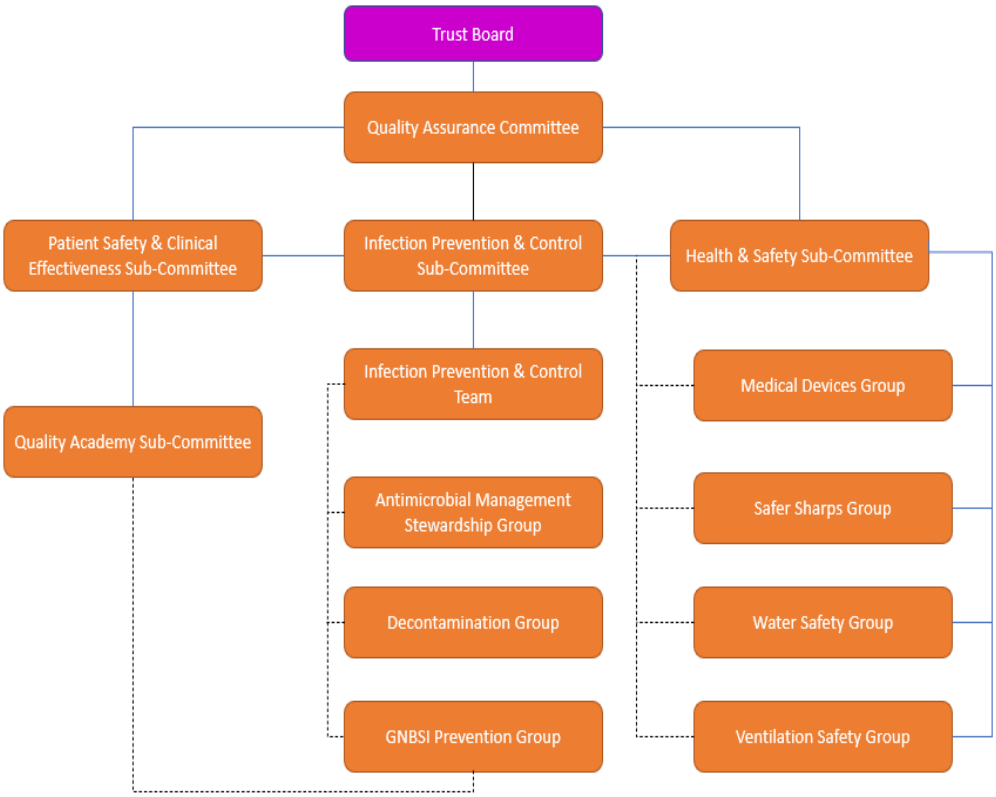
The Consultant Medical Microbiologist/Infection Control Doctor/Deputy DIPC chairs the Infection Control Sub-Committee, which met eleven times during the year.

Membership comprises of the Chief Nurse/DIPC, Operational IPCT, Lead Nurses or Matron from each Clinical Business Unit (CBU), Estates and Facilities Managers, Lead Allied Health Professional and an Occupational Health and Wellbeing representative.

The Lead Nurses for each CBU and the Lead for Allied Health Professionals and Estates and Facilities representatives, submit reports at each meeting as a standing agenda item. This allows the Infection Control Sub-Committee to give assurance to the Quality Assurance Committee and Trust Board of Directors on infection prevention and control activity within the Trust, compliance with the Health and Social Care Act 2008: code of practice on the prevention of healthcare associated infections, being maintained and that there is a programme of continuous improvement.

High level briefing papers are submitted by the Infection Control Sub-Committee Chair to the Health and Safety Sub-Committee and the Patient Safety and Clinical Effectiveness Sub-Committee. The reporting line to Trust Board is detailed in figure 1.

Figure 1 Reporting Line to Trust Board



There are links to the Medicines Governance Group via: -

- Consultant Medical Microbiologists
- Lead Pharmacist in Antimicrobial Stewardship
- Antimicrobial Management Stewardship Group

DIPC Reports to Trust Board

Reports and high-level briefing papers, which included compliance assessments against the Infection Prevention and Control Board Assurance Framework, key performance indicators, HCAI surveillance data and outbreak/incident details were submitted to the Quality and Assurance Committee with onward reporting to Trust Board as detailed below.

- IPC Board Assurance Framework Compliance Report/Action Plan – July 2023
- IPC Board Assurance Framework Compliance Report/Action Plan – January 2024

- IPC Healthcare Associated Infection Report Q1 – August 2023
- IPC Healthcare Associated Infection Report Q2 – November 2023
- IPC Healthcare Associated Infection Report Q3 – February 2024
- IPC Healthcare Associated Infection Report Q4 – May 2024

- DIPC Annual Report – July 2023

Annual work plan

The IPCT work plan was developed to give assurance that each element of the Code of Practice for Prevention of Healthcare Associated Infections, which underpins the Health and Social Care Act (2008) linked to Regulation 12, is adhered to and that appropriate evidence of compliance is available.

This work plan is underpinned by action plans for key performance indicators/prevention of mandatory reportable healthcare associated infections and a programme of audit that provides evidence of policy/guideline compliance. Progress against planned activity was impacted by Covid-19 cases, updating Trust guidance in line with frequently updated Covid-19 guidance, staff turnover and emergent IPC issues. The annual work plan has been revised for 2024/25 and is included at Appendix 1.

Covid-19

Activity to respond to the Covid-19 pandemic continued. A Covid-19 cohort ward was maintained until the volume of patients requiring admission subsided and reverted to use of single side rooms on the Covid-19 Cohort Ward and additional wards when this capacity was exceeded. Admissions with Covid-19 peaked in October and January and hospital onset cases rose in line with these increases. Trust Covid-19 guidance documents were updated in line with national guidance.

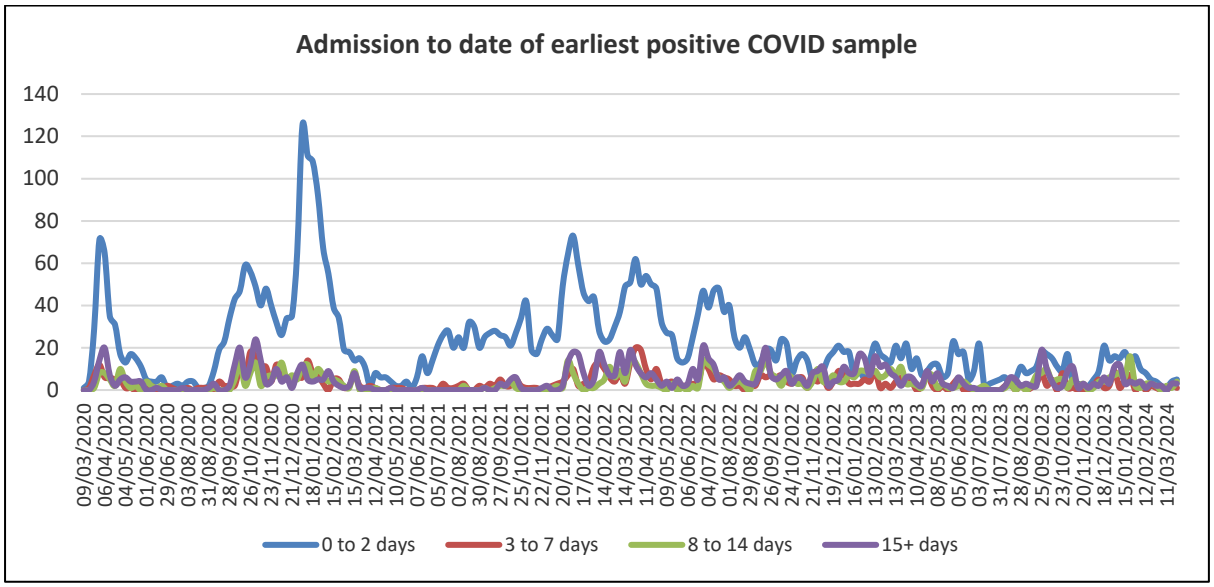
Covid-19 Nosocomial cases

The Trust reported hospital onset Covid-19 cases as per NHSE definitions of:

- Hospital onset/probable healthcare associated cases (days 8-14) = 166
- Hospital onset/definite healthcare associated cases (>15 days) = 198

Figure 2 shows inpatient cases according to NHSE definitions since the start of the pandemic.

Figure 2 Covid-19 Cases by NHSE definitions



The following Covid-19 related documents were developed and revised/updated throughout the year as per new/updated national guidance being published: -

- SOP for Non-Elective Patient Testing for Respiratory Viruses, Patient Placement & Infection Control Precautions
- Covid Self-Isolation and Routine Testing (Staff) SOP x2
- Non-elective patient testing for respiratory virus, patient placement & infection control precautions (Adults/Children) v21.
- SOP for Covid self-isolation and routine testing v13
- Revised SOP for Non-Elective Patient Testing for (Winter) Respiratory Viruses, Patient Placement & Infection Control Precautions (Adults/ Children)
- Face filtering piece FFP3 fit testing policy
- SOP for staff Covid-19 testing v14

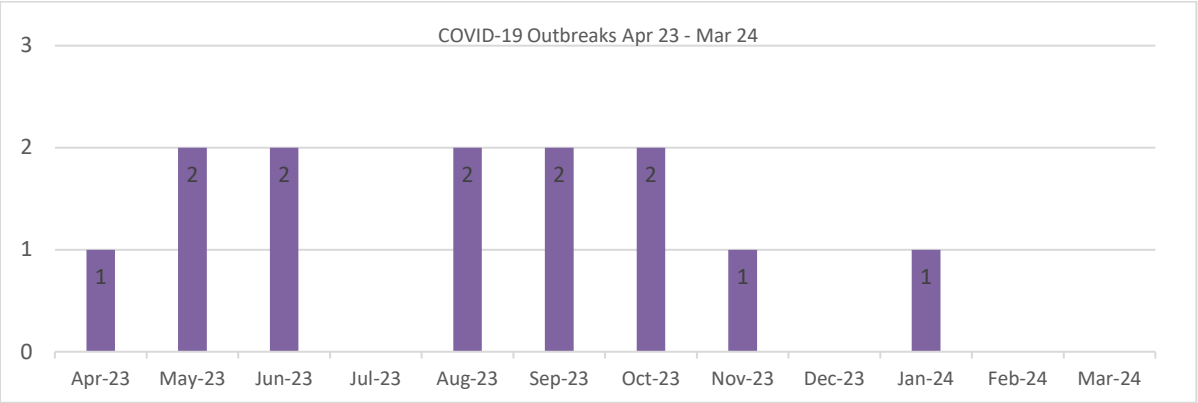
The programme of Fit Testing of Face Filtering Piece (FFP) 3 respirators, carried out by appropriately trained staff, continued throughout the year.

Covid-19 Outbreaks

The IPCNs conducted surveillance to detect Covid-19 clusters. Where outbreaks were declared, Outbreak Control Groups were established. A total of 14 Covid-19 outbreaks were reported to external partners including: - NHSE, UK Health Security Agency, Integrated Care Board Sub-Groups for Warrington and Halton, and the Care Quality Commission (CQC).

Figure 3 shows the Covid-19 outbreaks reported by month.

Figure 3 Covid-19 Outbreaks reported by month



Challenges to managing Covid-19 cases included: -

- Old estate – limited side rooms
- Patients' movements
- Poorly ventilated bays/wards
- Bed pacing <2 metres
- Return to open visiting

Action taken included: -

- Testing in line with national guidance
- Communication on updated Covid-19 guidance
- Streaming of patients to Covid/non-Covid wards

Covid-19 Recovery

The IPCNs continued to provide an out of hours on call service to ensure timely placement of patients with Covid-19.

Health and Social Care Act (2008) compliance assessment

Compliance assessment against the 10 criteria, specified in the *Health and Social Care Act 2008: code of practice on the preventions and control of infections and related guidance* (updated in December 2022) are carried out biannually.

Revised assessment against the updated Code of Practice shows : -

- 7 are fully compliant

- 3 have minor non-compliances

The CQC uses this code to assess registered provider compliance with the cleanliness and infection control requirement set out in the regulations. Compliance with the revised code of practice and areas requiring further action are detailed in table 2.

Table 2 Compliance with the Code of Practice on prevention of HCAIs

Criterion	Assessment	Action required/in progress
1. Systems to manage and monitor the prevention and control of infection.	Partially compliant	Solution being sought to strengthen surveillance using existing digital systems
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Partially compliant	Upgrades to some hand washing sinks required (design and location). Audit of handwashing facilities scheduled with Estates Team Ventilation systems review to ensure all comply with HTM 03 01
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Compliant	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.	Compliant	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Compliant	
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Compliant	
7. Provide or secure adequate isolation facilities.	Partially compliant	Continuous liaison with the Patient Flow Team to optimise use of side rooms for appropriate patient isolation
8. Secure adequate access to laboratory support as appropriate.	Compliant	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant	
10. Providers have a system in place to manage the occupational health needs of staff in relation to infection.	Compliant	

IPC Board Assurance Framework

The Infection Prevention and Control (IPC), Board Assurance Framework (BAF), was published by NHS England with the intention to replace the Covid-19 Board Assurance Framework and for organisations to use, to ensure compliance with IPC standards and assess measures set out in the National IPC Manual.

Compliance assessments are carried out biannually and an action plan is in place to: -

- Align IPC event reviews with the Patient Safety Incident Response Framework
- Ensure completion of action plans in relation to IPC audits
- Ensure efficacy audits include all members of the multi-disciplinary team
- Implement the NHS Waste Strategy
- Robust recording of competency assessments
- Recovery plan for IPC policies

Healthcare Associated Infection Statistics

The Trust participates in mandatory reporting of Healthcare Associated Infections (HCAI). There are 3 HCAI prevention action plans, linked to mandatory reporting requirements which were reviewed 3 times per annum.

Review of HCAI events was taken in line with the Patient Safety Incident Response Framework (PSIRF) and supported review of an action plans to promote learning from cases.

C. difficile

The Trust reported 86 C. difficile toxin positive cases with 55 cases apportioned to the Trust: -

- Hospital onset/healthcare associated = 45
- Community onset/healthcare associated = 10

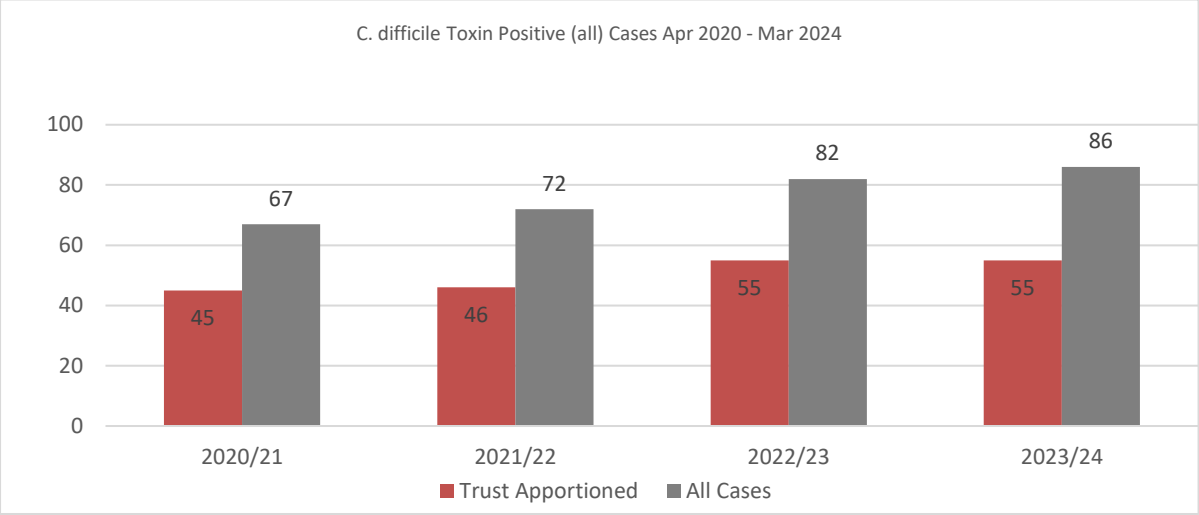
} 55 Trust apportioned

- Community onset indeterminate association = 6
- Community onset community associated = 25

The NHSE threshold for C. difficile was set at 36 cases or less (which includes both hospital onset/healthcare associated, and community onset/healthcare associated cases). The Trust was 19 cases over threshold with a total of 55 cases.

Cases reported were unchanged from the previous year. A comparison with previous year's data is displayed in figure 4.

Figure 4 C. difficile Toxin Positive Cases (all) April 2020 – March 2024



The IPCT focussed activity on C. difficile prevention by: -

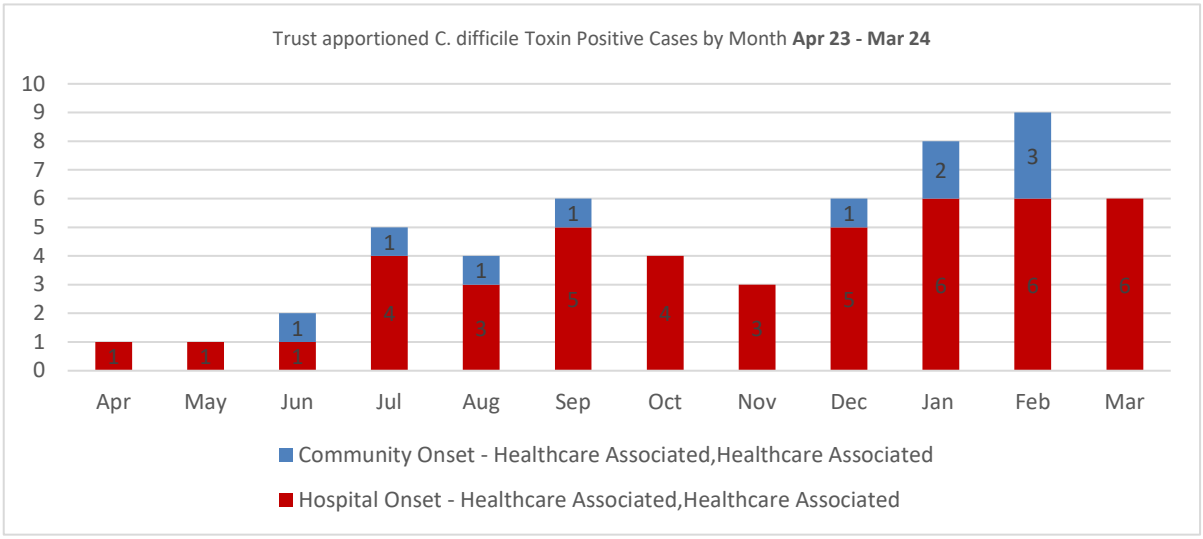
- Surveillance of cases/monitoring for periods of increased incidences
- Antimicrobial Management Stewardship Group
- Hand hygiene awareness raising events
- Promoting improvements to standards of environmental hygiene
- Use of hydrogen peroxide vapour for environmental decontamination
- Care Support Worker training to improve timely isolation and sampling

The Care Support Worker C. difficile training events, as shown in Figure 5, were well attended, and evaluated highly.

Figure 5 C. difficile Care Support Worker Training Events

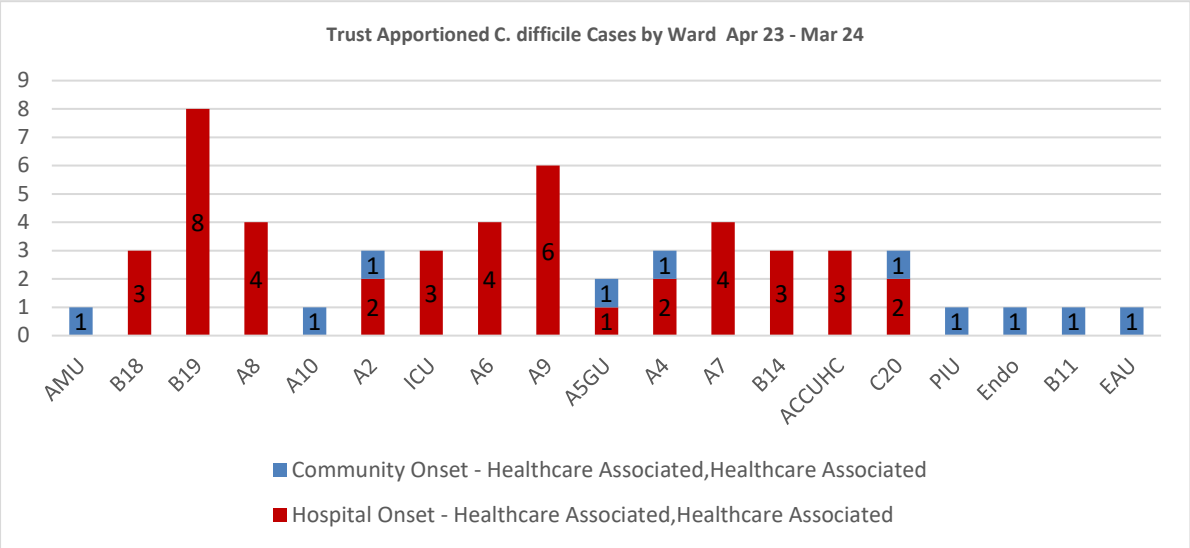
Figure 6 shows C. difficile toxin positive Trust apportioned (HOHA/COHA) cases by month.

Figure 6 Trust Apportioned HOHA/COHA C. difficile Toxin Positive Cases by Month



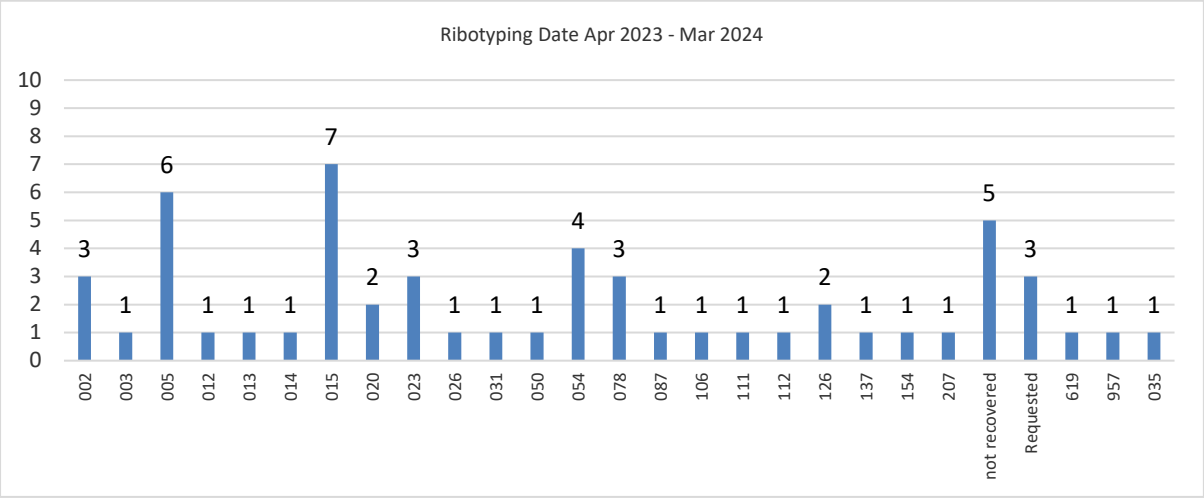
HOHA cases by location when the sample was taken and COHA cases by the discharging ward are displayed in figure 7. The location the specimens were obtained from is not necessarily where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

Figure 7 Trust Apportioned HOHA C. difficile Toxin Positive Cases by Location tested and COHA Cases by Ward/Department Discharged From



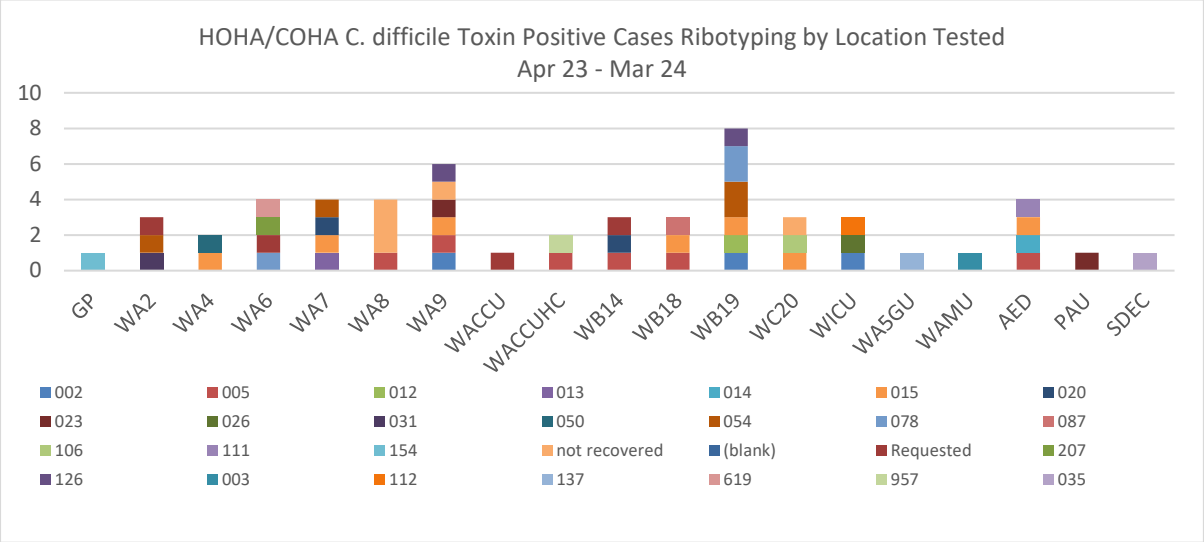
All Trust apportioned C. difficile toxin positive isolates are submitted for ribotyping. From the 55 isolates, 25 different ribotypes were identified. C. difficile was not recovered from 5 of the samples and 3 results are awaited at the time of writing this report. Ribotyping results are shown in figure 8 and demonstrate 015 and 005 ribotypes are seen more frequently.

Figure 8 HOHA/COHA C. difficile Toxin Positive Ribotyping Results



Ribotyping results by ward are shown in figure 9. Whilst Ward B19 has had a higher number of cases, with the exception of 2 case clusters, ribotyping results differed indicating that 4 of cases were not linked. There were 2 cases of 078 ribotype, which were confirmed link to each other by additional testing. Additionally, there were 2 cases of 054 ribotype, which occurred more than 28 days apart and may also be linked to each other, as this ribotype is seen less frequently in the Trust.

Figure 9 C. difficile Toxin Positive Ribotyping Results by Location



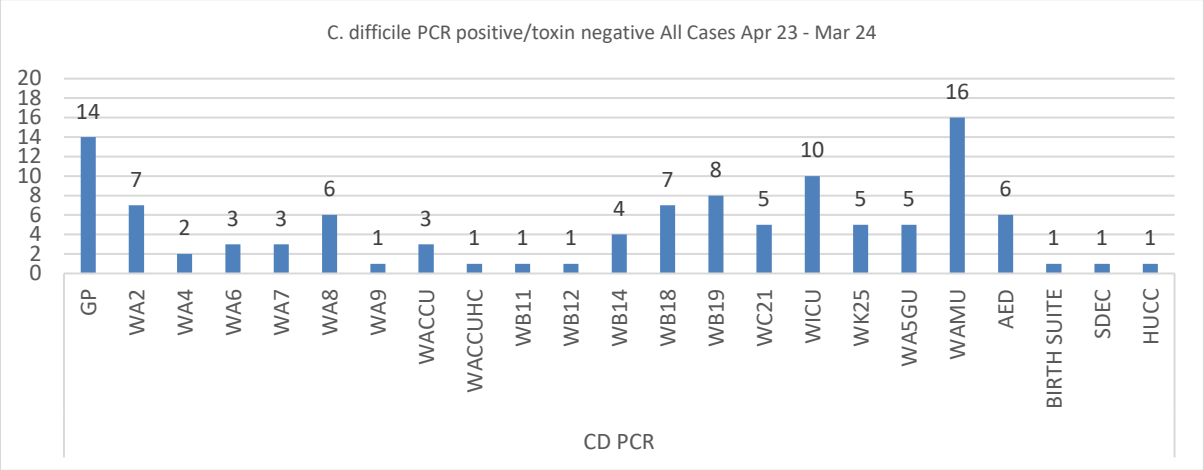
C. difficile (Toxin Negative/PCR Positive)

Diagnostic testing methods for C. difficile infection distinguishes between patients who are colonised with C. difficile (toxin negative/PCR positive), and those with C. difficile toxins present. Presence of toxins indicates infection is more likely.

The IPCT conduct local surveillance on the patients who are C. difficle toxin negative/PCR positive. These patients are at a higher risk of developing C. difficile infection than non-colonised patients. Inpatients falling into this category are reviewed and patients exhibiting symptoms are nursed in isolation and treatment advice provided.

Figure 10 shows the results for all patients (no apportionment) who were C. difficile toxin negative/PCR positive and location at the time of testing.

Figure 10 C. difficile PCR Positive/Toxin Negative cases (all) by Location Tested

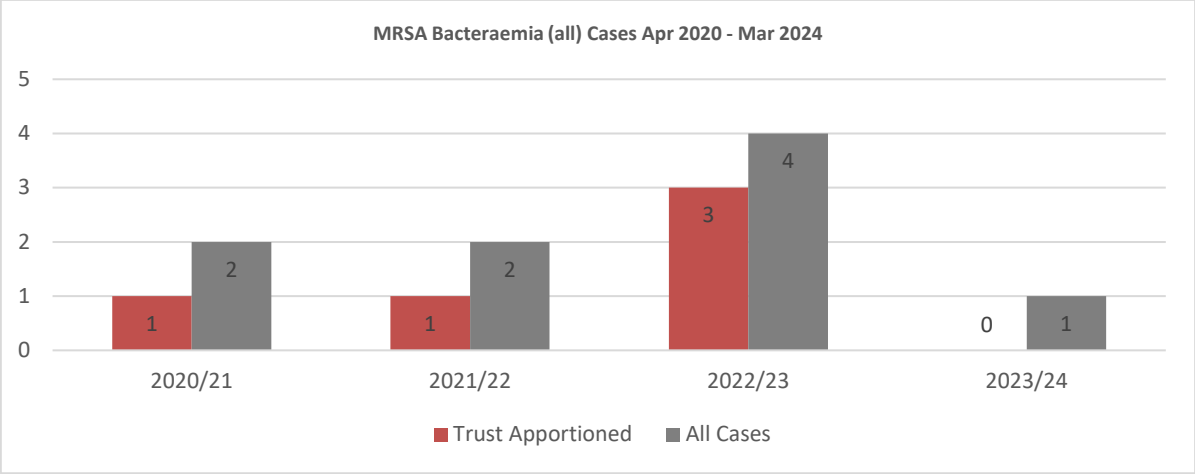


Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia

The Trust reported one community onset/community associated bacteraemia case.

The annual threshold of zero avoidable cases was met and a reduction in 3 cases from the previous financial year achieved. Data for comparison with earlier financial years is shown in figure 11.

Figure 11 MRSA bacteraemia cases (all) April 2020 – March 2023



Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

The Trust reported 93 cases of MSSA bacteraemia with 36 cases apportioned to the Trust.

- Hospital onset/healthcare associated = 26
- Community onset/healthcare associated = 10
- Community onset/community associated = 57

} 36 Trust apportioned

This was an increase by 15 Trust apportioned cases from the previous financial year. Thresholds for the reduction of MSSA bacteraemia have not been set. Data for comparison with previous financial years is shown in figure 12.

Figure 12 MSSA bacteraemia cases (all) April 2020 – March 2023

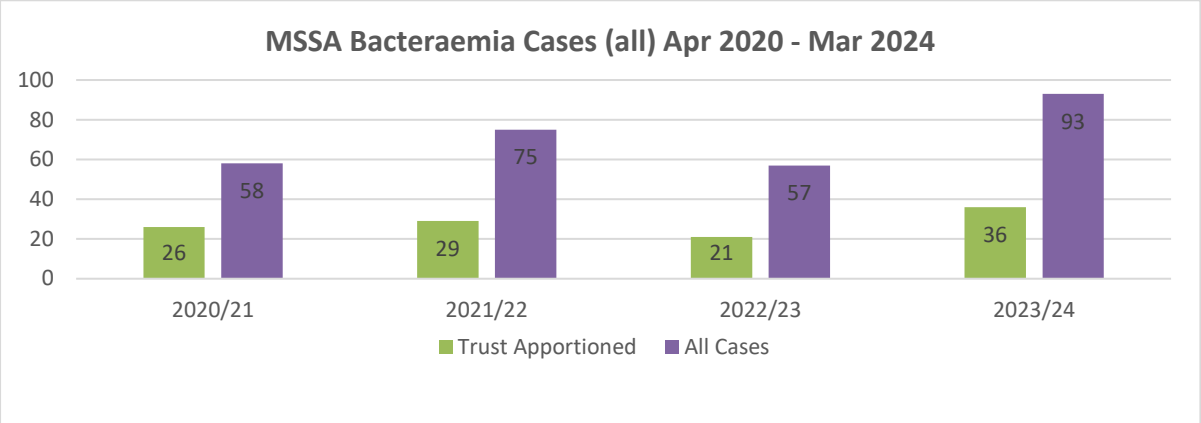


Figure 13 shows the Trust apportioned MSSA bacteraemia cases by month.

Figure 13 Trust Apportioned MSSA bacteraemia cases by month

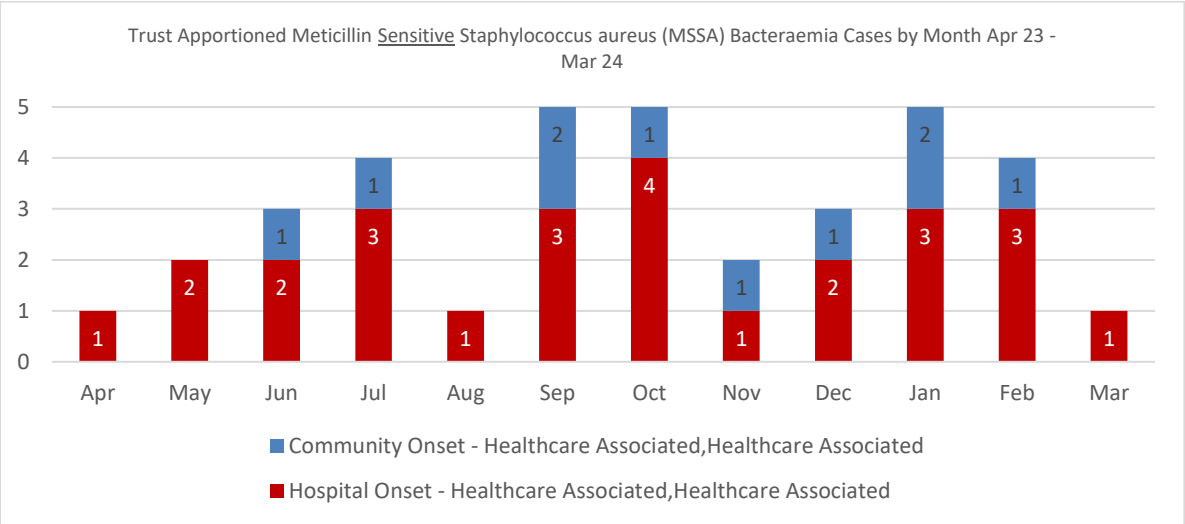


Figure 14 shows the patients' locations at the time the specimen was obtained for HOHA cases and discharging ward for COHA cases.

Figure 14 Trust Apportioned MSSA Bacteraemia Cases by Location

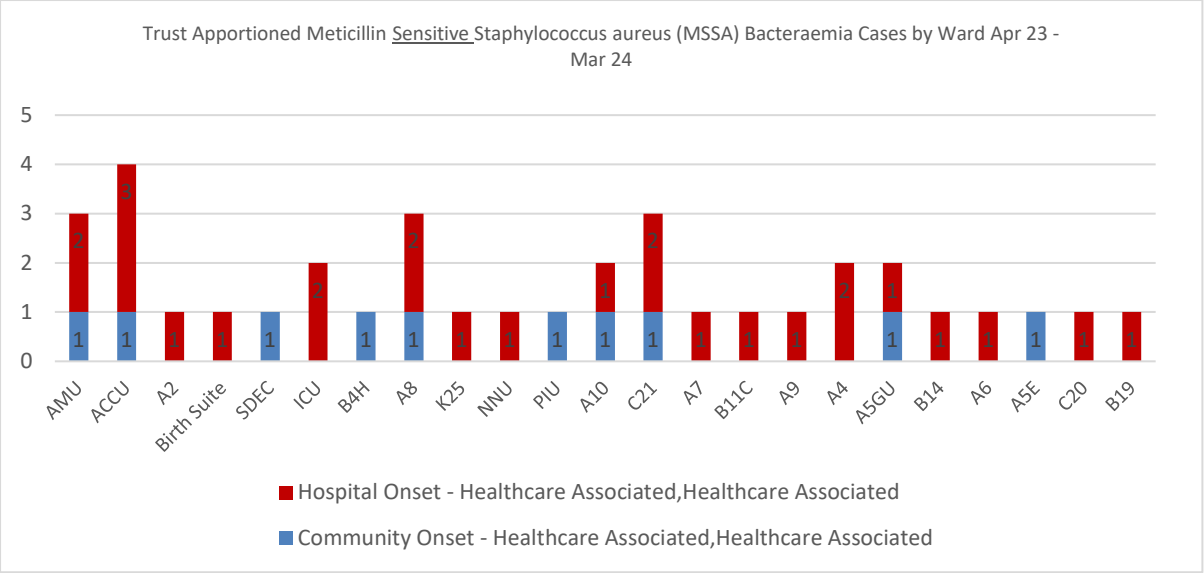
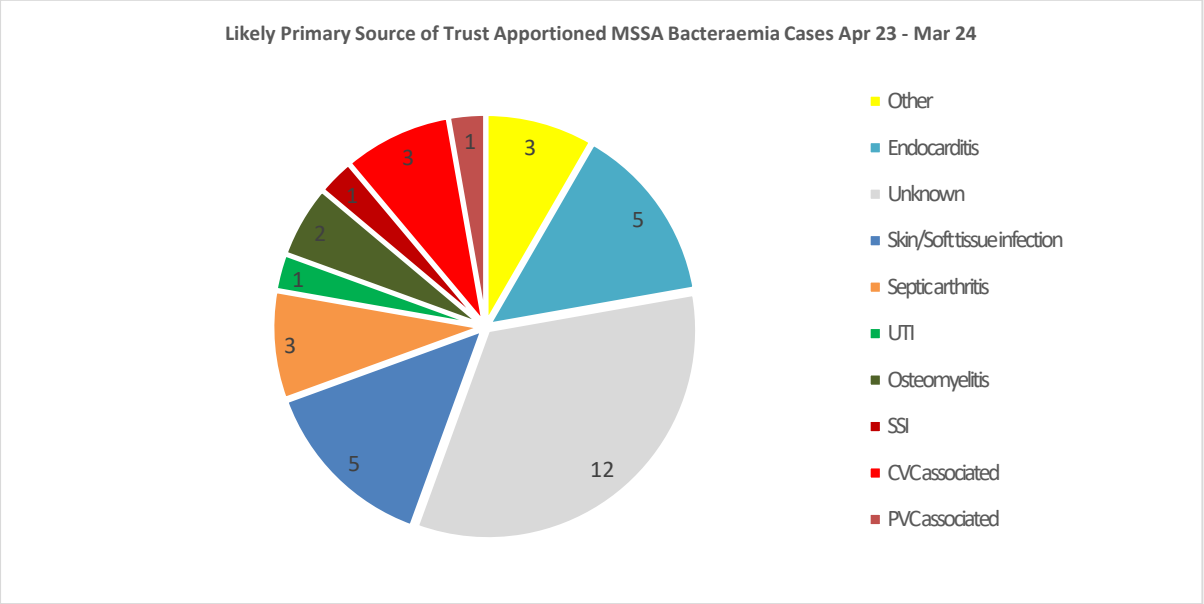


Figure 15 shows the likely primary sources of the Trust apportioned cases.

Figure 15 Likely Primary Source of Trust Apportioned MSSA Bacteraemia Cases



An action plan is in place that sets out the work required to prevent the risks of MRSA/MSSA bacteraemia cases.

Focus continues on Aseptic Non-Touch Technique training and care of invasive devices.

Gram Negative Bloodstream Infection (GNBSI)

A deep dive analysis of GNBSI cases was carried out and presented to the Quality Assurrance Committee in April 2024. This analysis showed the challenging nature of the reduction thresholds against the background of an increasingly elderly population.

Additional audits were carried out on hepatobiliary source infections and the findings are under review against other audit data on gallbladder surgery on first presentation. Audits were also carried out into Pseudomonas aeruginosa cases, and urinary tract infection diagnosis and management. Learning from these cases is being used to inform prevention action plan updates for the next financial year.

E. coli bacteraemia Cases

The national target to reduce GNBSI (E. coli; Klebsiella spp. and Pseudomonas aeruginosa) published in the Tackling Antimicrobial Resistance 5-year plan (January 2019) remained in place.

The IPCT continued work with the Quality Academy to focus on hydration, continence management, reducing usage of urinary catheters and improving catheter care, hand hygiene (including patients) and urinary tract infection detection and management, however an increase in trust apportioned cases was reported. The Trust reported a total of 241 E. coli bacteraemia cases, 81 of these were Trust apportioned cases. The threshold of 54 cases set by NHSE was exceeded by 27 cases.

81 Trust apportioned

- Hospital onset/healthcare associated = 42
- Community onset/healthcare associated = 39
- Community onset community associated = 160

This was an increase by 14 Trust apportioned cases from the previous financial year. Data for comparison with previous financial years is shown in figure 16 .

Figure 16 E. coli bacteraemia cases (all) April 2020 – March 2024

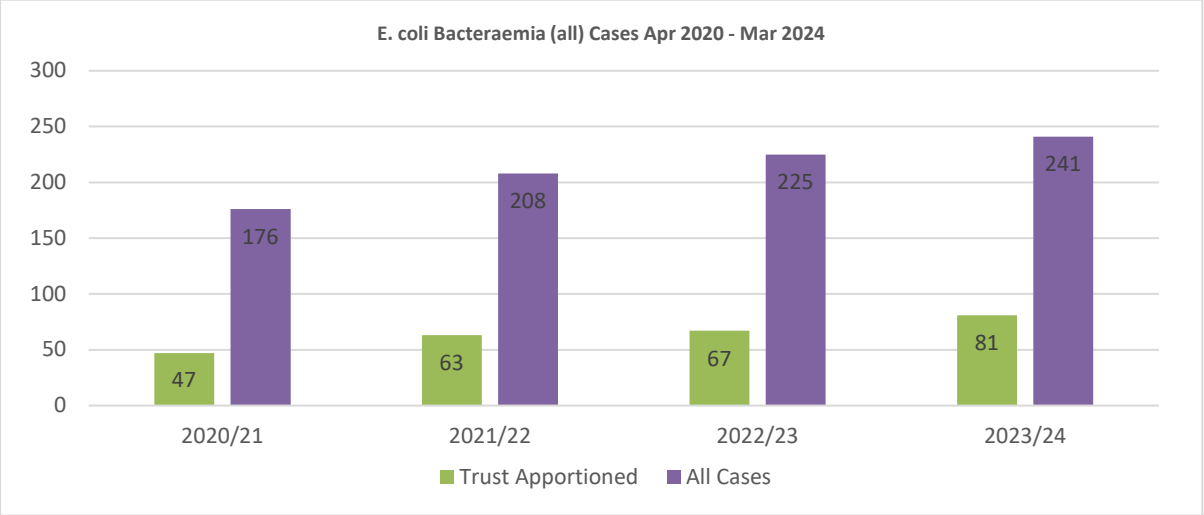
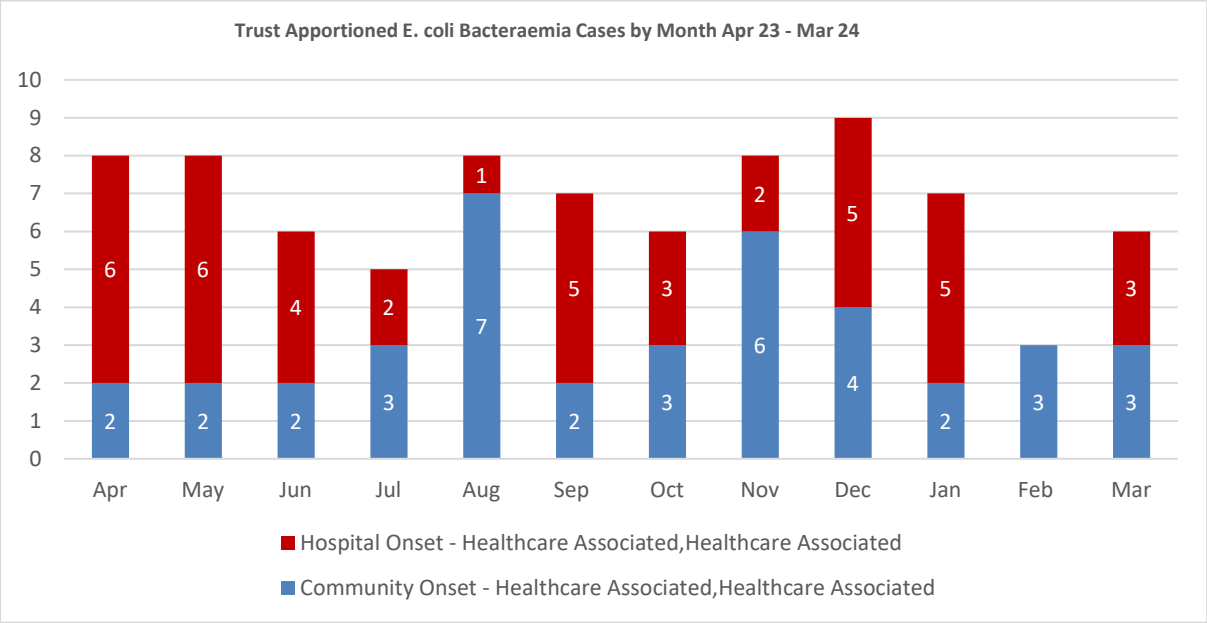


Figure 17 shows Trust apportioned cases by month.

Figure 17 Trust Apportioned E. coli Bacteraemia Cases by Month



The Trust apportioned E. coli bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases are shown in figure 18.

Figure 18 Trust apportioned E. coli Bacteraemia Cases by Location

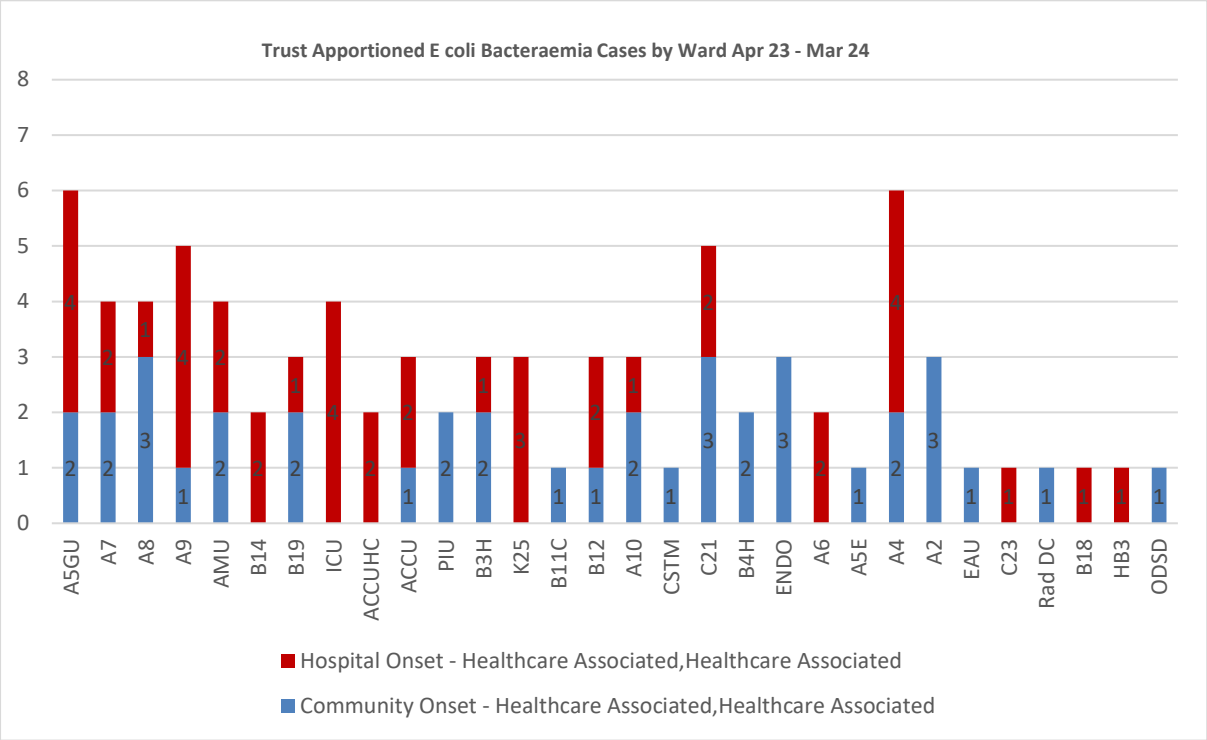
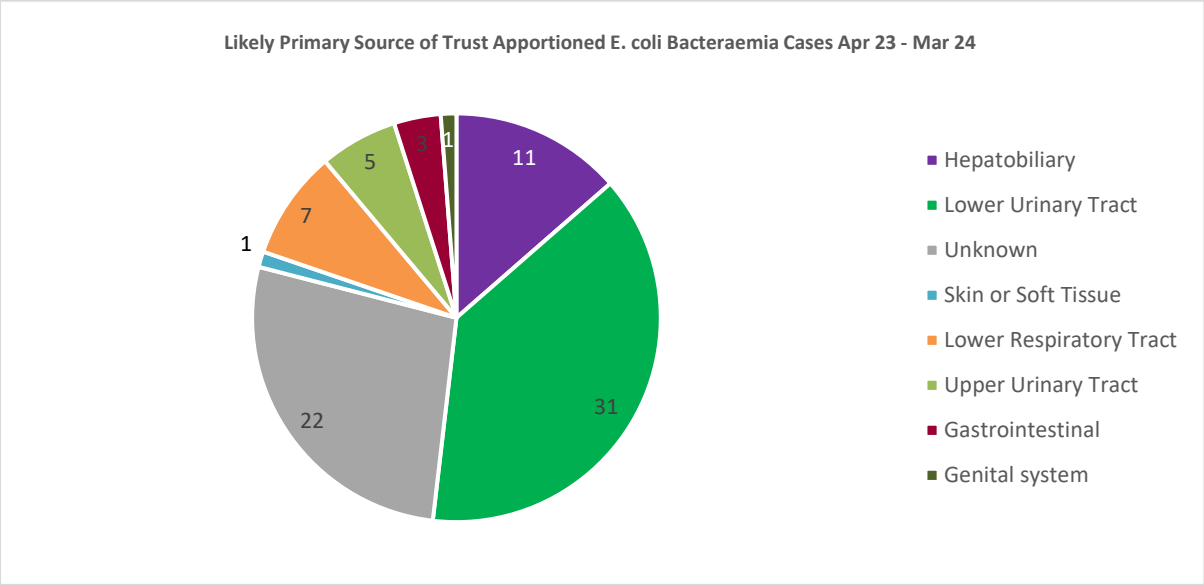


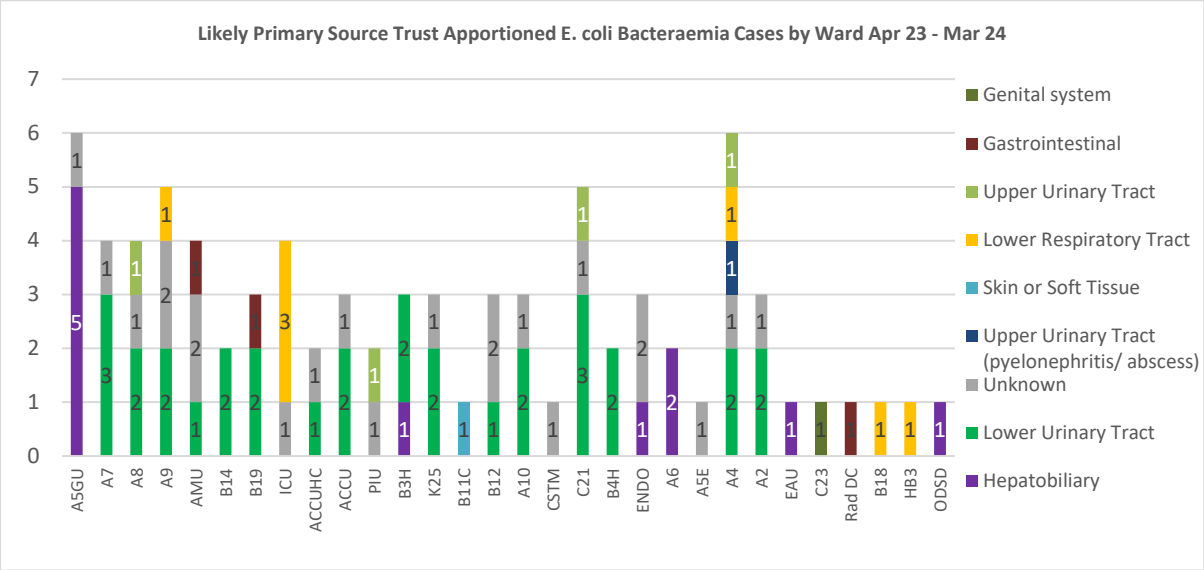
Figure 19 shows the likely primary sources of the Trust apportioned E. coli cases.

Figure 19 Likely primary sources Trust apportioned E. coli Cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 20.

Figure 20 Trust Apportioned Cases - Likely Primary Source by Location



Klebsiella spp. Bacteraemia

The Trust reported a total of 65 Klebsiella spp. bacteraemia cases, 26 of these were Trust apportioned cases. The threshold of 18 cases set by NHSE was exceeded by 10 cases.

- Hospital onset/healthcare associated = 12
- Community onset/healthcare associated = 16

} 28 Trust apportioned

- Community onset community associated = 37

A comparison with previous year's data is shown in figure 21.

Figure 21 Klebsiella spp. bacteraemia (all) April 2020 – March 2023

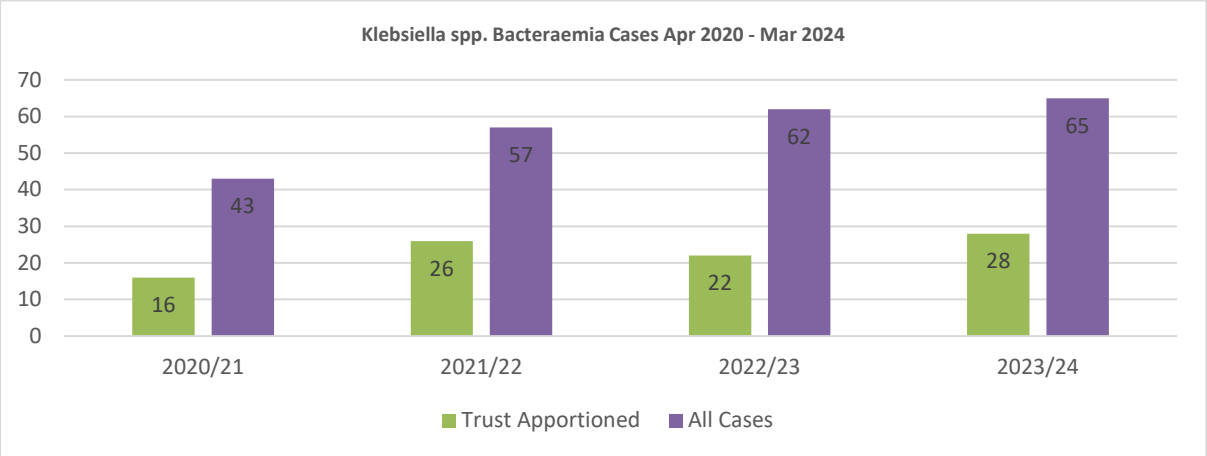


Figure 22 shows Trust apportioned cases reported each month.

Figure 22 Trust Apportioned Klebsiella spp. Bacteraemia Cases by Month

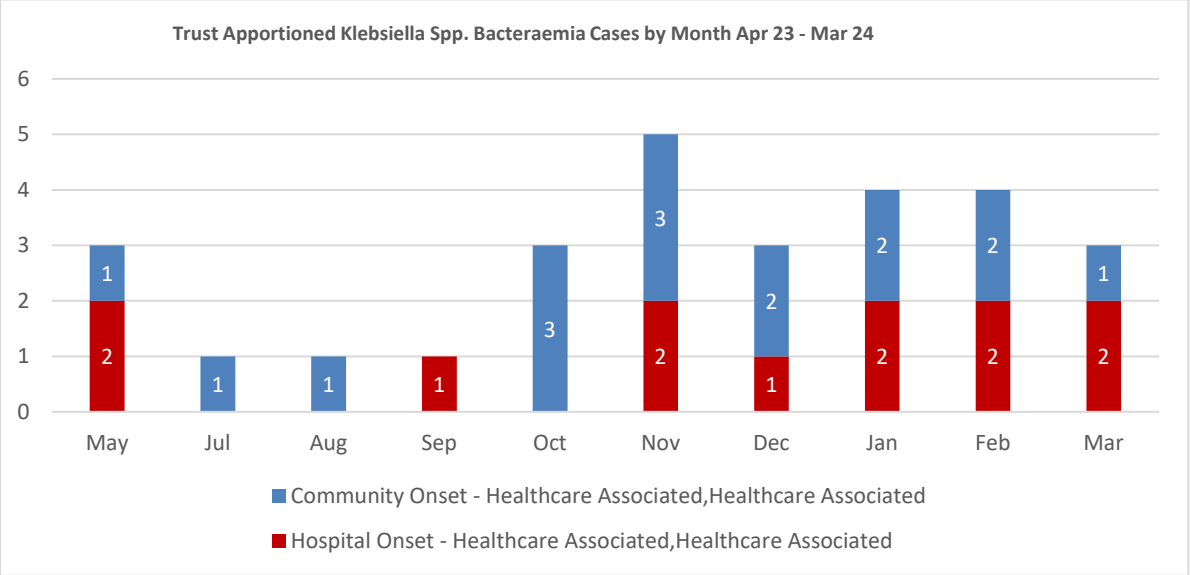


Figure 23 shows Trust apportioned Klebsiella bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 23 Trust Apportioned Klebsiella Bacteraemia Cases by Ward Location

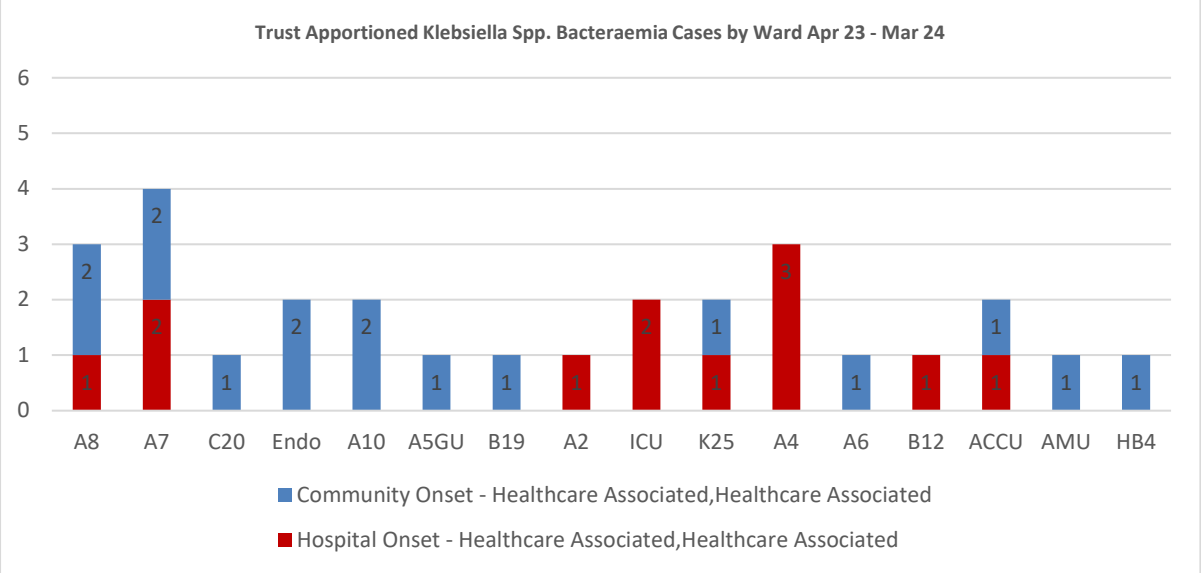
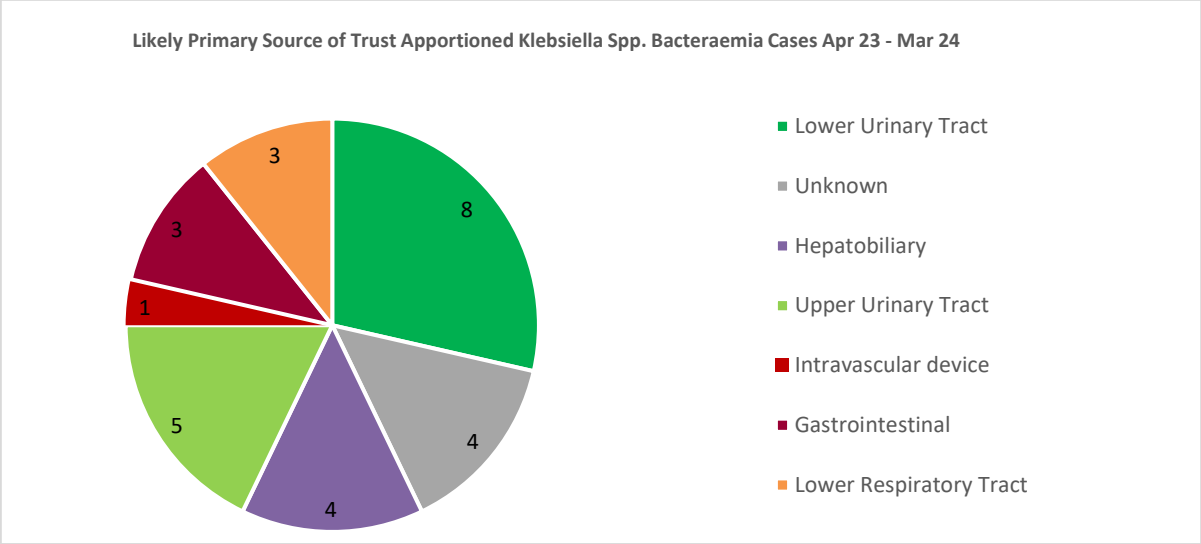


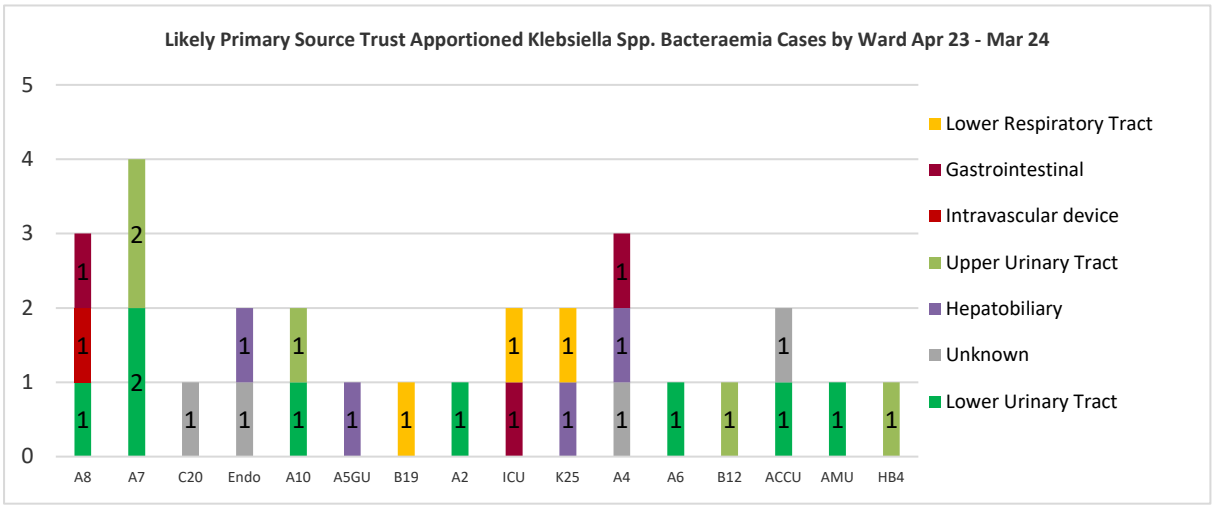
Figure 24 shows the likely primary sources of the Trust apportioned cases.

