WHH Board of Directors Meeting Part 1

Wednesday 29th March 2023
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 29th March 2023, 10.00am – 12.30pm
Trust Conference Room/Via MS Teams

AGENDA ITEM	TIME	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
BM/23/03/22	**10:00**	Engagement Story – Military Veteran Story	***To Note***	**Presentation**	Jen McCartney - Head of Patient Experience and Inclusion
BM/23/03/23	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***		Steve McGuirk Chairman
BM/23/03/24	**10:17**	Minutes and Action Log of the previous meeting held on **25 January 2023**	***For decision***	***Minutes***	Steve McGuirk, Chairman
BM/23/03/25	**10:20**	Matters Arising	***For assurance***	***Verbal***	Steve McGuirk, Chairman
BM/23/01/26	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/23/03/27	**10:35**	Chair's Report	***For info/update***	***Report & Verbal***	Steve McGuirk, Chairman
BM/23/03/28	**10:45**	Board Assurance Framework	***For approval***	***Report***	John Culshaw, Company Secretary

Quality People Sustainability

BM/23/03/29	**10:50**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a)		**Quality Dashboard** **Including** Assurance Reports – Quality and Assurance Committee (QAC) – 07.02.23 & 07.03.23	***For assurance***	***Report & Presentation***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO; Dan Moore, Chief Operating Officer; Paul Fitzsimmons, Exec Medical Director Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Report - Strategic People Committee (SPC) – 22.02.23, 22.03.23	***For assurance***	***Report & Presentation***	Michelle Cloney, Chief People Officer Julie Jarman, Committee Chair
(c)		**Sustainability Dashboard** **Including** Assurance Report – Finance and Sustainability Committee (FSC) – 22.02.23 & 22.03.23	***For assurance***	***Report & Presentation***	Andrea McGee, Chief Finance Officer & Deputy CEO John Somers, Committee Chair
(d)					

(e)		Clinical Recovery Oversight Committee (CROC) – 14.02.23, 21.03.23			Jayne Downey, Committee Chair
(f)		Assurance Report – Audit Committee 23.02.23	***To note for assurance***	***Report***	Mike O'Connor, Committee Chair
(g)		Assurance Report – Charitable Funds Committee 09.03.23	***To note for assurance***	***Report***	Steve McGuirk, Chairman
Quality					
BM/23/03/30	**11:45**	Maternity Update including. I. Ockenden Review Updates II. Avoiding Term Admission into Neonatal Unit (ATAIN) Q3	***To note for assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
People					
BM/23/03/31	**11:55**	Freedom To Speak Up Guardian Bi-annual Report	***To note for assurance***	**Paper**	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
Sustainability					
BM/23/03/32	**12:05**	Strategy Refresh Update • Bi-monthly update	***To note for assurance***	***Presentation***	Lucy Gardner, Director of Strategy & Partnerships
BM/23/03/33	**12:10**	Draft Trust Strategy 2023- 2025	***To approve***	***Report/ Presentation***	Lucy Gardner, Director of Strategy & Partnerships
GOVERNANCE					
BM/23/03/34	**12:20**	Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	***For approval***	***Report***	John Culshaw, Company Secretary
BM/23/03/35		Amendments to the Constitution	***For approval***	***Report***	John Culshaw, Company Secretary
BM/23/03/36		Disestablishment of Clinical Recovery Oversight Committee (CROC)	***For approval***	***Report***	John Culshaw, Company Secretary
BM/23/03/37		Cycle of Business – Trust Board 2023/24	***For approval***	***Report***	John Culshaw, Company Secretary
BM/23/03/38		Cycle of Business 2023/24: • Audit Committee • Charitable Funds Committee	***For approval***	***Report***	John Culshaw, Company Secretary
FOR APPROVAL					
BM/23/03/39		Performance Assurance Framework	***For approval***	***Report***	Chief Finance Officer & Deputy CEO
BM/23/03/40		Integrated Performance Report Refresh	***For approval***	***Report***	Chief Finance Officer & Deputy CEO

SUPPLEMENTARY PAPERS (see Supplementary Pack for page numbers)

TO NOTE FOR ASSURANCE					
BM/23/03/41	Digital Strategy Group Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 22.02.23 & 22.03.23 Agenda Ref: FSC/23/02/35 & FSC/23/03/59	***Paper***	Paul Fitzsimmons Executive Medical Director

			Outcome: Noted		
BM/23/03/42	Guardian of Safe Working – Q3	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 22.02.23 Agenda Ref: SPC/23/02/22 Outcome: Noted	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/23/03/43	Learning from Experience Summary Report – Q3	***To Note***	Committee: Quality Assurance Committee Date of Meeting: 07.02.23 Agenda Ref: QAC/23/02/38 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/03/44	Directors of Infection Prevention and Control (DIPC) Quarterly Report – Q3	***To Note***	Committee: Quality Assurance Committee Date of Meeting: 07.02.23 Agenda Ref: QAC/23/02/39 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/03/45	Safe Nurse Staffing Report; 6 Monthly Acuity Review	***To Note***	Committee: Quality Assurance Committee Date of Meeting: 07.02.23 Agenda Ref: QAC/23/02/33 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/23/03/46	Mortality Review (Learning from Deaths Quarterly Report) – Q3	***To Note***	Committee: Quality Assurance Committee Date of Meeting: 07.03.23 Agenda Ref: QAC/23/03/56 Outcome: Noted	***Paper***	Paul Fitzsimmons Exec Medical Director
BM/23/03/47	Changes to Enhanced Monitoring Status – General Medical Council	***To Note***	Council of Governors Date of Meeting: 16.02.23 Agenda Ref: COG/23/02/11 Outcome: Noted	***Presentation***	Paul Fitzsimmons Executive Medical Director
BM/23/03/48	Any other Business	***To note***		***Verbal***	Chair
Date and Time of next meeting – 7th June 2023					

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 25 January 2023 Halton Education Centre/Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Simon Constable (SC)	Chief Executive
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Andrea McGee	Chief Finance Officer & Deputy Chief Executive
Kimberley Salmon-Jamieson	Chief Nurse & Deputy Chief Executive
Michelle Cloney (MC)	Chief People Officer
Dan Moore (DM)	Chief Operating Officer
Paul Fitzsimmons (PF)	Executive Medical Director
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Kate Henry (KH)	Director of Communications & Engagement
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Adrian Carridice-Davids (ACD)	Associate Non-Executive Director
Dave Thompson (DT)	Associate Non-Executive Director
Ailsa Gaskill-Jones	Acting Head of Midwifery *(in attendance for Agenda Item BM/23/01/05)*
Jen McCartney (JMcC)	Head of Patient Experience and Inclusion *(in attendance for Agenda Item BM/23/01/01)*
Emma Painter (EP)	Associate Chief of Nursing - Unplanned Care Group *(in attendance for Agenda Item BM/23/01/01)*
Debby Gould (DG)	Local Maternity and Neonatal System (LMNS) Quality Lead, Women's Health & Maternity *(in attendance for Agenda Item BM/23/01/05)*
Liz Walker (LW)	Secretary to the Trust Board (minute taking)
Observing Governors	
Norman Holding	Lead Governor
Paul Bradshaw	Public Governor
Kuldeep Dhillon-Singh	Appointed Governor
Colin Jenkins	Public Governor
Sue Fitzpatrick	Public Governor
Nichola Newton	Appointed Governor
Cllr Paul Warburton	Appointed Governor
Anne Robinson	Public Governor
Staff Observers	

Emily Kelso	Corporate Services & Membership Manager

Agenda Ref	Agenda Item
BM/23/01/01	**ENGAGEMENT STORY – MEETING THE NEEDS OF THE UNEXPECTED** Jen McCartney & Emma Painter presented the Engagement Story around supporting religious needs of patients. The patient concerned presented to the ED with a large number of family members, in a period where there was a high number of patients in the ED. It was noted that despite the significant operational pressures and high patient acuity/dependency, the team in the ED recognised the importance in the quality of experience for this particular patient and their family, to meet their cultural needs. ACD queried the promotion of learning and the communication of lessons learned to the wider team. MOC added that a number of religions had similar cultural requirements and noted the importance of developing clear pathways in advance. JMcC responded that the learning formed part of wider trust discussions in the context of equality and diversity. DT raised the importance of the Trust gaining the confidence of the diverse communities served by the Trust to better handle situations of this nature in future. SMcG responded there were a number of mechanisms in place to ensure this happened. **The Trust Board discussed and noted the Patient Story and thanked Jen McCartney and Emma Painter for attending the meeting to present.**
BM/23/01/02	**WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST** The Chair welcomed the Board guests and observers to the meeting, no apologies of absence were received. **The Trust Board noted the welcome.**
BM/23/01/03	**MINUTES AND ACTION LOG FROM THE PREVIOUS MEETING HELD ON 28 SEPTEMBER 2022** The minutes of the meeting held on 30th November were agreed as an accurate record and approved subject to minor amendments. The Action Log was reviewed and noted. **The Trust Board approved the minutes of the meeting held on 30 November 2023 and noted the Action Log.**
BM/23/01/04	**MATTERS ARISING** JC informed the Board that the Charity Annual Report and Accounts had been recommended for approval at the Charitable Funds Committee and formally

	approved by the Trust Board. **Trust Board noted the verbal update in relation the approval of the Charity Annual Report and Accounts.**
BM/23/01/05	**MATERNITY INCENTIVE SCHEME** Debby Gould from LMNS had been invited to join the Trust Board meeting to discuss the process of final sign off and approval of the Maternity Incentive Scheme. The formal process was detailed within the report. KSJ explained that NHS Resolution was operating in its fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safety maternity care, by implementing 10 safety standards. A final review of progress against these standards had been presented to the Quality Assurance Committee on 10 January 2023 and was being presented today to the Trust Board for approval, before submission to the ICB for sign off on the 27th January, and then final submission of the completed Board declaration form to NHS Resolution by 12 noon on Thursday 2 February 2023. There was a question raised in relation to neonatal staffing. KSJ identified that the issues were around vacancy and sickness levels and also encompassed a review of COTS. SMcG raised the question around the financial aspect as currently the Trust was awaiting £179k of agreed funding in relation to Ockenden. It was agreed that KSJ, AMcG and DG would meet outside of the meeting to discuss further. AMcG added that a review of 2023/24 funding opportunities would also be undertaken. SMcG added it was important to consider long term resources and ensure support for maternity staff. DG responded that in relation to engagement with maternity staff there was a good level of assurance, as evidenced by the data provided which was robust for MIS submission. **The Trust Board noted the content of the report and approved completion of the Board declaration.**
BM/23/01/06	**CHIEF EXECUTIVES REPORT** The paper was noted as read and SC welcomed any questions. SC confirmed that since the last Board meeting the Trust had encountered unprecedented demand for emergency care, but that the level of demand, was beginning to recede, to some extent. KSJ identified that there had been a need to accelerate admissions and while there had been no incidents resulting in harm, one incident of patient experience had been recorded on Datix. In addition, there had been a need for ward 'boarding' to be undertaken which was also recorded on Datix. MOC asked for further information in relation to Super Stranded and NCTR

	patients. SC responded that while the national average for patients with 'no criteria to reside' (NCTR) was around 12% of the acute G&A bed base, WHH had seen levels reach 30% over the recent period, with the figures consistently at around 25 – 30%. Currently the average was around 20%, in order for the Trust to operate and achieve the 4-hour standard this needed to reduce to 12%, which will become a focus from April 2023. DT queried admission avoidance and whether there was opportunity for this to be managed elsewhere. SC responded there was work being undertaken around this. JD Queried CMAST's role and the pressures in the system and the system's responsibility to manage. SC confirmed that the ICB team have conversations with local authorities on behalf of the NHS which would help to identify and support any local authority concerns. **The Trust Board noted the Chief Executive's Report.**
BM/23/01/07	**CHAIR'S UPDATE** The report was taken as read. No further questions were raised. **The Trust Board noted the Chair's update**
BM/23/01/08	**BOARD ASSURANCE FRAMEWORK (BAF)** JC presented the BAF update and highlighted: • one new risk had been added **Risk #1757** in relation to Industrial Action at a rating of 16. • The wording of Risk #1215 had been amended to remove COVD-19 as a specific cause for capacity issues. • there had been no amendments to the ratings of any other risks and no risks had been closed or de-escalated. AMcG suggested that Risk #1215 would benefit from further review, specifically around the financial impact if the Trust was unable to deliver elective care programme, in particular noting the return of Payment By Results (PBR), rather than block contract. It was noted that previously the Quality Assurance Committee had oversight of all risks, however going forward, these would be equally shared across Assurance Committees, and reported to Board for ratification. In addition, the Audit Committee would continue to monitor the BAF, with further scrutiny via MIAA (internal auditors). 1. **The Trust Board discussed and noted the report and supported the proposed changes to the risks highlighted.** 2. **It was agreed that Risk #1215 be reviewed.**
BM/23/01/09	**INTEGRATED PERFORMANCE REPORT**

It has been agreed that a new format would be used in presenting the IPR, Executive Leads would present each of their individual areas and highlight specific concerns or issues using a 'single slide'. SC added that the presentation should flag up issues in relation to the executive domains.

Quality – Access & Performance (DM)

DM noted the highlights in relation to Access and Performance, and in particular the targets for elective and urgent care, specifically achieving the removal of '78-week waits' by the end of March. He also highlighted the impact on further industrial action.

Ambulance handover delays were also highlighted, and it was noted the Trust escalation capacity, which remains open, with work ongoing in both Warrington and Halton to reduce NCTR with national discharge funding.

Work was underway in relation to productivity and efficiency and insourcing was being discussed, as along with discussions with system partners to identify mutual aid opportunities.

SMcG sought clarity on the term insourcing, DM explained it referred to the use of a nationally recommended external company to provide clinical services, using WHH facilities & equipment. DM confirmed that the governance remained the responsibility of WHH.

The Board discussed the importance of virtual and face-to-face appointments, PF confirmed that the trust was committed to finding the right balance for patients, across clinical settings to suit individual needs.

Quality of Care (KSJ)

KSJ explained the reasons for the issues in relation to Pharmacy staff vacancies (40%), identifying that this was both a local and national problem. The medicines reconciliation target had suffered as a result of the staffing issue, which had led to the withdrawal of some pharmacy services from wards, which was impacting the timeliness of discharge of patients.

Questions were asked about the fracture clinic data which reported that only 8.16% of patients were seen in the Fracture Clinic within 72 hours in month. PF responded that data had been the issue rather than an operational failure. On review of the data, it showed that 90% of fracture patients had been seen within 72 hours. Further review of the data would be completed prior to the March Board meeting to provide assurance to the Board.

CR highlighted the issues and concerns raised at the Quality Assurance Committee around Arbury Court (a local, secure mental health unit), in particular the numbers of people being transferred to hospital for care, many attending in handcuffs. Additionally, there was concern about the difference in approach taken by staff associated with Arbury Court and WHH staff relating to patient welfare including, for example, restraining patients. KSJ confirmed that safeguarding concerns were being managed with the CQC, specialist commissioners and the local authority, and that the other aspects of concern were also under consideration by regulators.

The Board were assured that the Quality Assurance Committee were monitoring the position through receipt of regular updates and would report back to the Board on progress.

A positive update was provided on the new Acute Kidney Infection service, which had shown a reduction in mortality, numbers of AKI and a reduced length of stay.

People (MC)

MC provided an update, highlighting that the impact of the industrial action was still unclear, to date only one union had received a mandate to take action, and WHH was not a site where industrial action would be taking place.

At the January meeting in January several policies had been amended, to incorporate industrial action matters.

In relation to recruitment and retention, there had been a consultation regarding an amendment to the NHS pension scheme that would potentially impact on retention, and this would need to be communicated appropriately with staff once full details were available.

ACD enquired about the performance concerning "welcome back" conversations which had shown a significant downturn in performance since October 2022 currently reporting 69.55% compliance (December 2022), and whether an improvement was achievable in the near future.

MC responded that this would be a focus but was reliant on individuals undertaking the conversations and inputting data into the system. There had been marked improvements seen in specific areas and reminders were being sent to managers to undertake conversations.

DT asked about time to hire currently reporting at 96 days with a target of 65 days or below. MC explained that performance had been impacted by the latest NHS recruitment software, NHS Jobs Version 3, which had caused significant delays, The trust was currently processing procurement of a new system (TRAC), assurance on progress would be fed into the Strategic People Committee.

Finance & Sustainability (AMcG)

AMcG highlighted a number of areas for noting which included the year to date deficit of £8.2m which was on plan and the forecast was £6.1m deficit which had been confirmed to the ICS. It was noted another pot of money was available to support organisations who have had larger capital allocations which would increase capital charges and that WHH would receive c£600k.

There were a number of key risks to highlight, and these included;

- not achieving elective recovery and assume receipt of £8m, but this was not certain so signals risk next year for elective recovery.
- Significant pressures on pay relating to NCTR in opening additional capacity and pressures in A&E so risk to planning if capacity remains open.
- Agency expenditure of £4.9m and the Trust would be expected to reduce this

	by 40% next year and therefore it was important to think about how we manage agency and oversight in relation to this. • CIP is behind plan with the majority being non-recurrent and sitting into next year. • Healthy level of cash this year c. £35m, potential risk to next year depending on the 2023/24 plan • Capital underspend and discussions with the ICS regarding capital slippage. • Preparation of operational plan for 2023/24 SMcG asked about elective recovery and whether everyone was at risk or just WHH. AMcG responded that from an activity perspective, some specialist trusts were overperforming significantly, as opposed to the Trust's with Eds - so not all in the same situation across the ICS. DM added the 78 week delivery target, which was part of the operational plan, needed to commit a certain level of activity over and the 2019/20 baseline. There were three specialist trusts achieving, with the rest slightly under in Cheshire and Merseyside. In relation to capital risks, AMcG explained it was about what hits this year and what hits next year, an example being the kitchen refurbishment, which was about to start, there had been an issue with the design team so had gone through another procurement process which had led to a 2 month delay, with £1m now planned to be delivered this year and £800k next year. JS highlighted that from the Finance and Sustainability Committee (FSC, that a paper in relation to non-recurrent productivity and GIRFT would be presented in February and the over spend on Urology and Paediatrics would be concluded also. In relation to capital, it would be useful to be able to make decisions quickly as we know there will be pots of money available at the end of the year and should be able to life and shift projects to use any monies available, with the Committee having delegated authority of £5m. With a shift in planning guidance and PBR, this will be significant, and it was important to get output from the Clinical Recovery Oversight Committee (CROC) and feed into FSC. **The Trust Board noted the IPR updates from the Executive Leads.**
BM/23/01/10	**MATERNITY UPDATE** ***Ockenden*** KSJ provided the update in relation to Ockenden for end of October 2022 and it was noted that; • **Ockenden Part 1a**: WHH is 98% compliant and on trajectory to be compliant by 30th November 2022. • **Ockenden 1b**: WHH is 92% compliant and on trajectory to be 100% compliant by 31st May 2023. • **Ockenden 2:** WHH is 45% compliant and on trajectory to be 100% compliant by 30th June 2022. This trajectory has been impacted by cancellation of 6-month High Dependency Training Programme scheduled for Band 7 staff, but the training is rescheduled to commence May 2023.

	• Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023. ***ATAIN*** In relation to ATAIN it was noted that things were moving forward significantly and were doing well against the national position. ***East Kent Review*** It was noted the East Kent report of the independent investigation into Maternity and Neonatal services in East Kent was published on 19th October 2022. The actions included in the report were for all Trusts, in particular the need to review their approach to reputation management and ensure proper representation of maternity care on their boards. SC added there was no clarity on what was expected of the boards, or board leadership, however it was important to discuss what this might mean for WHH. KSJ commented that the National Midwifery Team had suggested that there should be midwifery representation on the board. It did vary on what was expected from NHSE and the CQC felt a midwife should attend board. However, KSJ added there was already the Chief Nurse, Medical Director and NED Maternity Safety Champion as members of the board, along with the option to call on subject matter experts when required. ***PMRT*** The report published by MBRRACE in 2022 was based on deaths that occurred in 2020. This paper analyses the previous five reports published by MBRRACE for WHH (2016-2020) and the variations over that time. The paper noted that WHH had performed equal to or better than other comparator maternity units with regards to perinatal deaths until 2019 where a slight adverse variation was noted, and then again in 2020. **The Trust Board noted the updates in relation to Maternity.**
BM/23/01/11	**ENGAGEMENT DASHBOARD** The Dashboard was noted, and a question was asked in relation to the social value policy. LG responded that the social value aspect was included in the Anchor Institution work. **The Trust Board noted the Engagement Dashboard update.**
BM/23/01/12	**STRATEGY UPDATE** The report was noted, and it was highlighted that the levelling up bid had not been supported for Warrington or Halton; The Institute of Technology for Cheshire & Warrington, had been approved (£14m) and work was underway with Warrington

	and Vale Royal College to look at improved access to education and technology. **The Trust Board noted the report.**
BM/23/01/13	**OPERATIONAL PLANNING GUIDANCE** The report was noted as read. **1. The Trust Board noted the Planning Guidance.**
BM/23/01/14	**RISK APPETITE** JC presented a report in relation to the Risk Appetite Statement, and it was noted this would be reviewed annually in line with the strategic objectives. JJ asked about adding a statement in relation to reputational risks above the care of patients. **The Trust Board approved the Risk Appetite Statement.**
BM/23/01/15	**CYCLE OF BUSINESS – QUALITY ASSURANCE COMMITTEE** The Cycle of Business for the Quality Assurance Committee was presented for approval. **The Trust Board approved the Cycle of Business for the Quality Assurance Committee.**
BM/23/01/16	**CYCLE OF BUSINESS & TERMS OF REFERENCE – STRATEGIC PEOPLE COMMITTEE** The Cycle of Business and Terms of Reference for the Strategic People Committee were presented for approval. **The Trust Board approved the Cycle of Business and Terms of Reference for the Strategic People Committee.**
SUPPLEMENTARY PAPERS	
BM/23/01/17 **BM/23/01/18** **BM/23/01/19** **BM/23/01/20**	**Infection Prevention and Control - BAF** **Digital Strategy Group Report** **Trust Organisational Chart** **Handover and Ward Round Standard Operating Procedure** **The Trust Board noted the papers presented for noting and assurance purposes.**
BM/22/11/162	**ANY OTHER BUSINESS** There was no other business raised. The meeting closed at 12.30 p.m.
The Date and Time of the next Trust Board Meeting is Wednesday 29th March 2023	

Approved …… Dated ……

CHAIRMAN: Steve McGuirk

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/23/03/24	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	29 March 2023

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/22/11/148	30.11.22	Use of Resources	To be added as an Annual Report to the Trust Board CoB for 2023/24.	John Culshaw	March 23		Added to Cycle of Business Agenda Item BM/23/03/37	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

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

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/01/08	25.01.23	BAF	To review Risk #1215	John Culshaw	March 23		Completed and updated	

RAG Key

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/03/26**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	29th March 2023			
AUTHOR(S):	Simon Constable, Chief Executive			
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 BAF RISK:	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The 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			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/23/03/26

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 25th January 2023, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ISSUES

2.1 Current COVID-19 Situation Report

As at the time of writing (25th March 2023), we have a total of 36 COVID-19 positive inpatients (14 days or less since their first positive sample). In total, 78 of our inpatients have tested positive at any time during their admission. There has been a continuous steady burden of COVID-19 disease, either incidental or as a primary cause of admission, since the beginning of this year.

We have discharged a total of 5251 patients with COVID-19 to continue their recovery at home. Sadly, a total of 859 patients testing positive for COVID-19 have died in our care.

Appendix 1 graphically represents the total number of patients with COVID-19 in our hospitals, including critical care, since the start of the pandemic. You will note the successive waves and the differential impact upon critical care versus our General & Acute bed-base since 2021 and the implementation of the COVID-19 vaccination programme.

2.2 Overview of Trust Performance

Appendix 2 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete datasets. In this case, this is month 11 - February 2023. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

Our single most important operational performance challenge remains length of stay. Our total number of super stranded patients with a length of stay greater than 21 days remains extremely high at 145. The number of patients that do not meet the criteria to reside (NCTR) is similarly very high at 163. For Warrington Borough Council residents in hospital, this latter number is 114 (31.9%); for Halton Borough Council residents in hospital, it is 33 (30.8%); for residents of other local authorities, it is 16 (25.8%). These figures are over double the national average.

Although there are of course other factors, such levels of patients who have a long length of stay and who do not meet the criteria to reside in an acute hospital is the major contributory driver to our inability to maintain a normal operating capacity through the non-elective/urgent care pathway, starting at our Emergency Department.

The Trust continues to undertake an elective recovery programme with minimal interruption despite urgent and emergency care pressure; the priority has been on the elimination of waiting lists longer than 78 weeks by the end of this financial year on 31st March. Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality Assurance and the Finance & Sustainability Committees.

2.3 NHS Annual Staff Survey 2022

The annual NHS staff survey, delivered by Quality Health, took place between September and December 2022. The Trust had a 35% response rate which is lower than 2021 (40%) and equates to 1,520 members of staff sharing their experiences of working at WHH, aligned to the themes that are in the national NHS People Plan:

- *We are compassionate and inclusive*
- *We are recognised and rewarded*
- *We each have a voice that counts*
- *We are safe and healthy*
- *We are always learning*
- *We work flexibly*
- *We are a team*
- *Morale*
- *Staff engagement*

We clearly still have much work to do, although we have scored better than other Acute Trusts nationally in relation to 5 out of the 9 themes; the same as the national Acute Trust average score in 3 themes; and are worse than the Acute Trust average nationally in one.

The organisation's below average score relates to the "*we are always learning*" theme, focusing on the level of support staff are receiving to further develop and how their role contributes to the developments in patient, care, service development or innovations.

The results of the staff survey have been disseminated Trust-wide and following publication, a range of clinics have been set up for Care Groups with the Staff Engagement and Business Partnering team to analyse team results and identify three key priorities which will be reported through the Operational People Committee.

There is also an organisational review of the results being undertaken. I will be leading a review with senior leaders at this year's Start of the Year Conference in May, with the aim to develop several organisation-wide actions.

2.4 Paediatric Audiology

In 2021 the British Academy of Audiology published an independent review into the paediatric audiology service at NHS Lothian in Scotland. The review found systemic failings which led to some babies and children being undiagnosed or significantly delayed in diagnosis and appropriate treatment for their hearing issues.

Following this, NHS England conducted an audit of paediatric audiology services in England to see whether the diagnostic testing carried out identified an appropriate number of babies

with hearing problems. This has identified potential issues with the specialist hearing testing undertaken at a number of Trusts across the country, including WHH. It is important to note that we are talking about specialist hearing tests carried out in a relatively small percentage of babies, not the routine hearing screening test undertaken in all new-borns.

As expected, we are taking this seriously. We have set up an incident response group, chaired by the NHS Cheshire and Merseyside Integrated Care Board, and we have temporarily suspended our specialist hearing testing (auditory brainstem response testing, to be precise).

We are working with an accredited NHS partner organisation who are supporting us by providing interim testing, undertaking a multidisciplinary team review of each case, and providing training to our audiology staff. We plan to recall patients for further testing where required and restart testing more widely as soon as possible.

It goes without saying that our priority is the care of our patients. We have written to all families affected, providing contact details for them to get in touch if they have any concerns at all about their child's hearing. We are working at pace to have all the reviews complete by the end of April.

This has been a really challenging time for the audiology team. Their first thoughts have not been for themselves, but for their patients. The team really live the WHH values; from the time the incident came to light they have galvanised themselves to support the incident response positively and proactively. They have worked tirelessly with the incident response team to ensure that patients and families are able to be provided with the correct information about the testing they have received. And they have ensured that they move forward in a positive way, embracing change with great relish. It is a privilege to see how kind and passionate they are about their patients and the service.

The incident response has needed support from a wide number of people and teams across WHH who have risen to the challenge to support patients, the audiology team and wider CBU team. There is a lot of work to do, and together we will ensure our services continue to provide safe and effective care for our patients.

2.5 BMA Industrial Action

Since our last Trust Board meeting, the British Medical Association announced that junior doctors would take industrial action across the NHS for a period of 72 hours. Our junior doctor colleagues at Warrington and Halton Teaching Hospitals took strike action from 0659 on Monday 13th March, finishing at 0700 Thursday 16th March. There were no derogations in place (negotiated exemptions for certain activities).

Throughout the strike period our patients and essential services were managed by our Consultant and SAS (Staff Grade, Specialist and Associate Specialist) doctors, working alongside the other professions. Planning was underway since the announcement of industrial action.

Detailed plans were prepared and delivered by the Care Groups to ensure that we could continue to deliver effective care and keep our patients safe through the strike. These included:

- Asking consultants to alter the way that they work to support safe care and ensuring continuity of essential services and ward cover.
- Putting on additional training to ensure our Consultants and SAS doctors are familiar with tasks they might not usually undertake.
- Seeking support from other professional groups such as our advanced clinical practitioners and physician associate workforce.
- Reviewing the elective programme to ensure that those most in need of urgent elective care continue to receive it.

Any patient safety issues were escalated to the 24/7 Trust Control Room, although fortunately nothing extraordinary was reported.

I put on record my thanks and gratitude to colleagues for their hard work and commitment to delivering safe care whilst managing the impact of industrial action. Patients were kept safe with good cover on the wards and effective handover processes between shifts, with our tactical checkpoints helping us to flag and manage any issues and risks as they arose.

It was also heartening to witness the care and consideration that colleagues have shown for one another over the period while so many of our working practices have been disrupted. This compassion, camaraderie and professionalism has undoubtably benefitted both staff and patients in enabling us to maintain an environment which keeps our patients safe, and our colleagues supported.

2.6 WHH Thank You Awards 2022/23

On Friday 17th March 2023, just over 300 staff, volunteers and sponsors attended the Concorde Conference Centre as we celebrated our Thank You Awards this year. A total of 13 awards were handed out during the evening under the wings of British Airways' most famous aircraft.

The awards have not been held in person since 2019 – pre-COVID pandemic – making it an extra special occasion for the Trust and for all who attended the event, hosted superbly by Smooth Radio presenter, Jo Lloyd.

It is the first time since launching these awards back in 2009 that we've held them out of town. It was, admittedly, something of a risk leaving our own boroughs and asking people to travel, but the overwhelmingly positive feedback we've had since indicates that it was the correct decision. We have put a marker down for ever bigger, more glittering and ever more inclusive events, indicative of our confidence and ambition as an organisation.

I would like to say thank you to everyone involved – to those who took the time to send in a nomination right at the very start of this process, to our WHH individuals and teams who were shortlisted for an award and became our 2022-23 cohort of finalists and winners; to our sponsors for making the event possible, and our WHH Awards organising committee and

communications team who worked so hard to make it a night to remember. Our full list of winners is below:

- Star of the Future – Theo Roberts, Medical Engineering Department
- Team Care & Support – Clinical Education Team
- Inclusion Advocate – Nisha Agarwal, Therapies Team
- Innovation & Quality Improvement – Research and Development Team
- Leadership Award – David Gallagher, Ward K25
- Supporting Excellence Award – Catering Team
- Excellence in Patient Care Award – Emergency Department/SDEC Team
- Volunteer of the Year – Wayfinder Volunteers
- Student/Trainee of the Year - Dr Haran Selvachandran (Surgery)
- Patients' Choice Award – Endoscopy Team
- You Made a Difference Award – Tom Owens (Security)
- Special Recognition Award – Cath Jones (Warrington Borough Council)
- Outstanding Contribution Award – Mark Jones (Radiology)

I am also delighted to announce that a record total of £2,005 was raised on the night for Warrington and Halton Teaching Hospitals Charity, thanks to a superb raffle with some brilliant prizes.

2.7 Medical Education

The General Medical Council (GMC) has removed Medical Education at WHH from its enhanced monitoring program. This is a fantastic recognition of the improvement in the quality of Medical Education delivery and the huge amount of improvement work which has been undertaken in Medical Education at WHH over the last few years.

Following deteriorating National Training Survey results and medical trainee concerns expressed during Deanery quality visits, Medical Education at WHH was placed into GMC enhanced monitoring in 2015. This affected our reputation as an educator, and Medical Education at WHH was put under additional scrutiny with extra quality visits and assessments from Health Education England and the GMC.

We developed and delivered an extensive improvement plan, invested in additional Educational Supervisors for doctors, and improved our educational governance and approach to managing issues trainees tell us about. This approach has delivered real benefits for trainees and patients, and we have seen progressive improvement in National Training Survey results and quality visit outcomes.

Following these, in late February the GMC removed WHH from its enhanced monitoring program. It gives us assurance around improvements in the quality of medical education and care delivered at WHH and is an important milestone towards University Teaching Hospital status. Delivering a good education experience to our trainees is vital for recruitment and retention of medics – trainees who have a great experience at WHH often come back to us as consultants and we are already seeing a positive impact on consultant recruitment.

I would like to congratulate every member of medical staff, and every member of the Medical Education team under the leadership of Dr Paul Fitzsimmons, Executive Medical Director, who has contributed to medical education while we have been in enhanced monitoring. Their commitment and the hard work that has gone in over a period of years has delivered this fantastic result.

2.8 Echocardiography Accreditation

In February we received news that we have been successful in gaining British Society of Echocardiography Accreditation in Transthoracic (TTE), Transoesophageal (TOE), Stress echo (SE) and Echocardiography training. We are the only cardiology department in Cheshire to have achieved this, and the third in Cheshire and Merseyside, alongside the specialist centres of Liverpool University Hospitals and Liverpool Heart and Chest Hospital.

The accreditation is awarded to departments who meet five key standards and some of the things they review within these standards are: leadership, equipment, estate, timeliness of reporting, appointment slot times, number of examinations performed, indications and protocols for examinations as well as patient information.

Accreditation schemes like this one, and the ones we have for services like endoscopy, pathology and, most recently, anaesthetics and theatres, provide a great deal of assurance about our quality standards and our journey to providing consistently outstanding care.

2.9 Special Days/Weeks for professional groups

Since our last Board meeting in January 2023, a number of topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. WHH has recognised, embraced and celebrated all of these:

LGBT+ History Month: February 2023
Apprenticeship Week: 6th – 10th February 2023
Race Equality Week: 6th – 12th February 2023
International Women's Day: 8th March 2023
National No Smoking Day: 8th March 2023
Nutrition and Hydration Week: 13th - 19th March 2023
Healthcare Science Week: 13th - 19th March 2023
Moisture Associated Skin Damage Awareness Day: 16th March 2023

2.10 Local political leadership engagement

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

2.11 Employee Recognition

Our *You Made a Difference Awards* is now into its second year of operation. Nominations are reviewed and awards are made by a multi-professional panel.

You Made a Difference Award (December 2022): Edna Ashton

Edna Ashton, Volunteer (Cantreat Delamere Centre, Halton Hospital) was given this award in recognition of the excellent support and care provided to patients. She was nominated by a member of staff who said: "*Edna supported me during cancer treatment and has been a long-standing volunteer. This year she is self-funding and making items for the current cohort of cancer patients receiving active treatment, which is a lovely gesture and really does make a difference. I also benefitted from some therapy from Edna, she goes above and beyond, and has a sound understanding, she is emotionally intelligent*".

You Made a Difference Award (January 2023): Jane Breeze

Jane Breeze, WHH Charity Administrator, was nominated for a *You Made a Difference Award* following an incident where her kind actions helped the relatives and loved ones of a patient in the Intensive Care Unit. Jane went above and beyond on her day off to collect and drop off a 'Heartbeat Recording Bear' to our Intensive Care Unit. Her actions made a massive difference for the family of a patient who was sadly at the end of life; by doing this she enabled them to receive a recording of their loved one's heartbeat; this is something which will be treasured by them and will help them during their grieving.

You Made a Difference Award (February 2023): Refugee Midwifery Team

Leanne Lawrenson, Sarah Aley and Paula Marsh, Midwives (Women's & Children's Health) were given this award in recognition of the excellent support and care provided to newly arrived refugees in Warrington, hard work and dedication to the women arriving at Fir Grove Hotel in November of last year. At extremely short notice, they began planning, with interpretation services, the immediate next steps. Considering the vulnerability of the women and pregnancy gestation, they were all very keen to provide midwifery care as a matter of urgency. They identified four pregnant women and commenced the assessment, review and booking of the ladies, completing all the notes, scans requests, onward referrals and all appropriate emergency contact numbers/details provided to the women. No prior antenatal care had been provided to the women who were all over 27 weeks gestation.

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

Chief Executive Award (December 2022): Finance Team

I was very pleased to present to present this award to our Finance Team to acknowledge their commitment and hard work in support of front-line clinical teams. They have assisted us stay on our financial plan this year, and more recently managed our year-end position and accounts at the same time as another complex planning round for next year. They do this as well as driving improvement within themselves as individuals and the team as a whole. They are a group of truly committed, diligent and helpful individuals who work hard as a team to support colleagues.

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

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

- Ms Frances Oldfield, Consultant Surgeon - Digestive Diseases
- Clara Dennis, Cancer Nurse Specialist - Digestive Diseases
- Natalie Starkey, Senior Midwife - Women's & Children's Health
- Glenna Smith, CBU Manager - Digestive Diseases
- Cecilia Critchley, Senior Biomedical Scientist - Clinical Support Services
- Dr Chew Tan, Consultant Gastroenterologist - Digestive Diseases
- Mr Ayman Abdelrazeq, Consultant Surgeon - Digestive Diseases
- Barbara Lyons, Bereavement Officer - Clinical Governance
- Louise Dyer, Complaints Resolution Officer - Clinical Governance
- Gary Siddall, Medical Devices Safety Officer - Corporate Nursing
- Christine McErlaine, Healthcare Assistant (ICU) - Medical Care
- Sheila Fields-Delaney, CBU Manager - Urgent & Emergency Care
- Lesley O'Hara & TeamNurse Manager, Ophthalmology - Surgical Specialities
- James Parker, Deputy Chief Pharmacist - Clinical Support Services
- Deborah Carter, Patient Safety Project Director - Corporate Nursing
- Dr Karthik Vee, FY3 Doctor (Ward K25) - Integrated Medicine & Community
- Mr Stephen Porter, Hospital Dental Practitioner - Surgical Specialities
- Jacqueline Whittaker, Domestic Assistant - Estates and Facilities
- Maria Leicester, Domestic Assistant - Estates and Facilities
- Russell Cottier, Biomedical Consultant - Clinical Support Services
- John Goodenough, Deputy Chief Nurse - Corporate Nursing
- Ray Haskayne, Security Officer – Estates and Facilities
- Diane Floyd, Senior Physiotherapy Assistant - Clinical Support Services
- Carol Burgess, Healthcare Assistant (PIU) - Digestive Diseases
- Pamela Carter, Ward Sister (Ward A5 Gastro) - Digestive Diseases
- Christine Jonkers, Specialist Radiographer - Clinical Support Services
- Rebecca Thomson, Financial Accounts Assistant - Finance & Procurement
- Theo Roberts, Medical Engineering Assistant - Estates and Facilities
- Sian Warburton, Administration Assistant - HR/OD
- Angela Roberts, Lead Nurse - Occupational Health
- Alison Critchley, Finance Officer - Finance & Procurement
- Clinical Education Team, Corporate Nursing
- Nisha Agarwal, AHP Workforce Lead - Clinical Support Services
- Jeanette Jones, Chair - Staff Disability Awareness Network
- Adam Grindley, Vice Chair - Staff Disability Awareness Network
- Gemma Leach, Head of Workforce Systems & Intelligence
- MRI Team, Radiology - Clinical Support Services
- Research & Development Team, Quality Academy - Corporate Nursing
- Neonatal Unit Neonatal Unit, Paediatrics - Women's & Children's Health
- Ward B11 Team, Paediatrics - Women's & Children's Health
- Emergency Department/SDEC Team, Urgent & Emergency Care
- Carolyn Hart, Assistant Accountant - Finance & Procurement

- Acute Care Team, Medical Care
- Catering Team, Estates and Facilities
- Safeguarding Team, Corporate Nursing
- Dave Gallagher, Ward Manager (Ward K25/A10) - Integrated Medicine & Community
- Sonia MacDiarmid, Head Orthoptist - Surgical Specialities
- Lisa Horne, Senior Physiotherapist (MSK/CATS) - Surgical Specialities
- Carole Baker, WHH Charity Volunteer
- Discharge Lounge Volunteers
- Wayfinder Volunteers
- Franz Arnedo, Physician Associate (Emergency Medicine) - Urgent & Emergency Care
- Dr Haran Selvachandran, Core Surgical Trainee - Digestive Diseases
- Katie Toole, Assistant Practitioner (Occupational Therapy) - Clinical Support Services
- Halton Urgent Treatment Centre Team, Urgent & Emergency Care
- Endoscopy Team, Digestive Diseases
- CSTM Orthopaedic Team, Surgical Specialities
- Tom Owens, Car Park & Security Attendant - Estates and Facilities
- Amy Pearson, Healthcare Assistant (Ward B19) - Integrated Medicine & Community
- Carole Daly, Sister (Paediatrics) - Women's & Children's Health

2.12 Signed under Seal

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

- Lease for Warrington Town Deal Living Well Hub
- Underlease for part of Bath Street Health & Wellbeing Centre

3) MEETINGS ATTENDED/ATTENDING

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

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

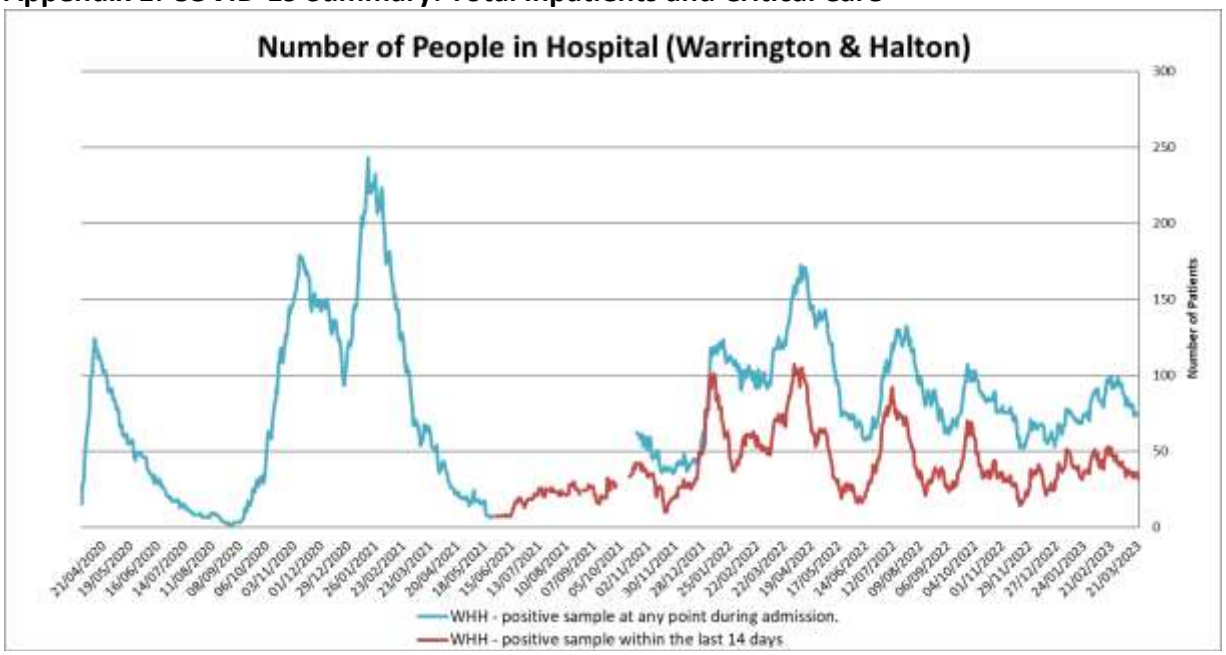
4) RECOMMENDATIONS

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

5) APPENDICES

Appendix 1: COVID-19 Summary: total inpatients and critical care
Appendix 2: CEO Dashboard – Month 11 (February 2023)

Appendix 1: COVID-19 Summary: Total inpatients and Critical Care



Appendix 1 - CEO Dashboard Month 11 – February 2023

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	99.00%	78.46%	F
RTT 18 Weeks	92.00%	57.54%	F
RTT 104 Weeks +	0	1	F
A&E % patients seen within 4 hours	95.00%	65.13%	F
A&E % waiting longer than 12 hours	< 2.00%	19.91%	No SPC
Cancer 14 Days	93.00%	83.60%	F
Breast Symptomatic 14 days	93.00%	89.66%	?
Cancer 28 Day Faster Diagnostic Standard	75.00%	63.95%	?
Cancer 62 Days Urgent	85.00%	57.29%	F
Ambulance Handovers within 60 mins	100%	75.02%	F
Discharge Summaries 24 hours	95.00%	87.85%	F
Cancelled Operations – 28 days	0	N/A	No SPC
Fracture Clinic – 72 Hours	95.00%	8.16%	F
% Outpatient Appointments Delivered Remotely	25.00%	11.34%	F
Super Stranded Patients	Trajectory	145	No SPC

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	0	P
Sepsis Screening Emergency	90.00%	86.00%	F
Sepsis Screening Inpatients	90.00%	88.00%	F
Sepsis Antibiotics Emergency	90.00%	78.00%	F
Sepsis Antibiotics Impatient	90.00%	80.00%	F
Inpatient Falls (cumulative)	20.00% reduction	46	No SPC
VTE	95.00%	95.58%	?
Pressure Ulcers (cumulative)	10.00% reduction	10	No SPC
Medication Reconciliation (24 hrs)	80.00%	43.00%	F
Complaints over 6 months	0	0	P
Continuity of Carer	51.00%	82.20%	P
Healthcare Infections - MRSA	N/A	3 (20 YTD)	?
Healthcare Infections – CDI (cumulative)	Less than 37	3 (52 YTD)	No SPC
Healthcare Infections - E. coli (cumulative)	Less than 57	4 (62 YTD)	No SPC
Healthcare Infections – Klebsiella (cumulative)	Less than 19	1 (22 YTD)	No SPC
Healthcare Infections - P. aeruginosa (cumulative)	Less than 6	0 (2 YTD)	No SPC

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.60%	F
Welcome Back Conversations	85.00%	72.54%	?
Vacancy Rates	9.00% or less	11.53%	F
Retention	85.00%	83.36%	F
Core/Mandatory Training	85.00%	86.11%	P
Role Based Training	85.00%	84.21%	P
Pay spend (month)	Budget (£19m)	£19.5m	?
PDR Compliance	79.00%	64.24%	?

Sustainability

Finance

Indicator	Plan	Actual	SPC
Income & Expenditure (culm)	-£6.83m	-£5.61m	?
Capital Spend	£15.40m	£9.30m	?
Cash	£23.60m	£33.90m	P
Better Practice Payment Code (culm)	95.00%	92.00%	F
CIP In Year Delivered (culm)	£2.10m	£2.10m	No SPC
CIP Forecast (Recurrent)	£5.60m	£1.90m	No SPC

Strategy

Strategy

- **Trust Strategy Refresh** - Following opportunities to input into the planned refresh of the Trust Strategy over the last 6 months, a final draft of the strategy has been produced and incorporates feedback from Committees to the Board, the Council of Governors, staff and wider stakeholders and partners.
- **Halton Health Hub** – The Halton Health Hub was formally opened on Friday 3rd February by Weaver Vale MP Mike Amesbury. The opening was well attended by Trust staff and governors, and other local leaders, including the Chief Executive of Halton Borough Council and the Director of Public Health.
- **Community Diagnostic Centre (CDC)** – Work has now commenced on the space in the Nightingale building on the Halton site to create the first phase of our new CDC. Design work is also almost complete for the second phase over in the new Halton Health Hub located in Runcorn Shopping City.
- **Breast relocation** - Building works to enable the remaining Breast services from Kendrick Wing to transfer to Bath Street will conclude this month. The service is scheduled to be fully operational from the refurbish location in May 2023.
- **Acute Collaboration with STHK**– work continues to develop a shared ENT on-call rota with STHK. A key enabler is joint recruitment into several vacant consultant posts. The roles will go to advert in March 2023.

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

January 2023

ICB Update

NHS Cheshire and Merseyside's first Board meeting of 2023 was held at the Floral Pavilion in New Brighton, Wirral on Thursday, January 26th.

At the meeting Graham Urwin reflected on a difficult Christmas period for the local NHS, exacerbated by the double impact of COVID-19 and flu. He reported that, in early January 2023, a number of acute hospitals across Cheshire and Merseyside were at OPEL 4 – the highest level of escalation – meaning both the quality of many local NHS services and the access to them was compromised. Too many people were being cared for in hospital corridors. With hundreds of people who are medically-fit for discharge still remaining in hospital, intensive work to improve flow is ongoing. This work has, however, already supported an easing of pressure in recent weeks.

On NHS industrial action, Graham singled out action on February 6th, 2023, as likely to have a significant impact on the delivery of health services locally. For the first time, nurses and ambulance service staff will be taking action on the same day, with more organisations in Cheshire and Merseyside taking strike action on February 6th than in any other region of England.

Liverpool Place Director Jan Ledward presented the key findings of a Carnall Farrar report following a recent Liverpool Clinical Services Review. The Board noted the contents of the report and recognised the need to move forward with the next phase of the work to help establish where improvements could be made with the support of an independent clinical advisor. A commitment was also made to respond to all related questions from the public in a timely way and to publish both the questions and the responses via the NHS Cheshire and Merseyside website.

An interim Cheshire and Merseyside Health and Care Partnership Strategy was supported, especially the emphasis on prevention and reducing health inequalities, with a related two-year operational plan now in development following the publication of national planning guidance.

Assistant Chief Executive Clare Watson also presented an update around public engagement and involvement, noting that a developing Citizens' Panel across Cheshire and Merseyside has already recruited more than 600 people.

CMAST Update

CMAST Leadership Board met on 3 February. Per its standing commitment to, at least quarterly, engage with Trust Chairs, this was a broader meeting and was used to review and reflect on the vision and priorities of CMAST and its programme delivery through 2022/3. The meeting also included a look forward to projected milestones and activities in 2023/4.

The headline summary from each programme was as follows:

Elective Recovery Programme

2022/3 delivery headlines

- Zero-breach position for 104 week waits by July 2022
- Reduced 78 week waits by over 25,000 in the last 19 weeks
- Upper quartile performance theatre utilisation
- Over 19,000 additional treatments through efficiency improvement.
- Established and supported clinical improvement networks for 8 key challenged specialties
- We have secured over £76m capital funding for elective recovery for the system and over £1m other revenue sources – delivering additional elective capacity for C&M wide use
- Supported the design and build of Clatterbridge Elective Hub

Anticipated 2023/4 delivery milestones

- Wating List Management
  - System-level focus on elimination of 78 week waits by March 2023 and reducing 52 week waits over the course of the year
  - Continued validation and risk stratification and harm reviews for waiting lists
  - Waiting well initiatives providing support for patients waiting
  - Multiple initiatives to aid the reduction of outpatient waiting lists

- System Resources
  - Establishing elective hubs as shared resources for system use
  - Mutual aid facilitation for challenged specialties
  - Separating elective and emergency care to ring fence elective surgery
  - Moving towards a system-level PTL where appropriate to support equity of care
  - Maximising independent sector opportunities

- Reducing variation
  - Aiming to achieve top decile performance for all trusts across clinical and administrative indicators
  - Workforce transformation initiatives for elective care
  - Implementing GIRFT and best practice pathways
  - Sharing and promoting best practice across C&M and tailoring for individual Trusts efficiency

Clinical Pathways Programme

2022/3 delivery headlines

- Established formal governance structure, including NED sponsors & links across ICB
- Established clinical leads for specialties
- Review of Orthopaedics Service, 2 workshops and report
- Agreed cold site surgery principles and roadmap with clinical consensus

- Established Orthopaedic Alliance
- Commenced review of ENT and Dermatology services, engagement with clinical and operational teams for the services
- Established ENT and Dermatology clinical networks
- Facilitation of GIRFT reviews and action plans

Anticipated 2023/4 delivery milestones
- Progress established model of work in dermatology and ENT
- Identify any future areas or system initiatives benefiting from attention and/or CMAST alignment

Diagnostics Programme

2022/3 delivery headlines:
- £112m investment secured
- 105,000 tests per month (18% growth in year)
- Improved waiting times for patients - 79% now seen in 6 weeks, improvement from 75%
- Improved performance diagnostic ICB ranking position from 20th to 11th
- Delivery of multiple CDCs
- Overarching programme for all diagnostics including establishing system oversight and reporting

Anticipated 2023/4 delivery milestones:
- Reduce waiting times across all specialities
- Increase productivity – targeting imaging and pathology
- Improved turnaround times – processing and reporting – targeting imaging and pathology
- Deploying digital investment to increase collaboration
- System wide transformation - Future Pathology needs assessment for the ICS
- Vanguard for AI deployment across diagnostics
- Deploy collaborative staff bank
- Whole system view and utilisation – beyond acutes

Workforce Programme

2022/3 delivery headlines - Established work programme to:
- Reduce competition between Trusts to attract and retain staff
- Have a consistent C&M offer for certain staff groups i.e., midwifery
- Attract and retain staff within Cheshire and Merseyside

Anticipated 2023/4 delivery milestones will support delivery of objectives by:
- Working towards a single staff contract to support movement of staff across the system supporting mutual aid and resource placement with greatest need
- Developing an evidence base to support intelligence led action on - staff recruitment, retention and market development
- Developing consistent workforce approaches / responses for staffing and employment issues
- Connecting with universities, local authorities, AHSN and wider agencies to develop whole system approach to education, recruitment and routes to employment
- Using digital and systems requirements to support development and implementation of consistent evidence based clinical practices, expectations across organisations to support movement of staff / increase productivity.

Finance Efficiency and Value Programme

2022/3 delivery headlines

- Delivery of an agreed financial plan and control totals at organisation and ICB level.
- MDT peer reviews of underlying financial issues and drives of the deficit.
- Development of a suite of financial reports incorporating I&E, exception reports, capital, cash and agency spend at organisational and aggregate levels.
- Productions of deep dive productivity and efficiency data shared at the December workshop and for Boards to review to target opportunities.
- Membership of the ICB specialised services commissioning steering group advising on provider input to delegation pace through the PDAF process.
- Established Efficiency at Scale work programme with initial focus on medicines optimisation, workforce (collaborative bank), financial systems and procurement

Anticipated 2023/4 delivery milestones include key system delivery and contribution to:

- Financial Strategy
- Funding flows
- Governance and risk
- Assurance and regulation
- Delivery of efficiency at scale work programme and expanded scope

Recognising C&M Cancer Alliance's (CMCA) accountability to NHSE, the Board also received an update on 2022/3 deliverables and future plans in line with CMAST programmes recognising the absolute interconnectivity of this programme and the alignment of priorities across member organisations and with elective recovery, pathways and diagnostics in particular.

2022/3 delivery headlines:

- Activity: 3000 additional patients seen pcm
- PSFU: 41 PSFU protocols now live releasing 100k outpatient appointments
- FIT: investment in 83k kits reducing colonoscopy by 60%
- Prehabilitation: 5% reduction in length of stay 50% reduction in complications, 8% reduction in 30 day admissions
- Cancer Faster Diagnosis standard - 21 best practice timed pathways fully established. C&M Cancer Alliance currently top performing Alliance in England
- Targeted lung health checks - 80,000 invited since starting in July 2021. 73% cancers found are stage 1 or 2. Fastest roll-out in England.
- Education and patient experience: 500 learners registered in CMCA Cancer Academy, 10 community outreach roadshows and patient representatives recruited
- NHS Galleri – largest cancer screening trial. CMCA is highest recruiter 22k C&M places
- Innovation – Europac Plus – Risk stratification at risk pancreatic patients

Anticipated 2023/4 delivery milestones:

- Continue to reduce the number of patients waiting over 62 days
- Meet the cancer faster diagnosis standard by March 2024, so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028,
- Follow through pre-existing initiatives. Embed / Extend / Accelerate / Innovate
- Additional targeted investment and support to trusts with most challenged performance
- Eliminate colonoscopy waits above 14 days for suspected cancer patients. Target 7 days from request.

- Targeted lung health checks, roll out to three more places in 2023/24. 100% coverage in 2024/5.
- Develop and test improved cancer pathways for people with dementia
- Focus on high-risk patients – Lynch syndrome, BRCA, liver surveillance
- Primary care / community cancer pathways

The Board received an update on the ICB led Joint Forward Plan. A document that the ICB is required to deliver and which provides an NHS delivery framework to realise the ambition of the ICP strategy. The Board received a proposal for the C&M collaboratives to consider a draft of the plan by the end of March aligned to when NHSE will require an initial submission. Opportunity for system and partner engagement, including Trust Boards, would be possible from April through June.

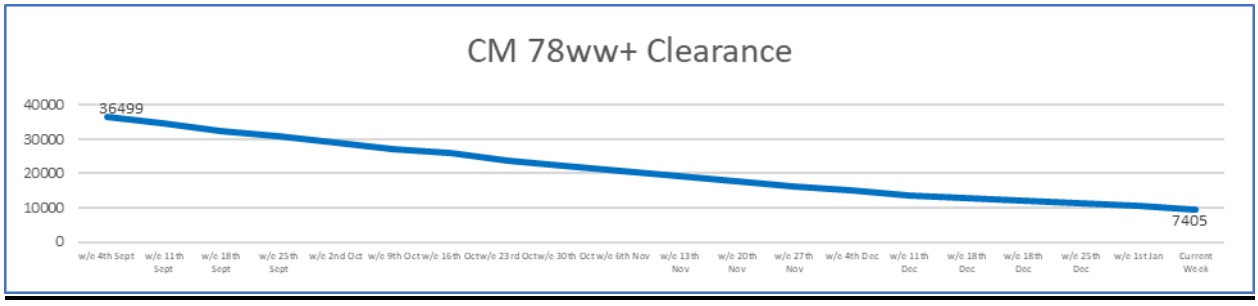
Prior to the planned business of the meeting being considered the Board used the meeting to consider recent ICB discussions in response to the conclusion of the Liverpool Clinical Services Review. The Board recognised the need to make progress on the issues and evidence found within the report but also the importance of aligning these activities with existing work programmes across the ICS, including CMAST, and the need to ensure that health inequalities and access across C&M were actively considered.

The meeting also received for information the now standard system performance and finance reports. The meeting also received its first summary quality report. It has been agreed that to ensure a quality update is additive and supplements existing trust activity that the report will cover the business of the ICB's Quality Surveillance Group.

Elective Recovery and Transformation Programme

Waiting times update

Trusts continue to focus on clearing the long waiting patients in order to deliver the key target of zero people waiting over 78 weeks by end of March 2023. Over the last 20 weeks the system have cleared nearly 30,000 patients in this long wait cohort. The total number of patients to clear by March is now at a low of 7405 and a key focus this week is to get as many of these patients booked in as possible. The elective recovery programme team are working hard to support trusts with mutual aid, independent sector support and operational management input where needed.



Outpatients

The outpatient improvement team have been successful in securing funding to undertake a key project to deliver digital text validation to the longest waiting patients across trusts in C&M. This project will help to remove people no longer needing to be seen, prioritise those whose condition has deteriorated and identify patients who are suitable for mutual aid. Benefits will include a

reduction in the waiting lists and improved patient experience.

The system has been closely involved in the most recent national initiatives under the 'Action on Outpatients' programme. Stakeholders have benefited from a series of webinars around Referral Optimisation as well as focused analysis and engagement around reduction of patients who do not attend (DNAs). This work is being complemented by system level projects to support delivery at trust level including a dashboard which will reflect waiting list data and tracking key interventions and metrics.

Theatre utilisation

The theatre utilisation programme continues, and each month an "opportunity pack" is produced to show where there are specialty-level opportunities to increase throughput focused on targeted interventions on theatre planning and operational logistics, booking and scheduling, staffing availability and planning or vacancies.

The Cheshire Elective Surgical Hub

Contractors are on site to deliver the new surgical hub facility on the Victoria Infirmary site. The clinical pathway planning is underway for ophthalmology, urology, ENT and general surgery.

For ophthalmology it has been agreed to create a dedicated hub waiting list for cataract patients at point of referral. This will be shared between all participating providers, meaning the end to end pathway will be hosted through the hub and a true hub service can be offered with equity of access for all patients in the region.

A robust governance structure to deliver the hub over next 12-15 months is now in place, with system and trust representatives from each organisation supporting key enabling work streams.

Paediatric dental hub

Funding has been secured to establish a pilot paediatric dental hub to treat the low complexity patients requiring dental surgery. We currently have over 600 patients who've been waiting over 52 weeks from 11 organisations that provide paediatric dental surgery across C&M.

Proposed hub session sites will be Bridgewater and Whiston, with a possible opportunity for a Countess of Chester hub serving Chester patients. Representatives from across the C&M geography have formed a Paediatric Elective Recovery Group to work on the clinical pathway for these patients and agree the logistical arrangements.

Clinical Pathways

ENT

- Engagement meetings have been held with trust medical, nursing, operational leads, commissioners, and other key stakeholders to gather insight into the current state assessment for ENT services across C&M. The ENT network has been re-energised and have held 2 well attended, successful sessions.

- Teams are enthusiastic to move forward with identifying areas for improvement. Due to winter non-elective pressures and industrial action, we postponed the first workshop planned for January and have instead sent the intelligence pack via remote engagement

with a plan to move forward on solution focussed improvement at the revised workshop planned for 28th February.

Dermatology

- Engagement meetings have been held with stakeholders from all known acute, intermediate and community providers, commissioners, and place leads. The insights gained are being used to complete the first draft of the current state intelligence pack.

- Clinical network meetings have taken place with growing representation from acute, community and commissioning colleagues to provide collaborative clinical, operational, and quality focused speciality discussion. The first workshop is planned to take place on 15th February bringing stakeholders together to gain consensus on the current challenges facing the speciality across C&M, agree what good looks like and establish principles we will adhere to going forward.

Orthopaedics

The orthopaedics team are working on the implementation phase of the work, building on the principles that were agreed by the Orthopaedics Alliance, which were:

- Each trust should already be working to achieve the “Getting It Right First Time” (GIRFT) standards. This will be monitored through the national GIRFT gateway review process with ownership and support from the C&M Orthopaedic Alliance. This includes 85% utilisation (as minimum), and upper quartile performance for day case rates, and length of stay.

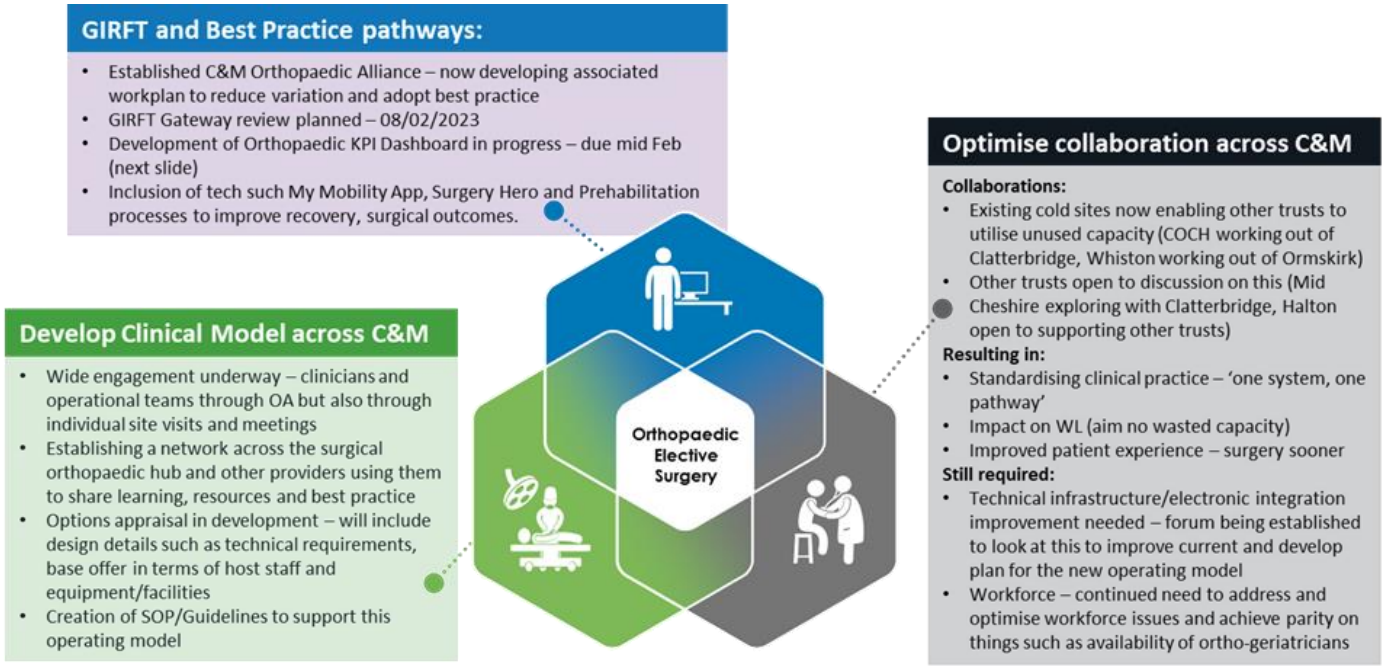
- Each trust should have access to a dedicated elective cold site (without a co-located Type 1 Emergency Department) for elective orthopaedics with ring-fenced staff and beds (for all but the most extraordinary circumstances; 365 days a year).

