Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting Part 1 (held in Public)

Wednesday 3 April 2024
10.00am -12.30pm
Seminar Room, Education Centre, Halton/Via MS Teams

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 3 April 2024, 10.00am – 12.30pm
Halton Education Centre, Seminar Room, Halton Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/24/04/001	**10:00**	Engagement Story – A Parents Story.	***To note***	**Presentation**	Claire Grice Interim Head of Patient Experience, Equality, Diversity & Inclusion and Corrine Roe Paediatric Ward Manager
BM/24/04/002	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/24/04/003	**10:17**	Minutes and Action Log of the previous meeting held on **7 February 2024**	***For decision***	***Minutes***	Chair
BM/24/04/004	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/24/04/005	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/24/04/006	**10:35**	Chair's Report	***For info/update***	***Report & Verbal***	Chair
BM/24/04/007	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aim:					
BM/24/04/008	**10:40**	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) 13.02.24, 12.03.24	***For assurance***	***Report & Presentation***	Chief Nurse & Deputy CEO, Chief Operating Officer, Exec Medical Director Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee (SPC)	***For assurance***	***Report & Presentation***	Chief People Officer Julie Jarman, Committee Chair

(c)		21.02.24, 20.03.24			
		Sustainability Dashboard Including Assurance Reports Finance and Sustainability Committee (FSC) 28.02.24, 27.03.24	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
(d)		Audit Committee Assurance Report 22.02.24			Mike O'Connor – Senior Independent Director
(e)		Charitable Funds Committee Assurance Report (CFC) 13.03.24			Chair Director of Communications & Engagement
Strategic aim:					
BM/24/04/009	**11:20**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/24/04/010	**11:30**	**Maternity Update** i. Ockenden ii. Maternity & Neonatal Review iii. Cheshire & Merseyside Perinatal Mortality Review Tool (PMRT) Report Q3 iv. Midwifery Safe Staffing Report (SPC) v. Avoiding Term Admissions into Neonatal units (ATAIN)	***To note for assurance***	***Report***	Director of Midwifery
Strategic aim:					
BM/24/04/011	**11:40**	NHS National Staff Opinion Survey	***To note for assurance***	**Paper**	Chief People Officer
BM/24/04/012	**11:50**	Communications & Engagement Update – Q4	***To note for assurance***	**Paper**	Director of Communications & Engagement
BM/24/04/013	**12:00**	Freedom to Speak Up Guardian Report	***To note for assurance***	**Paper**	Freedom to Speak Up Guardian

Governance					
BM/24/04/014	**12:15**	Board Cycle of Business	***For approval***	**Paper**	Company Secretary
BM/24/04/015		Committee Cycles of Business and Terms of Reference I. Quality Assurace Committee II. Strategic people Committee III. Finance & Sustainability Committee IV. Audit Committee	***For approval***	**Paper**	Company Secretary
BM/24/04/016		Board and Board Development Effectiveness Review Outputs	***To note for assurance***	**Paper**	Company Secretary

For Approval					
BM/24/04/017	**12:20**	Performance Assurance Framework	***For approval***	***Report***	Chief Finance Officer
BM/24/04/018		Integrated Performance Report Refresh	***For approval***	***Report***	Chief Finance Officer

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/24/04/019	Compliance Update Q3 Report	Quality Assurance Committee Date: 13.02.24 Ref: QAC/24/02/297 Outcome: Noted	***To note for assurance***	***Report***	Chief Nurse
BM/24/04/020	Infection Prevention & Control Q3 Update	Quality Assurance Committee Date: 13.02.24 Ref: QAC/24/02/299 Outcome: Noted	***To note for assurance***	**Paper**	Chief Nurse
BM/24/04/021	Learning From Experience Summary Report Q3	Quality Assurance Committee Date: 13.02.24 Ref: QAC/24/02/301 Outcome: Noted	***To note for assurance***	**Paper**	Chief Nurse
BM/24/04/022	Learning from Deaths Q3	Quality Assurance Committee Date: 12.03.24 Ref: QAC/24/03/325 Outcome: Noted	***To note for assurance***	**Paper**	Executive Medical Director
BM/24/04/023	Mortuary Inquiry (Fuller) Phase 1 – Gap Analysis	Quality Assurance Committee Date: 12.03.24 Ref: QAC/24/03/315 Outcome: Noted	***To note for assurance***	**Paper**	Chief Nurse
BM/24/04/024	Paediatric Audiology Brainstem	Quality Assurance Committee Date: 12.03.24	***To note for assurance***	**Paper**	Chief Nurse

	Response Update Report	Ref: QAC/24/03/322 Outcome: Noted			
BM/24/04/025	Digital Strategy Group Update	Finance & Sustainability Committee Date: 27.03.24 Ref: FSC/24/03/247 Outcome: Noted	***To note for assurance***	**Paper**	Executive Medical Director
Closing					
BM/24/04/026	**12:30**	Review of the Meeting	To discuss	**Verbal**	Steve McGuirk Chair
BM/24/04/027		Any Other Business	To discuss	**Verbal**	Steve McGuirk Chair
Date and Time of next meeting - 5 June 2024, Trust Conference Room, Warrington Hospital					

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Parent Experience

A parent's journey through their child's inpatient stay

Corrine Ward, Ward Manager B11 and PAU

Claire Grice, Interim Head of Patient Experience

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Background

18 month old Rivan attended Warrington Emergency Department in December 2023 after his parents Lucy and Simon had noticed he had a high temperature, runny nose, was losing weight and made a grunting noise when breathing.

Cared for by the Paediatric Emergency team and then transferred to B11; Rivan was suffering from a collapsed lung and pneumonia due to a viral infection.

Lucy

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Lucy, Rivan's Mum, stayed with Rivan throughout his week's admission at Warrington Hospital and later at Alder Hey Children's Hospital. Their local hospital is Wigan, however, due to a poor experience had travelled to Warrington instead.

Lucy was upset and frightened; she could not comprehend how poorly Rivan was and how quickly he was deteriorating. Coupled with being the first time away from her newborn daughter who she was breastfeeding and recovering from a c-section. Their daughter had recently recovered from Sepsis at 6 weeks old. The worry and fear of the unknown in unfamiliar surroundings; whilst tying to care and comfort her son 24 hours a day.

Lucy was very impressed by the care Rivan received and played her role by:

- Providing Rivan security and care whilst occupying him and helping with normal day to day care activities.
- Acting as source of key information.

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"My husband and I felt like we were just surviving"

But who looks after the parents? What do they need?

Lucy praised WHH for:

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Staff:

- Dr Wong in A&E; recognising Rivan was deteriorating and immediate action – very caring, knowledgeable and fantastic at his job.
- Dr Vayetti's support by being lovely, approachable, professional and keeping us as parents in the loop at every stage; nothing was too much trouble.
- All staff amazing in A&E, passionate about their jobs. They cared about Rivan, they cared about me.

Examinations:

- Speed of Rivan's assessment in A&E as they recognised something was wrong.
- Speed of tests and x-rays taking place and results communicated straight away.

Communications:

- My feelings and feedback was listened to in A&E.

Environment:

- ED waiting area clean.
- ED Chairs comfortable.
- ED modern and new.
- Ward visiting allowing husband to be flexible with times.
- Ward shower room facility, basic but clean.

What Lucy felt could be better on the ward:

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Environment:

- More comfortable sleeping provision for parents; bad back after sleeping on a chair for a week.
- Ward felt outdated and in need of refurbishment.
- Lack of seating for visitors and comfortable for long visits.

Provisions:

- Toiletries available for parents.
- Catering for parents; did not want to leave my son so did not eat:
    - Food/drink provision nearer to ward if can't provide; not offered food during stay.
    - Vending machines in area but not very nutritional when need energy as tired.
    - Occasionally offered drinks but not consistent.
    - Overpricing felt scandalous in place you feel vulnerable.
    - Not made aware of parking concessions.

Feelings:

- Some staff made me feel ignored as a parent on a few occasions as they were caring for Rivan.
- Made to feel like a paranoid mum and felt stupid for crying.

Ward action plan

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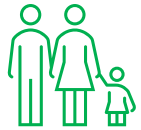
Ensure parents are informed about the provisions already in place; food, drink, toiletries, parking, intentional rounding.

Review long stay bed facilities (wardrobe bed) with Estates and Facilities Team, including feedback from Experts by Experience visit.

Staff training on verbal communications, tone, body language and engagement with parents.



Continue to engage with Experts by Experience and Patient Safety Partners.

Share this story with the ward; importance of supporting parents and communicating support available.

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Rivan's recovery

Rivan was not responding to the IV antibiotics at Warrington Hospital following his X-ray results. He urgently required a chest drain and was transferred quickly to Alder Hey Children's Hospital for this surgery and to be cared for there.

Rivan was discharged in time for Christmas and is still recovering at home with Mum, Dad and his two sisters.

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"It was the first time we used Warrington Hospital and it will be only place I will use for my family going forward".

Lucy Reid

Rivan's story gained national press coverage

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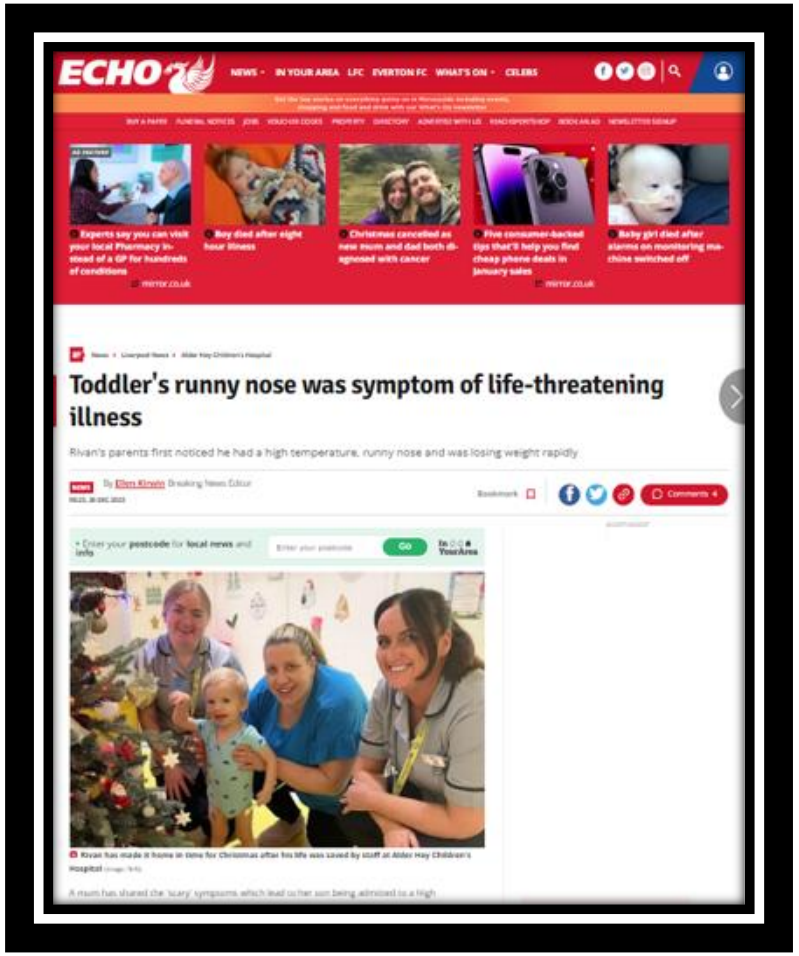

Conflicts of Interest

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.

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Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 7 February 2024 Trust Conference Room – Warrington & MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jan O'Driscoll (JO'D)	Partner Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Simon Constable (SC)	Chief Executive
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
Jane Hurst (JH)	Chief Finance Officer
Dan Moore (DM)	Chief Operating Officer
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Apologies	
Adrian Carridice-Davids (ACD)	Associate Non-Executive Director
In Attendance	
Lucy Gardner (LG)	Director of Strategy & Partnerships
Kate Henry (KH)	Director of Communications & Engagement
Dave Thompson (DT)	Associate Non-Executive Director
Ailsa Gaskill-Jones	Director of Midwifery
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Karen Mason	Cancer Nurse Transformation Manager
Emma Painter	Associate Chief of Nursing - Unplanned Care Group
Mark Forrest	Associate Medical Director
Natalie Crosby	Associate Chief of Nursing – Planned Care Group
Emily Kelso	Corporate Governance & Membership Manager **(minute taking)**
Observing	
Norman Holding	Lead Governor
Kerry Lloyd	Deputy Director of Nursing & Care
Bethan Thompson	Senior Performance and Systems Development Lead
Hayley Heard	Deputy Director of Strategy & Partnership

Agenda Ref	Agenda Item
BM/24/02/157	Engagement Story – **My Cancer Journey** The Trust Board received the patient story presented by KM, on behalf of a patient diagnosed with Colorectal cancer in July 2021.

	The story detailed the patients journey through; chemo-radiotherapy, cycles of neo-adjuvant chemotherapy (CAPOX), major surgery, 6 months of adjuvant chemotherapy, diagnostic tests, gynaecological interventions, and a day in AED. The story highlighted many positive elements of the care received at WHH, particularly the support from staff. In addition, some key areas for improvement were also identified. The Board took assurance from the action plan developed to improve those areas identified, and the update on progress against each of the actions. SMcG reflected on the patient's story and asked KM if she were required to rate the patients journey from a CQC perspective, what rating would be considered appropriate. KM responded that many parts of the patient's journey would be rated as Outstanding particularly the culture demonstrated across Cancer care staff, however there were elements that could be improved most of which were related to estates and facilities (patient TVs, catering, ward environment) details were provided in the presentation. KSJ commented those issues identified particularly the patient TVs which was ongoing and being monitored by the Patient Experience Sub-Committee, it was recognised that communication across staff groups on the interim position was important so that patents and staff could be assured on the ongoing work to improve. KSJ further confirmed that the Nutrition Food & Hydration Steering Group had been established to improve the standards of catering on offer particularly for those with specialist dietary requirements. The Board formally thanked the patient for sharing their story, it was confirmed that progress on actions would be shared with the patient. **The Trust Board discussed and noted the Engagement story.**
BM/24/02/158	**Welcome, apologies and declarations of interest.** SMcG welcomed the Trust Board, guests, and observers to the meeting, and noted the apologies received (as detailed above). There were no declarations of interest. SMcG informed the Trust Board that the meeting was the last WHH board meeting for KSJ who had Chief Nurse at the Trust for seven and a half years. SMcG extended his thanks on behalf of the Trust Board and the wider communities of Warrington and Halton, noting that KSJ would leave the Trust in a positive position following the recent CQC inspection of Maternity Services which had rated the Trust as "Good". **The Trust Board noted the welcome, apologies, and declarations.**
BM/24/02/159	**Minutes and action log from the previous meeting held on 6 December 2024.**

	The minutes of the meeting held on 6 December 2023 were agreed as an accurate record. The Action Log was reviewed, completed actions were noted, there were no outstanding/ongoing actions. **The Trust Board approved the minutes of the meeting held on 6 December 2023 and noted the Action Log.**
BM/24/02/160	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/24/02/161	**Chief Executive's Report** SC introduced the paper, which was taken as read. SC explained the key items to highlight from the report were to be discussed in detail under agenda item BM/24/02/164. **The Trust Board noted the Chief Executive's Report.**
BM/24/02/162	**Chair's Report** SMcG introduced the report, which was taken as read, no further questions were raised by Board members. **The Trust Board noted the Chair's Report.**
BM/24/02/163	**Board Assurance Framework (BAF)** JC introduced the report which provided the Board with an update on each of the strategic risks. The key highlights from the report, were as follows: • The proposal to reduce the rating of risk #115 from 20 to 16 - as a result of sustained reduction in registered nurse turnover and overall vacancy. • The proposal to update the description of Risk #224 to ensure the risk aligned and linked with the current Tier 1 metrics and removing reference to COVID-19 • The proposal to update the description of Risk #125 in order to better reflect the current position of the funding of the hospital estate. It was noted that Risk Appetite levels for each of the strategic risks had been applied and supported by the appropriate monitoring Committees, these were included in in Appendix 1. Furthermore, the report detailed the amendments to BAF throughout the 2023/24 financial year and the Corporate Risk register in full which was monitored at least bi-monthly by each of the subcommittees and the Risk Review Group. The Board discussed in detail the need to align risk appetite for individual risks to target risk scores. JC confirmed that that a Deep Dive had been requested by SPC which would be the starting point to focus on this in detail and make recommendations to adjust scores accordingly. **The Trust Board:**

	• **Discussed and approved the changes and updates to the Strategic Risk Register** • **Noted the addition of risk appetites to each risk on the Strategic Risk Register** • **Noted the annual review of the amendments made to the Strategic Risk Register in financial year 2023/24** • **Noted the Corporate Risk Register** • **Approved the Risk Appetite Statement** • **Noted the next steps**
BM/24/02/164	**Care Group Presentation – Quality, Performance & Governance** SC introduced the presentation noting that the item followed well to the discussions on the BAF and the bulk of the discissions around IPR. SC explained that a CQC Engagement and Risk meeting had taken place on Monday 29 January at the request of the CQC as part of their new inspection and review methods. The CQC had identified three core services and requested additional assurance on: 1. Urgent and Emergency Care 2. Medicine 3. Surgery Service leads from each of the 3 areas had presented the on the Trust's current position, challenges and plans in place. In order to provide assurance to the CQC. EP presented on **Urgent & Emergency Care** covering the following: • Key challenges and risks, highlighting 17% increase in ambulance attend over the last 12 months, provision of care in escalation areas e.g. care on the corridor. • ED improvements schemes including but not limited to continuous flow Emergency Admissions Unit, Emergency Department CT scanner. • ED Improvement next steps - including work with Newton, ECIST, GIRFT and internal data review to improve 12-hour time in department. • What makes us proud including but not limited to ambulance handover sustained performance despite a significant increase in attendances, mechanisms in place to maintain safety, improvements in key workforce metrics, schemes to improve staff safety including the success of body cams worn by staff, which had seen a reduction in anti-social events/incidents. The Board engaged in robust discussion around the contents of the presentation in relation to UEC, the key points highlighted from the discussion were: • the live conversations with NWAS around admission avoidance • culture concerns particularly fatigue amongst ED staff due to capacity and demand. recognition from Trusts senior leaders that ED pressures were relentless as evidenced in the figures being presented and also witnessed during observational visits. It was recognised that the work being undertaken by WHH to improve was positive. However, system wide change and support was requited to sustain and further drive improvements. • open and honest Board conversations with ED staff were frequent, reassurance that senior managers knew ED staff well and understood staff

frustrations with the sustained pressures being experienced. The current position of the Trust moving between Opel 3 and Opel 4, evidenced the sustained pressures with “no end in sight”.
- positive metrics in relation to staff turnover in UEC, however noting that more active listening and improved communications with staff were required to sustain.

SC reiterated the underpinning issue of No Criteria to Reside (NCTR) patients and delayed discharges. KSJ provided examples of the current position of boarding patients across Trust wards. One specific example was noted as stroke ward b14 with two boarding patients, including a patient bed in the middle of the ward which impacted both patient experience in regard to privacy along with increasing pressures on staff.

DT queried the out of area admissions and why patients were being brought to WHH in ambulances rather than their local E.Ds. DM responded that the Trust was in the process of trying to understand whether there was a link to the Trust’s good performance around ambulance handovers. It was explained that NWAS were now managing divert flow and further analysis of the data was taking place. It was noted that St Helens local authority was now attending NCTR meetings, however Liverpool, Cheshire East and West were not.

The Board discussed the lack of system support for an Urgent Treatment Centre (UTC) in Warrington. DM confirmed that at present there were no plans to stand up a UTC in Warrington, he further described the work of the Same Day Access Group which LG and strategy/partnership team were part of, and who had been sighted on the work of ECIST and Newton (although limited as did not cover attendances). It was noted that despite lack of system support, WHH were working on writing a statement of case for a UTC in Warrington.

LG provided reassurance that the Trust was undertaking an analysis on ED attendances to gain clarity on those attendances that could be alternatively managed through a UTC pathway. Once available this data would be shared with PLACE, it was noted that there were uncertainties around funding.

MF presented on **Medicine** highlighting the following:
- Key challenges and risks – NCTR across pathways sitting at 28.6%.
- Recovery was being achieved through insourcing/outsourcing, mutual aid, increasing CDC capacity.
- Elective recovery and the innovative response of teams to work towards the ambition to not have any patient exceed 60 weeks.
- Medicine improvement goals – in relation to delayed discharges, patients with mental health presentations, increased demand on medical take, completion of MUST scores in a timely manner.
- Key improvement highlights were noted including workforce metrices, CDC spirometry service, Enhanced Respiratory Care Unit (B18), virtual wards.
- It was noted that the CQC had asked for more detail around the success of ward B18.

JS commented on the success of virtual wards and queried whether there was any evidence to suggest an increase in readmissions as a result. PF responded that given the nature of the patients on virtual wards readmission within 28 days was around 25%, however evidence was suggesting a small decrease in readmissions and no negative impacts from a quality perspective.

	NC presented on **Surgery** highlighting the following: • The five key challenges (it was noted that each should not be seen in isolation) 1. Improvement of fragile service performance within Surgery – the fluid reporting structure for fragility of services was noted, the example was given of ophthalmology which had been stepped down 2. Elimination of Never Events in Theatre - establishment of Procedural Safety Steering Group and Theatre development work 3. Elective restoration - 78ww, 65ww and 52ww by March 2025 4. GIRFT/Improvement work - Improving service delivery to support elective restoration. 5. Cancer - Maintaining low 62-day backlog and good compliance against 28-day Faster Diagnosis Standard The Board reflected on the QAC assurance report specifically "never events" in theatre and being able to triangulate with the information from the CQC presentation. It was agreed that a presentation on culture, would be scheduled for the Board Development Day in March. **The Trust Board thanked the Service Leads for the presentation which they had discussed in detail and noted the content which had been presented at the CQC Engagement and Risk meeting.**
BM/24/02/165	**Integrated Performance Report** SC introduced the agenda item which provided a summary of the Trust performance, it was highlighted that the report would be taken as read given the lengthy discussion around the most challenging IPR metrics in the previous agenda item, the Board noted the importance of viewing the IPR metrics through the lens of the CQC. ***Quality (KSJ)*** The report was noted, with no further discussion. ***People (Workforce) (MC)*** The report was noted, with no further discussion around the People section of the IPR. ***Finance & Sustainability (JH)*** JH highlighted the following from the finance section of the report: • **Cash Borrowing Principles & Processes** JH explained that due to the deteriorating deficit position for 2023/24, cash support would be required for March 2024 onwards. The paper outlined the options and likely impacts. A 2023/24 deficit of £22.4m would require cash support of £8.335m. A deficit of £27.8m would require cash support of maximum £13.335m, at present this was more realistic with lack of schemes to bridge the current gap. The Board noted that cashflow would be reviewed daily. The estimated support required for Q1 2024/25 is £13.760m and would be brought back to Board in March 2024 to confirm. It was noted that the Finance and Sustainability Committee had supported the request at the meeting on 24th January 2024.

	The Trust Board: • **Noted the content of the report which had been discussed in detail in the previous agenda item BM/24/02/164** • **Discussed and approved the principles, processes and request to drawdown.** • **Noted the KPI amendment as outlined in the paper**
	Quality
BM/24/02/166	**Fragile Clinical Services Update** PF introduced the report which provided the Board with a high-level overview of services currently identified as being Fragile. The following key points were highlighted from the report: **Urology** • The Trust's highest risks in fragile services sat within urology. It was noted that no new harm incidents had been identified since the previous report to board. • Significant volume of high-risk patients had been confirmed by AI list validation. **Gynaecology** • AI validation work has identified 30 waiting list patients with critical urgency scores – all have undergone harm reviews with no harm identified, 2 patients have had their surgery expedited. SMcG queried the impact of AI, and asked if a future Board development session could be scheduled to focus on Cyber Security including implications of AI. **The Trust Board noted the current list of Fragile Services and associated high level progress updates.**
BM/24/02/167	**CQC Maternity Inspection** KSJ introduced the presentation which provided the Trust Board with an update on the outcome following the recent CQC Inspection of WHH Maternity Services (14 September 2023), the following key points were highlighted: - The factual accuracy had concluded, and the final report was published on 17th January 2024 with an overall **"Good"** rating. - 0 Must Do actions had been identified. - 5 Should Do actions had been identified and an action plan was in place which was being monitored through the Quality Assurance Committee (QAC). CR confirmed that the QAC were well sighted on progress against those should do actions identified, confirming that sufficient assurance was being received at committee level, with no requirements for escalation to the Trust Board. SMcG praised the maternity team lead by AGJ, on behalf of the Trust Board for their hard work and efforts, to maintain the Trusts Maternity Services CQC rating of "Good".

	The Trust Board noted the update.
BM/24/02/168	**Maternity Update** AGJ highlighted the following key points from each of the maternity papers. **i. Ockenden Review Updates** **Key highlights:** • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 96.58% compliant and is on trajectory to be 100% compliant by 31st March 2024. • **Ockenden 2**: WHH is 83.56% compliant. It was confirmed that Ockenden 2 did not have any national timelines. Following a review of all actions, WHH has set internal timelines to complete all actions by 31st March 2024. **ii. Maternity & Neonatal Quality Review – September 2023** AGJ introduced the paper which provided an update in relation to maternity and neonatal quality for November and December 2023. The paper had been presntded to and discussed in details by the QAC with no escalations. The folloing key ponts were highlighted from the report: • The vacancy rate for maternity and child health staff was continuing on a positive trajectory. • In regards to triage it was explained that a national piece of work on the staffing model around telephone and face to face triage was taking place, which would petentially remove telephone triage from individual Trusts. It was noted that this was a long term plan with no confirmed completion date as yet. DT congratulated AGJ on the improvement trajectory for staff vacancies. AGJ respond that while the trajectory was very good staffing was a dynamic metric requiring constant focus. KSJ added that improvement in staff vaccancies was attributable to the interventions from senior leaders including meeting with teams regularly and having a physical presence on wards. SMcG queried the nature of the perinatal cultural leadership programe. AGJ confirmed this was part of the maternity incentive scheme a national programme exploring leadership methodolgy and developing a broader understanding of the Quadrumvirate leadership model. It was confirmed that the SCORE survey closed at the end of November and results should be avaiable to share with the QAC in March. Based on the results the Quad would develop an action/improvement plan to focus on any staff development and culture issues requiring focus. ASJ confirmed that the NED Board Safety Champion (JD) would meet quarterly with the Quad to provide support and progress would be monitored by the QAC. **The Trust Board discussed and noted the maternity reports as per national recommendations.**
People	

BM/24/02/169	**Freedom to Speak up (FTSU) Development for 2024 onwards.** SC introduced the report which provided detail of the developments in the Freedom to Speak Up (FTSU) service across the Trust. This followed a recent review of the FTSU structure alongside other recommendations made nationally and regionally. It was noted that two positions had been appointed to: • Deborah Carter (Interim Patient Safety Project Director) as the new FTSUG, from 1 February 2024. (3 days per week) • Alison Jordan (Associate Director of Information) would provide additional support with 1 day a week as Deputy FTSU Guardian. SC thanked JH on behalf of the Board, for her commitment during her time as the Trusts FTSUG the Board were reassured of the continuity and support JH would provide to the two new FTSUG appointees. **The Trust Board noted the developments in the delivery of the Freedom to Speak Up service.**
BM/24/02/170	**Communications & Engagement Dashboard Quarterly Report Q3** KH introduced the paper, explaining the new format of reporting which combined the Working with People and Communities Strategy and elements of the previous Communications Dashboard into one report, which going forward would be presented as a single report on a quarterly basis. KH reflected on the discussion under previous agenda items around communications and what more the Trust could be doing to communicate messages to staff at all levels and not only from a hierarchical point of view. It was noted that work was ongoing and that the refreshed Communications Strategy would help to drive improvements. SMcG quired whether there had been much reaction from the public around the recently published CQC Maternity Inspection outcome of “Good”. AGJ responded that the feedback a from staff had been overwhelmingly positive with recognition and congratulations received from teams both regionally and nationally. In addition, interactions on social media from the public had been largely positive. **The Trust Board noted the contents of the report.**
Sustainability	
BM/24/02/171	**Bi-monthly Strategy Programme Highlight Report** LG introduced the report explaining that the report provided a progress update on key strategic projects and initiatives that underpin a number of WHH’s strategic (QPS) priorities. JG Highlighted the following three key points from the report:

	1. The Community Diagnostic Centre (CDC) 2nd phase had opened on the 19 December in Runcorn shopping city and had so far seen 1700 patient appointments. It was highlighted that the Trust Board would be required to make some further decisions around finances, depending on where costs came back in line with plans. It was further explained that the Trust was in the process of applying for additional funding. 2. The anticipated Laboratory Information Management System (LIMS) full business case was not yet ready to present to Board, it was explained that a final revised model was being developed by the regional team, which would be presented at the February FSC meeting and following to the Trust Board. 3. The Living Well Hub in Warrington Town centre had, been visited by the CQC for registration on Tuesday 6th February, it was expected that formal registration would be approved and that an opening date would be confirmed as the 1 March 2024. SMcG queried the engagement with stakeholders around the Living Well Hub to tackle health inequalities. SC responded that the Living Well Hub symbolised success in aggregating partners across the system to work on tacking health inequalities together. However, this was only a start, recognising health inequalities was a widespread concern (particularly prevalent in the northwest) and would require both system and national focus to drive improvements at scale. SMcG asked that a session on the Living Well Hub with a focus on working with partners and stakeholders on tackling health inequalities be scheduled for the March Board Development Day. **The Trust Board noted the report for information and assurance.**
BM/24/02/172	**Strategy Bi-annual Delivery Report** LG introduced the report explaining that in May 2023 the Trust Board ratified governance and reporting arrangements for the updated Trust Strategy 2023-25. It was agreed that reporting against the delivery of the Strategy would be standardised, including a bi-annual update of progress against the priorities within each of the strategic aims Quality, People & Sustainability to the appropriate Board committee. It was highlighted that, the Trust was on target to meet 37 priorities, 21 are behind expectations with mitigations and programmes in place to bring back in line with expectations, and 3 were behind expectations with limited or no mitigations. In addition, 1 priority had not yet rated. **The Trust Board noted progress of the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims.**
Governance	
BM/24/02/173	**Update on Approach to Non-Executive Director Champion Roles** JC introduced the report which provided background in relation to

	the release of *'Enhancing Board Oversight – A New Approach to Non-Executive Director Champion Roles'* and the new approach set out to ensure Board oversight of important issues. The report provided detail of the current arrangements to enhance board oversight for key issues, by ensuring they are embedded in governance arrangements and assurance process, and actions identified by Committees. JJ noted an error in the report around violence and aggression sitting with SPC for oversight, JC confirmed this was a typo, noting that QAC was and would continue to have oversight. CR commented that the refresh better described the role of the NED as having responsibility for ensuring assurance was received on core activities rather than having responsibility for the operational delivery of those activities. **The Trust Board noted the current NED Champion role arrangements.**
Supplementary Papers	
BM/24/02/174	Digital Strategy Group Update Report
BM/24/02/175	Infection Prevention and Control Board Assurance Framework Compliance Bi-annually
BM/24/02/176	Mortality Review -Learning from Deaths Quarterly Report – Q2
BM/24/02/177	Guardian of Safe Working Quarterly (Q2) Report
BM/24/02/178	Trust Senior Management Organograms
BM/24/02/179	(FULL) Care Group Presentations – Quality, Performance & Governance
BM/24/02/180	**Review of the Meeting** SMcG reflected on the meeting highlighting the important conversations around CQC Care Group presentations and the ongoing challenges as detailed in the IPR. In addition, the discussions around the BAF risk scoring and ongoing work of the committees to review risk appetite and target risk scores for individual risks. JS highlighted that yesterday had been the last meeting of the Shadow Board, reflecting of the talent and inquisitive nature of the WHH staff involved in the programme, and how the programme leant itself well to succession planning. **The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items.**
BM/24/02/181	**Any Other Business** No further business was raised. **Meeting ended at 12:38pm**
The Date and Time of the next Trust Board Meeting is Wednesday 3 April 2024, Education Centre, Halton Hospital	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE	BM/24/04/003	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	03 April 2024

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/23/12/146	06.12.23	Emergency Preparedness Resilience Response	To provide a progress report on compliance in time for the EPRR Annual Assurance process 2024/25,	DM	June 2024			
BM/23/12/141	06.12.23	Maternity Update Perinatal Mortality Quarter 2 2023-24	Trust Board be provided with details of MBRACE in future papers.	AGJ	April 2024			

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

BM/24/02/166	07.02.24	Fragile Clinical Services Update	A future Board development session could be scheduled to focus on Cyber Security including implications of AI	PF/TP	March 2024	06.03.23	BDD/24/03/38 Cyber Security Training delivered to Trust Board at Development Day	
BM/24/02/171	07.02.24	Bi-monthly Strategy Programme Highlight Report	A Board session on the Living Well Hub with a focus on working with partners and stakeholders on tackling health inequalities be scheduled.	LG	March 2024	06.03.23	BDD/24/03/37 Living Well Hub Tour & Presentation at Board Development Day	
BM/24/02/164	07.02.24	Care Group Presentation – Quality, Performance & Governance	It was agreed that a presentation on culture - in particular culture around 'theatres' - would be scheduled for the Board Development Day in March.	MC	March 2024	06.03.23	BDD/24/03/39 Cultural Stocktake -presentation at Board Development Day	

RAG Key

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/005**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	3rd April 2024			
AUTHOR(S):	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			

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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/24/04/005

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 7 February 2024, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 11 - February 2024. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

The Trust continues to undertake an elective recovery programme; the priority this year has been on the elimination of waiting lists longer than 78 weeks by the end of March 2024. Activity reports and dashboards are reported routinely at Executive Director Meetings, Quality Assurance and the Finance & Sustainability Committees.

2.2 Senior Leadership Changes

Further to previous communications and an appointments process which concluded in March 2024, I am pleased to announce that Daniel Moore, Chief Operating Officer, has been appointed as Deputy Chief Executive, effective 1st April 2024. The appointment was subsequently ratified by the Nominations and Remuneration Committee.

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

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

2.4 NHS Staff Survey Result 2023/24

From September to November last year, I urged everyone to complete the NHS Staff Survey and share views about what it is like working here at WHH. More than 2,000 (45.3%) of us did so, up from the 35% response rate we had the year before.

On 7 March 2024 the results of the NHS Staff Survey 2023 were officially published.

For context, the survey is made up of nine areas – the seven themes of the NHS People Promise plus the two additional themes of staff engagement and morale. They were developed by the NHS by staff across different roles and organisations as "a promise we must all make to each other – to work together to improve the experience of everyone working in the NHS."

For WHH, these are arguably our best staff survey results ever, it can be summarised in three key points:

- We have improved across all nine survey areas compared with the year before, with four of the nine areas seeing a significant improvement.

- We performed better than the national average when compared to other acute/acute and community trusts across all nine survey areas, with six of the nine areas seeing significantly better results than comparator organisations.

- We have received extremely valuable insights to help us continue to make improvements and focus our attention on areas where we know we still have more work to do.

We will use the wealth of information from these results to continue to make WHH an inclusive and safe space where everyone feels like they belong. Our People Directorate will be working with Care Groups, Clinical Business Units, departments and teams to help understand and act upon the results for their own areas. It really matters what it's like in each team, and the data will help us inform the right things.

We will communicate more detailed results over the weeks to come, including focusing on specific areas such as the views of different staff groups and results broken down by protected characteristics such as race and disability.

And as we develop and implement actions in response to these results, we will share details of those too. Our staff networks and other staff voice groups will play a key part in developing improvement plans.

2.5 Opening of the Living Well Hub in Warrington

On 1 March 2024 I attended the official opening of our new multi-million-pound health and wellbeing facility, the Living Well Hub in Warrington town centre.

The concept first came about four years ago following conversations with Warrington Borough Council around improving health outcomes and reducing inequalities across the town (there is a 10-year difference in life expectancy between the most and least deprived members of the community). The Hub subsequently became part of the Town Deal-funded programme.

It is incredibly rare to have so many partner organisations on the same page let alone under the same roof, however thanks to a huge team effort, led by our own dedicated Strategy and Partnerships Team, we've managed to achieve it. All credit must go to the leadership of Lucy Gardner, Steve Bennett and Caroline Lane to see the vision through to delivery and reality.

We have got 25 partners on board including Warrington Borough Council, Bridgewater Community Healthcare NHS Foundation Trust and Mersey Care NHS Foundation Trust, voluntary and charitable sector partners – along with more than 350 staff – who will be providing a wide range of NHS and non-clinical services.

Some of the services on offer at the Hub would previously only have been delivered in a hospital or traditional clinic setting, however it's important that we're now able to deliver them in the town centre, providing better access for those who need the most support. By doing so we can start to tackle some of these inequalities, improve patient outcomes, and reduce the pressure on our own acute services, while also helping to create jobs and support the regeneration of the town centre.

The Hub is on Horsemarket Street - a really welcoming and fully accessible space, with Warrington residents able to drop in at any time during opening hours (initially 9am to 5pm weekdays, and until 8pm on Mondays and Wednesdays) to access advice and support about their overall health and wellbeing.

2.6 Thank You Awards 2023/24

We have announced the finalists of this year's WHH Thank You Awards.

Our judging panels have had the very rewarding but difficult task of whittling down hundreds of nominations to get to our final shortlist of 33 nominees. It is testament to the positive culture we want to continue to build here at WHH that we received so many brilliant submissions from across the Trust.

Our 2023/24 finalists are (listed in alphabetical order within each category):

Clinical Team of the Year
- Acute Medicine Team
- Radiology CT Team
- Ward C23 (Maternity)

Support Team of the Year
- Quality Academy Teams
- Security and Portering Teams
- Transfusion Team

Patient Safety Award
- Dr Premkumar Martin, Neonatal Team
- Maternity Triage Team
- Paediatric Seven Day Services Project Team

Innovation and Improvement Award
- Acute Respiratory Virtual Ward Team
- Pharmacy Team
- Strategy and Partnerships Team

Inclusion Champion
- Clare Payne, Knowledge and Evidence Service
- Peer Café Team
- Sarah Robinson, Finance

Rising Star Award
- Esstta Griffiths, Communications and Engagement Team
- Gill Tyrer, Discharge Team
- Olivia Rogers, SDEC

Leadership Award
- Daniel Palmer, Lead Physician Associate, Emergency Department
- Jaclyn Proctor, Advanced Practice Trust Lead
- Janette Pennington, Trauma Theatres

Special Recognition Award
- Claire Hulmes, Wards B10/B11
- Derek Gates, Halton Radio Volunteer
- Diane Skidmore, Finance

Living Our Values Award: Colleague of the Year
- Anthony Connolly, Rheumatology
- Daniel Masters, Halton Education Centre
- Dr Liz Nolan, Consultant Geriatrician

People's Choice Award (nominated by members of the public and readers of the Warrington Guardian / Runcorn and Widnes World)

- Neonatal Unit Team
- Sheila McNie, Healthcare Assistant, Ward B18 (Respiratory)
- Warrington Diabetic Foot Clinic

You Made a Difference Award

- Paediatric, Anaesthetic and Physiotherapy Teams (June 2023 winner)
- Orthopaedic and Anaesthetic Multi-disciplinary Team (November 2023 winner)
- Warrington Theatres, Midwifery & Obstetric, Anaesthetic, Transfusion, Surgical and Intensive Care Teams (January 2024 winner)

The winners will be announced at our WHH Thank You Awards ceremony on Friday 10 May at Concorde Conference Centre, where we will be celebrating the contribution made by all of our colleagues and volunteers over the past 12 months. A special Outstanding Achievement Award will also be presented on the night.

2.7 Special Days/Weeks for professional groups

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

- LGBTQ+ History Month: February 2024
- World Lymphoedema Day: 6 March 2024
- International Women's Day: 8 March 2024
- Nutrition and Hydration Week: 11 – 17 March 2024

2.8 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.

2.9 Employee Recognition

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

You Made A Difference Award (November 2023): Orthopaedic & Anaesthetic Multi-disciplinary Team

This award was made in recognition of the team approach in their unwavering teamwork, support and kindness of a clinically complex patient.

You Made A Difference Award (January 2024): Maternity, Surgical, Anaesthetic, Critical Care & Transfusion Teams

We received a nomination in December 2024 from someone who had been looked after by lots of different clinical teams within the Trust, after becoming seriously unwell following the birth of her fifth baby.

The lady in question nominated all the teams involved for a 'You Made a Difference' award, and after reading the nomination – one line being "*I cannot thank the NHS enough, no words are enough to reflect my gratitude to still be here, alive. I'm grateful every day for them not giving up on me and allowing me to continue to be a mum, wife, and a daughter to my family*." – the teams undoubtedly won the award for January 2024.

On 1 March 2024, we were able to host an extraordinary You Made a Difference Award presentation in the post graduate dining room, for the multi-disciplinary teams to come together, and were even joined by the patient herself, her husband and beautiful baby girl to say an extra special thank you to the teams involved which included Midwifery & Obstetrics, Anaesthetics, ICU, Theatres, Surgical Team and the Transfusion Team.

You Made A Difference Award (February 2024): Emergency Department

The team were nominated by a patient and their partner after they arrived in ED on the advice of NHS111. They praised the team's "timely decision making, care and professionalism but particularly the warmth and compassion" they were shown.

It was quickly identified by the ED team that this patient had had a stroke and, having already contacted the Whiston Stroke Unit to arrange an urgent ambulance transfer, the team ensured that the patient and their partner were kept fully informed throughout, and reassured them during a very frightening and stressful time.

The nomination stated that: "Every single person that was involved was amazing. We were brought coffee, we were looked after, and we knew without a doubt that we had the finest care that was humanly possible. Every single team member worked as a team...conferring with and helping each other at all times. How on earth they cope, whilst still smiling, whilst saving lives, is difficult to comprehend. They are all superstars."

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

Chief Executive's Award (February 2024): Stephen Bennett and Caroline Lane, Strategy & Partnerships Team

I made this award in recognition of the persistence, hard work and dedication of Stephen Bennett and Caroline Lane for the delivery of our Living Well Hub Project (as above), seeing this through from the very beginning.

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

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

- Katie Docherty - Staff Nurse, Ward C20
- Dr Aysha Parveen - Bank Doctor, Ward C20
- Denise Evans - Estates and Facilities
- Carol-Anne Morris - Sister, SDEC
- Janice Shaw - Staff Nurse, Integrated Medicine & Community

- Christine Peel - Healthcare Assistant, Outpatients
- Peter Doughty - Charge Nurse, Outpatients
- Nigel Cornell - Healthcare Assistant, Outpatients
- Reynaldo Gervacio - Domestic Assistant, Estates and Facilities
- Lynn Duxbury - Healthcare Assistant, Discharge Suite
- Angela Wallace - Medical Clerical Officer, Medical Education
- Abigail Sadler - Sister, Emergency Department
- Suchie Vellilankal Sajeev and Team - Ward A6, Digestive Diseases
- Gina Coldrick - Communications Specialist
- Robert Wilkinson - Haematology Service Manager
- Dave Thompson - Associate Non-Executive Director
- Adrian Carridice-Davids - Associate Non-Executive Director
- Karen Wardle - Senior Biomedical Scientist
- Dr Zoe Apple - Consultant Anaesthetist

2.10 Signed under Seal

Since the last Trust Board meeting, no items have been signed under seal:

3 MEETINGS ATTENDED

The following is a summary of key external stakeholder meetings I have attended in February and March 2024 since the last Trust Board Meeting.

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

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 11 (February 2024)
Appendix 2: CMAST Brief Issue 23 February 2024

Appendix 1 - CEO Dashboard Month 11 – February 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	88.57%	
RTT 18 Weeks	92.00%	56.71%	
RTT 65+ Weeks	0	997	
A&E % patients seen within 4 hours	> 75.00%	58.96%	
A&E % waiting longer than 12 hours	< 2.00%	23.98%	
Cancer 14 Days	93.00%	54.04%	
Breast Symptomatic 14 days	93.00%	19.61%	
Cancer 28 Day Faster Diagnostic Standard	75.00%	77.65%	
Cancer 62 Day Wait	85.00%	78.18%	
Ambulance Handovers within 60 mins	100%	80.42%	
Discharge Summaries 24 hours	95.00%	89.89%	
Cancelled Operations – 28 days	0	2	
Super Stranded Patients	Trajectory	158	
Theatre Utilisation	85.00%	82.20%	
Day cases	85.00%	88.46%	

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	0	
Sepsis Screening Emergency	90.00%	68.00%	
Sepsis Screening Inpatients	90.00%	80.00%	
Sepsis Antibiotics Emergency	90.00%	58.00%	
Sepsis Antibiotics Inpatient	90.00%	92.00%	
Inpatient Falls	20.00% reduction	40	
VTE	95.49%	94.42%	
Pressure Ulcers	10.00% reduction	10	
Medication Reconciliation (24 hrs)	80.00%	50.00%	
Complaints over 6 months	0	0	
Healthcare Infections - MRSA	N/A	0 YTD	
Healthcare Infections – CDI (cumulative)	Less than 36 (2023/24)	49 YTD	
Healthcare Infections - E. coli (cumulative)	Less than 54 (2023/24)	75 YTD	
Healthcare Infections – Klebsiella (cumulative)	Less than 18 (2023/24)	25 YTD	
Healthcare Infections - P. aeruginosa (cumulative)	Less than 2 (2023/24)	10 YTD	
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	6.30%	
Maternity 3rd and 4th Degree tears	Less than 1.85%	2.10%	
Maternity Pregnancy Bookings before 10 weeks	75%	56.70%	
Maternity Pregnancy Bookings before 13 weeks	90%	82.30%	
MUST nutritional assessment completion	85%	52.48%	

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (culm) (£m)	-£0.28	-£2.44	
Capital Spend (£m)	£19.34	£15.97	
Cash Balance (£m)	£16.34	£14.80	
Better Practice Payment Code (culm) (£m)	95%	91%	
CIP In Year Delivered (culm) (£m)	£15.51	£13.70	
CIP Forecast (Recurrent) (£m)	£15.51	£7.00	
Agency Ceiling	Less than 3.7%	2.40%	

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.60%	
Retention	85.00%	87.64%	
Core/Mandatory Training	85.00%	90.73%	
PDR Compliance	85.00%	74.67%	

Strategy

Strategy

- **Living Well Hub:** Over 3 years in the planning, the Living Well Hub, was launched in Warrington on 1st March. Demonstrating true partnership working, with the aim of reducing health inequalities whilst encouraging economic regeneration of the town centre, the Hub will be a significant asset for the residents of Warrington.
- **Strategic Priorities 2024/25:** A round of collaborative business planning meetings with Clinical Business Units have been undertaken and strategic priorities for next year identified. Priorities have been discussed with Care Groups and will be used by the finance team leading this work to develop a plan on a page for approval by Trust executives in early April.
- **Community Diagnostics Hub:** The Community Diagnostic Centre continues to provide significant additional capacity for our patients with over 21,000 additional diagnostic tests having been undertaken since it went live in May 2023. Designs for phase 3 (new build at Halton Hospital) have been completed and planning permission has been granted for the development.
- **Runcorn Health and Education Hub:** Designs for stage 4 of the Runcorn Health and Education hub have been completed and planning permission has been granted for the development. Work continues with partners to develop a collaboration agreement, which will formalise working arrangements going forward in anticipation of the launch next year.

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

February 2024

CMAST Update

The CMAST Leadership Board met on 1st March in a meeting which included Chairs and CEOs.

The focus of discussions related to a review of programmes' delivery for 2023/4 and projected year end milestones. Significant progress was reported and acknowledged across all programmes. The Board also noted the planned closure of the CMAST workforce programme and intentions for development of CMAST Programme commitments and delivery approach for 2024/5. It is expected that a draft Annual Plan will be discussed by the Leadership Board from May onward before sharing with the ICB.

The Board also noted the continued impact of UEC pressures and hospital flow on acute performance and the intentions of the Health and Care Partnership to prioritise health and care prevention funding.

ICB Update

NHS Cheshire and Merseyside's latest Board meeting was held at the Floral Pavilion in New Brighton, Wirral, on Thursday 25th January.

Chief Executive, Graham Urwin, cited a recent visit to Leighton Hospital in Crewe, which provided an opportunity for Board members to tour the facilities and find out more about work to improve care quality. It also provided an opportunity to learn more about Mid Cheshire Hospitals NHS Foundation Trust's involvement in the national New Hospital Programme.

Director of Population Health, Ian Ashworth, updated on the national measles outbreak, including how partners across Cheshire and Merseyside - and in each of the nine Places – have come together to reinforce the vaccination message.

Director of Finance Claire Wilson updated that NHS Cheshire and Merseyside is now aiming for a break-even position at the end of March 2024, partly due to additional funding. There remains risk – however – particularly related to the impact of recent NHS industrial action which wasn't accounted for in the forecasting.

Director of Performance and Planning, Anthony Middleton, updated on system pressures and the impact that industrial action, cold weather and seasonal flu has had on providers. North West Ambulance Service increased the number of vehicles on the road by more than 30% to match demand during this busy period, while primary care also increased capacity.

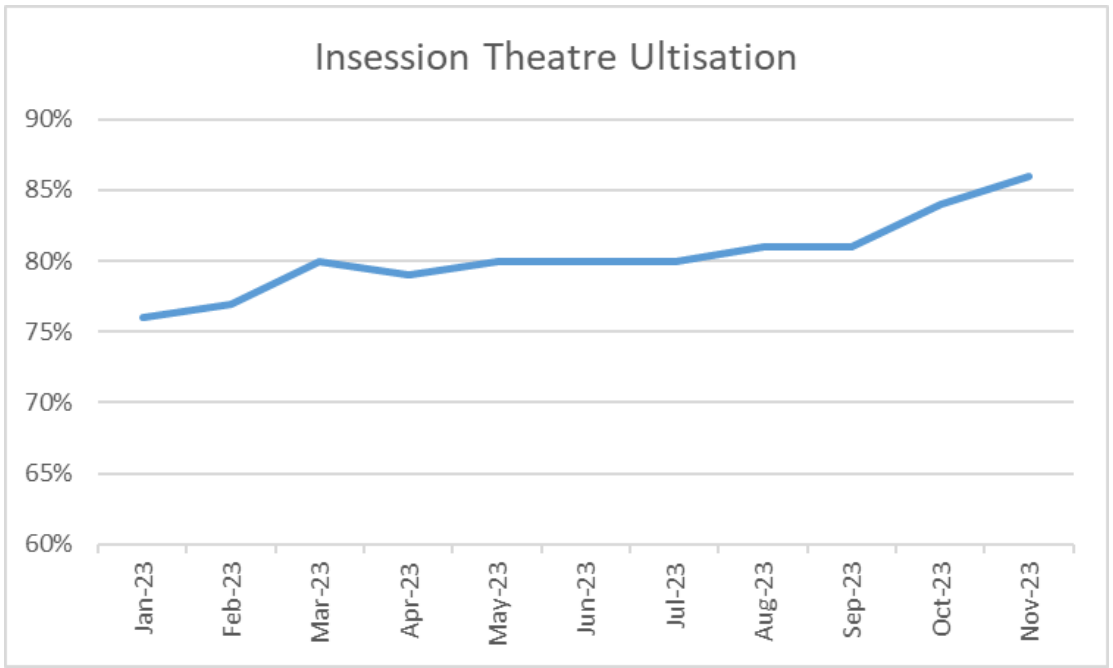
Elective Recovery and Transformation Programme

Waiting times reduction

- As of 20th February 2024, C&M has 4,640 patients waiting over 65 weeks for treatment. This time last month we had 5,358, which shows a reduction of 718 in the cohort over the last month.
- The national target is to eliminate 65 week waits by March 2024, which would require 9,569 patients to be treated by then. This time last month, we had 15,376 to clear by the end of March, and we have shown a positive reduction month on month. However, there are significant pressures on the system currently, including more industrial action which makes clearance of these patients challenging. It is likely it will take us into the next financial year to clear them.
- There are still a small number of 78 week waits to clear, which includes allowable exceptions relating to patient choice and clinical complexity. We are working hard to clear these by the end of March too.
- Our "alternative choice" programme has been praised by the national team as exemplar, and our PTL team have been asked to share the protocols and processes with other systems both within the NW and nationally.

Theatres

- 4 of the Cheshire & Merseyside trusts are achieving the national target of 85% utilisation for theatres, 3 trusts are very close at over 81%, however there are 3 trusts that require additional support. This support is being offered through the theatre programme team and will include deep dives into the opportunities for improvement, support around booking and scheduling, and data quality input.
- The Theatre Academy training programme has been shortlisted for a national award based on the improvements to the system performance. C&M have achieved 10% in-session theatre utilisation within that cohort.



Clinical Pathways

The CPP Programme continues to work with Orthopaedics, Dermatology, ENT, Gynaecology and Cardiology.

Orthopaedics

- As planned, 5 additional Chester Orthopaedic Surgeons commenced operating lists at C&MSC (Clatterbridge Elective Hub) in January 2024 for Chester patients.
- The first meeting of the Arthroplasty subgroup met in January with a second session planned for 9th February. The group is made up of nominated leads at all trusts with the purpose of safely reducing overall length of stay (LOS) for primary joint replacement in line with best practice guidance.
- A working group made up of trust leads for # NOF has been established with two meetings scheduled in February 2024. The data available to understand delays in discharge for these patients is being refined and an update to the Orthopaedic Dashboard incorporating this and more granular detail re arthroplasty LOS is due to be released imminently.
- A paper summarising the activity of Orthopaedic CPP, and the Orthopaedic Alliance has been drafted and will be circulated more widely when it has been through appropriate approvals.
- The members of C&Ms Orthopaedic Alliance and the wider Orthopaedic teams at individual trusts continue to enjoy a free membership to the National Orthopaedic Alliance (NOA). A request has been made to NOA to extend the free membership period to allow further exploration of the benefits before any decision to join is taken.
- The next Orthopaedic Alliance meeting is scheduled for 28th February and dates for the rest of 2024 established including face to face in March and September.

Dermatology

- Teledermatology implementation is currently at 76% across Cheshire and Merseyside as of February 2024.
- A business case is being drafted to secure future funding for teledermatology, whilst a full procurement process is due to begin.
- A task and finish group is being established to develop a system specification for the procurement of Teledermatology.
- The next dermatology alliance meeting is scheduled for 27th March 2024.

Gynaecology

- Following a planned implementation session with network leadership in November, a 12-month forward plan and provider briefing was outlined which provided a one-year vision for the network, and an immediate offer to providers within the briefing – aiming to support on-site with waiting list reduction (focusing on presenting conditions) and mapping of ‘as is’ pathways.
- Both the plan and briefing summary was supported with wider network on 18th January 2024 and was also agreed at the Gynaecology operational managers forum on 25th January 2024.
- ‘Phase 1’ of Trust visits expected to begin at pace, starting at Liverpool Women’s Hospital.
- Engagement with network representatives, who presented in January’s session, in progress to explore opportunities to ‘scale up’ great work happening within Trusts which may have opportunity for adoption across C&M.

ENT

- AClinical Lead is now in post and work has begun to outline the 24/25 overall plan for ENT network.
- As part of the national Further Faster programme, ENT has been agreed to be a priority area and

therefore network leadership have agreed initiatives to end of March 2024. These initiatives will also be tracked within the Further Faster Working Group, with operational and project membership at Trust level, who met for the first time on 11th January 2024.

- All network meetings are planned for 2024 and membership agreed.
- Scope of C2AI as part of the networks forward plan is being evaluated during this reporting period.

Diagnostics Programme

Key Performance Headlines

(Data Source: December 2023 DMO1)

- 97,934 tests performed in December – 6% higher than planned and 8% over plan YTD
- 83% of patients have been waiting 6 weeks or less (1% decrease since last month)
    - ICS ranking 7th out of 42 ICSs (Significant improved from 12th in November 23)
    - 11,017 patients have waited 6 weeks or more (reduction of 20 since last month)
    - Total number of patients waiting has reduced to 69,206(was 71,808 last month)

Endoscopy

- Completion of colonoscopy deep dive to ensure no patients wait >13 weeks for a colonoscopy by 31st March 2024
- Eight out of nine Trusts are utilising >96% of their lists
- Orders have been placed for equipment to deliver the £8.1m Transformation Bid
- 503 colonoscopy have been delivered at LUFT Broadgreen funded by the Network
- 170 colonoscopy will be delivered at Wirral on behalf of CoCH funded by the Network (increase of 50)
- Upgrade in colonoscopes for endoscopy hub at Halton

Pathology

Dr Lisa Bailey appointed as Interim Clinical Lead. Lisa is a Consultant Clinical Scientist in Biochemistry and Clinical Director of Blood Science within LCL, with 30 years' experience working within Pathology predominantly within the C&M region. Lisa will begin this role on 26 Feb 24.

LIMS (Laboratory Information Management System) – Revised timescales have been set due to agreed change to financial model and agreement of capital re-allocation. Now planning for business case completion in March and approval by five trusts in April. LIMS Oversight Group meeting is meeting fortnightly to oversee and manage programme.

Digital Test Ordering System – Options appraisal and risk assessment completed to establish the programme plan. Slides were presented at the Diagnostic Delivery Board and agreed initial phase should focus on eradicating paper ordering for tests provided by Alder Hey and The Walton Centre. £600,000 funding has been allocated to this.

Workforce – A task and finish group has been established in collaboration with colleagues in Greater Manchester to scope options for a virtual cross-site training solution to make use of the Institute of Biomedical Science Training Solution Grant opportunity.

Target Operating Model (TOM) Delivery Plan – Hub meetings commenced, and formal TOM Delivery Group fully established with terms of reference approved. Benchmarking data collection to understand the current state position has commenced, alongside meetings with specialist labs to understand their benchmarking needs.

Pathology Network Team Recruitment – Recruitment underway for Programme Lead, Senior Programme Manager and Project Manager.

Physiological Science

Artificial Intelligence (AI) in Echocardiology Clinics

- Procurement mobilisation meeting held, and timelines agreed to pilot system in 2 x one stop heart failure clinics. If successful, this will reduce the time required (for clinically appropriate patients) to undertake an echo.

Paediatric Audiology – Continue to support quality improvement process. Quality check-ins held with Trust teams in Jan with ICB quality team and Deputy Director of Nursing. Outcome letters circulated. NHSE Quality Assessment Tool distributed to all Trusts for assessment against.

Respiratory Network – scoped Spirometry and FeNo test availability across C&M with clinical lead.

C&M Test mapping survey – Service availability maps by place for areas of focus; Spiro and FeNo re in first draft.

Practice Educator Coordinators - draft JDs developed for these posts to support training across C&M.

Radiology

AI for Chest X-Rays – Confirmed supplier selected. Draw down of funds confirmed, to be transferred from ICS to Clatterbridge before year end.

Intelligent Data – New focused imaging reports for Cardiac CT, Cardiac MR, CT Colon, and nuclear medicine are ready to launch. Nuclear medicine report will give us better oversight of patient waiting times for these tests, which is critical given concerns relating to constraints around Radiopharmacy services. All reports set to be published in February.

Radiology Reporting Collaborative - Stakeholders sent a pilot report for comment. This initiative looks at how reporting can be carried out collaboratively by NHS Staff rather than outsourced.

Diagnostic IT Network – 2 more circuits installed this month taking the total to 17/26 with 9 outstanding, and four edge switch installations completed taking the total to 16/26 with 10 outstanding. Routing work to fully connect our first sites (St Helens and Whiston) was successful and data migration testing is further along than anticipated.

Cyber resilience – A business case has been written for an immutability solution, outlining detailed risks around the current architecture, and costs and benefits of implementation. The cyber resiliency risks identified have been raised on the regional Digital Design Authority (DDA) and Chief Information Officer's calls, and two third parties have presented their solutions.

Waiting List Recovery – Trusts are continuing to support each other with long waiters. The biggest pressure is MRI performance at East Cheshire, which was at 36.9% at the end of this month. The Trust have identified 247 patients who are willing to travel to Paddington Community Diagnostic Centre (CDC).

CAMRIN Radiology Clinical Reference Group (RCRG):

Meeting took place at Warrington Hospital on 24 Jan 24 and included discussion on:

- Proposed survey re: biopsies on patients presenting with metastatic spinal cord compression with an unknown primary
- Progress on alerts and notifications project
- Discussion re: access to unreported PET CT images
- Discussion re: use of Liverpool HITS scoring system for patients with head trauma
- Increased demand for imaging to follow up melanoma patients - new NICE guidance
- Update form NW Imaging Academy
- Discussion re: experiences of setting up and using CDCs

Community Diagnostic Centres (CDCs)

- 24/25 activity plans - confirmation received from national team
- Review of capital plans to confirm spending in line with 23/24 profile
- Halton Shopping City's formal opening took place on 15 Feb 24
- All relevant system CDCs signed up for Experience Based Design, patient feedback started
- Additional international recruitment (funded through NHS England) being commenced for histopathology, endoscopy and respiratory services.

Finance, efficiency, and value workstream

The overall C&M Financial position is a deficit of £79.8m against a deficit plan of £22.1m. 9 CMAST Trusts are currently reporting deficits.

Month 10	Plan (£m)	Actual (£m)	Variance (£m)	FYE Plan (£m)	FYE Forecast (£m)	FYE Variance (£m)
CMAST (deficit)	(77.5)	(110.4)	(32.9)	(66.1)	(95.2)	(29.1)
Others surplus	5.9	6.1	0.2	6.6	11.8	5.2
Total Provider (deficit)	(71.6)	(104.3)	(32.7)	(59.5)	(83.4)	(23.9)
Total System (deficit)	(22.1)	(79.8)	(57.8)	(0.0)	(22.7)	(22.7)

Financial Outturn Forecast

The forecast variance is wholly attributable to unfunded industrial action in December 2023 and January 2024. Excluding this, Trusts are anticipating a break-even position albeit with inherent risk at system and individual provider level.

Cost Improvement 2023/24

CIP delivery remains a challenge with anticipation that Q4 will see escalation of recurrent delivery.

CIP	YTD Recurrent CIP			23-24 Total Recurrent CIP		
Month 10	Plan (£m)	Actual (£m)	Variance (£m)	FYE Plan (£m)	FYE Forecast (£m)	Variance (£m)
CMAST	182.1	134.6	(47.6)	227.3	174.0	(53.3)
Others	27.8	28.0	0.2	33.5	34.3	0.8
Total Provider	209.9	162.6	(47.4)	260.8	208.4	(52.5)

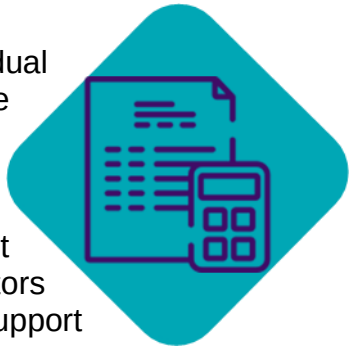
Capital & Cash

As of Month 10, 47% of the annual capital plan has been spent with concerns about delivering

against the full C&M CDEL by 31st March. Provider IFRS16 allocation (in relation to leases) of £28.3m has been distributed to the ICB to manage across the ICS. Leases between DHSC entities should net off within the group accounts, meaning that the ICS should be within its annual allocation. At Month 10 cash balances at provider level continue to reduce, with 4 CMAST providers having been advanced £81.7m from the ICB, and are applying to NHSE for cash distress support. Going forward more work is needed to manage the overall cash position across balance sheets.

Efficiency at Scale

Overarching Programme



2024/25 planning preparation continues for the E@S programme and individual workstreams, with medicines optimisation workstream attending the Place Associate Directors of Finance meeting and procurement planning workshop taking place in February 2024.

Discussions have taken place with ICB colleagues regarding a joint governance structure for estates. A proposal has been presented the Directors of Finance early February which was well received. Further discussions to support implementation are scheduled.

A CMAST E@S update was presented to the MHLDC CEO Forum and ICB Execs meeting in February 2024.

Finance/Legal

Work continues on the potential development of a single financial ledger vision, strategy and SOP, which can then be used to develop a full business case. A meeting to explore the funding options is scheduled.

The Liverpool legal collaboration (LUHFT, LWH & LHCH) continues and remains on track for an April 2024 implementation date. C&M continues to support national workstream looking at additional indemnity insurances and discussions are taking place with the regional NHSE team.

Medicines Optimisation

In December 2023 medicines optimisation reported YTD savings of £13.7million against a E@S and Place full year target of £17.5million and a stretch 23/24 forecasted position of £18.3million. Work continues with a focus on DOAC, AMD and Polypharmacy. Providers are working collectively with the ICB, E@S programme and Spec Comm to develop a single system business case for high-cost drugs and homecare.

A steering group and task and finish groups have been established to progress the improvement plan with regards to the Valproate patient safety alert. A briefing has been issued to all CEOs.

Procurement

The projected outturn is likely to land at £3.65 million whilst the remaining £575k is actively being progressed, and if this is secured it is likely to be delivered in 24/25. Meetings have been arranged with key stakeholders, in digital and estates, for a deep dive procurement opportunities assessment which is due to be concluded in March 2024.

11 C&M providers have now signed up to national energy contract with CCS and £8million plus estimated savings have been identified from April 2025. An extension has been supported by CCS for the remaining trusts to complete any necessary data analysis and internal approval processes as

appropriate.

Workforce

CMAST Workforce Programme

The Workforce Programme Board took place on 13th February and several agenda items were presented including an update from the Band 6 nurse project and an overview of the future governance arrangements for workforce projects. The programme will be formally closed at the end of March and the final Board meeting will take place on 26th March 2024.

Development of Band 6 Ward & Department Nurse Roles

The Development Toolkit pilot scheme was launched on 27th November at 3 Trusts in Cheshire & Merseyside: The Walton Centre NHS FT, Alder Hey Children's NHS FT and Warrington and Halton Teaching Hospitals NHS FT. In total, 29 Nurses enrolled onto the pilot scheme which will conclude on 1st March after 14 weeks. The working group met in January to agree the key metrics that will be used to evaluate the success of the Toolkit and evaluation is ongoing with pilot scheme participants.

Allied Health Professionals Faculty

Targeted placement expansion funding was awarded for the OT and PT practice educator project. Project management has commenced, and a project plan is currently being developed, alongside surveys and key activities at 2 C&M trusts. Resource for AHP career conversations has been developed and circulated for feedback prior to launching further. 3 new project leads are now in post for AHP Preceptorship, Educator Career Framework and Enhanced, Advanced and Consultant Practice Insights Report work.

Elective Recovery Workforce

The February meeting was stood down in due to the high number of apologies received.
The workforce planning piece undertaken by Attain concluded at the end of December and the outputs of this work were presented to the Workforce Programme Board. The following areas will be taken forward via the Clinical Pathways Programme for further consideration and implementation: GP with special interests, establishment of an MOU for the Elective Recovery hub and advanced practitioners. The Elective Recovery Workforce Enabling Group will be formally closed from February recognising that key workstreams have come to a conclusion and the implementation work will be taken forward via alternative groups.

Quality Focus

There are various pieces of work in place that have a focus on quality for our patients across Cheshire and Merseyside. Highlights from this month include:

- Responding to the current system quality challenges, including input and support to the Measles Management Group and Industrial Action Clinical Cell.
- Establishment of the Infection Prevention and Control workstream as part of the Efficiency at Scale programme, including data collation and review together with continued engagement with the relevant professional groups.
- Continuing to work closely with each of the programmes to develop patient care and experience infographics which showcase the benefits our patients are seeing as a result of the work taking place.

Urgent and Emergency Care – System Control Centre

The urgent and emergency care (UEC) system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside, with the majority of trusts across C&M consistently reporting at OPEL 3 during 2023 to date. The system has been escalated overall at OPEL 3, which is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'.

C&M has shown a slight deterioration for patients admitted, transferred, or discharged within 4 hours, with January performance at 68.9% compared to December 69.4% this is against a 2023/24 year-end national recovery target of 76%. Current performance is slightly below 2023/24 plans, however, is performing better than the North West (67.4%).

The percentage of beds occupied by patients with a length of stay over 14 days was 35.9% at 18/2/2024, whilst length of stay over 21 days continues to account for around quarter of occupied beds (25.1%).

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/04/006**			
SUBJECT:	**Chair's Report**			
DATE OF MEETING:	3 April 2024			
AUTHOR(S):	Steve McGuirk, Chair			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will... Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will ...Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	This report highlights activity and strategic issues that, in the opinion of the Chair should be drawn to the attention of the Board but are not necessarily covered elsewhere on the agenda, as well as seeking to represent the point of view of the Council of Governors (COG) at the Board level.
	
	This update draws attention to:
	• **General Trust Update**
	  ○ Changes to the Executive Team
	  ○ Staff Survey Results
	  ○ Living Well Hub opening in Warrington Town Centre
	  ○ Warrington & Halton Diagnostics Centre – Halton Health Hub
	• **WHH Meetings and Events**
	  ○ Board Development Day
	  ○ Council of Governors			

	• **System Working & National Updates/Events**
	  ○ CMAST Update
	  ○ Chair & Chief Executive Network, NHS Providers
	  ○ Industrial Action – Junior Doctors
	
	• **Governor Observation Visits**		

PURPOSE: ***(please select as appropriate)***	**To note** ✓	**Approval**	**Decision**
RECOMMENDATION:	The Trust Board is asked to: I. Note the matters being brough to the attention of the Board. II. Make any comments or ask any questions arising from the report.		
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		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chair's Report	AGENDA REF:	BM/24/02/006

BACKGROUND/CONTEXT

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

MEETINGS/ ENGAGEMENT SINCE PREVIOUS BOARD

Date	Location	Meeting
13.02.24	Manchester University NHS FT	Interview for group non-executive
13.02.24	Video Conference	North West System leaders
14.02.24	Lakeside	C&M Trust Chairs Bimonthly meeting
15.02.24	Warrington Hospital	Council of Governors
20.02.24	Science Museum, London	National Leadership Forum
19.03.24	Royal College of Obstetricians and Gynecologists	Chair & Chief Executives Network, NHS Providers
20.03.24	Video Conference	CMAST Chairs Meeting

KEY ISSUES TO DRAW TO THE BOARD'S ATTENTION

1. General Update

1.1 Changes to the Executive Team

There have been a number of changes to the Executive Team, which took effect on the 1st April 2024.

Ali Kennah was successfully appointed to the position of Chief Nurse. Ali has worked at the Trust since 2017, most recently as Associate Chief Nurse and then Deputy Chief Nurse. Ali takes over from Kimberley Salmon-Jamieson, who has joined Manchester University NHS Foundation Trust as their Executive Group Chief Nurse.

Following Expressions of Interest and a robust appointment process, Chief Operating Officer Dan Moore has been appointed to the role of Deputy Chief Executive.

Associate Non-Executive Directors Adrian Carridice Davids and Dave Thompson, finished their term of office on 31st March 2024. We thank them both for their contribution to the Trust and wish them both the best in their future endeavors.

1.2 Staff Survey

The results of the survey published on Thursday 7th March, reveal that the Trust's scores for each of the survey themes have improved on the previous year and survey participation increased. The Trust's scores were also consistently better than the average when benchmarked nationally. In summary the results showed:

- We have improved across all nine survey areas compared with the year before, with four of the nine areas seeing a significant improvement.

- We performed better than the national average when compared to other acute/acute and community trusts across all nine survey areas, with six of the nine areas seeing significantly better results than comparator organisations.
- We have received extremely valuable insights to help us continue to make improvements and focus our attention on areas where we know we still have more work to do.

1.3 Living Well Hub opening in Warrington Town Centre

A ribbon cutting ceremony was held 1st March 2023, to mark the official opening of the new Living Well Hub, a welcoming and fully accessible 'one-stop shop' aimed at empowering residents to live as happily, healthily, and independently as possible.

The Town Deal-funded Hub, on Horsemarket Street, is one of the first of its kind in the country and a true collaboration, with 25 organisations and more than 350 staff set to provide a wide range of NHS and non-clinical services under one roof.

Thousands of people are expected to use the three-storey building over the next 12 months, with spaces shared by teams from Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), Warrington Borough Council, Bridgewater Community Healthcare NHS Foundation Trust and Mersey Care NHS Foundation Trust, and support from voluntary and charitable sector partners.

1.4 Warrington & Halton Diagnostics Centre – Halton Health Hub

The second phase of Warrington and Halton Diagnostics Centre (WHDC) officially opened at Halton Health Hub Friday 16 February 2024. The centre is one of only a few government-funded Community Diagnostic Centres in the country – and the first in Cheshire and Merseyside – to open in a shopping centre setting.

Diagnostic services are already under way offering additional checks and scans including ultrasound, blood testing, sleep studies, audiology and lung testing, which can identify health conditions including heart disease and cancer.

The centre is part of a three-phase £16.6m programme of work being carried out by the Trust, with the initial stage of the development having been focused on the refurbishment and modernisation of existing space within the Nightingale Building at Halton.

2. WHH Meetings and Events

2.1 Board Development Day

Members of the Board took part in a learning and development day on Wednesday 6 March 2024, the day took place in the new Living Well Hub – Warrington. The first item on the agenda was a presentation and tour of the hub. The board received a presentation covering; the main objectives of the living well hub, the role of the living well hub in tackling health inequalities, an overview of the services provided from the hub, details of collaboration work with partners and next steps.

Other items on the agenda were:

- Cultural Stock take – which was a review of Culture at WHH and plans for the coming year
- Operational Plan 2024/25

2.2 Council of Governors Meeting

The Council of Governors meeting took place on: 15 February 2024. The next Council of Governors meeting will take place on Thursday 16 May 2024, 3-5pm in the Halton Education Centre.

Papers for Council of Governors meeting are made available to the public prior to meetings on the Trust Website. The meetings are open to members of the public to observe.

3. System Working and National Updates

3.1 CMAST Update

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

3.2 Chair & Chief Executive Network, NHS Providers

The key topics covered at this national conference were:

- A strategic policy update from NHS Providers; an up-to-the-minute overview of the current policy landscape
- An opportunity to hear directly from Chris Hopson, NHS England's chief strategy officer, on the key priorities for the sector
- A facilitated breakout session on NHS productivity, delegates discussed how trusts are currently approaching improving productivity, what enablers would support trusts to go further, faster, and what a productive health system looks like.
- A panel discussion on shared leadership with an opportunity to hear from peers about why trusts are increasingly sharing leadership roles, including establishing group models.

3.3 Industrial Action Junior Doctors

BMA junior doctors took action from 07:00 on Saturday 24 February to 11:59 on Wednesday 28 February. HCSA junior doctor members took action from 06:59 on Saturday 24 February until shifts starting after 07:00 on Thursday 29 February.

The action came at the same time as the Trust was battling winter viruses and sustained pressures. Trust staff worked incredibly hard to keep patients safe and cover striking colleagues.

NHS England data indicated that since strikes began, the cumulative total of acute inpatient and outpatient appointments rescheduled is now 1,424,269.

4. Governor Observation Visits

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

- 12 February 2024 – Ward B3 Halton
- 20 March 2024 – ophthalmology outpatients/day ward

Governors have also taken part in a Chair's Briefing on Thursday 14 March, which was well attended by both staff and public Governors.

RECOMMENDATIONS

The Trust Board is asked to:

1. Note the matters being brough to the attention of the Board.
2. Make any comments or ask any questions arising from the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/007**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	3rd April 2024	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not	✓		
Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*

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

Since the last meeting:

- No new risks have been added;
- Since the last meeting there have been no changes to the ratings of any of the risks.

	• there have been no updates to the descriptions of any of the risks; • No risks have been closed or de-escalated; • The risk appetite of one risk (#1134) has been updated.		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to discuss and the changes and updates to the Board Assurance Framework.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee	
	Agenda Ref.	Multiple	
	Date of meeting	Multiple	
	Summary of Outcome	Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/24/04/007

1. BACKGROUND/CONTEXT

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

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

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

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New Risks

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

2.2 Amendment to Risk Ratings

Since the last meeting there have been no changes to the ratings of any of the risks; however, following a deep dive into risk at the February meeting of the Strategic People Committee (SPC), including a review of current and target scores, descriptions and risk appetite, it was agreed that the rating of risk #1134 will be reduced. A proposal will be submitted to the April SPC meeting to agree the rating.

2.3 Amendments to descriptions

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

2.4 De-escalation of Risks

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

2.5 Risk Appetite

Since the last meeting and following discussion and approval at the Strategic People Committee on 21st February 2024, the risk appetite of one risk (#1134) has been updated from **Cautious** to **Open** to help support the achievement of the target risk score and to better align with the agreed Trust Risk Appetite Statement, which states the following in relation to '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.*

2.6 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
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.	<u>Assurances</u> • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy.	20	No impact on risk rating
134	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	<u>Controls</u> • In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff. • NHSE have approved (March 2024) Cash support c£7m <u>Assurances</u> • Draft 2024/25 Operational Plan to be submitted by 22.02.2024 • C&M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding. Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		increase in bank and substantive staff. The 2024/25 challenge is to reduce agency to below the 3.2% ceiling. • C&M ICS have indicated that there should be a 2% reduction in staffing in the 2024/25 plan in line with the 5% CIP target. • Initial Draft 2024/25 Operational Plan has been submitted with further iteration to be submitted to the ICS by 25th April 2024 • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position • Letter received form the Chair and Chief Executive of ICB (5th March) setting out key considerations to complete 2023/24 effectively and the system response to the 2024/25 operational plan. • Audit Plan agreed with internal auditors. <u>Gaps</u> • Due to the deteriorating financial plan the Trust has requested cash support from NHSE for the remainder of the financial year and quarter 1 2024/25 • Further assurance required in relation to controls for pay and non-pay costs		
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 5.56% as at December 2023 and is showing an improving variation. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. This is the lowest annual absence rate since April 2020. Target is 4.2%. <u>Controls</u> • People Health and Wellbeing Group. The group review absence data to identify any patterns / trends / areas of concern and develop actions to address • Sickness absence, turnover and attraction workstreams have been reviewed in line with the Richard Barker/Graham Irwin letter and action	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		plans updated to ensure all actions from the letter have been considered. <u>Assurances</u> • Annual sickness absence in December 2023 is the lowest it has been since April 2020. • The People Health and Wellbeing group continue to provide a focus on improving the health and wellbeing of WHH staff and ensuring policy compliance. • As a result of the sickness absence data analysis undertaken by the People Health and Wellbeing Group, OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within the last 12 months who have experienced an absence of depression/stress/anxiety and are undertaking a deep dive to explore the split between work related and personal stress and any targeted interventions required. **Turnover and Attraction** Turnover in December 2023 was below target at 11.96% and is showing an improving variation. Turnover of permanent staff in December 2023 was 11.24% which was below Trust target. Target is 13%. The Trust's annualised vacancy rate is 10.4%, and is showing an improving variation, demonstrating the Trust is attracting staff to work within its workforce. Target is 9%. <u>Controls</u> • Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review. • Further review of the leavers process is underway with the development of a SOP for stay conversations and an		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		options appraisal review of the current exit interview process. • Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work. • A dedicated area to supporting Agile/Flexible working is available on the extranet, and a cultural change plan is in development which will encompass the Trust's approach to agile and flexible working. Pilots commence January 2024 To support with attraction, the Trust has adopted a coordinated approach to recruitment which includes: • International recruitment • Enhanced HCA recruitment events • Investment in TRAC (Recruitment system) • Enhanced Student Nurse recruitment • Enhanced wellbeing benefits package (financial and mental) • Improvements in agile/flexible working • Enhanced retirement support/offers Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention. <u>Assurances</u> • The responses to Exit Interviews are positive, only 15% of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions. **Temporary Staffing & Agency Spend** Bank and Agency reliance in December 2023 was 13.80% . Target is 9%. Bank reliance continues to increase and is 11.8% in December 2023 as agency reliance continues to decrease to 4% in December 2023.		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Assurances • Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards are to be reported to Finance and Sustainability committee, where it will be recommended an action plan related to the gap analysis is overseen. Gaps • Current annual welcome back conversation compliance is 82.96%% in December 2023 and has dipped below target, actions being taken to address. • Exit interview completion rates are low, currently reviewing process to improve completion rates.		
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	Controls • Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice. • Following national guidance available for Consultant IA • Recruiting Junior Doctors to WHH bank following legal challenge meaning collaborative bank cannot be utilised during IA. • Trust proposal for split pot LCEA's with eligibility criteria to go to Board 07/02/24 which is the reflective approach of the proposed pay deal. • Regular briefing sessions held in person and virtually for senior leaders and staff re. outcome of Band 2 HCA Acas collective conciliation agreement and subsequent process required to implement the agreement. • Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement. • Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, Practice Educator Facilitator and a member of the HR Business Partnering team. Assurance:	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• B2 HCA IA stood down following successful Acas collective conciliation agreement. • Consultant pay offer marginally rejected by BMA members, no further Consultant planned IA as at 06/02/24 whilst negotiations with the government continue. • BMA SAS doctors mandate for industrial action on hold whilst a ballot is underway on a government pay offer dates of the ballot to be confirmed by the BMA. <u>Gaps in Assurances & Controls</u> • Result of consultant ballot on government pay reform offer on 23/01/24 rejected the offer therefore the consult pay dispute remains an ongoing issue and they have a current mandate for industrial action until 18/06/24. No further planned dates for consultant industrial action as at 06/02/24 as further negotiations are underway with the government.		
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>Controls</u> • Agency reduction plan in place <u>Assurances</u> • Increase in registered nursing establishment in the Emergency Department, January 2024 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.51% in January 2024 • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.27% in February 2024 • Maternity: Turnover for all permanent staff has decreased from 14.81% in July 2023 to 7.42% in February 2024 • Twice yearly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy m • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Cost avoidance of £1.6m from agency managed service contract started August 2022 • International Nurse recruitment: Final cohort (11 staff) in post, pause for WHH in programme, pastoral care and retention is focus <u>Assurance Gaps</u> • Increased request to provide enhanced care • ED vacancy at 36.5% February 2024, due to increased establishment Pharmacist vacancy rate 32.4% February 2024 – some improvement but remains a challenge.		
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	<u>Assurances</u> • [DSPT Standard(s): 7.1.4] Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) <u>Controls</u> • [DSPT Standard(s): 1.3.5, 7.1.2. 7.1.3, 7.2.1, 7.2.2 & 7.3.2] • [DSPT Standard(s): 8.3.1, 8.3.2, 8.3.3] The use of automatic patching software to rollout security updates to devices. • [DSPT Standard(s): 4.5.3] MFA active on new starters for NHSMail <u>Gaps</u> • [DSPT Standard(s): 4.2.3 & 4.4.1] No dedicated logging tool to pull all key logs together and provide useable alerts. • CISCO network requires a hardware refresh • [DSPT Standard(s): 4.1.2] No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts	16	No impact on risk rating
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality	<u>Gaps in Controls</u> • Delay to implementation could push implementation date past Lorenzo contract and Lorenzo sunsetting date	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	and possible risk to patient safety			
1898	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	<u>Assurances</u> • Requirement to secure funding to complete the development of the phased new hospital plan	16	No impact on risk rating
125	If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns	<u>Assurances</u> • Confirmation from NHSE of funding to take the necessary remedial action to eradicate RAAC on the small extension. • Establishment of the Tactical Estates Group (TEG), reporting to the Capital Planning Group, to help support efficient decision making relating to estate allocation. • Director of Strategy & Partnerships represents the Trust on ICB Estates meetings	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	<u>Controls</u> • Refreshed programme for pathology collaboration shared by the Cheshire & Mersey Pathology Network. The first phase is to develop a full business case for the hub model expected by the end of 2024. <u>Assurances</u> • CDC phase 2 including ultrasound, spirometry, sleep studies, audiology & phlebotomy opened in Halton Health Hub in December 2023	12	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	patient care, reputation and financial position.			