Figure 24 Likely primary sources of the 26 Trust apportioned cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 25.

Figure 25 Trust Apportioned Cases - Likely Primary Source by Location



Pseudomonas aeruginosa bacteraemia

The Trust reported a total of 16 Pseudomonas aeruginosa bacteraemia cases, 11 of these were Trust apportioned cases. The threshold of 2 cases set by NHSE was exceeded by 9 cases and is an increase in 7 cases compared to the last financial year.

- Hospital onset/healthcare associated = 6
- Community onset/healthcare associated = 5
- Community onset community associated = 5

} 11 Trust apportioned

A comparison with previous year's data is shown in figure 26.

Figure 26 Pseudomonas aeruginosa bacteraemia cases April 2020 – March 2023

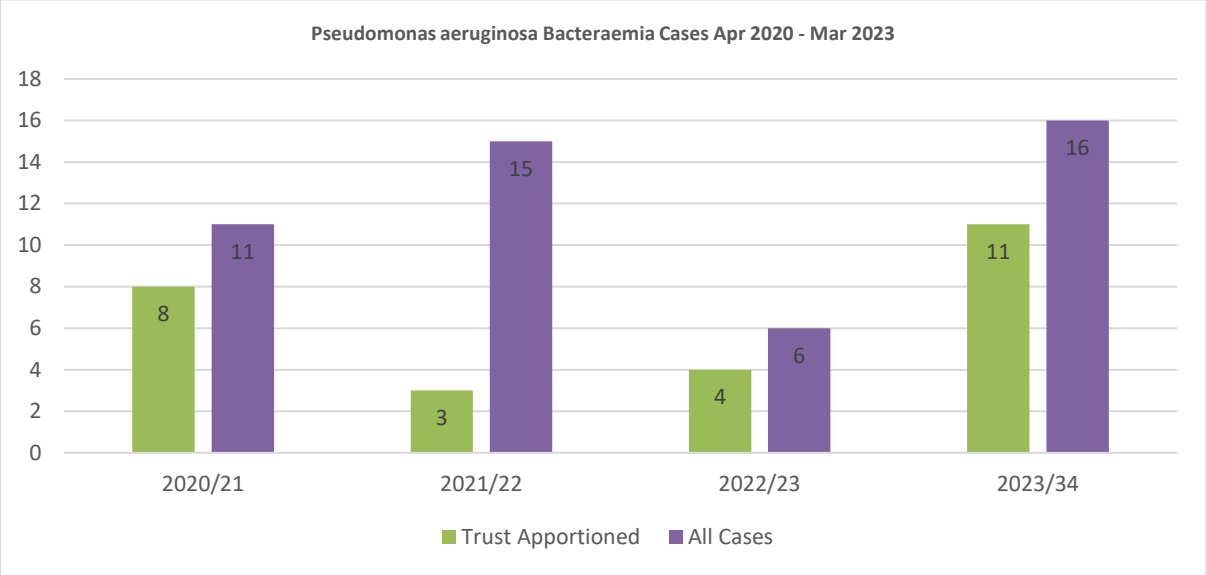


Figure 27 displays the Trust apportioned cases reported by month.

Figure 27 Trust Apportioned Pseudomonas aeruginosa Bacteraemia Cases by Month

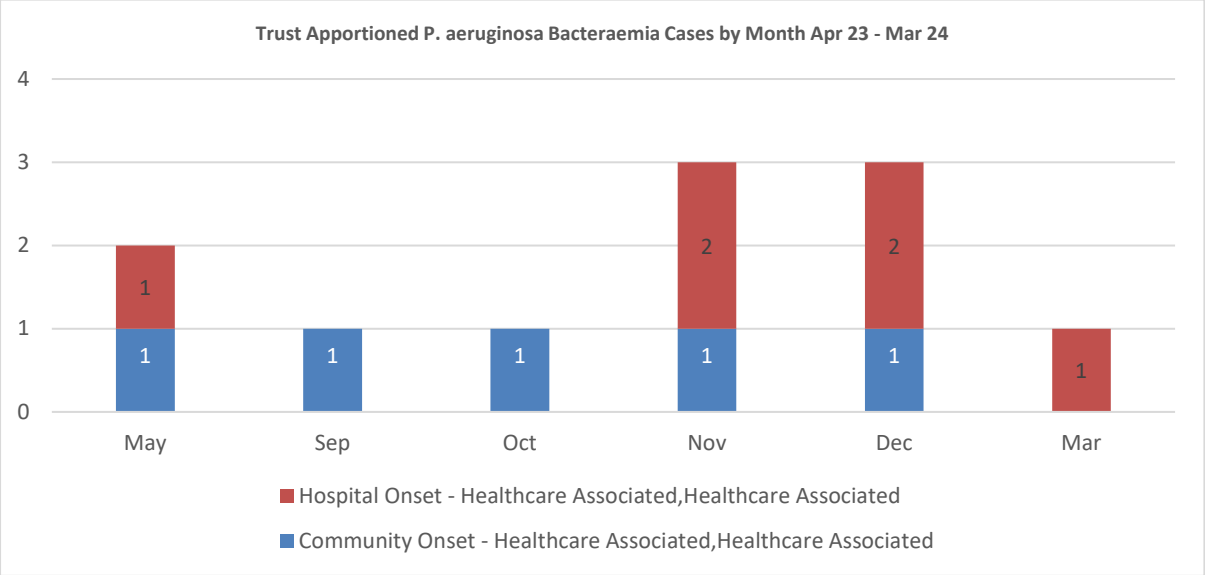
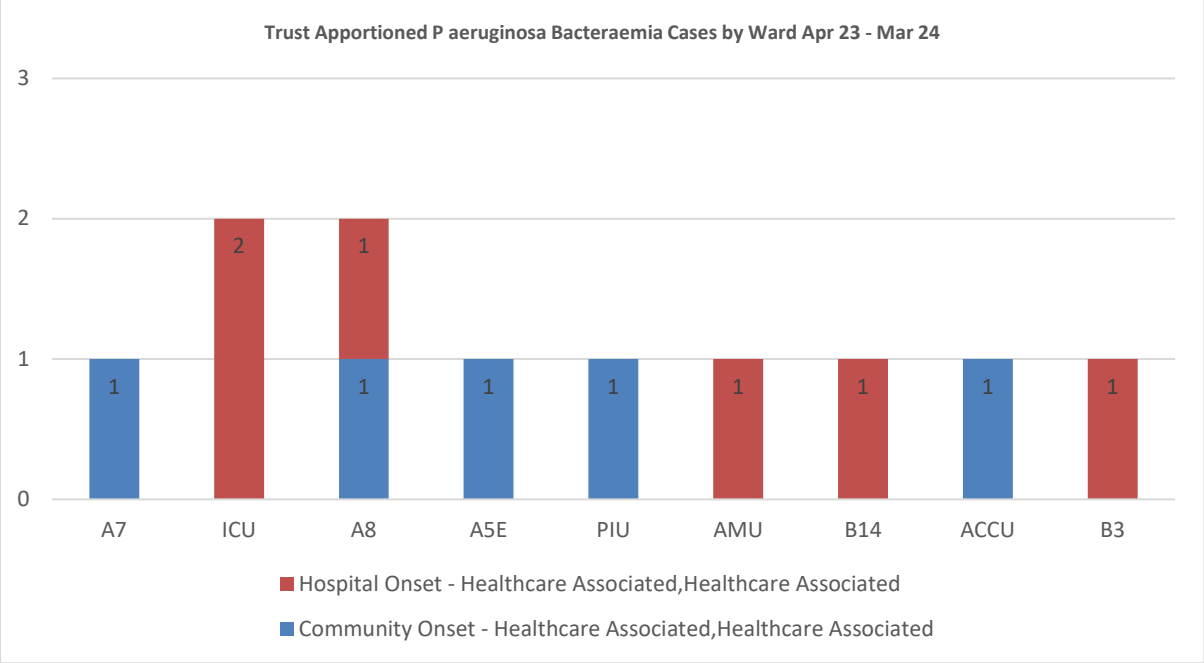


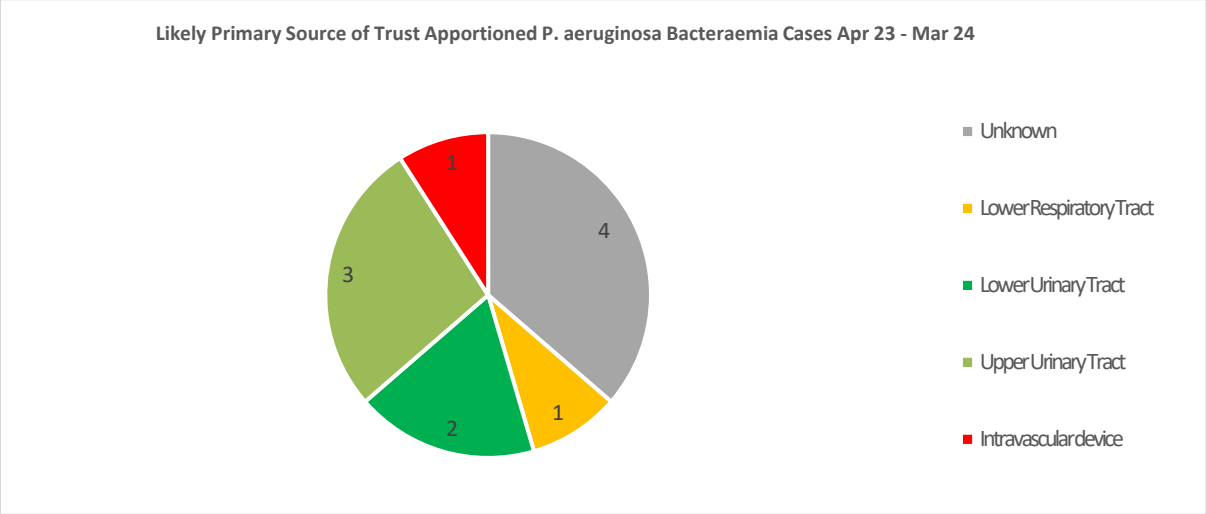
Figure 28 show Trust apportioned Pseudomonas aeruginosa bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 28 Pseudomonas aeruginosa bacteraemia cases by location



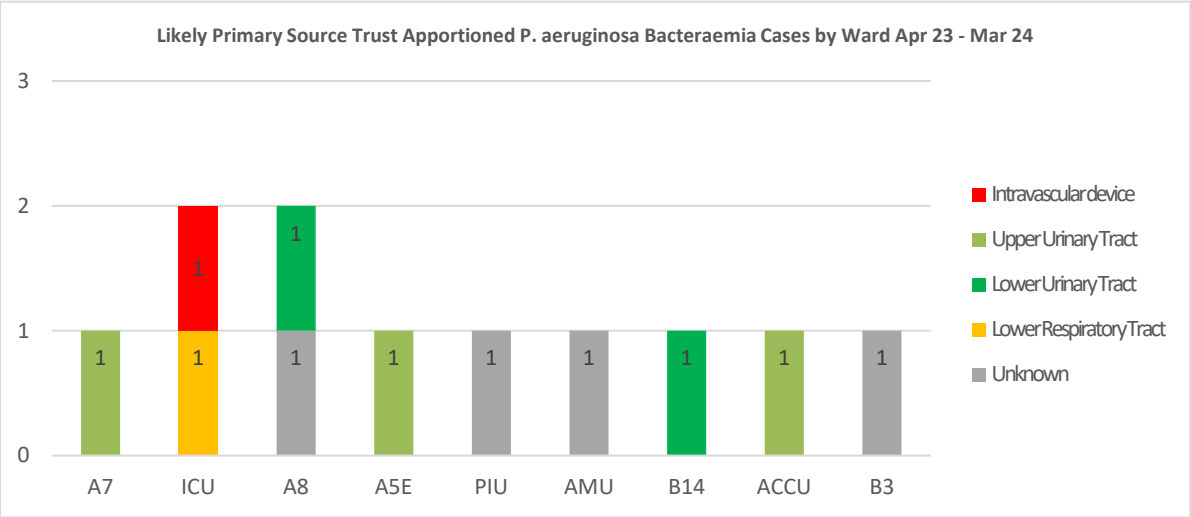
A breakdown of Trust apportioned cases to show likely primary source is shown in figure 29.

Figure 29 Likely Primary Sources of Trust Apportioned Cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 30.

Figure 30 Trust Apportioned P. aeruginosa Bacteraemia Cases Likely Primary Source by Location



There is recognition in the National Action Plan on Confronting Antimicrobial Resistance 2024 – 2029, that the incidence of GNBSIs is projected to increase and there is limited evidence in the literature for interventions which work to prevent GNBSIs.

Learning from the deep dive into GNBSI cases and audit findings will be applied and the focus for the next financial year will continue and includes: -

- Patient hydration
- Reduction in use of urinary catheters
- Improvements to care of urinary catheters
- Competency assessments incorporating Aseptic Non-Touch Technique
- Patient hand hygiene strategy

Information on all mandatory reported HCAIs is circulated weekly with up-to-date information on cases and learning from reviews. Dashboards are circulated monthly after data validation. Work is in progress with CBUs to ensure completion of action plans from HCAI events.

The IPCT continued to work with the Quality Academy and Clinical Business Units (CBUs) to prevent GNBSI cases.

Incidents/Outbreak Reports

Carbapenemase Producing Enterobacteriaceae (CPE) transmission B19
CPE are bacteria that are resistant to Carbapenem (considered last resort) antibiotics. In May 2023, a patient with CPE colonisation (not infection) was identified

in a bay on ward B19. The patient had been hospitalised abroad and was not admitted into a side room as per usual process.

Action was taken to isolate the patient. Follow-up screening of bay contacts and the whole ward identified one other patient with CPE from the same bay. Both CPE isolates were sent to UK Health Security Agency reference laboratory and typing confirmed they were the same, indicating transmission occurred. Both patients remained well and were discharged home. The bay was terminally cleaned following discharge of all other patients in the bay and no other cases detected from surveillance screening.

Norovirus A2

In June 2023, Ward A2 Warrington Hospital reported 11 patients with symptoms of diarrhoea and/or vomiting and 4 staff with nausea symptoms. Investigations identified 1 patient with a positive norovirus result. Patient and staff movement was safely managed to prevent transmission, the ward was terminally cleaned and affected bays re-opened and no further cases were identified.

Chickenpox exposure NNU

In July 2023, a sibling visitor to the Neonatal Unit (NNU) was clinically confirmed to have chickenpox, by a Consultant Paediatrician. Review identified the sibling visited during the infectious period and length of time on the NNU was significant for transmission to have occurred.

Five infant contacts were identified, immunity testing undertaken and post exposure prophylaxis given to two contacts who were non-immune. Both contacts were isolated from day 8 of exposure until day 21 (incubation period) and neither infant developed chickenpox.

Influenza A8

A cluster of 4 cases of Influenza A were detected in ward A8 Bay A. The other 2 patient contacts in the bay tested negative, were prescribed prophylactic treatment, and did not develop influenza. The 4 confirmed cases were treated with antiviral medication and recovered.

Surgical Site Infection Orthopaedics

In February 2024, the Trust flagged as a high outlier for knee replacement surgery in the Jul-Sep 2023 period, with a 0.7% risk noted over the last 4 periods (quarters). Work was in progress in relation to a previous high outlier letter for hip replacement surgery in Apr- Jun 2022 with a 0.8% risk.

Discussion took place with the Orthopaedic Consultants to review suspected surgical site infections, via the existing Trauma and Orthopaedic Oversight Group and actions agreed included: -

- Review of cases (2)

- Review of theatre standards
- Suppression treatment (antiseptic skin wash and antimicrobial nasal ointment for higher risk procedures

Nil further infection cases have been observed.

Measles exposure ED
UK Health Security Agency have reported an increase in measles cases since October 2023 with increased prevalence in areas of the country with lower Measles, Mumps and Rubella (MMR) vaccination uptake.

In February a patient attended ED who was later confirmed to be infectious for measles at the time of visit. Contact tracing of staff and patient was initiated and an epidemiologically linked case in a patient was identified 2 weeks later. In addition, 2 members of staff were also considered likely epidemiologically linked. Both members of staff were fully MMR vaccinated and these cases were considered breakthrough measles. Additional contact tracing was carried out and no further linked cases identified. Rapid implementation of text alerting for signs and symptoms supported identification of epidemiological links between cases.

Hand Hygiene and Aseptic Protocols

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. The average compliance rate for the year was 99%. Audits are completed by each ward with a small number of peer audits. The programme is being revised in 2024 to introduce a more robust programme of peer auditing. Overall results by month are shown in table 3.

Table 3 Trust wide hand hygiene audit results by month

Month	A	M	J	J	A	S	O	N	D	J	F	M
Compliance	99 %	99 %	99 %	99 %	99 %	99 %	98 %	99 %	99 %	99 %	99 %	99 %

Decontamination
All surgical instruments are decontaminated off site by a company that provides decontamination services for several Trusts within the region. There is a programme of internal and external validation. The Trust is compliant with Department of Health and NHS Estates guidance. The terms of reference for the Decontamination Group have been revised and meetings are held quarterly.

DOMESTIC SERVICES

Management Arrangements
Warrington and Halton Hospitals Domestic Team are employed as an in-house service and are part of the Trust Estates and Facilities Management Team. The

team is led by the Head of Facilities and on a day-to-day basis managed by a Support Services Manager on each site.

The Domestic Team provide 24 hour, 7 days per week cover. The team are also supported by 'as and when' staff who cover vacancies and partially cover annual leave and sickness.

The Domestic Task Team provides a valuable service, dealing with emergency leaks/spills, routine and emergency curtain changes, terminal cleans, and any cleaning required following infection outbreaks. They also form the core team progressing deep cleans in clinical areas. The Trust uses a number of hydrogen peroxide fogging machines to assist with decontamination of the environment.

Budget Allocation

The budget allocation for domestic services was £5.5 million with 150 whole time equivalent (WTE) staff.

Cleaning Arrangements

In line with the National Standards of Healthcare Cleanliness (2021), which were implemented in 2022/23, the functional groups are divided into levels of cleaning intensity, based on the risks associated with inadequate cleaning in that specific area with recommended rectification timescales:

FR1 98%: Assessment within 20 minutes and task completed at the next scheduled clean or within 2 hours (if the area is accessible) whichever is the soonest.

Areas include A&E, ICU, All Theatres, Birthing Suite, Neonatal, A5 elective, Cantreat, Urgent Care PACU

FR2 95%: Assessment within 20 minutes and task completed a the next scheduled clean or within 4 hours whichever is the soonest.

Areas include All wards not above, Angio, Endoscopy, Day case, TSSU, Ophthalmic Day case, Nest, UCC, Xray, Renal Dialysis, GUM, Blood rooms

FR3 90%: Assessment within 1 hour and task completed at the next scheduled clean or within 12 hours whichever is the soonest.

Areas include Orthodontics, Mortuary

FR4 85%: Assessment within 1 hour and task completed at the next scheduled clean or within 72 hours whichever is the soonest.

Areas include CT, Pharmacy, MRI, Ultrasound, Radiology Day Case, Breast screening, Blood rooms, Surgery Pre-op, Occupational Health, Main linen store, entrances and exits, OPD, Daresbury, Halton Eye clinic, SAU, X Ray, Anti-Coagulation, ANDU, Physio, Surgical Appliances, Gynae Clinic, Pathology laboratory, Childrens OPD, Vascular lab, Clinical skills, Delamere Centre, ECG, Audiology, Cardiology, Diabetic drop in, Occupational Therapy, Cardiac rehab

FR5 80%: Assessment within 24 hours and task completed at the next scheduled clean or within 96 hours whichever is the soonest.

Areas include Medical Engineering, Chapel, Main Receptions, linen and waste cupboards, equipment store

FR6 75%: Assessment within 24 hours and task completed at the next scheduled clean or within 120 hours whichever is the soonest.

Areas include Offices, Medical Records, Stores, Drs Mess

Monitoring Arrangements

There is a dedicated Monitoring Team within Facilities, who monitor standards of cleanliness within clinical and non-clinical areas at both sites and sharps waste compliance in clinical areas. This team is led by a facilities Manager to ensure there is no conflict of interest. The team are all trained to British Institute of Cleaning Science (BICS) standard.

The monitoring of ward kitchens is undertaken by the Catering Department, who monitor cleanliness and food hygiene standards. A schedule is in place to routinely monitor ward kitchens. Any serious breaches of food hygiene are dealt with immediately. An annual inspection of ward kitchens is also carried out by the Local Authority's Environmental Health Team.

The monitoring programme complies with the Department of Health specifications, covering domestic cleaning, patient equipment, and estates issues.

The monitoring frequency is dictated by the risk grading of areas, which are as follows: -

FR1 Areas Weekly
FR2 Areas Monthly
FR3 Areas Every 2 Months
FR4 Areas Every 3 Months
FR5 Areas Every 6 Months
FR6 Areas Every 12 Months

Copies of the monitoring reports are circulated to the Lead Nurses, Matrons, Ward Managers, Support Service Managers and Estates, to address any remedial action required.

Ward Housekeepers are responsible for ensuring any actions on monitoring forms are dealt with promptly. If there are any specific areas of concern, this is reviewed, and focus is given to address the issue. When necessary, the frequency of monitoring is increased to address any problem areas.

Any Estate actions are now monitored through the Invida Digital system.

Terminal Cleaning

Terminal cleaning is carried out by the Task team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours. Number of terminal cleans by month is shown in table 4

Table 4 Terminal cleaning

Terminal cleans	A	M	J	J	A	S	O	N	D	J	F	M	Total
2022/2023	698	491	522	578	550	405	471	457	642	462	392	404	**6072**
2023/2024	369	479	385	348	360	428	448	435	552	660	578	561	**5603**

Curtain changes:

Number of curtain changes by month is shown in table 5

Table 5 Curtain changes

Curtain changes	A	M	J	J	A	S	O	N	D	J	F	M	Total
2022/2023	208	158	164	186	170	134	261	265	441	211	268	232	**2301**
2023/2024	204	252	204	185	169	244	263	275	289	362	273	296	**3016**

HPV decontaminations by month are shown in table 6:

Table 6 HPV decontamination

HPV use	A	M	J	J	A	S	O	N	D	J	F	M	Total
2022/2023	74	51	48	42	26	14	34	26	21	18	23	29	**406**
2023/2024	27	25	13	31	34	34	20	21	22	64	24	27	**308**

Cleanliness Scores

The 2023/24 cleanliness monitoring scores (Domestic only) for Very high risk and high-risk clinical areas were as follows:

FR1 Target score 98%

Warrington: 99%
Halton: 99%

FR2 Target score 95%

Warrington: 97%
Halton: 98%

PLACE (Patient Led Assessments of the Care Environment)

A PLACE assessment was carried out in November 2023 and was completed on both sites. A full action plan was produced and is being worked through with clinical teams.

Corporate Reporting

A monthly report is submitted by Facilities to the Infection Control Sub-Committee regarding cleanliness standards scores, number of terminal cleans/curtain changes,

process audits for cleaning hand wash sinks and personal protective equipment (PPE), ward kitchen monitoring, linen, pest control and waste.

Training

The Domestic Staff receive specific theoretical and practical cleaning training as part of their induction, which includes infection control elements including the use of face filtering piece (FFP) 3 masks and this is supported by subsequent refresher training.

Random process audits are carried out to ensure that staff follow the correct procedure and wear the correct PPE when cleaning hand washing sinks. Staff competency audits are also carried out to ensure that domestics are working in accordance with their training and the Trust Cleaning Standards Policy and Cleaning manual.

This year the team have also introduced Efficacy audits which have included the Infection Control Team and housekeeping staff.

Clinical Access/Responsibility

The domestic staff are centrally managed by the Facilities team; however, the Ward Managers and the Housekeepers are able to direct the domestic staff based on each ward regarding day-to-day priorities. There is also close liaison with the Matrons, who have a specific responsibility for cleanliness standards for their Clinical Business Unit.

Facilities also have a close working relationship with the Ward Housekeepers and attend their monthly meetings to share concerns or offer support as and when required.

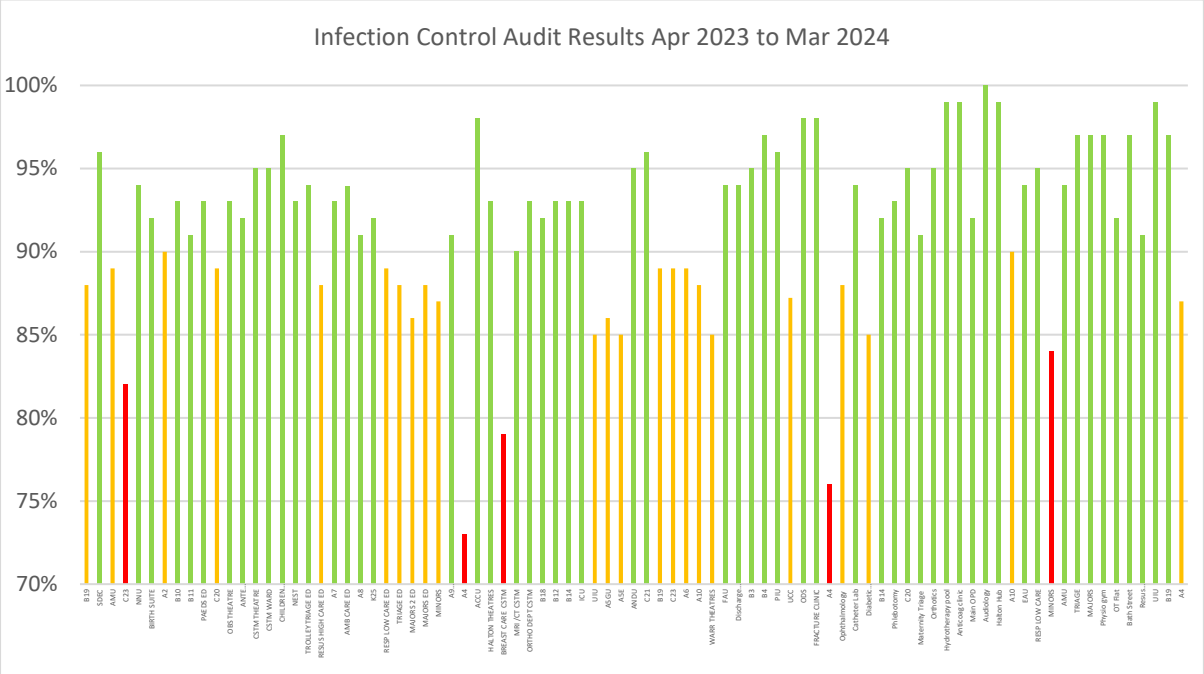
Audit

The aim of the IPC Audit Programme is to measure compliance with Infection Prevention & Control policies/guidelines and assess environmental standards in the patient care environment. This audit programme contributes to providing assurance that infection control policies are followed, and risks are effectively managed within the Trust.

The audits are carried out by the IPCNs using an approved Infection Prevention and Control audit tool. The audit tool has a total of 11 components. A rolling programme of audit is in place to cover all in-patient areas.

Additional audits are completed outside of the rolling programme when infection events occur. A summary of overall scores is shown in figure 31.

Figure 31 Infection Control Audit Results



Reports on findings are fed back to the nurse in charge of the clinical area at the time of the audit. This is followed up by a written report within one week of the audit. The manager of the clinical area is responsible for producing an action plan to address areas for improvement. In addition, the Brilliant Basics in IPC campaign is being launched to drive up IPC practice standards.

High Impact Interventions

The CBUs have continued a rolling programme of audit to assess compliance with the Department of Health's High Impact Interventions Toolkit. Audit scores are mostly in the region of 90-100%. The results are discussed at the Infection Control Sub-Committee and fed back to the ward teams. Action plans are produced by wards and departments for areas where care improvements are required.

An increase in auditing frequency is requested when scores are below accepted standards. Matrons are directed to provide assurance that the audits drive improvements rather than being a monitoring process.

Antimicrobial Prescribing

From 1 April 2023 - 31 March 2024, 83 joint Consultant Microbiologist and Antimicrobial Pharmacist ward rounds (joint ward rounds) were conducted at Warrington Hospital.

This was an increase in the number of Joint ward rounds carried out compared to the previous year where there were 72 joint ward rounds. To cover maternity leave, a senior Clinical Pharmacist was seconded into the Antimicrobial Pharmacist post for 2023/24 and they successfully maintained and developed the service. Additional

Pharmacists have been trained to cover the antibiotic ward round to build resilience within the service and there are plans to extend this training further.

The weekly Outpatient Parenteral Antimicrobial Therapy (OPAT) Multi-Disciplinary Team (MDT) has continued.

In addition to the joint ward rounds the Consultant Microbiologists have continued to undertake additional ward rounds/MDTs in select areas.

- Daily ICU antimicrobial ward rounds (Mon-Fri) with a Consultant Intensivist
- A Consultant Microbiologist attends board round every Friday (when staffing allows) on the acute medical unit (AMU) to review patients prescribed antimicrobials and establish individualised treatment plans for the weekend and help with early supported discharge
- A Consultant Microbiologist attends a weekly MDT on ward B19 (*C. difficile* cohort facility) to review antimicrobial prescribing in patients who have a diagnosis or history of *C. difficile* infection. This MDT is not exclusive to patients with a current diagnosis/history of *C. difficile* infection and other patients on the ward are frequently discussed
- This year we have also continued the additional weekly antibiotic MDT on ward A9 due to persistent low compliance with the antimicrobial formulary (identified in the quarterly point prevalence audit). Focused support and engagement with the clinical teams in this area has helped to drive up antimicrobial prescribing standards to the point where there is no longer a concern on this ward (as evidenced by the latest point prevalence audits) so this MDT was stepped down from Jan 2024

Joint Consultant Medical Microbiologist and Antimicrobial Pharmacist Ward Rounds

Public Health England's (now UK Health Security Agency), Antimicrobial Stewardship (AMS) Toolkit, states that improving antimicrobial prescribing and stewardship is dependent on strong clinical leadership. They recommend that antimicrobial quality improvement should be done in collaboration with a Consultant Microbiologist/infectious diseases specialist and the Antimicrobial Pharmacist.

Within the Trust, we aim to undertake three joint Consultant Microbiologist and Pharmacist ward rounds each week at Warrington Hospital. These ward rounds target patients who are prescribed specific "target antimicrobials", wards with higher rates of antimicrobial prescribing or wards where there are concerns about compliance with the Trust antimicrobial formulary (picked up through the quarterly antimicrobial point prevalence audit) or higher incidence of HCAIs.

"Target antimicrobials" are antimicrobials that we have determined locally require closer monitoring than other antimicrobials because they are either: -

- Broad-spectrum antimicrobials that should be reserved for the treatment of more complicated infections that are not responding to the Trusts first line antimicrobials or
- Antimicrobials that are more commonly associated with the development of *C. difficile* infection

The “target antimicrobials” within the Trust are: -

- Piperacillin/Tazobactam (Tazocin®)
- Meropenem
- Cephalosporins
- Co-amoxiclav
- Linezolid
- Clindamycin
- Quinolones

Due to concerns about an increase in prescribing of piperacillin/tazobactam (Tazocin®) across the Trust over the previous 18 months, one of the ward rounds focuses exclusively on reviewing Piperacillin/Tazobactam (Tazocin®) prescriptions.

Patients prescribed “target antimicrobials” are identified from a prescribing report that pulls directly from the Electronic Prescribing Medicine Administration (EPMA). The ward rounds are a way of gaining assurance that the “target antimicrobials” are being prescribed appropriately across the Trust.

Ward Pharmacists are also able to refer patients for review on the antimicrobial ward round. Common reasons for Ward Pharmacist referral are: -

- Concerns that patient is deteriorating from an infection point of view and the clinical team have requested a review
- Patient is prescribed antimicrobials that are non-compliant with the antimicrobial formulary
- Culture and sensitivity results are available to allow rationalisation of antimicrobials but not actioned by clinical team
- Patient clinically well and suitable for oral step down or cessation of antimicrobial therapy but the team with clinical responsibility for the patient are not undertaking this or are requesting Consultant Microbiologists advice

Aim of the Ward Rounds

Ward rounds are undertaken to promote AMS and improve antimicrobial prescribing standards across the Trust. The ward rounds are undertaken in partnership with the clinical teams. We promote that every time a patient is reviewed the **5 antimicrobial prescribing decision options** are considered and the outcome is clearly documented within the electronic patient record (EPR).

1. Stop antibiotics
2. Switch IV to oral antibiotics (IVOS)

3. Change antibiotics as per culture and sensitivity results (escalation or de-escalation as appropriate)
4. Continue antibiotics
5. Refer to Outpatient Parenteral Antibiotic Therapy (OPAT) team.

In 2023/24 NHS England made prompt IVOS a National CQUIN as it is recognised as an important antimicrobial stewardship intervention. To support the Trust, achieve this CQUIN we introduced an IVOS decision aid across the Trust to support prescribers in making this decision.

Benefits of the Ward Rounds

Patient Safety & comfort

During or prior to each ward round the Consultant Microbiologist accesses MOLIS (lab information system) and a review is undertaken of each patient's recent microbiology samples to see if any organisms have been isolated during this admission that will influence antibiotic prescribing decisions. Additional factors that are also considered include history of multi-drug resistant organisms or *C. difficile* infection.

The ward rounds are not just about reviewing the antibiotics prescribed but also ensuring the patient has had the appropriate microbiological samples sent or undergone appropriate clinical investigations to ensure antimicrobials can be stopped, escalated, or de-escalated as appropriate. These interventions ensure that patients are exposed to fewer days of broad-spectrum antimicrobial treatment or antibiotics are changed to more appropriate antimicrobial treatment in a timely manner. Consequently, this improves patient safety because if patients are exposed to fewer days of unnecessary broad spectrum antimicrobial therapy, then the risk of the patient going on to develop a HCAI such as *C. difficile* infection is reduced. Likewise, if it is identified that the patient has grown a multi-drug resistant (MDR) organism in the past then this may be relevant and antimicrobial therapy will be tailored to cover this organism and ensure safe and appropriate antimicrobial treatment.

The ward rounds allow the Consultant Microbiologist and Antimicrobial Pharmacist to review patients with complex histories/infections who benefit from more specialist input i.e., patients with infective endocarditis and patients who are prescribed antimicrobials with a narrow therapeutic window, providing specific advice on dosage adjustment and duration of treatment.

Research evidence has shown that prompt IVOS can reduce risk of the patient going on to develop a bloodstream or catheter related infection, reduce hospital length-length-of-stay and increase patient mobility and comfort.

Junior Doctors & Antimicrobial Stewardship (AMS)

The Consultant Microbiologists and Pharmacist use the ward rounds as an opportunity to build up relationships with ward teams and provide education to junior doctors. Appropriate

prescribing is just one part of good antimicrobial stewardship, timely and appropriate microbiological sampling, and regular clinical review of both the patient and the diagnosis are also vital parts of the Start Smart, Then Focus (SSTF) antimicrobial prescribing algorithm. The ward rounds seek to engage all doctors (but mostly junior doctors) and promote these vital steps and help them develop a wider understanding of AMS.

The antimicrobial formulary is actively promoted on each ward round and the junior doctors are reminded of the importance of AMS and their vital role in slowing down antimicrobial resistance (AMR). Junior doctors are encouraged to participate in the ward rounds, and they are informed of the reasons for any suggested changes to antimicrobial therapy which develops their knowledge of microbiology. It is hoped that the education provided during the ward rounds will influence their prescribing practice as they progress in their career and develop their confidence around diagnosis and management of different infections.

Financial benefits

Cost savings are made through the ward rounds by reducing unnecessary consumption of antimicrobials by timely cessation of antimicrobial treatment or de-escalation in treatment where appropriate. Nursing time is saved by the appropriate cessation of antimicrobials, particularly intravenous antimicrobials, releasing the nurse to provide additional time to care for the patient. There is also a cost saving associated with reduced equipment costs by prompt IVOS.

Identification of patients who may be suitable for early supported discharge for completion of long-term IV antibiotic therapy in the community setting via the OPAT team has financial savings for the Trust by reducing hospital length-of-stay.

Compliance with NICE Guidance

NICE guideline NG15 recommends that all care settings should establish an antimicrobial stewardship programme. This ward round is part of the Trusts AMS programme and ensures compliance with NICE guidance. It provides an opportunity to feedback to individual prescribers, monitor prescribing habits and provides education and training.

Other benefits

The ward rounds help the Trust to manage antimicrobial shortages.

Participation in the antimicrobial ward rounds is a good development opportunity for Junior Pharmacists and improves their knowledge and confidence in AMR and AMS. Trainee Advanced Care Practitioners, medical students and various practitioners undertaking non-medical prescribing qualifications have also joined the ward rounds this year as an educational experience.

Future Developments

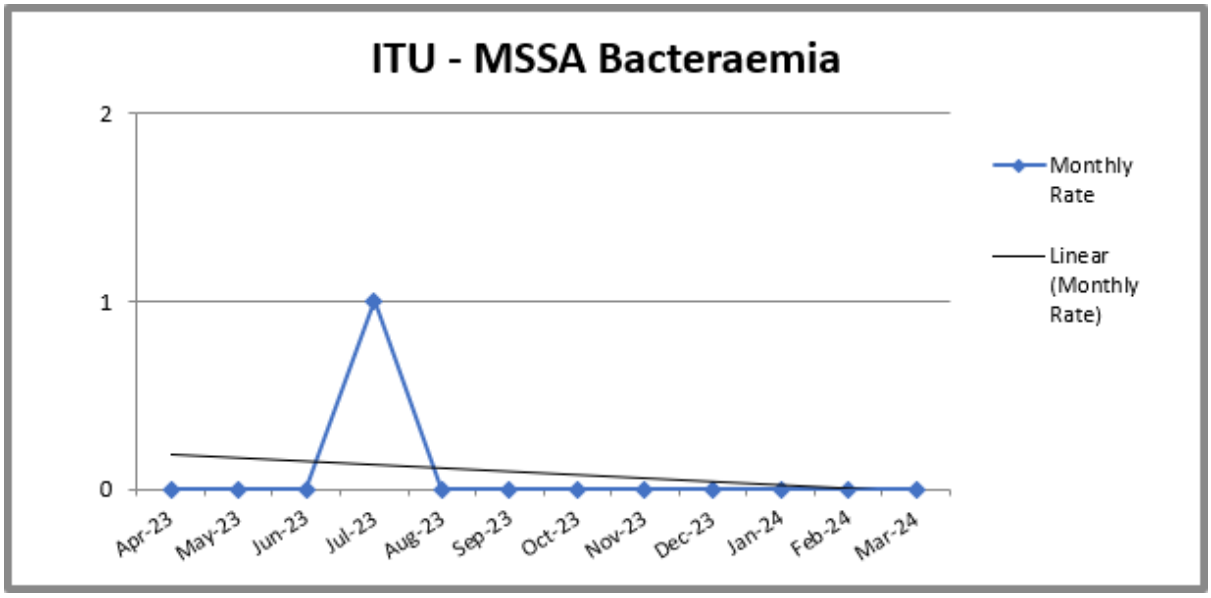
- The antimicrobial ward rounds could be expanded or further ward-based MDTs added so that more patients on antimicrobials are reviewed. However, this is limited by Consultant Microbiologist and Antimicrobial Pharmacist availability. This is mitigated currently by targeting wards found to have lower compliance with the antimicrobial formulary on the point prevalence audit on the existing weekly antibiotic ward rounds.
- Ensure outcomes associated with the Tazocin-specific ward round are recorded in the same way as the other ward rounds.
- Develop the Antimicrobial Ward Form to make it easier to extrapolate data from EPMA.

Critical Care Surveillance

The Critical Care Unit conducts enhanced surveillance of bloodstream infections and ventilator associated pneumonia cases.

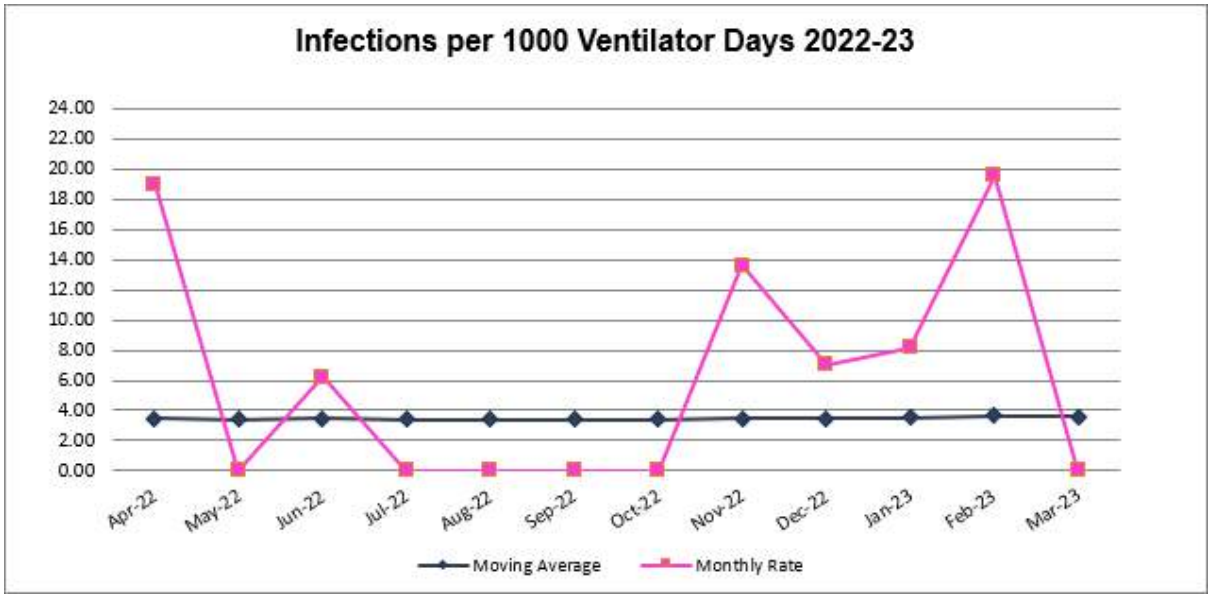
MSSA bacteraemia cases were monitored, and one intravascular line associated case was observed as shown in figure 32.

Figure 32 Critical Care MSSA Bacteraemia Surveillance



The Critical Care Unit also collates data on ventilator associated pneumonia (VAP) cases. This facilitates identification of trends of bacterial pneumonia in ICU patients who are mechanically ventilated with data shown in figure 33.

Figure 33 Ventilator Associated Pneumonia Surveillance



Targets and Outcomes

Activities

The Infection Prevention and Control Team has been involved in several initiatives within the Trust to promote the importance of infection prevention and control. These included: -

- Hand hygiene awareness raising events
- Unannounced spot checks
- World hand hygiene day
- Matron/Facilities Walkabouts
- World Antibiotic Awareness Week
- C. difficile care support worker training
- Response to complaints
- Response to FOI requests

Awareness raising events

The team had a proactive approach to awareness raising events using Trust wide safety brief, good morning WHH global email, desktop messages and promotional campaigns.

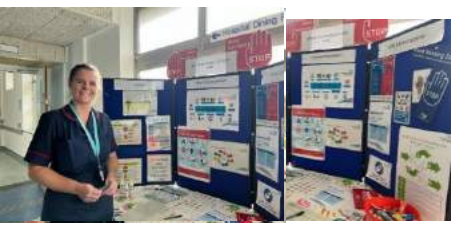
World Hand Hygiene Day May 2023






International Infection Prevention Week October 2023





World Antimicrobial Awareness Week November 2023

Nutrition and Hydration Week February 20024

Facilities Team – Waste Management

Updated policies and guidelines

Policies and guidelines relating to Covid-19 were developed as per the Covid-19 section of this report. The following documents were revised and approved by the Infection Control Sub-Committee: -

- CPE Screening and Patient Placement SOP
- MRSA screening and Suppression Treatment for Elective Orthopaedic procedures
- CPE patient information leaflet
- CPE contacts leaflet
- Scabies guidelines

- Revised SOP for Non-Elective Patient Testing for (Winter) Respiratory Viruses, Patient Placement & Infection Control Precautions (Adults/ Children)
- Cleaning Standards Policy
- Face filtering piece FFP3 fit testing policy
- Influenza (pandemic and seasonal) policy
- Working with dogs in healthcare policy
- Measles Risk Assessment
- ED Measles Triage and Patient Placement SOP

Revised and updated infection control policies, procedures and information leaflets are available from the Trust's intranet for staff to access.

Contribution to other initiatives

Capital Projects
All areas that have undergone upgrade work have been reviewed and signed off by the IPCT prior to re-occupation by patients.

External groups
The Infection Prevention and Control Team participated in the following external groups: -

- Northwest Boroughs Partnership Mental Health Trust Infection Control Committee
- Place-based System Collaborative for Infection Prevention
- NW Nutrition and Hydration Group
- NHSE Regional NW IPC Network Meeting

Training Activities
The Infection Prevention and Control Team continue to provide a structured annual programme of education. This includes an Infection Control eLearning package for all staff. Training attendance figures, for substantive staff, were monitored monthly with details shown in table 7.

Table 7 Infection Control Training compliance

IPC Mandatory Training	A	M	J	J	A	S	O	N	D	J	F	M
Level 1 – Non-Clinical	94%	96%	94%	95%	95%	96%	95%	95%	96%	96%	96%	96%
Level 2 – Clinical	83%	84%	85%	86%	86%	86%	87%	87%	87%	87%	87%	86%
Overall compliance	**84%**	**90%**	**90%**	**91%**	**91%**	**91%**	**91%**	**91%**	**92%**	**92%**	**92%**	**91%**

The Infection Prevention and Control Nurses (IPCNs) provided a weekly face to face mandatory training session. CBUs with compliance below 85% have been directed to set improvement trajectories. Additional training sessions have been offered by the IPCNs to support the CBUs.

The following sessions are included in the infection control training plan: -

- Trust corporate induction: all new starters
- Mandatory training: all staff
- Patient facing staff – annual
- Non-patient facing staff – 3 yearly

Other training was provided to: -

- F1/F2 Doctors
- Induction and updates
- Blood culture specimens (indications; aseptic technique and performance management)
- Prudent use of antibiotics

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

Ad hoc clinical based teaching

Single point lessons are provided in response to incidents for: -

- C. difficile management
- CPE screening
- Isolation priorities
- Linen Management
- MRSA screening and suppression therapy
- Outbreak Management
- Personal protective equipment

Conclusion

The IPCT have worked hard throughout the year to provide education and guidance in response to the Covid-19 pandemic and deliver the annual work plan.

The team members have provided a high output of education, guidance, and positive outcomes for the Trust. It is to their great credit that team members stepped up to meet the additional requirements for education, updates to policy documents and meeting attendance alongside a proactive agenda to address C. difficile cases and bloodstream infections from MRSA/MSSA and GNBSI.

Assurance on the prevention and control of infections is provided by a matrix approach of updating policies to incorporate best practice/legislation; robust and regular auditing of policies and practice; spot checks and self-assessment. Although

some policies are overdue review, there was a vast amount of proactive and responsive activity for Covid-19.

High Level Briefing Papers and reports submitted to the Patient Safety and Clinical Effectiveness Committee and quarterly reports submitted to the Quality Assurance Committee and Board of Director reports, provide assurance on infection control activities and outcomes.

Gratitude is extended to the Infection Prevention and Control Team for maintaining their proactive leadership of a challenging and extremely busy agenda.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Quality Committee is asked to receive the Infection Prevention and Control DIPC Annual Report and note the progress made.

4. IMPACT ON QPS?

Q = Improvements to quality by reducing cases of healthcare associated infection

P = Training of staff to care for patients with suspected/diagnosed infections

S = Work with procurement to support the carbon net zero 2040 ambition

5. MEASUREMENTS/EVALUATIONS

Monitor: -
Progress against the Infection Control Sub-Committee work plan

- Healthcare associated infection surveillance data
  - C. difficile
  - MSSA bacteraemia
  - MRSA bacteraemia
  - E. coli bacteraemia
  - Pseudomonas aeruginosa bacteraemia
  - Klebsiella spp. bacteraemia
  - Covid-19 – Hospital onset probable and Hospital onset definite cases
  - Outbreaks of infection

- Progress against HCAI prevention plans
  - Gram negative bloodstream infection reduction
  - *Staphylococcus aureus* bacteraemia reduction (MRSA/MSSA)
  - C. difficile infection reduction
  - IPC Brilliant Basics Campaign

- Delivery of the Infection Prevention and Control Strategy
- Education and training compliance figures
- Audit of policy/guideline compliance and action plan for non-compliance
- Progress with policy revisions

Progress against the IPC Strategy and Annual Action Plan will be monitored at the Infection Control Sub-Committee.

Compliance assessment against the Health and Social Care Act (2008), Code of practice on preventing infections and related guidance (2022) will be conducted biannually.

6. TRAJECTORIES/ OBJECTIVES AGREED

2023/2024 Trajectories

- C. difficile ≤ 36 cases
- MRSA bacteraemia cases - Zero tolerance to avoidable cases
- MSSA bacteraemia cases – no threshold
- Gram negative bloodstream infections
  - E. coli bacteraemia ≤ 54 cases
  - P. aeruginosa bacteraemia ≤ 2 cases
  - Klebsiella spp. bacteraemia ≤ 18 cases
- IPC Strategy Delivery

Objectives for 2024/2025 are awaited

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to: -

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted to the Quality Assurance Committee and Trust Board quarterly.

Verbal updates are provided to Trust Board monthly as part of the IPR (in full) report.

A Director of Infection Prevention and Control Report is submitted to Trust Board annually.

8. TIMELINES

Financial year 2023/24

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to receive and note the report and progress made.

Alison Kennah
Chief Nurse/ Director of Infection Prevention and Control (DIPC)
June 2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix 1 Annual Work Programme 2024/25

Progress against this action plan will be monitored at the ICSC monthly. Updates will be made where additional activities are identified.

Governance													
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Review of ICSC Terms of Reference	Annual	Deputy DIPC												✓
Review of ICSC Cycle of Business	Annual	ADIPC												✓
Review of Annual Work Plan	Annual	ADIPC												✓
Review of IPCT infrastructure and reporting lines	Annual	ADIPC		✓										
DIPC annual report	Annual	ADIPC			✓									
Quarterly DIPC reports to ICSC	Quarterly	ADIPC	✓			✓			✓		✓			
Quarterly DIPC reports to Quality Assurance Committee (QAC)	Quarterly	ADIPC		✓			✓			✓			✓	
Quarterly DIPC reports to Trust Board	Quarterly	ADIPC			✓			✓			✓			✓
Risk register review	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ICSC HLBP submission to PSCE; and H & S sub-committees and CSS Care Group Governance Meeting	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of revised HCAI (GNBSI/C. difficile Objective for 2024/25)	Annual	ADIPC	✓											
Review of progress against this work plan	Quarterly	ADIPC	✓			✓			✓			✓		
Review of progress against the IC strategy	Biannual			✓						✓				
Provision of commentary for Trust Quality Account	Annual	ADIPC	✓											
Code of Practice for prevention of HCAIs – compliance assessment	Biannual	ADIPC					✓						✓	
Review of HCAI prevention action plans C. difficile;	3 / annum	ADIPC		✓				✓				✓		
Review of HCAI prevention action plans GNBSI;	3 / annum	ADIPC	✓				✓				✓			
Review of HCAI prevention action plans Staphylococcus aureus	3 / annum	ADIPC			✓				✓				✓	
Committee/Group meeting attendance														
Antimicrobial Stewardship Group Meetings	Quarterly	AMSG Lead CMM	✓			✓			✓			✓		
Bed meetings	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDT MDT	Weekly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Decontamination Group	Quarterly	ICD / ADIPC	✓			✓			✓			✓		
Estates Planning Project Group	TBC	ADIPC												
Event planning Group	TBC													
HCAI Network – UKHSA	TBC													
Health and Safety Sub-Committee	Monthly		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Protection WBC	TBC													
Housekeeper Forum	Bimonthly	IPCN	✓			✓				✓		✓		✓
ICSC	Monthly	All												
ICU/IPC	Biannually													
Infective Endocarditis MDT	Weekly	CMM												
IPCT Meetings	Fortnightly	IPCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Committee/Group meeting attendance													
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
IPS	TBC	ADIPC												
Medical Devices Group	Quarterly	IPCNs	✓			✓			✓			✓		
NNU/IPC Meetings	Biannual	IPCNs												
Nursing & Midwifery Forum	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutritional & Hydration Group	Monthly	TBC												
NWB ICC	TBC	Deputy DIPC												
Occupational Health and Wellbeing/IPC														
Operational Patient Safety Group														
Patient Experience Sub-Committee	Monthly	IPC Matron	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Safety and Clinical Effectiveness Committee	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
PSIRF HCAI event meetings														
Quality Assurance Committee	Monthly	CNO/DIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Safer sharps group meeting	Monthly	IPCN	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sepsis Improvement Group														
System Collaborative for Infection Prevention														
Trust Wide Safety Brief														
Ventilation Assurance Group	Quarterly	ICD / ADIPC												
Ward B19 CDT MDT	Weekly	CMM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ward Managers Meeting														
Water safety group	Quarterly	ICD / ADIPC								✓		✓		✓
Surveillance														
Compliance with mandatory reporting of MRSA; MSSA; C. difficile; GNBSIs (E. coli, Klebsiella and Pseudomonas)	Monthly	IPCNs/ ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory reporting data validation and timely sign off	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Covid-19 outbreak reporting	Per incident	IPCNs												
MSK compliance with Mandatory orthopaedic surveillance	Quarterly	LN MSK	✓			✓			✓			✓		
Zero tolerance to avoidable MRSA bacteraemia cases	Monthly	ALL												
SSSI	Quarterly	LN DD	✓			✓			✓			✓		
HCAI surveillance reports – weekly to Chief Nurse, Associate Chief Nurses, Lead Nurses, and Matrons	Weekly	IPC Admin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surveillance of HAI alert organisms (MRSA, VRE, CDT etc.)	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting for Trust dashboards with commentary	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting to ICSC dashboards	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pseudomonas surveillance in Augmented care area (ICU: NNU : K25)	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VRE surveillance	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete Quarterly Mandatory Laboratory returns and submit to UKHSA	Quarterly	Deputy DIPC	✓			✓			✓			✓		
Antibiotic ward rounds daily on ICU	Daily	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Antibiotic ward rounds	Weekly	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Environmental cleanliness monitoring													
	Target date	**Lead**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Environmental cleanliness monitoring	Monthly	Facilities Manager	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matron and IPC Walkabouts	Monthly	Matrons /IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
First Impressions – SEE Walkabouts	TBC	IPC Matron												
Mock CQC inspections	TBC	Matrons	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estates PAM assessment	Annual	ADE												✓
Legionella Assessments and compass flushing reports	TBC	ADE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Cleaning standards and Cleanliness Charter Efficacy Audits	Monthly	HoF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audit														
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hand hygiene audits	Weekly	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRSA pre-operative screening audit	Quarterly	LN DD	✓			✓			✓			✓		
MRSA screening compliance audits	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support areas requiring improvements identified on the Quality Metrics programme	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Policy /guideline/SOP/Leaflet Reviews														
Alignment of NIPC Manual to all Trust Policies/guidelines/SOPs	TBC	IPCNs												
Blood Culture Policy	TBC	IPCNs												
CJD Nursing Management	TBC	IPCNs												
CJD Instrument Handling	TBC	IPCNs												
Tuberculosis	TBC	IPCNs												
Chickenpox	TBC	IPCNs												
Meningitis and Meningococcal Disease	TBC	IPCNs												
Viral haemorrhagic fevers	TBC	IPCNs												
Safe handling and disposal of waste	TBC	IPCNs												
Isolation of immunosuppressed patients	TBC	IPCNs												
High Consequence Infectious Disease Policy	TBC	IPCNs												
Infection Control Policy	TBC	IPCNs												
Hand Hygiene Policy	TBC	IPCNs												
Aseptic Technique	TBC	IPCNs												
Standard and transmission-based precautions policy	TBC	IPCNs												
Personal Protective Equipment Policy	TBC	IPCNs												
Group A Streptococcus Policy	TBC	IPCNs												
Outbreak Policy	TBC	IPCNs												
Notification Policy	TBC	IPCNs												
Terminal Cleaning Policy	TBC	IPCNs												

Awareness raising events													
	Target date	**Lead**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Global Hand washing Day	May	IPCNS		✓										
Uniform and workwear promotion	TBC	All												
October IC week – Topic Boards	Oct	IPCNs							✓					
Trust wide Safety Brief – IPC promotion	Oct	ADIPC							✓					
November World Antibiotic Awareness Week	Nov	CMM								✓				
Seasonal flu campaign with OHWB	Dec	OHWB							✓	✓	✓	✓		
Covid PPE refresher training	TBC	TBC												
World TB Day	Mar	IPCNs												✓
Education														
ANTT Peer Assessor Training	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Induction training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Single Point Lessons as requirement identifies	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

D = deferred
✓= Planned
✓= Completed

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/24/07/78**			
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Report**			
DATE OF MEETING:	9 July 2024			
ACTION REQUIRED:	To Note			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE:	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.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		N/A	N/A	N/A
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	N/A	N/A	N/A
	Further Information/Comments: Nil			
EXECUTIVE SUMMARY	This report provides a compliance assessment with the Code of Practice on Prevention and Control of Infections and related guidance and implementation of the national Infection Prevention and Control Manual. This Document replaces the previous Covid-19 Board Assurance Framework. There are 5 partial compliance points, with some underpinning actions relating to: - • Completing Healthcare Associated Infection events alignment with the Patient Safety Incident Response Framework • Completion of action plans following IPC audits • Implementation of the National Infection Prevention and Control Manual and alignment of policies and guidelines			

<table>
<tr><td></td><td colspan="3">

- Updates to information on infection Control on the Trust website
- Details on compliance with clinical competency assessments
- Prioritising backlog estate maintenance and introduction of efficacy audits with multi-disciplinary team members
- Alignment of the NHS waste management strategy

</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note ✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="3">The Quality Assurance Committee is asked to receive and note the report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Infection Control Sub-Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">ICSC/24/06/58</td></tr>
<tr><td>Date of meeting</td><td colspan="2">20 June 2024</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit to Quality Assurance Committee</td></tr>
<tr><td>NEXT STEPS:
State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">Choose an item.</td></tr>
</table>

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Board Assurance Framework Assessment	AGENDA REF	QAC/24/07/78

1. BACKGROUND/CONTEXT

This report provides details of a compliance assessment with the Code of Practice on Prevention and Control of Infections and Related Guidance 2015. This Code of Practice links to regulation 12 of the Health and Social Care Act 2008 and is used by regulatory bodies to assesses registered providers compliance.