- Trusts that do not have a dedicated elective cold site (without a co-located Type 1 Emergency Department) should be given access from those trusts that do through a buddying up system (multiple such relationships could exist to facilitate); no theatre session for elective orthopaedics should ever be ‘wasted’ by the system.

- Each cold site should be working to maximise throughput including the number of sessions (e.g. from 2 to 3 per day) or number of days services are running (e.g. from 5 days to 6 or 7 days).

- Guidance to support cold site utilisation such as no pooled patients (unless by consent) i.e. the patient follows the clinician, all clinic appointments should be as close as possible to the patient, clinicians agree to locations they are working from, IT support required to allow for maximum flexibility of staffing working across locations.

These key principles form the basis of the recommendations and roadmap that have been developed for the C&M orthopaedic services. There are now three key areas of focus for the orthopaedics team as shown below:



Other specialties

In order to ensure no duplication, and that we understand and manage any interdependencies we have agreed that we will have an oversight of other transformation work within other key specialties including cardiology, gynae and paediatrics. These groups have been invited to join our leadership team meeting for updates on a regular basis to enable alignment where needed, and offer support.

Diagnostics Programme

C&M CDCs

- C&M CDCs are delivering 140,000 tests per year. We are providing the highest levels of CDC activity in the Northwest and the 4th highest level (last month was 5th) out of 42 ICS regions. We now have 9 CDCs authorised. 6 are open with Southport having opened in month. Runcorn Shopping Centre, Halton & Liverpool Paddington due to open before 1 April 2023.

November Performance Headlines

- C&M ICS has maintained its ranked position of 11th out of 42 ICSs for diagnostic waiting time performance. This is an improvement from the ranking of 20th in November 2021.
- The highest level of activity (since C&M diagnostic performance reporting began) was recorded in month with 105,981 tests completed.
- The total number of patients waiting for a test has remained static at just over 70,000 patients.
- In CT and Colonoscopy, we are delivering significantly more activity (in excess of 110%) than we were before the pandemic.
- The waiting time standard of 95% of patients receiving their test with 6 weeks was hit for MRI scans.

- For the first month ever, (since C&M diagnostic performance reporting began) the number of patients waiting 13 weeks+ has dropped below 5000. 4790 patients (6.6% of the waiting list) have waited 13 weeks or longer.

- A third (1636 patients) of the over 13 week+ waiting list is made up of patients waiting for an endoscopy at LUHFT. Key discussions have taken place with the trust to support improvement.

Performance Improvement Plans

- NHSEI have asked all ICSs to submit plans to increasing diagnostic activity with particular focus on the month of March, resulting in an improvement in the percentage of patients seen within 6 weeks. C&M has submitted a plan with the aim that no patient waits longer than 52 weeks by the end of March 2023. All Trusts are asked to scrutinise diagnostic waiting time performance to ensure than plans are place for any patient falling into this wait banding.

NHSEI Priorities & Operational Planning Guidance

- We are working up a system level return to outline how we will meet the key asks for diagnostics which include:
    - Increase the number of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%.
    - Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic wait time ambition.
    - Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs.
    - Deliver 10% productivity improvement in pathology and imaging by 2024/25 through digital investments and meeting optimal test throughput rates.
    - Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24.

Diagnostic Data

- The C&M Diagnostics Programme currently does not have access to referral data. This information would allow us to review referral and access rates and to more accurately plan capacity to meet demand. A proposal was taken to the C&M Data Leads Meeting to obtain this information from acute and specialist trusts in the first instance. The proposal was supported and it is anticipated that this data will be available from Q3 in 20-23/24.

- We have data flows from acute/specialist trusts covering activity levels and waiting times/numbers. We do not have data flows for tests provided in primary care, community, mental health or independent sector settings, this prevents us from understanding all issues and opportunities and connecting different parts of the health system together. To fill this void, a piece of work has begun to survey all sections of the system so that we can implement standardised symptom based pathways and ensure that access within each place fits with this plan. Sponsorship by Trust leadership is essential to making this opportunity a reality.

Urgent and Emergency Care – Gold Command

- The urgent and emergency care system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside. In addition, there have been several days of industrial action impacting NWAS and a number of C&M Trusts during December and January

- As winter pressures continued to build over the course of December, a number of Trusts across C&M declared the highest level of escalation, OPEL 4, with in total 15 separate declarations of OPEL 4 during December/early January.

- North West Ambulance Service (NWAS) was consistently reporting at Resource Escalation Action Plan (REAP) Level 4, its highest escalation, and in addition declared critical incidents on a number of occasions over the same period, primarily due to the high numbers of ambulance handover delays and the consequent impact on response times.

- These pressures peaked in the period from the last week of December into the first week of January.

- The delays in ambulance handovers were largely a result of overcrowding in emergency departments due to insufficient bed capacity to admit all those patients requiring a hospital bed. During this peak period of pressure the majority of acute trusts saw significant numbers of patients being cared for on corridors and high levels of patients spending longer than 12 hours in department from arrival or awaiting discharge.

- The ICB has been working closely with local authorities, through Place Directors, and in conjunction with Trusts to focus on:
    - Increasing and then maintaining the run rate of hospital discharges every day
    - Moving patients to the first available slot, with a view to then moving then onward to the correct pathway, if correct pathway capacity is not readily available
    - Collectively increasing risk-based decisions about who can go home earlier with a lower package of care than might previously have been assessed

- Ambulance handover delays have reduced substantially from the peak period of pressure in early January. However, the system remains fragile.

- Whilst we have seen improvements in discharges and flow as a result of system wide efforts, our hospitals are still full with bed occupancy averaging 96.7% as at 25/01, despite significant surge and escalation bed capacity remaining open.

- Long stays are an issue, with 1,476 (28.5%) of beds occupied by patients who have been in hospital for at least 21 days as at 25/01.

Finance, efficiency and value workstream

Month 9	Plan(£m)	Actual(£m)	Variance(£m)	FYE Plan (£m)	FYE Forecast (£m)
CMAST (deficit)	56.3	83.6	27.1	59.3	62.2
CMHCD (surplus)	6.5	7.1	0.6	9.3	12.2
Total provider (deficit)	49.8	76.5	26.5	50.0	50.0
Total system (deficit)	34.9	71.9	36.9	30.3	30.4

The aggregate financial position of CMAST Trusts has worsened in overall terms to a Month 9 deficit of £71.9m with 5/17 providers adversely off plan to date; 9 providers are improving their planned forecast. 4 CMAST providers are showing increased cumulative risk of £22m with other providers offering improved outturns linked to potential capital incentive schemes. Should providers' deteriorate from their forecasts they will be subject to stringent conditions; additionally, the ICB will be under greater scrutiny. Capital expenditure is also under pressure as only 50% of the C&M allocation has been spent to the end of December.

Assurance & Regulation

A suite of reports have been developed by the ICB finance team and shared at the last Leadership Board. A set of key performance indicators linked to productivity and efficiency are being identified via the FD community.

Governance & Risk

Accountability for the overall system control total and individual providers' performance is being managed by the ICB CFO with a clear understanding of the implications for reforecasting.

Incentives for organisations to stretch to provide support to C&M bottom line are likely to be limited to a capital resource limit – unclear whether this is cash balanced. Incentives for driving effective performance will be driven by the new payment mechanisms.

Strategy & Planning

A Month 9 financial reforecast is under review and plans are being finalised for a 23rd February submission incorporating allocation changes and distance from target and market forces factor changes.

Capital prioritisation will follow the 2022/23 methodology.

Specialised Commissioning

Delegation will be deferred to April 2024 with an in year (PDAF) resubmission in June 2023. NSHE are seeking a single host for the NW Specialised Commissioning function and all relevant staff. 3 transformation priorities will be set for work during 2023/24 with CMAST input essential.

Efficiency at Scale

The inaugural Programme Board met on 9th January chaired by Ged Murphy – CEO East Cheshire Trust. The terms of reference and membership were agreed along with high level priorities.

Workforce

- A workforce programme scoping workshop took place on Friday 9th December from which 4 key areas were identified:
    - nursing,
    - health care assistants (HCAs),
    - maternity,
    - elective recovery workforce programme

- C&M Workforce development funding for 2022-23 has been approved for CMAST. Proposals and a Project Initiation Document have been completed and will be tabled for discussion at the C&M People Board on 8th February 23.

- A meeting has been held with Local Maternity System (LMS) to discuss opportunities for CMAST Workforce programme and the establishment of a task and finish group when key areas of work are defined.

- A round table meeting 19th January with Directors of Nursing in attendance to discuss priorities and establish key areas of work to progress and gain support for nursing and HCA workstreams.

- A Workforce Programme Board is being established with the first meeting scheduled for 7th March.

CMAST Board Update
February

CMAST Leadership Board met on 3 February for an extended meeting. Trust Chairs joined the meeting to jointly receive an update on CMAST delivery during 2022/3 and a look forward to anticipated deliverables and priorities in 2023/4.

Review and endorsement of CMAST's vision and continuing priorities were invited. Anticipated priorities for each of the programmes were then discussed as follows:

Elective Recovery Programme:

- Waiting List Management; reducing long waits, waiting list validation and risk stratification and a focus on outpatients.
- System Resources: capitalising on accessible, system wide, elective hubs, mutual aid coordination and optimisation; system wide patient treatment lists and independent sector optimisation
- Reducing variation: targeting top decile performance for all trusts, implementing GIRFT and best practice pathways in tandem with workforce transformation initiatives

Clinical Pathways Programme:

- Implementing established improvement models and focus in dermatology and ENT
- Implement outcomes and priorities from the Orthopaedics Alliance

Diagnostics Programme:

- Reduce waiting times across all specialities
- Increase productivity and turnaround times
- Deploying digital investment in a system directed way to increase collaboration
- System wide transformation – whole system view and optimisation coupled with future Pathology needs assessment for the ICS
- AI deployment across diagnostics
- Deploy collaborative staff bank

Workforce Programme:

- Working towards a single staff contract to support movement of staff across the system, supporting mutual aid and resource placement with greatest need
- Developing an evidence base to support intelligence led action on - staff recruitment, retention and market development
- Developing consistent workforce approaches and responses for staffing, recruitment and employment issues and needs including linking with wider partners and agencies to optimise routes to employment

Finance Efficiency and Value Programme

- Supporting delivery of an ICS wide financial strategy
- Establishing sustainable and transparent funding flows underpinned by common governance and risk approaches

- Bridging ICB / ICS led initiatives with the required Trust Board assurance and regulatory impact
- Delivery of efficiency at scale work programme and expanded scope

Recognising C&M Cancer Alliance's (CMCA) accountability to NHSE the Leadership Board also received an update on 2022/3 deliverables and future plans, in line with CMAST programmes, recognising the absolute interconnectivity of this critical programme of work and the alignment of priorities across member organisations and with elective recovery, clinical pathways and diagnostics in particular.

The Leadership Board considered recent ICB discussions in response to the conclusion of the Liverpool Clinical Services Review. The Board recognised the need to make progress on the issues and evidence detailed within the report but also the importance of aligning these activities with existing work programmes across the ICS, including CMAST, and the need to ensure that health inequalities and access across C&M were actively considered.

The Board also received an update on the ICB led Joint Forward Plan. A document which provides an NHS delivery framework to realise the ambition of the ICP strategy. The Board received a proposal for the C&M provider collaboratives to consider a draft of the plan by the end of March aligned to when NHSE will require an initial submission. Opportunity for system and partner engagement, including Trust Boards, would be possible from April through June.

CMAST Leadership Board Update
March 2023

The Leadership Board met on 3 March and discussed a number of key system issues:

A discussion on preparations for and considerations associated with upcoming junior doctors industrial action took place. The discussion provided an opportunity for system leaders to be updated on discussions amongst Trust Medical Directors and promoted the need for clarity with the public, partners and workforce, consistency of approach and response and the paramount importance of patient safety. System communications will be led by the ICB Medical Director and cascaded to Trust Medical Directors.

An update was received on progress toward achievement on the elimination of patients waiting greater than 78 weeks for treatment by the end of March 2023. Solid progress was being made, however, industrial action was noted to be a destabilising factor and risk to delivery. The Board was also briefed on implementation of the Mutual Aid Hub whose priorities included minimising variation in access and inequalities across Cheshire and Merseyside and will, going forward, include the coordination of shared, equitable access to the independent sector.

The group also discussed progress in responding to the Liverpool Clinical Services Review. The principles previously discussed by CMAST were reiterated: the need to respond to the review's recommendations; the need for this to be done in sight of partners; and for wider system implications to be considered. The conclusions of a national visit were also shared which had provided assurance on progress and the collaborative approach to system delivery within C&M. Finally, the group noted that the first meeting of the ICB led aspect of the review and related to Women's Health had taken place and that as well as CMAST members being present in their own right at this committee CMAST was represented through the appointment of the Wirral Trust Medical Director following an ICB request.

The Leadership Board were informed that CMAST had been successful in its bid to the Provider Collaborative Innovators Scheme. The offer includes access to national policy development, peer support and a bespoke support offer which is to be confirmed.

CMAST Leadership Board will also meet at the end of the month in order to avoid Easter bank holidays in April

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/27**	
SUBJECT:	**Chair's Briefing**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	Steve McGuirk, Trust Chair	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will…Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will…Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3 We will…Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of the external activity of the Chair of the Trust, as well as drawing attention to matters the Chair believes are of significance to the Board of Directors. This update draws attention to: • National Industrial Action • Governor Induction • Ministerial Visit • (Liverpool) Clinical Services Review • ICP (Cheshire and Merseyside) Interim Strategy • Removal of 'Enhanced Monitoring' status (Health Education England) • Council of Governors' activity	

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

RECOMMENDATION:	The Trust Board is asked: i) To note the meetings/engagement of the Chair over the reporting period (since the last Board meeting) ii) To make any comments or ask any questions arising from the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.

SUBJECT	Chair's Briefing	AGENDA REF:	BM/23/03/27

1. BACKGROUND/CONTEXT

This report highlights activity and strategic issues that, in the opinion of the Chair should be drawn to the attention of the Board, as well as seeking to represent the point of view of the Council of Governors at the Board level.

2. MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

The period covered runs from 25 January 2023 to 22 March 2023 and only outlines 'formal' meetings for information and does not encompass day to day business in the hospitals.

DATE	ACTIVITY
9 February 2023	Ministerial visit
13 February 2023	Meeting with Place Director
21 February 2023	Governor Induction Day
28 February 2023	Combined NW System Meeting: Quality Priorities Meeting
1 March 2023	Board development day
8 March 2023	Meeting with Health and Wellbeing Board Chairs and portfolio holders - Warrington and Halton; 121 with CMAST Workforce Programme Team
9 March 2023	Charitable Funds Committee
13 March	Chair's Governor briefing
15 March	CMAST Chair's Meeting
16 March	Clinical Leaders Walkabout; Warrington Inspiration Awards
17 March	Thank You Awards 2022-23
21 March	Chair's Seminar (London)
22 March	NED Appraisals
28 March	NED Appraisals

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

Thankfully, while demand remains very high indeed, this last period has seen a welcome - if small – sense of reprieve from the earlier, frantic level of activity.

3.1 National Industrial Action

The Chief Executive will cover this issue more comprehensively in his report, but it is worth noting that the juxtaposition between the good news of a promising settlement approach between the government and nurses, contrasted with the launch of industrial action by junior doctors. That being said, there also remains uncertainty about the funding for the nurses' pay settlement and which, if required to be found within existing budgets, will have a very significant financial impact.

3.2 Ministerial visit/ new hospital submission

The Minister of State for Health and Social Care, Helen Whately MP, visited Warrington on Thursday 9 Feb. Initially, she spent time at Warrington and Vale Royal College talking to Place partners (including our CEO) about the issues associated with social care and delayed discharges. She then spent time at Warrington Hospital in the Emergency Department, Ward A10, and the Frailty Assessment Unit. Here she gained an appreciation of our difficulties in achieving patient flow, largely associated with the number of *no right to reside* patients (which reflect social care challenges and for which she has ministerial responsibility).

While it is difficult to point to any direct benefits from such visits, they are nevertheless vital in ensuring key political decision makers (especially ministers) have the fullest understanding of the problems on the ground in support of policy and other briefings they receive from advisers, officials, and lobbyists/ interest groups at a government/ central level.

The Minster was also asked about when a decision would be taken in relation to our new hospital submission but was unable to advise on a specific date when an announcement would be made.

In respect of the new hospital submission, in December 2022 I wrote to Lord Markham CBE, who had recently been appointed as the relevant Parliamentary Under-Secretary of State (following the new Prime Minister's reshuffle/ appointments) to establish timescales for when any announcements would be made. The Minster responded on 14 Feb 2023 identifying that 128 expressions of interest were in the process of being evaluated and that a final outcome would be announced in 'due course'. It should be noted that a decision was expected many months ago and there is no clarity on a decision yet. It is therefore important to manage expectations in this regard.

'We' believe that we have a very strong - if not compelling - case, not least as Warrington is one of the fastest growing towns in the country and our estate is old with many problems. We have continued to make necessary investments on a small scale - so we are not standing still and waiting. But there remains a bigger need for investment, for which we have not formulated any development plans, given the strength of our bid/ new hospital case. (I would add that there has also been a major investment in time and resources when assembling the bid.) That being said, the other 127 places expressing interest will feel the same way. We remain optimistic, and we remain very much 'in the game', but we must also recognise the challenges of the economic circumstance of the country and the likelihood of a general election within eighteen months which will impact the evaluation process. Consequently, we

will maintain pressure and effort, but we should be under no illusions that we are still a long way from putting 'spades in the ground'.

3.3 Liverpool Clinical Services Review

In one sense, this review is not directly connected to Warrington and Halton, but it is important to note that it signals a more collaborative direction of travel and that some if its implications in the context of the specialty trusts are more far reaching than just Liverpool. Consequently, it is worth raising awareness of the review for Warrington and Halton.

In spring 2022, Cheshire and Merseyside Integrated Care System was asked by NHS England to commission an independent review to identify recommendations for greater collaboration between Liverpool's acute and specialised hospital trusts (which, of course, serve a bigger footprint than Liverpool).

Compared to other areas, Liverpool has a high number of acute and specialist provider trusts and, while many of these provide outstanding care, there are challenges around fragmentation of services, variation in quality, financial positions, experiences of care, workforce capacity and sustainability. Moreover, now that there is a statutory requirement for system finances to be in balance, over provision in one area can deleteriously affect provision in another.

The review was also intended to consider alignment and interdependencies with the *One Liverpool* strategy, the city's health and wellbeing strategy, and the wider Cheshire and Merseyside system.

The six organisations within the scope of this review were:

- Alder Hey Children's NHS Foundation Trust
- Clatterbridge Cancer Centre NHS Foundation Trust
- Liverpool Women's NHS Foundation Trust
- Liverpool Heart and Chest NHS Foundation Trust
- Liverpool University Hospitals Foundation Trust
- The Walton Centre NHS Foundation Trust

Other stakeholders involved with the review included:

- Mersey Care NHS Foundation Trust
- General practice, including the Local Medical Committee and the city's ten Primary Care Networks (PCNs)
- Liverpool City Council
- Cheshire & Merseyside Acute & Specialist Trusts (CMAST) provider collaborative and Cheshire and Merseyside Mental Health and Community provider collaborative

The review was overseen by the One Liverpool Partnership Board made up of key partners within the Liverpool health and care system, including the NHS, local authority and voluntary sector.

The review identified 12 opportunities for greater collaboration, which are set out in the full report.

While some of these are already being implemented through the One Liverpool strategy, the One Liverpool Partnership Board identified three priorities which it believes should be taken forward immediately:

1) Solving the clinical sustainability challenges affecting women's health in Liverpool.

2) Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Broadgreen and Royal Liverpool Hospital sites.

3) Significant opportunities to achieve economies of scale in corporate services.

The first two are not directly relevant to WHH though they are of interest, but the opportunity to achieve economies of scale in corporate services is more applicable and will be taken forward within the CMAST work programme (outlined below).

3.4 CMAST Update

For the avoidance of doubt, CMAST stands for the Cheshire and Merseyside Acute and Specialist Trusts and is one of the two provider collaboratives - the other being mental health and community services' trusts – that form part of the Cheshire and Merseyside ICS architecture.

In the spirit of sharing information related to the wider agenda, the latest CMAST briefing is attached to the Chief Executive's Briefing and, equally, in the spirit of not making comment for the sake of it, I do not propose to repeat that update in my report.

The only issue to which I would wish to draw attention is that there is now a new requirement for the CMAST collaborative to produce an 'annual plan'. Of course, when it is available that plan will be administered and managed through the Trust's governance arrangements as well as the Place Partnerships' governance arrangements.

3.5 ICS Update

The role of the Partnership Board in setting the strategy for the ICS has previously been explained, and it was also previously identified that work was taking place to develop a new strategy. That work has now been completed and a strategy produced, albeit it is recognised to be an interim strategy.

The strategy itself may be found here: cheshire-merseyside-draft-interim-hcp-strategy-2023.pdf (cheshireandmerseyside.nhs.uk).

As previously identified this ICS/ ICP strategy will be embedded in the refreshed strategy of the Trust (considered elsewhere on the agenda). There is the opportunity to comment on the interim strategy via an online survey which may be found here - Citizen Panel Wave - Landing Page (snapsurveys.com).

3.6 Change to Enhanced Monitoring Status with the General Medical Council (GMC)

The first step for anyone wanting to pursue a career as a doctor is to study medicine at undergraduate level or via a graduate medical course, following which students progress onto postgraduate training, via the foundation programme and higher specialist training. During this time, they are known as junior doctors.

All medical graduates must then undertake and complete an integrated two-year foundation programme of general training, in order to practice as a doctor in the UK.

The foundation programme consists of foundation year one (FY1) and foundation year two (FY2) and people will see junior doctors identified as 'F1's or 'F2's by lanyards. The programme acts as a bridge between undergraduate medical training and specialty and general practice training.

During this period, the doctors are employed by respective trusts, but their training programme comprises a pre-approved series of six 4-month placements in a variety of specialties and healthcare settings and other trusts.

The approach is overseen by Heath Education England – in our case the North-West Health School of Foundation Training and Physicians Associates, but also under the aegis of the GMC.

It is vitally important for the professional development of future doctors that the programme is well managed, but it is also important for the reputation of the trust as it is often the experience of people when working as a junior doctor that shapes their decision in later life about where to pursue their career as a consultant.

When a postgraduate training organisation (HEE) is concerned about the quality of training or receiving negative feedback about the experience of doctors, they seek to work with trusts to make improvements. But if the situation doesn't improve, they inform the GMC, who then work with all involved to improve the quality of training. As part of this approach, the GMC can also place the trust concerned into an enhanced monitoring process. It is fair to say that once a trust is in an enhanced monitoring situation it can take some time for that to change as it is often a qualitative issue/ judgement rather than a quantitative one and, thus, it is difficult to establish hard criteria at the outset by which the enhanced monitoring may be lifted.

In the case of WHH, I have been the Chair of the Trust for nearly eight years now and we have been in an enhanced monitoring status with the GMC throughout that period. That is

not to say we haven't been making progress and addressing the issues raised in the first instance. On the contrary we have made big changes and a recurrent theme when recruiting consultants is positive feedback about their experience as a junior doctor at WHH. Moreover, we have had CQC inspections - including receiving a *Good* rating - and the regulator was satisfied that the actions being taken were authentic and appropriate. But this speaks to the above point that there have not really been any specific criteria that would result in the situation changing, until now.

I am therefore please to report that, following a recommendation from Health Education Northwest, the GMC has now changed our status and has taken us out of enhanced monitoring. This is to the enormous credit of many people as it reflects not just medical/ clinical improvements over an extended period which, of course, are important; but it also reflects a much better overall training experience of people when placed at WHH and this reflects a much wider - and positive - cultural change that has taken a long time to embed.

3.7 Council of Governors

There was a full COG on Feb 16, 2023. The minutes of that meeting will shortly be available online. But it is worth drawing attention to important proposed changes to the Trust constitution supported at the COG. This relates to changing the number and arrangements of constituencies to try to ensure better citizen representation, as well as addressing new duties arising from the shift to ICSs. It is also worth drawing attention to a new approach for governors' questions, arising from a new, regular 'governors only' meeting led by the Lead Governor. While there were a few tweaks required, for example, ensuring that there was clarity about potential conflicts of interest particularly for staff governors, the new approach had worked well.

Governors Induction Day

There was a very good governor induction day on 21 Feb which was attended by all new governors and was well supported by existing governors as well. Feedback has been good, and the work done in the previous months on the governors' handbook was particularly well received.

3.8 Governor Observation Visits

There was a governor observation visit to the new breast screening/ breast service in January and while several areas for improvement were highlighted - and will be taken forward - it was overall a positive visit.

3.9 Thank You Awards

Many people will be aware that we recently held out staff Thank You Awards 2022-23. This was a heavily sponsored event in recognition of the need to avoid any additional burden to the public purse. In this respect, I wanted to express my appreciate to all the Board of Directors for not only paying for their own attendance, but additionally, 'paying forward' for other staff members to attend the event who otherwise would not have been able to do so. In addition, I also wanted to express my appreciation to the organising committee of volunteers who did an amazing job.

This was a fantastic event - and hugely important to say a sincere thank you to so many people for their incredible contribution over the last year and in the most difficult circumstances we have ever faced.

3.10 Governors Q and A Sessions and Working Group

Governors have held two Q and A sessions with the Chair since the last meeting (see list of activity above).

10. RECOMMENDATIONS

The Trust Board is asked:

i) To note the meetings/ engagement of the Chair over the reporting period.
ii) To make any comments or ask any questions arising from the report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/03/28**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
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 Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, 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: • It is proposed to add one new risk • The rating of one risk has been reduced • The description of one risk on the BAF has been amended • No risks have been closed or de-escalated Notable updates to existing risks are also included in the paper.	
PURPOSE: ***(please select as appropriate)***	Information | Approval ✓ | To note | Decision	
RECOMMENDATION:	The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Audit Committee, Finance & Sustainability Committee, Clinical Recovery Oversight 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 and Strategic Risk Register report	AGENDA REF:	BM/23/03/28

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

2.1 New Risks

Following discussion at the Quality Assurance Committee and Risk Review Group it is proposed to add one new risk to the BAF (detailed below) at a rating of 16

ID	Risk description	Rating	Executive Lead
1846	If the Trust does not provide the Auditory Brainstem Response (ABR) special screening tests then patients will have to access services elsewhere which may cause delays leading to potential patient harm, reduced patient experience and reputational damage	16	Kimberley Salmon-Jamieson

2.2 Amendment to Risk Ratings

Since the last meeting and following approval at the Quality Assurance Committee on 7th February 2023, the rating of one risk (#1275) has been reduced.

Following the introduction of additional controls and assurance in place and the reduction in outbreaks, it was agreed to reduce the rating of **risk #1275** (detailed below) from 20 to 16

ID	Risk description	Rating (previous)	Rating (current)	Executive Lead
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.	20	16	Kimberley Salmon-Jamieson

2.3 Amendments to descriptions

Since the last meeting there has been an amendment to the descriptions of one of the risks.

Risk #1215

Following approval by the Quality Assurance Committee on 7th February 2023, the description of the risk was further updated to reflect the impending change from Block contract to Payment by Results (PbR)

Previous: *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.*

Current: *If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm, failure to achieve constitutional standards and financial plans.*

2.4 De-escalation of Risks

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

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
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	<u>Controls</u> • Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E • Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside. • Work plan to reduce super stranded and o criteria to reside in 2023/24 is being finalised by the System Sustainability Group <u>Gaps in Controls</u> • Ongoing industrial action across a number of staffing groups including junior medical staff and nursing. • Notified March 2023 of the potential closure of the 60 bedded Lilycross facility supporting transitional care capacity. If the closure takes place this will impact from the end of quarter 1 2023	25	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	quality and patient safety.	<u>Gaps in Assurances</u> • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care		
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm, failure to achieve constitutional standards and financial plans.	<u>Controls</u> • Use of Insourcing via 18 Weeks (NHS approved contractors) commenced in January 2023 to support 78-week target. Following approval by Execs. There are further plans to expand Insourcing to Maxfax and Gynae by the end of Q4 2022/23. • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 <u>Assurances</u> • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists. • Planning round for 2023/24 activity plan in progress to achieve targets set in the guidance issued this year. Final submission due end of March 2023. This is triangulated with finance and workforce plans. <u>Gaps</u> • Operational planning guidance 2023/24has indicated a movement away from Block to PBR, clarification of detail is awaiting	25	No impact on risk rating
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	<u>Assurances</u> • Key posts appointed to in Maternity 2 x Matron (April) Emergency Department 1 x Matron 1 x Lead Nurse (commenced) • Reduction in experienced midwife vacancies to 4.35 WTE in March 2023, have 6.0 WTE vacancy for New Qualified interviews planned 29th March 2023 • No further resignations from the Emergency Department since December 2022 • 4WTE starters for the emergency Department in February 2023 <u>Gaps</u>	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• 17.01% turnover – December 2022 • National increase in nursing vacancies • National increase in Allied Health Professional vacancies		
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> • CDC phase 1 has now been approved (£10.5m over 3 years) • Undertaken a review of a number of mitigations to support delivery of the Trust's Control Total and engaged with system partners to seek support. • Daily review of Non-Pay requests to reduce Non-Pay spend in the last quarter • Annual Planning timetable established for 2023/24 • CDC phase 2 application approved for £4.5m capital over three years • Capital & Revenue Plans being developed for 2023/24 • Contract negotiations underway with a move to part black part PbR contracts • Undertaken a review of a number of mitigations to support delivery of the Trust's Control Total and engaged with system partners to seek support; therefore, forecasting delivery of the control total. • Additional £2.4m funding to support additional capacity. • Introduced system of escalation where there are risks to CIP delivery. <u>Assurances</u> • Annual Planning timetable established for 2023/24 • Additional funding received to support capital changes which will improve forecast outturn to £5.4m deficit. • We have allocated CIP targets under an approved new methodology for 2023/24 <u>Gaps</u> • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability should the capacity remain open and funding withdrawn at 1st April 2023. • Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Currently developing operational plan for 2023/24 noting the significant overspend will impact on cash • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR		
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** Sickness absence has decreased from 7.6% in December 2022 to 5.6% in February 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. The rolling 12-month sickness absence rate it 6.44% as at February 2023. <u>Controls</u> • New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, update policy to be implemented April 2023. • 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. These actions have all supported an increase in compliance with target being met September 2022 - December 2022. <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 2.82% in February 2023. • Actions to improve WBC compliance have all supported an increase in compliance with target being met September 2022 - December 2022. **Turnover and Attraction** Turnover in February 2023 was 15.98% compared to 15.87% in December 2022. Turnover of permanent staff in February 2023		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		was 14.73% compared to 14.84% in December 2022. <u>Controls</u> • To support with the development of an Agile/Flexible Working Toolkit, views of the staff have been sought on the current agile working culture, barriers, opportunities and best practice. A dedicated area to supporting Agile/Flexible working is available on the extranet, and in April 2023, a summary of the survey will be provided to the Executive team, before further promotion of the various tools available for managers/employees. <u>Assurances</u> • 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. **Temporary Staffing & Agency Spend** Bank and Agency reliance in February 2023 was 17% compared to 15.84% in December 2022. Reasons for the variation can be attributed to sickness absence, high turnover and additional capacity. <u>Controls</u> • A Resourcing Task and Finish group has been established to review any gaps identified through the Agency Controls best practice toolkit. This will support plans to work with agencies to ensure they are operating within controls and improve the use of the Trusts bank rather than agency staff.		
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and	<u>Gaps</u> • Limited 24/7 dedicated cyber cover • Version 7 of Clinisys Ice is end of life	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	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.			
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.	<u>Controls</u> • Nosocomial COVID-19 action plan reviewed at the Infection control Sub-committee • Winter Respiratory Virus Testing & Escalation Plan in place • Cleanliness Standards for Functional risks 1 and 2; 4 or 5 star ratings with 2-4 hour timescale to rectify issues • IPC Team and patient flow collaboration on optimal use of side rooms <u>Assurances</u> • Working with NHSE to revise hand hygiene audits using QR codes and visitor reporting <u>Gaps</u> • Assurance on hand hygiene audits	16	Rating reduced from 20 to 16
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	<u>Assurance</u> • A revised OBC has received Trust Board approval in Feb 2023 in line with emerging guidance on managed convergence. • Working with our partners STHK & S&O to finalise procurement timetable and align OBS timelines to deliver a partnership procurement. • MOU and Partnership Procurement Group in Place reporting to EPR Project Group (and escalation/assurance through Digital, FSC and Trust Board) <u>Gaps in controls</u> • Delay due to a re-launch of procurement to ensure compliance with managed convergence guidance puts the procurement process out of schedule with current national Digital funding programs	16	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 as yet unresolved capital expenditure scheduling issues • Any further delay due to delays incurred through nonalignment of timelines across the partnership procurement timetable risk procurement exceeding the approved funding period for the Lorenzo extension and/or the Lorenzo product withdrawal date		
1757	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	<u>Assurances</u> • Results for Junior Doctors have met the IA threshold IA planned for the 13-17 March 2023 - special March IA rate card agreed to support the Trust's response. • AfC IA paused whilst decision made to accept/reject government offer	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>Gaps</u> • Threat to the delivery of capital schemes due to the lengthy process to obtain full design costs in an uncertain market.	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, 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.	<u>Controls</u> • Revised plans for CDC approved by Trust Board and national diagnostics team. • Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Contractors appointed to commence the capital works for Health & Wellbeing Hub. • Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 presented to Trust Board for approval. • Director of Strategy & Partnerships co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Adaptive Reserve Fund created with Warrington PLACE partners. <u>Assurances Gaps</u>	12	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Pace of Pathology collaboration enhances the risk to the Trust's delivery of Pathology services. • Trust's capacity to deliver significant number of capital projects		

3 RECOMMENDATIONS

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

Appendix 1

Board Assurance Framework

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety.	1	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight 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	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	20 (5x4)	12 (4x3)	TBC	Quality Assurance Committee
134	Andrea McGee	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee
1114	Paul Fitzsimmons	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee

Board Assurance Framework

1275	Kimberley Salmon-Jamieson	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.	1	16 (4x4)	5 (5x1)	TBC	Quality Assurance Committee
1372	Paul Fitzsimmons	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1757	Michelle Cloney	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	2	16 (4x4)	8 (4x2)	TBC	Strategic People Committee
125	Daniel Moore	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	1	15 (3x5)	4 (4x1)	TBC	Executive Management Team
145	Simon Constable	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (3x4)	8 (4x2)	TBC	Executive Management Team

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.

Board Assurance Framework

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

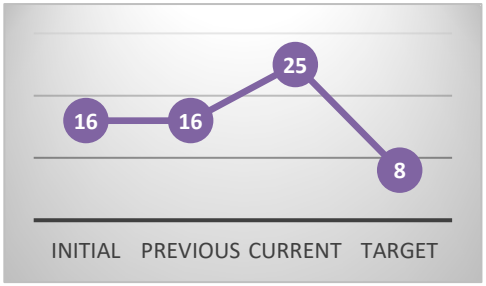
Board Assurance Framework

Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety			**Initial:**	16(4x4)
				Current:	25(5x5)
				Target:	8 (2 x 4)

Assurance Details:

Controls

- Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day
- Discharge Lounge/Patient Flow Team/Silver Command
- ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing
- Private Ambulance Transport to complement patient providers in and out of hours
- FAU/Hub operational operating 5 days per week.
- Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance.
- Increase IMC provided by the system such as the opening of the additional bedded capacity
- Increase IMC at home
- Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place.
- Same Day Emergency Care Centre (SDEC) completed July 2022.
- Upgrade to Minor's resulting in Oxygen points in all cubicles
- Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients
- ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised.
- Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly.
- Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings
- Additional Senior Manager on call support a weekends
- Senior Dr at Triage Function
- Ward A10 opened as winter escalation capacity funded by the ICB.
- Plans being progressed to procure and install a new CT scanner co-located in the main body of the ED department. This will support increases urgent care pathway efficiency in the ED. This is set to be operational in September 2023.
- Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.
- Plans to co-locate ED Minors in the SDEC building to enhance patient pathways. The capital project is now agreed and set to be operational in April 23.
- Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter
- Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E
- Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside
- Work plan to reduce super stranded and o criteria to reside in 2023/24 is being finalised by the System Sustainability Group



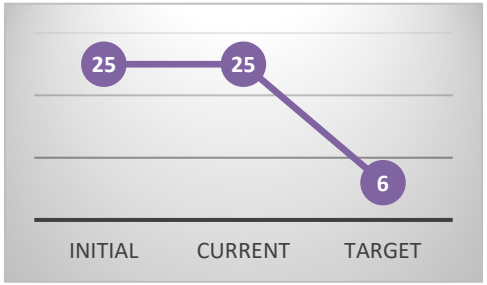
Assurances

Board Assurance Framework

	• 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	
Assurance Gaps:	**Gaps in Controls** • Staffing pressure created in part as a result of COVID-19 Global pandemic. • Ongoing industrial action across a number of staffing groups including junior medical staff and nursing. • Notified March 2023 of the potential closure of the 60 bedded Lilycross facility supporting transitional care capacity. If the closure takes place this will impact from the end of quarter 1 2023 **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	30/06/2023	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	30/06/2023	

Board Assurance Framework

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	6 (3x2)
Assurance Details:	**Controls** • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Reconfigured of ED to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance. • Plans to create a co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Due to be operational by April 23. • Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted. • Waiting lists are reviewed through the Performance Review Group Weekly • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers • To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive 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 • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward A5 on the Warrington site. • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks • Continue to ensure urgent cancers are prioritised in line with national guidance • Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends. • Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients • Use of Insourcing via 18 Weeks (NHS approved contractors) commenced in January 2023 to support 78-week target. Following approval by Execs. There are further plans to expand Insourcing to Maxfax and Gynae by the end of Q4 2022/23. • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24				

Board Assurance Framework

	Assurances • Operational planning monitored by Cheshire & Merseyside on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly and the Clinical Recovery Oversight Committee (CROC) & Clinical Services Oversight Group (CSOG). This relates to elective surgical activity. • 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 • Planning round for 2023/24 activity plan in progress to achieve targets set in the guidance issued this year. Final submission due end of March 2023. This is triangulated with finance and workforce plans.	
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 • Operational planning guidance 2023/24has indicated a movement away from Block to PBR, clarification of detail is awaiting.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/08/2023	

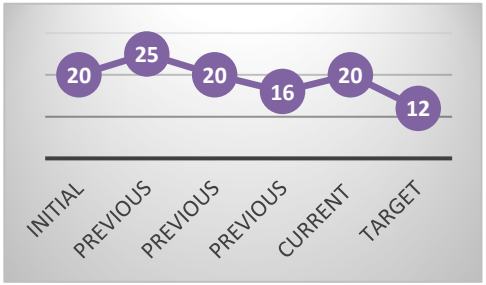
Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If 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 (5x4) **Current:** 20 (5x4) **Target:** 12 (4x3)

Assurance Details:

Controls

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



Assurances

- Key posts appointed to in Maternity 2 x Matron (April) Emergency Department 1 x Matron 1 x Lead Nurse (commenced)
- Reduction in experienced midwife vacancies to 4.35 WTE in March 2023, have 6.0 WTE vacancy for New Qualified interviews planned 29th March 2023
- No further resignations from the Emergency Department since December 2022
- 4WTE starters for the emergency Department in February 2023
- International Nurse recruitment in place
- Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead
- Part of National Recruitment Programme and Care Support Worker Development Programme for HCAs
- Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly
- Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends this is a full day shift
- Rolling recruitment for RN and HCA posts, 2- 4 weekly interviews, over recruitment plans approved
- Retention – Internal Transfer process in place for staff

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. B3, B4, A10, Catheter Laboratory)
- Increased staffing pressures experienced prolonged
- Time to post when recruiting new staff
- 17.01% turnover – December 2022
- Predicted 30 WTE Vacancies in Emergency Department
- Predicted 60%-80% Band 6/7 Pharmacy vacancies
- National increase in nursing vacancies

Board Assurance Framework

	• National increase in Allied Health Professional vacancies				
Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • Domestic and international nursing recruitment • Position and plans for staff retention. • Planning for the future – succession planning and staff development. • 6/12 establishment reviews. • Triangulation of staffing position alongside patient safety measures.	Kennah, Ali	31/03/2023	

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	10 (5x2)

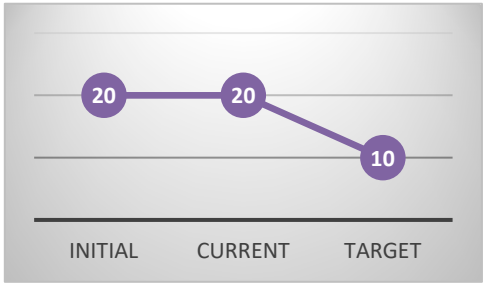
Assurance Details:

Controls

•Core financial policies controls in place across the Trust
•Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning
•Weekly review at extended Executive team meeting
• Workshop undertaken with - Exec, CBU, Corporate to review 2022/23 cost pressures
• Workshops undertaken 2022/2023 budget setting
• Capital Plan 2022/23 approved by Trust Board on 30th March 2022
• Procurement/tender waiver training in place
• Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M
• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m over 3 years)
• Latest guidance from MIAA Counter Fraud Team circulated
• Counter Fraud campaign took place for national anti-fraud week in November 2022
• Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance.
• Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced.
• Appointed GIRFT Finance Lead and 3 Clinical Leads
• Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022
• ICS executive peer to peer review June 2022, and September 2022.
• Undertaken a review of a number of mitigations to support delivery of the Trust's Control Total and engaged with system partners to seek support; therefore, forecasting delivery of the control total
• Daily review of Non-Pay requests to reduce Non-Pay spend in the last quarter
• Annual Planning timetable established for 2023/24
• CDC phase 2 application approved for £4.5m capital over three years
• Capital & Revenue Plans being developed for 2023/24
• Contract negotiations underway with a move to part block part PbR contracts
• Additional £2.4m funding to support additional capacity
• Introduced system of escalation where there are risks to CIP delivery

Assurances

• Achieved Break Even in 2021/22
• Delivered 2021/22 Capital Plan
• Unqualified audit opinion (2021/22)
• Completed MIAA Governance Checklist received by Audit Committee



Board Assurance Framework

	• Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Capital is reported monthly to F&SC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • ICS review undertaken of increases in WTE and pay run rates which are less than C&M ICS. Increases relate to Clinical Staffing in the main. • HFMA self-assessment completed and audited. • All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed. • Annual Planning timetable established for 2023/24 • Additional funding received to support capital changes which will improve forecast outturn to £5.4m deficit • We have allocated CIP targets under an approved new methodology for 2023/24	
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) • Risk of unforeseen costs due to further COVID-19 / Flu surge • Availability of social care to support the current super stranded position (currently c25% of bed base). Estimated annual cost of at least £11m • Introduction of protocol for changing forecast outturn with the potential impact of restricting financial freedoms and access to capital. • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability should the capacity remain open and funding withdrawn at 1st April 2023. • Non-recurrent income support for additional capacity presents a risk to the 2023/24 financial plan • Currently developing operational plan for 2023/24 noting the significant overspend will impact on cash • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Identify CIP to support delivery of the overall financial plan	Identify CIP	Establish Leadership and oversight with the Executive Medical Director and meeting with Care Groups. Joint reporting to F&SC	McGee, Andrea & Fitzsimmons, Paul	30.03.2023	
Develop Financial Plan for 2023/24	Develop Plan	Trust Board to approval 2023/24 Financial plan	McGee, Andrea	31.03.2023	

Board Assurance Framework

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

Control & Assurance Details:

Sickness Absence

Sickness absence has decreased from 7.6% in December 2022 to 5.6% in February 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. The rolling 12-month sickness absence rate it 6.44% as at February 2023.

Controls

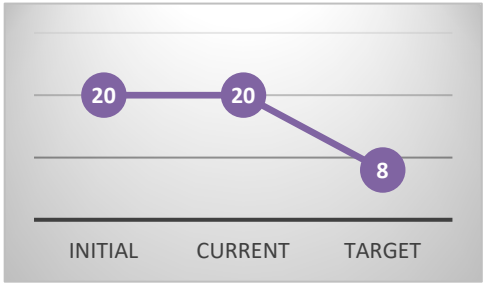
- New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, update policy to be implemented April 2023.
- Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and 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. These actions have all supported an increase in compliance with target being met September 2022 - December 2022.
- Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management,
- People Health and Wellbeing Group. The group have focused on understanding the Trust's absence reasons and reducing the volume of absences recorded as 'unknown'.
- Supporting Attendance Month - roadshows, drop-in sessions, comms and events to showcase the Trust's commitment to Supporting Attendance
- Focused welcome back conversation recording and internal audit
- Review of policy implementation in September 2022 internally with Trade Unions, staff and managers. Awaiting feedback from NHSE

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 2.82% in February 2023.
- 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
- Actions to improve WBC compliance have all supported an increase in compliance with target being met September 2022 - December 2022.

Turnover and Attraction

- Turnover in February 2023 was 15.98% compared to 15.87% in December 2022. Turnover of permanent staff in February 2023 was 14.73% compared to 14.84% in December 2022.
- Work-life balance continues to be the number one known reason people leave WHH, followed by retirement. A significant number of people delayed their retirement plans in 2020 and 2021, and we have now seen a significant



Board Assurance Framework

	increase in the number of individuals choosing to retire, with some chosing to return to the workplace (retire and return) (these still count as a leaver)
	
	Controls
	• Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted action. This information is available on the Trust Workforce Information Dashboard.
	• Rugby League Cares have been supporting WHH since July 2021
	• Grief and Menopause cafes
	• Social media accounts have been created to support recruitment attraction across a number of social media platforms
	• Financial wellbeing resources have been implmented to support the workforce and retention including Wagestream
	• To support with the development of an Agile/Flexible Working Toolkit, views of the staff have been sought on the current agile working culture, barriers, opportunities and best practice. A dedicated area to supporting Agile/Flexible working is available on the extranet, and in April 2023, a summary of the survey will be provided to the Executive team, before further promotion of the various tools available for managers/employees.
	
	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.
	
	Temporary Staffing & Agency spend
	
	Bank and Agency reliance in February 2023 was 17% compared to 15.84% in December 2022. Reasons for the variation can be attributed to sickness absence, high turnover and additional capacity.
	
	Controls
	• The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are:
	  ○ ECF process for non-clinical vacancies approval
	  ○ ECF process for bank and agency temporary staffing pay spend approval
	  ○ Medical Rate Escalations approved by Medical Director
	• A Resourcing Task and Finish group has been established to review any gaps identified through the Agency Controls best practice toolkit. This will support plans to work with agencies to ensure they are operating within controls and improve the use of the Trusts bank rather than agency staff.
	
	Assurances
	• Compliance against our processes and rate cards monitored through the Finance and Sustainability Committee
	• To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings is in development. Streamlining the approval process to replace the ECF will ensure better oversight of the use of Temporary Staffing within the Medical and Dental Staff group. This report will be updated accordingly.	

Board Assurance Framework

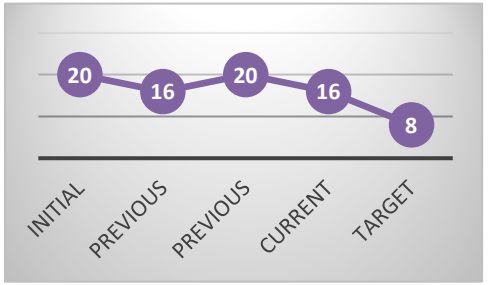
Assurance Gaps:	• Sickness absence continues to be above target. This is reflective of sickness absence regionally • Turnover continuing to be above target, review of actions to reduce and make impact • Agency spend above previous years, definitive actions to be identified to reduce agency spend • Compliance with NHSE Agency Rate card very low, need identified actions to support increase in compliance • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop Trust approach to agile working	Establish a best practice toolkit, processes and policies to support agile working at WHH	• Establishment of T&F group • Survey of organisation to identify best practice • Review of national best practice recommendations Development of toolkit	Carl Roberts	31.03.2023	
Establishment of Resourcing Task and Finish Group	Establishment of Resourcing Task and Finish group to review: agency cap, agency spend reduction, agency controls, retention and recruitment marketing	• Establish group and ToR • Establish governance structure for group to support reporting • Establish action plan	Carl Roberts	31.03.2023	
Develop a recruitment marketing approach to support retention and attraction	Develop a recruitment marketing approach to support retention and attraction to WHH. Initial specific focus on ED, Pharmacy and Maternity	• Identify organisation that can provide recruitment marketing • Develop recruitment marketing campaign and agreed timescales for implementation	Carl Roberts	31.05.2023	
Establish action plan to reduce agency spend	Through the resourcing Task and finish group, establish an action plan to reduce agency spend	• Establish group and ToR • Establish governance structure for group to support reporting • Establish action plan to include: • Assessment by Deputy Medical Director and Deputy Chief Nurse against a combined NHSE and East Lancs Best Practice Toolkit for controlling agency spend • Development of recommendations and approaches to bring down agency costs including: • Reduction in commission for long line bookings • Walk down Medical and Dental agencies over a period of time; firstly, to within the 50% cap and then to close to the rate cap • Implementation of tiering of agencies, offering priorities to agencies who are within rate cap	Carl Roberts	31.03.2023	

Board Assurance Framework

		• Implementation of check and challenge around agency use • Review of Frameworks to ensure best service and value for money • Development of a refined ECF process for Medical and Dental temporary staffing bookings is in development			

Board Assurance Framework

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 (5x4)
				Current:	16 (4x4)
				Target:	8 (2x4)
Assurance Details:	**Assurance:** • Risks for Cyber on risk register in line of national requirements of the DSPT & NHS Digital • **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures). • **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee. • **Trust benchmarking** activities including Use of Resources reviews (Model Hospital). • ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021) • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • Cisco Phase 2 business case being approved (for financial year 22/23). Providing the procurement mini tender is done on time and the orders are place in advance and there are no other world-wide changes happen impacting on supplies, kit will be delivered and installed within 22/23. **Controls:** • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active membership of the **Sustainability Transformation Partnership Cyber Group.** • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • **Cyber Training** for the Trust Exec Board • The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved). • Office 2010 being used while end of life due to the N365 deployment plan (100% migrated)				

Board Assurance Framework

	• Secondary secure backup at Halton Data Centre • Remote devices no longer bypassing the web proxy • Active Directory password set to expire again (covid working from home-related). • Fully recruit to the Digital Service restructure Phase 1 restructure • Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness. • Local device (PC & laptop) based firewalls now enabled	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving 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) • ITHealth Assurance Dashboard license expires this financial year **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) • Using SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security).. • No controls in place for Bluetooth connectivity. • The extension of the mainstream support for SQL Server 2012 ended on 12 July 2022 • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS • Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server • MFA on limited number of systems • Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • Although got the licenses for SQL migration, some 2012 servers still need a migration plan/support to migrate them • Version 7 of Clinisys Ice is end of life	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital	Deacon, Stephen	30/06/2023	

Board Assurance Framework

Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]		Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]			
Cisco Phase 2 upgrade to replace aging network equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	Waterfield, Tracie	31/03/2023	
Mitigations to be put in for ORMIS security issue	Mitigations to be put in for ORMIS security issue	To set up security groups to stop unauthorised access to the SQL database.	Deacon, Stephen	31/03/2023	
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommsion Server 2012 servers	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to the latest Windows Server operating system or decommission them.	Waterfield, Tracie	31/10/2023	
Upgrade and enable DLP to enable USB read-only. Disabled as its is crashing desktops, needs the ePO agent on the server to be upgraded.	Upgrade and enable DLP	Upgrade and enable DLP	Waterfield, Tracie	31/03/2023	
Renew ITHealth Assurance Dashboard	Renew ITHealth Assurance Dashboard as this provides NHSD, Trust and ICB assurance regarding out Cyber Stance including NHS Digital's Cyber Security Bulletins	Obtain capital and renew the license	Deacon, Stephen	31/03/2023	
Upgrade Clinisys Ice to the new version	Upgrade Clinisys Ice to the new version	Meet with Clinisys Ice regarding funding, contractual questions and V7 End of life	Deacon, Stephen	31/03/2023	

Board Assurance Framework

Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If 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.			**Initial:**	25 (5x5)
				Current:	16 (4x4)
				Target:	5 (5x1)

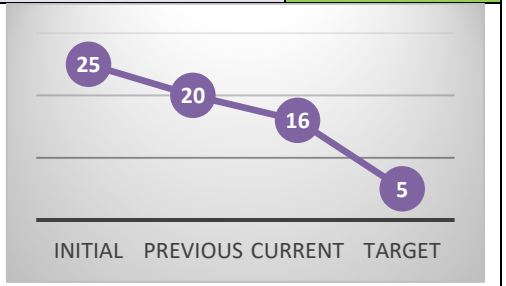
Assurance Details:

Controls

Triage and testing on emergency admission using molecular and PCR testing remains paused for asymptomatic patients.
Planned procedure testing SOP
Guidance for staff returning to on-site working (previously considered extremely vulnerable)
COVID-19 incidents are monitored daily.
Risk assessments are in place in all Wards/Departments and rest rooms and have been revised as per hierarchies of control.
Mask stations and sanitiser remain in place at most entrances and designated points throughout the Trust.
Agile working policy is in PLACE Information technology infrastructure is in place to support remote working.
Risk assessment in place to support safe visiting.
Providing and maintaining a clean environment that facilitates the prevention and control of infections.
Communications through TWSB to staff reinforcing updates to Covid-19 SOPs.
PPE audits completed weekly on wards and increased frequency during outbreaks.
PPE & swabbing champions identified.
Bioquell Pods now in place in ICU, ED and B18.
Cohorting of COVID-19 positive patients in place.
Surveillance of patient in bays for 7 days following Covid-19 exposure; early release plan from 1/09/2022 (5 days)
Revised guidance in place for respiratory and non-respiratory pathway.
Testing amended to include Influenza A&B & RSV. Agreed patient flow pathways based on results of screening.
IPC Team liaison with clinical teams on AGP precautions
IPC Team liaise with Patient Flow Team on patient placement
FFP3 fit testing programme in place.
Updates to Trust Guidance/SOPs in line with publication of national guidance and upload to the Hub
09/01/2023 concern relating to an emerging strain in China and triaging implemented to identify returning travellers for isolation and further national laboratory-based testing
Clear curtains in bays have been removed & Asymptomatic staff testing has ceased
Attention focussed on isolation of immunosuppressed patients from 01/09/2022
Nosocomial COVID-19 action plan reviewed at the Infection control Sub-committee
Winter Respiratory Virus Testing & Escalation Plan in place
Cleanliness Standards for Functional risks 1 and 2; 4 or 5 star ratings with 2-4 hour timescale to rectify issues
IPC Team and patient flow collaboration on optimal use of side rooms

Assurance

Trust completed learning from Nosocomial outbreaks sessions.
Outbreak meetings held with lessons learned shared across the Trust.
Updated IPC measures in place including the relaxation of mask wearing in certain areas of the Trust, a return to pre pandemic visiting arrangements and 1 relative/carer to accompany patients in the Emergency Department.
COVID-19 quality metrics in place.
Staff training in safe donning and doffing of PPE is included in mandatory training
Updated National Guidance in place from 1st September 2022

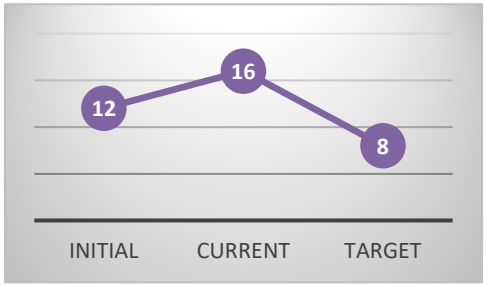


Board Assurance Framework

	Working with NHSE to revise hand hygiene audits using QR codes and visitor reporting	
Assurance Gaps:	Increased risk from return to pre-pandemic standards with removal of social distancing requirements, removal of universal masking and opening up visiting Non-compliance with PPE Mask station not present at all entrances Site-wide assessment of ventilation (mechanical and manual) – action plan required to ensure all areas with mechanical ventilation are compliant with standards Assurance on hand hygiene audits	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Review Nurse cleaning roles & responsibilities	Reviewed as part of a Task & Finish Group to implement revised cleanliness standards (published April2021) within an 18-month timescale	Agree roles and responsibilities	McGreal, Julie	18/02/23	
Site-wide assessment of ventilation	action plan required to ensure all areas with mechanical ventilation are compliant with standards	Production of action plan	Wright, Ian	31/03/23	

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Paul Fitzsimmons	**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 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 (3 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	**Assurance:** • A revised OBC has received Trust Board approval in Feb 2023 in line with emerging guidance on managed convergence. • Working with our partners STHK & S&O to finalise procurement timetable and align OBS timelines to deliver a partnership procurement • MOU and Partnership Procurement Group in Place reporting to EPR Project Group (and escalation/assurance through Digital, FSC and Trust Board) • Regular, documented conference calls with the ICS NHSE and NHSD – external partners supportive of managed convergence relaunch. **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 includes 3-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 collaboration 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:** • Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC • ICS strategic approach to managing financial consequences of delivering managed convergence through partnership procurement remain unclear **Gaps In Controls:** • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Delay due to a re-launch of procurement to ensure compliance with managed convergence guidance puts the procurement process out of schedule with current national Digital funding programs resulting in as yet unresolved capital expenditure scheduling issues • Any further delay due to delays incurred through nonalignment of timelines across the partnership procurement timetable risk procurement exceeding the approved funding period for the Lorenzo extension and/or the Lorenzo product withdrawal date				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	1757	**Executive Lead:**	Michelle Cloney	**Rating**	
Strategic Objective:	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				
Risk Description:	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action, then this could result in significant workforce gaps which would negatively impact service delivery and patient safety			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (4 x 2)

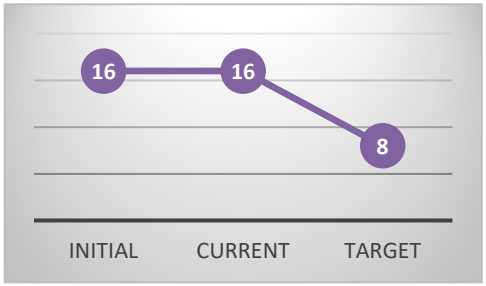
Control & Assurance Details:

Controls

- Weekly IA Task and Finish group established from 28th October 2022 requiring representatives from across all departments to attend to plan for IA.
- Derogation list for required services drafted for review as required with Staff Side once notification of strike received.
- Weekly meetings with Staff Side established to manage partner relationships.
- Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible.
- IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH.

Assurance

- Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice.
- Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action.
- Results received so far are that only Chartered Society of Physios have met IA threshold for WHH.
- Results for Junior Doctors have met the IA threshold IA planned for the 13-17 March 2023 - special March IA rate card agreed to support the Trust's response.
- AfC IA paused whilst decision made to accept/reject government offer

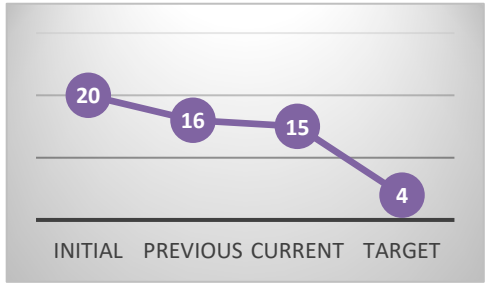


Assurance Gaps:

- Uncertain whether IA will be national or regional approach and potential impact for different unions. RCN approach is based on individual Trusts.
- Lack of clarity from the ICB regarding mutual aid
- Lack of MOU from ICB

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Weekly meeting with staff side chair and deputy	Weekly meeting with staff side chair and deputy to be diarised to take place with People Directorate in order to plan and update regarding Industrial Action	Weekly meeting to be diarised to include People Directorate representatives and Staff Side	Hilton, Laura	31/05/2023	
Weekly Industrial Action Update to Execs	Executive Management Team to receive weekly updates on Industrial Action	Executive Management Team to receive weekly updates on Industrial Action	Hilton, Laura	28/03/2023	
Set up Industrial Action task and finish group	To set up a Trust wide Industrial Action Task and Finish group to prepare for industrial action	Identify key stakeholders Set terms of reference and frequency of meeting Set work plan	Hilton, Laura	31/05/2023	
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	31/05/2023	
Clarify mutual aid and MOU approach from ICB	Communicate with ICB to clarify regional mutual aid and MOU approach	Through HR and Emergency preparedness meetings with ICB, work to establish ICB mutual aid and MOU approach	Hilton, Laura	31/05/2023	

Board Assurance Framework

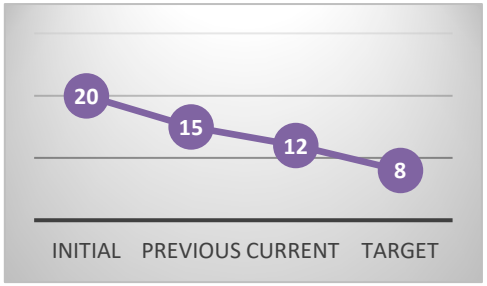
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns			**Initial:** 20 (5x4) **Current:** 15 (3x5) **Target:** 3 (3x1)
Assurance Details:	**Controls:** Annual capital funding is allocated to business critical, mandated and statutory estates projects Planned Maintenance Program Reactive maintenance process Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments **Assurance:** Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Non funded capital schemes are risk rated and monitoired through the above group Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment with subsequent action plan Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks Cleanliness monitoring identifies estates issues that are addressed through the estates building officer Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations Mechanical Craftsperson and Electrician business case approved providing stability of workforce and retention of skills In September 2022 it has been confirmed that phase 1 of the CDC & the Targetted Investment Fund (TIF) for delivery of elective recovery at the Halton site have both been approved. The capital builds in these cases will substantially increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a daycase unit and increased CT and MR capacity			
Assurance Gaps:	Limited capital funding to address backlog Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM) Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market.			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	30/06/2023	

Board Assurance Framework

Develop estates maintenance compliance monitoring tools	Integrate performance and compliance into0 routing estates maintenance operations	Head of compliance and performance in post in April 2022 and will develop initiatives, processes and protocols to drive estates maintenance performance and in turn improve compliance against recommended guidelines and internal KPIs	Ian Wright	31/03/2023	
Procure new and improved Computer Aided Facilities Management (CAFM) software	Procure software that will improve estates and facilities compliance and forward planning	Liaise with procurement team to develop tender specification and subsequent awarding of contract to service provider	Ian Wright	31.7.2023	

Board Assurance Framework

Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
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.			**Initial:**	20 (5x4)
				Current:	12 (3x4)
				Target:	8 (4x2)
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. Some examples include: • The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. • Council and PLACE Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level have been refreshed • Breast Centre of Excellence opened. Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved. • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside has been approved. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. • Revised plans for CDC approved by Trust Board and national diagnostics team. • Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington Town Centre. Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. Health & Social Care Academy opened. - Full Business Case for the Health & Wellbeing Hub approved by the Government. Contractors appointed to commence the capital works for Health & Wellbeing Hub. • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 presented to Trust Board for approval. • 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 newly established place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected.				

Board Assurance Framework

	• £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Drafts of both reviews complete. • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities. • Director of Strategy & Partnerships co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Adaptive Reserve Fund created with Warrington PLACE partners • Discussions with neighbouring Trusts to accelerate collaboration taking place **Assurances** • 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. • Regular Strategy updates are provided to the Council of Governors & Trust Board • Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services. Halton Health Hub in Shopping City opened in November 2022. • Full refresh of the Trust 5-year strategy in progress and due to complete in April 2023 • 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.	
Assurance Gaps:	• Risk to securing capital funding to progress new hospitals • 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. • Pace of Pathology collaboration enhances the risk to the Trust's delivery of Pathology services. • Trust's capacity to deliver significant number of capital projects	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/10/2023	
Accelerate Pathology Collaboration Programme	Review options to accelerate Pathology Collaboration Programme	Review options to accelerate Pathology Collaboration Programme	Lucy Gardner & Paul Fitzsimmons	31/05/2023	
Ensure sufficient capacity to deliver increased number of capital projects	Undertake Gap Analysis of requirements vs resource	Address any gaps identified	Lucy Gardner & Dan Moore	31/08/2023	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/03/29**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	29th March 20323	
AUTHOR(S):	Marie Garnett – Head of Contracts, Performance and Commercial Development Bethan Thompson – Senior Performance and Systems Development Lead	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four-hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#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. **#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. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer, and ED Performance.	

EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 82 IPR indicators which have been placed into the following categories based on SPC/Making Data Count "Assurance" principles and performance over the last 6 months: **Consistently passes the target: 18** **Consistently fails the target: 25** **Inconsistently passes/fails the target: 10** **No SPC/Not enough datapoints: 29** There is special cause variation of a concerning nature, as the Trust has consistently failed to meet the following indicator variance targets in the last 6 months: Medicines Reconciliation within 24 hours, Staffing – Care Hours Per Patient Day, RTT 18 Weeks, A&E 4 Hour Standard, Super Stranded Patients, Outpatient Appointments Delivered Remotely, Recruitment Time to Hire (Days), Vacancy Rates, Better Payment Practice Code (Cumulative). SPC assurance cannot be determined for the following indicators that have not achieved their target in the last 6 months: A&E Waiting Times (12 Hours), COVID-19 Recovery (Inpatient/Daycase), COVID-19 Recovery (Outpatients), RTT – Number of Patients Waiting 78+ Weeks, Safeguarding Training, Friends and Family – ED and UCC, Sepsis Screening for all emergency patients within 1 hour, Sepsis Screening for all inpatients within 1 hour, Sepsis within an emergency setting receiving antibiotics with 1 hour, Sepsis within an inpatient setting receiving antibiotics with 1 hours. The Trust has submitted a £6.1m deficit plan for 2022/23, the revised forecast is a £5.4m deficit. The month 11 position is a £5.61m deficit year to date which is slightly better than plan.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive. 2. Note the changes approved by the Finance and Sustainability Committee on behalf of the Trust Board as per the delegated authority set out in Section 2.5. 3. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee		
	Agenda Ref.			
	Date of meeting			

	Summary of Outcome	• Capital Requests Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	**AGENDA REF:**	**BM/23/03/29**

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

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

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

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

- Quality
- Access and Performance
- Workforce
- Finance 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" category. **Table 2** contains the number of IPR indicators in each Making Data Count "Variation" category.

Table 1: Assurance Categories*

		Quality	Access & Performance	People	Finance & Sustainability
	**Consistently Passes the Target (based on the last 6 months)**	9	5	3	1
	**Consistently Fails the Target (based on the last 6 months)**	7	11	6	1
	**Inconsistently Passes/Fails the Target**	1	4	3	2
	**No SPC/Not Enough Datapoints/Not Applicable**	10	15	1	3
Total		**27**	**35**	**13**	**7**

*based on the last 6 months performance.

Table 2: Variation Categories

		Quality	Access & Performance	People	Finance & Sustainability
	**Common Cause Variation**	9	13	5	0
	**Special Variation of an Improving Nature**	3	4	3	0
	**Special Variation of a Concerning Nature**	2	4	2	1
	**No SPC/Not Enough Datapoints/Not Applicable**	13	14	3	6
Total		**27**	**35**	**13**	**7**

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**.

2.2 QUALITY

Assurance

There are 7 Quality indicators which are consistently failing the target in February, these are:

- 10. Medication Reconciliation within 24 hours – the Trust achieved 43%, against a target of 80%
- 12. Care Hours Per Patient Day (CHPPD) – the Trust achieved 7.2 hours against a target of 7.9 hours.
- 18. Friends & Family Test (Urgent & Emergency Care) – the Trust achieved 78%, against a target of 87%.
- 21. Sepsis Screening (Emergency Patients) – the Trust achieved 86%, against a target of 90%.
- 22. Sepsis - % screening for all inpatients within 1 hour – the Trust achieved 88%, against a target of 90%.
- 23. Sepsis Antibiotics Administration (Emergency Patients) – the Trust achieved 78%, against a target of 90%.
- 24. Sepsis Patients receive antibiotics administered within 1 hour of diagnosis– the Trust achieved 80%, against a target of 90%.

There is 1 Quality indicator which is inconsistently passing/failing the target in February, this is:

- 7. VTE Assessment – the Trust achieved 95.58%, against a target of 95%. Therefore, this target was achieved in February.

Variation

There are 2 Quality indicators which are indicating special cause variation of a concerning nature in February, these are:

- 10. Medicines Reconciliation within 24 hours
- 12. Staffing – Care Hours Per Patient Day

2.3 ACCESS AND PERFORMANCE

Assurance

There are 11 Access & Performance indicators which are consistently failing the target in February, these are:

- 28. Diagnostics 6 Week Waiting Times – the Trust achieved 78.46%, against a target of 99%.
- 29. Referral to Treatment – 18 Weeks – the Trust achieved 57.54%, against a target of 92%.
- 30. Referral to Treatment – 104 Week Waits – there was 1 patient waiting over 104 weeks, against a target of 0. Whilst this indicator doesn't comply with the target, this is in line with the Trusts 2022/23 plan.
- 31. A&E Waiting Times – 4 hours – the Trust achieved 65.13%, against a target of 95%.
- 35. Cancer 14 Days – the Trust achieved 83.60% in January, against a target of 93%.

- 41. Cancer 62 Day Urgent – the Trust achieved 57.29% in January, against a target of 85.00%.
- 43. Ambulance Handovers within 15 minutes – the Trust achieved 45.80%, against a target of 65%.
- 44. Ambulance Handovers within 30 minutes – the Trust achieved 68.66%, against a target of 95%.
- 45. Ambulance Handovers within 60 minutes – the Trust achieved 75.02% in February, against a target of 100%.
- 46. Discharge Summaries (24 Hours) – the Trust achieved 87.85%, against a target of 95%.
- 55. % Outpatient Activity Delivered Remotely – the Trust achieved 10.79%, against a target of 25%.

There are 3 Access & Performance indicators which are inconsistently passing/failing the target in the last 6 months, these are:

- 36. Breast Symptoms 14 Days – the Trust achieved 89.66% in January, against a target of 93%. Therefore, this target was not achieved in January.
- 37. Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 63.95% in January, against a target of 75%. Therefore, this target was not achieved in January.
- 47. Discharge Summaries (7 Days) – there were 51 discharge summaries not sent within 7 days to meet the requirement, against a target of 0. Therefore, this target was not achieved in February.

SPC Assurance cannot be determined for the following indicators which have failed to meet the target in February:

- 33. A&E Waiting Times (12 Hours) – the Trust achieved 19.91%, against a target of 2% or less.
- 52. COVID-19 Recovery (Inpatient/Daycase) – the Trust achieved an average of 85.07% for inpatient/day cases combined, against a target of 104%.
- 54. COVID-19 Recovery (Outpatients) – the Trust achieved 87.68% of outpatient activity, against a target of 104%.
- 58. RTT – Number of Patients Waiting 78+ Weeks – the Trust achieved 171 patients, against a target of 0.

Variation

There are 4 Access & Performance indicators which are indicating special cause variation of a concerning nature, these are:

- 29. Referral to Treatment – 18 Weeks
- 31. A&E Waiting Times – 4 Hours
- 51. Super Stranded Patients
- 55. % Outpatient Activity Delivered Remotely

2.4 PEOPLE

Assurance

There are 6 People indicators which are consistently failing the target in February, these are:

- 60. Supporting Attendance – the Trust achieved 5.6%, against a target of 4.2% or less
- 62. Recruitment Time to Hire – time to hire average days was 105, against a target of 65 days or less
- 63. Vacancy Rate – the Trust achieved 11.53%, against a target of 9% or less
- 64. Retention – the Trust achieved 83.36%, against a target of 86%
- 65. Turnover – the Trust achieved 15.98%, against a target of 13% or less
- 66. Bank & Agency Reliance – the Trust achieved 17%, against a target of 9% or less

There are 3 People indicators which are inconsistently passing/failing the target in February, these are:

- 61. Welcome Back Conversations – the Trust achieved 72.54%, against a target of 85%, therefore the target was not achieved in February.
- 67. Monthly Pay Spend – monthly pay spend was £19.5m, against a budget of £19m. Therefore, this target was not achieved in February.
- 72. PDR Compliance – the Trust achieved 64.24%, against a target/trajectory of 79%. Therefore, this target was not achieved in February.

SPC Assurance cannot be determined for the following indicator which has failed to meet the target in February:

- 70. Safeguarding Training – the Trust achieved 64.24%, against a target/trajectory of 79%.

Variation

There are 2 People indicators which are indicating special cause variation of a concerning nature, these are:

- 62. Recruitment Time to Hire (Days)
- 63. Vacancy Rates

2.5 FINANCE AND SUSTAINABILITY

Assurance

There is 1 Finance & Sustainability indicator which is consistently failing the target in February, this indicator is:

- 76. Better Practice Payment Code – the Trust achieved 92% (cumulative), against a target of 95%.

There are 2 Finance & Sustainability indicators which are inconsistently passing/failing the target, these are:

- 73. Trust Financial Position For the period ending 28 February 2023, the Trust recorded a year-to-date deficit position of £5.6m against a plan of £6.8m. Therefore, this target was achieved in February.

- 75. Capital Spend – Capital expenditure year to date is £9.3m, a variance of £6.1m compared to plan of £15.4m. Therefore, this target was not achieved in February.

Variation
There is 1 Finance & Sustainability indicator which is indicating special cause variation of a concerning nature, this is:

- 76. Better Payment Practice Code (Cumulative)

The Income and Activity Statement for February 2023 is attached in **Appendix 5**.

The Trust has agreed a control total of £6.1m deficit with Cheshire & Merseyside ICS, this has been adjusted to £5.4m deficit follow receipt of additional income. There are several risks to the achievement of the planned £6.1m deficit. The key risks are as follows:

- CIP delivery.
- Achievement of Elective Recovery Fund (ERF) - during February 2023 elective activity has underperformed against plan. The position also shows an under performance against all elective activity to date, however the income has been assumed in the forecast.
- A&E staffing pressures.
- Additional capacity.

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

The Trust is forecasting delivery of £5.4m deficit. The M11 position is £5.61m deficit. Therefore, the Trust is in a strong position to ensure delivery of the control total.

Cash
The cash balance at the end of February is £33.9m, which is £10.3m higher than plan (£23.6m). This is due to a timing difference in the payment of trade creditors and capital creditors, additional income from contracts and additional VAT recovery.

CIP
At 28 February 2023, the Trust has delivered a CIP of £11.0m against a target of £13.8m year to date. £1.1m CIP remains unidentified. Only £1.6m recurrent CIP has been identified presenting a risk to future sustainability. The level of non-recurrent CIP will significantly impact on the 2023/24 Operational Plan and work continues to develop CIP plans for 2023/24.

Capital Programme
The Trust has a capital programme of £25.3m (reduced from £29.5m due to £2.2m reduction in CDC and slippage of £2.1m of the Warrington Town Deal Wellbeing Hub to 2023/24. In February 2023, the Trust received notice of capital funding approved for medical equipment; Cancer Treatment – Pintuition £41k and NW Endoscopy £42k slight increasing the plan).

At 28th February 2023, the year-to-date capital spend is £9.3m, a variance of £6.1m compared to plan of £15.4m. The Capital Planning Group continues to monitor any underspends or

slippage of schemes and looks to bring forward any mandatory schemes from 2023/24 as necessary.

Table 3 provides a breakdown of capital expenditure by category.

Table 3: Capital Expenditure by category as at 28 February 2023

	Annual Plan	Plan YTD	Actual YTD	Variance against Plan YTD
	£'m	£'m	£'m	£'m
Estates	7.8	7.3	5.1	2.2
IM&T	2.2	2.0	1.3	0.7
Medical Equipment	2.5	1.3	1.5	-0.1
Contingency	-	-	-0.7	0.7
Sub total	12.5	10.6	7.1	3.5
External Funded	12.8	4.8	2.2	2.6
Total	25.3	15.4	9.3	6.1

Table 4 highlights the current contingency and **Appendix 6** contains the updated Capital Programme.

Table 4: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 11		**197**
Additional capital request approved at FSC 22nd February		
Therapies Staff Room	-13	
Sub total		**- 13**
Emergency capital request approved by the CFO & Deputy CEO		
Tissue Processor	-47	
ECG Machine	-8	
Patient Meal Trolleys	-42	
Sub Total		**-97**
Capital change to plan from the Capital Planning Group (10 Mar 2023)		
Vat Rebate	4	
Year End Accruals - no longer required	198	
Catering Slippage - prioritise in 2023/24	485	
ED Minors slippage - prioritise in 2023/24	149	
Induction Labour - prioritise in 2023/24	251	
Bath Street Lease - funded from IFRS16 CDEL	305	
Mammography Equipment Replacement (enabling works only) Bath Street underspend	12	
Neonatal Scanner underspend	18	
Tissue Processor - price is less than expected	10	
Sub Total		**1,432**
Capital request from the Capital Planning Group (10 Mar 2022)		
Capital request Brought forward from 23/24 as presented in FSC 22 Feb 2023		
Warrington & Halton Hand Rails to Circulation Areas	- 100	
Anaesthetic Machines (CSTM)	- 175	
Laparscopic Stackers	- 113	
Patient Postioning Stirups	- 40	
Anaesthetic Ultrasound to meet ASCA Standards	- 60	
Device Replacement (Tech Refresh) - some brought forward	- 500	
Sub Total		**- 988**
Contingency as at 10 Mar 2023 - following CPG		**531**

Capital Requests

The Trust Board is asked to:

- Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive.
- Note the changes approved by the Finance and Sustainability Committee on behalf of the Trust Board as per the delegated authority set out in Section 2.5.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Strategic People Committee
- Clinical Recovery Oversight Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the emergency capital requests approved by the Chief Finance Officer and Deputy Chief Executive.
2. Note the changes approved by the Finance and Sustainability Committee on behalf of the Trust Board as per the delegated authority set out in Section 2.5.
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 (over 40 days old)	0	0	Feb-23		0	Jan-23	P
2	Duty of Candour (serious incidents)	100.00%	100.00%	Feb-23		100%	Jan-23	P
3	Healthcare Acquired Infections - MRSA	0	0	Feb-23	L	0	Jan-23	P
4	Healthcare Acquired Infections – CDI	Less than 37 for 2022/23	3	Feb-23		7	Jan-23	No SPC
5	Healthcare Acquired Infections – Gram Negative (E.coli)	Less than 57 for 2022/23	4	Feb-23		2	Jan-23	No SPC
6	Healthcare Acquired Infections - COVID-19 Outbreaks	N/A	7	Feb-23	No SPC	2	Jan-23	No SPC
7	VTE Assessment	95.00%	95.58%	Feb-23		95.47%	Jan-23	?
8	Inpatient Falls & Harm Levels	20.00% annual reduction based on 590 in 2021/22	46	Feb-23		40	Jan-23	No SPC
9	Pressure Ulcers (Total)	10.00% reduction based on 91 in 2021/22	10	Feb-23		12	Jan-23	No SPC
10	Medication Safety (24 Hours)	80.00%	43.00%	Feb-23	L	52.00%	Jan-23	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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11	Staffing – Average Fill Rate (Combined)	90.00%	90.02%	Feb-23	No SPC	94.88%	Jan-23	No SPC
12	Staffing – Care Hours Per Patient Day	7.9	7.2	Feb-23	L	7.4	Jan-23	F
13	Mortality ratio - HSMR	N/A	92.38	Feb-23	No SPC	93.20	Jan-23	No SPC
14	Mortality ratio - SHMI	N/A	96.72	Feb-23	No SPC	96.72	Jan-23	No SPC
15	NICE Compliance	90.00%	91.65%	Feb-23	H	92.31%	Jan-23	P
16	Complaints (open over 6 months)	0	0	Feb-23		0	Jan-23	P
17	Friends & Family – Inpatients & Day cases	95.00%	97.00%	Feb-23	No SPC	98.00%	Jan-23	P
18	Friends & Family – ED and UCC	87.00%	78.00%	Feb-23	No SPC	84.00%	Jan-23	F
19	Mixed Sex Accommodation Breaches (Non ITU Breaches Only)	0	0	Feb-23	No SPC	0	Jan-23	P
20	Continuity of Carer	51.00%	82.20%	Feb-23	H	80.90%	Jan-23	P

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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21	Sepsis - % screening for all emergency within 1 hour.	90.00%	86.00%	Feb-23	No SPC	69.00%	Jan-23	F
22	Sepsis - % screening for all inpatients within 1 hour.	90.00%	88.00%	Feb-23	No SPC	74.00%	Jan-23	F
23	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.	90.00%	78.00%	Feb-23	No SPC	72.00%	Jan-23	F
24	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.	90.00%	80.00%	Feb-23	No SPC	81.00%	Jan-23	F
25	Ward Moves between 10:00pm and 06:00am	N/A	68.00	Feb-23	No SPC	N/A	N/A	No SPC
26	Number of Hospital Acquired Acute Kidney Injuries	Less than previous month	148	Feb-23	No SPC	184	Jan-23	No SPC
27	Number of CAS Alerts Actions Breached	0	0	Feb-23		0	Jan-23	P

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
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
28	Diagnostic Waiting Times 6 Weeks	99.00%	78.46%	Feb-23	H	73.25%	Jan-23	F
29	RTT - Open Pathways (18 Weeks)	92.00%	57.54%	Feb-23	L	58.14%	Jan-23	F
58	RTT – Number of Patients Waiting 78+ Weeks	0	171.00	Feb-23	No SPC	209	Jan-23	No SPC
30	RTT – Number of Patients Waiting 104+ Weeks	0	1	Feb-23	L	4	Jan-23	F
31	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	95.00%	65.13%	Feb-23	L	64.53%	Jan-23	F
32	A&E Waiting Times – ICS Trajectory	Trajectory TBC for 2022/23			No SPC			No SPC
33	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2.00% or less	19.91%	Feb-23	No SPC	22.37%	Jan-23	No SPC
34	Average time in department ED (mins)	N/A	379	Feb-23	No SPC	435	Jan-23	No SPC
35	Cancer 14 Days*	93.00%	83.60%	Jan-23		85.15%	Dec-22	F
36	Breast Symptoms 14 Days*	93.00%	89.66%	Jan-23	H	100.00%	Dec-22	?

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

37	Cancer 28 Day Faster Diagnostic*	75.00%	63.95%	Jan-23		72.72%	Dec-22	
38	Cancer 31 Days First Treatment*	96.00%	97.50%	Jan-23		98.48%	Dec-22	
39	Cancer 31 Days Subsequent Surgery*	94.00%	100.00%	Jan-23		100.00%	Dec-22	
40	Cancer 31 Days Subsequent Drug*	98.00%	100.00%	Jan-23		100.00%	Dec-22	
41	Cancer 62 Days Urgent*	85.00%	57.29%	Jan-23		73.81%	Dec-22	
42	Cancer 62 Days Screening*	90.00%	90.63%	Jan-23		100.00%	Dec-22	
43	Ambulance Handovers within 15 minutes	65.00%	45.80%	Feb-23		24.18%	Jan-23	
44	Ambulance Handovers within 30 minutes	95.00%	68.66%	Feb-23		47.65%	Jan-23	
45	Ambulance Handovers within 60 minutes	100%	75.02%	Feb-23		57.61%	Jan-23	
46	Discharge Summaries - % sent within 24hrs	95.00%	87.85%	Feb-23		90.89%	Jan-23	
47	Discharge Summaries – Number NOT sent within 7 days	0	51	Feb-23		0	Jan-23	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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48	Cancelled Operations on the day for a non-clinical reasons	Please note: Validation for this indicators was in progress at the time of reporting.						No SPC
49	Cancelled Operations– Not offered a date for readmission within 28 days							No SPC
50	Urgent Operations – Cancelled for a 2nd time	0	0	Feb-23		0	Jan-23	P
51	Super Stranded Patients	Trajectory TBC for 2022/23	156	Feb-23	H	159	Jan-23	No SPC
52	COVID-19 Recovery Elective (Inpatient/Daycase) - (Average)	104%	85.07%	Feb-23	No SPC	85.07%	Jan-23	No SPC
53	COVID-19 Recovery Diagnostic Activity - (Average)	104%	111.27%	Feb-23	No SPC	111.27%	Jan-23	No SPC
54	COVID-19 Recovery Outpatient Activity	104%	90.87%	Feb-23	No SPC	86.89%	Jan-23	No SPC
55	% Outpatient Appointments delivered remotely	25.00%	10.79%	Feb-23	L	10.31%	Jan-23	F
56	% of Patients seen in the fracture clinic within 72 hours	95.00%	89.00%	Feb-23		97.70%	Jan-23	?
57	% patients referred to long COVID service not assessed within 15 weeks	N/A	0	Feb-23	No SPC	0	Jan-23	No SPC
59	% of zero-day length of stay admissions (as a proportion of total)	N/A	89%	Feb-23	No SPC	84%	Jan-23	No SPC
80	Reduction in Outpatient Follow Ups	N/A	85%	Feb-23	No SPC	88%	Jan-23	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

81	COVID-19 Recovery Cancer First Treatment	N/A	0%	Feb-23	No SPC		0%	Jan-23	No SPC
82	% Patients discharged to their usual place of residence	N/A	96%	Feb-23	No SPC		94%	Jan-23	No SPC

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
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
60	Supporting Attendance	4.20%	5.60%	Feb-23		6.09%	Jan-23	F
61	Welcome Back Conversations	85.00%	72.54%	Feb-23	H	84.91%	Jan-23	?
62	Recruitment Time to Hire (Days)	65	105	Feb-23	H	102	Jan-23	F
63	Vacancy Rates	9.00%	11.53%	Feb-23	H	11.92%	Jan-23	F
64	Retention	86.00%	83.36%	Feb-23		83.39%	Jan-23	F
65	Turnover	13.00%	15.98%	Feb-23		16.24%	Jan-23	F
66	Bank & Agency Reliance	9.00%	17.00%	Feb-23		17.61%	Jan-23	F
67	Monthly Pay Spend (Contracted & Non-Contracted)	£19,007,534.00	£19,545,162.74	Feb-23		£20,015,333.95	Jan-23	?

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

68	Core/Mandatory Training	85.00%	86.11%	Feb-23	H	85.43%	Jan-23	P
69	Role Specific Training	85.00%	84.21%	Feb-23	No SPC	85.09%	Jan-23	P
70	Safeguarding Training	83.00%	76.04%	Feb-23	No SPC	75.02%	Jan-23	No SPC
71	% Workforce carrying out an Apprenticeship Qualification	2.30%	2.98%	Feb-23	No SPC	3.09%	Jan-23	P
72	PDR Compliance	79.00%	64.24%	Feb-23	H	63.89%	Jan-23	?

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

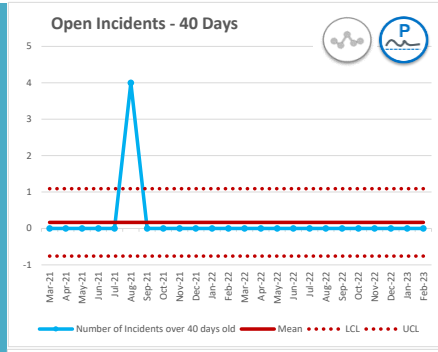
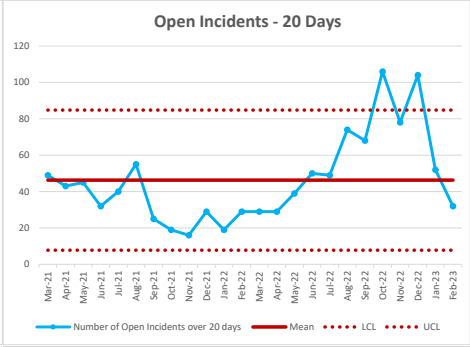
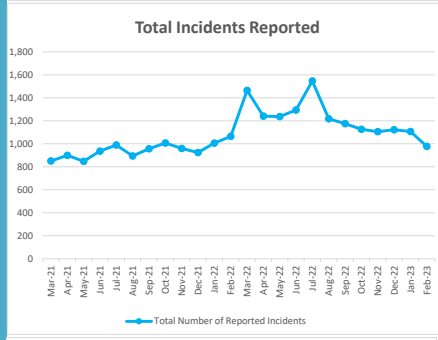
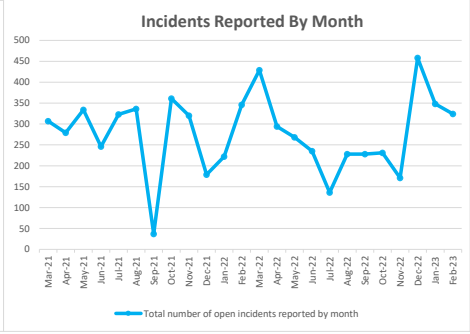
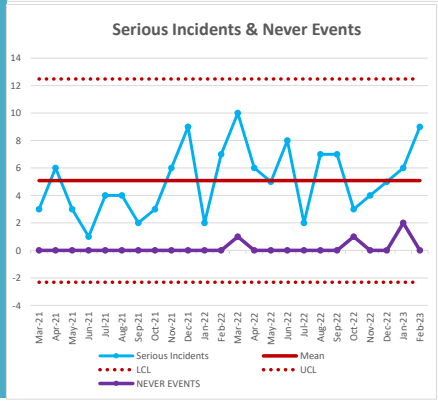
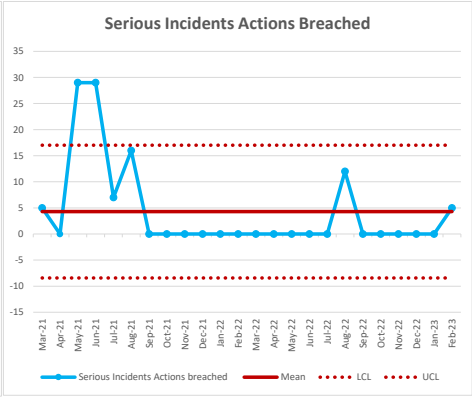
- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target*
- Inconsistently passes and fail the target*
- Consistently fails the target*

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
73	Trust Financial Position £m (Cumulative)	-6.83	-5.61	Feb-23	No SPC	-7.05	Jan-23	?
74	Cash Balance £m	23.60	33.90	Feb-23	No SPC	34.34	Jan-23	P
75	Capital Programme Spend £m (Cumulative)	15.393	9.30	Feb-23	No SPC	7.42	Jan-23	?
76	Better Payment Practice Code (Cumulative)	95%	92%	Feb-23	L	92%	Jan-23	F
77	Use of Resources Rating	Please note: This indicator is currently suspended. The Trust is awaiting further guidance from NHSE/I.						No SPC
78	Cost Improvement Programme – Performance (Recurrent and Non-recurrent delivered) £m	2.10	2.10	Dec-22	No SPC	1.20	Nov-22	No SPC
79	Cost Improvement Programme – Forecast (Recurrent) £m	5.60	1.90	Dec-22	No SPC	N/A	N/A	No SPC

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 **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	  **There were 0 incidents over 40 days old and 32 incidents open over 20 days old. These have all had a first review and have been sent to the relevant department, no concerns noted with those over 20 days.**	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**Incident reporting remains within range with little variance across the Trust.**	**A weekly governance dashboard is overseen by the Executive Team. This monitors trends in reporting. This will be supported further going forward through the transition of the Patient Safety Incident Response Framework.**
	 		**There are 0 overdue 40-day incidents.**	**Weekly CBU monitoring continues to ensure supports with timely escalate that the position is maintained.**
	 		**There were 9 serious incidents reported in February 2023. No themes identified or specific areas.** **There were 5 breached serious incident actions in February 2023.**	**This is within statistical control.** **Weekly monitoring continues with appropriate escalation to the CBU leads. The position has occurred in ED as a result of staffing challenges. This is improving and a Lead Nurse has now commenced post. The Lead Nurse will provide direct oversight of incident actions. All other areas remain stable.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

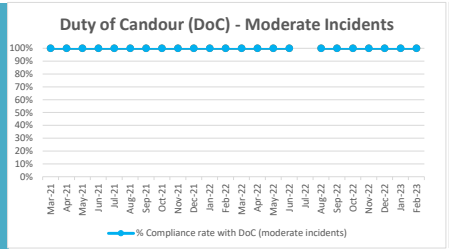
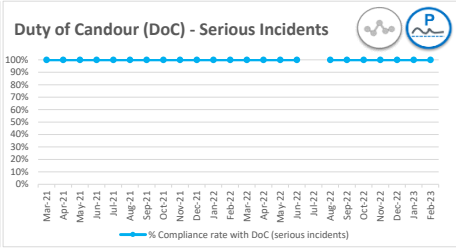
Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116 Risk Register
Trust Strategy

Quality Improvement - Trust Position

Appendix 2

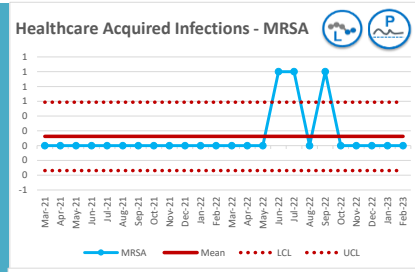
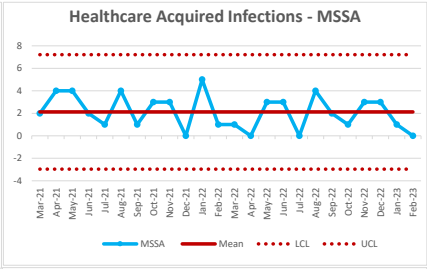
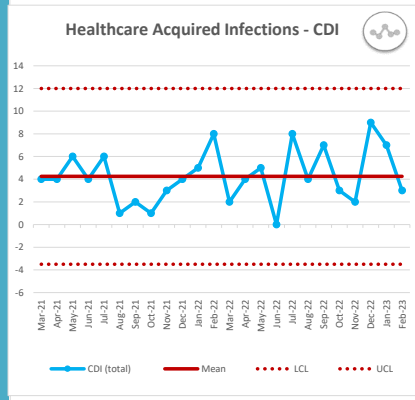
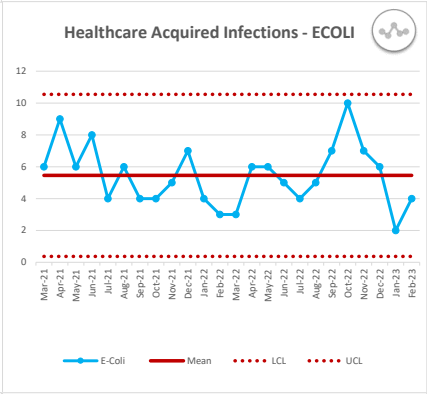
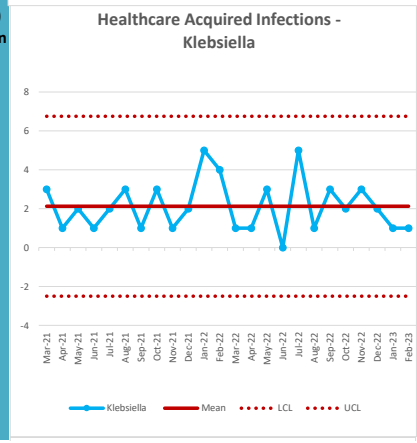
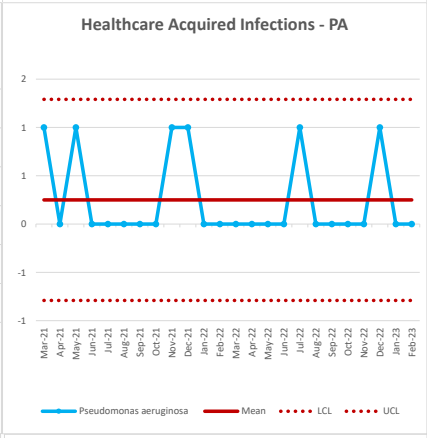
2. Duty of Candour

Target: 100%

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)?
CQC **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, the Trust remains 100% compliant.**	**Robust weekly monitoring is undertaken by the Patient Safety Manager to ensure compliance is maintained.**

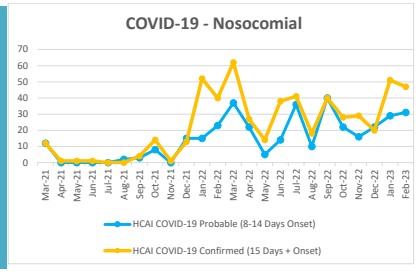
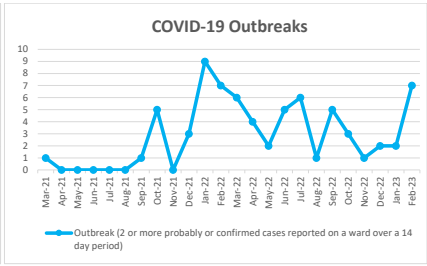
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO 4. Healthcare Acquired Infections (CDI) Target: Less than 37 -annual 5. Healthcare Acquired Infections (Ecoli) Target: less than 57 - annual (Klebsiella) Target: Less than 19 - annual (PA) Target: Less than 6 - annual	MRSA 3 cases over threshold MSSA 20 cases YTD - no threshold set CDI 52 cases YTD, annual threshold exceeded by 15 cases E. coli 62 cases YTD (1 case over the annual threshold) Klebsiella spp. 22 cases YTD (2 cases over the annual threshold) P. aeruginosa 2 cases YTD (within trajectory) Covid-19: 249 day 8-14 cases probable healthcare associated cases YTD 354 day 15+ cases definite healthcare associated YTD 7 in month COVID-19 outbreaks	     	(MRSA) Assurance: The Trust consistently passes the target. (MRSA) Variation: Special Cause Variation of an improving nature. (CDI) Assurance: N/A Annual Target (CDI) Variation: Common Cause (Normal) variation. (ECOLI) Assurance: N/A Annual Target (ECOLI) Variation: Common Cause (Normal) variation.	Case 1 (A8) - highly likely urinary tract infection associated and considered avoidable. Case 2 (C23) - household contact, considered unavoidable. Case 3 (A2) - considered unavoidable. Higher incidence of C. difficile across the northwest which NHSE are reviewing. Increase in antibiotic prescribing associated with respiratory infections following Covid-19/influenza and winter season The change in the apportionment rule to include COHA cases has increased the number of GNBSI cases apportioned to the Trust.	Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with invasive devices. CDI prevention action plan in place. RCA investigations & review meetings will continue, approach will be aligned to PSIRF, SIGHT mnemonic education will continue, review of approach to auditing hand hygiene with NHSE, C. difficile study days in April. Audit of hepatobiliary cases has commenced, revise GNBSI RCA template and re-introduce RCA investigation of hospital onset cases - aligning approach to PSIRF, review urinary catheter use and protocol for nurse led removal, focus support on wards with higher UTI associated cases. Reconvene the GNBSI Prevention Group.

Quality Improvement - Trust Position

Appendix 2

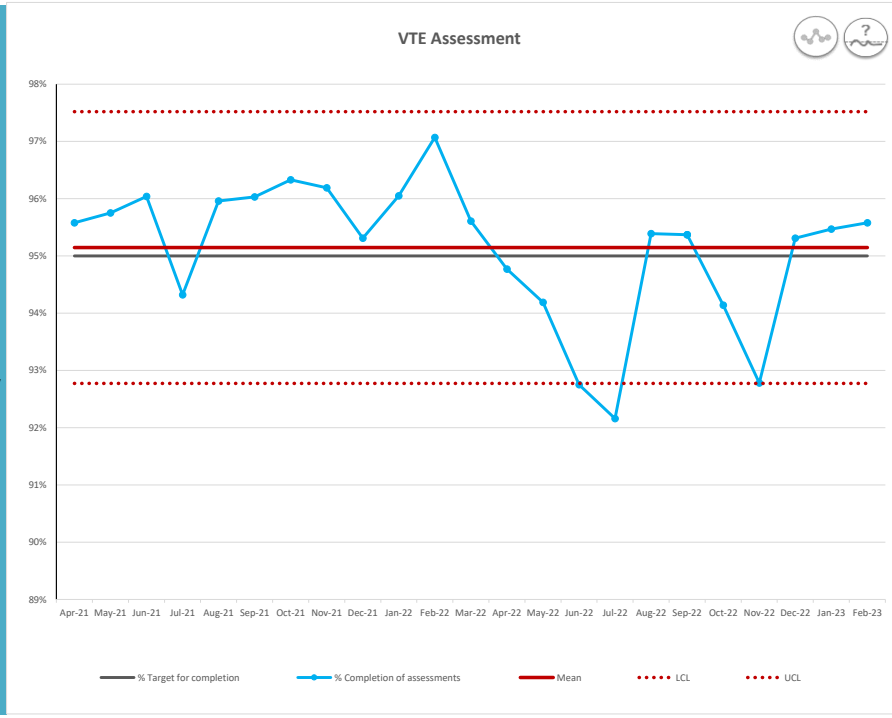
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
6. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)	RR1275	 	N/A - No target.	Implementation of revised national approach to testing. Admission, day 3 and day 5 testing paused. Winter season with increase in respiratory infections.	Close liaison with operational teams for patient placement. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients, staff and visitors. Respiratory infection (including influenza ward escalation plans for winter pressures in place). The national requirements to report Covid-19 outbreaks remains in place.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

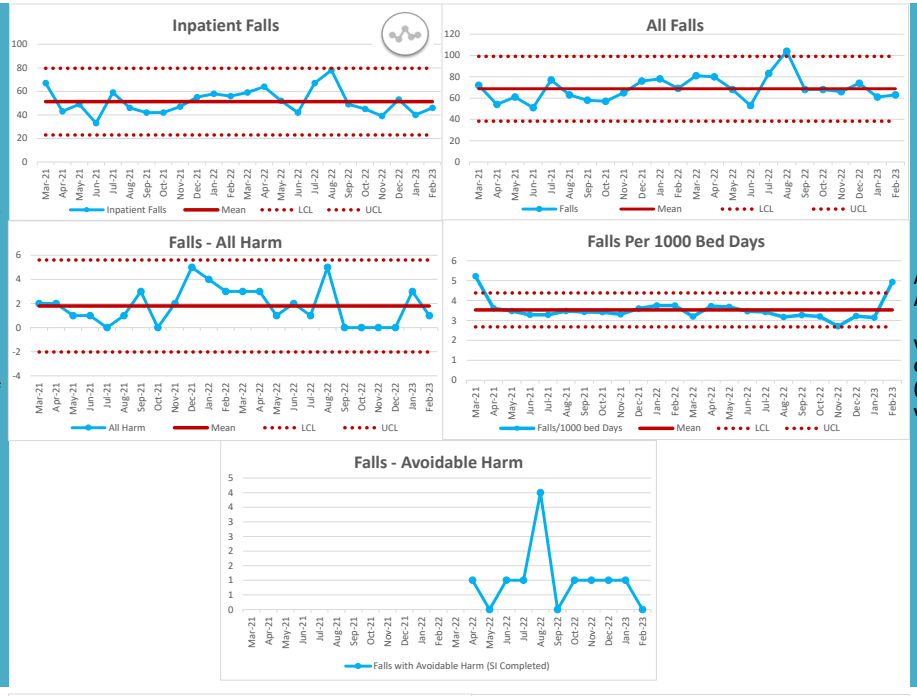
Quality Improvement - Trust Position

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)?
7. VTE Assessment **Target: 95% (quarterly position)** SOF ☆ **The Trust achieved the required target at 95.58% for VTE assessments in January 2023.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Year to date performance from April 2022 has been on track at 95.52 %.**	**Current systems in place to improve VTE compliance:** **1. Inconsistent use of the standardised RWW CDC initial clinical assessment and ward round forms within the surgical specialties** **2. Monthly CBU VTE RA compliance data with the breakdown at ward level has been distributed to all CBU governance meetings with the figures not completed at ward level to sustain the performance.** **3. to continue to raise awareness of the need for VTE completion with the changeover of junior doctors into 2nd 4 month placement.** **Future proactive approach/plan to improve VTE compliance within 14 hours of admission:** **1. To get the feedback from all CBUs how to improve future CBU VTE risk assessment compliance** **2. To add VTE risk assessment data to be visible at ward level for ownership of overall VTE compliance. This was endorsed by PSCESC as an one of the improvement plans based on VTE report.**

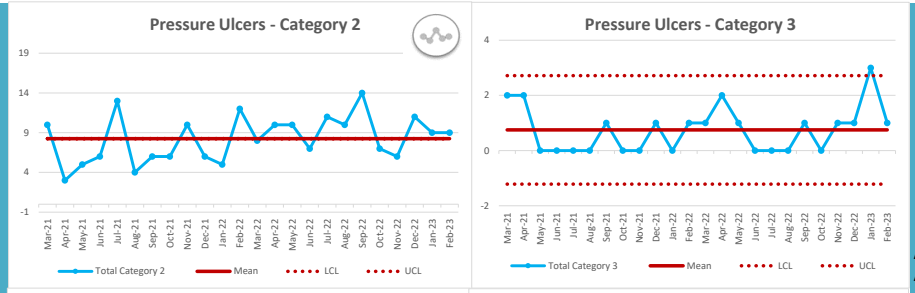
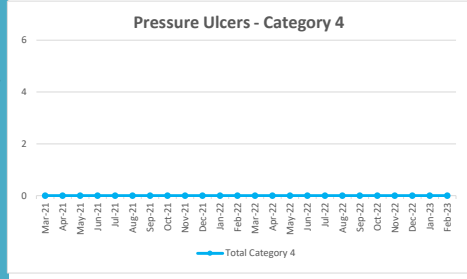
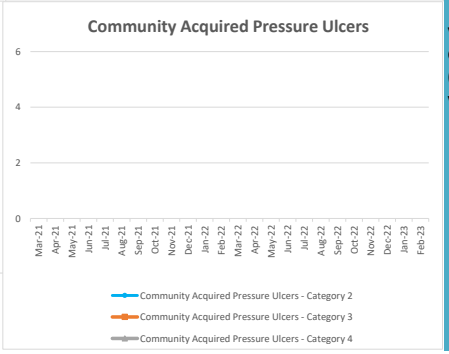
Quality Improvement - Trust Position

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)?
8. Inpatient Falls & harm levels **Target: 20% or more decrease from 21/22 (590 Inpatient Falls in 2021/22)**		**Assurance: N/A Annual Target.** **Variation: Common Cause (Normal) variation.**	**The number of no harm inpatient falls for February remain within normal variation and below the Trust mean. The fall with harm occurred in the Emergency Department with escalation within the department a contributory factor.**	**Actions to improve the position include:** **1. Falls link nurse meetings restarted, scenario based learning day held in February** **2. Trust documentation for falls is all within the Lorenzo system to support the clinical teams with access** **3. Falls are discussed at the Weekly Harm Free Care meeting, with feedback and learning shared across the ward teams** **4. Quality Improvement work with the clinical teams continues** **5. Senior oversight from the Associate Chief Nurses is in place with individual action plans monitored for areas of higher risk** **6. Ward reviews by the Patient Safety Improvement Nurses are undertaken to support the clinical areas**
63 total falls were reported in Febuary 2023. 43 of these were inpatient falls, however 4 were catagorised as patient lowered to the floor. There has been a 1% increase from January 2023. However there has been a decrease of 3% of Trust wide falls compared with same period - Febuary 2022. There was 1 inpatient falls in Febuary with harm.				

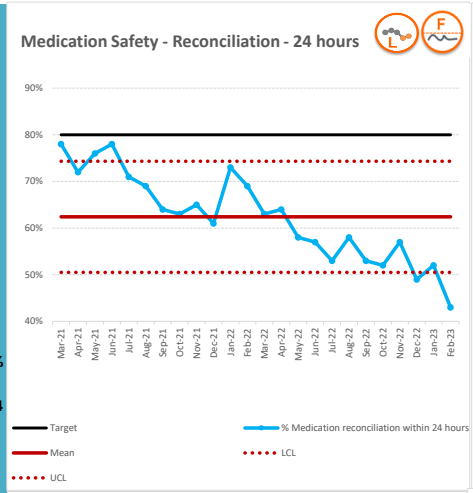
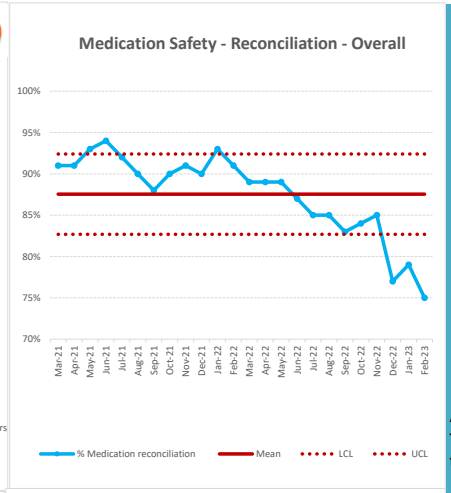
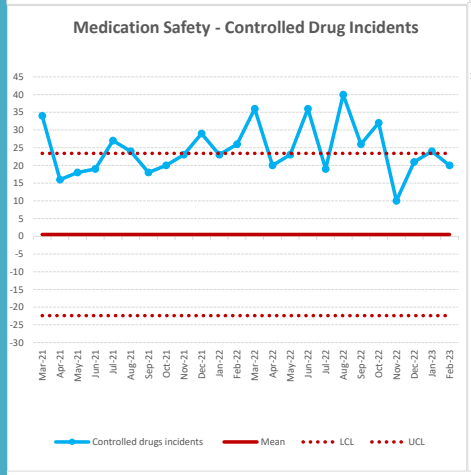
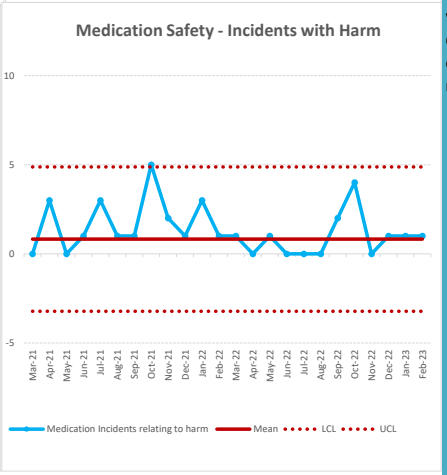
Quality Improvement - Trust Position

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)?
9. Pressure Ulcers Target: 10% reduction based on 91 in 2021/22 There were 9 hospital acquired category 2 pressure ulcers and 1 unstageable pressure ulcer in February 2023.	  	Assurance: N/A Annual Target. Variation: Common Cause (Normal) variation.	Prolonged length of time on trolleys in the Emergency Department continues to be a contributing factor. Delay in upgrading to pressure relieving mattress and medical devices have also been identified as contributary factors to pressure ulcer development. The incorrect use of preventative measures was a primary factor leading to the development of the unstageable pressure ulcer.	Actions to improve the position include: 1. The QI team support the matrons to monitor the sustainability of the change package 2. Senior clinical oversight is provided by the Associate Chief Nurses with action plans for areas of higher incidence 3. Face to face pressure ulcer prevention training is held monthly, the Tissue Viability Team also provide training on a monthly basis for preceptees and international nurses and shadowing opportunities for clinical staff 4. Monthly RCA meetings continue with lessons learned shared across teams 5. Reinforce the use of preventative dressings in ED 6. Provide further teaching at ward level supported by the Matrons

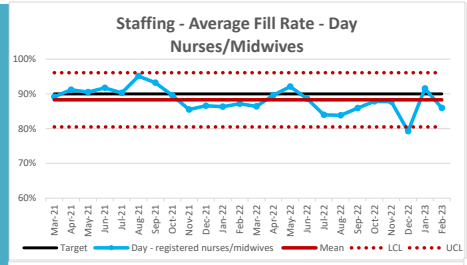
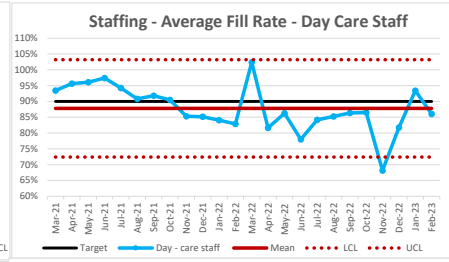
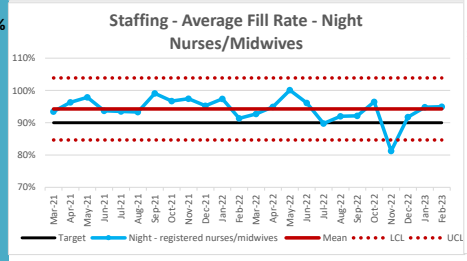
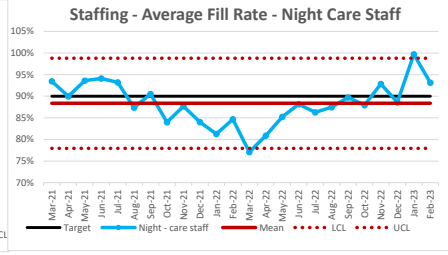
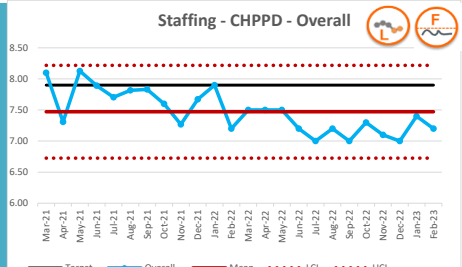
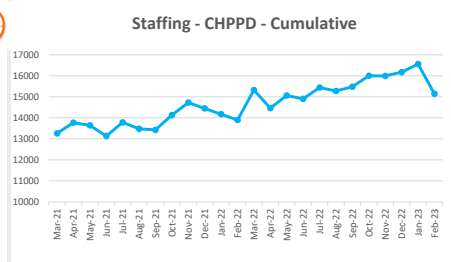
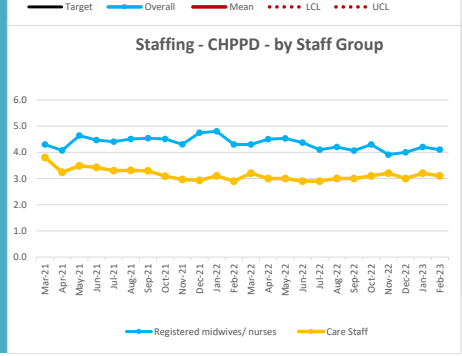
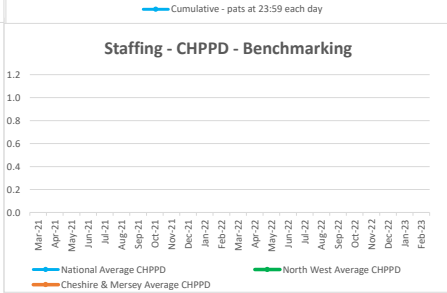
Quality Improvement - Trust Position

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. Medication Safety Reconciliation within 24 hours Target: 80%	**The Trust achieved 43% for medicines reconciliation within 24 hours and 75% for overall medicines reconciliation. There were 20 controlled drug incidents. There was 1 medication harm incident reported in January.**	   	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**Performance out with national targets continues to be adversely impacted by pharmacy workforce issues. Currently only 59% of established pharmacist posts filled.** **There is no target for this metric. The most common type of incident were administration errors (n=6) and documentation errors (n=5). No themes in the reported incidents were identified.** **There is no target for this metric. The incident related to a delay in prescribing thromboprophylaxis and subsequent hospital-acquired VTE.**	**Ongoing recruitment campaign through Just Recruit and locum support.** **Monthly self-assessment and quarterly CD audits are undertaken. Themes identified and addressed with specific action plans. Support given to areas with poor compliance.** **All medication incidents reviewed by governance and pharmacy team and lessons learned shared within the organisation.**

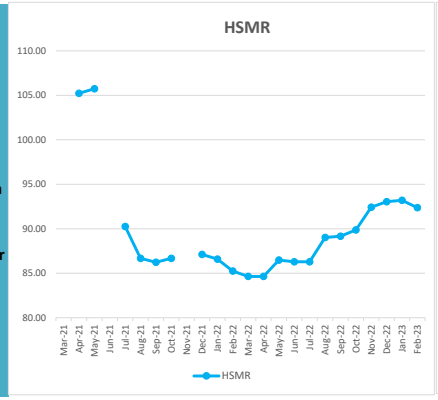
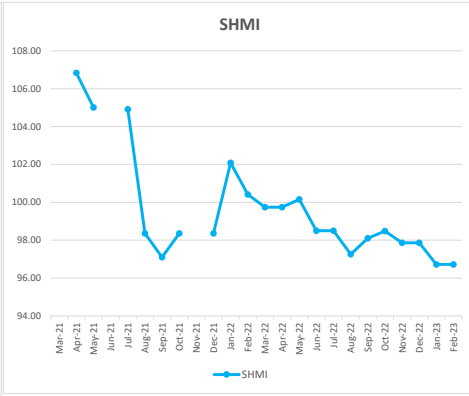
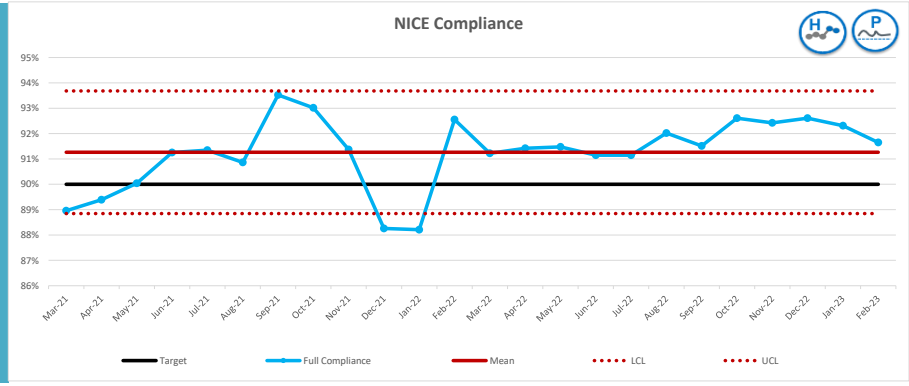
Quality Improvement - Trust Position

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)?
11. Staffing - Average Fill Rate Target: 90%	In February 2023, the average staffing fill rates were: Day (Nurses/Midwife) 85.94% Day (Care Staff) 86.03% Night (Nurses/Midwife) 94.97% Night (Care Staff) 93.12%	   	Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	Additional beds in use across the Trust due to increased demand in AED alongside 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. Vacancy trends are monitored through the Trust Workforce Review Group. Recruitment and retention plans are in place and overseas recruitment programmes continue. Specialist recruitment continues for hard to recruit areas with successes noted in Maternity. Bi-weekly shortlisting and interviews continue. A Trust recruitment event was held in February with 30 posts allocated to - all to be filled by September 2023.
12. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	In February 2023, the average CHPPD were: Nurse/Midwife: 4.1 hours Care Staff: 3.1 hours Overall: 7.2 hours	   	Assurance: The Trust consistently fails to hit the target. Variation: Special Cause Variation of a Concerning Nature.	The CHPPD February is lower data than noted for January which was 7.4 overall. The Trust continues to work on vacancy fill alongside NHSP increased shift fill and the reduction of agency usage through the NHSP CAMS project.	Staff are moved across the Trust to areas of greater need which is reviewed twice daily by the senior nursing team. Vacancy trends are monitored through the Trust Workforce Review Group. Temporary staff are utilised when required. Recruitment and retention plans are in place and overseas recruitment programmes continue. 38 International Nurses will join the Trust in March and May 2023, with a further 40 planned to join for 2023/24 recruitment round. Successful recruitment event held in February 2023 with 30 posts appointed to, a further recruitment event is planned for May 2023.

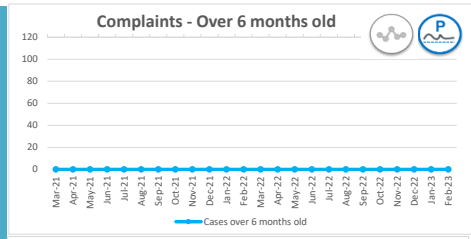
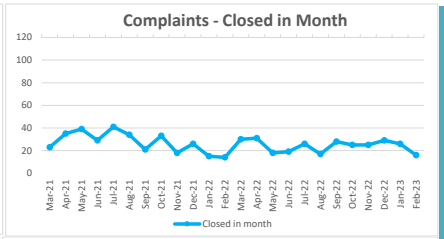
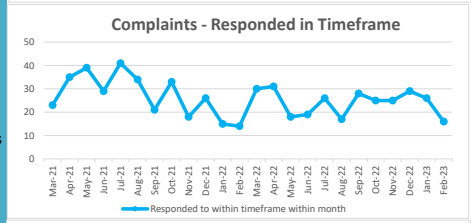
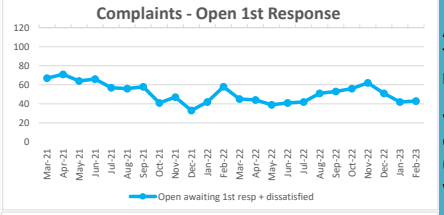
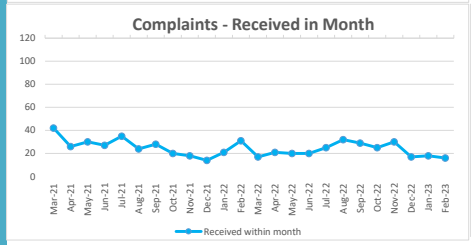
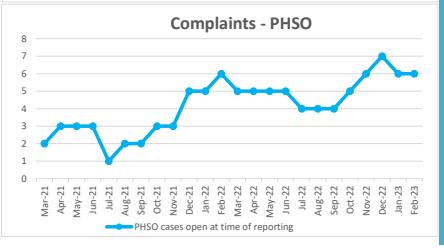
Quality Improvement - Trust Position

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)?
13. Mortality ratio - HSMR Target: Plan 14. Mortality ratio - SHMI Target: Plan	CQC SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 92.38. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 96.72.	 	N/A - No SPC/Target	No variation. HSMR and SHMI remain within expected range. NB: The gaps in the SPC relate to the time periods whereby our external provider (HED) did not produce a report with the HSMR/SHMI.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. Should an SJR be rated as poor / very poor care then an incident will be raised.
15. NICE Compliance Target: 90%	The Trust achieved 91.65% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	The Trust has met the target of achieving over 90% compliance. The number of guidelines under review has slightly increased. All under review are within the 90 day deadline.	Action plans are in place across all CBUs. These are monitored by the Clinical Effectiveness Manager.

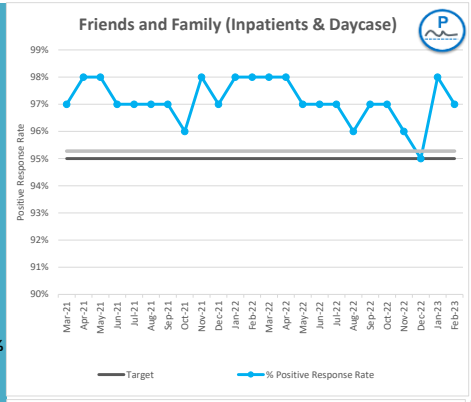
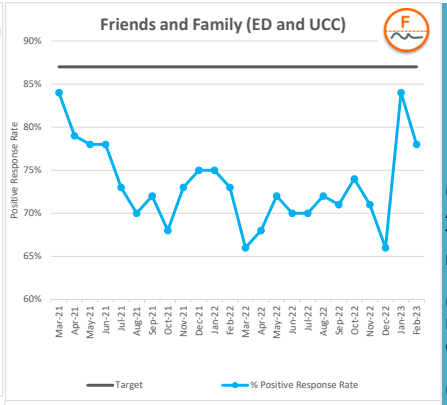
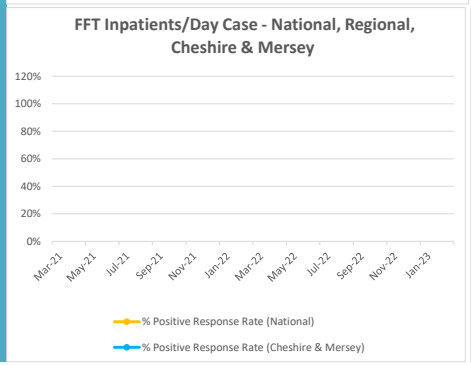
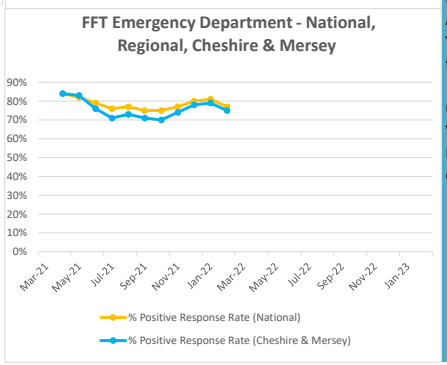
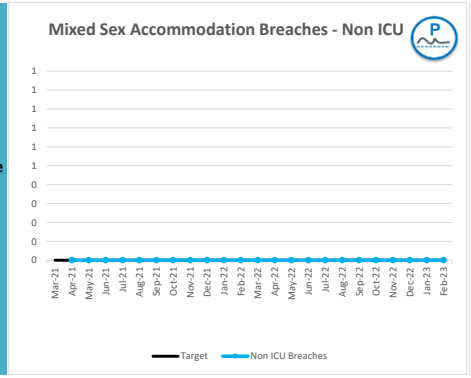
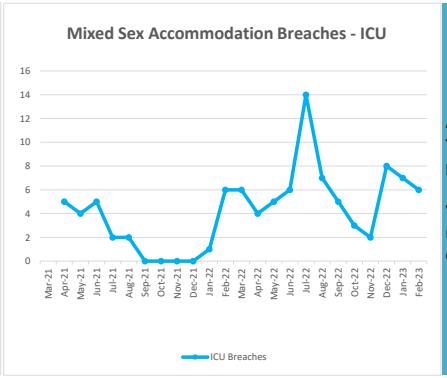
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Complaints Target: Zero complaints open over 6 months old/in the backlog.	In month, 16 new complaints were received to the Trust which was a decrease of -2 from the previous month. There were 4 dissatisfied complaints received in month, which is an increase from the previous month.	     	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The Trust continues its performance in the timeliness of responding to complaints. There continue to be no complaints over 6 months old.	All complaints continue to be monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. Meetings are routinely offered as part of the complaints process, supporting timely resolution.