5 RECOMMENDATIONS

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

Appendix 1

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Board Assurance Framework

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival	1	20 (L5xC4)	8 (L2xC4)	Cautious	Quality Assurance Committee
1215	Daniel Moore	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (L4xC5)	6 (L3xC2)	Cautious	Quality Assurance Committee
134	Jane Hurst	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (L5xC4)	10 (L5xC2)	Open	Finance & Sustainability Committee
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 (L4xC5)	8 (L4xC2)	Open	Strategic People Committee
1757	Michelle Cloney/Paul Fitzsimmons	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	2	20 (L5xC4)	8 (L4xC2)	Cautious	Strategic People Committee
2001	Paul Fitzsimmons	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (L5xC4)	6 (L2 xC3)	Minimal	Quality Assurance Committee
115	Ali Kennah	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	16 (L4xC4)	12 (L4xC3)	Minimal	Quality Assurance Committee

1114	Paul Fitzsimmons	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (L4xC4)	8 (L2xC4)	Minimal	Finance & Sustainability Committee
1372	Paul Fitzsimmons	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (L4xC4)	8 (L2xC4)	Cautious	Finance & Sustainability Committee
1898	Lucy Gardner	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	3	16 (L4xC4)	4 (L1xC4)	Seek	Finance & Sustainability Committee
125	Daniel Moore	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	1	15 (L3xC5)	10 (L2xC5)	Open	Executive Management Team
145	Simon Constable	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (L3xC4)	8 (L4xC2)	Open	Executive Management Team

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

Risk Appetite Statement

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

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

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

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

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

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

<u>Quality</u>

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

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

People

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

Financial and Operational Sustainability

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

Regulation

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

Reputation

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

General Risk Appetite Principles

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

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

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

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

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

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

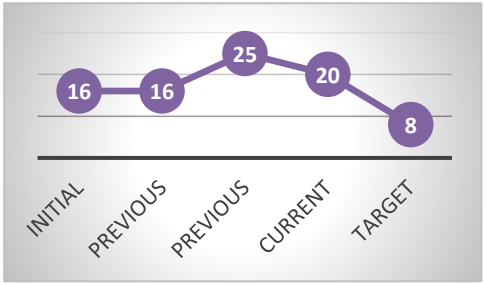
Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival			**Initial:**	16(L4xC4)
				Current:	20(L5xC4)
				Target:	8 (L2 xC4)
Risk Appetite	**Cautious** – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Controls** • Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day • Discharge Lounge/Patient Flow Team/Silver Command • ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing • Private Ambulance Transport to complement patient providers in and out of hours • FAU/Hub operational operating 5 days per week. • Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. • Increase IMC provided by the system such as the opening of the additional bedded capacity • Increase IMC at home • Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. • Same Day Emergency Care Centre (SDEC) completed July 2022. • Upgrade to Minor's resulting in Oxygen points in all cubicles • Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients • ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. • Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. • Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings • Additional Senior Manager on call support a weekends • Senior Dr at Triage Function • Ward A10 opened as winter escalation capacity funded by the ICB. • Plans being progressed to procure and install a new CT scanner co-located in the main body of the ED department. This will support increases urgent care pathway efficiency in the ED. This is set to be operational in September 2023. • Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients. • Plans to co-locate ED Minors in the SDEC building to enhance patient pathways. The capital project is now agreed and set to be operational in April 23. • Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter • Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E • Working with PLACE and system partners to agree how to spend Adult Social Discharge Fund to support reduction in no criteria to reside • Work plan to reduce super stranded and no criteria to reside in 2023/24 is being finalised by the System Sustainability Group • Executive led ED Improvement Group established chaired by the Chief Operating Officer with Chief Nurse & Medical Director as co-chairs				

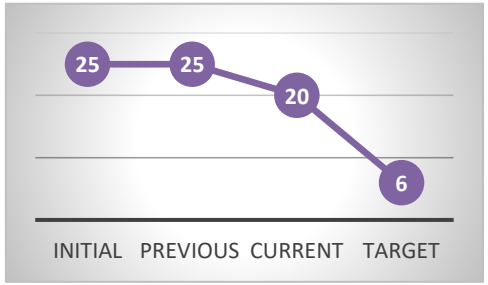
	• Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas to be submitted to the Trust Board in December 2023 • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy. **Assurances** • Systemwide relationships including social care, community, mental health and CCGs • System actions agreed supporting the Winter Plan • Redeveloped ED 'at a glance' dashboard • Trust implemented NHS 111 allowing for directly bookable ED appointments • Integrated discharge Team in place • Respiratory Ambulatory Care Facility agreed by CCG • Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved • Reinstated CAU 24/7 • Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 • Same Day Emergency Care Centre (SDEC) opened July 2022 • Plans to reduce length of stay for criteria to reside patients using SAFER methodology. This will form part of the GIRFT programme for 2023/24 • Following closure of the Lilycross facility at the end of May 2023, additional capacity has opening in Statham Manor, Grapenhall Manor and Oak Meadow. This replacement capacity is open and operational. • As a result of national urgent care tiering (Warrington placed in Tier 1), the Trust will be working with ECIST to support a service improvement programme. • New CT Scanner located in ED went live in August 2023. • Continuous flow commenced on 8th October 2023 and is planned for a full roll out in medicine by the end of November 2023 • Triage and streaming test of change to commence in November 2023 – This is to improve productivity and utilisation of assessment areas to support lowering ED occupancy. • Transition to type 5 SDEC reporting to go live on 1st November 2023. This will support improvements in streaming and data to allow the organisation to plan access and flow more robustly. • Reconfiguration of the ED footprint due to take place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12 hour time in department as referenced in the Tier 1 urgent care metrics. • Funding agreed to progress with the co-location of Minors with SDEC capital works. 12 week programme of work will commence in October 2023 to complete in March 2024. This will improve utilisation and flows away from the main ED in to Minors assessment areas. • As part of being in tier 1 urgent care, the Trust and wider system are being supported by Newton to undertake a place diagnostic on capacity and demand. The outcome will help improve flow, reduce attendances and thus lower bed occupancy. • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. This would constitute phase 3 and onwards of the ED footprint following the building of Same Day Emergency Care Centre (SDEC) • Update nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor	
Assurance Gaps:	**Gaps in Controls** • Staffing pressure created in part as a result of COVID-19 Global pandemic. • Ongoing industrial action across a number of staffing groups including junior medical staff, nursing and consultants. **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	31/03/2024 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	31/03/2024 (ongoing)	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial:**	25 (L5xC5)
				Current:	20 (L4xC5)
				Target:	6 (L3xC2)
Risk Appetite	**Cautious** – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Controls** • Clinical Services Oversight Group (CSOG) established • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery • Reconfigured of ED to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance. • Plans to create a co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Due to be operational by April 23. • Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted. • Waiting lists are reviewed through the Performance Review Group Weekly • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers • To support additional care bed availability throughout winter to protect the elective programme the Trust is actively working with system partners on increasing the Warrington Borough Council ICAHT service through the Adaptive 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 • Digital Validation commencing in May 2023 to improve data quality of the Trust waiting lists				

	Assurances • All elective patients have been clinically reviewed and categorised in line with national guidance. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery. • Same Day Emergency Care Centre (SDEC) opened in August 2022 • Bioquell Pods in ED live and operational • Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee. • Additional ultrasound contract awarded and commenced in January 2022 • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Regular meetings and communication with the ICB and primary care GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems. This is being progressed with the support of the estates and capital planning team. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • GIRFT/Efficiency programme to increase theatre productivity and utilisation • New theatre day case and endoscopy facilities due to be complete at Halton site by end of 2023/24. This is as a result of national Targeted Investment Fund (TIF) in support of restoration and recovery. • The Trust has been confirmed as the regional diagnostic hub to support the reduction of local and system waiting lists. • New CT and MR scanner replacement to be undertaken in 2023/24 • CDC phase 1 gone live in July 2023 which will increase capacity for diagnostic pathways • Executive Team support for additional use of independent sector to treat all outpatients in 65 week wait cohort by 31st October 2023 in line with the NHS England letter dated 4th August 2023. • Additional ENT Locum supported to help target ENT specialty long waiters. Thie will specifically help treat 78 and 65 week waiters before the end of March 2024 • Regional funding secured to support reduction in the echocardiogram waiting list. This is with third party providers and is due to start on 1st November 2023. • The Trust Board supported (1st Nov 2023) an additional £400k for third party providers to help treat all 78 week waiters before the end of March 2024 and significantly reduce 65 week waiters. Further support to be considered by the Trust Board in December 2023.	
Controls & Assurance Gaps:	• Capacity challenge with social workers to keep on top of demand and necessary patient assessments. • Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • Limited bed base within A5 elective footprint • Ongoing industrial action across a number of staffing groups including junior medical staff, nursing and consultants.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/03/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	134	**Executive Lead:**	Hurst, Jane	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			**Initial:**	20 (L5xC4)
				Current:	20 (L5xC4)
				Target:	10 (L5xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				

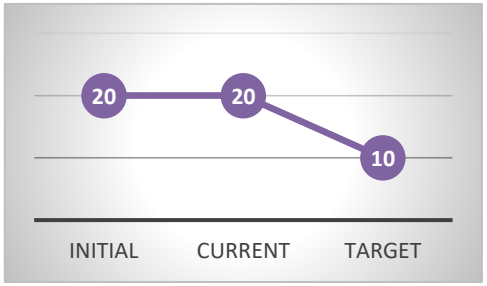
Assurance Details:

Controls

•Core financial policies controls in place across the Trust
•Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning
• Weekly CEO led recovery meeting (inc finance & operations) in place
• Procurement/tender waiver training in place
• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years)
• Latest guidance from MIAA Counter Fraud Team circulated
• Counter Fraud campaign took place for national anti-fraud week in November 2023
• Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced.
• Appointed GIRFT Finance Lead and 5 PAs allocated.
• Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022
• CDC phase 2 application approved for £4.5m capital over three years
• Capital & Revenue Plans for 2023/24 approved by the Trust Board in March 2023 & updated and approved by the Trust Board in May 2023
• Introduced system of escalation where there are risks to CIP delivery
• Reviewed of all aspects of 2023/24 operational plan resulting in an improved finance forecast
• New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified.
• In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff.
• Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the Finance & sustainability Committee
• Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023
• Tightening controls of non-pay expenditure
• Director of Recovery in place from October 2023 – January 2024 to review CIP, Cost Pressures and Benefit realisations.
• NHSE have approved (March 2024) Cash support c£7m

Assurances

• Achieved ICS control total in 2022/23
• Delivered 2022/23 Capital Plan
• Unqualified audit opinion (2022/23)
• Completed MIAA Governance Checklist received by Audit Committee
• Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process.

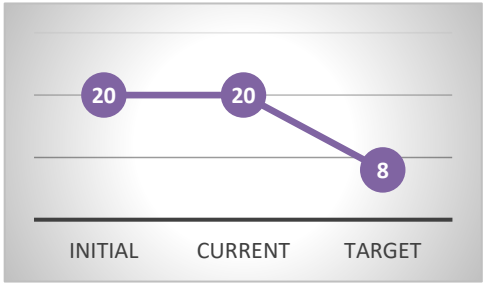


	• Capital is reported monthly to F&SC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • C&M ICS have indicated that there should be no increase in staffing in the 2023/24 plan. The ICS has reviewed each Trust plan, WHH has a small increase in pay budget linked to external funding. Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge is to reduce agency to below the 3.2% ceiling • C&M ICS have indicated that there should be a 2% reduction in staffing in the 2024/25 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • All conditions and actions of the 2022/23 Operational Planning Round letter from Julian Kelly have been completed. • We have allocated CIP targets under an approved new methodology for 2023/24 • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Participate in the monthly ICS Expenditure Control Group established in October 2023. • Working with the ICS on the forecast position. Letter received confirming additional £4.8m non-recurrent funding, including £1m tier 1 urgent care. • Key financial controls review 2023/24 received substantial assurance for general ledgers and high assurance for accounts receivable and treasury management. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • Initial Draft 2024/25 Operational Plan has been submitted with further iteration to be submitted to the ICS by 25th April 2024 • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position • Letter received form the Chair and Chief Executive of ICB (5th March) setting out key considerations to complete 2023/24 effectively and the system response to the 2024/25 operational plan. • Audit Plan agreed with internal auditors	
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. • Risk of unforeseen costs and under delivery of activity and income due to further COVID-19 / Flu surge / Industrial action • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Non-recurrent income support for additional capacity presents a risk to the 2023/24 and 2024/25 financial plans • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Not all cost pressures have been funded in plan for 2023/24 • Risk to financial freedoms as the Trust has a deficit plan • Industrial action uses management capacity to plan for safety which places CIP/GIRFT programme at high risk as capacity/focus is diverted • New 65 week target will require investment of circa £1.4m • Further assurance required in relation to controls for pay and non-pay costs	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Output of review undertaken of CIP, cost pressures and benefits realisation to be monitored via the Committee structure	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane	31.03.2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			**Initial:**	20 (L4xC5)
				Current:	20 (L4xC5)
				Target:	8 (L4xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Control & Assurance Details:	**Sickness Absence** The rolling 12-month sickness absence rate is 5.56% as at December 2023 and is showing an improving variation. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which were prevalent over winter. This is the lowest annual absence rate since April 2020. Target is 4.2%. **Controls** •New Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. •Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers. •Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. •Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management. •People Health and Wellbeing Group. The group review absence data to identify any patterns / trends / areas of concern and develop actions to address •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 •Following an MIAA Audit, the HR team are working with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. •Sickness absence, turnover and attraction workstreams have been reviewed in line with the Richard Barker/Graham Irwin letter and action plans updated to ensure all actions from the letter have been considered. **Assurance** •The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub. •The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.9% % in December 2023. • Annual sickness absence in December 2023 is the lowest it has been since April 2020. •The People Health and Wellbeing group continue to provide a focus on improving the health and wellbeing of WHH staff and ensuring policy compliance. •Pilot took place in maternity services where WBC compliance improved from 20% to 85% and is now cited as a best practice case study by NHSE •Pro-active health interventions offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate. Well attended by staff. •As a result of the sickness absence data analysis undertaken by the People Health and Wellbeing Group, OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within the last 12 months who have experienced an				

	absence of depression/stress/anxiety, and are undertaking a deep dive to explore the split between work related and personal stress and any targeted interventions required. **Turnover and Attraction** Turnover in December 2023 was below target at 11.96% and is showing an improving variation. Turnover of permanent staff in December 2023 was 11.24% which was below Trust target. Target is 13%. Retirements are reducing, with relocation the fastest growing reason for people leaving, however work/life balance remains the main reason for leaving. The Trust's annualised vacancy rate is 10.4%, and is showing an improving variation, demonstrating the Trust is attracting staff to work within its workforce. Target is 9%. **Controls** •Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review. •Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process. •Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work •Grief and Menopause cafes implemented to support individuals •Social media accounts have been created to support recruitment attraction across a number of social media platforms •Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream •A dedicated area to supporting Agile/Flexible working is available on the extranet, and a cultural change plan is in development which will encompass the Trust's approach to agile and flexible working. Pilots commence January 2024 •HR are working with pilot areas to review their approach to rostering and the impact on agile/flexible working to support a reduction in turnover. To support with attraction, the Trust has adopted a coordinated approach to recruitment which includes: • International recruitment • Enhanced HCA recruitment events • Investment in TRAC (Recruitment system) • Enhanced Student Nurse recruitment • Enhanced wellbeing benefits package (financial and mental) • Improvements in agile/flexible working • Enhanced retirement support/offers Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention. **Assurances** •The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH. •As a result of analysis of exit interviews, a theme identified was working hours and flexible working. Pharmacy are working towards changes to working hours, which have been raised as a factor by leavers and potential joiners as a barrier. •The responses to Exit Interviews are positive, only 15% of questions answered are negative, with lack of career progression receiving the highest proportion of negative responses. Feedback is being reviewed to inform future actions. • As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. Dec 23 staff in post is 4,195 FTE.	

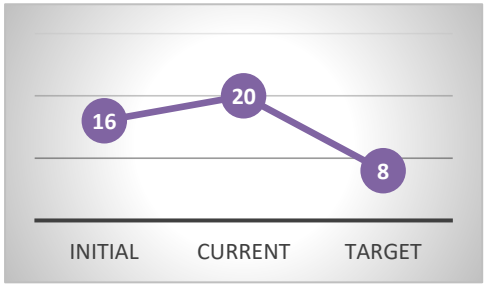
	• Staff completing apprenticeships is above target at 4.4%, target is 2.3% **Temporary Staffing and Agency spend** Bank and Agency reliance in December 2023 was 13.80% . Target is 9%. Bank reliance continues to increase and is 11.8% in December 2023 as agency reliance continues to decrease to 4% in December 2023. **Controls** •The increase in bank reliance is being driven by the Trusts industrial action response and as part of a plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. •The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are: o ECF process for non-clinical vacancies approval o ECF process for bank and agency temporary staffing pay spend approval o Medical Rate Escalations approved by Medical Director • The Resourcing Task and Finish group are developing robust processes to support compliance with national guidelines/standards for using temporary workers. All staff groups/CBUs will be monitored against these standards. Compliance is to be reported within the Medical and Nursing/AHP Workforce Groups and to FSC. A dashboard is being developed that will summarise workforce related intelligence to inform decision making regarding vacancies and temporary staffing. •The Resourcing Task and Finish group is working with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis from this will allow the organisation to develop plans to improve the effectiveness of workforce deployment. **Assurances** •Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee •To support agency controls, a refined ECF process for Medical and Dental temporary staffing bookings is in development. Streamlining the approval process to replace the ECF will ensure better oversight of the use of Temporary Staffing within the Medical and Dental Staff group. •Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards are to be reported to Finance and Sustainability committee, where it will be recommended an action plan related to the gap analysis is overseen.	
Assurance Gaps:	• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating special cause variation of a concerning nature. • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend. • Lack of assurance regarding industrial action ending which impacts bank and agency utilisation. • Current annual welcome back conversation compliance is 82.96%% in December 2023 and has dipped below target, actions being taken to address. • Exit interview completion rates are low, currently reviewing process to improve completion rates.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including wellbeing days, cardiac clinics, smoking cessation.	• Analysis of areas with high sickness absence to develop targeted interventions • Review of health inequalities data for local area to inform proactive health interventions for staff	Laura Hilton	31.03.2024	

		• Develop a plan for implementation of proactive health support for staff			
Embed an agile and flexible working culture within all WHH Teams	Through engagement, development and refined processes, support WHH leaders to embrace agile and flexible working.	• Engage with Senior Leaders to establish support for an agile and flexible working culture within all WHH Teams • Develop a campaign to promote WHH as an agile working/flexible employer • Development of WHH Leaders to enable them to support their teams to work in an agile/flexible way • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2024	
Develop an options appraisal related to improving the Trusts levels of attainment for both Job Planning and Rostering, following the gap analysis and associated action plan	Following the development of a workforce assessment framework the Trust has undertaken a gap analysis for Job Planning, Rostering and Workforce Reporting. As a result of the gap analysis, an action plan has been developed. To understand the appetite to improve the Trusts approach to Rostering and Job Planning as per the action plan, an options appraisal will be developed for discussion.	• Engage with the Workforce Resourcing groups (Medical and Nursing/AHP) to seek their agreement with the levels of attainment and associated gap analysis/action plan. • Share the findings of the workforce assessment framework with the relevant Executive leads. • Develop an options appraisal to outline actions required to deliver the action plan, to improve the Trusts approach to Rostering and Job Planning.	Carl Roberts (working alongside the Staff Group Leads)	30/06/2024	
Review of Exit Interview Process to Support Improvement of Completion Rates	• Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine future actions to address exit interview compliance.	Laura Hilton	30.05.2024	
Review of Welcome Back Compliance to improve performance.	Following target for WBC missing target in December 2023, a targeted review of data to be undertaken to support achievement of the target	• Targeted review of WBC data to support achievement of target	Laura Hilton	31.03.2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

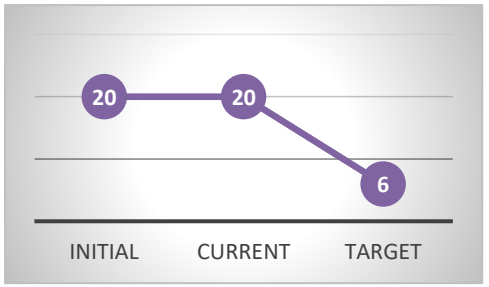
Risk ID:	1757	**Executive Lead:**	Cloney, Michelle/Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future. Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If 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 (L4 xC4)
				Current:	20 (L5 xC4)
				Target:	8 (L4 xC2)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Control & Assurance Details:	**Controls** • Trust policies updated in relation to industrial action • Trust approach to industrial action established following implementation of IA Task and Finish group. • Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible. • Executive led IA Operational Task and Finish group in place for each period of IA with an Executive led check and challenge session to ensure strike rosters support safe staffing. • IA tactical meetings established for the days of strike action, including where system IA being taken and not specific to WHH. • Participation in ICB IA Clinical Cell calls where applicable. • Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA. • IA Task and Finish group completed organisational preparedness for industrial action policies and procedures ratified and FAQ documents created and published and updated regularly. • Executive Medical Director led check and challenge meetings for periods of industrial action to prepare and mitigate risk. • Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice. • Following national guidance available for Consultant IA • Recruiting Junior Doctors to WHH bank following legal challenge meaning collaborative bank cannot be utilised during IA. • Trust proposal for split pot LCEA's with eligibility criteria to go to Board 07/02/24 which is the reflective approach of the proposed pay deal. • Regular briefing sessions held in person and virtually for senior leaders and staff r.e. outcome of Band 2 HCA Acas collective conciliation agreement and subsequent process required to implement the agreement. • Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement. • Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, Practice Educator Facilitator and a member of the HR Business Partnering team. **Assurance** • Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action. • AfC pay agreement implemented in June 2023 pay. Back pay for 22/23 and 5% uplift for 23/24 • RCN ballot that closed on the 23/06/23 did not meet the mandate therefore no further planned RCN IA at present time. Society of Radiographers did not meet their mandate at WHH. • Mandate met for Junior Doctors Industrial Action mandate will run until 28/02/2024 • BMA have published letter 13/07/23 r.e. the process for requesting derogations. No derogations been required thus far. • Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of industrial action • Long term NHS Workforce plan published 30/06/23 to address gaps in workforce. • NHS England letter 03/10/23 to BMA welcoming pause to any further industrial action dates reiterating concerns formally re Christmas Day cover and patient safety concerns. • B2 HCA IA stood down following successful Acas collective conciliation agreement. • Consultant pay offer marginally rejected by BMA members, no further Consultant planned IA as at 06/02/24 whilst negotiations with the government continue.				

	• BMA SAS doctors mandate for industrial action on hold whilst a ballot is underway on a government pay offer dates of the ballot to be confirmed by the BMA.	
Assurance Gaps:	• Medical IA is based on nationally negotiated Terms and Conditions which are outside of the influence and control of the Trust. • Lack of clarity from the ICB regarding mutual aid • Lack of MOU from ICB • Lack of clarity from BMA process for requesting derogations • No further updates on national position regarding talks with Trade Unions, specifically the BMA for Junior Doctors • BMA derogations process means unlikely to get derogations signed off for critical services. • High court ruling on 13/07/23 that employers can no longer use agency staff to fill in for striking workers for industrial action from 10/08/23. Also, Collaborative banks cannot be utilised. • Increasing fatigue amongst the Consultant and SAS doctor body is resulting in these doctors being increasingly reluctant to undertake additional extra contractual work to cover junior doctor roles during strikes, particularly in out-of-hours periods. This is assessed to be a particular risk in a number of patient safety critical areas including ED, Acute General Surgery and Obstetrics • Result of consultant ballot on government pay reform offer on 23/01/24 rejected the offer therefore the consult pay dispute remains an ongoing issue and they have a current mandate for industrial action until 18/06/24. • No further planned dates for consultant industrial action as at 06/02/24 as further negotiations are underway with the government.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Check and challenge meetings to commence for Junior Doctor Industrial Action	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Check and challenge meetings to commence for Junior Doctor Industrial Action from 07/08/23	Fitzsimmons, Paul	ongoing when IA dates announced	
Check and challenge meetings to commence for Consultant Industrial Action	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Check and challenge meetings to commence for Consultant Industrial Action from 07/08/23	Fitzsimmons, Paul	ongoing when IA dates announced	
Participate in regional ICB Workforce Industrial Action preparedness group	Participate in regional ICB Workforce Industrial Action preparedness group	Attending and participating in regional ICB Workforce Industrial Action preparedness group	Hilton, Laura	ongoing whilst national disputes continue	
Regular briefing sessions re outcome of Band 2 HCA Acas collective conciliation agreement	Regular briefing sessions held in person and virtually for senior leaders and staff re outcome of Band 2 HCA Acas collective conciliation agreement and subsequent process required to implement the agreement.	Regular briefing sessions held in person and virtually for senior leaders and staff re outcome of Band 2 HCA Acas collective conciliation agreement and subsequent process required to implement the agreement.	Laura Hilton	31/03/24	
Weekly Task and Finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Weekly task and finish group meetings established to implement the Band 2 HCA Acas collective conciliation agreement.	Laura Hilton	31/12/24	
Consistency panel meetings established to review and consider Band 2 HCA banding review claims.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Regular consistency panel meetings established to review and consider Band 2 HCA banding review claims consisting of senior nurses, practice educator facilitator and a member of the HR Business Partnering team.	Ali Kennah	31/12/24	

Board Assurance Framework

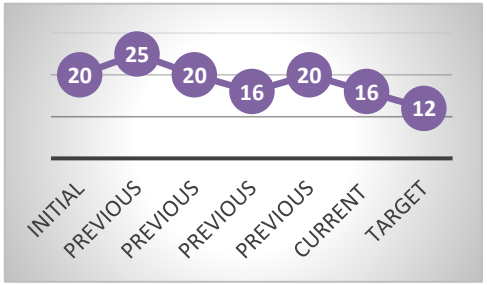
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	2001	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.			**Initial:**	20 (L5 xC4)
				Current:	20 (L5xC4)
				Target:	6 (L2 xC3)
Risk Appetite	**Minimal – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.**				
Assurance Details:	The Trust defines a Fragile Service for inclusion in its oversight program as 'A Service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm'. Current services included in the Fragile Services Oversight program are: • Gynaecology • Urology • Orthopaedics – Fractured Neck of Femur • Ophthalmology – Paediatric Ophthalmology • ENT Surgery **Controls** • Formal process in place for identification and designation of Fragile Services • Focussed additional support to Fragile service from senior Medical, Nursing and Operational leadership teams • Appropriate prioritisation of Fragile Service Revenue and Capital Requests **Assurances** • Monthly oversight through standardised Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC) • Escalation to Quality Assurance Committee via PSCESC escalation reports • Bi-monthly Fragile Services report to Trust Board				
Assurance Gaps:	•Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bedbase) •Ongoing industrial action •Increasing demand				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

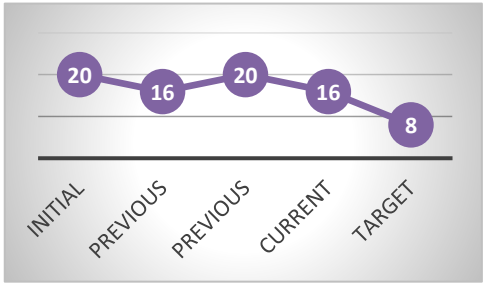
Risk ID:	115	**Executive Lead:**	Kennah, Ali	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial:**	20 (L5xC4)
				Current:	16 (L4xC4)
				Target:	12 (L4xC3)
Risk Appetite	**Minimal – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.**				
Assurance Details:	**Controls** • 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG) • 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 • Agency reduction plan in place • Local workforce plans in place for Emergency Department and Maternity with additional support from Executive team **Assurances** • Increase in registered nursing establishment in the Emergency Department, January 2024 • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.51% in January 2024 • Overall CHPPD sustained improvement at national standard of 8.0 • No requirement for staffing incentive scheme YTD • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 15.27% in February 2024 • Maternity: Turnover for all permanent staff has decreased from 14.81% in July 2023 to 7.42% in February 2024 • Twice yearly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy m • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme • Cost avoidance of £1.6m from agency managed service contract started August 2022 • Reduction in agency spend of £392K since April 2023. • International Nurse recruitment: Final cohort (11 staff) in post, pause for WHH in programme, pastoral care and retention is focus • Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead • Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly • Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends this is a full day shift • Rolling recruitment for RN and HCA posts, 2- 4 weekly interviews				

	• Leaver data is closely monitored and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner • Retention – Internal Transfer process in place for staff • A7, A8 and A9 uplift in healthcare support workers for night shifts has been approved to support the provision of enhanced care • Re-launch of what was the Safe Staffing Group, now the Nurse Staffing and Clinical Outcomes Group to provide a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk	
Assurance Gaps:	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours • Increased request to provide enhanced care • ED vacancy at 36.5% February 2024, due to increased establishment • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients • Continued escalation of ward A10 and intermittent escalation of Cardiac Catheter lab • Pharmacist vacancy rate 32.4% February 2024 – some improvement but remains a challenge • Partially funded revenue requests • Time to post when recruiting new staff • Ensuring safe staffing in response to doctor and healthcare support worker strikes	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • Domestic and international nursing recruitment • Position and plans for staff retention • Planning for the future – succession planning and staff development. • 6/12 establishment reviews. • Triangulation of staffing position alongside patient safety measures.	Kennah, Ali	19/10/24	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			**Initial:**	20 (L5xC4)
				Current:	16 (L4xC4)
				Target:	8 (L2xC4)
Risk Appetite	**Minimal** – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Assurance:** • Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • [DSPT Standard(s): 7.1.4] Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) **Controls:** • [DSPT Standard(s): 1.3.5, 7.1.2. 7.1.3, 7.2.1, 7.2.2 & 7.3.2] • **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • Active core member C&M Cyber Core Group and the C&M Health and Care Partnership Cyber Security Group. • **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • External NHS England approved Cyber Training for the Trust Exec Board • [DSPT Standard(s): 8.3.1, 8.3.2, 8.3.3] The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • [DSPT Standard(s): 7.3.4] Secondary secure backup at Halton Data Centre				

	• [DSPT Standard(s): 9.6.5] Remote devices no longer bypassing the web proxy • Outcome of the third 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 • [DSPT Standard(s):] Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • [DSPT Standard(s): 4.5.3] MFA active on new starters for NHSMail • [DSPT Standard(s): 8.1.4 & 8.4.2] Funding provided for MUSE migration	
Assurance Gaps:	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting “remember me” • [DSPT Standard(s): 4.2.3 & 4.4.1] No dedicated logging tool to pull all key logs together and provide useable alerts. • [DSPT Standard(s): 8.3.6] Lack of process to check antivirus/MDE alerts in console. MIAA to review processes and tools • [DSPT Standard(s): 4.4.2] Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • [DSPT Standard(s): 8.1.4 & 8.4.2] Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • [DSPT Standard(s): 8.1.2] Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • [DSPT Standard(s): 4.5.3] MFA on limited number of systems • [DSPT Standard(s): 8.3.4] Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • [DSPT Standard(s): 8.1.4] Version 7 of Clinisys Ice is end of life • [DSPT Standard(s): 9.3.8] Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • [DSPT Standard(s): 4.1.2] No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts	

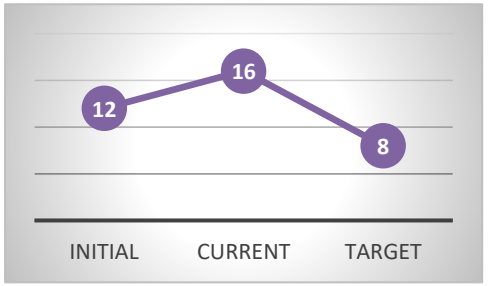
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for 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	Migrate all 2003 and 2008 servers to 2016.	The data from SharePoint to be migrated has been delayed until Jan 24, this is due to Governance still testing the system and updating materials. Once completed the last 2 2008 Windows Servers will be decommissioned. Paper being produced regarding options and mitigations by IT Services as the extended support by Microsoft has expired.	Deacon, Stephen	31/03/2024	

Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).					
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommsion Server 2012 servers	Update to the 2012 EOL project: WHHUSOFTV1 IT elements complete. Working with Operations and Digital Analytics to complete work target decommission the server in Q4 WHHNBSSV1 The third-party informed us that due to a software issue the 21st migration date has been postponed. Target date 16th January 2024. NCHVPRISM01 Work scheduled with the third-party. Team leaders of users have been informed of maintenance work. Migration completed and the server to be decommissioned W/C 11/12/23 WHHMUSEV1 Awaiting on funding decision emergency capital prioritisation submitted awaiting CPG support in December 2023 WHHMUSEV2 Awaiting on funding decision emergency capital prioritisation submitted awaiting CPG support in December 2023 WHHDWH1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in January 2024 WHHDWW1 The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in January 2024 WHHLEV1	Waterfield, Tracie	31/03/2024	

		The cutover is scheduled 25th January 2024. Decommissioning of service will be completed in March 2024 WHHCONWRXV1 PO raised works will be scheduled in Q4. WHHCONWRXV2 PO raised works will be scheduled in Q4.			
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	Order has been submitted and is with Procurement. Once order complete the software can be rolled out to the desktops and laptops. No changes can be made over the Christmas holiday period to systems, so will be in January 24 before any installation can happen.	Waterfield, Tracie	30/04/2024	
Seek funding for Cynerio Medical Devices Module	Seek funding for Cynerio Medical Devices Module	Applied for capital funding 24/25 to purchase the Medical Devices module, waiting on outcome.	Deacon, Stephen	29/03/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

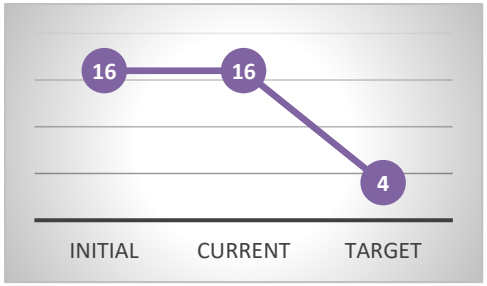
Risk ID:	1372	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 3: We will…Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety			**Initial:**	12 (L3 xC4)
				Current:	16 (L4xC4)
				Target:	8 (L2 xC4)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Assurance Details:	**Assurance:** Clear reporting line from EPR Project Group via escalation/assurance route through Digital Strategy Group, FSC and Trust Board) • Regular, documented conference calls with the ICS and NHSE – external partners supportive of managed convergence relaunch. • Updated OBC following departure from partnership procurement has received Trust Board approval and an ICB letter of support • Trust approval of updated OBC includes extension of Lorenzo contract to enact option to retain to Nov 26 if required due to previous delays in EPR program • NHSE Electronic Patient Record Investment Board (EPRIB) has confirmed approval of the EPR Outline Business Case (OBC) • EPR project group has oversight on state of readiness for deployment and associated risks **Controls:** • Business case approved and contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling in OBC includes 5-year Lorenzo costs • ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance. • Senior Programme Manager assigned • Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits				
Assurance Gaps:	**Gaps In Assurance:** • ICS strategic approach to delivering managed convergence through open procurement remains unclear **Gaps In Controls:** • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Delay to implementation could push implementation date past Lorenzo contract and Lorenzo sunsetting date • Phasing of frontline Digitisation Funding with funding availability not matching the timing of forecast expenditure • Deficit in programme year 3 • Further assurance required regarding state of readiness for implementation				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure ICS and NHSE Digital leadership sighted and supportive of procurement approach	Ensure ICS and NHSE FDIB leadership fully sighted and remain supportive of procurement approach including Tender format	Ongoing engagement with ICS and NHSE FDIB leadership	Fitzsimmons, Paul	01/04/2024	
Assurance regarding state of readiness for implementation should be provided to DSG and FSC	To ensure that the Trust is ready to implement its new EPR following procurement	Reports from EPR Project Group to DSG and FSC to include risks and assurances regarding state of readiness for deployment	Poulter, Tom	28/03/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1898	**Executive Lead:**	Gardner, Lucy	**Rating**	
Strategic Objective:	Strategic Objective 3: We will…Work in partnership with others to achieve social and economic wellbeing in our communit				
Risk Description:	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.			**Initial:**	16 (L4xC4)
				Current:	16 (L4xC4)
				Target:	4 (L1 xC4)
Risk Appetite	**Seek** - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).				

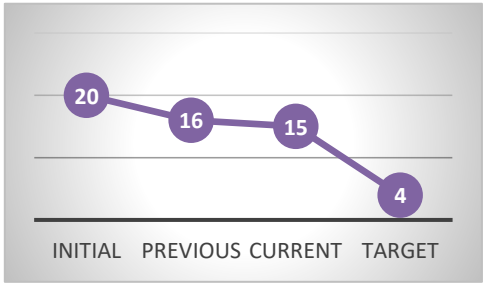
Control & Assurance Details	**Controls**
	• Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
	• Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have been carried out
	• Estates strategy incorporating options and enablers for new hospitals plans complete
	• External funding sought to enable estates developments which support delivery of new hospitals plans and estates strategy
	• All partners, including MPs, Councils, Education Providers, Place Partners and ICB supportive of our new hospitals plans
	• Financial and economic cases for new hospitals being updated and funding options explored
	
	Assurances
	• DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside ICS to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M.
	• Funding secured to deliver:
	  ○ Community Diagnostics Centre,
	  ○ Additional theatre ward and endoscopy capacity at Halton
	  ○ Community Hubs in Runcorn and Warrington
	• Development of business cases for initial phases of Estates Strategy in progress
	• Developing scope for work required to create phased new hospital plan for the Warrington site
					

Assurance Gaps:	• Confirmation received that the Trust was unsuccessful in securing funding via HIP phase 3. Future rolling programme of funding has been indicated; however, the details are currently unclear. • Requirement to secure funding to complete the development of the phased new hospital plan				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
New Hospitals Strategy Refresh	Produce updated estates strategy outlining steps required to create new hospital estate for Trust.	Complete and sign off Estates Strategy.	Moore, Dan	31/03/2024	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Gardner, Lucy	31/03/2024	

Board Assurance Framework

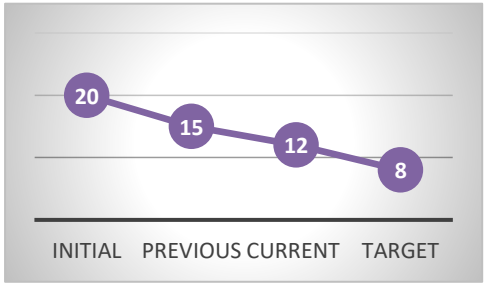
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	125	**Executive Lead:**	Moore, Dan	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns			**Initial:**	20 (L5xC4)
				Current:	15 (L3xC5)
				Target:	10 (L2xC5)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Assurance Details:	**Controls:** Annual capital funding is allocated to mandated and statutory estates projects The estates team operate a Planned Maintenance Program (PPM) The estates team operate a reactive maintenance process Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Estate strategy 2024-2029 which addresses several backlog issues to reduce future costs and to develop both the Warrington and Halton sites with available capital funding **Assurance:** Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Non funded capital schemes are risk rated and monitoired through the above group Fire Safety Group – monitors fire safety issues across the trust PLACE assessment with subsequent action plan Capital Planning Group – determine how the trust capital is spent Cleanliness monitoring identifies estates issues that are addressed through the estates building officer Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations Operational and Safety groups linked to Health Technical Memorandum (HTM) that identify compliance issues and put in place actions to reduce any resultant risk Complete formal RAAC survey undertaken across whole estate. Small extension building identified as having RAAC present. Confirmation from NHSE of funding to take the necessary remedial action to eradicate RAAC on the small extension Following an environmental health inspection, upgrades to the Warrington kitchen facilities have been supported. Establishment of the Tactical Estates Group (TEG), reporting to the Capital Planning Group, to help support efficient decision making relating to estate allocation. Director of Strategy & Partnerships represents the Trust on ICB Estates meetings				
Assurance Gaps:	Limited capital funding to address backlog Estates staffing - as maintenance (reactive and planned) increase due to limited backlog funding or new national standards, staff are asked to do more, with less and the estates maintenance team is currently under resourced Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market.				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warrington Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	30/06/2024	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.			**Initial** 20 (L5xC4) **Current** 12 (L3xC4) **Target** 8 (L4xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.			
Risk Description:	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.			
Assurance Details:	**Controls** • The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • The Trust has developed effective clinical networking and integrated partnership arrangements. • Council and Place Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level are refreshed annunallly • 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. • Refreshed programme for pathology collaboration shared by the Cheshire & Mersey Pathology Network. The first phase is to develop a full business case for the hub model expected by the end of 2024. • 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. • Health & Wellbeing Hub (Living Well Hub) due to open in March 2024 • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 approved by the Trust Board. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside.			

	• Consistent Trust representation within Cheshire & Merseyside ICS. WHH CEO appointed as lead for Clinical Pathways within C&M and the Trust is playing an active role within the Cheshire & Merseyside Acute & Specialist Trust (CMAST) provider collaborative. • Trust representation on place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • Funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Both reviews have been completed. • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities. • Director of Strategy & Partnerships co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Adaptive Reserve Fund created with Warrington Place partners • Discussions with neighbouring Trusts to accelerate collaboration taking place **Assurances** • Regular Strategy updates are provided to the Council of Governors & Trust Board • Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services. Halton Health Hub in Shopping City opened in November 2022. • Full refresh of the Trust 5-year strategy complete • In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. • Pace of pathology collaboration no longer poses a such significant risk to service delivery for WHH as challenges within histopathology are being addressed via mutual aid and recruitment. • Capital bid for strategic capital project resource submitted as part of the 2024/25 capital planning process • National funding secured for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside. Draft business case in development to be presented to the Trust Board in March 2024. • Detailed work commenced, supported by external consultants, to help address no criteria to reside & enable admission avoidance. • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside • CDC phase 2 including ultrasound, spirometry, sleep studies, audiology & phlebotomy opened in Halton Health Hub in December 2023	
Assurance Gaps:	• Self assessments of both Warrington & Halton place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is established (stage 3 of 4). There is a requirement to further develop as places to ensure both boroughs can benefit from potential future autonomy. • Trust's capacity to deliver significant number of capital projects	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at Place & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	30/04/2024	
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Capital bid to be shared with the Executive Team	Lucy Gardner & Dan Moore	30/04/2024	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/04/008**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	3rd April 2024	
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Kimberley Salmon-Jamieson – Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer 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.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✔
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✔
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✔
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust has 75 IPR indicators which have been placed into the following categories based on SPC/Making Data Count "Assurance" and "Variation" principles and performance. **Table 1** sets out the "Assurance" and "Variation" of all indicators, of these, there are **9 indicators that are both failing and have special cause variation of a concerning nature**, these are: ***Quality*** • *5. Healthcare Acquired Infections (CDI)* • *6. Healthcare Acquired Infections (Ecoli)* • *10. VTE Assessment* • *23. Sepsis - % screening for all emergency patients* • *25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis* ***A&P*** • *35. Referral to treatment Open Pathways* • *37. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge* • *39. Cancer 14 Days* • *67. RTT - Number of patients waiting 65+ weeks* Of which, indicators **5** and **25** are new to the category, due to declining Assurance and Variation. Indicators **13** (Medication Safety – Reconciliation within 24 hours) and **71** (Bank and Agency Reliance) now have normal variation, so have been removed from the top category since the Month 9 IPR. At Month 11 the plan is a £15.1m deficit, however, the actual deficit was £24.3m with the overspend being due in the main to a shortfall in Industrial Action (IA) funding, activity delivered under plan, additional capacity in A&E, specialling and CIP not delivered.			

PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 2. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSC/24/01/195; FSC/24/01/202; FSC/24/01/201	
	Date of meeting	24/01/2024	
	Summary of Outcome	Changes to the capital contingency supported and approved.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/24/04/008

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 75 Integrated Performance Dashboard (IPR) indicators have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count.

Appendix 1 details "Making Data Count" icons and data in relation to SPC.

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

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

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

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

Table 1: KPIs by Assurance and Variation Categories

	 Special Variation of a Concerning Nature	 Common Cause Variation	 Special Variation of an Improving Nature	 No SPC/Not Enough Datapoints/NA
 **Consistently Fails the Target (based on the last 7 months)**	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 6. Healthcare Acquired Infections (Ecoli) **(65 YTD – *less than 54 YTD target*)** 5. Healthcare Acquired Infections (CDI) **(49 YTD – *less than 36 YTD target*)** ⬇ 10. VTE Assessment **(93.51% - *95% target*)** 23. Sepsis - % screening for all emergency patients **(70% - *90% target*)** 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis **(58% - *90% target*)** ⬇ **A&P** 35. Referral to treatment Open Pathways - **(50.59% - *92% target*)** 37. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge **(23.89% - *2% target*)** 39. Cancer 14 Days **(58.06% – *93% target*)** 67. RTT - Number of patients waiting 65+ weeks **(1521 - 0 *target*)**	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 13. Medication Safety - Reconciliation within 24 hours ⬆ 24. Sepsis - % screening for all inpatients 33. MUST nutritional assessment completion **A&P** 36. A&E Wait Times - % patients waiting under 4 hours 47. Ambulance Handovers within 15 minutes 48. Ambulance Handovers within 30 minutes 49. Ambulance Handovers within 60 minutes 50. Discharge Summaries - % sent within 24hrs 51. Discharge Summaries - Number NOT sent in 7 days **Finance** 78. Better Payment Practice Code ⬇ 80. Cost Improvement Programme (recurrent forecast) – In year performance to date **Workforce** 71. Bank and Agency Reliance ⬆	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 21. Friends and Family (ED and UCC) 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis 31a. Maternity Pregnancy Bookings before 10 weeks 31b. Maternity Pregnancy Bookings before 13 weeks **A&P** 34. Diagnostic Waiting Times 6 Weeks 58. Elective Outpatient Activity **Workforce** 68. Supporting Attendance 73. Safeguarding Training 74. PDR **Finance** 77. Capital Programme	**CONSISTENTLY FAILING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **A&P** 40. Breast Symptoms 14 Days 43. Cancer 31 Days Subsequent Surgery	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 12. Pressure Ulcers 28. Acute Kidney Injury **A&P** 53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation 65. Theatre Utilisation (measured as productive operating time only) ⬇	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** 11. Inpatient Falls & harm levels ⬇ 15. Staffing Care Hours per patient day (CHPPD) **A&P** 41. 28 Day Faster Cancer Diagnosis Standard 59. Patients seen in the Fracture Clinic within 72 hours	**INCONSISTENTLY PASSING TARGET & NO SPC**

	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE	CONSISTENTLY PASSING TARGET & NO SPC
Consistently Passes the Target (based on the last 7 months)		**Quality** 1.Incidents 2. Duty of Candour (serious incidents) 19. Complaints 20. Friends and Family (Inpatients & Day cases) 22. Mixed Sex Accommodation Breaches (Non ITU Only) **A&P** 52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. 54. Urgent Operations Cancelled for 2nd Time 66. Day case (measured as an aggregate of total cases) **Finance** 79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m) ⬇	**Quality** 3.Healthcare Acquired Infections (MRSA) 14. Staffing - Average Fill Rate 18. NICE Compliance **Workforce** 69. Retention ⬆ 70. Turnover ⬆ 72.Core/Mandatory Training **Finance** 81. Agency Ceiling	
	NO ASSURANCE SPC & DECLINING PERFORMANCE	**NO ASSURANCE SPC & VARYING PERFORMANCE**	**NO ASSURANCE SPC & IMPROVING PERFORMANCE**	**NO ASSURANCE SPC & NO SPC**
No SPC/Not Enough Datapoints/Not Applicable		**Quality** 3. Healthcare Acquired Infections (MSSA) 17. Mortality ratio - SHMI ⬇ 32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **A&P** 38. Average time in department ED 55. Super Stranded Patients 62. Reduction in Outpatient Follow Ups 64. % Patients discharged to their usual place of residence	**Quality** 9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks 16. Mortality ratio – HSMR **A&P** 61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	**Quality** 27. Ward Moves between 10pm and 6am 29. Maternity Postpartum Haemorrhage 30. Maternity 3rd and 4th Degree tears **A&P** 42. Cancer 31 Days First Treatment 43. Cancer 62 Days First Treatment 56. Elective Recovery Activity (Grouped SPCs) 57. Elective Recovery Diagnostic Activity 60. % patients referred to long COVID service not assessed within 15 weeks **Finance** 75. Trust Financial Position (£m) 76. Cash Balance (£m)

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

Areas exceeding the target and continuously maintaining/improving performance

Areas of a concerning nature due to either:
- **indicators not meeting (failing) their set target**
- **declining nature of the performance**

⬆ Improved category from previous IPR

⬇ Declined category from previous IPR

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

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

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

The Trust agreed a revised control total of £21.2m deficit with Cheshire & Merseyside ICS. There has been a shortfall in funding for Industrial Action between December and February (£2.5m) and £1.5m of the £5.3m stretch target set by the ICS has been identified resulting in a £27.5m deficit. There are several risks to the achievement of the revised £27.5m deficit. The key risks are as follows:

- CIP delivery.
- Cost pressures – the Trust was unable to fund circa £8m cost pressures and has put in a process to oversee mitigation plans and risk management.
- Achievement of Elective Recovery Fund (ERF) and payment by Results (PBR), activity delivered is under plan resulting in loss of income.
- A&E staffing pressures and the additional cost of specialling.
- Additional capacity open due to the levels of no criteria to reside patients.

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

Cash

The cash balance at the end of February is £20.6m. The cash flow forecast has been updated to reflect the revised forecast deficit of £27.5m. Given the current cash position, the likely forecast to the end of 2023/24 and the current operational plan for 2024/25 the Trust has requested external support. £7.245m was received in March 2024 and a request for £21.022m has been submitted for Q1.

CIP

At 29 February 2024, the Trust has delivered a CIP of £13.7m against a target of £15.5m. The full year CIP target is £17.9m which has all been identified, however £2.5m remains at a high risk of delivery. In order to deliver the revised £27.5m deficit, £1.5m of the £5.3m stretch target is forecast to be delivered.

Capital Programme

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 11		**80**
Proposed changes in month		
Underspend to be returned to contingency		
MRI Scanner Works	41	
MRI Turnkey	6	
3Dimensions System with 3MP Monitor (static) (BSP)	13	
MRI Coil	19	
Histology Cassette Printer	4	
Sub total		**83**
Slippage to be returned to contingency but ringfenced for 2024/25		
Appleton Wing fire dampers final phase	80	
Sub total		**80**
Requests supported at CPG - 08/03/2024		
TCU Equipment	- 22	
Warrington Town Deal Health and Wellbeing Hub- Capital Works*	- 137	
Additional costs to clinic room	- 18	
Sub total		**- 177**
Contingency balance at end of month 11		**66**

The Trust Board is asked to:

- Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.

Financial Forecast

A revised deficit forecast has been produced (**Table 4**) and submitted to the ICS. The adjusted deficit forecast in November 2023 was £21.2m. There is a shortfall in funding associated with the national industrial action that took place between December 2023 and February 2024 (£2.5m) along with only £1.5m of the £5.3m stretch target being identified results in a £27.5m deficit.

Table 4: Revised deficit forecast

	Revised deficit forecast
	£m
Plan	(15.7)
CIP	(2.5)
Pressures*	(3.8)
Income*	(3.1)
Band 2 to 3	(1.6)
IA costs not funded*	(2.6)
Pay award gap not funded	(2.0)
December to February IA funding shortfall	(2.5)
Forecast	**(33.8)**
ICS Support (Tier 1 £1m, 2% ERF £1.2m and IA £2.6m)*	4.8
Trust further stretch target	1.5
Revised forecast	**(27.5)**

*Gross revenue impact prior to ICS support

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Quality & Assurance Committee
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
2. 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	1. Incidents	0	0	Feb-24		0	Jan-24	P
2	2. Duty of Candour (serious incidents)	100.00%	100.00%	Feb-24		100.00%	Jan-24	P
3	3. Healthcare Acquired Infections (MRSA)	0	0	Feb-24	L	0	Jan-24	P
4	4. Healthcare Acquired Infections (MSSA)	No target set	4	Feb-24		5	Jan-24	No SPC
5	5. Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	9	Feb-24	H	8	Jan-24	F
6	6. Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	3	Feb-24	H	7	Jan-24	F
7	7. Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	4	Feb-24		4	Jan-24	?
8	8. Healthcare Acquired Infections (PA)	Less than 2 - annual	0	Feb-24		0	Jan-24	?
9	9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	0	Feb-24	L	1	Jan-24	No SPC
10	10. VTE Assessment	95.00% (quarterly position)	94.42%	Feb-24	L	94.58%	Jan-24	F

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

11	11. Inpatient Falls & harm levels	20% or more decrease from previous year	40	Feb-24	L	41	Jan-24	?
12	12. Pressure Ulcers	10% reduction	10	Feb-24		11	Jan-24	?
13	13. Medication Safety Reconciliation within 24 hours	80.00%	50.00%	Feb-24		60.00%	Jan-24	F
14	14. Staffing - Average Fill Rate	90.00%	97.77%	Feb-24	H	90.43%	Jan-24	P
15	15. Staffing - Care Hours Per Patient Day (CHPPD)	7.9	8.4	Feb-24	H	7.8	Jan-24	?
16	16. Mortality ratio - HSMR	No target set	86.74	Feb-24	L	88.97	Jan-24	No SPC
17	17. Mortality ratio - SHMI	No target set	95.20	Feb-24		96.98	Jan-24	No SPC
18	18. NICE Compliance	90.00%	92.99%	Feb-24	H	92.66%	Jan-24	P
19	19. Complaints	Zero complaints open over 6 months old/in the backlog	0	Feb-24		0	Jan-24	P
20	20. Friends and Family (Inpatients & Day cases)	95.00%	97.00%	Feb-24		97.00%	Jan-24	P
21	21. Friends and Family (ED and UCC)	87.00%	71.00%	Feb-24	H	76.00%	Jan-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

- Special Cause Variation of a improving nature.
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*based on the last 6 datapoints/months

22	22. Mixed Sex Accommodation Breaches (Non ITU Only)	0	0	Feb-24		0	Jan-24	
23	23. Sepsis - % screening for all emergency patients.	90.00%	68.00%	Feb-24		54.00%	Jan-24	
24	24. Sepsis - % screening for all inpatients	90.00%	80.00%	Feb-24		84.00%	Jan-24	
25	25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	58.00%	Feb-24		48.00%	Jan-24	
26	26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90%	92.00%	Feb-24		88.00%	Jan-24	
27	27. Ward Moves between 10:00pm and 06:00am	0	58	Feb-24	No SPC	58	Jan-24	No SPC
28	28. Acute Kidney Injury	Less than previous month	174	Feb-24		197	Jan-24	
29	29. Maternity Postpartum Haemorrhage	3.70%	6.30%	Feb-24	No SPC	3.00%	Jan-24	No SPC
30	30. Maternity 3rd and 4th Degree tears	<1.85%	2.10%	Feb-24	No SPC	1.00%	Jan-24	No SPC
31a	31a. Maternity Pregnancy Bookings before 10 weeks	10-week Target: >75%	57%	Feb-24		54%	Jan-24	
32b	31b. Maternity Pregnancy Bookings before 13 weeks	13-week Target: >90%	82%	Feb-24		83%	Jan-24	

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

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32	32. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	37%	Jan-24		14%	Dec-23	No SPC
33	33. MUST nutritional assessment completion	above > 85%	52.48%	Feb-24		54%	Jan-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
34	34. Diagnostic Waiting Times 6 Weeks	95.00%	88.57%	Feb-24	H	85.67%	Jan-24	F
35	35. Referral to treatment Open Pathways	92.00%	56.71%	Feb-24	L	50.88%	Jan-24	F
36	36. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	75%	58.96%	Feb-24		62%	Jan-24	F
37	37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	23.98%	Feb-24	H	23.4%	Jan-24	F
38	38. Average time in department ED	No Target	449	Feb-24		437	Jan-24	No SPC
39	39. Cancer 14 Days	93%	54.04%	Jan-24	L	56.99%	Dec-23	F
40	40. Breast Symptoms 14 Days	93%	19.61%	Jan-24	L	26.83%	Dec-23	?
41	41. 28 Day Faster Cancer Diagnosis Standard	75%	77.65%	Jan-24	H	78.22%	Dec-23	?
42	42. Cancer 31 Day Wait	96%	96.43%	Jan-24	No SPC	97.14%	Dec-23	No SPC
43	43. Cancer 62 Day Wait	85%	78.18%	Jan-24	No SPC	72.34%	Dec-23	No SPC

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47	47. Ambulance Handovers within 15 minutes	65%	37.50%	Feb-24		25.19%	Jan-24	F
48	48. Ambulance Handovers within 30 minutes	95%	69.17%	Feb-24		47.76%	Jan-24	F
49	49. Ambulance Handovers within 60 minutes	100%	80.42%	Feb-24		59.77%	Jan-24	F
50	50. Discharge Summaries - % sent within 24hrs	95%	89.89%	Feb-24		90.52%	Jan-24	F
51	51. Discharge Summaries - Number NOT sent within 7 days	0	0	Feb-24		4	Jan-24	F
52	52. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	0.20%	Feb-24		0.04%	Jan-24	P
53	53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	2	Feb-24		0	Jan-24	?
54	54. Urgent Operations Cancelled for 2nd Time	0	0	Feb-24		0	Jan-24	P
55	55. Super Stranded Patients	Trajectory	158	Feb-24		143	Jan-24	No SPC
56	56. Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

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57	57. Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
58	58. Elective Outpatient Activity	0%	92%	Feb-24	H	89%	Jan-24	F
59	59. Patients seen in the Fracture Clinic within 72 hours	95%	0.00%	Feb-24	H	0%	Jan-24	?
60	60. % patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Feb-24	No SPC	0	Jan-24	No SPC
61	61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions	No Target set	91%	Oct-23	H	91%	Sep-23	No SPC
62	62. Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	92%	Feb-24		89%	Jan-24	No SPC
64	64. % Patients discharged to their usual place of residence	No Current Threshold	94%	Feb-24		93%	Jan-24	No SPC
65	65. Theatre Utilisation (measured as productive operating time only)	85%	82.20%	Feb-24		83%	Jan-24	?
66	66. Day case (measured as an aggregate of total cases)	85%	88.46%	Feb-24		88%	Jan-24	P
67	67. RTT - Number of patients waiting 65+ weeks	0	997	Feb-24	H	1233	Jan-24	F

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		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
68	68. Supporting Attendance	4.20%	5.60%	Feb-24	L	5.57%	Jan-24	F
69	69. Retention	86.00%	87.64%	Feb-24	H	87.47%	Jan-24	P
70	70. Turnover	Below 13%	12%	Feb-24	L	12%	Jan-24	P
71	71. Bank and Agency Reliance	9% or Below	15.34%	Feb-24	Common	15.45%	Jan-24	F
72	72.Core/Mandatory Training	85.00%	90.73%	Feb-24	H	90.82%	Jan-24	P
73	73. Safeguarding Training	Trajectory	86.88%	Feb-24	H	86.14%	Jan-24	F
74	74. PDR	85.00%	74.67%	Feb-24	H	75.99%	Jan-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
75	75. Trust Financial Position (£m)	-£0.28	-£2.44	Feb-24	No SPC	-3.29	Jan-24	No SPC
76	76. Cash Balance (£m)	£16.34	£20.65	Feb-24	No SPC	8.24	Jan-24	No SPC
77	77. Capital Programme (£m)	£19.34	£15.97	Feb-24	H	£0.00	Jan-24	F
78	78. Better Payment Practice Code	95%	91%	Feb-24		93%	Jan-24	F
79	79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£15.51	£13.70	Feb-24		12.14	Jan-24	P
80	80. Cost Improvement Programme (recurrent) – In year performance to date (£m)	£15.51	£7.00	Feb-24		13.12	Jan-24	F
81	81. Agency Ceiling	Less than 3.7%	2.4%	Feb-24	L	3%	Jan-24	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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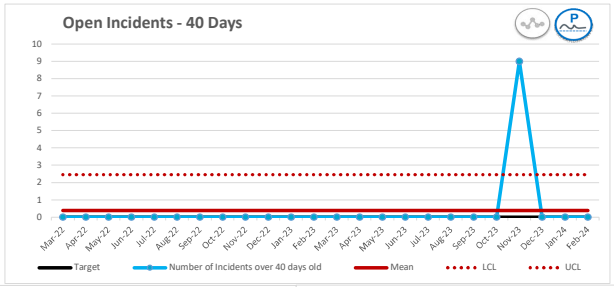
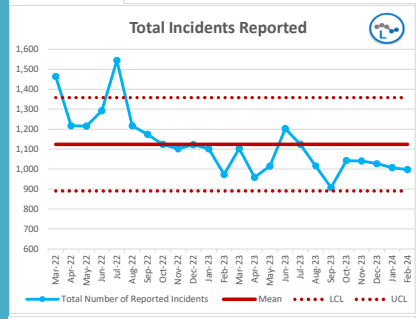
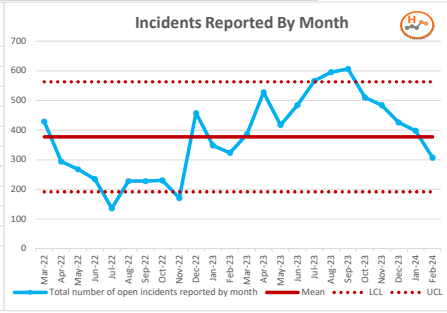
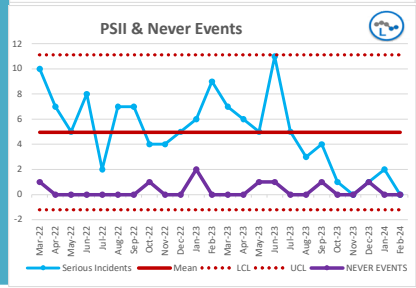
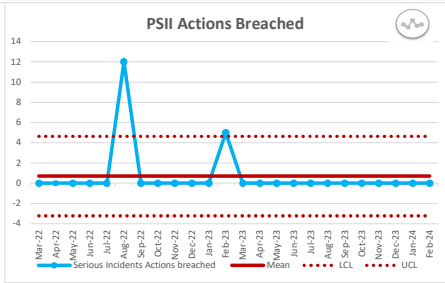
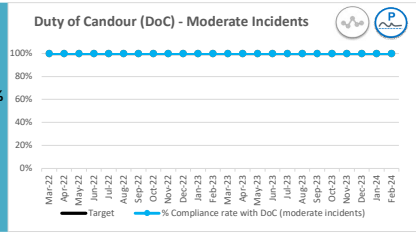
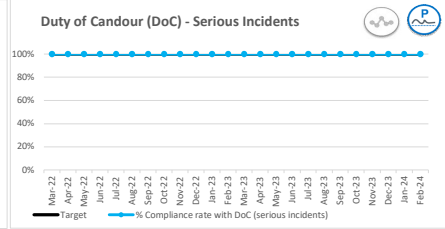
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	SOF CQC **There were 0 incidents over 40 days old.**	    	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**Incident reporting remains within range with little variance across the Trust. The number of open incidents is within normal control limits.** **There are no overdue 40-day incidents.** **There were no PSII's reported in February 2024.** **There were no breached serious incident actions in February 2024.**	**Incident Reporting** **A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Each CBU is supported by a designated member of the Governance Team to ensure consistency.** **Number of incidents within 40 days** **Weekly CBU monitoring supports timely escalation to the Associate Director of Governance, thus ensuring the position of zero incidents over 40 days continues to be maintained. Datix system now alerts at an additional lower threshold (30 days) to enable further support to be provided.** **PSII's** **Weekly monitoring continues with appropriate escalation to the CBU leads.**
2. Duty of Candour (serious incidents)	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.**	**Weekly monitoring is undertaken by the Patient Safety Manager to ensure that compliance continues to be sustained.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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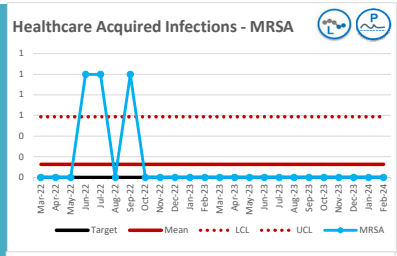
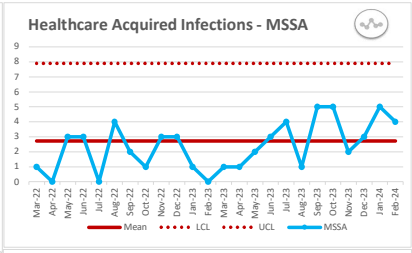
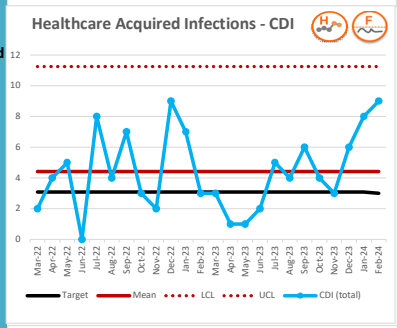
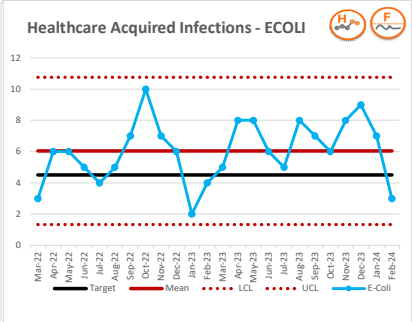
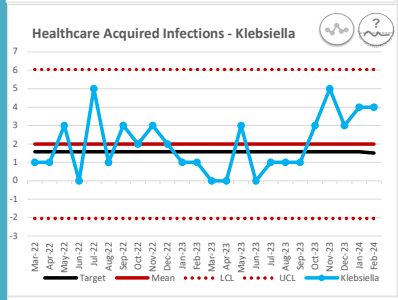
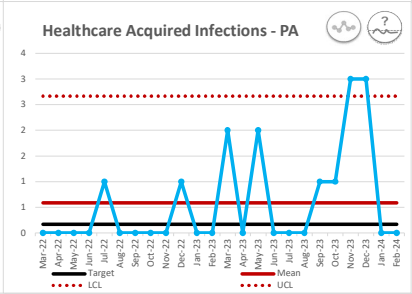
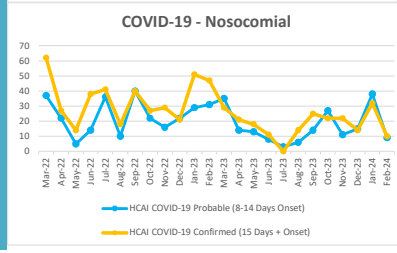
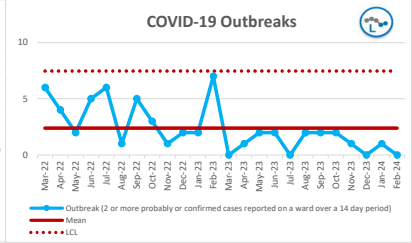
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO	MRSA cases YTD - annual threshold exceeded by 0		(MRSA) Assurance: The Trust consistently passes the target. (MRSA) Variation: Special Cause Variation of an improving nature.	MRSA: Nil returns for Apr 23 - Feb 24	MRSA: MSSA: Drive compliance with ANTT training and competency assessments, revise audit schedule to provide assurance on compliance with care of invasive devices. Revise patient safety investigation template to align with PSIRF.
4. Healthcare Acquired Infections (MSSA) Target: No set Target	MSSA 35 cases YTD - no threshold set			MSSA: 4 Trust apportioned cases in Feb; 35 cases YTD: different locations and likely sources, some deep seating infections not associated with healthcare	
5. Healthcare Acquired Infections (CDI) Target: Less than 36 -annual	CDI 49 cases YTD - annual threshold exceeded by 13 cases		(CDI) Assurance: The Trust consistently fails the target. (CDI) Variation: Special cause variation of a concerning nature	CDI: 9 Trust apportioned cases in Feb; 49 cases YTD: FY threshold breached by 13 cases against annual threshold of 36 cases	CDI: CDI prevention action plan in place. MDT review meetings are aligned to PSIRF, SIGHT mnemonic education will continue.
6. Healthcare Acquired Infections (Ecoli) Target: less than 54 - annual	E. coli 75 cases YTD - annual threshold exceeded by 21 cases		(ECOLI) Assurance: The Trust consistently fails the target. (ECOLI) Variation: Special cause variation of a concerning nature	ECOLI: 3 Trust apportioned cases in Jan; 75 cases YTD: Mainly UTI associated cases, followed by hepatobiliary. FY threshold breached by 21 cases against annual threshold of 54 cases	ECOLI: Klebsiella: Pseudomonas aeruginosa: Audit of hepatobiliary cases has commenced, revise investigation of hospital onset GNBSI cases - aligning approach to PSIRF, review urinary catheter use and protocol for nurse led removal, focus support on wards with higher UTI associated cases. The GNBSI Prevention Group has been reconvened and Lead Nurses engaged to drive prevention activity.
7. Healthcare Acquired Infections (Klebsiella) Target: Less than 18 - annual	Klebsiella spp. 25 cases YTD - annual threshold exceeded by 7 cases		(K) Assurance: The Trust inconsistently passes/fails the target. (K) Variation: Common Cause (Normal) variation.	Klebsiella: 4 Trust apportioned cases in Feb; 25 cases YTD: FY threshold breached by 7 cases against annual threshold of 18 cases	
8. Healthcare Acquired Infections (PA) Target: Less than 2 - annual	P. aeruginosa 10 cases YTD - annual threshold exceeded by 8 cases		(PA) Assurance: The Trust inconsistently passes/fails the target. (PA) Variation: Common Cause (Normal) variation.	Pseudomonas aeruginosa: 0 Trust apportioned cases in Feb; 10 cases YTD. FY threshold breached by 8 cases against threshold of 2 cases.	
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No	0 in month COVID-19 outbreak. Covid-19: 9 day 8-14 cases probable healthcare associated cases YTD 10 day 15+ cases definite healthcare associated YTD	 	Assurance: N/A - No target. Variation: Special cause variation of an improving nature		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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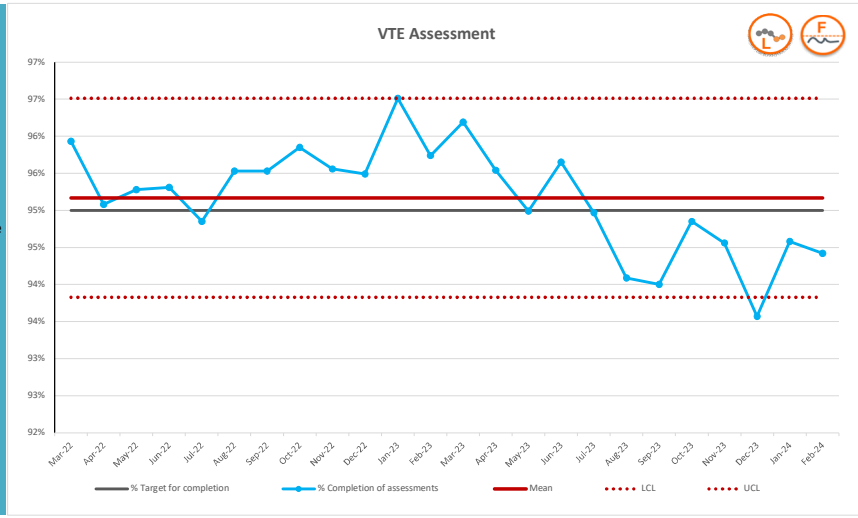
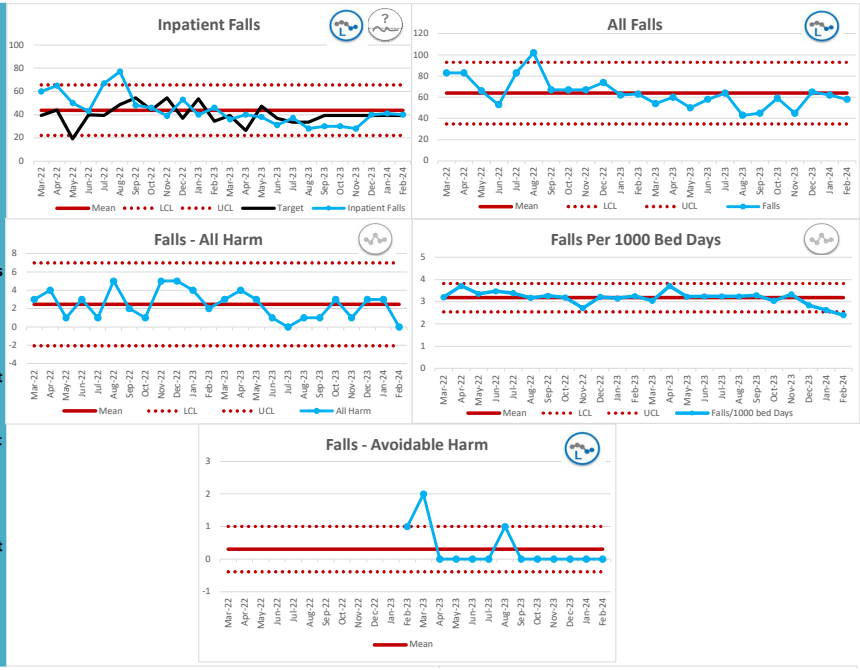
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. VTE Assessment **Target: 95% (quarterly position)**	**The Trust did not achieve the required target at 94.42% for VTE assessments in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of a concerning nature**	**Performance target in February 2024 was just below the threshold at 94.42 %. The number needed to meet the 95% compliance was 25.**	**Actions taken to improve VTE RA compliance:** **1. GIRFT In-patient Ward productivity dashboard developed in house at WHH now includes VTE risk assessment data at the ward level daily for data sharing purpose and for the ownership of this VTE RA data to improve overall compliance. It has been launched trust wide in Early December 2023.** **2. To work in partnership with CBU governance at the ward level to improve overall performance to meet target threshold >95%.** **3. To consider implementing ward level SPC chart for VTE data compliance – in discussion with corporate information team.**
11. Inpatient Falls & harm levels **Target: 20% or more decrease from 22/23 (610 Inpatient Falls in 2022/23)**	**58 total falls were reported in month. 40 of these were inpatient falls.** **There were 0 fall(s) in month with harm.** **There were 841 total falls in 2022/23. There have been 609 total falls YTD in 2023/24.** **We are expecting a 21% decrease in falls from last year.** **There were 610 inpatient falls in 2022/23. There have been 383 inpatient falls YTD in 2023/24.** **We are expecting a 32% decrease in falls from last year.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**The number of patients requiring enhanced care continues to be high, with many wards boarding patients for extended time periods. Overall the picture is one of sustained improvement.**	**The Trust wide falls audit was completed during February, early recommendations indicate focussed work required in relation to the use of visual aids at the patients bed to indicate risk. An audit of falls alarm is planned for April to reinforce the requirement and appropriate use. A thematic review of all falls with harm will be completed in April 2024. Weekly Harm Free Care meeting continues with lessons learned shared across the clinical teams.**

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

Quality Improvement - 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)?
12. Pressure Ulcers **Target: 10% reduction based on 91 in 2021/22**	Pressure Ulcers - Category 2; Pressure Ulcers - Category 3; Pressure Ulcers - Category 4; Community Acquired Pressure Ulcers	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	Contributory factors to the development of pressure ulcers include inconsistent repositioning and recognition of risk, particularly from medical devices. A 50% increase in referrals over the last 3 years into the Tissue Viability Team with a YTD figure of 6514, which demonstrates the frailty demand of patients.	Actions to improve the position include: 1. After Action Reviews have commenced and lessons are shared with ward teams and via Operational Patient Safety Group. 2. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses. 3. Shared learning for teams from areas of improvement such as A9, A6 and B14. 4. Temporary TVN (CPD funded) is supporting the TVN team and providing pressure ulcer prevention training to high incidence areas with a positive impact. 5. The Tissue Viability Nursing (TVN) Team continue to have an increased presence in the Emergency Department. 6. Shared learning across Trusts from Cheshire and Merseyside Pressure Ulcer Steering Group and NM Network Group. 7. Tissue viability training for preceptorship nurses and international nurses. 8. Nursing staff regularly shadow the TVN Team to gain experience in pressure ulcer prevention and management.
There were 9 hospital acquired category 2 pressure ulcers and 1 Category 3 pressure ulcer in month. **There were 57 community aquired pressure ulcers in month.**				
13. Medication Safety **Reconciliation within 24 hours Target: 80%**	Medication Safety - Reconciliation - 24 hours; Medication Safety - Reconciliation - Overall; Medication Safety - Controlled Drug Incidents; Medication Safety - Incidents with Harm	Assurance: The Trust consistently fails the target. Variation: Variation: Common Cause (Normal) variation.	Medicines Reconciliation: despite an improving trajectory in recent months, continued failure to achieve target which is linked to vacancy rate in pharmacy establishment resulting in some ward areas having reduced/no pharmacist or pharmacy technician cover. We have lost three locum/bank pharmacists in 2024, which coupled with maximum permitted annual leave, has impacted pharmacist ward cover. Controlled drug incidents: there is no target for this metric. 21 controlled drug incidents were reported in February 2024. The most common type of incident related to balance calculation errors or under/overage in liquid CDs and administration errors. Incidents causing harm: there is no target for this metric. There were 2 incidents causing harm in February 2024, one of which was an interface incident reported to an external organisation.	Actions to improve performance against Medicines Reconciliation performance: 1. Deliver actions agreed in pharmacy recruitment plan - two new B6 pharmacists have started in 2024, and 10 band 6 pharmacists have been appointed, the majority of whom will start in August 2024 upon registration. 2. Deployment of pharmacy team to ED - pilot undertaken on 2 weekends in January to assess the impact of focussing weekend resource in ED. Data being analysed to assess impact. 3. Allocation of pharmacy staff being amended from w/c 5.2.24 based on activity and acuity. Medication/controlled drug incidents: all incidents are reviewed by a multiprofessional group and lessons learned are disseminated. Themes are identified and action plans developed through the medicines governance structure. An emerging theme has been identified around controlled drug incidents relating to administration and confusion of immediate- and modified release preparations. As short life working group with nursing and pharmacy representation has been set up identify changes required to drive improvements and reduce the frequency of this incidents.
Medicines reconciliation was completed within 24 hours of admission for 50% of patients. 74% of patients had MR completed during inpatient stay. **There were 22 controlled drug incidents. There was 2 medication harm incident reported in month.**				

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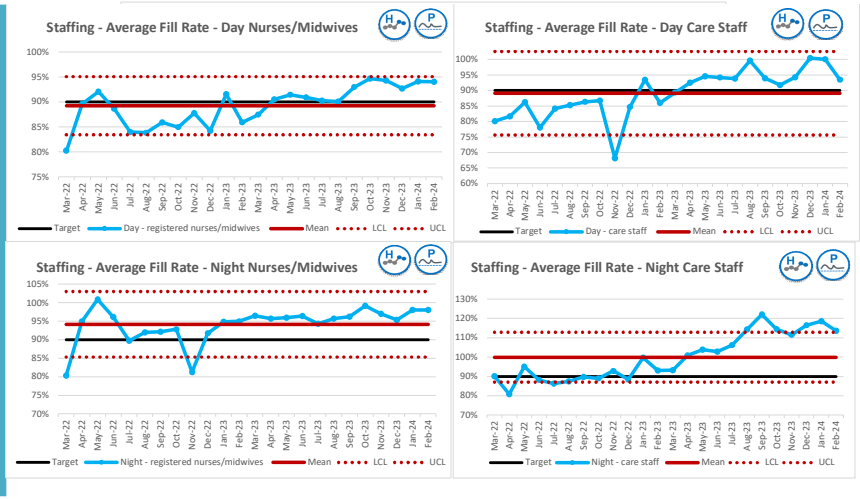
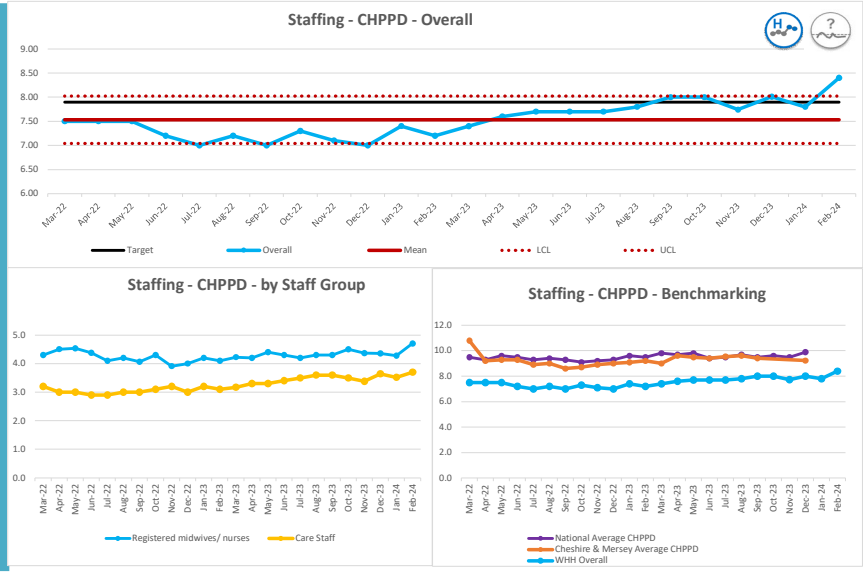
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 94.03% Day (Care Staff) 93.47% Night (Nurses/Midwife) 98.06% Night (Care Staff) 113.63% RR115 RR1108		Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	Additional beds in use across the Trust due to increased demand in AED, in addition to acuity and a large number of super stranded patients and escalated beds open.	Staffing is reviewed twice daily by the senior nursing team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a matron and lead nurse. RN vacancy on the PWR is 87.79 wte with 85.42 in pipeline. A further does not include 16 students who quality in 2024 already appointed to the trust. There were a further 29 staff members appointed at the recruitment event on the 9th Feb 2024. HCSW vacancy on the PWR is 75.02 wte. Once all HCSW are in post the trust will have 42.74 wte vacancy. There were a further 9 staff appointed on 1st March with a further 20 shortlisted to be interviewed on 15th March.
15. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	In month, the average CHPPD were: Nurse/Midwife: 4.7 hours Care Staff: 3.7 hours Overall: 8.4 hours		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of an improving nature.	The CHPPD February increased to 8.4 which is above national target.	Staffing is reviewed twice daily by the Senior Nursing Team to maintain safety and work is ongoing to reduce agency usage, recruit to posts and migrate regular agency workers to NHSP. There are clear processes for escalation to ensure staffing is based upon acuity to ensure patient safety.

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

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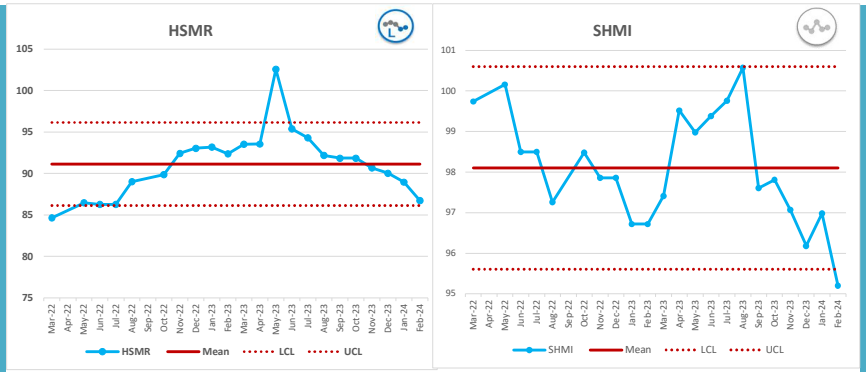
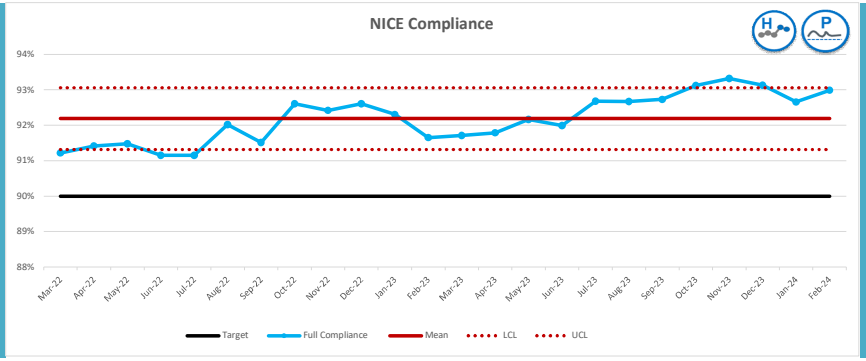
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 86.74. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 95.2.		(HSMR) Assurance: NA - no target Variation: Special Cause Variation of an improving nature. (SHMI) Assurance: NA - no target Variation: Common cause (normal) variation.	The SHMI relates to 12 months data up to and including August 2023. This result is in band 2 which means this result is as expected using an over-dispersed funnel plot. Please note that HES SHMI outliers (produced by HED) may differ slightly from NHS Digital SHMI outliers as they are based on more up-to-date data to form an early warning system.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. •In relation to the coding used, R69 relates to the filler code for uncoded episodes (coding backlog) and R54 relates to frailty •We are currently in line with, or better than, our peers for R codes other than R69 and R54 •The coding of Frailty R54 at our Trust has been commended by GIRFT The main diagnoses within SHMI diagnosis group 42: Mental retardation, Senility and organic mental disorders which is the case study, are diagnoses such as dementia, Alzheimer's, delirium, learning disability and frailty.
18. NICE Compliance Target: 90%	The Trust achieved 92.99% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Performance against the target of 90% continues to be sustained.	The Clinical Effectiveness Manager continues to work closely with the CBUs with focus upon partial compliance and those 'under review' to ensure timeliness of progress and completion.

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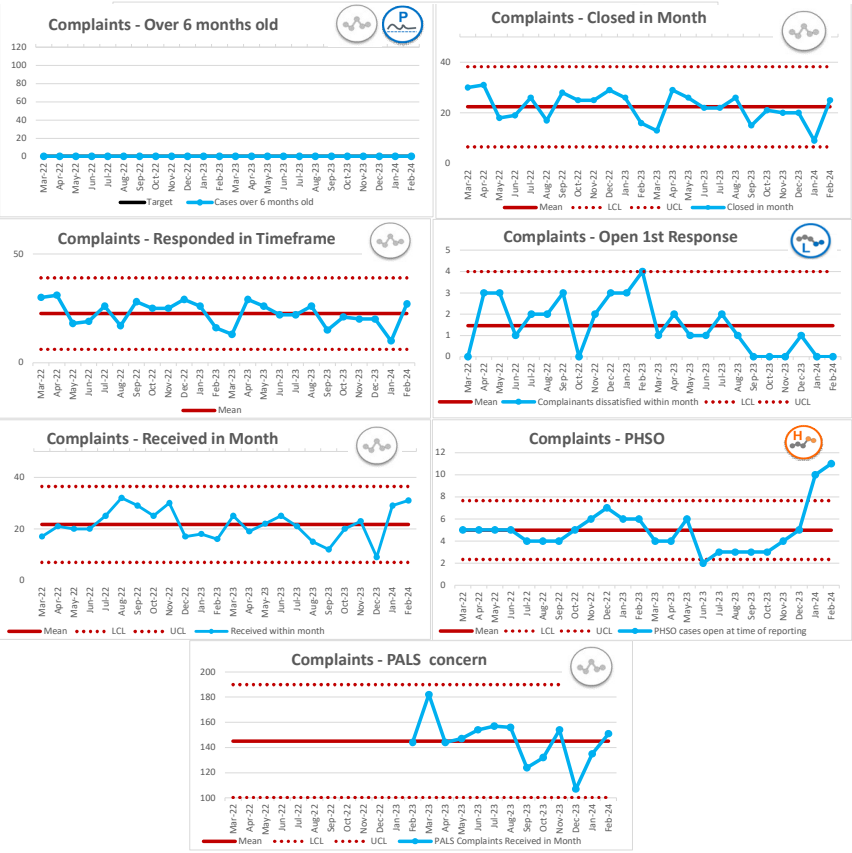
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
☆		Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The Trust continues to sustain performance in the timely completion of complaints. There continues to be no complaints over 6 months old. The complaints team and wider Trust are working hard to sustain this position.	Complaints position of 48 open complaints. All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the clinical teams. All CBUs have a designated complaints case handler to ensure consistency.

16. Complaints Target: Zero complaints open over 6 months old/in the backlog.

In month, 31 new complaints were received Quality!to the Trust which was an increase of 2 from the previous month. There were 0 dissatisfied complaints received in month, which is a decrease from the previous month.