2. KEY ELEMENTS

The assessment has been completed using an assessment tool, published by NHS England, which autogenerates summary plots and a red, amber, green status for each criterion. Use of this framework is not compulsory, however there is a recommendation it is used by registered providers to ensure compliance with infection prevention and control (IPC) standards.

The assessment focusses on compliance with the National Infection Prevention and Control Manual and is aligned to the Code of Practice (Code of Practice) on Prevention of Healthcare Associated Infections and Related Guidance. The assessment tool abridges the Code of Practice, is guidance and does not include all elements.

Summary compliance information is displayed below and the full assessment is included at appendix 1.

Figure 1 Overall compliance

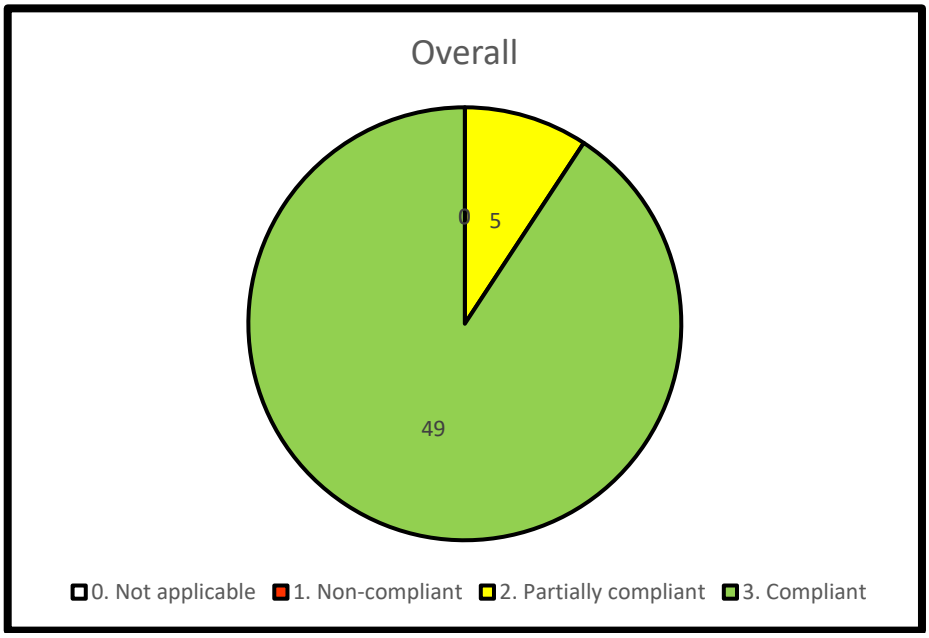
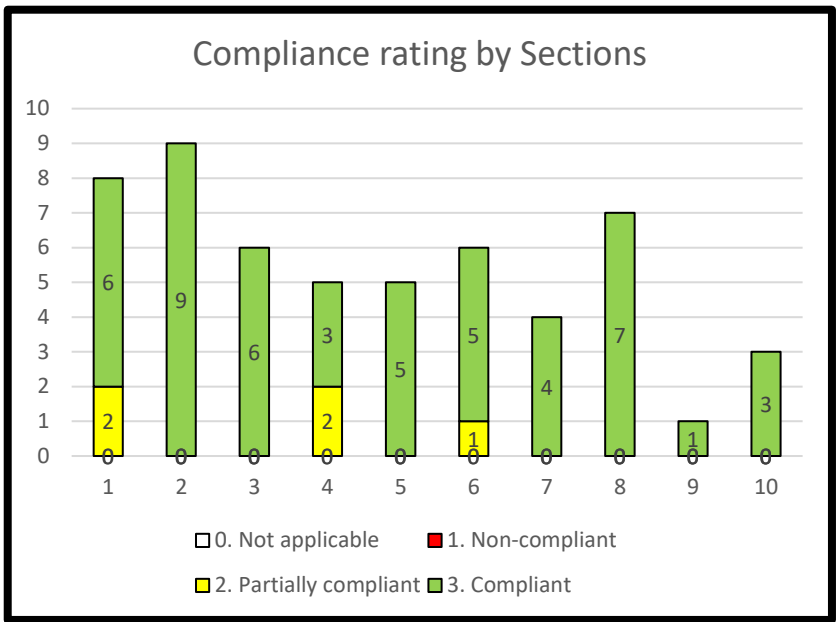


Figure 2 Compliance by section



An action plan is in place, which is monitored by the Infection Control Sub-Committee to ensure that activity is undertaken to achieve full compliance.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies recovery plan
- Delivery of the Infection Prevention Strategy
- Provision of infection prevention and control expert advice to colleagues

4. IMPACT ON QPS?

- Q: A reduction in healthcare associated infections (HCAI) will demonstrate a positive impact on patient outcomes
- P: Attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAI and involvement in procurement supports sustainability and the green plan

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of HCAI to UK Health Security Agency
- Surveillance of nosocomial Covid-19 cases/reporting Covid-19 outbreaks
- The Infection Prevention and Control Team monitor HCAI. Action is implemented in response to increased incidences of infection/infection control related events
- The Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents
- Review of HCAI events, reports, audits and agreed actions to support care improvements
- HCAI data is included in the ward dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

IPC Strategy Objectives: -

- Prevention of healthcare associated infections. The thresholds for 2024/2025 are awaited
- Strengthening Antimicrobial Stewardship – Participation in the IV Oral Switch CQUIN CCG3
- Improving standards of environmental cleanliness
- Implementing action in line with the NHS Waste Strategy

7. MONITORING/REPORTING ROUTES

High level briefing papers from Infection Control Sub-Committee are submitted to:-

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Infection Control Sub-Committee, Quality Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

The Director of Infection Prevention and Control Report is submitted to Trust Board annually and published on the Trust website.

Monitoring by the Senior Executive Oversight Group.

8. TIMELINES

2024 – 2025 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported and progress made.

Appendix 1 Compliance Assessment and Action Plan Infection Prevention and Control Board Assurance Framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include - an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	- Infection Control Sub-Committee - Chief Nurse/Deputy CEO is DIPC IPC infrastructure and reporting lines organisation chart for the IPC Team WHH Internal Governance Structure				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Compliance with mandatory reporting of HCAIs to UKHSA HOHA COHA cases are reported on the digital incident reporting system Surveillance data is reported and discussed at Infection Control Sub-Committee			Increase in mandatory reportable HCAIs. Action and project plan in place to address the rise in these cases.	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Digital incident reporting system Task and Finish Group working to implement PSIRF	Healthcare associated infection safety incident response is being aligned with PSIRF to promote systemic, compassionate, and proportionate responses	Healthcare associated infection matrix in development detailing alignment of IPC with PSIRF, Use of swarm huddle and MDT review. Thematic analysis in progress to identify additional learning.		2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Policies, guidelines, and SOPs in place aligned to the National Infection Prevention and Control Manual Programme of Matron and IPC monthly visits implemented Programme of infection prevention audits in place	Some policies are beyond their review dates.	Review of IPC audit programme, support being offered to Ward Managers to develop action plans and Matrons to provide leadership oversight on implementation. Existing policies are evidence based.	Increase in mandatory reportable HCAIs. Action and project plan in place to address the rise in these cases.	2. Partially compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Compliance with mandatory reporting of HCAIs to UKHSA HOHA/COHA healthcare associated infection cases are reported on the digital incident reporting system Surveillance data is reported and discussed at Infection Control Sub-Committee HCAI Prevention Plans are in place and are			In 2023 the Trust flagged as an outlier; however, number of infections remain low and rates of infection have since been on a downward trend. There is an increase in C. difficile and an action plan has been produced to address this.	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		reviewed and updated 3 times per annum Quarterly DIPC reports are submitted to Trust Board				
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Infection Control Policy outlining responsibilities Managerial responsibilities are included in the risk management framework for vulnerable staff				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Mandatory training Level 1 and Level 2 Additional training - Single point lessons Care support worker specific sessions Contractors Information leaflet			Additional training is carried out in response to incidents and locally at ward/department level.	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Managerial responsibilities are included in the risk management framework			Additional risk assessments are introduced in response to national incidents (e.g. rise in measles cases). Hierarchies of control have been added to level 3 health and safety training.	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g., ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Commitment to cleanliness charter implemented Functional risk categories agreed and auditing in place Star ratings are displayed in all areas	Functional Efficacy Audits not in place	Head of facilities is arranging PLACE and drawing up a plan for functional audits	Efficacy audit programme in development	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE report and action plan to address findings				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Roles and responsibilities are included in the cleaning standards policy				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Ventilation Safety Group Ventilation assessments Authorising Engineer (ventilation) included in all capital projects Water Safety Group Water Safety Plan Legionella Policy				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Planned preventative maintenance policy	Backlog maintenance	Prioritisation plan to rectify areas identified for improvement		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Laundry Policy				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste Policy Waste Segregation Guidelines Duty of Care visits to waste contractors	NHS Waste Strategy not fully implemented to meet the ambition of 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste	Task and finish group established and plan to trial implementation of offensive waste stream		3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	External sterile services provided for decontamination of surgical instruments			Increase in Datix reports relating to instruments, and a visit to the sterile services provider is planned.	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer, or staff this must be stored in line with food hygiene regulations.	Food Safety Policy				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
System and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	A Consultant Microbiologist is the nominated lead for AMS. Antimicrobial Management Steering Group (AMSG) minutes. AMSG Terms of Reference, meeting agendas and meeting minutes.				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving	An annual account of antimicrobial stewardship activity is included in the DIPC annual report				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	the UK AMR National Action Plan goals.					
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	DIPC has responsibility for AMS				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.	Prescribing advice is included in the Trust Antibiotic Formulary (Micro-guide) Antibiotic ward rounds are conducted (ICU daily - weekdays) C. difficile cohort ward weekly by Consultant Microbiologist Consultant Microbiologist and Antibiotic Pharmacist ward rounds twice weekly				3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are	IVOS CQUIN reduction in patients on IV antibiotics beyond the time they could switch reduced (lower percentage = better	Gap in assurance on performance against the UK: AMR 5-year plan	Include in AMSG meeting as a standard agenda item		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	performance) from 28% in Q1 to 11% in Q4				
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	Micro-guide (Antibiotic Formulary) 24/7 access to antimicrobial prescribing advice				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care, or treatment nursing/medical in a timely fashion						
System and process are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Patient information leaflets are shared with a reader group by the Communications Team Review in progress to use NHS Choices information				3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g., digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/ visitor/advocate.	Communications and Patient Experience Team support for accessible formats				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key	WHH Website Visiting guidance	Website IPC information requires review	Communications team contacted to update information		2. Partially compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	aspects of the registered provider's policies on IPC and AMR.					
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g., AMR awareness/vaccination programmes/seasonal and	Visitor guidance Cleanliness reporting Signage during outbreaks	Sharing information to service users on participation in national campaigns	Communications team contacted to update information on patient facing website		2. Partially compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors, and advocates to minimise the risk of transmission of infections.					
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Digital tie to share information with community IPC Team and GPs Development and sharing of urinary catheter passport across Cheshire and Merseyside				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment	Admission infection risk assessment	Limited access to isolation facilities in Ed and on wards	Close liaison with the Patient Flow Team on safe patient placement Side room audit tool to support reviews Digital tool in use to support contact tracing following exposure		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	to reduce the risk of infection transmission.			incidents and text messaging to warn and inform of symptoms		
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Infection risk assessments included in digital care plans Cohort bays for C. difficile and Covid-19. Escalation plan for winter respiratory viruses				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	SBAR transfer form includes section on infection status				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage in place when there are outbreaks of infection ED triage tool				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	C. difficile surveillance Covid-19 surveillance Incidents are reported on the digital incident reporting system, escalated to DIPC internally and where appropriate reported to UKHSA				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
System and process are in place to ensure that:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Mandatory training level 1 and level 2 Additional training - Single point lessons Care support worker specific sessions Contractors Information leaflet				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Audit programme in place, ANTT competency programme in place				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
6.3	Monitoring compliance and update IPC training programs as required.	Compliance with mandatory training is monitored at Infection Control Sub-Committee The packages are updated annually in line with Core Skills for Health guidance				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Included in mandatory training presentation				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Programme of FFP3 Fit testing in place	Revision to denominator baseline to ensure accuracy of reporting	Development of an escalation plan to support response to future pandemics		3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to	Clinical skills training records Aseptic non-touch technique	Return of completed competency assessments for central recording			2. Partially compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	undertake the procedures independently.					

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Infection control admission risk assessment in the electronic patient records				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Infection prioritisation standard operating procedure Daily side room audit Winter respiratory virus escalation plan				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Isolation door notices			Refresh of isolation signage in progress	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	SBAR transfer form includes section on infection status				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Microbiology laboratory has UKAS accreditation				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	On call consultant Microbiologist On call IPC service				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology	Microbiology Department SOPs				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.					
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	All SOPs, policies, guidelines are aligned to national standards				3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Local testing protocols in place				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Support offered to partner organisations for outbreak investigation				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Laboratory Users Handbook	Testing of the protocol	Review of incident reporting		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
Systems and processes are in place in line with the NIPCM to ensure that:						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording,	Policies, guidelines, and SOPs in place Surveillance in place to detect outbreaks Reporting is in line with UKHSA requirements	Some policies beyond review date	Recovery plan in place		3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	escalation, and reporting of an outbreak/incident by the registered provider.					

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Included in Risk Management Framework				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Blood borne virus policy in place Sharps injury data is reviewed at the Health and Safety Sub-Committee and at Infection Control Sub-Committee				3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Health clearance policy in place for pre-employment checks				3. Compliant

Action Plan for the IPC BAF 12/2023

Criterion	Key line of enquiry/standard required	Action required	Lead	Review date	RAG
	Change approach to review of HCAI incidents	Align IPC incidents with PSIRF	ADIPC	31/03/2025	
1	Return of action plans following IPC audits	IPCNs to support Ward Managers with development of action plans	IPCNs	31/03/2025	
	Efficacy cleaning audit programme to include MDT	Implement programme of efficacy audits	HoF	31/03/2025	
	Backlog maintenance prioritisation schedule	Agree priorities and implement schedule of works	HoEMCR	31/03/2025	
2	Implement NHS Waste strategy	Task and Finish Group - deadlines to be set up	FMC	31/03/2025	
4	Provision of information to visitors/carers	Update to Trust patient facing website	IPCNs	31/03/2025	
6	Recording of clinical competency assessments	Assurance on completion of competency assessments and sign off following clinical skills training	HoCE	31/03/2025	
9	IPC policies	Policy recovery action plan	IPCNs	31/03/2025	

ADIPC	Associate Director of Infection Prevention & Control
FMC	Facilities Manager Contracts
HoCE	Head of Clinical Education
HoEMCR	Head of Estates Maintenance, Compliance & Risk
HoF	Head of Facilities
IPCNs	Infection Prevention & Control Nurses

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/06/58**			
SUBJECT:	**Safeguarding Annual Report 2023 - 2024**			
DATE OF MEETING:	11 June 2024			
ACTION REQUIRED:	For noting and approval			
AUTHOR(S):	Katie Clarke, Head of Safeguarding			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This report provides the Quality Assurance Committee with a summary of the safeguarding activity during 2023/2024 and assurance that WHH is meeting all necessary statutory obligations in safeguarding both adults and children. Key highlights: - Re-structure of the safeguarding team in September 2024. - Significant increase in activity across all areas of safeguarding evidencing that staff are recognising and responding to safeguarding concerns. - Increase in complex cases requiring coordinated multi-agency responses. - In April, The Department of Health and Social Care (DHSC) announced that the implementation of the Liberty Protection Safeguards will not go ahead this side of a general election, however WHH continues to raise awareness of the Mental Capacity Act. - Referrals and notifications to the learning disability nurse has increased by 80% - Whilst training compliance has increase throughout the year, level 3 children and level 3 adult safeguarding training has remained under the contractual standards target for 2023/2024 despite trajectories being in place			

<table>
<tr><td></td><td colspan="3">across all care groups. A full review of the safeguarding training programme is planned which will explore the electronic recording of compliance, accessibility and the possibility of combining elements of children and adult safeguarding to make better use of the workforce's time

2023/2024 has been a challenging year in respect of increasingly complex safeguarding cases requiring multi-agency intervention. WHH continues to work collaboratively with Safeguarding Partnerships and Adult Safeguarding Boards to support the development of various strategies and associated workstreams. In addition to challenges describes throughout the report, the WHH Safeguarding Team have gone through a period of change of leadership and structure, however the team continues to deliver a robust service across the Trust in supporting and developing front line practitioner enabling them to keep patients safe</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval
√</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Quality Committee is asked to approve the Safeguarding Annual Report prior to submission to the board.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Safeguarding Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">Virtual meeting</td></tr>
<tr><td>Date of meeting</td><td colspan="2">1 June 2024 - Virtual</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Approved</td></tr>
<tr><td>NEXT STEPS: State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Whole FOIA Exemption</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Choose an item.</td></tr>
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Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals

NHS Foundation Trust

Safeguarding Annual Report 2023-2024

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1. Executive Summary

Safeguarding is a Care Quality Commission (CQC) standard and a duty at the centre of our daily business. The scope of safeguarding is wide reaching and incorporates all categories of abuse. This is the fifth Annual Report regarding adult and children's safeguarding within Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH).

The Trust is committed to continually providing best practice standards in the delivery of a positive Safeguarding culture and considers this a fundamental component in providing a safe environment for staff, patients and the public.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. The embedding of safeguarding practices across the organisation are fundamental in achieving this.

2. Introduction

This report provides the Safeguarding Committee and Quality Assurance Committee with a summary of the safeguarding activity during the financial year 2023/2024. This Annual Report provides assurance that WHH is meeting all necessary statutory obligations in safeguarding both adults and children.

The Safeguarding of children, young people and adults at risk in the NHS, accountability and assurance framework (2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding agenda, thus forming the basis of this report.

In recognition of the legislation as described in the Children Act 2014 and the Care Act 2014, WHH are supported by policies, Standard Operating Procedures, and risk assessments to ensure that all WHH staff are aware of how to discharge their safeguarding duties and responsibilities. The Children Act 2014 and the Care Act 2014 requires the Trust to provide and maintain:

- Safeguarding Unborn Babies, Children and Young People Policy
- Safeguarding Adult at Risk Policy
- Safeguarding Training and supervision
- Processes to support recognition and response to safeguarding situations.
- Information resources to support in their decision making.
- Subject matter experts that are available to support safeguarding practice.

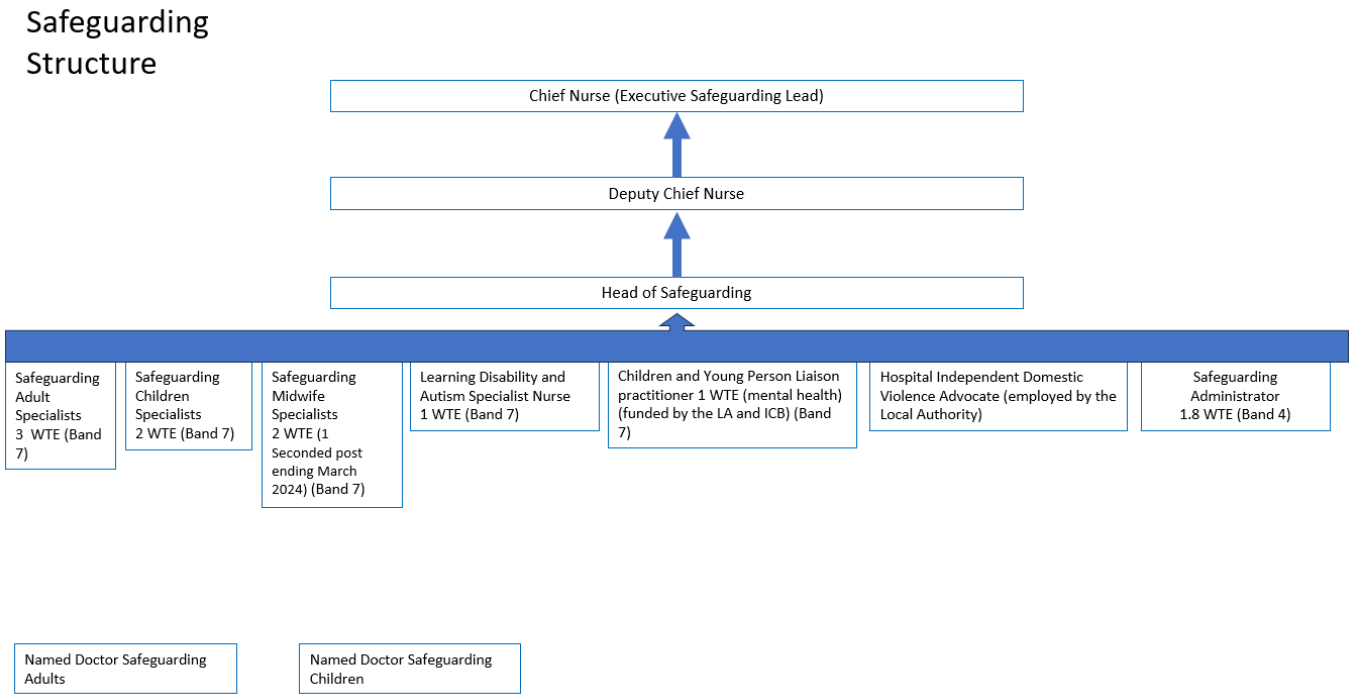
There are safeguarding reporting processes in place to provide assurance of compliance with proactive monitoring and triangulation through existing governance mechanisms.

Working Together to Safeguard Children is the statutory guidance that sets out expectations for the system that provides help, support and protection for children and their families. In December 2023 the Department and Education published a revised Working Together to Safeguarding Children. For the purpose of this document the previous version published in 2018 will be referred to. Safeguarding partners are expected to embed the changes

set out in the newly published guidance with the support of multi-agency partners. Work will now begin to review and update existing WHH policies to ensure they align with any changes. An update will be provided in the 2024/2025 bi-annual report.

3. WHH Safeguarding Management Structure

Following the departure of the Lead Nurse for Safeguarding Adults in September 2023, a restructure of the Safeguarding Team was implemented as a temporary measure. A 6-month pilot period has been a success and the structure describe in figure has been made substantial. The changes included the Lead Nurse Safeguarding Children taking up the post of the Head of Safeguarding and an additional band 7 Safeguarding Adult Practitioner being recruited.

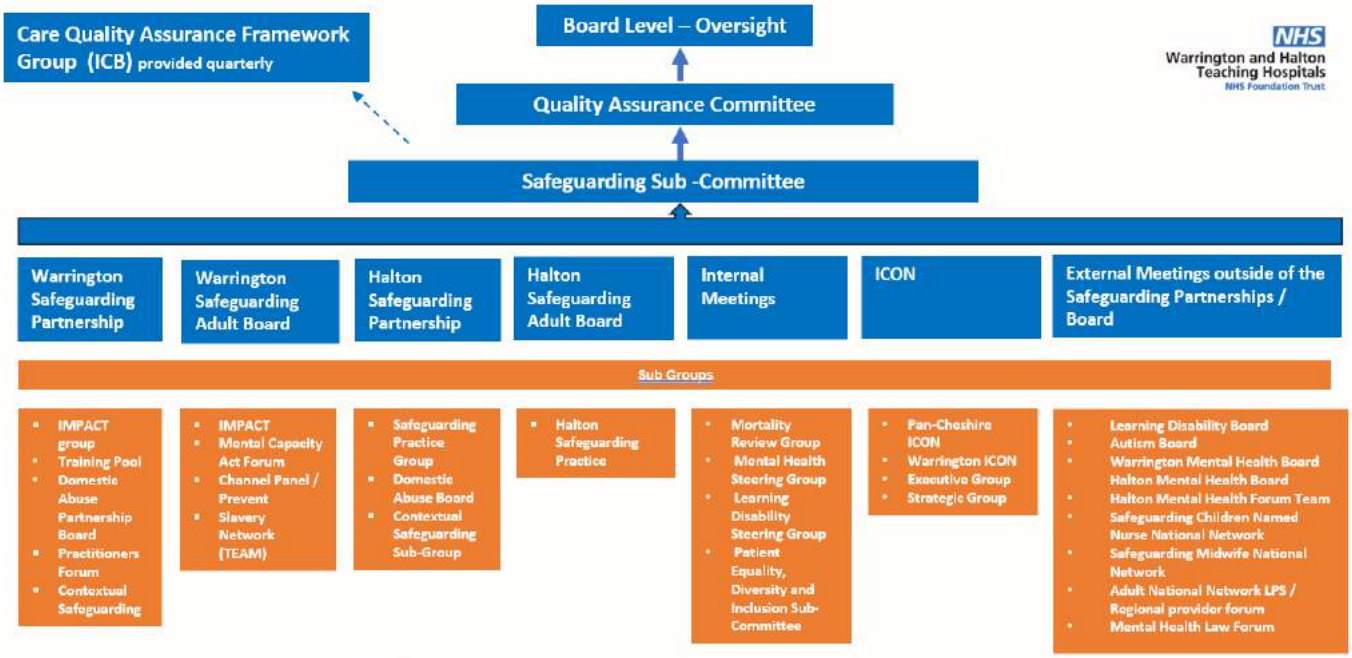


4 Safeguarding Committee Structure

The Safeguarding Committee is a sub-committee of the Quality Assurance Committee (QAC). It is responsible for monitoring the development, implementation, audit and delivery of safeguarding throughout the Trust. The Safeguarding Committee receives reports and has responsibility for the ratification of policies. It is in this way that compliance with external organisational requirements such as the Care Quality Commission, Safeguarding Children Partnerships and Safeguarding Adult Boards are managed.

The Chief Nurse is the Chair of the Safeguarding Committee which is accountable to the Quality Assurance Committee (QAC) ahead of Trust Board.

The Safeguarding Committee reporting structure offers assurance from internal to external safeguarding partners as detailed in the below chart.



5. Underpinning Legislation

The following regulations underpin the Trust's approach to safeguarding enabling a safe environment to be maintained *(the list is not exhaustive).*

In addition to the Safeguarding of children, young people, and adults at risk in the NHS, accountability and assurance framework (2019) framework there are several key legislative documents which drive and support the safeguarding agenda:

The Children Act 2014	Mental Capacity Act (2005)
Care Act 2014	Mental Health Act (2007)
Human Rights Act (1998)	Children and Social Work Act 2017
Deprivation of Liberty Safeguards (2007)	Mandatory reporting of female genital mutilation (2016)
Sexual Offences Act (2003)	Domestic Violence, Crimes and Victims Act (2004)
Data Protection Act (1998)	Public Interest Disclosure Act (1998)
Modern Slavery Act (2015)	Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework (2015)

6. Safeguarding Activity

The following data describes the activity and provides an analysis of safeguarding activity.

Safeguarding notifications to the Safeguarding Teams are completed using the ICE electronic system. Each ICE notification is reviewed and actioned by a Specialist Safeguarding. The data collected from the ICE notifications, telephone calls, emails and face to face contacts have been captured to provide the date in this report.

6.1 Safeguarding Unborns, Children and Young People

6.1.1 Safeguarding notifications

The Safeguarding Children Team activity is difficult to measure with specific data due to the level of complex multi-agency working. Whilst internal activity can be measured with the number if ICE notifications received, the number of phone calls, email requests and intelligence gathering for Multi-Agency Meetings is not collated. Further analysis of this activity is explored later in this report.

When compared to the previous year there has been 19% increase in internal notifications to the Safeguarding Children Team (2475 in 2022/2023 versus 2936 2023/2024). Figure 1 provides data for all safeguarding children ICE notifications under the three categories, Children, Maternity and Domestic Abuse. There has been significant increase of 49% in Maternity ICEs which could be attributed to the additional Safeguarding Midwife seconded to the role for 18 months. Further exploration regarding the impact of this additional safeguarding role is explored later in the report. The activity generated from the ICE referrals is explained under this section of the report.

Figure 1

ICE Notifications to the children's team	Children's	Maternity	Domestic Abuse (Children / unborns in the Family)	Adult Patient (where there are safeguarding children concerns)
2020/2021	2021	827	94	371
2021/2022	2421	901	132	402
2022/2023	1786	689	122	399
2023/2024	1908	1028	116	471
% change 2022/2023 to 2023/2024	↑7%	↑49%	↓5%	↑18%

6.1.2 Safeguarding Children - inpatients

WHH utilise a 'concerns form' to highlight and ensure compliance with the Laming recommendations. These recommendations set out to safeguard children ensuring best practice is applied. Review of data when compared to the previous year indicated a further decrease of 36% similar to the previous year. (205 in 22/23 versus 130 in 2023/2024). As described in the 2022/2023 annual report, the significant reduction can be accounted for following

the review and updating of the Safeguarding Children Policy. Historically concerns form pathway was commenced on all children with mental ill health and any child open to social care at any level. The policy was reviewed and updated to reflect that the pathway would only be commenced on those children who are admitted and when there are safeguarding concerns that require addressing. To ensure compliance with the policy, an audit will be completed in Quarter 4 of 2024 as per the Safeguarding Audit Plan.

The age distribution of the 'concerns form' remains similar to previous year in relation to the under 1s however the 13-17 years there has been a significant decrease. See figure 2. Analysis of the data has identified that the concerns identified for those aged 13-17 years old predominantly relate to mental health concerns (therefore no longer requiring a concerns form). In addition to the change in policy, in July 2022 the role of the Children and Young People Liaison Practitioner was introduced, and 18 months on the impact of this role can be evidenced with the reduction of children admitted with mental health concern.

Figure 2

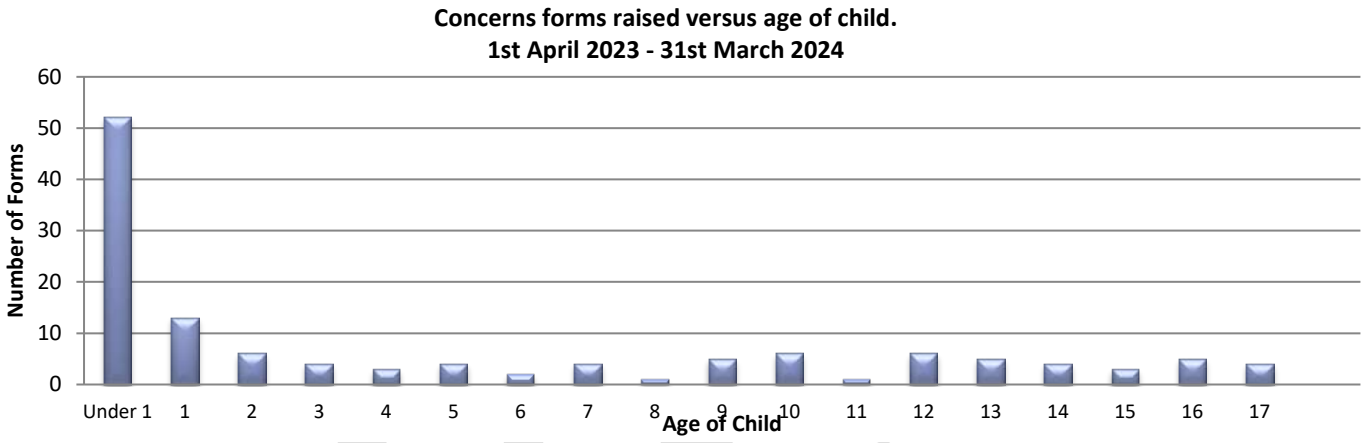


Figure 3

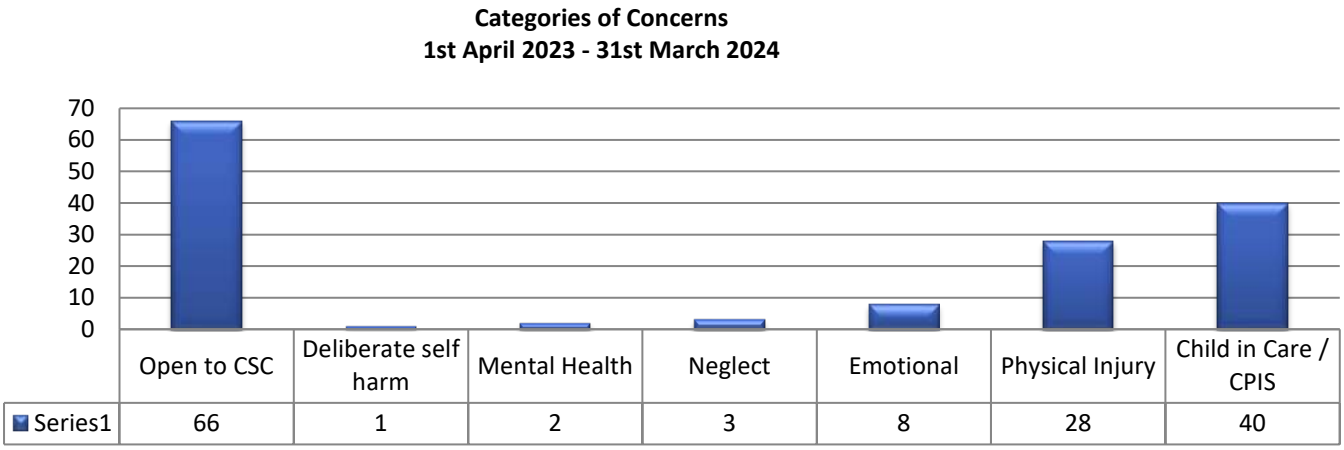


Figure 3 provides an overview of the categories of concern. Several patients identify under more than one category. For example, children who cause harm to themselves could also be known to children's social care. In comparison to the previous year, there has been a significant reduction in the categories of mental health and deliberate self harm, 3 in 2023/2024 versus 119 in 2022/2023. Against this can be attributed to the change in policy and staff understanding of when to raise a safeguarding concern.

6.1.3 Contextual Safeguarding

Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.

There is a Pan-Cheshire Children's Contextual Safeguarding Strategy 2021 – 2023 driving the priorities which WHH continue to support. Operationally, Warrington Local Authority and Halton Local Authority have slightly different approaches to the Multi-Agency Meetings required to monitor individual children.

Operational meetings are held by both Local Authorities (Warrington and Halton) requiring screening and information sharing from WHH. During this reporting period, 1062 searches were conducted to support the contextual Safeguarding Screening Meetings.

As a Trust, staff are informed of the Pan-Cheshire Pathway and are trained to recognise and respond to concerns of contextual safeguarding. Continued education and support to front line professionals, the number of exploitation screening tools has significantly increased in 2023/2024. There were 45 instances in which exploitation was considered at the first contact and 29 of these were referred on the relevant exploitation meetings for further exploration, this is a significant increase of 866% evidencing that WHH staff are understanding exploitation signs and features. Figure 4 provides a comparison to the previous year.

Figure 4

Year	Pan-Cheshire screening tools completed by WHH staff	Screening tool resulted in high risk - Referred on to risk meeting
22/23	29	3
23/24	45	29

6.1.4 Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children

In March 2021 new guidance on perplexing presentations and fabricated or induced illness in children was launched. The new guidance provides procedures for safeguarding children who present with PP or FII and best practice advice in the medical management of these cases to minimise harm to children.

The guidance updates definitions of FII and PP. The new and wider interpretation of FII includes any clinical situation where the parent or carer's actions are aimed at convincing doctors and other professionals that a child is more seriously ill than is the case. In these circumstances, the parent or carer may be acting on erroneous beliefs about the child's state of health or, in some cases, deceiving professionals. There is a risk that the child will be directly harmed by the parent or carer's behaviour but in some cases, and inadvertently, also by the Medical Team's response.

In response to the new guidance a health focussed working group has been developed. WHH works in collaboration with Warrington Integrated Care Board, Bridgewater NHS, Mersey Care NHS and the Named GP to ensure the health

safeguarding concerns in respect of perplexing presentation are discussed, addressed and escalated where required.

WHH are currently tracking 6 families with concerns of PP / FII which involves 9 children. Each case is incredibly complex requiring a high level of research and analysis of care. Whilst this is a decreased from 14 families and 27 children the previous year, due multi-agency working a number of the cases from the previous year have concluded with positive outcomes for the children and the cases now closed.

6.1.5 Child Protection Medicals

A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children Act 1989 (and 2004) which places a statutory duty on the Local Authority to make enquiries to enable it to decide whether it should take action to safeguard and promote the welfare of a child. A total of 36 child protection medicals were completed during the reporting period which is an increase of 64%% from the previous year which was 22. All child protection medicals and cases of physical harm are discussed at a monthly peer review meeting which is attended by internal teams and multi-agency partners. Figure 5 provides the detail regarding the geographical areas of the children who attended for a child protection medical. In 2023/2024 77% of child protection medicals were completed on Warrington children, whereas on 2023/2024 this has decreased to 67%. There has been a marked increase of Halton children attending WHH for child protection medicals 28% in 2023/2024 compared to 9% in 2022/2023)

Figure 5

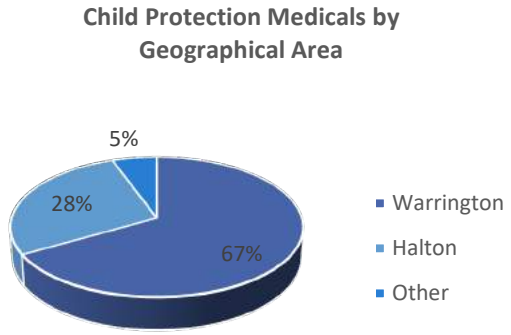


Figure 6

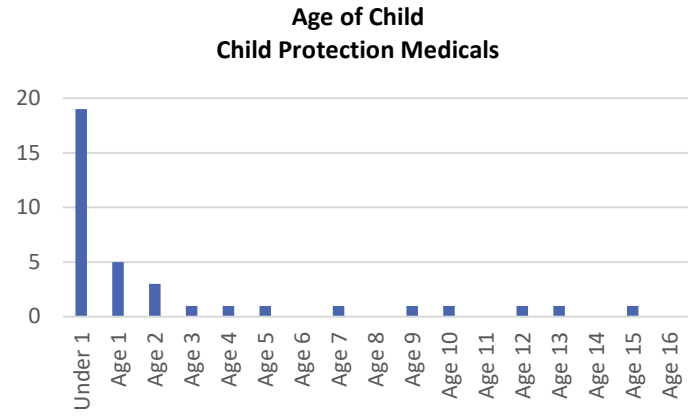


Figure 6 provides a breakdown of age of children requiring child protection medical. 53% of the cases involved under 1s, which is consistent with the previous reporting period. During 2020, the independent Child Safeguarding Practice Review Panel (the Panel) received 482 Serious Incident Notifications (SINs) relating to 514 children; 35% of these concerned babies under 1 year old.

6.1.6 Child Death

Working Together to Safeguard Children 2018 Chapter 5 sets the functions and processes of the Child Death Overview Panel (CDOP), which includes the collection and collation of data following the death of a child and subsequent recommendations following data analysis.

The Sudden Unexpected Death in Childhood (SUDIC) Proforma & Guidelines was updated in 2021. This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child. Due to confidentially and ongoing investigations / meetings the causes of deaths cannot be documented within this annual report. Bereavement support is offered to the family and the staff involved in any child death incident. Following relevant multi-agency meetings, feedback and learning is presented internally to the Mortality Review Group. Figure 7 demonstrates the number cases which have required WHH input.

Figure 7

	2021/2022	2022/2023	2023/2024
Number of deaths pronounced at WHH	5	6	3
Total number of child deaths requiring further information sharing / input from WHH	10	12	6

6.1.7 Safeguarding Unborns and their families

Safeguarding within midwifery is constantly changing and becoming more complex. The 2016 analysis of serious case reviews (DfE, 2016) found that the largest proportion of cases were in relation to children under one year of age with nearly half of these (43%) being under three months of age. This has been a pattern in Child Protection since records began to be kept and seems to relate to 3 factors – physical vulnerability of the infant; their invisibility in the wider community and inability to speak for itself; and the physical and psychological strain their places upon its caregivers. It is critical, therefore, that WHH have robust procedures in place, both to identify the unborn children most at risk and then to effectively manage their welfare and safety at the earliest opportunity.

In 2023/2024 the number of women with identified vulnerabilities who are being supporting through their pregnancy has significantly increased (17%) from 617 in 2022/2023 versus 724 in 2023/2024 as detailed in Figure 8. Information sharing and safeguarding advice provided for the 724 cases has increased by 49% with 1028 ICE notifications being received. In addition to the ICE notifications received, the number of emails received from external services regarding unborn is consistently high. In 2023/2024 WHH Midwifery Team seconded an additional Midwife to support with the increasing demand for safeguarding advice, support, and supervision. With the additional Midwife being in post, this enabled increased face to face support to all Midwifery Teams therefore providing a timelier and more personalised safeguarding response. It was highlighted in the WHH CQC Inspection report 2024 that midwifery staff understood how to protect women and birthing people from abuse. From April 2024 the funding of the seconded Midwife ended resulting in 1 Midwife being in post. Regular reviews of the Safeguarding Teams capacity will continue as this will undoubtedly impact on the capacity of the remaining Midwife to continue with the proactive work referred to in the CQC inspection report.

Consistent with the previous year's data mental health continues to be the most prevalent reason for concern (30%). WHH provides a Peri-Natal Mental Health Service to support the increasing demand which included the recruitment of a Specialist Midwife for Mental Health. For the second consecutive year there has been a significant increase in women accessing maternity care with concerns of domestic abuse (158 increased to 174). The Safeguarding Children Team provide a robust channel of communication with external partners and ensure that patient records and care plans are up to date in readiness for delivery of the baby. The data below in Figure 9 provides detailed information regarding the number of special circumstance forms commenced and from which geographical area the patients are from. Families identified as requiring lower level support has increase from 50 to 203 evidencing that professionals are exploring the needs of the families at the earliest opportunity in an effort to reduce the concerns escalating. Figure 9 provides an overview of the categories of concern, please note that some women will be identified as more than one category.

Figure 8

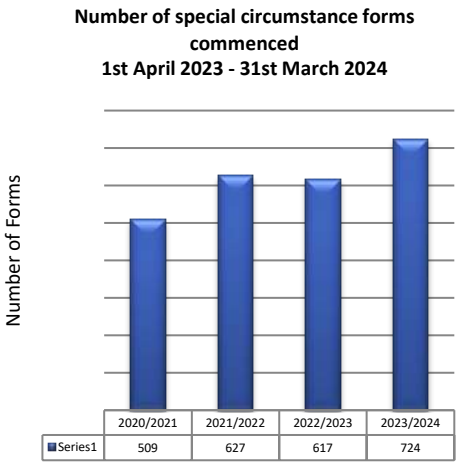
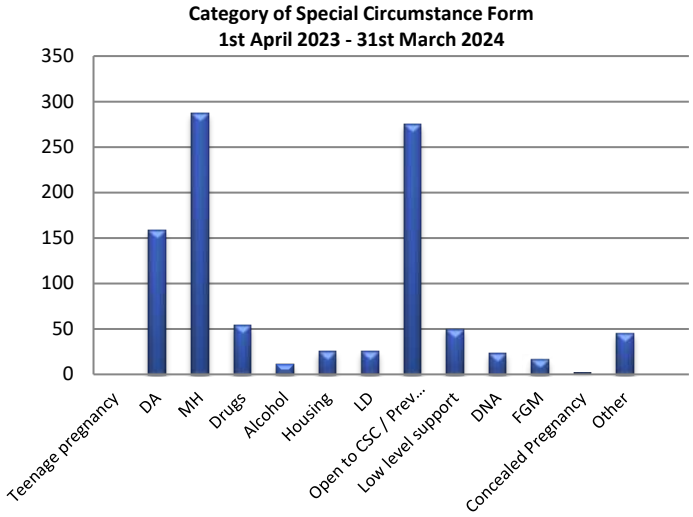


Figure 9



Each midwifery notification is reviewed and categorised by a Safeguarding Midwife. Warrington Safeguarding Partnership Continuum Tool identifies four areas of vulnerability, risk and need to assist practitioners to identify the most appropriate service response for children, young people and their families.

A review of the data evidences the significant change in the complexity of cases. Figure 10 provides an overview of the midwifery cases over the last 3 years. It is evident from the data that there in an increase in families being notified to the Safeguarding Team with lower-level concerns therefore service are able to provide support at an earlier opportunity. This would account for the reduction in families being referred at the statutory/specialist level, 204 reduced to 159. The table below also provides an explanation of each level.

Figure 10

Area of Vulnerability	Warrington Safeguarding Partnership Continuum Tool – description and colour code	21/22	22/23	23/24
Universal	No emerging concerns. Services are available to everybody and can be accessed by anyone without additional support. Universal provision is fluid throughout all the levels.	183	50	63
Universal Plus	Providing support as soon as a problem emerges. Usually, a single agency response and coordination is usually by the service/ agency who knows the family well. An Early Help Assessment is the recommended tool to identify needs	209	243	331
Partnership Plus	Multiple and complex concerns apparent which require a multi-agency and targeted approach. Early Help assessment is essential and lead professional identified to support.	82	117	167
Statutory / Specialist	Complex and acute needs likely to require statutory or specialist intervention under the Children's Act 1989 and where a Children's Social Care assessment is required. This includes children with complex health needs and disabilities.	140	204	159

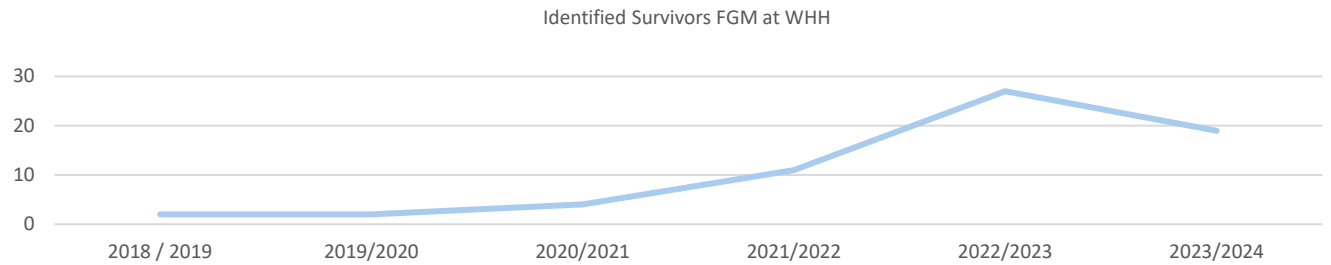
6.1.8 Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The duty to mandatory report all FGM cases in under 18 years old came into effect in October 2015.

The National Female Genital Mutilation - April 2019 to March 2020 Annual Report identified there were 6,590 individual women and girls who had an attendance where FGM was identified. These accounted for 11,895 total attendances reported at NHS trusts and GP practices where FGM was identified. Nationally the number of total attendances during 2019-20 has remained broadly stable.

Screening for FGM is a routine part of midwifery booking. Within this reporting period, nineteen survivors of FGM have been identified via WHH Midwifery Services. This is a decrease of 29% (27 in 22/23 versus 19 in 23/24) Figure 11. The appropriate pathways were followed, and relevant agencies notified to ensure the safety of the unborn and any siblings were assessed.

Figure 11



The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is submitted on a quarterly basis. The dataset supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England.

6.2 Safeguarding Adults at Risk

The Safeguarding Adult Team activity results from concerns raised internally from WHH wards and Depts. and from external agencies, it is difficult to measure specific data resulting from complex multi-agency working. Whilst internal activity can be measured with the number if ICE notifications received, the number of phone calls, email requests and intelligence gathering for multi-agency meetings is not collated.

When compared to the previous year there has been there has been a 28% overall increase of safeguarding adult activity, this increase is across the whole of the adult safeguarding portfolio. When the data is compared across the whole 4 years of data this an increase of 97.3%. The increase in complexity of the cases is remarkable, with many patients presenting with multi-factual safeguarding concerns. For example, patients with mental ill health who's resulting self-neglecting behaviour has resulted in physical health management challenges. The work in place to support the implementation of LPS has resulted in an increase in safeguarding activity relating to the Court of Protection as awareness of the process has been raised during the LPS preparations. The Safeguarding Adult Team receive ICE notifications under five categories, safeguarding adults, domestic abuse (where only adults are identified), learning disabilities, DoLS and Prevent. The activity generated from the ICE referrals is explained in figure 12 below.

The recruitment of a Learning Disability (LD) and Autism Nurse Specialist has enabled a clear focus on developing existing pathways further, ensuring patients with a Learning Disability and or Autism diagnosis are appropriately flagged and supported. With this focussed work, the number of patients attending hospital who were flagged to ward/department teams. The table below demonstrates that the support required from the LD/Autism specialist Nurse has increased by 80% in year.

6.2.1 Safeguarding Adults Activity

The information detailed in the charts below (figure 12 &13) describes the adult safeguarding activity from 2020. As the data demonstrates, the overall activity of referrals to the Safeguarding Team has continuously increased year on year. This has ultimately had an impact on the workload and capacity of the Safeguarding Team, Nursing and Medical Teams. The addition of another Safeguarding Practitioner was piloted from September to March with a positive outcome being evident. Hospital staff voice they felt supported, and the Safeguarding Team were more visible. The recruitment of a substantive 3rd Safeguarding Practitioner is currently in progress.

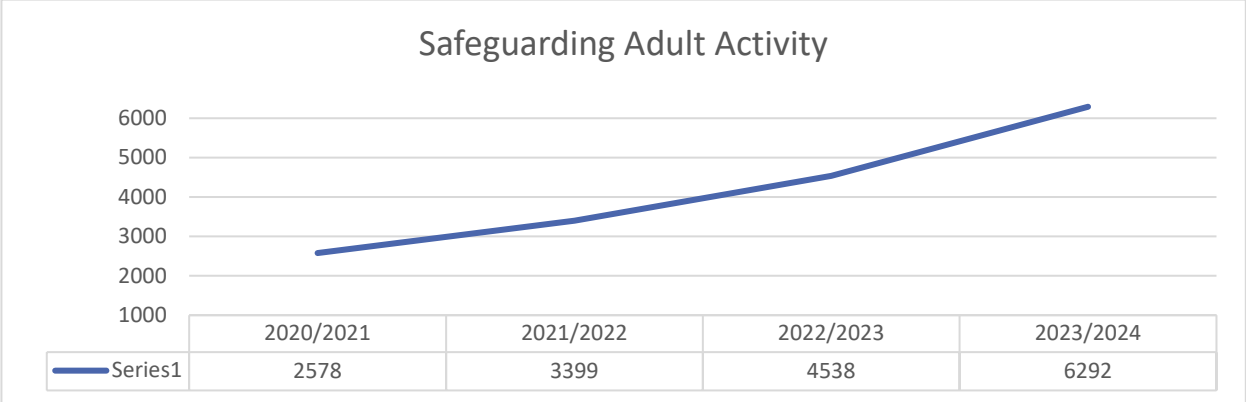
Through further scrutiny it has been identified that a significant number of ICE notifications submitted to the Safeguarding Team are not due to safeguarding concerns and are in relation to issues / concerns that could be addressed by different services. For example, patients with mental health concerns / families needing lower-level support/care packages are often referred to the Safeguarding Team as routine. The word 'safeguarding' can be interpreted in different ways, and this can create some confusion for professionals, when deciding what course of action to take when they have encountered a person who needs support. 'Safeguarding' can mean two things; a formal safeguarding response under s42 of the Care Act, or a general response to keep someone safe and to ensure their needs are met.

Warrington Safeguarding Adult Board have published guidance Safeguarding versus safeguarding to support practitioners in recognising and providing the correct response to the two types of safeguarding. Safeguarding with a capital 'S' which requires a formal safeguarding response and safeguarding with a small 's' to which requires a more general response to keep someone safe. WHH will promote this guidance throughout training, campaigns and Safeguarding Meetings. With the intended promotion of the guidance and increased face to face support from the Safeguarding Team, it is expected that the number of ICE notification on 2024/2025 should decrease. This will ensure that timelier responses are provided to those concerns of Safeguarding nature (with a capital S)

Figure 12

ICE Notifications to the adult's team	Safeguarding Adult ICE	DA Adult Only Cases	LD In-Patients	Prevent	DoLS	Overall increase effect
2020/2021	1823	116	158	1	480	2578
2021/2022	2501	153	198	4 cases	547	3399
2022/2023	3367	136	291	2	742	4538
2023/2024	4482	148	524	0	1138	6292
% change 2020/2021 to 2023/2024 = 4 years	↑ 145%	↑ 28%	↑ 232%	Fluctuating picture	↑ 137%	↑ 144%

Figure 13



6.2.2 Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) (and Liberty Protection Safeguards (LPS)

When a person is deemed to lack capacity and a deprivation of liberty is identified, if appropriate a DoLS is applied for. Applications are completed by wards and emailed to the relevant LA and the WHH Adult Safeguarding Team who contact wards to offer advice and education about the management of DoLS. Staff are also advised about advocacy and the Court of Protection (COP) process where required and have access to an MCA Policy and an SOP, applications are audited for accuracy and standard of documentation.

CQCs previous State of Care Reports highlighted the number of applications to deprive a person of their liberty has grown significantly over the last decade. This is mostly the result of a landmark judgement handed down by the Supreme Court in 2014, which clarified and broadened the definition of what constitutes a Deprivation of Liberty. WHH DATA follows this upward trend with a staggering increase of 137% in the number of DoLS applied for in 2023/2024 versus 2022/2023 (figure 13).

In November 2022 a temporary MCA and DOLS Training Professional was recruited in preparation for Liberty Protection Safeguards. On 5 April 2023, The Department of Health and Social Care (DHSC) announced that the implementation of the LPS will not go ahead this side of a general election. WHH proceeded to increase the education and awareness in relation to MCA and DOLS which continues to positively impact on patient care. Professionals misunderstanding or misapplication of the MCA is often the root of most of the problems about Deprivation of Liberty therefore getting the MCA fundamentally right was the cornerstone of preparation for LPS, and it remains essential for good practice without those reforms. The MCA and DOLS Training Professional post ended March 2024.

Figure 14 demonstrates the number of DoLS applied for in the reporting period with comparison to previous years. Figure 15 describes how many of the applications were authorised by the respective LA in which the patient is registered with a GP. The Trust is responsible for ensuring, where appropriate, that patients have an urgent DoLS application in place, in line with the MCA guidance, this lasts for a maximum of 7 days and can be extended for a further 7 whilst the LA DoLS team commence their review. If the urgent DoLS expires during the review period, the LA retains overall responsibility for the authorisation. There are tools and processes in place to support staff in managing expired urgent DoLS that ensure that the LA are kept informed of changes in the patient's condition or if they are discharged. The LA use a national tool to assess the urgency of a DoLS application so that the most urgent are authorised and the least being unlikely to be authorised.

Figure 14

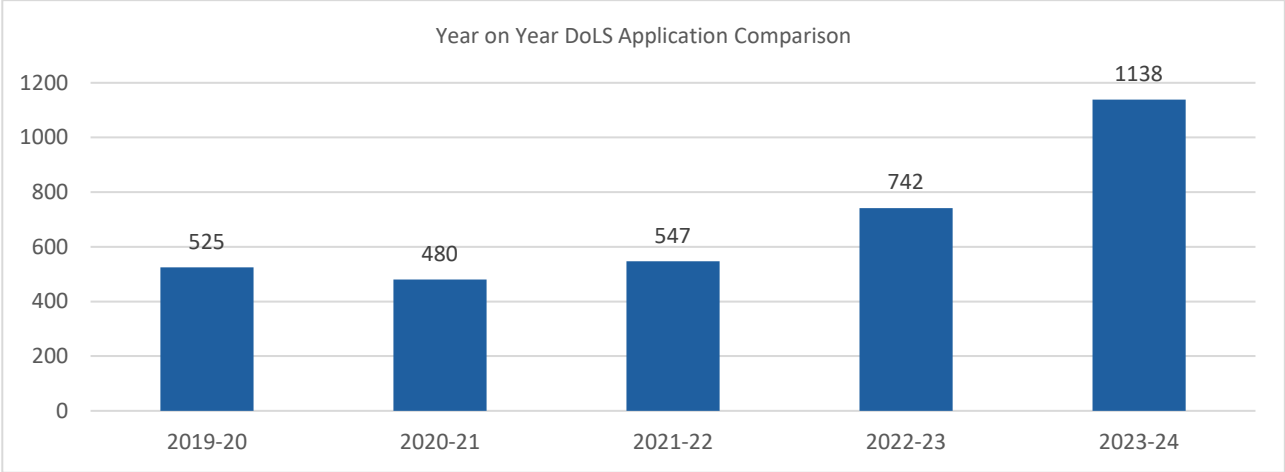
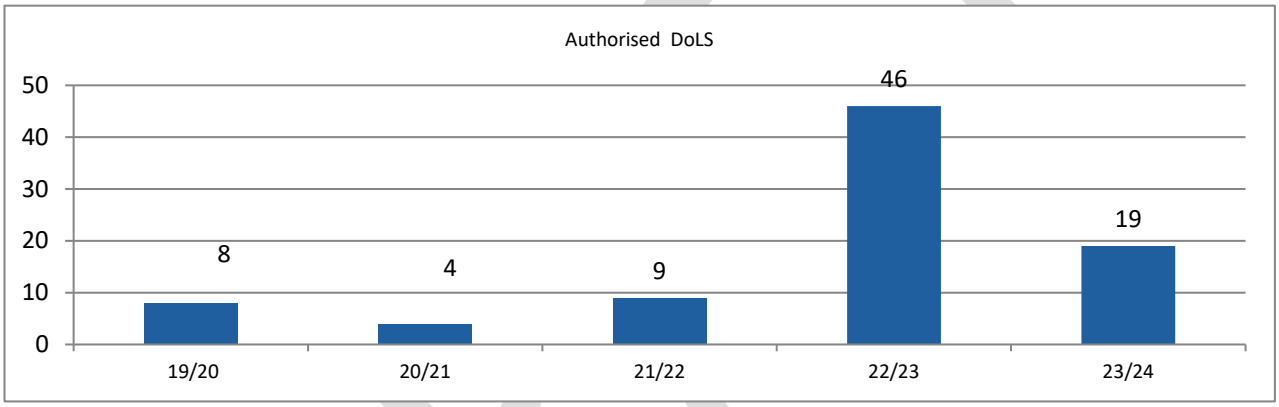


Figure 15

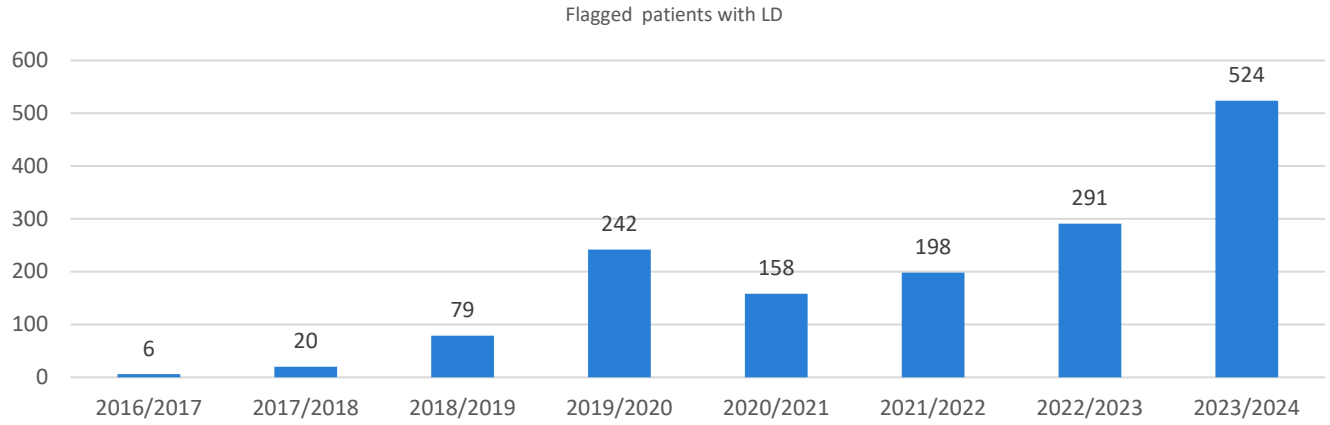


CQC report- The state of health care and adult social care in England 2022/23 (October 2023) highlighted ongoing problems with the current system have left many people who are in vulnerable circumstances without legal protection for extended periods. In 2022/23, the number of applications to deprive a person of their liberty increased to over 300,000, with only 19% of standard applications completed within the statutory 21-day timeframe. For patients admitted to WHH, 1.6% standard application submitted were authorised which is well below the national data (see figure 15).

6.2.4 Learning Disability/Autism

There are 1.5 million people believed to have a learning disability in the UK equating to 2.16% of adults and 2.5% of children (Office for National Statistics (2020). The chart below describes the activity associated to patients with LD who required intervention to WHH from 2016/17 which was prior to the introduction of the flagging process to the current reporting year, 2023/2024. The increase in the number of patients notified to the Learning Disability and Autism Nurse has notably increased year on year with an annual increase of 80% from 2022/2023 – see figure 16.