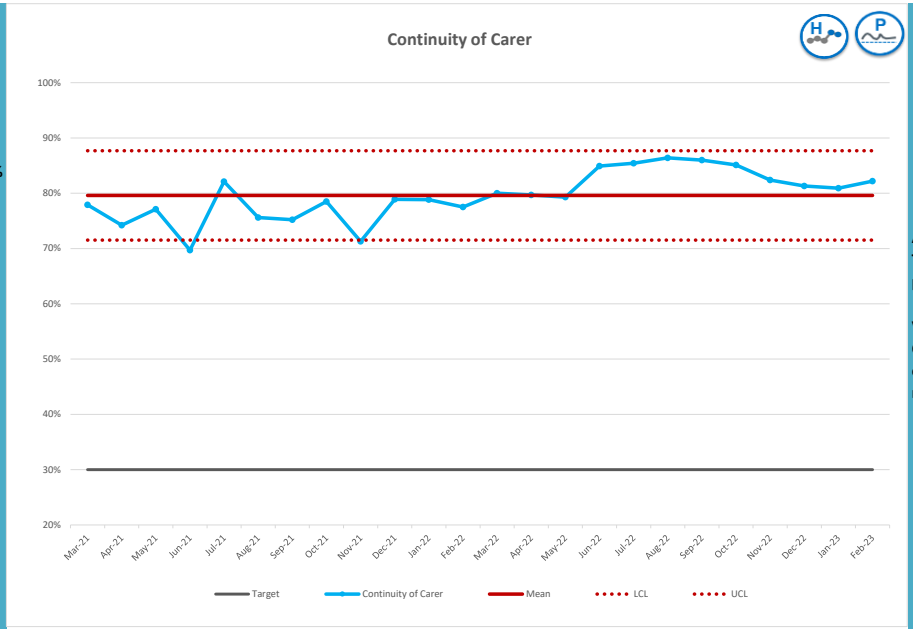
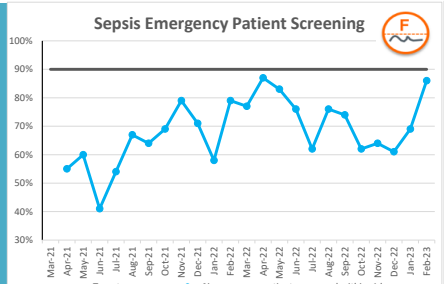
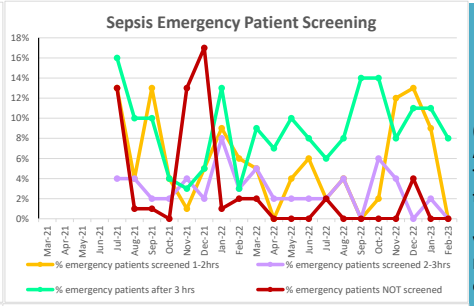
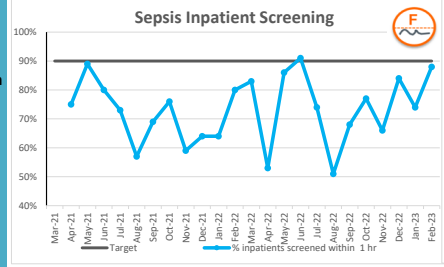
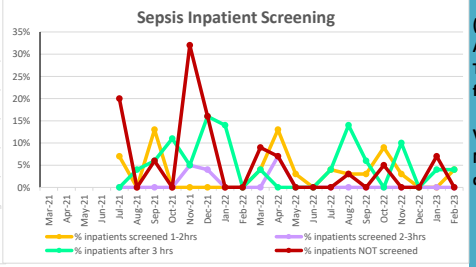
Quality Improvement - Trust Position

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)?
17. Friends and Family (Inpatients & Day cases) **Target: 95%** **18. Friends and Family (ED and UCC)** **Target: 87%** The Trust achieved 97% in month for Inpatient & Day case FFT and 78% for ED/UCC FFT.	   	**(IP/DC)** **Assurance: The Trust consistently passes the target.** **(IP/DC) Variation: N/A - Not enough datapoints.** **(ED/UCC)** **Assurance: The Trust consistently fails the target.** **(ED/UCC) Variation: N/A - Not enough datapoints**	**ED/UCC - The Trust achieved 78.00% positive feedback in Friends and Family Test results in February 2023 which is a 5% decrease from the previous month. This data mirrors ED FFT performance across the Cheshire and Merseyside footprint with recent data from January 2023 of a recommendation rate of 84%.** **Inpatient/Day Case - The Trust achieved 97.00% positive recommendation rate in February 2023.**	**ED/UCC - Key themes for improvement in relation to positive recommendation rates are largely attributed to communication and extended wait times. This is perpetuated by the super stranded position, operational pressures within the Trust and the increased attendees within the department. Measures taken in month to improve include but are not limited to:** **- Volunteer role fully embedded into the department assisting in nutrition and hydration and holistic needs of patients in the department** **- Work has commenced to review communication on notice boards within the department with regards to what patients should expect** **Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients.**
19. Mixed Sex Accommodation Breaches (Non ITU Only) **Target: Zero** There were 0 mixed sex accommodation incidents outside of the ITU during February 2023. There were 6 MSA incidents within the ITU.	 	**Assurance: The Trust consistently passes the target.** **Variation: N/A - not enough datapoints.**	**There were 6 mixed sex accommodation breach reported in February 2023 in the Intensive Care Unit. There were zero breaches within any other ward area.**	**Work is ongoing in the Unplanned Care Group in relation to the continued challenge of patient flow to ensure the prioritisation of patients from ITU into the general bed base. Patients requiring step down from ITU are a standing agenda item at each bed meeting. A contributing factor to these breaches are the high number of super stranded patients within the Trust bed base.**

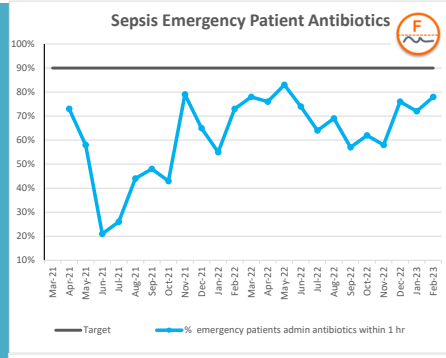
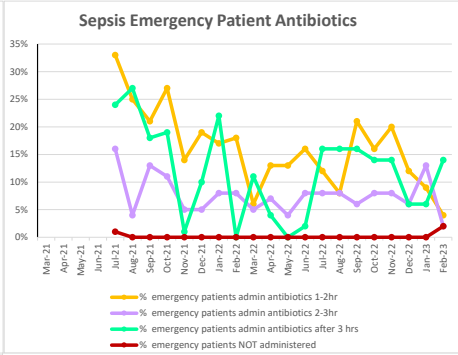
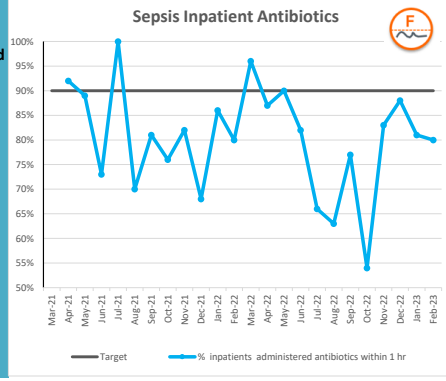
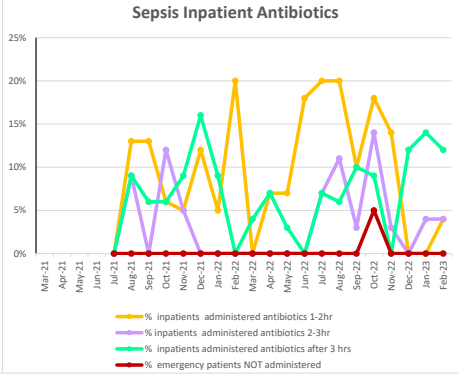
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Continuity of Carer Target: 51%	In February 2023, 100% of Warrington & Halton women are booked onto a MCoC pathway, if 'out of area' bookings are included the figure is 82.2% as we cannot provide the postnatal aspect of the pathway. 10 BME women were booked, all reside in area and were booked onto MCoC pathway.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	The Trust achieved 82.2% onto a CoC pathway (including intrapartum care) in February 2023. This figure varies month on month as it is impacted by the number of women who are "out of area" being booked for care at WHH.	WHH continues to work towards ensuring women booked on a pathway receive continuity across the pathway. Updated national guidance was published in October 2022 which removed all national targets for MCoC. As a result and in light of other staffing pressures WHH is reviewing our model of care.
21. Sepsis - % screening for all emergency patients. Target: 90% 22. Sepsis - % screening for all inpatients Target: 90%	The Trust achieved: • 86% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 88% screening for all inpatients with suspected sepsis within 1 hour.	   	(Emergency) Assurance: The Trust consistently fails the target. Variation: N/A - Not enough datapoints (Inpatient) Assurance: The Trust consistently fails the target. Variation: N/A - Not enough datapoints.	Improvements in both ED and inpatient areas for screening. Delays were identified with obtaining blood cultures in ED for 3 patients due to increased escalation in the department.	Education sessions continue to support staff, a full review of the Sepsis pathway has been completed, a new Task and Finish Group which includes the Medical Lead for Sepsis and lived experience representative. Display material provided for the wards and departments . Quality Improvement support in place to drive improvements across the Trust. Sepsis management remains a focus on Safety Huddles.

Quality Improvement - Trust Position

Appendix 2

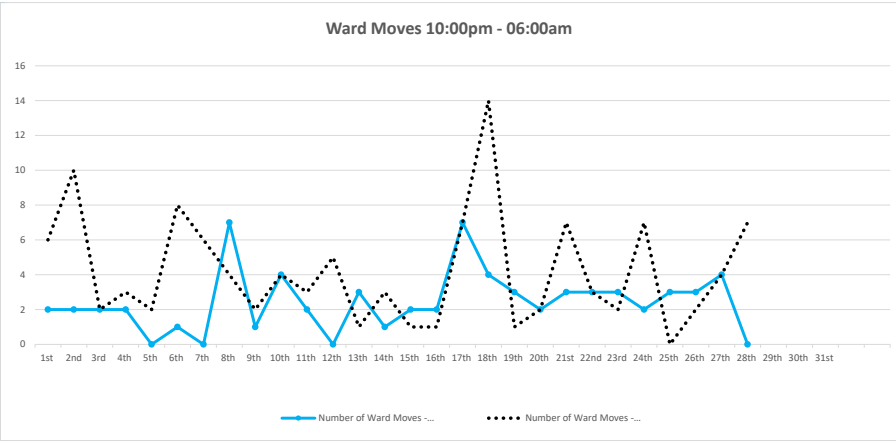
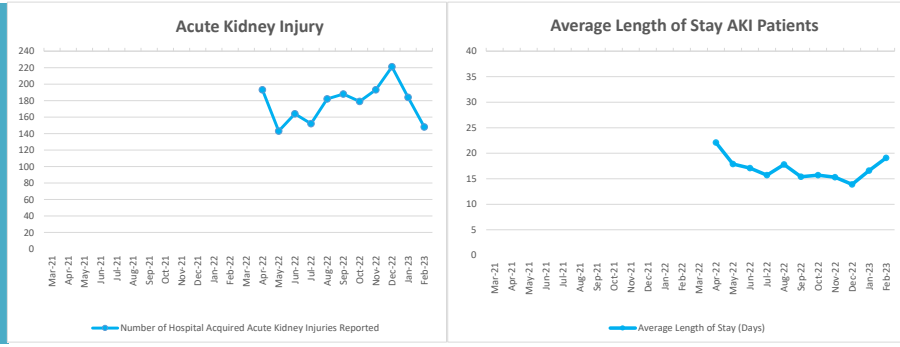
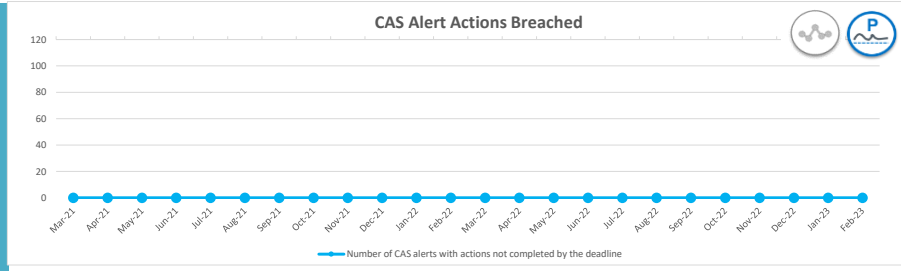
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag Target: 90% **24. 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.** **• 80% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	   	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: N/A - Not enough datapoints** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: N/A - Not enough datapoints.**	**The increased number of attendances to the ED continues to contribute to the inability to administer antibiotics within an hour in the department, as delays for prescriptions are noted to be a theme.**	**The Patient Safety Nurses review NEWS 2 scores for inpatients to support the wards to recognise symptoms of sepsis and have planned visits to 2 other Trusts to share learning and practice. Senior Nursing Teams reinforce the importance of sepsis recognition across the clinical areas. The clinical teams reinforce the need to ensure prescriptions are completed to allow for timely administration.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

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)?
25. Ward Moves between 10:00pm and 06:00am No Target	There was a total of 68 ward moves between 10pm-6am in February 2023 compared to 117 in February 2022.		N/A - Monthly/Annual Comparison.	The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non essential clinical patient moves.	The Senior Manager on call (SMOC) and Patient Flow Team work together to minimise the movement of patients across the Trust after 10pm. Automatic notifications are applied for patients who have a learning disability or mental health needs to ensure no inappropriate moves have taken place. This notification is monitored by senior nurses who undertake a welfare check.
26. Acute Kidney Injury Target: Less than previous month	There were 148 acute kidney injuries reported in month.		N/A - Not enough datapoints.	There has been a decrease in the number of Hospital Acquired AKI's and a slight increase in length of stay.	Since the introduction of the AKI nursing role within the ACT We have noticed an improvement in Mortality, LOS and rates of progression of AKI. We are no longer an outlier for Mortality. Hospital Aquired AKIs are also consitently down on 2019 levels.
27. CAS Alerts - Target: All relevant CAS Alerts actioned within timescales	There were 0 CAS alerts which breached actions in month.		Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) Variation.	There have been zero breaches to date.	CAS alerts are moniotred via the Trusts Health Safety Sub-Committee and Medical Devices Group. Action plans and monitoring arrangements are reviewed weekly by the Health & Safety Departments with escalation as necessary to the Director of Governance.

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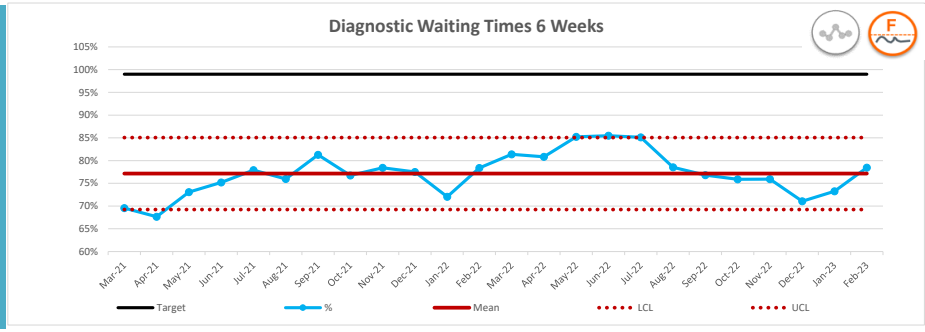
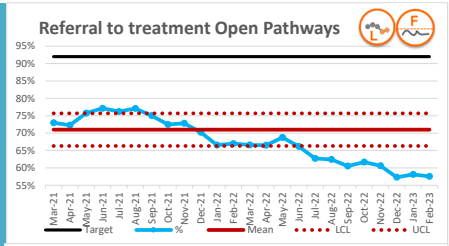
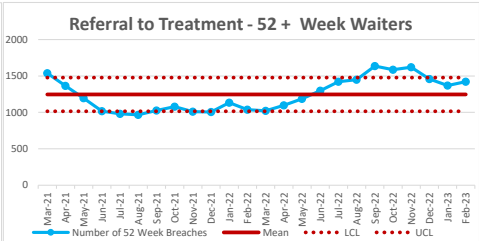
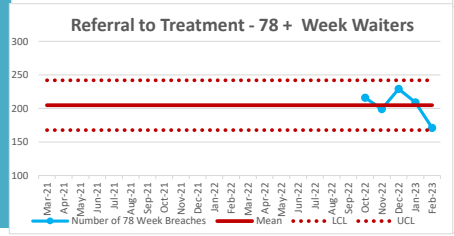
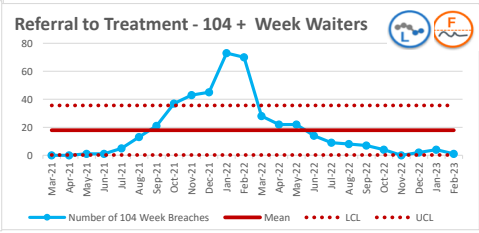
Key: RR116 Risk Register; SOF System Oversight Framework; CQC Care Quality Commission

	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)?
28. Diagnostic Waiting Times 6 Weeks Target: 99%	SOF CQC **The Trust achieved 78.46% in month.** RR1215 RR1125		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.**	**A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies.**
29. Referral to treatment Open Pathways Target: 92% 30. RTT - Number of patients waiting 104+ weeks Target: ZERO	SOF CQC **The Trust achieved 57.54% in month. There were 1421, 52 week breaches, 171, 78 week breaches and 1, 104 week breaches in February 2023.** RR1125 RR1215	   	**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.** **Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a improving nature.**	**RTT performance, 52 and 104 week wait performance in the reporting period was in line with the Trust's 2022/23 plan.**	**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 2022/23 have been drawn up in line with Operational Planning Guidance.** **• The 1 104 breach is a complex case where the patient has failed to attend diagnostic appointments at a tertiary service**

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Key:
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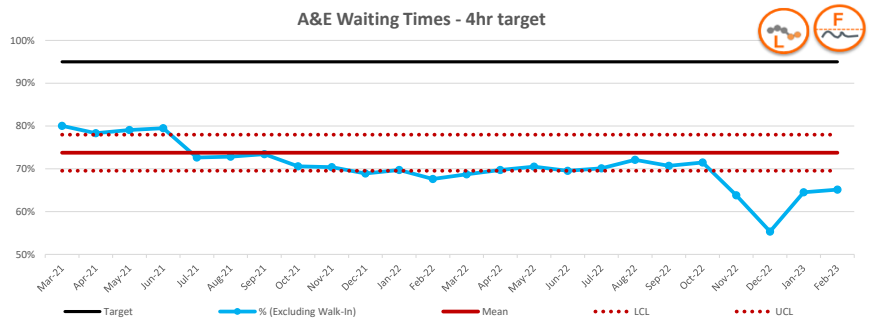
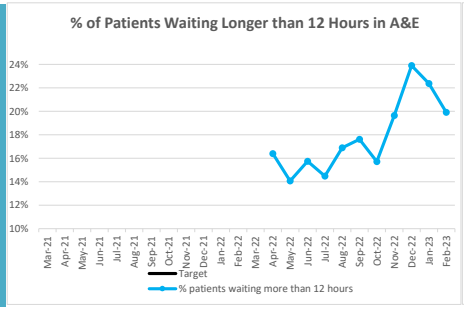
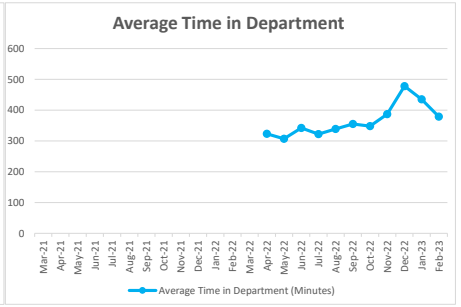
SOF System Oversight Framework
CQC Care Quality Commission

	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)?
31.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 95%	CQC **The Trust achieved 65.13% excluding Widnes walk ins in month.** RR224		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature**	**Performance continues to be negatively impacted by high attends, long length of stay as a result of community discharge delays and the impact of COVID-19 Waves and Influenza.**	**• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.** **• System resource investment in order to support Pathway 1 discharges.** **• Additional beds remain open on the Halton site to support bed capacity and flow.** **• Ward A10 opened in October (14 Beds) to support performance.**
32. Four Hour Standard Waiting Times - ICS Trajectory Target: Trajectory					
33. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	**19.91% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 379 minutes.**	 	**N/A - Not enough datapoints.**	**12 hour performance continues to be monitored. This is also in line with the trend seen regionally and nationally. The Trust continues to perform well when compared to other Trusts against this standard. The key themes for the breaches are the continuing high urgent care attends and high occupancy restricting flow through ED.**	**The Trust will continue to monitor and manage compliance around the 12 hour standard.**
34. Average time in department ED No Target					

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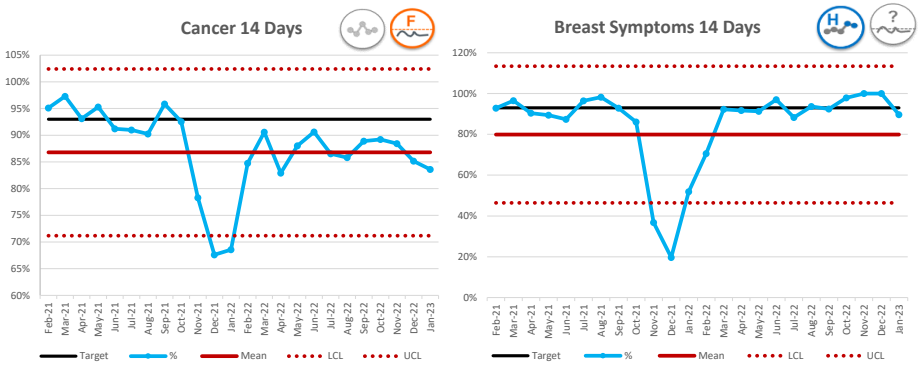
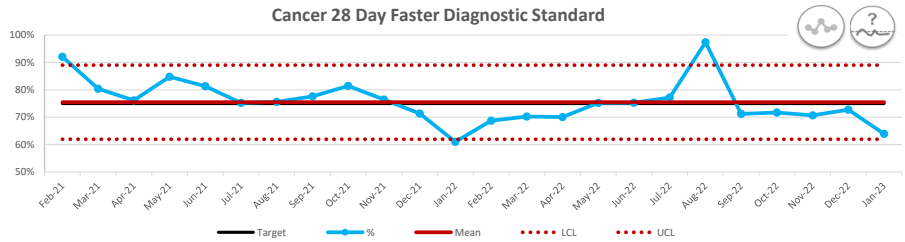
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
35. Cancer 14 Days Target: 93% 36. Breast Symptoms 14 Days Target: 93% RR1125	SOF CQC The Trust achieved 83.6% in November 2022 for Cancer 14 days and 89.66% in month for Breast Symptomatic.		(C14) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation. (Breast) Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Overall the 2 Week Wait narrowly missed the target in the reporting period with the continued. Breast symptomatic fell just below the standard.	The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard. Performance against this standard is monitored via the Performance Review Group (PRG), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG). Targeted capacity and demand work has been initiated for the Breast service.
37. 28 Day Faster Cancer Diagnosis Standard Target: 75%	SOF The Trust achieved 63.95% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	This indicator is impacted by continued high volumes of referalls into General Surgery creating pressures on 2 week wait capacity. Short term additional capacity continues to be put in place.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG) and the KPI Sub-Committee.

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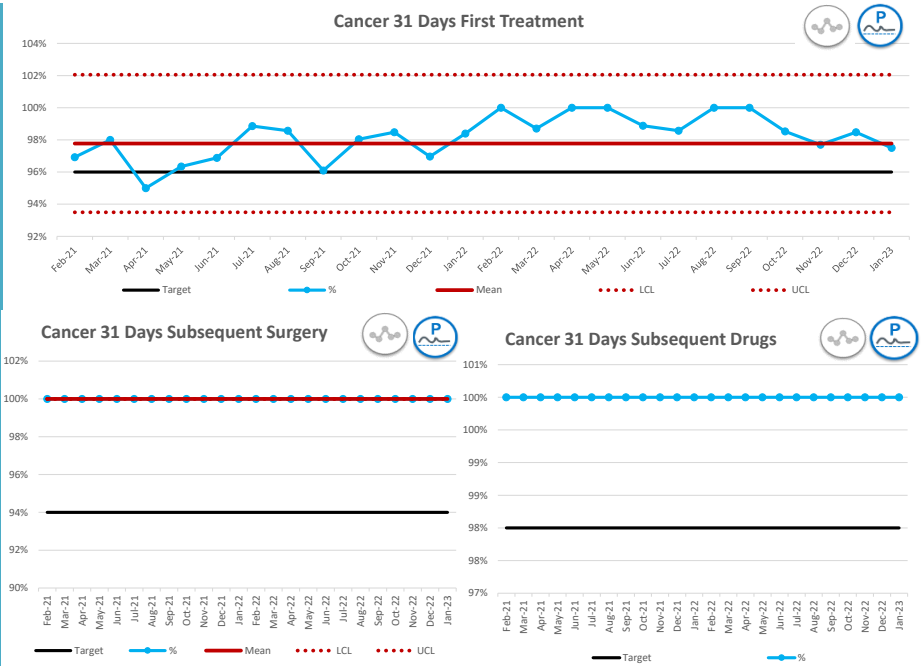
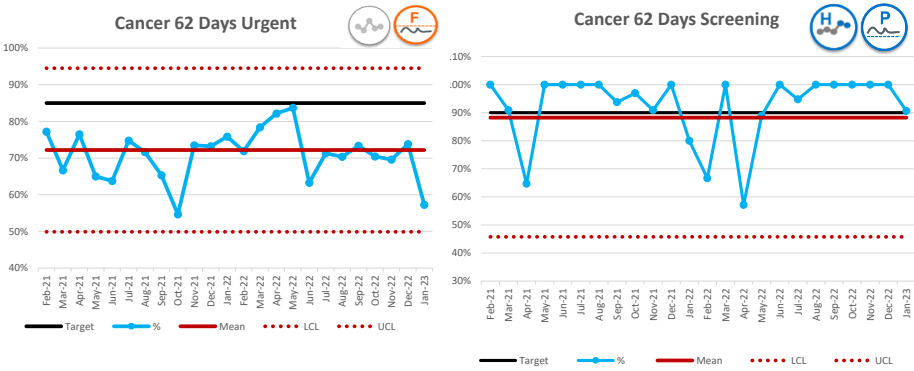
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
38. Cancer 31 Days First Treatment Target: 96% 39. Cancer 31 Days Subsequent Surgery Target: 94% 40. Cancer 31 Days Subsequent Drug Target: 98%	SOF CQC **The Trust achieved 97.5% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in month.** RR1125		**Assurance: The Trust consistently passes the target.** **Variation: There is Common Cause (Normal) variation.** **(Surgery) Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.** **(Drugs) Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**The 31 day cancer target was achieved in this reporting period. Good compliance against this standard continues to be tracked.**	**There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.**
41. Cancer 62 Days Urgent Target: 85% 42. Cancer 62 Days Screening Target: 90%	SOF CQC **The Trust achieved 57.29% for Cancer 62 Day Urgent and 90.63% for Cancer 62 Day Screening in month.** RR1125		**(Urgent) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(Screening) Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of an improving nature**	**The 62 day urgent target was not achieved in this reporting period, despite an improving position. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.**	**There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.**

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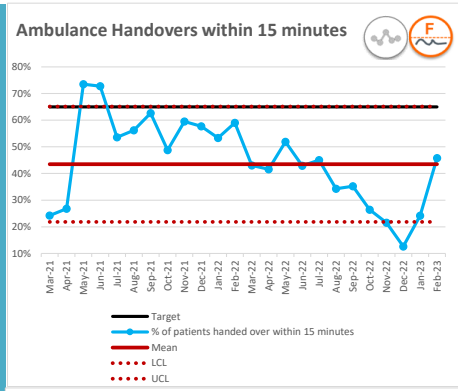
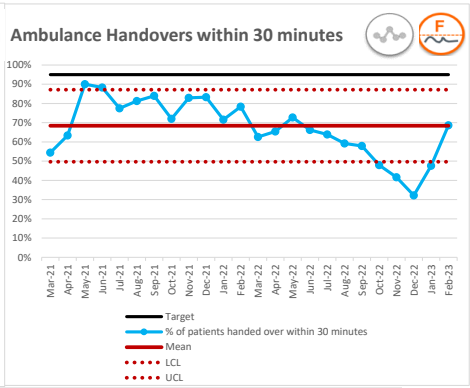
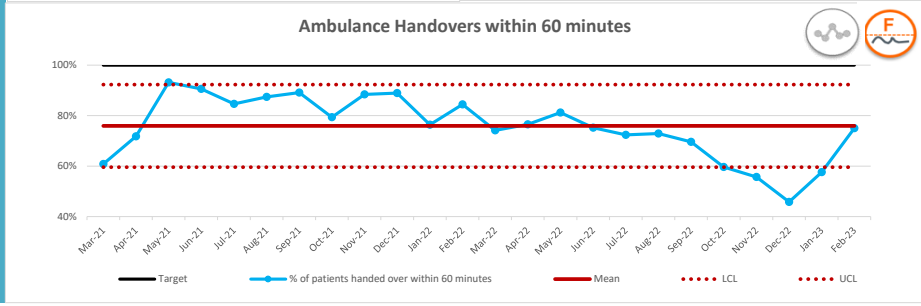
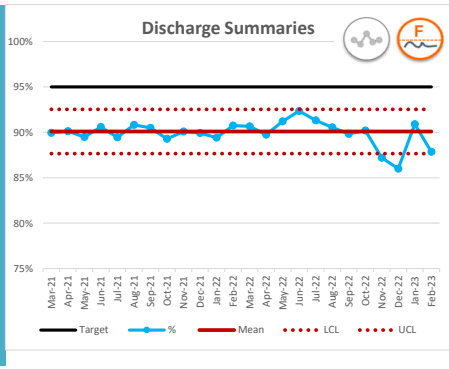
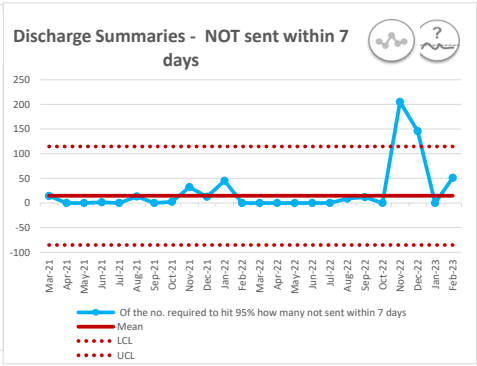
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
43. Ambulance Handovers within 15 minutes Target: 65% 44. Ambulance Handovers within 30 minutes Target: 95% 45. Ambulance Handovers within 60 minutes Target: 100%	In month 45.8% of patients were handed over within 15 minutes, 68.66% were handed over within 30 minutes and 75.02% were handed over within 60 minutes. SOF	  	(15) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (30) 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 has declined as a result of the increase in bed demand and occupancy which impacts on flow out of the Emergency Department. This continues to be monitored and the Trust is working closely with NWAS to improve this.	In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with NWAS to identify and implement improvements. A new service improvement initiative commenced in December aimed at releasing crews ahead of the 60 minute standard using a red card time awareness system.
46. Discharge Summaries - % sent within 24hrs Target: 95% 47. Discharge Summaries - Number NOT sent within 7 days Target: ZERO	The Trust achieved 89.97% in month. There was 1 discharge summary not sent within 23 days required to meet the 95.00% threshold.	 	(24 hrs) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (7 Days) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.	The Performance Review Group (PRG) continues to monitor this standard to support improvements.

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Key:
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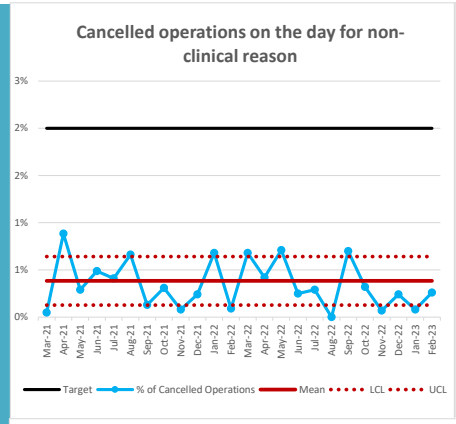
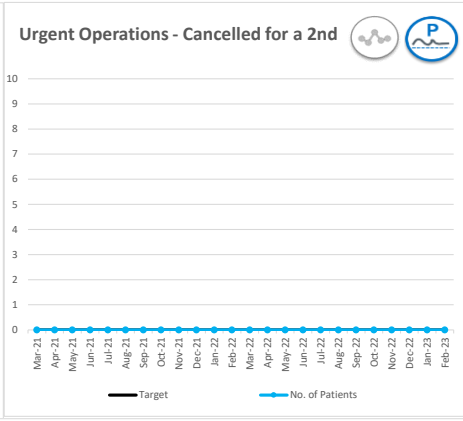
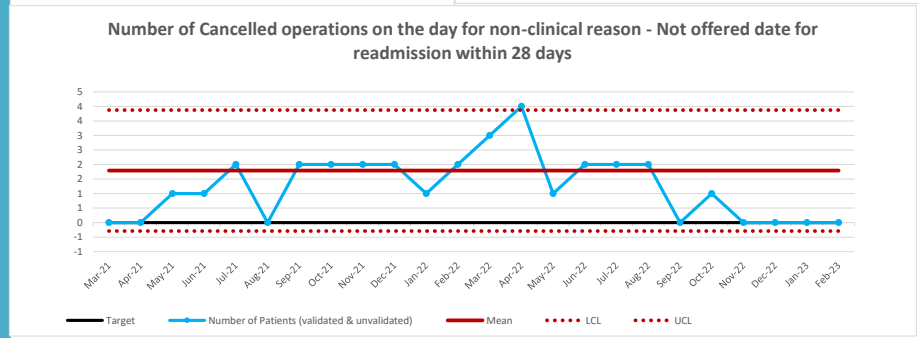
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
48. Cancelled Operations on the day for a non-clinical reason Target: Less than 2% 49. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO 50. Urgent Operations - Cancelled for a 2nd Time Target: ZERO	  	(Urgent Ops) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.	Compliance against this standard remains below the monitored threshold of 2.00% (positive).	Recovery of elective activity continues to be monitored via the Clinical Services Oversight Group (CSOG).

Cancelled operations data validation for February is in progress.

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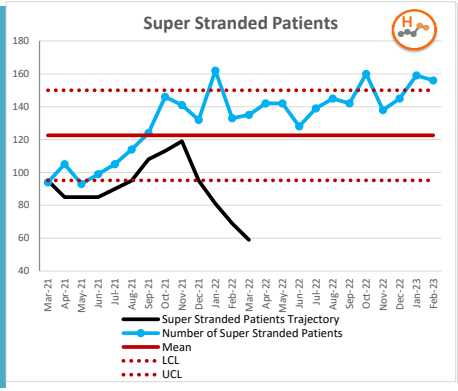
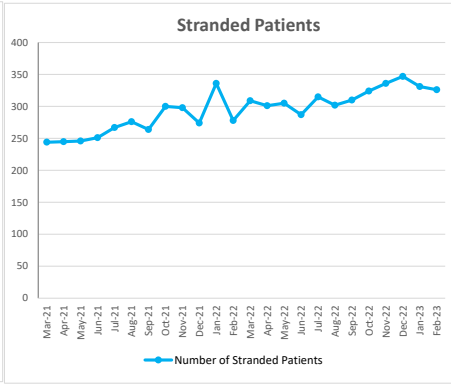
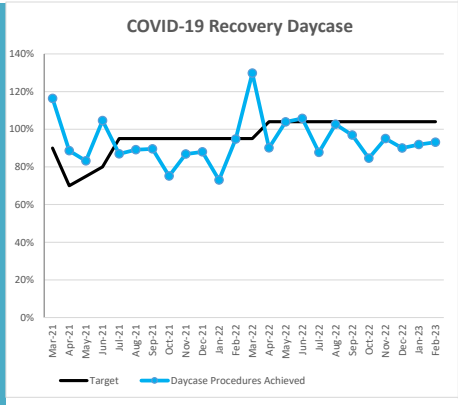
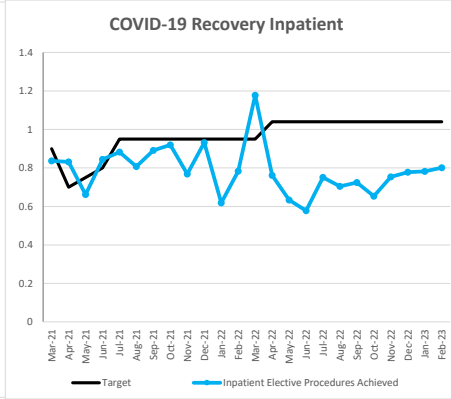
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
51. Super Stranded Patients Target: Trajectory There were 326 stranded and 156 super stranded patients at the end of February 2023. A Superstranded Patient Trajectory has not yet been agreed for 2022/23.	 	Assurance: N/A Trajectory Not Agreed Variation: There is special cause variation of a concerning nature.	The number of Super Stranded patients continues to remain higher than trajectory as a result of the impact of COVID-19 and community and Local Authority discharge delays.	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.
52. COVID-19 Recovery Elective Activity 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 93.07% of Daycase Procedures and 80.12% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Inpatient activity for the reporting period is below the Trajectory due to a higher than average profile as a result of additional activity being undertaken in October 2019 and a underperformance in key areas due to workforce constraints	The Trust monitors progress weekly via PRG and Clinical Services Oversight Group (CSOG)

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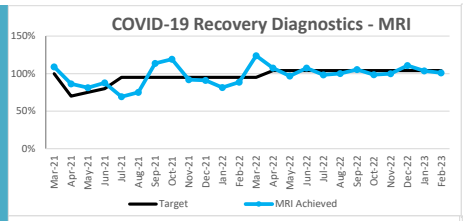
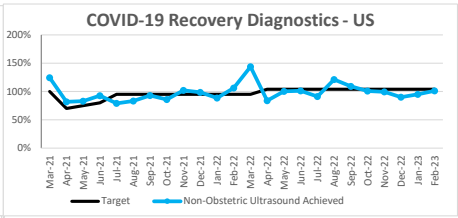
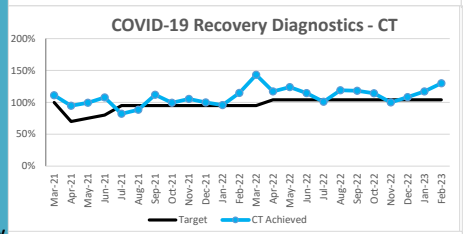
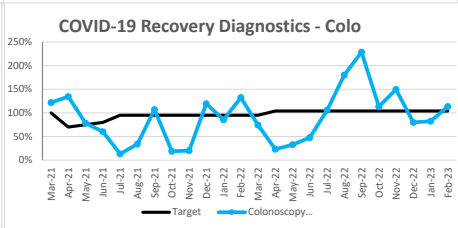
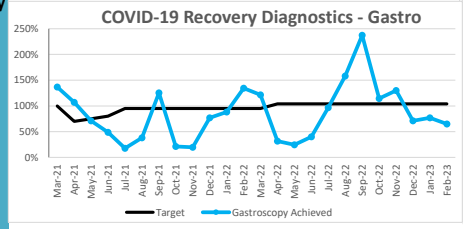
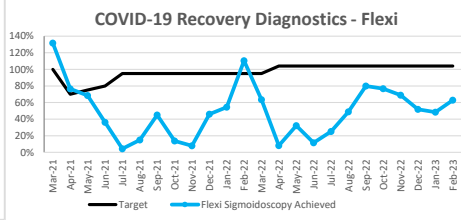
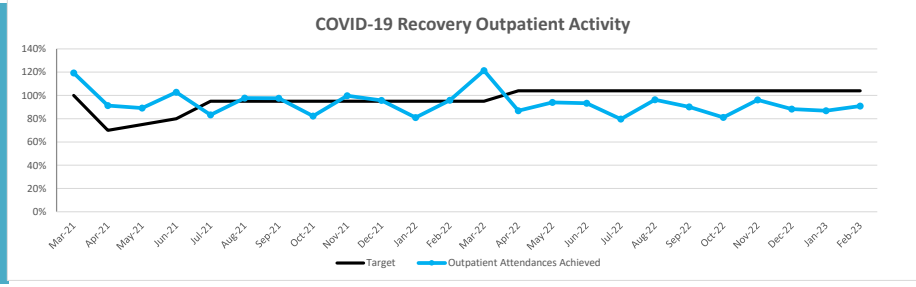
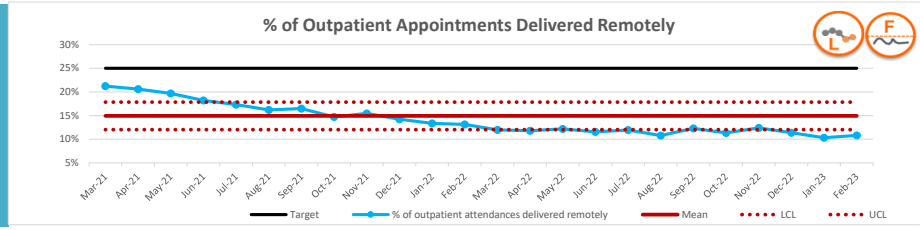
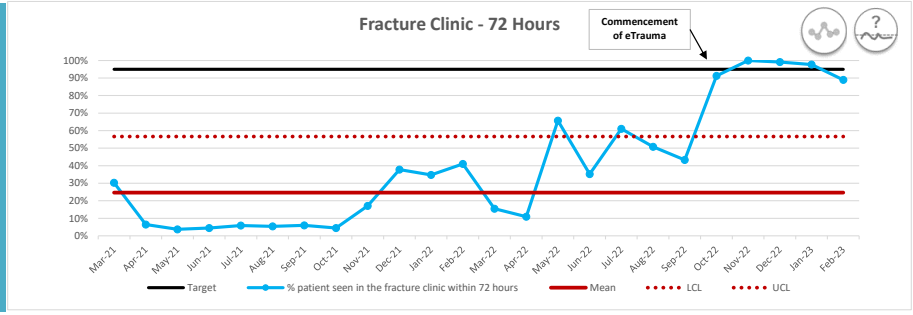
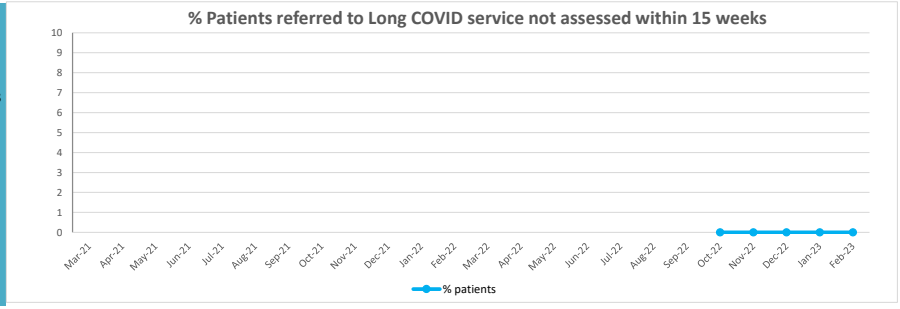
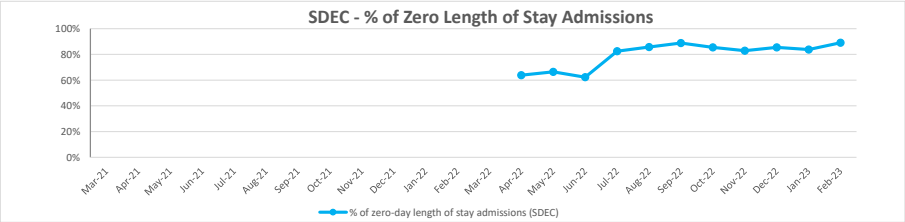
Key: RR116 Risk Register; SOF System Oversight Framework; CQC Care Quality Commission

	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)?
53. COVID-19 Recovery Diagnostic Activity Target: 104% % activity is against activity in the same month in 2019/20	SOF **In month, the Trust achieved the following % of activity against 2019. This included:** **100.92% of MRI** **129.95% of CT** **101.21% of Non-Obstetric Ultrasound** **62.79% of Flexi Sigmoidoscopy** **113.39% of Colonoscopy** **64.84% of Gastroscopy** RR1125	     	**N/A - Grouped indicator.**	**The Trust did not meet the diagnostic activity recovery trajectories for the reporting period across a number of specialties due to COVID-19 sickness. Colonoscopy, Flexi Sig and Gastroscopy have started to show an improvement. Cardiorespiratory, particularly Echo and sleep studies remain the most challenged areas although now improving.**	**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.** **The Trust has approached the ICB to close Out of Area referals into the sleep service to help reduce demand.**
54. COVID-19 Outpatient Activity Target: 104% % activity is against activity in the same month in 2019/20	SOF RR1125 **In month, the Trust achieved 90.87% of Outpatient activity against 2019.**		**N/A - Grouped indicator.**	**The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative servcies such as patient initiated follow up.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

February 2023
Access & Performance - Trust Position

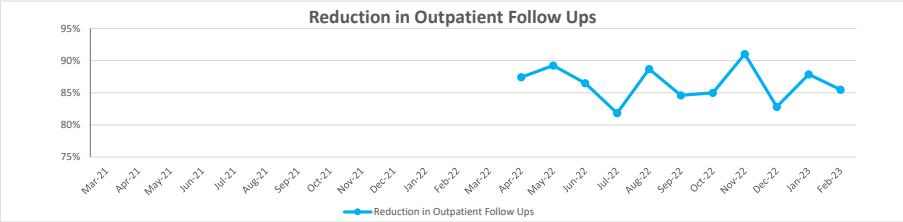
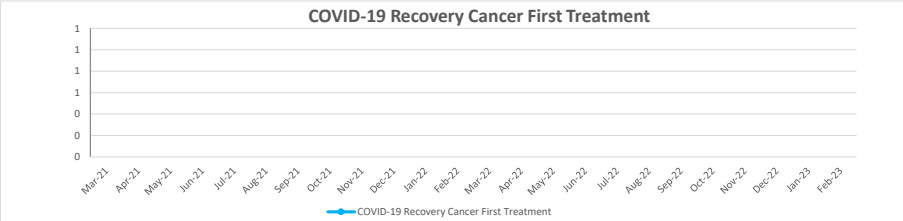
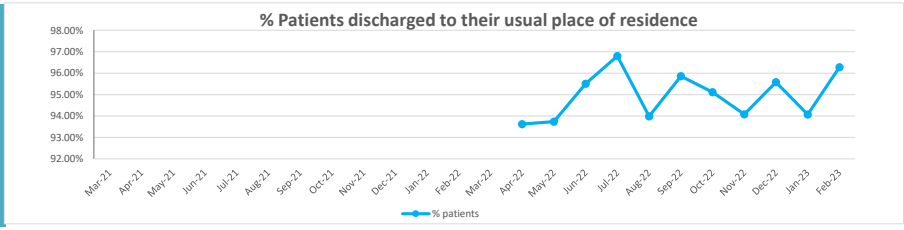
Key: RR116 Risk Register; SOF System Oversight Framework; CQC Care Quality Commission

	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. Outpatient Activity Delivered Remotely Target: 25%	10.79% of Outpatient Appointments were delivered remotely in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature.	The Trust did not achieve the standard in month for % of outpatient appointments delivered remotely. This is in line with reginal benchmarks and attributable to clinicains requesting first appointments being face to face given the time waited.	The Trust continues to identify opportunities to deliver additional outpatient activity remotely.
56. Patients seen in the Fracture Clinic within 72 hours Target: 95%	The Dashboard data for this indicator is no longer reflective since the commencement of eTrauma.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	The Dashboard data for this indicator is no longer reflective since the commencement of eTrauma.	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. The Data from the etrauma system is outline below: January - 99.1% February - 89% - issue around completion which has now been addressed.
57. % patients referred to long COVID service not assessed within 15 weeks	The Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks for February 2023.		N/A - Not enough datapoints.		
59. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	89.09% of SDEC Emergency Admissions had a zero day length of stay.		N/A - Not enough datapoints.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

February 2023
Access & Performance - Trust Position

Key:
RR116 Risk Register
SOF System Oversight Framework
CQC 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)?
80. 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 85.49% of 19/20 activity in month.		N/A - Not enough datapoints.		
81. COVID-19 Recovery Cancer First Treatment Target: 100%	0% of people each month who receive their first treatment for cancer compared to the equivalent month in 2019/20 adjusted for number of working days.		N/A - Not enough datapoints.		
82. % Patients discharged to their usual place of residence Target: No Current Threshold	96.28% patients in month who were discharged to their usual place of residence.		N/A - Not enough datapoints.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

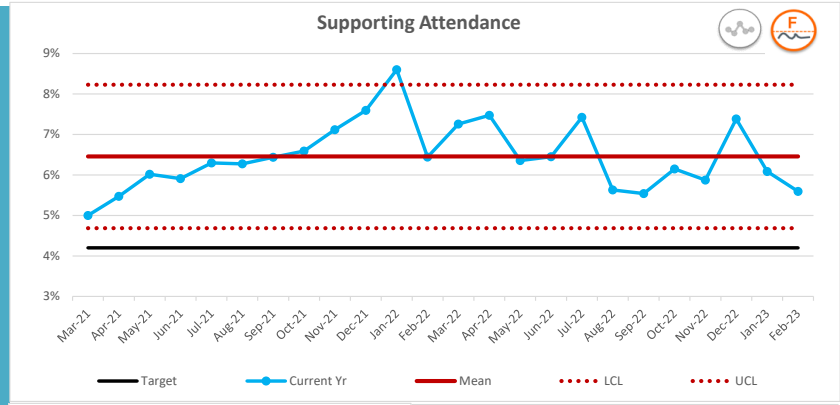
Key:
- SOF: System Oversight Framework
- UoR: Use of Resources Assessment
- RR200: Risk Register
- CQC: Care Quality Commission
- S: Trust Strategy

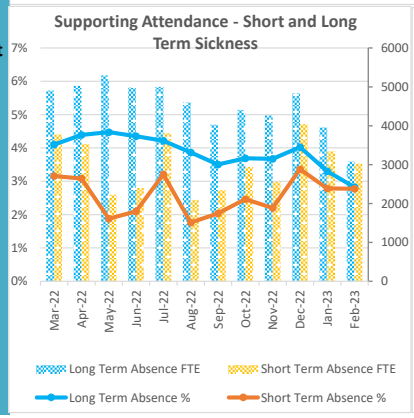
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

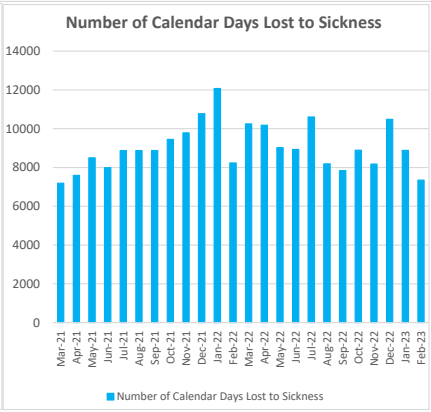
60. Supporting Attendance

Target: Below 4.2%

The Trust's sickness absence rate was 5.6% in month. There were 7351 calendar days lost to sickness in month.







Assurance: The Trust consistently fails the target.

Variation: There is a common cause (normal) variation.

Sickness absence has decreased from 7.6% in December 2022 to 5.6% in February 2023.

Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter.

The Trust implemented an updated Supporting Attendance policy in February 2022. Consequently, the Trust has seen a significant improvement in long term sickness absence rates reducing from 4.39% in April 2022 to 2.82% in February 2023.

The rolling 12-month sickness absence rate is 6.44% as at February 2023.

A deep dive exercise has recently been carried out into absence reasons. As a result of this review, a decision was made to hold a pilot H&WB drop in event. This event was extremely successful. Next steps will be to offer some tailored interventions starting with physio. Given the success of the pilot, we plan to roll out the offer of H&WB drop-in sessions across the organisation.

Workforce - Trust Position

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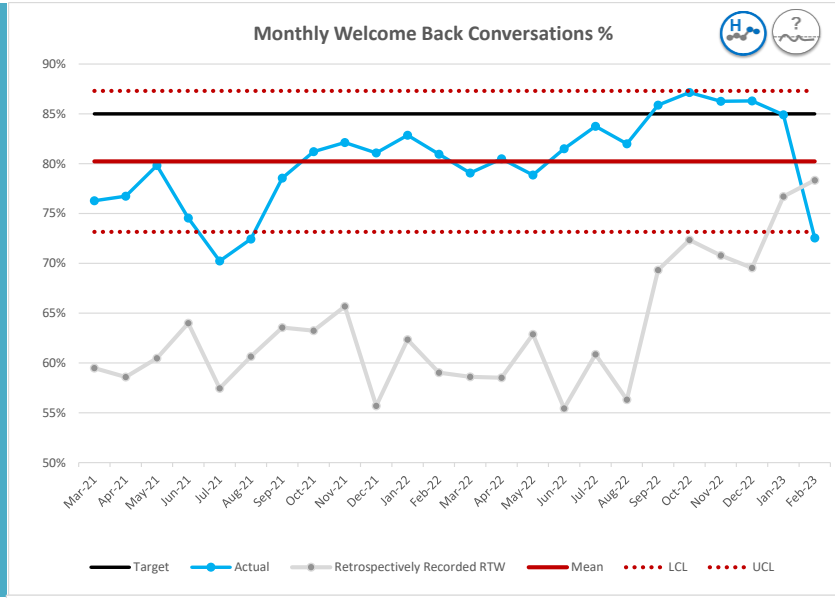
CQC Care Quality Commission
S Trust Strategy

61. Welcome Back Conversations

Target: 85%

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)?
RR1108 RR1134 **Welcome Back Conversation compliance was 72.54% in December 2022.**		**Assurance: The Trust inconsistently passes/fails the target** **Variation: Special Cause Variation of a improving nature.**	**Welcome Back Conversation compliance for February 2023 was 72.54% compared to 86.3% in December 2022.** **Reasons for the variation can be attributed to WBC compliance increasing for previous months as managers input historic WBCs that occurred but were not recorded on the system at the time of reporting.**	**The rolling 12-month average as at February 2023 is 82.71%.** **Actions to improve compliance thus far have included one to one coaching, automated reminders, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. These actions have all supported an increase in compliance with target being met September 2022 - December 2022.** **To increase current compliance, hot spot reviews are being undertaken across all Care Groups with actions to address areas of low compliance.**

Workforce - Trust Position

Key:
SOF System Oversight Framework
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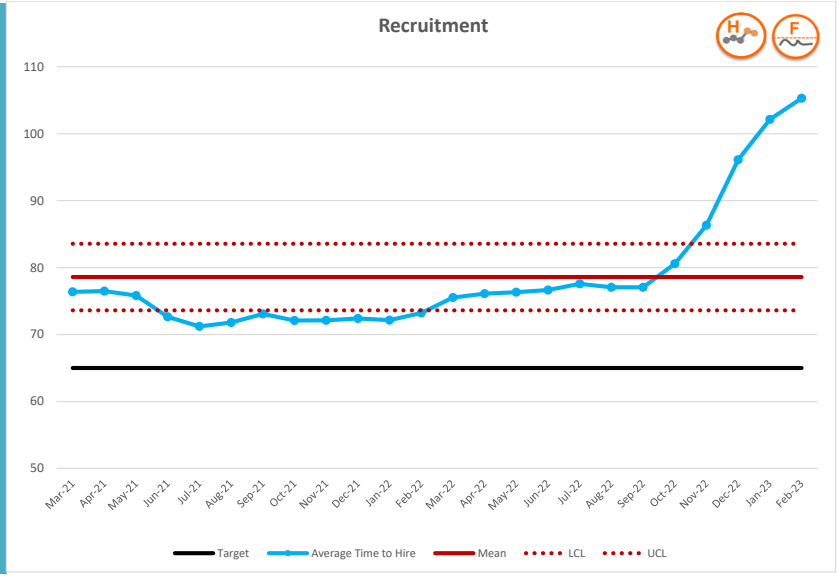
S Trust Strategy

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)?
62. Recruitment Target: 65 days or below The average number of working days to recruit is 84 days, based on the last 12 months average.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Recruitment time to hire for February 2023 was 105 working days, compared to 96 working days in December 2022. This includes notices periods. Reasons for the variation can be attributed to time to hire continuing to be impacted by the complexities of the new NHS Jobs 3 system.	The Trust is currently procuring a new recruitment system to support improved time to hire. A new Occupational Health system implementation is also underway which will digitalise new starter pre-employment checks with the aim of reducing time to hire.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

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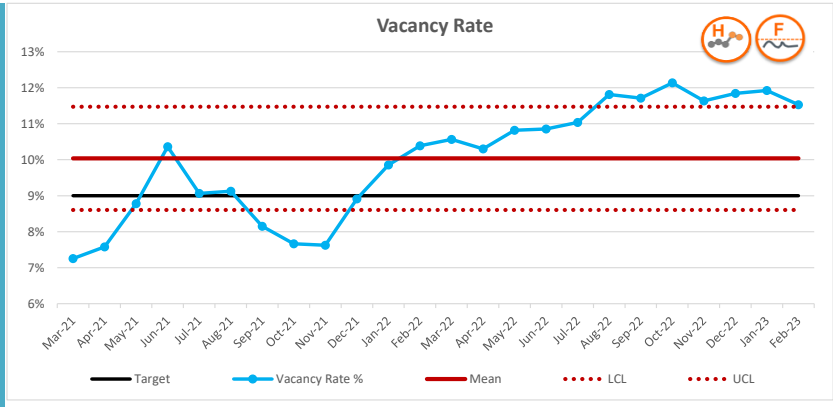
63. Vacancy Rates

Target: 9% or Below

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)?
UoR **The Trust's vacancy rate was 11.53% in December 2022.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**The Trust vacancy rate was 11.53% in February 2023 compared to 11.84% in December 2022.** **Reasons for the variation can be attributed to a continuing increase in the Trust establishment. Establishment has increased by 110 FTE in the last 12 months, which as well as turnover, is increasing the vacancy rate.**	**The Trust continues to engage with national directives such as international nurse recruitment, AHP return to practice, international fellow recruitment and international AHP recruitment.** **For longer terms plans, the People Directorate are working in conjunction with the Trust Strategy Team and senior Nursing/ Medical teams to develop a template for developing workforce plans at service/staff group level to address workforce shortages through role redesign.** **The Trust is also engaged in a PLACE based programme of work 'Warrington Together', which has recently commissioned a Warrington wide health and social care workforce strategy to address workforce shortages and support a system wide approach.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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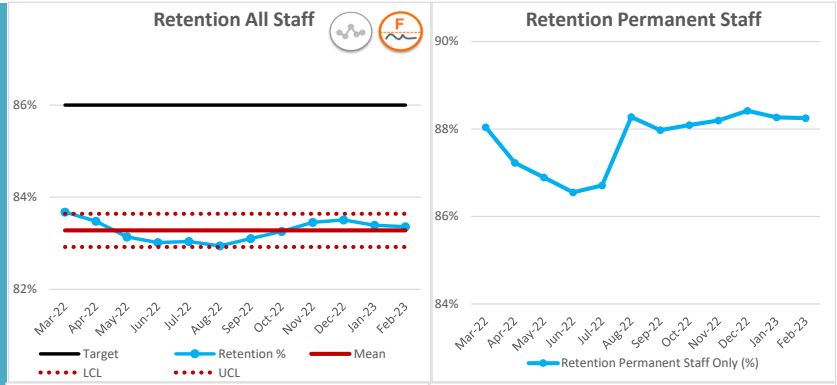
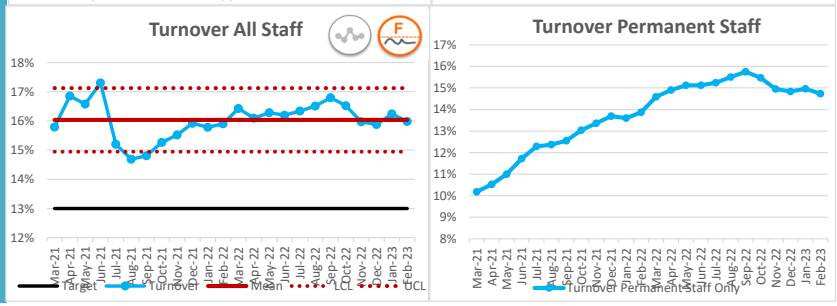
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
64. Retention	Retention of all staff was 83.36% and Retention of Permanent staff only was 88.25% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Retention of all staff in February 2023 was slightly below target at 83.36% compared to 83.51% in December 2022. Retention for permanent staff remains above trust target at 88.25% in February 2023 compared to 88.42% in December 2022.	Work-life balance continues to be the number one known reason people leave WHH, followed by retirement. A new exit interview process has been implemented to further understand the details as to why people are leaving. As a result of analysis of exit interviews, a pilot area has been identified and is working towards changes to working hours to support flexible working and work-life balance.
65. Turnover Target: Below 13%	Turnover of All staff was 15.98% and Turnover of Permanent staff only was 14.73% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Turnover in February 2023 was 15.98% compared to 15.87% in December 2022. Turnover of permanent staff in February 2023 was 14.73% compared to 14.84% in December 2022.	To support with the development of an Agile/Flexible Working Toolkit, views of the staff have been sought on the current agile working culture, barriers, opportunities and best practice.