4 PHSO cases were opened in January, these were not linked to a specific area or theme.

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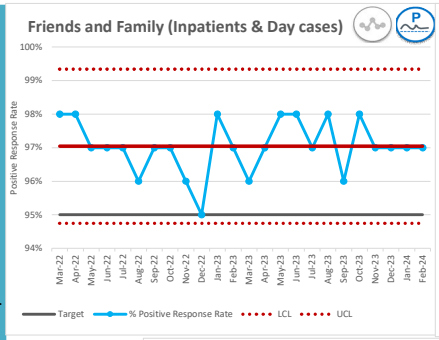
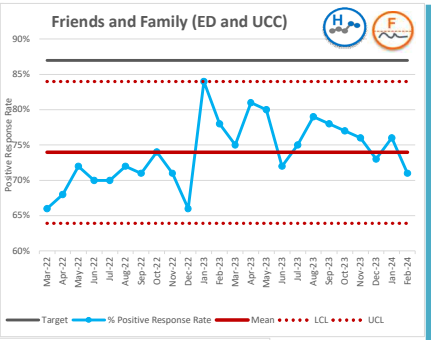
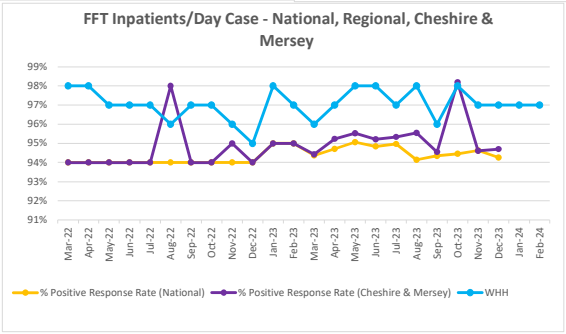
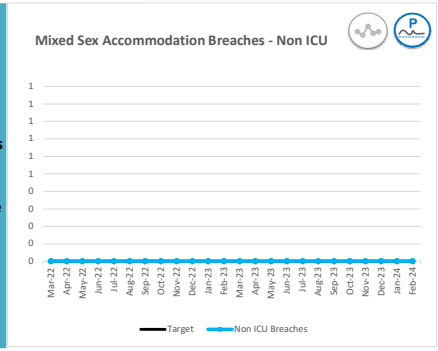
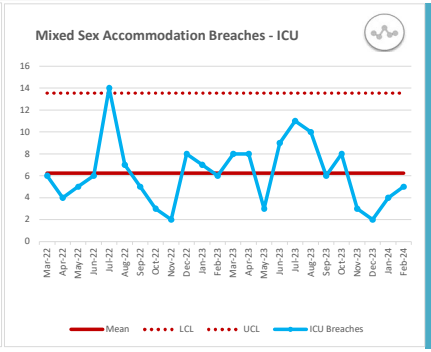
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) **Target: 95%** **21. Friends and Family (ED and UCC)** **Target: 87%**	**The Trust achieved 97% in month for Inpatient & Day case FFT and 71% for ED/UCC FFT.** **The most recent National average for FFT was 94.26% and for C&M was 94.7%.**	  	**(IP/DC) Assurance: The Trust consistently passes the target.** **(IP/DC) Variation: Common Cause (Normal) variation.** **(ED/UCC) Assurance: The Trust consistently fails the target.** **(ED/UCC) Variation: Common Cause (Normal) variation.**	**Inpatient/Day Case - A maintained position of 97% positive recommendation rates are noted for February 2024. The departmental teams continue to maintain a high positive response rate by monitoring feedback regularly and are currently working on increasing response rates with our Quality Improvement Team.** **ED/UCC - 71% positive feedback in Friends and Family Test results in February 2024. Operational challenges which result in longer waits in ED and high attendance levels have impacted the response rates.**	**Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis to look for improvement areas, maintain and share best practice. Patient experience team observations, feedback to departments and at Trust level. The Trust continues to be highly recommended through the FFT responses for Inpatients and Outpatients.** **ED/UCC - Key themes for improvement in relation to positive recommendation rates continue with communication, waiting times, pain management and the environment. Patient experience also to visit and audit areas, feeding back at a local and trustwide level. Measures taken to improve patient experience within the Emergency Department include but are not limited to:** **-monitoring of care and comfort rounds** **- visual communications to be prominent in areas** **- mapping patient journeys to understand the support required at each touch point.**
22. Mixed Sex Accommodation Breaches (Non ITU Only) **Target: Zero**	**There were 0 mixed sex accommodation incidents outside of the ITU in month. There were 5 MSA incidents within the ITU.**	 	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**There were 5 mixed sex accommodation breach reported in November 2023 in the Intensive Care Unit. There were zero breaches within any other ward area.**	**The prioritisation of patients from ITU into the general bed base is considered as a standing agenda item at all bed meetings and work is underway in the Unplanned Care Group to improve the position. A contributing factor to these breaches are the high number of super-stranded patients within the Trust bed base.**

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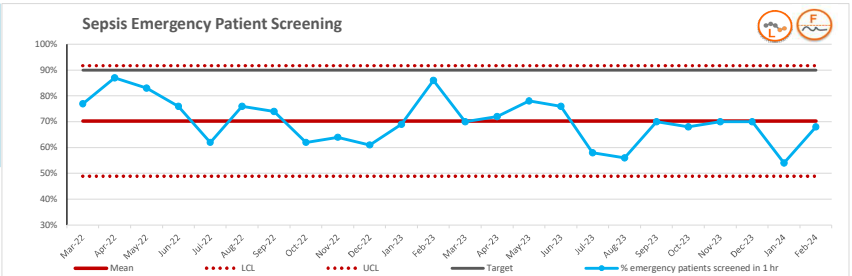
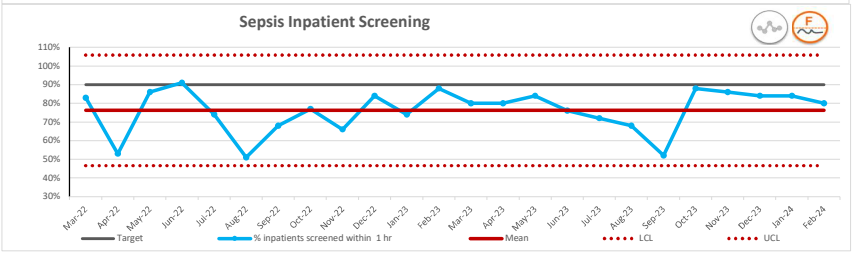
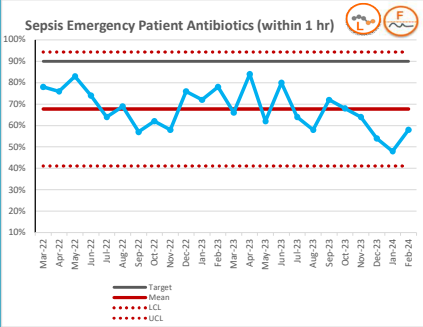
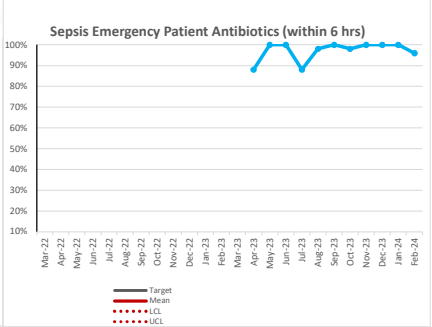
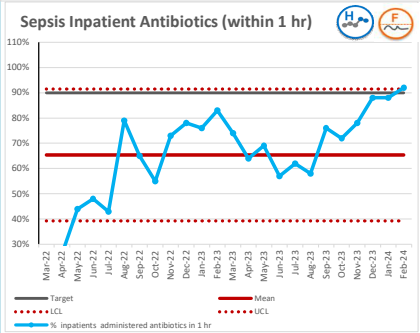
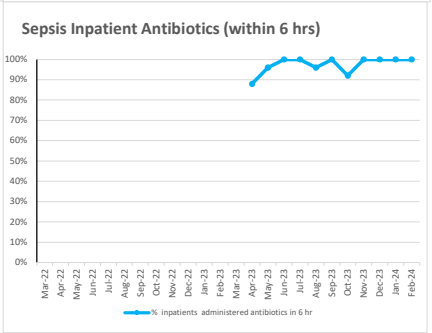
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. **Target: 90%** **24. Sepsis - % screening for all inpatients** **Target: 90%**	**The Trust achieved:** **• 68% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.** **• 80% screening for all inpatients with suspected sepsis within 1 hour.**	 	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**An increase is seen in month for the screening of patients for Sepsis in the Emergency Department. High attendances and numbers nursed in the ED are a contributory factor challenges in compliance. In patient screening has seen a slight decline with an outstanding 5 patients who did not receive a full screen but did receive antibiotics.**	**Quality Improvement support remains in place to drive improvements across the Trust. There are four workstreams with a focus for improvement: ED, In-patient, Paediatrics and Maternity. Sepsis management remains a focus on Safety Huddles. Improvements in vacancy fill in ED will support completion of screening as blood culture training is undertaken by nurses in ED to support practice.**
25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **Target: 90%** **26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis** **Target: 90%**	**The Trust achieved:** **• 58% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 92% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	   	**(Emergency) Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of a concerning nature.** **(Inpatient) Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.**	**A delay in completion of prescription was the main contributory factor for the inability to administer antibiotics within 1 hour. Inpatient antibiotic administration showed an improvement at 92% with the remaining 2 patients receiving antibiotics within 2 hours.**	**NG51 updated at the end of January 2024, with the new changes to be discussed. The PSIN have compiled a presentation outlining the significant changes, which has been circulated to key stakeholders for comments. Any patients who have had a delay in antibiotic administration have their details sent to the Trusts sepsis clinician to provide further assurance and identify any gaps in learning.**

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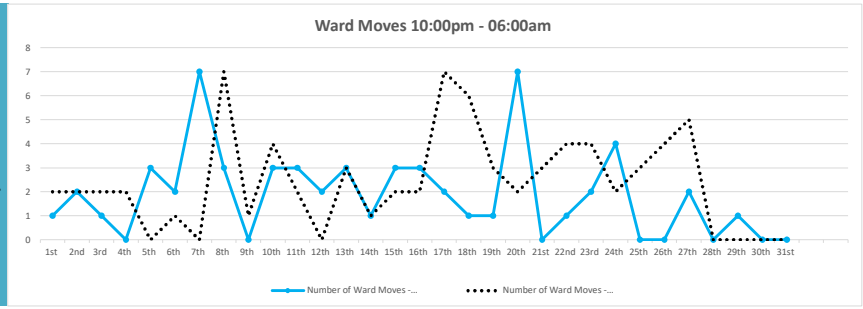
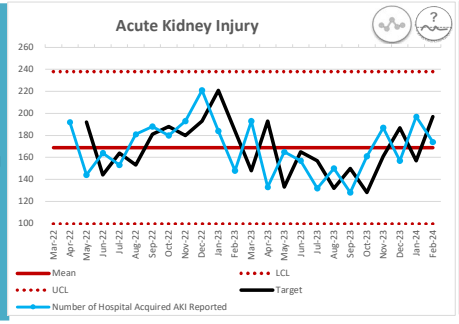
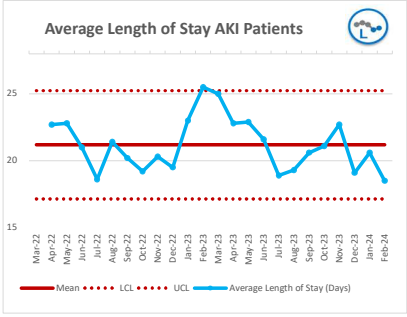
27. Ward Moves between 10:00pm and 06:00am No Target	There was a total of 58 ward moves between 10pm-6am in month, compared to 74 in 2022.		Variance and Assurance - N/A - Monthly/ Annual Comparison required for SPC.	The reason for the reduction on ward moves after 10pm for this reporting period compared 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.
28. Acute Kidney Injury Target: Less than previous month	There were 174 acute kidney injuries reported in month.	 	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	No Variation with LOS and HA-AKI both showing a positive decrease.	Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient. Move towards a deteriorating patient bundle to reduce work and improve prevention and management. Staff survey undertaken to understand 'barriers to completion' and suggested E-learning / ward-based teaching package to be developed. Ward based further AKI education as part of the AKI role. Drive to increase the AKI bundle to improve practice and utilise the AKI clinics each week to reduce the 30-day readmission rate.

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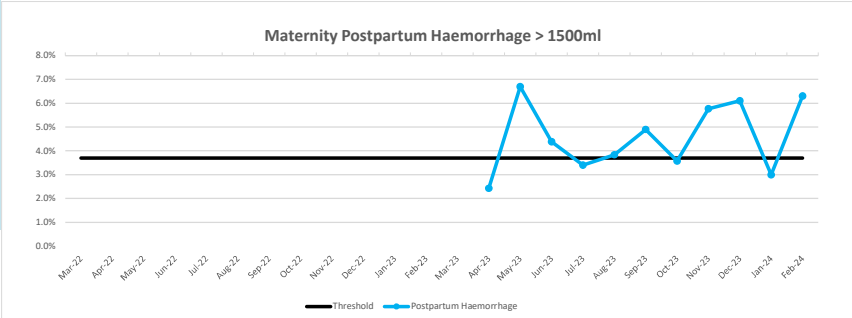
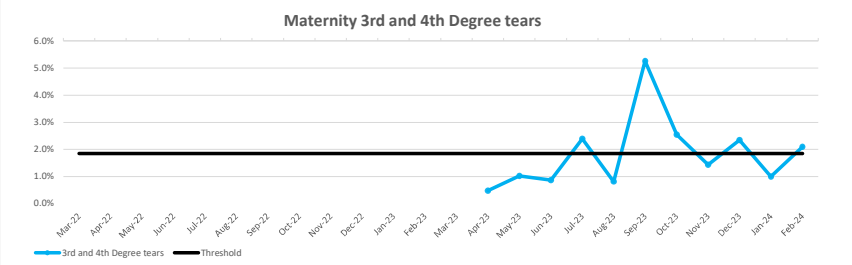
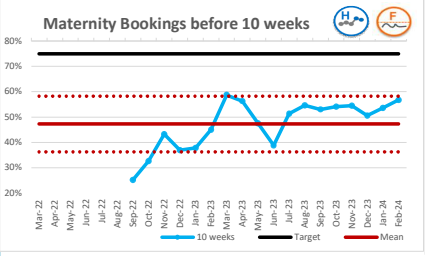
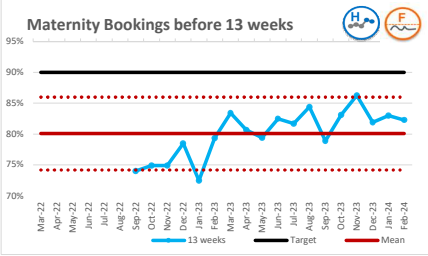
Appendix 2

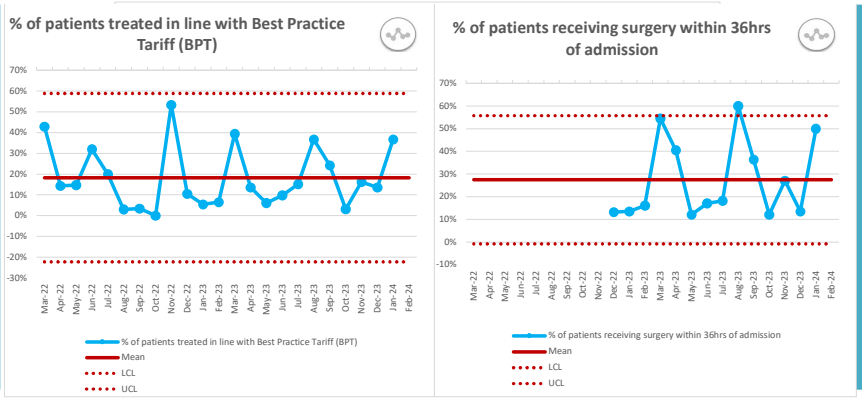
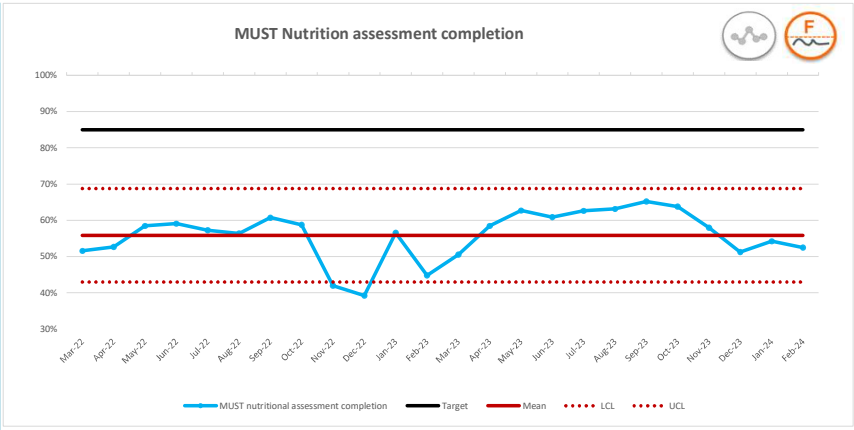
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 6.3% Postpartum Haemorrhages >1500ml in month.**		**N/A - Not enough datapoints.**	**Rates for February have shown a significant increase and the monthly rate is above the benchmark. This will be monitored closely to ensure it does not mark an ongoing deteriorating position. A full audit of PPH >1500mls March 2023 - September 2023 was reported to Quality Assurance in January 2024 with learning and actions identified.**	**A retrospective audit of PPH is underway. PPH >1500mls will continue to be reviewed on an individual basis via governance processes but will also be subject to additional review through the Intrapartum Incident Review Group which meets regularly to review patterns and themes from incidents of PPH >1500ml. In addition a PPH QI group has been established. This QI group is leading on the improvements identified as part of the audit.**
30. Maternity 3rd and 4th Degree tears **Threshold: <1.85%**	**There were 2.1% 3rd and 4th Degree tears in month.**		**N/A - Not enough datapoints.**	**Incidence of 3rd & 4th degree tears has increased in February. There were four cases in February. 3rd & 4th degree tears are reviewed via governance processes and the learning from these reviews is then shared.**	**Incidence of 3rd & 4th degree tears continue to be reviewed via governance processes and the learning from these reviews is then shared. In view of the increased rates these will be reviewed as a cluster to ensure we are capturing any themes and improving practice and shared via Women's Health Governance meeting.**
31. Maternity Pregnancy Bookings before 10 weeks and 13 weeks **10-week Target: >75%** **13-week Target: >90%**	**56.7% bookings before 10 weeks and 82.3% bookings before 13 weeks.**	 	**(10 weeks) Assurance: The Trust consistently fails the target.** **(10 weeks) Variation: Special cause variation of an improving nature.** **(13 weeks) Assurance: The Trust consistently fails the target.** **(13 weeks) Variation: Special cause variation of an improving nature.**	**An action plan is in place to improve timeliness of bookings and there had been general improvement over the last 12 months. Bookings prior to 10 weeks have continued to improve and are nearing that of local provider best averages (58.9%) Bookings <13 weeks have slightly reduced in February 2024 and are not yet meeting the local provider best average. Work will continue to meet the stretch target to achieve best practice results.**	**Actions remain in place to improve timeliness of bookings and there has been significant improvement. Work will continue to achieve best proactive KPIs.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission
RR116

Quality Improvement - Trust Position

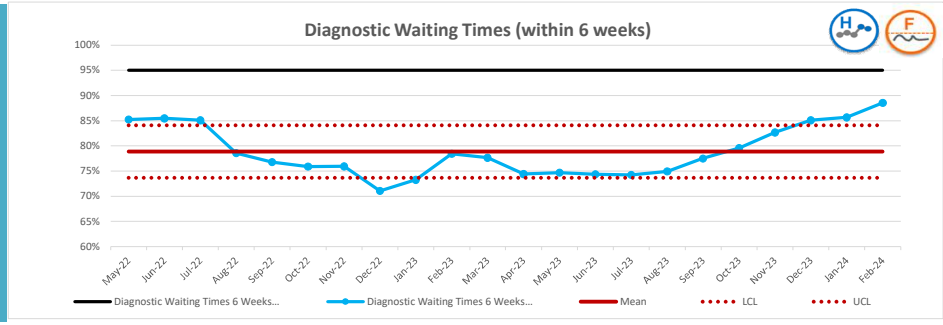
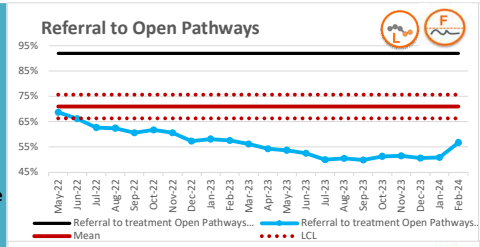
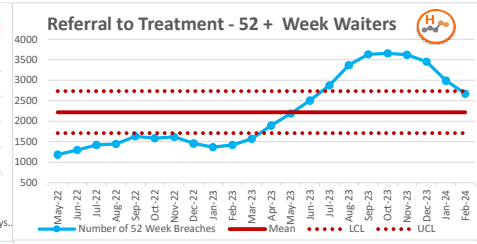
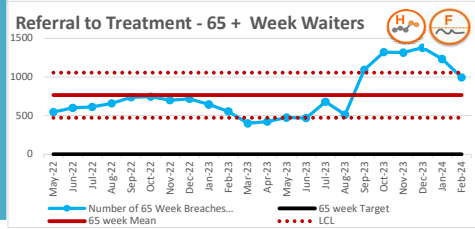
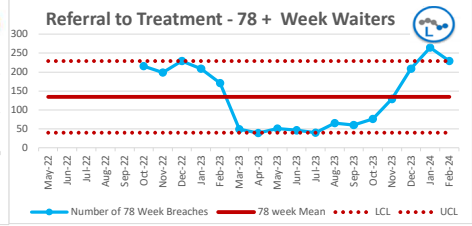
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
32. Fractured Neck of Femur **Target: Best Practice Tariff**	**36.7% of patients were treated in line with Best Practice Tariff (BPT) in Jan-24.**		**Variation: Common Cause (Normal) variation.**	**Improvements seen in both metrics for January 2024 with a contributory factor being the theatre improvement work.**	**Continue theatre improvement work to increase efficient performance of trauma lists. Further work with Clinical Leads for T&O and BPT, Senior Nursing and Operational Leads to interrogate action plan further to identify opportunities to sustain and build upon improvement.**
33. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 52.48% in month.**		**Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.**	**Contributing factors to the reduction in compliance seen in February 2024 are: Increased acuity on wards including boarding extra patients and the increased need for temporary staffing to support over winter period.**	**Local assurance mechanisms in place and gap analysis to be completed in April to ensure accurate data quality. Nutritional Specialist Nurse appointed to support the focus to ensure MUST passement is completed. Oversight by Matron and Lead Nurses to reinforce required standard with action plans in place for improvement.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

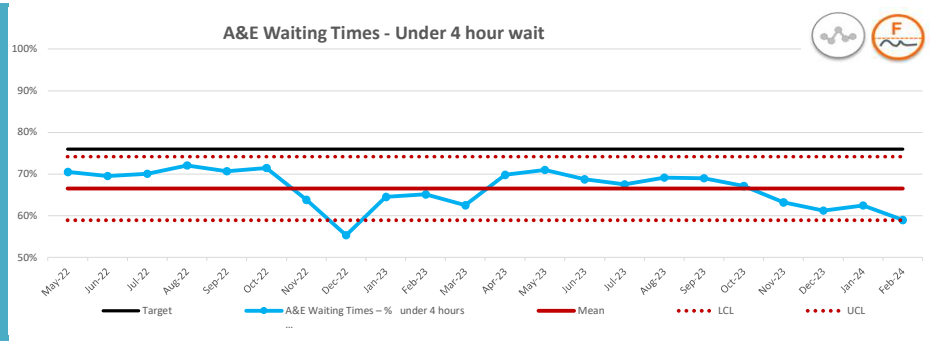
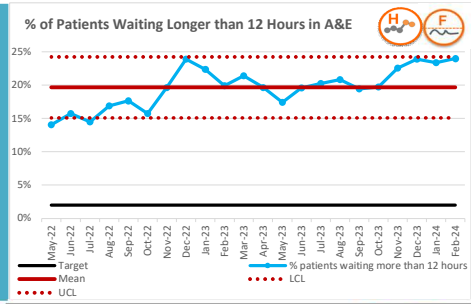
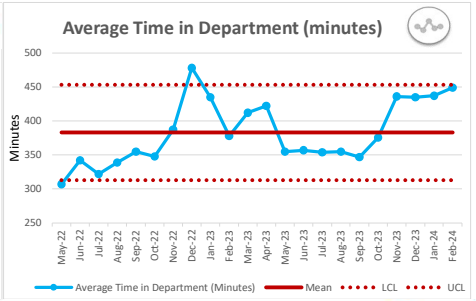
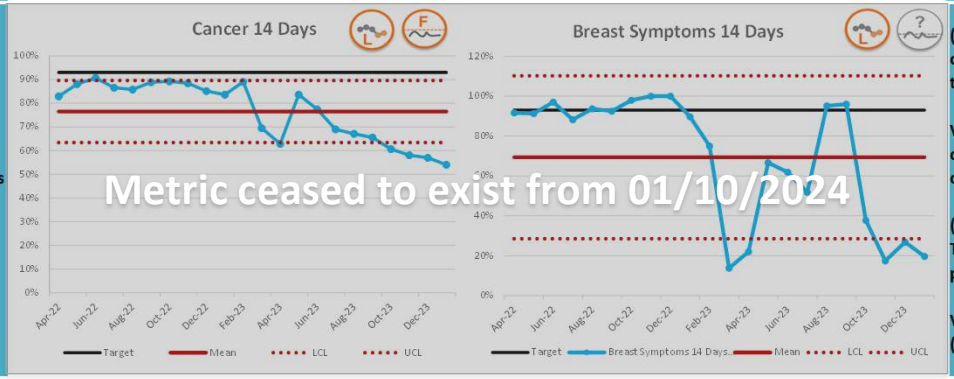
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

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)?
34. Diagnostic Waiting Times 6 Weeks Target: 95% **The Trust achieved 88.57% in month.** RR1215 RR1125		**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of an improving nature.**	**The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.**	**A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies, recovery plans are in place for all modalities**
35. Referral to treatment Open Pathways Target: 92% 67. RTT - Number of patients waiting 65+ weeks Target: 0 **The Trust achieved 56.71% in month. There were 2674, 52 week breaches, 229, 78 week breaches and 997, 65 week breaches.** RR1125 RR1215	   	**(Open Pathways) Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.** **(65+) Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.**	**RTT performance - 52 week waits have started to improve in line with the trajectory, 78 weeks and 65 remain challenged, mitigation plans through use of insourcing and mutual aid are supporting recovery plans**	**Recovery of the elective programme is taking place with:** **• Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.** **• Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre.** **• Restoration and recovery plans for 2024/25 have been drawn up in line with current Operational Planning Guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

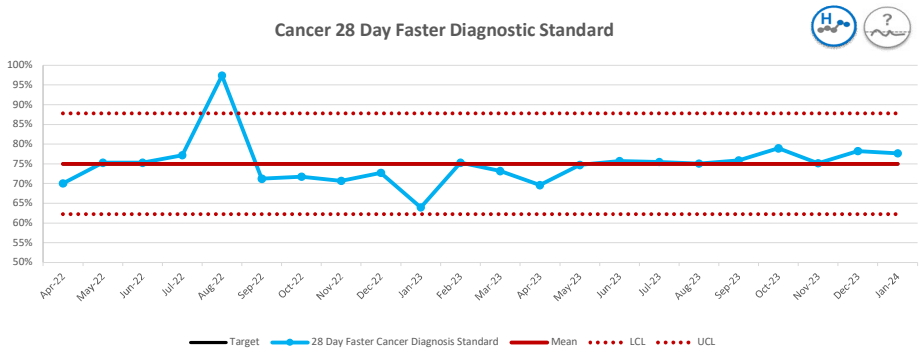
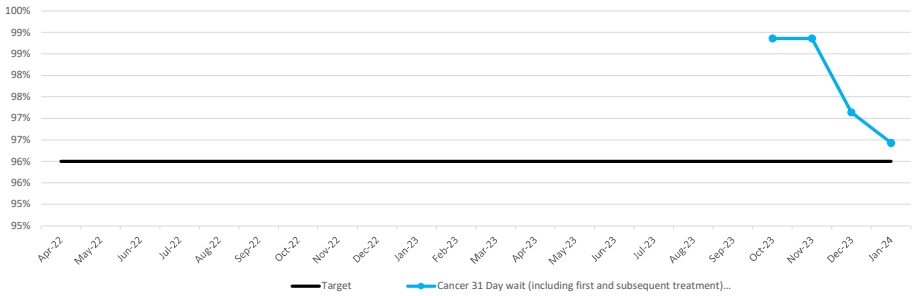
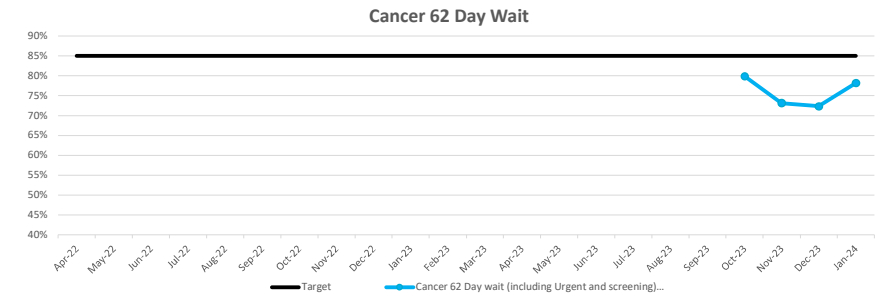
Key: Risk Register | System Oversight Framework | Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
36.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. Target: 75% 37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow. • System resource investment in order to support Pathway 1 discharges. • Additional beds remain open on the Halton site to support bed capacity and flow.
38. Average time in department ED No Target	 	Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature.	12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED.	The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 23/24 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 23/24 is set up to support improvement.
39. Cancer 14 Days Target: 93% 40. Breast Symptoms 14 Days Target: 93%		(C14) Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature. (Breast) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	This metric ceased to exist from the 1st October 2023 with the 28 day Faster Diagnosis standard (FDS) becoming the focus. It is important to note, that in order to achieve the 28 FDS, then there will be a requirement for patients to have their first OPD appointment in 2 weeks or less.	The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard. Performance against this standard is monitored via the Performance Review Group (PRG). Targeted capacity and demand work has been initiated for the Breast service.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

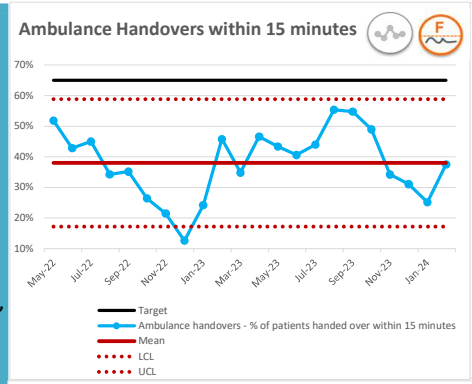
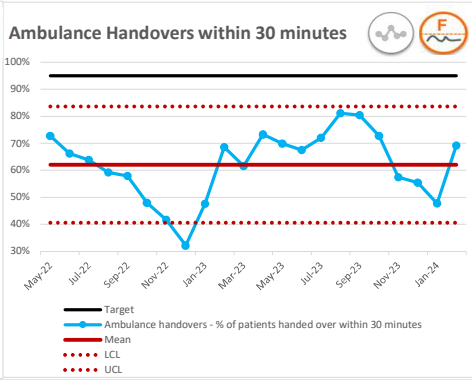
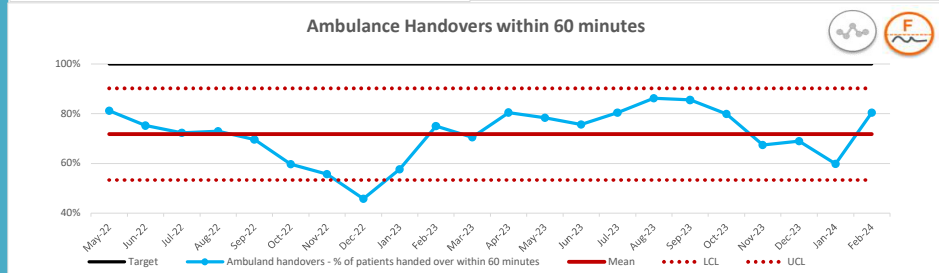
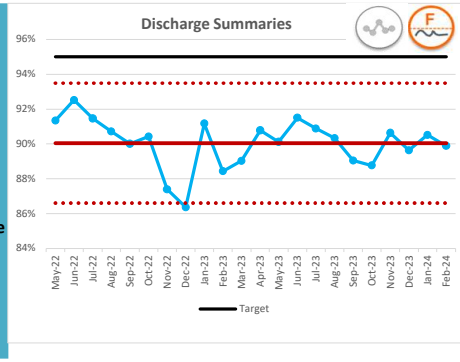
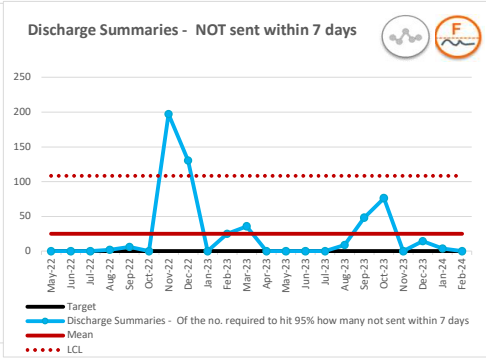
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

	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)?
41. 28 Day Faster Cancer Diagnosis Standard Target: 75%	SOF The Trust achieved 77.65% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	The Trust is currently meeting the 28 Day FDS. This remains challenging due to delays in some pathways including gynaecology that whilst now resolving may affect performance in forthcoming months. Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG)
42. Cancer 31 Day wait Target: 96%	SOF CQC The Trust achieved 96.43% in month for Cancer 31 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	The Trust achieved the 31 day target	
43. Cancer 62 Day wait Target: 85%	SOF CQC The Trust achieved 78.18% in month for Cancer 62 Day Wait.		Assurance: NA - not enough data Variation: NA - not enough data	From 1st October 2023 62-day screening and 62 day consultant upgrades became combined. Whilst the operational standards remains 85% there is a commitment to reach 70% by March 2024.	There remains a risk for performance due to the impact of the pandemic and increased cancer referrals.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
47. Ambulance Handovers within 15 minutes Target: 65% 48. Ambulance Handovers within 30 minutes Target: 95% 49. Ambulance Handovers within 60 minutes Target: 100% **In month 37.5% of patients were handed over within 15 minutes, 69.17% were handed over within 30 minutes and 80.42% were handed over within 60 minutes.**	  	**(15) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(29) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(60) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Handover performance has seen a improvement despite winter pressures, it is important to note that this is an improved performance compared to the same period last year**	**The Trust will continue to work in partnership with NWAS to identify and implement improvements.**
50. Discharge Summaries - % sent within 24hrs Target: 95% 51. Discharge Summaries - Number NOT sent within 7 days Target: ZERO **The Trust achieved 89.89% in month for discharge summaries sent within 23 days, against the target of 95%.** **There were 0 discharge summaries in month not sent within 7 days, against the target of 0.**	 	**(24 hrs) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(7 Days) Assurance: The Trust consistently 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.** **A deep dive is underway into the increase of discharge summaries not sent within 7 days.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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

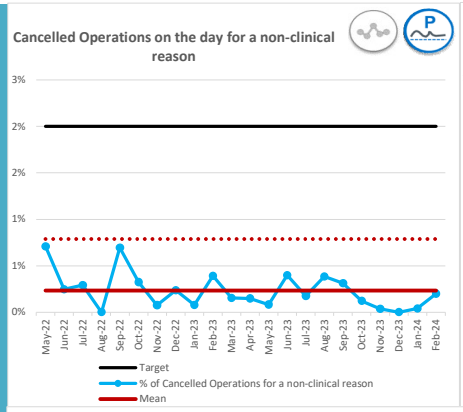
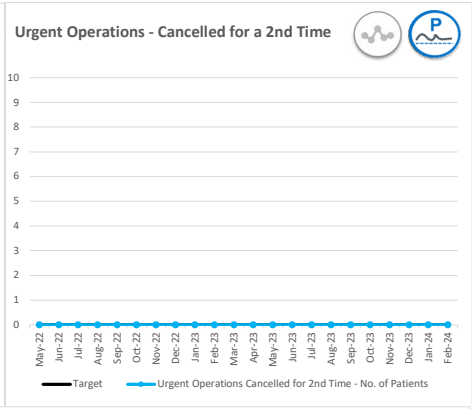
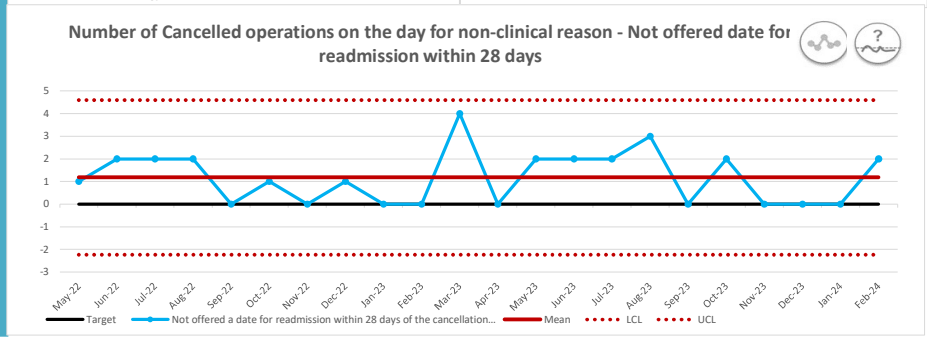
52. Cancelled Operations on the day for a non-clinical reason

Target: Less than 2%

53. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation

Target: ZERO

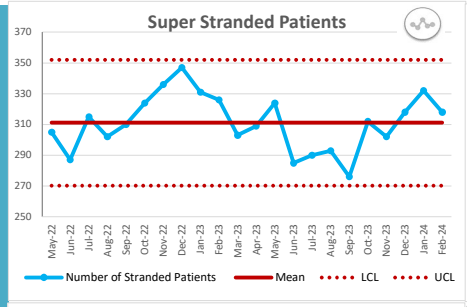
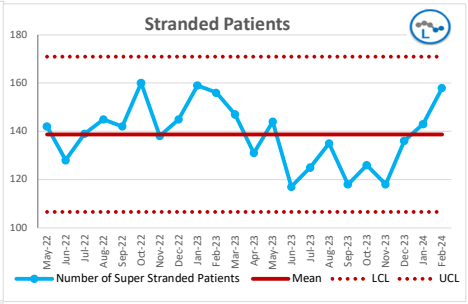
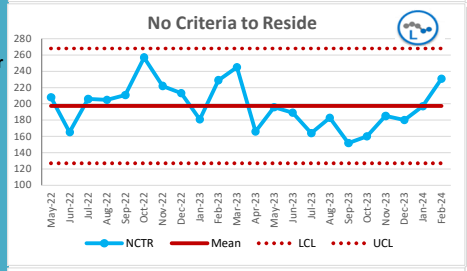
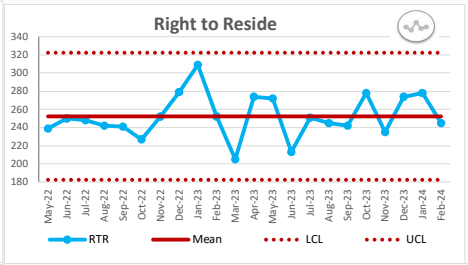
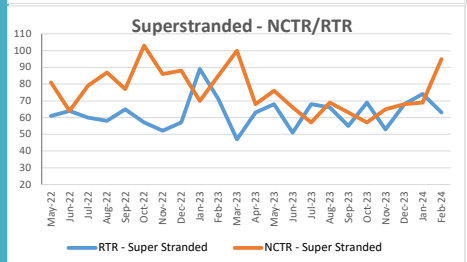
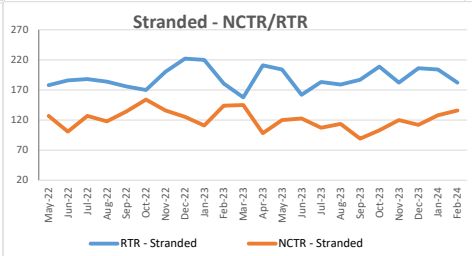
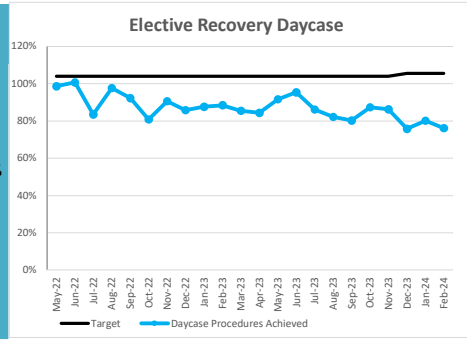
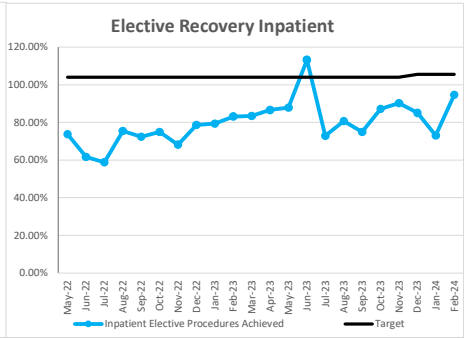
54. Urgent Operations Cancelled for 2nd Time

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 **Cancelled operations for a non-clinical reason was 0.2% in month. 2 cancelled operations were not offered a date for readmission within 28 days.**	  	**(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target.** **Variation: Common Cause (normal) variation.** **(Not offered 28 days) Assurance: The Trust consistently passes the target.** **Variation: Common Cause (normal) variation.** **(Urgent Ops cancelled 2nd time) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (normal) variation.**	**Compliance against this standard remains below the monitored threshold of 2.00% (positive).**	**Recovery of elective activity continues to be monitored via Performance review group.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

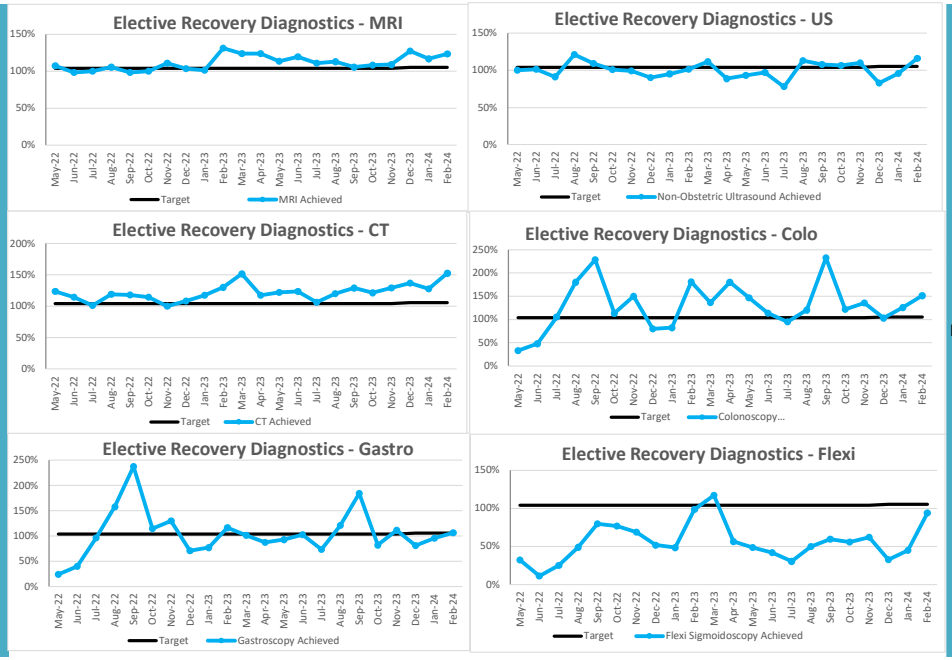
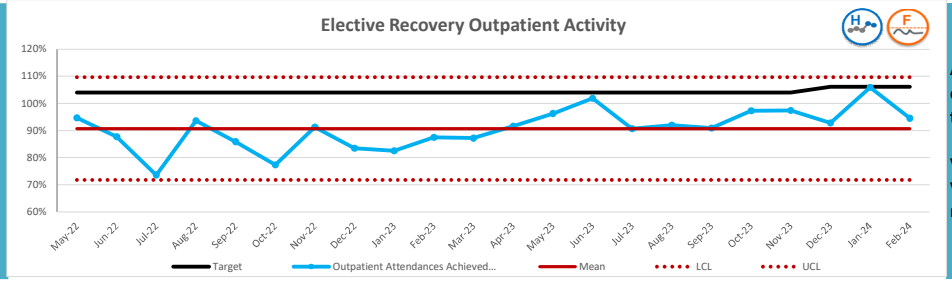
Key: Risk Register (RR116) | System Oversight Framework (SOF) | Care Quality Commission (CQC)

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Super Stranded Patients Target: Trajectory	There were 318 stranded and 158 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	     	(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Special Cause Variation of an improving nature. (NCTR) Assurance: N/A Trajectory Not Agreed. Variation: Special Cause Variation of an improving nature. (RTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.	The number of Super Stranded patients has shown a increase over the winter period, this figure still remains lower than the same time last year	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
56. Elective Recover Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	In month, the Trust achieved the following % of activity against 2019. This included 76% of Daycase Procedures and 94.61% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Elective activity remains challenged, IA did have some impact in December	The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

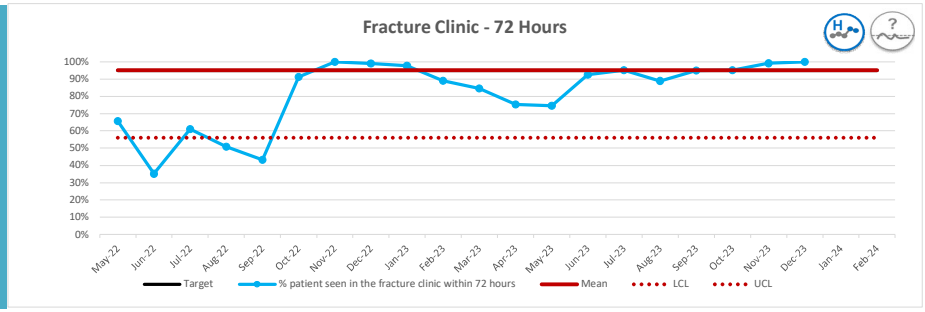
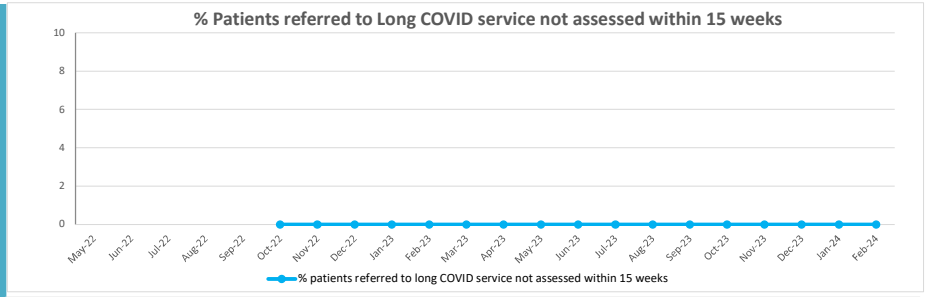
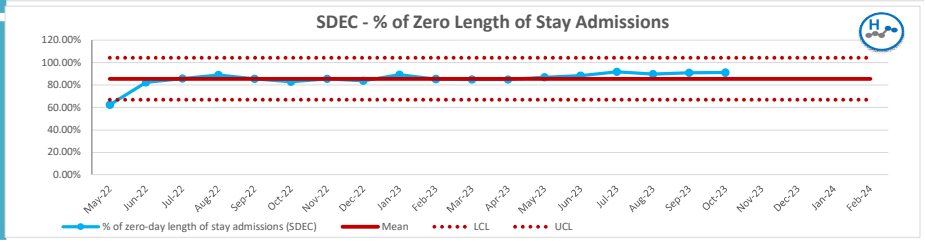
Key: RR116 Risk Register | SOF System Oversight Framework | CQC Care Quality Commission

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)?
57. Elective Recovery Diagnostic Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20				
SOF RR1125 **In month, the Trust achieved the following % of activity against 2019.** **This included:** **123.57% of MRI** **152.48% of CT** **115.91% of Non-Obstetric Ultrasound** **94.19% of Flexi Sigmoidoscopy** **151.28% of Colonoscopy** **106.59% of Gastroscopy** RR1125		**N/A - Grouped indicator.**	**Recovery trajectories Radiological specialties and Endoscopy are in line with recovery trajectories.** **Challenges remain in Cardiorespiratory services.**	**The Trust continues to restore clinical services in line with the national operating guidance.** **Additional insourcing support for Echo is being progressed to help reduce waiting times.** **Underperformance in Flexi sig will be explored at the Performance Review Group.**
58. Elective Recovery Outpatient Activity Aggregate Target: 104%				
SOF RR1125 **In month, the Trust achieved 94.55% of Outpatient activity against 2019.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**The Trust continues to work towards outpatient recovery including a reduction in follow ups with signposting to alternative services such as patient initiated follow. Activity is impacted by Industrial Action.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

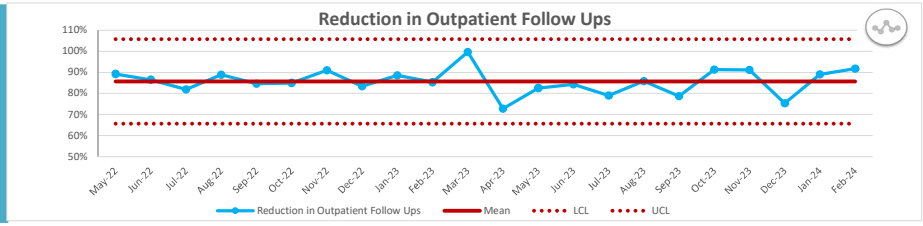
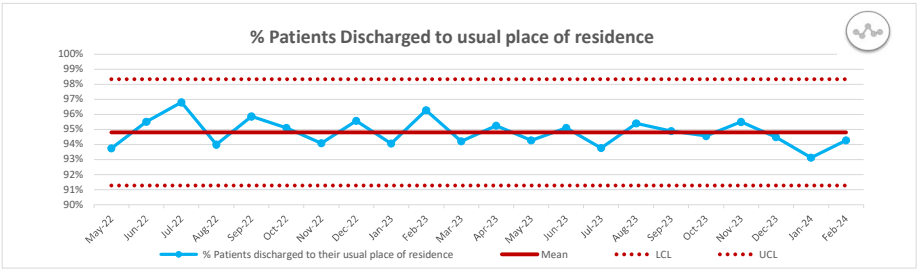
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	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)?
59. Patients seen in the Fracture Clinic within 72 hours Target: 95%	**In monthly, the fracture clinic saw 0% of patients within 72 hours.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**Issue of non-compliance addressed in-month.**	**This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.**
60. % patients referred to long COVID service not assessed within 15 weeks	**This month, the Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks.**		**N/A - Not enough datapoints.**		
61. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	**0% of SDEC Emergency Admissions had a zero day length of stay.**		**Variation: Special Cause Variation of an improving nature.**	**As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

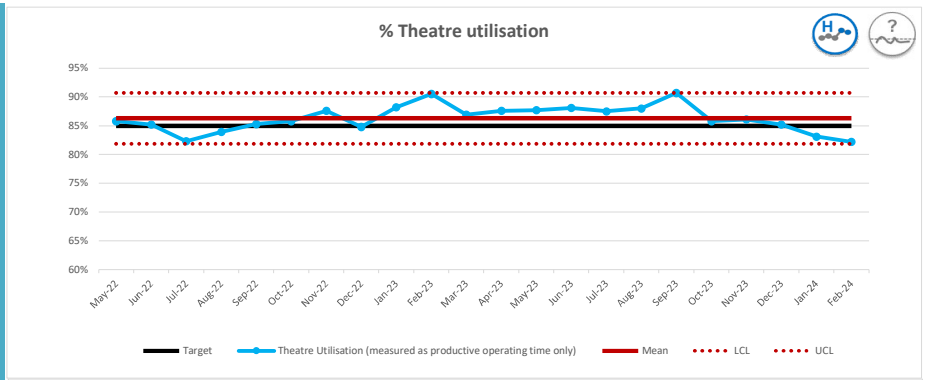
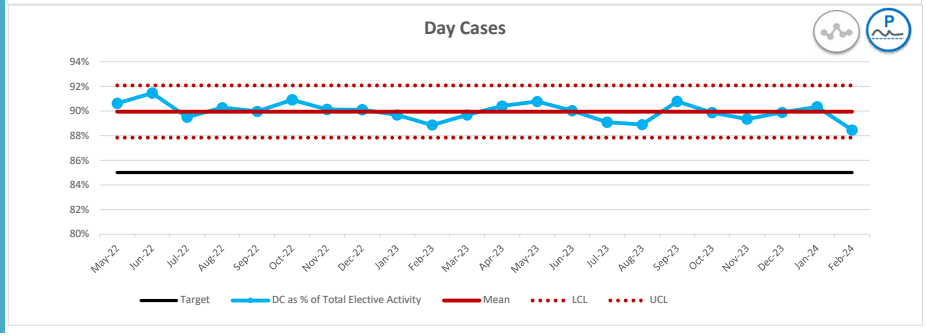
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	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)?
62. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 91.71% of 19/20 activity in month.**		**Variation: Common Cause (Normal) variation.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
64. % Patients discharged to their usual place of residence Target: No Current Threshold	**94.27% patients in month were discharged to their usual place of residence.**		**Variation: Common Cause (Normal) variation.**		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

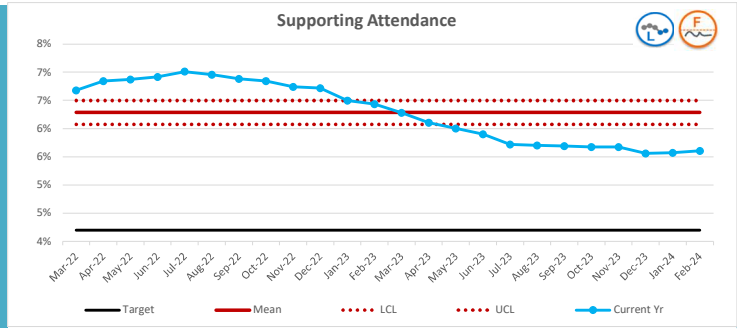
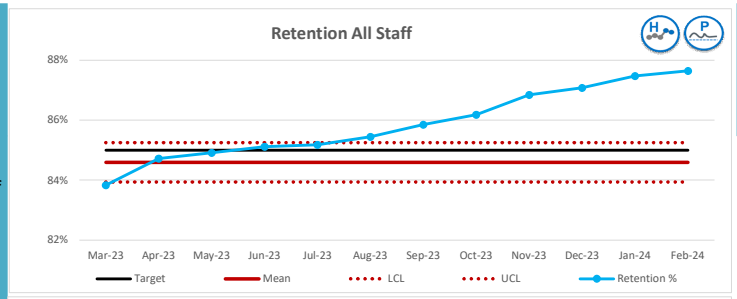
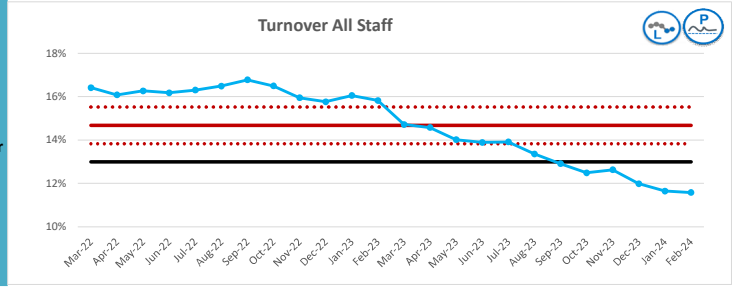
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

	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)?
65. Theatre Utilisation (measured as productive operating time only) Target: 85%	82.2% Theatre utilisation in month (measured as productive operating time only). There were 88.46% Day cases, of total activity in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature.	Theatre Utilisation remains a challenged area, a focus on late starts and improving prodctivity are key priorities for 24/25 *Please note, data in the IPR has been revised to reflect utilisation - previously a combined utilisation and productivity figure. As a result, figures are different from those previously reported in the IPR.	The Planned Care Transformation Group is focussed on increased utilisation, with a key area of priority of Late Starts in line with the Model Hospital data. Relaunch of late start program is 11th September, following agreement with Planned Care Clinical Directors.
66. Day case (measured as an aggregate of total cases) Target: 85%			Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	Daycase rates have been higher in 2023/24 with majority hitting the target.	The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates. Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

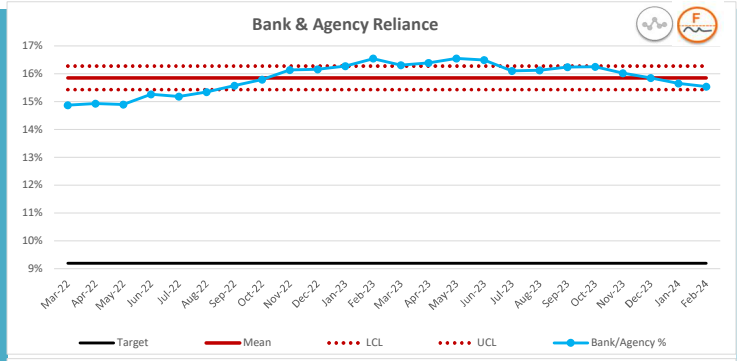
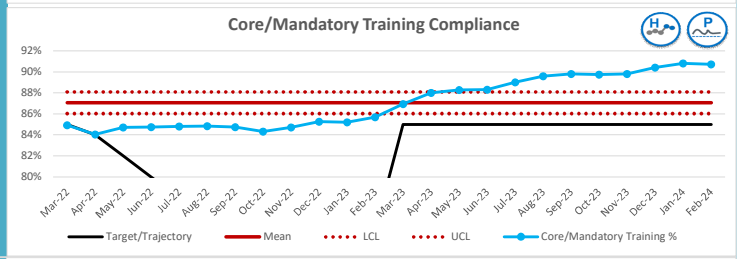
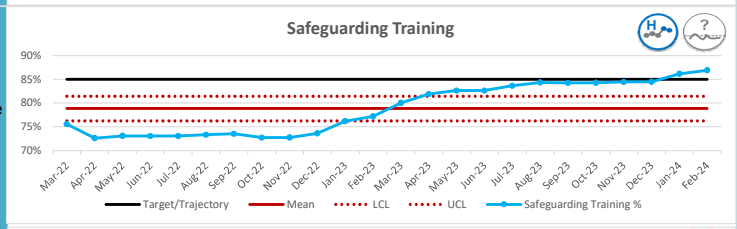
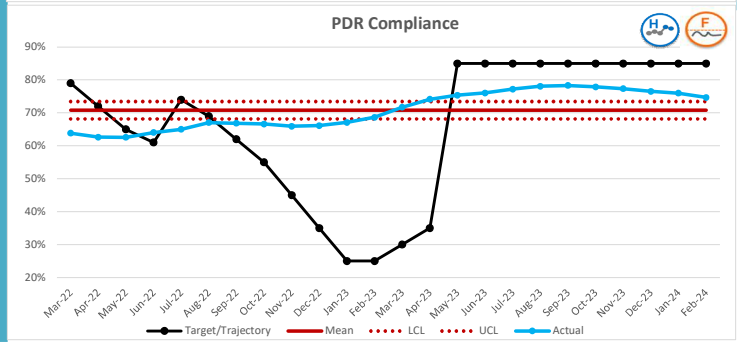
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
S Trust Strategy
RR200 Risk Register

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
68. Supporting Attendance **Target: Below 4.2%** UoR SOF S The Trust's annualised sickness rate was 5.6%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence is showing an Improving Variation. The annualised sickness absence percentage in February 2024 was 5.6%, a slight increase from 5.56% in December 2023. Reasons for the variation can be attributed to seasonal fluctuation in sickness absence including flu and covid which are prevalent over winter.	Sickness absence levels remain below 2022/23 absence rates. A focus on improving sleep, noting the impact on sickness absence has been launched, with specific support available via trained OH professionals. OH are monitoring referral patterns and have identified a pattern of increased referrals for stress, anxiety and depression among recruits new to the NHS. Work has commenced to identify recruitment, induction and first 12 months interventions.
69. Retention **Target: 85%** UoR RR1108 RR1134 The Trust's annualised retention of all staff was 87.64%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Annualised retention is showing an Improving Variation. Retention of all staff in February 2024 was above Trust target at 87.64%, an increase from 87.08% in December 2023. Retention for permanent staff in February 2024 remains above Trust target at 89.98%.	Relocation continues to be the fastest growing reason for people leaving, but work/life balance remains the main reason. Retirement is the third reason and the Trust continues to have a good track record of supporting these individuals back into the workplace. To support agile/flexible working, pilot areas have been identified who are going to review their approach to rostering and seek to introduce an alternative approach to improve the impact on agile/flexible working.
70. Turnover **Target: Below 13%** S CQC SOF UoR The Trust's annualised turnover of all staff was 11.57%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in February 2024 was above Trust target at 11.57%, a slight improvement from 11.98% in December 2023. Turnover of permanent staff in February 2024 was above Trust target at 10.78%.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

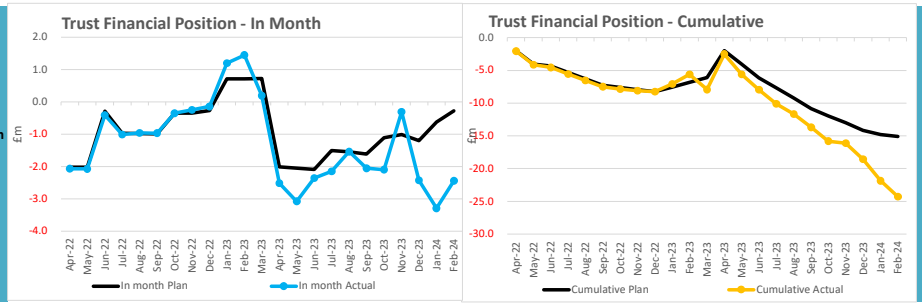
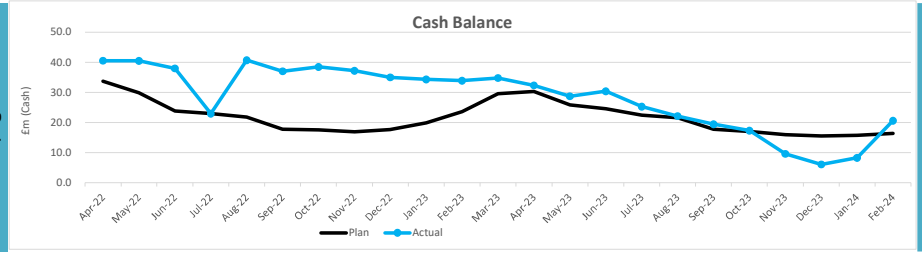
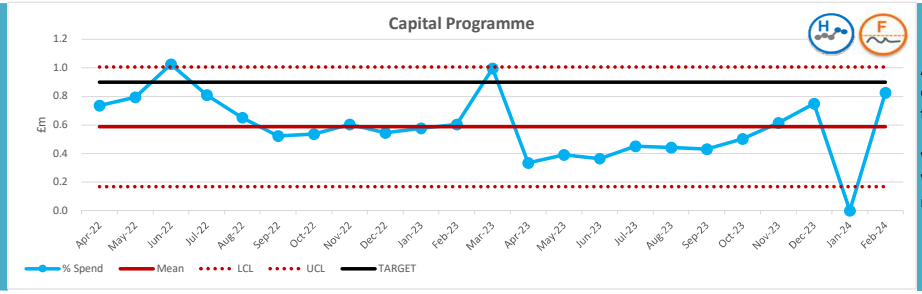
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
Trust Strategy
RR200 Risk Register

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
71. Bank and Agency Reliance **Target: 9% or Below** UoR **Annualised Bank and Agency Reliance was 15.34%.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (normal) Variation.**	**Bank and Agency reliance is showing a Concerning Variation.** **Bank and Agency reliance in February 2024 was 15.34%, a slight improvement from December 2023 at 15.65%.** **Bank reliance continues to increase and is 12.1% in February 2024 as Agency reliance continues to decrease to 4% in February 2024.**	**The increase in bank reliance is being driven by the Trusts industrial action response, and as part of a conversion programme whereby agency workers have been offered an opportunity to join the Trusts' bank.** **The next focus of the Workforce Review Groups is to convert bank into substantive posts. Recruitment to substantive posts remains the priority, however the contingent workforce remains part of safe care.**
72.Core/Mandatory Training **Target: 85%** UoR CQC **Core/Mandatory training compliance was 90.73% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**CSTF Training (exclusive of Safeguarding) is showing an Improving Variation.** **In February 2024, CSTF Mandatory Training compliance was 90.73%, excluding Safeguarding Training (Children's and Adults); Safeguarding (Children's and Adults) compliance was 86.88%.**	**Compliance continues to be supported by the continual review of training and accessibility at the Mandatory and Role Specific Training Panel and the offer of face to face training.** **Care Groups report compliance at Operational People Committee with actions required to ensure targets are met.**
73. Safeguarding Training **Target: Trajectory** **Safeguarding Training compliance was 86.88% in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of a improving nature.**		
74. PDR **Target: 85%** S CQC **Annualised PDR compliance was 74.67%.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a improving nature.**	**Appraisals are showing an Improving Variation.** **In February 2024, Appraisal compliance was 74.67%, a decrease from 76.52% in December 2023.** **Currently Appraisal rates are below the trajectories but higher than 2022.**	**A new electronic appraisal has been launched with associated guidance, dedicated extranet pages and training as a result of a workforce feedback and includes EDI objectives and a wellbeing section.** **Further review with Care Groups via OPC is ongoing to improve compliance and the Corporate Risk register is being reviewed to reflect the risk of not meeting the target.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and 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)?
75. Trust Financial Position **Target: Plan** The Trust has recorded a deficit position of £24.3m at 29 February 2024 against a deficit plan of £15.1m.			The main drivers for the deficit being worse than plan are unfunded Industrial Action (IA) costs, activity delivered under plan, the cost of additional capacity in A&E and specialling as well as undelivered CIP.	Following work with the ICS, the Trust is now forecasting a £27.5m deficit, which is £11.8m worse than plan. Work is ongoing as part of 2024/25 planning to reduce cost pressures from the current financial year.
76. Cash Balance **Target: On or better than plan** UoR The cash balance as at 29 February 2024 is £20.6m. RR134			The current cash balance is £20.6m which is £4.3m better than the cash plan. This is due to capital PDC receipts during February relating to year end spend. Of the £20.6m cash, £14.1m is related to capital expenditure.	The worsening deficit position has led to the Trust requiring external cash support. An application for external cash support for March 2024 and Q1 2024/25 has been submitted.
77. Capital Programme **Target: On plan 90%-100%** UoR Capital expenditure at the end of month 11 is £16m against a plan of £19.3m.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	The monthly profile of the Trust plan has been updated to be more reflective of the expected position. Compared to the NHSI plan, expected spend is £19.34m, which gives a variance of £3.37m. Compared to the Trust plan the variance is £2.28m at February 2024.	The underspend year to date is mainly due to the timing of externally funded schemes. The month 12 budget is circa £13m and significant spend has taken place in March particularly on externally funded schemes such as CDC, TIF, Endoscopy Hub and LIMS.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

Key:
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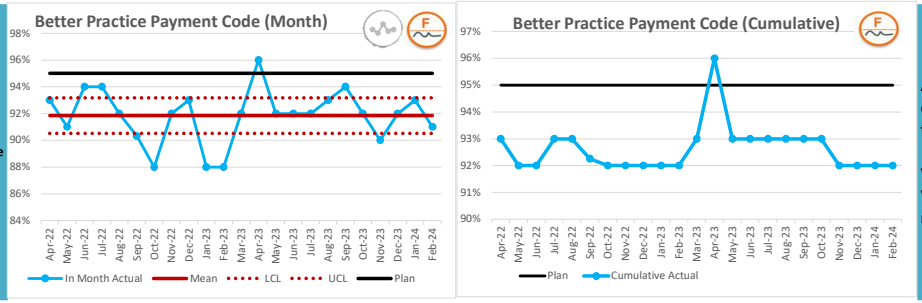
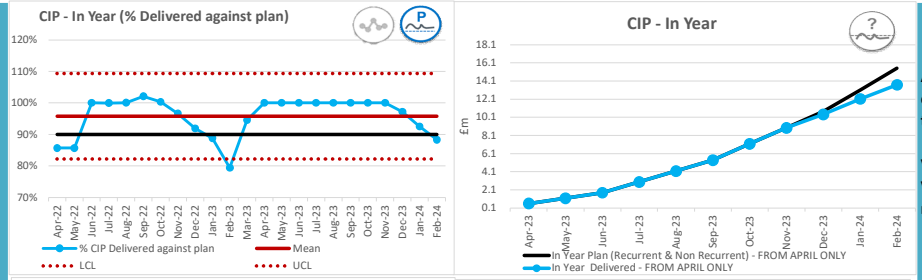
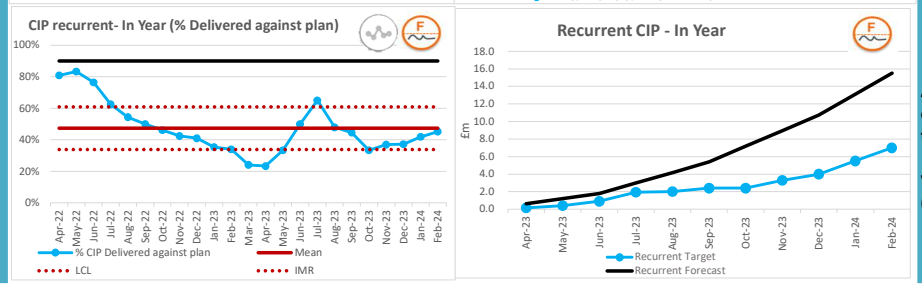
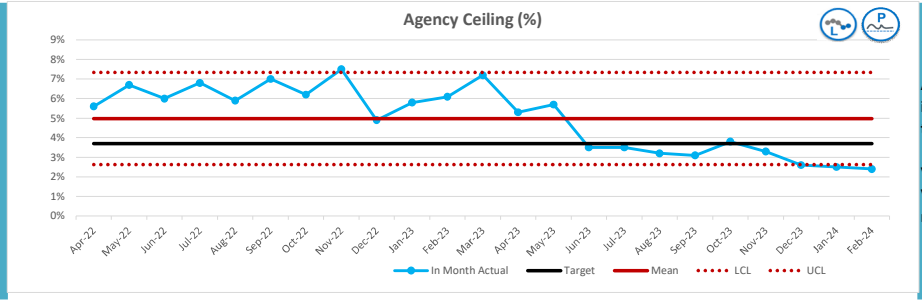
- Trust Strategy

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)?
78. Better Payment Practice Code **Target: Cumulative performance 95%**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**Timely raising of requisitions, matching of purchase orders and approval of invoices enables invoices to be paid within the 30 day threshold for Better Payment Practice Code (BPPC). There are some occasions where this is not always possible which has led to the achievement of 92%.**	**Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments. Waiver training has also been rolled out across the Trust which will also speed up the PO approval process.**
79. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of an improving nature.**	**The shortfall of £1.8m year to date relates to the high risk schemes including GIRFT schemes which have not delivered cash releasing savings due to the Trust not achieving the ERF target.**	**CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT programme with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust.** **Plans are underway to identify schemes to meet the 2024/25 CIP target.**
80. Cost Improvement Programme (recurrent) – In year performance to date **Target: Recurrent Forecast is more than 90% of annual target**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (normal) variation.**	**Where recurrent CIP has not realised during the year, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all. This increases the pressure into 2024/25 with circa £10.6m forecast to be non-recurrent by the end of the financial year.**	**The Trust is in the process of identifying recurrent CIP schemes for 2024/25. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Hospital and GIRFT is being used.**
81. Agency Ceiling **Target: Agency spend should not exceed 3.7% of total pay (ICS target)**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**For the months of June 2023 to February 2024 the monthly percentage has been below 3.7% with the exception of October which was 3.8%. This is due to moving agency staff onto the bank, a reduction in vacancies and tightened controls.**	**The Resourcing Task and Finish group has been established to develop a system/process to report on factors influencing temporary staffing spend such as:** **- Agency controls best practice** **- Rostering compliance** **- Rate card compliance** **- Establishment Control compliance (or an alternative approach)** **- Unplanned absences** **- Recruitment activity**

Cumulative performance is 92% which is below the national target of 95.

The month 11 CIP plan is £15.5m and £13.7m has been delivered.

£7m CIP has been delivered recurrently against the target of £15.5m.

The Trust Agency spend in month is 2.4% against a target of 3.7%

Appendix 3 – Trust IPR Indicator Overview

	Indicator	Detail
	Quality	
1.	**Incidents**	• Number of incidents reported in month. • Number of incidents open over 20 days and 40 days. • Number of serious incidents reported in month. • Number of serious incidents where actions have breached the timescale. • Number of never events reported in month.
2.	**Duty of Candour**	• Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where the Trust contacts the patient or their family to advise of the incident; this has to be done within 10 working days.
3. **4.** **5.** **6.** **7.**	**Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)**	• Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. • MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin. • Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. • Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. • Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis. • Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.
9.	**Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks**	• Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. • Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
10.	**VTE Assessment**	• Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month, however this indicator is reported quarterly.
11.	**Inpatient Falls & Harm Levels**	• Total number of falls which have occurred in month. • Falls per 1000 bed days in month. • Total number of inpatient falls which have occurred in month. • Levels of harm reported as a result of a fall in month. • Level of avoidable harm which has occurred in month.
12.	**Pressure Ulcers**	• Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).
13.	**Medication Safety**	Overview of the current position in relation to medication, to include: • Medication reconciliation within 24 hours. • Medication reconciliation throughout the inpatient stay. • Number of controlled drugs incidents. • Number medication incidents resulting in harm.

14.	**Staffing Average Fill Levels**	• Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
15.	**Care Hours Per Patient Day (CHPPD)**	• Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
16.	**HSMR Mortality Ratio**	• Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
17.	**SHMI Mortality Ratio**	• Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
18.	**NICE Compliance**	• The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. This indicator monitors Trust compliance against NICE guidance.
19.	**Complaints**	Overall review of the current complaints position including; • Number of complaints received in month. • Number of dissatisfied complaints in month. • Total number of open complaints in month. • Total number of cases over 6 months old in month. • Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month. • Number of complaints responded to within timeframe in month. • Number of PALS complaints received and closed in month.
20.	**Friends and Family Test (Inpatient & Day Cases)**	• Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
21.	**Friends and Family (ED and UCC)**	• Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
22.	**Mixed Sex Accommodation Breaches (Non-ITU)**	• Number of MSA Breaches in month (outside of ITU).
23. **24.** **25.** **26.**	**Sepsis**	• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.
27.	**Ward Moves Between 10pm and 6am**	• Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
28.	**Acute Kidney Injury**	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.

29.	**Postpartum Haemorrhage >1500ml**	• To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard. • PPH>1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH>1500mls when compared to the North West Coast Maternity Dashboard.
30.	**3rd and 4th Degree tears**	• To monitor rates of 3rd & 4th degree tears against North West Coast Regional Dashboard. • WHH are not currently an outlier for 3rd & 4th degree when compared to the North West Coast Maternity Dashboard, but 3rd and 4th degree tears are a significant outcome with the potential for long term impact of women's health and wellbeing.
31.	**Maternity bookings**	• To monitor pregnancy bookings met within the 10 and 13 week target. • Timeliness of pregnancy booking is a key performance indicator. • WHH is currently an outlier for bookings before 10 weeks when compared to the North West Coast Maternity Dashboard. • WHH is also currently an outlier for bookings before 13 weeks gestation when compared to the North West Coast Maternity Dashboard
32.	**Fractured Neck of Femur**	• The % of patients treated in line with Best Practice Tariff (BPT). • The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database (nhfd.co.uk)). • Shorter time to theatres significantly reduces risk of mortality and improves pain.
33.	***MUST nutritional assessment completion***	• To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE) • In hospital, disease-related malnutrition has been shown to result in increased wound infections, chest infections and pressure ulcers; increased length of admission; increased numbers of re-admissions; and increased overall morbidity
	Access & Performance	
34.	**Diagnostic Waiting Times – 6 weeks**	• All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.
35. **67.**	**RTT Open Pathways and 52 & 65 week waits**	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
36.	**Four hour A&E Target and ICS Trajectory**	• All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.
37.	**A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.**	• % of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.
38.	**Average Time in Department (ED)**	• How long on average a patient stays within the emergency department (ED).
39.	**Cancer 14 Days**	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
40.	**Breast Symptoms – 14 Days**	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.

41.	**Cancer – 28 Day Faster Diagnostic Standard**	• All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.
42.	**Cancer 31 Day wait**	• All patients to receive treatment for cancer within 31 days of decision to treat.
43.	**Cancer 62 Day wait**	• All patients to receive treatment for cancer within 62 days of decision to treat.
47.	**Ambulance Handovers 15**	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
48.	**Ambulance Handovers 30 – 60 minutes**	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
49.	**Ambulance Handovers – more than 60 minutes**	• % of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).
50.	**Discharge Summaries – Sent within 24 hours**	• The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
51.	**Discharge Summaries – Not sent within 7 days**	• If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
52.	**Cancelled operations on the day for non-clinical reasons**	• % of operations cancelled on the day or after admission for non-clinical reasons.
53.	**Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days**	• All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
54.	**Urgent Operations – Cancelled for a 2nd Time**	• Number of urgent operations which have been cancelled for a 2nd time.
55.	**Super Stranded Patients**	• Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
56.	**Elective Recovery Activity**	• % of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20.
57.	**Elective Recovery Diagnostics**	• % of Diagnostic Activity against the same period in 2019/20.
58.	**Elective Recovery Outpatients**	• % of Outpatient Activity against the same period in 2019/20.
59.	**Fracture Clinic**	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
60.	**% Outpatient referred to long covid service within 15 weeks**	•
61.	**% of zero-day length of stay admissions (SDEC)**	• % of zero length of stay admission (SDEC).
62.	**Reduction in Outpatient Follow Ups**	• % reduction of Outpatient follow ups compared to 19/20 activity.
63.	**COVID-19 Recovery Cancer First Treatment**	• % of people who received their first treatment for cancer compared to the equivalent month in 19/20.
64.	**% Patients discharged to their usual place of residence**	• % of patients who were discharged to their usual place of residence.

65.	**Theatre Utilisation (measured as productive operating time only)**	• Increase productivity and meet the 85% day case and 85% theatre utilisation expectations using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings. • Aim is to support providers and systems to maximise the effectiveness and throughput of their surgical theatres through improvements across the surgical elective pathway. As part of the High-Volume Low Complexity (HVLC) programme, GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time utilisation by 2024/25.
66.	**Day case (measured as an aggregate of total cases)**	
	Workforce	
68.	**Supporting Attendance**	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
69.	**Retention**	Staff retention rate % over the last 12 months.
70.	**Turnover**	A review of the turnover % over the last 12 months.
71.	**Bank & Agency Reliance**	The Trust reliance on bank/agency staff.
72.	**Core/Mandatory Training**	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
73.	**Safeguarding Training**	A summary of safeguarding training compliance.
74.	**Performance & Development Review (PDR)**	A summary of the PDR compliance rate.
	Finance	
75.	**Trust Financial Position**	The Trust operating surplus or deficit compared to plan.
76.	**Cash Balance**	The cash balance at month end compared to plan.
77.	**Capital Programme**	Capital expenditure compared to plan.
78.	**Better Payment Practice Code**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
79.	**Cost Improvement Programme – Plans in Progress in Year**	Cost savings schemes in-year compared to plan.
80.	**Cost Improvement Programme – Recurrent**	Cost savings schemes recurrent compared to plan.
81.	**'Agency Ceiling'**	At ICS level, agency spend should not exceed 3.7% of total pay. The Trust ceiling is still to be confirmed.