Figure 16



WHH currently have one whole time equivalent Learning Disability and Autism Specialist Nurse who support the Nursing, Medical and Corporate Teams in meeting the needs of the patient group. The increased in patients requiring support and guidance from the LD and Autism Nurse has undoubtedly impacted on the capacity of the nurse, therefore a review of the current service is required to ensure the care to patients remains of a high standard.

Several tools have been developed to assist staff to deliver better care to patients who have an LD and or Autism diagnosis and policies and SOPs including a care plan and SOP to support staff in the application of reasonable adjustments have been reviewed and updated. WHH supports attendance at Warrington LD and Autism Boards along with regional forums and LeDeR review meetings.

LeDeR, the National Mortality Review Program is supported by WHH Safeguarding Team and Mortality Review Group (MRG). Lessons from LeDeR reviews are relayed to WHH via the MRG newsletter.

National Health Service Improvement (NHSI) published Learning Disability Improvement Standards for NHS Trusts in 2018. The document highlights four overarching areas for improvement; with three of those areas being key to Acute Hospital's.

1. Respecting and protecting rights (5 improvement measures)
2. Inclusion arrangements (5 improvement measures)
3. Workforce (4 improvement measures)

An action plan for improvement in in place and monitored via the internal Learning Disability Steering Group. In line with equality standards, WHH are required to ensure reasonable adjustments are made to support access to health care for people with an LD diagnosis.

As part of the Trust Quality Priority for 2023, (Patient Experience (PE): To reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods) an objective was set that: Patients with a learning disability are referred and reviewed by the Specialist Nurse/Team to ensure that communication needs are met >90%. A new data set was developed in September 2023 which captures the evidence that this objective is being met. In addition to the new data set, the following actions were set up to support the overall quality priority:

- Regular review of LD and Autism Steering Group purpose and membership

- ICE notifications received and notification via data warehouse are used to identify both children and adults who are admitted with a LD
- Hospital communication booklet is available to support patients with LD and communication difficulties.
- Widgit and Widgit health are available to support easy read material for communication aids.
- Flashcards are available on the intranet (safeguarding workspace) for all Trust staff
- Training sessions made available to support how to use the communication aids.
- LD awareness day
- Makaton subscription for signs within the hospital to support patients who have a LD and use this sign language to be more inclusive.
- Makaton sign and symbol of the week completed within safety brief every Monday.
- Makaton training by an External Makaton trainer on a quarterly basis.

6.3 Domestic Abuse – Children and Adults

There are some 2.4 million victims of domestic abuse a year aged 16 to 74 (two-thirds of whom are women) and more than one in ten of all offences recorded by the police are domestic abuse related.

WHH, working with the Domestic Abuse Partnership Board, takes its role in helping to prevent domestic abuse and offering support for victims very seriously. WHH supported the development of the Warrington Domestic Abuse Strategy and continues to support the progress of the priorities set. The strategy sets out intentions for the next three years whereby we aim to create sustainable change across the system through continued partnership work.

In comparison to the previous year the number of referrals has decreased to 247 (was 258 in 2023/2024) which equates -4% / 11 referrals (Figure 17). As demonstrated in figure 18, the geographical split of referrals remains Warrington and Halton being the highest.

Figure 17

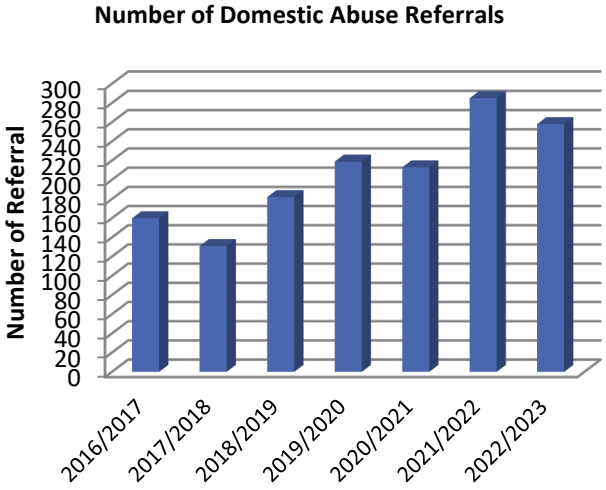
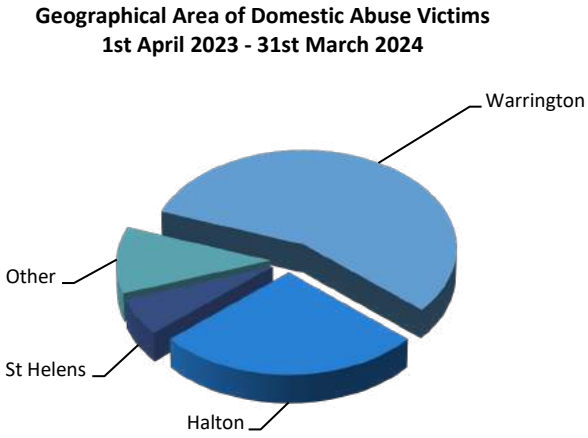


Figure 18



Key statistics for WHH include:

- 247 domestic abuse cases identified
- 24% victims were identified as men (58 of 247) which is an increase from 10% the previous year.
- 40% of cases were referred to the children's team as they had children / unborns in the family
- 38% cases were referred on to MARAC (Multi -Agency Risk Assessment Conference)

Warrington Local Authority have recruited to the role of the Hospital Independent Domestic Violence Advocate (IDVA). The hospital IDVA is co-located with the hospital safeguarding 4 days pre week providing advice and support to the wider teams. In addition to the newly developed E-LEARNING package, the hospital IDVA can provide bespoke training to teams across the Trust.

7 Incident Reporting

There has been a 68% increase in safeguarding DATIX for 2023/2024, 284 DATIX 2022/2023 versus 478 2023/2024. Whilst this is a significant increase, it should be noted that the categories and reasons for DATIX that are submitted through safeguarding are not always reflective of a true safeguarding concern. Where patients have presented with escalating behaviours or episodes of self-harm on site, these are reported through DATIX under the category safeguarding. Work is ongoing to review the categories and separate these in new categories, therefore the bi-annual report for 2024-2025 is likely to report a reduction in DATIX. Analysis of the safeguarding concerns have identified the following trends as the top three reporting concerns:

- **Domestic Abuse pathway not followed.** Whilst it is positive that cases of domestic abuse were identified and reported to the Safeguarding Team. DASHs, safety planning and safe discharges were not always completed. It is important to ensure the DASH is completed asap to establish the level oof risk and actions required.
- **Missed / Delayed opportunity to safeguarding unborn in midwifery**. Some examples of this include – FGM pathway not followed, mental health / social concerns reported at booking but not acted upon by Midwife.
- **Concerns regarding care provided internally**. Some examples included - Instances of bruising being identified on patients with no mechanism of how this occurred / Medic suggestion providing concealed medication / relatives raising concerns that staff have forcefully fed patient / relatives raised concerns that staff are not following SALT plan.

An overview of Safeguarding DATIXs and actions taken to address the concerns are reported through the monthly Safeguarding Committee meeting by each Clinical Business Unit (CBU)

8. Safeguarding Training

8.1 Training Compliance

The table below (figure 19) provides an update on the training compliance as of March 2024. With the exception of the Learning Disability and Autism (LD & A) level 1 all level of training has increased in compliance across this reporting period for the second consecutive year. The LD & A level 1 training was merged in March 2024 therefore it was expected that there would be a slight drop in percentage. Safeguarding children and adult training compliance remains under the expected standard however have significant increased in the last 12 months (children's by 5.86 % and Adults by 17.89%)

Training compliance is monitored monthly via the Safeguarding Committee through action plans and training trajectories provided by Clinical Business Unit (CBU) leads which provides assurance that safeguarding training is high on the agenda across WHH.

All training is delivered in line with the Children's Intercollegiate Document and the Adult Intercollegiate Document. The safeguarding training programmes are frequently reviewed and updated to ensure that learning from case reviews, hospital incidents and National guidance (Intercollegiate Documents) is incorporated in a timely manner. Accessibility of training has been reviewed to support the workforce in achieving the compliance target. E-learning, pre-recorded webinars and bespoke training have been provided throughout the year.

It is recognised that level 3 children and level 3 adult safeguarding training has remained under the contractual standards target for 2023/2024 despite trajectories being in place across all care groups. Operational pressures, including increased clinical activity and industrial strike action have impacted on workforce resulting in lower compliance than expected. A full review of the safeguarding training programme is planned which will explore the electronic recording of compliance, accessibility and the possibility of combining elements of children and adult safeguarding to make better use of the workforce's time. That being said, it is important to also recognise that staff across WHH have been provided with information in a variety of ways which would not be captured within the compliance. For example multiple 7 minute briefings circulated; group supervision sessions; individual safeguarding supervision when contacting the safeguarding team for advice and support; awareness raising information stalls held across both sites; lunchtime workshops/webinars and bespoke training for any areas requesting support. In addition to this learning, it is acknowledged that compliance for subjects that fall under the safeguarding agenda remain above target (domestic abuse, MCA and DOLS and Prevent).

Figure 19

Training – 1st April 2023 – 31st March 2024	Number of people to be trained	Number of people trained	Compliance March 2023	Compliance March 2024	Comparison to previous year
DoLS	2816	2678	89.51%	95.10%	↑ 5.95%
MCA	2913	2719	90.16%	93.34%	↑ 3.18%
WRAP	1929	1838	94.76%	95.28%	↑ 0.52%
Prevent Basic Awareness	4635	4216	88.35%	90.96%	↑ 2.61%
Safeguarding Children Level 1	1781	1643	90.44%	92.25%	↑ 1.81%
Safeguarding Children Level 2	2323	2054	79.50%	88.42%	↑ 8.92%
Safeguarding Children Level 3	503	362	66.11%	71.97%	↑ 5.86%
Adult safeguarding level 1 Face to face	1711	1575	85.39%	92.05%	↑ 6.66%
Adult safeguarding level 1 eLearning	1711	1613	91.46%	94.27%	↑ 2.81%
Adult safeguarding level 2 Face to face	1616	1435	78.23%	88.80%	↑ 10.57%
Adult safeguarding level 2 eLearning	1616	1453	86.90%	89.91%	↑ 3.01%
Adult safeguarding level 3	1284	849	48.23%	66.12%	↑ 17.89%
LD and Autism level one *	1449	1008	76.90%	75.09%	↓ 1.81%
LD level two*	3072	2391	66.18%	77.83%	↑ 11.65%
Autism level two*	3074	2419	65.66%	78.69%	↑ 13.03%
Domestic Abuse Level 1*	4635	4257	84.93%	91.84%	↑ 6.91%
Domestic Abuse Level 2*	2152	1956	63.06%	90.89%	↑ 27.8%

- (this data is indicative of the training commenced in February 2021)

9. Learning and improving

9.1 Safeguarding Reviews

Safeguarding Practice Reviews / Local Learning Reviews

A Local Child Safeguarding Practice Review (LCSPR) is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death, and/or there is cause for concern as to the way in which agencies have worked together to safeguard the child.

The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children. The statutory guidance for Serious Child Safeguarding Reviews was updated in 2018, see Working Together to Safeguard Children 2018. Previously, these types of reviews were called Serious Case Reviews (SCRs).

Where the threshold is not met for a LCSPR however lessons to be learned have been identified the Safeguarding Partnerships may decide to hold a Local Care Review/learning circle to ensure learning is extracted and shared across the multi-agencies.

WHH are supporting Warrington Safeguarding Children Partnership (WSP) and Halton Children and Young People Safeguarding Partnership (HCYPSP) with a total of 3 case reviews. Any actions that arise from the reviews are monitored and tracked through the Safeguarding Committee.

Safeguarding Adult Reviews (SAR) / Domestic Homicide Reviews (DHR)

The Local Authority has a duty to investigate when an adult at risk comes to harm as a result of abuse or neglect. The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard adults, identify what needs to be changed and as a consequence, improve inter-agency working to better safeguard and promote the welfare of adults. Statutory guidance laid out in the Care Act (2014) explains that the LA should investigate where a concern meets this statutory guidance under section 42 of the Act. Where necessary a Serious Adult Review (SAR) is conducted in cases that meet section 44 of the Act, this happens where multi-agency involvement has contributed to the patients serious harm or death. Where death is the result of domestic abuse a Domestic Homicide Review is undertaken. At the time of writing WHH are supporting 5 reviews (some of which may not progress to full reviews).

9.2 Mortality Review

The Mortality Review Group (MRG) meets monthly and has safeguarding representation to facilitate safeguarding oversight of the cases reviewed. In cases where issues/concerns are found learning is shared and used to update training. All patients who have passed away in the Trust who have a Learning Disability or were on DoLS when they passed away receive a Standard Judgement Review (SJR). The medical examiners review all deaths and those with identified learning are taken to MRG. Patients who have and LD, Autism diagnosis and those that passed away whilst on DoLS receive an additional review conducted by the Safeguarding Team that focuses on safeguarding, MCA and DoLS, mental health and LD/Autism practice and care delivery. Learning from this is shared at MRG and with the wider Trust via MRG newsletters and Safeguarding Committee. The LeDeR process is recognised by the MRG, completed SJRs contribute to the overall LeDeR review process. Child death cases are presented quarterly.

10. Prevent

Responsibilities under the Home Office Prevent Strategy were placed on a statutory footing from July 2015 with the introduction of the Counter Terrorism and Security Act 2015. Following a change announced in 2019 Prevent training is no longer reported via the Home Office and prevent trainers are no longer required to register with the Home Office. Instead, prevent activity and compliance is reported quarterly via NHS digital.

In line with National guidance, WHH Head of Safeguarding is the prevent lead who attends regional and local prevent meetings ensuring that important information and learning is shared via Safeguarding Committee. Following the increase in terror activity in 2017 the Home Office instructed all Trusts of a requirement to achieve 85% training compliance with 3 yearly updates. WHH are currently above the required training target with 95% compliance. In 2023-2024 WHH have made 2 prevent referrals to Cheshire Police.

11. Allegations against staff

All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person, who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

This procedure must be applied when there is such an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

All allegations of abuse of adults by staff who are caring for patients using our services are taken seriously. Allegations against WHH staff, agency staff and those who come to our attention who work in other agencies are supported using WHH policy and the national PiPoT guidance.

This guidance is applied when:

- An allegation of assault to a patient has been made about a staff member
- A member of staff has been found to have committed a criminal offence related to an adult at risk
- Staff on staff assault or abuse
- A member of staff has accessed patient records inappropriately

WHH have made further enquiries in relation to 6 employees that would require the support of the Local Authority Designated Officer (LADO) or PIPPOT (People in Position of Trust).

12. Assurance Statement

2023/2024 has been a challenging year in respect of increasingly complex safeguarding cases requiring multi-agency intervention. WHH continues to work collaboratively with Safeguarding Partnerships and Adult Safeguarding Boards to support the development of various strategies and associated workstreams. In addition to challenges describes throughout the report, the WHH Safeguarding Team have gone through a period of change of leadership and structure, however the team continues to deliver a robust service across the trust in supporting and developing front line practitioner enabling them to keep patients safe.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/07/96**
SUBJECT:	**Safe Staffing Report; 6 Monthly Acuity Review, July 2024.**
DATE OF MEETING:	3 July 2024
AUTHOR(S):	Tracy Fennell, Deputy Chief Nurse & Director of Clinical Governance
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	This report is the bi–annual Nursing and Midwifery Staffing review. It fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB)2016)): How to ensure the right people, with the right skills, are in the right place at the right time. It provides an update to the Quality Assurance Committee in relation to the following: • Actions agreed in the Chief Nurse Annual Establishment Review April 2024 • Vacancy and turnover data for Nursing and Midwifery • Analysis of staffing establishments, using Safer Nursing Care Tool (SNCT) • Analysis of staffing and impact on patient outcomes • Planned and actual staffing fill rates • Care Hours Per Patient Day (CHPPD) figures. The previous paper (August 2023 data) was presented to Quality Assurance Committee (QAC) and Trust Board of Directors in August 2023. A Bi-Annual Safe Staffing Report has not been presented since this date due to the requirement to introduce the new safer Nursing Care Tool from May 2024. **Areas of improvement:** • Registered staff turnover has remained under the Trust target of 13% since December 2023 and unregistered staff turnover has remained static over the last 6 months at an average of 15.78%. • Overall vacancy for registered staff has remained at an average of 11.36% over the last 6 months with a large establishment increase for ED following investment. • The rolling advert for both registered and non-registered staff continues with regular shortlisting and interviews taking place. • The average CHPPD over the last 6 months has been 7.9 in line with the National target of 7.9. • The next recruitment event is taking place at the Education Centre Halton on 16 October 2024 for both Registered and Non-Registered staff alongside ongoing specialist recruitment for areas with outstanding vacancy.

	The Safer Nursing Care Tool (SNCT) was amended to include two new acuity scores for enhanced care (1C and 1D) and all previously existing tools became obsolete. Staff have received training on the new tool and data collection took place in March 2024. 20 wards completed the collection, of those 18 suggested additional staff was required for enhanced care purposes. This would equate to a total of 76.0 WTE. Ward C21 had the highest recommendation, requiring an additional 11.58 WTE. The data collection for May 202 recommended Safer Nursing Care establishment figures are 857.37 WTE with an additional recommendation of 76.0 WTE required to care for 1c and 1d patients who requiring additional care to maintain their safety. This is a total of 933.57 WTE recommended opposed to the current budgeted establishment of 821.52 WTE. Whilst SNCT is the recognised national tool, recommendations must be reviewed applying professional judgement. Professional Judgement must be applied, as SNCT currently does not account for requirements such as national guidance for specific patient groups, environment and assessment pathways. 20 areas were reviewed using the SNCT Tool, of those there are 13 areas where professional judgement agrees further review of the staffing model is required. Whilst the requirement for additional staff may not be as high as SNCT suggests in all areas, wards that are recommended to increase the WTE triangulate to those who have constant use of temporary staffing. Some of these are noted to be due to a change in patient profile and acuity since the wards were established. As this collection is incomplete for the year, the second data collection will be required using the new SNCT in November 2024 to enable comparison and analysis with recommendations actions. Therefore, presently no recommendations are being taken forward to amend establishments at this stage until the process has concludes in Quarter 3. The next Chief Nurse Establishment Review will take place in April 2025 with an Allied Healthcare Practitioner (AHP) review taking place in July 2024. Actions from the establishment review that took place in April 2024 are recorded and being tracked in each Care Group and the Workforce Review Group.			
PURPOSE: (please select as appropriate)	**Information** **X**	**Approval**	**To note** **X**	**Decision**
RECOMMENDATIONS:	It is recommended that the Quality Assurance Committee discuss and note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**		**Not Applicable**	
	Agenda Ref.			
	Date of meeting			

	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Submit to Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release in Full	
FOIA EXEMPTIONS APPLIED: ***(If relevant)***	Choose an item.	

QUALITY ASSURANCE COMMITTEE

SUBJECT	Safe Staffing Report 6 Monthly Acuity Review, July 2024	AGENDA REF:	QAC/24/07/96

1. INTRODUCTION

1.1. This paper provides the bi-annual comprehensive report to the Quality Assurance Committee on Nursing, Midwifery and Allied Health Professional (AHP) staffing. This report details the six-monthly review of nurse and midwifery staffing in line with the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016), and the NHS Improvement (NHSI) 'Developing Workforce Safeguards' guidance, published in October 2018. The guidance recommends that the Board of Directors receive a Biannual Report on staffing to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework.

1.2. A triangulated approach to nurse workforce establishment planning is utilised at WHH in line with NQB recommendations. This includes:

- Twice-yearly review of nursing establishments using an evidence-based acuity tool such as the Safer Nursing Care Tool (SNCT)
- Daily analysis of the Allocate E Roster Safe Care results, which provide a twice daily breakdown of patient acuity, completed by a senior nurse.
- Annual Chief Nurse led review of staffing establishments.
- Monthly analysis of Care Hours Per Patient Day (CHPPD)
- Daily monitoring of staffing capacity versus demand with a review of harm data and the relationship to staffing

1.3. As per the NQB guidance, this Bi-Annual Report will provide the results and analysis from the SNCT data collection which took place in May 2024 and details next steps. The report also includes the current Trust nursing and midwifery workforce position and a summary workforce position for the Care Groups and Allied Health Professions (AHP) workforce.

2. NATIONAL/LOCAL CONTEXT

2.1. Nursing and midwifery workforce supply continues to be a significant challenge nationally with the shortfall in registered nurses well-documented across all NHS organisations and oversight bodies. As of June 2024, the nursing vacancy rate in England stands at 9.9% which equates to approximately 40,000 nursing posts remain unfilled. There is an ongoing national drive to meet the target of recruiting 50,000 new nurses.

2.2. It was noted in *Student nursing numbers - good news at last*, The King's Fund (January 2021) the number of nursing students in the UK has been fluctuating over the past decade due to changes in funding and policies. However, in 2020, the number of student nurses rose by 25% compared to 2019, an increase of just over 6,000 in one year. In 2023, the government reinstated the maintenance grant which made the prospective cost of taking up a nursing course more affordable for students of all ages. This has a positive impact on the numbers of applications to the University of Chester, the main provider of healthcare students for WHH.

2.3. According to the Nursing and Midwifery Council (NMC), the average age of a UK Registered Nurse in 2024 is approximately 41 years old. However, the age range of nursing students can vary depending on the type of program they are enrolled in, however nationally Bachelor of Science in Nursing (BSN) programs have an average age of early to mid-20's. The University of Chester receive many applications from mature students; therefore, work is underway between WHH and the University of Chester to attract younger students to programmes and the Trust is working with other providers including Liverpool John Moores (LJMU) and Edgehill Universities (EHU) to increase their student placement capacity here at WHH.

Placement capacity is managed through a system called 'In Place'. Work has commenced by the Clinical Education Team to reassign placement capacity to EHU and LJMU on In Place. The Trust continues to support the STEPP program with currently 220 students on the program completing placements at WHH.

2.4. The impact of ongoing emergency pressures combined with the current challenges faced across the NHS, continues to influence some of the detailed actions and outcomes contained within the report. There is robust professional leadership in place by the Senior Nursing Team, supported by safer staffing governance frameworks and clear escalation guidance and accompanying actions. It is clear however, that the staffing situation remains challenging due to high bed occupancy, increased patient acuity and dependency, and the continued focus on delivering the highest possible standard of care.

3. TRUST WORKFORCE & TURNOVER POSITION

3.1 An increasing trend can be seen for the numbers of nursing and midwifery staff in post across the last 12 months, with a level of sustainability since December 2023, particularly in ED. Recruitment and retention planning is fundamental to ensure this improvement is maintained. Further information for WHH recruitment and retention planning is described in section 5.2.

Fig. 1 Nursing and Midwifery Staff in Post

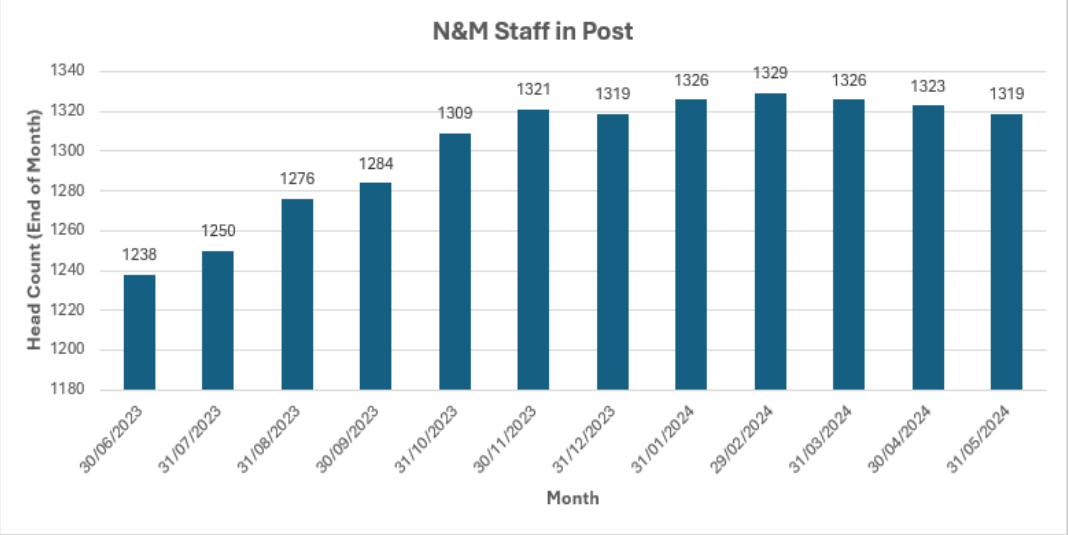
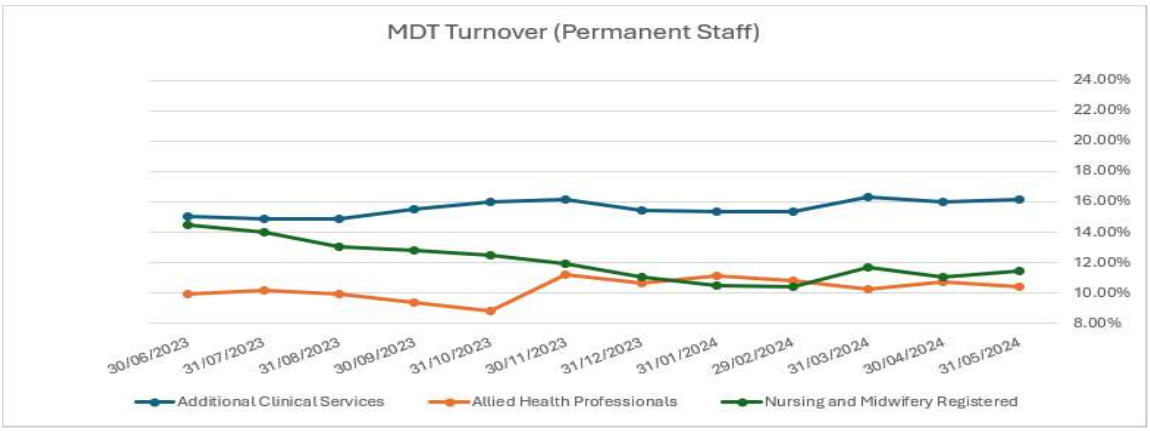


Fig. 2 Trust Turnover Nursing, Midwifery, AHP



3.2 In general, turnover rates are reducing favourably against the Trust target of 13% and the national median of 13.1% with nursing, midwifery and AHP all below Trust target. Total turnover rates for the Care Groups have all reduced over the last 12 months as shown in figure 3 below. Leaver data is analysed weekly to establish themes and ED have reduced turnover by offering an extended supernumerary period and ED training week for new starters. The Trust has employed a People Promise Manager who is awaiting a start date and Human Resources Teams (HR), and the Workforce Team are currently developing a Wellbeing and Engagement pian for unregistered staff.

Fig. 3 Care Group Total Turnover June 2023 to May 2024

Care Group	Total % Turnover June 2023	Total % Turnover May 2024
Clinical Support Services	13.30%	11.38%
Unplanned Care	15.13%	13.85%
Planned Care	13.57%	11.73%

3.3 Vacancy Position

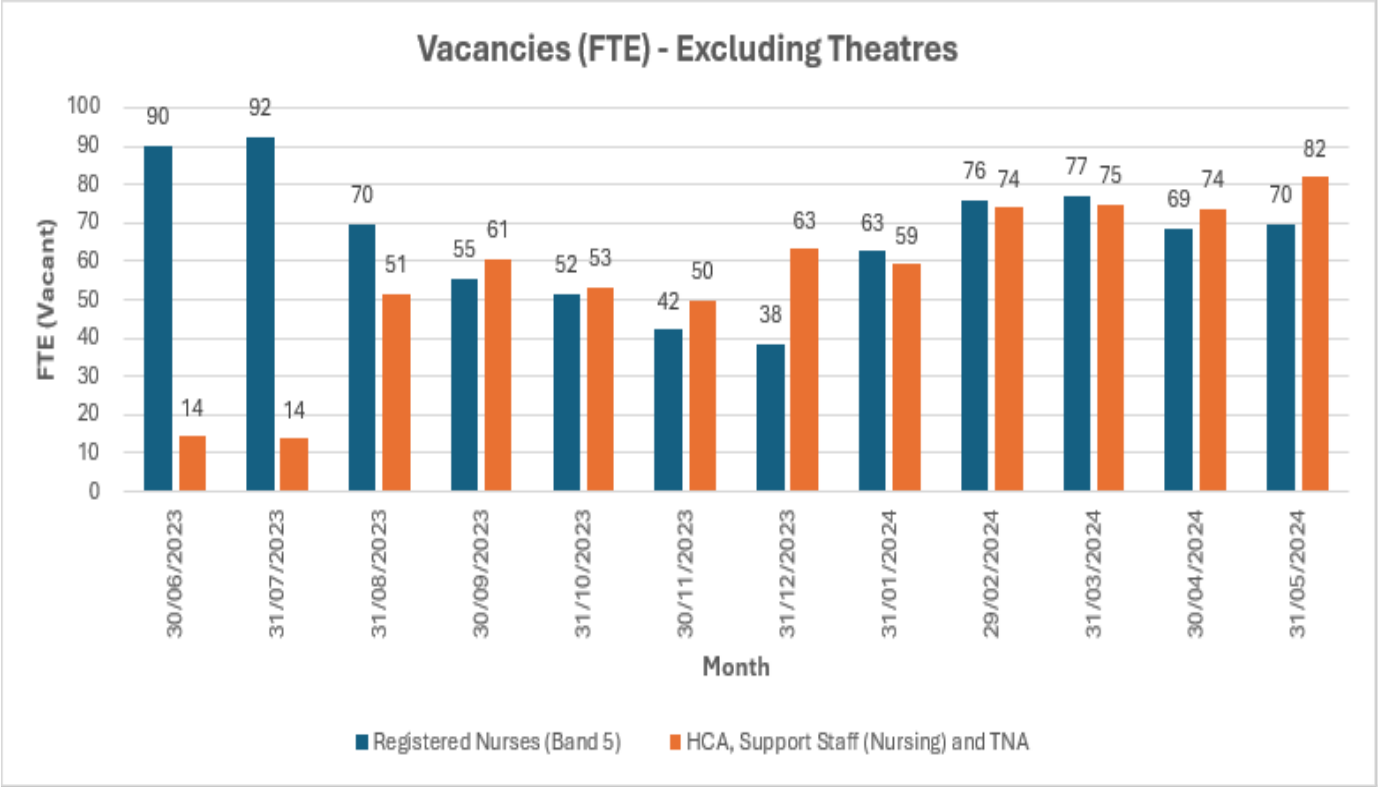
Fig. 4 Care Group Total Vacancy June 2023 to May 2024

Care Group	Total % Vacancy June 2023	Total % Vacancy May 2024
Clinical Support Services	14.15%	11.90%
Unplanned Care	12.94%	13.69%
Planned Care	8.86%	6.23%

3.3.1 Proactive recruitment continues for both registered staff and unregistered staff with rolling adverts, regular short listing and interviews. The overall percentage vacancy for unregistered staff has decreased from 11.11% in December 2023 to 10.84% in May 2024, however the percentage vacancy for registered staff increased from 9.10% in December 2023 to 10.84% in May 2024. This is due to significant investment for ED, Endoscopy, A7, A8 and A9 to increase nursing establishments.

3.3.2 WWH are required to report externally on the Provider Workforce Return (PWR) that reports to NHS digital. As the data source is measured on number in staff in post who have received payment, staff who are in pipeline or have commenced in post but not yet received their first salary will not be accounted for. In May 2024 submission, 70 staff in pipeline would not be accounted for. To resolve this, monthly meetings are held between the Finance Department, Human Resources Teams, the Workforce Team, and Trust Workforce Lead to compare and validate data to ensure correct reporting.

Fig. 5 Registered Nurse Band 5 and Health Care Support Worker Vacancies (excluding theatres)

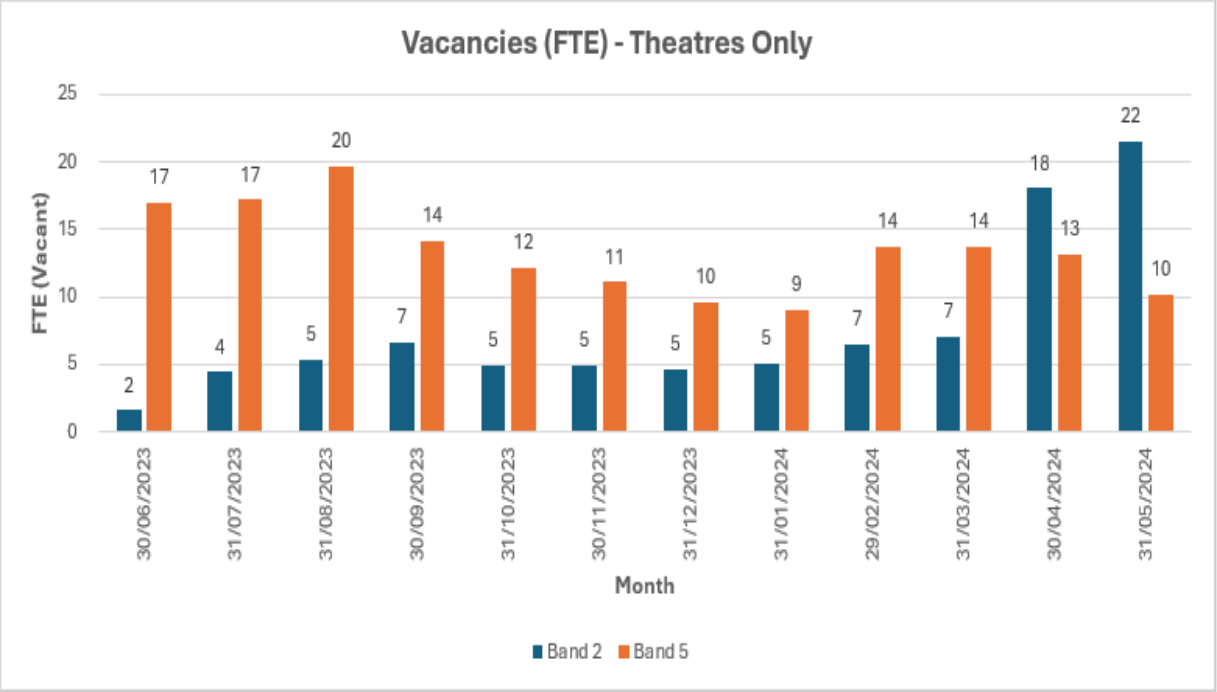


N.B. Theatre staff are excluded due to the job titles of their staff in post- they are demonstrated separately below in Fig 5

3.4. Due to successful revenue investment and Trust bids for extension of services ED and Endoscopy have significantly increased nursing establishment. Endoscopy have now successfully recruited into these additional nursing roles and the appointed staff are currently going through the recruitment process. ED will be fully established at Band 7 once appointed staff are in post with Band 6 interviews taking place in June 2024 alongside a Band 5 development programme currently being created. There were 6 Band 5 nurses appointed and 10 students who qualify in Quarter 2, 2024 have been provided with offers of employment. The remaining Band 5 vacancy advert is currently live again.

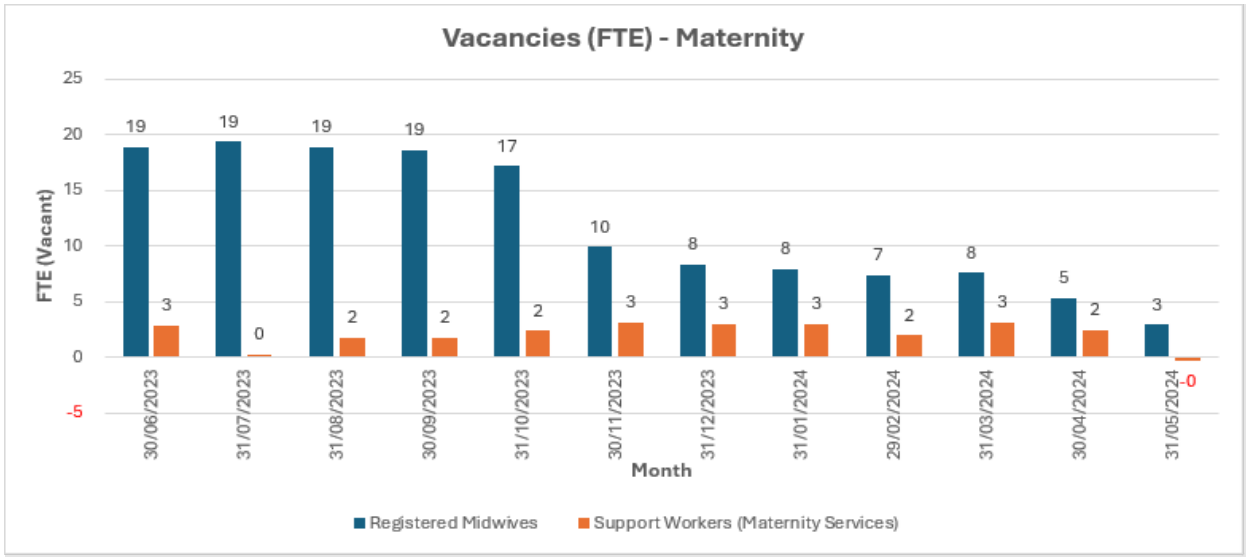
3.4.1 There has been continued focus on recruitment of Health Care Support Workers. It remains challenging to achieve a sustained operationally zero vacancy position due to high attrition of this staff group. This is supported by a rolling advert alongside regular shortlisting and interviews. Where areas have a high HCSW vacancy, nurse managers attend the Corporate Recruitment Interview Panels to ensure all areas vacancies are filled, in addition areas also advertise in specialist recruitment drives for key areas.

Fig. 6 Theatres Band 5 and Band 2 Vacancies



3.4.2 Pipeline data also shows there will be a decrease in Theatres vacancies, theatres will be fully established once all staff in pipeline have commenced in post.

Fig.7 Midwives and Maternity Support Workers Vacancies



3.4.3 As shown in figure 6 the vacancy rate for registered midwives has significantly reduced during 2023 into 2024.

4. CHIEF NURSE ANNUAL STAFFING REVIEW

4.1 Imperial College Innovations Limited working in collaboration with the Shelford Group recognised that the Safer Nursing Care Tool (SNCT) did not reflect the need to identify the significant increase in patients requiring complex enhanced care resulting in increased staffing. In October 2023 the tool was amended to include two new acuity scores for enhanced care (1C and 1D) and all previously existing tools became obsolete. Training took place within the Trust during April 2024 for all staff involved in the data collection, to enable them to understand the new SNCT before commencing the data collection in May 2024.

4.2 The National Quality Board recommend a SNCT data collection is completed twice yearly, data collections have taken place within the Trust in June and November 2022, July, and December 2023 utilising the previous tool.

4.3 The SNCT data collated in May 2023 and reported in this paper is the first data collection using the newly updated SNCT. It is recommended to undertake a summer and winter data collection before true comparison, analysis and recommendation can be made. This paper will reflect and discuss the May 2024 data collection; however, a full comparison will take place after the second data collection in November 2024, as recommended.

4.4The two new scores have also been added to the Allocate Safer Care Tool in E-roster, this is completed twice daily by nursing teams. The data and associated narrative from the SNCT and the Safe Care Acuity Tool have been reviewed by the Senior Nursing Team and analysed against current establishment. This analysis was presented for scrutiny at the Chief Nurse establishment reviews held in April 2024.

4.5 The SNCT data collection excludes the Intensive Care Unit (ITU) who align to the guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations and Maternity who utilise Birth Rate Plus tools in line with guidance. During this recent data collection, the Emergency Department and Children's Ward have also completed a data collection using tools recreated specifically for those areas.

4.6 All senior nurses taking part in the data collection and all validators received training to use the newly updated tool and calculator. Additional validators who were allocated a ward outside the Clinical Business Units (CBUs) also received training to enable the external validation outlined as a key requirement in the SNCT guidance.

4.7 Skill mix requirements form part of the triangulation of data, as recommended by the Developing Workforce Safeguards' (2018) guidance. Skill mix reviews are conducted as part of the Annual Establishment Reviews or if a ward has changed from their primary function.

4.8 The annual Chief Nurse Establishment Review was completed in April 2024, where robust scrutiny was applied and associated actions developed. The actions are being tracked within the Care Groups and at the Workforce Review Group. An AHP staffing review will take place in July 2024.

Key points:

- It was identified that establishment reviews need to take place for: SEDC, UTC, ACCU, B19, B14, Discharge Lounge, FAU, A2, PACU and the Pain Team.
- Medical coding issue escalated for resolution.
- A further revenue request for A7, A8 & A9 is proposed.
- Required refurbishment on Ward A8.
- A two-part revenue request required for Ward A2.
- Trust commitment to TNA/RNA programme and placement of appointed staff.
- Interim solution to Endoscopy roster until able to add onto the Allocate system.
- Succession plan for ACP for GAU.

- Continued recruitment/specialist recruitment into the remaining nursing vacancy.
- The Safer Nurse Care Tool (SNCT) data collection to take place in May 2024 for all areas excluding ICU and Maternity utilising the newly amended tool.
- The Trust has significantly reduced agency spend which is supported by an agency reduction action plan and this is to continue with the newly created bank reduction action plan.

5. SAFER NURSING CARE TOOL DATA COLLECTION

5.1 The Safer Nursing Care Tool (SNCT):

5.1.1 In line with NQB recommendations, the Safer Nursing Care Tool (SNCT) was developed to ensure the right staff, with the right skills are in place to support safe patient care. Originally developed by the Shelford Group and utilised for adult inpatient wards, it has recently been adapted nationally for the assessment of patients in the Emergency Department (ED). In 2023 the SNCT for acute wards was amended to include Level's 1c and 1d patients who require arm's length or continuous observation by 2 or more members of staff. In addition to this a new tool was also created for Paediatrics. The Paediatric Senior Nursing Team at the Trust staff completed their training to enable them to use the tool and completed their first data collection in May 2024.

5.1.2 It is recommended data collections should be undertaken twice yearly, the first data collection using the newly updated tool took place in May 2024.

5.1.3 The twice daily data collection is entered into to the SNCT calculator which indicates the number of staff required for patient care based on acuity and dependency and this was also updated to include calculations of the new acuity scores of 1c and 1d.

5.1.4 NQB recommends the Safer Nursing Care Tool (SNCT) is used to assist senior nurses to ensure safe nurse staffing levels are applied for the patients in their care. Professional Judgement must be used alongside triangulation of data from Nurse Sensitive Indicators (NSIs) such as infection rates, complaints, pressure ulcers and falls Additionally, when reviewing staffing levels skill mix, competence, leadership, morale, and compliance needs to be considered.

5.1.5 In line with national guidance a minimum 30-day data SNCT capture was undertaken across 20 wards, utilising the Adult Inpatient Wards in Acute Hospitals SNCT during May 2024.

5.1.6 The Children's & Young People Inpatient Wards, and The Acute Medical Unit (AMU) completed data collections using the Adult Acute Assessment Unit SNCT(AMU) and the Children's and Young People's Inpatient Wards SNCT (children's areas).

5.1.7 The data collections do not include ITU who align to the Guidelines for the Provision of Intensive Care Services (GPICS) staffing recommendations. Maternity Services complete Birth Rate Plus in line with national recommendations and are therefore also not included.

5.1.8 ED completed the required SNCT data collection using the Emergency Department SNCT. This tool is specifically designed for Emergency Departments, and therefore has different criteria, than the standard SNCT. The recent data collection was conducted for the recommended 12-day collection twice daily to enable a 24-hour period to be captured. The summer data collection was completed in late May/early June 2024.

During the 12 days of the summer data collection, ED experienced a period of reduced corridor care compared to the previous and subsequent weeks/months. This is in line with seasonal/weather variation. As with all SNCT data, the results must be interpreted with caution until two sets of data are collected, one

in the summer months and one in the winter months so a true reflection of patient demand can be quantified.

The ED SNCT data tool has other restrictions as the tool considers the ED as a whole and does not account for staffing for many individual sub areas of the department. Patients in all areas the Emergency Department should be counted. This includes all Majors patients, as well as those patients in Minors and the ED Paediatric Department. During the period of this data collection, patients who were on the ED Ambulatory pathway were not included, as this service was being delivered from the Same Day Emergency Care (SDEC) Unit at the time of data collection.

The ED SNCT does not consider the department footprint/environment, so it is important professional judgement is applied. This is particularly important when analysing Warrington ED. Due to lone working requirements all 10 individual sub areas within ED (not including corridor care), all need to have at least two staff in each clinical area to comply with safety and medication requirements thus resulting on a higher number of staff required, this would be a baseline requirement before any clinical patient acuity scores are applied.

The requirement for an ambulance handover nurse (1 WTE), supernumerary co-ordinator (1 WTE) and a triage co-ordinator (1 WTE) are also not included within the SNCT data. Additionally, the tool does not reflect the requirements to meet the national quality, safety and performance standards (e.g. 15-minute triage target, 4 and 12-hour standard) that are set. Therefore, professional judgement that considers all these factors must be applied, as these can significantly alter the required staffing establishment against the recommendations outlined from the SNCT when reviewed in isolation.

The ED tool also does not consider the enhanced care requirements of patients in the ED, which are often significant due to the nature of the patients and the environment they are in. There is a daily demand for additional staff beyond establishment to provide enhanced care, which contributes to the ongoing cost pressures. ED SNCT continues to be evaluated by Shelford.

The results of the summer SNCT data collection for ED indicated that 21 WTE were required. This is significantly less than the 34 WTE staff in the funded establishment. As described above, analysis or comparison of a singular data set conducted in the summer months, must be taken with caution. Consideration must also be given to all the factors that SNCT data does not reflect in its recommended staffing levels.

5.1.9 A full staffing review was undertaken by the Associate Chief of Nursing for Unplanned Care in Autumn 2023. A revenue request to increase the nursing establishment for ED was supported in July 2023 for 8.5 WTE and then an additional revenue request was supported in December 2023, which resulted in a further establishment increase of 45.12 WTE. These posts are actively being recruited in to, with oversight from the Associate Chief of Nursing. This recruitment runs alongside a retention programme, which has been designed with the aim of reducing turnover within the ED Nursing Team.

5.2 Analysis and Next Steps –

SNCT May 2024 data collection – (Red review of model required based on professional Judgement / blue no suggested change from summer data collection based on professional judgement)							
Ward	Total current WTE Budgeted Establishment (RN & HCSW) WTE	Total WTE staff (RN & HCSW) currently in Post	SafeCare Recommended WTE (Excluded 1c +1d)	Difference between Current establishment and SafeCare recommended (excluding 1C/1D)	SafeCare Recommended for 1c +1d. WTE	Total recommended SafeCare establishment WTE (WTE+/- current budgeted establishment)	Is recommendation consistent with / Inconsistent with Professional Judgement (PJ)
AMU	62.22	48.89	63.97	-1.75	4.92	68.89(-6.67)	PJ confirms ward model requires review ward not funded for supernumerary coordinator – requirement 5.32 WTE
A2	38.10	33.90	44.67	-6.57	6.49	51.16(-13.06)	PJ confirms ward – model requires review need to quantify WTE requirements in November SNCT
A4	49.16	39.69	47.44	1.72	4.35	51.79(+2.63)	PJ confirms ward is not overstaffed ward is a high acuity surgical – Patients requiring TPN – complex IVs vac dressings– previous uplift staffing to 5+5 on day 2 yrs. ago, acuity continues to increase
A5 G	24.96	24.72	30.07	-5.11	1.47	31.54(-6.58)	PJ confirms this ward model requires review of HCAs, HCAs were reduced in previous years in line with Acuity, now seeing, increase in detoxing patients, 1-1, mental health patients, PJ suggests additional HCA required, not pursuing Revenue requests presently looking for movement within CBU to flex staff
A5 E	19.62	17.81	15.19	4.43	0.51	15.70(+3.92)	PJ disagrees noting the ward is not believed to be overstaffed – keep model the same.

							Not all patient's day case now due to Elective recovery programme, overnight stay – not capture. Patient bed can admit 2 – 3 patients during shift for procedure 2+2 (16 post operative patients pts) 2+1 at night
A6	50.26	44.80	50.43	-0.17	5.43	55.86(-5.6)	PJ confirms – additional HCA needed orthopeadic trauma unit, Many require 2 staff, dementia/ enhanced care needs high
A7	42.53	36.33	53.29	-10.76	3.51	56.80(-14.27)	PJ confirms ward model requires review unlikely to require 14 – revenue request in development for HCA
A8	48.80	45.03	53.62	-4.82	0.64	54.26(-5.46)	PJ confirms ward model requires review month on month requirement for this for enhanced care-MH Patients
A9	44.46	39.05	62.42	-17.96	1.37	63.79(-19.33)	PJ confirms ward model requires review Revenue request in development, WTE requirement to be quantified, funded for cohort covid ward function changed to acute medical ward medical ward, acuity significantly increased
B3	49.08	32.42	57.48	-8.40	0	57.48(-8.4)	PJ confirms ward when in escalation – ward increased by 10 beds – HCAs needed presently due to higher acuity than ward criteria. When ward to 16 bed medically fit

							would not require additional staff
B12 FMN	45.12	40.42	39.14	5.98	3.83	42.97(+2.15)	PJ confirms more HCA required establishment SNCT does not account ward layout with high-risk patient group
B14	34.48	31.64	35.19	-0.71	9.59	44.78(-10.3)	PJ confirms if ward was used as contracted function for rehab stoke patients ward would not be understaffed– however currently taking acute stroke patients. Rehab model post stroke – acute pts – work on stroke pathway ongoing
B18	58.40	46.40	50.63	7.77	1.6	52.23(+6.17)	PJ does not agree with SNCT that ward is overstaffed as SNCT does not account for NIV requirement, and supernumerary coordinator- no change to current model recommended
B19	38.14	35.46	43.40	-5.26	3.71	47.11(-8.97)	PJ does align with SNCT due to increase of CDT– Additional staff required for 4 CDT patients in cubicles at time of audit – when CDT patients not on ward no change to staffing model would be required
C20	20.18	19.11	28.88	-8.70	10.51	39.39(-19.21)	PJ does not align with SNCT not believed to require 19 more WTE
ACCU	47.93	44.57	52.07	-4.14	0.54	52.61(-4.68)	PJ confirms this recommendation. Due to the requirements to monitor telemetry across the hospital – staffing drops to 3 RNs at night
C21	37.31	35.89	39.03	-1.72	11.58	50.61(-13.3)	PJ confirms the ward is required to review staffing model – was

							discharge ward 2021 when established – now medical ward, WTE to be quantified
K25	27.61	26.44	34.99	-7.38	1.6	36.59(-8.98)	Agree for current patient model. Establishment was set for discharge ward currently sub-acute general medical – monitor admission against criteria / plan for K25 for next year
CSTM	32.01	25.82	32.66	-0.65	4.35	37.01(-5)	PJ disagrees as no more staff are required
B10/B11	51.15	41.88	22.80	28.35	0	22.35(+28.35)	PJ confirms no change to model is required
Total	821.52	710.27	857.37	-35.85	76	933.37(-111.85)	

In accordance with the data collection for May 2024, the recommended Safer Nursing Care establishment figures are 857.37 WTE a deficit 35.85 WTE against the current establishment.

5.3 There is also the additional recommendation of 76.0 WTE required to care for 1c and 1d patients who require additional care to maintain their safety. This is a total of 933.37 WTE recommended opposed to the current budgeted establishment of 821.52 WTE.

5.4 The tool is suggesting to meet the requirements of current patient demand and ensure safety for enhanced care a further 111.85 WTE would be required. This is likely to recommend higher numbers of staff are required following the winter collection commencing in November 2024 that is likely to show increased demand, higher acuity and higher volumes of frail patients in line with season variance.

5.5 A number of areas highlighted as requiring additional investment have continued to flag monthly via the Monthly Safe Staffing Report presented to the Strategic People Committee. 11 of the 20 wards recommend an increase in staffing, these areas also appear on the Trust Cost Pressure Plan. These wards regularly utilise significant overspend each month to maintain safety, with only a small number of areas having had partial investment to bridge the gap of the actual staffing required. Some key examples of those featuring on the Cost Pressures Plan can be seen below –

5.6 A2 30 Bed Diabetic/Endocrinology /Medicine ward- This ward receives patients stepping down from ITU higher level care, patients routinely have multiple infusions/complex monitoring and medication regimes. The ward receives high volumes of acutely unwell patients from other wards and has seen an increase in patients with mental health needs as well as older dependent patients with diabetic foot/amputations. **SNCT** suggests the ward is generally **-6.57 WTE** understaffed, with an additional requirement of **6,49 WTE** required for enhanced care (total deficit **13.06 WTE** to maintain safety). **NHSP -** In May 2024 an additional 234 NHSP shifts were requested to maintain safety, 87 shifts related to 2.54 WTE vacancy, 34 shifts to sickness, the remaining shifts related to enhanced care acuity and escalation. **Cost Pressure** This ward has a £108,116 overspend at M3 with a forecast of £1,689,162 variance against budget this year.

5.7 A7 34-bed general medical ward for Elderly Care/Frailty patients (over the age of 65) This ward is routinely used for extra capacity (90 days from January – May). This cohort of patients have a number of co-morbidities, therapy needs and high dependency with a large majority suffering from dementia or delirium. **NHSP**- In May 2024 an additional 216 NHSP shifts were requested to maintain safety, 35 shifts

related to the 6.2 WTE vacancy, 17 shifts to sickness the remaining shifts related to enhanced care acuity and escalation **SNCT** suggests the ward is generally **-10.76** WTE understaffed, with an additional requirement of **3.51** WTE required for enhanced care (total deficit **14.27** WTE to maintain safety). **Cost Pressure** – this ward has a £525,569 overspend at M3 with a forecast of £2,113,434 variance against budget this year.

5.8 A8 34 Bed General Medical Ward This ward is routinely used for extra capacity (80 days from January – May). These patients often have high dependency needs often with two staff required to assist with activities of daily living, as well as commonly having complex discharge needs. A8 have had an increased number of patient's who need escorting off the ward for investigations. The ward also takes a large cohort of patients with mental health needs. **NHSP**- In May 2024 an additional 197 NHSP shifts were requested to maintain safety, 33 shifts related to the 3.77 WTE vacancy, 60 shifts due to sickness, the remaining shifts related to enhanced care acuity and escalation **SNCT** suggests the ward is generally **4.82** WTE understaffed, with an additional requirement of **0.64** WTE required for enhanced care (total deficit **5.46** WTE to maintain safety). This is believed to be significantly underrepresented compared to the previous 12 months due to the discharge of 3 long term dependant mental health patients at the point of data collection. This will be validated through the second winter data collection in November 2024. **Cost Pressure** – this ward has a £544,135 overspend at M3 with a forecast of £2,183,574 variance against budget this year.

5.9 A9 34 bed general medical ward. This was previously the COVID ward. When the ward gets used for infection control purposes additional staff are required. Since COVID has reduced the ward has seen an increase in highly acute medical patients. This ward is also routinely escalated. (56 times in May). The ward has 2 cubicles that sit outside the ward footprint that require additional staff when in use. **NHSP-** 194 NHSP shifts were requested to maintain safety, 55 shifts related to the 2.86 WTE vacancy, 20 shifts relate to sickness the remaining shifts related to enhanced care acuity and escalation **SNCT** suggests the ward is generally **17.96 WTE** understaffed, with an additional requirement of **1.37 WTE** required for enhanced care (total deficit **19.33 WTE** to maintain safety). This is believed to be significantly underrepresented compared to the previous 12 months due to the discharge of 3 long term dependant mental health patients at the point of data collection. This will be validated through the second winter data collection in November 2024. **Cost Pressure** – this ward has a £589,055 overspend at M3 with a forecast of £2,126,716 variance against budget this year.

5.9.1 **C20** Ward C20 Gynaecology has inpatients from mixed speciality, general surgery, orthopaedic, elderly medical care, medical care, ENT, and urology. The staffing establishment is budgeted as a 14 bedded unit; however, the ward is regularly escalated up to 16 patients utilising Gynaecological Assessment Unit (GAU) space. Patient acuity increases due to the complexity of the non-gynaecological patients. **SNCT** suggests the ward is generally **8.7 WTE** understaffed, with an additional requirement of **10.51 WTE** required for enhanced care (total deficit **19.21 WTE** to maintain safety).

5.9.2 **B18:** The May 2024 SNCT results show that the ward establishment is higher than the total SNCT recommended levels (by 6.17 WTE). B18 is a 28 bedded Acute Respiratory Unit with 7 respiratory enhanced care beds, 4 bioquell pods and 3 cubicles. Additionally, the ward is routinely escalated by an additional patient due to hospital capacity pressures. The ward can provide care for level 2 respiratory support patients, who may historically have been cared for in a High Dependency Unit/Intensive Care Unit environment, and therefore the correct number of appropriately skilled staff is key to maintaining patient safety. The current staffing model is based on recommendations from the combined British Thoracic Society and Intensive Care Society guidelines where 1 nurse to 2 patients is required for level 2 patients. Due to the high acuity of patients on this unit a coordinator role is necessary to ensure safe management of respiratory patients throughout the organisation by supporting flow. SNCT data does not reflect the ward environment/layout or the need for a coordinator. The environmental layout of the ward does not allow oversight of all areas from the nursing station so professional judgement needs to be applied when reviewing this staffing model in line with national recommendations for patients on respiratory support.

5.9.3 **B10 / B11** This is a complex children's area including planned and emergency admissions and a children's assessment area. The SNCT Childrens and Young People Inpatient Wards Tool that was used for this collection does not take into account the need to have higher staff numbers for assessment areas. Therefore, when reviewing staffing levels for B10/B11, as with specialist areas such as ED. AMU and wards with higher level care requirements, professional judgement needs to be applied in line with national recommendations for staffing this area. The Trust uses The Royal College of Nursing Guidance for Safe Staffing Levels in the UK (2010,2013) that sets out there should be a minimum of 1 registered nurse per every 3 children who are aged under 2 years at all times on general wards and 1 nurse per every 4 children aged over 2. RCN note higher smaller ratios may be required for children requiring assessment or higher levels of care.

5.9.4 Overview of the outputs of SNCT can be seen in section 5.2. Whilst SNCT is the recognised national tool, recommendations must be reviewed applying professional judgement. This is because SNCT currently does not account for requirements such as national guidance for specific patient groups, environment and assessment pathways.

5.9.5 20 areas were reviewed using the SNCT Tool, of those there are 13 areas where professional judgement confirms a further review of the staffing model is required. Whilst the requirement for additional staff may not be as high as SNCT suggests in all areas, wards that are recommended to increase the WTE triangulate to those who have constant use of temporary staffing. Some of these are noted to be due to a change in patient profile and acuity since the wards were established.

6. TEMPORARY STAFFING

6.1 Temporary Staffing

6.1.1 WHH are contracted to work with NHS Professionals (NHSP) for the provision of temporary bank and agency staff. Systems are in place to monitor usage and work is ongoing to reduce the use of agency staff. Cost Pressure Clinics are being held with the wards chaired by the Deputy Chief Nurse from July. Monthly meetings are held with NHSP colleagues to review key performance indicators. There has been no utilisation of off framework agency since July 2023 and no NHSP staff incentive since Christmas 2022. The use of temporary staffing via a "nurse pool" for registered staff has only been utilised in extremis and there continues to be reduction in the number of unregistered staff requested on "nurse pool". The nurse pool has now been significantly reduced as a result of the Band and Agency Reduction Plan. The migration of staff across from agency to NHSP continues to be a focussed piece of work with the successful transfer of 60 staff since April 2022.

6.1.2 Work to reduce the reliance on agency continues supported by the Agency Reduction Action Plan with a reduction of £121,353.00 from December 2023 to May 2024.

6.1.3 In conjunction with the Agency Reduction Plan the Agency Managed Service has been in place since April 2023, this has resulted in total cost reduction of £1,896,348. The Agency Reduction Plan was implemented in 3 phases, Phase 1 and phase 2 of the plan took place in April and May 2023 with phase 3 taking place in November 2023. In phase 3 all areas had a golden key applied for management of agency shifts, except for 4 areas at risk due to vacancy. These keys prevent automatic escalation to agency. During March and April 2024, the remaining areas had golden key authorisation added. The golden key is only taken off using a strict senior authorisation process if there is a concern around safety.