Workforce - Trust Position

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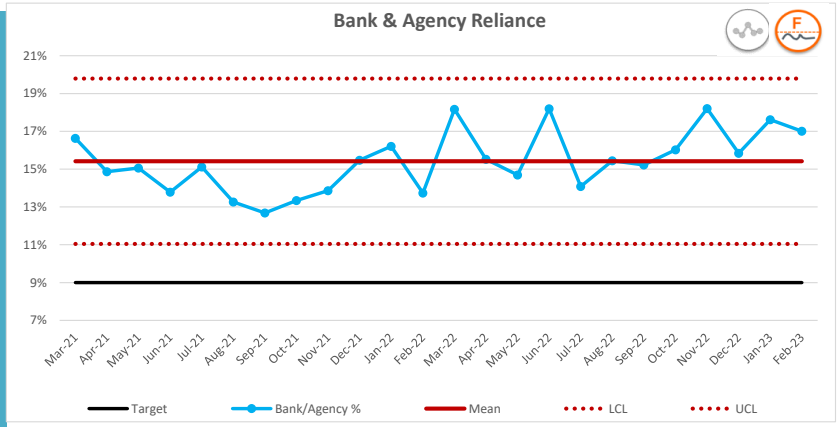
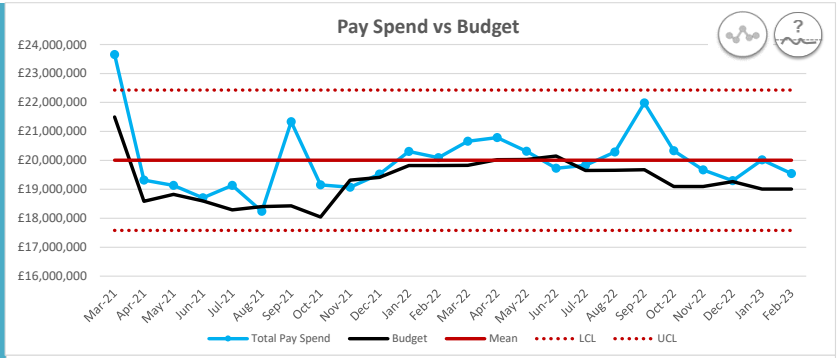
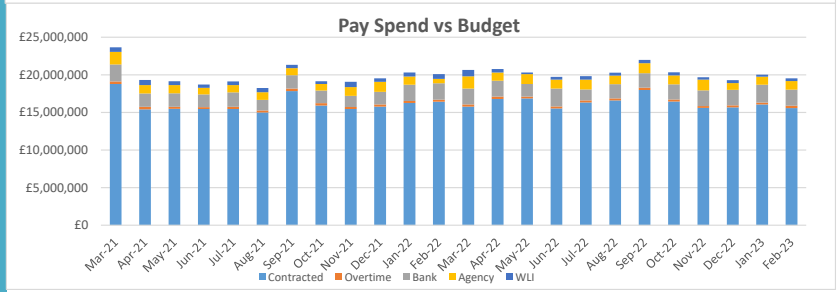
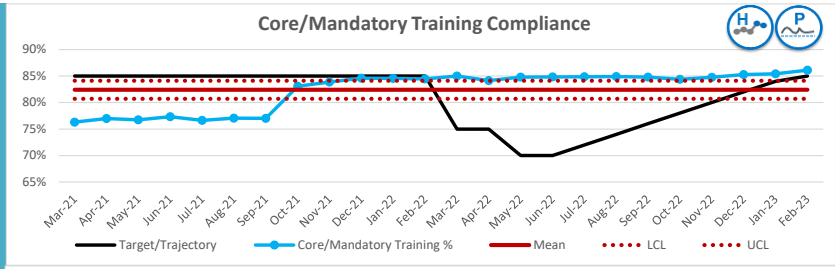
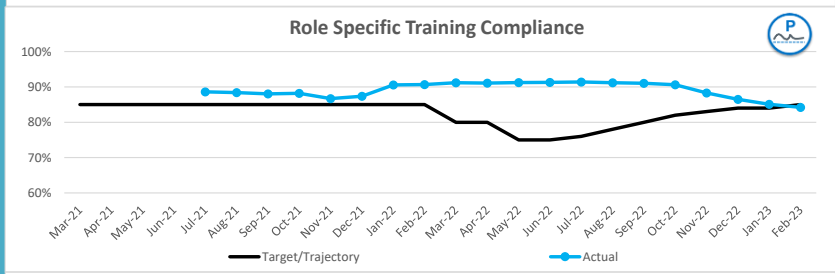
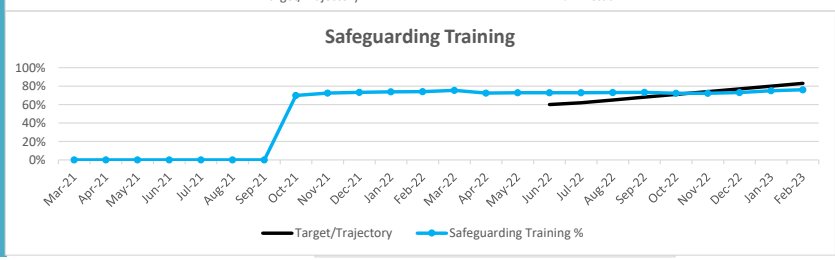
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
66. Bank and Agency Reliance **Target: 9% or Below** **Bank and Agency Reliance was 17% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Bank and Agency reliance in February 2023 was 17% compared to 15.84% in December 2022.** **Reasons for the variation can be attributed to sickness absence, high turnover and additional capacity.**	**A Resourcing Task and Finish group has been established to review any gaps identified through the Agency Controls best practice toolkit. This will support plans to work with agencies to ensure they are operating within controls and improve the use of the Trusts bank rather than agency staff.**
67. Pay **Target: On or Less than Budget** **Trust pay was above budget in month.**	 	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Total pay spend in February 2023 was £19.5m against a budget of £19m compared to December 2022, pay spend was £18.3m against a budget of £19.2m.** **The total pay spend for February 2023 is made up of the following elements:** **•£15.6m contracted** **•£2.1m Bank** **•£1.2m Agency** **•£0.37m WLI** **•£0.30m Overtime**	**The additional controls for pay spend that have been identified to support a reduction in premium pay are:** **•ECF approval process for non-clinical vacancies** **•ECF approval process for bank and agency temporary staffing pay spend (non-NHSP)** **Through the Finance and Sustainability Committee, compliance against our processes and rate cards continues to be monitored.** **There is currently work underway to establish clear actions that will be monitored through the Resourcing Task and Finish group to support pay spend within budget.**

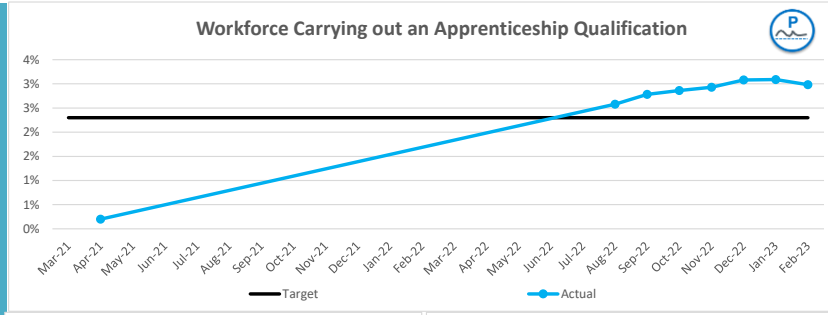
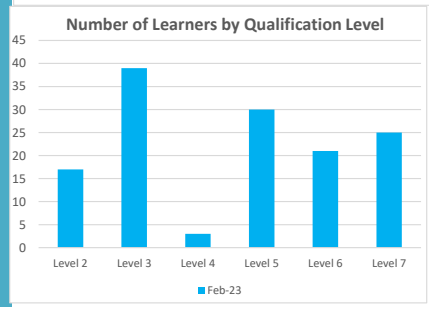
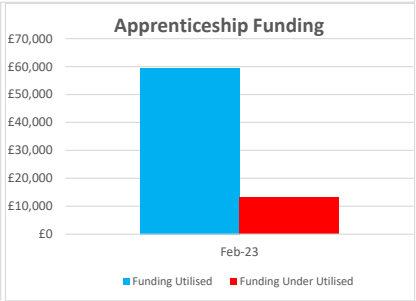
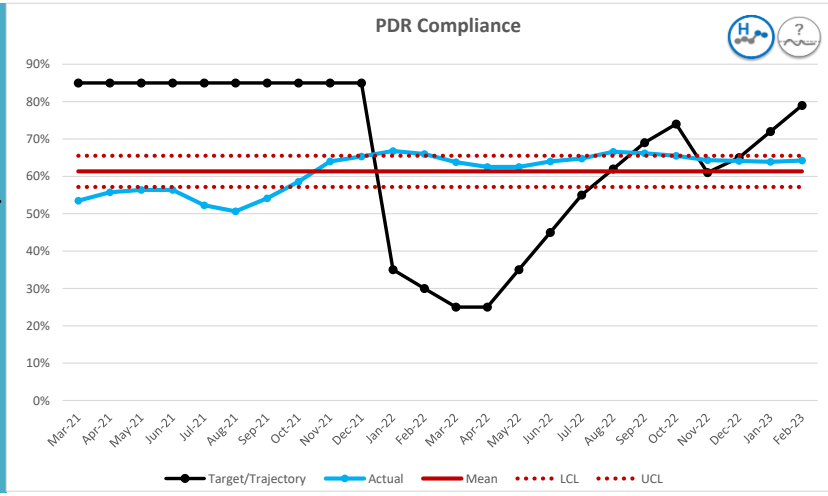
Workforce - Trust Position

Key:
SOF System Oversight Framework
UoR Use of Resources Assessment
RR200 Risk Register
CQC Care Quality Commission
S 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)?
68. Core/Mandatory Training **Target: 85%** **Core/Mandatory training compliance was 86.11% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**In February 2023, CSTF Mandatory Training compliance was 86.11%, excluding Safeguarding Training (Children's and Adults); Safeguarding compliance 76.04%, and Role Specific Training compliance 84.21%. In December 2022, CSTF was 85.29%, Safeguarding compliance was 73.11% and Role Specific was 86.49%**	**Trajectories have been developed in order to improve compliance which continue to be monitored through workforce governance structures and QPS.** **To ensure all training offered remains fit for purpose and relevant to staff, the Mandatory and Role Specific Training Group have developed a multi-disciplinary panel approach to support SMEs from March 2023 to review and identify accessibility, training needs analysis and justification for mandatory status.** **Following feedback from staff, block training sessions/days have been developed from Q1 2023-24 to support delivery and access to training for clinical and medical colleagues.**
69. Role Specific Training **Target: 85%** **Role Specific Training compliance was 84.21% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: N/A Not enough datapoints.**		
70. Safeguarding Training **Target: Trajectory** **Safeguarding Training compliance was 76.04% in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: N/A - Not enough datapoints.**		

Workforce - Trust Position

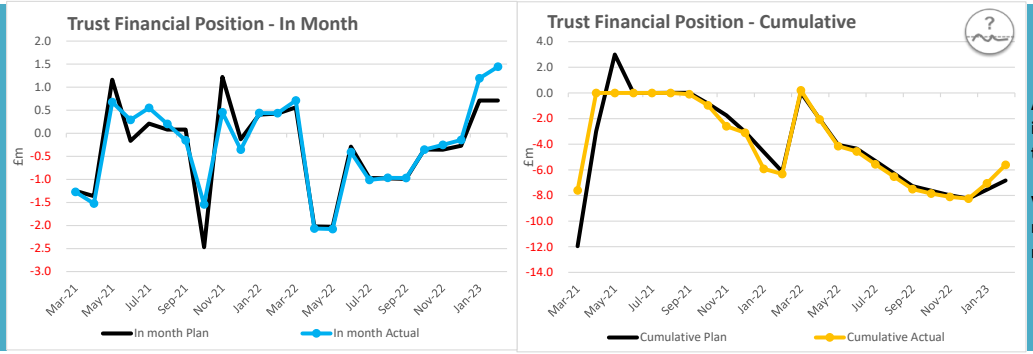
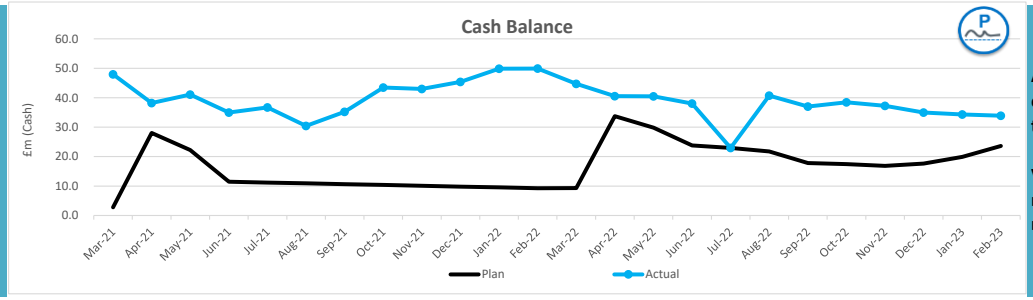
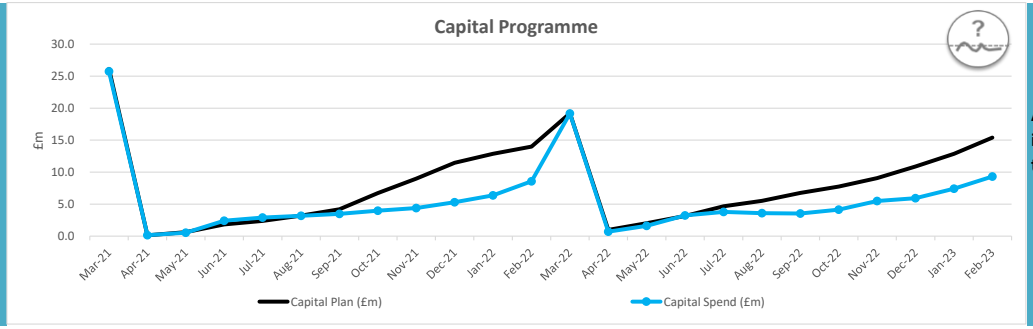
Key:
- SOF: System Oversight Framework
- UoR: Use of Resources Assessment
- RR200: Risk Register
- CQC: Care Quality Commission
- S: Trust Strategy

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)?
71. Workforce carrying out an Apprenticeship Qualification **Target: 2.3% or above** **81.84% of staff were carrying out a qualification in month.**	  	**Assurance: The Trust consistently passes the target.** **Variation: N/A - Not enough datapoints.**	**In February 2023, 2.98% of the workforce were carrying out a qualification compared with 3.08% in December 2022.**	**The organisation continues to support 5 local organisations through the Levy Transfer opportunity which meets WHH's ambitions as an anchor institution and our corporate social responsibility within the local area.** **The ECF Panel, supported by the Trusts Apprentice Team, continue to review all vacancies and support managers to supplement the vacancy with an external development offer, paid for by the Levy. This supports the Trust achieving above the 2.3% target of the percentage of the workforce carrying out a qualification.**
72. PDR **Target: 85%** **PDR compliance was 0% in month. SPC - there is evidence of special cause variation for PDR compliance.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of a improving nature.**	**In February 2023, PDR compliance was 64.24%. In January 2023, PDR compliance was 64.13%.** **Currently PDR rates are below the trajectories but higher than 2021.**	**The CBUs and Corporate Areas have been supported to develop trajectories and associated actions to improve PDR compliance, these continue to be monitored through the workforce governance structures and QPS.** **Feedback from the Operational People Committee in terms of improving appraisal compliance has resulted in a committment to refreshing the check-in conversation approach that was utilised during the COVID-19 pandemic and will be expanded to include specific questions relating to talent management and WHH values and behaviours.** **Pay progression is also being implemented from April 2023 which requires an in date appraisal to support pay progression.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

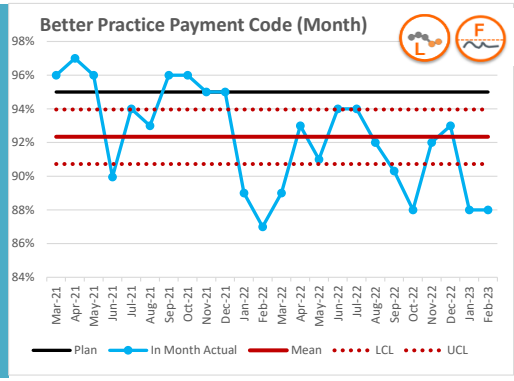
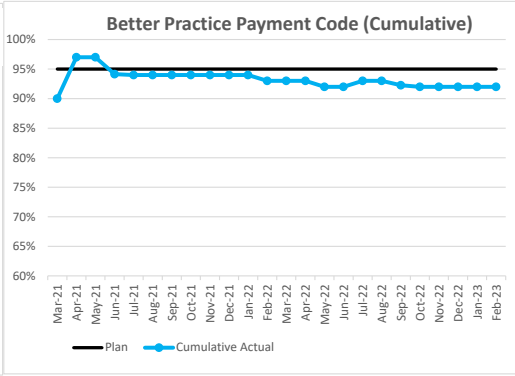
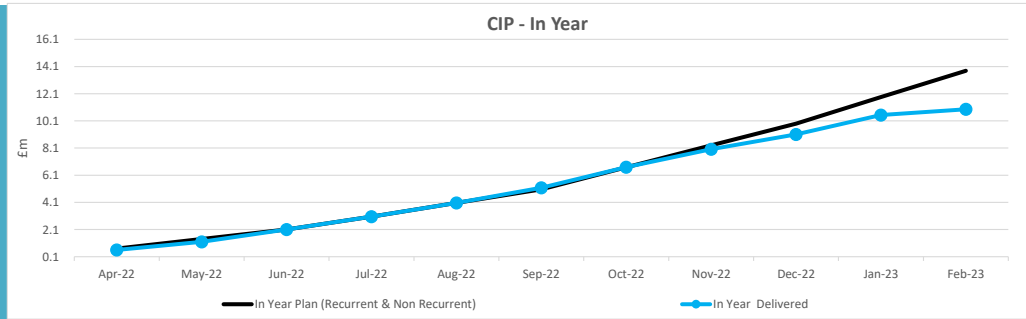
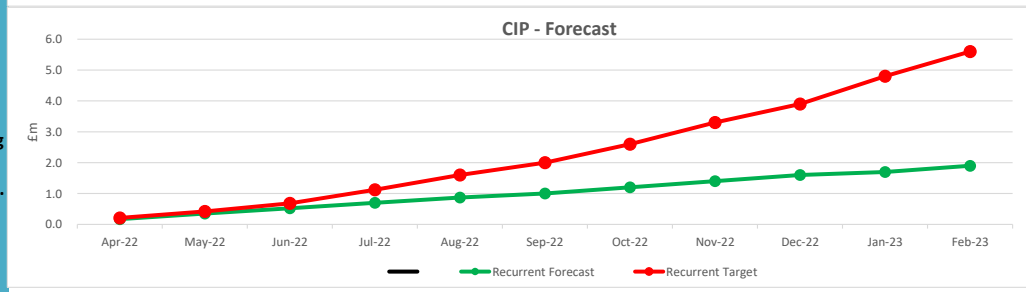
Key:
- SOF: System Oversight Framework
- UoR: Use of Resources Assessment
- RR116: Risk Register
- CQC: Care Quality Commission
- Trust Strategy

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)?
73. Trust Financial Position **Target: Plan**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: SPC Variance is not relevant for this metric**	**For the period ending 28 February 2023, the Trust has recorded a deficit of £5.61m, which is slightly better than plan. The position includes £7.3m ERF.**	**The Trust is forecasting delivery of the forecast £5.4m deficit.**
The Trust has recorded a deficit position of £5.61m which is slightly better than plan as at 28 February 2023.				
74. Cash Balance **Target: On or better than plan**		**Assurance: The Trust consistently passes the target.** **Variation: SPC Variance is not relevant for this metric**	**The current cash balance is £33.9m which is £10.3m better than the initial cash plan. This is due to a timing difference in the payment of trade creditors and capital creditors, additional income from contracts and additional VAT recovery.**	**Payment of the creditors on receipt of invoices will get the cash back to plan.**
The cash balance as at 28 February is £33.9m.				
75. Capital Programme **Target: On plan 90%-100%**		**Assurance: The Trust inconsistently passes/fails the target.**	**The current cash balance is £33.9m which is £10.3m better than the initial cash plan. In the main this relates to a timing difference in the payment of trade creditors, a timing difference in the payment of capital creditors, additional income from contracts and additional VAT recovery.**	**The underspend year to date relates to some delays on backlog maintenance schemes and externally funded schemes which will catch up. There is slippage on the catering scheme which will require mitigation in Q4. In addition, there has been £0.5m VAT reclaim increasing the underspend. Schemes, wherever possible, are being brought forward from**
Capital expenditure year to date is £9.3m against a £15.4m plan.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
SOF System Oversight Framework
UoR Use of Resources Assessment
RR116 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)?
76. Better Payment Practice Code Target: Cumulative performance 95%	UoR The Better Payment Practice Code performance based on volume for NHS is 76% and non-NHS is 92%. The Better Payment Practice Code performance based on value for NHS is 82% and non-NHS is 92%.	 	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Cumulative performance is 92.00% which is below the national target of 95.00%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.
77. Use of Resources Rating Target: Use of Resource Rating 1 and 2	UoR **The Use of Resources Rating is not currently being reported. The Trust is awaiting further guidance from NHSE/I.**				
78. Cost Improvement Programme (recurrent & non recurrent) - In year performance to date Target: >90% Plan delivered YTD	UoR The year to date CIP plan is £13.8m and £11m has been delivered.		N/A - Not enough datapoints.	In year savings identified are £14.6m against a plan of £15.7m, leaving £1.1m unidentified and £0.6m is high risk. As at month 11 £11m has been achived against at £13.8m target. A significant amount of the CIP programme is non recurrent which will impact on 2023/24 Operational Plan.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT conversations with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust. The plan for 2023/24 is being developed for the £18m target.
79. Cost Improvement Programme (Recurrent Forecast) - Target: Recurrent Forecast is more than 90% of the annual target	The Trust is in the process of identifying recurrent CIP schemes for 2022/23.		N/A - Not enough datapoints.	The Trust is working to identify recurrent CIP for 2023/24. A key driver will be GIRFT efficiencies throughout the Trust.	To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.

Appendix 3 – Trust IPR Indicator Overview

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

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

20.	**Continuity of Carer**	• Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
21. **22.** **23.** **24.**	**Sepsis**	• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.
25.	**Ward Moves Between 10pm and 6am**	• Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
26.	**Acute Kidney Injury**	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.
27.	**National Patient Safety Alerts not completed by deadline**	• Number of CAS (Central Alerts System) alerts with actions not completed by the deadline.
	Access & Performance	
28.	**Diagnostic Waiting Times – 6 weeks**	• All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.
29. **30.**	**RTT Open Pathways and 52 & 104 week waits**	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
31. **32.**	**Four hour A&E Target and ICS Trajectory**	• All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.
33.	**A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.**	• % of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.
34.	**Average Time in Department (ED)**	• How long on average a patient stays within the emergency department (ED).
35.	**Cancer 14 Days**	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
36.	**Breast Symptoms – 14 Days**	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
37.	**Cancer – 28 Day Faster Diagnostic Standard**	• All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.
38.	**Cancer 31 Days - First Treatment**	• All patients to receive first treatment for cancer within 31 days of decision to treat.

39.	**Cancer 31 Days - Subsequent Surgery**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery.
40.	**Cancer 31 Days - Subsequent Drug**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments.
41.	**Cancer 62 Days - Urgent**	• All patients to receive first treatment for cancer within 62 days of an urgent referral.
42.	**Cancer 62 Days – Screening**	• All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers.
43.	**Ambulance Handovers 15**	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
44.	**Ambulance Handovers 30 – 60 minutes**	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
45.	**Ambulance Handovers – more than 60 minutes**	• % of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).
46.	**Discharge Summaries – Sent within 24 hours**	• The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
47.	**Discharge Summaries – Not sent within 7 days**	• If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
48.	**Cancelled operations on the day for non-clinical reasons**	• % of operations cancelled on the day or after admission for non-clinical reasons.
49.	**Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days**	• All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
50.	**Urgent Operations – Cancelled for a 2nd Time**	• Number of urgent operations which have been cancelled for a 2nd time.
51.	**Super Stranded Patients**	• Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
52.	**COVID-19 Recovery Elective Activity**	• % of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20.
53.	**COVID-19 Recovery Diagnostics**	• % of Diagnostic Activity against the same period in 2019/20.
54.	**COVID-19 Recovery Outpatients**	• % of Outpatient Activity against the same period in 2019/20.
55.	**% Outpatient Attendances Delivered Remotely**	• Part of the transformation of outpatient care, this indicator will monitor the % of outpatient appointments delivered remotely via telephone or video consultation.
55.	**Fracture Clinic**	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
56.	**% Outpatient Attendances Delivered Remotely**	•
57.	**Advice & Guidance (A&G) Activity Levels**	• Number of Advice & Guidance contacts in month.
58.	**Patient Initiated Follow Up (PIFU) Activity Levels**	• Number of Patient Initiated Follow Ups (PIFU) in month.

59.	**% of zero-day length of stay admissions (SDEC)**	• % of zero length of stay admission (SDEC).
80.	**Reduction in Outpatient Follow Ups**	• % reduction of Outpatient follow ups compared to 19/20 activity.
81.	**COVID-19 Recovery Cancer First Treatment**	• % of people who received their first treatment for cancer compared to the equivalent month in 19/20.
82	**% Patients discharged to their usual place of residence**	• % of patients who were discharged to their usual place of residence.
	Workforce	
60.	**Supporting Attendance**	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
61.	**Welcome Back Conversations**	A review of the completed monthly return to work interviews.
62.	**Recruitment Timeframe**	A measurement of the average number of days it is taking to recruit into posts.
63.	**Vacancy Rates**	% of Trust vacancies against whole time equivalent.
64.	**Retention**	Staff retention rate % over the last 12 months.
65.	**Turnover**	A review of the turnover % over the last 12 months.
66.	**Bank & Agency Reliance**	The Trust reliance on bank/agency staff.
67.	**Pay Spend – Contracted and Non-Contracted**	A review of Contracted and Non-Contacted pay against budget.
68.	**Core/Mandatory Training**	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
69.	**Role Specific Training**	A summary of role specific training compliance.
70.	**Safeguarding Training**	A summary of safeguarding training compliance.
71.	**Workforce carrying out an Apprenticeship Qualification**	% of the workforce carrying out an apprenticeship qualification.
72.	**Performance & Development Review (PDR)**	A summary of the PDR compliance rate.
	Finance	
73.	**Trust Financial Position**	The Trust operating surplus or deficit compared to plan.
74.	**Cash Balance**	The cash balance at month end compared to plan.
75.	**Capital Programme**	Capital expenditure compared to plan.
76.	**Better Payment Practice Code**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
77.	**Use of Resources (Finance)**	Suspended – awaiting further guidance from NHSE/I
78.	**Cost Improvement Programme – Plans in Progress in Year**	Cost savings schemes in-year compared to plan.
79.	**Cost Improvement Programme – Recurrent)**	Cost savings schemes recurrent compared to plan.

Appendix 4 - Statistical Process Control

1.0 What is SPC?

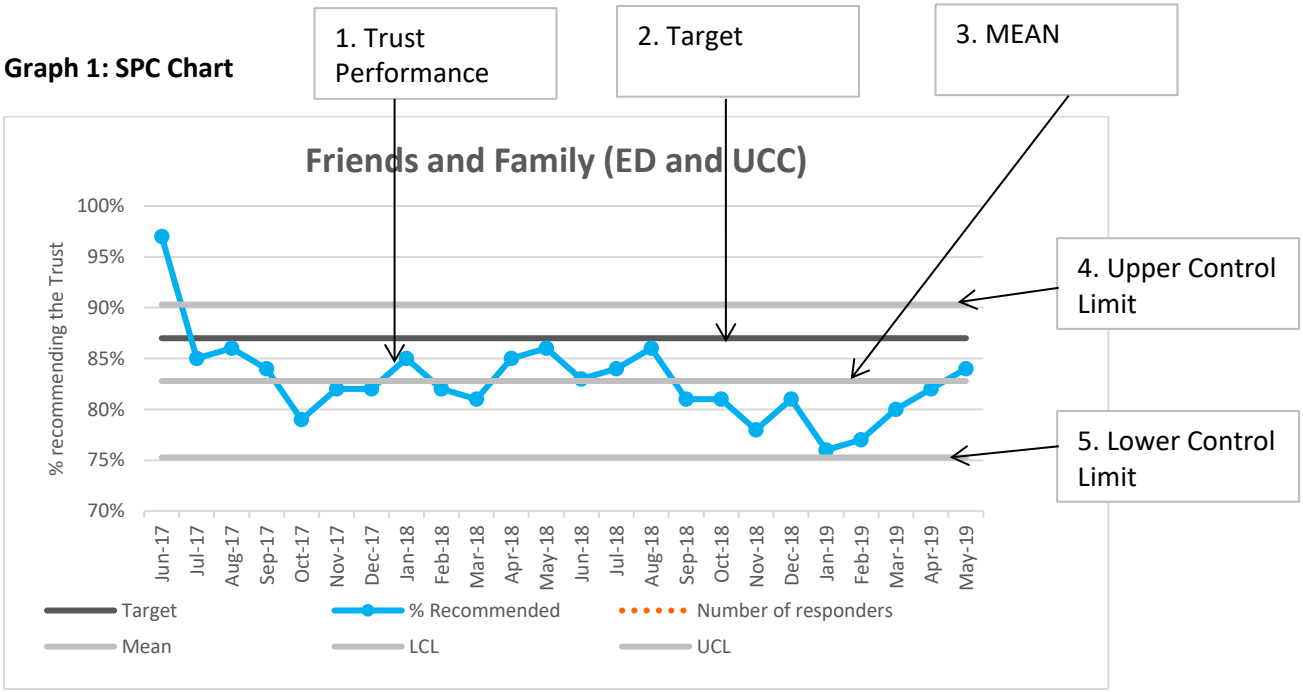
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

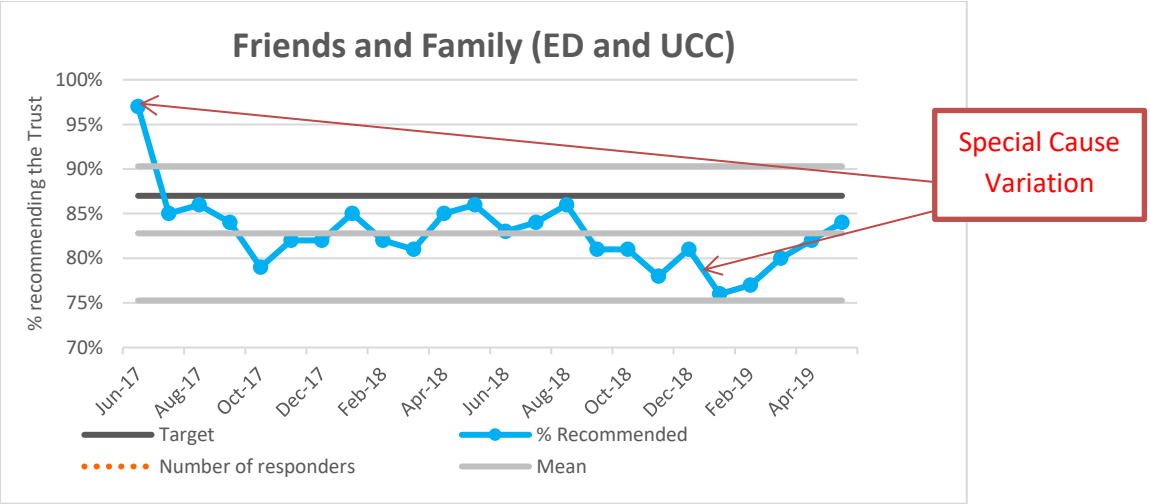


2.1 Interpreting a SPC Chart

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.

Appendix 5: Income Statement

Income Statement as at 28th February 2023

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income							
Elective Spells	33,658	2,586	2,249	-337	30,557	27,441	-3,117
Elective Excess Bed Days	360	28	23	-6	325	96	-228
Non Elective Spells	76,974	7,134	6,209	-925	69,589	64,297	-5,291
Non Elective Bed Days	2,049	190	235	45	1,852	2,622	770
Non Elective Excess Bed Days	2,930	272	245	-27	2,649	2,433	-216
Outpatient Attendances	47,788	3,817	4,142	325	43,570	36,860	-6,710
Accident & Emergency Attendances	15,398	1,169	1,229	60	14,371	15,176	806
Other Activity	70,668	6,122	6,633	511	65,593	83,510	17,917
ERF	7,964	664	664	0	7,300	7,300	0
COVID Block Income (Liverpool CCG)	35,420	2,952	2,980	28	32,469	32,469	0
Sub total	**293,208**	**24,933**	**24,608**	**-325**	**268,274**	**272,204**	**3,931**
Non NHS Clinical Income							
Private Patients	0	0	1	1	0	10	10
Non NHS Overseas Patients	0	0	0	0	0	90	90
Other non protected	996	83	-2	-85	913	658	-256
Sub total	**996**	**83**	**-1**	**-84**	**913**	**757**	**-156**
Other Operating Income							
Training & Education	9,093	758	875	118	8,336	8,889	554
Donations and Grants	2,910	700	35	-665	1,983	550	-1,433
Miscellaneous Income	13,248	1,271	2,920	1,649	11,980	18,113	6,133
Sub total	**25,251**	**2,729**	**3,830**	**1,101**	**22,299**	**27,552**	**5,253**
Total Operating Income	**319,455**	**27,745**	**28,437**	**693**	**291,486**	**300,513**	**9,028**
Operating Expenses							
Employee Benefit Expenses	-233,200	-18,969	-19,254	-285	-214,240	-219,093	-4,853
Drugs	-17,585	-1,450	-1,852	-403	-16,135	-18,255	-2,120
Clinical Supplies and Services	-20,415	-1,641	-1,502	140	-18,774	-19,513	-739
Non Clinical Supplies	-32,995	-2,735	-3,088	-354	-30,259	-33,494	-3,235
Depreciation and Amortisation	-13,760	-1,147	-1,030	117	-12,614	-11,916	698
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	**-317,955**	**-25,941**	**-26,726**	**-785**	**-292,022**	**-302,272**	**-10,250**
Operating Surplus / (Deficit)	**1,501**	**1,804**	**1,711**	**-93**	**-537**	**-1,759**	**-1,222**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	59	59
Interest Income	166	14	148	134	152	815	663
Interest Expenses	-192	-16	-13	3	-176	-148	28
PDC Dividends	-4,863	-405	-405	0	-4,458	-4,458	0
Total Non Operating Income and Expenses	**-4,889**	**-407**	**-270**	**137**	**-4,482**	**-3,732**	**750**
Surplus / (Deficit) - as per Accounts	**-3,388**	**1,396**	**1,441**	**45**	**-5,018**	**-5,491**	**-472**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	-2,910	-700	-35	665	-1,983	-550	1,433
Add Depreciation on Donated & Granted Assets	192	16	37	21	176	430	254
Total Adjustments to Financial Performance	**-2,718**	**-684**	**2**	**686**	**-1,807**	**-120**	**1,687**
Adjusted Surplus / (Deficit) as per NHSI Return	**-6,106**	**712**	**1,443**	**731**	**-6,826**	**-5,610**	**1,215**

Appendix 6: Capital Programme

PERIOD ENDING 28TH FEBRUARY 2023

	Budget						
	Budget B/F from 21/22	Original Board Approved Budget	PDC Funded	Externally Funded	Budget Adjustments YTD	Budget Adjustments in Month	Total Revised Budget
	2022/23	2022/23	2022/23	2022/23	2022/23	2022/23	2022/23
Scheme Name	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
ESTATES							
ED Plaza	2,859				(167)		**2,692**
Paeds (Childrens Outpatients)	130				251		**381**
Urology (Estates)	240				249		**489**
ED Plaza further slippage	115				(115)		**0**
L Shaped Corridor	129				37		**166**
Nurse Call Minor injuries	25						**25**
CMTC Replacement Emergency Lighting	72				(4)		**68**
Breast Relocation of Breast Equipment (Kendrick to Bath Street)		30			39		**69**
Shopping City 21/22 underspend		35			128		**163**
Shopping City Retension of 2.5%		18					**18**
Appleton Ventilation Upgrade		300					**300**
Appleton Wing circulation Area Fire Doors Deferred from 21/22		300			(100)		**200**
Appleton Fire doors final phase					200		**200**
Estates Capital Staffing		260					**260**
Dementia & Accessibility - Site Wide		200					**200**
Fixed electrical testing site wide (£100k was b/f from 21/22)		150			100		**250**
Emergency lighting to stairwells and exits		115					**115**
6 Facet Annual Survey Review		55			(19)		**36**
Annual Asbestos Site Management survey		30					**30**
ED Fire Barrier (actual work for above - added 28/02/2022)		125			23		**148**
Catering Upgrade		1,800			(800)		**1,000**
Removal of C21 Bathroom and installation of storage		24					**24**
Induction of Labour Ward		300					**300**
Replacement Hot Water Cylinder CSTM					13		**13**
Boiler Block 1					21		**21**
Fire - Relocate and replace medical gas AVSU's to clinical wards					8		**8**
Halton 30 Minute Fire Compartmention							**0**
UPS Main Server Room Warrington							**0**
MRI Works							**0**
CSTM Ward Modification					114		**114**
Corporate Offices Decoration					14		**14**
Chiller Compressor - Daresbury Theatres					7		**7**
Roof Leaks - Halton					59		**59**
Repairs to roads & footpaths across both sites					150		**150**
Appleton Wing fire dampers final phase					0		**0**
CCTV Upgrade site wide					60		**60**
Replacement of AVSU's - part 2					40		**40**
Safe surface temperatures (radiators) final part					30		**30**
Breast Screening Pad at CSTM					25		**25**
Mortuary Fencing					9		**9**
Estates Department Roof Upgrade					175		**175**
Ultrasound Wider Doors					17		**17**
ED Minors					149		**149**
Bath Street Lease					305		**305**
Endo Ventilation							**0**

Therapies Staff Room						13	**13**
Estates Total	**3,570**	**3,742**	**0**	**0**	**1,018**	**13**	**8,343**

IM&T							
005 Cisco Refresh (Phase 1)	22				(22)		**0**
007 IP Telephony	27				(27)		**0**
EPMA 1-4	8						**8**
Electronic Patient Record Procurement	50				(50)		**0**
Patient Flow (Tif)	10						**10**
Cisco Refresh Phase 2		817					**817**
IT Staffing		316			(31)		**285**
Tech Refresh 22/23		85					**85**
Halton SAN Refresh (DR site)		200			(200)		**0**
Network Switches - reduced network switches to £49k per HG 16.02.22		49					**49**
Programme and Benefits Resource/Phase 2 Structure		165					**165**
EPR EPCMS		155			(155)		**0**
New Maternity System - Extended Project Management Support		109					**109**
WIFI Upgrade							**0**
Comms Cabinets (Phase 3)		100					**100**
Digital Analytics Staffing					20		**20**
ICE 2012 OS and Application Upgrade					70		**70**
Information Technology Total	**117**	**1,996**	**0**	**0**	**-395**	**0**	**1,718**

MEDICAL EQUIPMENT							
Image Intensifer	78						**78**
Urology Equipment - Bladder Scanner	10				(10)		**0**
Video Laryngoscope	13						**13**
Decontamination Shelter	2						**2**
Hamilton Cold Vent							**0**
Radiology - Fluoroscopy Room (turnkey costs)		105			16		**121**
Mammography Equipment Replacement (enabling works only) Bath Street		50			(38)		**12**
Video Laryngoscopes		77			(37)		**40**
Neonatal Scanner		104					**104**
Security - NEST/neonatal unit/C23/Paediatrics		50			(25)		**25**
Obstetric Portable Ultrasound Machine		27					**27**
UCC X-ray Turnkey costs		80					**80**
Microtomes and slide writers		25			3		**28**
Platelet Incubator / Agitator		8					**8**
Audiology ABR replacement		22			10		**32**
Resuscitaires		91					**91**
Replacement of the Pharmacy Automated Dispensing System Robot		1,084			(583)		**501**
Knee Coil							**0**
Ultrasound Radiology							**0**
Dishwasher A3					6		**6**
Boiling Pan					8		**8**
Spine Coil					19		**19**
CT Scanner - ED				200			**200**
V60 Machine - V800				130			**130**
Ophthamology				308			**308**
Echo Machines				500			**500**
Concealment Trolley					6		**6**
TV Transducer					6		**6**
Curvilinear Transducer					7		**7**
MRI Turnkey					6		**6**

Upper Limb Articulated Surgical Positioning Attachment					19		**19**
Portable operating lights in theatres					10		**10**
Cell Saver - Theatres					17		**17**
Cell Saver - Maternity					17		**17**
Vapotherm Machine					9		**9**
Anterion					21		**21**
Defibrillator Replacement - Warrington					355		**355**
Grid Replacement Xray Room 3					8		**8**
Myosure Fluid Management System					32		**32**
Replacement of Urodynamics System					41		**41**
Cooking Boiling Pan					27		**27**
Dishwasher C23					7		**7**
Portable Bladder scanner					7		**7**
ECG Machine						8	**8**
Tissue Processor						37	**37**
Patient Meal Trolleys						42	**42**
Medical Equipment Total	**103**	**1,723**	**0**	**1,138**	**-36**	**87**	**3,015**

Total Trust Funded Capital	**3,790**	**7,461**	**0**	**1,138**	**587**	**100**	**13,076**

CONTINGENCY							
Prior Year Adjustments (VAT Rebates)							**0**
Contingency		400			(715)	(100)	**(415)**
Year End Accruals 21/22							**0**
Slippage from schemes		-295			295		**0**
Contingency Total	0	**105**	**0**	**0**	**(420)**	**(100)**	**(415)**
Total Trust Funded Capital	**3,790**	**7,566**	**0**	**1,138**	**167**	**0**	**12,661**

Externally Funded Schemes							
Warrington Town Deal Health and Wellbeing Hub- Capital Works*				471			**471**
Shopping City 21/22 underspend (added 04/02/2022)	350						**350**
3Dimensions System with 3MP Monitor (static) (BSP)			320		58		**378**
Halton Elective Centre (TIF Funding/PDC) £1367			1,419				**1,419**
Community Diagnostic Centre (CDC)			6,867				**6,867**
MRI Software Upgrade			17				**17**
Electronic Patient Record Procurement £50k			50				**50**
EPR EPCMS £155k			155				**155**
Digital Radiology Network DDCP			270				**270**
Digital Pathology Remote Reporting/Resilience			40				**40**
Pacs Licencing			186				**186**
CT Scanner			1,200		(225)		**975**
MRI Scanner			1,400				**1,400**
Pintuition (Magnetic Breast Tags)			41				**41**
NW Endoscopy			42				**42**
Total Externally Funded	**350**	**0**	**12,007**	**471**	**-167**	**0**	**12,661**
Grand Total	**4,140**	**7,566**	**12,007**	**1,609**	**0**	**0**	**25,322**

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 a		Trust Board	**DATE OF MEETING**	29 March 2023

Date of Meeting	07 February 2023
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/02/32	**Update report for the management of patients with Sepsis at WHH (Quarter Three 2022/23)**	The Committee received the report providing an update for Q3, on the progress to improve compliance with Sepsis Assessment and Treatment for patients. It was noted that whilst the inpatient position was improving, ED had shown a reduction in compliance when compared to previous quarters. The audit completed by the MIAA (finalised January 2023), concluded limited assurance with 2 high and 6 medium recommendations for action. The committee noted the next steps to review the full pathway for patients from arriving in ED to inpatient transfer using the MIAA audit recommendations and actions – with a completion date of February 2023. The committee took some assurance from the AQuA benchmarking data provided; confirming that WHH were performing above average. The committee were reassured of the plans to embed new processes and across whole teams, the development of a digital support tool, appointment of an educational facilitator and a focus on ED specific sepsis training.	**The Committee discussed the presentation and received moderate assurance.** **Progress on the pathway review using MIAA audit recommendations, would be monitored by the Committee.**	**QAC to receive Q4 Update report for the management of patients with Sepsis at WHH**

QAC/23/02/33	**6 Monthly Staffing Report**	The committee received a comprehensive report detailing the challenges in increased nursing vacancies, increased acuity and dependency on the wards, the continuing number of patients with 'no right to reside' and the significant impacts on the ability of the senior nursing teams to ensure sufficient nurses to provide the standards of care expected. The committee were assured of the triangulated approach to nurse workforce establishment in line with National Quality Board recommendations – detail was provided within the report. The committee took assurance in the continuation of proactive recruitment and retention plans along with processes and mitigation to ensure safe levels of care. Despite these efforts nurse establishment remains a high risk for the Trust and a national concern. The committee requested additional data for future 6 monthly reports to quantify incident/harm data and the correlation to staffing levels.	**The Committee discussed the report and received moderate assurance, noting that this was a system wide issue requiring a national approach in order to drive improvement.**	**Quality Committee August 2023 (6 months)**
QAC/23/02/36	**Arbury Court Update**	The committee received a presentation providing an update on Arbury Court concerns, following the system partner meeting which had taken place at the request of WHH on the 27th January. The Director of Arbury Court reaffirmed the position that this was a high-risk area, themes of insertion and ingestion were agreed it was confirmed that Quality assurance checks would take place every 8 weeks by Specialist commissioners. The committee were assured of the agreed next steps; • The group would meet in again in February 2023 • Arbury Court would present a review of incidents • Assurances were to be provided to the group with actions and learning identified	**The Committee discussed the presentation and received moderate assurance.**	**February 2023 – QAC to receive update**

		• The task and finish group would report into Warrington Adult Safeguarding Board Assurance of Section 17 documentation on every attend • A Benchmark exercise was to be undertaken with a similar provider The committee agreed that the item required escalation to the Board and that if progress was not achieved within the agreed timescales, the Board would be requested to escalate.		
QAC/23/02/40	**Patient Safety & Clinical Effectiveness Sub Committee Exception Report**	The Committee received the exception report which escalated the difficulties being experienced within the Stroke Care Pathway - with significant numbers of Acute stroke patients being admitted to the Warrington site for the first 72 hrs of care rather than being admitted to the Whiston site as per the commissioned pathway. It was noted that for a 48-hour period during severe service pressures in January 2023, StHK suspended admissions from Warrington and Halton places for acute stroke patients who were outside the thrombolysis time window, resulting in direct admission to WHH. It was highlighted that WHH were not commissioned to deliver the first 72hrs of Stroke Care and the Warrington site was not a HASU site. The Committee discussed the risk that patients may receive delayed or substandard care, not in line with national standards. It was noted that the Risk was currently scored as 20 on the Corporate Risk Register.	**The Committee discussed the item and received moderate assurance agreeing further escalation to Trust Board was required**	**To be highlighted to Trust Board – progress update to be provided by MD**

The Committee also received the following items:

QAC/23/02/24 – Hot Topic – Mortuary Capacity Update
QAC/23/02/25 - Deep Dive – Safety Response to Operational Pressures – Unplanned Care

Matters for Approval
QAC/23/02/26 - Board Assurance Framework & Risk Register

Papers to Discuss and Note for Assurance
QAC/23/02/27 Quality IPR Metrics
QAC/23/28 Maternity Update

i. Ockenden Review Update
    a. Maternity Incentive Scheme
    b. Perinatal Mortality Q

QAC/23/02/30 CQC Maternity Survey
QAC/23/02/31 CQC Position & Preparedness
QAC/23/02/34 Review of Risk Management Maturity Arrangements and Practice
QAC/23/02/35 CIP/GIRFT Programme 2022/23 1st April 2022-31st December 2022 QIA Report

Papers to Note for Assurance
QAC/23/02/37 IG & Corporate Records Quarterly Report
QAC/23/02/38 Learning from Experience Q3
QAC/23/02/39 DIPC Infection Control Q3
QAC/23/02/40 Patient Safety & Clinical Effectiveness Sub Committee Exception Report

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 a ii		Trust Board	**DATE OF MEETING**	29 March 2023

Date of Meeting	07 March 2023
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/23/03/54	**Quarterly Maternity Safety & Quality Update**	The Committee received the paper which provided an update in relation to Safety & Quality applicable to the Maternity Service for the period November 2022 to January 2023. It was noted that the themes raised by colleagues were issues which had in the most part, already been identified as areas for action within the maternity service. The committee noted the key projects to implement a number of improvements which would resolve the estates issues. The committee sought assurance on progress of repairs to the "call bell" system, which was delaying the re-opening of the Nest (Midwifery led Unit). It was noted that the contractor had confirmed their ability to repair the system and progress would be reported into the committee. The committee also noted the delays in the Maternity Triage and Induction of Labour Bay estates work, it was highlighted that a completion date had still not been set.	**The Committee discussed the report and received moderate assurance, noting the estates actions in place to resolve.**	**Update to the Committee April 2023.**

QAC/23/03/60	**Patient Safety & Clinical Effectiveness Subcommittee Escalations Paper**	**Histopathology Turnaround Times & Urology MDT Pathway** The Committee received the report providing an update on the establishment challenges impacting Histopathology Turnaround Times & Urology MDT Pathway. It was noted that despite turnaround times performance continuing in an improvement trajectory, there remains significant risk around prostate and wider urology histopathology. The Committee were informed of the difficulties in histopathologist participation in the urology MDT and reporting activity which has been exacerbated by the retirement of 2 Consultant Pathologists in early December. The committee took assurance that alternative support for the urology MDT other than in-person consultant attendance had been implemented and that capacity had been increased through remote reporting. The committee noted the recruitment action plans in place; however it was agreed that the vulnerability of the service should be escalated to the Board.	**The Committee discussed the report and received moderate assurance.** **Histopathology to remain under monthly oversight as a fragile service at PSCESC.**	**QAC to receive progress updates via PSCESC escalation paper.**
QAC/23/03/59	**Arbury Court**	The Committee received a presentation providing an update on Arbury Court concerns. The committee received assurance on the system meetings that had taken place and those that were scheduled for future dates with WHH, Arbury Court (Elysium), PROSPECT, to agree improvement actions and to monitor progress against those actions. The Committee agreed that if progress was not achieved within the agreed timescales, the Board would be requested to escalate.	**The Committee discussed the presentation and received moderate assurance on the progress to date.**	**Monthly Updates to QAC.**

The Committee also received the following items:
QAC/23/03/47 Hot Topic – Diabetic Foot Clinic
QAC/23/03/48 Hot Topic – Paediatric Audiology, Auditory Brainstem Responses (ABR)
QAC/23/03/49 Deep Dive – Blood Transfusion

Matters for Approval

QAC/23/03/50 Quality Priorities 2023/24
QAC/23/03/51 Enabling Strategies Update

Papers to Discuss and Note for Assurance
QAC/23/03/52 Review & Refresh of Trust KPIs
QAC/23/03/23 Maternity Update
i. Ockenden Review Update
ii. ATAIN Q3
QAC/23/03/54 Quarterly Maternity Safety & Experience (Safety Champion themes, FFT, MVP, infection control)
QAC/23/03/55 Quarterly Transitional Care Audit
QAC/23/03/56 Learning from Deaths Review Q3
QAC/23/03/57 Clinical Audit Forward Plan
QAC/23/03/58 Quarterly Quality Priorities Report Q3

Papers to Note for Assurance
QAC/23/03/60 Patient Safety & Clinical Effectiveness Sub Committee Exception Report
QAC/23/03/61 Revised Committee Effectiveness Review Process 2022/23
QAC/23/03/62 High level enquiries & External Assessment / Inspections (when notified)

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 b	MEETING:	Trust Board	DATE OF MEETING	29th March 2023

Date of Meeting	22nd February 2023
Name of Meeting & Chair	Strategic People Committee, Julie Jarman
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/02/12	**BAF and Risk Register – Workforce**	The Committee received the report and assurance on the progress made against the risks identified. Due to the Committee frequency moving to a monthly basis, a proposal was endorsed by the Committee to move the BAF and Risk Register (Workforce) agenda item to bi-monthly.	**The committee received good assurance and approved the move to bi-monthly reporting.**	**SPC 22nd March 2023**
SPC/23/02/13	**Hot Topic: Workforce Issues in ED, Maternity and Pharmacy**	The Committee received a presentation and were advised of some of the workforce issues in these hot spot areas within the organisation and the efforts made to focus on retention of staff and attraction to the organisation through the implementation of a marketing organisation Just-R which has had a positive impact on maternity services. The Committee noted the issues and requested a further update in 2023/24.	**The committee received good assurance on the approach so far and requested a further update.**	**SPC 22nd March 2023**
SPC/23/02/14	**Deep Dive: Appraisal linked to pay progression and talent**	The committee received a presentation on organisational and regional context in relation to appraisals. The Committee received assurance on the steps that have been taken in order to improve compliance and the future link to pay progression, noting responding the staff feedback to provide an updated template to encourage further compliance. The Committee were assured of progress but requested a follow up to understand the reasons why the organisation may be an outlier and impact of the updated paperwork.	**The committee received good assurance and requested a further update to demonstrate impact of the changes**	**SPC meeting Q2**
SPC/23/02/16	**Chief People Officer Report**	The Committee were advised of the changes to pensions following national consultation and the implementation of the McCloud remedy in order to address	**The Committee received good assurance and noted**	**Not applicable.**

		previous age discrimination (nationally) with the introduction of the 2015 scheme. The Committee were assured that the People Directorate are currently scoping options for pension recycling and awaiting a further steer from regional NHS colleagues.	**changes to pensions moving forward.**	
SPC/23/02/17	**EDS2**	The Committee received an overview of the 2022-23 EDS2 ratings for the organisation which, based on the evidence and engagement with workforce stakeholders results in "Developing" and is aligned to other Cheshire and Merseyside providers. The Committee approved the EDS2 ratings for 2022-23.	**The Committee received good assurance and approved EDS2 for 2022-23**	**Published on Trust website by 28th February 2023.**
SPC/23/02/18	**Gender Pay Report**	The Committee received the Gender Pay Report for WHH which details the Gender Pay Reporting for 2021/22. The Committee were assured by the robust action plan included in order to minimise any gender pay gaps within WHH. The Committee approved the report to be published on the Trust website and submitted to the Government portal by the 30th March 2023.	**The Committee received good assurance and approved the report to be published and uploaded onto the Government portal by 30th March 2023**	**Published on Trust website by 30th March and submitted to Government portal**
SPC/23/02/19	**Annual Workforce IPR 2023/24**	The Committee received a proposed change to the Workforce IPR to reduce the workforce indicators from 16 to 6 which include: 1. Monthly sickness absence – rolling 12 month average 2. Turnover 3. Retention 4. Core / mandatory training 5. Safeguarding training 6. PDR compliance In addition, reporting relating to apprenticeships such as the utilisation of the levy and percentage of the workforce developing as part of apprenticeship opportunities will be reported and monitored by SPC. The Committee approved the report for recommendation to Trust Board.	**The Committee approved the IPR 2023/24 for recommendation to Trust Board to focus on 7 workforce indicators:** **1. Monthly sickness absence – rolling 12 month average** **2. Turnover** **3. Retention** **4. Core / mandatory training** **5. Safeguarding training** **6. PDR compliance**	**Trust Board 29th March 2023.**

The Committee also received the following items:

Matters to note for assurance
SPC/23/02/15 – Kindness, Civility and Respect
SPC/23/02/20 – Preceptorship update
SPC/23/02/21 – CPD update
SPC/23/02/22 – Guardian Safe Working Hours Junior Doctors in Training Q3
SPC/23/02/23 – Staffing Assurance Report October and November 2022 Key Issues

Sub-Committee Chairs Logs
SPC/23/02/24 – Nursing and AHP Workforce Resourcing Group (02.02.2023)
SPC/23/02/25 – Operational People Committee (13.02.2023)

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 b	MEETING:	Trust Board	DATE OF MEETING	29th March 2023

Date of Meeting	22nd March 2023
Name of Meeting & Chair	Strategic People Committee, Julie Jarman
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/23/03/30	**Hot Topic: Improving People Practices Lessons Learnt – Race Discrimination NHSE**	The Committee received a presentation on the recent NHSE employment tribunal which upheld race discrimination and whistleblowing claims against NHSE. The Committee were provided assurance regarding current WHH processes, and actions that have been identified as lessons learnt from the case for WHH to implement. The Committee noted the actions identified for implementation and requested further updates in 2023-24.	**The Committee received moderate assurance on the review so far and requested further updates throughout 2023-24.**	**SPC April 2023.**
SPC/23/03/31	**Workforce Brief – Health Care Support Workers**	The Committee were advised of the national review of Health Care Support Workers roles at Band 2 and Band 3. Information was provided regarding the workforce review that has taken place at WHH and assurance was provided regarding the implementation of the review, including consultation and communication plans.	**The Committee received good assurance on the review and implementation process.**	**Not applicable.**
SPC/23/03/31	**Workforce Brief - Staff Facilities**	The Committee were provided an overview of the food provision for staff across both the Warrington and Halton sites aligned to the National Standards of Healthcare Food and Drink, including an overview of proposals to enhance and extend provision for night shift workers and individuals working out of hours.	**The Committee received good assurance on the review and implementation process.**	**Not applicable.**
SPC/23/03/33	**Equality Duty Assurance Report**	The Committee received the Equality Duty Assurance Report (EDAR) for approval. In line with reporting requirements, the Trust must publish its EDAR by 30th March 2023. As public sector organisations, all NHS Trusts are required to	**The Committee received good assurance and approved the report for publication.**	**SPC March 2024.**

	(EDAR) PSED Standards and Armed Forces Act Report	demonstrate how they meet the general and specific duties of the Public Sector Equality through the EDAR. The Committee approved the report for publication.		
SPC/23/03/34	**Workforce IPR**	The Committee received the report for assurance and approval. For assurance, the report detailed the current People IPR for 2022-23. For approval, the paper outlined recommendations for updates to the workforce indicators which are relevant to the remit of the Strategic People Committee (SPC) for 2023-24. It also detailed a Chairs action for an amendment to the Trust Board IPR proposals for 2023-24 to include bank and agency reliance. The Committee noted the 2022-23 People IPR for assurance and approved the SPC IPR for 2023-24, and amendment to the Trust Board IPR for 2023-24.	**The Committee received good assurance on the 2022-23 People IPR and approved the SPC IPR and recommendations to Trust Board for People IPR 2023-24.**	**SPC May 2023.**
SPC/23/03/35	**Freedom to Speak Up**	The Committee received the Freedom to Speak Up (FTSU) bi-annual report for assurance. The Committee were assured regarding the FTSU approach and processes. Assurance was received on the speed with which FTSU address any patient safety concerns, and working closely with clinical leaders on these cases. The Committee received good assurance.	**The Committee received good assurance on FTSU processes.**	**SPC September 2023.**

The Committee also received the following items:

Matters to note for assurance:
SPC/23/03/32 – Chief People Officer Report
SPC/23/03/36 – Staffing Assurance Report, December 2022, January 2023 and February 2023 - Key Issues
SPC/23/03/37 – Workforce Policies and Procedures Overview Q3
SPC/23/03/38 – Trust Strategy Refresh Update
SPC 23/03/42 – Revised Committee Effectiveness Review Process

Sub-Committee Chairs Logs:
SPC/23/03/39 – Workforce Equality, Diversity and Inclusion Sub-Committee

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29d i		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29th March 2023

Date of Meeting	22 February 2023
Name of Meeting + Chair	Finance and Sustainability Chaired by John Somers
Was the meeting quorate?	Yes

REF/AGENDA ITEM	ASSURANCE	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
		Matters to discuss and note for assurance		
FSC/23/02/21	BAF & Risk Register	The Committee considered the BAF report noting: - • No changes on BAF or corporate risks	The Committee was assured and **noted** the report	FSC March 2023
FSC/23/02/22	Pay Assurance	The Committee considered and reviewed the report noting: - • Reliance on off framework due to current pressures and escalated areas. • Recruitment – looking at creative ways of bringing workforce in. • Use of recruitment marketing for Midwifery, ED, Pharmacy – dedicated campaign on top of what we normally do • Annual leave – working with care groups to ensure accurate recording and usage of annual leave / appropriate approval has been sought.	The Committee was partly assured and **noted** the report	FSC March 2023

FSC/23/02/23	CIP & GIRFT	The Committee considered and reviewed the monthly CIP & GIRFT report noting: - • Delivered £10.5m against a plan of £11.8m • Concern for next year as only £2.0m recurrent CIP highlighted • CIP/GIRFT presentation with progress to date to come to next months FSC • ICS expecting 5% of expenditure for 2023/24 CIP for any Trust with deficit plan. • CIP allocation based on 50% of the target on budget and the remaining 50% on reference cost performance. proposal then introduces a further step where there is an option for the Care Groups to realign within Care Group and / or across Care Groups and for Operational management to also consider realignment across all areas including Corporate services • Oversight framework to be formalised for underperformance against CIP target	The Committee was **NOT ASSURED**, however the Committee **supported** the suggested CIP methodology for 2023/24 and **noted** the progress achieved so far but noted the risk to the financial position.	FSC March 2023
FSC/23/02/24	KPI Refresh	The Committee considered and reviewed the paper noting: - • CROC committee no longer continuing and therefore access and performance KPIs to be integrated into FSC • One new indicator • Updated indicators • Indicators to be removed	The Committee **noted** the update and **supported** the proposed changes to KPIs	
FSC/23/02/25	EPCMS Business Case Update	The Committee considered and reviewed the paper noting: - • Partner Trusts have developed and signed a MOU • Will be inviting suppliers to tender for two EPR Systems – one for WHH and one for STHK and S&O as part of the partnership approach • Actions taken to date has been in line with the system requirements • Total costs increased to £32.4m from £26.2m • Risk of revenue affordability in year 3	The Committee was partly assured and **noted** the update and **supported** the presentation of the revised case to Trust Board	FSC March 2023 Trust Board March 2023

		• Risk of capital profiling – funding in earlier financial years than when it is required • Capital and revenue mitigations discussed, will require support from the ICS to manage the system capital across a number of years, revenue will change when the exact costs are understood, and negotiation with selected supplier in relation to profiling of expenditure – meeting to be set up with the ICS to seek capital solution		
FSC/23/02/26	Monthly Finance report	The Committee considered the report. Key points to note included: • Month 10 position £7.1m deficit, better than plan year to date by £0.4m which was largely due to £0.7m additional capital charges funding from the ICS of which £0.58m is included in the month 10 position • The forecast has improved from £6.1m deficit to £5.4m • Capital is behind on the capital plan by £5.5m. The Trust will not get any underspend back in 2023/24	The Committee was partly assured and **noted** the update, risks and mitigations to support in year delivery. The Committee **approved** the capital changes (below) with delegated responsibility from Trust Board	FSC March 2023

FSC/23/02/27	Capital Expenditure Update	The Committee considered and reviewed the presentation and reports noting: -
		CPG Capital Update
		• Emergency items approved £92k
		• Underspend / slippage returned to contingency £316k
		• Approval for the following expenditure:
		  ○ Pharmacy Robot phasing £106k
		  ○ CCTV Upgrade works addendum £10k
		  ○ ICE 2012 OS and application upgrade £70k
		• Management of the contingency fund
		Capital Schemes Greater Than £500k:
			The Committee was partly assured and **noted** the update
			
			The Committee **approved** the capital changes with delegated responsibility from Trust Board
				FSC March 2023

		• Catering scheme potential overspend of £1m to be brought to Execs – clarification requested by the Committee • Concern in relation to the Paediatric and Urology over spend and potential legal matters - to be brought to Execs, clarification of next steps requested by the Committee		
FSC/23/02/28	Capital Requests –	The Committee considered and reviewed the paper noting: - • Extension of Ultrasound Department £0.5m	The Committee **approved** the paper	
FSC/23/02/29	Operational Plan 2023/24 (First Draft)	The Committee considered the report noting items to escalate to FSC include: • Income figure provided by ICB and therefore activity, workforce and finance are not triangulated – further work required • Expectation of 105% of 2019/20 outturn activity. Activity has been worked up using bottom-up approach with current capacity to calculate a stretched activity for the Trust • Workforce expect an additional 8 staff vacancies are filled each month. Included 40 additional international nurses, use of recruitment campaigns. Impact on agency and bank. • Draft plan of £29m deficit with key movement of £12m reduction in income and increase of operating expenditure of £9m compared to 2022/23 forecast • ERF £10m – risk of non delivery of activity • Challenging CIP 5% of expenditure - £18m • Impact of deficit – would run out of cash in October 2023 and increased scrutiny/ potential impact on SOF rating • Capital £0.6m oversubscribed	The Committee was partly assured and **noted** the presentation and **supported** the draft operational plan to be submitted – aware this is a high level first draft with work in progress - to be presented to Trust Board on 1 March and final version to be submitted 31 March following Board approval 30 March	
FSC/23/02/30	Annual Capital Programme 2023/24	The Committee considered and reviewed the paper noting: - • Draft capital plan is oversubscribed • Capital plan to be submitted will be within the allocated CDEL • Actions taken to manage across financial years	The Committee **noted** the presentation and **support** the draft capital plan to be	

			submitted with the operational plan	
FSC/23/02/31	CQUINS 2023/24	The Committee considered and reviewed the paper noting: - • 8 CQUINs in total • Of which 5 have financial incentive	The Committee **noted** the report and **support** for the five CQUINs for financial incentive.	
FSC/23/02/32	Financial Risks to CDC Programme	The Committee considered and reviewed the papers noting: - • Revenue risk due to move to the tariff based costing system being brought forward to April 2023. Planning to submit return based on the activity that the Trust requires at this stage rather than available capacity. Included a ramp up of activity in the first 12 weeks to get to 100% capacity. Reliance on delivery of sleep studies to generate surplus. • Additional set up costs to be submitted for 2023/24. • Capital draw down £2.475m less than the £9.062m that was approved by the NHSE national team due to timings and design. Phasing risk in 2023/24	The Committee was **NOT ASSURED,** and **noted** the update around the new emerging financial risks within the CDC programme and the potential mitigations to these risks. **Escalated to the Board Development session in March**	Trust Board Development March 2023
FSC/23/02/33	Medical Staffing Review Q3	The Committee considered and reviewed the paper noting: - • Cost pressure of £4.8m on Trust medical staffing budget • Progress in consultant recruitment to areas with high cost locums • Enhanced oversight continuing	The Committee **noted** the report	
FSC/23/02/34	Benefits Realisation Q3	The Committee considered and reviewed the paper noting: - • 2020/21: 2 returned • 2021/22: 5 returned, 1 requesting a deferral in relation to some benefits, 1 requesting a deferral • Reasons for long deferral to be provided for next meeting	The Committee **noted** the report	
FSC/23/02/35	Digital Strategy Group HLB	The Committee considered and reviewed the paper noting: - • Digital strategy refresh to be brought back at a later stage	The Committee **noted** the report	

	AOB	The Committee considered and reviewed the paper noting: - • Capital request of £12.5k for improving Therapies	The Committee **approved** the capital request with delegated responsibility from Trust Board	

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/01/29d ii		Trust Board	**DATE OF MEETING**	29 March 2023

Date of Meeting	22 March 2023
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:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/23/03/42	**Deep Dive – Sleep Studies**	The Committee received the presentation noting:- • Recap in the changes in activity and payment mechanism for Community Diagnostics Centre discussed in February FSC • Changes in the operational plan activity impact on CDC • Risks remain linked to actual activity verses the plan • Sleep studies reduced significantly in this version of the plan and is based on demand and capacity • Spirometry previously provided by GPs has also reduced in this version • CDC is breakeven however the plan does make a contribution to overheads • There is a risk of further changes to funding • Assurance that it is a sustainable model not just managing a waiting list (NR activity)	The Committee **noted** the presentation receiving **moderate** assurance	**FSC June 2023**
FSC/23/03/43	**Pay Assurance Report**	The Committee received the report noting • 500 vacancies being supported • Bed occupancy and escalation areas putting additional pressures on staffing and finances and further support is need from the System • Annual leave for AFC staff circa 92%	The Committee **noted** and discussed the report, receiving **good** assurance	**FSC April 2023**

FSC/23/03/44	**Monthly CIP report**	The Committee received the report noting:- • The current position of CIP £m against a plan of £13m • Significant level of non recurrent CIP and the risk this presents to 2023/24 • CIP methodology for 2023/24 and values agreed with Executive, Care Groups and Corporate although a significant level of risk is acknowledged • Ongoing work on GIRFT schemes • Model Hospital suggests lots to do, some is outside our influence and requires System support • Agreed key work areas with Care Groups:- • Planned Care - Infrastructure to fulfil job plans efficiently as possible – daycases, theatre utilisation including start time and point system • Unplanned – reducing LOS / NCTR, increase Virtual Wards • Clinical Support Services – reduction DNA, Increase Advice and guidance along with Virtual offerings, new to follow up ratios • Further detail on escalation to be brought to the next FSC • Focus on the priority areas to ensure delivery	The Committee discussed and **noted** the report and presentation receiving **moderate** assurance. It was agreed that a Care Group update would be presented to the meeting in April 2023.	**FSC April 2023**
FSC/23/03/46	**Finance Report**	The Committee received a report noting:- • The current financial position of £5.6m deficit year to date which is slightly better than plan • The Trust is forecasting achievement of the £5.4m deficit control total • Approve the capital schemes outlined • Items for escalation from FRG and CPG	The Committee discussed the paper considering the review of capital underspend and **approved** the capital requests and received **moderate** assurance in relation to capital delivery and **good** assurance in relation to delivery of the 2022/23 revenue forecast.	**FSC April 2023**
FSC/23/03/47	**Capital Position**	The Committee received a presentation noting:- • The highlighted underspends, slippage, bring forward of 2023/24 schemes and catch up of schemes • Schemes over £500k reviewed in detail including Catering, Pharmacy, CISCO, CDC, and Town Deal.	The Committee **noted** the update and the risks and was **not assured**	**FSC April 2023**

		• Further detail on Catering scheme is required • Mortuary scheme from 2021 noted human error led to an email being missed with potential cost of £500k, the invoice was received in August. It was agreed that an external review is commissioned in relation to this specific scheme and to review the revised procedures and controls in place.		
FSC/23/03/48	**Capital Requests**	The Committee received a paper noting:- • The requirement for additional space is expected to continue • Purchase can be accommodated in the 2022/23 capital programme and will reduce future revenue costs	The Committee **supported** the Mortuary capacity case. Final approval will be requested in the Trust Board meeting on 29 March 2023. The Committee will receive updates on the capital schemes as part of the capital standing agenda item	**Trust Board March 2023**
FSC/23/03/49	**Revenue Requests**	The Committee received papers which have already been supported by the Executive Team noting:- • Local Clinical Excellence Award – standard calculation, highlighted the process followed. Future process will include EIA • Band 2 to Band 3 HCSW – scoping exercise undertaken to review Trust requirement for Band 3 staff. The recent announcement of the national pay ward will need to be calculated and reflected. • Lorenzo Extension – non recurrent funding 2024/25 and 2025/26	The Committee **supported** the revenue cases. Final approval will be requested in the Trust Board meeting on 29 March 2023.	**Trust Board March 2023**
FSC/23/03/52	**Operational Plan**	The Committee received a presentation noting:- • C&M position and the WHH £4.5m improvement from the February draft plan, anticipate distribution of UEC funds next week • Current national context need to improve further • Capital plan including risks and mitigations • Activity plan 103.8%	The Committee retrospectively **approved** the draft submission of £24.1m and **supported** the capital programme to the Trust Board	**Trust Board March 2023**

		• Workforce still reviewing cost pressures and CIP impact. Regionally being told if you are a deficit Trust there should be no growth in WTE. The next submission is Monday 27th March • Risks in the current plan and exit plans for escalation areas needed • Final submission 29 March to ICS and 30 March 2023 to NHSE		

The Committee also received the following items:

Papers for Approval
FSC/23/03/50 Performance Assurance Framework
FSC/23/03/51 IPR
FSC/23/03/53 Trust Strategy

Papers to Discuss and Note for Assurance
FSC/23/03/41 Board Assurance Framework
FSC/23/03/45 Private Patient Report
FSC/23/03/54 Service Line Reporting
FSC/23/03/55 Digital Strategy Group
FSC/23/03/56 Runcorn Shopping City

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 ei		Trust Board	**DATE OF MEETING**	29 March 2023