Appendix 4 - Statistical Process Control

1.0 What is SPC?

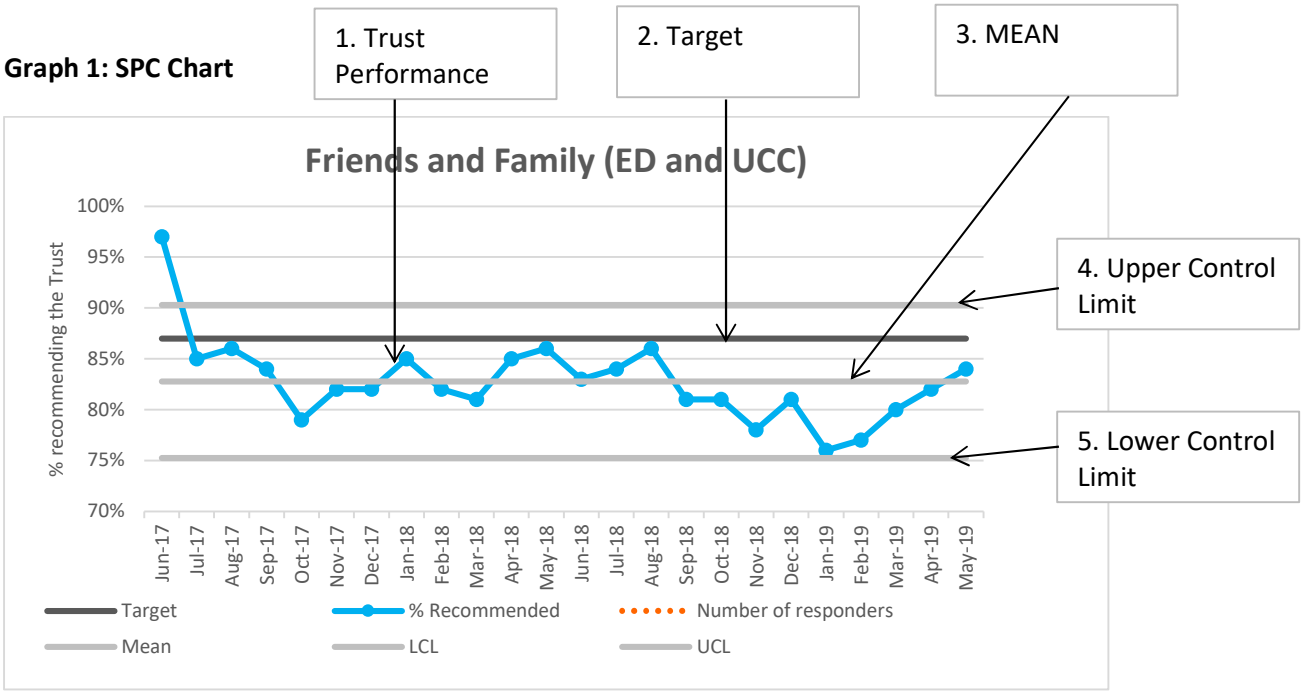
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

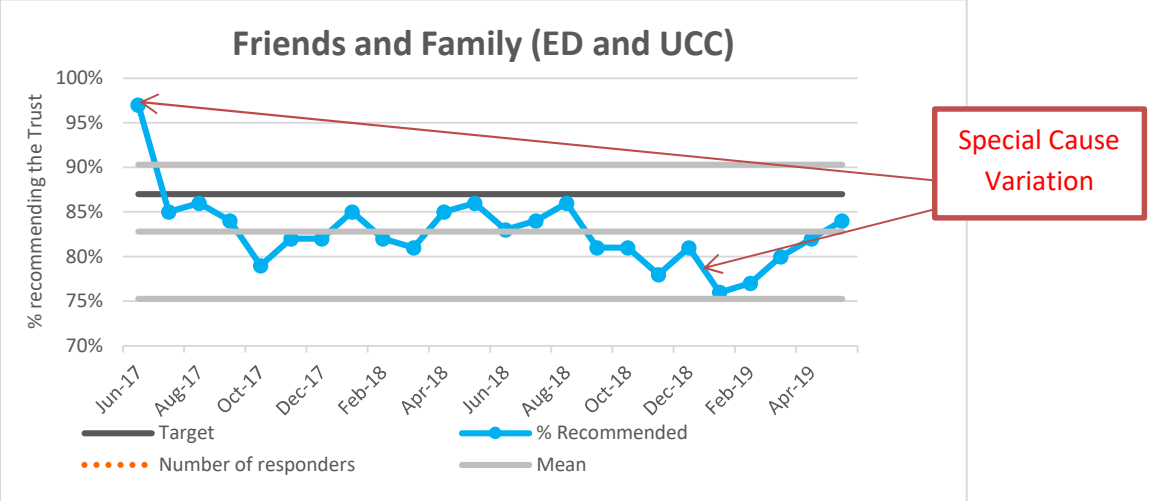


2.1 Interpreting a SPC Chart

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

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

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

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

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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

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

Warrington & Halton Teaching Hospitals NHS Foundation Trust

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 29th February 2024

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income	**308,681**	**25,868**	**26,114**	**246**	**282,779**	**281,016**	**-1,764**
Non NHS Clinical Income							
Private Patients	8	1	3	3	7	13	5
Non NHS Overseas Patients	60	5	-4	-9	55	65	10
Other non protected	728	61	41	-19	667	521	-146
Sub total	**796**	**66**	**40**	**-26**	**730**	**599**	**-131**
Other Operating Income							
Training & Education	9,093	758	1,028	270	8,336	9,904	1,569
Donations and Grants	2,095	0	75	75	2,095	1,936	-159
Miscellaneous Income	14,620	1,221	3,375	2,154	13,396	22,926	9,529
Sub total	**25,808**	**1,979**	**4,477**	**2,498**	**23,827**	**34,766**	**10,939**
Total Operating Income	**335,285**	**27,913**	**30,632**	**2,719**	**307,336**	**316,381**	**9,045**
Operating Expenses							
Employee Benefit Expenses	-248,897	-20,262	-23,281	-3,019	-228,590	-241,104	-12,514
Drugs	-20,191	-1,654	-1,809	-155	-18,537	-19,467	-930
Clinical Supplies and Services	-22,298	-1,761	-1,983	-223	-20,545	-22,339	-1,795
Non Clinical Supplies	-38,398	-2,846	-4,367	-1,521	-35,171	-39,301	-4,130
Depreciation and Amortisation	-14,278	-1,225	-1,220	5	-13,042	-12,920	122
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-344,062**	**-27,748**	**-32,660**	**-4,913**	**-315,885**	**-335,131**	**-19,246**
Operating Surplus / (Deficit)	**-8,777**	**166**	**-2,029**	**-2,194**	**-8,549**	**-18,750**	**-10,201**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	3	3	0	64	64
Interest Income	518	8	105	97	510	1,242	732
Interest Expenses	-191	-16	-11	5	-176	-127	49
PDC Dividends	-5,679	-474	-474	0	-5,205	-5,205	0
Total Non Operating Income and Expenses	**-5,352**	**-482**	**-377**	**105**	**-4,871**	**-4,026**	**845**
Surplus / (Deficit) - as per Accounts	**-14,129**	**-316**	**-2,406**	**-2,089**	**-13,420**	**-22,777**	**-9,357**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	-2,095	0	-75	-75	-2,095	-1,936	159
Add Depreciation on Donated & Granted Assets	475	40	40	0	436	440	4
Total Adjustments to Financial Performance	**-1,620**	**40**	**-35**	**-75**	**-1,659**	**-1,496**	**163**
Adjusted Surplus / (Deficit) as per NHSI Return	**-15,748**	**-277**	**-2,441**	**-2,164**	**-15,079**	**-24,273**	**-9,193**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/04/008a (i)	MEETING	Trust Board	DATE OF MEETING	3 April 2024

Date of Meeting	13 February 2024
Name of Meeting & Chair	Quality Assurance Committee – Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/24/02/293	**Deep Dive – Surveillance Programmes Backlogs Position update and risk**	A Deep Dive was presented in relation to Surveillance Programmes Backlogs Position update and risk. The Committee noted that as of 25 January 2024, 572 patients were overdue, the highest numbers of patients were those with wait times either 0-6 weeks or 7 – 13 weeks, with a smaller number waiting over this time. It was also noted that three actions were in place to address the backlog position, and these included; • **Action one:** Mobilisation of patients who have breached their date onto the RTT/DM01 pathways. It is proposed the date for all services will be 1 April 2024. • **Action two:** Review of patients who have been waiting over 52 weeks. • **Action three:** 12-month forward view to understand the impact on delivery of the RTT and DM01 pathways	The Committee discussed the presentation received and received **moderate level assurance.** The Committee requested that further detailed information to be presented to the Patient Safety & Clinical Effectiveness Committee (PSCESC) relating to cancer patients	PSCESC
QAC/24/02/295	**Patient Safety & Clinical**	The Committee received an update on the following items:	The Committee discussed the update and received	**Quality Assurance**

	Effectiveness Sub-Committee Exception Report	1. Fragile Services Updates: • Paediatric Ophthalmology • Urology • ENT • Fractured Neck of Femur • Gynaecology 2. Adult Critical Care Benchmarking Assurance Report 3. Society for Acute Medicine Benchmarking Audit (SAMBA) 4. Hospital Transfusion Group – BadgerNet transcription issues 5. Cancer Nurse Specialists Workforce Planning Pressure Ulcers Of the items escalated to the Committee in the Patient Safety & Clinical Effectiveness Sub-Committee Exception report; of particular note was the matter raised through the Hospital Transfusion Group in relation to issues with BadgerNet transcription and pressure ulcers.	**moderate assurance** and requested that and update on the BadgerNet issues and a timeframe in respect of a thematic review of pressure ulcers be provided at the next meeting	**Committee – March 2024**
QAC/24/02/296	**ED Improvement Programme Update**	The Committee received a presentation providing an update on the ED improvement programme. The following key challenges and risks were highlighted: • Emerging theme of increased acuity patients in the waiting room • Continued high acuity of patients on the ED corridor • Continued focus on oversight of patients with mental health needs in ED	The Committee discussed the update and actions in place and received **moderate assurance.** The Committee requested a harm profile to be presented to the next meeting.	**Quality Assurance Committee – March 2024**

		Of the items escalated to the Committee in the Patient Safety & Clinical Effectiveness Sub-Committee Exception report; of particular note was that Legionella was detected in some of the water outlets in Daresbury wing. Most outlets had shown low counts of Legionella apart from a shower. The Committee were advised the instances had been reported appropriately that testing and decontamination work was in place		
QAC/24/02/299	**Infection Prevention and Control Report Quarter 3**	The Committee received a report providing a summary of infection prevention and control activity for Quarter 3 of the 2023/24 financial year. The key areas of note were: • GNBSI cases were over threshold and more work needed to support prevention work • IV oral switch had reduced from 22.86% in Q2 to 14.63% in Q3 • Mandatory training was 92% against a target of 85% • There will be an audit on UTI assessment and management and planning for the increase in measles cases.	The Committee discussed the update and received **moderate assurance**. It was agreed that IPC would be the Deep Dive topic in April	**Quality Assurance Committee – April 2024**
QAC/24/02/300	**Quality Integrated Performance Report**	The Committee received a report providing an update on the quality measures noted within the Integrated Performance Report. The following was of particular note: **VTE** • Performance improved in December 2023 was just below Trust target at 93.51% **Medicines Reconciliation** • Medicines reconciliation was completed within 24 hours of admission for 45% of patients.	The Committee discussed and noted the update and actions in place and received **moderate assurance**	**QAC June 2024**

		The Committee was advised that 9 pharmacists had now been recruited.		
QAC/24/02/301	**Learning From Experience Update Q3**	The Q3 Learning from Experience Report providing an overview of the Learning from Experience across the organisation was received by the Committee. Areas covered were learning from Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Quality Improvement and Research and Development. It was particularly noted that there had been sustained improvement on falls and reduction in falls rate based on the QI methodology and multidisciplinary team approach.	The Committee noted the update and received **substantial assurance**	**QAC May 2024**

The Committee also received the following items;

QAC/24/02/292 - Hot Topic – Nutritional Update
QAC/24/02/294 - Board Assurance Framework & Corporate Risk Register (Quality)
QAC/24/02/297 - Compliance Update Q3
QAC/24/02/298 - Sepsis High Level Update Q3
QAC/24/02/302 - Mental Health Update
QAC/24/02/303 - Maternity Update (CQC Report, Ockenden, Maternity & Neonatal Review, Cheshire & Merseyside Perinatal Mortality Report Q3, Maternity Incentive Scheme including Saving Babies Lives Care Bundle
QAC/24/02/304 - IG & Corporate Records Q3 Update
QAC/24/02/305 **-** High Level Enquiry/ External Assessment/Inspection Update – Major Trauma Review

Assurance Key:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/04/x008a (ii)	MEETING	Trust Board	DATE OF MEETING	3 April 2024

Date of Meeting	12 March 2024
Name of Meeting & Chair	Quality Assurance Committee – Chaired by Cliff Richards
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/24/03/314	**Hot Topic – Orthopaedic Surgical Site Infection**	The Committee received a presentation on surgical site infection (SSI) following a recent letter describing the Trust as an outlier in knee replacement SSI. The Committee were advised that two infections had been reviewed and the learning, good practice and next steps were described. It was highlighted that there were no concerns in relation to Theatre practices and that effective processes were in place.	The committee discussed the presentation and received **significant assurance**	**Ongoing at Patient Safety & Clinical Effectiveness Committee**
QAC/24/03/314	**Deep Dive – Mortuary Compliance against David Fuller Inquiry Recommendations**	A Deep Dive was presented providing an analysis of the Trust position following the Independent Inquiry in to the issues raised by the David Fuller case. Of particular note was: • The HTA performed an inspection in May 2022 and the Trust was compliant with regulations Following WHH gap analysis of the 17 recommendations in the Fuller report, it was found that WHH have: • 1 x areas of non-compliance • 9 x partial compliance	The Committee discussed the presentation received and received **significant assurance.** It was agreed that bi-annual updates would be added to the Trust Board and Quality Assurance Cycles of Business	**Trust Board - April 2024**

		• 7 x full compliance It was confirmed that currently are recommendations and are not currently mandated by the HTA.		
QAC/24/03/317	**Committee Terms of Reference and Cycle of Business**	The Committee reviewed and supported the updated Committee Terms of Reference and Cycle of Business	The Committee reviewed and supported the updated Committee Terms of Reference and Cycle of Business and received **high assurance**	**Trust Board – April 2024**
QAC/24/03/318	**Maternity Strategy**	The 2024-2026 Maternity & Neonatal Strategy was presented to the Committee for approval. It was noted that the strategy had been developed in alignment with national policy and guidance as well as local learning from safety events which have occurred within the maternity and neonatal service at the Trust.	The Committee approved the Maternity & Neonatal Strategy and received **high assurance**	**Quality Assurance Committee – March 2024**
QAC/24/03/321	**Patient Safety & Clinical Effectiveness Sub-Committee Exception Report**	The Committee received an update on the following items: 1. Fragile Services Updates: • Paediatric Ophthalmology • Urology • ENT • Fractured Neck of Femur • Gynaecology 2. CQUIN and non-achievement of flu vaccination target due to vaccine hesitancy/fatigue 3. Pressure Ulcers – positive WHH Benchmark against other C&M provider Trusts 4. Drug & Therapeutics Committee – Botox treatment commissioning issue	The Committee discussed the update and received **significant assurance**.	**Quality Assurance Committee – April 2024**
QAC/24/03/322	**Paediatric Audiology Incident & Service Review**	The Committee received a presentation providing a summary of the service as the review draws to a close.	The Committee discussed the update and actions in place and received **high assurance** and agreed that	**QAC September 2024**

		It was noted that there was ongoing monitoring of eight remaining children with a final summary to be provided in 2024, date dependant of individual child's assessment.	the Committee would receive bi-annual updates.	
QAC/24/03/323	**Blood Transfusion Update**	Following a request from a previous meeting, the Committee received an update on the Trust's Blood Transfusion service. It was confirmed that there was a much improved position with actions in place to address issues in respect of the BadgerNet transcription, traceability and ED blood fridge	The Committee discussed the update and received **substantial assurance**	**Ongoing in Patient Safety & Clinical Effectiveness Sub-Committee**

The Committee also received the following items;

QAC/24/03/316 - Review & Refresh of Trust KPIs
QAC/24/03/319 - Quality Priorities 2024-2025
QAC/24/03/320 - ED Improvement Programme update
QAC/24/03/324 - Quality Priorities Q3 update
QAC/24/03/325 - Learning from Deaths Q3 update
QAC/24/03/326 - Maternity Update (Ockenden, ATAIN Q3, Maternity & Neonatal Quality Report, Transitional Care Audit Q3)
QAC/24/03/327 - High Level Enquiry/ External Assessment/Inspection Update – MRHA Inspection of Halton Blood Transfusion Department
QAC/24/03/328 - Quality Academy Sub-Committee minutes
QAC/24/03/329 - Notification of Committee Effectiveness Review

Assurance Key:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/04/008b (i)	Meeting	Trust Board	Date Of Meeting	3rd April 2024

Date of Meeting	21st February 2024
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/ Mandate to Receiving Body	Follow Up / Review Date
SPC/24/02/203 **and** **SPC/24/02/204**	**Deep Dive – Strategic and Corporate Risks** **Board Assurance Framework**	The Committee received a detailed presentation which included a brief on the Board Assurance Framework, risk appetite and target score. A robust conversation took place regarding the current People BAF risks 1134 and 1757 and the consideration of amendments to the scoring and descriptions. The Committee agreed risk 1134 would be amended to an 'open' risk appetite. It was agreed that further review of the current and target score would take place for 1134, along with the description of 1757, and would be brought back to the Committee for final agreement.	The Committee discussed the report and received **substantial assurance** regarding risk management.	**April 2024**
SPC/24/02/205	**Workforce Brief on National, Regional, ICB or Local Workforce Issues**	The Committee received a verbal update regarding the current national consultation on creating a separate pay spine for nurses. National agencies such as NHS Employers are coordinating responses as well at locally at the Trust where staff have	The Committee discussed the report and received **substantial assurance** regarding responding to the consultation.	**April 2024**

		been invited to share their views. A collective organisation opportunity to respond has been shared with Executive and Nursing colleagues and must be submitted by 4th April 2024.		
SPC/24/02/206	**Chief People Officer Report**	The Committee received the report which included updates on industrial action, organisation culture programme, B2/B3 rebanding update, Scaling People Services and SEQOHS accreditation. The Committee had a robust discussion regarding Scaling People Services and the governance for decision making at a system and organisation level for proposed changes. It was clarified that role descriptions for Governors now included a duty to consider the best interests of the system. Governance regarding decision making for Scaling People Services is yet to be finalised and will be reported to the Committee once clarified.	The Committee discussed the presentation and received **moderate assurance** regarding the governance for Scaling People Services.	**As updates received**
SPC/24/02/210	**Equality Delivery System (EDS)**	The Committee received the detailed report which provided a summary review of the stakeholder engagement which has been undertaken to formally score both the patient and workforce elements of the EDS. This included a summary of the actions to support continued improvement for 2024/25. The Committee approved the scoring recommended in the report and noted the excellent work being undertaken to support the achievement of EDS.	The Committee received **substantial assurance** and approved the EDS scoring.	**February 2025**

The Committee also received the following items:

Matters to Note for Assurance

SPC/24/02/202 – Staff Story Occupational Health – deferred due to staff sickness.
SPC/24/02/208 – Safe Staffing Report
SPC/24/02/209 – Midwife Safe Staffing Report

Matters for Approval

SPC/24/02/207 – Workforce Integrated Performance Report (IPR) 2024/25 Recommendations

Sub-Committee Minutes/Notes

SPC/24/02/211 – Workforce Review Group (1st February 2024)
SPC/24/02/212 – Workforce Equality, Diversity and Inclusion Sub-Committee (19th January 2024)
SPC/24/02/213 – Operational People Committee (12th February 2024)

Assurance Key:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/04/24b (ii)	Meeting	Trust Board	Date Of Meeting	3 April 2024

Date of Meeting	20th March 2024
Name of Meeting & Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/ Mandate to Receiving Body	Follow Up / Review Date
SPC/24/03/220	**Staff Story – Occupational Health**	The Committee received a detailed presentation on the development of the Occupational Health service at the Trust. The Committee acknowledged the work undertaken to achieve SEQOHS accreditation and the support the department provides staff at the Trust.	The Committee discussed the presentation and received **substantial assurance**.	**N/A**
SPC/24/03/221	**EDI Annual Report**	The Committee received the report which as public sector organisations, all NHS Trusts are required to demonstrate how they meet the general and specific duties of the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010. To comply with this, the Trust completes an annual Equality Duty Assurance Report (EDAR) and Workforce Equality Analysis Report (WEAR) which sets out the commitment of the Trust in how it will endeavour to adhere to statutory	The Committee discussed the report and received **substantial assurance**.	**March 2025**

		obligations, building upon progress achieved under previous equality schemes and directives. The Committee noted the accessible format in which the report was now presented and approved the report for publication in line with reporting requirements by 30 March 2024.		
SPC/24/03/222	**Deep Dive – EDI Strategy/National EDI Improvement Plan**	The Committee received a detailed presentation which referenced the EDI Strategy Update report from December 2023. The Committee noted the requirements of the EDI Improvement Plan by March 2024 and actions completed thus far. The Committee approved the risk regarding bullying, harassment, discrimination and violence and the requirement for reduction targets. The Committee noted the excellent work undertaken to analyse the Trusts' EDI data including Staff Survey to inform EDI actions.	The Committee discussed the presentation and received **substantial assurance**.	**Bi-annual**
SPC/24/03/224	**Workforce Brief on National, Regional, ICB or Local Workforce Issues**	The Committee received the report with updates on national People policies, C&M Workforce Insights report, Employment Tribunal fees consultation, Employment Tribunal themes and the Ensuring the Safe and Effective Integration of Physician Associates guidance. The Committee discussed the Trusts current approach to the utilisation of the role of Physician Associates with assurance provided regarding their practice. A full review of the guidance is being undertaken and will be provided to the Committee for assurance upon completion.	The Committee discussed the report and received **substantial assurance** in relation to the Trust's support for and use of Physician Associates.	**June 2024**
SPC/24/03/225	**Chief People Officer Report**	The Committee received the report which included updates on industrial action, B2/B3 rebanding update and the Trust approach to measles.	The Committee discussed the report and received **substantial assurance**.	**April 2024**

		The Committee were assured regarding the Trusts approach to the B2/B3 rebanding process and noted the lack of progress to address the matter at other Trusts.		
SPC/24/03/226	**Staff Survey**	The Committee received the detailed presentation with further Staff Survey results presented for CBUs, FTSU and PSIRF. The Committee noted the positive overall Staff Survey scores as well as how the data has been disaggregated at various levels to inform action plans.	The Committee discussed the presentation and received **substantial assurance**.	**March 2025**
SPC/24/03/227	**Workforce Integrated Performance Report**	The Committee received the report and noted the positive progress on the People metrics with particular reference to 'Time to Hire' which has decreased significantly following the implementation of TRAC.	The Committee discussed the report and received **substantial assurance**.	**May 2025**

The Committee also received the following items:

Matters to Note for Assurance
SPC/24/03/228 – Freedom to Speak Up Bi-Annual Report
SPC/24/03/229 – Workforce Policies and Procedures Report Q2
SPC/24/03/230 – Safe Staffing Report

Matters for Approval
SPC/24/03/223 – Terms of Reference and Cycle of Business

Sub-Committee Minutes/Notes
SPC/24/03/231 – Workforce Review Group (7th March 2024)

Assurance Key:

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/04/24 (i)	MEETING	Trust Board	DATE OF MEETING	3 April 2024

Date of Meeting	28 February 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by Julie Jarman
Was the meeting quorate?	Yes

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

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up / Review date
FSC/24/02/210	**Hot Topic – Operational Plan**	The Committee received the report noting:- **Activity -** Submitted as per Trust Board to achieve 104% **Workforce -** Submitted as per Trust Board (4,636.48 WTE) which is the same as forecasted for March 2024. Workforce plan has been accepted following review by the ICS however there is an expectation that WTE in deficit trusts should decrease rather than just remaining flat therefore this could be revisited **Finance** • Request from the ICS to explain the reasons for the position worsening from the 2023/24 forecast outturn which were understood • Highlighted to the ICS that the Board is extremely concerned about a 5% CIP • The Trust has been asked by the ICS to improve the position by at least £5m from a £43.4m deficit to £38.4m deficit in line with trusts of a similar size • £4.4m of the £5m ask has been identified. Reduction in cost pressures of £3.6m, increased inflation on miscellaneous income of £0.1m, increased CIP £0.8m to reach the 5% ask. Gap of £0.6m to be identified prior to resubmission • Cost pressures that are to be turned off in order to achieve the revised deficit plan are to be reviewed and monitored thoroughly throughout the year	The Committee discussed the report and **approved** resubmission of the finance element of the operational plan	**FSC March 2024**

		• Potential movement in NHS Oversight Framework (NOF) rating from segment 2 to segment 3 given the underlying deficit and non-achievement of financial plan • Discussed the importance of the role of the system and working together with other trusts to agree a common approach regarding assumed occupancy and reduction in NCTR		
FSC/24/02/212	**Corporate Performance Report**	The Committee received the report noting:- • Challenge remains in the 12 hour in the Emergency Department metric, interventions are in place along with external discussions with ECIST. • Between 500 and 600 65 week waits expected at the end of the year, expectation that these patients will be seen by September 2024 compared to original target of March 2024. 78 week waits are due to complexity and choice which is allowable • 4 hour performance decrease on last month to 62.47% • Requirement for Cath Lab to be bedded and an additional 6 beds on B4 throughout January and February, require plans to enable closure in March • An average increase of 13 Ambulance per day over the last 10 months • RTT performance – 50.88% which is behind trajectory • The diagnostic performance for patients waiting over 6 weeks has decreased to 14.3%, continued improvement, expected to reach 10% by the end of March • Cancer 31 day wait achieved in month. Cancer 62 day referral performance has achieved 71.5% against the 85% standard target is to achieve 70% by March 2025 • Achieved the combined 28 day cancer metric, against the 75% standard	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC March 2024**
FSC/24/02/213	**Monthly CIP & GIRFT Update**	The Committee received the report noting:- • CIP overview at month 10, shortfall of £1.0m delivery against a plan of £13.1m • CIP of £17.9m fully identified of which 55% is recurrent, high risk CIP of £2.5m remains • £5.3m stretch remains a significant risk to the financial position, £0.4m identified to date with work ongoing to identify further savings	The Committee **noted** and discussed the report, receiving **moderate** assurance	**FSC March 2024**

		• An improvement in theatre late starts with 62% now starting on time however, theatre utilisation is still below the 90% target • Virtual wards usage is improving • Outpatient improvements throughout the year across DNAs, short notice cancellations, PIFU and new to follow up ratios		
FSC/24/02/214	**Improvement Model**	The Committee received the report noting:- • Current year has been about setting the building blocks. Next years approach to improvement is to focus on a few areas and bring expertise together to support operational teams. The Improvement Team will be made up of the GIRFT, Transformation and Quality Academy • Work with the Care Groups will take place to identify priority schemes for 2024/25 which will get the most return for the time invested • Improvement will be led by the CEO with matrix working by other Executives • Newton have provided a quote to implement the recommendations included in their report with a team of circa 20WTE compared to an internal team of 8WTE. The Trust is unable to proceed given the current deficit position of the Trust	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC April 2024**
FSC/24/02/216	**Pay Assurance Report**	The Committee received the report noting:- • Review and scrutiny of increase in WTE continues • Industrial Action – ICS approved increased rate for Junior Doctors being on strike • ECF panel has been strengthened with external challenge from the Halton ADOF • 5.6% remaining annual leave to be booked/taken by the end of March, therefore on target (always small amount untaken due to long term sick, maternity leave, etc) • Improvement in agency usage overall, continue focus on high usage areas • Expectation is that bank reduction will become the focus during 2024/25	The Committee **noted** the report, receiving **substantial** assurance	**FSC March 2024**
FSC/24/02/218	**Benefits Realisation Q3 Update**	The Committee received a report noting:- • UIU highlighted as not delivering benefits due to the delay in recruitment of the post holder. Benefits will be re-reviewed in 6 months • Discussion around the need to be tougher on both setting benefits and the subsequent realisation review in the current financial context.	The Committee **noted** the paper receiving **moderate** assurance	**FSC May 2024**

		• Deep dive request to review benefits realisation for requests >£1m in the last 4 years		
FSC/24/02/221	**Finance Report**	The Committee received a report noting:- • The month 10 ytd position is £21.8m deficit (£7m worse than the original plan) • Forecast expected to be circa £28m deficit and cash support has been requested • More scrutiny required on cash with a quarterly report going forward • Revenue request supported by the Executive Team highlighted in the report • Risks highlighted included activity, unfunded cost pressures, CIP delivery and no provision for backpay for Band 2 to 3	The Committee **noted** the paper receiving **limited** assurance.	**FSC March 2024**
FSC/24/02/222	**Elective Restoration 2024/25 Revenue Request**	The Committee received a revenue request noting:- • A request for non-recurrent funding of £4,604,301 to provide independent sector and WLI to support achieving the Trust's elective recovery target of 104% in 2024/25 as well as removing all the 78, 65 and 52 week waits • The funding will enable circa 8,000 additional patients to be seen during 2024/25 • Guidance has not yet been received around the date for 52 week waits, current plan is March 2025 however this activity is required to achieve the 104% target. • The £4.6m cost has been included in the operational plan and forms part of the revised £38.4m deficit plan for 2024/25 and the 104% activity • Efficiencies need to be made to at least get to 100% to reduce the reliance on outsourcing • Amendments to be made to the request to include options if the request is not approved, benefits realisation from the requests approved for 2023/24 activity and noting that a call off contract will be put in place with review at FSC linked to efficiency of our own service provision.	The Committee requested some amends to the revenue request prior to going to Trust Board for approval.	**Trust Board March 2024**
FSC/24/02/223	**Capital Position and Annual Plan 2024/25**	The Committee received a presentation approving:- • Movements in capital contingency, now stands at £399k	The Committee **noted** the presentation and **approved** the changes	**FSC March 2024**

Assurance Key:

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

Items for noting

FSC/24/02/211 Board Assurance Report and Risk Register
FSC/24/02/215 Cost Pressures M10 2023/24
FSC/24/02/217 Annual Review of KPIs - supported
FSC24/02/219 Medical Staffing Resource Review Group Q3 Update
FSC/24/02/220 CDC New Build update
FSC/24/02/223 Schemes over £500k
FSC/24/02/224 Digital Strategy Group Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/24/04/008c (ii)	Meeting	Trust Board	Date Of Meeting	3 April 2024

Date of Meeting	27 March 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Recommendation / Assurance/ mandate to receiving body	Follow up / Review date
FSC/24/03/230	**LLP Update**	The Committee received the presentation noting:- • LLP will be established by the end of March 2024 initially by T&O Consultants and the expectation is that other specialities will then be onboarded • Issue raised re: T&O productivity, available theatre lists are being reviewed to address this	The Committee **noted** and discussed the presentation receiving **substantial** assurance of the process and costs therefore supporting the proposal	
FSC/24/03/231	**Hot Topic – Digital Key Projects**	The Committee received the presentation noting:- • 2 years Digital Strategy includes several digital priorities • EPCMS Procurement – 4 tenders received which meet affordability cap • Patient Engagement Project (PEP) – all NHS Providers required to implement and funding received to support • Picture Archiving Communication System (PACS) – migration to the Cloud, working across the region to implement • Technology Infrastructure - £5m invested over the last few years, in final stage • Business continuity plans are being reviewed to address risks	The Committee **noted** and discussed the presentation receiving **substantial** assurance due to the detail and content of the presentation	
FSC/24/03/232	**Deep Dive – Review of**	The Committee received the presentation noting:-	The Committee **noted** and discussed the	

	Effectiveness of Elective Recovery Spend	• How the 104% ERF target is achievable across four main specialities (ENT, Gynae, Respiratory and T&O) • How this ensures all 65 week waiters are seen by September 2024 and 52 week waiters by March 2025 (guidance pending for 52 week) • The finance report will include progress of elective restoration	presentation receiving **moderate** assurance as required more detailed monitoring.	
FSC/24/03/235	**Monthly CIP & GIRFT Update**	The Committee received the report noting:- • CIP overview at month 11, shortfall of £1.8m delivery against a plan of £15.5m • CIP of £17.9m identified of which 55% is recurrent, high risk CIP of £2.5m remains • £5.3m stretch is impacting on the financial position, £1.5m is identified • The impact of the £10.6m non-recurrent CIP on the 2024/25 financial plan • CIP allocation for 2024/25 supported by Executive Team • Improvement schemes for 2024/25 are a priority and are being worked up	The Committee **noted** and discussed the report receiving **limited** assurance on the delivery of next years plan and **approved** the 2024/25 CIP allocation	**FSC April 2024**
FSC/24/03/238	**Pay Assurance Report**	The Committee received the report noting:- • Review and scrutiny of increase in WTE continues • 2% reduction in establishment as part of operational planning, (excluding externally funded posts) • Review undertaken on the Establishment Control Process and Place Based Associate Director of Finance also attends to provide challenge for the ICS • Notification received from ICS that non-clinical vacancy reduction expected, all posts to go through additional panel with expected reduction of circa 50 WTE • Full vacancy freeze discussed, recognising this could lead to clinical people doing non-clinical tasks and risks in the organisation (BAF) could increase or not be mitigated as required	The Committee **noted** the report, receiving **substantial** assurance on the detailed workforce information.	**FSC April 2024**
FSC/24/03/241	**Operational Plan & Budgets 2024/25**	The Committee received the presentation noting:- • Finance - £35.3m deficit plan • Activity – 104% ERF achievable through use of Independent Sector • Workforce – 2% reduction in establishment • Suggestion proposed by ICS to reduce deficits across ICS – use last year's plan plus allowable adjustment (£2.5m Adaptive Reserve) giving a £18.3m deficit • Alternative suggestion proposed – based on outturn for deficit trusts adjusted for if surplus trusts can maintain the same surplus	The Committee **noted** and discussed the presentation receiving **limited** assurance due to the concerns regarding potential ICS control total methodology.	**Trust Board April 2024**

		• Control totals to be circulated by the ICS • Extraordinary Board expected to be required to sign off a revised plan mid April • Concern raised about the achievability of the plan, FSC do not support any further changes at this point		
FSC/24/03/242	**Finance Report**	The Committee received a report noting:- • The month 11 ytd position is £24.3m deficit (£9.2m worse than the original plan) • Forecast expected to be £27.5m deficit, (£1.5m of the £5.3m stretch identified) • £2.5m shortfall on Industrial Action funding contributing to the forecast deficit • £20.6m cash balance of which £14.1m is related to capital expenditure • Revenue request supported by the Executive Team highlighted in the report	The Committee **noted** the paper receiving **limited** assurance, due to the cash support requirement and the overspend against plan.	**FSC April 2024**
FSC/24/03/243	**Revenue Request - EBCMS**	The Committee received a revenue request noting:- • Revenue funding for 1 year expected (previous 3 year funding) with 35% reduction from original case • Funding for Real Time Location Services (RTLS) and a Care Coordination Centre • There is a recurrent cost pressure of £141k which is expected to be covered by cash releasing benefits related to RTLS this need to be quantified • There is a potential mitigation around reducing staff costs included in the case • Support for the case, however need to show there is a return on investment	The Committee **supported** the revenue request from a quality point of view with a review of benefits required prior to Trust Board approval. **Moderate** assurance as saving will be delivered however they need evidencing in the business case.	**Trust Board April 2024**
FSC/24/03/244	**Laboratory Information Management System (LIMS) Full Business Case**	The Committee received the business case noting a number of issues and risks:- • A C&M benefit of £9.4m over a 10 year period by implementing a single LIMS System across C&M, the Trust' share of this is £774k • Costs exceeding income in the early years which will be partly covered by the ICS with payback in later years. The timing of this payback needs to be confirmed. • Duplicate tests cash releasing benefit is £1.4m overstated for the Trust • The cost to replace the Phlebotomy App £200k • Supportive in principle, with highlighted issues resolved prior to approval	The Committee **supported** the business case in principle with a number of caveats to be resolved prior to Trust Board approval. **Limited** assurance due to the issues noted.	**Trust Board April 2024**

FSC/24/03/246	**Capital Position and Annual Plan 2024/25**	The Committee received a presentation:- • Approving movements in capital contingency, now stands at £66k • Supporting the 2024/25 capital plan for Trust Board approval noting the oversubscription of £1.76m which will need to be managed	The Committee **noted** the presentation receiving **moderate** assurance, **approved** the contingency changes and **supported** the 2024/25 plan for Board approval	**Trust Board April 2024**

Assurance Key:

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

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

Items for noting

FSC/24/03/233 Board Assurance Report and Risk Register
FSC/24/03/236 Cost Pressures M11 2023/24
FSC/24/03/237 Investments in excess of £1m
FSC/24/03/239 Costing Update Q3
FSC/24/03/240 Performance Assurance Framework (PAF) Annual Refresh – supported
FSC/24/03/246 Terms of Reference and Cycle of Business – supported
FSC/24/03/246 Schemes over £500k
FSC/24/03/247 Digital Strategy Group Update

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/04/008(d)	MEETING	Trust Board	DATE OF MEETING	3 April 2024

Date of Meeting	22 February 2024
Name of Meeting & Chair	Audit Committee – Chaired by Mike O'Connor
Was the meeting quorate?	Yes

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
AC/24/02/94	**Internal Audit Plans and Fees**	The committee received details of the proposed Internal Audit Plan coverage for 2024-25, which had been linked to the BAF and other risk sources and supported by the Executive Team It was explained that the associated fees were not included in the report as NHS planning guidance was awaited, The Committee noted that the fees would be bought back to the committee for review and approval in April.	The Committee received supported the plan and received **High Assurance**	Fees would be bought back to the committee for review and approval in April.
AC/24/02/96	**Internal Audit Progress Report**	The committee received the report which set out the outcomes of the reviews that had been completed since the last audit committee. It was noted that two reports had been issued since the last audit committee. • waiting list management (substantial assurance) • key financial systems controls (substantial/high assurance) It was further noted that four reviews were in progress; • fractured neck of femur pathway • bank & agency • data quality • consultant job planning	The Committee received **Substantial Assurance**	The four reviews in progress would be issued within the agreed timeframes.

AC/24/02/98	**Informing the Risk Assessment**	The committee paper was circulated following the committee meeting and. The committee approve the responses within the "Informing the audit risk assessment" via email.	The committee received **Substantial Assurance** between the meetings around the responses within the informing the audit risk assessment.	Approved between meetings.
AC/24/02/100	**Review Losses & Special Payments Q2 2023/24**	The committee received the report which provided details of the Losses and Special Payments for the period 1 October 2023 to 31 December 2023. The committee sought clarity around Damage to Building and Property – Stores Losses. It was explained that the main element of the loss occurred in this quarter was for chemotherapy medicines. The Committee requested that further information be provided at the next Audit Committee meeting in relation to medicine losses	The Committee revived **Moderate Assurance** Review Losses & Special Payments Q2 2023/24, and agreed further assurance would be sought in relation to medicine losses	Further assurance to be presented to the committee in April around medicines losses.
AC/24/02/101	**Review Of Quotation & Tender Waivers Q2 2023/24**	The committee received the report which provided information on selected quotations and tenders to ensure compliance with the Trust's quotation and tender criteria. It was noted that in the period 1 October to 31 December 2023 there had been a total of 34 waivers. The Committee asked that further assurance be provided at the next meeting in relation to the reoccurrence of retrospective waivers in estates and facilities.	The Committee revived **Moderate Assurance** requesting further assurance around retrospective waivers within estates and facilities would be requested for a future meeting.	Item scheduled for the April meeting around estates and facilities retrospective waivers.

The Committee also received the following items;
AC/24/02/91 - Changes or updates to the BAF
AC/24/02/92 - Committee Assurance update from Chairs of FSC, SPC, QAC
AC/24/02/93 - Internal Audit Progress Report on Follow Up Actions
AC/24/02/95 - Internal Audit Follow Up Report
AC/24/02/97 - Anti-Fraud
I. Progress Report
II. Work Plan 2024-25
AC/24/02/99 - External Audit Progress Report & Sector Update
AC/24/02/102 - Annual Report & Accounts Timetable and Plans

AC/24/02/103 - Draft Annual Accounts Accounting Policies
AC/24/02/104 - NW Skills Network (NWSD)Bi-Annual Report
AC/24/02/105 - ICON Programme Bi-Annual Report
AC/24/02/106 - Terms of Reference & Cycle of Business Annual Review
AC/24/02/107 - Fire Alarm Scheme update

Assurace Key:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE	BM/24/04/008 (e)	MEETING	Trust Board	DATE OF MEETING	3 April 2024

Date of Meeting	13 March 2024
Name of Meeting & Chair	Charitable Funds Committee, Chaired by Steve McGuirk
Was the meeting quorate?	Yes

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

AGENDA REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
CFC/24/03/69	**Annual Operational Plan**	The Committee approved the 2024/25 plans for the Charity, which included areas of focus such as: • Digital marketing • Awareness raising • Campaigns • Income generation • Staff engagement • Working with partners • Resource requirements Thanks to NHS Charities Together development grant funding, significant work to further develop the charity has been undertaken in 2023/24 (year two of the Charity's three-year strategy). For this reason, the Committee agreed that the current three-year Charity strategy will cover a four-year period.	The Committee received **substantial assurance** on the Charity Annual Operational Plan	Monitoring through CFC quarterly
CFC/24/03/70	**Charity Budget for 2024/25**	The Committee approved the Charity's annual budget and cashflow for 2024/25. The budget has been stress tested in relation to: • confidence in receipt of donation • confidence in the level of donation • confidence of the timing of the donation	The committee received **substantial assurance** and approved the annual budget	Monitoring through CFC quarterly

CFC/24/03/68	**Bid Applications**	The Committee approved one bid application at a value of £11,275.20 for the creation of a staff wellbeing room within Warrington Hospitals Theatres.	The committee received **substantial assurance** on the bid application process	Monitoring through CFC quarterly

Additional agenda items presented included:
CFC/24/03/65 Fundraising Report and Quarterly Workplan
CFC/24/03/66 Finance Report
CFC/24/03/67 Investment Annual Update
CFC/24/03/71 Governing Document & Cycle of Business

Assurance Key:

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
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Note: *Please fill the Recommendation / Assurance/mandate to receiving body column with the correct colour and state the Committees' level of assurance i.e. No Assurance, Limited Assurance, Moderate Assurance, Substantial Assurance or High Assurance*

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/009**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	06/04/24	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	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)***	**#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff , reduced patient experience and reputational damage	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			✓
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			✓
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			✓
Further Information:			

EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper aims to provide assurance with regards to the Trust's oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile: Urology Gynaecological surgery Orthopaedics – Fractured Neck of Femur ENT Paediatric Ophthalmology		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	Trust board is asked to: - Note the current list of Fragile Services, associated clinical risk and high-level progress updates - Note that no services have been stepped up into, or down from, Fragile Services Oversight since the last report - Receive further Fragile Service Oversight reports		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/24/04/009

1. BACKGROUND/CONTEXT

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

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

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

2. SER VICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

None

3. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- 5 in year incidents of moderate/severe harm identified which have been subject to appropriate investigation and Duty of Candour has been discharged. No new harm identified since previous report to board.
- Position improved following middle grade and locum consultant colleagues commencing in post
- Transperineal Biopsy position very significantly improved
- Surveillance cystoscopy position improved (>50% reduction from peak).
- P2 backlog decreased in month
- Significant volume of high risk patients confirmed by AI list validation
- Ongoing risk of harm remains given P2/Stone and surveillance cystoscopy backlogs
- Service exceeding clinical activity targets (>105% of 19/20 activity)
- Completed Actions
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved
    - 3 Middle Grade doctors commenced in post
    - Locum consultant commenced in post
- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site – to increase frequency
    - PCNL Stone patients transferred to Chester
- Ongoing improvement plan actions:
    - Mutual aid request to C&M Hub and WWL
    - Plan to reintroduce PCNL at Warrington site with new IR Radiologist

- Specialist nurse delivered cystoscopy training plan now confirmed – training May (2 colleagues) and September (2 colleagues) followed by 3 months direct supervision

Gynaecological Surgery

- Demand and capacity mismatch – driven predominantly by workforce issues with some initial diagnostic equipment pressures (hysteroscopes – now resolved)
- 6 incidents of moderate harm identified in year due to delays which have been subject to appropriate investigation and Duty of Candour has been discharged. No new harms identified since previous report.
- Service has recovered its Cancer 2WW position – no breaches since December - monitored daily as position remains volatile. Dedicated 2WW / CFT clinic continues to mitigate for risk
- 30 complex cohort patients transferred to Liverpool Women's Hospital have been repatriated to WHH due to LWH lacking capacity and differences in clinical opinion on treatment – all such patients now have a plan to complete treatment at WHH
- A number of patients have been returned to the Trust with incomplete treatment pathways from outsourcing (ASET) treatment – all such patients now have a plan to complete treatment at WHH
- Successful trial of 'Complex Surgery Super Week' at Halton Theatres
- Completed Actions
    - Full complement of hysteroscopes now purchased and in service.
    - Gynaecological surgery capacity supported by approved elective c-section revenue request.
    - Full consultant job plan review completed informed by demand and capacity exercise.
    - 2 consultants recruited (2 replacements). 1 new post remains vacant.
    - Successful trial of 'Complex Surgery Super Week' at Halton Theatres
- Current mitigations
    - Insourcing and WLI as appropriate/available
    - AI aided Harm Review process in place
    - Daily 2WW performance tracker in place
- Ongoing improvement plan actions:
    - Further new Consultant post to advert
    - Triage/Advice and Guidance workstream
    - Further development of Halton HVLC and Complex patient 'Superweeks'

Orthopaedics – Fractured Neck of Femur

- Demand and capacity mismatch – driven predominantly by increased demand, increased pressures on bed base and insufficient theatre capacity for Trauma workload
- Significant improvement across majority of performance indicators – performance at or close to national average in these domains
- Prompt surgery remains remaining significant challenge
- Test of change to deliver additional trauma theatre capacity completed and undergoing evaluation, work up of resourcing required to make permanent
- Current mitigations:
    - CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits

    - Additional orthogertiatrican and orthogeriatric fellow in post
    - Additional ad hoc fractured neck of femur list utilising bank locum consultant
- Ongoing improvement plan actions:
    - Focused improvement plan to deliver 'prompt surgery'
    - Agreement of ringfencing process to allow direct admission to specialist ward
    - Evaluation of theatres test of change
    - Review of escalation policy to ensure that prolonged delays to theatre are escalated appropriately

Ear Nose and Throat Surgery

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand.
- Significant medical staffing challenges
- Emergent growth in 2 week wait cancer demand
- ENT currently has the Trust's largest backlog

- No harm reported to date
- Recent P2 harm review exercise undertaken

- Outsourcing and insourcing with is supporting the reduction of patients awaiting 1st OPD appointment within the 65 and 78-week waiting cohort

- New OP waiting list has reduced significantly in month from >3500 to <2500.
- FU OP waiting lists remain a challenge
- High risk FU patients continue to be prioritised

- Completed Actions
    - Task and finish group established
    - Enrolled in phase one of GIRFT Further Faster program
    - NHS Locum recruited and has commenced in post
    - Additional ENT stacker and scope procured for Warrington site

- Current mitigations
    - Outsourcing sessions funded

- Ongoing improvement plan actions:
    - GIRFT Further, Faster baseline assessment and action plan outstanding
    - Capital bid for further scope and stacker equipment in 24/25
    - Triage and clinical waiting list validation exercise underway
    - To revisit case for 4th consultant in 2024/25

Ophthalmology - Paediatric Ophthalmology

- Demand and capacity mismatch – driven predominantly by workforce issues
- NHS Locum consultant commenced in post February 2024
- Markedly improved position
- Significant improvement in both long waits and high risk waits in month following new consultant commencing in post (all high risk patients now dated)

- There has been marked improvement in the admitted pathway with a Paediatric surgery re-start on the 13th March 2024. Some children have been removed from the waiting list after a face-to-face assessment with the new consultant
- No harm identified to date

- Current mitigations:
    - Monthly review of all high risk and 17 week plus patients
    - Regular interim orthoptic/optometry review if potential risk to sight
    - Re-prioritisation as clinically indicated by patient level risk
    - Agreement with specialist Trust to accept paediatric emergencies and any patients deemed at risk of sight loss requiring surgery should internal consultant capacity not suffice
    - Additional activity from external consultant as available

- Ongoing improvement plan actions:
    - Retinal Screening Camera procured to increase capacity for Retinopathy of Prematurity screening through 'batching' – develop training plan for camera use
    - Develop long term medical staffing plan

  Service likely to be stepped down Fragile Service oversight in coming months

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

None

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high level progress updates
- Note that no services have been stepped up into, or down from Fragile Services Oversight since the last report
- Receive further Fragile Services Oversight reports

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="4">BM/24/04/010i</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Maternity Update – Ockenden Report</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="4">3rd April 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="4">Ailsa Gaskill-Jones, Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="4">Ali Kennah, Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:</td><td colspan="3">SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.</td><td>✓</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</td><td colspan="4"></td></tr>
<tr><td rowspan="8">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td>✓</td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="4">The paper relates to care of pregnant people/those on the pregnancy continuum. The principles within the Ockenden recommendations are to ensure safer care for this cohort. Achieving the principles of Ockenden will have a positive impact on this group.</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="4">The Ockenden recommendations require the Trust Board of Directors to be informed and have oversight of maternity safety updates. This paper provides the Quality Assurance Committee (QAC) oversight of the update with regards to Ockenden recommendations, and the report will also be noted at Trust Board.

In summary, WHH has 3 Ockenden action plans: Ockenden Part 1a, following release of the first Report, Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a</td></tr>
</table>

	evidence submitted, and Ockenden Part 2 following the launch of the second Report. The WHH Ockenden update as of 31st January 2024 is: • **Ockenden Part 1a**: WHH is 100% compliant. • **Ockenden 1b**: WHH is 99% compliant and is on trajectory to be 100% compliant by 31st March 2024. • **Ockenden 2**: WHH is 90.27% compliant. Ockenden 2 does not have any national timelines. WHH has set internal timelines to complete all actions by 31st March 2024.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to receive and discuss this report as per Ockenden recommendations.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/24/03/326i	
	Date of meeting	12 March 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Update Ockenden Report	AGENDA REF:	BM/24/04/010i

1. BACKGROUND/CONTEXT

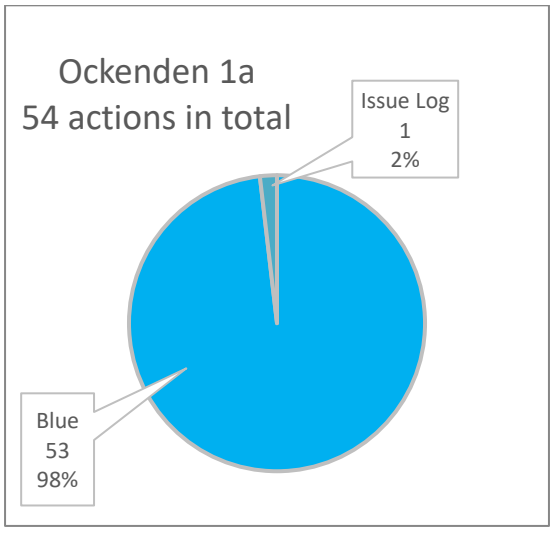
1.1 Warrington and Halton Teaching Hospital (WHH) compliance with the Immediate and Essential Actions (IEAs) outlined in Part One and Part Two of the Ockenden Report·

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

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

1.1.2 WHH Compliance with Ockenden 1a Report

Chart 1: WHH Ockenden Part 1a Compliance



Update

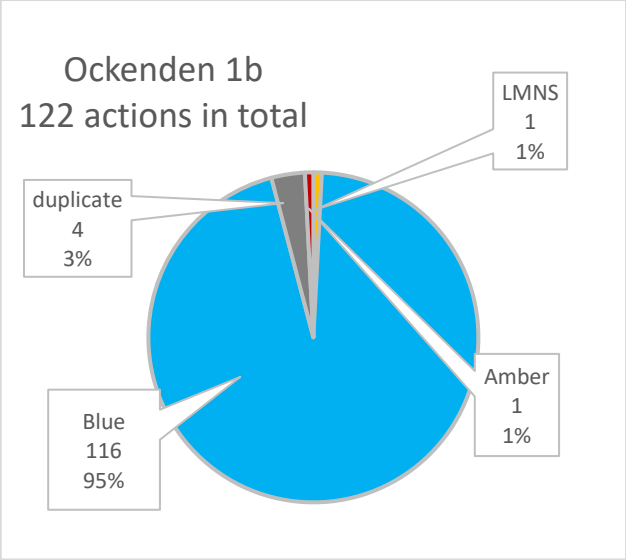
No change from previous month.

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

1.1.3 WHH Compliance with Ockenden 1b Report

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

Chart 2: WHH Ockenden 1b Compliance



1 Outstanding Action (no change):

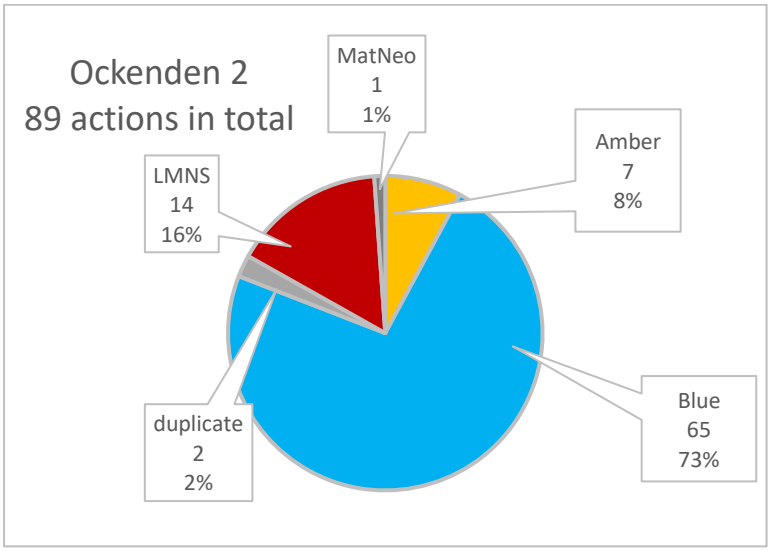
1 Amber Action

Excluding the 1 LMNS and 4 duplicate actions, Ockenden Part 1b action plan is currently 99% compliant at 31 January 2024 (no change from previously reported).

1.1.4 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



7 Outstanding Actions (previously 11)

7 Amber Actions

1 action transferred to a MatNeo Digital Group (Issue Log).

All actions due to be completed by 31 March 2024.

Excluding the 14 LMNS, 1 MatNeo and 2 duplicate actions, Ockenden 2 action plan is 90.27% compliant at 31 January 2024 (previously 84.72%).

a. WHH Risks for Escalation

Ockenden recommendations within Part 1b and Part 2 identifies the introduction of specific roles within the maternity workforce:-

- The Lead Obstetrician in Fetal Surveillance role is included in a new Consultant post. An appointment was made following interviews undertaken on 5 December 2023. Fulfilment of this recommendation will be achieved following commencement in post of the newly appointed Consultant, expected to be May 2024.
- Within the Ockenden report additional supernumerary clinical skills facilitators are recommended. Having reviewed the current provision it has been agreed, following recruitment into the Retention Midwife post (interviews scheduled for 12 March 2024), and utilising other experienced colleagues in a supernumerary capacity, this recommendation will be met.

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 Action Plan is 100% compliant.
- Ockenden 1b Action Plan is 99% compliant.
- Ockenden 2 Action Plan is 90.27% compliant.

8 Ockenden actions in total remain outstanding, all due to be completed by 31 March 2024.

2. MONITORING/REPORTING ROUTES

The Ockenden Action Plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee and Trust Board.

3. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 12th March 2024.

4. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/24/04/010ii</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Monthly Maternity & Neonatal Quality Update</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">3rd April 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Ailsa Gaskill-Jones, Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Ali Kennah - Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">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.</td><td>✓

</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</td><td colspan="5"></td></tr>
<tr><td rowspan="8">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="5">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td>✓</td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td>✓</td><td></td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="5">This paper provides an update in relation to maternity and neonatal quality for December 2023 and January 2024. The paper provides oversight of key national safety and quality issues in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 (Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal</td></tr>
</table>

	safety and quality issues). This information is reported monthly to Quality Assurance Committee. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Complaints • Coroner Regulation 28 position This paper will also provide an overview of emerging regional/local issues as appropriate. including: • Maternity Triage • PPH QI workstream In December 2023 and January 2024 there were four moderate harm events across the maternity and neonatal service. There were no severe harm or fatal events At the end of January 2024 compliance for mandatory training across maternity and child health colleagues was 86.62% for Trust mandatory training and 85.94% for role specific training, both above the Trust target of 85%. Compliance for mandatory safeguarding training has increased from 82.05% to 84.06%, slightly below the Trust target. Action plans remain in place to achieve and maintain compliance in these areas. Workforce measures related to retention and vacancy rate remain much improved. Improving and maintaining compliance with fetal surveillance training remains ongoing. Fetal surveillance competencies have improved across all staff groups, in particular amongst midwifery and medical colleagues. Work is ongoing to sustain improvement with a particular focus on agency staff. A further update will be provided to April Quality Assurance Committee and June Trust Board. The results of the NHS Maternity Services Survey 2023 have now been received. Potential areas for improvement and next steps are included within the paper. The service has received individual feedback regarding care experience, this is included in appendix one. A number of listening events with staff were held across January facilitated by the Director of Midwifery. There were no significant concerns raised and no matters for escalation.

	Much of the feedback was forward and solution focussed which was positive. The detailed feedback has been shared with the Midwifery leadership team and will be used to inform ongoing and new workstreams. In January 2024 87.3% of attenders to Maternity Triage were seen within 15 minutes of arrival (best practice guidance), and is below the KPI of 90% review within 15 minutes. 97.4% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes. A multidisciplinary PPH QI group has been established and work is underway with an aim as follows: ***"To reduce the occurrence of PPH at WHH from 3.74 mean to 3.5 mean by October 2024."*** The PPH action plan is attached for information in Appendix One. Six complaints were received in the CBU in December 2023 and January 2024. Two of these complaints related to care within the maternity and neonatal services. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/24/02/305iii QAC/24/03/236iii	
	Date of meeting	13th February 2024 12th March 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Monthly Maternity & Neonatal Quality Update	AGENDA REF:	BM/24/04/010ii

1. BACKGROUND/CONTEXT

This paper provides an update in relation to maternity and neonatal quality including relevant data and metrics for the months of December 2023 and January 2024.

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

2. HARM INCIDENTS

There were 114 events reported across the CBU in December 2023 which is a decrease of 13% from the 131 events reported for November 2023.

Below shows a breakdown of events reported and investigations declared in December 2023:

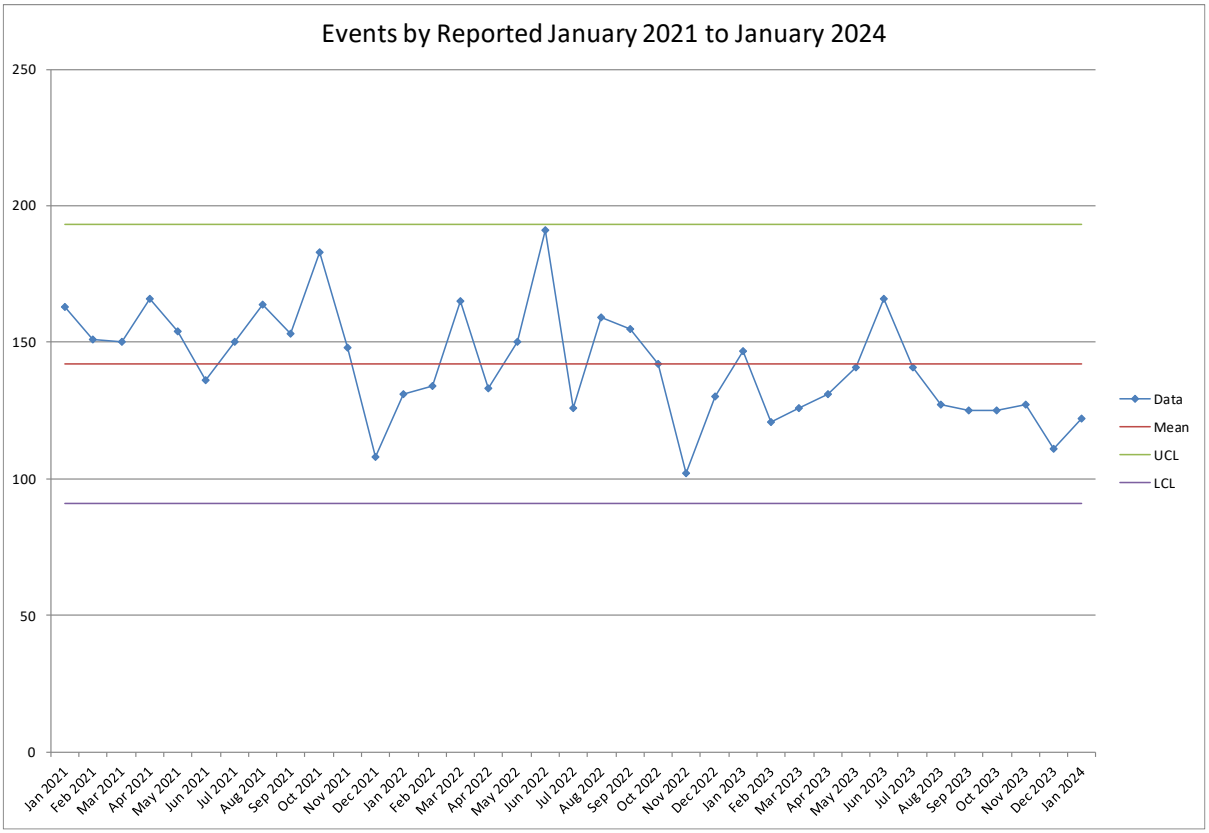
Severity	Nov 2023	Dec 2023
1 – No Harm	100	85
2 – Low Harm	26	22
3 – Moderate Harm	1	4
4 – Severe Harm	0	0
5 – Fatal	0	0
Total	127	111

There were four moderate harm events in the CBU in December 2023, all related to care in the maternity and neonatal service. Four Initial Safety Reviews (ISR) were undertaken. Following the four ISRs, two cases were reported to MNSI for external investigation. One case related to a baby transferred to tertiary unit due to meconium aspiration. MNSI have rejected this case due to lack of family consent. The second MNSI case relates to a baby transferred to a tertiary unit for cooling due to potential HIE. The investigation into this case is ongoing.

One ISR related to a baby who experience a fractured skull following a forceps birth. A further After-Action review has been completed. From this, actions and learning have been identified and are being progressed. The fourth ISR related to a Major Obstetric Haemorrhage (MOH), a full review has been completed. No care concerns were identified, good practice was noted and will be shared.

There were no severe harm or fatal events in December 2023.

There were 122 events reported in January 2024.



Below shows a breakdown of events reported and investigations declared in January 2024:

Severity	Dec 2023	Jan 24
1 – No Harm	81	92
2 – Low Harm	25	30
3 – Moderate Harm	4	0
4 – Severe Harm	0	0
5 – Fatal	0	0
Total	110	122

There were no moderate harm events in the CBU in January 2024. There were five Initial Safety Reviews undertaken in January, resulting in one report to MBRRACE. There were no severe harm or fatal events in January 2024.

3. WORKFORCE METRICS

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

At the end of January 2024 compliance for mandatory training across maternity and child health colleagues is 86.62% for Trust mandatory training and 85.94% for role specific training, both above the Trust target of 85%. Compliance for mandatory safeguarding training has increased from 82.05% to 84.06%, slightly below the Trust target.

Below shows the position with regard to mandatory training as at 31/1/2024, action plans remain in place to achieve and maintain compliance in these areas.

Compliance with PDR completion is an ongoing piece of work. Rates in December (excluding long term absence) for maternity staff is 84.66%, a significant improvement from 78.26% the end of November. The rate for child health colleagues is 78.2% a slight reduction in position from November. The overall rate for maternity and neonatal services is 81.76%, an increase from 79.31% in November. This remains below the Trust target of 85%. An action plan for improvement remains in place.

Compliance with PROMPT (multidisciplinary team skills drill training) is excellent. WHH met the Maternity Incentive Scheme Year 5 target of 90%. Compliance overall for PROMPT is 97.4%.

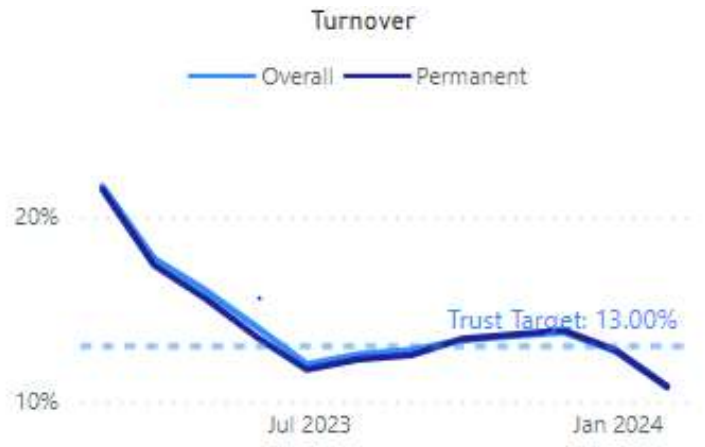
Compliance for MAMU2 at end of January 2024:

	Percentage of staff who have received CTG and IA training:			Percentage of staff who have successfully completed competency assessments:		
	Midwives	**Doctors**	**Agency staff**	**Midwives**	**Doctors**	**Agency staff**
July 23:	97%	100%	80%	86%	76%	80%
August 23:	88%	94%*	72%	56%*	50%*	67%
September 23:	88%	93%	72%	51%	50%	67%
October 23:	81%	75%	79%	54%	50%	58%
November 23:	84%	71%	84%	52%	50%	68%
December 23:	95%	89%	94%	68%	56%	72%
January 24:	98.4%	89%	94%	96.7%	94%	76.4%

*Full review of K2 competencies completed

Improving compliance with fetal surveillance training remains ongoing and is meeting national targets for midwives and agency staff (90%). Medical colleague compliance is almost at target. Fetal surveillance competencies have improved across all staff groups, in particular amongst midwifery and medical colleagues. Work is ongoing to sustain improvement with a particular focus on agency staff. A further update will be provided to April Quality Assurance Committee and subsequently to Trust Board.

Turnover for maternity and child health staff is following a positive trajectory with a rate of 13.76% in November 2023 reducing to 10.8% in January 2024, below the Trust target.



The vacancy rate for maternity and child health staff continues to improve from a peak of 17.23% in September 2022 to 6.17% in January 2024. This is illustrated in the graph below:

The positive trajectory with midwifery vacancies continues. In January 2023 the vacancy rate for registered midwives was 19.97%. At the end of January this rate was 4.24%, an improvement of 15.73%. This vacancy rate excludes those in the recruitment pipeline. The actual vacancy rate for registered midwifery staff is 0.8%.

4. SERVICE USER FEEDBACK

The results of the NHS Maternity Services Survey 2023 have now been received.

Individuals were invited to participate in the survey if they were aged 16 years or over at the time of their baby's birth and had a live birth at an NHS Trust between 1 February and 28 February 2023. If there were fewer than 300 people within an NHS trust who gave birth in February 2023, then births from January were included, this would be the case for WHH.

4.1 Response rates

Response rate for WHH was 41% which is in line with average national response rate albeit a reduced response rate for WHH compared to the survey completed in 2022.

A review of the demographic of those who responded notes responses generally reflective of Warrington and Halton Office for National Statistics (ONS) data in relation to ethnicity, religion and sexuality with a positive response rate from those within the BME population (WHH BME population receiving maternity care in 2023 was 6.9%, response rate from this group 12%)

Further analysis will be completed via additional BadgerNet reporting to assess whether responses were also reflective of the parity and age of those birthing at WHH.

Taking account of the reduced response rate in 2023, and to improve response rates for 2024 (individuals birthing this month) additional measures have been implemented for the 2024 survey.

4.2 Results

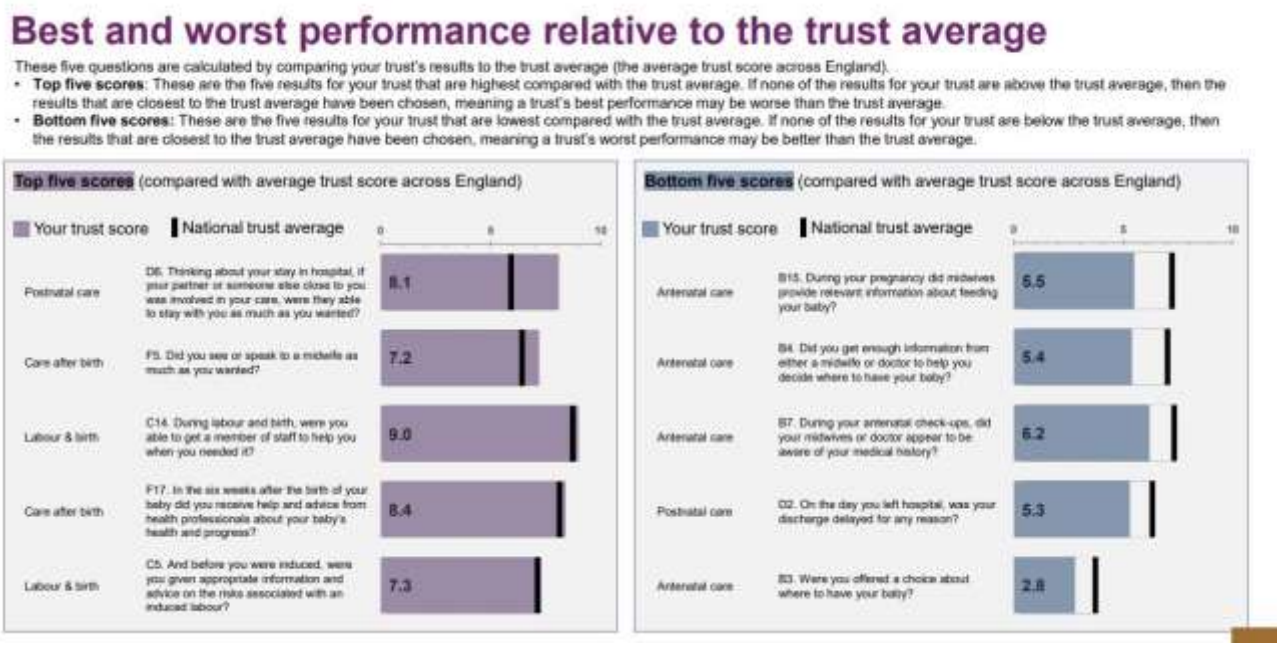
The results from the 2023 survey show WHH performance about the same as other trusts with 49/54 measures within that margin. There are five measures where performance was either ‘worse than expected’ or ‘somewhat worse than expected’

The five areas for improvement highlighted based on the experience of those birthing in January and February 2023 were as follows:

- Were you offered a choice about where to have your baby? (somewhat worse)
- Did you get enough information from either a midwife or doctor to help you decide where to have your baby? (worse)
- During your antenatal check-ups, did your midwives or doctor appear to be aware of our medical history? (worse)
- During your pregnancy did midwives provide relevant information about feeding your baby? (worse)
- Did you have confidence and trust in the staff caring for you during your antenatal care? (somewhat worse)

All measures related to experience in the antenatal period.

When comparing results in 2023 to 2022, there was no statistically significant change in 48 of the 49 measures. There was a statistically significant increase related to the ability of a partner or someone else close to woman/birthing person being involved in care/able to stay as much as was wanted.



When comparing the WHH score to the average trust score across England, the results show the maternity service performs well in two measures related to labour and birth (information about induction and support when needed) and care after birth (time with a midwife and help and advice in relation to baby's progress).

Areas for improvement reflect those areas previously noted, alongside that of delay in discharge from the hospital.

4.3 Discussion/next steps

It is disappointing that 'worse than expected' measures have been identified. However this is experience as at January and February 2023. Trust Board will be aware the service was in a challenged position at that time with a high midwifery vacancy rate and limited leadership capacity. There have been numerous positive changed and improvements to the service since that time.

As noted, worse than expected performance all related to measures within the antenatal period, two of these related to discussions and options around birth choice. At the time of the survey, the Nest (Midwifery Led Unit) was closed due to estates issues and there was no Consultant Midwife in post to support with birth choices and out of guideline care planning. It is likely this impacted on birth choice discussion.

The Nest reopened in April 2023 and a new Consultant Midwife commenced in post in August 2023 and is supporting a regular Birth Choices clinic and a robust individualised care planning process.

The infant feeding workstream had been subject to various changes in leadership since 2021. However a new Specialist Midwife - Infant Feeding is now in post and an infant feeding action plan has been developed to support immediate improvements alongside longer term changes with a view to undertaking a formal Baby Friendly

Initiative (BFI) accreditation assessment in 2025. This is in line with the national three year delivery plan for maternity and neonatal services. The maternity service is also working closely with partners to develop a system wide approach to infant feeding. This feeds into the wider service activity with regard to population health

The findings of the maternity survey report have been shared with the midwifery leadership team, and it is proposed for all 'worse than'/bottom scores, a hotspot audit of experience will be completed to ascertain current position in relation to these specific measures (versus Feb 2023 position). The outcome of this will inform a formal action plan. Colleagues from the Quality Academy have agreed to support this process. Once agreed, the action plan will be monitored via CBU processes with quadrumvirate oversight

The service has received individual feedback regarding care experience from AD, the woman who experienced a major obstetric haemorrhage of 15 litres. This is shared for information in appendix one.

Also included is feedback from birth experiences across all three birthing settings offered at WHH. A homebirth, a Nest birth and a Birth Suite birth which highlights the way in which the multidisciplinary team at WHH are able to facilitate positive experiences across the intrapartum pathway in line with women's choices.

5. STAFF FEEDBACK

A number of listening events with staff were held across January facilitated by the Director of Midwifery. Themes discussed are detailed below:

- Increasing complexity of need amongst families cared for by the WHH maternity team and the impact this has on workload in particular for those continuity/community midwifery teams providing an enhanced level of care.
- Impact of the maternity ward environment on patient experience and staff wellbeing
- The benefits of reinstating a process of rotation for experienced midwives who wish to develop their skills and confidence across other areas of midwifery.
- The importance of a positive workplace culture, feedback was positive in relation to this albeit with the caveat that maintaining positive culture would always be a work in progress.
- Student experience and how this can be improved.
- Ways in which bereavement care within the maternity service can be further optimised

There were no significant concerns raised and no matters for escalation. Much of the feedback was forward and solution focussed which was positive.

Following these listening events further individual team meetings have been held with colleagues from the Community/Continuity service and with those staff based on the Nest/Maternity Triage.

Discussions with community/continuity colleagues related to caseload size and the impact of the implementation of reduced caseloads for newly qualified midwives on more experienced team members. A piece of work is underway to review all caseloads. This will inform a broader review of community midwifery services across the WHH footprint to ensure it reflects changes in demand/location of families as well as the opportunity to move forward with measures to reduce inequalities and improve equity through a model of enhanced continuity of carer.

Positive discussions were held with colleagues based in the Nest/Maternity Triage. Concerns were raised in relation to the staffing model, particularly during night shifts when, on occasion Maternity Triage has been relocated back to Birth Suite to support safe staffing. It was also noted as part of the discussion the positive impact removing telephone Triage from the clinical area would have. It was felt this would increase both safety and experience. The proposed staffing model for Maternity Triage was shared and a number of actions taken away. It has been agreed a further meeting will be held with the team at the end of March to discuss all the matters raised further.

The initial results of the SCORE survey have been received and these were reviewed by the quadrumvirate with the WHH “culture coach” on 4th March 2024. The SCORE survey is a significant component in the workplace culture workstream which is being facilitated as part of the NHSE Cultural leadership programme. An update from the survey and next steps will be taken to Quality Assurance Committee in April and to Trust Board in June.

6. MATERNITY TRIAGE

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

Current performance

- In January 2024 573 triage attendances were recorded on the BadgerNet patient record system, this is an increase of 14.8% from December 2023.
- 15.7% attendees were seen immediately on arrival, this is a decrease of 1.9% from December.
- The longest wait recorded for initial review was 108 minutes. This has been investigated and was a data input error. The woman had been sent from Antenatal Unit to facilitate a CTG assessment and should not have been included within the Triage data.
- 87.3% of attenders were seen within 15 minutes of arrival (best practice guidance), this is a reduction compared to previous months, and is shy of the

KPI of 90% review within 15 minutes. The reasons for this have been explored and is the result of both higher acuity, challenges with staffing and new midwives within the team. This will continue to be monitored closely to ensure it is not a developing trend.

- 97.4% of attenders were seen within less than 30 minutes of arrival (NICE guidance). This is performance beyond the KPI of 95% review within 30 minutes.
- 1.2% of attendees were categorised as red on arrival. All were seen within 15 minutes for initial assessment and received immediate appropriate ongoing care.

Activity in place to support a safe service

- A new staffing model has been agreed with the clinical team which considers acuity audits and best practice guidance the initial cost of the new model was £510,000. Other options have been implemented including utilising the specialist midwife cohort to support clinical activity in Triage and amending the rotation process for newly qualified midwifes. Further measures will also be implemented with regard to Maternity Support Worker cover within the Nest/Triage footprint. This has enabled an updated staffing model which would require a reduced investment of £275,471. A paper will be taken to the Executive Board in March 2024.
- To ensure a safe service in the interim, midwives flex across the clinical areas with priority given to support Maternity Triage and Birth Suite as the most acute areas. This is working well albeit impacts on the timely facilitation of planned work such as commencement of induction of labour pathways.
- In Q3 2023/24 32.1% of Safe Care red flags raised related to induction of labour, either in delays within the pathway (13.9% of all red flags) or of care of women on the IOL bay being transferred to the maternity ward team to support staffing in other areas (18.2%). By comparison, only 3.7% red flags were raised in relation to delay in initial triage review. When WHH performance against IOL is measured against other local providers (via the LMNS monthly SitRep reporting pack) WHH is one of the top three providers with the greatest number of IOL delays (164) . Liverpool Women's Hospital reports the greatest number of IOL delays (242) over the reporting period (January 2023 to December 2023) followed by Wirral University Trust Hospital (234). More comparably sized providers, the Countess of Chester and Mid Cheshire Hospitals Trust reported 59 and 121 delays in IOL respectively. The majority of delays at WHH are related to midwifery staffing.

Next Steps (January – June 2024)

- Maternity Triage task and finish group in place.
- Audit of timeliness of medical review is being completed for the period Jan-March 2024 to support further improvement in quality of care provision.

- Shift leader for triage to be identified from next roster to support oversight and effective escalation processes
- Implementation of new staffing model
- Telephone triage to be moved from the clinical triage area, this will be dependent on the new staffing model being implemented.
- Telephone system to be upgraded

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

7. POSTPARTUM HAEMORRHAGE

Work is ongoing within the maternity team to ensure WHH performance with regard to incidence and management of post-partum haemorrhage (PPH) is optimised.

A PPH audit was presented previously to Quality Assurance Committee from which a number of actions were identified. A multidisciplinary PPH QI group has been established and work is underway with an aim as follows:

"To reduce the occurrence of PPH at WHH from 3.74 mean to 3.5 mean by October 2024."

The PPH action plan is attached for information in appendix two.

8. COMPLAINTS

Six complaints were received in the CBU in December 2023 and January 2024. Two related to care within the maternity and neonatal services.

One complainant raised concerns following the birth of their baby when it was identified the baby only had one kidney. The family raised concerned this should have been identified antenatally via ultrasound scan surveillance. This complaint has been fully investigated and a meeting arranged with the family to discuss the outcome of the investigation The second complaint related concerns regarding a lack of clear communication and explanation after the birth of her child. This complaint is currently being investigated.

9. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

10. MONITORING/REPORTING ROUTES

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

11. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committees on 13th February 2024 and 12th March 2024.

12. RECOMMENDATIONS

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

Appendix One – Service user feedback

AD – email feedback received

Good Afternoon Mr Constable,

I hope you don't mind me emailing you.

My name is Adele Darlington and your amazing teams in Warrington saved my life on Tuesday 28th November 2023 when I had a planned section (placenta previa) with my 5th daughter, Jasmine (she is 8 weeks old tomorrow).

I cannot thank the NHS enough, no words are enough to reflect my gratitude to still be here, alive.

Your staff worked tirelessly to save my life when I lost 15L of blood (and received 70 units of blood products) across 2 operations (C section & life saving emergency surgery shortly after). I was then put into an induced coma (awoken the next day) and spent 13 days in ICU. I'm aware of how many incredible teams came together to save me. I'm grateful every day for them not giving up on me and allowing me to continue to be a mum, wife and a daughter to my family. My family are also eternally thankful for the care they received whilst I was in surgery and receiving hourly updates.

Throughout all of my aftercare, the staff were so caring and became 'friends' during my 2 weeks in ICU. The staff helped make visits from my children possible, with discretion and care so that they didn't know they were visiting on ICU (my children are thankfully unaware of what happened bar thinking I was recovering for slightly longer, after the birth). Theatre staff visited me on their breaks and around their shifts to constantly check on how I was. ICU staff did everything in their power to get me home in time for my children's Nativity & Christingles. This meant so much to my family and I (I actually came home on the evening of Monday 11th December, the day before my 6 year olds Nativity). I was able to attend these events and I'll be forever grateful to the NHS for this.

I'm still under care by predominantly Endocrinology (I experienced Sheehans Syndrome so my Pituitary Gland isn't working properly) and I'm continuing to have fantastic care.

I'm having a debrief tomorrow AM with Dr Ayra and Dr Polkampalli (Obstetrics) to go through what happened. During this visit I am taking tea room hampers I've made, into C23/Neonatal, Maternity Theatre Staff & ICU/Physiotherapy (they're all aware). It's just a small way to say thank you (I can never express how thankful I am. There are no words or ways to express this).

I wanted to email you to pass on my gratitude and to let you know that the NHS gave us a very special Christmas. I've attached a couple of photos so that you can see.

NHS Blood Donations have also been in contact and I'm speaking to them next week to discuss possibly being involved in campaigns for raising awareness. I'm forever indebted to this service also, and to all the amazing people that donate blood.

Thank you from the bottom of my heart. If you could please pass my gratitude on to all the relevant people who were involved in my care, I'd really appreciate it.

Thank you for taking the time to read my email.

Kind Regards,
Adele Darlington.

Feedback following intrapartum care:

Feedback from PL sent to WHH Consultant Midwife. PL birthed at home:
I'm honestly thrilled with the level of care and support I've received from Team Lunar and in particular wanted to favourably note:

- The fact that I was placed immediately with the homebirth team from notification of pregnancy despite my previous GD (gestational diabetes) pregnancy. That my preferences were taken seriously from word go and to receive continuous care from that team was wonderful
- That the vast majority of my appointments were with the same person (Sarah Aley) enabling me to develop trust and good communication with her. Sarah has been incredibly caring, empowering and everything you could wish for in a midwife. She has always made me feel respected, listened to and cared for, and you can see she always goes an extra mile for the people she cares for. I also encountered Natalie and Laura a couple of times - all three of them upheld the most professional and compassionate communication that I've ever come across from maternity professionals, never once using coercing language, always explaining to me policy, research but being clear my choices were my own. This was also the case on the phone conversation I had with you and so thank all of you for that. That fact prevented me from experiencing any extra anxiety in the late stages of pregnancy and kept me confident with my birth plan. I would love to see obstetrics and other maternity professionals emulate that level of excellent communication that your team have.
- I am so impressed that Warrington bought the blood testing equipment to make home birth possible for GD mothers and truly hope more women will get use out of it.

- Although I had a very positive Hospital birth in another trust in 2021, the difference in being able to birth at home was remarkable and I hope more women access the service in Warrington- I already feel more recovered at 3 days post birth than I did at three months post-partum with my first. Breastfeeding has also been so much more successful and I really do believe the environment was a huge factor in achieving this.
- Lastly, I also had very positive dealings with the diabetic nurses and I really liked their approach to management. They never made me feel over scrutinised or like I was getting things 'wrong'. My first GD pregnancy felt almost over policed and whilst it was great that they took it seriously it also made me very anxious with food and exercise. The one thing I would say though is that in my first pregnancy in Kent we did a half day workshop with a dietician and that advice was invaluable in my management- I'm sure that without that knowledge I would not have managed to stay metformin controlled during this pregnancy, which makes me wonder how many women could be on less medication with this sort of support and it would be amazing if Warrington considered this sort of service.

Thank you once again for facilitating me to have a wonderfully positive and easeful birth of my second child with the highest quality of care

A student's experience of being involved in providing care on the Nest:
I had the most beautiful experience on the Nest! We had a women come through triage, multip, labouring naturally. SROM confirmed on attendance. Taken through to the Nest , she was so relaxed and had previous hypnobirthing classes- we provided a calming environment by using the pool led lights and in room speakers playing white noise sounds as requested. The woman also brought along her own fairy lights which we put around the room for her. Her and her partner were so trusting in each other, it was so lovely to see- she progressed so quickly and naturally in the pool, breathing through contractions, baby's FH was lovely!

Myself and the midwife were able to sit and observe how the woman's body can amazingly progress through labour without interference, she was honestly amazing! Upon pushing, she had the most beautiful pool birth, with a hands-off approach! Mum also caught her own baby and put straight into skin to skin- baby was born within 3hrs of arriving into the hospital, no pain relief requested , no interruptions from professionals, just the woman's body doing what it needed to do in a calming environment!

You could literally feel the natural oxytocin being released into the room- sensational. Both mum and dad were absolutely over the moon with their experience on the Nest!

Email feedback from KS who received care on Birth Suite:
I just wanted to email you to let you know about my positive pregnancy and birth experience with WHH and for you to pass on our thanks to the whole team. This was my third high risk pregnancy due to severe PET and EMCS at 29/40 and 33/40. Naturally, I was very worried this time around but I needn't have been. Charlotte Newby was my community midwife, she is such an amazing asset to the team. She was so calm, approachable & supportive throughout. Nothing was ever too much trouble for her. Joanna Hanna cared for me one night in Rm7 & was so sensitive & calming. I couldn't have asked for better care.

Amy Morris in triage…I'd seen her many times and she was always so caring & warm, whilst being so professional - she's an amazing midwife! Helen Marriott, Deb Whittle & Mary Hornby all looked after me & my family whilst in RM 7 too, we can't thank them enough.

Also, huge thanks to Rita Arya for her help and support in getting me as close to term as she could, whilst keeping both of us safe. Whilst I understand the fine balance, we have in situations like ours, her diligence and additional monitoring ensured the safety of both of us.

Lastly, but by no means least, the lovely Sr Kath Jones. For her kindness and support throughout the whole pregnancy and then for coming in on her day off to deliver me. I'll be forever grateful. Her knowledge, experience & expertise is next level & I only wish we could bottle it up! She's everything you need in a midwife & so much more (I'm sure she's relishing not being 'on call' for me now though!) Please can you pass on our sincere thanks to all of the team. Thanks to them, I'm now settled at home with George, Arthur & Albert and feeling incredibly blessed for the care we received and to work alongside you all in the best maternity unit."

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NHS
Warrington and Halton Teaching Hospitals
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Appendix two - PPH QI Project Action Plan

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

To share learning from most recent thematic review- Documentation/recognition of loss in theatre		15.11.23- Safety brief will be updated at the end of the month	
Actions - 15.11.23			
KF to ensure that PPH guideline has been re-circulated with added comments	KF		
KF to set meetings to Bi-weekly	KF		
Actions- 22.11.23			
Data Analysis MDT meeting TBA	KF/MG/CH/AC	20.12.23 Data analysis has now been sent to AK/CB to present at QAC in January. Currently data analysis is in progress.	
Actions- 20.12.23			
KJ- To include on Badger newsletter an issue that was raised in Prompt. PPH proforma completion will save even if baby not yet admitted.	KJ	To include in newsletter	
AC- To ensure theatre algorithm of recognition escalation is in view of staff	AC		
KF- To liaise with RA/CB as to surgeon responsibility of escalating loss.	KF	No reply from e-mail- for update next week	
Actions-31.1.24			
AC to invite team to theatre SIM	AC	28.2.24 -SIM not completed due to ward acuity- Team invited.	
Next PPH group meeting to process map another walk through- Kim to book the croft	KF	28.2.24- Walk through complete	
Actions- 28.2.24			
Process mapping of walk through (completed today)- Book croft for next meeting	KF/QI		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/010iii**	
SUBJECT:	**Quarter 3 2023-24 Perinatal Mortality Review/Audit**	
DATE OF MEETING:	3rd April 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			✓
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and focusses attention on improving outcomes for this protected group.			

EXECUTIVE SUMMARY *(KEY ISSUES):*

The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025.

The Perinatal Review Tool has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland, and Wales.

NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 5) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports.

	This report presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 3 (Q3.) PMRT report for the period covering 01/10/2023 – 31/12/2023. During Q3, WHH reported one baby to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK): One stillbirth - baby born at 26+4 weeks. The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 4 2023/24 QAC following a PMRT review panel. WHH stillbirth rate for Q3 2023/24 was 1.59 per 1000 births. WHH annual Mean stillbirth rate (2023/24) is 2.03 per 1000 births. The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births. WHH Neonatal mortality rate during Q3 2023/2024 was 1.59 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births. During Q3, WHH undertook three PMRT review panels. Parental perspective of the care they received were sought in all cases. The panels reviewed: Two stillbirths: • One baby born at 30+4 weeks. • One baby born at 32+6 weeks. One neonatal death: • One baby born at 37+3 weeks (baby born at a neighbouring trust) In one case, issues with care of the mother and baby up to the point that the baby was born were identified which would have made no difference to the outcome for the baby. This was the baby born at the neighbouring trust. In two of the cases, issues with care of the mother and baby up to the point that the baby was confirmed to have died were identified which may have made a difference to the outcome for the baby. These cases relate to the baby born at the neighbouring trust and the baby born at 32+6 weeks gestation. In one of the cases, issues with care of the mother and baby up to the point that the baby was confirmed to have died were

	identified which would have made no difference to the outcome for the baby. This relates to the baby born at 30+4 weeks gestation. In one case, issues with care of the mother following confirmation of the death of her baby were identified which may have made a difference to the outcome for the mother. This relates to the baby born at the neighbouring trust. In two of the cases, there were no issues identified with the care of the mother following confirmation of the death of her baby. Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee. Full compliance is reported in relation to Maternity Incentive Scheme, Safety Action 1 standards being met.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/24/02/305iv	
	Date of meeting	13th February 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quarter 3 2023-24 Perinatal Mortality Review/Audit	AGENDA REF:	BM/24/04/010iii

1. BACKGROUND/CONTEXT

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

MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

The aim of the MNI-CORP MBRRACE-UK programme is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

MBRRACE-UK achieves this by:

- Surveillance of all maternal deaths
- Confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy
- Confidential enquiries into cases of serious maternal morbidity on a rolling basis
- Surveillance of perinatal deaths including late fetal losses (22-23 weeks gestation), stillbirths and neonatal deaths
- Confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis

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

This quarterly report includes details of all WHH perinatal deaths reviewed and action plans implemented. This report presents WHH Quarter 3 PMRT audit data for

2023/2024 and highlights good practice and lessons learned during the mortality reviews. Q3 covers the reporting period from 01/10/2023 to 31/12/2023.

Definitions:

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

2. KEY ELEMENTS

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

During Q3 reporting period one case was reported to MBRRACE-UK:

One Stillbirth:
One baby born at 26+4 weeks. The death was notified to MBRRACE, and surveillance is complete. The PMRT review panel for this case will take place on 18th March 2024 and will be included in the Q4 2023/24 Perinatal Mortality Review Audit report to QAC.

2.1 Quarter 3. WHH Stillbirth Rate:

- WHH Q3 stillbirth rate for 2023/2024 is 1.59 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2022 is 4.1/1000 births.
- WHH had no intrapartum stillbirths.
- WHH had no term stillbirths (babies born from 37 weeks gestation).

In view of the small number of babies being stillborn when reviewing the data, it is also important to measure the numbers and findings over a longer time to contextualise the overall rate and learning. WHH current annual stillbirth rate for Q1-Q4 2022/23 is 2.03 per 1000 births. The MBRRACE-UK national rate is 4.1 per 1000 births.

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

Metric	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	12-month total
Number of live births	633	603	600	627	2463
Total number of stillbirths >24 weeks	1	1	2	1	5
Total Stillbirth Rate >24 weeks (per 1000 births)	**1.58**	**1.65**	**3.32**	**1.59**	**2.02**
Number of intrapartum still birth rate	**0**	**0**	**0**	**0**	**0**
Number of stillbirths >37 weeks	**0**	**0**	**0**	**0**	**0**

2.2 Q3. WHH Neonatal Mortality Rate:

There was one early neonatal death reported in Q3 2023/2024. This baby was born at a neighbouring trust and transferred to WHH from home by the Northwest Ambulance Service (NWAS) in cardiac arrest and subsequently pronounced dead shortly after arrival at WHH.

WHH Neonatal mortality rate during Q3 2023/2024 was 1.59 per 1000 live births. The MBRRACE-UK national rate is 2.7/1000 live births.

2.3 Quarter 3 PMRT Review Panel Key Findings

Synopsis of Findings

One baby born at 30+4 weeks gestation was a stillbirth. The cause of death identified at post-mortem gastroschisis with placental abruption.

One baby born at 32+6 weeks gestation was a stillbirth. The cause of death identified at post-mortem was uncontrolled maternal Type I Diabetes Mellitus.

One baby, born at a neighbouring trust at 37+3 weeks gestation was a neonatal death. The cause of death identified at post-mortem was hyperplastic left heart with partial anomalous pulmonary venous connection.

Surveillance Findings:

- Two of the babies were of a singleton pregnancy.
  One of the babies was initially a DCDA twin with a vanishing twin in early pregnancy.

- Two women were aged between 20-24.
  One woman was aged between 30-34.

- All of the women were identified as white ethnicity.

- Two of the women spoke English as their first language.
  One woman was Hungarian, with English as a second language. The PMRT review considered whether this contributed to the outcome. The panel assessed this was not a contributory factor.

- None of the women had any communication problems because of learning difficulties/hearing problems.

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

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

- None of the woman booked late.

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

2.4 PMRT Grading of Care

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

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

2.4.1 PMRT Grading of Care - Stillbirth

During Q3 three PMRT stillbirth review panels took place. Parental perspective of the care they received were sought in all cases.

In one of the cases, issues with care of the mother and baby up to the point that baby was born were identified which would have made no difference to the outcome for the baby.

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

In one of the cases, issues with care of the mother and the baby up to the point that the baby was confirmed as having died were identified that would have made no difference to the outcome for the baby.

In one of the cases, issues with the care of the mother following confirmation of the death of her baby were identified that may have made a difference to the outcome for the mother.

In two of the cases, there were no issues identified with the care of the mother following confirmation of the death of her baby.

An action plan has been implemented (Table 8).

Table 3: Q3 WHH Grading of Care following a Stillbirth.

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

2.4.2 PMRT Grading of Care – Neonatal Death

During Q3 there was one neonatal death PMRT review panel which was undertaken in conjunction with a neighbouring trust who provided the antenatal, intrapartum, and postnatal care.

In this case, issues with care up to the point of the birth of the baby were identified that would have made no difference to the outcome for the baby. Care issues up to the point that the baby was confirmed as having died were identified which may have made a difference to the outcome for the baby and care issues following confirmation of the death of the baby were identified that may have made a difference to the outcome for the mother. The learning from this case all related to care received at the neighbouring trust who will take the relevant actions forward. Any learning relevant to WHH will be shared via internal learning processes.

Table 4: Q3 WHH Grading of Care Following Neonatal Death

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

2.4.3 PMRT reporting for Saving Babies Lives Care Bundle v3- Q3 2023/24:

As part of the Saving Babies Live Care Bundle version three, there is also a requirement to consider whether fetal growth restriction (FGR) identification and management, reduced fetal movement (RFM) management and/or intrapartum monitoring were a contributory factor to perinatal mortality. Table 5 details the outcome of the PMRT reviews completed in Q3 assessed against these interventions:

Table 5 – Saving Babies Lives interventions

Intervention		%
Intervention 2.8	Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue	0.0%
Intervention 3.2	Percentage of stillbirths which had issues associated with RFM management identified	0.0%
Intervention 4.3	Percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	0.0%
Intervention 5.2	Percentage of late second trimester singleton births and preterm births (using PMRT) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared, and percentage of late second trimester singleton births and preterm births	0.0%

2.5 Q3. WHH PMRT Panel Attendance

There have been three PMRT panel reviews in Q3 which were attended by multidisciplinary internal and external panel members.

Table 6: Q3 WHH PMRT Panel Attendance

	Number of participants involved in PMRT reviews. Total number of reviews from 01/10/2023 – 31/12/2023 = 3		
Role	Total Stillbirth Review Sessions	Total Neonatal Death Review Sessions	Reviews with a least one in attendance
Chair	3	-	3
Admin/Clerical	3	-	3
Bereavement Midwife	3	-	3
External Rep	3	-	3
Management Team	3	-	3
Midwife	3	-	3
Neonatal Nurse	-	-	-
Neonatologist/Paediatrician	1	1	2
Obstetrician	3	-	3
Other	3	-	3
Governance Manager	3	-	3
Safety Champion	0	-	0

2.6 Maternity Incentive Scheme Year 5 Compliance

WHH is compliant with all elements of Perinatal Mortality Review Tool (PMRT) in line with the requirements of Maternity Incentive Scheme Year 5 as per table 7.

Table 7: PMRT MIS Safety Action 1 Compliance

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

2.7 Learning and Good Practice

- The one case has been notified to MBRRACE and surveillance completed within the required timescale.
- Antenatal care was graded C in one of the PMRT panel meetings which included feedback from the parents. This relates to difficult compliance with diabetes care. Learning from this case forms part of the PMRT Action Plan (Table 8).
- Postnatal care was graded C in one of the PMRT panel meetings, which included feedback from the parents. In this case the learning was related to care delivered in a neighbouring trust and does not form part of the WHH PMRT Action Plan (Table 8).
- Postnatal care was graded A in two of the PMRT panel meetings, which included feedback from the parents.
- Parental involvement was sought in all cases as part of PMRT panel review.

Action Plan Summary
All actions identified following PMRT reviews are recorded in full on the Datix incident reporting system and monitored through Women's and Children's Governance Meetings.

There were four actions recorded from the Q3 2023/24 PMRT review panels and all actions are complete:

Table 8: PMRT Action Plan

Action	Lead	Start date	Due Date	RAG rating
Highlight the BSOTS guidance for maternity triage assessment to midwifery and student body.	Charlotte Hampson, Birth Suite Manager	03.07.23	Complete	
A review of the DKA guideline associated with pregnancy is required.	Paula Chattington, Consultant Endocrinologist	06.11.23	Complete	
Update the guidance for the Management of Nausea and Vomiting of Pregnancy/Hyperemesis Gravidarum to reflect national guidance and share through the Women's & Children's governance group.	Rekha Agrawal, Consultant Obstetrician & Gynaecologist	07.07.23	Complete	
Share guideline for escalating admissions to non-maternity wards with UEC team	Chris Bentham, Consultant Obstetrician & Gynaecologist	11.07.23	Complete	

2.8 Summary

- WHH Q3 PMRT audit recorded one baby reported to MBRRACE who was born between 01/10/2023 and 31/12/2023.
- The key findings, learning, good practice, and action plan for this case will be reported in the Quarter 4 2023/24 QAC report following the PMRT review panels due to be held on 18th March 2024.
- WHH stillbirth rate for Q3 2023/24 was 1.59 per 1000 births. WHH annual Mean stillbirth rate is 2.42 per 1000 births which is below the 2022 MBRRACE-UK national rate 4.1 per 1000 births.
- WHH Neonatal mortality rate during Q3 2023/2024 was 1.59 per 1000 live births. This includes one baby who was born at a neighbouring Trust at 37+3 weeks and transferred from home to WHH in cardiac arrest at 6 days old. The MBRRACE-UK national rate is 2.7 per 1000 births.