Fig.8 Bank and Agency Spend April 2024 and May 2024

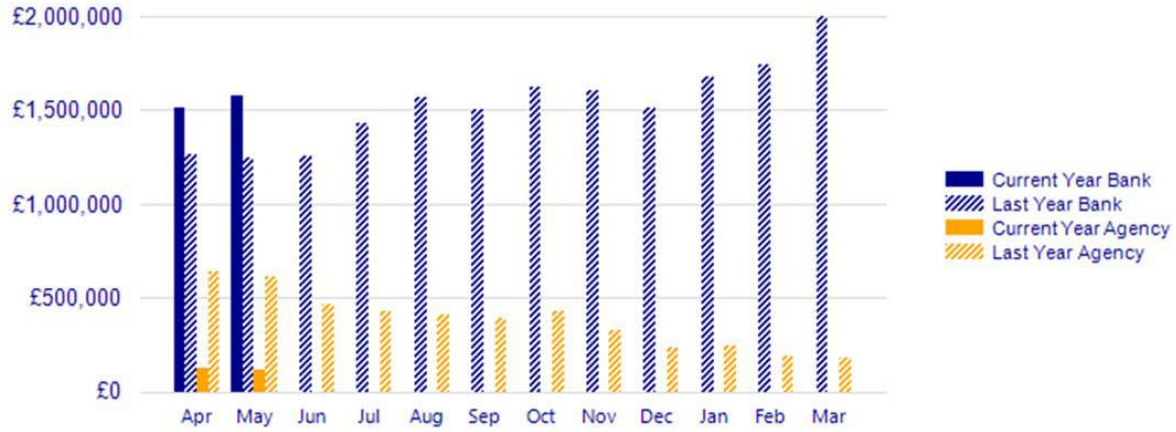
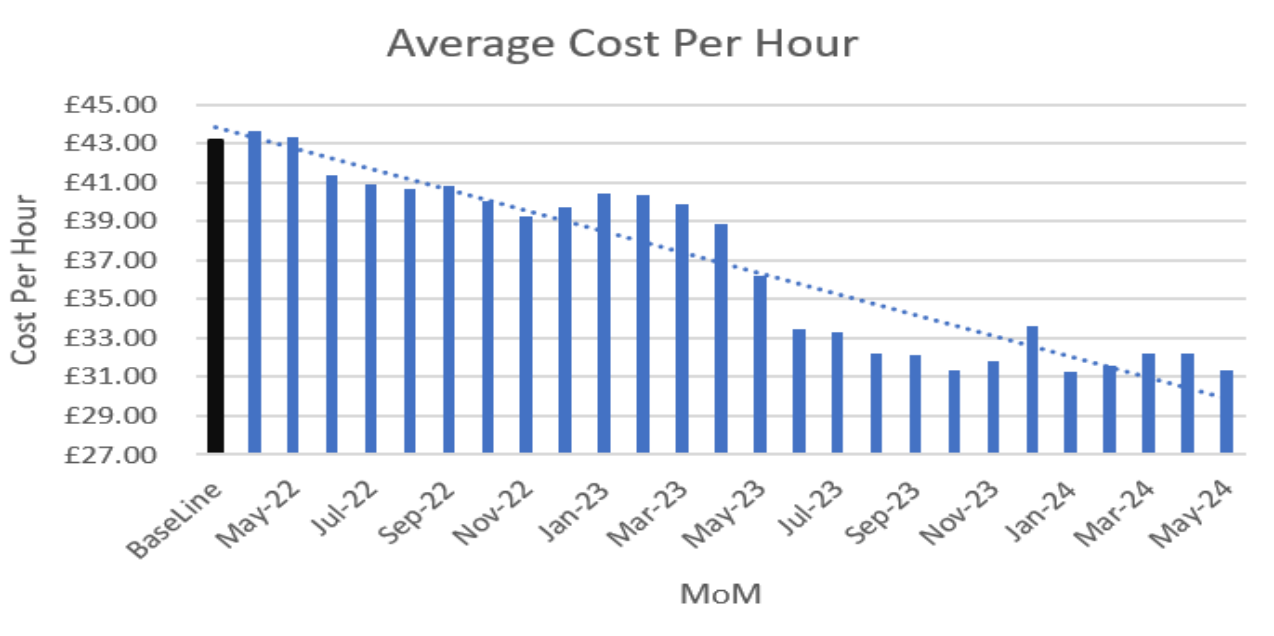


Fig. 9 Summary of NHSP Bank and Agency Usage for May 2024

6.1.4 The Table above demonstrates a continued improvement in bank fill which was 90% in May 2024. There was a noted reduction in agency use in May 2024 by 19% compared to April 2024.

6.1.5 Figure 10 below demonstrates the reducing cost of agency workers with an overall cost avoidance of £1,896,348 since the introduction of Centrally Agency Managed Service (CAMS) via NHSP in April 2022.

Fig.10 Average Cost of Agency Per Hour Since April 2022



6.1.6 Figure 10 above demonstrates the reducing cost of agency workers with the reduced hourly rate reduced from £43.30 in April 2022 to £31.32 in May 2024.

6.1.7 The Trust continued to be extremely challenged with increased activity which resulted in additional areas being opened for escalation and the introduction of the accelerated discharge process in October 2023. The process supports the de-escalation of ED when attendances and acuity are increased by the identified wards accepting additional patients. Temporary and substantive staff are moved around the Trust to make areas safe when escalated may lead to increased risk in other clinical areas. Despite this WHH has not used any 'off framework' agency workers since early July 2023.

6.2 WHH Recruitment and Retention:

A number of initiatives are in place to support recruitment and retention and are reported via the monthly Staffing Assurance Report to the Board of Directors and Strategic People Committee.

Examples of Key points:

6.2.1 **A Trust Recruitment and Retention Action Plan is in place,** monitored via the Workforce Review Group. Retention planning is supported by the Cheshire and Merseyside Health Education England (HEE) Retention Lead, work continues with Trust Workforce Lead and the Clinical Education Team to ensure progress with this workstream continues to move forward.

6.1.2 **The NHSE Nursing and Midwifery Retention Self-Assessment** has been shared with the Integrated Care Board (ICB) Lead. This will facilitate development of high impact actions and inform future work plans. The Trust is represented at the Cheshire and Merseyside Staff Retention Forum.

6.1.3 **Monthly generic recruitment** for band 5 RNs continues with bespoke recruitment where required and larger recruitment events twice yearly in line with student intake and qualification. There is a rolling Trust advert for experienced registered staff with regular shortlisting and interviews. There is a rolling advert for HCSW's with regular shortlisting and interviews.

6.1.4 **Legacy Mentoring:** WHH successfully bid and was awarded 12 months funding from HEE for a Legacy Mentor Role to focus attention on nursing and midwifery staff within the first 24 months of their working life in the NHS with the intention of improving their experience and reducing attrition. The funding will finish at

the end of March 2024. This will be replaced by the People Promise Manager for a 12-month period and this post has been appointed to and awaiting confirmation of start date.

6.1.5 One of the most successful initiatives was the International Recruitment Programme, with 250 nurses having joined WHH to date. International recruitment is currently on hold, instead WHH have committed to local recruitment of student nurses through the STEPP programme.

6.1.6 All CBU's have already or plan to appoint a Practice Nurse Educator to support staff new to post and reduce attrition.

6.1.7 ED have extended the supernumerary time of staff new to post and introduced a bespoke ED training week.

7 STAFFING AND HARM

7.1.2 Red flag data is reviewed daily by the Senior Nursing Team and reported as part of the daily staffing briefing. The Senior Nursing Team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that safe care can be provided on inpatient wards. Any potential care issues associated with staffing are also recorded here using the Red Flag system. Red Flags are reviewed and acted upon/mitigated where possible in real time and remain open until resolved, reports are sent to Lead Nurses and Matrons on a weekly basis to allow them to review their trends and themes. Frequency and themes inform responsive and planned nurse staffing reviews and inform future establishment requirement.

7.1.3 A monthly report is also shared with the senior nurses that triangulates staffing incidents, staffing red status, red flags and patient harms. The table below shows how many red flags reported and how many occasions wards showed a red staffing status.

Fig.11 Red Flags Reported and Number of Occasions Wards Showed a Red Staffing Status. Escalation red flags 2023/2024

Time Period	Q1	Q2	Q3	Q4
No. Red Flags opened	1021	1007	1181	1899
Red Status reported	319	318	327	258

7.1.4 Since the start of Quarter 1 there has been an increase in the number of red flags raised. From Quarter 1 to Quarter 4 there has been a 54% increase in the total number of red flags raised. This correlates with the introduction of the Accelerated Discharge process that was introduced in October 2023 to support the de-escalation of ED at times of increased attendances. Red Flags are raised by the wards when they receive additional patients above normal capacity of beds. In September 2023 (before the process was introduced) there were 16 red flags raised for patient numbers above agreed capacity. In May 2024 the number of red flags raised was 115 which was an 86% increase from September 2023. WHH has noted an increase in older patient admissions, frailty patients who require enhanced care, as well as patients requiring strict 2:1 care due to complex mental health needs. Additional staff are requested to maintain safety but if these are not filled red flags are raised. From May 2023 to May 2024 there was a 24% increase in red flags raised linked to this theme.

Fig.12 Distribution of Harms Across 2022/2023

	Dec 23	Jan 24	Feb 24	March 24	April 24	May 24
Red Flags	412	602	727	570	640	539
Red status on gold	109	86	77	95	77	89
Total number of falls	43 No Harm/Low Harm 2 Moderate Harm	37 No Harm/Low Harm 1 Moderate Harm	40 No Harm/Low Harm	28 No Harm/Low Harm 4 Moderate Harm	28 No Harm/Low Harm 1 Moderate Harm	31 No Harm/Low Harm
Key Areas	A8, A7, K25, C21, A6, B3, A4	A5G, A9, AMU, ACCU, B12, B18, B3	A8, A9, A7, A2, B14, A5G	AMU, A9, B19, A4	AMU, A8, A7, B12, B14	A8, B14, K25, B18, A6
Total number of pressure ulcers	16 Cat2 2 Cat 3	10 Cat2 1 Cat 3	9 Cat2 1 Cat 3	14 Cat2 4 Cat 3	13 Cat 2 1 Cat 3	9 Cat 2
Key Areas	K25, A8, A6, C21, B14	C21, AMU, AED	ICU, A2, ACCU, A7, A4, A8	A8, AED, ICU	ICU, B14, ACCU, A9, A6, C21, A7, A5G	B18, AED, K25, A8, ACCU, A10, AMU

7.1.5 The main areas reporting falls over the 6-month period are A8, A7, A9, AMU & B14. Additional staff are requested for patients requiring 1:1 care and staff moves made in the twice daily staffing meeting to support this.

7.1.6 The main areas reporting pressure ulcers over the 6-month period are A8, C21, ACCU, AED & ICU. There is focused work following the commencement of a Pressure Ulcer Task and Finish Group in May, a full year work plan has been produced this will be reported via several sources to Patient Safety and Clinical Effectiveness Sub Committee.

Historically the ED nursing establishment did not meet the demand of the number of patients attending the Department, particularly when an increased number of patients frequently had to be nursed on the corridor. This provided risks to patient safety and experience, including the increased risk of falls and pressure ulcers. To manage this risk WHH have invested a significant amount to enable nursing establishment to be increased in December 2023 by 45.12 WTE registered nursing staff. The Workforce Team are supporting ED with filling the additional vacancy following investment.

7.1.7 Each ward's harm profile is reviewed within the CBU, and an associated action plan is supported and lead by either the matron or lead nurse dependent on the level of severity.

7.1.8 Ward A9 currently have an extensive action plan in place to support the Ward Manager and Nursing Team to improve standards and reduce risks on the ward.

8 EVIDENCE BASED STRATEGIC WORKFORCE PLANNING

8.1 Staffing Fill Rates

8.1.2 Staffing fill rates are demonstrating an improving picture since December 2023 and are consistently over the 90% standard for all 4 elements measured.

8.2 Care Hours Per Patient Day (CHPPD)

8.2.2 Care Hours Per Patient Day (CHPPD) was developed and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside E-Rostering systems and supports the daily assessment of operational staffing requirements. CHPPD are monitored monthly via the Trust IPR and reported via the monthly Trust Board Staffing Paper. Since December 2023 the average CHPPD has been 7.9 across WHH which is in line with the national target of 7.9.

Finyear	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2023/24	April	16057	4.2	3.3	7.6
	May	16895	4.4	3.3	7.7
	June	16141	4.3	3.4	7.7
	July	16810	4.2	3.5	7.7
	August	16763	4.3	3.6	7.8
	September	16566	4.3	3.6	8.0
	October	16567	4.5	3.5	8.0
	November	16627	4.4	3.4	7.7
	December	16447	4.4	3.6	8.0
	January	17413	4.3	3.5	7.8
	February	14849	4.7	3.7	8.4
	March	17343	4.3	3.5	7.7
2023/24 Total		198478	4.4	3.5	7.8
2024/25	April	16144	4.5	3.6	8.1
	May	17194	4.4	3.4	7.8
2024/25 Total		16144	4.5	3.6	8.1

9 CARE GROUP UPDATES

9.1 Planned Care

- Workforce metrics - continued recruitment progress is paying dividends with reduction in vacancy rates across the Care Group. The vacancy percentage for registered staff is currently 7.94% which is below Trust target compared to 13.09% in July 2023. Unregistered staff percentage has improved from 13.64% in March 2024 to 12.48% in May 2024 and the filling of remaining vacancy will remain a focus within the Care Group.
- Turnover has improved within the Care Group with registered staff turnover being under the Trust target of 13% at 9.47% for May 2024. Unregistered staff turnover has improved from 15.37% in December 2023 but is currently over Trust target at 13.71%.
- There is an improvement in registered staff sickness at 5.27% in May 2024, however, unregistered staff sickness is currently 10.34% in May 2024. of which 6.68% is long term sickness which is being managed in line with Trust policy.

- Mandatory training has also shown an improvement for unregistered staff and in May 2024 CSTF is 91.83% and appraisals are 81.13%. Registered staff Core Skills Training Framework (CSTF) is currently 88.47%, however, the focus will remain on the improvement of appraisals that are currently 76.91%.
- Ward B4 de-escalated at the end of March 2024 with B3 additional bay of 6 patients also de-escalated in May 2024.
- Urology Band 6 Triage Nurse - Cheshire and Merseyside Cancer Alliance (CMCA) have agreed to extend the provision of funds until October 2024 in order to further develop the role. Following successful implementation within the prostate pathway, the aspiration is to expand the process across the whole of Urology, into Renal and Bladder services. This will improve the referral quality for urology patients, reduce the time from triage to diagnostics and increase overall patient experience for urology patients.
- Urology Investigation Unit – Band 7 Department Manager commenced in December 2023.
- Endoscopy - The Trust has been successful in bidding to become an Endoscopy Hub at Halton Hospital. This will involve an additional 3 endoscopy rooms and recovery area on the Halton site to provide shared endoscopy capacity for all of Cheshire and Merseyside. The Trust was also successful in bidding to become a provider for alternatives to Endoscopy on the Warrington site which will involve upgrading a current treatment room. These two schemes are part of the Cheshire and Merseyside Endoscopy Network Transformation Programme and need to be delivered by the 1 April 2024. The Workforce model approved at the Trust Board of Directors; the additional staff have been appointed to.
- In April 2023 CSTM Theatres were added to the golden key process with all unfilled NHSP shifts having the golden key in situ as all other areas with an authorisation process in place for the removal of the golden key to cascade to agency. Focus on reduction of Bank and Agency spend continues with senior oversight, in line with the current Trust action plans.
- Targeted Investment Fund developments on Halton site – 'roadmap' of programme of works through to February 2025 with associated workforce plans in progress to ensure all teams are aware of service moves required for completion of project. Establishment reviews have been undertaken across 3 theatre sites, with a view to forward planning future workforce.

9.2 Unplanned Care

- Workforce metrics - continued recruitment progress is paying dividends with reduction in vacancy rates across the Care Group. The vacancy percentage for registered staff is currently 16.03% which is due to Trust investment to increase ED registered staffing by 53.62 WTE. Unregistered staff percentage has improved to below the Trust target of 9% to 8.97% in May 2024. The focus within the Care Group is to actively recruit into the remaining vacancy within ED due to the increase in establishment.
- Turnover has improved within the Care Group for registered staff from 15.76% in June 2023 to a current percentage of 11.84% and this is due to the work in ED to improve turnover by extending supernumerary time for staff new to post and introducing a bespoke ED training week. Unregistered staff turnover remains high at 19.32% and this remains a focus for the Care Group who will be part of the worked planned for wellbeing and engagement for the Trust's unregistered staff.
- There is an improvement in registered staff sickness at 4.68% in May 2024 which is a mixture of both short- and long-term sick. There is also an improvement in unregistered staff sickness which is currently 8.41% in May 2024 with a large percentage of 4.64% of short-term sickness. All sickness is being managed in line with Trust policy within the Care Group.
- Mandatory training with the Care Group continues to improve with unregistered staff CSTF currently at 90.51% and registered staff at 90.30%. The focus within the Care Group is now to further improve appraisals which are currently 80% for unregistered staff and 80.57% for registered staff.
- During staffing reviews A2 is consistently shown to be under established, and the use of temporary staff to support the safe delivery of care is being utilised. However, this is being run at a cost pressure which is currently not mitigated.
- Work is ongoing within the Unplanned Care Group looking at the cost pressures associated with enhanced care.

- All areas now have the golden Key attached to unfilled registered NHSP shifts with an authorisation process in place for their removal. Focused work continues within the Care Group for the reduction of Bank and Agency spend in line with the current Trust Action Plans to support this.

9.3 ED Workforce Update

- Development plans in place for all staff, extended supernumerary periods for all new starters including an "ED training week", dedicated Practice Education Facilitator (PEF) for preceptees which has significantly reduced turnover.
- Band 8A Matron post is now appointed to and an interim Nurse Manager is currently in post covering maternity leave.
- Increased vacancy is mainly due to the increased ED nursing establishment.

9.4 Paediatrics and Neonatal Unit (NNU)

- Newly appointed Lead Nurse for Paediatric and Gynaecology Services, commenced on 16 October 2023
- The Neonatal Unit has successfully fully recruited into their band 7 posts and two Band 6 positions have been appointed to and will commence in July 2024. There is one Band 5 post currently advertised and 4.8 WTE appointed to and will commence in September 2024.
- Children and Young Peoples Outpatients are currently advertising for a Respiratory Nurse Specialist following retirement and a 12-month secondment has been appointed to cover maternity leave.
- PART (Paediatric Acute Response Team) – Following the retirement of the Team Leader agreement has been sought to convert the Band 7 monies to Band 6 creating a 0.58 WTE clinical band 6 position within the service which has been required for some time, Band 7 oversight of this service will be achieved within the current establishment.
- NNU are currently out to recruitment for a 0.39 WTE Governance role following monies from NHS England, alongside a current advert for a Band 7.
- In March 2024 NHSE published a service specification stating that AHP roles are now essential requirements within NNU's and not just recommendations, these roles include Psychology, SALT, Physiotherapy and Dietetics, a paper will be submitted to QAC with further information, this has also been added to the CBU risk register.
- The NNU community team have both retired in quick succession of each other, an ECF has been approved to convert the Band 7 hours to Band 6 which is in line with NNU's across the region which has created a 1.8 WTE Band 6, this role will also rotate to clinical duties on the unit, and this is currently being advertised.

9.5 Allied Health Professional (AHP) Update

- Workforce metrics - continued recruitment progress is paying dividends with reduction in vacancy rates across the AHP's. The percentage vacancy for both registered AHP's and Clinical Support Workers is currently under the Trust target of 9% due to successful recruitment and this will remain a focus.
- Registered AHP and Clinical Support Workers turnover rate continues to remain below Trust target and has been since March 2023.
- A 3 Month action plan is in place to improve appraisal rates with a further review taking place in June 2024.
- The WHH AHP Workforce Plan 2024/25 is in the final stages of ratification with the end of project report for the past 18-month AHP workforce plan (June 22 – December 2023) being prepared.
- The AHP Preceptorship self-assessment has been completed with the preceptorship lead to compare with the national AHP standards for preceptorship. The outcomes and action plan have been discussed with the Lead AHP and Head of CPD. There was agreement on commencing a Task and Finish Group to plan improvements.
- Northwest NHSE have communicated that there is funding for Level 3 and Level 5 apprenticeships for AHP clinical support workers. This can be used for backfilling and can be spread over the duration of the apprenticeship. The Trust is awaiting further details before commencing the scoping for staff who can start in September 2024.

- A Chief Nurse AHP Establishment Review will take place in July 2024.
- Therapy International Recruitment Project – There has been 8 Occupational Therapists and 4 Physiotherapist's appointed, and the next step is to commence retention activity with these staff members.

10 OVERALL SUMMARY

10.1 Improvements have been seen in recruitment across staff groups with a positive trajectory of over recruitment going forward. This is further supported by a positive reduction in turnover. Work continues to focus on retention and to proactively recruit to maintain a consistent workforce pipeline.

10.2 Staffing capacity and the impact on safe care is recorded on the Board Assurance Framework, with a current high-risk rating of 16. The Lead Nurse for Workforce continues to work with the Care Groups and CBU nursing leads to support the recruitment and retention plans in place, overseen by the Deputy Chief Nurse and monitored via the Trust Workforce Review Group.

10.3 A robust ward staffing establishment review will be undertaken with the Chief Nurse In April 2024 using a mixed methodology of approaches in line with the recommendations from the NQB, NICE guidance and the RCN Nursing Workforce Standards.

10.4 Overall, the staffing establishments remain appropriate and within recommended guidelines, there are some key exceptions where acuity and dependency levels and growing demand continue to exceed nursing numbers, these are supplemented with temporary staff where possible.

10.5 Safe staffing and staffing escalation are monitored and utilised and is always a priority for the clinical teams. These processes remain in place to support staff and protect the safety of patients at WHH.

10.6 The Agency Reduction Plan in place has resulted in a significant cost reduction and reliance on agency staff. There is a process in place for authorisation to take place before agency fill for outstanding shifts. There is now a Bank Reduction Action Plan in place also.

10.7 The NHSP reason codes have been reviewed and reduced from 15 to 8 to enable more accurate reporting and monitoring.

10.8 The SNCT was updated in October 2023 and two additional acuity scores 1C and 1D for enhanced care were added. Training took place in April 2024 for all Senior Nurses within the Trust ready for the data collection in May 2024. Allocate "safecare" have since had the 1C and 1D added to reflect the amended tool and each area scores each patient twice daily.

10.9 Overview of the outputs of SNCT can be seen in Section 5.2. Whilst SNCT is the recognised national tool, recommendations must be reviewed applying professional judgement. This is because SNCT currently does not account for requirements such as national guidance for specific patient groups, environment and assessment pathways.

10.10 20 areas were reviewed using the SNCT Tool, of those there are 13 areas where professional judgement confirms further review of the staffing model is required. Whilst the requirement for additional staff may not be as high as SNCT suggests in all areas, wards that are recommended to increase the WTE triangulate to those who have constant use of temporary staffing.

11. RECOMMENDATIONS

It is recommended that the Quality Assurance Committee members discuss and note the progress to date and the contents of the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCECOMMITTEE

AGENDA REFERENCE:	**QAC/24/06/60**			
SUBJECT:	**Quality Strategy Initial Consultation and Proposed Quality Strategic Goals**			
DATE OF MEETING:	**11 June 2024**			
ACTION REQUIRED:	The Quality Assurance Committee is asked to note the contents of this paper.			
AUTHOR(S):	Ernesto Quider, Associate Director of Quality Tracy Fennell, Deputy Chief Nurse/Director of Clinical Governance			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper provides the Quality Assurance Committee (QAC) with an update on the consultation process of developing a new Quality Strategy in line with Trust Strategy and linked with domains of quality and defined in our Annual Quality Priorities 24/25. 1. Patient Safety 2. Clinical Effectiveness 3. Patient Experience			
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**	
RECOMMENDATION:	The Quality Assurance Committee is asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Quality Strategy Consultation and Proposed Strategic Goals	AGENDA REF:	QAC/24/06/60

1. BACKGROUND.CONTEXT

This paper provides the Quality Assurance Committee with an update on the consultation process of developing a new Quality Strategy in line with the Trust Strategy, as well as linked with domains of quality and defined in our Annual Quality Priorities 24/25.

1. *Patient safety* – quality care is care which is delivered so as to reduce the risk of avoidable harm to patients and a culture of support, openness and honesty when something has gone wrong.

Patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. The patient experience domain of quality also embraces accessibility, understood in the sense that we must provide services in an inclusive way that recognises the diversity of our population.

Clinical effectiveness – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes.

2. KEY ELEMENTS

The proposed Quality Strategy outlines our commitment to prioritise quality above all else. In the new strategy, we continue to build on the progress made so far in line with the National Quality Board's (NQB) Shared Commitment to Quality and the progress we have achieved for the past three years. We will outline our aims to continue to embed a culture of learning, innovation, and continuous improvement to increase and sustain the quality of our services for the people of Warrington and Halton.

The Trust is on a journey to achieve an overall rating of 'Outstanding' with the CQC, whilst increasing harm free care, implementing a strong culture of team led continuous improvement and having one of the most engaged and satisfied staff in the NHS. This Quality Strategy will set out the approach and help shape the direction of improvements in achieving our ambitions to become an outstanding for our patients, staff and communities.

This strategy has been developed in consultation with our staff and stakeholders who have shared their views and indicated what they believe our priority areas for improvement is. We will consider their views and that of our commissioners and regulators in developing this strategy.

Initial Consultation Process

We asked our patients, Trust members, governors, staff and members of the public, and the groups and individual who together make up our Involvement Network two questions via an on-line survey:

"Thinking about healthcare services, what does 'outstanding quality' mean to you?"
And

"If you need hospital care, what matters most to you?"

We held patient and public engagement events online in January to March 2024 in various forums including local HealthWatch, Experts by Experience Group to hear in person about "What matters to me?".

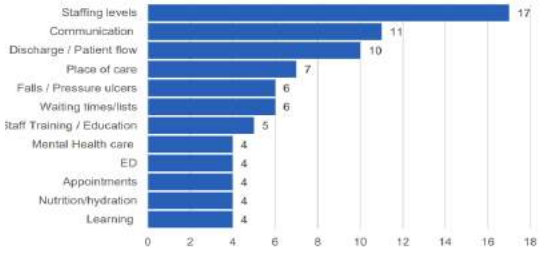
We reviewed feedback received by the Trust when it consulted on its organisational strategy in 2022/23, and also the key PSIRF themes and previous Quality Accounts subsequently made by the Trust.

We reviewed best practice nationally across the NHS, including NHS peer Trusts. We also reviewed our own existing Quality Strategy.

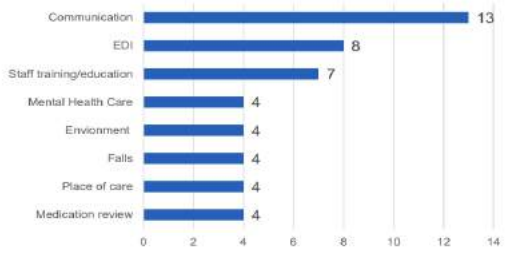
Please refer below the survey outcomes in the 3 domains of quality based on our initial consultation process.

Suggest another aspect of Patient Safety that you think we should focus on improving.

Survey



Engagement meetings

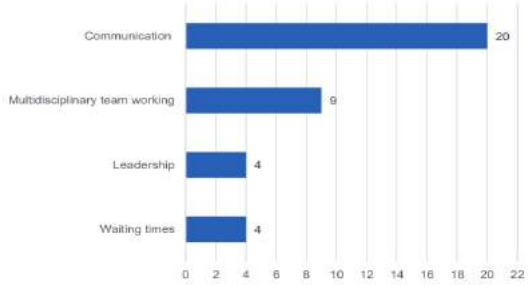


*Included here are the responses which received 4 suggestions or above.

Suggest another aspect of Clinical Effectiveness that you think we should focus on improving.

Survey

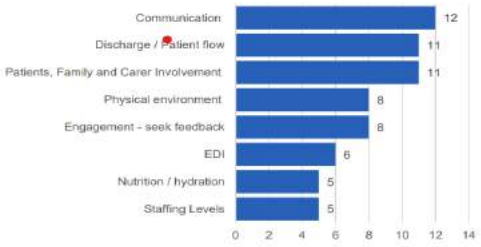
Engagement meetings



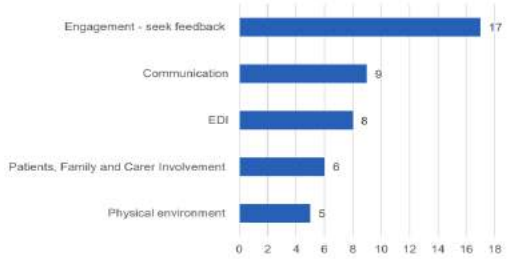
*Included here are the responses which received 4 suggestions or above.

Suggest another aspect of Patient Experience that you think we should focus on improving.

Survey



Engagement meetings



*Included here are the responses which received 4 suggestions or above.

Proposed Quality Strategic Goals: What we plan to achieve within 2025-2027.

Key Strategic Goals	Measures of success
Patient Safety	
We will keep our patients, service users and staff safe from harm through the delivery of harm free care.	1. To reduce the number hospital acquired pressure ulcer across the Trust. 2. To reduce the likelihood of nosocomial infections in our patients based annually with NHS planning guidance. **3.** We will ensure our inpatients receive adequate nutrition and hydration based on best practice standards.
We will create a culture where the safety of patients, their relatives and our staff is our foremost priority	1. We will establish Human Factors Hub and link with Quality Academy work streams to align safety improvement programmes with PSIRF priorities. 2. We will develop a Patient Safety Learning platform in for all staff and work with our Patient Safety Partners, EbyE to extend the learning platform to our patients, carers, and stakeholders.

	3. We will establish Learning From Excellence programme through knowledge mobilisation to evolve our Safety II ambition and to celebrate work of safety improvements and positive clinical outcomes.
Design and support safety programmes that deliver effective and sustainable change	1. Increasing learning opportunities and building staff confidence in leading innovative change and improvement through safety management system. 2. Practice a Restorative, Just and Learning Culture where all our staff, and patient safety partners are psychologically safe.

Clinical Effectiveness/Responsive	
We will make sure we 'get it right first time' by providing consistent care and supporting productivity improvement projects which deliver the best outcomes for our patients	1. GIRFT (Getting it Right First Time) – Further Faster Programmes to be embedded with frontline clinicians to identify and reduce unwarranted variations in service delivery and clinical practice across Care Groups/CBUs. 2. To include in-situ training in areas where invasive procedures are carried out. We will ensure 95% compliance in the use of LocSSIPs across the organisation.
We will prioritise the application of QI training to empower staff and achieve measurable improvement work with identifiable learning and sustainable results.	1. Establish Leadership for Improvement for all senior leaders and QI Coaching Programme in line with NHS Impact Recommendations and Improvement Capability and Capacity Building Plan. 2. Achieve consistent NHS Staff Survey results around engagement with improvement (Questions 4b, 4c and 4d) to target areas requiring extra support and link with organisational culture plan. 3. All completed QI projects to be assessed against benefit realisation or value management model to draw learning and outcome with results shared locally and Trust wide with regular Executive-led improvement celebration events.
We will work with our partners to understand and address the causes of health inequality to help people stay in control of their own health.	1. We will ensure all patients are offered smoking cessation referrals, and work with our partner organisations to support people on discharge. 2. We will establish Health Equity Improvement Programme to create cohesive and defined work streams across the Trust in addressing health inequalities.

	3. We will ensure that we Make Every Contact Count (MECC), offering advice and signposting our patients and community to support them to make healthy choices.

Patient Experience/Caring	
We will ensure a positive patient experience, enhancing the experience of our patients and service users.	1. We will improve the care and management of patients with Dementia, and their families and carers ensuring they have the opportunity to contribute to their care. 2. We will ensure our patients are assessed for Frailty and offered Advance Care Planning in hospital or in the community, including further advice and signposting to the relevant healthcare agencies. **3.** End of Life Care – Continue to develop a system wide approach to EOLC with development of processes that aim to ensure patients in their last year of life are recognised and supported, with particular focus on our patients achieving their preferred place of care in a timely manner.
We will maintain our focus on patients and their families' equality, diversity and inclusion.	1. We will ensure we use our patient level data to determine how protected characteristics affect outcomes and patient experience through analytics and research. 2. We will deliver the Accessible Information Standard across our Trust to ensure all people are able to access services and understand their care. 3. We will work with our partner organisations to ensure we are actively seeking the experience of those with protected characteristics through our Patient Panel programmes.
The patients and the publics' voice is integral in the decision making process when making changes to services or care delivery.	1. We will establish and evaluate the Always Events programme with EbyE involvement in line with Patient Experience Strategy work plans. 2. We will continue to deliver and review the impact and learning from quarterly projects on the overall patient experience using business intelligence information.

3. RECOMMENDATIONS

This Quality Assurance Committee is asked to receive and note the information contained in this paper.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/07/97**			
SUBJECT:	**Risk Management Strategy Annual Report 2023/24**			
DATE OF MEETING:	15 July 2024			
ACTION REQUIRED:	Quality Assurance Committee to note the findings of the Risk Management Strategy Annual Report 2023/24			
AUTHOR(S):	Helen Wynn, Head of Health, Safety and Risk			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	√
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	**Assurance statement** Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) has a fully implemented Risk Management System in place at both a corporate and strategic level. This report details the risk management arrangements in place throughout 2023/24. • Various levels of risk registers are in place and are actively managed and reviewed by identified leads and Clinical Business Units. • A full review of all Clinical Business Units risk registers took place in 2023/24. • A full review of the Corporate Risk Register took place in 2023/24. • The Board Assurance Framework is sighted the Trust Board of Directors and recommendations on gradings, risk descriptions are discussed and agreed. • A two weekly Risk Review Group meeting takes place and is chaired by the Chief Nurse.			

	• The Trust Board Risk Appetite Statement was reviewed in February 2024, and this was approved for a further 12 months. • The Trust has received the MIAA Core Controls Assignment Report for 2023/24. The overall assurance opinion within this report is high noting that the Trust has a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed. • The Trust has received a briefing note for the Risk Framework Review 2023/24. This provided high assurance which informs the Head of Internal Audit Opinion. • An Internal Audit Annual Report and Head of Internal Audit Opinion has been received for 2023/24. The overall view for this period is the Trust has substantial assurance that there is a good system of internal control in place		
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	The Quality Assurance Committee is asked to receive and note the report.		
	Committee	Risk Review Group	
	Agenda Ref.	W&HFT/RRG/24/066	
	Date of meeting	4 July 2024	
	Summary of Outcome	Remove reference to the External Risk Review which was undertaken in December 2022 and is out of date. Include reference to the following audits which have identified high assurance within the Trust. • Head of Internal Audit Opinion. • The briefing notes for the Assurance Framework Review that feeds the Head of internal Audit opinion. • Draft Risk Management Controls Audit.	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***None***		

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication

QUALITY ASSURANCE COMMITTEE

SUBJECT	Risk Management Annual Report 2023/24	AGENDA REF:	QAC/24/07/97

1. BACKGROUND/CONTEXT

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) has a fully implemented Risk Management System in place at both corporate and strategic level.

This report details the risk management arrangements that were in place throughout 2023/24.

2. KEY ELEMENTS

2.1 Introduction

The management of risk is achieved by ensuring an effective Governance Framework is in place and embedded fully across the organisation.

WHH acknowledges, a robust risk management system will have a positive impact on service delivery and therefore ensure the safety of all patients, visitors and staff.

The Trust has made improvements to strengthen this process over the past 12 months by:

- The Board Risk Appetite Statement was reviewed in February 2024, and this was approved for a further 12 months.
- WHH received a MIAA Core Controls Assignment Report for 2023/24. The overall assurance opinion within this report is high and details that the Trust has a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed. (Further details can be found in section 2.2 of this report).
- The Trust has received a briefing note for the Risk Framework Review 2023/24. This provided high assurance which informs the Head of Internal Audit Opinion.
- An Internal Audit Annual Report and Head of Internal Audit Opinion has been received for 2023/24. The overall rating for this period notes the Trust has substantial assurance that there is a good system of internal control in place.
- Various levels of risk registers are in place and are actively managed and reviewed by identified leads and Clinical Business Units.
- A full review of all Clinical Business Units risk registers took place in 2023/24.
- A full review of the Corporate Risk Register took place in 2023/24.
- The Board Assurance Framework is sighted at the Trust Board of Directors and recommendations on gradings, risk descriptions are discussed and agreed.
- A monthly Risk Review Group meeting takes place and is chaired by the Chief Nurse.
- A full review of risk descriptors (including implementation of a new descriptor model) to ensure that risks are consistent, clear and concise.

- A data cleanse exercise of the DATIX risk module was undertaken.

2.1.1 MIAA Core Controls Assignment Report for 2023/24

The review focused on risk management controls. Detailed testing of compliance e.g. reviews of specific risks, risk registers etc. was not undertaken as part of this review.

Key Findings/Conclusion

Overall control design for risk management within the Trust was robust.

Governance processes were clearly defined, and the Trust had a Risk Appetite statement in place. Roles and responsibilities relating to risk management were clearly outlined, and processes for identifying and assessing risks were established.

Risk reporting, monitoring and escalation processes were defined and supported by regular risk reporting mechanisms.

Objectives Reviewed	RAG Rating
Governance and leadership	
Roles and responsibilities	
Staff awareness and training	
Risk management and processes	
Monitoring and feedback	
Risk reporting	
Overall Rating	**High**

2.1.2 Assurance Framework Review (AF)

The overall objective was to assess the approach to which the organisation has maintained and uses the Assurance Framework (AF) to support the overall assessment of governance, risk management and internal control. The reviewed identified a high level of assurance.

Key Findings:

- The Trust AF structure includes consideration of risk appetite, initial score, current score and target score.
- The Trust AF provides updates of progress against actions including deadline and completion dates to implement or review.
- The Trust AF uses dashboards and graphs to provide visual overviews.
- The risk appetite was reviewed by the Board in February 2024.
- Risk responses are reflective of the corresponding risk appetite.

- System risks are clearly articulated and consider Trust and system wide position (set out in controls, gaps in controls and assurances).
- There is evidence that the Board of Directors are connecting risks in papers and discussions to the AF, examples include:

    - The Board of Directors are aware of WHHs higher risk services, therefore request a Fragile Services Report featuring updates for all those services to be presented at Board.
    - The Board were aware the serious incident framework was being stepped down creating a risk high risk incidents would not be seen. Therefore, the Board of Directors requested the Patient Safety Incident Response Framework Policy and Plan be presented for approval to the Board prior to the Serious Incident framework being stepped down.

2.1.3 Internal Audit Annual Report & Head of Internal Audit Opinion 2023/24

This Annual Report provides the Trust with 2023/24 Head of Internal Audit Opinion.
The overall view for the period 1st April 2023 to 31st March 2024 provides Substantial Assurance, 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.
Strategic

2.2 Risk Management Strategy

The purpose of the Risk Management Strategy is to encourage a culture where risk management is seen as an essential process of the Trust's activities to ensure structures and processes are in place to support the assessment and management of risks throughout the Trust.

The strategy outlines the processes in place to manage risk at all levels across the Trust to ensure the delivery of organisational objectives.

Having a robust Risk Management System means having a planned and systematic approach to the identification, evaluation and control of the risks facing Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and is a means of preventing harm to patients and staff, minimising costs and disruption to the Trust, caused by undesired events.

The aim of this strategy is to ensure that the Trust has an effective process to support better decision making through the understanding of risks and their likely impact. Effective risk management supports a safe, caring, effective and responsive service for patients, families and staff and contributes to the Trust being a well-led organisation.

The key objectives of the Risk Management Strategy are to:
- Embed the principles of risk management at all levels of the organisation.
- Create a culture which supports effective risk management.
- Provide the tools and training for staff to be able to support effective risk management.

- Ensure that lessons are learnt from adverse incidents.

There is a clear risk management process embedded across the Trust. The process described in the table below involves identifying possible risks before they occur, ensuring proactive management in minimising and mitigating risk and potential impact.

<table>
<tr><th colspan="4">Identification</th></tr>
<tr><td colspan="2"><u>Identification:</u>
Using incidents, complaints, claims, patient feedback, safety inspections, external review, objectives or ad hoc assessments.</td><td colspan="2"><u>Board assesses risks to objectives:</u>
Risk identification to be aligned to annual/business planning process.</td></tr>
<tr><th colspan="4">Quantification</th></tr>
<tr><td colspan="4"><u>Risks Scored:</u>
Using a matrix of 1 to 5 in likelihood & severity giving a maximum score of 25; this affects how the risk is escalated. Support for risk assessment can be given by the Governance Department.</td></tr>
<tr><th colspan="4">Risk Registers</th></tr>
<tr><td colspan="4"><u>Board Assurance Framework</u>
• Those risks mapped against delivery of the Trust Strategic Objectives.</td></tr>
<tr><td colspan="4"><u>Corporate Risk Register:</u>
• Those risks mapped against delivery of corporate objectives.
• Those risks that are deemed to deserve corporate visibility following cross-sectional analysis of impact and likelihood.</td></tr>
<tr><td colspan="4"><u>Operational Risk Registers:</u>
• Risks 8 and below – Local Risk Registers managed at ward/departmental Level.
• Risk 9 and above – CBU Risk Register managed by the CBU.

All risks 15 or above will be escalated & considered for inclusion on the Board Assurance Framework at the Risk Review Group.</td></tr>
<tr><td colspan="4"><u>Board:</u>
• Establishes principal strategic and corporate objectives and for ensuring the organisation achieve these.
• Ensuring that there are effective systems in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and through the Corporate Risk Register.</td></tr>
<tr><td><u>Audit Committee:</u>
• Annual Governance statement – reviewing systems of internal control.
• Internal audits of issues linked to strategic risks & monitoring of these action plans.</td><td><u>Quality Assurance Committee:</u>
• Monthly review of Board Assurance Framework.</td><td><u>Finance & Sustainability Committee:</u>
• Oversees financial risk on behalf of the Trust and report on any additional risk, controls, assurances which will be recorded on the appropriate risk register.</td><td><u>Strategic People Committee:</u>
• Oversees all workforce risks on behalf of the Trust and report on any additional risk/ controls/ assurances which will be recorded on the appropriate risk register.</td></tr>
</table>

Risk Review Group	Care Group Governance Meetings
• High Level Briefing Paper to the monthly Patient Safety and Clinical Effectiveness Sub Committee. • Rolling review of Care Group and Corporate Services Risk Registers.	• Review and discuss all risks at a score of 9 or above. • Review and discuss all services risks from Wards, Departments on a monthly basis. • Any changes must be recorded on the risk register and communicated to all relevant staff.

2.3 Risk Registers.

Board Assurance Framework (BAF)
The Board Assurance Framework (BAF) is fully embedded within the Trust. This assurance framework records the principal risks that could impact on the Trust. The key information reported to the Board of Directors includes: • Identifying controls in place to manage risks. • Provide assurance about the effectiveness of the controls in place. • Identify those objectives at risk because there are gaps in the assurance.
Corporate Risk Register
The Corporate Risk Register is fully embedded within the Trust. The risk register comprises of all risks which may potentially prevent the Trust from carrying out daily operations. The Corporate Risk Register effectively links with the BAF. Risks from the Corporate Risk Register are escalated/de-escalated to and from the BAF as appropriate.
Clinical Business Unit (CBU) and Corporate Services Risk Registers
All CBU''s and Corporate Services have risk registers in place. There is a consistent and standardised approach to the reporting and managing of risk registers.
Local Risk Registers
Local risk registers are in place and are managed at ward/departmental level. There is an escalation process in place should the risks need to be added to the CBU risk register for further review.

2.5 Assurance:

- Risks are managed and reviewed to assure both operational and strategic objectives are being met.
- The Trust can be assured that risks are being mitigated and/or escalated when required with oversight of this taking place at the Risk Review Group.
- The Trust has sight of all levels of risk which are monitored and reviewed through the structures in place noted within this report.

- There is an escalation process in place to ensure that risks are placed on the most appropriate risk register. Any risks escalated or de-escalated from the BAF or Corporate Risk Register is done so via the recommendation of the appropriate Committee.

2.6 Risk Review Group.

The Risk Review Group takes place monthly to oversee the recording and monitoring of risk registers within the Trust. These have been increased to fortnightly to enable a more detailed review of risk registers.

The two weekly meetings will undertake a more detailed review the effectiveness of the controls in place, actions to mitigate risks as well as increased scrutiny regarding outstanding risks and review dates. All Care Groups and Corporate Services attend the meeting on a 12-month rolling programme. The Risk Review Group scrutinises Risks scoring 12 and above.

Both the Board Assurance Framework and Corporate Risk Register reports are presented at each meeting.

2.7 Risk Register Annual Position Statement.

The table below represents the **total** number of risks on **all** risk registers in DATIX.

Risk Register	Total no of Risks
CBU/Dept Risk Register	536
Corporate Risk Register	19
Board Assurance Framework	12
Total:	567

The table below represents the number of risks grouped by risk score by CBU.

CBU Risk Register	1 to 3 Low Risk	4 to 8 Moderate Risk	9 to 12 High Risk	15 to 25 Extreme Risk	Total
Clinical Support Services	0	21	19	5	45
Corporate Services	5	65	79	18	167
Digestive Diseases	0	12	8	7	27
Integrated Medicine and Community	2	13	7	3	25
Medical Care	0	15	11	4	30
Surgical Specialties	2	9	4	8	23
Urgent and Emergency Care	0	4	19	9	32
Women's and Children's	1	9	12	1	23
Trust Wide	0	0	2	2	4
Total:	10	148	161	57	376

The table below provides a breakdown of Corporate Service by Specialty by risk score.

Corporate Services by Specialty	1 to 3 Low Risk	4 to 8 Moderate Risk	9 to 12 High Risk	15 to 25 Extreme Risk	Total
Communications, Marketing and Engagement	0	0	4	0	4
Corporate Nursing	0	4	3	1	8
Digital Services (IM&T)	0	1	6	5	12
Education & Organisational Development	0	1	2	0	3
Elective Care and Performance	0	0	2	1	3
Estates & Facilities	0	20	29	3	52
Finance	2	5	2	0	9
Human Resources	2	6	11	4	23
Governance & Quality	0	15	7	1	23
Strategy	0	13	7	2	22
Medical Records	0	0	0	1	1
Total:	4	65	73	18	160

2.8 Corporate Risk Register.

The Corporate Risk Register comprises of all risks that could prevent the Trust from carrying out its daily operations. This links into the Board Assurance Framework which is managed by the Trust Secretary.

Risks on the Corporate Risk Register may be escalated or de-escalated to or from the Board Assurance Framework as appropriate. Currently there are 19 risks on the Corporate Risk Register, the table below shows risks grouped by score.

	1 to 3 Low Risk	4 to 8 Moderate Risk	9 to 12 High Risk	15 to 25 Extreme Risk	Total
Corporate Risk Register	0	0	12	7	19

The table below shows risks grouped by CBU.

	Clinical Support Services	Corporate Services	Surgical Specialties	Digestive Diseases	Urgent & Emergency Care	Women & Children	Total
Corporate Risk Register	1	14	1	1	1	1	19

A Corporate Risk Register Report is presented to the Risk Review Group on a monthly basis. The report details any changes to the Corporate Risk Register, such as new risks, changes to risk ratings and assurances.

Overview of changes to the Corporate Risk Register from April 2023 to March 2024.

Risk activity	Number of Risks
Risks added to the Corporate Risk Register	9
Risks closed or de-escalated from the Corporate Risk Register	10
Risk escalated from the Corporate Risk Register to the Board Assurance Framework	0
Risks de-escalated from the Board Assurance Framework to the Corporate Risk Register	1
Changes to Risk Descriptions	2
Changes to Risk Ratings	6

3 ACTIONS FOR 2024/25

To further strengthen the risk process, the following actions will be undertaken within the next 12 months:

- Review of the Risk Management Strategy.
- Full review of Risk Management Training to include the implementation of a training booklet, e-learning and drop-in sessions for all levels of staff.
- Full review of all risk registers with the Care Group and Corporate Heads of Services.
- To close risks after a 12-month period and if required add a new risk reflecting the current year which will avoid static risks.
- To review reports and information that the DATIX Risk Module can provide.
- To provide position statements for all risks.
- To develop a Health and Safety Risk Register.
- To ensure Risk Management is on all standing item agendas within each Care Group.

4 RECOMMENDATIONS

The Quality Assurance Committee is asked to note the contents of this Risk Management Strategy Annual Report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Assurance Committee

AGENDA REFERENCE:	QAC/24/07/98			
SUBJECT:	**Health and Safety Annual Report 2023/24**			
DATE OF MEETING:	16 July 2024			
ACTION REQUIRED:	The Quality Assurance Committee is asked to note and accept the contents of this Annual Report for 2023/24.			
AUTHOR(S):	Helen Wynn, Head of Health, Safety and Risk			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	√
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	**Assurance statement:** There is an established pro-active safety management system within the Trust with clear processes and procedures to ensure compliance with all relevant Health and Safety regulations. The Health and Safety Annual Report describes the structures and responsibilities of the Trust in ensuring a healthy and safe environment for staff, patients and the public. The information provided within this report relates to the financial year 2023/24. The report provides assurance of the monitoring of incidents to ensure that efforts for improvement remain focused. In 2023/24, there were 1,903 Health and Safety incidents reported. During 2022/23, there were 1,655 Health and Safety incidents reported. The top 5 themes of incidents for 2023/24 were: • Antisocial, abusive and violent behaviour, e.g. violence and aggression and verbal abuse etc			

- Equipment/medical devices e.g. unavailability, failure of equipment, or training issues pertaining to equipment/medical devices etc.
- Infrastructure/environment and resource, e.g. car parking issues, environment cleanliness, workplace temperatures, estates issues etc.
- Needlestick injury, e.g. sharps inoculation, fluid splashes etc
- Lost property incidents, e.g. loss of SMART/ID cards, personal belongings etc.

Incidents relating to violence/antisocial behaviour are largely due to increased waiting times due to high volumes of patients attending Emergency Department and an increase in the number of vulnerable and mental health patients attending the Emergency Department, A1 (AMU), B12 and B14.

There were 17 RIDDOR reportable incidents reported within the Trust in 2022/23 compared to 25 in the previous financial year. This reflects an improved reporting culture.

During the 2023-2024 financial year, 78 audits were planned of which 70 audits were completed. This was due to limited capacity in the Health and Safety Team following sickness. The 8 outstanding audits were deferred for completion in Quarter 1, 2024. The outcome of these audits will be monitored via Health and Safety Sub Committee in the 2024 workplan.

• 61 wards/departments achieved 100% compliance.

• 7 areas achieved over 90%.

• 2 areas were below 90%.

The areas not 100% compliant, received action plans which were reviewed in April 2024. Each of the areas have since gained full compliance.

By regularly reviewing compliance against key standards, the Trust can:

- Provide assurance that there is an effective system of internal control to monitor identified Health and Safety related risks.
- Monitor control measures stemming from local risk assessments.
- Monitor safety performance using agreed criteria to enable continual improvement.
- Provide a safe and healthy environment (including welfare arrangements) for staff and patients.

Areas that were not fully compliant with the Health and Safety compliance audit, have an agreed action plan in place. There is an audit schedule in place which is monitored by the Health and Safety Subcommittee.

Health and Safety related mandatory training compliance is noted as the following: Plans are in place to increase capacity of places for de-escalation training. The course is presently under review in a bit to reduce face to face time in a bit to increase attendance/improve compliance.

Course/Compliance	April-23
Conflict resolution	94.04%
Corporate induction	99.20%
Health Safety and Welfare	93.40%
Local induction	96.55%
Moving and handling Level 1	93.07%
Moving and handling Level 2	84.12%
De-escalation training	54.53%

De-escalation training is noted to be lower than expected. Improvement work is ongoing to increase capacity and reduce the face-to-face element of the training in a bid to improve compliance.

The management of sharps has shown good compliance overall and is detailed within this report. Where improvement is required, this has been identified with action plans in place and is supported by a planned bi-monthly audit programme for 2024/25.

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

RECOMMENDATION:

This report provides assurance to the Quality Assurance Committee that responsibilities for Health and Safety are understood and monitored to fulfil the Trust's statutory duties.

WHH deems statutory compliance as the minimum standard to be achieved. This is driven to ensure WHH builds a strong Health and Safety culture throughout the organisation.

	The Quality Assurance Committee is asked to note and accept the contents of this Annual Report for 2023/24.	
	Committee	Health and Safety Sub Committee
	Agenda Ref.	W&HFT/HSSC/24/58
	Date of meeting	2 July 2024
	Summary of Outcome	Noted
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***None***	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication	

Quality Assurance Committee

SUBJECT	Health and Safety Annual Report 2023/24	AGENDA REF	QAC/24/07/98

1. BACKGROUND/CONTEXT

All Health Care Organisations are regulated by the Health and Safety Executive (HSE). The Trust Board of Directors accepts the statutory obligations under the Health and Safety at Work etc. Act 1974 which, along with subordinate and other legislative requirements are recognised as the minimum standards to be achieved.

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is committed to continually providing best practice standards in the delivery of a positive Health and Safety culture and considers this a fundamental component in providing a safe and healthy environment for staff, patients and the public.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. The embedding of Health and Safety practices across the organisation are fundamental in achieving this.

2. KEY ELEMENTS

2.1 Introduction

This report provides the Health and Safety Sub Committee and Quality Assurance Committee with a summary of Health and Safety activity during the financial year 2023/24. This includes analysis of standards that relate directly to the management of Health and Safety.

The Health and Safety at Work etc. Act 1974 provides a legislative framework to promote and encourage excellent Health and Safety standards at work with delegated responsibility from the Chief Executive Officer to the Chief Nurse. The standards as noted below are supported by policies, Standard Operating Procedures and risk assessments to ensure that all WHH staff are aware of how to optimise safety at work for themselves, our patients and the public.

The Health and Safety at Work etc. Act 1974 requires that the Trust provides and maintains:

- A Health and Safety Policy.
- Safe systems of work to control risks in connection with the use, handling, storage and transportation of articles and substances.
- A safe and secure working environment, including provision and maintenance of access and egress to premises.
- Safe and suitable plant and work equipment.
- Information, instruction, training and supervision as necessary.

There are Health and Safety mechanisms in place to provide assurance of compliance with proactive monitoring and triangulation through existing governance mechanisms.

2.1.1 WHH Health and Safety Management Structure

The law places an 'absolute duty' on employers to carry out risk assessments, which must include:

- Identified hazards arising from or in connection with the work.
- Who will be affected by the hazards.
- The control measures in place or proposed control measures.
- Evaluation of the risk.
- Review date.

WHH adopts a structured approach to the completion of risk assessments to ensure consistency across the organisation. Risk assessments are completed on the Trust's risk assessment form and are reviewed as follows:

- Whenever there is a significant change e.g. staff, environment or equipment.
- After an accident or 'near miss".
- After noncompliance identified through audits and inspection programmes.
- At least annually.

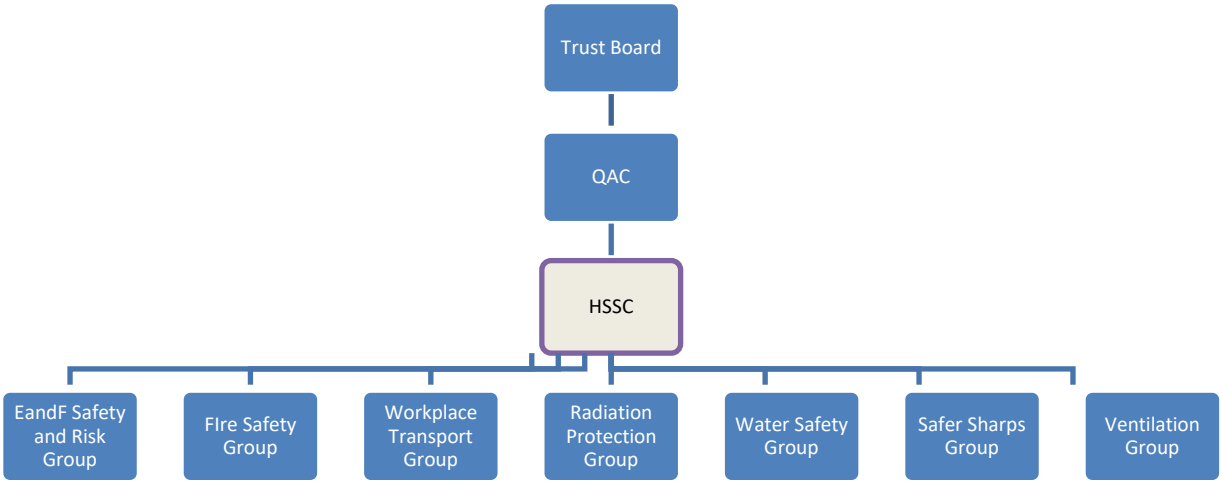
All Wards and Departments have in place risk assessments as part of the Risk Management Framework, with escalation to the appropriate risk register if required. Specific items are escalated to the Health and Safety Sub Committee (as required) for additional scrutiny, oversight and assurance.

2.1.2 Health and Safety Committee Structure

The Health and Safety Sub-Committee is responsible for monitoring the development, implementation, audit and delivery of Health and Safety organisational management throughout the Trust. The Health and Safety Sub-Committee receives reports and has responsibility for the ratification of policies approved at sub-group level. It is in this way that compliance with external organisational requirements such as the Health and Safety Executive, Care Quality Commission and NHS Resolution are managed.

The Director of Integrated Governance and Quality is the Chair of the Health and Safety Sub-Committee which is accountable to the Quality Assurance Committee (QAC), which in turn reports to Trust Board. Moving forward in 2024/25, the newly appointed Director of Clinical Governance/Deputy Chief Nurse will Chair this meeting.

The Health and Safety supporting committees are structured as follows: Medical Gases will be added from 2024.


Trust Board
QAC
HSSC
EandF Safety and Risk Group
FIre Safety Group
Workplace Transport Group
Radiation Protection Group
Water Safety Group
Safer Sharps Group
Ventilation Group

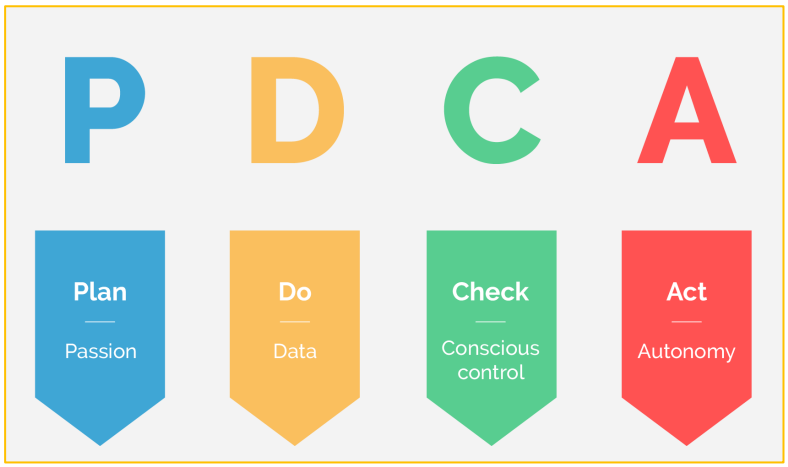
2.2 Health and Safety Policy

WHH follow the approved Health and Safety Executive guidance for the management of Health and Safety known as HSG 65.

This document provides clarification and direction in relation to:

- Effective Health and Safety policies.
- Organisation of Health and Safety.
- Planning and implementation of requirements.
- Measuring and auditing performance.

The diagram below describes the essential requirements of successful Health and Safety management (HSG 65).



By using this model, the Trust ensure that the requirements noted below are met with evidence collated:

- Legal and statutory obligations under the Health and Safety at Work etc. Act 1974 and subsequent regulations are met.
- Health and Safety management is understood and effectively managed.
- Health and Safety compliance is evidenced providing assurance to the Trust Board.
- Health and Safety is an integral part of WHH culture and its daily operating systems.
- To protect staff, patients, public, services, reputation and finances, through the process of early identification of risks relating to Health and Safety. Where risks are identified sufficient assessments, controls and mitigation are in place.
- Safe systems of work are in place and adhered to.
- Provide a safe working environment without risks to health.
- Adequate provision of welfare facilities.
- Provision of sufficient training, instruction and information to enable all employees to contribute positively to their own safety and health at work.
- There are safe arrangements for the use, handling and storage and transport of articles, materials and substances.
- There is safe access and egress.

- Staff understand the need to comply with Health and Safety Policies and procedures.
- There is a top-down commitment to Health and Safety.
- Workplace risks are assessed, and safe systems of work are in place.
- A supportive culture to learning from incidents is evidenced.

2.2.1 Underpinning Legislation

The following regulations underpin the Trust's approach to safety management enabling a safe and secure environment to be maintained *(the list is not exhaustive).* These are referenced within and supported by the Health and Safety at Work etc. Act 1974 which has four main objectives:

1. Provide training and information on how to carry out work processes safely.
2. Provide a safe place to work and working environment.
3. Develop a Health and Safety policy.
4. Undertake risk assessments.