Date of Meeting	14 February 2023
Name of Meeting & Chair	Clinical Recovery Oversight Committee (CROC) Chaired by Jane Downey
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
CROC/23/02/20	Harm review process.	• No harms identified • A proposal to change the Harm review process was presented and will be shared with Primary Care for next steps.	**The Committee discussed the update and received good assurance**	Update due at March meeting
CROC/23/02/21	78 Week Wait issues remain a risk	78 week wait Trajectory; • January is likely to be finalised around 211 (Ongoing Validation) • This has decreased by 18 from December • February estimate is 155 against a trajectory of 141 Forecast to have between 80 patients over 78 weeks by March end. Action was being taken to reduce that number. LUFT, COCH, WIRRAL and STHK all expected to not meet the target.	**The Committee noted the update**	Update due at March meeting
CROC/23/02/22	Echo and sleep studies	DM advised that both areas remained one of the Trust's most challenged area for waiting list recovery and the Trust was receiving agency support form IMC has commenced to support clearing the echo backlog. Recruitment and retention is also being looked at. Echo, contrast and stress echo;	**The Committee discussed the update and received moderate assurance**	Update due at March meeting

		• 45 min slots commenced w/c 30/1/2023 • Agency support from IMC in place until 12th March additional 91 slots per week • IS funding £54,168 approved to support clearing echo backlog • Fortnightly calls with IS to monitor progress • 1WTE B7 vacancy from 20th Jan and sickness in the team has led to lost capacity in Jan Sleep studies; • Closed to out of C&M referrals • Continue to perform above plan New OP activity 340 above plan and follow up OP activity 2094 above plan • 12 NOX machines ordered with CRD funding • 1WTE B6 appointed • Action plan in progress to increase capacity from March 2023		
CROC/23/02/23	Change to PbR	Discussion took place regarding the ERF process and the PbR process going forward. DM provided assurance that conversations will be triangulated through the Annual Planning process.	**The Committee discussed the update and received good assurance**	Update due at March meeting

The Committee also received the following items:

Papers to Discuss and Note for Assurance

23/02/18 – Board Assurance Framework (BAF) / Risk update
23/02/20 - Harm Profile Update
23/02/21 - Corporate Performance Report
23/02/22 – Waiting List updates
23/02/23 – Access to recovery fund update
23/02/24 - Cheshire & Merseyside update

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 e ii		Trust Board	DATE OF MEETING	29 March 2023

Date of Meeting	21 March 2023
Name of Meeting & Chair	Clinical Recovery Oversight Committee (CROC) Chaired by Jane Downey
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
CROC/23/03/33	Harm Review Profile	No new harms recorded.	**The Committee discussed the update and received good assurance**	**n/a**
CROC/23/03/34	Corporate Performance report	**78 Week delivery** – an improved performance since the last meeting, with a reduction in the amount for forecast breaches. Down from 80 in Feb, to 40-60 now forecast. 4 other Trusts in C&M **Issue around cancer focus '28 day' and patient experience –** Focus on this standard by the Cancer Alliance and Cancer Networks in C&M. Discussion and assurance that the cancer pathway team continue to support all patients on a cancer pathway and not just to focus on targets.	**The Committee discussed the update receiving moderate assurance**	**n/a**
CROC/23/03/35	Echo waiting list reduction	Capacity for Echocardiography remains challenged and impacting recovery of the DMO1 6 week performance standard. Additional insourcing commenced in Jan 23 and is funded by the regional diagnostic recovery fund until mid April. This will need to be continued into 23/24.	**The Committee discussed the update receiving moderate assurance**	**n/a**

CROC/23/03/36		ERF for 22/23 equates to £8m, despite the activity target only being achieved in 2 months. ERF for 2023-24 has been set at £10m. There is a risk that this could be clawed back if not achieved. Therefore it may be necessary to invest some of that into elective services in 23-24, which is something that did not take place in 22-23.	**The Committee discussed the update and received good assurance**	**n/a**
CROC/23//03/38	Disestablishment of committee	The Clinical Recovery Oversight Committee supported the disestablishment of the committee. JD thanked everyone for their dedication and hard work over the last couple of years to support the committee and waiting list restoration and recovery.	**The Committee supported the proposal.**	**n/a**

The Committee also received the following items:

Papers to Discuss and Note for Assurance

23/03/31 – Board Assurance Framework (BAF) / Risk update
23/03/32 - Draft Minutes from the Clinical Services Oversight Group meeting held on 8 Feb 2023
23/03/33 - Harm Profile Update
23/03/34 - Corporate Performance Report
23/03/35 – Waiting List updates
23/03/36 – Access to recovery fund update
23/03/37 - Cheshire & Merseyside update
23/03/38 – Disestablishment of the Committee

		The committee noted that recommendations had been reviewed by the Finance and Sustainability Committee (FSC) on 18th January and noted the outcomes from the FSC discussions.		
AC/23/02/14	**Review Losses and Special Payments Q2 2022/23**	The Committee received the report which provided the Q3 (31st December 2022) update in relation to losses and special payments. The committee were informed of two claims, resulting in a higher amount being paid out, one of those had been an injury caused by assault by a patient. The committee took assurance around the Emergency Department pilot of staff wearing body cams, feedback from staff was positive, it was hoped incidents would decrease.	**The committee received moderate assurance from the data presented, future reports would determine downward trajectory as a result of the bodycam plot.**	**Q4 report to AC**
AC/23/02/15	**Review of Quotation + Tender Waivers Q2 2022/23**	The committee received the paper which provided detail on waivers for the period Q2 2022/23, 4 of which were retrospective. The committee took assurance in the ongoing programme to educate staff on the appropriateness of waivers in line with Trust Standing Orders and a Standing Financial Instructions to improve and reduce the number of retrospective waivers.	**The committee received substantial assurance in the ongoing education programme and the downward trend in waivers. when benchmarked against Q2 2021-22.**	**Q3 Report to QAC**

Other items included on the agenda were:

AC/23/02/04 – Changes and updates to the BAF
AC/23/02/05 Update from Chairs – FSC, SPC, QAC & CFC
AC/23/02/06 - Progress Report on Internal Audit Follow-up Action
AC/23/02/07 - Internal Audit Plan & Fees
AC/23/02/09 - Internal Audit Progress Report
AC/23/02/10 - External Audit Plan & Fees
AC/23/02/11 - Report & Updates from External Audit
AC/23/02/12 - Counter Fraud Progress Updates
AC/23/02/16 - NW Skills Development Agency Bi-Annual Report
AC/23/02/17 - ICON Programme Bi-Annual Report
AC/23/02/18 - Annual Report & Accounts Timetable & Plans
AC/23/02/19 - Draft Annual Accounts & Accounting Policies
AC/23/02/20 - Cycle of Business Annual Review

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 g	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29th March 2023

Date of Meeting	9th March 2023
Name of Meeting & Chair	Charitable Funds Committee, Chaired by Steve McGuirk
Was the meeting quorate?	Yes

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

Agenda Reference	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/mandate to receiving body	Follow up/ Review date
CFC 23/03/005	**Annual Operational Plan**	The committee received the presentation which explained the development of the revised WHH Charity 3-year strategy which aimed to raise the profile of the charity and strengthen operational methods. The committee agreed this was a positive step forward and would provide more robust structure required to focus on big/more profitable campaigns.	**The Committee received substantial assurance on the development of the strategy and noted that the final version of the strategy would be presented to the committee for approval.**	**Quarterly progress reporting into CFC**
CFC 23/03/009	**2023/24 Charity Financial Plan**	The committee received the report detailing the proposed annual budget and cashflow for 2023/24. The committee took assurance that an independent review of the workplan would take place in March 2023 and if any changes are made, which affect income or expenditure an updated budget would be presented back to the committee.	**The Committee received substantial assurance that the financial plan showed improvement on previous years.** **The committee approved the Annual Budget for 2023/24.**	**Quarterly reporting into CFC**

Other items included on the agenda were:

CFC23/03/004 – Fundraising Report and Quarterly
CFC23/03/006 – Finance Reports
CFC 23/03/007 – Bid Applications
CFC 23/03/008 - Investment Annual Update
CFC23/03/010 - Overhead Policy
CFC23/03/011 – Cycle of Business
CFC23/03/012 - Revised Committee Effectiveness Review Process 2022/23
CFC23/03/013 – Charity Risk Register
CFC23/03/014 - Delegated Authority Request

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/23/03/29 f	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29th March 2023

Date of Meeting	23 February 2023
Name of Meeting & Chair	Audit Committee, Chaired by Michael O' Connor
Was the meeting quorate?	Yes

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

Agenda Reference	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/mandate to receiving body	Follow up/ Review date
AC/23/02/08	**Internal Audit Follow Up Report**	The committee received the report which provided assurance that, as at 31st January 2023; all internal Audit recommendations had been implemented, with the exception of 1 recommendation from the Discharge Planning Review, a deadline extension had been requested for the two actions within the recommendation: • The first action related to Waiting List Management Review 2022/23, required an extension until 28 February to ensure user guide as part of SOPs. • The second action relating to Patient Level Information and Costing Systems was on track, and full details of these actions were included in the report – revised deadline was to be confirmed.	**The Committee received substantial assurance on progress and agreed a further update be circulated committee once the first action had been completed – 28th February 2023. Further progress reports would be presented to the Committee.**	**AC April**
AC/23/02/13	**Runcorn Shopping City Review**	The committee received the report providing assurance on the independent review commissioned by the Trust, undertaken by Prop Care, following award of additional capital funding to complete the refurbishment of the Halton Health Hub within Runcorn Shopping City in August 2022. The report described recommendations and learning for the Trust to consider adopting. It was noted that there would be costs associated with the adoption of some of the process changes suggested.	**The Committee received substantial assurance from the update and it was agreed a further update be presented to the meeting in April.**	

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/30 i**	
SUBJECT:	**Maternity Update – Ockenden Report**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	Ailsa Gaskill-Jones, Deputy Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Ockenden recommendations require the Trust Board 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 for end January 2023 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 92.5% compliant and on trajectory to be 100% compliant by 31st May 2023. • **Ockenden 2**: WHH is 51% compliant and was on trajectory to be 100% compliant by 30th June 2023. This trajectory has been impacted by cancellation of a 6-month High Dependency Training Programme scheduled for Band 7 staff. Training is rescheduled to commence May 2023 for 6 months to end November 2023. • Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023. The CBU has received a draft report following a MIAA audit of Ockenden 2 actions on 18th and 19th January 2023. The overall objective has been to review the process the Trust has in place to monitor and report on the implementation of the Immediate and Essential Actions raised in the Ockenden Report (Part 2). The draft report indicates 'substantial	

	assurance'. There are two recommendations, one with a risk rating of medium and one with a risk rating of low. A management response has been returned to MIAA and final report will be shared via WCH Governance and QAC.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/23/03/53		
	Date of meeting	7 March 2023		
	Summary of Outcome	The report was 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/23/03/30 i

1. BACKGROUND/CONTEXT

The report will update the Quality Assurance Committee of the Ockenden reports position.

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

KEY

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	Action on track to achieve completion date
Green	Action complete but assurance embedded not received
Blue	Action complete, assurance evidence embedded and passed to CBU for monitoring
LMNS	Action for LMNS/National/Regional
duplicate	Action duplicated/combined with another action

2. KEY ELEMENTS

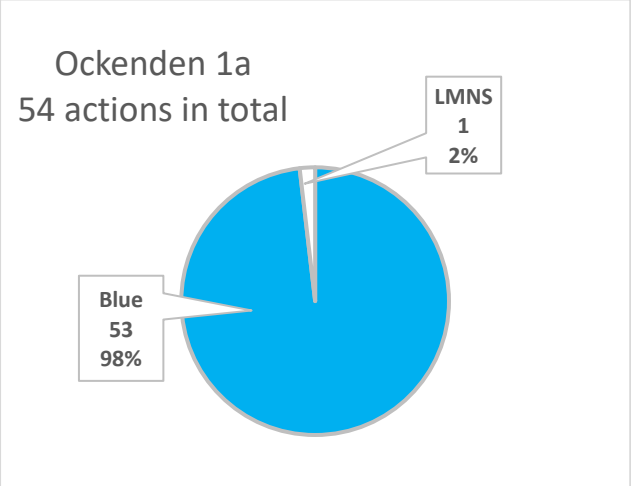
2.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report

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

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

2.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

0 Green (previously 1): -

53 blue (previously 52)

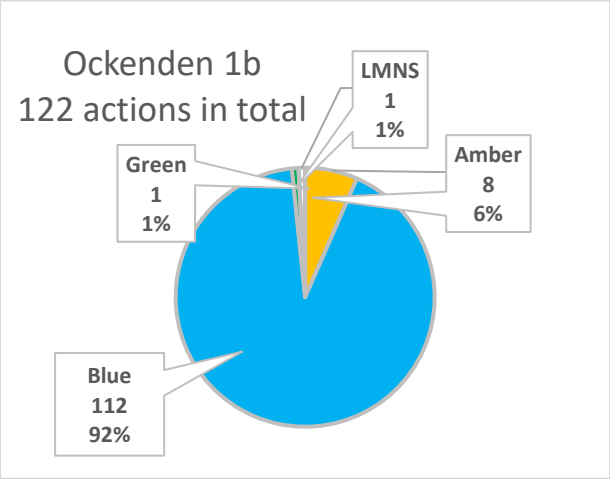
1 action not for WHH

Excluding the LMNS action, Ockenden Part 1a action plan is 100% compliant.

2.1.3 WHH Compliance with Ockenden 1b Report

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

Chart 2: WHH Ockenden 1b Compliance



Update

8 Amber (previously 7): -
On track to move to green as follows:
4 end March 2023
4 end May 2023

1 Green (previously 3): - –
On track to move to blue end March 2023

112 blue (previously 111)

1 – action not for WHH

8 amber actions relate to:-

- 4 actions are attributed to the role of Lead Obstetrician in Fetal Surveillance. This role will be included in the vacant Consultant post when advertised.

- 4 actions are for scheduled audits concerning complex pregnancies having a named consultant lead, and informed decision making around place of birth and caesarean section.

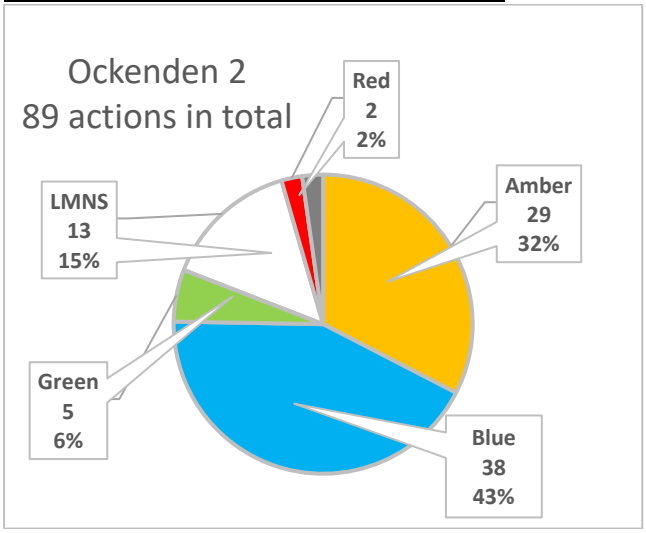
1 Green action relating to evidence gathering concerning ongoing review of intended place of birth based on developing clinical picture.

Excluding the 1 LMNS action, Ockenden Part 1b action plan is currently 92.5% compliant, with a trajectory to be 100% compliant by end May 2023.

1.4 WHH Compliance with Ockenden 2 Report

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

Chart 3: WHH Ockenden 2 Compliance



Update

2 Red (previously 2)

29 Amber (previously 28)

On track to move to green as follows:
2 end January 2023
7 end February 2023
15 end March 2023
4 end April 2023
1 end May 2023

5 Green (previously 6)
On track to move to green as follows:
2 end February 2023
3 end March 2023

38 blue (previously 40)

13 – actions not for WHH

2 – actions duplicated (combined)

2 Red actions relate to:-

- Cancellation of training for High Dependency care skills by the University of Salford. Three members of staff were due to commence a 6-month course in October 22, this has now been postponed until May 2023.
- Lack of funding to recruit an Education Midwife, options being explored by the CBU.

29 Amber and 5 Green actions relate to evidence gathering and completion of audits which have been scheduled and are all on track.

Trajectory for completion of this action plan was the end of June 2023. However, this has been impacted by the cancellation of training for High Dependency care skills by the University of Salford, a six-month course which will now not commence until May 2023.

Excluding the 13 LMNS and 2 duplicate actions, Ockenden 2 action plan is 51% compliant, with a trajectory to be 100% compliant by end November 2023.

a. WHH Risks for Escalation

Ockenden Part 2 identifies the introduction of specific roles within the maternity workforce. The Lead Obstetrician in Fetal Surveillance role will be included in a new Consultant post. Funding has been identified for this new post and once signed off recruitment will commence. Meeting this recommendation will be dependent upon successful recruitment.

There is also requirement for an Audit Midwife and Education Midwife. In addition, the Ockenden Insight visit in July 2022 identified the need for a Failsafe Clerk to support screening compliance. Whilst WHH has not received any additional funding to support the Trust in becoming compliant in these recommendations, funding has been identified via vacancies to fund a full time Audit and Assurance Midwife and a part time Band 4 Failsafe Clerk. The Audit and Assurance Midwife post is currently out to advert with a closing date of 13th March 2023. The Failsafe Clerk job description is being processed. These recommendations can now be removed as a risk to meeting compliance. The education workstream will be explored as part of the review of the Practice Development Midwife role which is underway following notification of the retirement of the current postholder.

Following Ockenden 1a, the Trust incurred a financial deficit in the region on £179K due to a discrepancy in projected and actual funding received. This has been escalated via Trust Board to the LMNS.

b. Ockenden Summary

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

- Ockenden 1a is 100% compliant.
- Ockenden 1b is 92.5% compliant and on trajectory to be 100% compliant by 31st May 2023.
- Ockenden 2 is 51% compliant and was on trajectory to be 100% compliant by 30th June 2023. This trajectory has been impacted by the cancellation of training for High Dependency care skills by the University of Salford. Three members of staff were due to commence a 6-month course in October 22, this has now been postponed until May 2023.
- Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 30th November 2023.
- The CBU has received a draft report following a MIAA audit of Ockenden (Part 2) on 18th and 19th January 2023. The overall objective was to review the process the Trust has in place to monitor and report on the implementation of the Immediate and Essential Actions raised in the Ockenden Report (Part 2). The draft report indicates 'substantial assurance'. There are two recommendations, one with a risk rating of medium and one with a risk rating of low. A management response has been returned to MIAA and final report will be shared via WCH Governance and QAC.

3. MONITORING/REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This Report was shared at the Women's and Children's Clinical Business Unit Governance Meeting on 28th February 2023.

4. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report as per Ockenden recommendations.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/30 ii**			
SUBJECT:	**Avoiding Term Admission into Neonatal Unit (ATAIN) Q2 2022/23**			
DATE OF MEETING:	29th March 2023			
AUTHOR(S):	Ailsa Gaskill-Jones, Deputy Director of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***				
EXECUTIVE SUMMARY ***(KEY ISSUES):***	• Q3 2022/23 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 5.1% which continues to remain well under local and national targets. The Q3 ATAIN rate in 2021/22 was 5.2%. • The WHH ATAIN rate has met and gone beyond the national ambition of 6% and the North West Neonatal Operational Delivery Network (NWNODN) target of 5.6%. • All term admissions in Q3 were reviewed and learning from these cases informs the ATAIN action plan. The ATAIN action plan is monitored via WCH Governance.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/23/03/53		
	Date of meeting	7 March 2023		
	Summary of Outcome	The report was noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Avoiding Term Admission into Neonatal Unit (ATAIN) Q2 2022/23**	**AGENDA REF:**	**BM/23/03/30 ii**

1. BACKGROUND/CONTEXT

NHS Resolution is operating a fourth 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 weeks to the neonatal unit (NNU). The national ambition is to ensure that term admission rates are below 6%. 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 avoid 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 4 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 4 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 Q3 reporting period from 1st October 2022 to 31st December 2022.

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

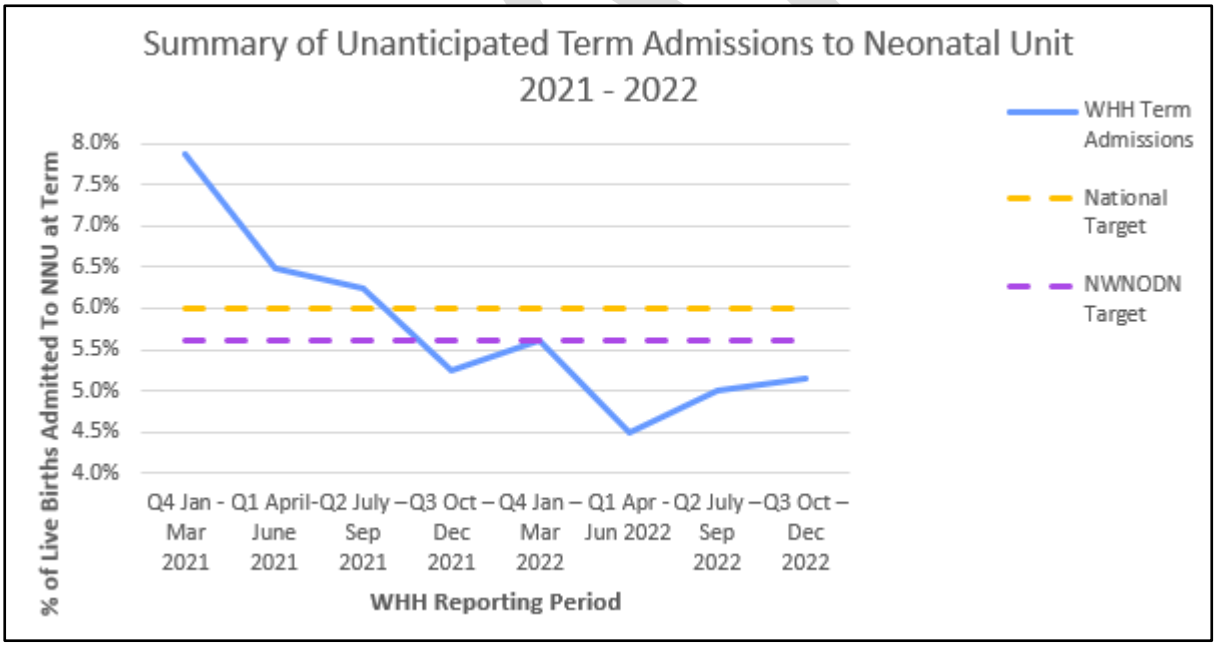
MIS specification directs providers to report the ATAIN data to the Trust Board on a quarterly basis. However, when reviewing the quarter data, it is important to review the data over a longer time period due to the small number of babies involved.

Summary of unexpected term admissions to NNU

WHH is pleased to report a Q3 ATAIN Rate of 5.14% that remains well under the local and national targets.

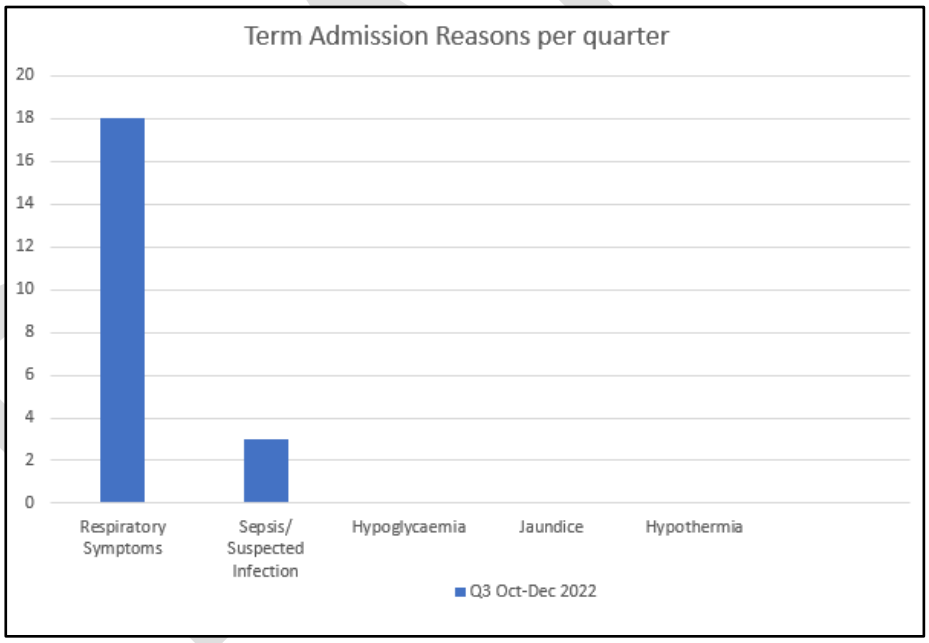
It is noted that there has been a slight increase in term admission rate and there are no trends identified associated with this. The most important factor is trying to reduce **avoidable** admissions to the Neonatal Unit and our avoidable admission rate has reduced significantly since the last quarter, therefore, the slight increase in numbers of cases is just due to unavoidable individual cases that have arisen.

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%
Q4 Jan – Mar 2021	597	47	7.87%		
Q1 April- June 2021	617	40	6.48%		
Q2 July – Sep 2021	706	44	6.23%		
Q3 Oct – Dec 2021	687	36	5.24%		
Q4 Jan – Mar 2022	647	36	5.56%		
Q1 Apr – Jun 2022	574	26	4.52%		
Q2 Jul – Sept 2022	682	34	4.98%		
Q3 Oct – Dec 2022	642	33	5.14%		



Reasons for term admissions

WHH Number Live Births 2021-2022		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
Q3 Oct-Dec 2021	687	36	5.24%	13	36.1%	6	16.7%	2	5.6%	2	5.6%	0	0%
Q4 Jan-Mar 2022	647	36	5.56%	13	36.1%	3	8.3%	3	8.3%	0	0%	0	0%
Q1 Apr-Jun 2022	574	26	4.52%	13	50.0%	4	15.4%	0	0%	2	7.7%	2	7.7%
Q2 Jul-Sep 2022	682	34	4.98%	21	61.8%	5	14.7%	0	0%	0	0%	0	0%
Q3 Oct-Dec 2022	642	33	5.14%	18	54.5%	3	9.1%	0	0%	0	0%	0	0%



54.5% (18) 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). Of these, 6 cases were diagnosed with Transient Tachypnoea of the Neonate (TTN). Of the babies with TTN, 1 was deemed an avoidable admission as the baby could have been cared for on the Transitional Care Unit.

Of the other respiratory-related admissions, 3 babies were admitted following aspiration of either meconium or milk. All unavoidable and appropriate admissions. 3 babies had Respiratory Distress Syndrome (RDS), of which none were deemed avoidable admissions. Other diagnoses included delayed transition and surfactant deficiency/pneumothorax.

Themes and Learning: Outcomes of ATAIN review

WHH 2020/21 2021/2022	Number of Term Admissions	Outcome of ATAIN review	
		Avoidable Admissions	Unavoidable Admissions
Q1 Apr – Jun 2022	25	6	19
Q2 Jul – Sept 2022	34	13	21
Q3 Oct – Dec 2022	33	5	28
TOTAL	92	24	68

Reasons for categorising term admissions as avoidable included 1 baby that could have had delivery safely delayed in line with national guidance and 1 baby who could have had a high lactate observed for longer/rechecked before the decision was made to admit to the Neonatal Unit.

Good Practice:

- Generally excellent neonatal care resulting in reduced separation of mother and baby noted
- Evidence of women being involved in decision-making
- Good early identification of deterioration of the neonate with timely intervention and escalation
- Excellent documentation

Learning Points/Themes/Actions:

- CTG learning – multidisciplinary
- Intrapartum ward rounds to include review of prescribed medications in order to give full clinical picture
- Increased clarity on when to call the Neonatal team required
- To ensure APGARs are recorded on BadgerNet for every baby

Individualised learning has taken place for specific intrapartum and postpartum care issues as appropriate with the support of colleagues including Fetal Surveillance Lead Midwife, Birth Suite Manager, and Clinical Educational Supervisors.

Recommendations:

- Continuation of targeted support for staff as required from cases requiring individualised learning
- Regular ATAIN meetings to discuss cases and actions/progress
- Focussed learning from ATAIN to continue to be included on the lessons learned to be shared and discussed with all midwifery and obstetric staff
- Continued participation in Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) training with a focus on perinatal optimisation and ATAIN
- Regular review of ATAIN actions to ensure timely completion

ATAIN ACTION PLAN

No	Action	Owner	Review Date	Target Completion Date	RAG status
1	Induction of Labour (IOL) guideline to be reviewed in relation to timing of induction for Large for Gestational Age (LGA) and maternal request; no Propess to be given following Spontaneous Rupture of Membranes (SROM).	Associate Clinical Director	30/6/2023	31/01/23 – date extended to allow task & finish group meetings to take place. Will continue to be reviewed.	
2	Review of process of transferring women from the Nest for emergency delivery.	Nest Manager / Obstetric Governance Lead Consultant	In progress with new Nest Manager	31/01/23 (NB Nest not currently open) 26/02/23 Nest reopening target date 01/04/23.	
3	To achieve 90% or greater compliance with CTG training as per MIS Safety Action 8 recommendations.	Fetal Monitoring Lead Midwife	Complete	Target met – action completed and closed.	
4	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 Co-ordinator / Birth Suite Manager / Infant Feeding Co-ordinator	Complete	28/02/2023 – skin to skin is now facilitated in theatre. There has not been agreement on removal of weighing scales from theatre.	
5	Appointment of fetal monitoring lead consultant as per Ockenden requirements. Associate Clinical Director currently fulfilling role.	Associate Clinical Director / CBU Manager	30/4/2023	Associate CD fulfilling this role still. Funding for new consultant still being confirmed. 26/02/23 Delay in advertising new Consultant post – expected to be advertised in March 2023. ATAIN Lead fulfilling some of the role requirements	
6	Participation in Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) training with a focus on perinatal optimisation, which will also have positive implications for ATAIN (reducing TTN in particular).	ATAIN Lead Consultant / Neonatal Lead Consultant	Complete	Training commenced already 20/9/22 26/02/22 Participation ongoing. Action completed and closed.	
7	Raise awareness of perinatal optimisation tool in line with Saving Babies' Lives (SBL) 2 recommendations and forthcoming SBL 3 expected Jan 2023 at December audit meeting.	ATAIN Lead Consultant / Neonatal Lead Consultant	Complete	Presentation made at dept Audit meeting 27/1/23. Will represent once SBL 3 recommendations published	
8	Improve multidisciplinary attendance and participation in CTG teaching (C-SHOP) by increasing frequency and ensuring mailing list of invitees is up to date.	Fetal Monitoring Lead Midwife	Complete	26/02/23 C-SHOP learning sessions are now taking place fortnightly on birth suite and simultaneously via Teams with good attendance. Action completed and closed.	

Action overdue or no update provided

Update provided but action incomplete

Update provided and action complete

3. MONITORING/REPORTING ROUTES

The ATAIN programme and action plan is monitored at the monthly Women's Health Governance and Women's and Children's Clinical Business Unit Governance meetings.

4. RECOMMENDATIONS

The Trust Board is asked note the findings within this paper for information as per MIS Year 4 recommendations.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/31**			
SUBJECT:	**Freedom to Speak Up**			
DATE OF MEETING:	29 March 2023			
AUTHOR(S):	Jane Hurst, Deputy Chief Finance Officer & FSTUG			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO			
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)***	N/A			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	Between April and December 2022 the FTSU team managed 35 disclosures compared to 18 for the same period 2021/22. The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD to support individuals and teams to resolve the issues that are highlighted. The FTSU team continues to engage with medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to make them aware of FTSU. The Wellbeing Services across the Trust continues to offer a good resource for FTSU to sign post staff to access further support.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/23/03/35		
	Date of meeting	22 March 2023		
	Summary of Outcome	The report was noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/23/03/31

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Committee on the activity of the Freedom To Speak Up (FTSU) Team. April 2022 to December 2022 saw a total of 35 disclosures compared to April 2021 to December 2021 which had 18. 2021/22 full year there was 20 cases, nationally there were 20,362 cases raised in 2021/22.

The majority of the disclosures in our Trust last year and year to date relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with HR and OD to support individuals and teams to resolve the issues that are highlighted. FTSU continues to welcome new Champions with regular meetings to improve communication, there are currently around 25 Champions. The FTSU Guardian continues to meet with Executive and Non-Executive FTSU leads and the Chairman to give updates.

2. DISCLOSURES

The April to December disclosures for last year and this year are in **Table 1**.

Table 1 Disclosures

	2021/22	2022/23
Quarter 1	4	17
Quarter 2	8	5
Quarter 3	6	13
Quarter 4	2	TBC
Total	**20**	**35**

Quarter 1 was higher than the previous Quarter 1 with 6 corporate disclosures (different areas and different issues) and 3 Doctors speaking up. Quarter 3 is also higher than previous with 11 disclosures during October and November linked to October FTSU month with the team undertaking walk arounds and stalls. The last face to face FTSU month was 2019/20 with 14 disclosures during October and November. Highlighting the importance of the FTSU team being visible. The cases can be grouped as follows:-

Table 2 Types of disclosures

	2021/22 Q1 – Q4	2022/23 Q1 – Q3
Behaviour, culture and relationships	15	27
Process	2	3
Patient safety	1	3
Staff levels / patient care	2	1
Communication		1
Total	**20**	**35**

There has been 3 patient safety concern raised relating to Emergency Department demand and staffing, radiology training and unplanned care relating to areas being used for escalation during winter. All 3 cases were immediately escalated to the Chief Nurse & Deputy Chief Executive and Executive Medical Director as appropriate. Following a review of each, it was concluded that there was no patient safety issue and the concerns highlighted had already been managed through usual management support.

The 35 disclosures have been across a variety of operational and corporate areas. The professional groups of staff who have spoken up can be broken down as follows:-

- 1 midwife
- 9 administration (A&C) / managers
- 9 nurses
- 11 Therapies, Radiology, Pathology and Ophthalmology
- 3 Medical
- 2 other

FTSU continues to check in with the People Directorate on a weekly basis to check the progress.

3. ACTIVITY

The FTSUG and Champions continue to talk at events across the Trust, in particular to the rotational doctors, preceptorship nurses and international nurses. October was National FTSU month and the team raised awareness of FTSU through Safety Huddle, GMWHH, Ward visits and stalls at both Warrington and Halton and a walk around CSTM.

The FTSU Champions continue to meet every 4 – 6 weeks to check in and have welcomed speakers on mediation, PSIRF, Behaviours and Values.

4. DEVELOPMENTS

The national results to the staff survey are now available. On reading the results for the speaking up questions in the staff survey, Dr Jayne Chidgey-Clark said:

“It is disappointing that the staff survey results reflect a decrease in workers’ confidence to speak up, and especially concerning that this includes about clinical matters.”

“However, fostering a culture where speaking up is supported, and actions taken as a result is the responsibility of each and every one of us. Whether you are a government minister, a regulator, a board member or senior leader; whether you work in a department, in a team, on a ward, or in a GP practice.”

“No one should feel they cannot speak up to protect their patients or their colleagues. These survey results must be a wake up call to leaders at all levels that Freedom to Speak Up is not just a ‘nice to have’ – it is essential for safe services.”

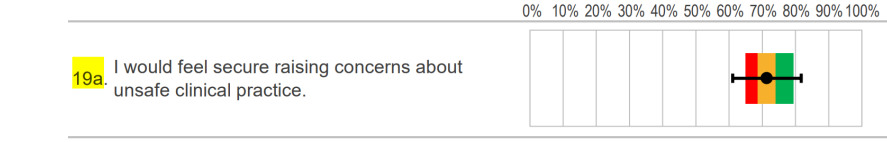
There are 4 question in the staff survey linked to FTSU under People Promise 3 subscore 2 -Raising concerns. The following extracts from the Staff Survey results indicate the responses were similar to the average sector score.

1.3.1. Sector Benchmarking

1.3.1.2. Percentiles

Raising concerns

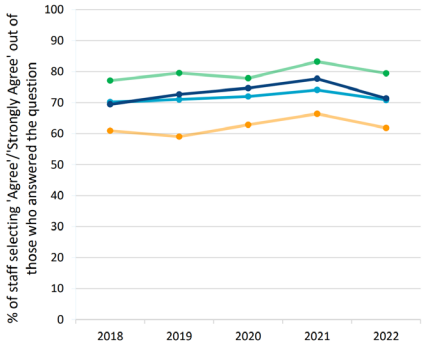
People Promise 3, Subscore 2 - Raising concerns	Org. Score	Sector Score	RAG Rating
19a. I would feel secure raising concerns about unsafe clinical practice.	71.4%	71.1%	
19b. I am confident that my organisation would address my concern.	59.1%	55.5%	
23e. I feel safe to speak up about anything that concerns me in this organisation.	60.7%	60.1%	
23f. If I spoke up about something that concerned me I am confident my organisation would address my concern.	48.7%	47.1%	



People Promise elements and theme results – We each have a voice that counts: Raising concerns

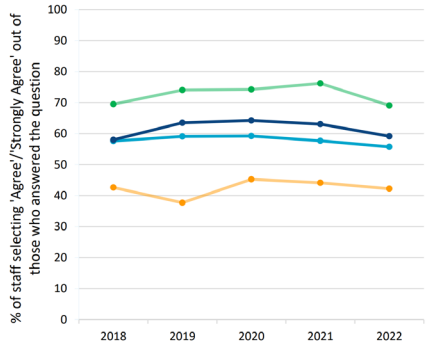
Survey Coordination Centre

Q19a I would feel secure raising concerns about unsafe clinical practice.



	2018	2019	2020	2021	2022
Your org	69.5%	72.7%	74.7%	77.7%	71.3%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1959	2092	1467	1732	1511

Q19b I am confident that my organisation would address my concern.



	2018	2019	2020	2021	2022
Your org	58.0%	63.5%	64.2%	63.0%	59.1%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1956	2093	1468	1727	1509

5. ONGOING WORK

The senior lead for FTSU in the organisation is responsible for completing reflection tool, this was last completed 2018/19 and is recommended to be reviewed every 2 years. This revised reflection and planning tool is designed to help identify strengths in FTSU Leads, our leadership team and our organisation and any gaps that need work. Completing this improvement tool will demonstrate to our senior leadership team and Trust Board the progress we have made developing our Freedom to Speak Up arrangements. This work is still on going and over the coming months FTSUG will work with the Executive Team and Senior Leaders to complete the reflection tool. B1245_iii_Freedom-To-Speak-Up-A-reflection-and-planning-tool_060422.docx-RC_RW_Final_Arial12.docx (live.com)

Discussion at FTSU Regional meetings have included making the FTSU training mandatory which the Trust should consider and having a full time FTSU Guardian is now considered necessary in many Trusts.

6. LESSONS LEARNT

Lack of or incorrect/inappropriate communication continues to be one of the main reasons for FTSU disclosures. Civility continues to be a key theme, staff members may not realise the impact that their words or the tone can have on colleagues or team members. The compassionate leadership work undertaken by the People Directorate does supports this however, when issues escalate to FTSU we work with HR to put extra support in those areas. Changes in management structure and style can also impact on teams and how they work together, highlighting how any change needs to managed carefully.

The further development of the mediation offer will support many staff to quicker resolution reducing stress in the workplace. The FTSU Champions invited the mediation leads to talk at their last meeting and will sign post people to this service as appropriate.

7. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/32**			
SUBJECT:	**Bi-monthly Strategy Programme Highlight Report**			
DATE OF MEETING:	29th March 2023			
AUTHOR(S):	Stephen Bennett, Head of Strategy & Partnerships			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#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.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The following Strategy Programme Highlight Report provides a progress update on key strategic projects and initiatives that underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Bi-monthly Strategy Programme Highlight Report**	**AGENDA REF:**	**BM/23/03/32**

1. BACKGROUND/CONTEXT

This report summarises the progress of key strategic projects which underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives. It is intended to be a useful reference point for regular updates.

2. KEY ELEMENTS

The Strategy Programme Highlight Report consists of the following elements:

- The stakeholder engagement log provides a snapshot of external stakeholder engagement over the 2-month period. It is not a comprehensive list of all stakeholders engaged and does not include the extensive stakeholder engagement via regular external meetings and forums
- Individual project updates, including budget updates, key milestones (RAG rated), progress since the last report, risks
- Details of how the overall Trust Strategy is being developed
- Description of strategic opportunities that are in the pipeline

The report is produced every two months and therefore the most recent version (appended to this paper) reflects the status of the key strategic projects as at the end of January 2023.

Since the end of January, the following key updates should be noted:

Living Well Hub in Warrington – The lease for the building that will accommodate the Living Well Hub is now signed and funds ready to transfer in order to complete the transaction on Monday 27th March.

The procurement exercise for the build contractor has now completed with the Trust awarding the tender to Morris & Spottiswood. The successful bid value is within the available capital funding allocation for the project. Discussions are now underway with Morris & Spottiswood to agree a robust programme plan for the refurbishment works before work commences on site in April.

Community Diagnostic Centre – Refurbishment work has now commenced on the first phase of the CDC programme within the Nightingale building on the Halton site. Designs are complete for the second phase of the programme at the Halton Health Hub in Runcorn Shopping City and design work has commenced for the third and final new build phase.

Significant work to review detailed capacity and demand for each proposed CDC service has been undertaken to ensure financial projections for the project are robust.

Breast Service Reconfiguration (Phase 2) – Since January, the full lease on the new space at Bath Street Health & Wellbeing Centre has been signed and we are due to exchange and complete the lease by the end of the financial year. The plan remains on track for the service to be operation in the newly refurbished clinical space by mid-May.

Development of Overall Trust Strategy – Work to complete the final draft of the refreshed Trust strategy for 2023-25 is now complete and to be shared with Trust Board in March.

The next full report produced will reflect these updates and the status of the key strategic projects as at the end of April 2023 (adjusted timeframe to bring into line with Trust Board meeting cycle).

3. MONITORING/REPORTING ROUTES

Key strategic projects report to the Strategy and a Greener WHH sub-committee which reports to Finance and Sustainability Committee.

4. TIMELINES

This report is be produced and circulated every two months.

5. RECOMMENDATIONS

It is recommended that the Trust Board note the report for information.

We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Strategy Programme
Highlight Report – January 2023

Page	Project	SRO	Strategy Lead	Status
3-4	Stakeholder engagement overview	All		
5	Living Well Hub in Warrington	LG	SB/CL	
6	Runcorn Town Deal	LG	CM	
7	Halton Health Hub	LG	CM	
8	New Hospitals Programme	LG	KJ	
9	Community Diagnostic Centre	LG	SB/LZ	
10	WHH Green Plan	IW	VR	
11	Warrington Wider Estates Review	LG	KJ	
12	Halton Blocks	LG	CM	
13	Breast Service Reconfiguration – Phase 2	LG	CL	
14	C&M Pathology Network	LG	KJ/VR	
15	Anchor Programme Development	LG	KJ	
16	Development of Overall Trust Strategy	LG	KJ/SB	
17-18	Pipeline of Strategic Opportunities	All		

Key code	
	On track
	Potential delay that is recoverable and/or does not impact materially on completion date
	Likely material delay to completion date

This strategy report provides a progress update on key strategic projects and initiatives that underpin WHH's Quality, People and Sustainability (QPS) Aims and Objectives.

The stakeholder engagement overview provides a snapshot of external stakeholder engagement over the 2 month period. It is not a comprehensive list of all stakeholders engaged and does not include the extensive stakeholder engagement via regular external meetings and forums.

Should further information be required on any projects contained within the report, please contact the strategy team directly.

Stakeholder Engagement Overview

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Andy Carter	MP	New Hospitals Programme and promotion of case of need to key decision makers
Charlotte Nichols	MP	New Hospitals Programme and promotion of case of need to key decision makers
Mike Amesbury	MP	Visit to Halton Health Hub
Derek Twigg	MP	New Hospitals Programme and promotion of case of need to key decision makers
Warrington Together People & Community Voice	Various members	Presentation and engagement around Living Well Hub project
Cath Jones	Director of Adult Social Services, Warrington Borough Council	Living Well programme across Warrington and Community-Led Support programme board
Alex Pinches	National Programme Director - CDC Programme, NHS England	Revision and subsequent approval of CDC business case
Ian Triplow	CDC Programme Director Cheshire & Merseyside	Revision and subsequent approval of CDC business case
Liz Bishop	CEO Clatterbridge Cancer Centre & SRO for C&M CDC Programme	Revision and subsequent approval of CDC business case
Nicki Goodwin	Senior Programme Manager, One Halton	One Halton Programme, Shopping City Clinical Hub, Prevention Pledge at Place
Kier Construction	Various members of staff	Formal appointment as design and build contractor for the CDC and TIF programmes
Stephen Woods	Transformation and PMO Lead, Warrington Together	Partnership working across local place from service transformation perspective
Dave Thompson MBE	CEO, Warrington Disability Partnership	Expert advice re: design of Living Well Hub and disability access
Alison Cullen	Head of Warrington Voluntary Action	Involvement of voluntary and charity sector in Living Well programme, Living Well Hub and Talking Points

Stakeholder Engagement Log

Key Stakeholder Engagement in Period	Job Title, Organisation	Topic/Nature of Engagement
Linda Buckley	MD Provider Collaborative, Cheshire & Merseyside	Regular catch up with Provider Collaborative leadership
Andy Davies	NHS C&M	New hospitals
Wayne Longshaw	Integration Director, STHK	Service collaboration opportunities
John McCabe	Divisional Medical Director (Surgery and Clinical Support), STHK	Joint recruitment for ENT
Steve Park	Growth Director, Warrington Borough Council	Local plan, new hospitals, Estates planning
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
Nikki Stevenson	Chair Medical Directors Network, CMAST	C&M fragile services
Steven Broomhead	CEO, Warrington Borough Council	New hospitals
Nichola Newton	CEO, Warrington Vale Royal College	Health and Social Care Academy, Living Well hub
Matthew Philpott	Executive Director, Health Equalities Group	Prevention Pledge
Lindsey Ashley	Transformation Manager for Primary Care (Halton), NHS C&M	Use of Halton Health Hub for vaccine outreach service to target areas of low uptake
Sinead Clarke	Associate Medical Director for System Quality and Improvement C&M ICS	Addressing health inequalities
Diane Hanshaw	Business Manager, GP Health Connect	GP Health Connect use of Halton Health Hub for primary care services.
Grace Grange	Health Protection Programme Manager, Halton Borough Council	Use of Halton Health Hub for vaccine outreach service to target areas of low uptake
Wesley Rourke	Operational Director, Economy, Enterprise and Property	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Huw Jenkins	Lead Officer – Transport Policy, Active Transport ,Liverpool City Region	Opportunities to link with and support active transport.

Living Well Hub in Warrington

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

WHH is leading a major project to develop a system-wide Health and Wellbeing Hub in Warrington Town Centre. The project forms part of the Town Deal programme, which covers 7 different infrastructure projects across Warrington, funded as part of the Government's "levelling up" agenda. The Health & Wellbeing Hub (to be known as the Living Well hub) will be 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 close proximity to the areas of the town with the highest levels of deprivation. The Hub will be a space where providers from across mental and physical health, social care and the third sector can come together to deliver integrated services, support and learn from one another for the collective benefit of the local population.

Progress since last report

- Heads of Terms for the lease have been approved ands signed off by both parties
- The build contract has been out to tender and has received 3 bids which are currently undergoing evaluation. Subsequent to this award of contract is expected on the14th February
- Significant progress has been made to finalise the timetable, this is now nearing completion and reflects the integrated model that has formed the project vision.
- Regular monthly delivery group meetings are now taking place as we move into the mobilisation phase of the project.
- The potential to have a changing places facility in the hub has been investigated. It was agreed that a full scale version would be too big for the space, however, a smaller version has been proposed and explored for inclusion on the ground floor.
- Integration of the Living Well Hub with systemwide programmes of work continues

Financial Implications/ Budget Update

Total project value is £3.1m, which is funded via central government. Ongoing revenue implications and how they will be covered across all system partners are to be confirmed.

Upcoming Key Milestones	Date	Status	Comments
Appoint build contractor	Feb 23		Tender issued November 22. To be appointed in conjunction with the lease sign off, February 2023
Full lease signed	Feb 23		
Commence build work	April 23		
Build work completed	Sep-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Formal agreement to be reached with all partners around ongoing financial and management arrangements of the Hub.	Significant impact on project if agreement is not reached. Alternative options will need to be considered.	12	All partners fully engaged in discussions around possible options and impacts.	8
Failure to secure preferred building from Landlord Caused by: Landlord having other plans for the building/ unsuccessful lease negotiations	Project delays whilst scoping new location for the hub	12	Progress lease negotiations as quickly and strategically as possible	4

Runcorn Town Deal

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.

Progress since last report

- Initial funding released to Halton Borough Council
- Cassidy and Ashton contracted to lead design team and produce stage 3 report
- Programme timeline, risks, and budget reprofiled following award of national funding

Financial Implications/ Budget Update

Total value of project as submitted through Runcorn Town Deal Programme: £3.89mil (across 5 years). Town Deal contribution: £2.85mil. Providers, including education, Council and Health bodies expected to meet remaining project costs of: £1.04m (across 5 years)

Upcoming Key Milestones	Date	Status	Comments
RIBA Stage 3 Report Produced	May 2023		
Planning Application Submitted	June 2023		
Ongoing revenue funding principles ratified	Sept 2023		
Opening	Summer 2025		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Failure to: procure the programme to time and / or budget Caused by: programme overruns / unforeseen issues requiring spend	Failure of project, no health and education hub	8	Good partnership working arrangements, clear project governance, implementation of best practice from Halton Health Hub project	6
Failure to: reach formal agreement regarding ongoing financial and management arrangements Caused by: various causes	Alternative options for delivery will need to be considered	9	All partners fully engaged in discussions around options, mitigations and impacts	6

Halton Health Hub

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Halton Health Hub programme aims to utilise void space in Runcorn Shopping City to deliver health and wellbeing services closer to community in line with the NHS Long Term Plan.

The scheme includes a refurbishment of retail space to re-purpose for access to hospital services, including audiology, ophthalmology and dietetics. This programme is part funded by Liverpool City Region Combined Authority.

Progress since last report

- Unit opened to first patients on 30th November 2022
- Clinics have been running on site since this date with no forced interruptions
- Third parties have begun delivering services from the site, including Halton Borough Council's flu and covid vaccine service, and GP Health Connect's GP-led Acute Respiratory Hub
- Discussions underway to utilise vacant space as part of the Trust's Community Diagnostic Centre plans

Financial Implications/ Budget Update

Total Programme Budget: £950.4k

Upcoming Key Milestones	Date	Status	Comments
Ceremonial Opening	Feb 22		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Failure to: secure long term sustainability of services Caused by: Ability to afford revenue costs over time	Resulting in: reconfigured service offer, delayed delivery	12	Revenue case agreed March 2021, additional controls agreed Autumn 2022, additional services in place demonstrating proof of concept	8

New Hospitals Programme

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 for Warrington, either on the current site or elsewhere in the town.

Within Halton this is the redevelopment of the Halton Hospital site, including extending CSTM to incorporate all existing services and additional services, whilst releasing land to support Health and Wellbeing Campus vision.

Progress since last report

- Initial outputs from the refreshed economic and financial appraisal have been reviewed with finance colleagues and refinement opportunities identified to improve the cost benefit ratio. Work is ongoing throughout January.
- A meeting took place with CBRE to identify opportunities to take forward a wider review of the Trusts estate requirements on a service by service basis, to support new hospital planning and identify opportunities to reduce costs.
- Discussions have commenced about how to incorporate the enabling estates work, such as the community hubs, in the new hospitals programme as these developments will support our future estate requirements.
- An update on the New Hospitals Programme was given at Warrington's Health and Wellbeing Board.
- Next steps for the New Hospitals programme are dependent on the outcome of the EOI process. Until a decision is made nationally progress will be limited.

Financial Implications/ Budget Update

Agreed capital funding to progress with financial affordability model and benefits enhancement work has been spent as planned. Capital costs for the programme have been revised by Turner and Townsend, following a review from EDGE and updated drawings from Gilling Dodd. This will determine future budget requirements

Upcoming Key Milestones	Date	Status	Comments
Outcome received from EOI stage of application to the New Hospitals Programme	Spring-22		Results will determine next steps in the comms plan and project direction. Have been advised EOI results could arrive towards the end of the year due to government delays
Refresh of the Warrington and Halton financial and economic cases within the SOCs.	Jan-23		Original deadline of September-22 has been extended. No material impact to the programme due to the delay as this is prep for the next stage EOI.
Selection of preferred site for new Warrington Hospital	Sep-22		On hold pending review by the Strategic Oversight Group

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
The required investment may not be available if unsuccessful with the EOI process	May lead to scope of implementation being limited to meet an affordability envelope, reducing the benefits able to be achieved.	12	Exploring opportunities for external funding and buy in from C&M for investment prioritisation	12

Community Diagnostic Centre

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 will cover three phases. Phase 1 will develop a range of diagnostic services within the Nightingale Building at Halton. Phase 2 will see diagnostic services established within the Halton Health Hub at Runcorn Shopping City. Phase 3 will see the development of a small new build extension to the CSTM building on the Halton site to accommodate CT and MRI services.

Progress since last report

- On 12/01/23 the Trust were informed that the original plan to develop a large-scale new build CDC as the second part of a 2 phase plan was unlikely to be approved by NHSE.
- The project team then worked with clinical, operational, estates and finance colleagues to work up a revised plan that would be acceptable to NHSE and deliver within the revised parameters set for the programme.
- Subsequently, the three phase plan was approved (see project overview).
- The plan was signed off by Trust Execs, Finance committee and Trust Board as well the CDC programme teams both regionally and nationally.
- Kier Construction have been appointed as the construction partner for the project and are now working closely with the project team to develop robust plans for delivery.
- The overall programme links closely with other major improvement works on the Halton site.

Financial Implications/ Budget Update

Total programme budget allocated £15m capital + £13m revenue

Upcoming Key Milestones	Date	Status	Comments
Final sign off of designs for Nightingale build element of programme	Feb-23		Revised date following amendment to plan.
Services within Nightingale building to commence	Mar-23		
Services within Halton Health Hub to commence	Jun-23		
Services within new build CDC to commence	Dec-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Availability of workforce across multiple specialties to staff a potential large scale CDC in the short to medium term	Will significantly impact on ability to operate enhanced capacity.	15	National discussions re: workforce development strategy.	10
Risk around requirement to deliver project rapidly and utilise available funding	Inability to deliver programme of works in full or impact on Trust capital programme in	15	Close working between the Trust, Kier and the regional CDC network	10

WHH Green Plan

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The NHS has set the target to achieve net zero by 2040. The "For a Greener NHS" campaign was launched in 2020 by NHS England. While this is a nationally mandated programme, the Trust has a strategic commitment to developing and expanding on its role as an anchor organisation. The Green Plan will form a core pillar of this programme.

WHH has worked in partnership with WRM Sustainability to assess the Trust's current position and develop an implementation plan to achieve our emissions targets.

Progress since last report

- Feedback from action leads on progress to date and identification of potential future roadblocks received. Feedback to be reviewed and recommendations for priorities for 2023/24 to be presented to March Trust Board.
- Potential green technology solutions identified to address priority areas such as air quality monitoring and anaesthetic gas destruction. Proposals awaited from providers to assess suitability.
- Consultancy engaged to provide proposal for a heat decarbonisation plan, to provide prioritisation list and evidence to support future funding applications.

Financial Implications/ Budget Update

TBC. Significant investment will be required to enhance Trust estates to meet required carbon savings.
External funding opportunities are being researched.

Upcoming Key Milestones	Date	Status	Comments
Complete action review	Feb 2023		
1 year progress summary report to ICB Sustainability Board	Feb 2023		
2023/24 focus area recommendations to Trust Board	Mar 2023		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Insufficient funding to enable deliver against actions e.g. estate improvements, technological solutions	Do not achieve required reductions in emissions	15	Capital pressures to be assessed and logged via Capital Planning Group -External funding sources to be sought	9
Capacity and expertise – prog lead required to oversee and progress plan supported by technical expert	Do not achieve required reductions in emissions	15	Explore funding recurrent roles to provide Sustainability	9

Warrington Wider Estates Review

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Project Overview

The Trust, in partnership with Halton Borough Council and Warrington Borough Council, submitted a bid to the One Public Estate Programme in November 2020, via the Liverpool City Region Combined Authority, partly to:

- Review the wider estate across the Warrington region, and produce a shared delivery plan, recommendations and opportunities to improve utilisation of buildings, with an end product of a framework to utilise estate asset database to enable informed decisions on future use, configuration and occupancy

AIM: To get more from collective public sector assets, and take a strategic approach to asset management.

Progress since last report

- Following initial scoping discussions, Warrington Borough Council were exploring opportunities to host the asset map online. An update is pending and if a solution is not found, the request will be formally escalated back to the Place digital group to identify a solution.
- The Asset Map has been shared with GB Partnerships to inform Warrington's Place based Estates Strategy.
- Warrington's Transforming Estates Enabling Group has been under review and an update in pending on how the group will operate. It is envisaged maintaining and utilising the Asset Map will form part of the groups remit and this will be confirmed once the review is complete.

Financial Implications/ Budget Update

Total costs (inc. VAT) = £42,637
Externally funded via One Public Estate 8 funding agreement

Upcoming Key Milestones	Date	Status	Comments
Agree digital solution for the asset map	Feb-23		
Partners to work through their individual opportunities identified in the Delivery Plan and report back on the outputs.	Jul-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Technical queries around database hosting and enabling external access to refresh the database remain unresolved.	The potential solution may require capital investment and/or capacity from WHH to support a refresh.	12	Technical queries around database investigated, resolutions identified and escalated to Place for discussion on resolution across the partnership.	6

Halton Blocks

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Trust has been engaged with local partners, including Halton Borough Council, since 2016 in contributing to regeneration schemes within Halton Lea. This is reflected within the Trust's New Hospitals Programme, which outlined a bold and exciting future for the site as the Halton Hospital and Wellbeing Campus.

The Trust and its local partners are now keen to identify how best the Halton Blocks could be used to generate social value in line with the regeneration plans of the area, as well as providing a financial benefit if developed as part of the wider masterplan for the Halton site.

Progress since last report

- A fully drafted report has been issued and shared with key individuals for comment.
- Final draft delivered July 2022.
- Final draft reviewed internally. Additional changes requested.
- Notification of bid failure (January 2023) - bid submitted to Department of Levelling Up, Housing and Communities to relocate staff and facilities from the Blocks and decommission the site, totalling £1.41million
- Next steps for the project now to be agreed.

Financial Implications/ Budget Update

Total costs (inc. VAT) = £44,733.60
Externally funded via One Public Estate 8 funding agreement

Upcoming Key Milestones	Date	Status	Comments
Report to execs outlining report recommendations and next steps	Aug-22		Delayed to February 23 from August 22
Project planning to commence following funding decision	Feb-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
If Halton Blocks aren't reconfigured, then the Trust won't contribute to the Halton Lea regeneration programme in full and elements of the Halton Hospital and Wellbeing Campus masterplan will not be delivered in short term	Resulting in reputational damage among local delivery partners including Halton Borough Council, impacting access and opportunities for future funding	10	A number of other schemes are in development with Council to identify sources of funding and opportunities to strengthen the Trust's contribution to local regeneration	8

Breast Service Reconfiguration – Phase 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The Trust is looking to consolidate and expand Breast Screening Services at Bath St Health & Wellbeing Centre in Warrington through a relocation from Kendrick Wing on the Warrington Hospital site.
This is phase 2 of a reconfiguration and improvement of Breast services for Warrington, Halton, St Helens and Knowsley (WHSKBSS) following the relocation of Breast Assessment and Symptomatic clinics from Warrington Hospital to the new £1.2m Breast Care Centre located in the Captain Sir Tom Moore building at Halton.
The planned reconfiguration will improve WHSKBSS by increasing staffing efficiencies, modernising facilities and increasing the physical space available to carry out the screening.

Progress since last report

- The completed agreement to lease has been signed and shared with partners, allowing funds to be approved for the building work from partners
- Build work has started on site (30th Jan 23)
- A plan for the co-ordination of decomissioing the old leased mammography unit, transferring the unit from Kendrick wing to Bath Street and installing the new NHSE/I funded mammography unit has been produced.
- Final plans have been reviewed and any extra items identified for purchase by service
- A plan to minimise disruption to patients during the build works has been created, which includes re locating clinical activity from Bath Street to Kendrick wing during the build works.
- The colour scheme has been agreed which will mirror the new breast facility at Captain Sir Tom Moore to help create a familiar and consistent Breast screening brand

Financial Implications/ Budget Update

The renovation works for this project are being financed and completed by Renova. As such, the Trust do not share any of the financial risk surrounding the renovation element of the project. Funds secured for the first phase of the project included £30,000 for relocation of existing equipment from Kendrick Wing to Bath Street. Their will be a one off 6% capital charge which will be jointly financed by WHH and Warrington CCG (50:50 split). Ongoing rental agreements have also been agreed with Warrington CCG funding the majority of the costs.

Upcoming Key Milestones	Date	Status	Comments
Phase 1 build works to be completed	31/03/23		
NHSE/I new mammography unit to be delivered	March - 23		
Move all activity across to Bath Street from Kendrick Wing	June-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Disruption to current service caused by build works	Reduced number of appointments available	9	Produce a contingency plan and liaise closely with build team to minimise disruption	6

Cheshire & Merseyside Pathology Network

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

The transformation of the provision of pathology services in Cheshire & Merseyside by restructuring pathology services to generate levels of efficiency savings to the local health economy whilst maintaining and improving high quality standards.

Progress since last report

- Procurement for a managed service contract to replace the haematology automated track system has been complete. The networks preferred option of a shorter contract was explored but due to a detrimental financial impact which the network could not offset, a decision was made to contract for a 8 year contract with a plus 2 year extension option.
- The network have been engaged to input into procurement options for a microbiology contract which requires renewal in 2023 An initial meeting identified three routes for exploration, which procurement are investigating..
- Work is progressing to define the specification of a hub and ESL across all pathology functions. Work continues to keep pace with the new project plan and is on track completion in March 23.
- The Benchmarking Partnership have been commissioned by the network to work with Trusts to produce data to show a comparable cost of, and staffing provision in place for, delivering each pathology speciality within each laboratory, in a way that can then be compare each in an anonymised way with other departments nationally of similar size and complexity. This is intended to support discussions around activity flows and staff resources required to support the TOM.

Financial Implications/ Budget Update

Financial implications to be worked up through development of Collaboration Agreement to Business Case.

Upcoming Key Milestones	Date	Status	Comments
Sign off of Collaboration Agreement at Cheshire and Merseyside HCP.	Nov-20		Collaboration agreement reviewed but not formally approved. This may resurface through the readiness assessment.
Risk and Gain Share Principles agreed	Jun-21		Initial workshop undertaken and an options appraisal is underway. Refined timescales for this activity are awaited
Next steps from readiness assessment agreed	Nov-22		Pending.
FBC produced and reviewed by Board	TBC		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
Cellular Pathology – Cohort of Pathologists nearing retirement.	Shortage of staff in service and difficulties in recruiting until service configuration confirmed.	16	Mutual aid being provided by STHK.	8

Anchor Programme Development

Project Overview

As an anchor institution, WHH has an opportunity to positively influence the health and wellbeing of the patients we service and the local communities we are part of. The anchor programme seeks to ensure we use our position and influence to work with others in responsible ways, to have an even greater impact on the wider factors that create happy, healthy and thriving communities.

Collectively the Trust's strategic projects support delivery of the ambitions of the anchor programme

Progress since last report

- Progress continues to be made in advancing the Trust's anchor maturity and the anchor programme has been recognised as exemplary both within Cheshire and Merseyside and nationally.
- The action plan which informs the Trust's Prevention Pledge commitments is undergoing a refresh and will be informed by the priorities set across each CBU.
- The priorities being pursues to deliver the ambitions of the anchor programme are being fully embedded into the Trusts Strategy refresh and will be monitored as part of the strategy going forward.

Upcoming Key Milestones	Date	Status	Comments
Incorporating Anchor into Strategy refresh Embedding WHHs anchor ambitions will be further cemented by including them as core features of the Trusts strategy refresh. Anchor priorities will also be included in Place based delivery plans.	Apr-23		
Streamlining reporting Reporting against the key strategic projects which constitute the anchor programme will become part of reporting against the Trust's overall strategy	Apr-23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score
The anchor programme is vast and there is a risk the totality of work is not captured.	Gaps and opportunities may be missed and not reflected. Equally impact may be underrepresented.	8	Reporting linked to overall strategy report. Mechanism to visually identify anchor work to be implemented	6

Development of Overall Trust Strategy

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

Development and subsequent delivery of overall WHH Trust strategy.

Support to the development, delivery and governance of enabling strategies, clinical strategies, and strategic priorities.

Progress since last report

- Strategy development session held with Executive Team and Trust Board with feedback reflected in the emerging priorities
- Engagement sessions held with Warrington Together Partnership Board and One Halton Partnership Board to obtain views and input into the strategy refresh. Both Boards were supportive or the emerging strategic objectives and underpinning priorities.
- Emerging strategic objectives and priorities shared with CMAST and will feed into the ICB joint forward plan.
- Workshops are underway with each CBU to develop Service level strategic clinical priorities. The outputs will inform the rust strategy refresh and the annual priorities.
- Exec approval has been received to harmonise the planning horizon for enabling strategies and consolidate strategies that have natural alignment. A plan to deliver this change is underway.
- A template for enabling strategies is in development and will be supported by communications

Upcoming Key Milestones	Date	Status	Comments
Refreshed Trust Strategy approved	Aprt-23		
Service level strategic clinical priorities approved	April -23		

Risk description	Impact	Risk score	Mitigations	Mitigated risk score

No risks identified to date.