- Three PMRT review panels were held in Q3 which were attended by multidisciplinary internal and external panel members. PMRT reviews are all graded as either A B C or D as per outcome incurred.
- Parental perspective of the care they received were sought in all cases.
- In one of the cases there were issues with care of the mother and baby up to the point that the baby was born which would have made no difference to the outcome for the baby.
- In one of the cases there were issues with the care of the mother and baby up to the point where the baby was born that would have made no difference to the outcome for the baby.
- In two of the cases there were issues with the care of the mother following confirmation of the death of her baby which may have made a difference to the outcome for the mother.
- In one of the cases there were issues with the care of the mother following confirmation of the death of her baby which may have made a difference to the outcome for the mother.
- In two of the cases there were no issues identified with the care of the mother following confirmation of the death of her baby.
- Following the review panel findings, a PMRT action plan has been developed and implemented. The PMRT action plan is monitored at Women's and Children's Governance Committee and all Q3 PMRT actions are complete.
- Full compliance reported in relation to Maternity Incentive Scheme, Safety Action 1 standards are being met.

3. MONITORING/REPORTING ROUTES

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

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 13th February 2024.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/010iv**	
SUBJECT:	**Midwifery Summary Safe Staffing Report – February 2024**	
DATE OF MEETING:	3rd April 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

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

Further Information:

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

Further Information:

	Yes	No	N/A
3. Foster good relations between people who share a protected characteristic and those who do not			

The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of staffing matters to ensure a safe service. The paper also relates to workforce measures, in a majority female workforce. In ensuring safe staffing this will support the service in maintaining staff wellbeing in this group.

EXECUTIVE SUMMARY *(KEY ISSUES):*	The purpose of this paper is to provide assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents. This paper provides an overview of the staffing position at as 31st January 2024 (the latest available data) and red flag position for the period October – December 2023 alongside other key workforce metrics.

	This paper will also provide specific assurance in relation to safety standards as follows: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. • Evidence the maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. • The midwife:birth ratio The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 116.70wte, which includes an additional 10% for non-clinical roles. The midwifery funded establishment at the 31st January 2024 was 125.36wte. The vacancy rate for permanent registered staff as at 31st January 2024 is 4.24% and continues a positive trajectory. The vacancy rate registered staff in the recruitment pipeline and due to start in February and March which further improves the position Midwifery retention rates also continue to improve. Turnover for permanent registered staff has decreased from 28.49% at the end of January 2023 to 7.47% in January 2024 (a reduction of 21.02%). Sickness rates for January 2024 for registered midwifery staff were 7.8%, this is an increase from December 2023 when the rate was 6.03%. It is also an increase from the end of January 2023 when the rate was 6.06%. Monitoring of safe staffing levels is a requirement of the Maternity Incentive Scheme (MIS) Safety Action 5. Within the maternity service, staffing red flags across the maternity service are recorded within the Safe Care module of the health roster. As part of Safety Action 5 there is a requirement to closely monitor two key measures: • Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. • The provision of all women receiving one to one midwifery care in active labour

	In the period 1st October 2023 – 31st December 2023 there are four episodes recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary. This is 2.17% of shifts and occurs rarely. In the period 1st October 2023 – 31st December 2023 there are no episodes recorded in SafeCare where a woman in active labour is NOT receiving one-to-one care.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to receive and discuss this report and for the report to be shared with the Trust Board.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**SPC/24/02/209**	
	Date of meeting	21st February 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Midwifery Summary Safe Staffing Report – February 2024	AGENDA REF:	BM/24/04/010iv

1. BACKGROUND/CONTEXT

The purpose of this paper is to provide assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents. This paper will provide specific assurance in relation to safety standards as follows:

- Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service.
- The provision of all women receiving one to one midwifery care in active labour

This paper provides an overview of the staffing position at as 31st January 2024 and red flag position for the period October-December 2023 alongside other key workforce metrics.

2. MIDWIFERY ESTABLISHMENT

This report summarises the current funded and actual staffing establishment as of the 31st January 2024 in comparison to the Birthrate Plus® report and recommendations.

A full maternity workforce planning review using the nationally recognised Birthrate Plus® workforce planning tool was completed in March 2022. This full review followed a desktop review and audit submission undertaken as part of the Ockenden work programme. Birthrate Plus® considers clinical complexity, the number of births, the location of birth and the number of women cared for by Warrington and Halton Teaching Hospitals staff as well as those women who receive care from other providers but who choose to give birth at Warrington and Halton Teaching Hospitals. An additional percentage is added for specialist roles and managers within the service.

The calculated total workforce requirement for Warrington & Halton Teaching Hospitals NHS Foundation Trust as at January 2022 was 116.70wte, which includes an additional 10% for non-clinical roles. At the time of the Birthrate Plus® review there was a positive variance of 5.52wte registered midwives which supported the implementation of the rostered model for Continuity of Carer.

The Maternity funded establishment at the 31st January 2024 is 125.26wte and is therefore compliant with the outcomes of the Birthrate Plus® modelling. The position at 31st January 2024 shows a further positive variance of 3.04wte. This further variance

is the result of the addition of a number of new full time and part specialist midwifery roles to the midwifery establishment since January 2022 alongside an increase in WTE in some existing posts.

These changes have been made to meet the requirements of external reviews, national recommendations and frameworks including the Ockenden Report recommendations and the Maternity Incentive Scheme Years 4 and 5 (incorporating the Saving Babies Lives Care Bundle).

New posts/increased WTE since January 2022 are as follows:

- Specialist Midwife - Audit & Assurance (new post)
- Specialist Midwife - Pre term birth (new post)
- Specialist Midwife - Multiple Pregnancy (new post)
- Specialist Midwife - Practice Development (increase in WTE)
- Specialist Midwife - Bereavement (increase in WTE)
- Specialist Midwife - Screening (increase in WTE)
- Specialist Midwife - Diabetes (new post)
- Specialist Midwife - Midwifery Retention (new post)
- Specialist Midwife - Pelvic Health (new post)
- Specialist Midwife - Perinatal Mental Health (new post)

All new posts have been funded within the service via reallocation of existing establishment or via external funding streams.

3. MIDWIFERY RED FLAGS

3.1 Background

A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing with associated risk to the women and babies. If a midwifery red flag event occurs, the midwife in charge of the service should be notified, who should then determine if midwifery staffing is the cause and the action needed. Monitoring staffing red flags is recommended by NICE guidance NG4 ‘Safe Midwifery Staffing for Maternity Settings’ (2015).

NICE Midwifery Red Flags include:

- Delay in induction of labour
- Delay in administration of analgesia
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital or midwifery-led unit.
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage

- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process
- Delayed recognition of and action on abnormal vital signs
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

1.2 WHH Midwifery Red Flags

Staffing red flags across the maternity service are recorded within the SafeCare module of the health roster. Recording the midwifery red flags in SafeCare was introduced and implemented across the maternity service on 7 June 2021.

In addition to the NICE recommended criteria for midwifery red flags, WHH local red flags have been added to include:

- Delay in ongoing IOL
- Shortfall in RM time
- Birth Suite Coordinator NOT Supernumerary
- NEST Divert – Acuity
- NEST Divert – Staffing
- AMBER Alert – Acuity
- AMBER Alert – Staffing
- Red Status (Deflect)
- Homebirth Service unavailable
- Delay in review of a CTG
- Delay in Medical review in triage >30min
- Delay in triage >15mins

3.3 WHH Midwifery Red Flags reported

	Number of Red Flags raised		
Red Flag Reason	Oct 2023	Nov 2023	Dec 2023
Delay in med review triage >30min	4	2	8
Delay in review of CTG	0	0	1
Delay in triage >15min	6	0	1
Delay in triage >30min	0	0	0
Delayed IOL	1	1	7
Delayed MEOWS	0	0	0
Delayed >30min Pain relief	2	1	0
Full clinical examination not carried out when presenting in labour.	0	0	0
Inadequate Triage	0	0	0
Missed Medication	0	0	0
Delay in administration of analgesia	0	0	1
Missed/Delayed Observation	0	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0
Any occasion where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0	0
Delay in ONGOING IOL	4	6	3
Delay of 2 hours or more between admission for induction and beginning of process	0	0	0
Shortfall in RM Time	31	24	29
Birth Suite Coordinator NOT supernumerary	1	0	3
NEST Divert – Staffing	1	1	2
NEST Divert - Acuity	0	0	0
AMBER Alert - Staffing	1	0	3
AMBER Alert - Acuity	0	0	2
Red Status (Deflect)	0	0	1
IOL Handover to C23	15	7	12
Time critical activity	0	1	0
Homebirth Service suspended	0	0	0
Unable to provide Transitional Care	0	1	0
Patient number above agreed capacity	1	1	0
Missed intentional rounds C23 shortfall in MSW	0	1	1
Unplanned omission in providing critical meds	0	0	0

3.3.1 Birth Suite Coordinator NOT Supernumerary

Monitoring of Safe Staffing levels is a requirement of the Maternity Incentive Scheme for Safety Action 5. The midwifery coordinator in charge of Birth Suite has supernumerary status (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. The Birthrate Plus® acuity tool is used to monitor the supernumerary status of the Birth Suite Coordinator every 4 hours. If there is an occasion when the Birth Suite Coordinator does not have supernumerary status this is escalated to the Matron and mitigating action is taken to address the issue. A red flag should be recorded on SafeCare.

In the period 1st Oct 2023 – 31st December 2023 there are three episodes recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary. On one occasion non supernumerary status was recorded in the Birthrate Plus® acuity tool but not in SafeCare. This means there were four occasions when the Birth Suite Coordinator was not supernumerary. This is 2.17% of shifts and occurs rarely. When this occurred measures were taken as soon as was possible to release the Birth Suite Coordinator back to supernumerary status. Staff have been reminded of the importance of documenting red flag events appropriately.

Date	**Information recorded in SAFECARE**	**Information recorded in BR+ Acuity Tool**
20.10.23	Birth Suite co-ordinator not supernumerary X4 Midwives	Co-ordinator caring for antenatal patient awaiting ARM. Acuity - 0.35
12.12.23	All midwives had a patient. Established labourer come through triage. Re-shuffle of workload. Co-ordinator now has x2 AN patients (not in labour)	Not reported in BR+
16.12.23	Not reported in SafeCare	Co-ordinator caring for 2 postnatal patients awaiting transfer. Acuity - 0.60
28.12.23	Unable to remain supernumerary due to acuity. Escalated to SMOC	Co-ordinator caring for VBAC labourer and PN awaiting transfer. Acuity - 3.00

3.3.2 One-to-one care and support to a woman during established labour

If there is an occasion where a woman in active labour is NOT receiving one-to-one care the Birth Suite Coordinator will escalate to the Maternity Bleep Holder and mitigating action is taken to address the issue. A red flag is recorded on SafeCare. In the period 1st October 2023 – 31st December 2023 there are no episodes recorded in SafeCare where a woman in active labour is **NOT** receiving one-to-one care.

4. OTHER WORKFORCE METRICS

4.1 Vacancy rate

The vacancy rate for registered staff as at 31st January 2024 is 4.24%, an improvement of 14.05% from end of January 2023 when the vacancy rate was 18.29%.

The vacancy rate excludes 1.52wte registered staff in the recruitment pipeline and due to start in February and March 2024 which will further improve the position. Once all new staff commence there will be 1.91wte vacant registered posts. The service is also aware of a further 1.92fte future vacancies as a result of promotions, retirements and reduction in contractual hours. A midwifery recruitment campaign to fill these vacancies will commence in February 2024.

4.2 Retention rate

Midwifery retention rates continuing to follow a positive trajectory. Turnover for permanent registered staff has decreased from 28.49% at the end of January 2023 to 7.47% in January 2024 (a reduction of 21.02%).

4.3 Sickness absence

Sickness rates for January 2024 for registered midwifery staff were 7.8%, this is an increase from December 2023 when the rate was 6.03%. It is also an increase from end of January 2023 when the rate was 6.06%. The rolling 12 month rate is 7.13%.

Proactive management of matters relating to workforce are ongoing.

5. ASSURANCE COMMITTEE

The content of this report has previously been noted at Strategic People Committee on 21st February 2024.

6. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/010v**	
SUBJECT:	**2023-2024 Quarter 3 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**	
DATE OF MEETING:	3rd April 2024	
AUTHOR(S):	Ailsa Gaskill-Jones, Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah – Chief Nurse	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			✓
Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving the principles within ATAIN will have a positive impact on this group.			

EXECUTIVE SUMMARY *(KEY ISSUES):*

- Q2 2023/24 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 5.49%, which is under both the national and NWNODN targets of 6% and 5.6% respectively.
- 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.
- A quality improvement project is currently underway to put in place a further enhanced transitional care

	offering, which will reduce term admissions and separation of mothers and babies.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/24/03/326ii	
	Date of meeting	12th March 2024	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	2023/2024 Quarter 3 Avoiding Term Admission into Neonatal Unit (ATAIN)	AGENDA REF:	BM/24/04/010v

1. BACKGROUND/CONTEXT

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

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

This paper describes the current position of Warrington and Halton Teaching Hospital (WHH) against Safety Action 3 of MIS Year 5 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 5 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 2023 to 31st December 2023.

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

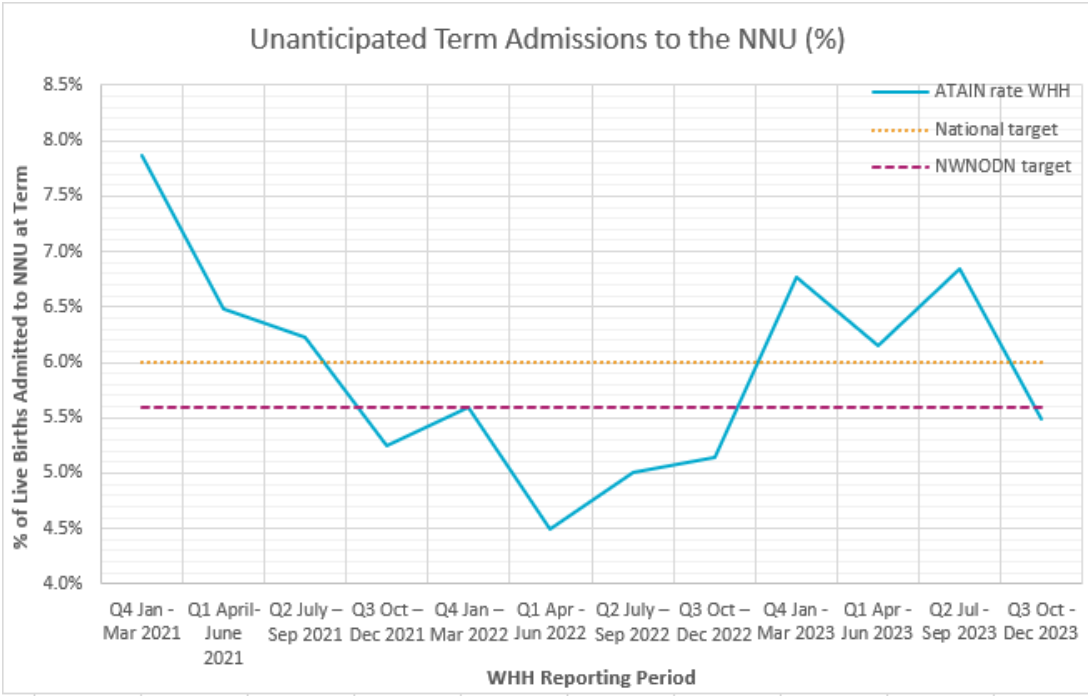
Maternity Incentive Scheme (MIS) specification directs providers to report the ATAIN data to the Trust Board on a quarterly basis. However, when reviewing the quarter data, it is important to review the data over a longer time period due to the small number of babies involved.

Summary of unexpected term admissions to NNU

The Q3 ATAIN Rate was 5.49%. Out of the 34 term admissions, two did not require review as part of the ATAIN process as the babies were well and admitted for compassionate reasons due to their mothers suffering massive obstetric haemorrhage requiring ICU admission, having explored all other available options for care of the babies with family members. If these two admissions were not included, this would bring the ATAIN rate for Q3 down further, to 5.17%.

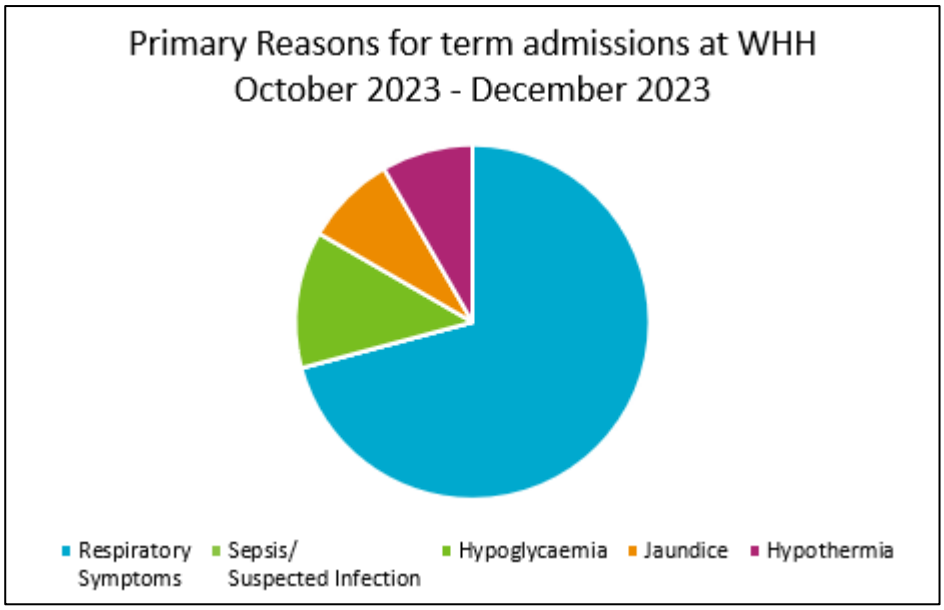
The overall ATAIN rate has met both the national and NWNODN targets for the first time since December 2022. This reflects a clear improvement compared to the last quarter suggesting that focussing actions on large QI projects rather than individual case learning and reflection has been a successful strategy for improving care. However, this focus and drive will continue to ensure we try to maintain this return to a good position.

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



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

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



50% (17) of term admissions were respiratory-related, i.e. required admission or additional observations due to signs of respiratory distress which includes grunting and low oxygen saturation (SATs or oxygen requirement). Only 4 of these cases were deemed avoidable if care had been optimal.

The respiratory-related admissions comprised:

- 6 cases with Transient Tachypnoea of the Neonate (TTN) – only 1 case was deemed an avoidable admission as caesarean section delivery should have been performed more urgently based on the clinical situation.
- 4 babies had Respiratory Distress Syndrome (RDS)
- 4 babies had pneumothorax
- 3 babies required respiratory support

Themes and Learning: Outcomes of ATAIN review

WHH Oct 2022 – Dec 2023	Number of Term Admissions	Outcome of ATAIN review	
		Avoidable Admissions	Unavoidable Admissions
Q3 Oct – Dec 2022	33	5	28
Q4 Jan – Mar 2023	43	7	32
Q1 Apr – Jun 2023	37	7	29
Q2 Jul – Sep 2023	41	11	30
Q3 Oct – Dec 2023	34	12	22

Reasons for categorising term admissions as avoidable included:

- Caesarean section should have been performed more urgently (Category 1)
- Environmental factors resulting in babies getting cold, which could have been addressed.
- Omission of antibiotic prophylaxis for PPROM while awaiting IOL, leading to chorioamnionitis.
- Fetal skull fracture/subgaleal haemorrhage sustained during sequential instrumental delivery.
- Neonate was suitable for transitional care.

Good Practice:

- Generally excellent neonatal care resulting in reduced separation of mother and baby noted.
- Immediate caesarean section anticipated in Maternity Triage and patient prepared for surgery in Maternity Triage.

- Obstetric doctor deferred elective caesarean section to allow time for steroid to reduce the risk of breathing difficulties.
- Timely decision-making following review of CTG.

Learning Points/Themes/Actions:

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

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

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

Recommendations:

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

3. MONITORING/REPORTING ROUTES

The ATAIN action plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This report was shared at the Women's and Children's Clinical Business Unit Governance meeting in March 2023.

4. ASSURANCE COMMITTEE

The content of this report has previously been noted and discussed at Quality Assurance Committee on 12th March 2024.

5. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/011**			
SUBJECT:	**NHS National Staff Opinion Survey 2023**			
DATE OF MEETING:	3 April 2024			
AUTHOR(S):	Adam Harrison-Moran, Head of Culture and Inclusion			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People 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.			
	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 PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of the annual NHS Staff Survey results for the organisation from 2023, which are aligned to the NHS People Promises as set out in the NHS People Plan. The survey took place between September – November 2023, with a 45% participation rate equating to 2,056 members of staff having their say. The results show that the organisation is better than the Acute Trust average in all nine themes of the NHS Staff Survey. The paper provides an overview of the engagement with the wider organisation to prioritise and enable meaningful change as a result of staff feedback, including next steps to ensure the voice of our workforce is utilised as intelligence for learning in the year 2024-25.			

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the 2023 Staff Survey results for Warrington and Halton Teaching Hospitals NHS Foundation Trust and priorities to respond to staff feedback and experience.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	SPC/24/03/226	
	Date of meeting	20 March 2024	
	Summary of Outcome	To Note	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD

SUBJECT	NHS National Staff Opinion Survey 2023	AGENDA REF:	BM/24/04/011

1. BACKGROUND/CONTEXT

The NHS Staff Survey is a nationally mandated survey across all NHS organisations to inform local improvement in staff experience and wellbeing. It is a national measure against the pledges set out in the NHS Constitution and provides useful intelligence to the Care Quality Commission and local commissioners. Data from the survey is also used to inform other statutory reports, including the Workforce Equality Standards.

The 2023 survey took place between September and November 2023. The Trust commissions IQVIA Quality Health to administer the survey process as an approved NHS survey provider. The Trust undertakes a mixed mode approach to the survey with the majority of staff receiving a digital questionnaire. For staff who do not have regular access to computers, paper copies were provided.

A full communications plan was implemented during the field work for the survey which included Staff Survey cafes, walkabouts and a series of 'You Said, We Did' messages to encourage participation.

The Staff Survey is made up of several questions split into nine themes, seven of which represent the NHS People Promise[1] as outlined below and in **Diagram One**:

- 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
- Staff engagement
- Morale

Diagram One: NHS People Promise

The results of the survey provide the Trust with the opportunity to understand staff experience, what is going well and the areas which require further improvement and intervention. This paper provides a high-level overview of the results for the 2023

[1] NHS People Promise: https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/the-promise/

survey, including the governance for monitoring of organisational and directorate action plans to respond to staff feedback.

2. KEY ELEMENTS

2.1. Response Rate

A total of 2,056 staff members completed the 2023 survey, which equates to 45.3% of the eligible workforce. This is a 10% improvement in comparison to the 2022 survey and **Diagram Two** highlights this is the best response rate for the Trust since the COVID-19 pandemic.

The results also highlight that the Trust is on par with the national average response rate of 45.2%, as demonstrated in **Diagram Two**.

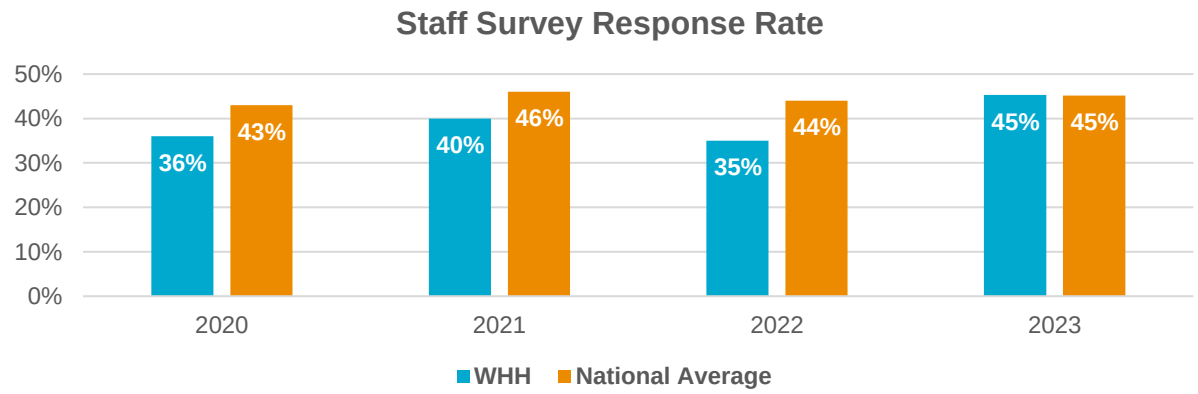


Diagram Two: Staff Survey Response Rate (2020 to 2023)

2.2. Overview of Results

The 2023 national NHS Staff Survey results highlight that the Trust saw a positive improvement across all nine themes of the survey in comparison with 2022 results. The Trust is benchmarked against other Acute and Acute & Community Trusts across the NHS as part of the survey analysis. This analysis highlights that the Trust performed better than the average Trust for all nine themes of the 2023 national NHS Staff Survey.

In addition, the results indicate that the Trust scored significantly higher than other Trusts in compassionate leadership, diversity and equality and staff health and wellbeing. Additionally, when looking at the previous year, the Trust saw a significant improvement across the following areas:

- A **7%** increase in the likelihood of staff recommending the organisation as a place to work.
- A **10%** improvement in staff reporting they received an appraisal, annual review, or development discussion.
- A **7.2%** rise in perceived effectiveness of immediate managers in addressing employees' concerns.
- A **7.6%** increase in employees feeling comfortable approaching their line managers to discuss flexible working options.

- A **6.3%** enhancement in teamwork effectiveness within the Trust towards achieving objectives.

Where questions are comparable to 2022, there are no question-level scores which have declined, with 50 questions demonstrating significant improvements. At theme level, there was an improvement across metrics for bullying, discrimination and harassment, including analysis across different protected characteristics. More information about these metrics can be found in Section 2.3. In addition, questions associated with the Patient Safety Incident Response Framework (PSIRF) will allow for further work to be developed in 2024-25 to improve incident reporting and embed a culture of learning.

The 2023 Staff Survey provided analysis at question level on the experience of our internationally educated staff (staff recruited from outside the UK), this particularly allows for any disparities in experience to be identified. Positively, the 2023 results indicate a 7.2% increase in those staff stating that the Trust respects individual differences, for example cultures, backgrounds, ideas etc. when compared with 2022.

Appendix One provides an overview of the survey results by theme, compared against the national best results, average results and worst results.

2.2.1. Sexual Safety Charter

For the first time, the survey included questions about sexual harassment and safety, revealing significant findings. Approximately 6.29% of staff at the Trust reported experiencing unwanted behaviour of a sexual nature from patients or members of the public in the past year, while 3.75% reported similar experiences involving staff and colleagues. In response, the Trust has committed to the NHS Sexual Safety Charter, pledging to implement clear policies, procedures, and actions by July 2024 to eradicate any form of sexual harassment or unwanted behaviour. This data will inform the Trust's People programmes for the coming year, ensuring it remains an inclusive and safe environment where every member of the workforce feels safe and empowered to be themselves.

2.2.2. Freedom to Speak Up

The 2023 Staff Survey includes four questions which provides intelligence for staff reporting on unsafe clinical practice and their experience of the organisation addressing concerns. The questions are:

- I would feel secure raising concerns about unsafe clinical practice – there was a 2.5% improvement compared to 2022, where 73.6% of staff felt they were able to raise concerns.
- I am confident that my organisation would address my concern – 61.3% of staff felt the organisation would respond if concerns were raised regarding unsafe clinical practice. This was an improvement of 2.1% compared to 2022.
- I feel safe to speak up about anything that concerns me in this organisation – 64.6% of staff reported feeling safe to speak up at the Trust, an improvement of 3.9% compared to 2022.
- If I spoke up about something that concerned me, I am confident my organisation would address my concern – 54.4% of staff felt confident the

organisation would address concerns raised, an improvement of 5.8% compared to 2022.

This data highlights an improvement in comparison to the 2022 results, however highlights that there is still work to be done in ensuring all staff feel they can speak up at the Trust. In addition, closing the loop on staff feeling that when they speak up, their concerns will be listened to and acted on.

To support this, further work will be done, in conjunction with the Freedom to Speak Up Guardian and Champion Network to encourage staff to speak up at work.

2.2.3 Patient Safety Incident Response Framework (PSIRF)

The 2023 Staff Survey includes four questions which provides intelligence on how the organisation addresses how staff will be treated should they reporting on errors, near misses or incidents and whether they will receive feedback should they raise a concern. The questions are:

- My organisation treats staff who are involved in an error, near miss or incident fairly - there has been a 2% improvement compared to 2022, where 63.17% of staff felt they were treated fairly. In 2022 there were 1112 staff who responded to this question compared to 2023 when 1525 staff responded.
- My organisation encourages us to report errors, near misses or incidents – there has been a 0.7% deterioration in this score when compared to 2022 with 86.71% feeling encouraged to report. In 2022 there were 1428 staff who responded to this question compared to 2023 when 1941 staff responded.
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again – there has been a 1% improvement since 2022 with 71.12% agreeing that the Trust takes action to ensure that an incident does not happen again. In 2022 there were 1298 staff who responded to this question compared to 2023 when 1792 staff responded.
- We are given feedback about changes made in response to reported errors, near misses and incident – there has been less than 1% improvement in this score when compared to 2022, with 64.57% of staff indicating that they have received feedback. In 2022 there were 1309 staff who responded to this question compared to 2023 when 1799 staff responded.

This data highlights an overall moderate improvement in comparison to the 2022 survey results, however highlights that there are improvements required in how staff feel they will be treated should they report an incident and whether they will receive feedback on any lessons learned should they report.

To support this, further work is being implemented via the PSIRF lead and is included in the 2024 Quality priorities for the Trust with feedback via Quality Assurance Committee.

2.2.4 Significance Testing: 2022 vs. 2023 Theme Results

Statistical significance is tested by the Trust survey provider, IQVIA. The results, as illustrated in **Table One**, demonstrate that in 2023 there has been a statistically significant change in four of the nine themes compared with the 2022 results.

Additionally, the results show a statistical positive difference compared with other Acute and Acute & Community Trusts for:

- We are compassionate and inclusive.
- We are recognised and rewarded.
- We each have a voice that counts.
- We are safe and healthy.
- We are a team.
- Staff engagement
- Morale

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sector Score
Theme - Staff engagement	6.74	Not Significant	6.98	Not Significant	6.91
Theme - Morale	5.81	Significantly Improved	6.22	Significantly Better	5.91
People Promise 1 - We are compassionate and inclusive	7.23	Not Significant	7.48	Significantly Better	7.24
People Promise 2 - We are recognised and rewarded	5.83	Not Significant	6.16	Significantly Better	5.94
People Promise 3 - We each have a voice that counts	6.66	Not Significant	6.91	Significantly Better	6.70
People Promise 4 - We are safe and healthy	6.10	Not Significant	6.37	Significantly Better	6.06
People Promise 5 - We are always learning	5.21	Significantly Improved	5.77	Not Significant	5.61
People Promise 6 - We work flexibly	6.01	Significantly Improved	6.38	Not Significant	6.20
People Promise 7 - We are a team	6.61	Significantly Improved	6.97	Significantly Better	6.75

Table One: Staff Survey Statistical Significance Testing (2022 vs. 2023)

2.3. Workforce Equality Standards (Staff Survey Analysis by Protected Characteristic)

The Staff Survey is used as a core element for the workforce equality standard reporting on an annual basis. Trusts are measured on their performance against certain questions of the survey and are expected to show improvement year-on-year. This is particularly pertinent for the 2023 survey due to the release of the national NHS Equality, Diversity and Inclusion Improvement Plan[2] in June 2023.

Additionally, from March 2024, Trusts are required under the plan to report and set targets for year-on-year improvements in bullying, discrimination and harassment related questions. This was approved by the Strategic People Committee on 20 March 2024, to reduce the disparities reported by each characteristic.

It is important to note that the 2023 results show a significant improvement for race, disability and sexual orientation, though they still demonstrate a negative disparity. In most questions, Black, Asian and minority ethnic staff, staff with a long-term health condition or illness, and those who declare their sexuality as lesbian, gay or bisexual, fare poorly in terms of experience when compared with white staff, staff who do not have long-term health condition or illness, or who declare their sexuality as heterosexual (straight).

[2] NHS England: NHS Equality, diversity and inclusion improvement plan - https://www.england.nhs.uk/publication/nhs-edi-improvement-plan/

2.3.1. Workforce Race Equality Standard

Table Two highlights the results of the Workforce Race Equality Standard metrics associated with the NHS Staff Survey in 2023.

Question	All Other Ethnic Groups		White		Improvement From Last Year?
	2022	2023	2022	2023	
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	25.5%	**28.2%**	21.2%	**19.7%**	No
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	30.9%	**21.9%**	21.8%	**17.6%**	Yes
Q15) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	40.8%	**51.0%**	61.7%	**64.9%**	Yes
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	18.9%	**13.3%**	4.7%	**5.35%**	Partial

Table Two: Workforce Race Equality Standard Results

2.3.2. Workforce Disability Equality Standard

Table Three highlights the results of the Workforce Disability Equality Standard metrics associated with the NHS Staff Survey in 2023.

Question	Staff With a LTC or Illness		Staff Without a LTC or Illness		Improvement From Last Year?
	2022	2023	2022	2023	
Q14a) Percentage of staff experiencing harassment,	26.8%	**25.75%**	19.9%	**18.83%**	Yes

Question	Staff With a LTC or Illness		Staff Without a LTC or Illness		Improvement From Last Year?
	2022	2023	2022	2023	
bullying or abuse from patients, relatives or the public in the last 12 months					
Q14b) Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	17.9%	**11.47%**	8.0%	**5.68%**	Yes
Q14c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	24.4%	**22.68%**	15.7%	**12.45%**	Yes
Q14d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	43.0%	**53.88%**	49.5%	**48.74%**	Partial
Q15) Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	54.0%	**58.04%**	61.0%	**64.80%**	Yes
Q11e) Percentage of staff who have felt pressure from their manager to come to work, despite not feeling	26.9%	**22.70%**	18.3%	**15.63%**	Yes

Question	Staff With a LTC or Illness		Staff Without a LTC or Illness		Improvement From Last Year?
	2022	2023	2022	2023	
well enough to perform their duties					
Q4b) Percentage of staff satisfied with the extent to which their organisation values their work	34.1%	**40.77%**	45.6%	**50.65%**	Yes

Table Three: Workforce Disability Equality Standard Results

2.3.3. Workforce Sexual Orientation Equality Standard

From the Staff Survey 2023 results, the Trust has piloted an internal version of the Workforce Sexual Orientation Equality Standard. This is an adaption of the Workforce Race and Disability Equality Standards. **Table Four** illustrates the results of the survey and will be used to inform actions and future benchmarking.

Question	Straight	Gay/ Lesbian	Bisexual
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	20.6%	22.5%	28.6%
Q14c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	14.7%	15.0%	28.6%
Q15) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	63.2%	65.8%	71.4%
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	6.6%	5.1%	3.6%

Table Four: Workforce Sexual Orientation Equality Standard Results

3. NEXT STEPS

3.1. Staff Survey Priorities

The 2023 Staff Survey results were released on 7 March 2024 and provide the Trust with the opportunity to directly respond to staff feedback through robust assurance and priority setting, both at organisational and local departmental level. Following their release, the results have been shared with the wider organisation in a variety of

accessible methods that capture all staff by utilising existing engagement approaches and communication channels. This includes verbal, written text and infographics, as illustrated in **Appendix Two**.

3.1.1. Setting Priorities for Improvement and Shared Learning

Following release of the results, all Care Groups and Corporate Services received their results by People Promise theme. Further work to develop local action plans for improvement are currently underway led by the Culture, Engagement and Inclusion Team and HR Business Partners. Service leads will work with the People Directorate to develop key priorities against their local results to deliver during 2024-25. This will be supported by a programme of work and support offered by the People Directorate.

Local actions will be presented and monitored through the People Directorate governance processes at Operational and Strategic People Committee. All Care Groups and Corporate services will have priority actions in place by mid Q1 2024-25 to make reasonable improvements towards completion, in preparation for the opening of the 2024-25 survey in September 2024.

In addition to local priorities, the Culture, Engagement and Inclusion Team are collaborating with Trade Unions, Staff Networks, People Champions and Clinical Leads to identify organisational priorities which demonstrate how the Trust are responding to feedback.

It is important that this is undertaken via a collaborative approach in order to secure buy-in, whilst also empowering individuals and ensuring that their contribution is valued by the organisation. This aims to have an impact on future staff engagement scores. This collaborative approach demonstrates that the organisation values the contribution and feedback that the workforce has made and enables the Culture, Engagement and Inclusion Team to facilitate collaborative interventions that directly resonate with and are owned by our workforce.

3.1.2. Protected Characteristic Priorities

Following analysis of the 2023 Staff Survey by protected characteristic, discussions will be held and reported through the Workforce Equality, Diversity and Inclusion Sub-Committee on next steps and recommendations to address the findings of the results.

This will be completed in conjunction with the Chairs and Vice Chairs of the WHH Staff Networks which represent:

- Multi-Ethnic Staff Network
- Progress LGBTQ+ Network
- Disability Awareness Network
- Armed Forces and Military Veterans Community Network
- Women’s Staff Network

Actions to inform improvement for the results of the survey by race, disability and sexual orientation will also form part of the annual Workforce Race, Disability and Sexual Orientation Equality Standard action plans, which will be presented to the

Strategic People Committee for ratification in August 2024 for submission and publication in October 2024.

4. MONITORING/REPORTING ROUTES

Reporting of Staff Survey action plans at Care Group, CBU and Corporate Service level will be reported through the Operational People Committee, chaired by the Chief People Officer. Actions will be monitored and shared learning cascaded through the Committee's Cycle of Business.

Specific actions associated with equality, diversity and inclusion, both at organisational and departmental level are reported through the Workforce Equality, Diversity and Inclusion Sub-Committee, chaired by the Chief People Officer.

5. ASSURANCE COMMITTEE (IF RELEVANT)

Assurance for the Staff Survey is via the Strategic People Committee. Updates on localised action plans will be presented through the Chairs Logs for Operational People Committee on a bi-monthly basis.

6. RECOMMENDATIONS

The Trust Board are asked to note the 2023 Staff Survey results for Warrington and Halton Teaching Hospitals NHS Foundation Trust and priorities to respond to staff feedback and experience.

Appendix 1: Overview of Survey Results by Survey Theme

People Promise elements and themes: Overview

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

	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	Staff Engagement	Morale
WHH	7.48	6.16	6.91	6.37	5.77	6.38	6.97	6.98	6.22
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2054	2050	2033	2034	1946	2036	2050	2053	2056

Appendix 2: NHS Staff Survey Results Infographic

Our staff survey results

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Our response rate increased to 45.3% compared to 34.9% in 2022, with 2,056 colleagues completing the survey.

We are proud that we improved across **all nine areas,** compared with the previous year, and performed better than the average trust.

We are compassionate and inclusive

- 63% would recommend WHH as a place to work

WHH scored significantly higher than average for compassionate leadership, diversity and equality

We are safe and healthy

- 64% feel that WHH takes positive action on health and wellbeing

WHH scored significantly higher than average for staff health and wellbeing

We are recognised and rewarded

- 74% feel that their immediate line manager values their work
- 68% say the people they work with show appreciation to one another

We are always learning

- 64% feel they can access the right learning and development opportunities when they need to

We each have a voice that counts

- 91% feel that they are trusted to do their job
- 76% feel that they have frequent opportunities to show initiative in their role
- 60% feel they are able to make improvements happen in their area of work

We work flexibly

- 74% feel they can approach their line manager to talk openly about flexible working
- 59% feel they can achieve a good balance between work and home life

We are a team

- 75% feel their immediate line manager encourages them at work
- 82% say they enjoy working with their colleagues

Staff engagement

- 71% say they are enthusiastic about their job.
- 60% feel they are able to make improvements happen in work

Morale

- 75% say their immediate manager encourages them at work

Results have been taken from the 2023 NHS Staff Survey published on 7 March 2024 and comparisons are benchmarked against acute and community trusts.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="5">BM/24/04/012</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Communications and Engagement Dashboard Q4 23_24</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="5">3 April 2024</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="5">Alison Aspinall, Head of Communications and Engagement</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="5">Kate Henry, Director of Communications & Engagement</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

(Please select as appropriate)</td><td colspan="4">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.</td><td>✓
✓
✓</td></tr>
<tr><td>LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):</td><td colspan="5"></td></tr>
<tr><td rowspan="6">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="5">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes
✓</td><td>No</td><td>N/A</td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes
✓</td><td>No</td><td>N/A</td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes
✓</td><td>No</td><td>N/A</td><td></td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="5">The report contains updates on communications and engagement activity during quarter 4 of 2023-34 and incorporates quarterly reporting on the Working with People and Communities Strategy.

The report consists of:
Communications and Engagement Team updates
Overview of Q4 activity – please note due to the timing of Board meeting, data for this quarter was compiled on 25 March 2024.
Updates on Experts by Experience involvement
Key campaigns and highlights during Q4</td></tr>
</table>

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Communications and engagement update

Quarter 4 2023-24 (January to March)

Trust Board Meeting

3 April 2024

Our role within WHH

The Communications and Engagement Team remit covers:

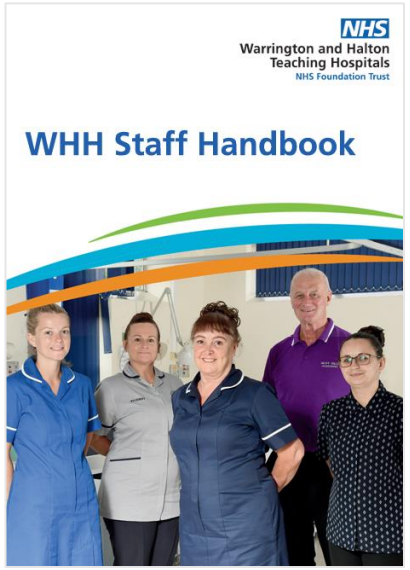
- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including – content development for trust's corporate social media channels and updates to the website
- Identity, branding and design
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information
- Freedom of Information (FOI) requests – **please note that FOI will move to Corporate Governance from 1 April 24**

During the Q4 period (January to 25 March 2024) the Communications and Engagement Team…

- processed and allocated **45** communications 'Job Requests' for design, film, photography and communications campaign support
- issued a total of **22** media releases/statements
- handled **21** enquiries from local, regional and national print and broadcast media
- processed **184** emails through the enquiries inbox
- received **207** Freedom of Information (FOI) requests
- processed and issued **171** FOI request responses

Q4 activity and achievements overview

- Coordinating the annual WHH Thank You Awards including promotion of a new People's Choice category via the public/media
- Promoting the national measles/MMR campaign and development of localised communications, shared across NHS North West region
- Working with Informatics Merseyside to scope and develop a new intranet and website – to be delivered spring/summer 2024
- Working with external provider to deliver an updated WHH staff handbook – fully funded by advertising
- Working with Pulse Outdoor advertising to secure advertising income from digital screens and static poster panels located on both sites
- Working with Cheshire and Merseyside Endoscopy Transformation Programme for the new Endoscopy Hub in Nightingale Building
- Supporting plans for an opening of the new day case unit and theatre at Captain Sir Tom Moore (phase one) as part of £9.3m TIF funding
- Producing communications for the Pharmacy First campaign to make relevant for our local population
- Continuing communications support for winter pressures, MaDE discharge campaigns and industrial action, where required



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

Media

The Trust issued 11 **proactive** media releases/statements during Q4 including:

Hospital transforms stroke care with innovative patient focused activities
Read the release

WHH celebrates 1,860 years of dedicated service at awards event
Read the release

People Promise

WHH sees improvements across all areas in the 2023 NHS Staff Survey
Read the release

Nominate your health hero for a WHH People's Choice Award
Read the release

In addition, the Communications and Engagement team facilitated interviews with local media on subjects including lymphoedema, new pharmacy robots and recognition for the team that saved the life of a woman who required 70 units of blood following a postpartum haemorrhage.

Engagement, involvement and insight

During Q4 (Jan to March 2024) we recruited 5 Experts by Experience (EbyEs)

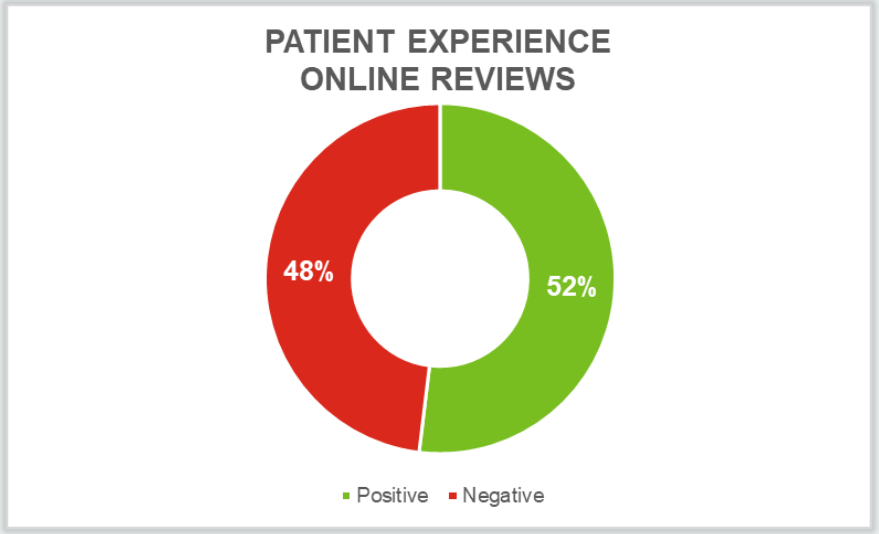
We received requests for engagement support for the following projects:

- Mental Health Strategy review and refresh
- Quality Strategy and priorities survey/engagement
- Draft Maternity Strategy 2023 - 2026
- PEP User Acceptance Testing
- Geriatric Medicine renaming survey
- Runcorn Health and Education Hub design

Quality Strategy and priorities engagement

Throughout Q4 Ernesto Quider, Associate Director of Quality, encouraged participation through a programme of community outreach and engagement, where participants were asked to identify top areas for improvement within the areas of Patient Safety, Clinical Effectiveness and Patient Experience.

Compiled outcomes and areas for future quality focus will be available once the survey and outreach responses are collated.



A total of 52 online reviews from patients rating their WHH experience were published in Q4.

Sources of data:

- NHS Choices
- Google reviews
- I want great care

Experts by Experience (EbyE) projects

Project Name	Overview	No of EbyEs req	Outcomes
Mental Health Strategy refresh	Request for EbyE to join strategy group to review and refresh WHH Mental Health Strategy	5	• 7 EbyEs recruited inc personal experience stories • Regular Strategy meetings to be held
Draft Maternity Strategy	Request for EbyE feedback on Trust Maternity Strategy content, wording and info	2	• 2 EbyEs recruited to feedback on draft Maternity Strategy • Feedback re: language, formatting and content shared with Director of Midwifery
Renaming Geriatric Medicine Dept survey	Request for EbyE to inform renaming of Geriatric Medicine from shortlist of choices, to be more meaningful for patients, carers and visitors	Unlimited	• 37 EbyE responses (currently) – survey closes 29/03/2024 • Current choices: Department of Medicine for Older People (57%), Care of the Elderly (35%), Geriatric Medicine (8%) • Finalised feedback to be shared with project lead
PEP - User Acceptance Testing	Request for EbyE involvement in final stage app testing of software, before app goes live	3	• 4 EbyEs recruited • Participant info and reasonable adjustment needs shared with project lead • Next steps TBC (delayed due to project changes)

EbyE projects (continued)

Project Name	Overview	No of EbyEs	Outcomes
Innovation survey	Request for EbyE survey participation re: understanding and focus for innovation at WHH	Unlimited	• 57 responses collected (in total) • Feedback collected by project lead • Final survey results being collated by RD&I Team
Quality Strategy and priorities survey	Request for EbyE survey participation to develop Quality Strategy 2024-2027 and alignment of Quality Priorities	Unlimited	• 160 responses collected • Feedback collected by project lead • Final survey outcomes and results being collated by QA Team
Runcorn Health & Education Hub development	Invitation for EbyE to contribute to design and accessibility of Runcorn Health & Education Hub	6	• 3 EbyEs recruited to take part in design workshops and project discussions • Next steps TBC (delayed due to project timeline changes)

Campaigns shared with EbyE: 1
(Halton Borough Council - HaltOnLoneliness survey)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key campaigns / highlights from Q4

Digital projects

Communications support for the implementation of digital projects:

Digital Strategy launch

- GMWHH and video message from WHH's Chief Information Officer Tom Poulter to explain our journey to be a 'Digital Trust'
- production of a Digital Strategy Roadmap (see image)
- creation of Digital Strategy section in the Digital Services extranet workspace with links to resources

Patient Engagement Portal (PEP)

- series of GMWHH messages to update staff on the new PEP procurement process, the requirement for all appointment letters to move to digital printing and appointment of supplier Dr Doctor
- creation of PEP page with FAQs in digital services workspace
- Patient/public messaging to include advertisements in community magazines/local media, paid social media advertising, editorial, plus 25k leaflet drop to households and information at community venues

New electronic patient record (EPR)

- GMWHH messaging to staff about procurement process commencing
- creation of EPR section including FAQs and a video update on the new EPR with WHH Executive Medical Director Paul Fitzsimmons

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

Living Well Hub launch

Communications and engagement support was provided for the official opening for the new Living Well Hub at Warrington town centre in March 2024.

Communications activity included:

- Coordination of opening event invitations to a range of stakeholders
- GMWHH message for staff and updates in Team Brief
- Media release to promote the official opening ahead of the opening to the public
- Social media updates on WHH and partner channels
- Arranging media presence at the opening and coordinating interviews with Trust representatives and partners
- Assisting the Strategy and Partnerships Team with pre-event planning and running order

Significant communications input will continue to be required to be able to promote the timetable of drop-ins and activity to encourage Warrington residents and those most in need of support to use the services on offer.

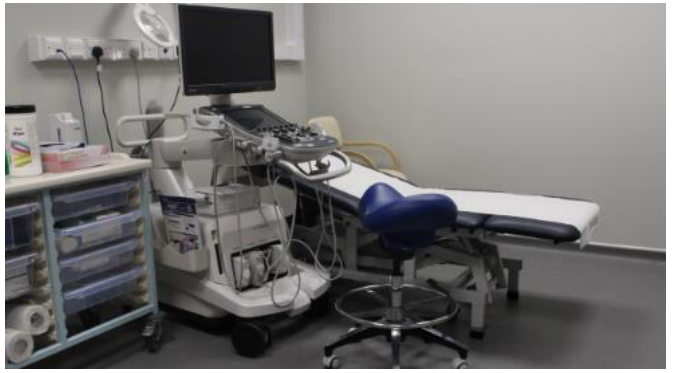
Warrington and Halton Diagnostics Centre (phase 2)

Communications and Engagement supported an event to mark the official opening of Warrington and Halton Diagnostics Centre (WHDC) at Halton Health Hub, Runcorn Shopping City.

Communications included:

- Invitations to key stakeholders
- GMMWH message for staff and updates in Team Brief
- Media release promoting the new facility

Further communications activity will be required to support the development of phase 3 – a £7.5m purpose-built diagnostics centre next to CSTM



Ministerial visits

Halton – 11 January

Minister for Health and Secondary Care, The Rt Hon Andrew Stephenson CBE MP, visited Halton Hospital to see developments which are supporting our elective recovery efforts. The tour included a visit to the Post Anaesthetic Care Unit in the Captain Sir Tom Moore Building (CSTM), before taking in the new theatre and day case unit, being delivered through the Targeted Investment Fund.

The Minister also travelled to the Halton Health Hub to see the services being delivered from within Runcorn Shopping City, which have recently been expanded to incorporate phase two of our Warrington and Halton Diagnostics Centre.

Warrington – 18 March

The Rt Hon Andrew Stephenson CBE MP paid his second visit of the year to learn more about our elective recovery efforts.

The Minister for Health and Social Care was welcomed to the WHH Urology Investigations Unit at Warrington before attending a presentation focused on gynaecology GIRFT and high volume, low complexity work.

The Minister was joined by Warrington South MP Andy Carter.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy
Q4 update

Pillar 1: Co-production in Service Change/ Development

Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• 61 Experts by Experience recruited during 23/24 (5 in Q4). • 129 Experts by Experience total (cumulatively to date). • Continuing to work with WHH colleagues to identify opportunities to involve EbyEs from the outset of projects (#StartwithPeople). • Hosted 3 stands at community events to promote EbyE recruitment.	• Ongoing
2. Support EbyE recruitment and retention	• 40 EbyE Projects delivered in 23/24 (plus 3 extended projects – Maternity Explainer content, Sepsis improvement and PEP). • 12 further EbyE projects pending (NHSE Criteria Led Discharge, Hospital Entertainment System, Paediatric Virtual Wards, Respiratory Therapies, Dementia Delirium Steering Group, Smoke free Steering Group, Food tasting, Bereavement QI Project, SG/Child Protection medicals QI Project, Lymphoedema Education and Awareness, Audiology service changes, Frailty QI Project). • 53 EbyEs (currently) participating in Q4 projects.	• Ongoing
3. Enhance our programme for involvement	• Annual involvement timetable for Awareness Days and Events informs engagement plan – dependent on team availability (see slides 20 and 21) • Discussions with Estates and Strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement or advocacy representation.	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• EbyE Refresher training session held 12/03/2023. • Inclusion of EbyE engagement from beginning of significant projects e.g. Runcorn Health and Education Hub, Breast Screening services website redevelopment (ongoing), WHH website redevelopment (ongoing).	• Ongoing
5. Ensure representation to support Place-Based integrated care delivery	• Governor representation on Warrington and Halton People's Voice forums. • Use our resources to support wider place-based initiatives and to access insight from our communities and advocacy/equality groups.	• Ongoing

Pillar 2: Accessible Information Standard (AIS)

Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Patient Letters	• A new Patient Engagement Portal (PEP) is being developed and accessibility functionality will be enhanced. The supplier has now been appointed following a procurement exercise and the system is due to be rolled out by the end of March 2024. Experts by Experience involved in PEP procurement exercise, testing and implementation stages. • Work has commenced on a tendering exercise for a new Electronic Patient Record (EPR) system to succeed the current system, Lorenzo. Functionality to support accessible information and communication needs will be key to this development.	• 2024-25
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• All updated content being compared against accessible content checklist to ensure it is up to date and accessible. • A new website (and intranet) have been commissioned. Communications and Engagement Team working with NHS Informatics Merseyside on both projects and accessibility and ease of navigation for patients/communities will be a key priority. Engagement with Experts by Experience will inform site structure and the content of the new website. To be launched mid 2024 onwards.	• Ongoing
3. Accessible content creation	• Worked with maternity on a series of six animations to provide information to women and families during pregnancy. Videos include subtitles and interpretations of five languages most commonly requested by users of the service, plus British Sign Language.	• Ongoing
5. Patient Information	• Production of Patient Information Policy is being updated to reflect increasing use of subtitled videos to support patients as part of the clinical pathway in addition to leaflets. • Awaiting completion of digital system changes to launch Communications Passport – see update on EPR above.	• Ongoing
7. Signage/Wayfinding	• Delivered via First Impressions programme.	• Ongoing

Pillar 3: Reducing Health Inequalities

Using WHH engagement and understanding health inequalities to geographical areas of Warrington North, Warrington South, Widnes and Runcorn

1. Strengthen WHH engagement programme	• Work with collective WHH teams (Patient Experience and Inclusion, Workforce EDI, Membership and Governance, Children/Young People, Dementia, Staff Health and Wellbeing team, charity, volunteers, chaplaincy, catering/estates, ward/service reps) to set/link events calendars and activities for 2024/25 • Quarterly WHH Events Meetings, co-hosted by Engagement and Involvement/Patient Experience, to discuss and agree 2023/24 plans together (held 17/05/2023, 31/08/2023, 06/12/2023). Next meeting due April 24.	• Ongoing
2. Provide opportunities for governors to engage in their communities	• Promotion and encouragement of governor event engagement opportunities i.e. speaking with visitors about the constituencies they represent, showcasing their roles, sharing info, collecting details of visitors interested in becoming a WHH Foundation Trust Member. Events undertaken were: ✓ WHH Shared Learning Forum ✓ Still Me/Warrington Dementia Network event ✓ WHH Carers Cafes ✓ Hong Kong Nationals engagement event During March 2024 we also undertook a mailout, to encourage uptake of Trust membership by EbyEs.	• Ongoing
3. Support Place Based activity and other key local events	• Governor representation at Warrington Together People and Communities Forum and One Halton People and Communities Forum. • Warrington Living Well Hub - developed as part of the borough-wide Living Well programme, formal opening held March 2024. • Community Diagnostic Centre Phase 2 official opening held in February 2024.	• Ongoing

Pillar 4: Anchor Institution/Building Social Value

Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Use WHH communication channels to increase engagement with the voluntary and third sector and raise awareness of key health improvement and economic wellbeing initiatives. • Support Wellbeing Enterprises to promote the Active Travel project, being delivered from WHH's Halton Health Hub. • Inclusion of Apprenticeship Team in Trust and community engagement events (i.e. 2024's upcoming Armed Forces Day, Disability Awareness Day, International Clinical Trials Day, Warrington Mela). • Ongoing Team sharing of '350 Careers, One NHS, Your Future' booklet and online link to information.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer in order to enhance the aspirations and life chances of local people. • Level of engagement with social media and websites. • Promoted Nurse Recruitment event in February 2024 at The Village Hotel, Warrington.	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Cherry Tree Courtyard hub – providing internal communications support for this project and working with People Directorate to ensure this facility is available to support patient/community engagement where appropriate. • Work with charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at Patient Experience Sub Committee (PESC) and Patient Equality, Diversity and Inclusion Sub-Committee (PEDISC). • Charity stakeholder and staff newsletters created and shared monthly.	• Ongoing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Upcoming engagement events

Upcoming engagement events: 2024

Date	Event	Time	Venue	Event purpose
3 April 24	Day case unit and theatre Opening Event	9am to 10am	Captain Sir Tom Moore Building, Earls Way, Palacefields, Runcorn, WA7 2HH	Official opening of the new day case unit and theatre at CSTM, funded by the national Targeted Investment Fund (TIF), to promote Covid-19 recovery.
w/c 14 May 24	Forget Me Not - 10 Year Celebration	TBC	Forget Me Not Unit, Burtonwood Wing, Warrington Hospital, Warrington, WA5 1QG	2024 is the 10-year anniversary of Warrington Hospital's Forget Me Not unit, our pioneering £1 million ward which aims to provide the best quality care for hospital patients who have dementia.
20 May 24	International Clinical Trials Day	10am to 2pm	Atrium, Warrington Hospital and George Lloyd Restaurant, Halton	Trust-led, annual event promoting the accomplishments of clinical research professionals in public health/medicine and their efforts in clinical trials.
8 June 24	Warrington Pride	TBC	Town Centre, Warrington	Annual partnership event celebrating Warrington's LGBTQ+ community.
29 June 24	Armed Forces Day	9am to 6pm	Crossfield's Rugby Club, Great Sankey, Warrington, WA5 1XU	Annual partnership event comprised of Armed Forces Rugby League games, military vehicle displays, stands and activities.

Upcoming engagement events: 2024

Date	Event	Time	Venue	Event purpose
4 July 24	WHH Quality Academy Showcase	9am to 4.30pm	Postgraduate Centre, Warrington Hospital, Warrington, WA5 1QG	Annual Trust-led event for partners, individuals, and staff to learn about QI initiatives and approaches. 2024's focus is health inequalities and meaningful engagement of patients and communities.
14 July 24	Disability Awareness Day	10 am to 4.30pm	Walton Hall and Gardens, Higher Walton, Warrington, WA4 6SN	Annual partnership family fun day, led by Warrington Disability Partnership, to promote services and celebrate pan-disability.
Sept 24	Warrington Mela	TBC	Queen's Garden, Palmyra Square, Warrington, WA1 1JN	Annual partnership event supporting cultural diversity and community inclusion within Warrington.
2 Oct 24	Annual Members' Meeting	3.30pm to 5pm	Post Grad Centre Warrington	Trust-led annual membership event, bringing together Foundation Trust Members, Governors, Directors and the Chair.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/013**	
SUBJECT:	**Freedom to Speak up**	
DATE OF MEETING:	20 March 2024	
AUTHOR(S):	Deborah Carter, Freedom To Speak Up Guardian	
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst, Chief Finance 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.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	all	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			✓
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			✓
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			✓
Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*

Up to the end of Q3 2023/24 the Freedom to Speak Up (FTSU) team managed 21 disclosures. During 2022/23 the FTSU team managed 42 disclosures (compared to 20 in 2021/22). The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, senior nursing and midwifery team members, HR and OD and corporate services to support individuals and teams to resolve the issues that are highlighted.

The FTSU team continues to engage with colleagues across the organisation including medical students and preceptorship

	nurses, midwives and allied health professionals as they join the Trust to raise awareness of FTSU. In February 2024 a new FTSU Guardian and Deputy Guardian commenced in post working two and one day each per week respectively.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the progress of Freedom To Speak Up.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**SPC/24/04/228**	
	Date of meeting	20 March 2024	
	Summary of Outcome	noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/24/04/013

1. BACKGROUND/CONTEXT

During the first three quarters of 2023/24 the FTSU team managed 21 disclosures. Whilst in 2022/23 the FTSU team managed 42 disclosures (compared to 20 in 2021/22). The majority of these 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 and corporate services to support individuals and teams to resolve the issues that they highlight.

The FTSU team continues to engage with colleagues from across the organisation including medical students and preceptorship nurses, midwives and allied health professionals as they join the Trust to make them aware of FTSU.

On the 1st February 2024 the new FTSU Guardian commenced in post working substantively two days per week, the Guardian is supported by a Deputy Guardian working one day per week. This represents a commitment by the organisation to the FTSU process undertaken to support colleagues in the organisation to raise awareness of any concerns in relation to work. The Guardian and Deputy Guardian work in partnership with over 30 champions, and work is underway to increase this number and increase engagement with the champions.

2. KEY ELEMENTS

Table 1 sets out the number of disclosures for the last 2 years and up to Q3 of 2023/24:

Table 1 Number of disclosures

	2021/22	2022/23	2023/24
Quarter 1	4	17	6
Quarter 2	8	5	6
Quarter 3	6	13	9
Quarter 4	2	7	TBC
Total	**20**	**42**	**21**

Table 2 sets out how cases are grouped:

Table 2 Types of disclosures

	2021/22 Q1 – Q4	2022/23 Q1 – Q4	2023/24 Q1-3
Behaviour, culture and relationships	15	31	18
Process	2	3	1
Patient safety	1	5	1
Staff levels / patient care	2	2	1
Communication		1	
Total	**20**	**42**	**21**

There has been one patient safety concern raised as of the end of quarter 3. Any patient safety issues are escalated immediately to the Chief Nurse & Deputy Chief Executive.

The Freedom to Speak up Guardian (FTSUG) and Champions continue to present at events across the Trust, in particular to the rotational doctors, preceptorship staff and international

nurses. The guardian has also commenced a series of walk arounds to speak directly to staff and raise awareness of FTSU and the value that the organisation places upon this.

In February the Trust Board received an update on FTSU as well as the results from the review of the FTSU reflection and planning tool which incorporated the Trust Board's views. This will be used to support the new guardian to develop the FTSU development plan.

The FTSU guardian has undertaken the national training and champions have been asked to complete the Electronic Staff Record (ESR) FTSU training.

3. MEASUREMENTS/Information

In 2022/23 FTSU guardians nationally handled over 25,000 cases; a record number which highlights how valued guardians are as a route to speaking up.

The national team has published its survey of FTSU guardians. The survey highlighting 84% of guardians who responded said that their organisation is working to tackle the barriers to speaking up. However, there is a sharp decline in their perceptions overall that the speaking up culture is improving.

Just over half (54%) said they had enough time to carry out their FTSU guardian role. In addition to supporting workers who speak up, guardians also need time for the proactive part of their role, identifying and tackling barriers to speaking up; yet 48% spent the majority of their time responding to workers, a reflection on the increased number of cases being raised to guardians.

As a Trust in recognition of local and national experience a decision was taken to recruit a substantive guardian and following a competitive process has appointed both a guardian and a deputy, to support the workforce within the organisation.

The Speak Up data from Q3 2023/24 is now available to view on the National Guardians Office - NGO website.

Almost 1 in every 25 cases reported to guardians are from workers indicating that they have suffered detriment after speaking up**.**

The Trust has responded to the Letby Enquiry first call for information in which there were questions relating to the role of FTSU. We will continue to engage with the Enquiry team and respond accordingly.

In February the National Guardian published a response to the following publications:

- NHS England's review into the culture review of ambulance trusts. Which was an independent review commissioned following the Speak Up Review and Listening to Workers report.

  The report echoes the stories told by workers in the Speak Up Review of a working environment where people experienced sexual harassment, racism and bullying. This report amplifies, that regulators and leaders must put staff experience on an equal footing with patient outcomes. The recommendation for ambulance trusts to ensure the effectiveness of Freedom to Speak Up functions to allow staff to report discrimination and harassment without fear of reprisal, by upholding policies, providing training to all staff and ensuring effectiveness of Freedom to Speak Up routes.

- Too Hot to Handle: why concerns about racism are not heard or acted upon this report amplifies the voices of workers experiencing racism. Conversations about racism are interlinked with Freedom to Speak Up because at the centre of this report remains the barrier for these workers, that speaking up is not worth it, because nothing changes, and the potential repercussions are not worth the risk. The report includes the recommendation for better use of Freedom to Speak Up guardians, who as part of their role have a focus on encouraging their organisations to remove the barriers which workers face in speaking up – particularly Black and minoritised workers.

  In response to the report, it has been agreed that mandatory annual refresher training for Freedom to Speak Up guardians is focused on equity, diversity and belonging in order to give all guardians an understanding of discrimination. This training will be a mandatory part of guardians' foundation training going forward. In addition, it is acknowledged that Freedom to Speak Up guardians can only be effective in their role if they are supported by the curiosity of their leadership. This requires a desire from leaders to listen to understand, and an appetite to take appropriate action.

Also, in February new Guidance has been published which will come into effect for FTSU cases reported into the National Portal from April 2024. This will see an expansion of the information regarding cases, including the characteristics of those speaking up.

4. LESSONS LEARNT

In response to the local and national disclosures and the publication of a number of reports which recommend the FTSU route to support organisations to influence culture change, investment has been made into the FTSU team. This will enable more engagement with staff across the Trust and provide opportunities bring about improvement and culture change.

5. RECOMMENDATIONS

The Trust Board is asked to note the report and the information provided regarding the developments and progress of Freedom To Speak

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/015**			
SUBJECT:	**Board Cycle of Business**			
DATE OF MEETING:	3 April 2024			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All✓			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board are required to review their Cycles of Business on an annual basis. The proposed amended Cycle of Business is attached for review and approval by the Trust Board. Once approve this will guide the planned business for Trust Board Agendas throughout 2024/25.			
PURPOSE: *(please select as appropriate)*	**Approval** ✓	**To note**	**Decision**	

RECOMMENDATION:	The Trust Board is asked to approve the Cycle of Business for 2024/25.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board
Cycle of Business 2024-25

	Frequency		Lead	03-Apr	05-Jun	07-Aug	02-Oct	04-Dec	05-Feb
				Yr End		2024			2025
Engagement Story	**Standing Item**	**Sup Pack**	**Chief Nurse Head of Patient Experience and Inclusion**	X	X	X	X	X	X
Opening Business									
Chairman's Welcome, Apologies & Declarations	Standing Item		**Chair**	X	X	X	X	X	X
Minutes of Previous Meeting(s) & Action Log	Standing Item		**Chair**	X	X	X	X	X	X
Chief Executive's Report	Standing Item		**Chief Exec**	X	X	X	X	X	X
Chairman's Report	Standing Item		**Chair**	X	X	X	X	X	X
QPS Assurance									
Integrated Performance Dashboard inc Monthly Nurse staffing report	Standing Item		**Execs**	X	X	X	X	X	X
Refresh of Trust Integrated KPIs (formal signing in May)	Annually		**Chief Finance Officer**	X					
Performance Assessment Framework (PAF)/ Review (formal signing in May)	Annually		**Chief Finance Officer**	X					
Quality									
Complaints Report	Annually		**Chief Nurse**			X			
Learning From Experience Summary Report	Quarterly	✓	**Chief Nurse**	XQ3	XQ4		XQ1	XQ2	
Health & Safety Report	Annually	✓	**Chief Nurse**			X			
Director of Infection Prevention & Control Annual Report (DIPC)	Annually	✓	**Chief Nurse**			X			
Infection Prevention & Control Update	Quarterly	✓	**Chief Nurse**	XQ3	XQ4		XQ1	XQ2	
Infection Prevention and Control Board Assurance Framework Compliance	Bi-Annually	✓	**Chief Nurse**			X		X	
Safeguarding Report	Annually	✓	**Chief Nurse**			X			
Compliance Update (was M2O)	Quarterly		**Chief Nurse**	XQ3	XQ4		XQ1	XQ2	
Learning from Deaths	Quarterly	✓	**Executive Medical Director**	XQ3	XQ4		XQ1	XQ2	
Medicines Management	Annually	✓	**Executive Medical Director**		X				
Controlled Drugs Annual Report	Annually	✓	**Executive Medical Director**		X				
Safe Nurse Staffing	Bi-Annually	✓	**Chief Nurse**			X			X
Violence Reduction Strategy	Bi-Annually	✓	**Chief Operating Officer**		X			X	
Patient Experience Strategy	Bi-Annually	✓	**Chief Nurse**		X			X	
In Patient Survey	Annually		**Chief Nurse**		X				
Fragile Clinical Services Update	Bi-Monthly		**Chief Nurse & Executive Medical Director**	X	X	X	X	X	X
Quality Strategy Update	Annually		**Chief Nurse**		X				
Quality Strategy Revised 2024-27	3-yearly		**Chief Nurse**		X				
Quality - Maternity Papers									
Monthly Maternity & Neonatal Review	Bi-Monthly		**Chief Nurse & Director of Midwifery**	X	X	X	X	X	X
WHH Maternity Services - Compliance with Ockenden	Bi-Monthly			X	X	X	X	X	X
Maternity Self-Assessment Tool Report	Bi-Annually				X			X	
Cheshire & Merseyside Perinatal Mortality Review Tool (PMRT) Report	Quarterly			Q3	Q4		Q1		Q2
Perinatal Mortality Report	Annually				X				
Maternity Incentive Scheme Submission	Annually								X
Maternity Incentive 5-Year Update including Saving Babies Lives Care Bundle V3 Update	Annually						X		
Midwifery Safe Staffing Report (SPC)	Quarterly			Q3		Q4	Q1		Q2
Avoiding Term Admissions into Neonatal units (ATAIN)	Quarterly			Q3		Q4	Q1		Q2
People									
NHS National Staff Opinion Survey	Annually		**Chief People Officer**	X					
GMC Re-validation Annual Report inc Statement of Compliance	Annually	✓	**Executive Medical Director**					X	
Communications & Engagement Dashboard Report	Quarterly		**Director of Comms & Engagement**		Q4 (year end)	X Q1		X Q2	xQ3
Guardian of Safe Working Report	Quarterly	✓	**Executive Medical Director**	XQ3	X Q4		X Q1	XQ2	
Guardian of Safe Working Report	Annually	✓	**Executive Medical Director**			X			
Freedom To Speak Up Guardian Report	Bi-Annually		**Freedom to Speak Up Guardian**	X			X		
Hospital Volunteer Report	Annually		**Chief Nurse**		X				
Health & Wellbeing Report	Annually		**Chief People Officer**		X				
Finance & Sustainability									
Operational Plan & Budgets Approval	Annually		**Chief Finance Officer**	X					
Capital Programme	Annually		**Chief Finance Officer**	X					
Emergency Preparedness Report	Annually		**Chief Operating Officer**			X			
EPRR Assurance Letter/Statement of Compliance	Annually	✓	**Chief Operating Officer**				X		
EPPR Compliance Update following Dec 2023 Report	one off		**Chief Operating Officer**		X				
Strategy Programme Highlight Report	Bi-Monthly		**Director of Strategy & Partnerships**	X	X	X	X	X	X
Strategy Bi-annual Delivery Report	Bi-Annually		**Director of Strategy & Partnerships**			X			X
Senior Information Risk Owner Report	Annually	✓	**Chief Information Officer**		X				
Digital Strategy Group Update	Bi-Monthly	✓	**Executive Medical Director**	X	X	X	X	X	X
Use of Resources Annual Report (on hold see FSC CoB)			**Chief Finance Officer**						
Committee Assurance Reports									
Audit Committee	Bi-Monthly		**Company Secretary**	X	X		X	X	
Quality Assurance Committee	Bi-Monthly		**Chief Nurse**	X	X	X	X	X	X
Finance & Sustainability Committee	Bi-Monthly		**Chief Finance Officer**	X	X	X	X	X	X
Strategic People Committee	Bi-Monthly		**Chief People Officer**	X	X	X	X	X	X
Charitable Funds Committee	Quarterly		**Director of Comms and Engagement**	X		X	X		X
Year End									
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	**May via email**		**Company Secretary**						
Code of Governance Compliance & Compliance with Licence Annual Return – completion of Cos7	Annually		**Company Secretary**		X Cos7				
Code of Governance Compliance & Compliance with Licence Annual report (for Year End / Audit Committee)	Annually			Yr End Audit					
Governance									
Strategic Risk & BAF	Bi-Monthly		**Company Secretary**	X	X	X	X	X	X
Annual Review of BAF & Risk Appetite Statement	Annually								X
Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	Annually		**Chief Finance Officer**					X	
Risk Management Strategy Report	Annually		**Chief Nurse**			X			
Board Cycle of Business	Annually		**Company Secretary**	X					
Board Sub-Committee Cycle of Business and Terms of Reference	Annually		**Company Secretary**	QAC & SPC, FSC					
Charitable Funds Committee Governing Document & Cycle of Business	Annually		**Chair/Company Secretary**						X
Charities Commission Checklist	Annually		**Director of Comms & Engagement**						X
WHH Charity Annual Report	Annually		**Director of Comms & Engagement**				X DRAFT	X FINAL	
Board Effectiveness Review (end of Financial Year April 2024)	Annually		**Chair/Company Secretary**	X					
Fit and Proper Persons Test - Annual Report on Board Members (audit)	Annually		**Chair/Company Secretary**		X				
Trust Senior Management Organograms	Bi-Annually	✓	**Chair/Company Secretary**			X			X
Committee Chairs Annual Reports									
Quality Assurance Committee	Annually		**Chair**		X				
Finance & Sustainability Committee	Annually		**Chair**		X				

Audit Committee	Annually		**Chair**		X				
Strategic People Committee	Annually		**Chair**		X				
Closing Business									
Review of Meeting	Standing Item		**Chair**	X	X	X	X	X	X
Any other Business & Date of next meeting	Standing Item		**Chair**	X	X	X	X	X	X

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/015**			
SUBJECT:	**Committee Terms of Reference and Cycles of Business**			
DATE OF MEETING:	3 April 2024			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	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 proposed amended Terms of Reference and Cycle of Business for the: I. Quality Assurace Committee II. Strategic people Committee III. Finance & Sustainability Committee IV. Audit Committee			

<table>
<tr><td></td><td colspan="3">Are attached for consideration and approval. Key updates include amendments to:

i. Quality Assurace Committee
• Amendments to section 3 – Quorum
• Amendments to section 4 - Membership
• Amendments to section 7 – Duties & Responsibilities

ii. Strategic People Committee
• Amendments to section 4 – Membership
• Amendments to section 7 – Duties & Responsibilities

iii. Finance & Sustainability Committee
• Amendments to section 4 – Membership
• Amendments to section 6 – Reporting
• Amendments to section 9 – Administrative arrangements

iv. Audit Committee

• Section 4 – Membership
• Section 5 – Authority
• Section 6 – Reporting
• Section 7 – Duties & Responsibilities

Each has been reviewed and agreed by the respective Committees and are presented to the Trust Board for ratification.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to review and approve the Committee Terms of Reference and Cycles of Business</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee, Strategic People Committee, Finance & Sustainability Committee and Audit Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">QAC/24/03/317, SPC/24/03/223, FSC/24/03/245, AC/24/02/106</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">QAC – 12.03.24, SPC – 20.03.24, FSC – 27.03.24, AC – 22.02.24</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Supported</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMMITTEE
CYCLE OF BUSINESS 2024/25

CALENDAR YEAR (APRIL 24 - MARCH 25)				2024									2025		
Item	**Reporting Frequency**	**Process**	**Lead**	**09-Apr**	**07-May**	**11-Jun**	**09-Jul**	**13-Aug**	**10-Sep**	**08-Oct**	**12-Nov**	**12-Dec**	**10-Jan**	**14-Feb**	**11-Mar**
STANDING AGENDA ITEMS															
Welcome, apologies, declarations, cycle business, rolling attendance log	Monthly	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review Minutes and Action Log	Monthly	**Approval**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
OPENING AGENDA ITEMS															
Patient Story	Bi-Monthly	**Noting**	Dep Chief Nurse	✓		✓		✓		✓		✓		✓	
Deep Dive	Monthly	**Assurance**	Chief Nurse & Dep CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Compliance Update	Quarterly	**Assurance**	Chief Nurse/Dep Dir Gov		**✓Q4**			**✓Q1**			**✓Q2**			**✓ Q3**	
Hot Topics	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
COMPLIANCE & OVERSIGHT															
Quality IPR Metrics	Bi-Monthly	**Discuss & Assurance**	CN & Dep CEO	✓		✓		✓		✓		✓		✓	
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	Chief Nurse												✓
MATERNITY UPDATE															
Ockenden Update	Monthly	**Discuss & Assurance**	Director of Midwifery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cheshire & Merseyside Perinatal Mortality Report (PMRT)	Quarterly	**Assurance**	Director of Midwifery		**✓Q4**			**✓Q1**			**✓Q2**			**✓ Q3**	
Avoiding Term Admission into Neonatal Unit (ATAIN)	Quarterly	**Assurance**	Director of Midwifery			**✓Q4**			**✓Q1**			**✓Q2**			**✓ Q3**
Perinatal Mortality Report	Annually	**Assurance**	Director of Midwifery	✓											
Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)	Monthly	**Approval**	Director of Midwifery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maternity Self Assesment Tool	Bi-Annually	**Assurance**	Director of Midwifery		✓						✓				
Materity & Neonatal Quality Review Report (inc Inpatient Maternity Survey)	Monthly	**Assurance**	Director of Midwifery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Transitional Care Audit (limited time)	Quarterly	**Assurance**	Director of Midwifery			**✓Q4**			**✓Q1**			**✓Q2**			**✓ Q3**
Post Partum Haemorrhage (Audit)	Bi-Annually	**Assurance**	Director of Midwifery						✓						✓
SAFETY															
Mental Health Update	Quarterly	**Assurance**	Chief Nurse		✓			✓			✓			✓	
Safeguarding Update Report (inc Annual Report)	Bi-Annually	**Assurance**	Dep Chief Nurse			✓						✓			
Medicines Management Report	Annually	**Assurance**	Exec Med Director		✓										
Controlled Drugs Report	Annually	**Assurance**	Exec Med Director		✓										
CIP/GIRFT Quality Impact Assessment Compliance (Finance)	Bi-Annually	**Assurance**	Exec Med Director / Chief Finance Officer & Deputy CEO		✓						✓				
Learning from Experience Report	Quarterly	**Assurance**	Director of Integrated Governance & Quality		**✓Q4**			**✓Q1**			**✓Q2**			**✓Q3**	

Staffing report - Safe Nurse Staffing	Bi-Annually	**Assurance**	Chief Nurse			✓						✓			
Director of Infection Prevention & Control (DIPC) Report	Quarterly	**Assurance**	Associate Director Infection Prevention and Control		✓**Q4**			✓**Q1**			✓**Q2**			✓**Q3**	
DIPC Report	Annually	**Assurance**	Associate Director Infection Prevention and Control				✓								
Infection Prevention and Control BAF	Bi-Annually	**Assurance**	Associate Director Infection Prevention and Control				✓						✓		
Violence Reduction Strategy Update	Bi-Annually	**Assurance**	Chief Nurse		✓						✓				
Health and Safety Report	Annually	**Approval**	Director of Integrated Governance & Quality				✓								
Sepsis High Level Update	Quarterly	**Assurance**	Dep Chief Nurse		✓**Q4**			✓**Q1**			✓**Q2**			✓ **Q3**	
Cardiopulmonary Resuscitation (CPR) Decisions and Discussions (Adults) Position Report	Bi-Annually	**Assurance**	Exec MD / Dep Chief Nurse	✓						✓					
CLINICAL EFFECTIVENESS															
Learning From Deaths Review	Quarterly	**Assurance**	Exec Med Director		✓**Q4**			✓**Q1**			✓**Q2**			✓**Q3**	
Clinical Audit Forward Plan	Annually	**Assurance**	Director of Integrated Governance & Quality												✓
Clinical Audit Report (inc Annual Report)	Bi-Annually	**Assurance**					✓					✓			
PATIENT EXPERIENCE															
Dementia Strategy Review	Annually	**Approval**	Dep Chief Nurse			✓									
Dementia Strategy Report	Bi-Annually	**Assurance**	Dep Chief Nurse								✓				
Complaints Report	Annually	**Approval**	Director of Integrated Governance & Quality			✓									
Patient Experience Report (inc Annual Report)	Bi-Annually	**Assurance**	Dep Chief Nurse	✓						✓					
COMPLIANCE & OVERSIGHT															
Board Assurance Framework/Corportate Risk Register	Bi-Monthly	**Approval**	Company Secretary	✓		✓		✓		✓		✓		✓	
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	CFO & Deputy CEO												✓
Quality Priorities Report	Quarterly	**Assurance**	Director of Integrated Governance & Quality			✓**Q4**			✓**Q1**			✓**Q2**			✓**Q3**
Quality Priorities 2023-24	Annually	**Approval**	Director of Integrated Governance & Quality												✓
Quality Account	Annually	**Approval**			✓ **DRAFT**	✓ **FINAL**									
Quality Strategy Update	Annually	**Assurance**				✓									✓
Quality Strategy Refresh 2024-27	3-yearly	**Assurance**			✓										
Risk Management Strategy Report	Annually	**Assurance**				✓									
Nursing & Midwifery Strategy Update	Annually	**Approval**	Dep Chief Nurse			✓									
ED Improvement Programme Update	Monthly	**For assurance**	COO/EDM/CN& Dep CEO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Improvement Progress Report	Bi-Annually	**Assurance**	Chief Nurse & Dep CEO	✓						✓					
Enabling Strategy Alignment Progress report	Bi-Annually	**Assurance**	Director of Strategy & Partnerships		✓						✓				
Patient Safety & Clinical Effectiveness Sub Committee Exception Report	Monthly	**Assurance**	Exec Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Palliative and End of Life Care Report (strategy updates)	Bi-Annually	**Assurance**	Cons Palliat Med /Dir Med Educ	✓							✓				
Information Governance + Corporate Records Group	Quarterly	**Assurance**	Chief Information Officer		✓**Q4**			**Q1**			✓**Q2**			✓**Q3**	
PATIENT Equality, Diversity & Inclusion Sub Committee Bi-annual Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓						✓					
Quality Management System (paused awaiting **Impact**)	Annually	**Assurance**	Director of Integrated Governance and Quality												
Quality Strategic Priorities Update	Bi-Annually	**Assurance**	Director of Strategy & Pships			✓					✓				
In-Patient Survey	Annually	**Assurance**	Chief Nurse	✓											
Ward Accreditation Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓						✓					

Claims Report	Bi-Annually	**Assurance**	Chief Nurse	✓						✓					
GOVERNANCE														
Terms of Reference	Annually	**Approval**	Chair/Co Secretary												✓
Cycle of Business	Annually	**Approval**	Chair/Co Secretary												✓
Committee Effectiveness Annual Review & Annual Chair's Report	Annually	**Assurance**	Chair/Co Secretary	✓											
Committee Effectiveness Action Update	Annually	**Assurance**	Chair/Co Secretary							✓					
High Level Enquires & External Assessment / Inspections (when notified)	Monthly	**Assurance**	Director of Integrated Governance & Quality	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MATTERS TO NOTE FOR ASSURANCE														
Minutes from the Quality Academy Sub-Committee	Bi-Monthly	**Assurance**	Chief Nurse		✓		✓		✓		✓		✓		✓
CLOSING MEETING														
Items for Escalation to the Trust Board	Monthly	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of Meeting	Monthly	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TERMS OF REFERENCE

QUALITY ASSURANCE COMMITTEE

1. PURPOSE

The purpose of the Quality Assurance Committee (the Committee) is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety.

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks in relation to Quality are managed appropriately in line with professional and regulatory standards.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

Quorum shall be seven members, of which at least one~~two~~ should be a Non-Executive Director~~s~~.

Commented [CJ1]: This is to put it in line with other ToR. We will always try to ensure there are two NEDs; however, one NED is unable to join at the last minute for example, the Committee would still be quorate

4. MEMBERSHIP

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

Core Members

- Chief Nurse ~~& Deputy CEO~~
- Executive Medical Director
- Chief Operating Officer
- Director of Integrated Governance & Quality
- Chief Finance Officer ~~& Deputy CEO~~
- Deputy Chief Nurse
- Director of Strategy & Partnerships
- Chief People Officer
- ~~Senior Information Risk Owner~~
- Company Secretary
- Associate Director of Quality
- Chief Pharmacist
- ~~Associate Medical Director - Patient Safety~~
- ~~Associate Medical Director - Clinical Effectiveness~~
- ~~Associate Chief Nurse/Associate DIPC~~
- Director of Midwifery & Associate Chief Nurse /Midwifery Safety Champion Lead
- Associate Director of Quality
- ~~Associate Chief Nurse (Planned Care)~~
- ~~Associate Chief of Nursing (Unplanned Care)~~

Commented [CJ2]: As discussed, I believe we should reduce the number of 'members' that are required to attend each meeting. They have been added to the 'attendee' list so they can attend as & when the Committee requires them to.