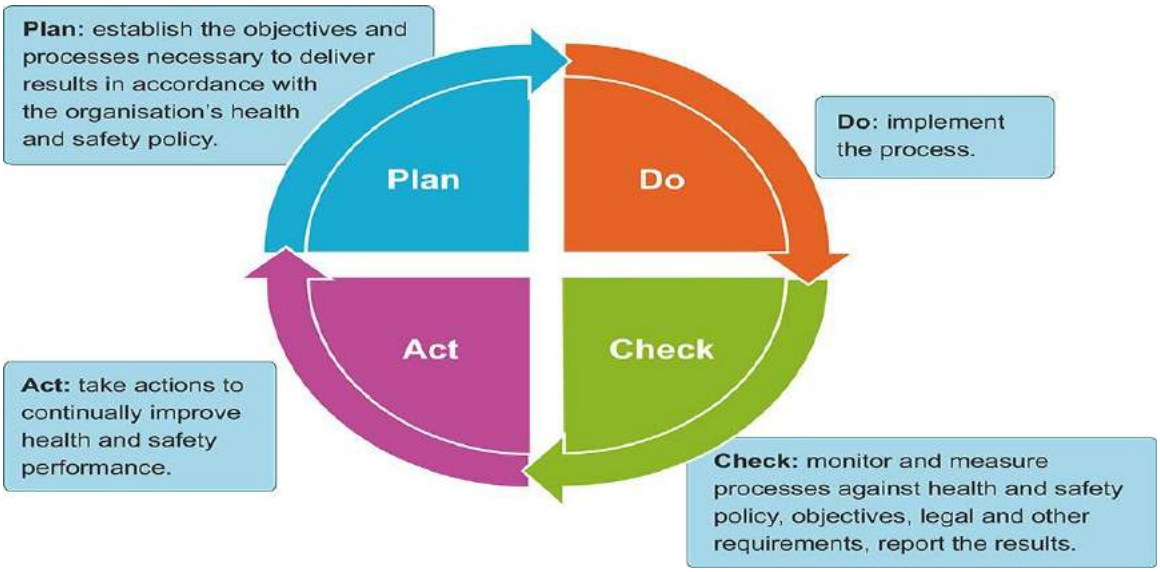
Health and Safety at Work etc. Act 1974, forms the basis of specific areas of focus detailed within table	
Workplace (Health, Safety and Welfare) Regulations 1992	Construction, Design and Management Regulations 2015
Control of Substances Hazardous to Health 2002	Management at Work Regulations 1999
Electricity at Work Regulations (sub section 1974)	Noise at Work Regulations 2021
Consultation with Employees Regulations (subsection 1974)	Personal Protective Equipment Regulations 2022
Display Screen Equipment Regulations 1992	Work Equipment Regulations 1998
Confined Spaces Regulations (sub section, 1974)	RIDDOR Regulations (sub section, 1974)
Control of Asbestos Regulations 2012	Manual Handling Regulations 1992
Lifting Operations and Lifting Equipment Regulations 1998	Work at Height Regulations 2005

2.2.2 Health and Safety Management System – HSG65

The Trust follows the approved Health and Safety Executive (HSE) guidance for management of Health and Safety known as HSG65.

HSG65 provides guidance for management, health and safety professionals and employee representatives who wish to improve health and safety in their workplaces as it focuses on effective health and safety policies, organising for health and safety, planning and implementation, measuring performance and auditing and reviewing performance.

The diagram below describes the essential requirements of successful health and safety management HSG65:



2.3 Health and Safety Audit

The Trust has developed a Health and Safety audit tool, to measure compliance against key regulatory standards (see table below).

By regularly reviewing compliance against these standards, the Trust can:

- Provide assurance that there is an effective system of internal control to monitor identified Health and Safety related risks.
- Monitor control measures stemming from local risk assessments.
- Monitor safety performance using agreed criteria to enable continual improvement.
- Provide a safe and healthy environment (including welfare arrangements) for staff and patients.

Risk Assessments	Night Work
Workplace Transport	Management of Sharps
Control of Substances Hazardous to Health	Slips, Trips and Falls (Non-Patient)
New and Expectant Mothers	Display Screen Equipment
First Aid	Incident Reporting
Work at Height	Legionella
Work Equipment	Radiation
Welfare Provisions	Stress at Work
Health and Safety Local Induction	Personal Protective Equipment
Manual Handling	Management of Ligatures

There are policies and guidance documents in place to assist managers in following processes and procedures which will enable them to reach full compliance.

The need for audit is detailed in the Trust's Health and Safety Policy and assigned to the Health and Safety Department who report findings in the Annual Health and Safety Report.

The whole process of the audit is to engender cooperation and provide support to departments as required, the audit is a scheduled event, and invitations are sent out to managers who can agree times and gives opportunity to prepare evidence.

During the 2023-2024 financial year, 78 audits were planned of which 70 audits were completed. This was due to limited capacity in the Health and Safety Team following sickness. The 8 outstanding audits were deferred for completion in Quarter 1, 2024. The outcome of these audits will be monitored via Health and Safety Sub Committee in the 2024 workplan.

The 70 audits were conducted across 8 CBU's of which:

- 61 departments scored 100% compliance.

- 7 departments scored over 90% compliance. The Health and Safety Department developed action plans for areas not meeting full compliance. These have since been reaudited throughout April 2024 and have reached a 100% compliance.

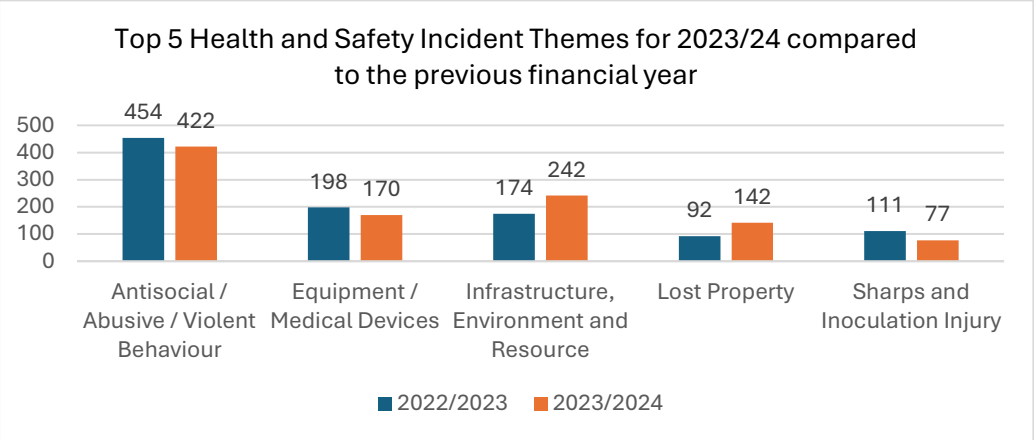
- 1 department scored 89% compliance and 1 department scored 77% compliance. At the point of audit in these areas, 2 individuals had been newly appointed to management roles and were upskilling themselves on the requirements of the role. Moving forward Health and Safety processes including management responsibilities will be added to the local induction form. In addition, the Health and Safety Management Training Booklet will be given to staff at Corporate Induction.

2.4 Incident Reporting 2023/24

In 2023/24, there were 1,903 Health and Safety incidents reported.

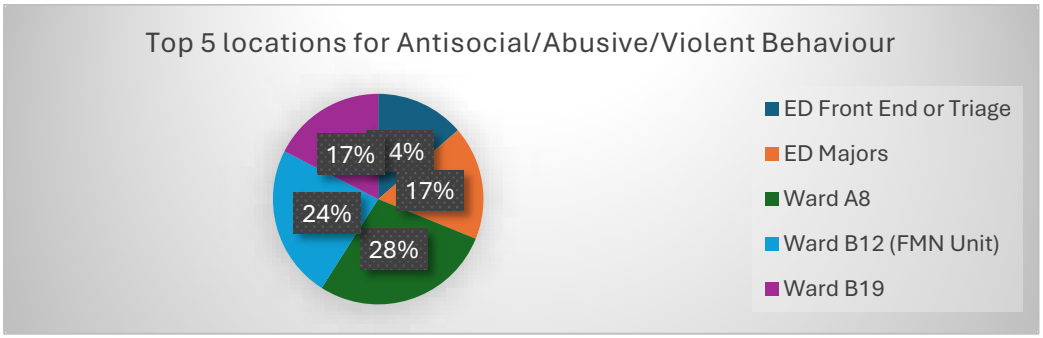
During 2022/23, there were 1,655 Health and Safety incidents reported.

Graph 1 below details the top 5 themes of incidents for 2023/24 with comparison to the previous financial year.



2.4.1 Antisocial, Abusive and Violent Behaviour incidents

The graph below identifies the exact location for Antisocial/Abusive and Violent Behaviour incidents that took place.



Ward A8 had the highest number of incidents (51). A8 is the Ward where the majority of patients presenting with mental health conditions are nursed when they also have physical health problems. Additionally, during this period there was a long-term-inpatient with very challenging behaviours that related to multiple incident reports.

In response long gowns with sleeves were issued to staff treating this patient to help prevent/ reduce scratches. Well-being support was also offered to staff.

Staff are compliant with de-escalation training with 100% of them having had this training. Trust Security Staff provide support at anti-social and violent incidents as required.

There were 43 incidents on Ward B12 (Forget-me-not). Most incidents were in relation to the changes in the patient's cognition or delirium.

NB All Antisocial, Abusive and Violent Behaviour incidents are reviewed and monitored by the Health and Safety Sub-Committee. Staff are supported through de-escalation and conflict resolution training and the role of the Local Security Management Specialist (LSMS) who is notified of all incidents of this nature.

2.4.2 De-escalation training

- Conflict resolution training compliance is reported at 94%.
- De-escalation training compliance is reported at 54.53%.

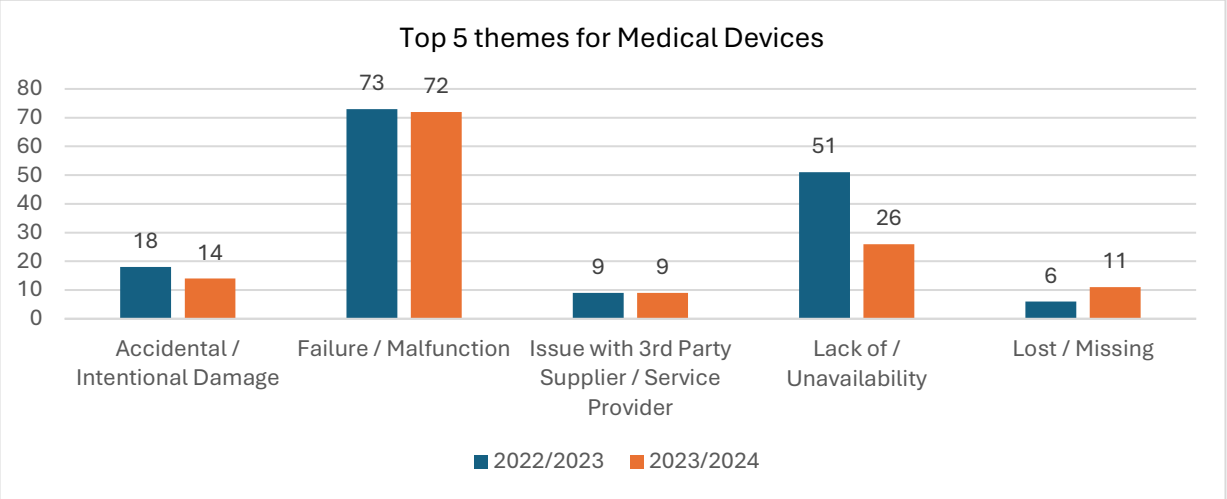
After increased promotion of both of conflict resolution and de-escalation training courses, sessions are now fully booked, and it is anticipated that there will be an increase in compliance throughout the year. Reports on training compliance are presented to the Health and Safety Sub Committee on a bi-monthly basis.
All areas have trajectories in place. There is a plan in place to train further security staff to deliver this training and this will consequently see a rise in training compliance.

The Head of Security has adapted the de-escalation training programme to increase the number of staff that can be trained to 15 candidates per course with additional dates scheduled.
Other opportunities are being explored to reduce the face-to-face element of this course to E-learning.

Course/Compliance	March 2024
Conflict resolution	94.04%
De-escalation	54.53%
Fire Safety	87.93%
Health Safety and Welfare	93.49%
Moving and handling Level 1	93.07%
Moving and handling Level 2	84.12%

2.4.3 Equipment, medical device incidents

During 2023/24, there were 170 Equipment and Medical Device incidents, a decrease of 28 compared to the 198 incidents during 2022/23.



Examples are as follows

- A lost docking station
- Items borrowed and not returned
- Items missing during my kit checklist due to no tag
- A missing phone,
- No thermometers available
- A snapped needle
- Sprinkles spilt on the floor
- Unable to find pod keys

No themes have been identified.

With regards to failure/malfunction, these 72 incidents occurred over 36 wards and departments. The highest number of 7 incidents occurred in the Main Theatres at Warrington and 7 in the CSTM Theatres, followed by Ophthalmology Theatres with 6 incidents.

The 14 incidents for accidental/intentional Damage, these related to

- An air conditioning unit leaking
- A foreign body in the anaesthetic machine due to the circuit being left open overnight
- A metal handle detached from casing
- 2 trapped cables
- A freezer transmitter snapped
- Broken ampules of fentanyl
- An incident with the catering trolley
- A staff member had left their laptop on the roof of their car and drove away of which a member of the public found it and was returned to WHH
- A positive blood culture bottle leaked inside the incubator
- UPS devices had become wet
- Inappropriate storage of equipment and the
- Security tag broken on the resus trolley and items moved inside

Again, no common themes have been identified.

For incidents relating to Issues with 3rd party suppliers/service providers, there were 9 incidents recorded. 5 occurred in theatres concerning general sets and items missing, wrong stickers in trays, human tissue found on a set of teale forceps, blood/fluid warming sets missing and an issue with the adjustable air flow in a helmet (Vivi toga) during a total knee replacement.

The other 4 related to no stock of Hydrogen Peroxide for the decontamination of rooms, unable to attach humified oxygen to oxygen ports as adapters would not hold the weight of sterile water, unable to read the numbers on the car park machines and the hoist broken on Ward A7 therefore having to borrow Ward A8.

There were 26 incidents for the lack of/unavailability of equipment. These related to:

- The shortage of EPOC cartridges used to measure blood gases.
- ANC only had one monitor screen for clinic.
- No alaris pumps in the equipment store, as well as syringe drivers and nebulisers. Situation higher at weekends and Security staff are having to search for items.
- Unable to support the purchase of Libre 3 technology to support patients with hypoglycaemia.
- Infrared thermometers not showing accurate temperatures on patients in the Emergency Department.
- Theatre case delayed due to endoscopic stacker being used in emergency theatre.
- No wheeled walking frame available for patient being discharged to Oak Meadow due to no advanced notice being provided.
- ED trolleys missing portable oxygen cylinders due to the lack of gauges.
- 3 CTG monitors down in birth suite, of which 1 was in medical engineering and the others had been taken out of service.
- Ward C23 only had one CTG machine available for 5 patients.
- The defibrillator was alarming “low battery”, and the mains cable was missing from the resus trolley. Cable found and device charged.
- Access removed from the Renal Drug Database due to non-payment of invoice.
- Air mattress delayed due to not reporting the request.
- In gynaecology waiting for the delivery of 5 alphascopes from Gemini. Clinics being cancelled due to inadequate number of available scopes.
- Lack of linen within the Trust.
- Lack of computers available in ED for nurses and doctors to complete medications/ observations and notes in a timely manner.
- Not enough x-ray gowns in theatres for staff at the CSTM theatres. Temporarily used Halton’s as an interim
- 4 Isoflurane cannisters were borrowed from Chester ICU and transported by taxi to Warrington ICU. Unable to locate items until found later in Theatres. Due to the delay, patient reverted to Morphine and Midazolam infusion.

- Wheelchairs purchased by the League of Friends have had their labels crossed out and replaced with the Discharge Lounge therefore reducing the number of available wheelchairs for the public.
- Insufficient CTG monitoring equipment on Ward C23 therefore borrowed from the Birth Suite

All incidents and themes are reviewed and monitored at the Trust Medical Device Group.

Any areas of risk are noted and tracked at the Trust Health and Safety Sub Committee to ensure any patient safety risks are resolved or added the relevant Risk Register. The Care Groups also manage risks locally, any outstanding significant risks are escalated for review at the Risk Review Group. This escalation ensures risks are managed appropriately and actions are taken timely to prevent failure of any statutory requirements and patient safety risks are resolved.

2.4.4 Infrastructure, Environment and Resource

The category of infrastructure, environment and resource contains 12 different subcategories such as car parking, catering issues, environmental cleanliness, workplace temperatures, estates issues leaks, fixture and fitting issues (this is not exhaustive).

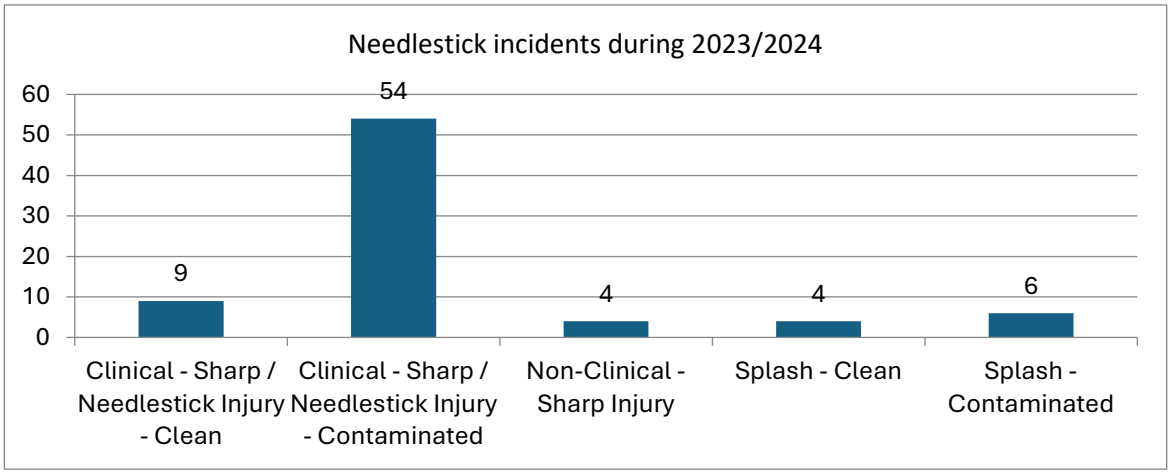
During 2023/24 of the 242 incidents, there were 122 due to a hot and cold workplace. The majority of these incidents related to extreme hot weather conditions experienced over several months, the highest being 51 incidents in June 2023. All patient areas were issued with portable air conditioning units and specific risk assessments were in place.

Other incidents related to fridges not reaching temperature.

There was an increase in lift failure incidents on the Warrington site. These were caused by the lifts not levelling off, the carriage dropping or the doors not opening. A replacement programme is being reviewed and a refurbished lift has been installed that supports the Appleton Wing. A second lift is being proposed through the Capital Planning Group. The risk of potential failure of lifts remains on the Estates and Facilities Risk Register until the remaining replacement programme is complete.

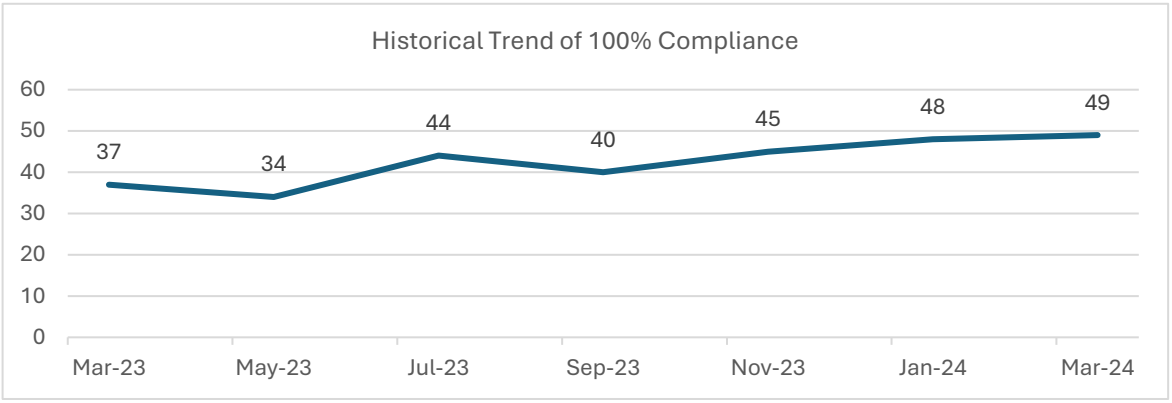
2.4.5 Needlestick injury incidents

There has been a significant decrease for needlestick incidents. During 2022/23, there were 111 incidents compared to only 77 incidents during 2023/24. The graph below highlights the sub-categories.



These incidents occurred over 34 wards and department. The top 5 areas were:

- Warrington Theatres – 8 incidents
- Birth Suite – 6 incidents.
- CSTM theatres – 5 incidents
- ED Majors – 5 incidents
- ICU – 5 incidents



Action plans are in place as required supported by a bi-monthly Sharps Management Audit Programme and focused weekly walk rounds undertaken by the Head of Health and Safety.

There is a full programme of sharps training available to clinical staff:

- Nursing and Midwifery: safer sharps training (day 3 of induction),
- HCAs: taught safer sharps techniques.
- Junior Doctors: during their extended induction have a skills refresh based on demonstration e.g. cannulation.
- Students or trainees: Clinical Education will follow up any sharp's incidents via the Practice Educator Facilitation Team.
- Clinical staff groups complete the Infection Control ESR module (annually), which includes updates on Sharps training.

2.4.6 Lost Property Incidents

During 2023/24, there were 142 lost property incidents, of which there were 114 lost smart cards and TAC cards throughout the Trust, an increase compared to only 79 lost during 2022/23.

The Information Security Manager undertakes regular ward/departmental audits, to review management of SMART cards and to highlight the implications leaving of smartcards in situ. The results of these audits are then disseminated to the Ward Manager's meeting to build awareness.

2.4.7 RIDDOR Reporting

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR), the Health and Safety Department within the Trust has the responsibility for reporting workplace accidents, incidents, ill health and certain near miss events that fulfil the criteria given under the RIDDOR regulations.

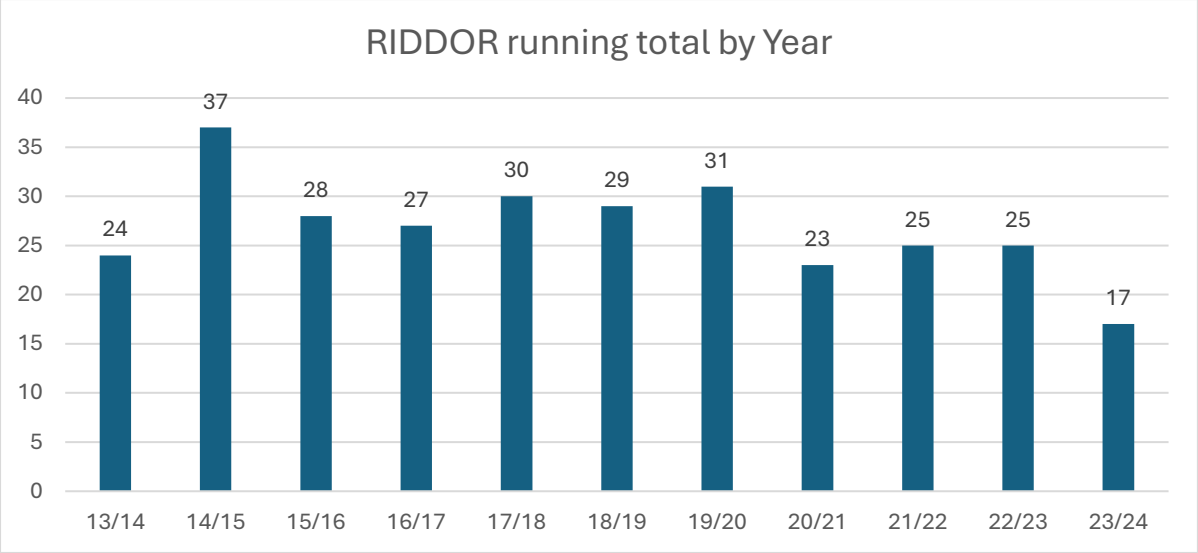
The process to support the requirement of policy and regulation is the daily review of all incidents and further investigation of incidents causing potential or actual harm. There is a formal investigation process in place which is fully embedded within the Trust. To date all investigations have been completed within the required timescales.

Through the financial year 2023 – 2024 there have been 17 incidents reported under RIDDOR 15 affected staff and 2 involved members of the public.

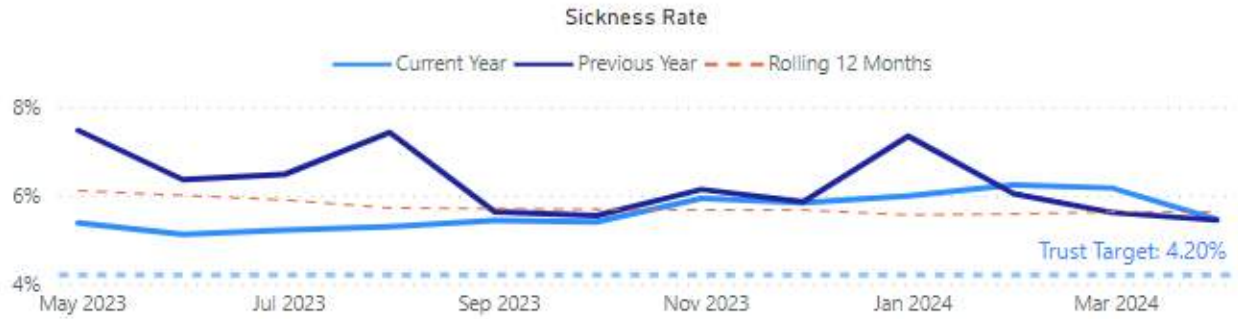
The majority of staff incidents categorised as over seven days absence from work following an injury at work, two incidents were categorised a specified injury being a fracture and one as a dangerous occurrence.

Injuries to the public have to be reported if the person receives treatment, which in the two incidents reported, both people attended the Emergency Department and received treatment to support their injuries.

The illustration below shows that there were 17 incidents reported through the current financial year of 2023 – 2024, this is less than the year 2022 – 2023 in which 25 incidents were reported.



The process for checking and the criteria for reporting incidents has not changed, therefore when looking at staff sickness rates for the Trust through 2023 – 2024 in comparison to the previous year, the graph below shows a potential correlation that the rate of sickness absence is less than previous year, suggesting improvements within the Trust.



(Source for above - Trust's Local Intelligence OnLine (LION) database)

All incidents reported under RIDDOR lead to an investigation by the Health and Safety Department and managers associated with the incident. Each investigation draws out the root cause of the incident and learning and improvements to support a reduction in the same type incidents.

RIDDOR incident relating to staff:

- April 2023 – Staff member tripped over a large absorbent mat at the entrance door.
- May 2023 – Staff member received soft tissue damage due to a clinically challenging patient on a ward.
- May 2023 – Hand injury to staff member whilst working on a dementia ward.
- July 2023 – Due to being obscured behind a PC monitor, a medicines trolley was accidentally pushed into a staff member's back causing pain.
- September 2023 – Manual handling incident to staff member whilst using a slide sheet.
- October 2023 – Staff member received a whip lash injury to the head (headaches and pain in arm) whilst supporting an agitated patient.
- November 2023 – Staff slipped on water in ED fracturing her ankle.
- February 2024 – Staff member received a sharps injury from a needle. Donor Hepatitis C positive
- February 2024 – Patient assaulted staff member on the Dementia Ward causing a haematoma to the ear and facial bruising
- February 2024 – When disposing of waste, staff member injured shoulder when lifting bag up into wheelie bin
- February 2024 – During a manual handling incident with a patient who was suffering from a seizure, staff injured their back
- March 2024 – Staff member lost footing in car park and fractured her wrist
- March 2024 – Patient on ICU became agitated and kicked staff member in the head causing headaches, dizziness and a ringing noise in her ear
- March 2024 – Bariatric patient required repositioning in bed. Four staff used a slide sheet. Healthcare Assistant injured their back

RIDDOR incidents relating to Public/Patient:

- August 2023 – A patient was holding open a clinic door and cut his hand.
- December 2023 – A member of the public slipped on ice and fractured her ankle.

2.5 Control of Substances Hazardous to Health (COSHH)

To ensure compliance with the Control of Substances Hazardous to Health Regulations, the Trust records the following information on a system called “SYPOL”:

- COSHH Risk Assessments
- COSH Control Sheets
- COSHH Safety Data Sheets

To-date, there are 1,308 completed COSHH Risk Assessments available with new assessments being added accordingly. There are 1,167 different materials used within the Trust.

Assurance:

- The majority of products and their activities fall within the category of low risk.
- All new COSHH risk assessments are created, approved and returned to the appropriate departments to be shared with staff.
- Bi-monthly reports are produced and circulated throughout the Trust to ensure Wards and Departments are notified of any updated risk assessments.
- Any substance rated as ‘high’ is managed with a robust Standard Operating Procedure, following advice from the safety data sheet and/or manufacturer.

2.6 Display Screen Equipment (DSE) Assessment

Health and Safety Advisors provide formal individual DSE workstation assessments for members of staff following a referral process undertaken by their manager or recommendation from Workplace Health and Wellbeing. The assessments generally take place when a member of staff is suffering pain and discomfort at their workstation, or they have a pre-existing medical condition.

During the period April 2023 to March 2024, the department carried out 82 workstation assessments for staff.

The main reason for other referral was existing health issues such as disc degeneration, sciatica, shoulder impingement, pain and discomfort during and after pregnancy, arthritis/osteoarthritis, carpal tunnel syndrome, migraines, previous hip replacement and general aches and pains in the lumbar region.

DSE assessments are to support staff within the workplace to prevent harm or any exacerbation of existing conditions. This is carried out by making reasonable adjustments to workstations.

Due to the increase in home working/agile working, additional information and advice has also been provided during the assessment regarding the setting up of workstations within the home to prevent poor posture.

2.7 Health and Safety Training

The following Health and Safety training is in place. A large number of the training sessions available are mandatory and this is recorded on the Trust central system – ESR. Monthly compliance reports are sent out via the Organisational Development Team. Compliance can be seen in section 2.4.2.

Topic	Training Requirements
Health and Safety Training for Senior Managers	Booklet to be read and signed 3 yearly.
Health and Safety Training	E-learning to be completed 3 yearly.
Non-Clinical Manual Handling	Classroom or e-learning to be completed 3 yearly.
Clinical Manual Handling	Classroom training to be repeated every 2 years.
Working at Height	Departmental based annually.

The programme consists of:

- Health and Safety Awareness Training for all Staff – This is a general awareness of Health and Safety law and how it is managed throughout the Trust. The training can be accessed via eLearning or a Health and Safety Awareness Booklet.
- Health and Safety Awareness for Senior Managers and Doctors – This is a training booklet which provides up to date information on current legislation and corporate.

2.8 Estates and Facilities Health, Safety and Risk Safety Group

Specific requirements:

- Promote and monitor the effective management of Health and Safety risks within the Estates, Facilities and Medical Engineering Departments.
- Continually review new and existing Health and Safety legislation, to ensure that the Estates, Facilities and Medical Engineering Department are compliant.
- To ensure that there are effective systems in place for the identification, control, monitoring and reviewing of risk, ensuring that they are evaluated using the Trust Framework for grading risk, and that the appropriate level of management action is decided and implemented accordingly.
- Ensure that effective arrangements are in place for planning, organizing, controlling, monitoring and reviewing preventative and protective measures.
- Ensure that all departmental staff are provided with comprehensive information on the risks within their areas and the mitigations in place to reduce those risks
- Review of all incidents and investigation of incidents involving Estates, Facilities and Medical Engineering Department or contracting staff, identifying trends and ensure that appropriate action is taken.
- Ensure that the Department of Health Estates and Facilities procedure for reporting defects and failures relating to non-medical equipment, engineering plant, installed services and building fabric is complied with (latest guidance DH (2008) 01).

2.8.1 Asbestos

The Trust continue to make consistent progress on asbestos management including the appointment of an Authorising Engineer for asbestos safety. The Trust carries out annual re-inspections in accordance with its new ratified Asbestos Policy and Asbestos Management Plan to meet its statutory requirements as set out within the Control of Asbestos Regulations 2012 (CAR 2012). A responsible person dedicated to asbestos management has been formally appointed as well as named Authorised Person who are responsible for ensuring the requirements of CAR 2012 are complied with for all projects and works where asbestos may be liable to be disturbed. The Asbestos Group has also implemented a training regime for all staff from basic asbestos awareness training up to detailed training on Regulation 4 CAR 2012 the Duty to Manage Asbestos.

Assurance: The Trust is confident that it fully complies with the duties placed upon it by the Control of Asbestos Regulations 2012.

2.8.2 Fire Safety Group

The Fire Safety Group meets monthly and is responsible for the review of all fire safety matters within the Trust. There are no noted incidents in relation to fire incidents in 2022/23.

Remedial Fire Works and Upgrades:

- Work to improve the landings and replace the fire doors for the wards has been completed.
- Ongoing in-house preventative maintenance continues, and a tender process is underway for an external certified and third party approved contractor to manage all fire door maintenance.
- The Fire Alarm system in Wards and Departments have been completed with the new systems commissioned. The new fire panels have been installed in all buildings and are interconnected with the communication centre main panel.
- An innovative project has been undertaken for this reporting period to support a solution to a compartmentation issue above our emergency department canopy. The project has been recognised as a huge success to a complex problem with multiple design considerations and is being showcased by the National Association of Healthcare Fire officers at both regional and national conferences.

2 External Health and Safety Audit

Due to gaps in the Health and Safety Team during 2023, the former Chief Nurse commissioned an external Health and Safety Review. The Review was undertaken on the 14 February 2024 by Stewart Crowe, Deputy Director of Health and Safety at Liverpool's University Hospital NHS Foundation Trust.

The key findings of the report were:

Health and Safety Plan and Performance

- Development of a Health and Safety Project Plan.
- Increase the number of Health and Safety Management Reports including inspection and audit data.

Health and Safety Risk Management

- To development a specific Health and Safety Risk Register.
- The Risk Register to be reviewed on a bi-monthly basis at the Health and Safety Sub Committee.
- Ensure all risk assessments are communicated with staff.

Health and Safety Training

- Introduce toolbox talks to Estates staff to include Asbestos, Electricity, Walking at Height, Confined Spaces.

Health and Safety Sub Committee

- Review of current membership.
- Ensure a full cycle of business for the current financial year.

3 Next Steps

- Review of Health and Safety Strategy Objectives and Relaunch of the Strategy. This was noted by the Health and Safety Sub Committee on 2 July 2024. This will be communicated Trust Wide throughout August 2024.

- A full Health and Safety Project Plan to be developed.
  A full Project Plan has been developed and this was noted by the Health and Safety Sub Committee on 2 July 2024. This is a weekly plan which will commence in August 2024. The plan will be tracked and monitored at the Health and Safety Sub Committee. The plan includes all areas of statutory compliance for Health and Safety Management.

- Development of quarterly Health and Safety Audit Reports to show trends and themes.

- Development of quarterly Health and Safety Dashboard Reports for Unplanned Care, Planned Care, Clinical Support Services and Corporate Services.

- Development of a Health and Safety Risk Register – to be reviewed at the Health and Safety Sub Committee.

- Review of the Health and Safety Sub Committee Terms of Reference.

- The Cycle of Business for the Health and Safety Sub Committee has amended to include Assurance Reports for the following:

  - Medical Gases
  - Asbestos
  - Workplace Transport
  - Electric
  - Water Safety
  - Fire Safety
  - Ventilation Safety
  - Working at Height
  - Confined Spaces.

4 RECOMMENDATIONS

The Quality Assurance Committee is asked to note and accept the contents of this Health and Safety Annual Report for 2023/24.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/07/100**			
SUBJECT:	**Complaints Annual Report 2023/24**			
DATE OF MEETING:	11 June 2024			
ACTION REQUIRED:	To note the report			
AUTHOR(S):	Tracy Fennell, Director of Governance/Deputy Chief Nurse. Sharon Berry, Head of Legal, Complaints and PALS			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	√
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This annual report includes a summary of formal complaints raised by patients or their relatives between 1 April 2023 and 31 March 2024. • 251 new complaints were received during the reporting period, a decrease of 34 (11.9% decrease from period 2022/23) when 285 complaints were received. • 1674 PALS enquiries were received (16.8% decrease from 2022/23) when PALS received a total of 2012 enquiries). • Overall, in 2023/2024 the Trust has maintained a position of a higher number of PALS rather than complaints evidencing active management of PALS concerns with resolve. • Whilst Urgent and Emergency Care CBU received the highest number of complaints (73). This is a reduction from the previous year of 98. • The Women's and Childrens CBU received a total of 45 complaints, a reduction from last year when there was 55. • Surgical Specialties have seen a small increase of 45 complaints compared with 41 in the previous year. • The Trust closed 240 complaints compared to 254 in the previous year (a decrease of 5.5%) • The percentage of upheld complaints has seen a slight increase in 2023/24 (11%), compared to 2022/23 (9%).			

<table>
<tr><td></td><td colspan="3">The majority of complaints in the reporting period that were partially upheld (36%) shows an improvement from the previous year.
The percentage of not upheld complaints has improved (53%) when compared with the 2022/23 reporting period (43%).
Following triage 9 complaints were considered to be Serious Incidents compared to 18 in 2022/23 (decrease of 50%).
52 complaints are open at the time of reporting (03/05/24), with no breached timeframes throughout the reporting period.
The PALS service has continued to provide a responsive service. The average response time being 3.74 working days, which falls slightly outside the Trust's response target of 3 days. A review of key contacts to enhance efficiencies has been undertaken and there is currently a focus on increasing the visibility of the PALS team at ward level, to assist with timely local resolution.
During the reporting period there was a 14% decrease from 257 PALS reported in 2022/23 to 222 in 2023/24, within the Women's and Children's Clinical Business Unit. In 2023/24 the highest number of PALS were received in Gynaecology (122) (55%) and Maternity (53) (23%). The Women's and Childrens CBU will undertake a deep dive.
The Trust received 8 PHSO notifications during 2023/2024, 6 of these remain under investigation, 2 of which have been closed with 1 upheld and 1 partially upheld. 2 PHSO cases are currently under investigation from previous reporting years.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
√</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Quality Assurance Committee is asked to note the report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>NEXT STEPS: State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Section 22 – information intended for future publication</td></tr>
</table>

QUALITY ASSURANCE COMMITTEE

SUBJECT	Complaints Annual Report 2023/24	AGENDA REF:	QAC/24/07/100

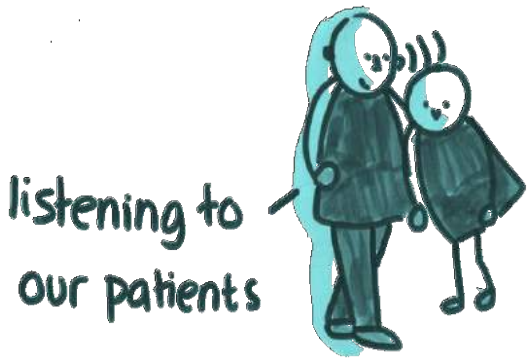
1. BACKGROUND/CONTEXT

Warrington and Halton Teaching Hospitals NHS Foundation Trust is committed to providing high standards of patient centred care utilising the views and opinions of patients and their families.

The purpose of the Complains Annual Report is to satisfy the requirements of the NHS complaints procedure in England, effective from 1 April 2009. The report provides analysis of formal complaints identifying themes and trends to support further learning.

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

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



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

In accordance with the NHS complaints procedure, the Annual Complaints Report is made available to the public. It is publishable as part of the Freedom of Information Act publication.

1.1 Principle of Application

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

1.2 NHS Complaints Standards 2022

In December 2022, the NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. The standards apply to NHS organisations in England and independent healthcare providers that deliver NHS-funded care. The Complaint Standards support organisations to provide a quicker, simpler and more streamlined complaint handling service. They have a strong focus on:

- Early resolution by empowered and training.
- All staff, particularly senior staff, regularly reviewing what learning can be taken from complaints.
- How all staff, particularly senior staff, should use this learning to improve services.

The focus referenced within these standards will continue to be progressed in 2024/2025, with a focus on seeking feedback on our service.

Complaints Monitoring

The Complaints Team report learning into the Patient Experience Sub-Committee each month. Learning is also shared in the quarterly Learning from Experience Report presented at the following committees:

- Patient Safety and Clinical Effectiveness Sub Committee.
- Quality Assurance Committee.
- Clinical Quality Focus Group (PLACE).
- Complaints Quality Assurance Group, led by the Trust Chairman.
- Council of Governors also receive updates on complaints.

The Complaints Quality Assurance Group, led by the Trust Chairman meets monthly. Assurances are provided with detailed learning on a cyclical basis from Clinical Business Units with full discussion regarding specific complaints. The Head of Complaints, Claims and PALS also presents a Trustwide overview for assurance detailing the number of complaints received, the location of complaints and any themes and trends identified.

2. KEY ELEMENTS

During the last financial year work has focused on:

- Maintaining the timeliness of responses to complainants.
- Working collaboratively with CBUs to improve standards of care and the production of high quality complaints responses.
- Ensuring a timely response to PALS concerns.
- Offering all complainants a meeting with appropriate teams as a first offer.
- Complaints handlers continue to meet with the CBU senior management teams weekly with dissemination of actions to the CBU teams.
- Triangulation of the themes of complaints and PALS concerns alongside incidents and claims to provide greater focus for improvement.

The successes in 2023/24 have included:

- Timeliness of complaints has consistently exceeded the Trust's target of 90%.
- WHH has continued to have 0 breached complaints throughout the reporting period.

The PALS service has continued to provide timely responses to concerns, with the average response time being 3.74 working days, which falls slightly outside the Trust's response target of 3 days.

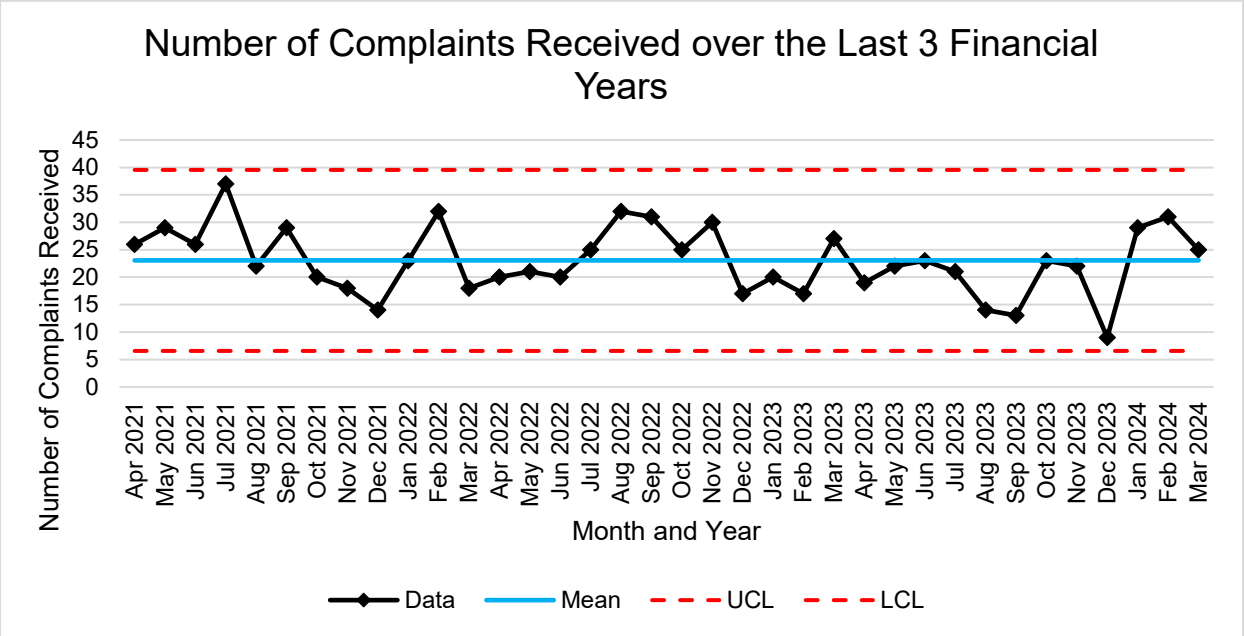
- Working collaboratively with the Trust's Patient Experience and Inclusion Team to identify what matters most to our patients and considering how the PALS and Complaints Team can continually improve services for our patients and their loved ones.
- The Trust Quality Assurance Group has continued to meet since being established in July 2017. Led by the Trust Chairman, the Complaints Quality Assurance Group

ensures all Clinical Business Unit (CBU) leads present a complaint and discuss their processes for complaints handling and learning.

- The number of reopened complaints received has reduced from 24 in 2022/23 to 10 in 2023/24.

2.1 Complaints received

251 complaints were received during the reporting period, a decrease of 34 from the previous year (285). The graph below details the number of complaints opened from 1 April 2023 to 31 March 2024. In 2023/2024 the Trust received an average of 21 complaints per month compared to 24 in the previous year. In February 2024 the Trust received the highest number of complaints for the 2022/23 financial year (31). The number of complaints received remains within normal variation. NB: the Trust has worked hard to ensure that concerns are resolved at local level, via PALS enabling a proactive response to resolution. Visibility of the PALS team has increased at ward level. All complainants are offered a meeting in person with the clinical teams to ensure that the opportunity for full discussion is made available to all.



2.2 Complaint themes

Formal complaints can be received for a variety of reasons. The table below identifies the themes noted for the reporting period with 2022/23 data displayed for comparison.

Subjects	2023/2024	2022/2023	Change
Clinical treatment	149	190	-41
Attitude and behaviour	25	30	-5
Communication (oral)	18	23	-5
Admissions / transfers / discharge procedure	13	13	0
Date for appointment	12	7	5
Competence	11	1	10
Communication (written)	3	4	-1

Patient property / expenses	3	2	1
Premises	3	2	1
Personal records	2	4	-2
Failure to follow agreed procedures	2	1	1
Shortage / availability	2	1	1
Consent to treatment	2	0	2
Patient privacy / dignity	2	2	0
Test results	1	0	1
Aids / appliances / equipment	1	0	1
Bed shortages	1	2	-1
Telephone	1	0	1

The most common cause for people to complain was associated with clinical treatment. When comparing the percentage of complaints relating to clinical treatment from 2022/23 to 2023/24, there has been a (22%) decrease (149 compared to 190) in the percentage of complaints received relating to this theme.

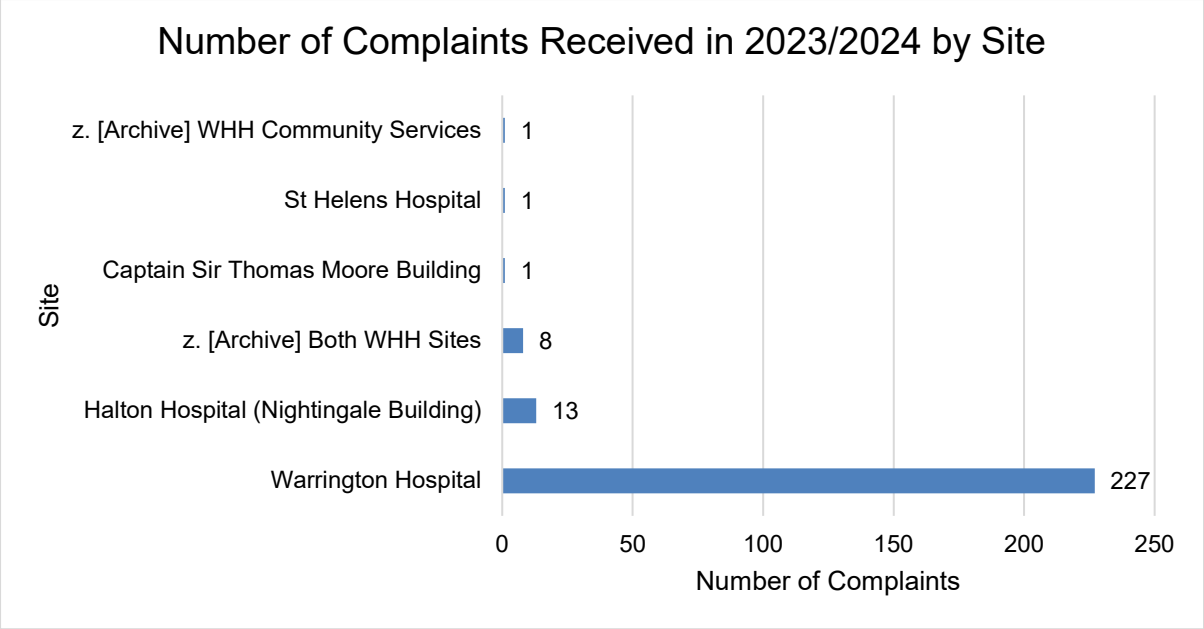
In 2022/23, the percentage of complaints relating to attitude and behaviour as the primary theme has reduced by 17% (25 in 2023/24 compared to 30 in 22/23), and the percentage of complaints relating to communication (oral) as the primary theme has reduced by 22% (18 in 2023/24 compared to 23 in 2022/23). Some examples of improvement impacted by learning are outlined in section 2.7.

The Complaints and PALS team work closely with the Patient Experience and Inclusion Team. Further improvements continue to be supported by the Patient Experience Strategy 2023 – 2025 which will work to ensure that we place the quality of patient experience at the heart of all we do where “seeing the person in the patient” is our norm by ensuring positive first and lasting impressions. This strategy will build on achievements and focus on four strategic objectives:

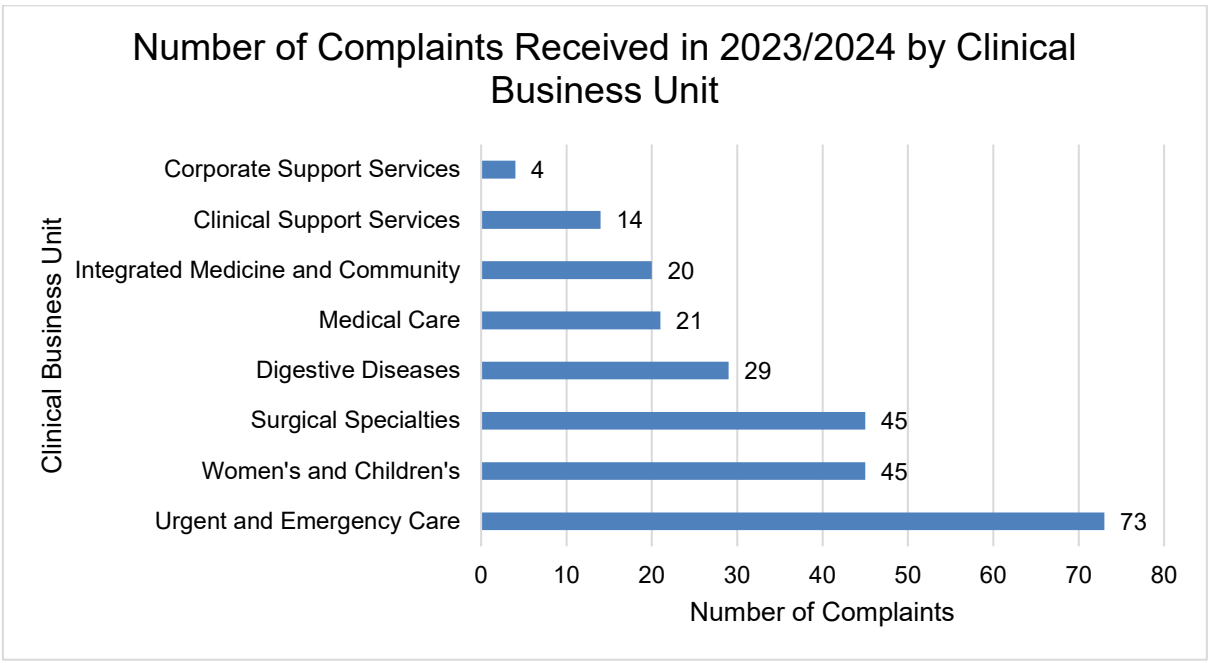
- Communication
- Actively listen and learn from lived experience
- Communicating in a way that people understand
- Utilising a shared care approach to learning

2.3 Complaints received by Locations/Service

The graph below details that the Warrington Hospital site reported more complaints (227) than the Halton site (13). This is to be expected as it is the larger site with significantly more activity and acute care delivery also housing an Emergency Department

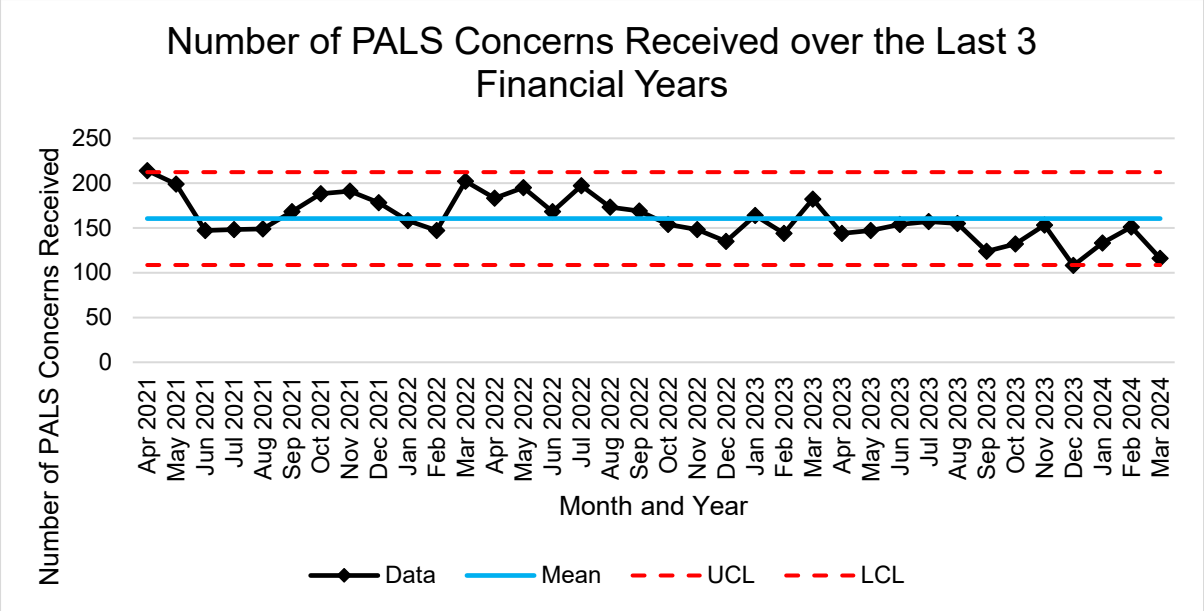


The following graph details the 251 complaints received by the Trust in the reporting period by Clinical Business Unit (CBU) and Trust wide service:



Urgent and Emergency Care received the highest number of complaints followed by the Women's and Childrens Clinical Business Unit. When comparing 2022/23 data to complaints received from 2023/24 for Urgent and Emergency Care, there was a reduction from 98 to 73.

When comparing 2022/23 data to complaints received from 2023/24 for Women's and Childrens, there was a reduction from 55 complaints reported in 2022/23 to 45 reported in 2023/24. In 2023/24 the highest number of complaints were received in Gynaecology 24 (53%), Maternity 17 (38%) and Paediatrics and Neonatology 4 (9%).



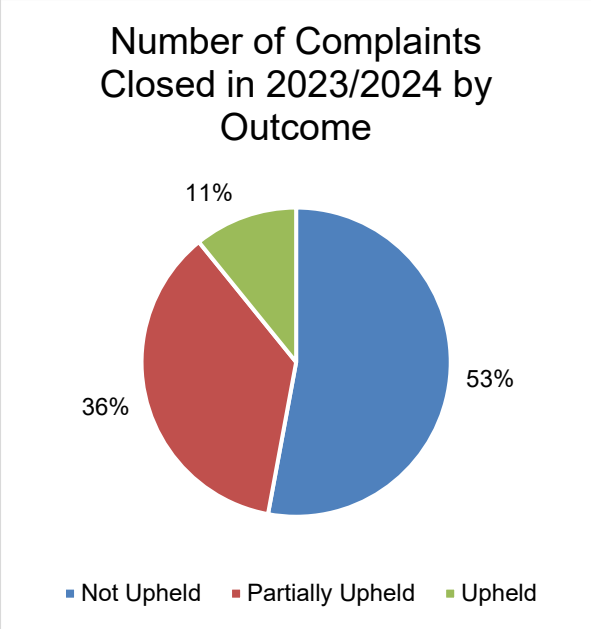
During the reporting period there was a 14% decrease from 257 PALS reported in 2022/23 to 222 in 2023/24, within the Women's and Children's Clinical Business Unit. In 2023/24 the highest number of PALS were received in Gynaecology (122) (55%) and Maternity (53) (23%). The Women's and Childrens CBU will undertake a deep dive.

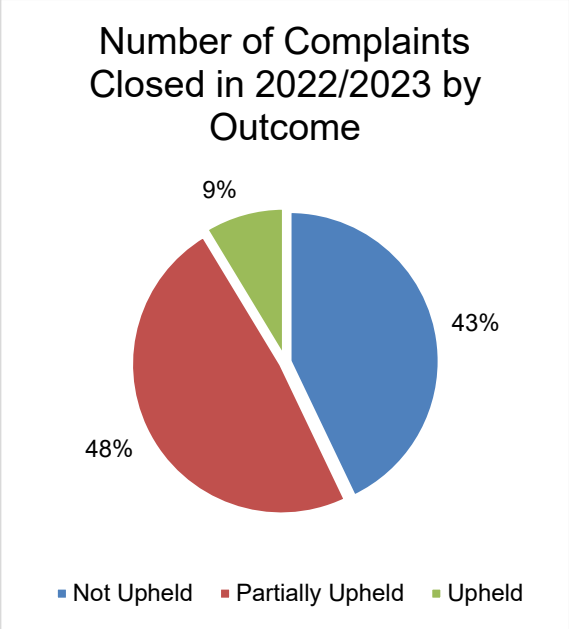
2.4 Complaints Outcomes

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome is recorded in line with the findings of the investigation. Upheld complaints are those where the concerns raised have been found to be valid. Not upheld complaints are those where the investigation has not found any deficiency in the care, treatment or service provided. Partially upheld complaints are those where aspects of the case are upheld, but the main issues are not.

The chart below shows the outcome of closed complaint during the reporting period:

- The percentage of upheld complaints has seen a slight increase in 2023/24 (11%), compared to 2022/23 (9%).
- The majority of complaints in the reporting period that were partially upheld (36%) shows an improvement from the previous year.
- The percentage of not upheld complaints has improved (53%) when compared with the 2022/23 reporting period (43%).
- The increase in complaints not upheld indicates that, complaint investigations are concluding that care provision has been appropriate albeit with learning identified.





2.5 Complaints Resolved

The Trust closed 240 complaints (this is due to closing those that were received in the previous reporting period). The graph below shows the closed complaints over time.

Timeliness of responding to complaints

Within the reporting period, the Trust had 0 breached complaints.

	2023									2024		
CBU	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Clinical Support Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Digestive Diseases	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Estates and Facilities	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Human Resources	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Integrated Medicine and Community	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medical Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgical Specialties	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urgent and Emergency Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Women's and Children's	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

2.6 Referrals to Parliamentary Health Service Ombudsman

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued

dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file and medical records together with any other relevant information. The PHSO may decide not to investigate further and no action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The Trust received 8 PHSO notifications during 2023/2024, 6 of which remain under investigation.

Date Investigation Started	**Number of Cases**
April 2023	1
June 2023	1
December 2023	1
January 2024	4
February 2024	1

The PHSO have concluded 4 investigations within the reporting period.

a) The first case was partially upheld in terms of poor communication, coordination of medical treatment, lack of pain management, lack of support, lack of clear explanation. The complaint received highlighted numerous concerns regarding the patients care prior to their death, including not being referred to an end-of-life hospice.

b) The second case was partially upheld following concerns relating to the consultants' behaviour towards the patient and the complainant.

c) The third case highlighted a lack of support and treatment. The PHSO did not uphold any outcome for both subjects.

d) The final case highlighted a lack of clear explanation when the next of kin was not informed when patient was taken to hospital. The PHSO upheld this complaint. In terms of learning actions, the importance of answering the telephone in a timely manner and ensuring all patients NOK are updated regularly was highlighted in a

safety brief. It was also highlighted the importance of the property list being completed and to ensure the correct property is given to the correct patient/family.

The Trust currently has 8 ongoing PHSO complaints 2023/2024.

2.7 Learning from Complaints

You Said….	We Did….
Risks associated with a gynaecological procedure were not highlighted on the consent form.	The consent form has been revised to include the risks and forms are currently being reprinted for dissemination within the service.
Complainant raised concerns that there were not enough blankets and pillows available for her mother to make her comfortable.	The Trust has increased the number of pillows delivered daily.
Patient highlighted her past difficult experiences when undergoing a smear test, which caused large amounts of pain and was very traumatic for her.	Triage Pathway has been reviewed and amended to consider past experiences and this has been disseminated by way of “Case on a Page” and a PowerPoint presentation delivered by the CBU manager to highlight the significance of taking into account past experiences.
Delay in swab results being provided to patient. Identified multiple missed opportunities for the results to be shared.	A digital update session has now been added to mandatory training to encourage and highlight the risks associated with not uploading data into Badgernet. A review of the current Results Pathway was completed in November 2023.

2.8 Patient Advice and Liaison Service (PALS)

During the reporting period, PALS received 1671 enquiries, a 17% decrease from 2022/23.

The below graph shows the variance between PALS received each month in 2022/23 against those received for each month in 2023/24, these remain within normal variation.