Strategic Opportunity Pipeline

Overview

This section lists the strategic opportunities that are currently in the pipeline and are in the process of being explored/assessed for the potential to progress by the Strategy Team. For more information about these opportunities or to suggest any further opportunities, please contact a member of the Strategy team.

Proposal Name	Brief Description	Strategy Team Contact
Warrington Wolves – Combined Training and Wellbeing Facility	Early discussions around the potential to create a new facility combining state of the art training space for the rugby team with community health and wellbeing space(s)	Lucy Gardner
Halton Health Hub– Phase 2	Additional space is available for development in Runcorn Shopping City adjacent to the facility that is being developed by the Trust and partners (see slide 7). Possibility of utilising some space as part of the Trust's Community Diagnostic Centre plans	Carl Mackie
Halton Primary Care Collaboration	Potential opportunities to work in collaboration with Primary Care services in Halton on a number of opportunities including; provision of health checks in Runcorn Health & Education Hub, use of GP ARRS roles, Use of Runcorn UTC, and the use of fallow sessions and out of hours at Halton Health Hub (this is partly implemented as of February 23)	Carl Mackie
Burtonwood Parish Council Building	Working alongside Warrington Borough Council (WBC) to scope out potential to repurpose some disused space in Burtonwood as a sports and wellbeing facility. Links to the wider Living Well agenda. Capital refurbishment requirements were submitted by WBC under the latest Levelling Up bids but unfortunately rejected.	Steve Bennett
Shared Education Facility	Very early discussions with WBC about potential to develop a new education facility that could provide a space for learning and education for both the council and the Trust.	Lucy Gardner
Time Square phase 2 development	Early discussions with WBC to look at potential for the Trust to utilise some space within the proposed new Time Square phase 2 development in Warrington town centre. Will link to New Hospitals planning and future estate requirements.	Kelly Jones
UK Shared Prosperity Fund - Warrington	Working with WBC to develop plans to make use of the UK Shared Prosperity Fund (UK SPF) monies – a UK replacement for European Regional Development Funding post-Brexit. Current ideas include investment in digital solutions to support improved health including a new Warrington Directory of Services and investment in voluntary sector to recruit and train volunteers to support good health and wellbeing conversations across the town.	Steve Bennett

Strategic Opportunity Pipeline Cont'd

Proposal Name	Brief Description	Strategy Team Contact
One Public Estate £140k	The Liverpool City Region One Public Estate programme was awarded £140k in April 2022. The funding is being utilised to complete an NHS Place Estates Asset Review across the boroughs in Liverpool City Region, with the goal of producing a five-year strategic pipeline which identifies opportunities to optimise current and future NHS estate and outline potential non-NHS funding routes to achieve this. Work is currently ongoing with outputs expected by March 2023.	Carl Mackie

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/33**	
SUBJECT:	**Trust Strategy Refresh**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	Kelly Jones, Head of Strategy & Partnerships	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#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) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#1114** If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **#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. **#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 **#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	

	#125 If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns **#145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report sets out the refreshed Trust strategy for 2023-25.			
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	It is recommended that the Board approve the refreshed strategy and the associated next steps highlighted in section 3.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.			
	Date of meeting	22nd March 2023		
	Summary of Outcome	Input was sought to finalise the draft strategy and comments were invited to ensure the right set of priorities are being pursued to deliver the Trust's strategic objectives. FSC confirmed support for the financial objective and associated priorities.		
	Committee	Strategic People Committee		
	Agenda Ref.			
	Date of meeting	22nd March 2023		
	Summary of Outcome	Input was sought to finalise the draft strategy and comments were invited to ensure the right set of priorities are being pursued to deliver the Trust's strategic objectives. SPC identified minor modifications to the examples within the people objectives and confirmed people requirements are appropriately represented within the strategy and there is alignment with the existing People Strategy.		
	Committee	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting	7th March 2023		
	Summary of Outcome	Input was sought to finalise the draft strategy and comments were invited to ensure the right set of priorities are being		

		pursued to deliver the Trust's strategic objectives. QAC highlighted minor modifications and confirmed the quality requirements are appropriately represented within the strategy and there is alignment with the existing quality Strategy and the 2023/24 quality priorities.
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Trust Strategy Refresh	AGENDA REF:	BM/23/03/33

1. BACKGROUND/CONTEXT

The Trust's original vision was built upon three key strategic aims of Quality, People and Sustainability, which remain relevant today, but the delivery of which must continue to be refined as our healthcare landscape evolves.

The refresh of the Trust Strategy has taken a holistic view of the health and public service landscape to ensure that our ambitions align with those of:

- Our immediate stakeholders (e.g. Warrington Council, Halton Council, Warrington Together and One Halton).
- Our neighbours and partner organisations across Cheshire and Merseyside.
- The ambitions set for the whole of the NHS by NHS England.

We have also considered the ongoing impact of the Covid-19 pandemic, including its impact in widening the gap in health inequalities; changes to the local health and social care system structures; increased demand and an ageing population; our own performance and local challenges, the move away from competition to collaboration; and a greater focus on preventing ill health.

Development of the strategy has been shaped through engagement with our stakeholders and builds upon the current quality and people strategies.

This approach ensures that we are making the best contribution towards delivering high quality, sustainable services to the communities we serve, responding effectively to the challenges facing health and social care and maximising opportunities to do this at scale with partners. The two-year timeline of the strategy has been set to bring the planning horizon of the overall Trust Strategy in line with the existing Quality Strategy and People Strategy, whilst also enabling agility while local and regional system structures embed fully.

2. KEY ELEMENTS

The refreshed strategy sets out our vision for the next two years and the plans that we have put in place to build on the strong foundations laid out in the previous strategy. It sets out twelve strategic objectives, which support delivery of our three strategic aims of Quality, People and Sustainability.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Subject to approval of the content in the strategy, the following actions will be progressed: -

- The strategy will be fully designed into a corporate document – Kate Henry, Director of Communications & Engagement (April 2023).

- A communications plan will be developed to share the strategy with staff and stakeholders, including a summarised 'strategy on a page' – Kate Henry, Director of Communications & Engagement (April 2023).
- The KPIs to monitor delivery of the strategy will be finalised – Lucy Gardner, Director of Strategy & Partnerships (April 2023).
- A refreshed Strategy Map which highlights strategic project's and their governance will be produced and presented to Board – Lucy Gardner, Director of Strategy & Partnerships (May 2023).

4. IMPACT ON QPS?

Delivery of our strategy enables the Trust to deliver our aims under Q, P and S, and it is essential that this is regularly refreshed to reflect the Trust's strategic intentions, monitored for assurance, and escalated where necessary. The refreshed strategy for 2023-25 sets out our vision for the next two years and the plans that we have put in place to deliver our aims.

5. MEASUREMENTS/EVALUATIONS

Delivery of each strategic objective will be measured against a series of outcomes, the monitoring of which will be supported by a set of KPIs. The full set of KPIs is scheduled to be brought to Board in May 2023 for review and approval, following which and subject to approval, the agreed Objectives, Outcomes and KPIs will be integrated into the Trusts governance to ensure Board level oversight.

6. TRAJECTORIES/OBJECTIVES AGREED

The strategy establishes the strategic priorities and associated priorities to be progressed over the next two years.

7. MONITORING/REPORTING ROUTES

Monitoring of the individual aims within the strategy will be through the associate committee - Quality Assurance Committee for Quality, Strategic People Committee for People and Finance and Sustainability Committee for Sustainability. Overall monitoring of the strategy will be through a report to Board.

A refreshed Strategy Map which highlights strategic projects and their governance will be produced and presented to Board following approval of the strategy.

8. TIMELINES

The strategy covers the period 2023-25.

9. ASSURANCE COMMITTEE

Each element of the strategy is assured at relevant committees as indicated above.

10. RECOMMENDATIONS

It is recommended that the Board approve the refreshed Trust Strategy for 2023-25.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our Strategy 2023-2025

Our mission is to be outstanding for our patients, our communities and each other

Contents

Working Together

We will work together to ensure patients come first and our staff feel valued

Excellence

We will provide excellent care

Inclusive

We will be inclusive in all that we do so that our patients and staff can be their whole and authentic selves

Kind

We will act with compassion, empathy and respect to relieve each person's pain, distress, anxiety or need

Embracing Change

We are always learning and improving for our patients, the public and each other

Foreword

We are rated highly for patient care, the way we look after our staff and for clinical outcomes and have achieved a great deal since our previous strategy was developed in 2018. This includes:

- We have commenced restoration of our clinical services, impacted by the Covid-19 pandemic, to reduce long waiting lists. We have delivered improvements in Referral to Treatment times and sustained improvements in Cancer waiting times and wait times for diagnostic tests.
- We have improved our ambulance handover times, in partnership with the North West Ambulance Service.
- Our clinical research offer has gone from strength to strength. We have worked in collaboration with Liverpool University Hospitals NHS Foundation Trust and the Clinical Research Network, which has created opportunities for commercial, non-commercial and academic research which provides patients with access to clinical trials. Examples include studies in critical care, gastroenterology, maternity, paediatrics, and rheumatology.
- We have invested in radiology services, including a new MRI Centre and scanner.
- We have re-opened Ward B18 as our new Acute Respiratory Unit.
- We have administered more than 75,000 doses of COVID-19 vaccines, of which more than 16,000 were boosters, rapidly delivering a full service to protect staff and our communities.
- We have invested and responded to the wellbeing and development needs of our staff. Focusing on workforce recovery we have introduced new roles, rolled out compassionate leadership programmes, supported our staff to enhance their resilience during unprecedented times, appointed a Non-Executive Wellbeing Guardian, been accredited with the Navejo Chartermark in recognition for the work we do with LGBTQA+ patients and staff, and embedded the national People Promise, which sets out what all staff should expect from working within the NHS.
- We have invested in our estate, facilities and equipment - such as opening our new Breast Care Centre at the Captain Sir Tom Moore building; the new two-storey expansion of our Emergency Department to create a Same Day Emergency Care unit which offers urgent clinics and assessment areas for ambulatory care; opening our new outpatient facility in Halton's Shopping City, making us one of the first hospitals in the country to provide outpatient services in a shopping centre.

But we don't stand still and we want to improve further.

The Trust's original vision is built upon three key strategic aims of Quality, People and Sustainability, which we believe remain relevant today, but the delivery of which must continue to be refined to reflect the changing landscape in which the NHS operates.

There are a number of reasons why now is the right time to refresh our priorities. We have taken into account the ongoing impact of the Covid-19 pandemic, including its impact in widening the gap in health inequalities; changes to the local health and social care system structures; increased demand and an ageing population; a move away from competition to collaboration; and a greater focus on preventing ill health. As our healthcare landscape evolves, we must build on the strong foundations already laid in the previous strategy.

Our commitment will continue to be providing high quality, safe, and sustainable services, delivered by staff who are trained and supported to deliver their best work. We will work with our partners, across all levels of health and social care, the voluntary sector and the independent sector, to achieve this and meet the needs of our local population.

This document sets out our vision for the next two years and the plans that we have put in place. We begin this two year period mindful of the challenges ahead but full of optimism about the opportunities available.

Steve McGuirk
Chair

Simon Constable
Chief Executive

Who we are... What we do

Serve a population of 330k across both Halton and Warrington boroughs

Employ around **4,800 staff** comprising 52 nationalities

Deliver **85,007** individual new outpatients appointments each year

Have an annual turnover of **£333 million**

Commissioned by NHS Cheshire and Merseyside Integrated Care Board and NHS England Specialist Commissioning

Provide 122k episodes of emergency care - 91,695 episodes at the Emergency Department and 30,654 at the Runcorn Urgent Treatment Centre Department

Deliver **58.045** procedures and stays each year

Operate **680 beds/assessment beds** and trollies across both sites

Team of **343 Registered Volunteers** with a variety of roles available

Deliver 3K babies in hospital and in the community

Currently have **139 staff** actively studying for an apprenticeship

The 2021/22 cleanliness monitoring scores for very high risk and high risk clinical areas were as follows:

Warrington: 97.8%
Halton: 97.5%

Very High Risk Areas
Theatres, Neonatal Unit, ICU, Endoscopy

High Risk Areas
Wards, Accident & Emergency, Public areas, Pharmacy, Ward Kitchens, Main Out Patients and X-Ray

Who we are… Where we do it

Our Trust comprises two acute (secondary) care hospitals and a number of community hubs, spread across the Boroughs of Warrington and Halton.

Warrington Hospital

Warrington Hospital provides district general services, with all the services required to treat patients with a range of complex medical and surgical conditions and provides a full range of expert inpatient and outpatient services. Warrington Hospital is home to our emergency department and maternity services as well as specialist critical care, cardiac and surgical units.

Services provided at Warrington Hospital include: Emergency Department, surgical services, general medicine, children's services (paediatrics), cardiac care and cardiac catheter lab, stroke care, cancer care, elderly care, maternity, gynaecology, neonatal, orthopaedic trauma, critical care and ophthalmology.

Support services include: Occupational therapy, pathology, physiotherapy, pharmacy, dietetics, outpatient services, diagnostic services, and a range of specialist nursing services.

Halton Hospital

Halton Hospital is located in Runcorn and is where the majority of elective and diagnostic care is delivered. The Runcorn Urgent Treatment Centre is also located here. Halton Hospital comprises two distinct buildings, the Captain Sir Tom Moore (formerly known as Cheshire and Merseyside Treatment Centre) and Nightingale (formerly known as Halton General) buildings. Some chemotherapy services are also provided on the site at the CanTreat Chemotherapy Centre and the site is home to the Delamere Macmillan Unit

Services provided at Halton Hospital include:

Nightingale building: General surgery, urology, minor injuries, endoscopy, step down care, cancer care, programmed investigations unit, renal dialysis, chemotherapy and cancer support, a full range of outpatient services. The Halton Clinical Research Unit is also located here.

Captain Sir Tom Moore building: Orthopaedic surgery, urology and gynaecology surgeries, cancer surgeries, post-anaesthetic care unit.

Support services include: Breast care centre, occupational therapy, physiotherapy, dietetics, outpatient services, diagnostic services, and a range of specialist nursing services. The Trust's Pre-treatment centre (pre-op and swabbing service) is located on the Halton site.

The Runcorn Urgent Treatment Centre provides care and treatment for illnesses and injuries that are not life or limb-threatening but require urgent attention. The centre is open from 8am to 9pm 7-days week

Through a network of community hubs, virtual service offers and mobile facilities we also provide a range of outpatient services in the local community. This is a step towards ensuring services are delivered in the right place to improve access to quality care and address health inequalities.

Halton Health Hub
The Halton Health Hub, a standalone outpatient unit situated within Shopping City in Runcorn, provides a range of services including optometry, orthoptics, audiology and dietetics. The Hub also provides space for partners to deliver preventative and early intervention services, such as the drop-in vaccine outreach service for Covid-19 and flu vaccinations provided by Halton Borough Council and primary care services, offered by our local GPs.

Mobile Screening Services
Designed to make access to screening services more accessible, mobile units in the community support access to diagnostic services.

The Halton Clinical Research Unit provides opportunities for members of the public to access clinical research and trials.

Bath Street Health and Wellbeing Centre
From this health centre, the Trust provides maternity and breast services.

Virtual Wards
Advances in digital technology and the improvements in NHS IT infrastructure means we have been able to introduce Virtual Wards. These allow patients to receive the care they need at home, including in care homes, safely and conveniently rather than in hospital.

Virtual consultations
Traditional models of outpatient care are not always accessible to patients or aligned to their needs, resulting in missed appointments, poor health outcomes and greater use of emergency care.

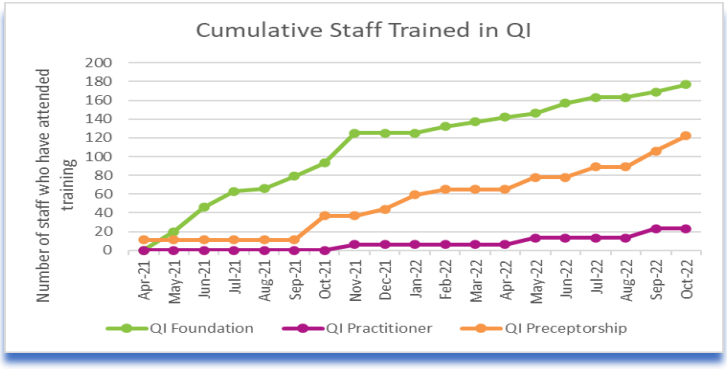
The Trust offers remote video outpatient consultations to enable flexible and responsive care, in additional to optimising virtual consultations to support when emergency care is required. For example, Virtual Fracture Clinics reduce wait times for patients who require emergency care with suspected breaks and fractures. Patients can receive immediate care and x-rays, then go home while a clinician reviews images remotely. Once reviewed the patient will be telephoned and treatment discussed.

Who we are… How we do it

Our workforce is our greatest strength. We know that getting things right for our staff is the best way for us to achieve our mission to be outstanding for our patients, our communities and each other. We believe that by harnessing the talents of our workforce and supporting them to develop their careers here at the Trust, we can create the conditions for staff to provide excellent care.

Michelle Cloney, Chief People Officer

We develop our quality improvement capabilities to continue to improve for our patients and each other. We continue to progress quality improvement training programmes both in terms of capacity and capability. These are delivered by our own Quality Academy to a variety of staff groups across the Trust. This ensures a culture that actively seeks to improve the quality of all that we do.



We seek to reduce inequalities in health

We recognise and act on our role as an advocate for the health and wellbeing of our local communities. We know unfair and avoidable differences in health can be caused as a result of society, the environment we live in and the opportunities we have.

It is our ambition to positively impact social value and lead others to do so, in order to enhance the well-being and life chances of our patients, and make a positive contribution to our local economy and community.

We use and learn from data

We are committed to using and acting upon the intelligence we gain from data to improve the health and care outcomes of our population in an equitable way.

We listen and learn from patients

We are committed to meaningful co-production and co-design, ensuring patient voices are at the heart of everything we do, and inform the plans and decisions we make about the delivery of service. *#Start with People*

We value volunteering as a way to improve care and enhance the lives of our volunteers

We work with our communities to increase the visibility and diversity of hospital volunteers to support holistic patient care.

Building on our successes

Whilst we recognise there is significant work to be done to meet the challenges faced by all health and social care systems, and the focus rightly is on what still needs to be done, it is important to recognise the great work achieved across our Trust and with our partners. The ability to learn and build on our successes is a great strength.

OUR QUALITY SUCCESSES

Active Hospitals - A stay in hospital can make patients feel weaker and everyday tasks can feel challenging and tiring. We are committed to helping people stay as active as possible whilst recovering from an illness in hospital is very important and helps with recovery.

How do our patients stay active in hospital?

- ✓Reconditioning Games
- ✓Ready Dress Go!
- ✓Readers Group
- ✓Tissue Viability & Falls Champions
- ✓Therapy ward based exercise classes
- ✓#Home4Noon
- ✓Fit2Sit MDT approach within the Emergency Department and on the wards
- ✓Hydration Campaigns

Service accreditation

The Trust participates in a number of accreditation schemes to ensure that clinical services remain of a consistently high quality. Since the previous strategy the following accreditation has been achieved: -

- ✓ Anaesthesia Clinical Services Accreditation – This is a voluntary scheme which focuses on quality improvement through peer review
- ✓ Joint Advisory Group (JAG) Accreditation for Gastrointestinal Endoscopy - JAG accreditation means that patients can have increased confidence in their endoscopy service and be assured of a high quality and safe service.
- ✓ Accredited as Resuscitation Council UK Newborn Life Support Training Centre
- ✓ Family Integrated Care accreditation - Facilitating a partnership between parents and the staff, to promote parent-infant interactions and to build parent confidence.

JAG accreditation feedback …

"Both sites operate to an equally exceptional standard and easily some of the highest standards we have seen in the UK. . . In summary the service epitomises what a quality, safe endoscopy service with embedded standards is all about"

Enhancing patient experience with a warm welcome

Our newly staffed reception in the atrium of Warrington Hospital provides an immediate one stop shop for anyone visiting the hospital. The reception can be the first time a patient has face-to-face interaction on site, whether that's to request help with way finding, portering for patients with physical needs or a general query. The investment has significantly increased our ability to create a good first impression and ensure an immediate point of contact for patients.

Introduced new research and development capability and capacity. This has resulted in:-

51 active studies
791 recruits
31 active investigators
18 Specialities

Key Achievements

- ✓ "Excellence in Commercial Life Sciences Research" NWC Awards 2020.
- ✓ Shortlisted "Research Collaboration of the Year" in the 2022 NWC Awards.
- ✓ Best recruiter to Moderna study – 1st of 32 sites.

Building on our successes

OUR PEOPLE SUCCESSES

In 2022, the Trust achieved the Disability Confident Level 3 Leader Status, part of a Government scheme, which recognises our commitment to supporting people living with a disability or long-term health condition to thrive in work.

Working with Warrington Vale Royal College, the Trust has established a Supported Internship Scheme to support the recruitment of students with SEND into placements across roles at the Trust. The aim of the project is to support the students to develop work-based skills so they can go onto apply for and secure future employment.

The Trust has established four Staff Networks who influence and drive change to improve the experiences of our workforce and patients with specific protected characteristics. They are:

- Multi-Ethnic Staff Network
- PROGRESS Staff Network
- Disability Awareness Network
- Armed Forces and Military Veterans Community Staff Network

We have joined Health Education England's Health Ambassador initiative in a bid to connect with school children of all ages to talk about the breadth of NHS roles available and to inspire them to consider a career in the NHS. Our Trust's NHS Ambassadors take part in activities such as speed networking, mock interviews, open days, career marketplaces, workplace visits, career days and many more, alongside interactive virtual sessions to connect with young people online.

The Trust engaged in a Reciprocal Mentoring programme with Executive Directors and Senior Leaders of the organisations' Staff Networks over a period of 12 months. This aim of the programme was focused on increasing the strategic influence of under-represented groups across the Trust, whilst reducing and removing barriers in access to opportunities and career progression.

To support financial wellbeing within the organisation, a range of resources are available to staff from cooking on a budget recipes, videos on financial wellbeing and links to charities that can help and support through a confidential telephone advice line. The Trust has also launched a Barclays Financial Wellbeing platform which gives free access to bespoke offers, access to a Money Mentor to help staff to review their finances, and access to a wide range of resources online and face to face support.

A leadership development programme 'Growing as a Leader' has been developed, with successful participants achieving their CMI Principles of Management and Leadership qualification as a result of successfully completing the course. All participants identify a work based service development project and a number of participants have progressed in their career utilising the skills they have developed on the course.

Building on our successes

OUR SUSTAINABILITY SUCCESSES

Digitally improved care that reduces inequalities and enhances patient experience. In 2021, BadgerNet, an electronic system aimed at giving mothers more control of their pregnancy records and care notes, was introduced to replace our old paper notes. The online portal and app allows expectant mothers to access their maternity records over the internet through a PC, tablet device or mobile phone in real-time and to interact with their midwife or other health professionals involved in their care by a message board.

Working in partnership to achieve social and economic wellbeing in our communities. Through strong partnership working with Warrington Borough Council and Halton Borough Council, investment has been secured from The Department for Levelling Up, Housing and Communities (DLUHC) for major investment in both Towns, known as the 'Town Deals'. Focused on economic growth, regeneration, improved transport infrastructure, better digital connectivity, skills and culture, the investment includes funding for the Living Well Hub in Warrington and The Runcorn Health and Education Hub.

Adapting how we deliver services to respond to changes in the way patients want to access care and enabling this by maximising technologies. We have introduced patient initiated follow ups across a range of services, which enables patients to initiate an appointment request when they need one, based on their symptoms and individual circumstances, rather than services setting routine appointments which may not be as impactful.

New Hospitals Programme

In September 2021, the Trust submitted an expression of interest (EOI) to be considered for one of the 8 remaining spaces on the Government's New Hospitals Programme, which was supported by commissioners, local government, educators including the University of Chester, social care, third sector partners and MPs. The EOI set out a compelling and cost efficient case for the investment required to build a new hospital in Warrington and redevelop the Halton hospital site (through an extension to the newest estate, Captain Sir Tom Moore Building). The vision for future-proofed, adaptable and appropriate healthcare facilities has been well embedded since the previous strategy and has strong support. While the outcome of the EOI is awaited, the Trust continues to maximise opportunities to progress plans within the current footprint and to work towards our new hospitals visions of modern, compliant estate, by changing and adapting how and where we deliver care, to set the foundations for the future.

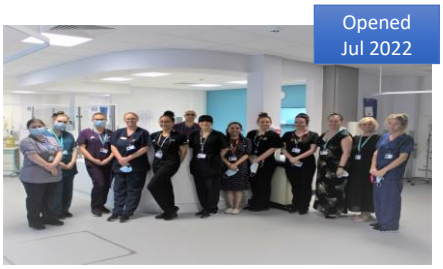
We are doing this by investing wisely in existing estate to support long-term plans and making the most appropriate and effective use of the clinical space we have. Successes include funding secured with partners to open community hubs, refurbishment of clinical areas and replacement of aging equipment.

Opened Oct 2022

New Halton Health Hub

Opened Sep 2022

Refurbished Paediatric Outpatients



Opened Jul 2022

New Same Day Emergency Care unit

Opened Oct 2021

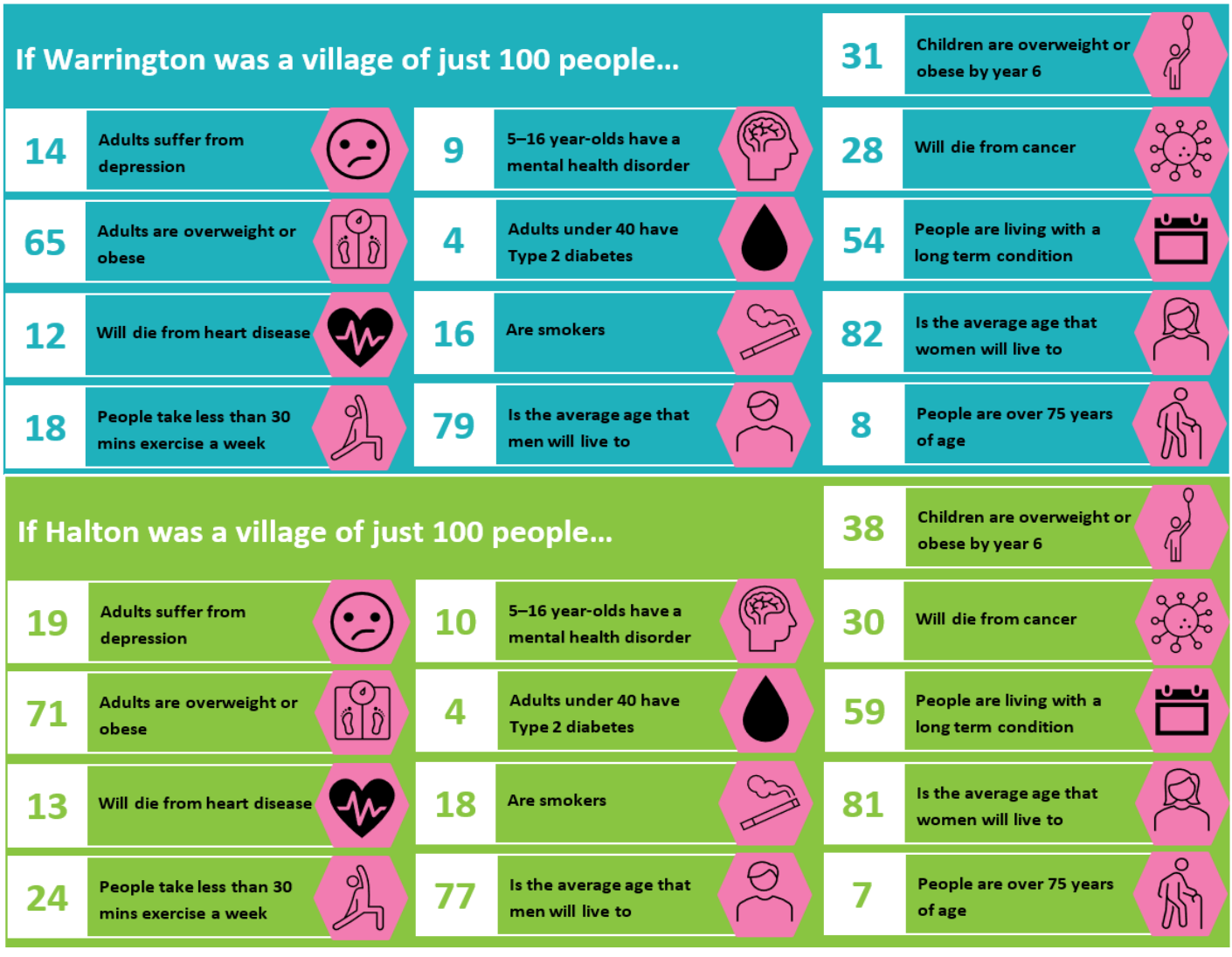
New breast care centre at the Captain Sir Tom Moore (CSTM) building

Our communities

One of the biggest challenges facing Warrington and Halton is the inequalities caused by socio-economic deprivation and the impact this has on the health and wellbeing of individuals and communities. Addressing the impact on the most vulnerable communities is a key challenge.

Inequalities in health are most starkly demonstrated by the gap in life expectancy between the most and least deprived areas of each borough, a difference of 10 years in both boroughs. Marked inequalities are evident in Warrington across a range of other areas such as educational attainment, income, employment, the experience and fear of crime, poor lifestyle, general health and mental wellbeing. Meanwhile, the poorest people in Halton are dying at a younger age than others living in wealthier areas – long-term health conditions, caused by poor lifestyle conditions are too often the cause. In older years, quality of life is often compromised because of increased fragility and poor health that can result in a loss of independence and a reliance on health and care services. Young children are not always getting the best start to their lives. There are high rates of smoking during pregnancy, low breastfeeding rates and higher than average levels of childhood obesity. As well as this too many under-18s are admitted to hospital because of alcohol.

The impacts of these inequalities puts significant pressure on services right across the system and demand a different focus and approach to the way we deliver healthcare, as well as how we work with our partners across Warrington and Halton.



The changing landscape

The current challenges facing the Trust and the NHS as a whole are multi-layered, sizeable and real. Recovery from a global pandemic, growing demand for services from an ageing population, constrained finances and national and local workforce availability and recruitment challenges, have coincided with political instability and influenced an unprecedented and ever-changing operating environment.

At the same time the structural landscape of how health and care is planned and delivered across England has changed. The Health and Care act (2022), introduced on 1st July 2022, created 42 Integrated Care Systems (ICS) nationwide, replacing over 100 Clinical Commissioning Groups. Warrington and Halton operate as 'Places' and form part of the Cheshire and Merseyside ICS which connects each Place through a structure which aims to bring together a wide range of partners to develop a plan to address the broader health, public health, and social care needs of the population. As the local context we work in continues to evolve and mature, it is important to reflect on local health and wellbeing outcomes which are below the national average.

In developing our strategy we have taken a holistic view of the health and public service landscape to ensure that our ambitions align with those of:

- Our immediate stakeholders (e.g. Warrington Council, Halton Council, Warrington Together and One Halton).
- Our neighbours and partner organisations across Cheshire and Merseyside.
- The ambitions set for the whole of the NHS by NHS England.

This approach ensures that we are making the best contribution towards delivering high quality, sustainable services to the communities we serve, responding effectively to the challenges facing health and social care and maximising opportunities to do this at scale with partners.

IMPACT OF KEY NATIONAL AND LOCAL PRIORITIES

Our strategy acknowledges the important role we play in each of the following strategies

.

The NHS Long Term Plan places a focus on moving to a new model in which patients get more joined-up care, closer to home. The plan emphasises the need to strengthen the NHS contribution to prevention and reduce health inequalities, improve mental health services, reduce pressure on the emergency treatment system, personalise care, and make the most of digital opportunities, innovation and research to truly transform care, for example in outpatients. It is essential we are aligned with the delivery of these ambitions.

Levelling up sets out aims to make life more equitable across the UK by recognising and tackling the wider determinants of health. We are and will continue to use population health data to determine what the needs of our communities are.

Health as the new wealth highlights the NHS's role in economic and social recovery and outlines the role health services should play in the wider recovery and rebuilding of communities and economies. We recognise this will be crucial to addressing inequalities and will actively take opportunities to make the economy more socially just by leveraging support towards local economic and environmental goals.

The **NHS People Plan** sets out the workforce strategy to deliver the Long-Term Plan. It has four core features which must inform our priorities: -

- looking after our people – with quality health and wellbeing support for everyone
- belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
- new ways of working and delivering care – making effective use of the full range of our people's skills and experience
- growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

The **NHS Patient Safety Strategy** seeks to maximise the things that go right and minimise the things that go wrong, an ambition we share and actively support.

Cheshire and Merseyside Health and Care Partnership – of which we are a part – was established to confront the health and care challenges in Cheshire and Merseyside of population health, the quality of care, access to care and increasing financial pressures. As a partner, our strategy also considers ways in which we can contribute to the aspiration of transforming health and social care for the residents of Cheshire and Merseyside, while supporting broader social and economic developments.

Warrington Together partnership and **One Halton Partnership** aim to deliver integrated health and social care through effective stakeholder collaboration. This approach is called 'place based care'. Our strategy seeks to support the individual 'place' priorities of both Warrington and Halton, which share many commonalities.

Warrington Together priorities

1. Improve population health and support vulnerable communities and individuals. Develop a place-wide 'Living Well' framework that supports people to start, live and age well, be active, and live healthy, fulfilling lives.
2. Deal with rising demand and respond to the changing needs and expectations of the local population.
3. Improve and maintain quality services and manage more complex needs locally.
4. Sustain and grow our workforce, volunteers and community led services.
5. Ensure good access to early help that will prevent crisis and needs from escalating.
6. Maintain an effective and financially sustainable health and care system, with budgets under pressure.

One Halton Partnership

1. Improve the employment opportunities for people in particular where it affects children and families.
2. Starting well: Enabling children and families to live healthy independent lives.
3. Living Well: Provide a supportive environment where systems work efficiently and support everyone to live their best life.
4. Ageing Well: Enabling older adults to live full independent healthy lives

Care Quality Commission

Our Trust delivers good care; however we recognise there is more to do to improve and to respond effectively to the challenges facing health and social care and there are opportunities to do this at scale with partners.

The Trust's previous strategy was built upon three key strategic aims of Quality, People and Sustainability, which remain relevant today and have been refined to reflect the changing landscape in which the NHS operates and key national and local priorities/policies.

Our refreshed strategy for 2023/24 and 2024/25 is summarised on the following pages.

Our mission, vision, values & aims

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Aims

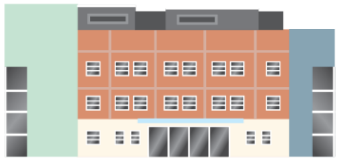
Quality

We will... **Always put our patients first** delivering safe and effective care and an excellent patient experience.

People

We will... **Be the best place to work** with a diverse and engaged workforce that is fit for now and the future.

Sustainability



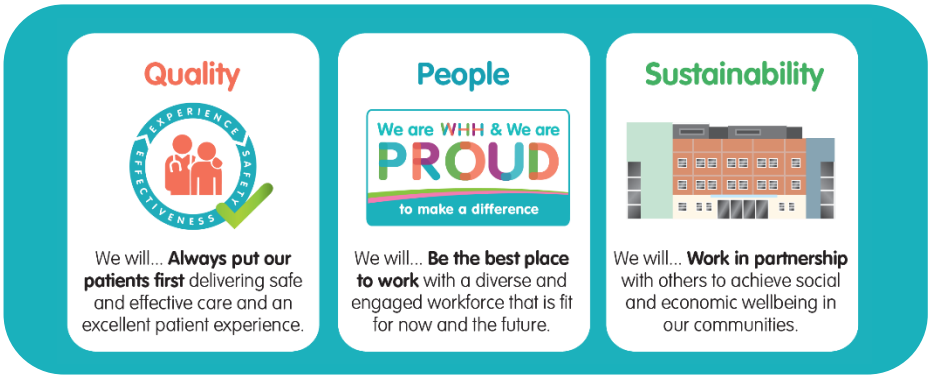
We will... **Work in partnership** with others to achieve social and economic wellbeing in our communities.

Our Values

Working Together | Excellence | Inclusive | Kind | Embracing Change

Our objectives for 2023 - 2025

We have three strategic aims framed around Quality, People and Sustainability. These aims are interdependent; they are woven into each of our strategic objectives, and throughout all of our plans, programmes and projects.



We have twelve strategic objectives to progress over the next two years. Each of these objectives will be realised through supporting priorities and plans. The following section describes in more detail the key work that will be delivered to achieve these strategic objectives.

Quality

1. Patient safety
We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.

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.

3. Patient experience
We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.

4. Research, Development and innovation
We will work in partnership on high quality clinical research for the benefit of patients, public and staff.

People

5. Looking after our people
We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.

6. Innovating the way we work
We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.

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.

8. Belonging in WHH
We will enable staff to have a voice through the development of a just and learning culture.

Sustainability

9. Working in partnership
We will work collaboratively to provide sustainable, high quality acute services and to support prevention and integrated care in the community.

10. Working responsibly
We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.

11. Sustainable estate and digitally enabled
We will provide our services in a fit for purpose estate, supported by the realisation of digital opportunities.

12. Financial sustainability
We will develop and deliver financial sustainability plans with our staff, system partners and stakeholders.

Our Objectives

We have twelve strategic objectives to progress over the next two years, which support our three strategic aims of Quality, People and Sustainability. Each strategic objective will be realised through a set of associated priorities and plans. The following section describes in more detail the key work that will be delivered to achieve these strategic objectives.

Quality

Our Quality strategic aim is "We will always put our patients first, delivering safe and effective care and an excellent patient experience". Our four strategic objectives for quality and associated priorities are summarised below to demonstrate how we plan to deliver on our strategic aim.

1. Patient Safety: We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.

How will we achieve this objective:	
Overarching priorities covering the duration of the strategy	
1.1	We will reduce avoidable harm and patient deterioration with a focus on Covid-19 elective recovery.
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.
1.3	We will enhance timely patient recovery through therapy led initiatives, including work around deconditioning and rehabilitation.
2023/24 annual quality priorities	
1.4	We will improve recognition and response to deteriorating patients.
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).
1.6	We will continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework.

What this means in practice

Our maternity services recently provided care to a very complex patient who, under the provisions of Section 3 of the Mental Health Act 1983, had been detained in segregation at a mental health facility due to significant violence. To ensure the best care for the patient, the team reached out for support and expertise internally, regionally and nationally. The conclusion was that this was such a rare situation no one had any experience of this in the country. As a result, the whole team was required to carefully risk assess and plan care with partners to deliver effective and compassionate care. They recognised the value of building memories for women who have to give their baby up for safeguarding reasons and this was critical. The result was :-

- ✓The de-escalation of the patient's behaviour since the birth of her baby
- ✓Full medication review achieved
- ✓Patient no longer needs care to be provided in segregation and can now be cared for with 1:1 support rather than 6 carers
- ✓Demonstrable difference in the patient's mental health

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.

How will we achieve this objective:

Overarching priorities covering the duration of the strategy

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.
2.2	We will continue to embed a positive risk management culture from ward to board.
2.3	We will recover core services and improve productivity in line with targets set in the NHS Long-term plan.

2023/24 annual quality priorities

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.
2.5	We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.
2.6	We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework).

Example of the work we will build on

Managing risk effectively

Clinical risk management is integral to the co-ordination and delivery of effective and safe care. Acknowledging that risk cannot always be completely eliminated; indeed some risks are difficult or even impossible to predict, we have developed a systematic approach to clinical risk management. This is underpinned by effective communication, record keeping and governance, to maximise the chances of managing risk.

We recognise that risk management also involves consideration of positive risk taking to promote independence and choice, once the potential benefits and harm to the individual and others have been thoroughly assessed.

As such, we have developed an open transparent culture, where clinical risks are appropriately discussed and escalated to reduce potential harm occurring.

"Utilising learning from the national Getting It Right First Time programme, we have developed plans to improve the treatment and care of patients based on benchmarking of best practice and data-driven evidence to support effective change. As these improvements are implemented they will improve care and patient outcomes". *Paul Fitzsimmons, Executive Medical Director*

3. Patient Experience: We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.

How will we achieve this objective:

Overarching priorities covering the duration of the strategy

3.1	We will empower patients to be active participants in their care, giving consistent information, listening and discussing next steps in their care.
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.
3.3	We will create first and lasting impressions which contribute towards a positive experience of care.

2023/24 annual quality priorities

3.4	We will improve patient experience for those with mental health attendance.
3.5	We will reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods.
3.6	We will improve patient experience by the pilot of a patient/family 'access line' primarily for out of hours.

Example of the work we will build on

hello my name is…

Hello my name is Vicky and in my life I have frequently used my local hospital in many services.

As a member of the deaf community I have found it difficult to communicate with your staff due to lack of awareness of the deaf community and lack of understanding for the requirement for me to have an interpreter present.

Most people assume that I can lip read very well but different backgrounds, lighting and facial hair make this really difficult for me and some deaf people can't lip read at all but it's always assumed. Other times I've been asked to write stuff down but I don't speak or write in English, I communicate in British Sign Language – this is why an interpreter is important. They help to translate English into a way that I can understand and also share with you my symptoms so you can properly diagnose and treat me.

During the pandemic communication has been harder for me and other members of the deaf community due to face masks that staff have had to wear. Sometimes clear face masks are used but with the steam and reflections this isn't always helpful.

Our Response

- Engagement is vital to learning and sharing lived experience
- New Diversity, Inclusion and Belonging Strategy will heavily feature engagement with the deaf community.
- Vicky signed up to be an Expert by Experience working with the Patient Experience and Inclusion Team
- Commissioning Deaf awareness training for all staff
- Including brilliant basics associated with Interpretation and Translation as part of the Staff Guide in all areas
- Launch of the Accessible Information Standards policy and project plan to ensure communication needs are recorded, shared and acted on
- Vicky's story will be used in Equality, Diversity and Inclusion Training

4. Research, Development and Innovation: We will work in partnership on high quality clinical research for the benefit of patients, public and staff.

How will we achieve this objective:

Overarching priorities covering the duration of the strategy

4.1	We will continue to create opportunities for members of the public to gain access to clinical research trials contributing to the health of our population.
4.2	We will further develop and grow our research capability through the application and selection for clinical trials.
4.3	We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.
4.4	We will grow the academic research portfolio supporting staff recruitment and retention.
4.5	We will seek to expand our research offer seeking opportunities for further collaboration through the Halton Clinical Research Unit.

Example of the work we will build on

"The new research facility represents a major opportunity for the people of Halton and Warrington to take part in research and improve the health of our communities"
Dr Chris Smith, chief operating officer, Clinical Research Network: North West Coast

Health research plays an integral part in how the NHS develops services and continues to provide high quality healthcare for our population. It is vital in providing the evidence we need to transform services, enabling earlier diagnosis, more effective treatments, prevention of ill health, better outcomes and faster returns to everyday life. Meanwhile, research is also beneficial to healthcare professionals who are able to develop imaginative solutions for real challenges facing the NHS, improving care and increasing job satisfaction.

Through our research alliance with Liverpool University Hospitals NHS Foundation Trust and the National Institute for Health Research (NIHR) Clinical Research Network, North West Coast, we are able to enhance our clinical research capability and give access to clinical trials for local people, while ensuring we benefit from the expertise of our research partners.

People

Our People strategic aim is “We will always be the best place to work, with a diverse and engaged workforce that is fit for now and the future”. Our four strategic objectives for people and associated priorities are summarised below to demonstrate how we plan to deliver on our strategic aim.

5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.

How will we achieve this objective:	
5.1	We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.
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.
5.3	We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.
5.4	We will equip line managers to use person centred engagement practices which improve employee experience.
5.5	We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.
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.

What this means in practice

In July 2022, absence for staff working in Estates and Facilities was higher than the Trust’s overall sickness absence. The Leadership team conducted a review to identify the common reasons for absence and any particular staff groups that were affected.

As part of this review, it was identified that 84% of our Domestic staff are over the age of 40, at an age when some people will find ageing processes combined with the physical nature of the Domestic role, impacts their overall health and wellbeing.

To support staff, a health and wellbeing event was delivered with partners, with advice and interventions framed around the needs of the staff group. This resulted in:-

- 36 health checks being performed, including blood pressure checks and health fitness checks.
- 18 referrals to various services including GPs, counselling and Reflexology.
- Tailored advice offered on topics such as smoking cessation, weight management and Menopause.
- Information handouts provided on Financial Wellbeing.
- Free day gym passes.

The impact of the support will be monitored. Feedback on the day was very positive from staff.

6. **Innovating the way we work:** We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.

How will we achieve this objective:	
6.1	We will develop strategic workforce plans which are reflective of current and future needs.
6.2	We will participate in system wide workforce planning.
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.
6.4	We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.
6.5	We will equip our workforce with the skills to shape and deliver effective and changing models of care.
6.6	We will enhance digital capability, skills and leadership which embrace digitally enabled services.
6.7	We will attract and retain a transformed and responsive workforce that can deliver care to patients in new and different ways.

Physician Associates are medically trained, generalist healthcare professionals, who work alongside Doctors and provide medical care as an integral part of the multidisciplinary team. Although the Physician Associate profession is still considered relatively 'new' in the UK, the role of Physician Assistant first developed in the US in the 1960s, and equivalent or similar roles exist in many healthcare systems around the world.

At WHH, there are currently 18 Physician Associates working in the Emergency Department, Paediatrics, Surgery and Care of the Elderly. We also host Physician Associate students from the University of Chester who gain experience in various departments such as Trauma & Orthopaedics, Endocrinology, Cardiology, Respiratory, Stroke, Obstetrics & Gynaecology, Paediatrics and the Emergency Department.

Physician Associates bring new talent to healthcare and can provide vital support to patients and the multidisciplinary team. Physician Associates are intentionally trained as 'generalists' so that they can switch into different types of work either for their own growth and satisfaction, or for the benefit of the community or hospital they work in. The profession has gone from strength to strength in the UK, with the adoption of the managed voluntary register for Physician Associates in 2011, and the launch of the Faculty of Physician Associates through collaboration with UKAPA and the RCP in 2015.

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.

How will we achieve this objective:	
7.1	We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.
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.
7.3	We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role 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.
7.5	We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.
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.

Example of how the priorities will be progressed

The Trust is undertaking a number of programmes of work to develop a pipeline for our workforce across various roles and professional groups, including the Supported Internship Scheme and Health Education England's Health Ambassadors scheme. We are working with partners to support the growth of our future workforce through grass-roots investment in academies. The Health and Social Care Academy, developed by Vale Royal College in partnership with a number of local organisations including the Trust and Warrington Borough Council, is a great example of our commitment to growing our future workforce.

By working collectively, local health and social care organisations can support identification of the areas of greatest need in terms of the health and social care workforce for future, and input into the student curriculum to ensure students leave with the skills required in the workplace.

8. **Belonging in WHH:** We will enable staff to have a voice through the development of a just and learning culture.

How will we achieve this objective:	
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.
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.
8.3	We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.
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.
8.5	We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.
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.

Commitment to equality, diversity and inclusion

In 2022, WHH achieved the Navajo Cheshire and Merseyside LGBTQ+ Charter Mark. The accreditation recognises the commitment WHH continues to make to improve the experience and health outcomes of the LGBTQ+ community – both for our patients and our workforce.
The Trust also became a Stonewall Diversity Champion to continue to improve our policies, procedures and workstreams for the future.

Commitment to our Armed Forces Community

The Armed Forces Covenant is a pledge to acknowledge and understand the needs of the Armed Forces community and aims to build a more open and honest relationship between employers, the Ministry of Defence and reservists. As an accredited Armed Forces Friendly Hospital and Silver accredited with the Employer Recognition Scheme, we identify and record our patients and staff within the military community to ensure they receive support needed.

Sustainability

Our Sustainability strategic aim is "We will work in partnership with others to achieve social and economic wellbeing in our communities". Our four strategic objectives for Sustainability and associated priorities are summarised below to demonstrate how we plan to deliver on our strategic aim.

9. Working in partnership: We will work collaboratively to provide sustainable, high quality acute services and to support prevention and integrated care in the community.

How will we achieve this objective:	
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.
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 community and prevention of ill health. It is proposed that this includes relocation of appropriate secondary care into the community, following the principle of the right service, delivered in the right place to deliver excellent patient care and experience and 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.

"We're delighted to have the NHS Trust and Halton Health Hub here in the heart of the community at Runcorn Shopping City. It forms a synergy between the continued development of the shopping centre and improves convenience and access for patients. We believe it will serve as a blueprint for other locations around the country."

Dave Pearman, Centre Manager, Runcorn Shopping City

Example of how the priorities will be progressed

The Runcorn Health and Education Hub will open in late 2024. In partnership with Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare, Halton Borough Council, voluntary and third sector partners and Riverside College. We will deliver services focused on prevention, women and children and long term conditions in the heart of the Runcorn community. In addition, flexible education facilities will support the growth of our future workforce, helping local people into local jobs.

10. Working responsibly: We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.

How will we achieve this objective:	
10.1	We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.
10.2	We willl identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.
10.3	We will drive improved social value for our local population increasing the social and economic wellbeing in the communities we serve.
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 net zero National Health Service by 2045.
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.

Examples of how the priorities will be progressed

The Living Well Hub The Hub will 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 close proximity to the areas of the town with the highest levels of deprivation. The Hub will be a key project for the local health and care system to work collaboratively to support early intervention and the prevention of ill health. Over time, it will reduce demand for health and social care services by empowering people to take greater responsibility for their own personal health and wellbeing and linking them to appropriate support within their local communities. The project represents an investment of £3.1m, has been co-designed with patients and system partners through extensive engagement and is on-track to be operational by Autumn 2023.

At Warrington and Halton Hospitals NHS Foundation Trust we recognise the scale of the issue that climate change presents in our community.

As a healthcare provider we acknowledge our responsibility to minimise our contribution to climate change and integrate sustainability into our organisation to reduce the potential risks for our local population. Our Green Plan outlines our commitment to embedding sustainability throughout our organisation and delivering net zero by 2045.

11. Sustainable Estate and digitally enabled: We will provide our services in a fit for purpose estate, supported by the realisation of digital opportunities.

How will we achieve this objective:	
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.
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 towards our realisation of our new hospitals.
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.
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.

Digital solutions for the future will focus on at scale solutions as highlighted below

Shared Care Records

Patient Empowerment Portals (PEPs) and Personal Health Records (PHRs)

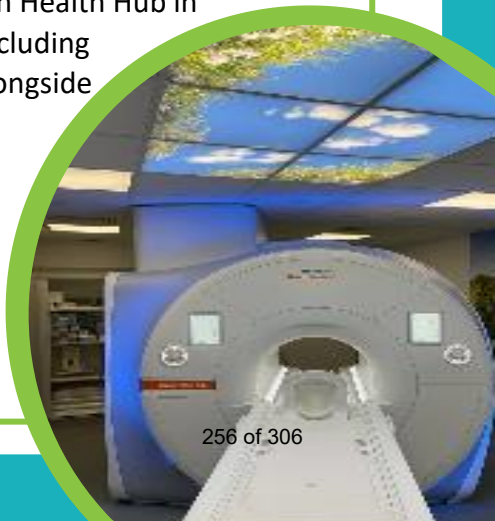
Remote Care

Intelligence Delivery Platforms

Creating a Community Diagnostic Centre

The Trust has been successful in bidding for funding from NHS England to develop a Community Diagnostic Centre, which will be located at the Halton site and at the Halton Health Hub in Runcorn Shopping City. This funding will deliver new diagnostic capacity, including ultrasound, phlebotomy with point of care testing, CT and MRI facilities, alongside additional audiology and sleep study services, to support easier access to diagnostic services and earlier diagnosis of disease for patients. It will also free up capacity at the Warrington site as the choice of locations for diagnostic services increases.

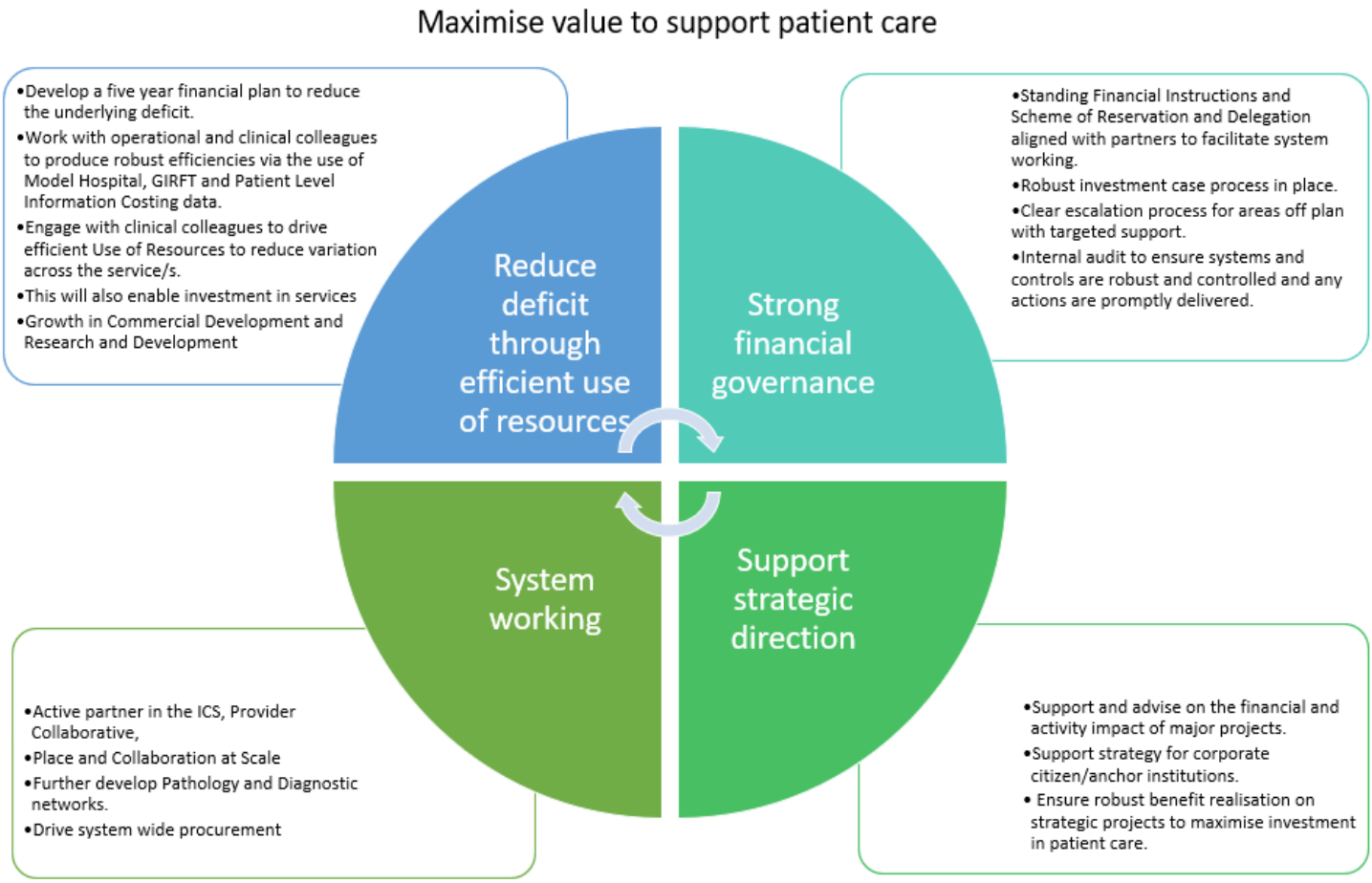
These plans are a step towards delivering care in future-proofed, compliant estate and support delivery of care in line with future new hospital plans.



12. Finance sustainability: We will develop and deliver financial sustainability plans with our staff, system partners and stakeholders.

How will we achieve this objective:	
12.1	We will deliver the Trust's agreed financial plan.
12.2	We will participate, lead and contribute to system wide programmes to drive increased efficiencies and benefits.
12.3	We deliver value for money by ensuring efficient use of resources.

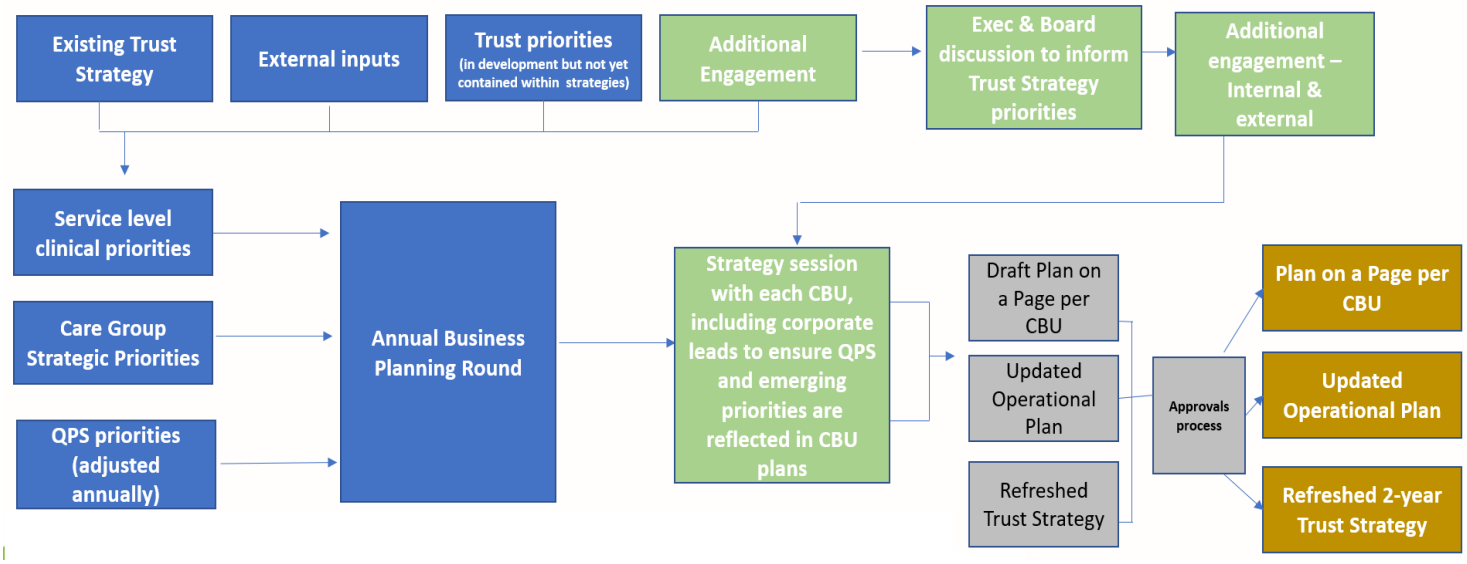
We will utilise the four principles below to help us embed our priorities



How we got here … engagement to date

Successful delivery of our future vision for the Trust is dependent upon the full engagement of our patients, staff and local system partners, who are the people who have informed and will bring this strategy to life.

The development of the strategy has been shaped through systematic communication and engagement with our stakeholders, using the process below, and we will continue to engage with all partners as delivery processes.



Specific engagement activities and events have included:-

- Market stall events, both at our hospital sites and in the community, to gather input from staff, patients and the public.
- Engagement with Healthwatch.
- Discussion with Council of Governors.
- Engagement with place partners, via Place Boards.
- Review of existing sources of patient insight and experience data.

Thank you

Lucy Gardner
Director of Strategy
and Partnerships

We would like to take this opportunity to thank our patients, carers, public, staff, governors, members, partners and all stakeholders for your support in developing and delivering our strategy.

Never has working together been so important and the strength of our partnerships is evident in many of our shared successes since our previous strategy was developed in 2018. Halton Health Hub delivered in 2022 and the development of both the Living Well Hub in Warrington and Health and Education hub in Runcorn are just a few examples of significant investment and innovative integrated service delivery, tailored to the needs of our communities, which would not be possible without working together with our local residents, councils, health and wellbeing and education partners and the commercial sector.

These important projects, alongside the delivery of all of our objectives outlined within our strategy, will support us to together reduce health inequalities within our boroughs, narrowing the 10 year gap in life expectancy between the most and least deprived.

We look forward to continuing to work together to be outstanding for our patients, our communities and each other. Together we can help support our communities to thrive, leading happy and healthy lives.

For more information on our strategy and to download copies of this and/or any of our supporting strategies, please visit our website ***www.whh.nhs.uk/strategy***

Contacting us: We would love to hear your comments and ideas about our future plans and what we'd like to achieve.

Strategy Office, Kendrick Wing
Warrington Hospital, Lovely Lane
Warrington WA5 1QG
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Polish:	Niniejsza publikacja jest dostępna w alternatywnych językach lub formatach na życzenie
Punjabi:	ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਬੇਨਤੀ 'ਤੇ ਵਿਕਲਪਕ ਭਾਸ਼ਾਵਾਂ ਜਾਂ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਉਪਲਬਧ ਹੈ
Urdu:	یہ اشاعت درخواست پر متبادل زبانوں یا وضعوں میں دستیاب ہے
Bengali:	এই প্রকাশনাটি অনুরোধের ভিত্তিতে বিকল্প ভাষা বা বিন্যাসে উপলব্ধ
Gujurati:	આ પ્રકાશન વિનંતી પર વૈકલ્પિક ભાષાઓ અથવા ફોર્મેટમાં ઉપલબ્ધ છે
Arabic:	هذا المنشور متاح بلغات أو تنسيقات بديلة عند الطلب
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REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/34**	
SUBJECT:	Amendments to the Scheme of Reservation & Delegation (SoRD) and Standing Financial Instructions (SFIs)	
DATE OF MEETING:	29th March 2021	
AUTHOR(S):	John Culshaw, Trust 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.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's Standing Financial Instructions (SFIs) determine a process for responsibility and delegation for the approval of Non-Pay Expenditure with specific responsibilities as detailed in the Scheme of Reservation and Delegation (SORD). This paper proposes the following changes to the: **SoRD** 1. Reservation of Powers to the Board of Directors - Regulations and Controls 2. Appendix 2 – Table B – Delegated Financial Limits – Section 1 Charitable Funds 3. Appendix 2 – Table B – Delegated Financial Limits – Section 4. Losses & Special Payments #7 Ex gratia payments. 4. Appendix 2 – Table B – Delegated Financial Limits – Section 6.3 Requisitioning Goods and Services and Approving Payments – Capital Expenditure 5. Appendix 1 – Table A – Delegated Authority & Appendix 2 Table B Section 10 Contract Award **SFIs** 1. Estates Emergency Orders	

PURPOSE: *(please select as appropriate)*	Information	Approval x	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the proposed amendments to the SoRD and SFIs			
PREVIOUSLY CONSIDERED BY:	**Committee**		Executive Management Team	
	Agenda Ref.		W&HHFT/EDM/23/175 & W&HHFT/EDM/23/186	

	Date of meeting	16.03.2023 & 21.03.2023
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Amendments to the Scheme of Reservation & Delegation (SoRD) and Standing Financial Instructions (SFIs)	**AGENDA REF:**	**BM/23/03/34**

1. Background / Context

The Trust's Standing Financial Instructions (SFIs) determine a process for responsibility and delegation for the approval of Non-Pay Expenditure with specific responsibilities as detailed in the Scheme of Reservation and Delegation (SoRD). This paper proposes changes to both the SoRD and SFIs and notifies of one approved Trust Board change

2. Amendments to the Scheme of Reservation & Delegation (SoRD)

The purpose of the SoRD is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions; even those delegated to Committees, Sub Committees, individual Directors or Officers.

Following a review of the SoRD, the following updates are proposed or are for noting:

1. Reservation of Powers to the Board of Directors - Regulations and Controls

Under the *Regulations and Control* section of the *Reservation of Powers to the Board of Directors* the adoption of organisational structures is described in the following statement as a decision reserved for the Board:

'Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and to agree any significant modifications.'

In order to support effective and flexible operational management of the organisation, it is **proposed** to add the supplementary information (highlighted in red) to the existing statement:

'Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and to agree any significant modifications. For the purpose of the Scheme of Reservation and Delegation, 'significant modifications' are those in excess of Executive Director's delegated limits.