- ~~Head of Therapy / Lead AHP~~

Attendees

- Chief Executive
- Obstetrics/Obstetrics Safety Champion Lead & Governance Lead
- Associate Chief Nurse (Planned Care)
- Associate Chief of Nursing (Unplanned Care)
- Head of Therapy / Lead AHP
- Associate Medical Director - Patient Safety
- Associate Medical Director - Clinical Effectiveness
- Associate Chief Nurse/Associate DIPC
- Senior Information Risk Owner

Observers

- ~~Public~~ Governor

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

5. AUTHORITY

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

6. REPORTING

The Committee will have the following reporting responsibilities:

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

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

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience Sub-Committee
- Health & Safety Sub-Committee

- Information Governance and Corporate Records Group
- Adult & Children Safeguarding Sub Committee
- Risk Review Group
- Complaints Quality Assurance Group
- Quality Academy Sub-Committee
- Infection Prevention and Control Sub Committee
- Palliative Care and End of Life ~~Steering Group~~ Sub Committee
- Patient Equality, Diversity, and Inclusion Sub Committee
- Medicines Governance Group
- Moving to Outstanding Group
- Strategy and a Greener WHH Sub-Committee (by exception)

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Monitor the quality objectives as set out in the Trust Strategy ~~via bi-annual reporting~~ on the agreed success/KPIs for each objective and the underpinning priorities.
- Oversee the development and implementation of the Trust's enabling strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;
- ~~Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring that there is scrutiny and oversight of the strategic risk register and Board Assurance Framework, prior to approval at the Board of Directors and that there is appropriate liaison with the Audit Committee, to ensure internal audit resources within the Trust are aligned appropriately to risk;~~
- Overseeing 'Deep Dive Reviews' of risks to quality identified by the Board or the Committee, particularly "Serious Incidents Requiring Investigation" and how well any recommended actions have been implemented;
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board;
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory and contractual requirements;
- ~~Ensure there is a process in place regarding assessing and monitoring the impact on quality from Trust transformation and efficiency plans;~~
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated;
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations;

- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust;
- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately and escalated when off track;
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit and assessments are communicated appropriately and changes in practice are facilitated;
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.
- Ensure that the Trust has effective communication channels in place forward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) ~~and risk management (Annual Governance Statement)~~ reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;
- To inform the Board where it has ~~significant~~ concerns about~~:~~ standards of care or safety
  - ~~Standards of care in the Trust~~
  - ~~Or where it considers any service (or part of) to be unsafe~~

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

10. REVIEW / EFFECTIVENESS

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

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

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality Assurance Committee
Version:	V5.1 DRAFT
Implementation Date:	April 2022
Review Date:	April 2022
Approved by:	Quality Assurance Committee
Approval Date:	QAC 05.04.2022 Trust Board 25.05.2022

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
V3 6 December 2016	5 - Membership	Revised to include Non-Executive Directors to be amended to read **two** Core Attendees – to read **Core Members** Delete Divisional Operational Directors from the Core Membership **ADD Transformation Director** **ADD - Co-Opted Members from the Workforce Sub Group.** The Quality Committee to receive minutes from the WSG and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters in relation to staffing, quality and safety. Quorum – change from 10 **to maximum of 7, to include 1 Executive Director, 1 Non-Executive Director and 1 representative from each Division.**	QAC 6.12.2016
	10 – Administrative Arrangements	The Committee will be supported by the Secretary to the Trust Board.	QAC 7.2.17
V3 10 January 2017	5 - Membership	Membership further reviewed to include Head of Midwifery and Associate Director Infection Control + Prevention.	QAC 7.2.17
V3 7 February 2017	5 – Membership	Delete Director of IM&T	QAC

			7.2.17
V3 02 January 2018	4 – Membership	Delete Chief Pharmacist, Chiefs of Service, Surgery, Women's & Children and Acute Care Services, Associate Directors of Nursing, Associate Director of Infection Control.	QAC 09.01.2018
V3 02 January 2018	2 – Frequency of Meetings	Meetings to move from monthly to bi-monthly	QAC 09.01.2018
V3 02 January 2018	6 – Reporting	Removal of Infection Control Committee, medicines management, Inclusion of Risk Review Group, Complaints Quality Assurance Group, Research and Development Sub Committee and Safeguarding Committee,	QAC 09.01.2018
V3 04 May 2018	4 – Membership	Add Audit and Governance Lead for Women's Health	QAC 03.08.2018
V3 08.01.2019	4 – Membership	**Add** CEO DoF + Commercial Development Chief Pharmacist AHP Lead **Replace Deputy HRD with** Director of HR + OD **Replace Deputy DoIM&T with** Chief Information Officer Change in titles of Director of Strategy, Associate Medical Directors and Associate Chief Nurses **Move** Audit and Governance Lead for Women's Health to attendee section	QAC 08.01.2019 + Trust Board 29.05.2019
V3 08.01.2019	6 – Reporting	**Add** Infection Prevention + Control SC End of Life Steering Group Divisional Governance Medicines Governance	QAC 08.01.2019 Trust Board 29.05.2019
V3 08.01.2019	10– Review/Effectiveness	**Add** Cycle of business reviewed annually	QAC 08.01.2019 Trust Board 29.05.2019
V4 07.01.2020	4 – Membership	**Add** Director of Medical Education Observer section – Public Governor **Remove** CEO **Amend**	QAC 07.01.2020 Board 29.01.2020

		Assistant Chief Nurses to Associate Chief Nurses Medical Director Strategy to Interim Associate Medical Director Innovation and Improvement Obstetrics/ Obstetrics Safety Champion Lead add and Governance Lead	
V4 07.01.2020	6 – Reporting	**Remove** Divisional Governance Medicines Governance	QAC 07.01.2020 Board 29.01.2020
V4.1 03.11.2020	6 – Reporting	**Add** Equality Diversity & Inclusion and change in titles CFO, Chief Nurse and CPO	QAC 03.11.2020 Board 25.11.2020
V5 05.10.2021	4 - Membership Core Members	**Amendments to titles**: Director of Strategy & Partnerships. Deputy ~~Assistant~~ Chief Nurse - Patient Safety & Clinical Education Director of Midwifery & Associate Chief Nurse ~~Head of Midwifery~~/Midwifery Safety Champion Lead & Governance Lead ~~Chief Information Officer~~ Senior Information Risk Owner **Delete:** Assistant Chief Nurse - Clinical Effectiveness	QAC 05.10.2021 Trust Board 24.11.2021
V5 05.10.2021	6 - Reporting	**Amendments**: Health & Safety ~~& Risk~~ Sub-Committee Quality Academy Committee ~~Research and Development Sub Committee~~ Palliative Care and End of Life Steering Group. **ADD** Patient Equality, Diversity and Inclusion Sub Committee, Medicines Governance Group, Moving to Outstanding Group, Strategy and a Greener WHH Sub-Committee (by exception)	QAC 05.10.2021 Trust Board 24.11.2021

		REMOVE Equality Diversity & Inclusion Sub Committee	
V5.1 05.04.2022	4 - Membership Core Members	**Amendments to titles**: • Director of Integrated Governance & Quality • Assistant Chief Nurse (Planned Care) • Assistant Chief of Nursing (Unplanned Care) • Head of Therapy / Lead AHP	QAC 05.04.2022 Trust Board 25.05.2022
V5.1 05.04.2022	6 - Reporting	**Amendments:** • Information Governance and Corporate Records Group • Adult & Children Safeguarding Sub Committee	QAC 05.04.2022 Trust Board 25.05.2022
V5.2 04.10.2022	4 - Membership Core Members	Amendments to titles:	Trust Board 25.01.2023
V5.2 04.10.2022	6 - Reporting	Updated reference to Committee Assurance Report	Trust Board 25.01.2023
V5.2 04.10.2022	9 – Administrative Arrangements	Removal of outdated guidance	Trust Board 25.01.2023
v5.3 13.06.2023	4 - Membership Core Members 11. Duties & Responsibilities	Amendments to job tiles - Company Secretary Addition of: - Associate Director of Quality **ADD** Monitor the quality objectives as set out in the Trust Strategy via bi-annual reporting on the agreed success/KPIs for each objective and the underpinning priorities.	QAC 13.06.2023
V6 12.03.2024	Section 3 – Quorum	Amend to require one NED for quoracy	
V6 12.03.2024	Section 4 – Membership	• Move some roles from core members to attendees • Update reference to Public Governor to Governor	
V6 12.03.2024	Section 7 – Duties & Responsibilities	Remove reference to QAC as the Committee responsible for oversight of the Strategic Risk Register	

Date	**Reason**	**Approved by:**
07.01.2020	**V3 – replaced with Version 4**	QAC 07.01.2020 Trust Board 29.01.2020
24.11.2021	**V4 – replaced with Version 5**	QAC 05.10.2021 Trust Board 24.11.2021
05.04.22	**V5 – replaced with Version 5.1**	QAC 05.04.2022 Trust Board 25.05.2022
25.01.2023	**V5.1 – replaced with Version 5.2**	QAC 04.10.2022 Trust Board 25.01.2023
13.06.2023	**V5.2 – replaced with Version 5.3**	QAC 13.06.2023
12.03.2024	**V5.3 – Replaced with Version 6**	QAC 12.03.2024

STRATEGIC PEOPLE COMMITTEE
CYCLE OF BUSINESS 2024/25

CALENDAR YEAR (APRIL 2024 - MARCH 2025)				2024									2025		
	Reporting Frequency	**Process**	**Lead**	**17.04.24**	**15.05.24**	**19.06.24**	**17.07.24**	**16 08 23**	**18.09.24**	**16.10.24**	**20.11.24**	**11.12.24**	**15.01.25**	**19.02.25**	**19.03.25**
OPENING BUSINESS (2024)															
Apologies for Absence	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Minutes of the last meeting	Standing Item	**Approval**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Matters Arising / action log	Standing Item	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√
People related Staff Story, Hot Topic, Deep Dive (as required)	Monthly	**Noting**	CPO	√	√	√	√	√	√	√	√	√	√	√	√
BAF & Corporate Risk Register - Workforce	Bi-Monthly	**For noting/approval**	CS/DCPO	√		√		√		√		√		√	
Workforce Brief on National, Regional, ICB, or Local Workforce Issues – as required	Monthly	**Assurance**	CPO	√	√	√	√	√	√	√	√	√	√	√	√
Chief People Officer Report	Monthly	**Assurance**	CPO	√	√	√	√	√	√	√	√	√	√	√	√
Workforce Integrated Performance Report	Bi-Monthly	**Assurance**	DCPO		√		√		√		√		√		√
Workforce Integrated Performance Recommendations for 2025/26 (annual)	Annually	**Assurance**	DCPO											√	
WHH People Strategy Update	Bi-Annually	**Assurance**	DCPO	√ **Annual Report**						√ **Bi-annunal Report**					
We are WHH Culture & Compassionate Leadership Plan	Bi-Annually	**Assurance**	CPO	√						√					
WHH Workforce Equality, Diversity, and Inclusion Strategy Update	Bi-Annually	**Assurance**	DCPO/HWEDI		√ **Annual Report**						√ **Bi-annunal Report**				
Workforce Policies and Procedures Overview Report	Bi-Annually	**Assurance**	DCPO			Q3&Q4						Q1&Q2			
Improving People Practices Report	Bi-Annually	**Assurance**	DCPO			√ **Annual Report**						√ **Bi-annunal Report**			√
National Staff Opinion Survey	Annually	**Assurance**	CPO												√
Freedom to Speak Up Report	Bi-Annually	**Assurance**	CN/FTSUG						√ **Annual Report**						√ **Bi-annunal Report**
Health & Wellbeing Guardian Report	Bi-Annually	**Assurance**	ACPO (C&WB) & HWBG		√ **Annual Report**						√ **Bi-annunal Report**				
Monthly Staffing Report – Key Issues Report	Monthly	**Assurance**	CN	√	√	√	√	√	√	√	√	√	√	√	√
Hospital Volunteer Report	Annually	**Assurance**	CN	√											
NATIONAL/STATUTORY REPORTS															
General Medical Council (GMC) Patient Survey Response Report	As required	**Assurance**	EMD												
Midwifery Staffing Report	Quarterly	**Assurance**	CN/DIR MIDWIFERY		**Q4**			**Q1**			**Q2**			**Q3**	
Health Education England (HEE) Monitoring Visit (Annual Assessment Visit)	Annually	**Assurance**	EMD						√						
General Medical Council (GMC) National Trainee Survey	Annually	**Assurance**	EMD						√						
General Medical Council (GMC) Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA)	Annually	**Assurance**	EMD						√						
Guardian of Safe Working Hours Report	Quarterly	**Assurance**	EMD	**Q3** (deferred from Feb)	**Q4**			**Q1**			**Q2**			**Q3**	

Guardian of Safe Working Annual Report	Annually	**Assurance**	EMD/GOSW				√								
Facilities Time Off Annual Report	Annually	**Assurance**	DCPO			√									
EQUALITY DIVERSITY & INCLUSION – Regulated Reports (as required)															
EDI Annual Report (Public Sector Equality Reporting – Patients and Workforce) – including: - Equality Duty Assurance Report - Workforce Equality Assurance Report - Pay Gap Reporting (Race and Disability) - National EDI Improvement Plan	Annually	**Assurance**	DCPO/HCI												√
Equality Delivery System (EDS) 2024	Annually	**Assurance**	DCPO/HCI											√	
Gender Pay Report	Annually	**Assurance**	DCPO/HCI		√										
Workforce Race Equality Standard (WRES)	Annually	**Assurance**	DCPO/HCI					√							
Workforce Disability Equality Standard (WDES)	Annually	**Assurance**	DCPO/HCI					√							
GOVERNANCE															
Terms of Reference	Annually	**Approval**	CoSec												√
Annual Cycle of Business	Annually	**Approval**	CoSec												√
Committee Chairs Annual Report to Trust Board	Annually	**Approval**	Chair/CoSec		√										
Committee Effectiveness – Annual survey	Annually	**Assurance/Approval**	CoSec	Advise of Survey	Report √					Update on actions					
SUB-COMMITTEE CHAIR'S LOGS															
Workforce Equality, Diversity, and Inclusion Sub Committee	Bi-Monthly	**Noting**	CPO	√		√		√		√		√		√	
Operational People Committee	BI-Monthly	**Noting**	CPO		√		√		√		√		√		√
Workforce Review Group	Monthly	**Noting**	CN	√	√	√	√	√	√	√	√	√	√	√	√
Items for Escalation to the Trust Board & Review of Meeting	Monthly	**Noting**	Chair	√	√	√	√	√	√	√	√	√	√	√	√

TERMS OF REFERENCE

STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

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

Linked to the Trust's 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* the Committee will ensure that there are arrangements in place to enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture and collaborative leadership development:
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers,
- Risks relating to workforce and culture as defined in the Risk Register and that the Board Assurance Framework are being managed and that action taken will result in the intended outcomes, and
- Trust's d~~D~~ue Regard for the Public Sector Equality Duties relating to the workforce, seeking to:
    - Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct,
    - Advance equality of opportunity between people who share a relevant protected characteristic and those who do not, and
    - Foster good relations between people who share a protected characteristic and those who do not.

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

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

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

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

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

4. MEMBERSHIP

Core Members

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

- Non-Executive Director & Freedom to Speak Up Champion (Chair)
- Non-Executive Director (Deputy Chair)
- Chief People Officer
- Deputy Chief People Officer
- Chief Finance Officer ~~& Deputy Chief Executive~~
- Chief Nurse ~~& Deputy Chief Executive~~
- Chief Operating Officer & Deputy Chief Executive
- Executive Medical Director
- Director of Strategy & Partnerships
- Director of Communications & Engagement
- Company Secretary & Associate Director of Corporate Governance

Attendees

Normally in attendance for specific agenda items scheduled in SPC annual Cycle of Business:

- Associate Chief People Officer ~~(Workforce Systems and Intelligence)~~(Resourcing & Employment Services)
- Associate Chief People Officer ~~(HR Business Partnering)~~(HR and Learning & Organisational Development)
- Associate Chief People Officer ~~(Staff Health, Wellbeing, Training, OD, Occupational Health, and Staff Engagement)~~(Culture & Wellbeing)
- Head of Workforce ~~Equality, Diversity, and Inclusion~~Culture & Inclusion
- Freedom to Speak Up Guardian
- Health & Wellbeing Champion
- Guardian of Safe Working
- Shadow Board participants or alumni participants

Observers

- Governor

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

arise, the Strategic People Committee may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members Trust email account.

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

5. AUTHORITY

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

6. REPORTING

The Strategic People Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair of the Committee will provide a written Committee Assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.

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

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Strategic People Committee by the Trust Board.
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board.
- To provide overview and scrutiny to the development of the People Strategy.
- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately.
- To ensure the 'We are WHH Culture & Compassionate Leadership Plan' is designed, developed, delivered, managed and monitored appropriately.
- To ensure the Workforce Equality, Diversity and Inclusion Strategy is designed, developed, delivered, managed and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided.
- To receive, agree and monitor progress on the People Strategy through receipt of exception reports and updates.
- To ensure that the Trust attracts and retains our workforce using the principles of Model Employer to become the employer of choice.
- To review the consultation, negotiation and approval of all employment policies, including:
    - Details of any delays in consultation timeframes which impact on the maintenance of a current valid policy,
    - Details of any employee relations negotiations delaying policy approval,

  - Details of extensions to policy dates,
  - Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and,
  - Details of any trends or employment issues associated with external factors influencing policy content.
- To receive the annual National Staff Opinion Survey results and to provide a set of recommendations for action by the Trust.
- To receive, agree and monitor the Health and Wellbeing activity in the Trust in order to be assured of the effectiveness of these activities on improving staff experience.

Duties – advisory:

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

Duties – monitoring:

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Integrated Performance Indicators relevant to the remit of the Strategic People Committee.
- To report any areas of significant concern to the Trust Board as appropriate via the ~~Chair Key Issues~~Committee Assurance Report.
- To monitor national policy changes to terms and conditions and any potential impact on industrial relations which may affect service delivery and colleague relationships.
- To monitor the Freedom to Speak up activity and arrangements.
- To monitor the implementation of Improving People Practices principles ~~through the adoption of a Restorative Culture,~~ including
  - Details of Employee Relations Cases in respect of numbers,
  - Summary of workforce demographics,
  - Analysis and impact assessment of emerging themes,
  - Identification of any risks associated with complex case work such as Employment Tribunal cases, Subject Access Requests, and costs,
  - Overview of lessons learned and actions taken to address these,
  - Specific information on those cases where suspension/exclusion is involved, including any Supporting Attendance dismissals/appeals.
- To monitor safe staffing arrangements
- To monitor maternity safe staffing arrangments
- To monitor arrangements for medical appraisals and revalidation
- To monitor the Guardian of Safe Working activity and arrangements
- Monitor the quality objectives as set out in the Trust Strategy on the agreed success/KPIs for each objective and the underpinning priorities.
- Oversee the development and implementation of the Trust's enabling strategies aligned to people.

Duties of members:

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

Sub-Committees (Groups):

- Operational People Sub Committee
- Workforce Equality Diversity & Inclusion Sub Committee
- Nursing and Allied Health Professionals Resourcing Group

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

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

Papers are to be submitted in the following format:

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

10. REVIEW / EFFECTIVENESS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	V7
Implementation Date:	January 2023
Review Date:	12 months from approval
Approved by:	Draft v3 approved by TRUST BOARD (July 2018) Draft v4 – to be presented to September TRUST BOARD Draft v5 - to be presented to May 2019 Trust Board Draft V6 – approved by SPC 18 March 2020 to Trust Board 25 March 2020 and approved Draft V6.1- approved by SPC 18.11.2020, Trust Board 25.11.2020 V6.2 SPC 21.07.2021, Trust Board 28.07.2021 Draft V7 – approved by SPC 18.01.23 to Trust Board 25.01.2023
Approval Date:	19 September 2018 – SPC V4 approved 26 September 2018 – Trust Board V5 approved 20 March 2019 – SPC V6 approved 18 March 2020 at SPC and Trust Board 25 March 2020 V6.1- approved by SPC 18.11.2020, Trust Board 25.11.2020 V6.2 approved by SPC 21.07.2021, Trust Board 28.07.2021 Draft V7 – approved by SPC 18.01.23 to Trust Board 25.01.2023

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
May 2018	Draft TORs v1		Amendments – AW / MC
June 2018	Draft TORs v2		Amendments – AW / MC
July 2018	Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval		Amendments – AW / MC
July 2018	Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees		Amendments – AW / MC
September 2018	**Purpose**	Clarification on Well Led KLOEs to be reported to SPC and further confirmation of role of SPC	Amendments agreed by members of the Strategic People

		as an assurance committee.	Committee 19 September 2018 Approved Trust Board (September 2018)
September 2018	**Membership**	Written approval by quorate membership rather than full membership.	
September 2018	**Duties & Responsibilities**	Section on Decision Making. Clarity on SPC role to assure actions taken to recruit and retain our workforce Section on Monitoring. Scope of Employee Relations Case Report clarified and to be included in workplan.	
September 2018	**Subcommittees**	To include Triangulation Group	
20 March 2019	**Section 3 – Membership**	Updated attendee titles	
20 March 2019	**Section 7 – Duties + Responsibilities**	Triangulation Group removed	
18 March 2020	**Section 3 – Membership**	Updated attendee titles	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 10 – Administrative Arrangements**	Updated submission of papers timeframe	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 3 - Membership**	Removal of reference to Head of HR Strategic Projects	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 4 - Quorum**	To amend in line with other assurance committees	V6 SPC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 8 - Attendance**	To insert the term 'nominated' before deputy	V6 SPC 18.03.2020 Trust Board 25.03.2020
22 July 2020	**Section 3 – Membership**	Updated Executive Director titles, Deputy HRD&OD and attendee titles	V6.1 SPC 22 July 2020
18 November 2020	**Section 7 – Duties & Responsibilities**	Added Equality Diversity & Inclusion Sub Committee	V6.1 SPC 18.11.2020 Trust Board 25.11.2020
14 July 2021	**Section 7 – Duties & Responsibilities**	Added Workforce Recovery Steering Group – meeting monthly	V6.2 SPC 22.07.2021 Trust Board 28.07.2021
14 July 2021	**Section 7 – Duties & Responsibilities**	Amended Equality Diversity & Inclusion Sub Committee to Workforce Equality Diversity & Inclusion Sub Committee	V6.2 SPC 22.07.2021 Trust Board 28.07.2021
TBC	**Sections 1 – Purpose**	Updated the description of the purpose of the	TBC

		Committee to include reference to equity for all	
TBC	**Section 6 - Reporting**	Updated reporting arrangements to the Trust Board	TBC
TBC	**Section 7 – Duties & Responsibilities**	Added Medical Education Quality Sub-Committee	TBC
18 January 2023	**Section 1 - Purpose**	Clarification on assurance related to Risks – BAF and Corporate. Inclusion of reference to assurance on Due Regard for Public Sector Equality Duties relating to the workforce. Reference to NHS People Promise	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 2 – Frequency of Meetings**	Moving from bi-monthly to monthly	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 3 - Membership**	Revision of new title for Company Secretary – to include Associate Director of Corporate Governance. Addition of Associate Chief People Officers, Head of Workforce Equality, Diversity and Inclusion and Shadow Board participants or Shadow Board alumni participants Removal of Head of Staff Engagement & Wellbeing; Head of HR & Head of Workforce Systems & Intelligence	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 4 – Quorum**	Changed quoracy to confirm that one of the members present must be a Non-Executive Director.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 7- Duties & Responsibilities** **Duties – decision making**	To include reference to the Workforce Equality, Diversity and Inclusion Strategy's design, development, delivery, management, and monitoring.	V7 SPC 18.01.2023 Trust Board 25.01.2023
		To review the consultation, negotiation, and approval of all employment policies, including:	

		○ Details of any delays in consultation timeframes which impact on the maintenance of a current valid policy, ○ Details of any employee relations negotiations delaying policy approval, ○ Details of extensions to policy dates, ○ Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and, ○ Details of any trends or employment issues associated with external factors influencing policy content.	
		To include reference to receiving, agreeing, and monitoring the Health and Wellbeing activity in the Trust in order to be assured of the effectiveness of these activities on improving staff experience. To remove reference to staff engagement, Staff FFT and morale.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 7- Duties & Responsibilities** **Duties – monitoring**	To include the term Integrated Performance Indicators.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023		To include monitoring of the implementation of Improving People Practices principles through the adoption of a Restorative Culture, including ○ Details of Employee Relations Cases in respect of numbers, ○ Summary of workforce demographics, ○ Analysis and impact assessment of emerging themes, ○ Identification of any risks associated with complex case work such as	

		Employment Tribunal cases, Subject Access Requests, and costs, ○ Overview of lessons learned and actions taken to address these, ○ Specific information on those cases where suspension/exclusion is involved, including any Supporting Attendance dismissals/appeals.	
18 January 2023	**Section 7- Duties & Responsibilities** **Sub-Committees (Groups)**	Change EDI Sub Committee to Workforce EDI Sub Committee. Include Nursing and Allied Health Professional Workforce Resourcing Group Remove Workforce Recovery Steering Group to report to Operational People Committee. Remove Medical Education Quality Sub Committee to report to Operational People Committee.	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 9 – Administrative Arrangements**	Bullet Point 3 – Members: Replacement of reference to HR/OD Service Leads to People Professional Service Leads	V7 SPC 18.01.2023 Trust Board 25.01.2023
18 January 2023	**Section 9 – Administrative Arrangements**	Bullet Point 5 – Presentation submission to also include statement: 'unless otherwise agreed with the Chair of the Committee'.	V7 SPC 18.01.2023 Trust Board 25.01.2023
20 March 2024	**Section 4 - Membership**	Updated titles & inclusion of Governor observer	
20 March 2024	**Section 7 – Duties & Responsibilities**	• Update reference to Committee Assurance Report • Updates to duties and responsibilities in relation to decision making, advisory and monitoring	

TERMS OF REFERENCE OBSOLETE

Date: 20.03.2024~~XXX~~ DRAFT ~~VXXX~~V7.1
Approved: SPC 20.02.24 V7.1 and Trust Board XX.XX.XXXX~~XXX~~
Review Date: (12 months from date of approval)

Date	Reason	Approved by:
	Version 5 replaced with Version 6	SPC 18.03.2020 and Trust Board 25.03.2020
	Version 6 replaced with Version 6.1	V6.1 SPC 18.11.2020 Trust Board 25.11.2020
	Version 6.1 replaced with Version 6.2	V6.2 SPC 21.07.201 Trust Board 28.07.2021
	Version 6.2 replaced with Version 6.3	TBC
	Version 6.3 replaced with Version 7	V7 SPC 18.01.2023 Trust Board 25.01.2023
	Version 7 replaced with Version 7.1	V 7.1 SPC 20.03.2024

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

FINANCE & SUSTAINABILITY COMMITTEE
CYCLE OF BUSINESS 2024/25

CALENDAR YEAR (APRIL 24 - MARCH 25)				2024									2025		
AGENDA ITEM	**Reporting Frequency**	**Process**	**LEAD**	**24.4.24**	**22.5.24**	**26.6.24**	**24.7.24**	**28.8.24**	**25.9.24**	**23.10.24**	**27.11.24**	**18.12.24**	**22.01.25**	**26.2.25**	**26.3.25**
INTRODUCTION & ADMINISTRATION															
Apologies for Absence	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Minutes of the Last Meeting & Action Log	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Rolling attendance log + cycle of business	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
Matters Arising	Monthly Standing Item	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√
GOVERNANCE & COMPLIANCE															
Hot Topic	Monthly Standing Item or as required	For Approval	**Chair/CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Deep Dive	Monthly Standing Item or as required	For Approval	**Chair/CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Committee Terms of Reference	Annually	For Approval	**Company Sec**												√
Committee Cycle of Business	Annually	For Approval	**Company Sec**												√
Pay Assurance Report	Monthly	For assurance	**CPO**	√	√	√	√	√	√	√	√	√	√	√	√
Board Asssurance Framework & Risk Register	Monthly	For Approval	**Company Sec**	√	√	√	√	√	√	√	√	√	√	√	√
Annual Rewview of BAF & Risk Register	Annually	For Assurance	**Company Sec**		√										
PAF Review and Refresh of Trust KPIs	Annually	For Assurance	**CFO**											√	
Committee Effectiveness Review including Annual Chair's Report to the Board	Annually	For Assurance	**Chair/Company Sec**	√ Report											Advise of survey
Sustainability Strategic Priorities Update	Bi-Annually	For Assurance	**DS&P**		√						√				
Emergency Preparedness Annual Report (EPRR) & Annual Assurance Letter Statement of Compliance	Annually	For Assurance	**COO**				√								
PERFORMANCE															
Corporate Performance Report	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Winter Plan	Annually	For Assurance	**COO**						√						
Recovery Updates	Monthly	For Assurance	**COO & CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Digital Services HLB & Digital Board minutes	Monthly	For Assurance	**CIO&SIRO**	√	√	√	√	√	√	√	√	√	√	√	√
SIRO (Senior Information Risk Owner) Report	Annually	For Assurance	**CIO&SIRO**		√										
FINANCIAL ASSURANCE															
Monthly Finance report, +	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Finance + Resources Group Minutes and escalation log				√	√	√	√	√	√	√	√	√	√	√	√
Cost Pressures	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Capital Planning Group planning cycle annual review	Annually	For Assurance	**CFO**			√									
Monthly CIP Report (including GIRFT & Theatre Productivity)	Monthly	For Assurance	**CFO**	√	√	√	√	√	√	√	√	√	√	√	√
Indicative Financial cost of harm annual report	Annually	For Assurance	**CFO**		√										
Capital Expenditure Approvals (schemes above £500k) wef May	Monthly	For Assurance	**Exec Lead**	√	√	√	√	√	√	√	√	√	√	√	√
Cash Support Update	Quarterly	For Assurance	**CFO**				Q1			Q2			Q3		

Elective Restoration Update	Quarterly	For Assurance	**COO**				Q1			Q2			Q3			
Benefits Realisation Quarterly Report	Quarterly	For Assurance	**CFO**		Q4			Q1			Q2			Q3		
Medical Workforce Review Group Quarterly Report	Quarterly	For Assurance	**EMD**		Q4			Q1			Q2			Q3		
Use of Resources Annual Report	**on hold**		**CFO**													
INVESTMENT																
Annual Capital Programme	Annually	For Assurance	**CFO**											√		
PLANNING																
Operational Plan & Budgets	Annually	For Approval	**CFO**	X Final 2024/25										X Draft 2025/26	X Final 2025/26	
Costing Update	Quarterly	For assurance	**CFO**			Q4			Q1			Q2			Q3	
CLOSING																
Items for Escalation to the Trust Board &	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√	
Any Other Business	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√	
Next Meeting Date & Time	Monthly	For Noting	**Chair**	√	√	√	√	√	√	√	√	√	√	√	√	

FINANCE & SUSTAINABILITY COMMITTEE
TERMS OF REFERENCE

1. PURPOSE

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

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

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

4. MEMBERSHIP

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

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

Core Members

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

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Chief Finance Officer ~~& Deputy CEO~~
- Chief Nurse ~~& Deputy CEO~~
- Chief Operating Officer & Deputy CEO
- Executive Medical Director
- Chief People Officer
- Deputy Chief Finance Officer
- Director of Strategy & Partnerships
- Company Secretary & Associate Director of Corporate Governance
- Associate Director of Estates and Facilities Management
- Chief Information Officer

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

Observers

- Governor

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

5. AUTHORITY

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

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

6. REPORTING

The Committee will have the following reporting responsibilities:

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

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

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

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

The following groups will report directly to the Committee:

- Capital Planning Group
- Financial Resources Group
- Digital Strategy Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group
- Improvement & Productivity Group

7. DUTIES & RESPONSIBILITIES

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

Finance and performance

- To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the NHS Provider License
- Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- To monitor the effectiveness of the Trust's financial performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the Trust's performance against its annual financial plan and budgets.
- Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- Overseeing the development and subsequent monitoring of an operational plan including activity, workforce, finance, annual budget, annual capital programme and cashflow for approval by the Trust board.
- To ensure that appropriate triangulation across portfolios ~~clinical advice and involvement~~ in the ~~MTFM and LTFM is~~ medium and long term financial models is provided.
- To review and monitor the in-year delivery of annual efficiency savings programmes.
- Consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Committee Assurance Report.
- To monitor compliance with NHSE requirements relating to pay policies
- To review and monitor the Trust's overall pay bill
- Benchmark financial and operational performance within the Integrated Care System, regionally and nationally
- Approve capital expenditure up to £5m on behalf of the Trust Board
- To oversee the Trust's Emergency Preparedness and Response (EPRR) Framework

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £5m or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

10. REVIEW / EFFECTIVENESS

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

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Finance and Sustainability Committee
Version:	V10.1~~V8~~ **DRAFT**
Implementation Date:	xx.xx.xx
Review Date:	xx.xx.xxx
Approved by:	Finance & Sustainability Committee
Approval Date:	FSC ~~Spril 2023~~March 2024, Trust Board xx.xx.xxxx

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

18 October 2017	**4. Duties and responsibilities** **6. Core attendees** **9. Reporting Groups**	- Delete items relating to Estates and IM&T - Delete Director of IM&T Remove IM&T Steering Cttee, Lorenzo Project Group, IM Governance and Records	
22 November 2017	**Section 4 Duties and Responsibilities** **Section 9 Reporting Groups**	- To monitor compliance with NHSI requirements relating to pay policies - To review and monitor the Trust's overall pay bill - To monitor all elements of the Board Assurance Framework that relate to the work of this Committee To include: reports on premium pay spend	
21 March 2018	**Core Attendees**	Addition of Medical Director	Trust Board 29.5.2019
19 September 2018	**Core Attendees**	Remove Director of Transformation	Trust Board 29.5.2019
20 March 2019	**Section 6: Core Attendees**	Remove Medical Director Add Head of Corporate Affairs	Trust Board 29.5.2019
20 March 2019	**Section 9: Reporting**	Add Financial Resources Group Remove Out Patient Turnaround Remove ICIC	Trust Board 29.5.2019
18 March 2020	**Section 6: Core Attendees**	ADD Medical Director Amend Title of Head of Corporate Affairs to read Trust Secretary Amend title of Deputy director of Finance Strategy to read Deputy Director of Finance & Commercial Development ADD Director of Strategy (when required)	FSC 18.03.2020 Trust Board 25.03.2020
18 March 2020	**Section 9: Reporting**	Remove Urgent & Emergency Care Improvement Committee	FSC 18.03.2020 Trust Board 25.03.2020
23 September 2020	**Section 4 Duties and Responsibilities**	Addition of reports from Digital Services	FSC 23.09.2020 Trust Board 25.11.2020
23 September 2020	**Section 6: Core Attendees**	Amend the titles of three Directors Add Chief Information Officer	FSC 23.09.2020 Trust Board 25.11.2020

23 September 2020	**Section 9: Reporting**	Add Digital Board	FSC 23.09.2020 Trust Board 25.11.2020
22 September 2021	**Section 6: Core Attendees** **Section 9: Reporting**	Amend title of Deputy Director of Finance & Commercial Development and Delete post of Chief Information Officer **Add Medical Staffing Review Group and Strategy & Sustainability Review Group**	FSC 22.09.2020 Trust Board 24.11.2020
21st September 2022	**Section 4: Duties & Responsibilities**	Updated reference to Committee Assurance Report and amended NHSI to NHSE following NHS Improvement becoming part of NHS England in July 2022	
21st September 2022	**Section 9: Reporting Groups**	Addition of GIRFT/Clinical productivity Group Amend title of Digital Board to Digital Management Group	
26th April 2023	**Section 4: Duties & Responsibilities**	• Updated reference to new Provider Licence • Re-instated review of performance following dis-establishment of Clinical Recovery Oversight Committee • Addition of oversight of annual operational plan • Removal of duplicate responsibility • Updated Committee Capital Spend limit • Remove reference to MTFM and LTFM	
26th April 2023	**Section 6: Core Attendees**	• Addition of Chief Executive and Associate Director of Estates & Facilities Management	
26th April 2023	**Section 9: Reporting Groups**	• Update of Report Group titles	
27th March 2024	**Section 4 - Membership**	• Update titles of members and add Chief Information Officer	
27th March 2024	**Section 6 - Reporting**	• Addition of Improvement & Productivity Group • Confirmation that the Committee oversees EPRR arrangements	
27th March 2024	**Section 9 – Administrative Arrangements**	• Affirmation of the Committee's duty ro review the Terms of Reference and Cycle of Business annually	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
20 March 2020	**V5 to be replaced by V6**	FSC 18.03.2020
23 September 2020	**V6 to be replaced by V7**	FSC 23.09.2020
22 September 2020	**V7 to be replaced by V8**	FSC 22.09.2022
21st September 2022	**V8 to be replaced by V9**	FSC 21.09.2022
26th April 2023	**V9 to be replaced by V10**	FSC 26.04.2023 Trust Board 07.06.2023
xx.xx.xxxx	**V10 to be replaced by V10.1**	FSC xx.xx.xxxx Trust Board xx.xx.xxxx

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

AUDIT COMMITTEE – CYCLE OF BUSINESS
2024-25

CALENDAR YEAR APRIL 24 - FEBRUARY 2025)				2024				2025
AGENDA ITEMS	**Reporting Frequency**	**Process**	**Lead**	**25-Apr**	**17-Jun YR END**	**22-Aug**	**17-Nov**	**27-Feb**
OPENING BUSINESS								
Welcome, apologies, declarations of interest, cycle of business, rolling attendance log	Standing Item	Noting	**Chair**	✓	✓	✓	✓	✓
Review Minutes and Action Log	Standing Item	Approval	**Chair**	✓	✓	✓	✓	✓
QPS ASSURANCE								
Update from Chairs of F&SC QAC CFC SPC	Standing Item	For assurance	**JS/CR/SMcG/JJ**	✓	✓	✓	✓	✓
Changes or Updates to BAF	Standing Item	For assurance/approval	**Company Secretary**	✓	✓	✓	✓	✓
INTERNAL AUDIT								
Internal Audit Plan & Fees	Annually	For assurance	**MIAA**					✓
Progress Report on Internal Audit follow-Up actions	Monthly	For assurance	**Chief Finance Officer**	✓		✓	✓	✓
Internal Audit Progress Report on Follow-Up actions	Monthly	For assurance	**MIAA**			✓		✓
Internal Audit Progress Report	Monthly	For assurance	**MIAA**			✓	✓	✓
Head of Internal Audit Opinion	Annually	For Approval	**MIAA**	✓				
Internal Audit Charter Annual Report	Annually	For Approval	**MIAA**	✓				
EXTERNAL AUDIT								
External Audit Plan & Fees		For Approval	**GT**	✓				✓
Report and Updates from External Audit		For assurance	**GT**	✓		✓	✓	✓
Annual Audit Letter (AC following year-end Audit Cttee)		For Approval	**GT**			✓		
Renewal/Refresh of External Audit Contract (at term)		For Approval	**GT/AMcG/JC**			✓		
COUNTER FRAUD								
FINAL Annual Counter Fraud Plan	Annually	For Approval	**MIAA**					✓
Counter Fraud Progress Updates	Monthly	For assurance	**MIAA**	✓		✓		✓
Annual Counter Fraud Annual Report	Annually	For Approval	**MIAA**	✓				
FINANCE								
Review Losses & Special Payments	Monthly	For assurance	**Chief Finance Officer**	✓		✓	✓	✓
Review Quotation and Tender Waivers of Standing Financial Instructions	Monthly	For assurance	**Chief Finance Officer**	✓		✓	✓	✓
Going Concern Report	Annually	For assurance	**Chief Finance Officer**	✓				
QPS GOVERNANCE AND COMPLIANCE								
Annual report and accounts timetable and plans	Annually		**Chief Finance Officer**					✓
Draft Annual Governance Statement	Annually		**Company Secretary**	✓				
Draft Annual Report	Annually		**Chief Executive**	✓				
Draft unaudited Accounts & Financial Statements	Annually		**Chief Finance Officer**	✓				
Annual Report	Annually		**Chief Executive**		✓			
Quality Account	Annually		**Dir Integrated Gov**		✓			
Draft Annual accounts accounting policies	Annually		**Chief Finance Officer**					✓
FINAL and Audited Accounts & Financial Statements	Annually		**Chief Finance Officer**		✓			
Review of Schemes Reservation & Delegation (SoRD) & Standing Financial Instructions (SFIs)	Annually/as required		**CFO/Company Secretary**				✓	
Head of External Audit Opinion Statement	Annually		**GT**	✓				
Review other reports and policies as appropriate – e.g. changes to standing orders – as arise			**ALL**					
Conflict of Interest Policy January 2024/Anti- Fraud Policy August 2023/Treasury Management Policy Aug 2023								
Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors Annual Report	Annually	For Approval	**Company Secretary**		✓			
Risk Management Annual Report update	Annually	For Approval	**Dir Integrated Gov/ to be advised**			✓		
Code of Governance Compliance Declaration – e.g. changes as required	As required	For Approval	**Company Secretary**					
Review of Trust Registers (e.g. Conflicts of Interest)	Annually		**Company Secretary**	✓				
Terms of Reference	Annually	For Approval	**Company Secretary**					✓
Fit & Proper Persons Test Annual Report	Annually	For assurance	**Company Secretary**	✓				
Cycle of Business Annual Review	Annually	For assurance	**Company Secretary**					✓
On-Call Annual Update Report	Annually	For assurance	**Chief People Officer**			✓		
Overtime Annual Update Report	Annually	For assurance	**Chief People Officer**			✓		
NW Skills Network Bi-Annual Report	Bi-Annually	For Assurance	**Chief Finance Officer**			✓		
ICON Programme Bi-Annual Report	Bi-Annually	For Assurance	**Chief Finance Officer**			✓		
EFFECTIVENESS								
Committee Chairs Annual Report (for Trust Board & Council of Governors)						✓		
Committee Effectiveness - annual review	Annually		**CHAIR**	✓				✓ **advise of survey**
DEEP DIVE REVIEWS								
Commission and receive ANY additional scrutiny projects			**Dir Integrated Gov (as required)**					
CLOSING								
Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually			**CHAIR**			✓		✓
Any Other Business			**CHAIR**	✓	✓	✓	✓	✓

Warrington and Halton Teaching Hospitals NHS Foundation Trust

DRAFT TERMS OF REFERENCE

Audit Committee

1. PURPOSE

The Audit Committee has primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Audit Committee shall provide the Board of Directors with a means of independent and objective review of assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical), both generally and in support of the Annual Governance Statement. In addition the Audit Committee shall:

- provide assurance of independence for external and internal audit;
- ensure that appropriate standards are set and compliance with them monitored in all areas that fall within the remit of the Audit Committee ; and
- monitor compliance with corporate governance requirements (e.g. compliance with the terms of the Licence; Constitution; codes of conduct; standing financial instructions; maintenance of registers of interest).

2. FREQUENCY OF MEETINGS

Meetings shall be held at least five times per year with additional meetings where necessary.

The internal auditor and external auditor shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

3. QUORUM

The quorum necessary for the transaction of business shall be two members.

4. MEMBERSHIP

The Committee shall be composed of all (~~6~~7) the Trust's independent non-executive directors, at least one of whom should have recent and relevant financial experience (Monitor Code C.3.1), as follows:

- at least one member of the Trust's Quality Assurance Committee will be a member of the Trust's Audit Committee
- the Chair of the Trust shall not be a member

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

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

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The Trust Chair may be invited to attend meetings of the Audit committee if required

The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed.

Only members of the Audit Committee have the right to attend meetings, but the following individuals shall normally be in attendance:

- Chief Finance Officer ~~& Deputy Chief Executive~~
- ~~-~~Director of Integrated Governance and Quality
- Representative(s) of the external audit service provider
- Representative(s) of internal audit service provider
- Representative(s) of counter fraud service provider
- ~~Trust Secretary~~ Company Secretary & Associate Director of Corporate Governance
- ~~Deputy Chief Finance Officer~~
- Head of Financial Services
- ~~Secretary to the Board~~
- Governor Observer
- Associate Director of Finance – Operational

The Chief Executive may also be invited to attend and should in any case, attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

The Audit Committee may require individual Trust Directors to attend in respect of specific agenda items and, in addition, will normally extend an open invitation to all Trust Directors to attend all meetings.

5. AUTHORITY

The Audit Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out, subject to amendment at future Board of Directors meetings. The Audit Committee shall not have any executive powers in addition to those delegated in these terms of reference.

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

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice on any matter within its Terms of Reference ~~to the total of £10,000 per annum,~~ and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

6. REPORTING

The Committee shall report to the Board of Directors and Council of Governors annually on how it discharges its responsibilities; specifically on its work in support of the annual governance statement, commenting on:

- The fitness for purpose of the assurance framework

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- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements
- The robustness of the processes behind the quality account

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The minutes of the Committee meetings will be formally recorded. The Chair of the Audit Committee shall draw to the attention of the Board any issues that require disclosure or require executive action via a Committee Assurance Report.

7. DUTIES & RESPONSIBILITIES

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

Integrated Governance, Risk Management, and Internal Control

Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring there is scrutiny and oversight of the Strategic Risk Register and Board Assurance Framework

The Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the governing body.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality Assurance Committee) so that it understands processes and linkages. However, these other committees must not usurp the Audit Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent

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assurance to the Committee, Accountable (or Accounting) Officer and governing body. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Liaising with the ~~Quality Assurance Committee Chair and~~Committee Chairs and the Trust's Executive Team to plan and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, including areas identified in the assurance framework
- Considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the governing body when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the governing body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud standards and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation after taking briefings from ~~Quality Assurance Chair~~Committee Chairs or the Executive Team

The Committee will also periodically review the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Standards of Business Conduct (Managing Conflicts of Interest) and examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension

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Financial Reporting
The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the governing body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference to the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances.

Other

Review performance indicators relevant to the remit of the Audit committee.

Examine any other matter referred to the Audit Ccommittee by the Board of Directors, the Chair ~~of the Quality Assurance Committee~~s of the Committees of the Board or the Executive Team and initiate investigation as agreed with the members of the Audit Committee.

Develop and use an effective assurance framework to guide the Aaudit Ccommittee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

~~Review the work of the CQC 'Moving to Outstanding' Group in connection with the Audit Committee's assurance function.~~

Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health [and social care] sector and professional bodies with responsibilities that relate to staff performance and functions.

8. ADMINISTRATIVE ARRANGEMENTS

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

9. REVIEW / EFFECTIVENESS

Date: ~~18.08.2022~~22.02.2024 DRAFT V4.2xx.xx.xxxx
Approved: AC 22.02.24 Trust Board xx.xx.xxxx
Review Date: (~~2 years~~12 months from date of approval)

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The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements and report on this to the Trust Board.

These terms of reference will be reviewed every two years by the Council of Governors and the Trust Board.

Date: ~~18.08.2022~~22.02.2024 DRAFT V4.2xx.xx.xxxx
Approved: AC 22.02.24 Trust Board xx.xx.xxxx
Review Date: (~~2 years~~12 months from date of approval)

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Audit Committee
Version	V4
Implementation Date	Immediate
Review Date	August 2022
Approved By	Audit Committee – 20 February 2020

REVISION			
Date	**Section**	**Reason for change**	**Approved by**
16.1.2017	10	- Review date amended from at least annually to every 2 years - Committee to be supported by the Secretary to the Trust Board.	Audit Committee 16.01.2017
22.2.2018	4 5 6	- Change Quality Committee to Quality Assurance Committee - Internal Audit to include liaison with the Trust's Q&A and TOB committees - Audit Committee to review SORD, SFIs, Standards of Business Conduct (MCoI) arrangements - Review Freedom to Speak Up Register - Review performance indicators relevant to remit of AC - Commission any investigations or 'deep dives' or request any other committee to do so - Develop and use an effective assurance framework to guide the audit committee's work - Review the work of the Trust Board's other Committees - Consider any external reviews by regulators and/or professional bodies that relate to staff performance and functions.	Audit Committee 22.02.2018

Date: ~~18.08.2022~~22.02.2024 DRAFT V4.2xx.xx.xxxx
Approved: AC 22.02.24 Trust Board xx.xx.xxxx
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	10	Membership - The Trust Chair may be invited to attend meetings of the Audit committee if required - The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed Attendance – to include: - Director of Integrated Governance - Head of Corporate Affairs - Secretary to the Board - A minimum of 75% attendance is required by members of the committee Committee will review effectiveness annually and report on this to Trust Board and Council of Governors	
23.3.2018	6	Attendance – amendments: - Remove Director Corporate Affairs and Head of Corporate Affairs. - Add Executive Medical Director, Executive Lead, Corporate Affairs	Audit Committee
20.02.2020	6	Attendance – amendments - Delete Executive Medical Director, Executive Lead, Corporate Affairs - Change title of Head of Corporate Affairs to Trust Secretary - Replace Director of Integrated Governance with Deputy Director Governance - ADD Governor Observer - Amend Text re: Director attendance	Audit Committee 20.02.2020 Trust Board 25.03.2020
20.02.2020	9	Administration Arrangements - Change title of Head of Corporate Affairs to Trust Secretary	Audit Committee 20.02.2020 Trust Board 25.03.2020
29.07.2022	5	Attendance – amendments	Audit Committee

Date: ~~18.08.2022~~22.02.2024 DRAFT V4.2xx.xx.xxxx
Approved: AC 22.02.24 Trust Board xx.xx.xxxx
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		- Change title of Deputy Director of Governance to Director of Integrated Governance and Quality - Addition of Deputy Chief Finance Officer and Head of Financial Services	18.08.2022
29.07.2022	8	Duties & Responsibilities - Change reference to Operational Board to Executive Team - Remove requirement to report Freedom to Speak up arrangements to the Committee. The Strategic People Committee provides oversight	Audit Committee 18.08.2022
22.02.2024~~xx~~.xx.xxxx	4	Membership - Update to titles - Removal of Deputy Chief Finance Officer & Secretary to the Trust Board - Addition of Associate Director of Finance - Operational	
22.04.2024xx.xx.xxxx	5	Authority - Removal of value to professional advice	
22.04.2024xx.xx.xxxx	7	Duties & Responsibilities - Update of specific reference to the Quality Assurance Committee to include all Committees of the Board and their respective Chairs. - Removal of reference to the Moving to Outstanding Group	

TERMS OF REFERENCE OBSOLETE	
Date	**Reason**
20.02.2020	**V3, replace with V4, approved by Audit Committee 20.02.2020 + Trust Board 25.03.2020**
18.08.2022	**V4 replace with version 4.1 approved by Audit Committee 18.08.2022**
22.02.2024	**V4.1 replace with version 4.2 approved by Audit Committee 22.02.2024**

Date: ~~18.08.2022~~22.02.2024 DRAFT V4.2xx.xx.xxxx
Approved: AC 22.02.24 Trust Board xx.xx.xxxx
Review Date: (~~2 years~~12 months from date of approval)

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Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Date: ~~18.08.2022~~22.02.2024 DRAFT V4.2xx.xx.xxxx
Approved: AC 22.02.24 Trust Board xx.xx.xxxx
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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/024/016**			
SUBJECT:	**Board and Board Development Effectiveness Review Outputs Report**			
DATE OF MEETING:	4 April 2024			
AUTHOR(S):	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):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The review of the effectiveness of Board and Board Development meetings throughout 2023/24 was undertaken during March 2024. Both Executive and Non-Executive Directors were asked to complete an online questionnaire consisting of 14 multiple choice questions (first question was name only) with space for comments and one free text question around topics for future Board Development. • 13 completed surveys were received out of a possible 16. • The scores from the multiple-choice questions were largely positive			

	• Board members were asked to suggest topics for future Board Development for the 2024/25 financial year. The suggested topics are listed within the report. • The Board is responsible for taking forward any actions for improvement identified in this report and from Board discussions and to monitor progress against those actions agreed.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**
RECOMMENDATION:	The Trust Board is asked to: • Note the survey results. • Agree any actions for improvement to take forward and monitor in 2024/25 to improve the Boards effectiveness		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Board and Board Development Effectiveness Review Outputs Report	AGENDA REF:	BM/24/04/016

1. BACKGROUND/CONTEXT

The Trust needs to be confident that effective corporate governance arrangements are in place to meet the requirements of the Board, to comply with NHS England's NHS Foundation Trust Code of Governance and to meet the KPIs set out in the NHS England well-led framework **(KLoE 4: Governance).**

This will be achieved through:

- Review of the record of attendance
- self-assessment of the Boards effectiveness
- identification of items for consideration for the following year (i.e., Cycle of Business, see Agenda Item **BM/24/04/015**)

2. KEY ELEMENTS

Review of Attendance

The complete attendance record, including Extra-Ordinary Private Board meetings, is included as **Appendix 1.** Trust Board members are asked to review, and advise if they feel there are any inaccuracies, as attendance data will be published in the 2023/24 annual report.

Formal apologies have been received on those occasions where Board members have been unable to attend, and in all cases, deputies have attended when Executive Directors have sent apologies, these details are recorded in the minutes for each meeting.

Quorum (given below) has been achieved for all Board meetings throughout 2023/24.

Trust Constitution

> *4.14 No business shall be transacted at a meeting of the Board unless at least half of the Board are present including at least two Executive Directors and two Non-Executive Directors.*

Corporate Governance Observations

Prior to Board meetings, Board members take part in leadership observational visits, the schedule for visits developed by the Trust's Patient Experience Team and cover clinical and non-clinical areas of the Trust. The visits provide an opportunity for Board members to meet staff members and triangulate in "real time" the information presented in Board and Committee meetings. Board members value this time spent with staff and complete an observational report following each visit, which is collated by the Patient Experience Team.

Meetings are always held on the scheduled date and begin promptly. Typically, meetings run to-time, which suggests agendas are well planned and Board meetings are chaired well, with structured discussions on agenda topics.

Circulation of agendas and papers is usually one week prior to the Board meeting. The agenda and papers for Part 1 of Trust Board meetings are made available in the public domain via the Trust Website.

The Lead Governor is invited to observe and is included in the paper circulation for both Part 1 and Part 2 of all Trust Board meetings. The Lead Governor is also invited to attend all extra-ordinary Trust Board meetings. Following meetings, the Lead Governor produces and presents an observation report to the Council of Governors at their next formal meeting.

Board meetings take place across Trust sites, typically alternating between Warrington and Halton Hospitals. The last Board Development Day of 2023/24 was held in the newly opened Living Well Hub Warrington which gave Board members the opportunity to experience the fully accessible facility aimed at empowering local residents to live as happily, healthily, and independently as possible.

The Survey

Board members were asked to complete an online survey consisting of 14 multiple choice questions and one free text question. There were 13 responses out of a possible 16.

All responses have been treated in confidence i.e., they are not individually attributed.

The scoring system **(Table 1)** applied to the responses/statements is given below:

Strongly Agree	
Agree	
Disagree	
Strongly Disagree	
Unable to Answer	

Table 1: Scoring System

The survey outputs are provided in full as **Appendix 2.**

Survey Outputs

The responses to survey questions were largely positive, with few comments attached to each of the questions. It is encouraged that Board members discuss the outputs of the questions detailed below.

Question 2: The frequency of the meetings is sufficient to ensure that assurance can be provided to the Board.

The response to the multiple-choice side of this question was positive with all board members either strongly agreeing or agreeing.
The comment below was provided:

"I think it is worthwhile us benchmarking what other trusts are doing in terms of frequency. We have a lot of activity going through monthly".

Given this comment a system benchmarking exercise has been undertaken, details are provided in the table below:

Table 1: Frequency of Board meetings of other FTs in the Cheshire and Merseyside Integrated Care System

Liverpool Heart and Chest Hospital NHS FT	Bi-Monthly
Wrightington, Wigan and Leigh Teaching Hospitals NHS FT	Bi-Monthly
Liverpool University Hospitals NHS FT	Bi-Monthly
Mid Cheshire Hospitals NHS FT	Bi-Monthly
Wirral University Teaching Hospital NHS FT	Monthly (no August meeting)
Clatterbridge Cancer Centre NHS FT	Monthly (no meeting July, August, December)
Liverpool Women's Hospital NHS FT	Bi-monthly
Alder Hey Children's NHS FT	Monthly (no meeting in August)
Bridgewater Community Healthcare NHS FT	Bi-Monthly
Mersey Care NHS FT	Bi-Monthly
East Cheshire NHS Trust	Bi-Monthly
Countess of Chester NHS FT	Bi-Monthly

Based on the benchmarking data above the frequency of WHH Board meetings compares well with other FTs in the system.

Question 5: The engagement/ patient stories are working well?

The responses to the question indicate that the board mostly agree Engagement/patient stories are working well rather than strongly agree. It should be noted that patient stories are also presented at Quality Assurance Committee meetings bi-monthly and staff stories are to the Strategic People Committee.

The comments below were provided:

"We just need to make sure we balance the negative stories with the positive ones. There are only six opportunities a year. Is this enough? Should we introduce monthly?

"Perhaps more 'in person' or films of the patients would be more powerful"

"Wonder if we can share these stories wider, e.g. new senior management forum"

The following actions are suggested:

Action	**Owner**
Identification and production of more negative patient stories with lesson learned identified and improvements made to present at Trust Board Meetings	Chief Nurse/ Patient Experience Team
To produce a schedule of patients/carers willing to share their story in person or via video at Trust Board meetings	Chief Nurse/ Patient Experience Team
Identify channels to share patient/engagement stories wider i.e. via social media or Trust Website, Intranet	Director of Communications & Engagement

Question 7: Strategic risks are a priority for the Board and are captured and discussed sufficiently.

Given the largely positive response to the question, it is clear that the work undertaken around the Board Assurace Framework and risk reporting during 2023/24 particularly around risk appetite and target risk scoring has been valued by the board. The Board should take assurance from the further work planned by Committees to align risk appetite and target risk scores, with a deep dive already undertaken for those risks aligned to the Strategic People Committee.

The comments below were provided:
"Significant work has been undertaken around risk tolerance and this has also featured appropriately in the associated Assurance Committees, especially linking target and tolerance scores."

"I think we could focus a bit more a couple of times per year into the detail"

Action	Owner
Board Assurance Framework Risk Review Deep Dives scheduled for Quality Assurance Committee and Finance and Sustainability Committee with focus on appetite and target risk scores	Company Secretary

Question 8: Reports are clear and concise, providing the Board with robust information and effective assurance.

The majority of Board members responded with agree, as opposed to strongly agree, and one board member disagreed. which was off trend when benchmarked against other question responses.

The comments below were provided:
"some exec summaries could be stronger and reports that merely add a multipage report with no summary are to be avoided if possible"

"Still work to do with pithy and 'nailed' exec summaries and maybe using shadow board colleagues to help?"

"Reports have generally improved over time"

"We can do better at this. Always a challenge to get right in terms of detail versus summary"

"Have got far better - could still be shorter. The Exec summaries are good"

Whilst it is recognised board reports have improved over time, given the comments received and the off-trend response to this question, it is recommended that some further guidance for report authors is produced and circulated during the first half of 2024/25.

Action	Owner
Development of an in-house training guide on effective report writing for senior staff (report authors)	Company Secretary

Supplementary Question

Question 14: List any suggested topics for future Board Development

Board members responses have identified 6 topics for future Board Development Days, these are given below:

	Topics	Linked comments
1	Leadership Competencies - what this means for NEDs and Execs going forward	
2	Phase 2 Newton work Future actions for WHH, partners and Place	
3	Health Inequalities - population health and WHH role in improving health / role of assurance committees etc	One respondent had also commented in Question 4: "Perhaps more discussion about Place and health inequalities"
4	Vision and future possibilities of the trust	
5	A published advanced cycle of business for Board Development, timed for the NHS year?	
6	Enhancing board function - becoming an excellent board	

The following actions will be taken forward:

Action	
A 2024/25 schedule for Board development topics to be developed, the schedule will remain fluid so that ad hoc items can be added as and when required	**Company Secretary**
The topics suggested by Board members (will be built into the 2024/25 schedule.	**Company Secretary**

3. RECOMMENDATIONS

The Trust Board is asked to:

- Note the results of the Board and Board Development Effectiveness Review
- Agree actions for improvement to take forward and monitor in 2024/25

TRUST BOARD ATTENDANCE LOG 2023-24												
	2023										2024	
Name	**07-Jun**	**02-Aug**	**Ex 06-Nov**	**04-Oct**	**Ex 1- Nov**	**Ex 9- Nov**	**Ex 16- Nov**	**Ex 21-Nov**	**06-Dec**		**07-Feb**	**Ex 21Feb**
Members & Attendees												
Steve McGuirk, Chair	A	√	√	√	√	√	√	A	√		√	√
Simon Constable, Chief Executive	√	√	√	√	√	√	√	√	√		√	√
Michael O'Connor, Non-Executive Director	√	√	A	√	√	√	√	√	√		√	A
Cliff Richards, Non-Executive Director	A	√	√	√	√	√	√	A	A		√	√
Julie Jarman, Non-Executive Director	√	√	√	A	√	√	√	√	√		√	√
John Somers, Non-Executive Director	√	√	√	A	√	√	√	√	√		√	√
Jayne Downey, Non-Executive Director	√	√	√	√	√	√	√	A	√		√	√
Jan O'Driscoll, Partner Non-Executive Director		√	A	√	A	√	A	A	A		√	A
Dave Thompson, Associate Non-Executive Director	√	√	√	√	A	A	A	A	√		√	A
Adrian Carridice-Davids, Associate Non-Executive Director	√	√	√	√	A	A	A	A	√		A	A
Andrea McGee, Chief Finance Office & Deputy CEO	√	√	√									
Jane Hurst, Chief Finance Officer			√	√	√	√	√	√	√		√	√
Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO	√	√	A/D	√	√	√	√	√	A/D		√	√
Dan Moore, Chief Operating Officer	√	√	√	A/D	√	√	√	√	√		√	√
Michelle Cloney, Chief People Officer	√	√	A	√	√	√	√	√	√		√	√
Paul Fitzsimmons, Executive Medical Director	√	√	√	√	√	√	√	√	√		√	√
Lucy Gardner, Director of Strategy & Partnerships	√	√	√	√	√	√	A	√	√		√	A
Kate Henry, Director of Communications & Engagement	√	√	√	√	√	√	√	√	√		√	A
John Culshaw, Company Secretary	√	√	√	√	√	√	√	√	√		√	√
Ailsa Gaskill-Jones, Director of Midwifery			√	√	N/A	N/A	N/A	√	√		√	N/A

KEY:

A = Apologies

A/D = Apologies/Deputy in Attendance

R = Left Trust

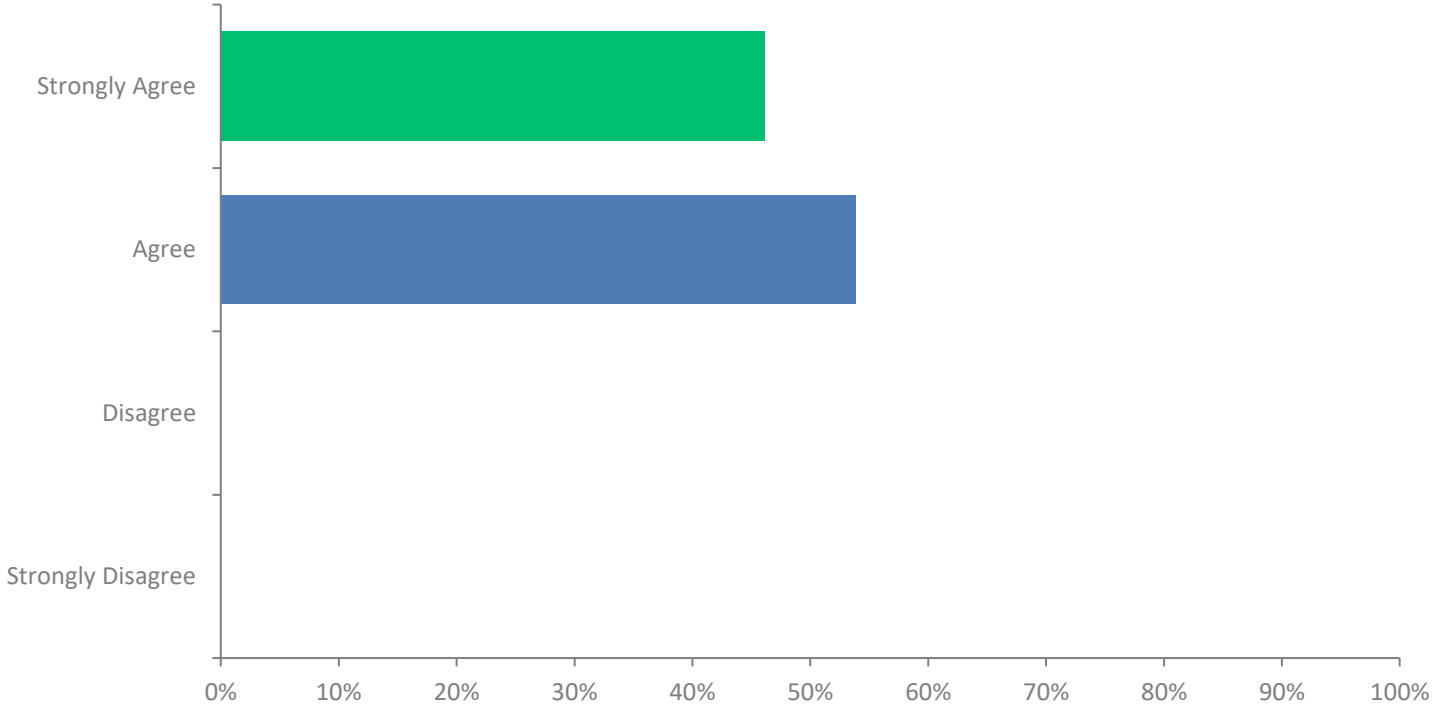
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Board and Board Development Effectiveness Survey

13 total responses

Q2: The frequency of the meetings is sufficient to ensure that assurance can be provided to the Board.

Answered: 13 Skipped: 0



Q2: The frequency of the meetings is sufficient to ensure that assurance can be provided to the Board.

Answered: 13 Skipped: 0

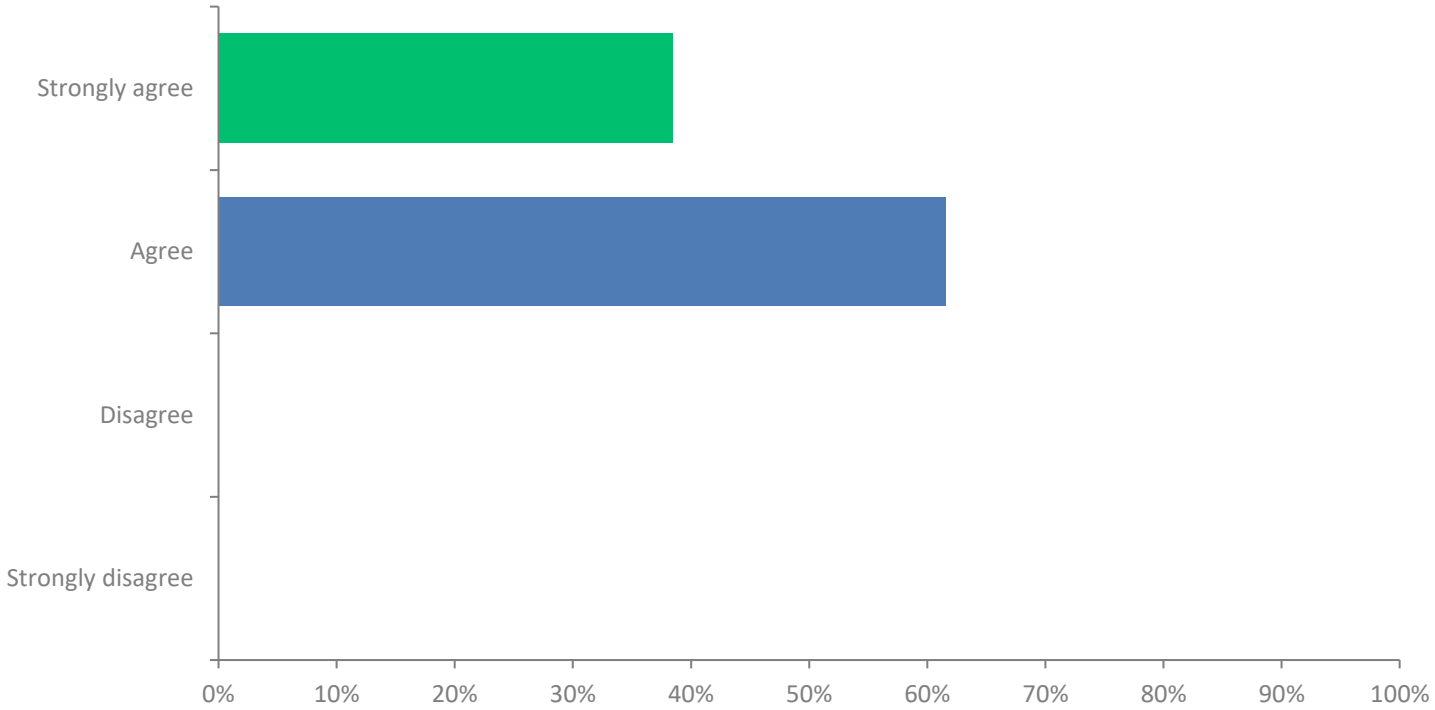
ANSWER CHOICES	RESPONSES	
Strongly Agree	46.15%	6
Agree	53.85%	7
Disagree	0%	0
Strongly Disagree	0%	0
TOTAL		13

Comments

- Because the bimonthly meeting is augmented by additional formal meetings as and when needed, real time decisions can be made
- I think it is worthwhile us benchmarking what other trusts are doing in terms of frequency. We have a lot of activity going through monthly.

Q3: The length of the meeting(s) is right.

Answered: 13 Skipped: 0



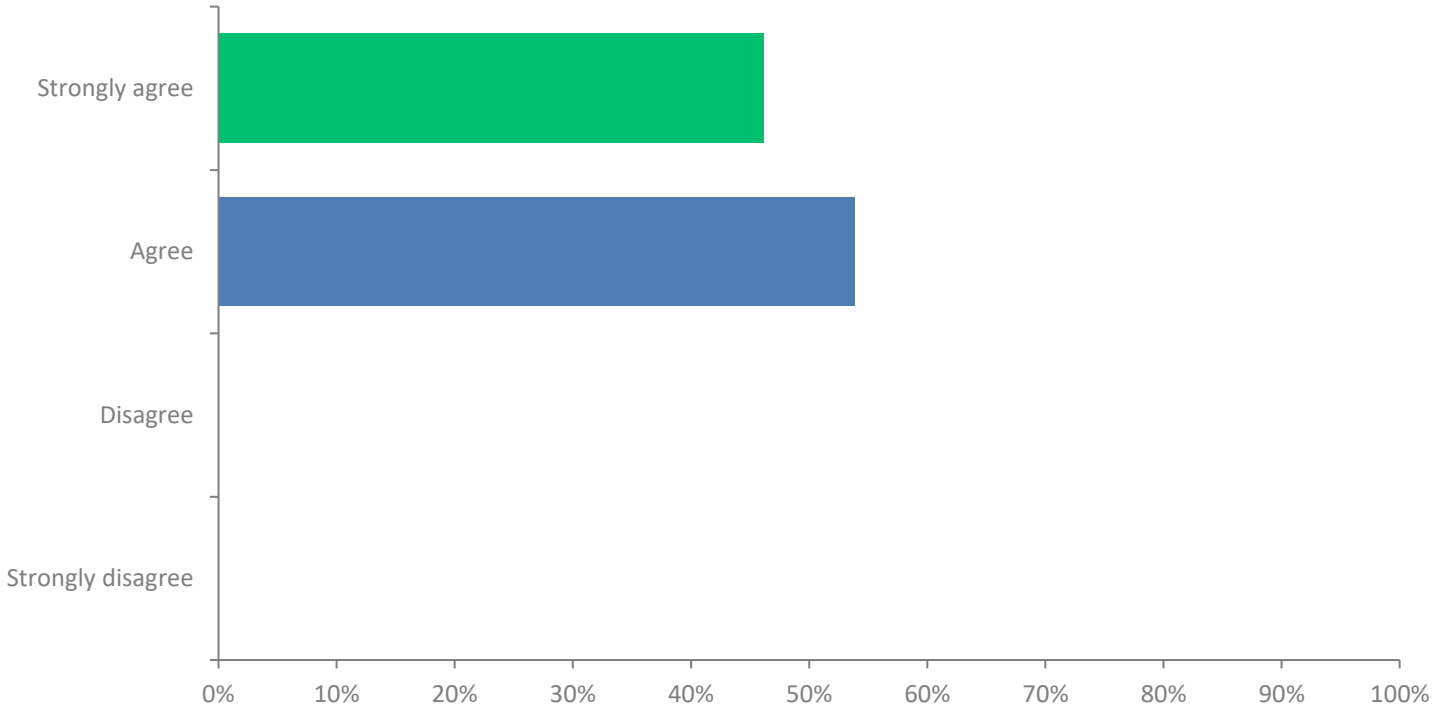
Q3: The length of the meeting(s) is right.

Answered: 13 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	38.46%	5
Agree	61.54%	8
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Q4: The agenda is appropriate and supports the assurance required.

Answered: 13 Skipped: 0



Q4: The agenda is appropriate and supports the assurance required.

Answered: 13 Skipped: 0

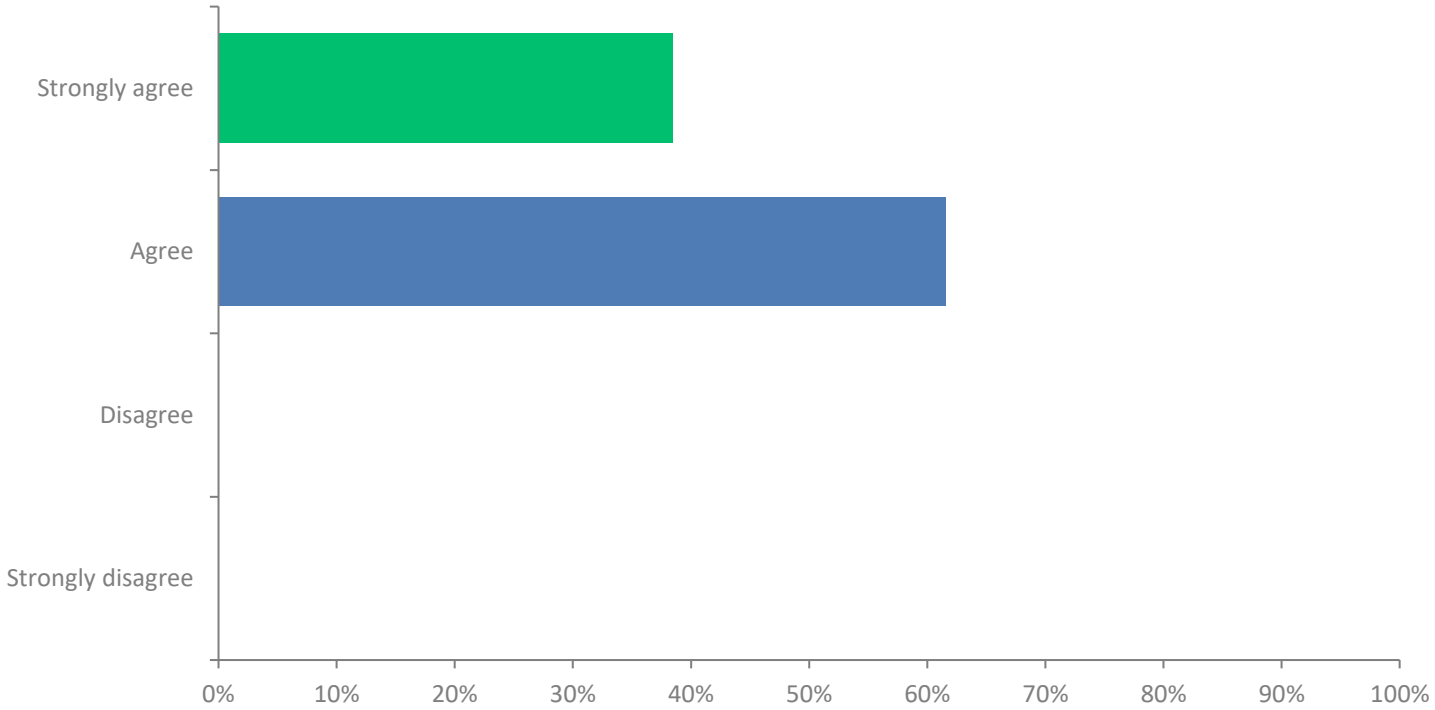
ANSWER CHOICES	RESPONSES	
Strongly agree	46.15%	6
Agree	53.85%	7
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Comments

- Significant work has been undertaken around risk tolerance and this has also featured appropriately in the associated Assurance Committees, especially linking target and tolerance scores
- Perhaps more discussion about place and health inequalities
- We have got much better at this over the years - driven by the PAF and KPIs.

Q5: The engagement/ patient stories are working well?

Answered: 13 Skipped: 0



Q5: The engagement/ patient stories are working well?

Answered: 13 Skipped: 0

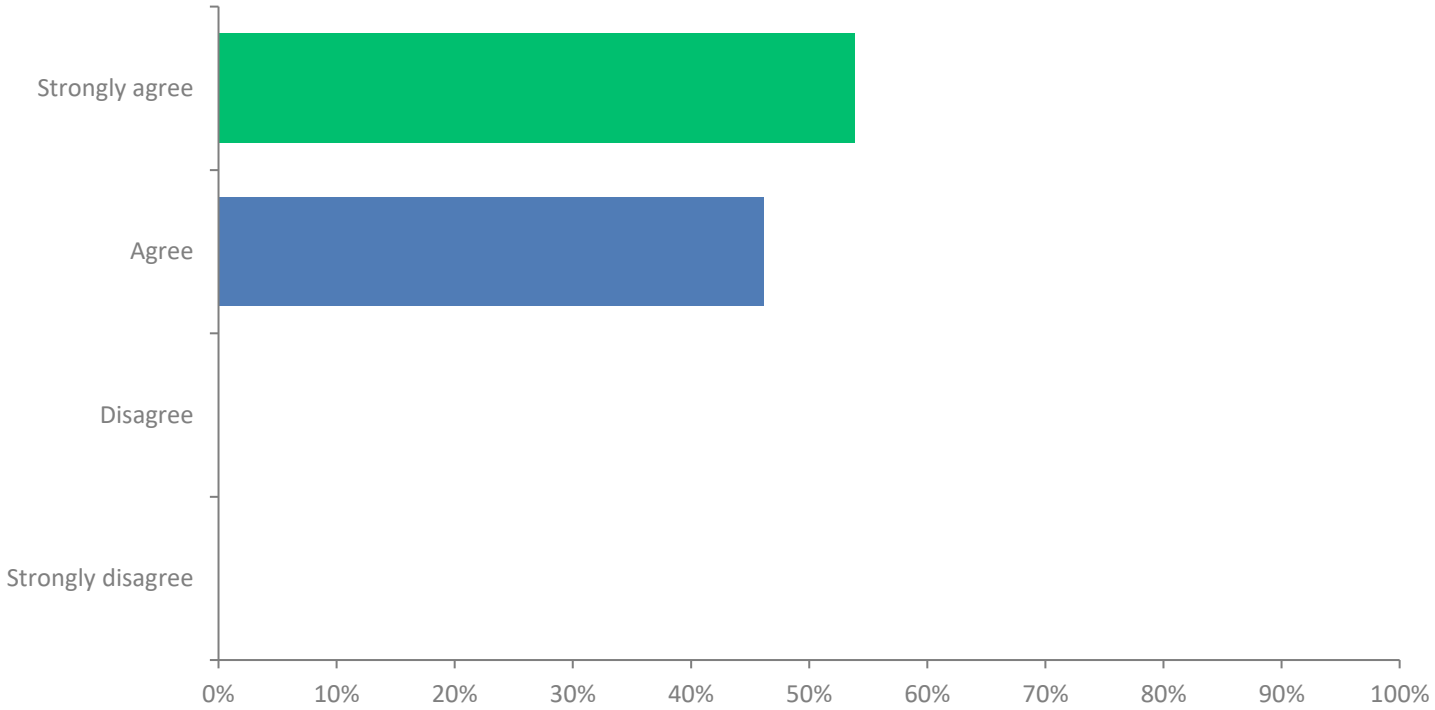
ANSWER CHOICES	RESPONSES	
Strongly agree	38.46%	5
Agree	61.54%	8
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Comments

- We just need to make sure we balance the negative stories with the positive ones. There are only six opportunities a year. Is this enough? Should we introduce monthly?
- Perhaps more 'in person' or films of the patients would be more powerful
- Wonder if we can share these stories wider, e.g. new senior management forum

Q6: The escalation from the Board Committees is working as it should be

Answered: 13 Skipped: 0



Q6: The escalation from the Board Committees is working as it should be

Answered: 13 Skipped: 0

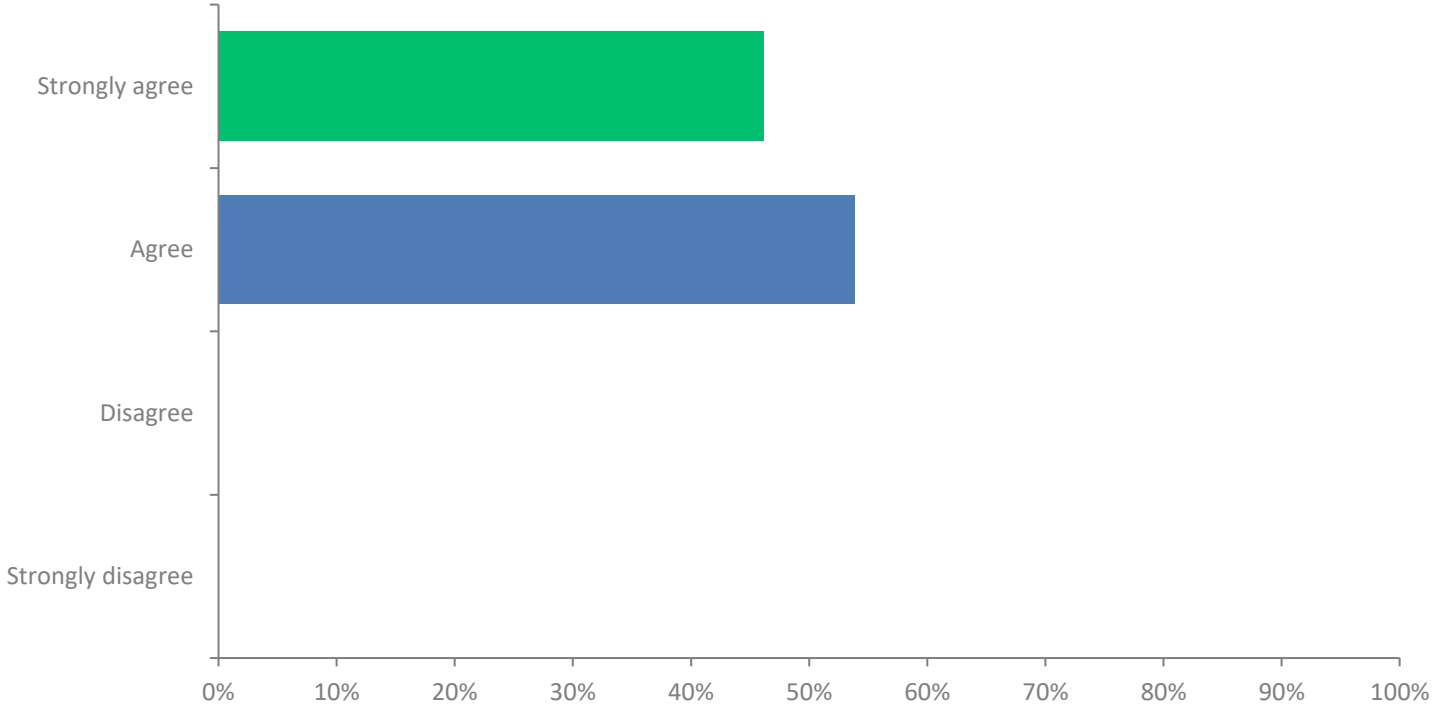
ANSWER CHOICES	RESPONSES	
Strongly agree	53.85%	7
Agree	46.15%	6
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Comments

- Very strong element of how we do things. Sub-committees working well.

Q7: Strategic risks are a priority for the Board and are captured and discussed sufficiently

Answered: 13 Skipped: 0



Q7: Strategic risks are a priority for the Board and are captured and discussed sufficiently

Answered: 13 Skipped: 0

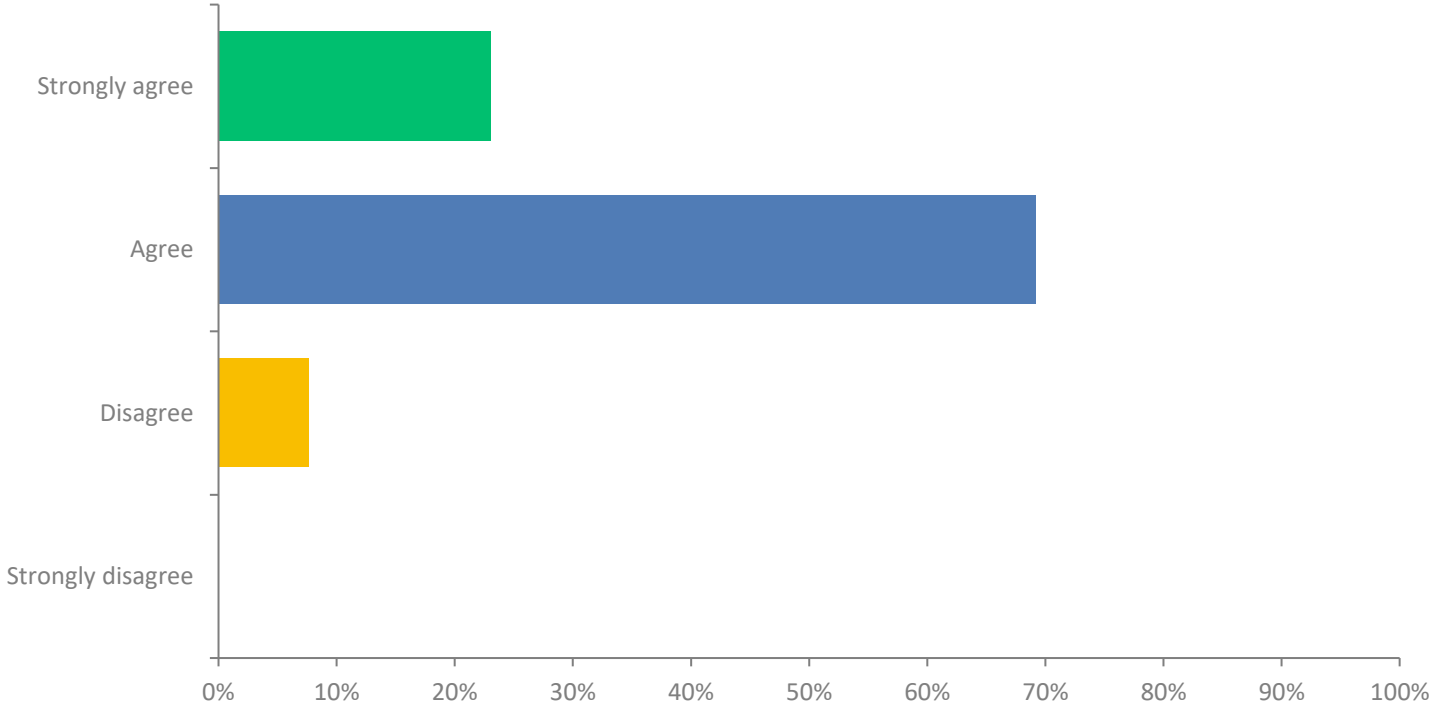
ANSWER CHOICES	RESPONSES	
Strongly agree	46.15%	6
Agree	53.85%	7
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Comments

- I think we could focus a bit more a couple of times per year into the detail
- Significant work has been undertaken around risk tolerance and this has also featured appropriately in the associated Assurance Committees, especially linking target and tolerance scores

Q8: Reports are clear and concise, providing the Board with robust information and effective assurance

Answered: 13 Skipped: 0



Q8: Reports are clear and concise, providing the Board with robust information and effective assurance

Answered: 13 Skipped: 0

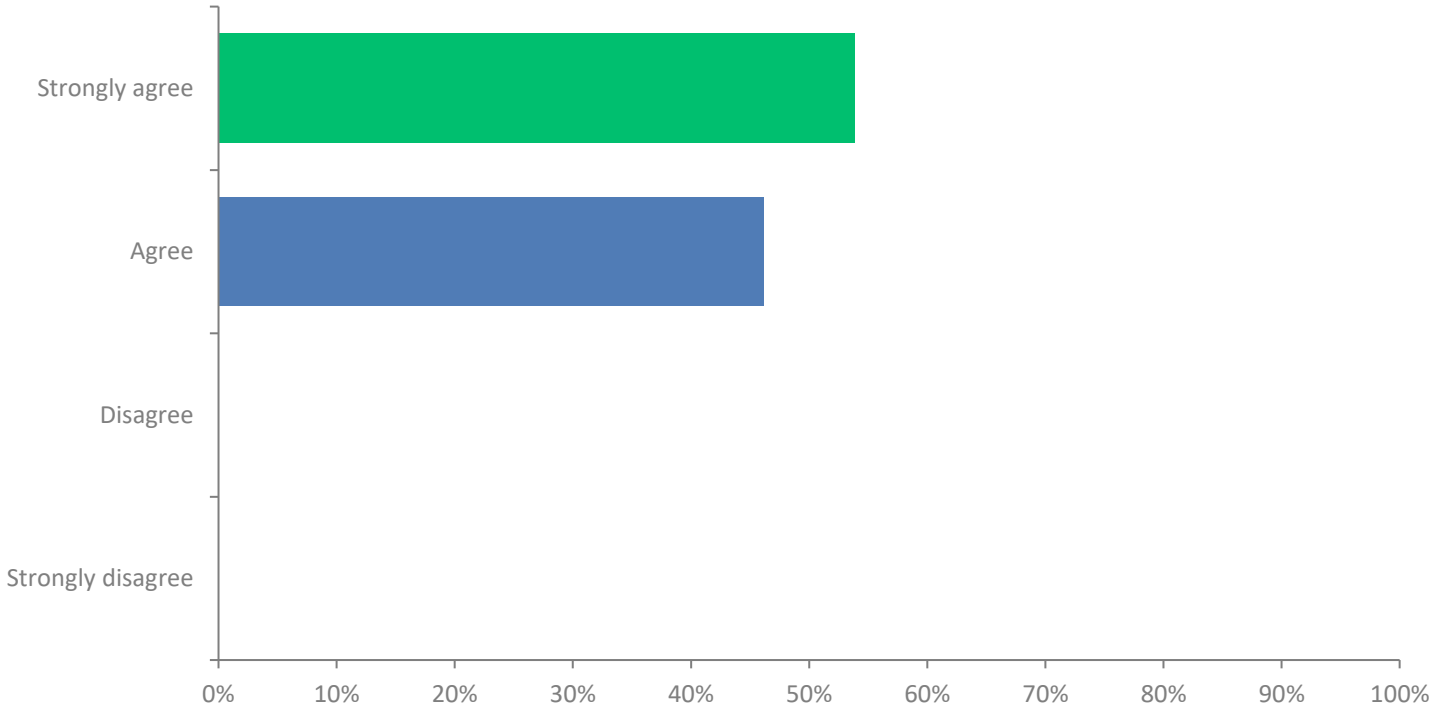
ANSWER CHOICES	RESPONSES	
Strongly agree	23.08%	3
Agree	69.23%	9
Disagree	7.69%	1
Strongly disagree	0%	0
TOTAL		13

Comments

- Still work to do with pithy and 'nailed' exec summaries and maybe using shadow board colleagues to help?
- some exec summaries could be stronger and reports that merely add a multipage report with no summary areto be avoided if possible
- Reports have generally improved over time
- We can do better at this. Always a challenge to get right in terms of detail versus summary
- Have got far better - could still be shorter. The Exec summaries are good

Q9: There is robust and appropriate challenge by all members of the Board.