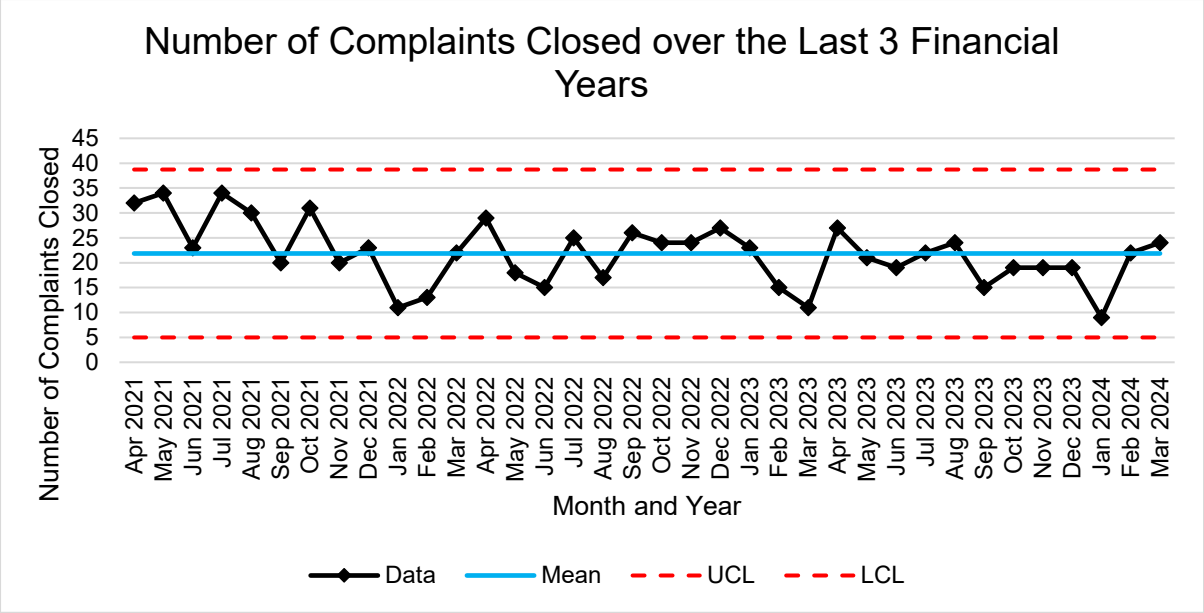


Table 2 below show the top themes for PALS during the 2022/2023 and 2023/24 reporting periods.

Table 2:

Theme	2023/2024	2022/2023	Change
Clinical treatment	345	410	-65
Date for appointment	345	421	-76
Communication (oral)	235	338	-103
Attitude and behaviour	193	173	20
Communication (written)	130	120	10
Patient property / expenses	84	115	-31
Test results	80	99	-19
Admissions / transfers / discharge procedure	77	98	-21
Date of admission / attendance	50	65	-15
Premises	32	29	3
Personal records	26	30	-4
Telephone	23	54	-31
Competence	10	0	10
Aids / appliances / equipment	10	9	1
Transport	8	2	6
Patient privacy / dignity	7	26	-19
Catering	3	3	0
Patient status	3	1	2
NHS board purchasing	2	0	2
Outpatient and other clinics	2	4	-2
Cleanliness / laundry	2	4	-2
Policy & commercial decisions of NHS board	1	0	1
Bed shortages	1	4	-3
Mortuary / post mortem arrangements	1	2	-1

Mixed accommodation	1	0	1

Clinical treatment is the highest theme with a significant reduction in both complaints and PALS noted for the current and previous year. There has been a significant reduction in the following areas:

- Date for appointment
- Communication
- Patient property and expense
- Test results
- Telephone
- Patient privacy and dignity

PALS provide a real time response following receipt of a concern, and the engagement and relationship between the PALS team and the CBU's is very positive which ensures timely responses. Recent improvements during the middle of the last quarter have seen increased visibility of the PALS team within the hospital ward areas, and the provision of updated contact details to ensure the most appropriate colleagues are contacted to be able to assist with an outcome.

Both attitude and behaviour and written communication have seen an increase via PALS for the current year.

3. RECOMMENDATIONS

The Quality Assurance Committee is asked to note the report.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/06/59**			
SUBJECT:	**Learning from Deaths Report Q3 2023-2024**			
DATE OF MEETING:	11 June2024			
ACTION REQUIRED:	**To note the report**			
AUTHOR(S):	Dr Lalitha Chinnappan, Consultant Gastroenterology and Trust Mortality Lead. Dr Judith Raper, Palliative Care Consultant and Deputy Trust Mortality Lead Emily Barnett, Clinical Effectiveness Manager			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				√
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper summarises 'Learning from Deaths' for Q4 2023 / 2024, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths.			
PURPOSE: (please select as appropriate)	Approval	To note √	Decision	
RECOMMENDATION:	Quality Assurance committee is asked to note the contents of the paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			

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

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Deaths Report Q4 2023 / 2024	AGENDA REF:	QAC/24/06/59

1. BACKGROUND/CONTEXT

The National Guidance on Learning from Deaths requires all Trusts to have processes and systems in place to review, investigate and learn from deaths that occur with due focus on:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved families and carers.

The Trust is committed to learning from both positive and negative aspects of a patient's care with clear processes in place for completing mortality reviews. Learning identified during mortality reviews allows individual specialties to improve their processes; collated learning provides corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

This report provides an overview of the processes and systems that are in place to ensure that deaths are reviewed appropriately and summarises the data for this quarter.

2. KEY ELEMENTS

WHH uses the HED (Healthcare Evaluation Data) system to assess overall mortality data, highlighting any themes or trends that support the requirement for reviews of deaths. The HED report also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report includes:

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

The Mortality Review Group (MRG) at the Trust reviews the HED report monthly. Deaths subject to a Structured Judgement Review (SJR) as per the criteria defined in the Learning from Deaths policy are reviewed at MRG to identify learning and improvement actions.

3. MEASUREMENTS/EVALUATIONS

A Structured Judgement Review will be completed if a patient death meets one or more of the below criteria:

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with severe mental health needs.
- Death of a patient who had a 'standard' DOLs in place during their admission. A 10% random selection will be made for any death of a patient with an 'urgent' DOLs in place during their admission.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality review process.
- At the request of the Medical Director or Chief Nurse.

NB: If a death is subject to a PSII (Patient Safety Incident Investigation) or other learning Response then an SJR is not undertaken.

MRG – Forward planning

1) Themed workstream continues to be undertaken ensuring that any common pattern in issues identified are addressed with the aim to bring about clinical changes and positively impact both patient care and trust mortality. The current list of workstreams are as follows:
   - DNACPR and DNACPR Palliative Workstream
   - Patient Transfers
   - Specialty Input
   - DoLS/ Capacity
   - SAFER
   - Trainee related learnings
   - Good practice- for positive commendation

2) The Clinical Effectiveness Coordinator continues to liaise with the Bereavement Team weekly to ensure that all deaths have been captured and are screened as part of the mortality process.

3) Yearly appraisals will commence in August 2024 for all MRG reviewers. The aim of the appraisal is to provide MRG reviewers feedback on their role within MRG and within the wider governance processes. Individualised feedback will be given

on the review completion rates, quality of reviews to help monitor and standardise reviewer's performances.

4) Reminders continue to be sent out monthly with an aim to ensure that each SJR does not exceed the deadline of 8 weeks.

During Quarter 4 there were between 21 - 23 deaths per month that were flagged as requiring an SJR to be completed. Therefore, the average deaths requiring an SJR per month are 22 which is a reduction of 2 from the last reporting period. Currently we have 7 Mortality reviewers, with each being allocated up to 5 cases per month, allowing a total monthly allocation of 35 SJRs.

We continue to remain up to date in the allocation of SJR's with currently no major delay from patients' death to ensure timely review. This is due to the changes in relation to the 10% criteria of 'urgent' DoLs cases and has allowed for more focused learning to be shared with the relevant teams to better improve our Quality of Care.

3.1 Mortality Review Data Q4 2023/2024

- During Quarter 4, 106 deaths met the criteria to be subject to a Structured Judgement Review (SJR). An increase of 27 from Q3.
- During Quarter 4, 65 deaths were allocated to a reviewer for a Structured Judgement Review to be completed.
- 82 SJR's have been completed in Q4, which is an increase of 28 from Q3.
- Of the 82 SJR's completed, 26 were allocated in Q4 2023/24 and 56 were allocation in previous quarters.

Fig. 1 – Key Mortality Data

Total deaths in Q4	Total LD Deaths Q4	PSII's commenced in Q4 relating to patient deaths	Those meeting SJR criteria Q4	Number of SJR reviews completed in Q4	Number of SJR Reviews that were allocated in Q4 23/24 and completed compared to Q3 22/23

363	3	2	106	82	Q3 23/24 Total SJR Completed – 54 Out of the 54 SJRs completed, 28 had been assigned in Q3. 63%	Q4 23/24 Total SJR Completed – 82 Out of the 82 SJRs completed, 26 had been assigned in Q3. 60%

Cases rated by reviewers as *1:* ***overall care very poor*** or *2:* ***overall care poor*** are reviewed by MRG to agree the overall care rating and then referred to the Governance Department if the consensus rating is Very Poor/Poor for further investigation.

A sample of cases rated as *3:* ***Adequate*** are referred to MRG for further discussion to identify themes for learning and improvement.

Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

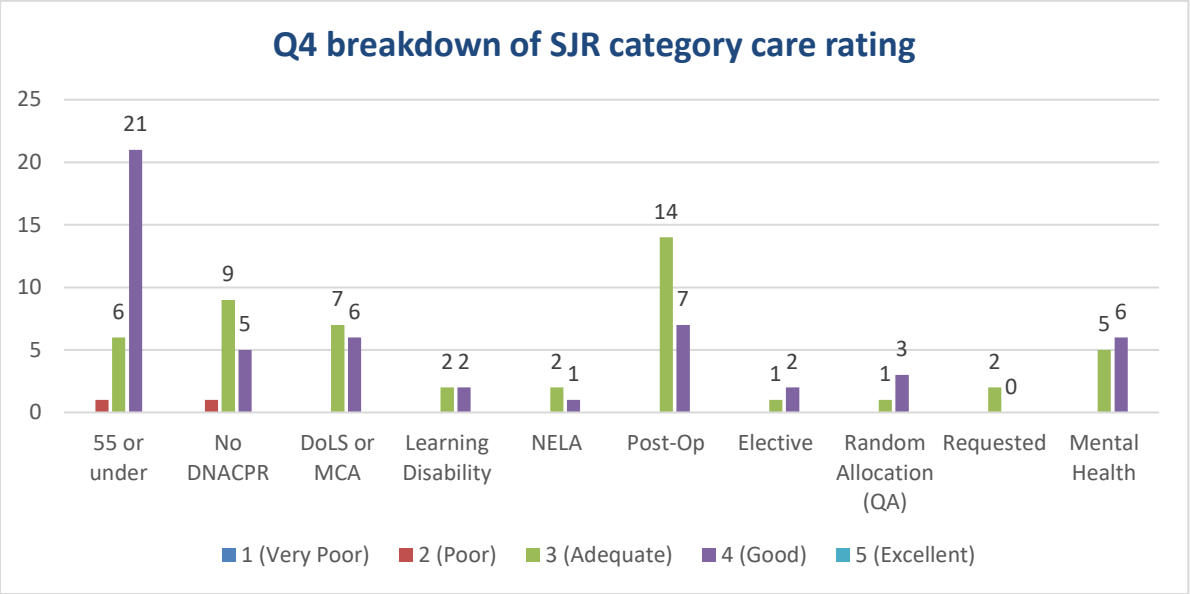
Fig. 2 – Shows the overall and phase of care ratings of the 82 SJRs completed in Quarter 4.

Phase of Care *	**N/A**	**Very Poor**	**Poor**	**Adequate**	**Good**	**Excellent**
First 24 hours/admission	4	0	1	24	52	1
Ongoing care	23	0	2	30	26	1
Care during procedure	65	0	0	8	9	0
End of life care	36	0	2	15	28	1
Patient records/documentation	5	0	1	20	56	0

Overall care	**5**	**0**	**2**	**36**	**39**	**0**

- In SJRs completed within Quarter 4, there has been no 'very poor' care ratings at any stage of admission.
- There was two SJRs that were identified as overall poor care as follows:
  - SJR ID 13274 was rated as overall poor care. It was not discussed at MRG as prior to the review of this case an incident raised (ID 177371) and was investigated as RCA (Root Cause Analysis). The RCA has been completed and appropriate learning has been noted within the action plan.
  - SJR ID 14218 was rated as overall poor care. This case was discussed during the April 2024 MRG meeting and was felt that a further ISR was required for this patient's case. A further ISR has been undertaken and the findings of this ISR are due to be discussed during May's MRG meeting.
- All phases of care and documentation records including overall care had a majority of 'good' ratings with 3 receiving an 'excellent' rating.

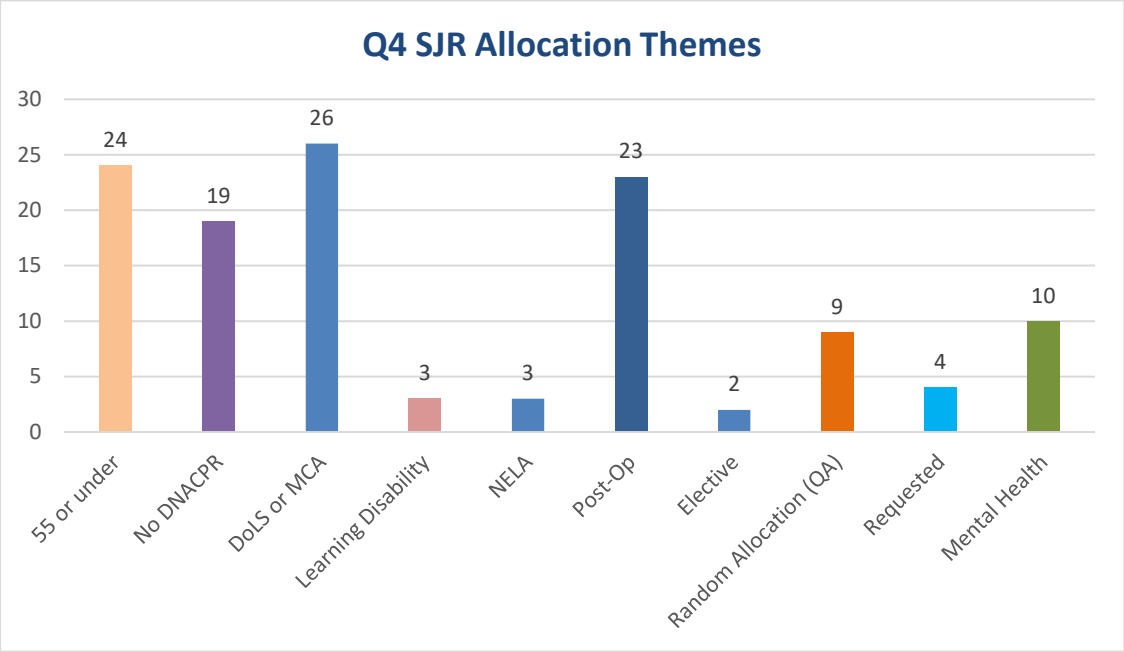
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 4.



- Most categories are predominantly receiving good / adequate care.
- Random Allocation patients show 'adequate' and 'good' care ratings. Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.

NB Some care ratings are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

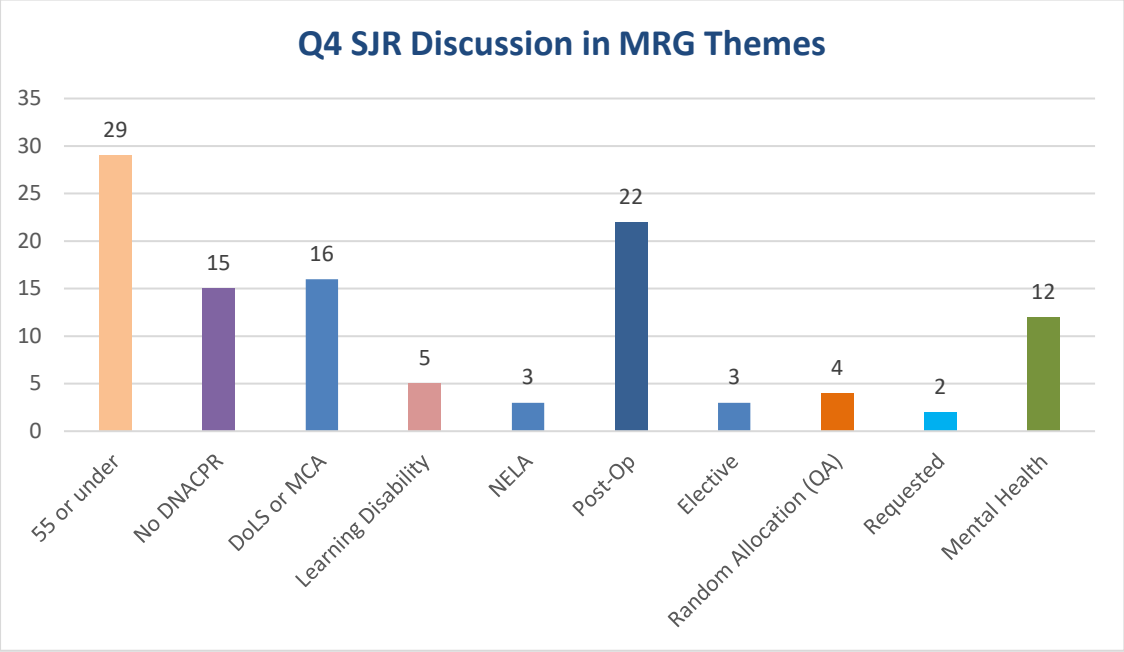
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 4



- 'DoLs or MCA' was the most frequently allocated category to reviewers in Q4.

NB Some allocations are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

Fig 5 - Shows the frequency of each SJR category presented at MRG in Quarter 3.



- The category with the highest number of SJR's requiring further discussion at MRG in Q4 is 'Post-Op'.

3.2 Learning from deaths

The below provides a sample of the learning following recent deaths and the actions taken.

Learning	**Action**
• It was felt during the MRG meeting that things could have possibly been done differently during the time leading up to and following the 11:55am ECG which confirmed acute STEMI. • An ISR was previously completed but it is felt that the cardiac opinion is based upon the fact that the STEMI had occurred during the arrest, but this was not the case. • PPCI does not appear to have been followed. • Nursing notes were clearly documented, and state patient was grey and clammy. This was escalated to the shift leader/ED consultant as significant changes were identified on the ECG. • LHCH discussion took place 30 mins post cardiac arrest. • MJ discussed the difficulties that ED face with bed space and explains the improvements that have been made since this case last year. • MRG agree that this case requires further, Governance review.	• The Clinical Effectiveness Manager has emailed the Clinical Governance Manager and requested that this case be re-reviewed and outlined the concerns raised by MRG lead and during MRG discussion. • A further ISR has been undertaken and the findings are due to be discussed during May's MRG meeting.
• An 87-year-old female admitted after episode of LOC which was witnessed by the family. Patient felt dizzy and faint and was helped to the floor. • ED review delayed by 10 hours. • Ortho review delayed by 8 hours after referral. • Question raised regarding the use of Esmolol fast AF with decreasing BP.	• The Clinical effectiveness Coordinator has sent this case to a Critical care Consultant to investigate, along with Anaesthetics Governance, to find out if alternatives such as Amiodarone or DC Cardioversion was considered. This will be brought back to MRG once the action has been completed. • MRG Chair will investigate the haematology opinion in this case
• Past medical history of AS/AR/MR and CCF. • Known to cardiology as AV replacement in 2014. • An urgent letter was sent from GP to LHCH as decline in functional reserve and symptomatic NYHA.	• The Clinical effectiveness Coordinator will send this to Palliative Medicine Consultant and will add this to the DNACPR workstream and any learning from this will be passed on to the relevant team(s) such as Cardiology.

• Patient had decompensated CCF, secondary to severe AS and MR. • No forward planning in terms of escalation of care/ DNACPR discussion	
Themes **Appendix 1** – MRG Newsletter 'Mortality Review Group'. Newsletters are included on CBU and Specialty Governance agendas each month.	

3.3 Learning from Serious Incident investigations:

A total of 2 PSII was reported during the quarter 4 period relating to a patient's death.

Mortality Indicators

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation.

To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

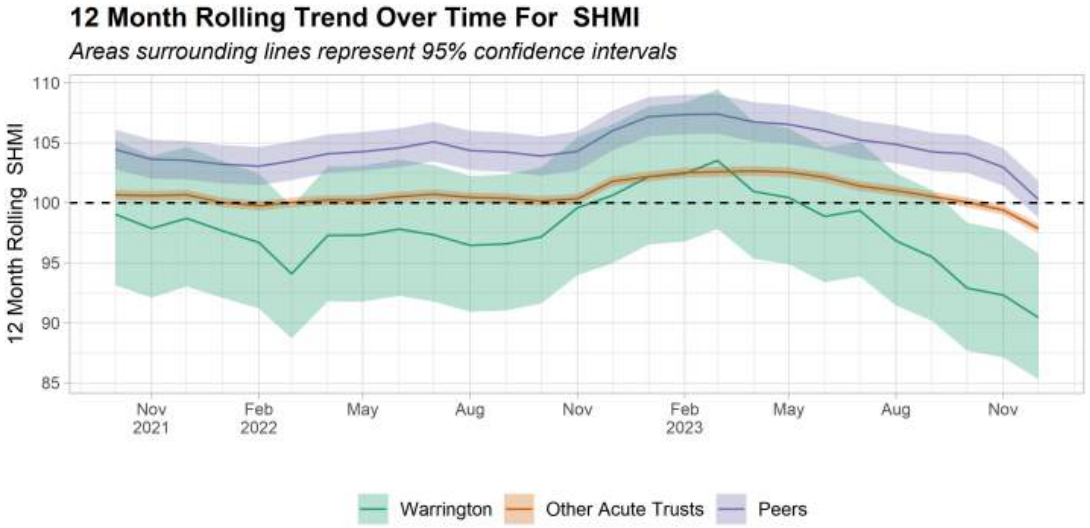
The SHMI data is the ratio between the actual number of patients who die within 30 days following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there.
The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected'.

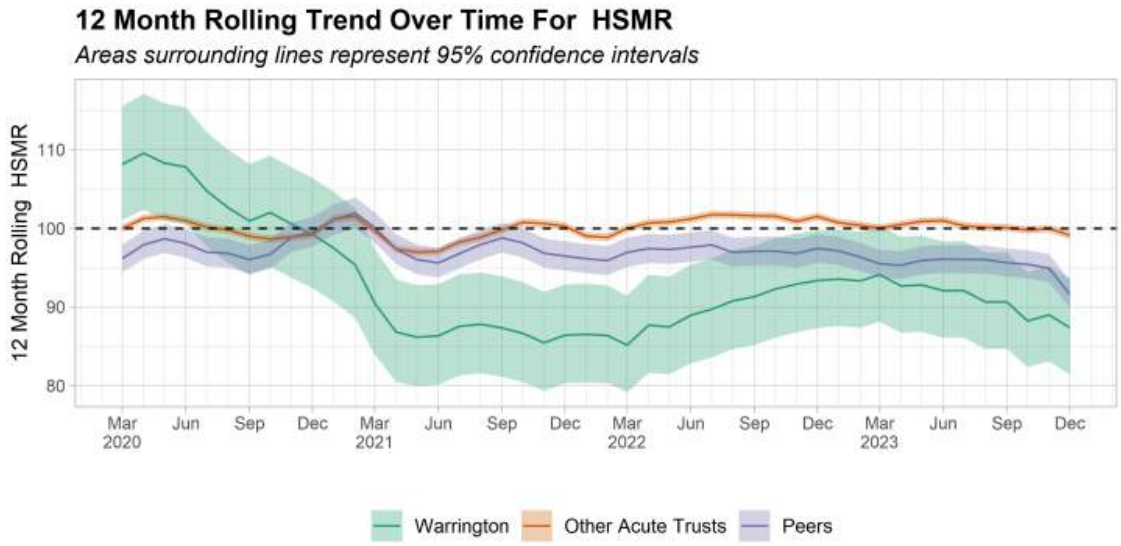
(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
November 2023	86.52	94.68	110
December 2023	88.50	92.22	113
January 2024	87.38	92.53	127

HES SHMI (which is based on 12 months data up to and including December 2023) is 90.45%. This result is not an outlier using an overdispersed funnel plot and is a low outlier based on the stricter Poisson method.





Standard 56 CCS group HSMR (which is based on 12 months data up to and including January 2024) is 86.31. This result is a low value outlier based on the 95% Poisson method.

- The 12-month rolling SHMI for Warrington has consistently been lower than the average of its Peer Group and is lower than the average for Other Acute Trusts.
- Warrington's 12 month rolling SHMI continues a decreasing trend since the year ending March 2023.

4. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Sub Committee, quarterly to the Quality Assurance Committee and annually to both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

5. TIMELINES

Ongoing - the Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.

6. RECOMMENDATIONS

The Quality Assurance Committee are asked to note this report.

Appendix One: Monthly MRG Newsletter

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Mortality Review Group (MRG)

The purpose of the Mortality Review Group is to contribute to the improvement of the quality of care by evaluating and analysing in-hospital mortality and channelling the improvement actions proposed as a result of this analysis.

As part of the Learning from Deaths Framework, all deaths within the hospital are screened for a select criteria, such as:

- Deaths of patients who have had an elective procedure.
- Patients who have had an emergency laparotomy (National Emergency Laparotomy Audit) and patients who have died post operatively.
- Mental health / MHA (Section 3)
- All DOLs cases that have been authorised by the Local Authority, as standard.
- 10% of DOLs cases, that are authorised as urgent by the Local Authority
- Patients who are under the age of 55
- Patients who die with no uDNACPR form in place
- Patients with a Learning Disability
- Deaths referred for SJR by the Medical Examiner/ Coroner/ departmental M&M meetings.

Hospital deaths meeting these criteria will be assigned for a Structured Judgement Review (SJR) undertaken in depth by MRG reviewers. The review highlights any learning that there may be from these patients journeys at the Trust, both good and bad.

The MRG meeting is then utilised to ensure that any completed SJR's which have highlighted the following are shared at the meeting with all reviewers for further discussion:

- Where poor care has been highlighted
- The patient has a learning disability.
- There is learning from the patient's journey.

During the review process, a reviewer may identify 'Good Practice' from a person or dept involved in patient's care. This is then shared with MRG, a commendation certificate is sent to the individual(s) to be used for their professional portfolios with positive feedback.

Any subsequent learning is shared through Speciality Governance Meetings (M&M section) to ensure that the wider teams are aware of what improvements can be made to patients care at departmental level. The departmental M&M section also contains list of all deaths within the speciality with additional information regarding any datix's linked or SJR's undertaken. Review of these deaths will help improve clinical practise & we would encourage departments to utilise this learning opportunity to strengthen their governance processes.

Any consultant or trainee who wishes to observe the meeting as a guest to improve their governance understanding, please contact either,

lalitha.chinnappan@nhs.net
judith.raper@nhs.net /
Tracey.pemberton3@nhs.net
to help arrange.

Working Together · Excellence · Inclusive · Kind · Embracing Change

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/06/55**			
SUBJECT:	**Medicines Management Annual Report 2023/24**			
DATE OF MEETING:	11 June 2024			
ACTION REQUIRED:	To note the contents of the report.			
AUTHOR(S):	Paul Mooney, Chief Pharmacist			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This report provides the committee with an overview of medicines management activities in 2023/24 and planned work for 2024/25. It provides a high-level overview of the key medicines management activities. Specific attention is drawn to the management of Homecare, which remains a significant risk due to increasing activity with limited dedicated workforce and manual, paper-based processes. Performance against the medicines reconciliation target continues to fall below the target, but recent successful pharmacy recruitment is expected to drive improvements against this metric in the next 12 months.			
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**	
RECOMMENDATION:	The committee is asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***None***			

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

QUALITY ASSURANCE COMMITTEE

SUBJECT	Medicines Management Annual Report 2023/24	AGENDA REF	QAC/24/06/55

1. BACKGROUND/CONTEXT

The objective of medicines management is to ensure that medicines are procured, prescribed, dispensed, administered, and monitored to optimise their safe, effective, and efficient contribution to patient care. Medicines management also focusses on the managed entry of new medicines, the financial implications of prescribing decisions and the safe and secure storage of medicines.

The national agenda aims to improve medicines management within NHS bodies and this report seeks to provide assurance that the Trust is aware of relevant legislation, regulatory and national standards, and best practice guidance. This includes NICE NG5, 'Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes', Royal Pharmaceutical Society 'Safe and secure handling of medicines', and CQC medicines management standards.

Practice with regards to medicines management at WHH is primarily governed by the Medicines and Controlled Drug policy and the procedures appended within this document.

This annual report updates the committee with progress made within the medicines management and optimisation agendas during the period April 2023 to March 2024, and an overview of the planned actions for the year 2024/25.

2. KEY ELEMENTS

2.1 Progress against last year's proposed actions

The following priorities and actions were listed in the 22/23 medicines management annual report:

Priority / action	Progress update
Undertake a QI project as part of the AQUA-led medicines management collaborative focussing on delays to critical medicines, particularly to ensure timely prescribing and administration	Completed. Project focused on reducing the incidence of missed doses of antiepileptic medicines in the emergency department. Several changes made related to stock lists and storage within ED. During the project missed doses of antiepileptics reduce by 15% and the changes also reduced the incidence of missed doses of other critical medicines such as insulin.
Support the production of the ICB-level homecare business case to provide resilience to support the increasing homecare workload.	Ongoing. WHH data submitted to support development of an invest-to-save scheme. Business case currently awaiting sign off from SLT at NHS England (outcome expected wc 10th June 2024). If successful, this will provide funding for a dedicated pharmacy technician

	and the finance required to deploy the Homecare module within the pharmacy stock control system.
Implement a new process for consenting patient to biosimilar drugs, rather than specific brands, to facilitate more agile and rapid uptake of new, lower cost biosimilar medicines once they become available.	Ongoing. Patient Information Leaflet and Clinician letter approved and ready to use. Plan to launch process alongside next biosimilar launch in Q2 2024/25.
Review the functions, standing agenda items, membership, and reporting routes for the two core medicines management meetings to reduce overlap between the agendas and Terms of Reference, and to ensure appropriate engagement with the CBUs on medicines management issues.	Completed. Medication Governance Group and Medicines Improvement Group replaced with Drug and Therapeutics Committee (DTC) and Medicines Optimisation and Safety Group (MSOG) respectively. Terms of Reference and Cycle of Business approved. DTC focuses on the managed entry of new medicines and prescribing guidance and policy. MSOG focuses on medication safety and assurance audits.
Recruit to the newly created medicines optimisation and safety nurse role to support the pharmacy team in delivering quality improvements linked to medicines safety initiatives.	Completed. Post filled in January 2024.
Reform the Medical Gases Group and ensure that all required activity relating to medical gases is undertaken and reported via this group.	Completed. The Medical Gases Group has been reformed. Terms of Reference approved, and meetings have occurred and are scheduled.
Deliver improvements to the process for undertaking ICS prescribing statement consultations to improve clinical engagement in the review process and to make sure that the views and opinions of WHH clinicians are heard in the decision-making process.	Ongoing. Processes are in place to disseminate consultation documents and APG decisions, but limited engagement with clinicians to date.

2.2 Drug and Therapeutics Committee

2.2.1 Medicines Management Policies

All core medicines management policies are in date. The Medicines and Controlled Drug policy was reviewed in 2023. Plans are in place to separate this document into a suite of policies for ease of access and review. Additionally, national recommendations are to have a standalone Controlled Drug policy.

2.2.2 Meetings

The Drug and Therapeutics Committee (Medicines Governance Group until July 2023) met on 10 occasions during 2023/24, the expected number in line with its Terms of Reference. All meetings were quorate.

2.2.3 Cheshire and Merseyside Area Prescribing Group (CMAPG) – attendance at subgroups

SAFE-11(a), one of the four Medicines Management Quality Indicators from the ICB, requires trusts to participate in the CMAPG and the work of its subgroups. Individual trusts are not represented on the APG, so WHH is represented by Paul Sanderson, Chief Pharmacist at Alder Hey Children's Hospital, who acts as the representative for the Cheshire and Merseyside Acute and Specialist Trust Collaborative (CMAST). The pharmacy team represent the trust at the various APG subgroups. The attendance record for 2023/24 meetings is shown in table 1.

Subgroup	Attendance record
Formulary and Guidelines	81% (9/11)
Interface Prescribing	80% (4/5)
New Medicines	63% (7/11)
Safety	83% (5/6)
Antimicrobials	80% (4/5)

Table 1: WHH attendance recorded at CMAPG subgroups in 2023/24

2.2.4 New drug applications

SAFE-11(a) also states that 'No decisions affecting prescribing (medicines and medical devices) in primary care should be made without prior consultation with the ICB.

DTC considered 8 applications for new medicines to be added to the trust formulary. All applications were for hospital-only, in-tariff medicines, and all were approved. The applications were for:

- Remimazolam as an alternative to midazolam in procedural sedation.
- Isoflurane for sedation in patients bedded within critical care
- Aymes Actagain Protein Shot for inpatient use only.
- Fortisip Plant Based 1.5kcal as an option for sip feeds in vegan patients.
- Three linked applications for Phoxilium, Prosm0cal and Prismocitrate as new fluids in citrate based anticoagulation in renal replacement therapy on ICU.
- Cefazolin for the treatment of susceptible infections on microbiology advice.

2.2.5 Individual Funding Requests (IFRs)

No Individual Funding Requests were submitted to either NHS England or Cheshire and Merseyside ICB during 2023/24.

2.2.6 Patient Group Directions (PGD)

PGDs provide a legal framework that allows the supply and/or administration of a specified medicine(s) to a pre-defined group of patients needing prophylaxis or treatment for a condition that is described within the PGD document, without the need for a prescription or an instruction from a prescriber.

There are 100 active PGDs approved for use within the trust, with 13 PGDs suspended as they have passed their review date.

2.2.7 NICE Technology Appraisals

NICE published 93 technology appraisals (TA) in 2023/24, including terminated appraisals. Of those, 30 TAs were relevant to WHH. All treatments were included on the WHH formulary and/or Cheshire and Merseyside APG formulary and made available within the statutorily required 90 days of the TA being published.

2.2.8 Horizon scanning

The agreed process for undertaking horizon scanning and submitting expressions of interest for new drugs due to be launched in 2024/25 was completed and received expressions of interest were submitted to the Medicines Management Team at the Cheshire and Merseyside ICB to inform the new medicines subgroup workplan. The regional workplan for new medicines for 24/25 includes all items where an interest was expressed.

2.3 Medicines management risks

The following medicines management risks are currently active on the risk register:

ID	Risk description	Date opened	Rating (initial)	Rating (current)
1504	If there is a closure of the aseptic facility, then the service will be unable to prepare aseptic medicines which will impact on: - Ability to provide aseptically prepared products to wards at the point of need in an agile way. - Cost implications for the medicines budget due to external purchase of ready to administer products. - Inability to retain aseptically trained staff. - Reliance on other Trusts' aseptic capacity to provide critical medicines such as Total Parenteral Nutrition. If this capacity drops and the Trust is unable to maintain supply WHH has little contingency.	08/09/21	12	16
1573	If the Trust is utilising storage infrastructure which is non-compliant with national standards and regulatory requirements, then we will be unable to store medicines safety and securely across multiple Trust clinical areas. This will leave in patients, staff and the Trust being exposed to the inherent risks of medicines being unfit for use due to inadequate storage conditions as well as being unsecured and at risk of diversion or inappropriate access secondary to inadequate security.	03/12/21	20	9
1646	If there is not an appropriately funded staffing resource for homecare, then there will be limited capacity to monitor KPIs provided by Homecare companies then this could cause limited oversight and assurance that homecare services are providing the required service specification for our patients.	25/04/22	10	8
1668	If the service does not have a full staffing establishment, then pharmacists will be unable to see patients within 24 hours of their admission and not all areas will have daily visits by pharmacists. Some areas may receive lower input from pharmacists than recommended by national standards. This could cause delays in medicines	08/06/22	16	20

	reconciliation, failure to review patients' prescription and optimise treatment, and delay and/or omission of medicines, including critical medicines.			
1841	If there is a lack of specific homecare module within the pharmacy stock management system, then a manual, paper-based system will be utilised to order, review and manage the charges for homecare supplies. This portfolio covers high-cost medicines for over 900 patients on behalf of the trust. There is a high-risk of human error in an increasingly saturated, manual, paper-based system which lacks internal checking mechanisms and patient-specific, centralised records.	21/02/23	10	10
1950	If the electronic prescription and discharge information contained within the Lorenzo EPMA application cannot be seamlessly integrated with the PharmOutcomes electronic transfer to community pharmacy (ETCP) platform, then inaccuracies in the medicines dataset will continue to exist, which could cause incorrect prescription information being sent to community pharmacies - potentially causing confusion, medication errors, or disturbances in continuity of care.	31/07/23	10	6
1994	If medicines storage rooms on wards and other clinical areas are not temperature controlled and detection of temperature deviations remains as a manual process using daily reading of max/min thermometers, then medicines will continue to be stored at temperatures outside their product licence without appropriate escalation for remedial action, resulting in patient harm (from receiving medicines with reduced efficacy due to temperature deviation) and/or loss of stock as the medicines require reduction in shelf-life.	28/09/23	12	12

2.4 Medication Incidents

1344 medication incidents were reported in 2023/24, an 11.8% increase from 2022/23 when 1202 incidents were reported. The harm profile of the reported incidents was: no harm/near miss, 90.0%; low harm, 9.2%; and moderate harm, 0.8%. No incidents were reported in 2023/24 that caused greater than moderate harm. Incident reporting figures represent a positive reporting culture, with good levels of reporting coupled with a low harm profile. All incidents reported in 2023/24 have been investigated and closed within Datix. Incidents are reviewed by a multidisciplinary team and actions implemented to reduce the chance of recurrence. Thematic analysis is undertaken via the Medicines Safety and Optimisation Group, and specific projects undertaken to address any themes identified.

Of the 11 incidents that caused moderate harm, four were interface incidents reported by WHH staff but where the incident occurred whilst the patient was under the care of another organisation. The remaining seven incidents occurred whilst patients were under the care of WHH:

1. Poor communication between OPD clinic and the patient resulted in the patient taking an accidental overdose of clarithromycin for 5 days causing AKI stage 3.
2. A patient took an overdose of diazepam after the bedside medicines locker was left unsecured.

3. A patient took an accidental overdose of rifampicin for 10 days after a nurse incorrectly amended the pharmacy dispensing label by hand, leading to the patient being admitted with deranged LFTs.
4. An occurrence of bone cement implantation syndrome, a known risk of cementing procedures. No deficiencies in care were noted and the adverse reaction was identified and managed promptly.
5. Two incidents of hospital acquired VTE.
6. Incorrect VTE risk score calculated for a maternity patient resulting in incorrect thromboprophylaxis being prescribed.

Table 2 shows the breakdown of incidents reported by area or CBU. All areas reported medication incidents during 2023/24, with Urgent and Emergency Care and Clinical Support Services accounting for 46% of all medication incidents reported.

CBU / area	No harm	Low harm	Moderate harm
Clinical Support Services	233	8	0
Corporate Support Services	4	2	0
Digestive Diseases	148	4	1
External Organisation	20	7	4
Integrated Medicine and Community	131	35	2
Medical Care	112	10	1
Surgical Specialties	96	6	2
Urgent and Emergency Care	334	43	0
Women's and Children's	131	9	1

Table 2: breakdown of incidents reported by CBU / area and associated harm level

The most reported category of medication incident is administration errors (n=456), followed by prescribing errors (n=204) and medicines management errors (n=194). A breakdown of the reports by category is shown in figure 1.

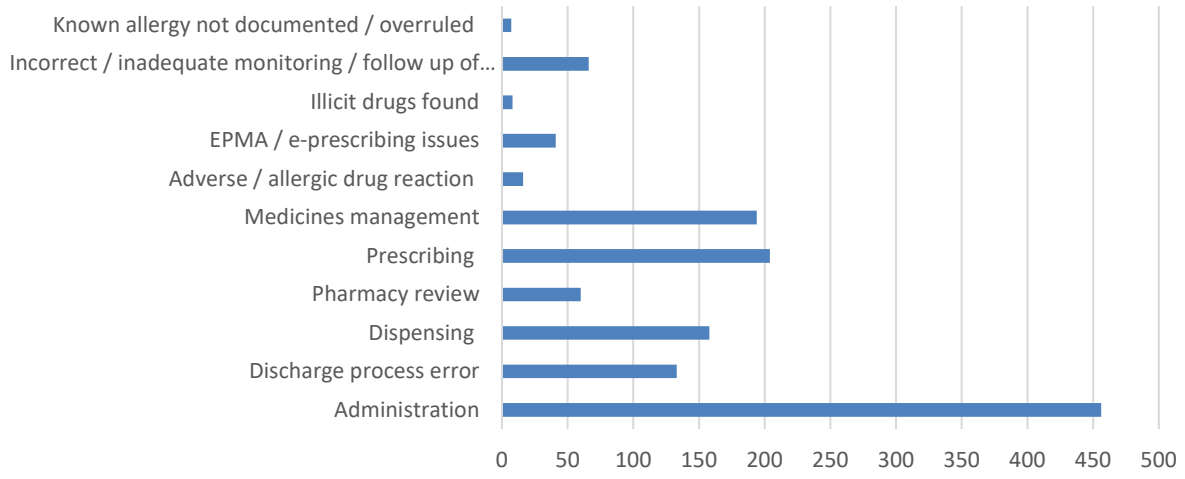


Figure 1: number of medication incidents reported by category

The most common subcategory of administration errors was missed/omitted doses (n=123), followed by wrong/unclear dose given (n=70) and wrong unclear medication given (n=63). Further detail about omitted medications is given in section 2.7,

including planned actions to reduce the occurrence of this type of incident. Wrong dose and/or medication incidents should be reduced by the implementation of the new EPCMS system once procured, as all bidders included the ability to scan medication prior to administration to confirm the correct product and strength has been selected.

An additional theme has been identified in administration errors, with 39 incidents occurring where medication was administered to the wrong patient. Lorenzo contains the functionality to scan the barcode on the patient's wristband prior to administration to confirm patient identity. Plans are in place to pilot this on ward A2, however the project has been delayed by hardware issues.

A deep dive into medication incidents has been proposed by the Chief Nurse and will be presented to QAC once completed.

Other medicines safety initiatives undertaken in 2023/24 include:

- Changing the routine administration time of warfarin (and other VKAs) from 6pm to 2pm. This change went live in January 2024 in response to a trend of incidents reporting delays or omission of warfarin due to delays in taking or reviewing the INR, meaning the out of hours team were being requested to dose warfarin. It is anticipated that this change will result in fewer delays or omissions of a critical medicine and reduced impact on the out of hours team. An audit of the impact is scheduled for 6 months post go-live.

- Trust policies, guidelines and procedures have been reviewed and developed in response to the ongoing safety alerts with regard to the prescribing of sodium valproate and pregnancy prevention programmes.

2.5 Quality Improvement

The pharmacy team has developed strong links with the Quality Improvement team, with several team members undertaking Foundation and/or Practitioner level training.

The following QI projects were undertaken by the pharmacy team in 2023/24:

- Reducing the incidence of 'medicine unavailable'.
- Journey to improving the inpatient medication request process.
- Implementing discharge carts in the emergency department.
- Reducing medicines wastage in the emergency department.
- Reducing the incidence of controlled drug administration incidents.
- Improving % of medication reviews completed by pharmacists.
- Optimising patient discharge; a collaboration between pharmacy and patient flow.
- Improve usage of the pharmacy tracker for TTOs.
- Reducing the number of medicines out-of-stock in pharmacy.

2.6 Medicines Reconciliation

Medicines reconciliation is defined as 'the process of identifying an accurate list of a patient's current medications (including over-the-counter and complementary

medicines) and carrying out a comparison of these with the current list in use, recognising any discrepancies and documenting any changes. It also takes into account the current health of the patient and any active or long-standing issues". NICE guidelines state that it should be completed for all inpatients within 24 hours of admission.

Medicines reconciliation was completed within 24 hours of admission for 42% of patients (no change from 22/23 performance), whilst 73% of patients had medicines reconciliation completed at some point during their inpatient episode. Figure 2 shows the monthly performance against the medicines reconciliation, as well as the performance by CBU.

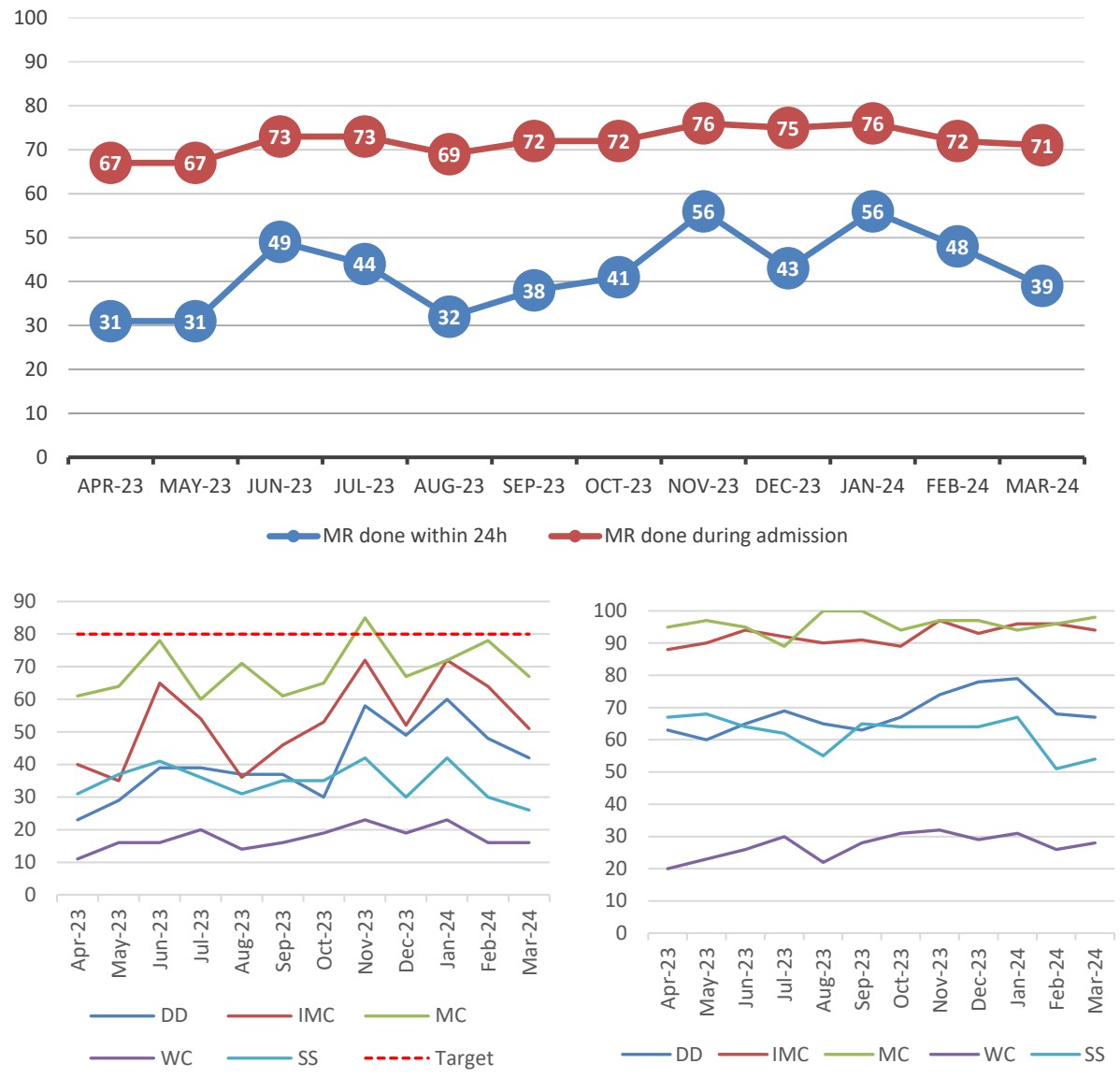


Figure 2: a) Trust performance against medicines reconciliation KPI; b) % medicines reconciliation completed within 24 hours by CBU; and c) % medicines reconciliation completed during inpatient episode by CBU

CBU performance reflects the deployment of pharmacy staff to ward areas. Due to ongoing vacancy rates in pharmacy, some areas have reduced or no pharmacy cover. The areas with reduced cover were agreed with senior nursing colleagues and is

based on the usual length of stay and acuity of the patients cared for. For example, maternity areas currently receive limited pharmacy input. Conversely, areas in Medical Care and Integrated Medicine and Community where higher acuity patients and those with more pharmaceutical care needs, e.g. problematic polypharmacy in frail patients, are prioritised by the pharmacy team, which drives the higher performance against the medicines reconciliation target in these areas.

The current pharmacy establishment has names against the majority of vacancies, with only 4.6wte vacancies remaining unfilled. The newly appointed staff are scheduled to join the team over the next 5 months, with the majority beginning in August 2024 upon their registration as a pharmacist. This shift in workforce will increase the staffing available to visit inpatient areas, reducing those areas receiving limited pharmacy input significantly. This is expected, in turn, to drive improvements against the medicines reconciliation KPI.

MIAA undertook a review of medicines reconciliation processes in March 2024. The overall assurance rating was substantial, and only one recommendation was made: to review the pharmacy SOP covering medicines reconciliation procedures, as it was out of date. This SOP is being retired and replaced with a Medicines Reconciliation guideline which is scheduled to be completed by the end of June 2024.

2.7 Omitted Medicines

3.58m doses of medicines were prescribed on Lorenzo in 2023/24. The omission rate (excluding appropriate omissions) was 5.30%. Table 3 shows the rate of omission of medicines by month per CBU across 2023/24.

	Unplanned Care			Planned Care			Total
	IMC	MC	UEC	SS	DD	WC	
April	2.97%	3.43%	8.74%	2.85%	5.25%	12.00%	**4.66%**
May	3.67%	3.72%	9.78%	2.68%	7.27%	11.63%	**5.35%**
June	3.47%	3.40%	10.52%	2.75%	6.50%	12.26%	**5.36%**
July	3.31%	3.44%	8.41%	2.91%	5.84%	17.35%	**5.13%**
August	3.79%	3.68%	9.07%	3.09%	6.28%	12.15%	**5.25%**
September	3.60%	3.55%	8.46%	2.98%	5.35%	12.29%	**4.96%**
October	3.35%	4.22%	8.96%	3.16%	7.47%	12.25%	**5.42%**
November	3.48%	4.20%	9.96%	3.08%	5.71%	15.82%	**5.55%**
December	3.77%	3.80%	9.86%	2.91%	6.13%	12.44%	**5.46%**
January	3.42%	3.61%	10.65%	3.47%	5.49%	11.17%	**5.56%**
February	3.60%	3.92%	10.17%	3.28%	5.30%	11.56%	**5.47%**
March	3.50%	3.54%	9.64%	3.05%	5.58%	13.55%	**5.32%**
Total	**3.49%**	**3.71%**	**9.57%**	**3.02%**	**6.01%**	**12.91%**	**5.30%**

Table 3: % of prescribed dose omitted broken down by CBU. *Excludes appropriate omissions (e.g. omitted for clinical reason, patient refused with/without capacity)*

The omitted medicines report on the BI portal has been reviewed and refreshed, and its use is being piloted in Digestive Diseases with a view to being rolled out to all areas in the next 6 months. Ward managers are being asked to review the omitted medicines report, which filters to provide patient level details of omitted doses in their area, and to identify trends or patterns which can be addressed.

This work is being supplement by the updated Critical Medicines guideline and critical medicines list, both of which have been reviewed and updated. Work is underway to have all critical medicines flagged with Lorenzo, so that they are visible to end users at the point of administration to try and reduce the inappropriate omission of critical medicines. Once this work is complete, it will be possible to report on the omission rate for critical medicines.

2.8 Cost-effectiveness

2.8.1 Best value biologic medicines uptake

Biosimilar medicines (also known as bioequivalents) contain a version of an active substance of an approved biologic medicine, known as the reference product (RP). They offer the same clinical effectiveness and safety as the RP, but at a significantly lower cost. WHH continues to achieve ≥80% uptake rates (national target) for the biosimilar products prescribed locally, generating significant savings for the health economy.

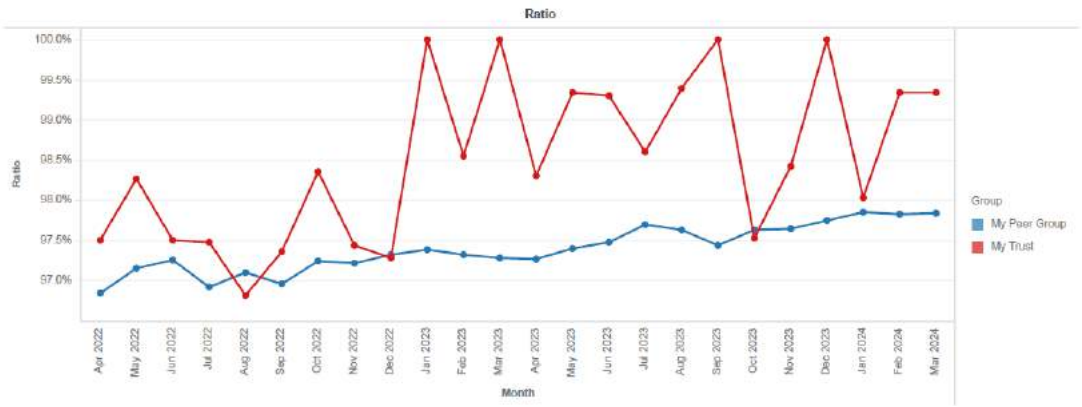


Figure 3: Infliximab biosimilar ratio

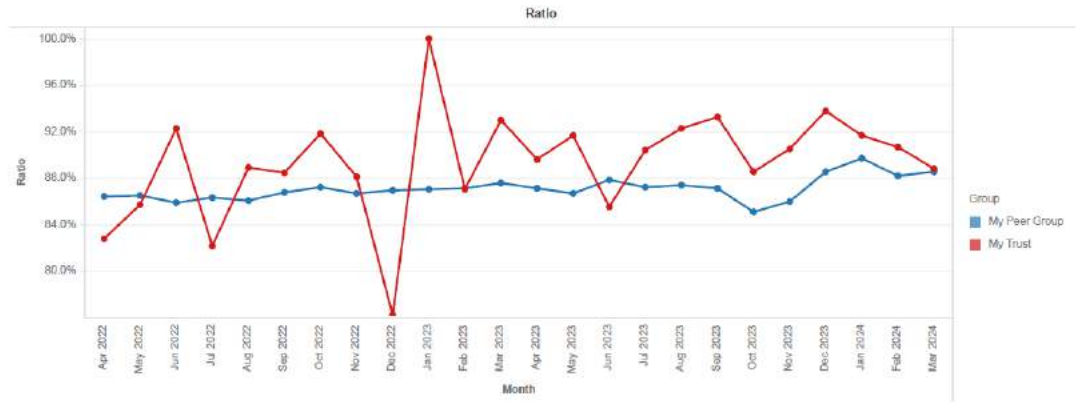


Figure 4: Etanercept biosimilar ratio

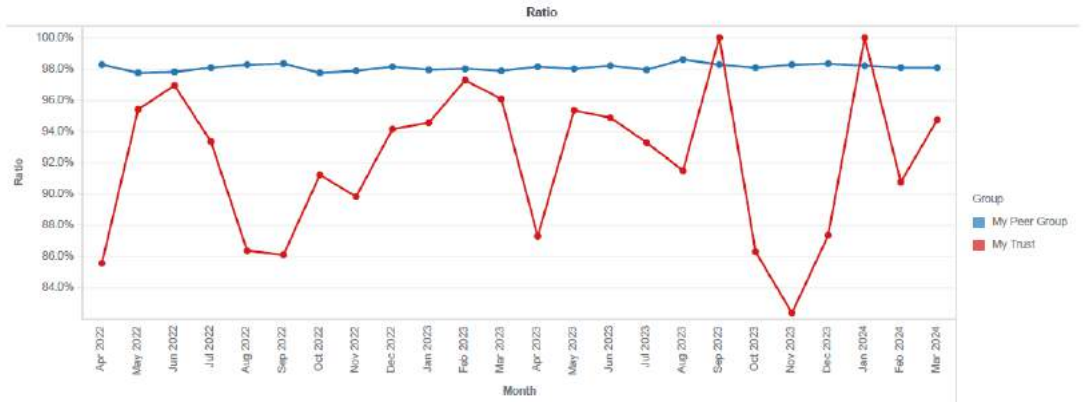


Figure 5: Rituximab IV biosimilar ratio

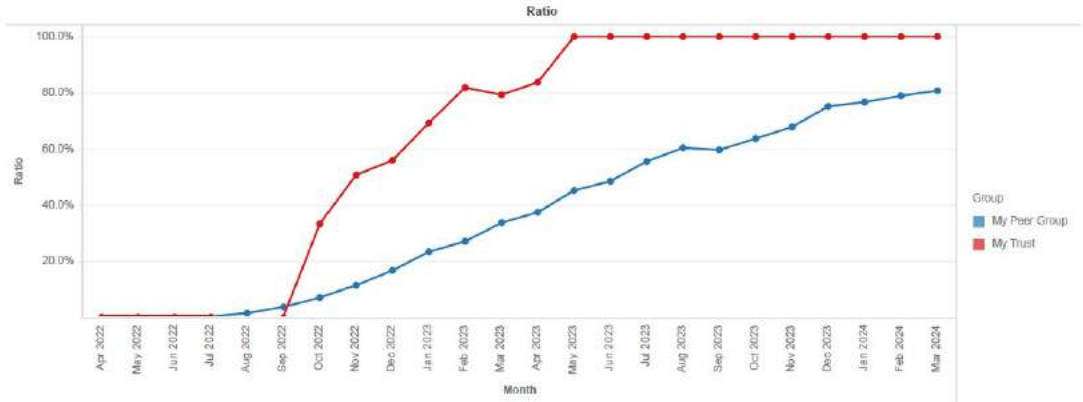


Figure 6: Ranibizumab biosimilar ratio

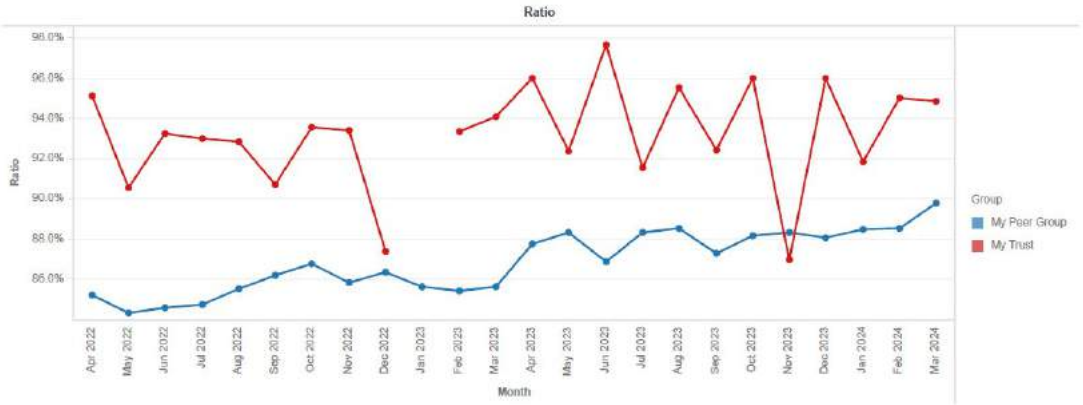


Figure 7: Adalimumab biosimilar ratio

Figures 3-7 show the trust uptake of five of the main biosimilar medicines by cost and volume. Figure 6 shows that the trust has achieved 100% uptake of biosimilar ranibizumab, an intravitreal injection used in the management of several ophthalmic conditions, every month since May 2023. Collaborative working between the clinical team and pharmacy enabled rapid uptake of this biosimilar and the originator product is no longer stocked in the trust. A piece of work is planned for 2024/25 to identify any additional savings that can be realised through switching patients who remain on originator products, particularly with regard to etanercept and rituximab.

2.8.2 CMU contract compliance

At the beginning of 2023/24, all acute trust pharmacy departments were given access to a web-based programme called Exend. This programme provides details of where

the price of procured medicines varied from the Commercial Medicines Unit contract (where one exists). Pharmacy teams were asked to review the contract compliance report each month and provide an explanation for the variation.

In 2023/24, Exend showed at total variation of £383k against CMU contract prices. Of this £23k were not true variations (primarily data mapping errors), meaning that there was £360k of true variation.

Almost half of the variation was due to medicines shortages / contract lines being unavailable necessitating an off-contract purchase. Medication shortages are becoming increasingly common, with the Specialist Pharmacy Services Medicines Supply tool currently listing in excess of 130 active medicines supply issues. This includes sixteen tier 3 medicines supply issues, which are classified as medicines shortages which are critical, with potential change in clinical practice or patient safety implications that require clinical or operational direction to the system.

A national process exists to submit 'off-contract claims', allowing the difference between the contract price and the purchase price to be reclaimed from the contract holder when certain criteria are met. This applied to £62k of the variance, but only £9k worth of off contract claims were submitted.