2. Appendix 2 – Table B – Delegated Financial Limits – Section 1 Charitable Funds

Section 1 of Appendix 2, Table B of the SoRD (detailed below) describes the current delegation arrangements in relation to the management of Charitable Funds

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
1. CHARITABLE FUNDS		
Charitable Spend (designated, restricted and unrestricted)	Up to £1,000	Financial Planning Accountant and Fundraising Manager
	£1,001 - £5,000	Chief Finance Officer & Deputy CEO and Chief Nurse/Deputy Chief Executive
	Over £,5000	Charitable Funds Committee

In order to provide greater assurance and flexibility in relation to the management of Charitable funds the following amendments are **proposed**:

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
1. CHARITABLE FUNDS		
Charitable Spend - Bids (designated, restricted and unrestricted)	Up to £1,000	~~Financial Planning Accountant and Fundraising Manager~~ Director of Communications & Engagement and Financial Planning Manager
	£1,001 - £5,000	~~Chief Finance Officer & Deputy CEO and Chief Nurse/Deputy Chief Executive~~ Executive Management Team and Financial Planning Manager
	Over £5,000	Charitable Funds Committee
Charitable Spend – Grants *Following successful grant applications, funds received can only be spent on the intended purpose in line with the original application.	Up to £5000	Director of Communications & Engagement and Financial Planning Manager
	£5,001 - £50,000	Executive Management Team and Financial Planning Manager
	Over £50,000	Charitable Funds Committee

3. **Appendix 2 – Table B – Delegated Financial Limits – Section 4. Losses & Special Payments #7 Ex gratia payments.**

Section 4. of Appendix 2, Table B of the SoRD (detailed below) describes the current delegation arrangements in relation to ex gratia payments, with **proposed** additions highlighted in red.

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
7. Ex gratia payments in respect of:		
a. loss of personal effects b. clinical negligence with advice c. personal injury with advice d. other negligence and injury e. other employment payments (not including special severance payments which are disclosed below) f. patient referrals outside the UK and EEA Guidelines g. other h. maladministration, no financial loss	up to £500	Ward Manager or Department Manager
	£501 - £1,500	Lead Nurse & Matron/Head of Service/CBU Manager
	£1,501 - £2,500	Associate Chief Nurse/Head of Financial Services
	£2,501 - £5,000	Deputy Chief Nurse/Deputy Chief Finance Officer
	£5,001 - £10,000	Chief Finance Officer & Deputy CEO
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors

4. **Appendix 2 – Table B – Delegated Financial Limits – Section 6.3 Requisitioning Goods and Services and Approving Payments – Capital Expenditure**

Previously the Trust Board agreed to delegate the approval of Capital Funds spend up to £5m to the Finance & Sustainability Committee. Section 6.3 of Appendix 2, Table B of the SoRD has been updated as detailed below to reflect the agreed delegation.

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
6.3 Capital Expenditure Annual capital programme and amendments to the capital programme	n/a	Board of Directors following recommendation by Capital Planning Group supported by Finance and Sustainability Committee
Orders for schemes within the approved capital programme	Up to £5,000,000	~~See section 6.1 Delegated Authority~~ Finance & Sustainability Committee
	Over £5,000,000	Trust Board

5. **Appendix 1 – Table A – Delegated Authority & Appendix 2 Table B Section 10 Contract Award**

Currently the SORD details two different approvals restricted to the approval of a Recommendation Report:

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42. Contract Award Recommendation Reports		
Completion of contract award recommendation reports	Chief Executive Chief Executive	Chief Finance Officer & Deputy CEO Deputy Chief Finance Officer
Approval of contract awards recommendation reports	Chief Executive	Director of Finance & Commercial Development

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10. Contract Award		
Approval of Contract Award Recommendation Reports	up to £50,000	Deputy Chief Finance Officer
	Over £50,000	Chief Finance Officer & Deputy CEO

It is **proposed** that these tables are replaced with a **Table 2** detailing the approval process for both the signing of the Recommendation Report and the signing of the Contract.

Table 2

Contract Award Recommendation Reports and Signing of Commercial Contracts			
	Delegated To	**Delegated Limit**	**Operational Responsibility**
Completion of Contract Award Recommendation Reports	Chief Finance Officer / Deputy Chief Executive	All values	Associate Director of Procurement
Approval of Contract Award Recommendation Reports and the signing of Commercial Contract	Chief Executive	Up to £100,000	Deputy Chief Finance Officer
		Up to £250,000	Chief Finance Officer & Deputy Chief Executive
		Over £250,000	Chief Executive

Currently there is no approval process for the signing of Change Control Notices (CCNs) related to a previously authorised commercial contract. It is recommended that this process is formalised to provide clear details on who can sign CCNs that may have an impact on service and/or budget. **Table 3** outlines the recommendation:

Table 3

Change Control Notices against approved Commercial Contracts			
	Delegated To	**Delegated Limit**	**Operational Responsibility**
*Ratification of the Change Control Notice	Chief Finance Officer / Deputy Chief Executive	All values	▪ Associate Director of Procurement

			▪ Deputy Associate Director of Procurement ▪ Head of Procurement and Performance ▪ Senior Contract Manager
Identification of Budget	Chief Finance Officer / Deputy Chief Executive	All values	Budget Holder
Verification of Budget	Chief Finance Officer / Deputy Chief Executive	All values	CBU Senior Business Accountant
Approval of Change Control Notice	Chief Finance Officer / Deputy Chief Executive	In accordance with the values detailed int the Scheme of Reservation and Delegation *'Requisitioning Good and Services and Approving Payments'*	In accordance with the values detailed int the Scheme of Reservation and Delegation *'Requisitioning Good and Services and Approving Payments'*

*This will be to confirm that the CCN is permissible within the existing contract.

3. Amendments to the Standing Financial Instructions (SFIs)

1. Estates Emergency Orders

To maintain a fully operational site, Estates will, on occasion, be required to undertake emergency repairs which can be within normal operational hours (Monday to Thursday 08:30 – 17:00 and Friday 08:30 – 16:30) or out of hours.

On occasion these will be considered an extraordinary emergency request defined as a requirement to meet an **immediate** need to avoid a regulatory breach and ensure patient, staff and visitor safety. The SFIs determine that orders must be generated for all goods and services (*all goods, services or works are ordered on an official order with the exception of purchases from petty cash or on purchasing cards*). To meet this immediate and urgent need and ensure compliance with SFIs, a change to the SFIs is **proposed** to permit the generation of emergency order numbers that can be provided to the supplier with the requisition raised retrospectively. Use of this process will vary depending upon whether the need arises within normal working hours or out of hours as described below. The financial threshold for emergency requests will be below he capital threshold of £5,000 where the Emergency Capital process will be used.

In-Hours Emergency Requests

- The need is escalated to the Associate Director of Estates and Facilities (or delegated deputy in their absence) to confirm that requirement meets the definition of an extraordinary emergency request that would result in a regulatory breach or risk the health and safety of patients, staff and visitors.

- The Associate Director of Estates and Facilities contacts Procurement confirming that requirement who will then determine if any existing frameworks or current contracts can be utilised to meet the need. It must be noted however, that time would be of the essences and the very nature of the emergency may preclude this.
- In the absence of any contract or framework, Procurement would issue Estates with an emergency order number to provide to the supplier to undertake the work.
- Estates appoint the supplier obtaining an indicative quote for the work and provide the pre-assigned order number to the supplier.
- Supplier completes the work and provides a comprehensive quote within five days of completed of the works.
- Estates submit a retrospective requisition providing full details inclusive of costs of the work undertaken.
- Procurement updates the order and issue a hard copy order to the supplier as a follow-up and against the which the supplier will invoice the Trust within five days of estates providing updated details of works undertaken.

Out of Hours Emergency Requests

Procurement will allocate a maximum of five emergency order numbers to Estates to be used in an out of hour emergency that meets the definition previously described. The process for out of hours is as follows:

- The need is escalated to the Associate Director of Estates and Facilities (or delegated deputy in their absence) to confirm that this meets the definition of an extraordinary emergency request that would result in a regulatory breach or risk the health and safety of patients, staff and visitors.
- The Associate Director of Estates and Facilities assigns a previously allocated emergency order number to the Estates Officer
- Estates liaise directly with known suppliers obtaining an indicative cost for the work to be undertaken.
- Estates appoint the supplier and provide the pre-assigned order number to the supplier.
- Supplier completes the work and provides a compressive quote.
- Estates request an amendment to the order providing full details inclusive of costs of the work undertaken within five days of completed of the works.
- Procurement updates the order and sends the amended order to the supplier within five days of estates providing updated details of works undertaken.

In all circumstances the emergency requests are only for expenditure that fall below the Public Contracts Regulations that the Trust is legally required to comply with. Where the cost exceeds the financial thresholds stated in the SFIs for formal tendering to be undertaken, a retrospective Waiver will be completed and reported to the Audit Committee.

The use of emergency orders will be monitored by the Procurement Team to ensure that they remain within the parameters specified and will be reported to the Finance and Sustainability Committee on a monthly basis.

5. Recommendation

The Executive Management Team are asked to support the changes to the SoRD and SFIs for submission to the Trust Board and note the approved delegation of up to £5m Capital Spend to the Finance & Sustainability Committee.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/35**	
SUBJECT:	**Amendments to the Constitution – Constituencies, Eligibility to be a Governor & Termination of office and removal of Governors**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	John Culshaw, Company Secretary & Emily Kelso Corporate Governance & Membership Manager	
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): ***(Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The Paper sets out the proposal to: • Merge the Runcorn & Widnes public constituencies to form Halton – a reduction of 3 elected public governors • Strengthen sections; Eligibility to be a Governor & Termination of office and removal of Governors	

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

RECOMMENDATION:	The Trust Board is asked to approve the amendments to the Constitution as outlined in the paper to support:
	• the merger of Runcorn & Widnes public constituencies
	• The increase of elected public governors from Rest of England constituency to 2
	• the updates to:
	  ○ Eligibility to be a Governor.
	  ○ Termination of office and removal of Governors	

PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	**COG/23/02/04**
	Date of meeting	16.02.2023
	Summary of Outcome	Recommended for approval by Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Amendments to the Constitution – Constituencies, Eligibility to be a Governor & Termination of office and removal of Governors**	**AGENDA REF**	**BM/23/03/35**

1. BACKGROUND/CONTEXT

The Trust's Constitution states:

45. Amendment of the constitution

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

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

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

2. KEY ELEMENTS

1. Composition of the Council of Governors

ANNEX 3 – COMPOSITION OF THE COUNCIL OF GOVERNORS, *of the Trust's Constitution currently states:*

The Council of Governors consists of:

1. Partnership Governors appointed by:

a) Local Authorities for an area which includes the whole or part of an area of a public constituency;
b) Partnership organisations, including local Universities and voluntary organisations;

2. Elected Governors elected by;

a) Members of the Public Constituency;
b) Individuals within each class of the Staff Constituency.

More than half of the members of the Council of Governors shall be elected by those in 2a above.

Public Constituency	***Number to be elected***
Area 1 Warrington North	*5*
Area 2 Warrington South	*5*
Area 3 Runcorn	*4*
Area 4 Widnes	*4*
Area 5 Rest of England	*1*
Total Elected Governors	***19***

Total Membership of Council of Governors	
Partnership Governors	***6***
Staff Governors	***5***
Elected Governors	***19***
Total	***30***

Historically the Trust has experienced difficulty in receiving sufficient nominations for Governor vacancies in the Widnes and Runcorn public constituencies resulting in vacancies, particularly in the Widnes constituency which is partially attributable to its close proximity to St Helens and Knowsley Teaching Hospitals NHS Trust. Given this, it is recommended that the constituencies are merged to form a Halton public constituency and the number of elected Governors is reduced from 8 to 5.

In addition, and to ensure the Trust still has sufficient public representation from other neighbouring areas and nationally, it is recommended that the number of Governors in the Rest of England constituency is increased from 1 to 2. This supports our commitment to Integrated Care System (ICS) working, by ensuring the WHH Council of Governors are equipped to form a rounded view of the interests of the 'public at large' – as per the updated guidance *System working and collaboration: The role of foundation trust councils of governors – May 2022.*

This means the total number of public Governors will reduce from 19 to 17, still adhering to the requirement stated within **Annex 3**.

> *More than half of the members of the Council of Governors shall be elected by those in 2a above.*

The revised composition is given below:

Public Constituency	**Number to be elected**
Area 1 Warrington North	5
Area 2 Warrington South	5
Area 3 Halton	5
Area 4 Rest of England	2
Total Elected Governors	**17**
Total Membership of Council of Governors	
Partnership Governors	**6**
Staff Governors	**5**
Elected Governors	**17**
Total	**28**

It is expected that this revised composition will enable better representation of the Trust's membership and prevent future vacancies in the Runcorn & Widnes constituencies, whilst still maintaining sufficient public representation on the Council.

2. Council of Governors – Eligibility to be a Governor & *Termination of office and removal of Governors*

The second set of amendments are in relation to *Eligibility to be a Governor* & *Termination of office and removal of Governors*. A review of this section has come about following some challenging

behaviours experienced at other NHS Foundation Trusts across the country, and the difficulties experienced in the exclusion of those Governors.

The additions/amendments are detailed below:

ANNEX 5 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

Eligibility to be a Governor

A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

12. They are a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

13. They are a person to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986;

19. They have been found to be a vexatious complainant, in that, the Board of Directors has unanimously agreed that, he/she has persistently and without reasonable grounds, made any unjustified complaint or requests of the Trust (or any of its staff, agents, patients or carers) causing inconvenience, harassment or expense;

Sections 11, 12 & 18 have been added to strengthen the constitution through best practice.

Termination of office and removal of Governors

8. They are removed from the Council of Governors by a resolution approved by a majority of the remaining Governors present and voting at a general meeting on the grounds that:

~~*d. The council of Governors consider that it s not in the best interests of the Trust for him/her to continue as a Governor.*~~

d. They have caused detriment to the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provision of services;

e. They have failed to discharge his/her responsibilities as a Governor;

9. The Governor concerned will be eligible to make representation, in writing, to the Council of Governors but not to vote on any resolution relating to his/her removal or suspension.

Section 8d has been deleted as removal should only be by resolution approved by the majority based on the grounds stated.

What is now **section 8d&e** have been added based on benchmarking with other NHS FT constitutions nationally in order to promote best practice, openness & transparency, this is also the case for the addition of **section 9.**

3. Impact on the Current WHH Council of Governors

The Trust is currently holding 3 vacancies out of 4 in the Widnes public constituency. By merging Widnes and Runcorn into a single Halton constituency with 5 seats, The Trust maintains the 5 Governors currently in post.

By extending the number of Governors to be elected in the Rest of England public constituency to 2 from 1, the Trust will go forward with 1 vacancy in this constituency, until the November 2023 Governor Elections.

3. ACTIONS AND RECOMMENDATIONS

Following approval by the Council of Governors at its meeting 16th February, The Trust Board is asked to ratify the amendments to the Constitution as outlined in the paper.

Following this the revised version of the WHH Constitution will be published on the Trust website.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/36**	
SUBJECT:	**Disestablishment of Clinical Recovery Oversight Committee (CROC)**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	#224 If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. #1215 If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) 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.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In March 2021 the Trust Board supported the establishment of the Clinical Recovery Oversight Committee (CROC) to be accountable to the Trust for providing oversight, assurance and triangulation in relation to: • Referral to Treatment (RTT) • Patient Cancer Pathways • Diagnostics including Endoscopy and Outpatients • Progress of clinical harm reviews (CHR) The Committee was a temporary Committee established during the COVID-19 pandemic and was accountable to the Board to ensure triangulation of matters detailed above under the purview of the Quality Assurance Committee and the Finance & Sustainability Committee; and ensuring that the organisational risks were managed appropriately in line with professional and regulatory standards. It is now proposed to disestablish the Committee and incorporate the above matters within the remit of the Quality Assurance Committee and Finance & Sustainability Committee as appropriate.	

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

RECOMMENDATION:	The Trust Board is asked to approve the disestablishment of the Clinical Recovery Oversight Committee	
PREVIOUSLY CONSIDERED BY:	**Committee**	Clinical Recovery Oversight Committee
	Agenda Ref.	CROC/23/03/38
	Date of meeting	21st March 2023
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/37**	
SUBJECT:	**Trust Board Cycle of Business**	
DATE OF MEETING:	29 March 2023	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Trust Board Cycle of Business 2023-2024 is presented for approval.	

PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the Cycle of Business 2023/24.			
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Trust Board - Cycle of Business
2023/24

	OWNER	25-Jan 2023	29-Mar 2023	Apr YEAR END	07-Jun 2023	02-Aug 2023	04-Oct 2023	06-Dec 2023	07-Feb 2024	Apr 2024
Engagement story (15 mins)	**CFO&Dep CEO & Head of Patient Experience and Inclusion**	X	X		X	X	X	X	X	X
OPENING BUSINESS										
Chairman's Opening Remarks, Welcome, Apologies & Declarations	**CHAIR**	X	X		X	X	X	X	X	X
Minutes of Previous Meeting & Action Log	**CHAIR**	X	X		X	X	X	X	X	X
Chief Executive's Report *(to include Covid-19 Situation Update)*	**CEO**	X	X		X	X	X	X	X	X
Chairman's Report	**CHAIR**	X	X		X	X	X	X	X	X
QPS ASSURANCE										
Integrated Performance Dashboard incl Monthly Nurse staffing report	**EXECS**	X	X		X	X	X	X	X	X
Refresh of Trust Integrated KPIs (April prior to formal signing in May)	**CFO&Dep CEO**		X							X
PAF/ Review (April prior to formal signing in May)	**CFO&Dep CEO**		X							X
QUALITY										
Annual Complaints Report	**CN&Dep CEO**					X				
Learning From Experience Summary Report	**CN&Dep CEO**	XQ2	X Q3		XQ4		XQ1	XQ2		XQ3
Annual Health & Safety Report	**CN&Dep CEO**					X				
DIPC Report Annual	**CN&Dep CEO**					X				
DIPC Quarterly Report	**CN&Dep CEO**		XQ3		XQ4		XQ1	xQ2		XQ3
Infection Prevention and Control Board Assurance Framework Compliance Bi-anually	**CN&Dep CEO**	X				X			X	
Safeguarding Annual Report	**CN&Dep CEO**					X				
Moving to Outstanding (M2O) Update Report	**CN&Dep CEO**		XQ3		XQ4		XQ1			XQ3
Mortality Review (Learning from Deaths Quarterly Report)	**EMD**		XQ3			XQ4	XQ1	XQ2		XQ3
Medicines Management & Controlled Drugs Annual Report	**EMD**				X					
Annual SIRO Report	**CIO**				X					
Nurse Staffing Bi-Annual report	**CN&Dep CEO**		X				X			X
Violence Reduction Strategy (bi-annually)	**COO**		moved to june		x			X		
Quality Strategy Update	**CN&Dep CEO**				X					
WHH Maternity Services - Compliance with Ockenden	**CN & Dep CEO**	X	X		X	X	X	X	X	X
Perinatal Annual Report	**CN & Dep CEO**				X					
MIS annual submission								X		
Cheshire & Merseyside Quarterly Perinatal Mortality Report	**HoM/Midwifery Safety Champion Lead**		XQ3		X Q4		X Q1	X Q2		X Q3
PEOPLE										
NHS Staff Opinion Survey	**CPO**				X					X
GMC Re-validation Annual Report incl Statement of Compliance	**EMD**						X			
Engagement Dashboard Quarterly Report - CoG	**DC&E**	X Q3			Q4	X Q1		X Q2		XQ3
Engagement Dashboard Year End Report - CoG	**DC&E**				X					
Two year Patient and Public Participation and Involvement (PPP&I) Annual Report - check Kate	**DC&E**				X					
Patient and Public Participation + Involvement Strategy Review - - check Kate	**DC&E**				X					

Guardian of Safe Working Quarterly Report	**EMD**		X Q3		X Q4	X Q1		XQ2		XQ3
Freedom To Speak Up – Guardian Bi-annual Report (Jane Hurst)	**CN&Dep CEO**		X				X			X
Hospital Volunteer Annual Report	**CN&Dep CEO**				X					X
Patient Experience Strategy Annual Review	**CN&Dep CEO**				X					X
Organisation Chart	**CEO**	X			X			X		x
SUSTAINABILITY										
Operational Plan & Budgets Approval	**CFO&Dep CEO**		X							X Final
Annual Capital Programme	**CFO&Dep CEO**		X							X
Emergency Preparedness Annual Report	**COO**					X				
EPRR Assurance Letter/Statement of Compliance	**COO**						X			
Strategy Update Report (Bi-Monthly)	**Director of Strategy & Partnerships**		X		X	X	X	X	X	X
Trust Strategy 2023-25	**Director of Strategy & Partnerships**		X DRAFT		X FINAL					
Use of Resources Annual Report	**CFO&Dep CEO**				X					
COMMITTEE ASSURANCE REPORTS										
Audit Committee	**CO SEC**		X		X		X	X		X
Quality Assurance Committee	**CN&Dep CEO**	X	X		X	X	X	X	X	X
Finance & Sustainability Committee	**CFO&Dep CEO**	X	X		X	X	X	X	X	X
Strategic People Committee	**CPO**	X	X		X	X	X	X	X	X
YEAR END										
Annual Report & Accounts Sign Off (inc Quality Account)	**CFO+Dep CEO/**			X						
	CN&Dep CEO									
Code of Governance Compliance & Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors – due end of May annually	**CO SEC**			Yr End Audit						
Code of Governance Compliance & Compliance with Licence Annual Return – completion of Cos7 - due end of June annually	**CO SEC**				X Cos7					
Code of Governance Compliance & Compliance with Licence Annual report (for Year End / Audit Committee)				Yr End Audit						
GOVERNANCE										
Strategic Risk & BAF Update	**CO SEC**	X	X		X	X	X	X	X	X
Annual Review of BAF & Risk Appetite Statement									X	
Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	**DOF**		X							X
Risk Management Strategy Annual Report	**CN&Dep CEO**					X				
Board Annual Cycle of Business	**CO SEC**		X							X
Board Sub-Committee Cycle of Business for Ratification	**CO SEC**	QAC & SPC	AC, FSC & CFC						QAC & SPC	AC, SPC & CFC
Board Sub-Committee ToRs for ratification	**CO SEC**				SPC, QAC & FSC				QAC	AC2022&2024
Charitable Funds Committee Governing Document (next March 2024)	**CHAIR/TRUST SEC**								X	
Charities Commission Checklist (annually)	**DC&E**					X				
WHH Charity Annual Report	**DC&E**						X DRAFT	X FINAL		
Digital Board Report	**EXEC MED DIRECTOR**	X	X		X	X	X	X	X	X
Committee Chairs Annual Reports:										
Quality Assurance Committee Annual Report	**CHAIR**					X				
Finance & Sustainability Committee Annual Report	**CHAIR**				X					
Audit Committee Annual Report	**CHAIR**						X			

Strategic People Committee	**CHAIR**				X					X
Clinical Recovery Oversight Committee	**CHAIR**				X					
CLOSING BUSINESS										
Any other business & Date of next meeting	**CHAIR**	X	X		X	X	X	X	X	X

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/23/03/38**			
SUBJECT:	**Committee Cycles of Business 2022-2023 :** • **Audit Committee** • **Charitable Funds Committee**			
DATE OF MEETING:	29 March 2023			
AUTHOR(S):	John Culshaw, Trust Secretary & Emily Kelso Corporate Governance & Membership Manager			
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.	x x x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Cycle of Business for the; • Charitable Funds Committee (CFC) • Audit Committee (AC) have been reviewed and approved by the respective committees and are recommend to the Trust Board for approval.			
PURPOSE: ***(please select as appropriate)***	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2022-2023 Cycle of Business for the Strategic People Committee and Audit Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee & Audit Committee		
	Agenda Ref	CFC 23/03/11 & AC 23/02/20		
	Date of meeting	9th March 2023 & 23 Feb 2023		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

AUDIT COMMITTEE – CYCLE OF BUSINESS
2023-24

AGENDA ITEMS	OWNER	2023					2024
		17-Feb	27-Apr	21-Jun (YEAR END)	18-Aug	17-Nov	23-Feb
OPENING BUSINESS							
• Welcome, apologies, declarations of interest, cycle of business	**CHAIR**	X	X	X	X	X	X
• Review Minutes and Action Log	**CHAIR**	X	X		X	X	X
• Review rolling attendance log	**CHAIR**	X	X		X	X	X
• Approve Chair's key issue report items for escalation (post meeting)	**CHAIR**	X	X		X	X	X
QPS ASSURANCE							
• Update from Chairs of F&SC QAC CFC SPC	**TA/MB/CR/JJ**	X	X		X	X	X
• Changes or Updates to BAF	**Company Secretary**	X	X		X	X	X
INTERNAL AUDIT							
• Internal Audit Plan & Fees	**MIAA**	X					X
• Progress Report on Internal Audit follow-Up actions	**CFO & Deputy CEO**	X	X		X	X	X
• Internal Audit Progress Report on Follow-Up actions	**MIAA**	X			X		X
• Internal Audit Progress Report	**MIAA**	X	X		X	X	X
• Head of Internal Audit Opinion	**MIAA**		X				
• Internal Audit Charter Annual Report	**MIAA**		X				
EXTERNAL AUDIT							
• External Audit Plan & Fees	**GT**	X	X				X
• Report and Updates from External Audit	**GT**	X	X		X	X	X
• Annual Audit Letter (AC following year-end Audit Cttee)	**GT**				X		
• Renewal/Refresh of External Audit Contract (at term)	**GT/AMcG/JC**				X		
COUNTER FRAUD							
• **FINAL** Annual Counter Fraud Plan	**MIAA**		X				
• Counter Fraud Progress Updates	**MIAA**	X	X		X	X	X
• Annual Counter Fraud Annual Report	**MIAA**		X				
FINANCE							
• Review Losses & Special Payments	**CFO & Deputy CEO**	X	X		X	X	X
• Review Quotation and Tender Waivers of Standing Financial Instructions	**CFO & Deputy CEO**	X	X		X	X	X
• Going Concern Report	**CFO & Deputy CEO**		X				
QPS GOVERNANCE AND COMPLIANCE							
• Annual report and accounts timetable and plans	**CFO & Deputy CEO**	X					X

• **Draft** Annual Governance Statement	**Company Secretary**		X				
• **Draft** Annual Report	**CEO**		X				
• **Draft** unaudited Accounts & Financial Statements	**CFO & Deputy CEO**		X				
• Annual Report	**CEO**			X			
• Quality Account	**Dir Integrated Gov**			X			
• **Draft** Annual accounts accounting policies	**CFO & Deputy CEO**	X					X
• **FINAL** and Audited Accounts & Financial Statements	**CFO & Deputy CEO**			X			
• Review of Schemes Reservation & Delegation (SoRD) & Standing Financial Instructions (SFIs)	**CFO & Deputy CEO/Company Secretary**	X	X		X	X	X
• Head of External Audit Opinion Statement	**GT**			X			
• Review other reports and policies as appropriate – e.g. changes to standing orders – as arise, Freedom to Speak Up • Conflict of Interest Policy January 2024/Anti- Fraud Policy August 2023/Treasury Management Policy Aug 2023	**ALL**					FTSU Policy	
• Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors Annual Report	**Company Secretary**			X			
• Risk Management Annual Report update	**Dir Integrated Gov**				X		
• Code of Governance Compliance Declaration – e.g. changes as required	**Company Secretary** ***(as req'd)***						
• Review of Trust Registers (e.g. Conflicts of Interest)	**Company Secretary**		X				
• Terms of Reference x 2 years (due Feb 2022 + Feb 2024)	**Company Secretary**						
• Cycle of Business Annual Review	**Company Secretary**	X					X
• On-Call Annual Update Report	**Chief People Officer**				X		
• Overtime Annual Update Report	**Chief People Officer**				X		
• NW Skills Development Bi-Annual Report	**CFO & Deputy CEO**	X			X		X
• ICON Programme Bi-Annual Report	**CFO & Deputy CEO**	X			X		X
EFFECTIVENESS							
• Committee Chairs Annual Report for Board & Council of Governors	**CHAIR**				X		
• Committee meeting effectiveness - annual review	**CHAIR**				**X (rep Nov)**	X	
DEEP DIVE REVIEWS							
• Commission and receive ANY additional scrutiny projects	**Dir Integrated Gov** ***(as req'd)***						
CLOSING							
• Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually	**CHAIR**	X			X		X
• Any Other Business	**CHAIR**	X	X	X	X	X	X

Charitable Funds Committee Cycle of Business 2023- 2024

	Exec Lead			Mar 2023	June 2023	Sept 2023	Dec 2023		March 2024
INTRODUCTION & ADMINISTRATION									
Apologies for Absence	Chair			X	X	X	X		X
Declarations of Interest	Chair			X	X	X	X		X
Minutes of the Last Meeting	Chair			X	X	X	X		X
Matters Arising+ Action Log	Chair			X	X	X	X		X
Rolling attendance	Chair			X	X	X	X		X
FUNDRAISING									
Fundraising Report + 1/4ly workplan	Director of Communications + Engagement			X	X	X	X		X
Charitable Funds Strategy	Director of Communications + Engagement			X					X
Annual Operational Plan	Director of Communications + Engagement			X					X
FINANCE									
Finance Report	Chief Finance Officer + Deputy CEO			X	X	X	X		X
Bid applications	Director of Communications + Engagement			X	X	X	X		X
Investment Strategy/update	Chief Finance Officer + Deputy CEO			X					X
Annual Review of Reserves Policy	Financial Planning Accountant				X				
Investment Guidance Annual update	Financial Planning Accountant			X					X
GOVERNANCE & COMPLIANCE									
Governing Document (Due Sept 23)	Chair/Trust Secretary				X				
Cycle of Business	Chair/Trust Secretary			X					X
Charities Commission Checklist	Director of Communications + Engagement				X		X		
Charity Risk Register	Director of Communications + Engagement			X	X	X	X		X
Risk Strategy	Director of Communications + Engagement				X				
Annual Report and Accounts	Chief Finance Officer + Deputy CEO					Draft	FINAL		
Committee Chair's Annual Report to Board	Chair					X			
Committee Effectiveness Annual Review	Chair/Trust Secretary			X Circulate Report to June	X Receive				X Circulate Report to June
Committee Effectiveness Progress Report	Chair/Trust Secretary						X		
CLOSING									
Key issues to the Board	Chair			X	X	X	X		X
Any Other Business	Chair			X	X	X	X		X

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/39**	
SUBJECT:	**Draft Performance Assurance Framework Review 2023/24**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	Bethan Thompson, Senior Performance and Systems Development Lead	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer & 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.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer, and ED Performance. **#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	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually. Proposed updates to the PAF for 2023/24 are: • Introduction of the Operational Management Sub-committee (OMS), led by the Chief Operating Officer, to replace the KPI Sub-Committee.	

	• Review of the Quality People and Sustainability (QPS) Terms of Reference, via a time limited QPS Review Working Group. • Minor amendments to the purpose of the Integrated Performance Report (IPR) **(section 3.1.1)** to move away from RAG rating and towards Statistical Process Control Charts (SPCs). • Updates to reflect changes to the organisation including team names and job titles.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the amendments to the PAF as part of the annual refresh.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	**FSC/23/03/50**		
	Date of meeting	22nd March 2023		
	Summary of Outcome	Update to be provided by the Chair of Finance & Sustainability Committee		
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Annual KPI Review & Refresh (Access & Performance and Finance & Sustainability)**	**AGENDA REF:**	**BM/23/03/39**

1. BACKGROUND/CONTEXT

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually.

The Executive Team has considered the effectiveness of the PAF and current accountability structure. The Executive team is proposing a number of amendments to the current PAF. These changes are laid out in section 2 of the report.

2. KEY ELEMENTS

The following amendments are being proposed to the PAF and have been incorporated into the draft updated PAF in **Appendix A.**

- The introduction of an Operational Management Sub-committee (OMS) led by the Chief Operating Officer. This will replace the current KPI Sub-Committee. A Terms of Reference is currently being drafted. The OMS will perform the same function as the KPI Sub-Committee and will review performance at Care Group/CBU level, however, the membership of the OMS will be wider than the KPI Sub-committee and will include Estates and Emergency Preparedness, Resilience and Response (EPRR), which fall within the COO's Portfolio. There will be a monthly standing Agenda item on the Executive Team Meetings whereby the COO will escalate any performance issues by exception.

- The QPS terms of reference, agenda and performance reporting format will be reviewed, via a time limited QPS Review Working Group to ensure QPS remains fit for purpose, receives performance reporting by exception and is triangulated to reflect the requirements of the Trust Board.

- Amendments have been made to the Integrated Performance Report (IPR) **(section 3.1.1)** to reflect that the Trust has moved away from the use of RAG ratings and now uses Statistical Process Control Charts (SPCs) and targets to measure performance. These changes were agreed by the Trust Board in 2022/23.

- The PAF has been updated to reflect changes to the organisation including team names and job titles.

3. RECOMMENDATIONS

The Trust Board is asked to approve the amendments to the PAF as part of the annual refresh.

Appendix A

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Performance Assurance Framework – Update for March ~~2022~~2023

Performance Assurance Framework

1. Introduction

1.1 Background

This Performance Assurance Framework (PAF) sets out principles of accountability and the commitment by Warrington & Halton Teaching Hospitals NHS Foundation Trust to establish, maintain and provide assurance of effective systems and processes for managing and improving performance across all levels of the Trust. The PAF was developed to provide clarity of accountability and subsequently assurance from 'Ward/Department to Board'. This is underpinned by a focus on health outcomes for patients and the community. The PAF supports the Trust's ambition of being "Outstanding".

1.2 What is Performance Measurement?

The Trust has many different processes for measuring performance at every level of the organisation. Measuring performance via dashboards, reports and systems is vital for ensuring our services are operating in line with National and Local standards. Measuring performance gives an early indicator of potential risks which can be resolved before they become an issue.

1.3 What is Performance Management/Improvement?

Performance management is about ensuring the delivery of timely, high quality, effective and safe patient care by using Trust resources in an efficient manner. This includes understanding how the Trust is performing, reasons for variation, and barriers to improvement. Once this is understood, actions can be planned and delivered in order to make improvement.

1.4 Scope

The PAF covers all performance requirements set out in the Trust's Operational Plan, NHSE/I System Oversight Framework, NHS Standard Contract, NHS Operational Planning Guidance, by the CQC and the Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff make to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust performance management policy/incremental pay progression policy.

1.5 Dependencies

The successful implementation of the PAF is dependent upon the production of information dashboards and reports by the Trust's Digital Analytics Team as well as Operational services who managed their own reporting processes (e.g., Theatres, Pathology, Radiology) and the timely supply of data by the Trust's Finance, Quality and HR teams.

1.6 Associated Polices and Strategies

Whilst the PAF incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures in place that will contribute to the delivery of this Framework.

2. Role and Function of the Performance Assurance Framework

2.1 Main Purpose

This PAF sets out the approach the Trust undertakes in ensuring there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating and appropriate actions will be implemented to bring performance back to an acceptable level. The PAF:

- Sets out clear lines of accountability and responsibility for delivery of performance from 'Ward/Department to Board'.

- Support the principle that all staff have a responsibility to contribute towards improving performance of the organisation and everybody should take ownership.
- Create clear understood accountabilities and oversight.
- Ensure performance objectives are agreed and transparent measurements are set to monitor performance against objectives.
- Ensure performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity.
- Provide assurance to the Board, Governors, Regulators, Stakeholders/Partners and the Public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Support the achievement of the Trust objectives.
- Support the delivery of the requirements of the Trust Foundation Licence, NHSE/I System Oversight Framework and the NHS Standard Contract.
- Provide focus on and assurance of best value for money ensuring that services meet the needs of the local population and local health economy.
- Support the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care.
- Recognise good performance and improvement and share good practice.
- Set out the process for managing performance risks/issues with a balance between challenge and support.

In 202~~32~~/2~~43~~, as the Integrated Care Systems & Boards (ICSs) & (ICBs) develop and mature, additional changes to the PAF may be required.

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3. Our approach to Performance Management

3.1 Ward to Board Accountability Structure

The accountability structure provides a line of sight from "Ward/Department to Board" and "Board to Ward/Department" as set out in **Appendix 1** and is detailed as follows:

3.1.1 Trust Board Level

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with an explanation about performance issues from relevant Executive Directors. The Trust Board may subsequently request one or more performance improvement actions (see 3.3.2) where there is variation with any area of performance.

The Integrated Performance Report (IPR) and the Care Group/CBU IPR are produced by the Trust Contracts & Performance Team with support from Finance, Quality, Governance, Digital Analytics and HR. The format of the IPR and Care Group performance reports have been designed to ensure:

- That information is presented in a way which supports an informed discussion by the Board about achieving improvement. This will include the triangulation of data to identify trends and areas considered to be an outlier in terms of performance.
- That the commentary presented by the respective Executive, along quantitative performance data, both explains current performance and identifies the actions that are being taken to provide assurance of continual improvement in quality, safety and performance.

KPIs within the Board IPR are reviewed and agreed at least annually by Board Committees with approval from the Trust Board. KPIs may be changed in year with the minuted support of the appropriate Board Committee and the approval of the Trust Board.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

- Exception Report – the front section of the document is an exception report which summarises all KPIs by both Assurance and Variation Category. This is followed by a report of KPIs consistently failing to meet set targets, and KPIs indicating special cause variation of a concerning nature.~~highlights KPIs which have been RAG rated Red as well as any movements in KPIs month to month~~. This section also contains additional information around the Trust's Financial Performance including the capital programme.
- ~~RAG Movements – this section shows a rolling 12 month RAG (Red, Amber, Green) rating and the movement in performance against each KPI.~~
- Assurance and Variation Movements – this section details areas of special cause variation across all KPIs using Statistical Process Control (SPC) Assurance and Variation Icons (supported by NHSE/I as part of the "Making Data Count" initiative). Also detailed is whether KPIs are achieving their set Targets.
- Dashboard – The dashboard details current and historic levels of performance, reasons for underperformance and/or performance deterioration and detail of actions and investigations underway in order to improve performance against the KPI. The dashboard contains Statistical Process Control charts which look at data over time to determine if a process is within control or not, or whether there is special cause variation which requires action. ~~These charts are used alongside traditional RAG ratings to identify areas of focus.~~

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There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which is facilitated by the Mersey Internal Audit Agency (MIAA).

3.1.2 Board Committees (Finance & Sustainability, Quality Assurance, Strategic People, Clinical Oversight Recovery)

Executive Directors and Senior Managers will present updates on performance relative to the Committee remit as appropriate and in addition to the bi-monthly IPR discussed at the Board. The Committee may request one or more performance improvement actions (see 3.3.2) where there is a variation with any KPI. The Committee will escalate any performance variation or highlights to the Trust Board as appropriate via the committee Chair's 'Issues' report.

Each Committee receives regular performance reports as part of its agenda. The KPIs contained in the Committee reports can be changed by approval of Committee members as there may be occasions where the Committee wants to report at a more granular level of detail. Any changes to KPIs need to triangulate to the Trust Board IPR. All changes must be minuted to include the rationale for the change.

3.1.3 Operational Management Sub Committee

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An Operational Management Sub Committee (OMS) will be established to replace the KPI Sub-committee. The OMS will be chaired by the Trust Chief Operating Officer (COO). The OMS will perform the same function as the KPI Sub Committee and will review performance at Care Group/CBU level, however, the membership of the OMS will be wider than the KPI Sub Committee and will include Estates and Emergency Preparedness, Resilience and Response (EPRR), which fall within the COO's Portfolio.

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The OMS may request one or more performance improvement actions (see 3.3.2) for any areas of concern. There will be a monthly standing agenda item on the Executive Team meetings whereby the COO will escalate any performance issues by exception.

The OMS receives the Care Group/CBU level IPR. The OMS may approve amendments to the Care Group/CBU Level IPR with a minuted rationale. KPIs at Care Group/CBU level should triangulate with the Trust Board IPR, however the OMS may monitor additional indicators at a more granular level to understand performance in-depth.

A Terms of Reference is currently being drafted to establish the terms of the new group.

~~***3.1.3 KPI Sub-Committee***~~

~~*The KPI sub-committee chaired by the Trust's Chief Operating Officer will review performance at Care Group/CBU level. The sub-committee may request one or more performance improvement actions (see 3.3.2) for any areas of concern. The KPI sub-committee will escalate to the Executive Team as appropriate.*~~

~~*The KPI sub-committee receives the Care Group/CBU level IPR. The KPI sub-committee may approve amendments to the Care Group/CBU Level IPR with a minuted rationale. KPIs at Care Group/CBU level should triangulate with the Trust Board IPR, however the KPI sub-committee may monitor additional indicators at a more granular level to understand performance in-depth.*~~

~~*CBU performance maybe monitored at other sub-committees/groups such as the Finance Resource Group (FRG) and local governance, HR and Finance meetings as appropriate.*~~

3.1.4 QPS Executive Team Review at Care Group Level

The Quality Performance and Sustainability (QPS) Executive Team Review is chaired by the CEO where a review of each Care Group's performance is undertaken. Discussions will take place to understand any barriers to performance improvement or reasons for variation and will look at any additional support required to address these barriers. The Care Group Triumvirate will be required to attend this forum twice a year and present their position, highlighting any areas of variation, as well as areas of improvement and good practice which can be shared across the Trust. This will form part of the Trust Learning Framework. Actions from the forum will be recorded by a member of the Performance Team. If urgent actions are required, the Care Group will provide an update to the next available Executive Team meeting and will not wait until their next bi-annual review.

Prior to the QPS review, the Care Group Triumvirate with support from the Performance Team will prepare a set of slides which contains information relating to performance issues by exception, in relation to Quality & Governance and Operational Performance (Quality), People (People) and Finance (Sustainability), that is triangulated to reflect the requirements and focus of the Trust Board. The slides will also include progress around priorities identified in business plans which in turn supports delivery of the CBU/Care Groups Strategy. A time limited QPS Review Working Group will take place during March and April 2023, to review the QPS Terms of Reference and ensure the QPS remains fit for purpose. ~~service level strategies and will also focus on the areas of performance around; Quality & Governance and Operational Performance (Quality), People (People) and Finance (Sustainability). The report will also include information about current issues, risks challenges and future plans. The slides will be designed to facilitate discussion.~~

The Executive Team may request one or more performance improvement actions (see 3.3.2) where there are any areas of variance. The Executive Team will escalate to the appropriate Board Committee or the Trust Board if it feels necessary to do so.

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The Executive Team may ask Care Groups to attend Executive Team meetings at any time outside of the review process where there is a potential performance issue.

3.1.5 Leadership Observational Rounds ~~(Draft)~~

Non-Executive & Executive Leadership Observational rounds ~~are currently being proposed for 2022/23~~have been in place since 2022/23, and ~~which will~~ focus on positive interactions, celebrating~~e~~ success, and utilising~~e~~ CQC Red Flags to guide key lines of enquiry with the goal of improvement. Leadership Observational Rounds may also utilise performance variation to guide key lines of enquiry. The Leadership Observational Rounds ~~will~~ take place 6 times per year and feedback will be collated as evidence as part of the CQC well led domain. ~~Leadership Observation Rounds are under development and as these mature throughout 2022/23, the role and function of these observations in relation to performance may change.~~

3.1.6 Care Group/CBU Level

The Care Group & CBU Triumvirate is expected to manage the performance of their services and have appropriate structures/forums in place to do so. The Care Groups & CBUs will be able to access performance information to enable them to monitor and manage performance in real time. Care Groups & CBUs are required to take corrective action to improve areas of underperformance, working with corporate services and other Trust departments as appropriate. Care Groups & CBUs should escalate any areas of performance variance to the appropriate forum. The Care Groups & CBU Triumvirates may request one or more performance improvement actions (see 3.3.2) for an individual Ward, Department, Service or Team where there are any areas of variation.

3.1.7 Ward, Department, Service or Team Level

Ward/Department/Service/Team managers will be able to access appropriate performance reports at that level in order to ensure they are managing day to day performance. Wards/Departments/Services/Teams are accountable to the CBU Triumvirate, who will provide any support, along with corporate services as necessary.

The production of quality, meaningful and timely performance information is fundamental to the delivery of the PAF. Information must be timely, accurate and complete; and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

3.2 Roles & Responsibilities

Specific roles and responsibilities in relation to the ongoing monitoring, management, and improvement for the performance of the Trust are as follows:

3.2.1 Chief Executive

The Chief Executive has overall corporate responsibility for performance across the Trust.

3.2.2 Executive Directors

Executive Directors have delegated authority, responsibility, and accountability for the areas within their portfolio for ensuring effective performance management structures, systems and processes are in place for reporting, managing and improving performance with robust arrangements in place for addressing performance concerns.

3.2.3 Chief Finance Officer & Deputy Chief Executive

In addition to responsibilities outlined in 3.2.2, The Chief Finance Officer & Deputy Chief Executive has delegated authority for ensuring the overarching Performance Assurance Framework is in place and Executive oversight of the Performance Team activities outlined in 3.2.4.

3.2.4 Contracts, Performance and Commercial Developments Team
The Contracts, Performance and Commercial Developments Team is responsible for the management, production and development of the Trust and Care Group/CBU IPR as well as the management of the QPS Executive Team Review process. The Performance Team is the gatekeeper of the IPR and is responsible for ensuring any changes are approved via the appropriate governance process and once approved are actioned.

The Contracts, Performance and Commercial Developments Team will provide training to the Care Groups & CBUs so that all staff have sight and understanding of the performance KPIs they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.2.5 Digital Analytics Team
The Digital Analytics Team will develop, generate and publish the necessary local reports and dashboards to enable the Care Group/CBU/Teams to monitor and manage performance and will provide data for the Trust and Care Group/CBU level IPRs.

3.2.6 Corporate Services
Corporate services (Finance, Governance, HR, IM&T, Strategy) has responsibility for the production and validation of data for Trust, Care Group & CBU IPR dashboards. Corporate services will provide the necessary support to Care Group/CBUs in order to improve performance in their area.

3.2.7 Care Group Triumvirates
The Care Group Triumvirates has responsibility and accountability for the management and improvement of performance for their CBUs and will implement appropriate performance improvement actions (see 3.3.2). Care Group Triumvirates will hold CBU Triumvirates accountable for the delivery of performance KPIs at CBU level.

3.2.8 CBU Triumvirates
The CBU Triumvirates has responsibility and accountability for the management and improvement of performance for their CBU and will implement appropriate performance improvement actions (see 3.3.2). Each CBU triumvirate will, in turn, hold individual service managers, clinical matrons, specialty leads and, where applicable, Professional Heads of Service, accountable for the delivery of performance KPIs at specialty and service level.

3.2.9 Ward/Department/Service/Team Managers
The Ward/Department/Service/Team managers have responsibility for the management and improvement of performance for their Ward/Department/Service/Team and will implement any improvement actions requested by the CBU Triumvirate.

3.2.10 All Staff
All members of staff contribute to managing and improving performance and are encouraged to suggest areas for improvement and ideas on how improvement can be made. All staff should have an understanding of how their role contributes to performance of the Trust and the impact this has on patient care.

3.3 Performance Risks/Issues

Where there is a risk to the Trust achieving a standard or target or where performance has deteriorated or is an outlier against a benchmark , this should be highlighted as a performance risk/issue and must be detailed as necessary on relevant risk registers All actions and interventions relating to performance risk/issues will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support, recognising any organisation wide resource needs.

3.3.1 Identification and Management

A performance risk/issue can be identified by any member of staff at any level of the organisation ("Ward/Department to Board").

Where a performance risk/issue has been identified, it is the responsibility of the Performance Oversight Group outlined below to oversee appropriate actions in order to resolve the issue as soon as possible.

Performance Issue/Risk Area	Performance oversight Group	Support
Ward, Department, Service or Team Level	CBU Triumvirate	Corporate Services
CBU Level	Care Group Triumvirate Operational Management Sub - Committee ~~KPI Sub-Committee~~ Executive Team	
Trust Level	Executive Team Finance & Sustainability Committee Strategic People Committee Quality Assurance Committee Clinical Oversight Recovery Committee Trust Board	

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3.3.2 Performance Improvement Actions

A. Informal

Some low/medium level performance issues/risks may be managed locally by reviewing processes and making the necessary operational changes. These performance risk/issues may be as a result of a temporary local issue such as a staff shortage or an unexpected increase in demand. In the first instance, these performance issues should be managed and resolved locally with the appropriate authority to do so.

B. Remedial Action Plan

Where a performance risk/issue cannot be resolved in the short term and it is likely to have a medium to long term impact on Trust performance, the Performance Oversight Group may request a Remedial Action Plan. The Remedial Action Plan will outline actions to be taken, impact, timescales and review timescales and will be reviewed at an appropriate forum each month. Once the performance oversight group is satisfied that the actions are complete and performance has returned to a satisfactory level, the Remedial Action Plan will be closed.

C. Deep Dive Review

The relevant Performance Oversight Group may request at any time a deep dive into areas where there is a continued performance concern. The Performance Oversight Group will set out terms of reference including timescales. Once the review has been concluded, the Performance Oversight

Group will agree next steps this may include setting quality improvement metrics, trajectories for improvement, further investigations, the implementation of a Remedial Action Plan or the establishment of an Improvement Group.

D. Improvement Group

Where performance issues/risks need additional support in order to return to satisfactory levels, a time limited Improvement Group will be established. The Improvement Group will be made up of representatives from corporate and clinical services as appropriate and will be sponsored by an appropriate Executive Director or Senior Manager and will report progress to the Performance Oversight Group.

E. Intensive Support

Where performance has not returned to a satisfactory level after the required support has been provided, the Performance Oversight Group may place a Care Group, CBU or Team into Intensive Support. Intensive Support is a recovery planning and delivering procedure and is a mechanism to direct additional management focus. The performance oversight group will write to the Care Group/CBU/Team to inform them of the decision and will outline the reasons this action has been taken. The Care Group/CBU/Team will be expected to report weekly to the Performance Oversight Group actions taken to improve performance and the impact this has had. This effort will be supported by appropriate corporate resources. The Care Group/CBU/Team will remain in Intensive Support until the performance issue has been resolved. Once the performance oversight group is satisfied that the performance issue has been sufficiently addressed, the performance oversight group will write to the Care Group/CBU/Team to inform them of the decision to bring them out of Intensive Support.

The Intensive Support procedure may be deployed in the following circumstances:

- Where there are continued and persistent performance issue in one or more areas.
- Where there is an ongoing risk to patient safety which has not been addressed, effective delivery of services or any other reasons where it is judged that the level of support is justified by the performance oversight group.
- Where delivery levels against operational performance targets is inadequate as determined by the Performance Oversight Group, where no robust plan has been agreed.
- Failure to operate within the financial parameters outlined without a legitimate reason or evidence of lack of financial controls.
- Any other circumstances where it is assessed that a risk exists which cannot be resolved via normal line management actions or where less intensive recovery actions have failed.

A summary of improvement groups and intensive support provision will be reported to the relevant board committee.

4. Structure and Governance to ensure delivery

4.1 Accountability, Responsibility and Reporting Structure

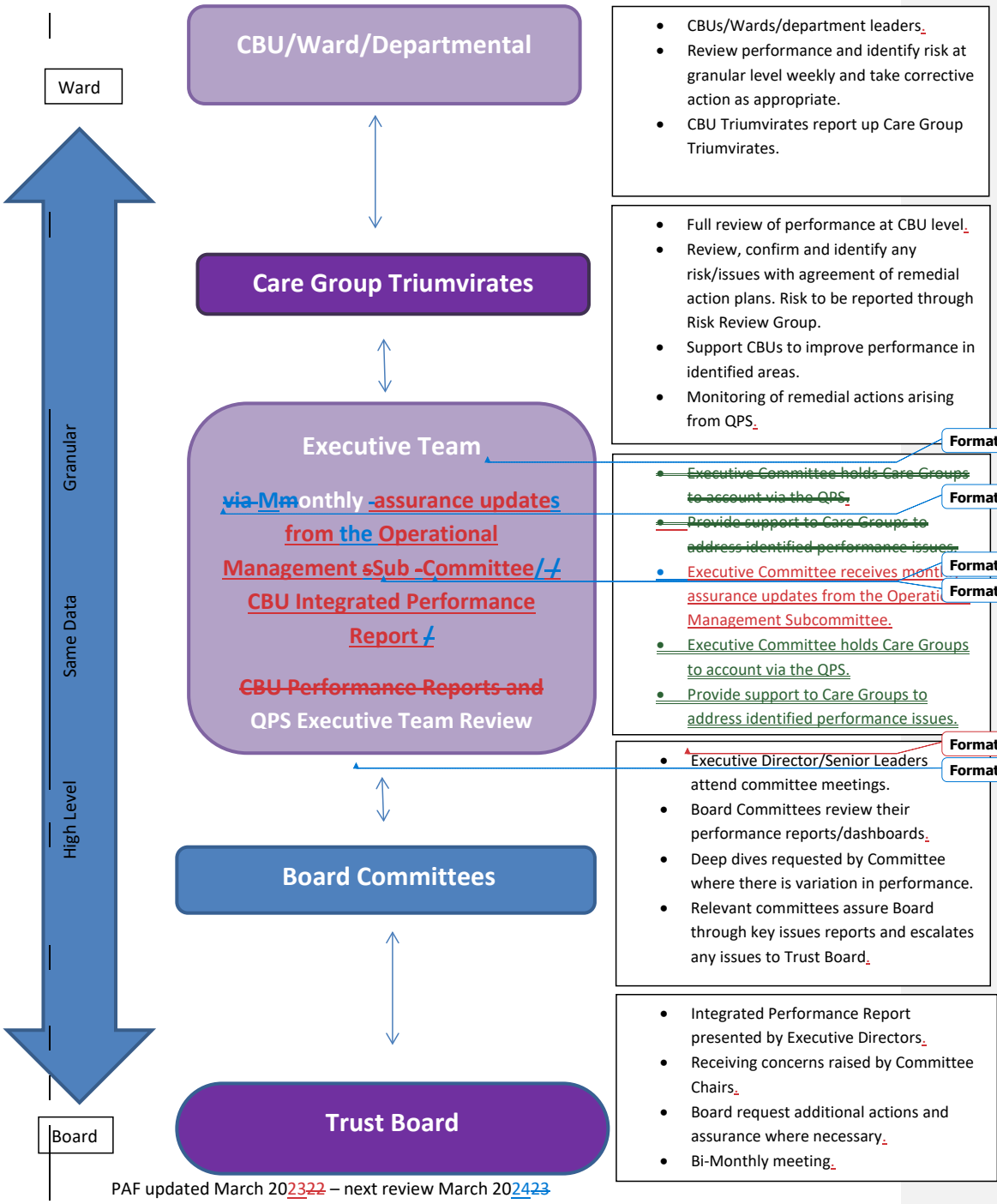
Appendix 1 sets out the Trust's Accountability, Responsibility and Information reporting structure. Each meeting will have a Terms of Reference, setting out clear roles and responsibilities, objectives and membership and the devolved responsibilities from Board to Ward.

5. Next Steps

This Performance Assurance Framework will be reviewed in March 20242~~3~~ as part of the annual planning cycle. The PAF will be reviewed and updated as appropriate as new guidance emerges in year.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 - Trust Accountability, Responsibility and Information Reporting Structure – "Ward/Department" to Board



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PAF updated March 20232022 – next review March 20242023

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/03/40**	
SUBJECT:	**Annual KPI Review and Refresh**	
DATE OF MEETING:	29th March 2023	
AUTHOR(S):	Bethan Thompson, Senior Performance and Systems Development Lead Kimberley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive Ali Kennah, Deputy Chief Nurse Michelle Cloney – Chief People Officer Jennie Dwerryhouse – Deputy Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Janet Parker, Associate Director of Finance - Strategy Dan Moore - Chief Operating Officer Zoe Harris, Director of Operations and Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer & 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.	X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer, and ED Performance. **#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.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust Integrated Performance Report (IPR) Dashboard 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. This paper outlines recommendations for new indicators and updates to existing indicators for Access and Performance, Quality, Workforce and Finance Sustainability and key performance indicators (KPIs).			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the proposed amendments to the IPR Dashboard for 2023/24.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	FSC/23/03/51		
	Date of meeting	22nd March 2023		
	Summary of Outcome	Update to be provided by the Chair of Finance & Sustainability Committee		
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Annual KPI Review and Refresh	AGENDA REF:	BM/23/03/40

1. BACKGROUND/CONTEXT

In April 2017, the Trust Board approved the implementation of the Performance Assurance Framework (PAF) which sets out the approach for ensuring effective systems are in place for monitoring, managing, and improving Trust performance.

As part of the introduction of the PAF, the Trust implemented the Integrated Performance Report (IPR) dashboard which brings together indicators from a range of sources including Contractual Standards, CQC Insight Indicators and Indicators relating to the NHSE/I System Oversight Framework. This dashboard provides assurance and oversight of performance at Trust Board level.

All IPR indicators are reviewed at least annually to ensure they remain relevant and up to date and to introduce any new indicators which are required.

This paper outlines recommendations for updates to indicators relating to Quality, Access and Performance, Workforce and Finance. The FSC is asked to support these changes, after which the Trust Board will be asked to provide approval.

2. KEY ELEMENTS

The Contracts & Performance Team has met with Executive and Operational leads to review current indicators and to ascertain requirements for new indicators. In addition, the 2023/24 draft NHS Standard Contract and NHSE Oversight Framework have been reviewed to understand changes which may affect performance monitoring. The recommendations outlined have been supported by the relevant committees and are show in **Tables 1, 2 & 3.**

Removed Indicators

Table 1 proposes the removal of Trust Indicators.

Table 1: Indicators to be Removed

KPI	Rationale
Quality	
Continuity of Carer	It has been agreed to remove this indicator as Continuity of Carer no longer has national targets.
National Patient Safety Alerts not completed by deadline	It has been agreed to remove this indicator as this process is managed internally to ensure completion.
Access & Performance	
% Outpatient Attendances Delivered Remotely	This is no longer measured nationally, however this KPI will continue to be measured via internal Clinical Business Unit (CBU) performance reports and form

	part of the Chief Operating Officer's key performance assurance meetings with the relevant Care Groups.
Workforce	
Short and long-term sickness absence	To be reported and monitored via SPC
Monthly sickness absence by staff group	To be reported and monitored via SPC
Monthly return to work	To be reported and monitored via SPC
Recruitment time to hire	To be reported and monitored via SPC
Vacancy rate	To be reported and monitored via SPC
Pay spend vs budget	To be reported and monitored via SPC
Role Specific training compliance	To be reported and monitored via SPC
Use of the Apprenticeship Levy	To be reported and monitored via SPC
Workforce Carrying out an Apprenticeship qualification	To be reported and monitored via SPC
Finance	
Use of Resources (Finance)	NHS England paused its Use of Resources assessments in response to the COVID-19 pandemic. The assessments remain paused until resumed by NHSE. In the meantime, the assessments are being re-evaluated and refreshed to ensure they are fit for purpose. Therefore, inspections do not currently include a Use of Resources assessment. This means that a Trust's use of resources and combined rating will not be updated until advised further by NHS England.

Updated Indicators

Table 2 provides details of updates required to Trust Indicators.

Table 2: Indicators to be Updated

KPI	Proposed Change	Rationale
Quality		
Community acquired Pressure Ulcers	Include data for the number of Community acquired Pressure Ulcers in month.	To support the prevention of pressure ulcers across the system
Incidents	Removal of the "20 days" criteria on the RAG rating. The graph will still show the number of open incidents between 20-40 days.	Standard incident reporting will include incidents open between 20-40 days as some incidents relating to safeguarding, pressure ulcers and those requiring external input will always require appropriate time to consider the complexities of the cases.
Complaints	Inclusion of an additional graph which outlines PALS specific concerns received and closed.	To provide additional assurance around PALS concerns.
Friends and Family – *Inpatient/Day case*	Inclusion of additional detail on the graphs which shows Cheshire & Mersey average performance, regional average performance and the National average performance. Please	To provide context and assurance, monitoring performance against Trusts both locally and nationally.

	note that this data maybe several months behind due to publishing timescales.	
HSMR Mortality Ratio and Summary Hospital-level Mortality Indicator (SHMI)	Inclusion of additional targets on the graphs which shows where we are benchmarked national/regionally, by including national/regional average ratio. Please note that this data maybe several months behind due to publishing timescales.	To ensure the Trust is performing in line with its agreed national trajectory.
Access & Performance		
RTT 52 Weeks	This indicator will be updated to reflect the new contractual target of no patients waiting over 65-weeks. The 52-week waiters will still be included on the graph for assurance; however, 104-week waiters will be removed from the graph. The 65-week target is to be achieved by March 2024.	Update to the NHS Standard Contract Quality Requirements.
A&E 4-hour trajectory	This indicator will be updated to reflect the new contractual standard of 76% waiting under 4 hours in ED from decision to admit, a reduction from the previous target of 95%. The 76% target is to be achieved by March 2024. In addition, the improvement trajectory will be replaced by the 76% target.	Update to the NHS Standard Contract Quality Requirements.
Diagnostic Waiting Times – 6 weeks	This indicator will be updated to reflect the new national target of 95% waiting less than 6 weeks for a diagnostic test from the request for the test being made, a reduction from the previous target of 99%.	As required by the 2023/24 priorities and operational planning guidance.
Stranded and Super Stranded Patients	Add 'No Criteria to Reside' (NCTR) to SPC. Add data breakdown for 'No Criteria to Reside' and 'Right to Reside' for both Stranded and Super Stranded patients.	For transparency of both length of stay (LOS) and no criteria to reside (NCTR).
Workforce		
Monthly sickness absence	Replace with rolling 12-month average.	To benchmark nationally / across the ICS. Provide overview over 12 months rather than in month which can skew performance data.
Finance		
There are no Finance and Sustainability indicators recommended to be updated at this time.		

New Indicators

Table 3 provides details of a newly proposed Trust Indicators.

Table 3: New Indicators

	KPI	Measurement Criteria	Rationale
	Quality *		
Maternity	Postpartum Haemorrhage >1500ml	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard. RAG Rating: Green: <3.7% Red: 4.1%	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.
	3rd and 4th Degree tears	To monitor rates of 3rd & 4th degree tears against North West Coast Regional Dashboard. RAG Rating: Green: <1.85% Red: >2.25%	WHH are not currently an outlier for 3rd & 4th degree when compared to the North West Coast Maternity Dashboard, but 3rd and 4th degree tears are a significant outcome with the potential for long term impact of women's health and wellbeing.
	Pregnancy Bookings before 10 weeks and 13 weeks	To monitor pregnancy bookings met within the 10-week target. RAG Rating: Green: >75% Amber >50% Red: <50% To monitor pregnancy bookings met within the 13 weeks. RAG Rating: Green: >90% Amber >80% Red: <80%	Timeliness of pregnancy booking is a key performance indicator. WHH is currently an outlier for bookings before 10 weeks when compared to the North West Coast Maternity Dashboard. WHH is also currently an outlier for bookings before 13 weeks gestation when compared to the North West Coast Maternity Dashboard.
	Fractured Neck of Femur	To include on the IPR for information but will not be RAG rated. The % of patients treated in line with Best Practice Tariff (BPT). *% of patients receiving surgery within 36hrs of admission.*	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.
	MUST nutritional assessment completion	To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE) RAG Rating: Green:>85% Red:<85% *% of completed within 24 hours of admission to hospital*	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 **		
	Theatre list scheduling and optimisation	**Theatre Utilisation (measured as productive operating time only)** Green: > 85%	Increase productivity and meet the 85% day case and 85% theatre utilisation expectations using Getting it Right First

	Amber 80 - 84.9% Red: < 80% **Day case (measured as an aggregate of total cases)** Green: > 85% Amber 80 - 84.9% Red: < 80%	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.
Workforce		
There are no new workforce indicators recommended at this time.		
Finance		
'Agency Ceiling'	At ICS level, agency spend should not exceed 3.7% of total pay. The Trust ceiling is still to be confirmed. Green: Agency spend less than 3.7% of total pay. Red: Agency spend is more than 3.7% of total pay.	For 2023/24 NHSE plans to base agency spend limits on agency spending as a proportion of systems' total pay costs, set at 3.7% of a system's total pay bill.

*The inclusions of omissions of Critical Meds are requested for the Quality section of the IPR, as there have been National Patient Safety Alerts (NPSA) in this area. However, additional work in the background is required around the data quality before this is reportable via the IPR. These NPSAs are currently monitored via Patient Safety meetings, however, are desired in the IPR as soon as accurate data is available.

**Further indicators will need be included in the Access & Performance section of the IPR once guidance is available as to how performance will be measured. Notification has been received from Cheshire and Merseyside ICB stating that there will be additional Indicators to be monitored in 2023/24. At this stage there is no performance threshold for these areas of focus, and it is unclear how these need to be measured. Further information is anticipated in relation to the targets, and an update will be brought to FSC when these are received.

Presentation Amendments to Indicators

Table 4 proposes the presentational amendments to Trust Indicators.

Table 4: Presentational Amendments to Indicators

KPI	Proposed Change	Rationale
Quality		
There are no presentational amendments recommended at this time.		
Access & Performance		
Covid-19 Recovery KPIs	KPIs that contain the wording 'Covid Recovery' to be changed to the wording 'Elective Recovery'.	Elective Activity is now the more applicable description.
Workforce		
There are no presentational amendments recommended at this time.		
Finance		
There are no presentational amendments recommended at this time.		

The proposed changes will result in a decrease of the KPIs from 82 to 79 as follows:

	2022/23	2023/24
Quality	27	30
Access & Performance	35	35
Workforce	13	7
Finance	7	7
Total	82	79

The Trust Board is asked:

- **To approve the proposed amendments to the IPR Dashboard for 2022/23.**

If approved by the Trust Board, these changes will be implemented from May's Board report (April's data).

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPI's 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:

- Quality & Assurance Committee
- Strategic People Committee
- Finance and Sustainability Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the proposed amendments to the IPR Dashboard for 2023/24.
2. Note the contents of this report.