Answered: 13 Skipped: 0



Q9: There is robust and appropriate challenge by all members of the Board.

Answered: 13 Skipped: 0

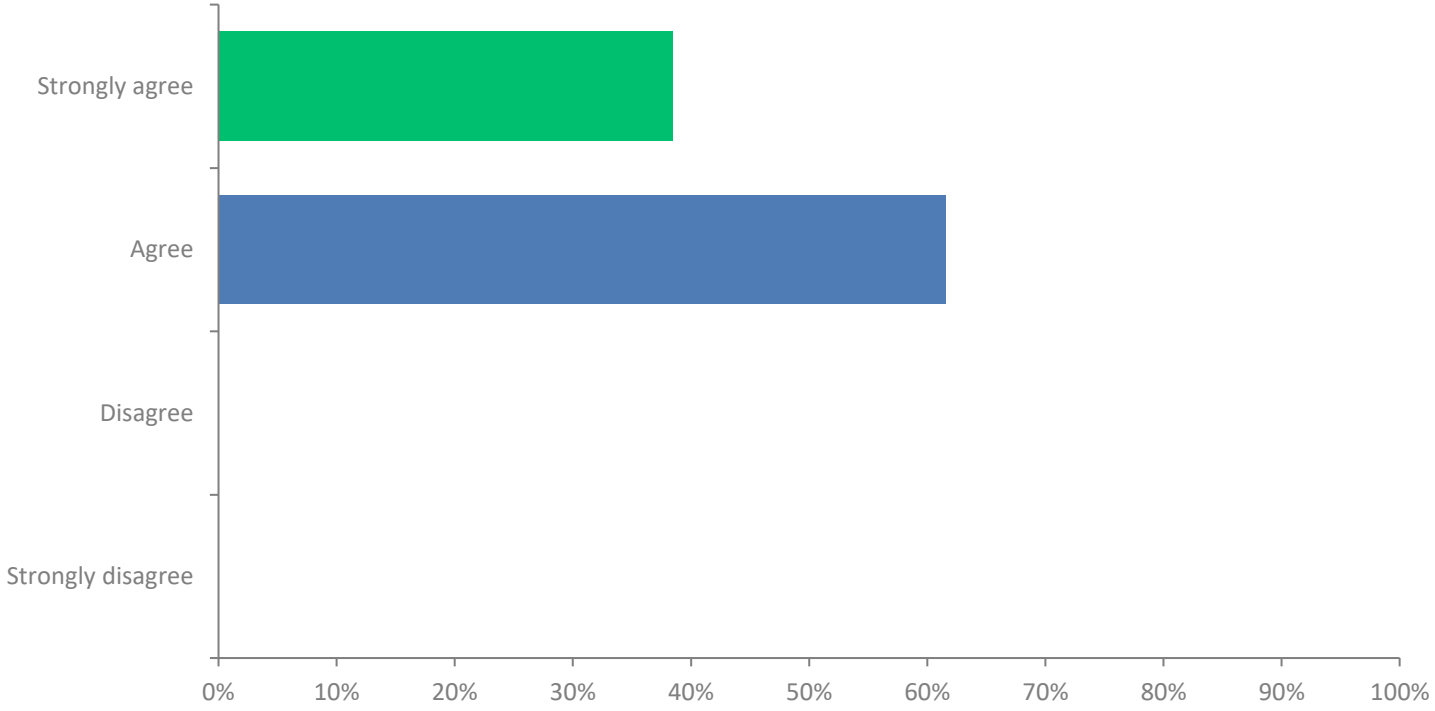
ANSWER CHOICES	RESPONSES	
Strongly agree	53.85%	7
Agree	46.15%	6
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Comments

- Appears to have grown into a psychologically safe space for people to speak up.

Q10: Each agenda item is ‘closed off’ with a clear conclusion and actions.

Answered: 13 Skipped: 0



Q10: Each agenda item is ‘closed off’ with a clear conclusion and actions.

Answered: 13 Skipped: 0

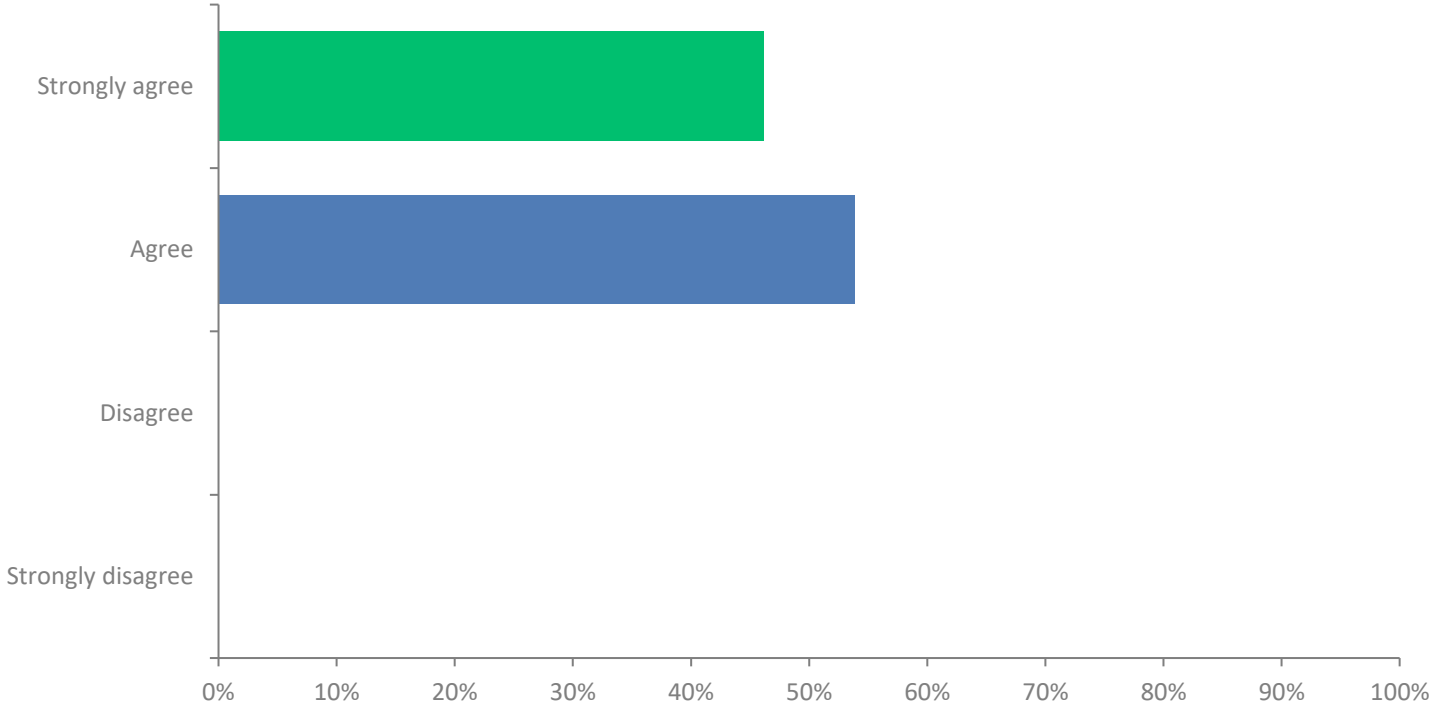
ANSWER CHOICES	RESPONSES	
Strongly agree	38.46%	5
Agree	61.54%	8
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Comments

- Usually - we could all get a bit better in our committees at making sure we do this

Q11: Board Development sessions help support the strategic objectives and development aims of the Board.

Answered: 13 Skipped: 0



Q11: Board Development sessions help support the strategic objectives and development aims of the Board.

Answered: 13 Skipped: 0

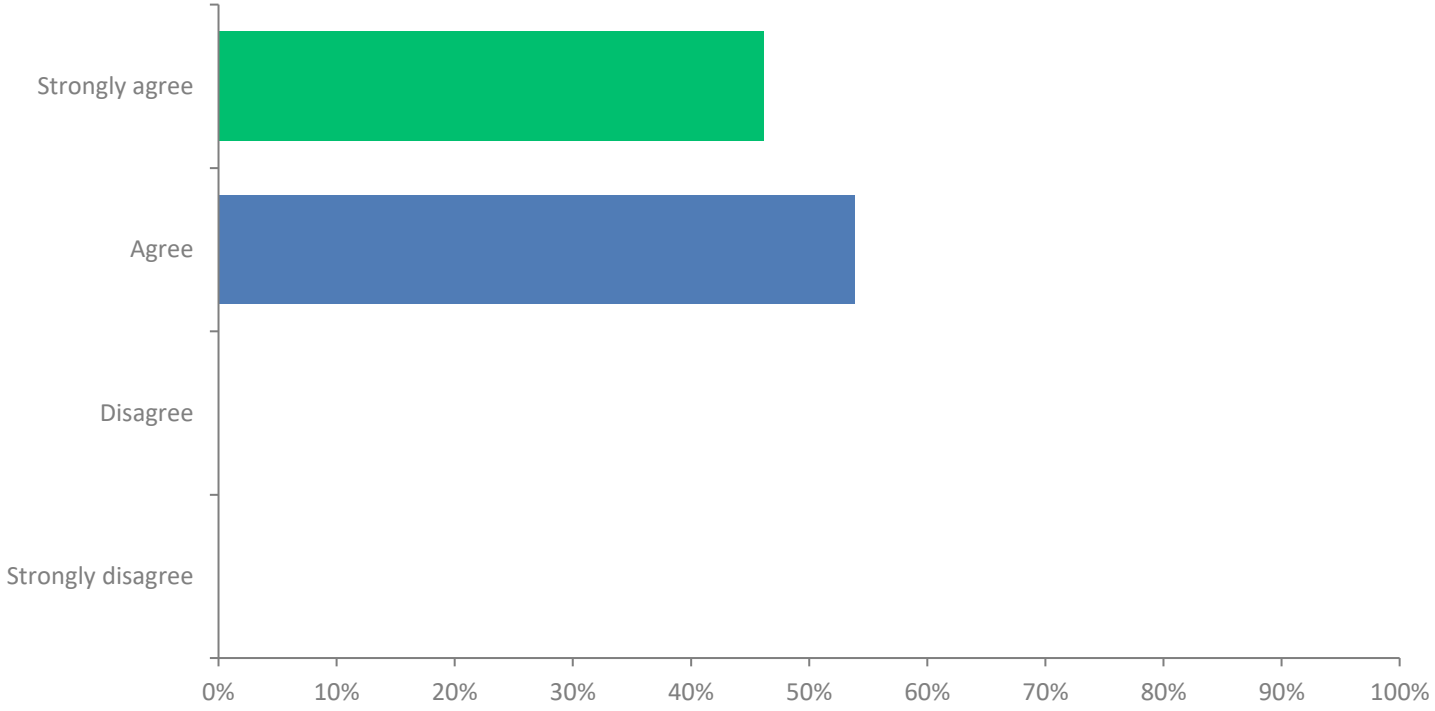
ANSWER CHOICES	RESPONSES	
Strongly agree	46.15%	6
Agree	53.85%	7
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Comments

- Maybe more time could be given to enhancing board function (becoming an excellent board)
- They are extremely valuable - and a chance to think more laterally around the issues we face

Q12: The frequency of development sessions are sufficient to help support the Board achieve its aims.

Answered: 13 Skipped: 0



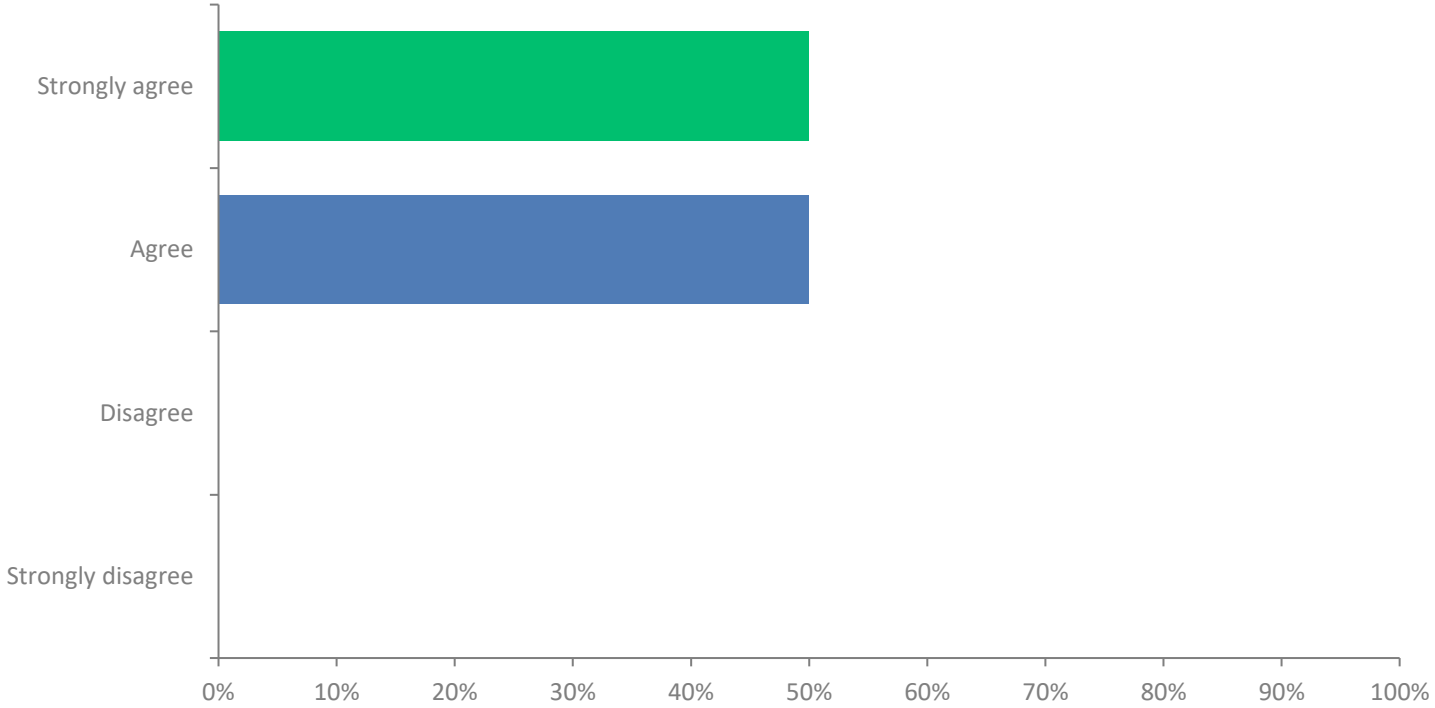
Q12: The frequency of development sessions are sufficient to help support the Board achieve its aims.

Answered: 13 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	46.15%	6
Agree	53.85%	7
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		13

Q13: The subjects covered in the development sessions are appropriate.

Answered: 12 Skipped: 1



Q13: The subjects covered in the development sessions are appropriate.

Answered: 12 Skipped: 1

ANSWER CHOICES	RESPONSES	
Strongly agree	50.0%	6
Agree	50.0%	6
Disagree	0%	0
Strongly disagree	0%	0
TOTAL		12

Comments

- Maybe some time to allow the board to discuss/develop the vision and future possibilities of the trust

Q14: List any suggested topics for future Board Development.

- Leadership Competencies - what this means for NEDs and Execs going forward
- Phase 2 Newton work (future actions for WHH, partners and place) - maintaining TB oversight
- Health Inequalities - population health and WHH role in improving health / role of assurance committees etc

- Quality improvement methodology would help with the making data count agenda this may have been done previously but a refresh may be helpful

- Role as charity trustees

- A published advanced cycle of business for Board Development, timed for the NHS year?

Included in comments for other questions:

- Maybe some time to allow the board to discuss/develop the vision and future possibilities of the trust

- Maybe more time could be given to enhancing board function (becoming an excellent board)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/04/017**			
SUBJECT:	**Draft Performance Assurance Framework Review 2024/25**			
DATE OF MEETING:	3rd April 2024			
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer			
EXECUTIVE DIRECTOR SPONSOR:	Jane Hurst – Chief Finance 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.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
		Yes	**No**	**N/A**

	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	The 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: • Amendment to the content and purpose of the Quality People and Sustainability (QPS) Review, to be led by performance and objectives set in the Care Group's 2024/25 Plan on a Page. • Updates to reflect changes to the organisation including team names and job titles. • Removal of reference to the Operational Management Sub Committee. If the remit of the newly established Improvement meeting has an impact on the 2024/25 PAF, an addendum will be put forward to FSC and Trust Board.		
PURPOSE: *(please select as appropriate)*	Approval ✓	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/24/03/240	
	Date of meeting	27/02/2024	

	Summary of Outcome	PAF changes supported at FSC.
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Draft Performance Assurance Framework Review 2024/25	AGENDA REF:	BM/24/04/017

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.
these changes.

2. KEY ELEMENTS

The following amendments are being proposed to the PAF and have been incorporated as track changes into the draft updated PAF in **Appendix A**.

- Amendments have been made to the content and purpose of the Quality People and Sustainability (QPS) Quarterly Performance Review (section 3.1.4). This chiefly includes amendments to the structure and content of QPS, which will be led by performance and objectives set through the Care Group's Business Planning discussions and Plan on a Page produced in April 2024. QPS dashboards will be created to support the measurement of Care Group performance against objectives.

- The PAF has been updated to reflect changes to the organisation including team names and job titles.

- Removal of reference to the Operational Management Sub Committee (OMS).

An Improvement meeting is currently in the process of being scoped out by the Executive Team. If the remit of the Improvement meeting has an impact on any aspect of the Trust's Performance Assurance Framework, then an addendum will be put forward to the proposed 2024/25 PAF and presented at a future Finance and Sustainability Committee (FSC) for support.

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 2023~~April 2024

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

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 2023/24, as the Integrated Care Systems & Boards (ICSs) & (ICBs) develop and mature, additional changes to the PAF may be required.

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.. This section also contains additional information around the Trust's Financial Performance including the capital programme.
- 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.

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**~~

~~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.~~

~~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~~4 QPS ~~Executive Team~~Quarterly Performance 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 against signed off Business Plans and will look at any additional support required to address ~~these~~ barriers preventing strategic priorities from delivery. The Care Group Triumvirate will be required to attend this forum ~~twice~~ four times ~~a~~per year and present their position alongside a 'QPS Performance Dashboard', which will highlig~~htht~~hting ~~any~~ key Care Group priorities set at business planning, as well as performance~~areas of variation~~. Alongside the dashboard, the Care Group Triumvirate will present on~~, 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~~quarterly 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,~~will review and update 'Business Planning Dashboards' in relation to Quality & Governance and Operational Performance (Quality and Performance), People (People) and Finance (Sustainability) that have been created based on the priorities set out at Business Planning. The Dashboards will monitor achievement against priorities, and will track Care Group delivery against Quality, People and Finance goals and targets. ~~, that is triangulated to reflect the requirements and focus of the Trust Board~~. The ~~slides~~ dashboards 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.~~

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.

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.~~4~~5 Leadership Observational Rounds

Non-Executive & Executive Leadership Observational rounds have been in place since 2022/23, and focus on positive interactions, celebrating success, and utilising 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 take place 6 times per year and feedback will be collated as evidence as part of the CQC well led domain.

3.1.~~5~~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.~~6~~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~~ Executive Team	
Trust Level	Executive Team Finance & Sustainability Committee Strategic People Committee Quality Assurance Committee Clinical Oversight Recovery Committee Trust Board	

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 2024~~April 2025 as part of the annual planning cycle. The PAF will be reviewed and updated as appropriate as new guidance emerges in year.

Appendix 1 - Trust Accountability, Responsibility and Information Reporting Structure – "Ward/Department" to Board

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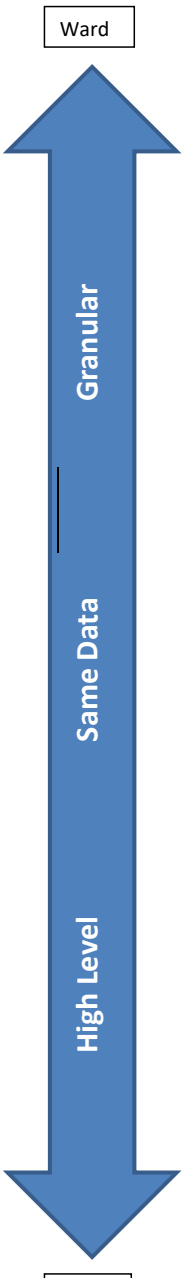

CBU/Ward/Departmental

- CBUs/Wards/department leaders.
- Review performance and identify risk at granular level weekly and take corrective action as appropriate.
- CBU Triumvirates report up Care Group Triumvirates.

Care Group Triumvirates

- Full review of performance at CBU level.
- Review, confirm and identify any risk/issues with agreement of remedial action plans. Risk to be reported through Risk Review Group.
- Support CBUs to improve performance in identified areas.
- Monitoring of remedial actions arising from QPS.

Executive Team

Monthly assurance updates from the: CBU Integrated Performance Report and QPS Executive Team Review (CBU/Care Groups)

- ~~Executive Committee receives monthly assurance updates from the Operational Management Subcommittee.~~
- Executive Committee holds Care Groups to account via the QPS.
- Provide support to Care Groups to address identified performance issues.

Board Committees

- Executive Director/Senior Leaders attend committee meetings.
- Board Committees review their performance reports/dashboards.
- Deep dives requested by Committee where there is variation in performance.
- Relevant committees assure Board through key issues reports and escalates any issues to Trust Board.

Trust Board

- Integrated Performance Report presented by Executive Directors.
- Receiving concerns raised by Committee Chairs.
- Board request additional actions and assurance where necessary.
- Bi-Monthly meeting.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/24/04/018**	
SUBJECT:	**Integrated Performance Report Refresh**	
DATE OF MEETING:	3 April 2024	
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Kimberley Salmon-Jamieson – Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer 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. **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#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	

<table>
<tr><td rowspan="7">LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="4">Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</td></tr>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td rowspan="7"></td><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>EXECUTIVE SUMMARY (KEY ISSUES):</td><td colspan="4">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).</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval ✓</td><td colspan="2">Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to approve the proposed amendments to the IPR Dashboard for 2024/25.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Strategic People Committee
Finance + Sustainability Committee
Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">SPC/24/02/207
FSC/24/02/217
QAC/24/03/316</td></tr>
<tr><td>Date of meeting</td><td colspan="3">21/08/2024
28/02/2024
12/03/2024</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3">Amendments approved at committee level.</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Whole FOIA Exemption</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report Refresh	AGENDA REF:	BM/24/04/018

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. Following support from the relevant subcommittees (QAC, FSC and SPC) The Trust Board is asked to support these changes.

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	
30. Maternity 3rd and 4th Degree tears	It has been agreed to remove this indicator as this process is managed internally on the Maternity Dashboard, which is continuously monitored by the Director of Midwifery to ensure the maternity targets are being met. There is a significant improvement in both metrics.
31. Maternity Pregnancy Bookings before 10 weeks and 13 weeks	It has been agreed to remove this indicator as this process is managed internally on the Maternity Dashboard, which is continuously monitored by the Director of Midwifery to ensure targets are being met. There is a significant improvement in both metrics.
Access & Performance	

39. Cancer 14 Days Target: 93%	14-day targets to be removed, as this standard is no longer monitored for compliance nationally. It is important to note, that in order to achieve the 28 Faster Day Standard (FDS), there will be a requirement for patients to have their first outpatient appointment in 2 weeks or less and this continues to be monitored internally at Performance Review Group (PRG). For supporting evidence to the '28-day FDS', the cancer 14 day will remain in the IPR under the '28-day FDS', alongside narrative around why this is relevant. Referral data is still submitted against this in order to assess data completeness against the 28-day FDS.
40. Breast Symptoms 14 Days Target: 93%	
66. Day Cases	To be replaced by additional theatre metrics (Capped Theatre Utilisation and Theatre Productivity which are more appropriate for monitoring the effectiveness of theatres utilisation/productivity.
Workforce	
73. Safeguarding Training Target: Trajectory	The Safeguarding Training compliance will be combined into the overall Core and Mandatory Training KPI, as detailed under the **Updated Workforce Indicators** section of the report. The organisation will still be able to report on individual core and mandatory training subject compliance should this level of detail be required. Safeguarding training compliance in January 2024 was 86% which is above target.
Finance	
There are no Finance and Sustainability indicators recommended to be removed at this time.	

Updated Indicators

Table 2 provides details of updates required to Trust Indicators.

Table 2: Indicators to be Updated

KPI	Proposed Change	Rationale
Quality		
1. Incidents	IPR to show patient safety incident investigation (PSII) data instead of serious incident data. A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Additional graphs to include: • Quantity of 'prevention of future death orders' • PSIIs recorded in month.	Nationally incidents are no longer referred to as SIs. This has been replaced by PSIIs in accordance with the nationally mandated Patient Safety Incident Response Framework.
12. Pressure Ulcers	Removal of Category 4 pressure ulcers graph.	Due to no category 4 Pressure ulcers being recorded over the past 24 months, category 4 pressure ulcers will be included with pressure 3

	Category 3 pressure ulcers graph to be amended to include Category 4 pressure ulcers.	pressure ulcers, in 'Category 3+ Ulcers'.
15. Care Hours Per Patient Day (CHPPD)	Removal of CHPPD graph 'by staff group'.	No longer a Trust requirement to monitor by staff group.
19. Complaints	Graph to be included on the quantity of reopened complaints by month.	To monitor the number of complaints which are being reopened within the Trust.
22. Mixed Sex Accommodation (Non-ITU only)	'ITU breaches' graph to be monitored as the KPI for Mixed Sex Accommodation. Currently, 'non-ITU breaches'. The KPI will be as per below: ***22. Mixed Sex Accommodation (ITU)***	Due to no Mixed Sex Accommodation breaches being recorded outside of ITU over the past 24 months, it will be more effective to monitor ITU breaches.
27. Ward Moves between 10pm and 6am	Removal of the current daily ward moves between 10pm and 6am. KPI to be replaced by monthly out of hour (10pm-6am) ward moves, capturing patients with an 'alert' only. The alert includes patients with dementia, learning disability and/or a mental health alert. The KPI will be as per below: ***27. Quantity of Ward Moves between 10pm and 6am, for patients with an alert*** Additional graphs to support the KPI to include: • monthly out of hour (10pm-6am) ward moves graph. • monthly average number of Ward moves (following A1 admission).	To increase Trust understanding of concerning Ward Moves (Ward moves where the patient has an alert, or where patients are being moved multiple time within a hospital admission).
28. Acute Kidney Injury (AKI) – number of AKIs reported	To include target based on in month performance for the previous year. Additional graph to include patients with Community acquired AKIs.	To improve SPC assurance and variation measurement of AKIs and improve the ability to detect special cause assurance and variation. To identify how many AKIs are community acquired AKIs.
Access & Performance		

65. Number of patients waiting 65+ weeks Target: Trajectory	To change the KPI to monitor 52+ week wait rather than 65+ week wait, as per below: ***65. Number of patients waiting 52+ weeks*** ***Target: National and Local Trajectory for 52+ week wait:*** • National Trajectory, which aims for a clearance of 52+ week waiters by March 2025 • Local Trajectory, which will be a trajectory for what we are funded to deliver (which will be agreed at Trust Board in April 2024)	The elective recovery plan was published in February 2022 and sets targets to reduce long waits for elective treatment – namely, to eliminate waits of over 104 weeks by July 2022, waits of over 78 weeks by April 2023, 65 week waits by March 2024, and 52 week waits by March 2025.
61. SDEC - % of Zero Length of Stay Admissions	Type 5 (previously SDEC) activity to be measured, rather than Length of Stay, as per below: ***61. Type 5 Activity*** Historical Type 5 attendances (pre-November 2023) to be provided as an estimate of what may have been considered a 'Type 5' attendance. Narrative will be included to recognise the month in which 'Type 5' attendances began. In July 2024, Type 5 will be expanding to include all the below assessment areas: • Gynaecology Assessment Unit (GAU) • Frailty Assessment Unit (FAU) • Paediatric Assessment Unit (PAU) This inclusion will be reflected in the August 2024 IPR.	Following guidance from NHS Digital, since November 2023 we have been recording 'SDEC attendances' as a Type 5 A&E attendance instead, to include within ECDS. Type 5 attendances are for same day emergency care, they are not the same as an attendance at an Urgent Care Centre or Accident and Emergency department.
Workforce		
72. Core and Mandatory Training Target: 85%	To combine Safeguarding Training compliance (currently KPI **74** in the IPR) with the Core Mandatory Training compliance KPI. The target is to remain at **85%.**	Safeguarding training is part of the NHS Core Skills Training Framework (CSTF) which forms part of the Trust's core and mandatory training requirements. Due to changes to Safeguarding training, a trajectory was set to support achievement of the 85% target, with the training reported separately to ensure oversight of the trajectory. The Trust has now moved beyond the trajectory timescale and the target has been achieved.
Finance		
There are no Finance and Sustainability indicators recommended to be updated at this time.		

To note regarding the Quality section, there are current discussions around Sepsis will guide amendments to Sepsis-related KPIs in the IPR. Following medical steer, any adjustments needed to Sepsis KPIs will be put forward to QAC, and the following Trust Board.

New Indicators

Table 3 provides details of newly proposed Trust Indicators.

Table 3: New Indicators

KPI	Measurement Criteria	Rationale
Quality		
There are no new Quality indicators recommended at this time.		
Access & Performance		
No Criteria to reside	To be included as a separate KPI – currently included on IPR, however, not included as a separate KPI for the Trust Board.	To enable the Trust Board to closely monitor No Criteria to reside within the Trust Board report.
Capped Theatre Utilisation	Touch time within planned session vs planned session time - General Surgery. **Target:** 85%	Uncapped Utilisation is currently monitored within the IPR; however, Capped Utilisation and productivity are not. Model hospital highlights the Trust is currently in the lowest quartile for uncapped and capped theatre utilisation. Inclusion of these additional metrics will enable the Trust Board to closely monitor theatre metrics.
Theatre Productivity	Touch time within planned session, *removing any gaps between operations*, vs total available minutes within session. **Target:** 85%	
Virtual Appointments	Percentage of virtual outpatient appointments carried out by the Trust. **Target:** 20%	
Workforce		
There are no new workforce indicators recommended at this time.		
Finance		
There are no new Finance and Sustainability indicators recommended at this time		

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		
Theatre KPIs	All theatre metrics, including cancelled for non-clinical reason **(52)**, cancelled for a 2nd time (**53**) and not readmitted within 28 days (**54**) are to be displayed together in the IPR.	To increase interpretability of theatre metrics
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 75 to 73 as follows:

	2023/24	2024/25
Quality	31	29
Access & Performance	30	31
Workforce	7	6
Finance	7	7
Total	**75**	**73**

The Trust Board is asked:

- **To approve the proposed amendments to the IPR Dashboard for 2024/25.**

If approved by the Trust Board, these changes will be implemented from the June Board report (April's data).

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Quality & Assurance Committee
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to approve the proposed amendments to the IPR Dashboard for 2024/25.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting - Part 1

Wednesday 3 April 2024
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

Supplementary Pack

BM/24/04/019– Compliance Update Q3 Report *(Quality Assurance Committee 13.02.24)*
BM/24/04/020 - Infection Prevention & Control Q3 Update *(Quality Assurance Committee 13.02.24)*
BM/24/04/021 - Learning from Experience Summary Report Q3 *(Quality Assurance Committee 13.02.24)*
BM/24/04/022 - Learning from Deaths Q3 *(Quality Assurance Committee 12.03.24)*
BM/24/04/023 - Mortuary Inquiry (Fuller) Phase 1 – Gap Analysis *(Quality Assurance Committee 12.03.24)*
BM/24/04/024 - Paediatric Audiology Brainstem Response Update Report *(Quality Assurance Committee 12.03.24)*
BM/24/04/025 - Digital Strategy Group Update (Finance & Sustainability Committee 27.03.24)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/24/04/019 – BM/24/04/125**	
SUBJECT:	**Supplementary Papers**	
DATE OF MEETING:	3 April 2024	
AUTHOR(S):	John Culshaw, Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
	SO1: We will.. Always put our patients first delivering safer and effective care and an excellent patient experience.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All Risks	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			
Further Information: ***Each paper is individually marked from September 2023***			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			
3. Foster good relations between people who share a protected characteristic and those who do not			
Further Information: ***Each paper is individually marked from September 2023***			

EXECUTIVE SUMMARY *(KEY ISSUES):*

In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 3 April 2024

No actions are required from the Trust Board they are provided for information only.
The papers provided are:

- **BM/24/04/019–** Compliance Update Q3 Report *(Quality Assurance Committee 13.02.24)*
- **BM/24/04/020 -** Infection Prevention & Control Q3 Update *(Quality Assurance Committee 13.02.24)*
- **BM/24/04/021 -** Learning from Experience Summary Report Q3 *(Quality Assurance Committee 13.02.24)*

	• **BM/24/04/022 -** Learning from Deaths Q3 *(Quality Assurance Committee 12.03.24)* • **BM/24/04/023 -** Mortuary Inquiry (Fuller) Phase 1 – Gap Analysis *(Quality Assurance Committee 12.03.24)* • **BM/24/04/024 -** Paediatric Audiology Brainstem Response Update Report *(Quality Assurance Committee 12.03.24)* • **BM/24/04/025 -** Digital Strategy Group Update (Finance & Sustainability Committee 27.03.24)		
PURPOSE: ***(please select as appropriate)***	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees, as listed above	
	Agenda Ref.	As listed above	
	Date of meeting	As noted above	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE
13 February 2024

Compliance Update

Kimberley Salmon- Jamieson, Chief Nurse, Deputy Chief Executive
Layla Alani Director of Governance, Deputy Chief Nurse

Contents

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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Single Assessment Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- 5 domains remain: referred to as ‘key questions’
- System view – Living Well Hub is good example as evidence (within presentation)
    - KLOEs now referenced as ‘quality statements alongside Behavioural Framework;
        - ‘I and we’ (33)

Assessed against 6 evidential categories and standards – all core services:

People’s Experiences (Patients, families, carers)	Feedback from staff/ leaders	Feedback from partners	Observations of care	Outcomes of care	Processes

- Assessment = data driven. No inspection necessary
    - National data sets, without Trust approval
    - Patient level data
    - Performance assessment – service specific
    - Internal / external report checks – red flag data

- CQC will provide an update session for WHH, February/ March 2024

Maternity Update

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- CQC Maternity Inspection was undertaken on 14th September 2023
- Factual accuracy concluded and final report published on 17th January 2024
- 0 Must Do's identified
- 5 Should Do's identified as follows, action plan is in place and will be monitored by the Quality Assurance Committee:

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

CQC engagement and risk meeting

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Held on Monday 29 January 2024 at the request of the CQC as part of their new inspection and review methods
- CQC identified three core services and requested additional assurance (summary slides detailed within):
  - Urgent and Emergency Care
  - Medicine
  - Surgery
- Each presented our current position, challenges and plans in place for assurance
- Followed by further information requests received from the CQC
- Presentation of Governance structures and systems provided
- Well led report Good Governance Institute shared
- Await formal letter following CQC Engagement and Risk Meeting. Progress any necessary action

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LIVING WELL

Supporting people to live well in Warrington
The *Living Well Hub* project – CQC Site Inspection 6th February 2024

Warrington Place Partners

Why do we need to support people to LIVE WELL in Warrington?

- ✓ Average healthy life expectancy in Warrington is around 65 years (but life expectancy is around 80 years)..

	Female	Male
Avg. Life Expectancy	83	79
Avg. Healthy Life Expectancy	65	64
Gap	**18**	**15**

Source: Public Health England

- ✓ Population of >65s projected to grow by 50% over next 20 years = significantly greater demand.
- ✓ Primary, secondary and social care services all currently over-subscribed.
- ✓ Scientific evidence tells us that 85% of what determines our health and wellbeing is related to community and economic connections; only 15% relates to medicine.
- ✓ National data suggests almost one-fifth of GP consultations are for 'social' or 'non-health' reasons.

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Living Well as part of Warrington Together

The three layers of the Hub “offer”

Clinical and non-clinical rooms and spaces for multiple providers to use in order to deliver service offers.

Rooms for booked and/or drop-in appointments with social prescribing team or link workers.

Open, welcoming space for the public to drop-in to start a conversation about health & wellbeing, pick up some information and/or get some basic advice and guidance.

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Example Timetable– Monday AM – Healthy Lifestyles

Time	Café Area	Open Space	Pod 1	Pod 2	Room 1	Group Room 1	Clinic Room 1	Clinic Room 2	Clinic Room 3	Room 2	Room 3	Room 4	Group Room 2	Group Room 3
09:00		LiveWire Healthy Lifestyles Adviser	torus foundation Torus Foundation Social Prescriber	Change Grow Live CGL (Substance Misuse) Rep	For general use		NHS Mersey Care Merseycare LD Wellbeing	NHS Warrington and Halton Teaching Hospitals Possibly: WHH Phlebotomy	mhm mentalhealthmatters Mental Health Matters Clinic Appts and Drop-In	LiveWire Weight management drop-in	MACMILLAN CANCER SUPPORT MacMillan Cancer Support Drop-In	Department for Work & Pensions DWP Drop-In	LiveWire Stop Smoking drop-in	WARRINGTON Borough Council Mental Health Outreach Positive Thoughts Course
09:30														
10:00														
10:30						NHS Warrington and Halton Teaching Hospitals WHH Cardiac Rehab								
11:00														
11:30														
12:00														
12:30														

Timetable as it stands – Monday PM & EVE – Women's Health

Time	Café Area	Open Space	Pod 1	Pod 2	Room 1	Group Room 1	Clinic Room 1	Clinic Room 2	Clinic Room 3	Room 2	Room 3	Room 4	Group Room 2	Group Room 3
13:00														
13:30			torus foundation Torus Foundation Social Prescriber	TALKING POINT WVA Talking Point Adviser	For general use	Menopause Education Sessions LiveWire	NHS Bridgewater Community Healthcare Bridgewater Bowel & Bladder Service	NHS Warrington and Halton Teaching Hospitals Pelvic Health Physiotherapy Clinic	mhm mentalhealthmatters Mental Health Matters Clinic Appts and Drop-In	LiveWire Weight management drop-in	MACMILLAN CANCER SUPPORT MacMillan Cancer Support Drop-In	Domestic Abuse Drop-in	NHS Mersey Care Merseycare LD Health Promotion	WARRINGTON Borough Council Mental Health Outreach Positive Thoughts Course
14:00														
14:30														
15:00														
15:30														
16:00														
16:30														
17:00					For general use		NHS Bridgewater Community Healthcare Possibly: Bridgewater Bowel & Bladder Service	NHS Cheshire and Merseyside Dr Steevart LARC						
17:30														
18:00	MENOPAUSE cafe Menopause café													
18:30														
19:00														
19:30														

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Next Steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Session offered by CQC regarding the new Single Assessment Framework - in discussion with the Director of Governance. Awaiting confirmation of date
- ‘Moving to Outstanding’ meeting to be reviewed alongside Single Assessment Framework requirements
- Enquiries will now be sent to all health providers via a ‘portal’ – no single point of contact to address enquiries. 0 enquiries outstanding
- Awaiting final outcome from CQC regarding Living Well Hub site inspection

Mock Inspection Programme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Area	Date of Mock Inspection
Medical Care	March 2024
Surgery	April 2024
Critical Care	May 2024
End of Life Care	June 2024
Outpatients	July 2024
Urgent and Emergency Care	Augus 2024

- Action plans will be tracked through governance meetings and Compliance Oversight Group
- ED action plan also monitored through ED Improvement Group
- Programmes of work also supported through Quality Improvement workstreams, quality priorities and CQUIN

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/24/02/299**			
SUBJECT:	**Infection Prevention and Control Report Quarter 3**			
DATE OF MEETING:	13 February 2024			
ACTION REQUIRED:	To Note			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		N/A	N/A	N/A
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	N/A	N/A	N/A
	Further Information/Comments: Nil			
EXECUTIVE SUMMARY	This report provides a summary of infection prevention and control activity for Quarter 3 (Q3) of the 2023/24 financial year (FY) and highlights the Trust's progress against infection prevention and control key performance indicators. Healthcare Associated Infection (HCAI) cases at end of Q3 are: - • E. coli bacteraemia 65 cases against an annual threshold of 54 • Klebsiella Spp. bacteraemia 17 cases against an annual threshold of 18 cases • P. aeruginosa bacteraemia 10 cases against an annual threshold of 2 cases • C. difficile 32 cases against an annual threshold of 36 cases • MRSA bacteraemia 0 cases and rolling 15 months MRSA bacteraemia free			

<table>
<tr><td></td><td colspan="3">

- MSSA bacteraemia 26 cases (no threshold)

Inpatient Covid-19 cases at end of Q3 are: -

- 388 (0-2 days)
- 73 (3-7 days)
- 111 (8-14 days – probable healthcare associated)
- 147 (15+ days – definite healthcare associated)

There were 12 inpatient Covid-19 outbreaks in Q1 – Q3:

- 6 mixed inpatient and staff outbreaks
- 6 inpatient only outbreaks

Outbreak Control Groups were established to manage the Covid-19 outbreaks with both Planned and Unplanned Care Groups.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note ✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="3">The Quality Assurance Committee is asked to receive and note the report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Infection Control Sub-Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">ICSC/24/01/239</td></tr>
<tr><td>Date of meeting</td><td colspan="2">18 January 2024</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit to Quality Assurance Committee</td></tr>
<tr><td>NEXT STEPS:
State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Choose an item.</td></tr>
</table>

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control Report Quarter 3	AGENDA REF:	QAC/24/02/299

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control (IPC) activity for Quarters 1 - 3 of the 2023/24 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) thresholds, continued response to Covid-19 cases and progress towards achieving the Infection Prevention Strategy.

There is a national ambition to halve Gram-negative bloodstream infections (GNBSI) by 2024. GNBSI include: - Escherichia coli (E. coli); Klebsiella species (Klebsiella spp.) and Pseudomonas aeruginosa (P. aeruginosa). NHS England (NHSE) set annual thresholds to minimise rates of *Clostridioides difficile* (*C. difficile*) and Gram-negative bloodstream infections (GNBSI).

The thresholds set for WHH for 2023/24 are shown in table 1.

Table 1: WHH HCAI Thresholds for 2023/2024

HCAI	WHH Threshold 2023/24
C. difficile	≤36
E. coli	≤54
Klebsiella spp.	≤18
P. aeruginosa	≤2

GNBSI and C. difficile cases meeting the definitions below are apportioned to acute trusts:

- **Hospital-onset healthcare-associated (HOHA) =** Specimen date is ≥3 days after the current admission date (where day of admission is day 1)

- **Community-onset healthcare-associated (COHA) =** is not categorised HOHA and the patient was discharged from the same reporting trust within 28 days prior to the specimen date (where date of discharge is day 1)

NHSE also set annual thresholds for all sub-Integrated Care Boards (ICB) geographical areas. These thresholds include all cases (comprising of the acute Trust and community cases).

The Cheshire and Merseyside ICB thresholds for 2023/24 are shown in table 2.

Table 2: Local ICB Sub-Group HCAI Thresholds for 2023/2024

C&M ICB	*C. difficile*	*E. coli*	*P. aeruginosa*	*Klebsiella spp.*
01X Halton	47	137	10	28
02E Warrington	45	130	5	37

The zero-tolerance threshold for avoidable cases of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia remains in place.

There is no threshold for Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia cases.

NHSE case definitions for Covid-19 are as follows with date of admission equalling day 1:

- Hospital-Onset Indeterminate Healthcare-Associated - First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission to Trust

A cluster of Covid-19 cases is defined as 2 cases arising within the same ward/department over a 14-day period. Further investigation is undertaken to assess if cases are linked, and if linked this is considered an outbreak and reporting is carried out in line with NHSE guidance.

2. KEY ELEMENTS

Healthcare Associated Infection Surveillance Data

RAG rating of Trust performance for HCAI by month is shown in Table 3.

Table 3: HCAI Surveillance Data

Indicator	Threshold	A	M	J	J	A	S	O	N	D	Total	In year status
C. difficile	≤ 36	1	1	2	5	4	6	4	3	6	32	Over trajectory
MRSA BSI	Zero	0	0	0	0	0	0	0	0	0	0	On trajectory
MSSA BSI	No target	1	2	3	4	1	5	5	2	3	26	No threshold
E. coli BSI	≤ 54	8	8	6	5	8	7	6	8	9	65	Over threshold
Klebsiella spp. BSI	≤ 18	0	3	0	1	1	1	3	5	3	17	Over trajectory
P. aeruginosa BSI	≤ 2	0	2	0	0	0	1	1	3	3	10	Over threshold

C. difficile: 13 cases reported in Q3 and over in year trajectory but within the annual threshold at the end of Q3. Ribotyping of Trust apportioned cases continues and no transmission has been identified between toxin positive cases.

MRSA Bacteraemia: Nil cases in Q3 and YTD. The Trust has been MRSA bacteraemia free for a rolling fifteen months.

MSSA Bacteraemia: 10 cases in Q3 and 26 cases YTD. The likely primary sources include: 4 skin and soft tissue infection; 3 central line associated; 3 endocarditis, 1 possible surgical site infection, 2 septic arthritis, 2 osteomyelitis, 2 other including discitis and psoas abscess and an infected haematoma and 9 with source unknown. Further review of the cases with unknown sources will take place to identify any areas for learning and improvement.

GNBSI: E. coli 23 cases, Klebsiella spp. 11 cases and P. aeruginosa 7 case reported in Q3. E. coli and P. aeruginosa are over the annual threshold, and Klebsiella cases are just below the annual threshold.

The GNBSI Prevention Group has been reformed and the GNBSI prevention action plan updated. Workstreams include : -

- Review findings from the audit of hepatobiliary cases
- Identify system level learning
- Continue work with the Quality Academy to introduce a nurse led protocol for urinary catheter removal
- Launch the Oral Care Policy to support prevention of hospital acquired pneumonia

Policy/Guideline/SOP Updates

The IPC Team have included a schedule of documents for review in the annual workplan and work has commenced to review and update these documents in line with the National IPC manual for England. The following documents have been updated and approved by the Infection Control Sub-Committee (ICSC): -

- Covid staff approach v13
- Scabies guidelines v2
- Revised SOP for Non-Elective Patient Testing for (Winter) Respiratory Viruses, Patient Placement & Infection Control Precautions (Adults / Children) v21
- Cleaning Standards Policy v1

Audit

During Q3, 22 audits were completed with results shown by Clinical Business Unit (CBU) in appendix 2. The audit tool is aligned to the NHS England National Infection Prevention and Control Manual and includes standard precautions. A summary of areas for improvement (list is not intended to be exhaustive) are included in table 4.

Table 4: Summary of Audit Findings

Element	Areas for improvement
Environment	General tidiness, high/low level dust, dusty IT equipment, storage of cleaning equipment, cluttered dirty utility/clean utility rooms, dusty fan blades, boxes floors impeding cleaning
Ward Kitchens	General tidiness, perishable items not stored in pest proof containers, labelling of staff food, recording of fridge temperatures, microwave cleanliness
Handling/Disposal of Linen	Correct storage of clean linen, used linen not being placed in a linen skip at the bedside, incorrect personal protective equipment for handing used linen
Departmental Waste	Waste segregation into correct waste stream for disposal
Safe Handling/Disposal of Sharps	Temporary closure system not activated
Patient Equipment (General)	Missing I am clean labels, some items dust and required cleaning
Personal Protective Equipment (PPE)	Overuse of gloves, readily available PPE for a patient with a high-risk infection
Short Term Catheter Management	Placement of catheter drainage bag and securing catheters
Care of Peripheral Intravenous Lines	Completion of ongoing monitoring charts
Isolation Precautions	Correct door signage, PPE not located outside isolation room
Hand Hygiene	Labelling of sinks for handwashing only, missed opportunity for handwashing after PPE removal

Concerns and issues requiring immediate action are reported to the nurse in charge at the time of the audit. Full audit findings are emailed to Ward Managers and an action plan to address findings is requested.

The re-audit schedule is set according to findings. For areas with lower scoring results, re-audit is completed sooner. All areas are monitored by an IPC and CBU Matron monthly visit and if concerns about IPC standards are identified, a repeat audit is completed.

Several actions are in place including: -

- Project to improve standards of environmental hygiene and equipment cleaning including standards for cleaners cupboards
- Audit tool education and action planning support for Ward Managers
- Implementation of the NHS Waste Strategy and education on waste segregation

Antimicrobial Stewardship

CQUIN03 IV Oral Switch

Antimicrobial stewardship is an objective in the IPC Strategy. The Trust is participating in the national Commissioning for Quality and Innovation (CQUIN) CCG3 which is concerned with prompt switching of intravenous (IV) antimicrobial to oral route of administration (IVOS) as soon as patients meet switching criteria. The lower the percentage equals better performance

This CQUIN includes an ambition to achieve 40% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria. The final results for Q1, Q2 and incomplete results for Q3 (not finalised at time of report writing) are shown in table 5.

Table 5 IVOS CQUIN results

Q1	Q2	Q3
28%	**22.86%**	**14.63%**

The IVOS decision aid tool was launched on medical wards with good feedback of usability and next steps include extending the use of the IVOS tool to the planned care division and surgical specialties (who do not currently use electronic forms for their ward round documentation).

Acute Trusts are required to take action to reduce broad-spectrum (UK Watch and Reserve category) antibiotic, in line with the UK five-year action plan for antimicrobial resistance 2019 to 2024. An updated national action plan will be published in 2024.

It is anticipated there will be a continued focus on reducing use of broad-spectrum antibiotics and the Antimicrobial Management Steering Group will continue to focus activity on promoting good practice to minimise broad-spectrum antibiotic usage.

Education and Training

Overall compliance with infection control mandatory training was 92% at the end of December 2023 (table 6). Mandatory training is available via eLearning, live training events and at corporate induction.

Table 6 Mandatory training Compliance

IPC Mandatory Training	A	M	J	J	A	S	O	N	D
Level 1 – Non-Clinical	94%	96%	94%	95%	95%	96%	95%	95%	96%
Level 2 - Clinical	83%	84%	85%	86%	86%	86%	87%	87%	87%
Overall compliance	**84%**	**90%**	**90%**	**91%**	**91%**	**91%**	**91%**	**91%**	**92%**

Environmental Hygiene

A programme of cleanliness monitoring is in place with frequency of auditing carried out according to the NHS Standards of Healthcare Cleanliness (2021). Audit results are emailed to ward/departmental managers and star ratings awarded according to scoring. All areas are scoring 4-star or 5-star ratings (out of a 5-star rating). Areas with reduced scores are given a 2-to-4-hour timescale to rectify concerns in functional risk 1 (highest risk areas) and functional risk 2 categories.

Efficacy audits were introduced in October 2023, which include representation from Estates, Facilities, IPC, and local area managers, as per the NHS Cleaning Standards. A schedule of fortnightly audits has been developed and is being implemented in Q4.

Incidents

Covid-19

Covid-19 continued to impact the Trust with details of all inpatient cases as shown in Table 7.

Table 7 Covid-19 Cases

Month	0 to 2 days	3 to 7 days	8 to 14 days	15+ days	Grand Total
Apr	44	14	14	21	93
May	51	6	13	18	88
Jun	58	6	8	11	83
Jul	32	0	3	0	35
Aug	26	6	6	14	52
Sep	47	10	14	25	96
Oct	59	18	27	22	126
Nov	21	2	11	22	56
Dec	50	11	15	14	90
Total	**388**	**73**	**111**	**147**	**719**

Covid-19 Outbreaks

Three Covid-19 outbreaks were reported in Q3, affecting patients. Outbreak Control Groups were established to manage the outbreaks with the Planned and Unplanned Care Groups with additional oversight of infection prevention and control precautions.

Collaboration with Estates

The Water Safety Group is reviewing and updating the water safety plan. The group includes review of capital projects with discussion on compliance with statutory/regulatory obligations and review of recognised risks.

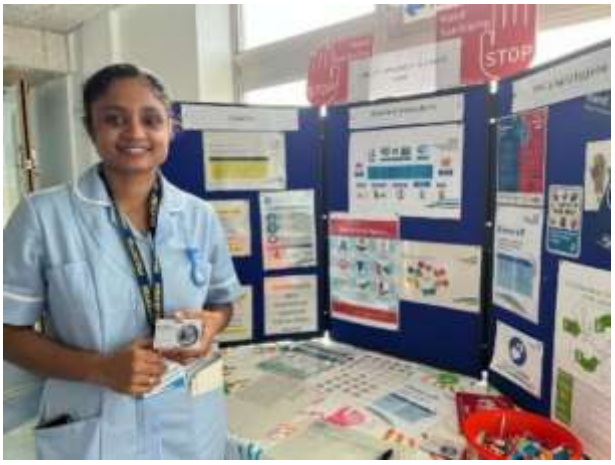
Legionella (serogroup1) was identified water outlets in Daresbury Wing. Action has been taken in accordance with the water safety plan including, isolation, disinfection and flushing and a risk assessment is in place and repeat testing results pending .

Awareness Raising Activity

International Infection Prevention Week

In October, the IPC Team hosted awareness raising events to highlight the importance of following standard precautions, timely hand hygiene, appropriate glove use and standards for care of patients in isolation.

The event was well attended by staff across both hospital sites.



World Antimicrobial Awareness Week

During November the IPC Nurses and the Lead Pharmacist for Antimicrobial Stewardship, promoted awareness of the importance of antimicrobial stewardship to preserving effectiveness of antibiotics and to reduce the development of antimicrobial resistance. The approach incorporated interactive stalls and visits to clinical areas across both Warrington and Halton hospital sites.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Infection prevention and control policies recovery plan
- Delivery of the Infection Prevention Strategy
- Provision of infection prevention and control expert advice to colleagues
- Review of escalations in infections jointly with the associated Care Group

4. IMPACT ON QPS?

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Improved attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAI and involvement in procurement supports sustainability and the green plan

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to UK Health Security Agency
- Surveillance of nosocomial Covid-19 cases/reporting Covid-19 outbreaks
- The Infection Prevention and Control Team monitor HCAI. Action is implemented in response to increased incidences of HCAI and infection control related incidents
- The Infection Control Sub-Committee meets monthly and discusses HCAI surveillance data and learning from HCAI incidents
- Review of HCAI incident investigation reports and audits and agree actions to support care improvements
- Healthcare Associated Infection data is included in the ward dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

IP Strategy Objectives

- Prevention of healthcare associated infections

Table 8 HCAI Thresholds 2023/24

HCAI	WHH Threshold 2023/24
C. difficile	≤36
E. coli	≤54
Klebsiella spp.	≤18
P. aeruginosa	≤2

- Strengthening Antimicrobial Stewardship – Participation in the IV Oral Switch CQUIN CCG3
- Improving standards of environmental cleanliness
- Implementing action in line with the NHS Waste Strategy

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to:-

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Infection Control Sub-Committee, Quality Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

The Director of Infection Prevention and Control Report is submitted to Trust Board annually and published on the Trust website.

Monitoring by the Senior Executive Oversight Group.

8. TIMELINES

2023 – 2024 Financial Year

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

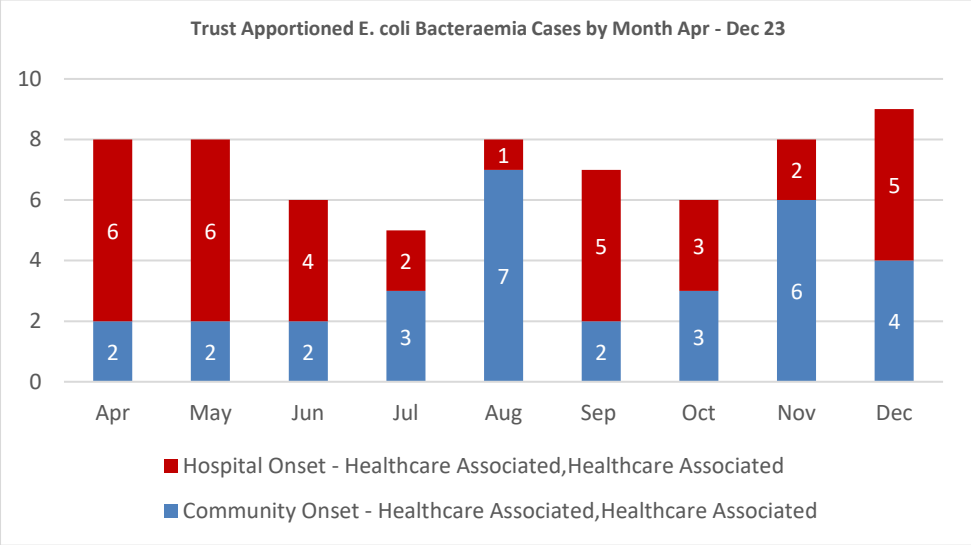
10. RECOMMENDATIONS

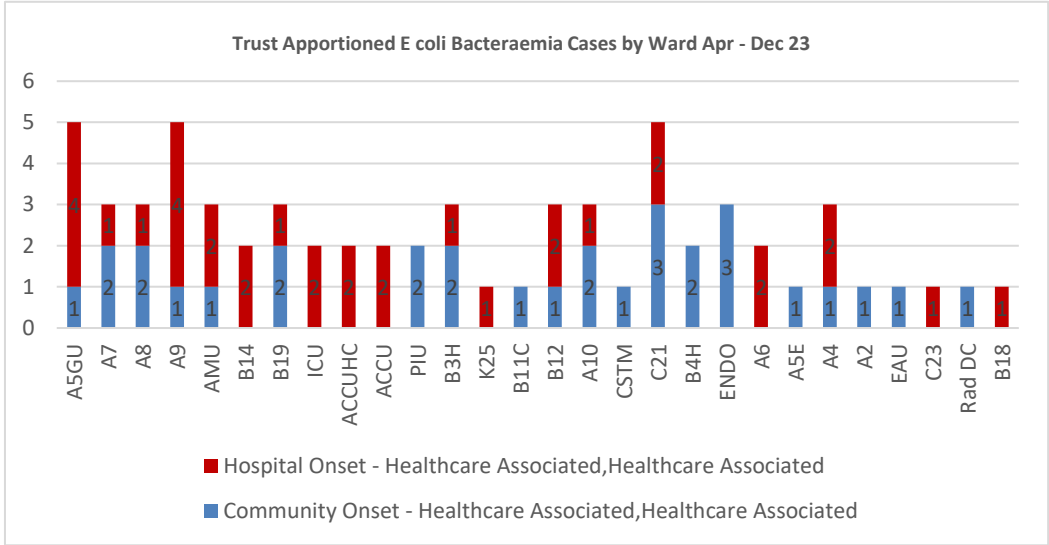
The Quality Assurance Committee is asked to receive the report, note the collaboration, commitment and contributions to quality improvement, exceptions reported and progress made.

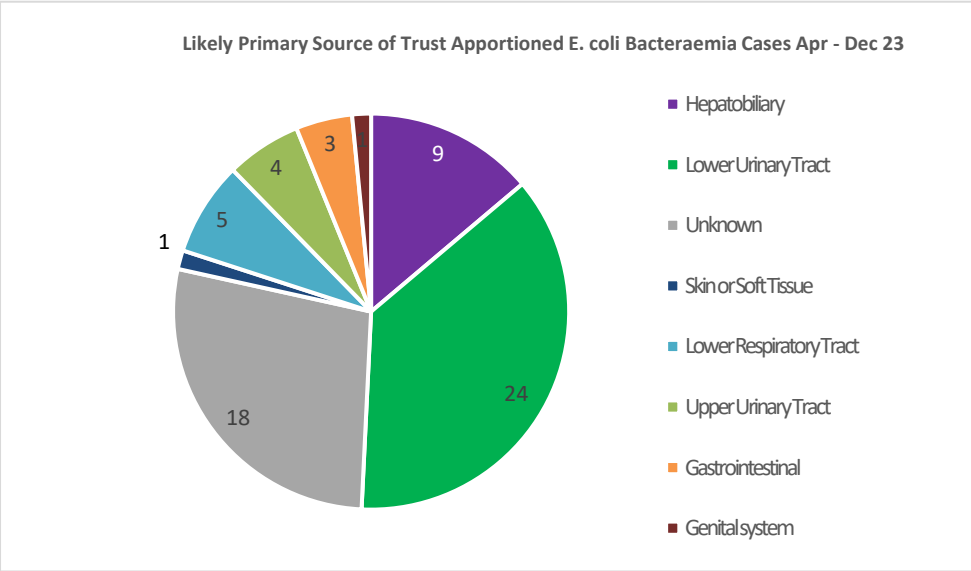
Appendix 1

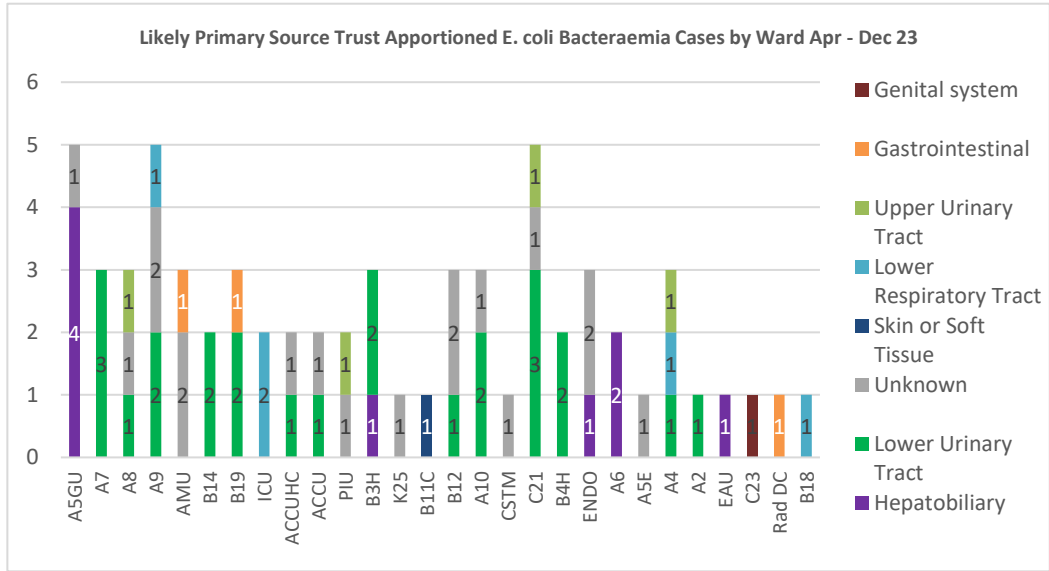
Gram Negative Bloodstream Infection: E. coli Apr – Dec 23

Threshold	54
YTD Total	65



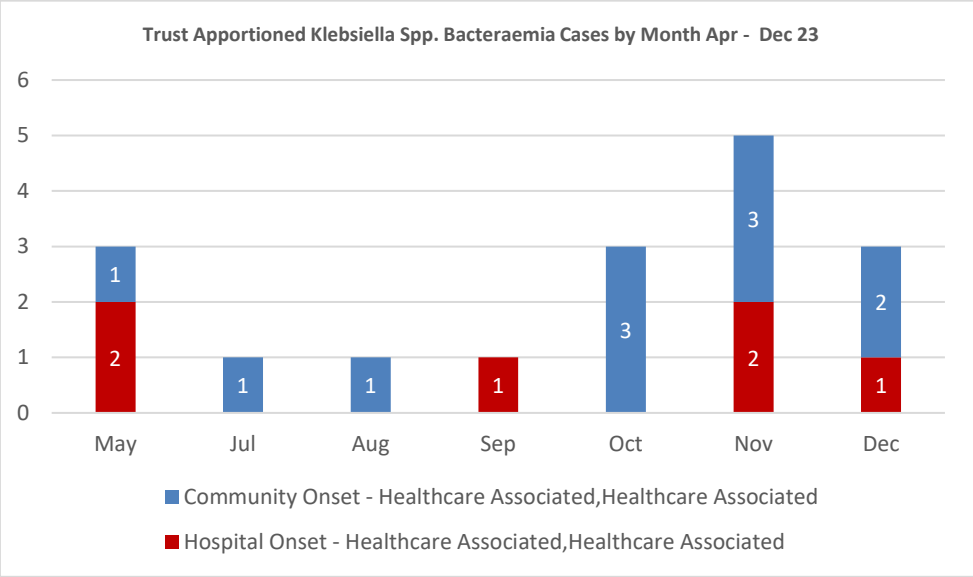


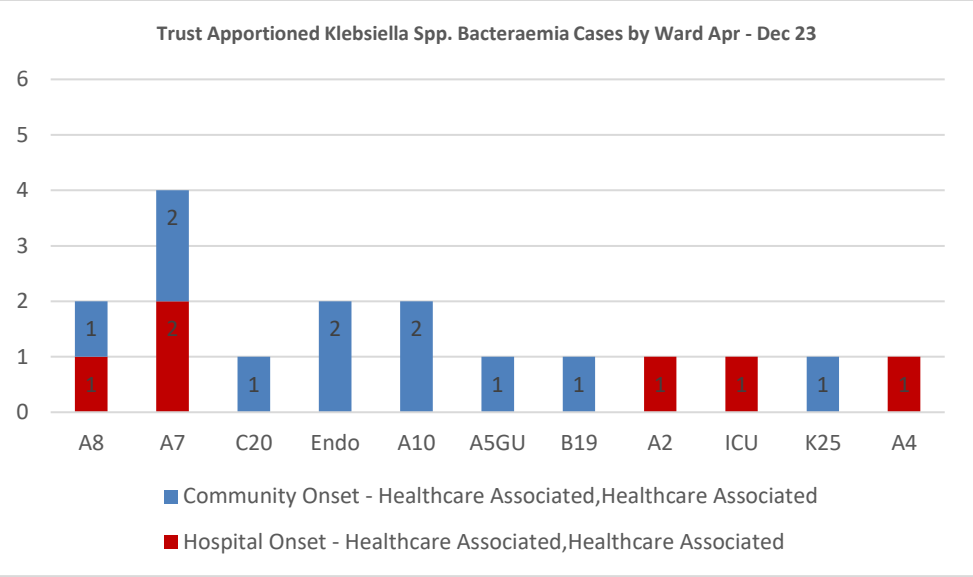


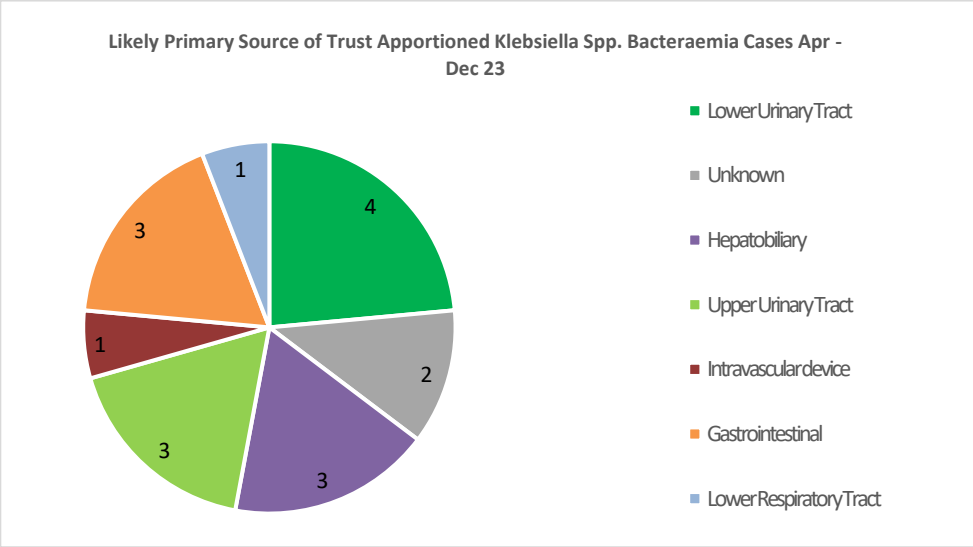


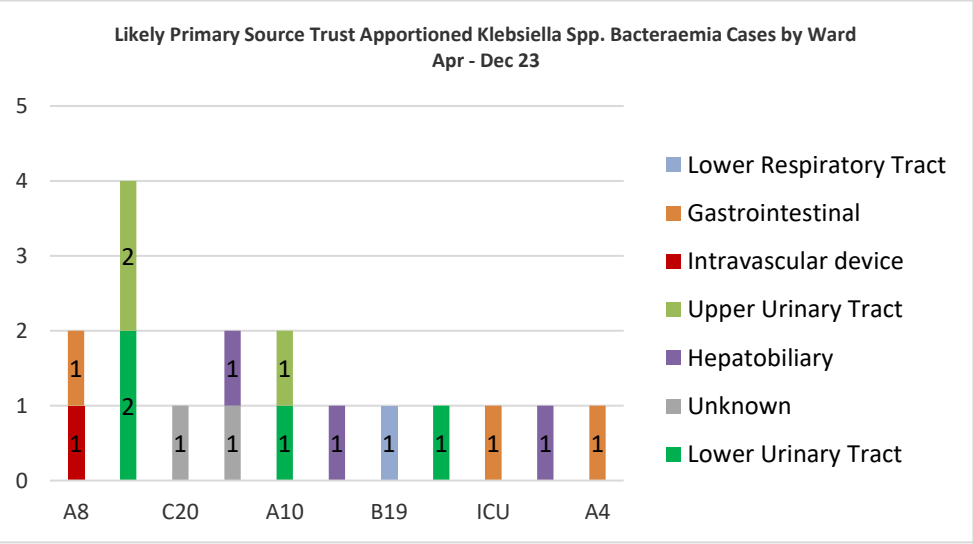
Gram Negative Bloodstream Infection: Klebsiella spp. Apr – Dec 23

Threshold	18
YTD Total	17



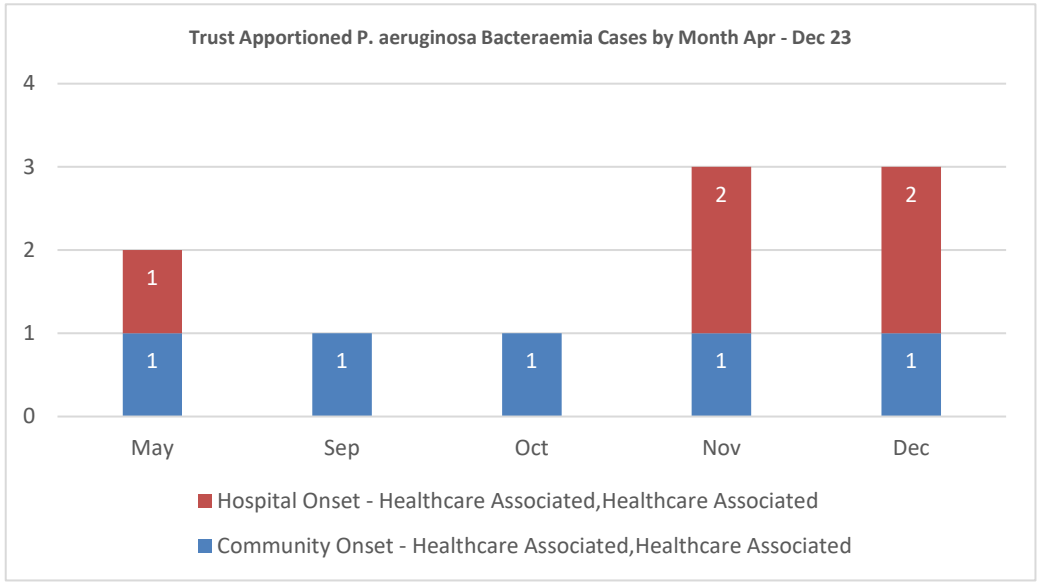


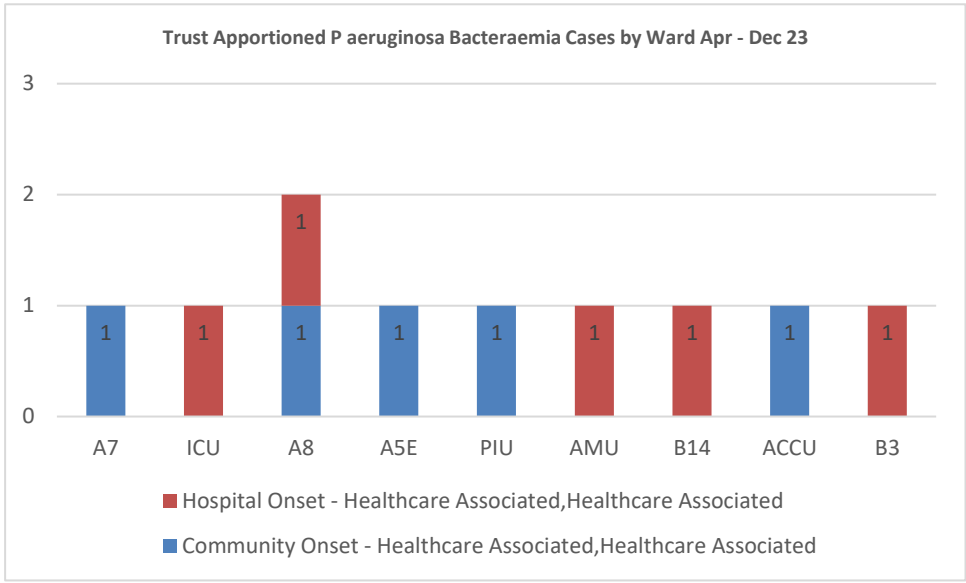


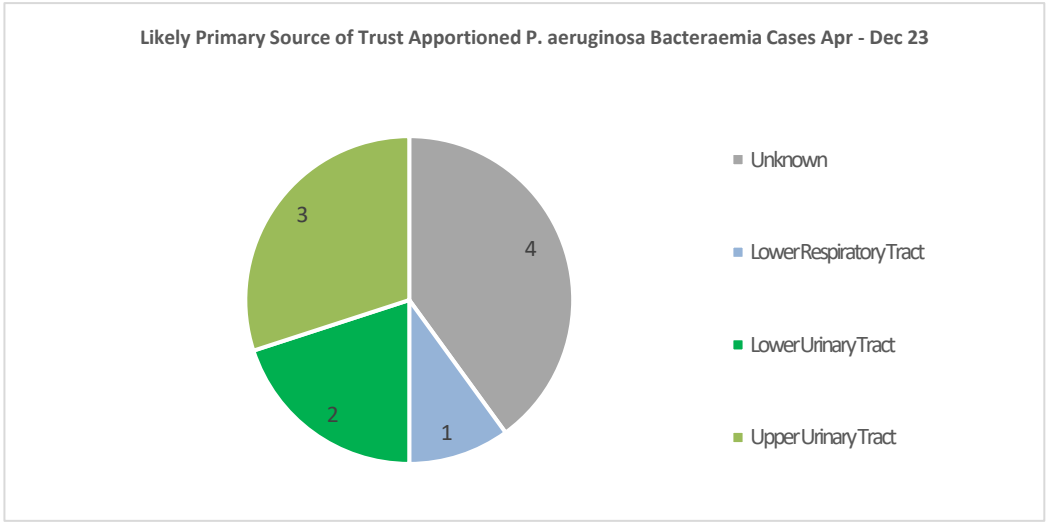


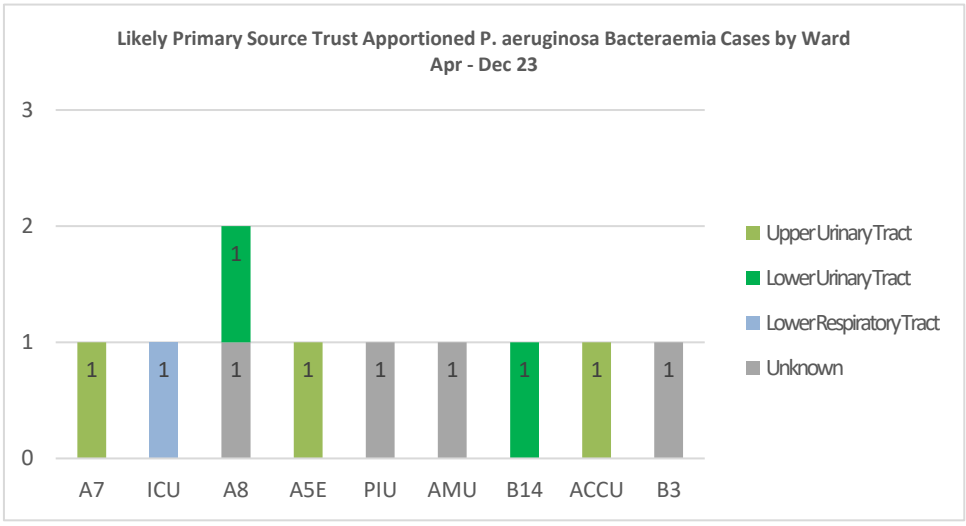
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa) Apr – Dec 23

Threshold	2
YTD Total	10









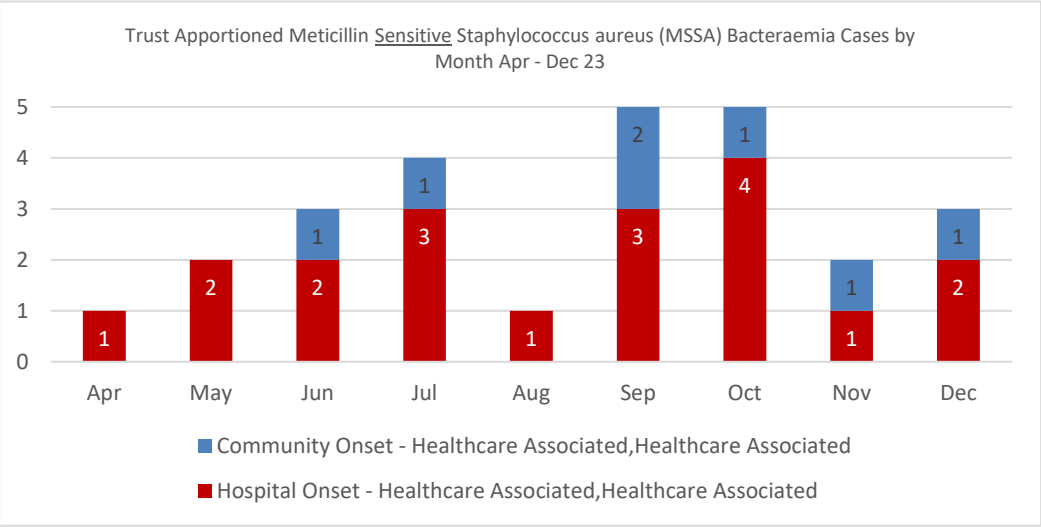
Threshold	**0**
YTD Total	**0**

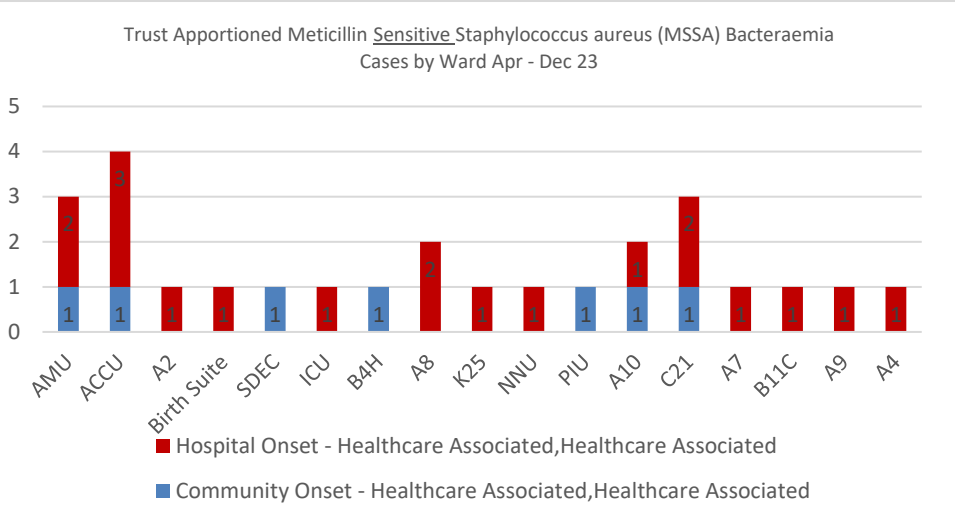
Gram Positive Bloodstream Infection: Meticillin-resistant Staphylococcus aureus Apr – Dec 23

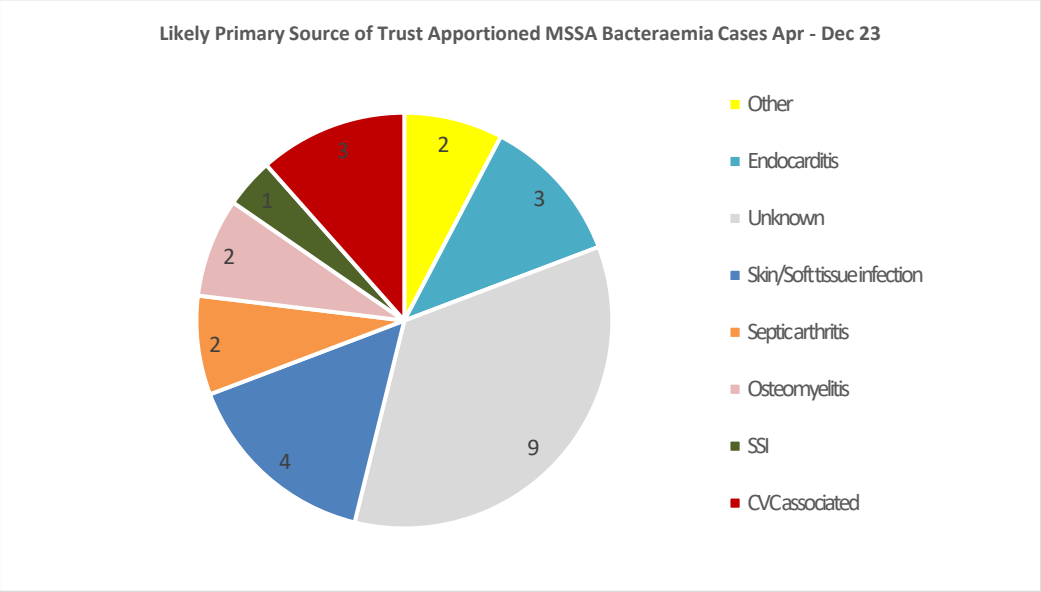
Rolling 15 Months MRSA bacteraemia free

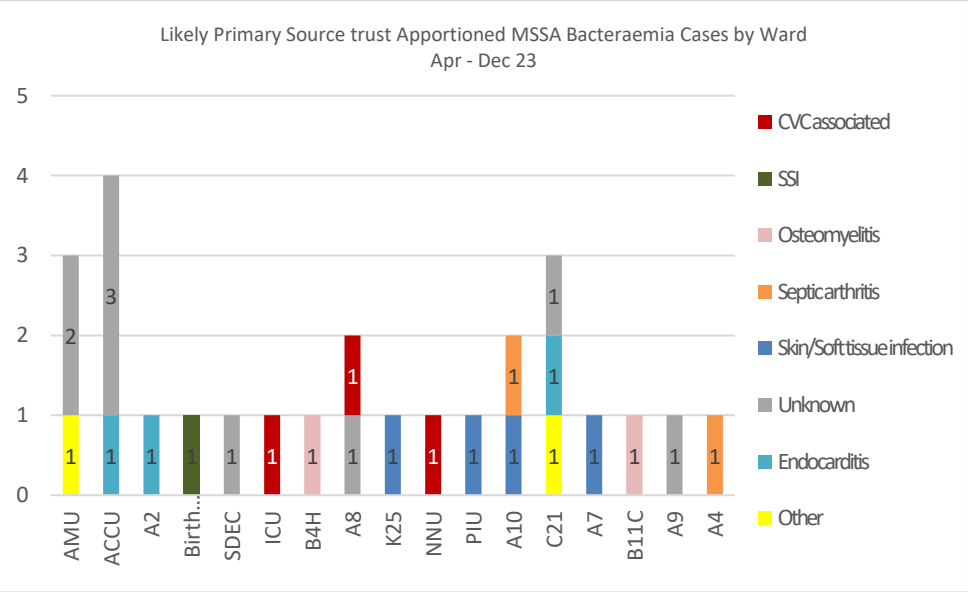
Gram Positive Bloodstream Infection: Staphylococcus aureus Apr – Dec 23