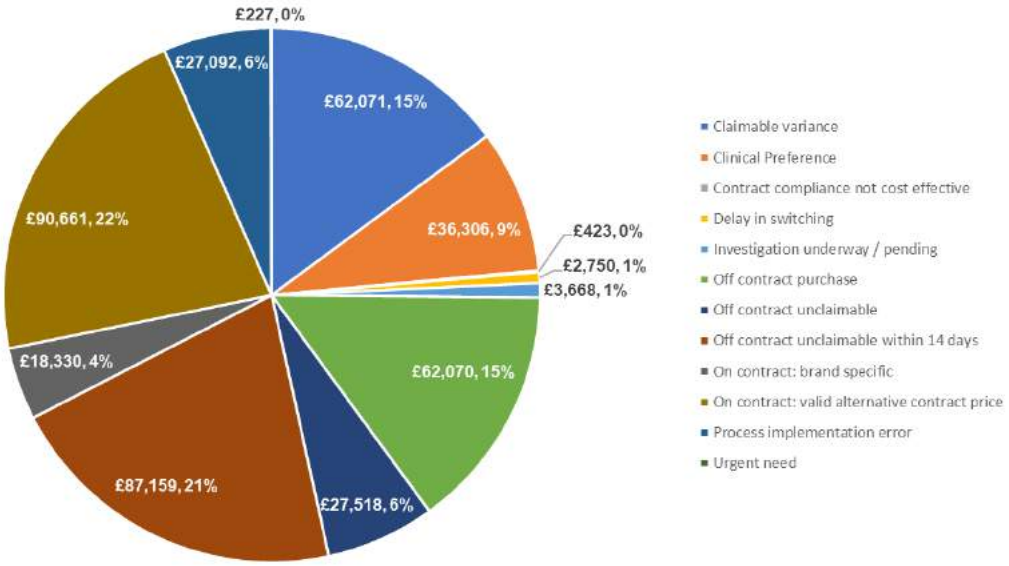


Figure 8: chart showing the breakdown of reasons for contract variation

2.9 Homecare

A Homecare Service is defined as a service that delivers ongoing medicine supplies and, where necessary, associated care, initiated by a hospital prescriber, direct to the patient's home with their consent, with the purpose of improving patient care and choice of their clinical treatment.' It is commonly used to supply NICE-approved, high-cost medicines.

The trust has 28 active Homecare SLAs, covering 23 different medications with five different Homecare providers. Over 1000 patients are currently registered to receive medication via Homecare, receiving 13061 items in 2023/24. The volume of items dispensed in 2023/24 was consistent with the volume recorded in 2022/23, meaning that homecare volume remained consistent for the first time since 2019/20. There has been 36% growth in Homecare activity since 2019/20, primarily driven by the expanding portfolio of NICE-approved biological (high-cost, tariff-excluded) medicines, intravenous to subcutaneous formulation changes and a shift to domiciliary care during the pandemic.

Ongoing risks have been identified through annual completion of the Royal Pharmaceutical Society Homecare Professional Standards audit, which is based on the recommendations from 2011 Hackett Report and subsequent 2014 update. Current compliance against the standards is 84.6% (self-assessment), with significant gaps in assurance around the workforce standards.

There are two open risks relating to Homecare (1646 and 1841), details of which are presented in section 2.3. An invest-to-save business case has been developed by the medicines management team at the ICB, with supporting information provided by all acute trusts. This scheme aims to deliver additional savings from homecare and biosimilar uptake by investing in staff and infrastructure within the provider organisations. It covers both ICB- and specialist commissioning-funded high cost drugs and is currently awaiting a final decision from the SLT at NHS England.

2.10 Digital Pharmacy and Medicines

The following Digital Pharmacy and Medicines Projects have been achieved in 2023/24:

- Completion of robot replacement on the Warrington site (April 2024) and implementation of automation on the Halton site (October 2024) for the first time.
- Development and deployment of a tool within Lorenzo to support clinical teams to review IV antibiotics in line with the Intravenous to Oral Antibiotic CQUIN requirements.
- Paediatic Diabetic order set launched within Lorenzo.
- Worked to resolve issues preventing automation of discharge notifications to community pharmacy as required by the Timely communication of changes to medicines to community pharmacists via the discharge medicines service CQUIN.

Work continues on several projects including e-prescribing for outpatients, electronic medicines stock tracker on LION, mandatory indications on antibiotic prescriptions and creation of a VTE landing page.

2.11 Actions proposed for 2024/25

The following actions are proposed for 2024/25:

- Separate Medicines and Controlled Drug policies into separate documents, with an overarching Medicines Policy complemented by a suite of associated

documents.

- Undertake a deep dive into medication incidents.
- Complete project to allow real-time reporting of omission of critical medicines through the BI portal and embed the new critical medicines guideline in practice to reduce the number of omitted medicines.
- Review and update medicines management mandatory training, providing training tailored to different roles involved in medicines management processes.
- Develop Medicines Reconciliation guideline and associated training package ahead of new intake of pharmacists in August 2024.
- Explore opportunities to increase biosimilar uptake further (particularly patients who have not switched to date).
- Review off-contract claim process to maximise compensatory income when off-contract purchases required due to supply issues.
- Review medicines procured where the rationale is 'clinical preference' or 'on-contract brand specific' categories used to identify any additional savings that can be realised, whist maintaining quality and access to required medications.
- Relaunch the Trust Medicines Formulary.

3. MONITORING/REPORTING ROUTES

Quarterly medicines safety reports and monthly high-risk medicines reports with trend and thematic analysis are reviewed at the Medicines Safety and Optimisation Group, with urgent issues escalated to Patient Safety and Clinical Effectiveness Subcommittee via High Level Briefing Papers as required.

Safe and Secure Medicines (Duthie) audits are monitored quarterly via the Medicines Safety and Optimisation Group.

Issues related to the managed entry of new medicines and financial aspects of medicines management are managed by the Drug and Therapeutics Committee.

Other aspects of medicines management are monitored via appropriate specialist groups e.g. pharmacy digital workplan, pharmacy speciality governance meeting, FRG.

4. ASSURANCE COMMITTEE

Patient Safety and Clinical Effectiveness

5. RECOMMENDATIONS

The committee is asked to note the contents of this report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/06/56**			
SUBJECT:	**Controlled Drugs Annual Report 2023/24**			
DATE OF MEETING:	11 June 2024			
ACTION REQUIRED:	To note the contents of the report and the work undertaken in the past 12 months relating to the safe management and use of controlled drugs.			
AUTHOR(S):	Paul Mooney, Controlled Drugs Accountable Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		√	√	√
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	There are established policies and processes for managing controlled drugs in place across the trust. The number of incidents reported was similar to the previous year (280 in 23/24 compared to 274 in 22/23). The harm profile remained low. No incidents resulting in moderate or above harm where recorded. There is evidence of a good reporting culture, with incidents investigated and lessons learned disseminated. Two of the three cycles of the rolling-controlled drug audit programme were completed. The third cycle was delayed until Q1 of 23/24 due to pharmacy staffing issues. Compliances against the audit standards remained high. Available benchmarking data show that WHH benchmarks well against peer organisations with regards to opioid prescribing but uses more pregabalin than peers, when viewed as a ratio compared to gabapentin usage. No specific trends have been noted in the usage of CDs, although there is significant increase in dihydrocodeine usage, which is being investigated.			

	All regulatory and legislator requirements are met with regards to CDs		
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	The committee is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***None***		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

QUALITY ASSURANCE COMMITTEE

SUBJECT	Controlled Drugs Annual Report 2023/24	AGENDA REF:	QAC/24/06/56

1. BACKGROUND/CONTEXT

This report provides the committee with an overview of Controlled Drug (CD) activity during the period April 2023 to March 2024.

The management of CDs is governed under the following legislation:

- Controlled Drugs (Supervision and Management of Use) Regulations 2013
- Misuse of Drugs Act 1971
- The Misuse of Drugs and Misuse of Drugs Designation Regulations 2013 Number 1362
- Dangerous Drugs – The Misuse of Drugs Regulation 2011 Number 3998.

Practice with regards to controlled drugs at WHH is primarily governed by the Medicines and Controlled Drug policy and the relevant procedures appended within this document. The trust policies and procedures are fully compliant with this legislation.

The statutory requirements for the safe management of CDs for designated bodies are outlined in the Controlled Drugs (Supervision and Management and Use) Regulations 2013. One of the requirements is the appointment of an accountable officer who has responsibility for all aspects of controlled drugs management with their organisation. The controlled drugs accountable officer (CDAO) quality assures processes for managing controlled drugs in line with legislation, regulatory standards, and best practice guidance. The CDAO is also required to provide reports to the organisation's board and NHS England, to provide ongoing assurances that CDs are used and handled appropriately, and that systems and processes are in place to ensure that patients, staff, and the organisation are safe. The CDAO for WHH is the chief pharmacist.

2. KEY ELEMENTS

2.1 Controlled Drug Incidents

There were 280 incidents reported that involved CDs across WHH in the period April 2023 to March 2024, compared to 274 reported in 2022/23. Of the 274 incidents, 5.7% (n=16) were recorded as causing harm (16 low harm). No incidents were found to have caused moderate or greater harm. The reporting pattern continues to represent a positive reporting culture with evidence of good levels of reporting incidents across all CBUs, but with a low harm profile.

All incidents have been reviewed and have been marked as 'finally approved' within the DATIX system.

A breakdown of incidents reported by CBU is shown in figure 1. Urgent and Emergency Care reported the most CD incidents (n=65), followed by Digestive

Disease (n=47) and Medical Specialties (n=46). The highest number of reports occurred in pharmacy (n=43).

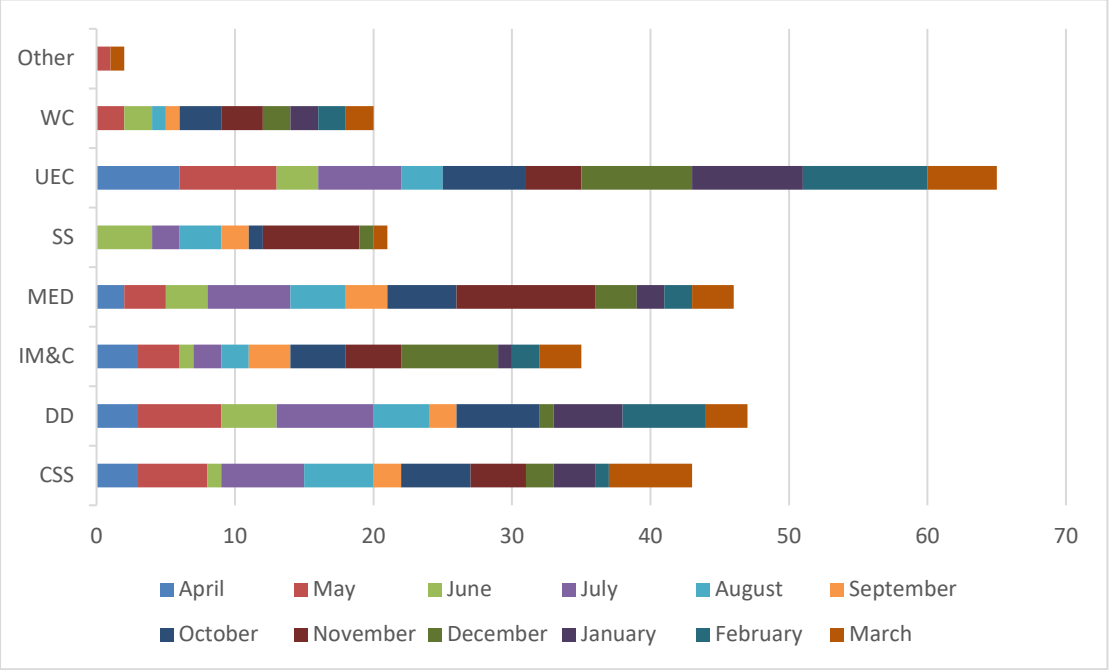


Figure 1: Controlled drug incidents reported by CBU by month in 2023/24
**Other relates to interface incident reports that occurred in a different organisation.*

The following themes were identified from the incidents reported:

- Administration and dispensing errors where modified-release and standard release preparations of oxycodone and tramadol. No patients have been harmed as a result of receiving the wrong preparation. A QI project looking at reducing CD incidents is underway, and it is hoped that the interventions planned as part of this project will reduce the frequency of this occurring.
- Delays in discharge prescriptions reaching wards as pharmacy porters and technical staff were not permitted to transport CD TTOs to the ward as per WHH Medicines and Controlled Drug policies. The practice of delivering CD TTOs with pharmacy staff is commonplace in other organisations. As a result, the policy and associated procedures have been amended to permit this practice.
- Expired stock not being removed from ward stock cupboard in a timely fashion by pharmacy staff. Work is ongoing to reduce the frequency of this occurring, including reviewing the CD destruction SOP to allow ward-based destruction of some CDs, and the introduction of weekly CD stock checks by ward-based pharmacy technicians.
- Balance errors relating to liquid CD preparations because of overage in bottles and multiple small volume manipulations. A pilot using a ‘dry measuring’ technique is planned on two areas in the coming months and, if successful, this intervention will be rolled out to all areas.

Organisations must also report incidents involving controlled drugs to NHS England via the Local Intelligence Network (CD LIN). In addition to submitting quarterly occurrence reports, CDAOs are required to report incidents and concerns, within 48 hours of identification, via the Controlled Drug Reporting website if the incident or

concern meets the any of the following criteria:

- Persons, professional or staff of interest or concern.
- Actual or suspected diversion of controlled drugs.
- Incidents classed as severe or fatal physical and/or psychological patient harm.
- Any other incident deemed to be significant by the CDAO.

Three such incidents were reported to the NW CD LIN during 2023/24:

1. Theft of FP10 prescriptions – a staff members car was broken into and belongings, including work bag containing 3 FP10 prescription pads, were stolen. An alert was circulated to all local community pharmacies by NHS England, and the prescriber wrote prescriptions in red ink to minimise the risk of fraudulent prescriptions being dispensed.
2. Loss of 5 ampoules of morphine sulfate injection from ED – a strip of five ampoules was found to be missing. A thorough investigation did not identify an explanation, and no further incidents have been reported. It is assumed that the strip was accidentally discarded into the waste.
3. Diversion and self-administration of alfentanil by a staff member – an unregistered member of staff withdrew alfentanil from a syringe attached to a patient on ICU and administered it to himself, resulting in loss of consciousness requiring emergency intervention. There was no harm to the patient.

There is a statutory duty to share intelligence and concerns, via the CD LIN, about healthcare professionals who may be harming themselves and/or others by misusing controlled drugs. A key role for the CDAO is information sharing via the network. All scheduled CD LIN meetings and training events were attended by the current CDAO and relevant safety alerts have been disseminated within the organisation as appropriate.

Concerns about the prescribing practices in the pain clinic, including recommendations relating to opioids and gabapentinoids, were communicated to the CDAO via the Medicines Management Team at Halton Place. These concerns were escalated to the Medical Director, who has met with the GP practices in question. An initial review of prescribing has not identified any evidence of harm, and the Medical Director has commissioned an external review of the service. Given the initial review did not identify specific concerns, this issue has not been escalated to the NHS England CD LIN. Following the conclusion of the external review, any concerns or issues identified will be reported as appropriate.

Incidents which are criminal in nature are reported to the police and incidents which involve wholesale supply of controlled drugs must be reported directly to the Home Office. The three incidents reported to the CD LIN were reported also to the police. No action was taken in any case. No incidents occurred that required reporting to the Home Office in 2023/24.

2.2 Controlled Drug Assurance Audits

Under regulation 12 of the Controlled Drugs (Supervision of Management and Use) Regulations 2013, a CDAO of a provider body must continue to establish and operate,

or ensure that the provider body establishes and operates, appropriate arrangements for monitoring and auditing the management and use of CDs. For this purpose, the trust's Medicines and Controlled Drug policy stipulates that audits of all areas using controlled drugs should be undertaken every 4 months. These audits are undertaken by the pharmacy team. In addition, ward areas undertake monthly spot checks against CD standards.

During 2023/24, audits were undertaken for all areas in July and November 2023 with results reported and action plans agreed at the Medicines Safety and Optimisation Group. The March 2024 audits were delayed until April/May 2024 due to operational pressures in pharmacy meaning there was not sufficient capacity in the team to undertake these audits. The schedule of audits will be revised for 2024/25 onward to avoid audits occurring in March, as this is often an operationally challenging month.

The proportion of areas achieving compliance with the audit standards is summarised in table 1, with a more detailed breakdown by ward in appendix 1 and audit standard in appendix 2.

	July 2023		November 2023		March 2024	
	n	%	n	%	n	%
≥90%	51	79.7	56	84.8	*Audits postponed until April/May 2024*	
≥80%-90%	10	15.6	8	12.2		
<80%	3	4.7	2	3.0		

Table 1: % areas by RAG rated compliance against 4 monthly controlled drug audits.

Forty-seven areas were rated green in both audits completed in 2023/24. A10 and The Nest were only open in November, so were only audited once, although both areas were rated green in the November audit.

Compliance against the controlled drug standards sustained the improvement seen in 2022/23, with the vast majority of areas being rated green across both audit cycles. This included 24 areas achieving 100% compliance against the audit standards in July 2023 and 26 areas achieving this in November 2023.

2.3 Controlled Drug Risks

There are no open risks relating to the management or use of CDs on the risk register. No risks relating to CDs were opened or closed during the 2023/24 reporting period.

2.4 Prescribing and Dispensing Data

2.4.1 Prescribing Metrics

IQVIA provides a suite of medicines usage reports, benchmarked against peer organisations, which include metrics relating the use of opioids and gabapentinoids. These metrics show that WHH has a lower usage of total opioids (figure 2) and of modified release morphine and oxycodone (figure 3) compared to peer organisations.

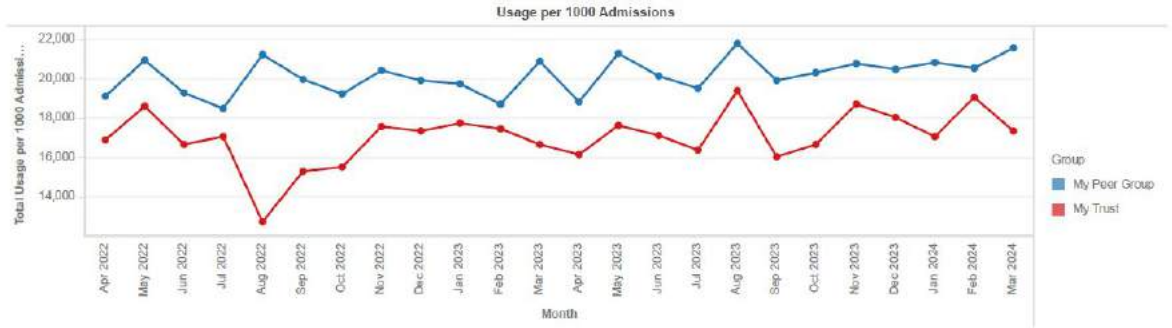


Figure 2: Total opioid usage per 1000 admissions compared to peer organisations

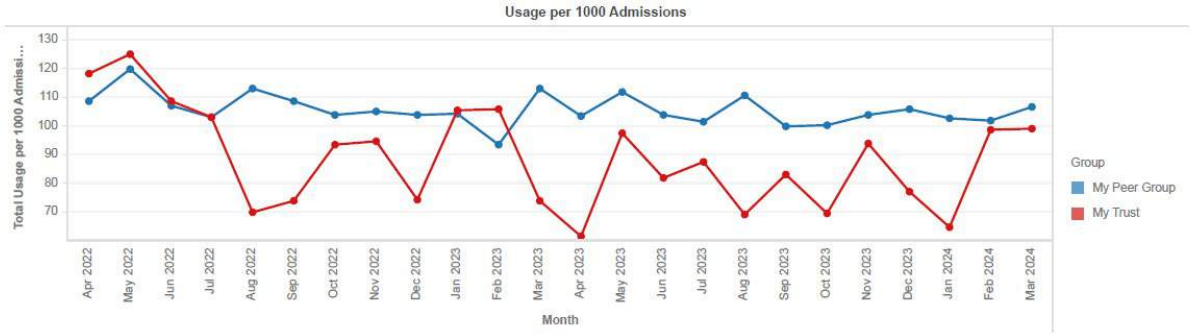


Figure 3: Total modified-release morphine and oxycodone usage per 1000 admissions compared to peer organisations

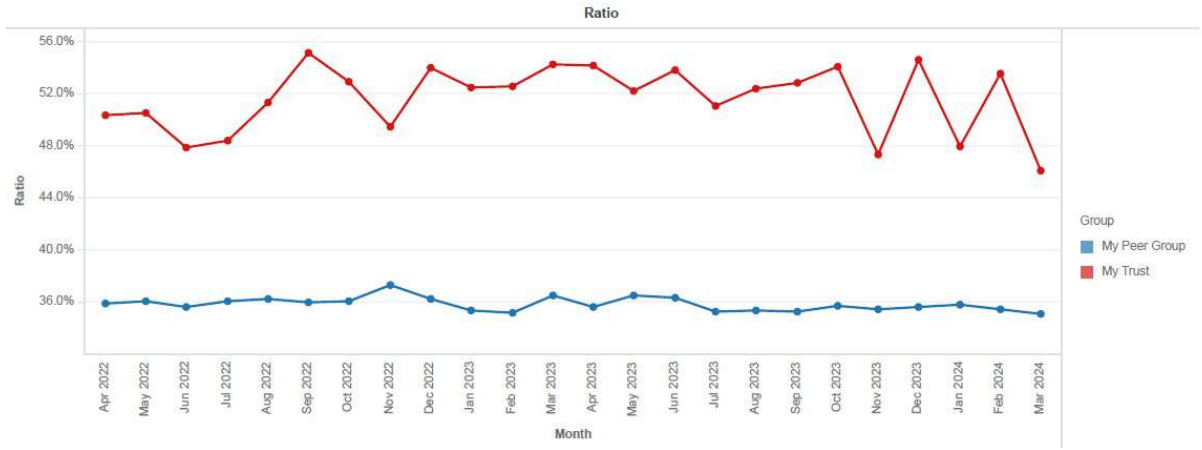


Figure 4: weak vs. strong opioid usage compared to peer organisations

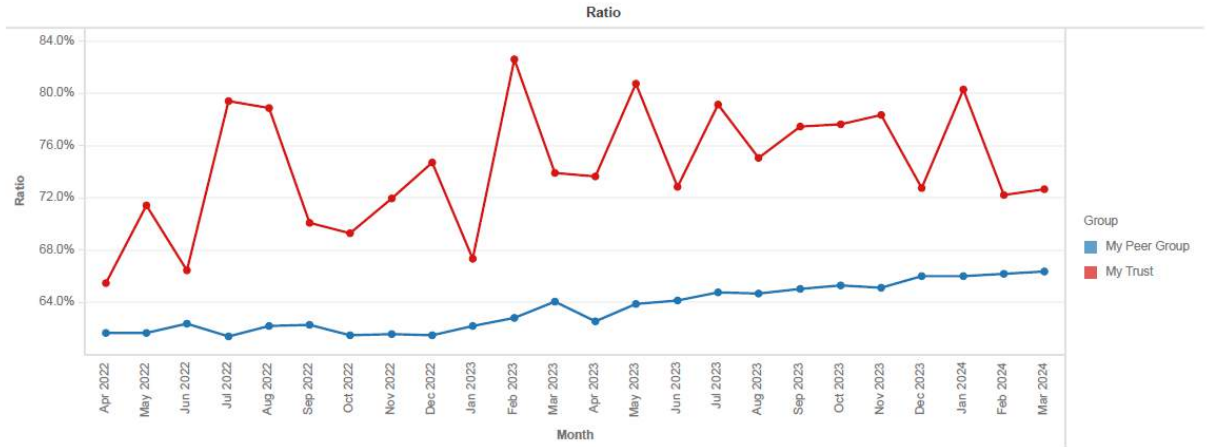


Figure 5: pregabalin vs. gabapentin ratio compared to peer organisations

Figures 4 and 5 show the ratio of weak to strong opioids and gabapentin to pregabalin, respectively, compared to peer organisations. The ratio of weak versus strong opioids used in the trust benchmarks positively against our peer organisations, but we use a higher proportion of pregabalin when compared to our peers. An audit of pregabalin prescribing is included on the pharmacy audit plan for the next year, to assess the appropriateness of pregabalin usage in practice.

2.4.2 WellSky Dispensing Data

The most issued controlled drug at WHH is codeine (including co-codamol preparations), followed by morphine and oxycodone. Supply data for the most used CDs at WHH is presented in appendix 3, along with year-on-year percentage changes. No specific trends of note have been identified in the data. Use of many CDs has returned to 2019/20 pre-pandemic levels because of the continued increase in activity/ recovery plan. The observed 300% increase in use of diamorphine follows the resolution of a long-term manufacturing issue that restricted availability of this drug during 2022/23.

The increase in use of dihydrocodeine, which has increased from 838 units in 2020/21 to 2216 units in 2023/24, requires additional investigation. There is currently no formal electronic system in place at WHH to aid with monitoring of usage and aid identification of unusual prescribing or usage patterns. The implementation of the ADIoS (Abusable Drugs Investigational Software) has previously been recommended but there is no funding available to implement this solution.

2.4.3 FP10 Prescribing Data

FP10 prescriptions are available in a variety of outpatient settings, community clinics and virtual wards. FP10s are prescriptions which may be dispensed in any community pharmacy of the patient's choice. Prescribing data is made available by NHS Prescription Services (via ePACT2) and is reviewed quarterly by the CDAO.

In 2023/24, 150 CD items were prescribed and dispensed on WHH FP10 prescriptions. Table 2 shows the breakdown of CDs prescribed on FP10 prescription by drug and cost centre.

	Orthopaedics Warrington	Respiratory Virtual Ward	Surgery Halton	Surgery Warrington	Womens Health Halton	Womens Health Warrington	**Total**
Co-codamol	57		13	1		2	**73**
Codeine	18		11	6			**35**
Diazepam			2	1			**3**
Dihydrocodeine	2		1				**3**
Fentanyl	1						**1**
Lorazepam		6*					**6**
Morphine sulfate	4	1*					**5**
Oxycodone	1						**1**
Pregabalin	5		4				**9**
Testosterone					3	10	**13**
Tramadol	1						**1**

Table 2: Number of CD items prescribed by WHH FP10 cost centre

**Items prescribed by Nurse IPs. No items were prescribed by pharmacist IPs.*

Of the 150 items, 2 were schedule 2 CDs, 10 were schedule 3 CDs, 22 were schedule 4 CDs and 116 items were schedule 5 CDs. Of these, 7 items were prescribed by nurse independent prescribers (IP), with the remainder being prescribed by doctors. The prescribing data do not present any safety concerns. Supply quantities and volumes were all appropriate.

In addition to the above items, 43 items were prescribed on FP10s against the Palliative Care Virtual Ward cost centre, 14 of which were prescribed by nurse independent prescribers. WHH is the budget holder for this cost centre, but prescribers working against the cost centre work at St Rocco's Hospice.

2.4.4 Wholesale Dealers' Authorisation (WDA) – Sale to External Customers

Controlled drugs were supplied to three external third party organisations during 2023/24: St Rocco's Hospice, Halton Haven Hospice, and Cheshire and Merseyside Fire and Rescue. Longstanding service level agreements (SLA) are in place with both hospices, whilst Cheshire and Merseyside Fire and Rescue was supplied for the first time during 2023/24. Ordering patterns for controlled drugs are monitored periodically as part of the SLA with each external customer. No issues have been noted in the orders from any external customer. If issues were noted, these would be escalated to the CDAO of the third party organisation for investigation.

2.5 Care Quality Commission (CQC) Annual Report and Recommendations

In July 2023, the CQC published their 2022 annual report, 'The safer management of controlled drugs', which provided a summary of their findings through the oversight activities around the management and use of CDs in England.

CQC recommendation	WHH commentary
1. Make sure your governance processes are up-to-date and fit for purpose.	Trust policies are in date and compliant with legislation, regulatory standards and best practice guidance. CDAO in post. Reporting structure defined and followed. CD policy currently sits within the overarching Medicines Policy but will be separate into a standalone policy in 2024/25 in line with national recommendations. Diversion pathway in draft and will be ratified in Q2 of 24/25.
2. Make sure prescribing at transfer of care is completely safe.	Communication of medication changes and required follow up is audited annually. Anaesthetics ACSA accreditation requires evidence that appropriate policies and procedures are regarding opioid stewardship, and the anaesthetic team are reviewing all policies and pathways to ensure compliance with this standard.

3. Know the identity of your local controlled drugs accountable officer (CDAO) and police controlled drug liaison officer (CLDO).	CDAO – Paul Mooney CLDO – Paul Corteen, Cheshire Police Medicines Management training is being updated currently and will include specific information about CDs, including contact details for the CDAO.
4. Work collaboratively to improve prescribing, managing and monitoring of controlled drugs.	Controlled drug incidents, risk and assurance audits are monitored via the Medicines Safety and Optimisation Group, which is a multidisciplinary meeting including pharmacy, nursing and medical representation. Interface issues can be raised via Drug and Therapeutics Committee, which has representation from Warrington Place, and Warrington Place Medicines Management Committee, which is attended by a member of the pharmacy team.
5. Make sure you have a valid Home Office controlled drugs licence if you are required to have one.	Home Office licence in place – more detail provided in section 2.7.2.

2.6 Legislation and Regulatory Bodies

2.6.1 Legislation changes – Reclassification of Nitrous Oxide

In November 2023, nitrous oxide was added to schedule 5 of the 2001 regulations, making possession and supply for “wrongful inhalation” unlawful. Medical administration/inhalation remains lawful under regulation 4C(5)(a) of the 2001 regulations. Outside of legitimate medical use, any patient’s own cannisters containing, or suspected of containing nitrous oxide, should be managed as an illicit substance, and removed and destroyed in line with local policies for the disposal of volatile gases. There are no specific additional requirements needed when destroying schedule 5 controlled drugs. However, as good practice, a record of the disposal should be made in the controlled drug register.

The Medicines and Controlled Drug policy has been updated to reflect this change in legal classification and work is underway to ensure A&E and other direct admissions areas have procedures in place to ensure that records of any cannisters suspected to contain nitrous oxide are recorded and disposed of according to relevant guidelines.

2.6.2 Home Office Controlled Drug Domestic Licence

The pharmacy department at Warrington hospital holds a Home Office Controlled Drug Domestic Licence (HOCDDL) to enable the supply of CDs to external organisations under the previously mentioned WDA. The current licence expires on 5 September 2024.

The licence requires the licensee to submit an 'Annual Statistical Report' by the end of January each year, unless otherwise exempt. Personal correspondence with the Drugs and Firearms Licensing Unit at the Home Office confirmed that all activity undertaken by Warrington pharmacy fell under the exemptions and, as such, a nil return was submitted.

The Home Office did not undertake any inspections or compliance visits at Warrington hospital during the period April 2023 – March 2024.

2.6.3 Registered Pharmacy Inspection Report

An unannounced inspection of the registered pharmacy premises at Warrington Hospital was undertaken by the General Pharmaceutical Council on 11 November 2023. The management of CDs was reviewed by the inspector as part of the assessment. The report found that the management of CDs complied with legislation and relevant good practice guidance, with no recommendations made in the final report relating to the management of CDs.

3. MONITORING/REPORTING ROUTES

The Medicines Safety and Optimisation Group receives:

- Monthly high-risk medicines incident reports, which includes all controlled drug incidents.
- Monthly ward spot check audit results.
- Report of the 4 monthly pharmacy-led controlled drug audits.

Incident monitoring, including thematic analysis, and assurance audits will be reported and monitored via MSOG and the appropriate CBU governance meetings.

Quarterly CDAO reports will be submitted to Patient Safety and Clinical Effectiveness Sub-committee, with urgent issues escalated via High Level Briefing Papers as required.

4. ASSURANCE COMMITTEE

Patient Safety and Clinical Effectiveness Sub-committee

5. RECOMMENDATIONS

The Quality Assurance Committee is asked to note the contents of this annual report.

Appendix 1: % compliance against CD audit standards (4 monthly pharmacy-led audit programme)

Ward/Dept/Area	Jul-2023	Nov-2023	Mar-2024
ED Hub	87%	91%	
ED Majors	81%	81%	
ED Minors	96%	91%	
ED High Care	87%	74%	
ED Paeds	91%	87%	
SDEC	91%	96%	
AMU	96%	100%	
A2	100%	88%	
ACCU Ward	88%	92%	
ACCU High Care	92%	96%	
A4	73%	88%	
A5 Elective	88%	91%	
A5 Gastro	85%	92%	
A6	77%	96%	
A7	96%	100%	
A8	100%	100%	
A9	100%	85%	
A10		100%	
B11	84%	88%	
B12	100%	92%	
B14	92%	100%	
B18	100%	96%	
B19	88%	100%	
C20	92%	96%	
C21	81%	96%	
C23	96%	90%	
NNU	87%	74%	
Birth Suite	100%	87%	
The Nest		100%	
K25	73%	100%	
ICU room 1	92%	92%	
ICU room 2	96%	96%	
CCL Lab	100%	100%	
CCL Ward	100%	100%	
Endo 1 (Warr)	96%	96%	
Endo 2 (Warr)	100%	96%	
Endo 3 (Warr)	100%	100%	
Max-Fax (Warr)	100%	96%	
Interventional radiology theatre	100%	100%	
Theatre 1 (Warr)	100%	96%	
Theatre 2 (Warr)	100%	100%	
Theatre 3 (Warr)	96%	100%	
Theatre 4 (Warr)	100%	96%	
Theatre 5 (Warr)	100%	100%	

Ward/Dept/Area	Jul-2023	Nov-2023	Mar-2024
Theatre 6 (Warr)	96%	96%	
Theatre 8 (Warr)	100%	96%	
Theatre Recovery (Warr)	96%	100%	
Maternity Theatre	100%	100%	
Maternity Recovery	96%	100%	
UTC Halton	96%	91%	
B3	92%	81%	
Endo 1 (Halton)	91%	91%	
Endo 2 (Halton)	96%	100%	
Max-Fax (Halton)	91%	100%	
Nightingale Theatre 1	100%	96%	
Nightingale Theatre 2	100%	96%	
Nightingale Theatre Recovery	100%	96%	
Walton Pain Clinic	96%	100%	
Clinical Treatment Room	100%	96%	
CSTM Ward	96%	96%	
PACU (Halton)	96%	91%	
CSTM Theatre 1	96%	100%	
CSTM Theatre 2	100%	100%	
CSTM Theatre 3	95%	100%	
CTSM Theatre 4	100%	91%	
CSTM Theatre Recovery	96%	100%	

Appendix 2: % of wards/areas/departments achieving compliance by standard (4 monthly pharmacy-led audit programme)

Audit Standard	Jul-2022	Nov-2022	Mar-2023
Are the CD keys held by a registered nurse/midwife/ODP?	100%	100%	
If not in use, is the CD cupboard locked?	100%	100%	
If not in use, are the CD registers stored in a locked cupboard/drawer?	100%	100%	
If not in pharmacy, is the CD requisition book stored in a locked cupboard/drawer?	100%	100%	
Is there only one CD requisition book in use?	94%	100%	
Has a stock check of both stock and patient's own CDs been recorded in the relevant CD registers once a day or at shift handover (or on each working day if the ward department closes at weekends/bank holidays)?	92%	98%	
Are two signatures present in the CD register against each CD stock check undertaken?	92%	92%	
Are only CDs, CD requisition book and CD registers present in the CD cupboard?	95%	98%	
Are all CDs in date?	97%	95%	
On the dispensing label for each stock CD item, does the ward/department stated on the label correspond to the ward/department that the audit is being completed on?	100%	100%	
Dose the quantity of each stock CD in the CD cupboard tally with the balance recorded in the CD register?	100%	98%	
Does the quantity of each patient's own CD in the CD cupboard tally with the balance recorded in the patient's own CD register?	90%	86%	
For patient's own CDs, is each CD correctly entered into the patient's own CD register?	78%	96%	
Are two signatures present for all entries in the patient's own CD register?	91%	96%	
Is the receipt of delivery line signed and date on pink copy in the CD requisition book?	78%	68%	
Are the drug and quantity of CD on the requisition correctly entered into the CD register?	97%	98%	
Are two signatures present in the CD register for the receipt of each CD?	95%	92%	
Is the strength of the CD stated on each page in the register?	100%	100%	
Is the formulation of the CD stated on each page in the register?	91%	98%	
Is the patient's name stated on each CD administration entry?	100%	98%	
Is the date and time recorded when dose of CD was administered?	92%	95%	
Is the dose of CD administered recorded?	98%	97%	
Are two signatures present for each administration recorded?	92%	94%	
Are documentation errors amended correctly using [ ] and no scoring out?	73%	75%	

Audit Standard	Jul-2022	Nov-2022	Mar-2023
Are any transfer of balances between pages in the CD register documented correctly?	84%	83%	
Does the CD cupboard meet the legislative and standard security requirements for the storage of CDs?	100%	98%	

Appendix 3: dispensing data for selected CDs

		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Alfentanil	Units	1170	982	1323	1397	1070	1065	1242
	% change		-16.1%	34.7%	5.6%	-23.4%	-0.5%	16.6%
Cocaine	Units	112	61	41	33	74	101	69
	% change		-45.5%	-32.8%	-19.5%	124.2%	36.5%	-31.7%
Co-codamol	Units	11478	9595	8550	6287	6483	8407	8042
	% change		-16.4%	-10.9%	-26.5%	3.1%	29.7%	-4.3%
Codeine	Units	11875	10136	11050	7776	9832	10623	12256
	% change		-14.6%	9.0%	-29.6%	26.4%	8.1%	15.4%
Diamorphine	Units	1750	568	362	193	200	69	277
	% change		-67.5%	-36.3%	-46.7%	3.6%	-65.5%	301.5%
Diazepam	Units	999	915	953	1001	1038	943	1074
	% change		-8.4%	4.2%	5.0%	3.7%	-9.2%	13.9%
Dihydrocodeine	Units	481	728	849	838	1595	1944	2216
	% change		51.4%	16.6%	-1.3%	90.3%	21.9%	14.0%
Fentanyl	Units	1488	1351	1269	689	1130	1249	1256
	% change		-9.2%	-6.1%	-45.7%	64.0%	10.5%	0.6%
Gabapentin	Units	833	722	537	600	645	567	583
	% change		-13.3%	-25.6%	11.7%	7.5%	-12.1%	2.8%
Ketamine	Units	83	58	70	120	126	93	145
	% change		-30.1%	20.7%	71.4%	5.0%	-26.2%	55.9%
Midazolam	Units	1898	2248	1854	3156	3141	1918	1868
	% change		18.4%	-17.5%	70.2%	-0.5%	-38.9%	-2.6%
Morphine	Units	5103	5178	5622	5565	5735	5565	5901
	% change		1.5%	8.6%	-1.0%	3.1%	-3.0%	6.0%
Oxycodone	Units	1388	1461	2107	1435	2051	2199	2476
	% change		5.3%	44.2%	-31.9%	42.9%	7.2%	12.6%
Pregabalin	Units	1182	1074	810	713	1010	962	1100
	% change		-9.1%	-24.6%	-12.0%	41.7%	-4.8%	14.3%
Temazepam	Units	69	95	66	39	54	29	22
	% change		37.7%	-30.5%	-40.9%	38.5%	-46.3%	-24.1%
Tramadol	Units	1508	1092	949	609	841	733	907
	% change		-27.6%	-13.1%	-35.8%	38.1%	-12.8%	23.7%
Zolpidem	Units	62	52	43	37	56	53	65
	% change		-16.1%	-17.3%	-14.0%	51.4%	-5.4%	22.6%
Zopiclone	Units	1396	1310	1230	938	917	775	853
	% change		-6.2%	-6.1%	-23.7%	-2.2%	-15.5%	10.1%

Warrington and Halton Teaching Hospitals NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REF:	**FSC/24/07/81**			
SUBJECT:	**Digital Strategy Group (DSG) update**			
DATE OF MEETING:	24 July 2024			
ACTION REQUIRED:	To note the report			
AUTHOR(S):	Tom Poulter, Chief Information Officer			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			√	
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on the 8th of July 2024. This report provides a summary of the updates received from the DSG feeder groups, providing the following assurance status for key delivery areas: ○ **Digital Maturity Assessment** Moderate Assurance ○ **Digital Transformation Highlight Report** Moderate Assurance ○ **Digital Service Delivery Highlight Report** Moderate Assurance ○ **Digital Analytics Highlight Report** Moderate Assurance ○ **Digital Care Delivery Group Highlight Report** Moderate Assurance ○ **EPCMS (Electronic Patient Care Management System)** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): ○ EPR Procurement – Waiting for the endorsement from the ICS to go forward for EPCMS procurement ○ Digital Analytics – Capacity Issues for digital analytics and concerns about the amount of work			

	that needs to be done for EPCMS and reporting. This will be coming to execs as a paper for discussion.		
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**
RECOMMENDATION:	FSC is asked to note the contents of the report, including assurance levels.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Share with Finance & Sustainability Committee***		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests		

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group update	AGENDA REF:	FSC/24/07/81

1. BACKGROUND/CONTEXT

This report provides an update on the status of the portfolio of programmes supporting delivery of the Trust's Digital Strategy and "business as usual" service delivery activities in Digital Services and Digital Analytics, providing the Board Committee with the latest internal assurance assessment for each area.

2. KEY ELEMENTS

Digital Services Programme Report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Our digital vision is ***to become a 'Digital Trust', routinely using technology and data to improve the lives of our patients and our staff***

Following "What Good Looks Like" (WGLL) framework our Digital Strategy sets out several digital priorities

	Project	Prioritisation reason	WGLL	Delivery RAG
1	**Electronic Patient Care Management System (EPCMS)** preparedness / business case (organisation and transformation activity)	• Obsolete system, clinical and commercial risk • Improve access to information, pt safety, cost improvement	• Smart Foundations • Improve Care • Support People	Off Track
2	**Procure and implement Patient Engagement Portal (PEP)**	• National initiative, funded • Supports elective pathway • Supports uptake of NHS App targets 75% March 24	• Empower Citizens • Improve Care	On Track
3	**Migration to new ICS Picture Archive Communication System (PACS).** Cloud hosted solution for diagnostic imaging	• Improved data flows, image storage & security • Improved access to clinical data on a regional basis	• Smart Foundations • Improve Care	On Track
4	**Upgrade end-user hardware / networks – devices, Microsoft 365 (M365), remove legacy systems**	• End of life – requires a refresh • Improve staff efficiency	• Smart Foundations	On Track
5	**Single C&M Laboratory Information Management System (LIMS)**	• Improved data flows across the region • Improved access to clinical data on a regional basis	• Smart Foundations • Improve Care	At Risk
	Digital Care Grp	• Clinical Optimisation	• Improve Care	On Track
6	**Electronic Bed Care Management System (EBCMS)** bed management, bed utilisation and patient flow	• Improve patient flow • Improve discharge process • Improve capacity and demand	• Improve Care • Support People	On Hold

EPCMS – Procurement

Off Track

EPCMS Procurement concluded procurement outcome report approved by Trust Board awaiting ICB endorsement. Standstill and contract finalisation timeline replanned from end of July subject to ICB endorsement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

10 Day Standstill — End of July 24
Contract Finalisation — 3rd October 24
FBC Final Draft — September 24
FBC Trust Board — 3rd October 24
EPRIB — 29th January 24
Go Live — September 2026

Workstream	Lead/s	Exec SRO	Overall Task for Readiness	Next Milestone	Critical Risks/Issues	Target Completion Date	Readi... RAG
Data Migration	Chris White	Jane Hurst	Develop a data migration strategy for WHH	Sign off data migration readiness work package following announcement of preferred supplier ITPMO to Schedule workshop to develop Data Migration Strategy. This group must include operational colleagues	Limited resources within the Digital Analytics team currently due to no extra resource funding being released until FBC approval Full BAU plan still being delivered with must do items scheduled to run until end July 2024 As is process mapping with be resource heavy and is likely to run beyond the end of July. It is critical that this mapping is comprehensive and short cuts would increase risk to success of overall programme	September 2024	
Data Cleansing	Gemma Jones	Paul Fitzsimmons	Analyse and correct poor data quality in current systems	Continue to review current processes in closing clinics Cleanse of clinical notes, not used within 6 months	Conflicting priorities on EPR team due to current state process mapping and other high-level projects such as Patient Portal	January 2025	
Current State	Emma O'Brien	Dan Moore	Mapping of all 'as-is' processes within the Trust including digital systems architecture and digital assets	Develop process maps for Theatres/UEC/Outpatients and Reporting Continue to develop FBC artefact for Current State	Operational pressures has caused the timeline for cohort 2 to slip Areas that were initially planned to be mapped by NHSE as part of the eBCMS offer are now to be absorbed by the EPR team. This includes ED which is seeing high operational pressures Work paused for 3-4 weeks as the EPR team needed to prioritise supplier demonstrations, evaluations and moderation sessions	August 2024	
Training	Diane Ashbrook Lakshmi Senthilnathan	Paul Fitzsimmons	Create training strategy including training plan	Distribute TNA to Trust staff to baseline WHH digital literacy		August 2024	
Reporting	Louise Ainsworth Michael Lysons	Jane Hurst	Develop a reporting strategy	Sign off data migration readiness work package following announcement of preferred supplier ITPMO to Schedule workshop to develop Reporting Strategy to include operational and clinical colleagues as the consumers of the reports	Limited resources within the Digital Analytics team no extra resource funding being released until FBC approval Full BAU plan still being delivered with must do items scheduled to run until end July 2024 As is process mapping with be resource heavy and is likely to run beyond the end of July. It is critical that this mapping is comprehensive and short cuts would increase risk to success of overall programme	September 2024	

Patient Engagement Portal (PEP)

Phase 1.1 LIVE

Warrington and Halton Teaching Hospitals NHS Foundation Trust

The Patient Engagement Portal went LIVE on 12th June 2024.
We have already seen benefits, with the below activity. Further benefits and financial profiling will be reported once the system has been live for 8 weeks

- **122K New Appointment Notifications sent**
- **50K First SMS Reminders sent**
- **45K Second SMS Reminders sent**
- **27K Booking Confirmation– 42% via the NHS App, 58% SMS**
- **47K Letters uploaded digitally with 45% viewed preventing a paper letter being sent**
- **2.2K Requests to reschedule / cancel appointments**
- **15% Increase in NHS App Sign Up**

Integration with Radiology — September 24
Pre-Op Assessment Go Live — August 24
AI DNA Predictor — August 24

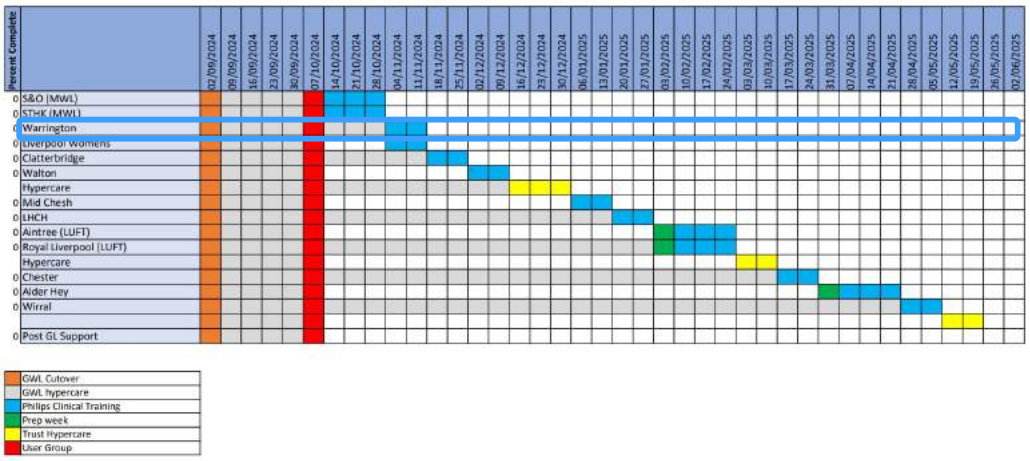
Milestone	Activity	RAG
1. Radiology Integration PEP to be integrated with CRIS the radiology system as part of Phase 1.2	• Workshops taking place to work through each modality for integration • Broadcast message already being used for some radiology patients	
2. Pre-Op Assessments Test pre-op forms built and being tested	• Pre-Op form built in DrDoctor TEST environment. • Great clinical engagement to ensure the forms are correct and complex logic being tested	
3. AI DNA Predictor Project start	• Build automated process that keeps clinic changes in Lorenzo ad radiology in sync via Synanetics with DrDoctor clinic config	

Picture Archiving Communication System (PACS)

On Track

Warrington and Halton Teaching Hospitals NHS Foundation Trust

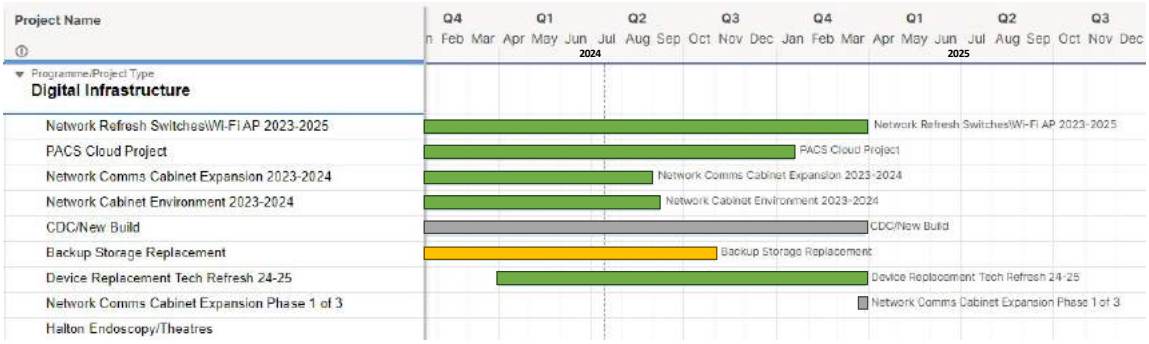
PACS migration to the Cloud– We have moved up the list in this revised plan from early December to early November. Dates to be finalised



Infrastructure - hardware / networks – devices, Microsoft 365 (M365), remove legacy systems

On Track

Warrington and Halton Teaching Hospitals NHS Foundation Trust



Digital Maturity Assessment Update

- This is the standard introduced by ICB which appears to be more in the public eye around DMA. They've issued a new assessment which has been circulated across Cheshire and Mersey, since last year's they've changed it so there will be more AI reporting to simplify some of the questions but richness in data that's collected. Therefore, we can get access to the data using AI technologies and there are no causes of concern, just a lot of data that needs to be responded too but the new approach should help in terms of standardisation. We were advised the changes will alter the pillar scores but overall, we have improved from 2.9 to 3.0

DMA Improvement Plan

The table below indicates how Digital Strategy initiatives will be aligned to WGLL pillars, ensuring we have a clear trajectory for improvement of our DMA scores.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

The survey was undertaken in May/June 2024 and following feedback through the validation process, NHSE made changes to the scoring methodology. The survey was therefore taken again in July 2024.

WGLL Pillar	2023/24		2024/25		2025/26
Well Led	3.5	ISD Level 2,Digital Services Structure Review	2.3	ISD Level 2,Digital Services Structure Review	
Smart Foundations	3.6	EPCMS, Infrastructure Refresh	3.3	New IT network & EPMCS FBC approval	
Safe Practice	3.3	Clinical Digital Safety & PSIRF	3.8	Established clinical digital safety processes	
Support People	2.8	Digital skills & culture	3.7	Digital skills & culture	
Empower Citizens	1.9	NHS App, PEP and ORCHA	3.3	NHS App, PEP and ORCHA	
Improve Care	2.7	EPCMS & Digital Champions	2.2	EPCMS	
Healthy Populations	2.4	CIPHA, Place Digital plans	2.2	CIPHA, Place Digital plans	
TOTAL	2.9		3.0		

DMA Score Comparison (C&M acute)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- The table below shows baseline (2024/25) DMA scores for all Acute trusts in C&M ICS
- WHH are the second highest scoring Acute in C&M, with the Countess of Chester being first
- All trusts are working closely with the ICB Digital Team to co-ordinate regional DMA plans and updates

WGLL Pillar	WHH	MWL	COCH	EAST	MID	LUFT
Well Led	2.3	3.7	3.7	1.7	2.3	2.3
Smart Foundations	3.3	3.6	3.6	2.0	2.5	2.3
Safe Practice	3.8	2.7	2.7	2.2	3.2	2.5
Support People	3.7	2.3	3.3	4.0	2.7	2.7
Empower Citizens	3.3	1.7	2.2	1.7	1.3	1.8
Improve Care	2.2	2.2	2.6	1.6	1.8	2.8
Healthy Populations	2.2	2.8	2.8	1.7	2.0	2.0
TOTAL	3.0	2.9	3.1	2.0	2.2	2.3

Items for escalation:

- None raised.

Digital Transformation Delivery Highlight Report (Moderate Assurance)

Programme Update

- ***Phlebotomy eBooking Go live:*** Warrington GP practices went live with 240 patients booked via the URL or WHH contact centre within the first of go live. It was highlighted that User error

from a GP perspective saw an increase to the number of calls received by the contact centre. Further clarity and training have been provided by the project team and trainers to resolve this issue and further support the practices going forward.

- ***Electronic prescribing in Outpatients:*** Logical printing element has progressed as the printers have now been configured appropriately. A pilot will take place with the community nurses in a first instance to ensure that the config is working before a wider rollout can be issued.
- ***Patient Engagement Portal (PEP):*** The PEP has been live for 2.5 weeks. The CIO provided some positive news outlining that there has been an additional 15% of signups to the NHS app (aged 13+) registered within Warrington over the past 2.5 weeks. Early to know if other statistics are cost effective/saving or if it has had direct response to patient DNA's but the group will continue to monitor stats and benefits that come with PEP launch.
- In this first phase, only Lorenzo will be included providing patients with the ability to view GP referrals as well as appointment information via SMS text message. Requests can be made to request or cancel an appointment where applicable. Appointment reminders will also be received via SMS in advance of patients appointment dates.
- **Warrington Together -** Working through the plans to progress with the relevant workstream leads. Prioritising WHH to be first from a Summary Care Record perspective as this is an urgent matter. Still require an update from the ICB on positioning of the strategy surrounding the summary care record.
- **Digital dictation** – will start training programme to transition from one system to the other.

Digital Infrastructure

- ***Backup Storage Replacement***: The procurement team are now able to complete the recommendation report and send this out for sign off. Once the supplier is agrreed, the award notifications will be sent out to the winning bidder.
- **Network Comms Cabinet Expansion and Network Cabinet Environment 23/24:** Good progress is being made working with City Build, however there are still a few rooms that need the power to be connected to the mains supply. Potential that the timeframes for this may be impacted, this is dependent on when it can be done working around the department's availability. Two areas in Kendrick with concerns around Asbestos, this has been resolved and the route for cabling has been agreed.
- **Device Replacement Tech Refresh 24/25:** Remains on track with a full resource to complete the device replacements.

Items for escalation:

- **None raised.**

Digital Service Delivery Highlight Report (Moderate Assurance)

SLA's status: The intention is to clarify KPIs and activity metrics that the trust will work towards. Hoping to have a standardised target for availability of the service desk and maintain the SLA even regarding staffing levels as we have a rota in place with IT and EPR which is working well in hope we will hit sla by end of the month. Digital services and reporting highlights number of tickets and the percentage which were closed.

Cyber Security: Following on from the recent Synnovis Cyber Attack, the ICB have asked for all organisations who have been affected directly or indirectly by the cyber-attacks to raise this to themselves. WHH's report detailed that against the Pathology records, 1275 patients have potentially been affected. The Regional Cyber Lead has communicated that we do not yet know what has been affected in terms of data output.

MFA: Concerns around a specific supplier have been raised. Responses are still being received in relation to the MFA review that is currently ongoing, some of the vendors response times vary and so

there is delay in obtaining the information which reflects in the asset register. MFA has been on there since October last year when the asset list was redone in line with what NHSE want to go forward.

Print server stats: 882,361 pages have printed so far in June. Just under 14 million pages printed across 23-24, aim of epr readiness is to convert to digital processes before the change freeze in December.

Vendor Management

- **Clinisys**: A new account manager has been allocated after a long period of not having one, awaiting introductory meeting with them. The move from Version 7 to 8 has also raised concerns, working collaboratively with the Pathology network to put forward the product queries raised by other Trusts as well. The move to version 8 is a whole new interface, although the product and databases are the same the change of programme is drastically different. Clinisys are not providing any assurance that they can move all the hospitals who are on a version that is EOL to version 8 and support with that transition

Items for escalation:
- No key items for escalation.

Digital Analytics Highlight Report (Moderate Assurance)

- Increased efforts for epcms and current state mapping is underway, and 2 sessions have taken place already. This is being done diligently as we don't want to miss any progress or reports.
- All workstreams will be epcms and statutory reporting until we have more detail on this will bring DA plan back to this meeting until September this year as limited space for any other work.

Items for escalation:
- Following on DA are looking for support for a hard stop of all things that are nothing to do with statutory reporting or EPCMS activity for the end of this month.

Digital Care Delivery Highlight Report (Moderate Assurance)

*Please note the following was raised by exception due to the meeting being stood down.

ePR Clinical Transformation
- The ePR Team have been supporting the transition of our Assessment Units to Type 5 recording.
- Gone live with FAU and GAU but working through processes with PAU.

Maternity
- Project ongoing to enable the blood results from Molis to import to the individual fields in the BadgerNet system, avoiding the need for manual transcription. Blood groups are currently not being input into the maternity system, which is causing a risk. Currently awaiting a response from System C to confirm the message changes that are required. EPR manager and integration team supporting the project. In recent weeks been testing with Neil from path lab generating messages to try and convert back into BadgerNet.

Items for escalation
- **None raised.**

EPCMS Electronic Patient Care Management System Report (Moderate Assurance)

- From a team perspective we have reached end of procurement with an outcome were keen to announce but are waiting for ICB endorsement. Our outcome report has gone through internal governance finishing at trust board with all in support. Unable to announce until we have ICB

endorsement. It is out of the project teams hands and will wait for those conversations. A neighbouring trust have a trust board meeting on 18th July for end of their procurement so hoping will get further update after neighbouring trust have gone through that process. We're working on the plan in hope the 2-week delay doesn't affect us.

- ***Next Steps:*** A Financial Impact assessment will be conducted as part of the FBC on spend across the years. Discussions to be arranged with Dedalus around the potential contract extension as timelines for delivery have slipped and the costs need to be included in the FBC.

Items for escalation

- Still waiting for the endorsement from ICS to go forward for EPCMS procurement.

EBCMS Electronic Bed Care Management System Report (Limited Assurance)

- A progress update for this project is required as there is still uncertainty around the funding allocations from NHSE to support the introduction of the system.

Items for escalation

- Funding arrangements escalated to NHSE CIO SRO - no response received.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

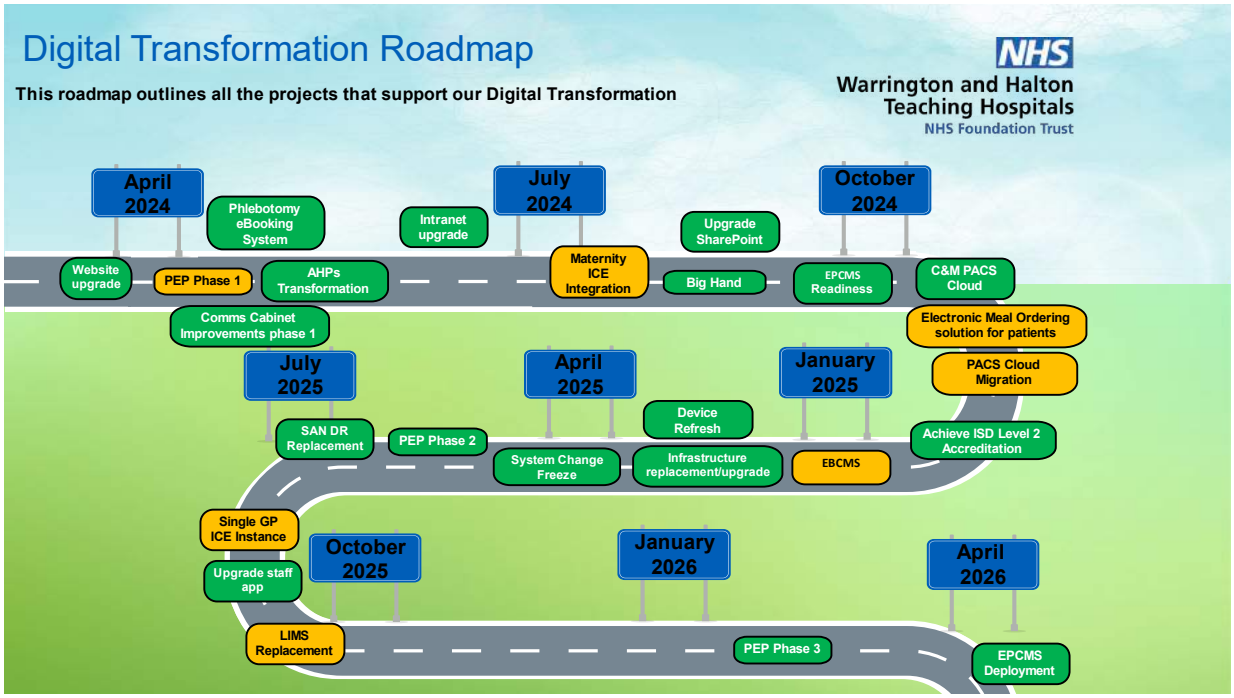
The Digital Strategy Group would like to highlight the following items the attention of FSC, but for information only:

4. MEASUREMENTS/EVALUATIONS

5. TRAJECTORIES/OBJECTIVES AGREED

6. MONITORING/REPORTING ROUTES

7. TIMELINES



8. ASSURANCE COMMITTEE (IF RELEVANT)

9. RECOMMENDATIONS

FSC is asked to note the contents of the report, including assurance levels.