No Threshold	
YTD Total	26



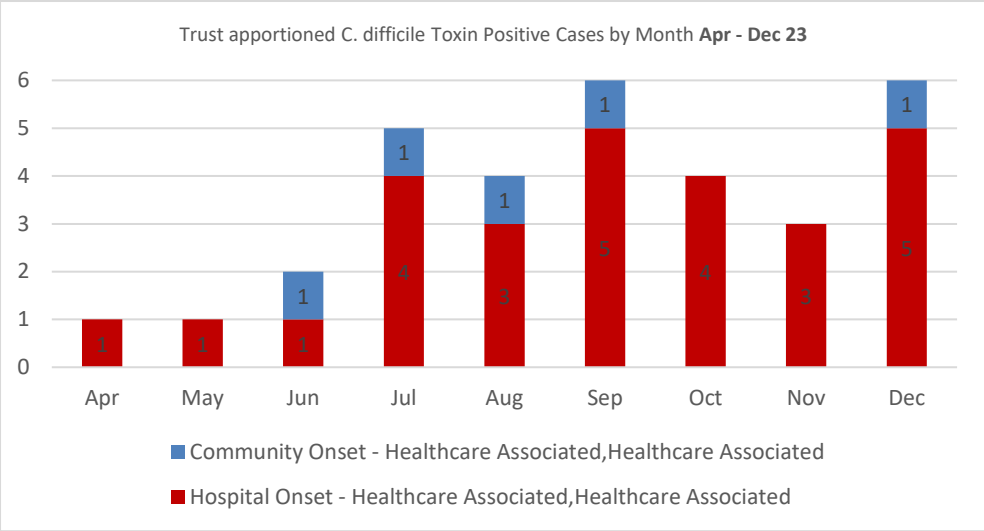


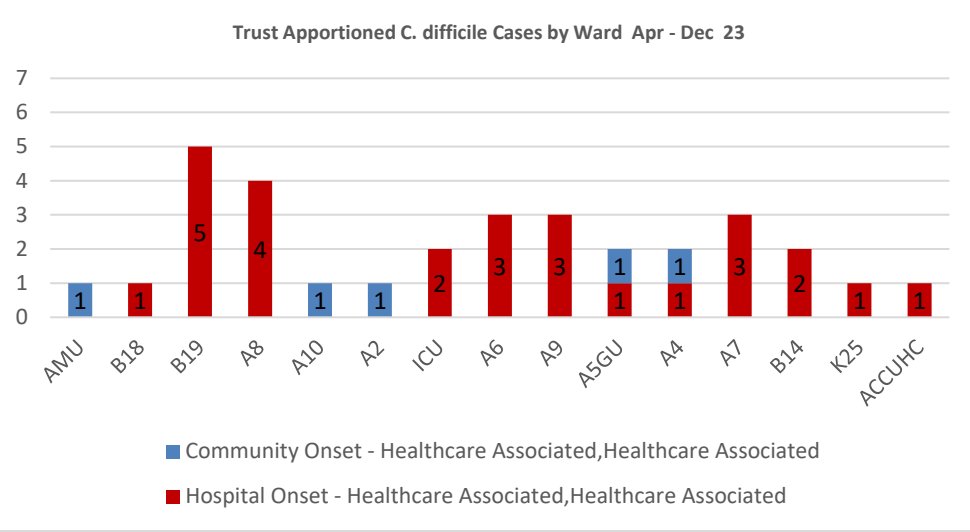


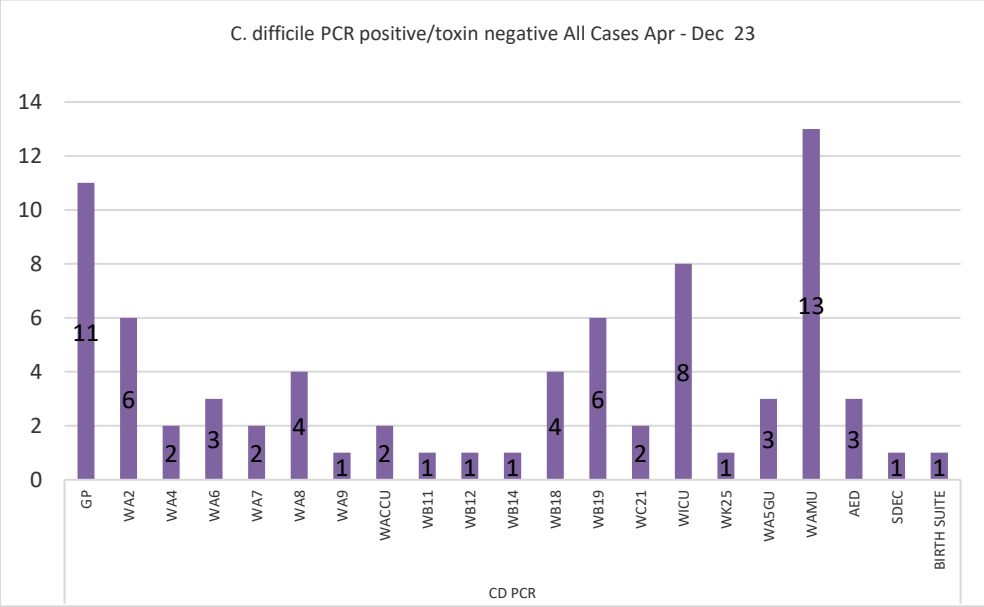


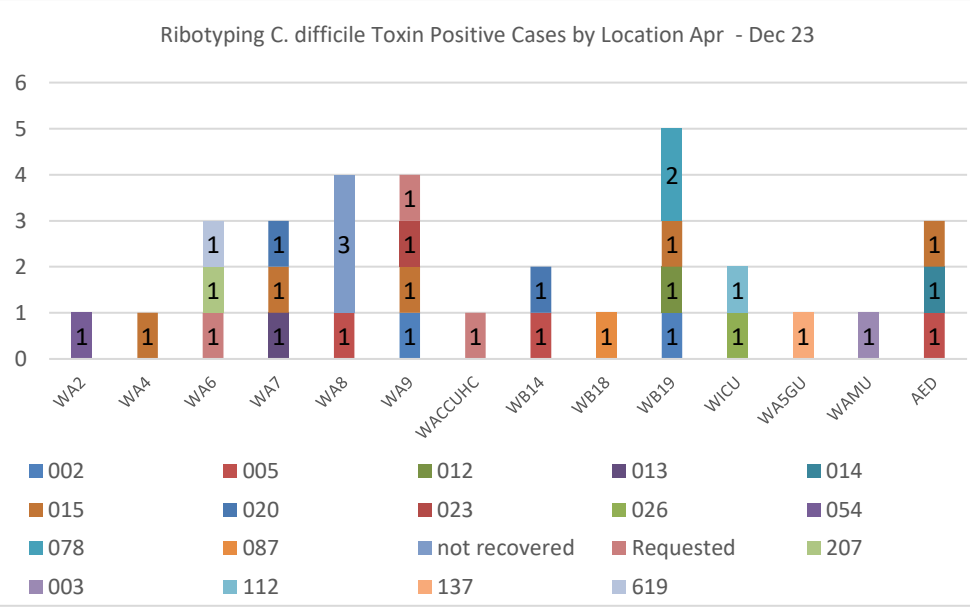
Clostridioides difficile (C. difficile) Toxin Apr – Dec 23

Threshold	36
YTD Total	32

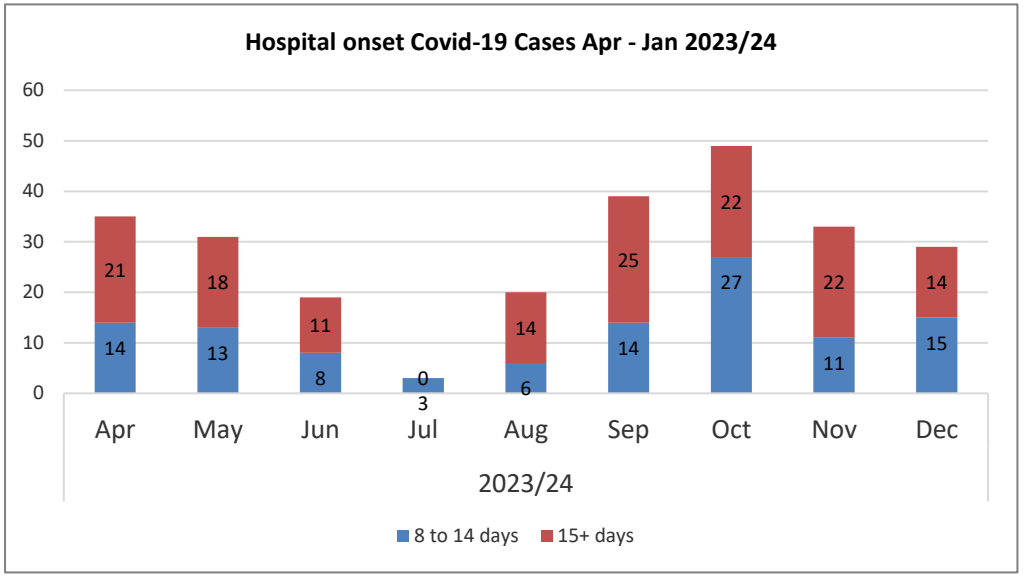


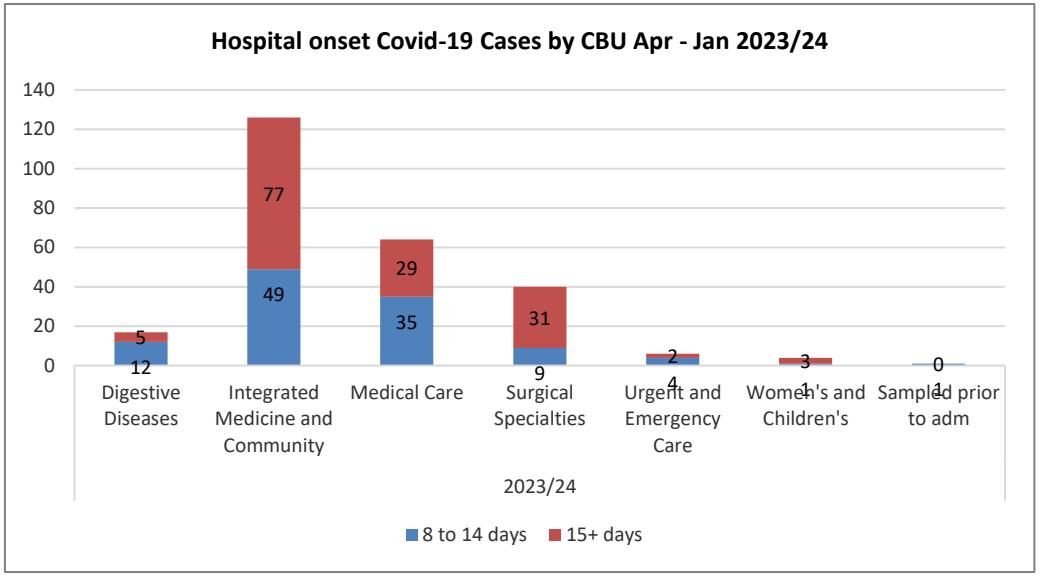


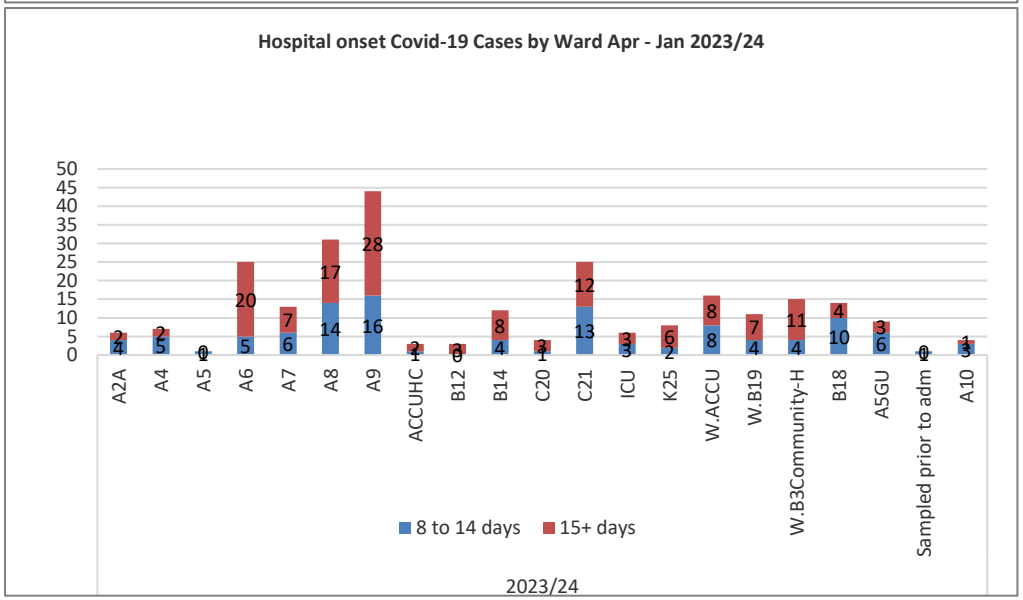


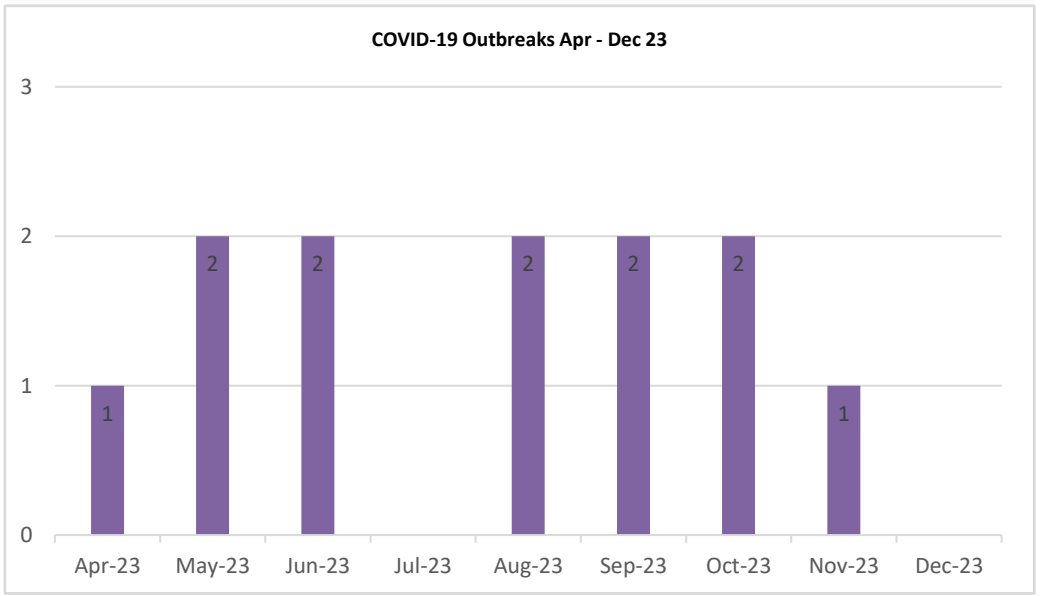


Covid-19 Surveillance Data Apr - Dec 23









Appendix 2 IPC Audits by CBU

UEC CBU

Ward	UCC (H)
Environment	77%
Ward Kitchens	88%
Handling/Disposal of Linen	80%
Departmental Waste	100%
Safe Handling Disposal of Sharps	100%
Patient Equipment (General)	95%
Personal Protective Equipment	50%
Short Term Catheter Management	N/A
Care of Peripheral Intravenous Lines	N/A
Isolation Precautions	100%
Hand Hygiene	95%
Overall Compliance	87%

IMC CBU

Ward	FAU	Discharge Lounge	B14
Environment	69%	83%	92%
Ward Kitchens	73%	89%	87%
Handling/Disposal of Linen	100%	67%	100%
Departmental Waste	100%	100%	92%
Safe Handling Disposal of Sharps	94%	100%	88%
Patient Equipment (General)	100%	100%	76%
Personal Protective Equipment	100%	100%	100%
Short Term Catheter Management	100%	100%	82%
Care of Peripheral Intravenous Lines	100%	100%	100%
Isolation Precautions	100%	100%	92%
Hand Hygiene	100%	100%	100%
Overall Compliance	94%	94%	92%

W&C CBU

Ward	C20	Maternity Triage
Environment	87%	82%
Ward Kitchens	88%	92%
Handling/Disposal of Linen	100%	86%
Departmental Waste	92%	92%
Safe Handling Disposal of Sharps	94%	94%
Patient Equipment (General)	91%	83%
Personal Protective Equipment	100%	100%
Short Term Catheter Management	100%	N/A
Care of Peripheral Intravenous Lines	100%	N/A
Isolation Precautions	N/A	N/A
Hand Hygiene	100%	100%
Overall Compliance	95%	91%

DD CBU

Ward	B4	PIU	A4
Environment	96%	90%	87%
Ward Kitchens	79%	79%	92%
Handling/Disposal of Linen	100%	100%	55%
Departmental Waste	100%	100%	75%
Safe Handling Disposal of Sharps	94%	100%	72%
Patient Equipment (General)	95%	86%	82%
Personal Protective Equipment	100%	100%	69%
Short Term Catheter Management	100%	100%	93%
Care of Peripheral Intravenous Lines	100%	100%	67%
Isolation Precautions	100%	100%	64%
Hand Hygiene	100%	100%	86%
Overall Compliance	97%	96%	76%

SS CBU

Ward	B3	ODS	Fracture Clinic	Ophthalmology	Diabetic Foot Clinic
Environment	95%	**100%**	93%	75%	82%
Ward Kitchens	77%	**100%**	N/A	67%	N/A
Handling/Disposal of Linen	100%	**100%**	100%	100%	N/A
Departmental Waste	100%	92%	100%	92%	78%
Safe Handling Disposal of Sharps	100%	**100%**	100%	87%	80%
Patient Equipment (General)	94%	92%	100%	86%	71%
Personal Protective Equipment	83%	**100%**	100%	100%	100%
Short Term Catheter Management	100%	**100%**	N/A	N/A	N/A
Care of Peripheral Intravenous Lines	100%	**100%**	N/A	N/A	N/A
Isolation Precautions	100%	**100%**	N/A	N/A	N/A
Hand Hygiene	95%	**100%**	90%	100%	100%
Overall Compliance	95%	**98%**	98%	88%	85%

Clinical Support Services

Ward	Catheter Lab	Phlebotomy	Orthotics	Hydrotherapy pool	Anticoagulation clinic	Main OPD	Audiology	Halton Hub
Environment	89%	83%	68%	93%	95%	92%	80%	95%
Ward Kitchens	81%	N/A	N/A	100%	N/A	89%	N/A	100%
Handling/Disposal of Linen	89%	N/A	N/A	100%	N/A	100%	100%	100%
Departmental Waste	92%	88%	100%	100%	100%	92%	100%	100%
Safe Handling Disposal of Sharps	100%	86%	100%	100%	100%	100%	N/A	100%
Patient Equipment (General)	100%	100%	100%	100%	100%	67%	100%	100%
Personal Protective Equipment	100%	100%	100%	N/A	100%	100%	100%	100%
Short Term Catheter Management	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Care of Peripheral Intravenous Lines	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hand Hygiene	100%	100%	100%	100%	100%	100%	100%	100%
Overall Compliance	94%	93%	95%	99%	99%	92%	100%	99%

Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/02/301**			
SUBJECT:	**Learning from Experience, Quarter 3 2023/24**			
DATE OF MEETING:	Tuesday 13 February 2024			
ACTION REQUIRED:	The Quality Assurance Committee is asked to note the contents of this paper.			
AUTHOR(S):	Layla Alani, Director of Integrated Governance and Quality, Deputy Chief Nurse, Nicola Edmondson, Associate Director of Governance, Ernesto Quider, Associate Director of Quality, Lisa Davies, Head of Patient Safety			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
EXECUTIVE SUMMARY:	The Learning from Experience Report, Quarter 3, 2023/24 provides an overview of the Learning from Experience across the organisation. The information within the report is extracted from the Datix Incident Management System and other Clinical Governance functions to triangulate the data and learning from Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Quality Improvement and Research and Development related to Quarter 3, 2023/24			
PURPOSE: (please select as appropriate)	Approval	To note ✓	Decision	
RECOMMENDATION:	The Quality Assurance Committee is asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(If relevant)***	Section 41 – confidentiality			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Experience, Quarter 3 2023/24	AGENDA REF:	QAC/24/02/301

1. BACKGROUND/CONTEXT

The Learning from Experience Report, Quarter 3, 2023/24 relates to data reviewed during the period of 1st October 2023 to December 2023 (Q3). It contains both quantitative and qualitative data analysis using information obtained from the Datix Risk Management System and other governance functions to triangulate the data and learning from incidents, complaints, claims, health and safety, clinical audit, compliance, quality improvement and research and development.

The report includes a summary of themes, trends and key findings that have influenced learning and action to support and sustain improvement.

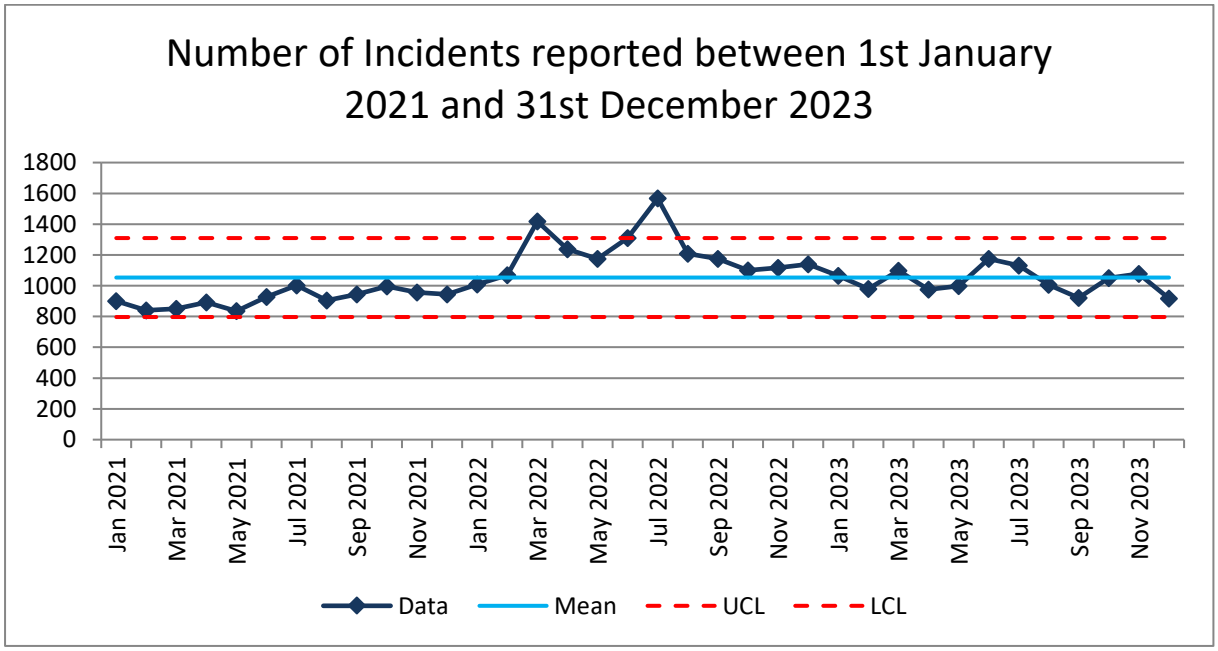
2. KEY ELEMENTS

2.0 Learning from Incidents

2.1 Incident Reporting Position

In 2023/24 Q3, a total of 3045 incidents were reported compared to 3059 incidents reported in 2023/24 Q2. This represents a decrease of 14 incidents (0.46%). The areas with the largest decrease in the number of incidents reported is Women's and Children's with a variance of 47 (12.6%) and Clinical Support Services (33) (14.4%).

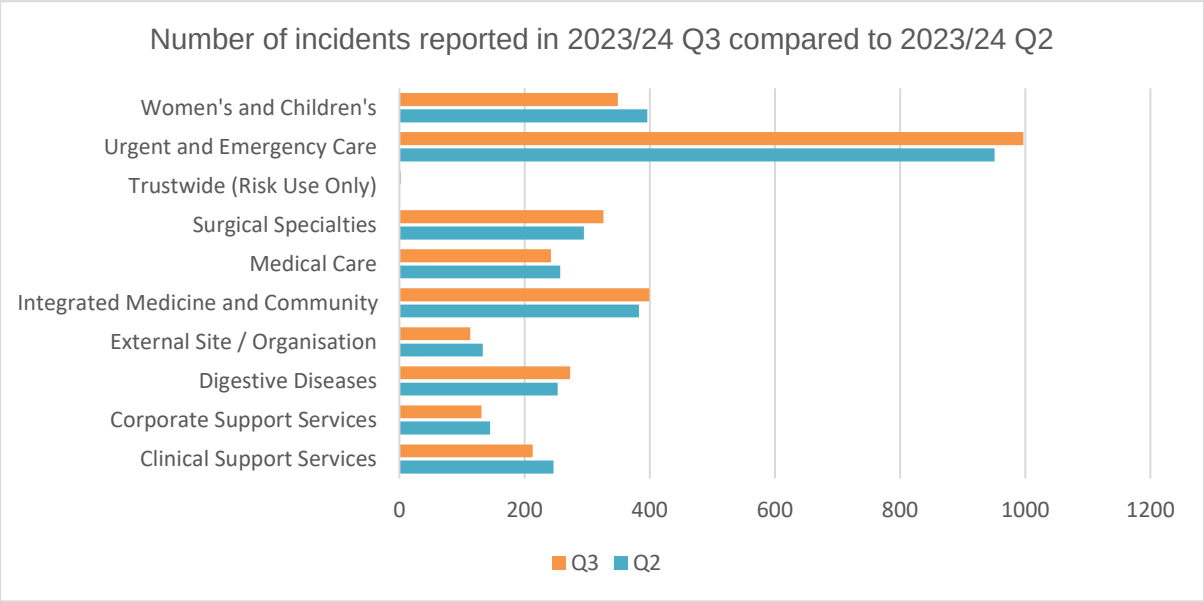
Graph 1



2.2 Incident Reporting Position per Clinical Business Unit (CBU).

In Quarter 3, a total of 2799 incidents were reported across the CBUs and Clinical Support Services as shown in graph 2 below. The remaining 113 were reported as external incidents, 2 were Trust wide incidents and 131 were reported within Corporate Services. Corporate Services incidents include the following areas: Digital Services, Education and Organisational Development and Estates and Facilities.

Graph 2



The largest increase in reporting is noted in Urgent and Emergency Care (46) (4.8%).

Urgent and Emergency Care

The largest increase in reporting in Quarter 3 2023/2024 in Urgent and Emergency Care relates to access, transfer and discharge and assessment, diagnosis, and investigation.

The Urgent and Emergency Care Governance Manager met with the Clinical Business Unit Manager and the Associate Chief Nurse to discuss events relating to occupancy and demand within the department. The Urgent and Emergency Care Matron has increased the frequency of safety walk rounds and is engaging with the procurement and patient experience teams to identify supportive measures that can be implemented during times of increased occupancy. This is a standing agenda item on the ED Improvement Group. A weekly harm profile report is populated weekly to enable oversight and support discussions.

Women's and Children's

Women's and Children's has had a decrease in reporting in Quarter 3 2023/2024 (349) from Quarter 2 2023/2024 (396).

There is an improvement in staffing within Women's and Children's. There has been a sustained significant improvement across workforce metrics. Turnover rates for registered midwifery staff are now at 13%.

Assessment, diagnosis and investigation, appointment issues have remained static across Quarter 3 2023/2024 when compared with Quarter 2 2023/2024. The Maternity team have been working with the digital midwife and continuity team leaders to improve pathways for women into Maternity services. The paediatric teams continue to work collaboratively with stakeholders to support the safe discharge of children with mental health or additional needs. There is a Badgernet task and finish group which meets monthly to manage and track improvements utilising DATIX information within that for themes and trends.

2.3 Themes and learning from incidents by CBU:

Urgent Emergency Care (UEC).

There have been four incidents (21 patients) submitted within Urgent and Emergency Care in Quarter 3 2023/2024 whereby patients were added to the Pathpoint system, however the patients were not added to FRACFNP (the Lorenzo booking system).

As the patients were not booked onto Lorenzo, E-outcome was not generated to communicate the results of the Virtual Fracture Clinic (VFC) assessment and therefore patients did not have necessary appointments booked. This was highlighted when the patients contacted VFC to chase their appointment date.

Learning and actions taken from this were:

- Assistant Clinical Business Manager has liaised with the Emergency Department administration team to ensure appropriate training and monitoring, with support from the Trauma and Orthopaedic team.
- Trauma and Orthopaedic teams have reviewed the patients, no harm has been identified.
- This issue is to be added to the risk register.
- Fracture clinic performance will be monitored through the Patient Safety and Clinical Effectiveness Sub Committee.

Medical Care. Burn/Scald incidents (B18/C21)

There have been 8 incidents reported as accidents in Quarter 3 2023/2024 within Medical care compared to 4 in Quarter 2 2023/2024. 2 incidents related to patients who had scolded themselves with hot drinks.

Reviews were undertaken on both incidents which identified:

- If a patient has capacity, staff are advised to assess if patients can safely hold a cup of hot drink or if consideration should be given to the temperature of the fluid and the volume held in the cup.
- Staff are to now document behind the bed if patients require assistance with eating and drinking and ensure very hot drinks are not left within reaching distance of patients who cannot drink independently.

Surgical Specialities. Stent Register

- Issues regarding stents being placed and subsequently removed with concerns raised around the maintenance of the Ureteric register.

Learning has been shared within the Governance meeting. An audit has been undertaken by the Urology Nurse Specialist, Matron and Lead Nurse (from March 2023 to December 2023).

- 207 patients have been reviewed
- 77 were under surveillance
- 127 patients had the stent removed
- 6 were transferred to other hospitals for continued treatment
- 7 patient had deceased; these were not urology related deaths

A meeting with the executive team was held on 5th January 2024 and actions below agreed:

- A Task and Finish group is in place
- Stent register reviewed each week by Specialist nurse
- Improvement required to the LION system, due to current data quality issues within the data and some confusion with the use of new CDC forms. IT are working with the Urology Nurse Specialists to resolve
- Adaptation of the WHO checklist to include a check that the stent register CDC form has been completed for any removal/exchange patients
- To be monitored through patient Safety and Clinical Effectiveness Sub Committee

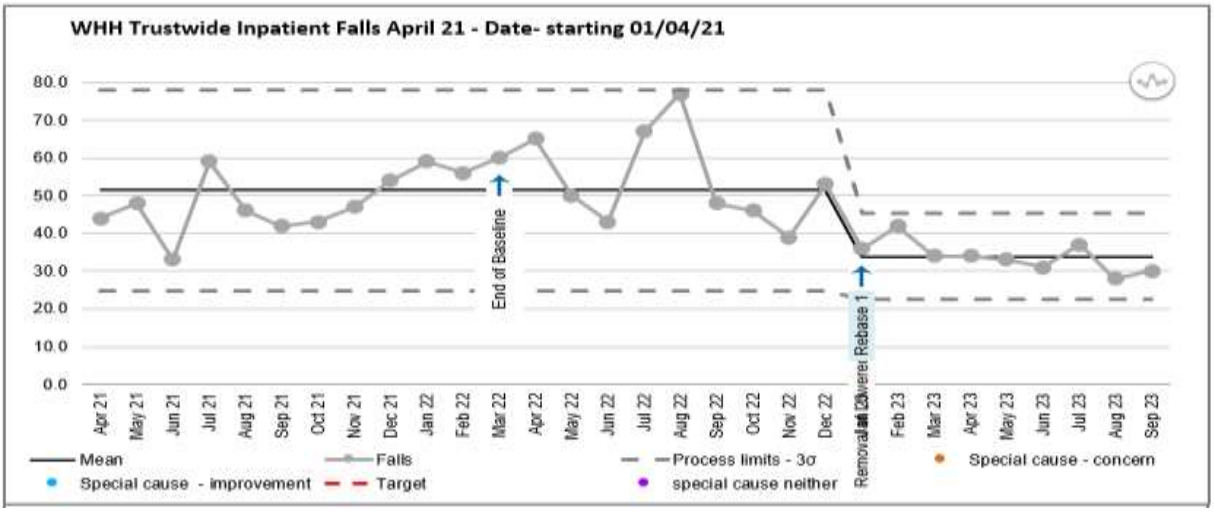
Integrated Medicine and Community (IMC) Falls.

In Quarter 3 2023/2024 there were 52 falls compared to 35 in Quarter 2 2023/2024. Two of these were confirmed as moderate harm and x1 occurred on Ward A8 and x1 occurred on Ward A9. All incidents have had an Initial Safety Review and duty of candour undertaken.

Themes for learning relating to falls relate to:

- Communication between ward areas
- Timely risk assessment on admission
- Documentation issues to be strengthened in year

Plans are in place to amend the ward handover sheet to include patient mobility information (during Q4 of 2023/2024). Learning from the safety responses is being fed into the fall's collaborative. The below graph shows a 34% reduction in trust wide monthly inpatient falls.



Digestive Diseases. Never Event

There was one never event declared in Quarter 3 2023/2024 in Theatre.

Patient admitted for pain injections in theatre to the facet joint. Patient nervous and needle phobic. Marked on the correct side by the consultant. When in theatre the Who check list was completed alongside the LOCCSIP. Unfortunately, the consultant inserted the local anaesthetic to the wrong side. Pain needle inserted in the wrong side when staff identified called a STOP moment to identify wrong side being injected. No pain medication was given however local Anaesthetic used on the wrong side:

- This has been declared a PSII
- DOC has been completed with patient
- Theatre staff are meeting patients on the ward with the ward staff to undertake checks and ensure patients are marked correctly.
- Ongoing implementation of the developed theatre action plan
- Feedback of the PSII progress will be available in Q4

Women's and Childrens. Cluster Review.

In Quarter 3 of 2023/2024 there were seven incidents reported relating to babies born before arrival of a midwife (BBA). Four of the incidents were planned homebirths where the midwife did not arrive at the home address until after the baby was born and three of the incidents were unplanned homebirths. Each individual case was reviewed, and a cluster review was also undertaken.

Learning identified:

- No themes were identified within the individual cases.
- A home birth board is now in place to improve the communication between the homebirth team and the maternity triage department.
- Examination torches were supplied within the kits for each homebirth team member to improve perineal review following birth.

The learning was shared through a 'case on a page' within the community midwifery team and the wider maternity areas.

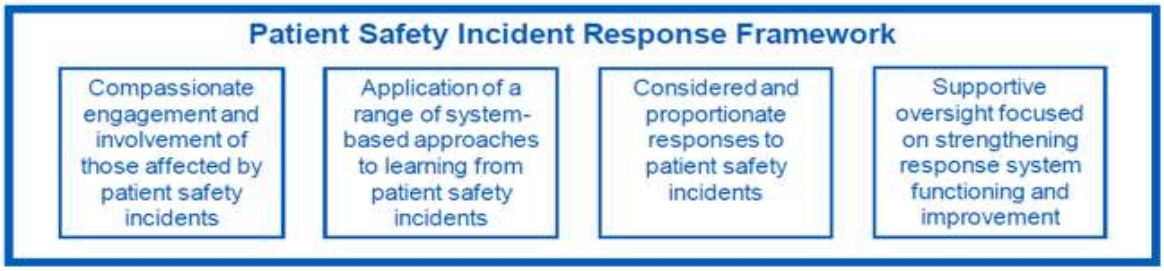
2.4 Learning from Incidents and Assurance.

The Patient Safety Manager continues to attend the PLACE (previous CCG) meetings to present Serious Incidents alongside the Investigating Officer. This ensures that learning is shared externally as well as internally. Incidents and complaints are also discussed at the Clinical Quality Focus Group (PLACE) by the Director of Governance. Learning is shared within governance and speciality meetings with wider learning shared through other modalities such as safety alerts and other relevant meetings such as the Nursing and Midwifery Forum, Mortality Review Group, and the Medical Cabinet.

2.5 Patient Safety Incident Response Framework (PSIRF) - learning and improving patient safety.

The PSIRF was adopted on the 1st September 2023 it is mandated for any organisation who provide funded NHS care, and currently approximately 50% of organisations across the NHS have gone live. The PSIRF policy and plan are available on the Trust's website and are based on the national template and is aimed to be written in plain English.

- PSIRF replaces the Serious Incident Framework but in itself is not an investigation framework.
- PSIRF aims to support organisations to change culture in order to improve patient safety.
- PSIRF does not mandate investigations as the only method of learning from patient safety incidents or prescribe what to investigate.
- PSIRF aims to move away from targets attached to incident investigations and instead focus on learning and improvement.
- PSIRF moves organisations away from using Root Cause Analysis, to ensure a more system based approach is adopted.
- PSIRF supports the development and maintenance of an effective patient safety incident response system with four main aims:



Via the PSIRF Task and Finish Group and the PSIRF Executive Oversight Group the implementation schedule has been worked through to ensure that appropriate plans and processes are in place to achieve successful implementation.

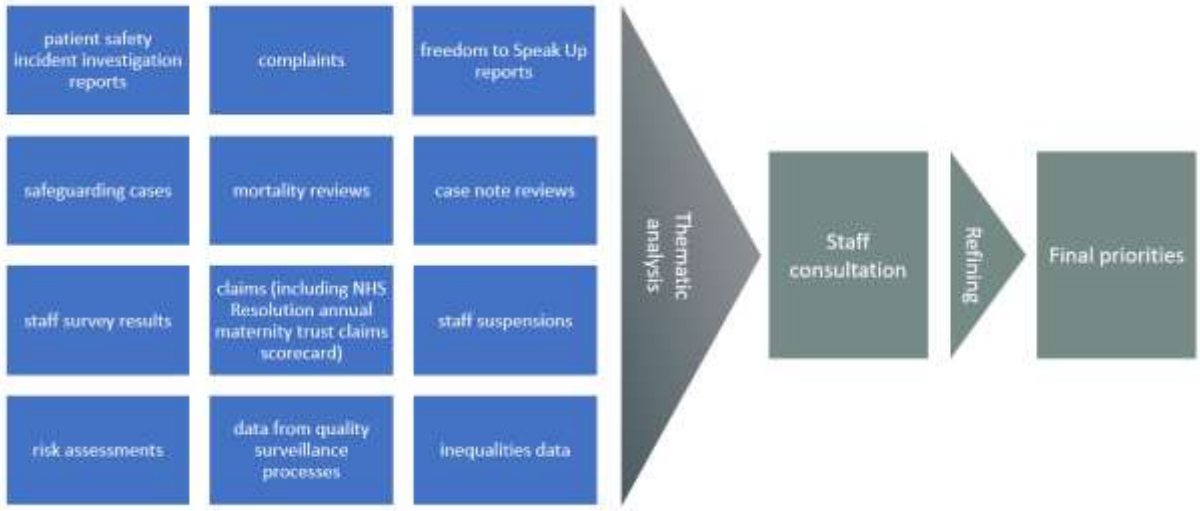
The various tools, and types of investigations and reviews that can be used for learning and improving patient safety include:

- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how.
- Multidisciplinary Team Review – aims to through open discussion to agree the key contributory factors and system gaps that impact on safe patient care.

- Swarm Huddle – initiated as soon as possible after an event and involves and MDT discussion. Staff 'swarm' to the site to gather information about what happened and why and decide what needs to be done to reduce reoccurrence.
- After Action Review (ARR) – structured facilitated discussion of an event, based around four questions.

WHH has been using the new learning response methodologies (to support incident investigations) and confidence is growing with the different approaches. These are supporting compassionate engagement with patients, families and staff through direct engagement and involvement where appropriate. And are also enabling proportionate responding to safety events.

The development of Local Priorities has taken place following extensive review of WHH data in order to identify issues which have been enduring and impact across a range of data sources in order to ensure opportunities for triangulation and maximise learning opportunities.



**Process adopted for developing WHH local priorities.*

This exercise has resulted in the development of 3 local priorities which will be investigated using PSII methodology.

- Missed or delayed diagnosis of a cancer
- Delay in the identification, recognition and response to a patient's deterioration resulting in delayed escalation and treatment.
- Delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)

There are currently 7 PSII's in progress, 3 of these are linked to the local priorities (one mapped to each of the 3 above) 2 relate to patients who have died, two are linked to never events. There are no remaining Serious Incidents investigations in progress.

Training is being provided to staff to support the PSIRF requirements, and the Patient Safety Training Syllabus has been mandated and is available through the Electronic Staff Record. The Trust Board have participated in Oversight training to support their roles in safety. In addition, Human Factors training has been provided to staff who are undertaking any safety or learning activities.

Training compliance is currently:

Patient Safety Essentials for boards and senior leadership - Level 1: 88.08%
Patient Safety Essentials - Level 1: 89.47%
Patient Safety - Level 2: 69.26%

The fostering of a culture which support staff to feel psychologically safe is imperative to the success of PSIRF and a programme is in development to support this important work.

Alongside the implementation of PSIRF the Trust have adopted the new national learning and reporting system Learn from Patient Safety Events (LFPSE) which in 2024 will replace both the current National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS). Datix remains as the local risk management system, but all patient safety events feed directly into the LFPSE system.

Approximately 60% of Trusts are now live with the LFPSE system. The new system is built on much improved technology and will include machine learning, which will support health care wide improvements and enable improvement efforts to be targeted to support organisations.

WHH continues to participate with PLACE and ICB partners across Cheshire and Mersey to share learning to further support embedding of PSIRF and LFPSE.

WHH has been working in conjunction with AQUA to arrange a two-day PSIRF training event, which will be piloted in March 2024.

Measuring the impact of learning.

Warrington and Halton capture learning and use many differing types of learning. Mechanisms range from Initial Safety Reviews and other learning responses to debriefs, work system walk throughs etc. Feedback from these is shared via the learning response itself as well as safety briefs, alerts and newsletters, whilst also drawing on wider system learning opportunities to integrate into local improvement events, QI workstreams and audit. Feedback, learning and improvement are crucial to making/building system safety, the plan referenced in Appendix 1 aims to assist greater impact of learning and sharing.

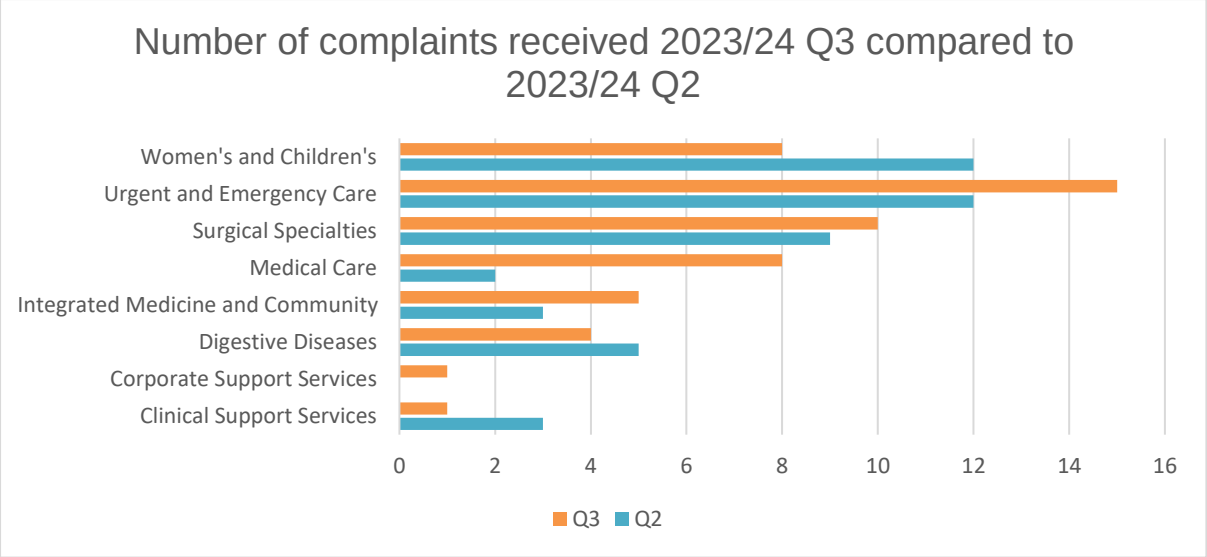
3. Learning from Complaints and PALS

3.1 Complaints.

3.1.1 Complaints received.

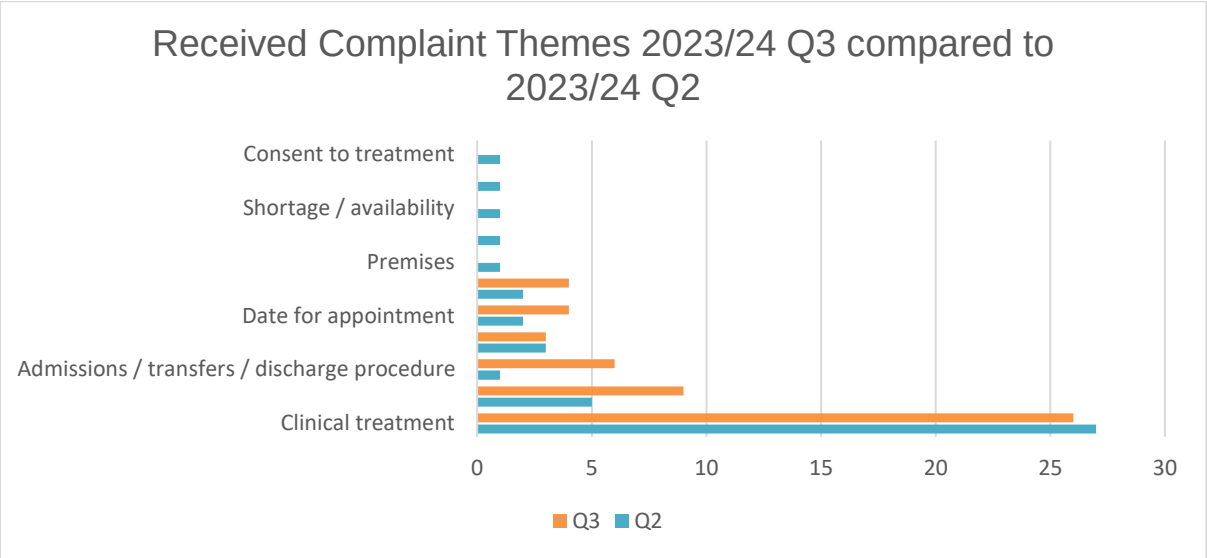
In 2023/24 Q3, there were 52 complaints received in which is an increase of 6 compared to 2023/24 Q2. **(Graph 3**).

Graph 3



The themes of complaints received in Q3 compared to Q2 are outlined within **Graph 4.** Clinical treatment remains the most common theme of complaints received. This category of complaints includes perceived delays in treatment, waiting times and/ or misdiagnosis. This is triangulated with the themes noted within incidents. The number of complaints relating to this theme has decreased from 27 in Q2 to 26 in Q3. The complaints received with a subject of 'clinical treatment' are spread across CBU's and a variety of specialties.

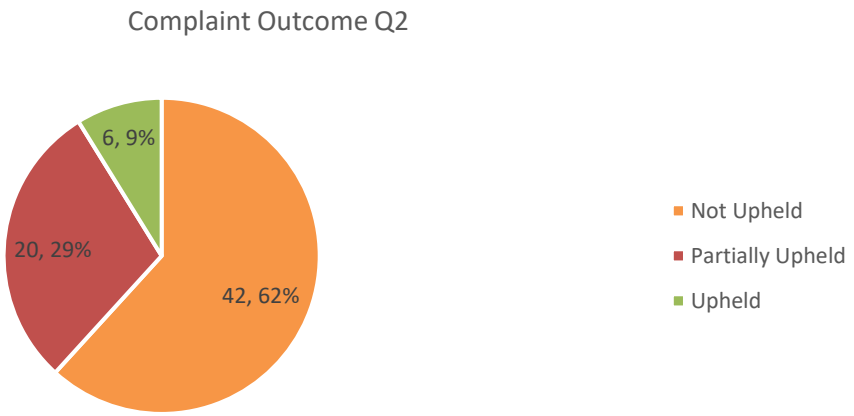
Graph 4

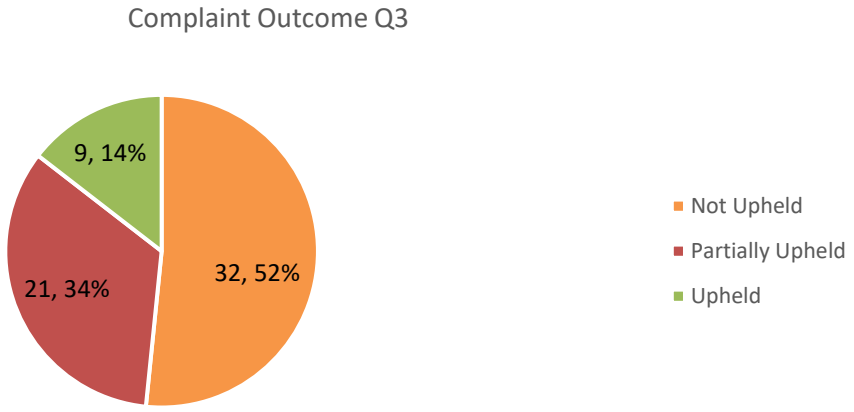


3.1.2 Complaints closed.

All complaints were closed in Q3 within timeframe. The below pie charts demonstrate the outcomes for complaints closed in Q3 compared to Q2. In Q3, a smaller percentage of complaints were not upheld (32% in Q3 vs 43% in Q2). There has been a greater percentage of complaints that were partially upheld (20% in Q2 vs 21% in Q3). The percentage of upheld complaints in Q3 has increased since Q2 (9% in Q3 vs 7% in Q2). There are no breached complaints or any complaints over 6 months old.

*Partially upheld complaints are those where aspects of the complaint are upheld, but the main issues are not.





3.1.3 Actions resulting from Complaint investigations.

The following table provides examples of complaints raised in Q3, and the actions taken to address the concerns raised as well as improvement processes. The Chairman holds a monthly complaint assurance meeting where a CBU or speciality will present a complaint, the lessons learnt, and the actions implemented.

You Said….	We Did….
Urgent and Emergency Care: The complainant had concerns over the attitude of the Triage Nurse and felt that they were rude and unhelpful.	Apologies were given regarding the experience. Staff have been asked to reflect with empathy upon how patients can feel at times of stress, and to be mindful of tone and the need to communicate waiting times. A written guide has been created for parents and families as to what to expect whilst waiting.
Women's and Childrens: The patient had concerns over a poor experience and	Compassionate engagement was undertaken by the Matron for Gynaecology.

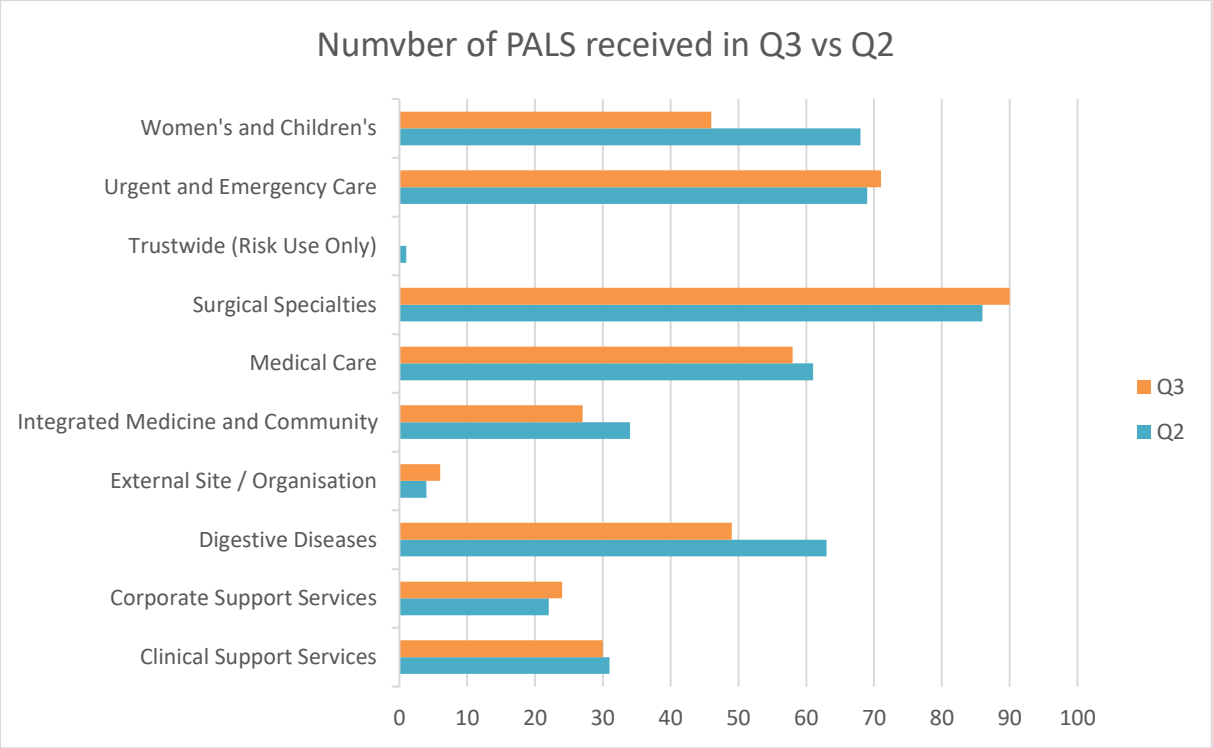
communication in regard to miscarriage aftercare.	A debrief and discussions were held with staff on duty to discuss the complainant's concerns and how we could have managed care and the situation differently. Learning resources were distributed to guide staff. An email was shared with the team with the original complaint redacted, guidance documents, video clips from the miscarriage association that provide patient stories of pregnancy loss and effects of admissions and processes patients have to deal with. Assurance was provided that the CBU is striving to work towards a 7-day Early Pregnancy Assessment Unit (EPAU) scanning service and improved access options for surgical management. The complainant gave some compassionate feedback regarding the positive care received.

3.2 Patient Advice and Liaison Service (PALS).

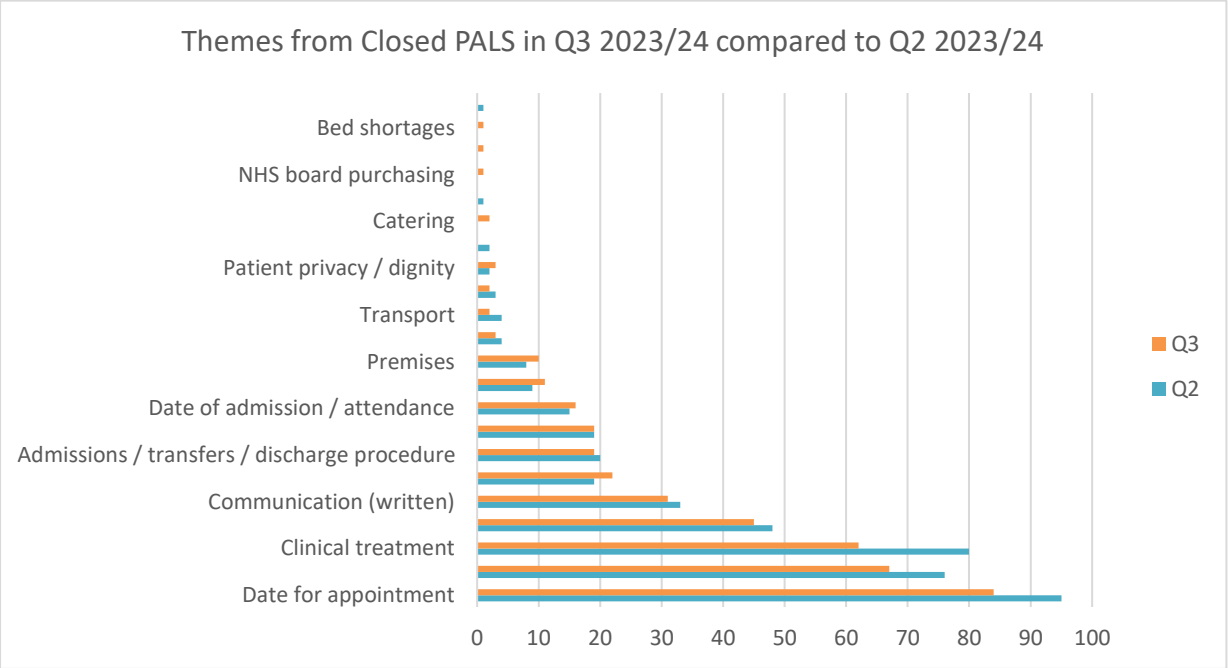
3.2.1 PALS received.

There were 401 new PALS referrals received in Q3, a decrease of 40 when compared to Q2. **Graph 5** demonstrates the breakdown of PALS received for each service.

Graph 5



Graph 6



4 Learning from Quality Improvement (QI)

4.1 Learning from QI training evaluation

We collect and review feedback following each training session delivered to ensure that we continuously learn and improve the training we provide to ensure we meet the needs and expectations of participants.

Figure 3: QI Foundation Course - On a scale of 1 to 10 (1 = very poor, 10 = excellent), how would you rate the training session overall?

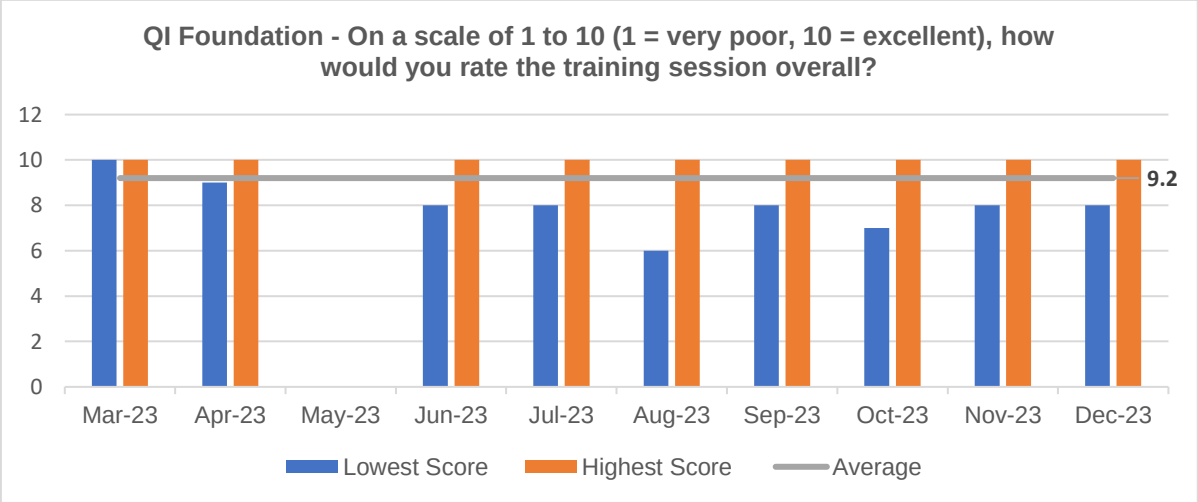
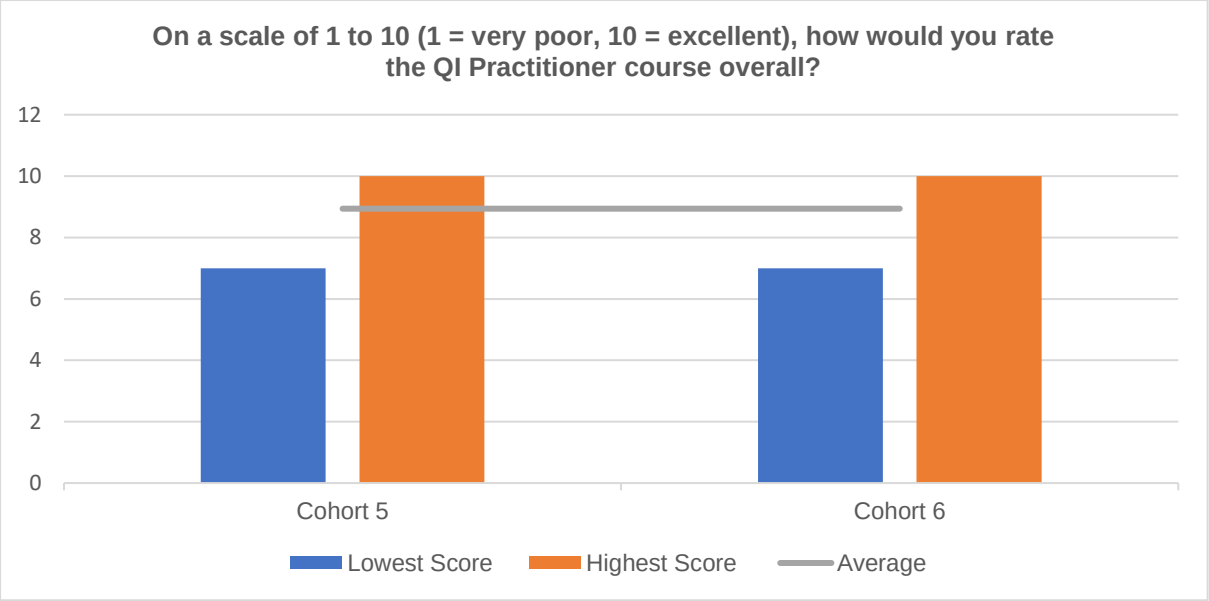


Figure 4: QI Practitioner Course - On a scale of 1 to 10 (1 = very poor, 10 = excellent), how would you rate the QI Practitioner course overall?



We asked cohort 6 how confident they felt in starting and delivering their own QI project at the start of day 1 (1 = Not confident at all, 10 = Extremely confident) to which the average score was 5. We asked the same question at the end of day 3 to which the average score had increased to 8.6.

Positive Feedback

We have received lots of positive feedback on the delivery of both courses, the practical activities and working through QI tools and methodology as a group. One to one support and coaching as part of the practitioner programme was also highlighted as beneficial.
In addition to changes based on participant feedback, we have also made several changes to our training materials to ensure further alignment with the Making Data Count programme and PSIRF with an emphasis on systems thinking.

4.2 Learning from registered QIPs completed within October-December 2023

Two QIPs were completed during Q3 and the following narrative is taken from the project lead reports.

Project 1: Improving enhanced care delivery on ward B19

Outcome: Significant improvement

Key learning points:

- Falls reduced
- Staff engagement with patients increased – activity trolley used more
- Staff will challenge more if not wearing apron and seen to be giving enhanced care
- Visitors less likely to ask staff in apron for assistance as aware of why they are there
- Increased understanding of barriers to improvement

Project 2: Implementation of Mental Capacity Act and Deprivation of Liberty Safeguards

Outcome: Moderate Improvement

Key Learning points:

- Surveys are only as good as the publicity you put in prior to rolling it out
- E-Learning has its place to capture all relevant professionals to complete within convenient times, with minimal disruption to the day to day running of wards and departments. The negative of this, is the lack of opportunity to relate that training to specific situations.
- Providing bespoke training to individuals and groups of practitioners on the wards, allowed for the face-to-face discussions around completing mental capacity assessments and correct completion of the Form 1 DoLs forms.
- The main difficulty for any Trust is the flow of new staff starting and the continued need for returning to wards to provide training.
- The major finding from the project was the lack of appropriate documentation for the mental capacity assessments and best interest decision process which is the bulk of MCA.

1.1. Patient Experience Strategy 23-25 Goal 3: Valuing our volunteers and partners to drive and sustain improvement.

1.1.1. Evidence into practice – Developing a comprehensive, Volunteers Policy and Procedure aligned to national best practice.

An evidence review conducted for the Patient Experience Team focusing on best practice in Volunteer Expenses Policies and Procedures across the NHS served as a foundation for the development of a comprehensive WHH Volunteers Policy aligned with NHSE Best Practice guidance.

Impact

- **Service enhancement, improved collaboration, compliance and transparency:** This document now outlines the responsibilities of both the Trust and its volunteers, providing a structured framework for effective collaboration. The policy will support the service's growth and development, ensuring clarity and adherence to best practice guidelines. WHH aims to create a culture of transparency and adherence to established guidelines, ultimately contributing to an improved volunteer experience and, by extension, enhanced patient care.

1.2. 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.

1.2.1. Overarching Priority: 8.1 Evidence into practice – The beneficial impact of an art group with patients who have experienced stroke.

Learning Outcomes

An evidence review was requested by a Clinical Lead Occupational Therapist, Janette Singleton. The evidence showed that creative art therapy combined with conventional physical therapy can significantly decrease depression, improve physical functions, and increase quality of life compared with physical therapy alone. Further, arts interventions can

provide a positive and valuable experience for longer staying stroke patients, contributing to their mental well-being during an otherwise distressing illness and hospital stay.
An art group is now running every Thursday on the ward as part of Active Hospitals, increasing therapy time and improving function.

Impact:

- **Support patient mood and reduce agitation:** Patients love the group and one said it is the “highlight of the week”. They can make friends through the group. Offers as much or as little interaction as each patient would like.
- **Improves long stay patients’ experience:** Helps to relieve boredom experienced by this group of patients.
- **Part of the Active Hospitals Approach**: Patients are motivated to get out of bed and they say they feel a real sense of achievement at the end.

Next steps:

- **To expand the service** through the involvement of a second therapy assistant and through continued working with the Stroke Association. To further evaluate through assessing patient mood on admission and discharge.

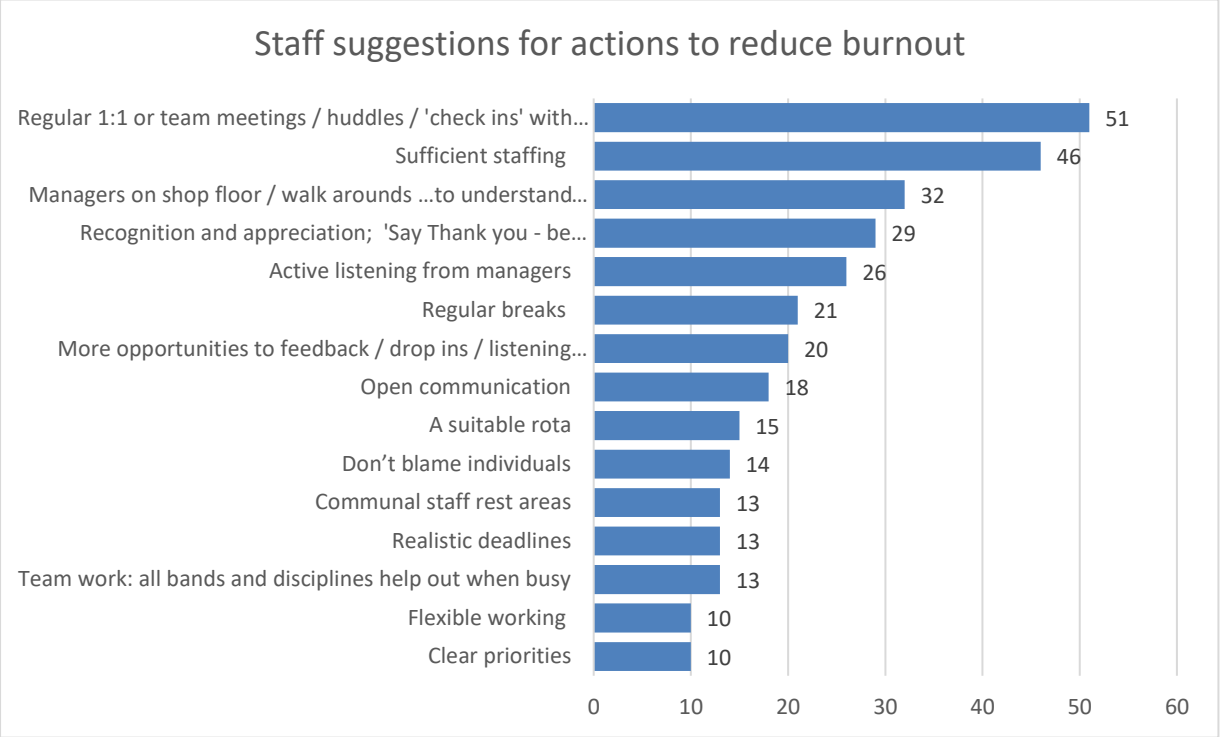
Consent was secured for the taking and sharing of these images.

1.3. People – Belonging in WHH

1.3.1. Overarching Priority: 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.

1.3.1.1. **Specific actions recommended by WHH staff to reduce burnout.**

58 WHH staff have generated actionable solutions to reduce burnout in the 10 areas which they identified as having the greatest impact on burnout.
Noticeably the action identified as most impactful in reducing burnout would be more time to meet with their managers, 1:1, as a team or huddle or to just check in. Although increased staffing levels was raised, it was the second priority after this.



The full report, with detail on proposed actions for each of the 10 most impactful areas alongside contextual insight provided through authentic WHH staff commentary is available on request from clare.payne4@nhs.net The most suitable forum for presentation of the findings is to be confirmed.

1.4. People – Innovating the way we work.

1.4.1. Overarching Priority: 6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.

1.4.1.1. International Nurses, Midwives and AHPs outline their suggestions to improve retention**.**

As part of the "Your Career Journey" Event held in October 2023 for nurses, midwives and AHPs, 15 attendees, 14 of whom were international staff members took part in a KM focus group, held by the KES, to explore attrition. Staff were invited to outline the key actions which would encourage them to remain working at WHH and/or in the NHS.

Areas highlighted include increased support through mentorship and local education at commencement, increased flexible working especially in relation to annual leave policies to allow international staff to visit family and reducing discrimination and inequality. The full report is available on request from emma.brown128@nhs.net.

1.5. Patient Safety Incident Response Framework (PSIRF)

At the request of the Project Director for Patient Safety, the KES have produced guidance on writing effective SMART action plans specifically for PSIRF. This was based on a comprehensive evidence review and consultation with early adopters of PSIRF and includes:

- Creating blame free actions
- Using the hierarchy of controls to create effective systems focused actions.
- How to ensure that actions are monitored and evaluated for impact.
- Quick reference 'Do's and Don'ts' guide to writing SMART actions, with examples taken from real SMART plans.

The slides, with voiceover commentary, can be found on the trust's Extranet pages here.
The guidance will be used to inform WHH staff on writing SMART actions as part of their patient safety incident investigation (PSII).

5 Learning from Safety Alerts

WHH uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily brief with 11 alerts being issued through Q2. When alerts are issued, some will be shared over a number of days, giving staff an opportunity to see the alert. National patient safety alerts are also shared widely and can provide learning from incidents that have occurred. Examples of learning are below:


Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls


Risk of delay in administering potentially lifesaving medication supplied in Ethypharm Aurum pre-filled Syringes.

Date: 4th September 2023

Reason for Alert: To raise awareness of the risk of delay in administering potentially lifesaving medication supplied in Ethypharm Aurum pre-filled syringes.


Warrington and Halton Teaching Hospitals

Potent synthetic opioids implicated in heroin overdoses and deaths

Date: 2nd August 2023

Paediatric Early Warning Scores (PEWS) - Currently there are two different PEWS tools being used within the Trust with a different scoring system. This means the Paediatric Emergency Department (PED) are using a different to tool to the paediatric inpatient ward. – Alert.

Inappropriate use of bed rails - From January 2018 to December 2022, the MHRA received 18 reports of deaths related to medical beds, bed rails, trolleys, bariatric beds, lateral turning devices and bed grab handles, and 54 reports of serious injuries. The majority of these were due to entrapment or falls. Factors in these incidents were found to include lack of risk assessment. – Single Point Lesson.

Safety Alert - Incorrect prescribing of paracetamol for adult patients - There have been two events in a week, where patients have been prescribed paracetamol regularly and when required concurrently on the inpatient prescription chart. – Safety Alert

6 Learning from Claims

6.1 Clinical Claims

6.1.1 Clinical Claims Received.

There were 24 clinical claims received in Q3, 35 were received in the previous quarter.

6.1.2 Clinical Claims Closed.

There were 34 ongoing Clinical Claims closed in Q3, 9 with damages (totalling £1,412,208.00 (excluding costs of instructing Trust solicitors), 2 Successfully repudiated and 13 withdrawn including closed due to lack of further correspondence from the claimant.

Specialty	Damages Paid	No of Claims
Acute Medicine	£35,000.00	1
Cardiology	£20,000.00	1
Emergency Medicine	£40,000.00	1
Gastroenterology	£10,000.00	1
Orthodontics	£5,377.00	1
Radiology	£15,000.00	1
Trauma & Orthopaedics	£1,226,831.00	2
Urology	£60,000.00	1
Grand Total	£1,412,208.00	9

6.2 Non-Clinical Claims (Employee Liability/Public Liability)

6.2.1 Non-Clinical Claims Received.

There were 2 employer liability claims and no public liability claims received in Q3 same as the previous Q2.

Quarter 3

Employer Liability	**2**
Accident that may result in an injury	2
Public Liability	**0**
Grand Total	**2**

6.2.2 Non-Clinical Claims Closed.

There was 1 Employer Liability Claims closed in Quarter 3 which was successfully repudiated. There were no public liability claims closed.

6.2.3 Claims Learning and Actions.

Following claims investigations for claims closed in Quarter 3, the following themes were identified, and actions implemented. The clinical claims review group continues to monitor themes and trends. All claims had previously been investigated through the incident process.

Claims Learning	
Closed: - 10/11/2023. The failure for timely referral and management led to the opportunity for early optimal treatment and recovery to be missed and directly contributed to extent of Left Ventricular (LV) impairment.	Education on identification of ST Elevation on ECG was provided to the ED clinical team. Re-iterated the Primary PCI policy to highlight the need to discuss potentially ischemic ECGs with the tertiary care centre in a timely manner. Staff on ward ACCU were reminded via the ward safety brief of the cardiac pathway in which patients are to have daily 12 lead ECGs completed for 72 hours post cardiac event.
Closed: 14/11/2023 Issues relating to delayed diagnosis/treatment of spinal cord compression.	Provided feedback to the clinicians involved in the investigation from both the expert review and Trust investigation. Reviewed current procedures for acting on and dealing with urgent MRI requests in light of the report findings so that assurance can be provided. Provided feedback to the Urology, MSK and Anaesthetic specialities regarding the importance of communicating and liaising through the Multidisciplinary Team (MDT) meetings when planning surgery for patients who have complex clinical conditions and are under the care of another speciality
Closed: 20/10/2023 Damage to kidney during procedure necessitating removal.	Induction of new Consultants includes discussion of requirements of theatre equipment. Review of consent process (2 stage consent, provision of information leaflets) in line with the Trust consent policy
Closed 24/10/2023 Ulnar collateral ligament injury Closed 06/11/2023 Missed schapoid injury	Negligence relates to the actions of an individual and will have been discussed within appraisal. No wider learning.

Claims Learning	
Closed 05/10/2023 Delay/incorrect diagnosis-treatment for abdominal discomfort and skin discolouration (subsequently confirmed liver disease) between December 2019 and March 2020 (inclusive)	There was a breach in not focusing on intrinsic liver disease as the cause of jaundice. Given the findings autoimmune liver disease should have been the most likely diagnosis. Case was shared with CBU for learning.
Closed 23/10/2023 Failure to repeat ECG and monitor potassium levels.	Shared with cardiology team.

7. Learning from Inquests

22 inquests were heard in Quarter 3, 10 with narrative verdicts, 4 with natural causes, 2 with industrial disease concluded, 1 with misadventure concluded, 2 with accidental death concluded and 3 with suicided concluded. The Cheshire Coroner was satisfied with the learning implemented. There were no Regulation 28 (prevention of future deaths) concerns.

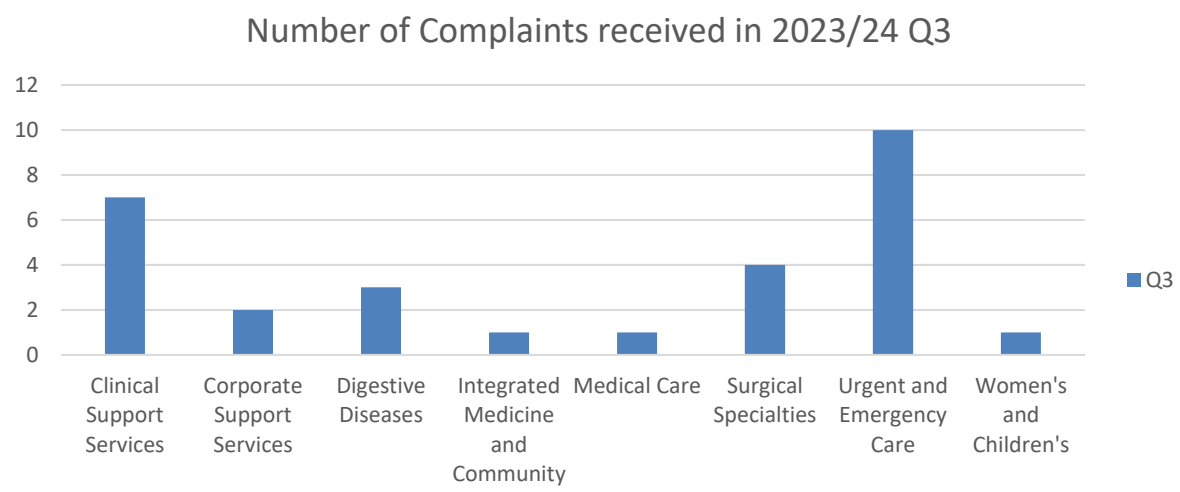
8 of the inquests had legal representation. 5 were a narrative verdict. The coroner confirmed she had heard the Trust has learned lessons from these deaths and was satisfied with the learning put in place since. The others were 2 natural causes and 1 misadventure verdict. There was no learning identified.

The Trust is in the process of liaising with the Trust solicitors to arrange a Mock Inquest event. This being a good learning opportunity for teams to understand the inquest process at coroners court.

8. Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a very useful tool for the Trust to be able to identify what areas are working well. In Q3, the Trust received 29 compliments which has decreased compared with the 35 compliments received in Q2.

Graph 7



It has been identified that compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. When investigating a formal complaint, another learning consideration is to share the positive messages contained within these. For example, although an experience can provoke a formal complaint, this does not been that all elements of care were negative.

9. Learning from Patient Experience

The Patient Experience and Inclusion team continue to develop monthly patient stories with Trust colleagues, Patients, Carers and Service Partners. These patient stories are shared across multiple committees such as Patient Experience Sub Committee, Patient EDI Sub Committee, Quality Assurance Committee, Trust Board and with the learning and development team. The purpose is to highlight areas of improvement required and identify good practice for shared learning.

The Patient Experience and Inclusion team use several methods to gain valuable qualitative and quantitative data reflecting patient experience. Again, this allows the celebration of good practice and to initiate improvements required that are identified via the feedback. Methods used include:

- The national Friends and Family Test.
- Local departmental surveys.
- National audits.
- Monthly Patient Experience and Inclusion team observation rounds.
- Monthly First Impression observation rounds.
- Monthly Governors observation rounds.
- Feedback from complaints / PALS.
- Feedback from Community Partners and Advocacy Groups.
- Knowledge and Evidence resource for best practice.
- Focus Group Sessions; Volunteers, Carers Café.

As a result of feedback received from these various methods, examples of improvements are as follows:

Improving our communication with the d/Deaf community; including:

- Continuing monthly d/Deaf awareness training sessions, running until March 2024, open to all Trust colleagues.
- Including the d/Deaf Community in EDS Engagement Events to reflect on services provided.
- Initiation of visual alert on patient paper notes and patient bedside to highlight communication support required.
- Focused meetings and ward visits to ensure compliance with the interpretation policy.
- Monthly meeting with Patient Experience and Inclusion, Deputy Chief Nurse and Deaf Advocacy Groups and contracted Interpretation Services

Updated visiting times, including:

- Revision of visiting times and launched in November.
- Communications to advise of guideline for visiting.
- Introduction of children visiting wards

Addressing comments around communal areas by:

- The Launch in September 2023 of First Impression observational rounds in communal areas continue. Represented by Patient Experience and Inclusion, Volunteer Team, Governors, Estates and Facilities.
- Initial focus on welcoming areas, keeping areas clutter free and tidy, with clear signage in place.
- Actions noted and will be reported through Patient Experience Sub Committee for updates.

10. Learning from Clinical Audit

10.1 Learning from National Audits

National Paediatric Diabetes Audit (NPDA) 1st April 2021 - 31st Mar 2022

Summary:

This continuous audit was established to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetes Units (PDUs) in England and Wales. This report covers the health checks (care processes) and outcomes for children and young people with diabetes aged 0-24 on the first day of the audit period.
Following the publication of the 2020-2021 data an action plan was initiated. It included:

- Raise awareness among patients for regular annual eye checks.
- Ensure communication to regional eye screening team to obtain annual screen reports.
- Training plus raising awareness for junior doctors at induction to ensure completion of thyroid and coeliac screening completed and chased at diagnosis.

Key Findings:

- Eye Screen Health checks (age 12+) are now higher than the regional average at 60.3% compared to 57.5%. However, they are just under the national average 62.6%.
- Thyroid checks improved to 94.5% which is higher than regional (86.9%) and national (84.1%) figures.

Further positive results from the audit include:

- Overall health completion rate and percentage receiving all six annual key health checks are better 92.5% than regional (87.4 %) and national averages (87.2%).
- Percentage of CYP in the trust with Median HbA1C < 58 mmol (patients with good control) is better than regional average and national average.
- Mean and Median HbA1C of CYP with diabetes in the trust are better than regional and national average and showing improvement compared to last year.

Improvement Action Plan:

To continually improve the results of this national audit further actions are in place:

- Improve care at diagnosis for coeliac and thyroid screen.
- Improve care at diagnosis for carbohydrate counting at diagnosis and the Insulin to Carbohydrate Ratio (ICR) within 2 weeks.
- Improve annual retinal screening capture information and data.
- Increase patients on continuous glucose monitor (CGMS) by supporting technology training and provision.

Assurance rating (using Trust assurance rating matrix): High assurance

10.2 Learning from Local Audits

Re-Audit of the Evening Surgical Handover against the RCSENG Safe Handover Guidance

Summary:

Following the first audit in September 2023, it was noticed during handover that essential information such as the name and role of members of the team were not specified at the start, nor the responsible consultant. Most would jump straight into talking about patients without giving a short brief or a role call prior. There were also no opportunities given to ask questions about the day or for the night, which would be an integral part learning for each team member, especially the foundation doctors.

An audit template was created for team members to follow during the evening handover. It included key aspects important for a safe and conducive handover.

Key Findings:

- The handover template guidance was used 7 out of 10 times during the handovers observed.

- The handover template guidance was not used usually if the leading clinician was not aware of the template (usually locum), or when the leading clinician was in a rush.
- Other members of the team who are aware of the template have encouraged the use of it.
- Even when the template was not used, some team members are now aware of the key aspects that should be added to a handover and do so without the need of the template, though they may still miss certain key aspects.

Recommendations:

- Educate members of team, including consultants, registrars, SHOs, FY1s and advanced practitioners on proper handover etiquette and encourage the use of the handover template during the audit and business meeting or via email to relevant team members.
- Gain feedback from members of the on-call team on any changes or improvements that can be made to the handover template.
- Create a more user friendly and appealing template to encourage and maintain its use.
- Include the audit template in the next surgical induction for the next batch of junior doctors and trainees.

Learning:

- Rollcall makes it easier to identify team members, especially if there are locum staff.
- The on-call team may face a different workload during the period after strikes.
- FY1s should look at the surgical handover as an opportunity to learn or ask questions.
- The handover template is a great tool to use to ensure safe and effective practices during the handover.

Improvement Action Plan:

- Improve handover template, introduce in the next induction meeting.
- Re-audit once intervention has been carried out.

Assurance rating (using Trust assurance rating matrix): High Assurance

11. Compliance

11.1 Learning from Mock CQC Inspections

The mock inspections which were scheduled for December and January were postponed due to winter pressures and ongoing industrial action.

However, progress continues to be made in relation to addressing ED actions following their mock inspection last year. There is a weekly ED Quality Improvement Meeting, where outstanding actions are tracked, and quality improvement initiatives are monitored and updated. A vast amount of work is being undertaken to improve patient flow, maximise the spaces within ED as efficiently and effectively as possible (in line with ever changing needs) and keep patients safe, whilst they are in the department. Work continues with NWAS and other health partners, particularly with the aim to increase appropriate utilisation of the UCC, and other alternative care pathways and avoid unnecessary overcrowding in ED. This, in turn,

allows ED to focus on patients with a higher level of acuity, who can only receive the treatment they need in hospital.

Another positive focus has been to review and update outstanding policies, as well as to focus on improving the mandatory training performance targets for staff.

11.2 Learning from the recent Maternity CQC Inspection

A formal Maternity Inspection took place on 14th September 2023, the draft report was received early November. Following receipt, the Trust completed a detailed and comprehensive factual accuracy report and submitted this to the CQC for their consideration. The final outcome of the CQC maternity inspection is due to be released on 17 January 2024.

11.3 Learning from the CQC for the future

From 6 February the CQC will be starting their new single assessment approach for all registered providers in the North and Midlands regions.

The new CQC assessment framework emphasises safety cultures that can learn and improve over time, with systems in place that plan and deliver safe, person-centred care. The emphasis is to triangulate information in terms of statistical performance data across health and social care partners, as well as actively listening, embracing, and acting on the views and experiences of staff, patients, carers, and members of the public.

The Trust has already been adopting this approach and the Weekly News had a dedicated Moving to Outstanding section, where examples of improvements are featured. Such initiatives can be aligned to the CQC's new "I" and "we" Statements – listening and learning in action.

12. Learning from Research and Development Activity

Process Mapping

The Research, Development & Innovation (RD&I) team, in collaboration with Pharmacy and Finance leads and supported by Quality Improvement, has actively engaged in a series of comprehensive process mapping exercises. The primary objectives of these exercises are to foster a shared understanding of our operational processes, identify inefficiencies, and pave the way for continuous improvement. This initiative aligns with our commitment to standardisation, improved communication, and the overall enhancement of organisational efficiency.

Objectives: The process mapping exercises have been instrumental in achieving the following objectives:

- Shared Understanding of Processes (departmental and organisational)
- Identification of Inefficiencies and areas for potential improvement
- Standardisation for consistency ensuring consistency in task execution, thereby enhancing overall quality and reducing errors.
- Enhanced Communication to facilitate more effective interdepartmental collaboration.
- Comprehensive analysis and redesign of processes to enhance efficiency, reduce costs, and improve overall performance.
- Compliance and Auditing Considerations to ensure adherence to regulatory standards.
- Risk Management - Identification and mitigation of risks associated with operational processes.

- Supporting Decision-Making- Facilitation of informed decision-making through a thorough understanding of processes and their interdependencies.

While the initiative is ongoing, early results have already demonstrated significant positive outcomes:

- Enhanced Team Working:
    - Improved collaboration and teamwork within the RD&I team, Pharmacy, and Finance leads.
- Improved Understanding:
    - Greater clarity and understanding of organisational processes across involved departments.
- Enhanced Communication:
    - Improved communication channels leading to more effective interdepartmental working.

The process mapping and improvement initiative signifies commitment to operational excellence. Early outcomes, including enhanced team collaboration, improved understanding, and effective communication, underscore the positive impact of this ongoing work. As we continue to analyse and refine our processes, we anticipate further improvements in efficiency and overall organisational performance. Subsequent updates will be provided as the initiative progresses, contributing to our continual pursuit of excellence.

Innovation at WHH

The Research, Development & Innovation (RD&I) department, in collaboration with the Quality Academy and with support from Health Innovation North West Coast, has initiated a comprehensive project to explore the meaning of innovation within WHH. This initiative aims to inform innovation pathways, engage both staff and the public, and ultimately enhance patient care, operational efficiency, and adaptability within our healthcare services.

A survey has been disseminated to all staff members, and a parallel survey is open to the public to gather insights on innovation. Additionally, a discovery workshop is scheduled to delve into the perspectives of executive and very senior leaders within the Trust regarding innovation. This ongoing project will be a focal point in an upcoming Quality Assurance Subcommittee (QASC) meeting.

The preliminary findings from staff and public responses reflect a collective commitment to leveraging technology, fostering collaboration, and streamlining processes. The emerging themes reflect a shared vision to enhance patient care, operational efficiency, and to adeptly navigate the evolving healthcare landscape.

Key Themes:

1. **Telehealth and Digital Solutions:**

- Implementation of telephone and virtual appointments for operational efficiency.
- Utilisation of digital platforms, AI in ophthalmology, and virtual wards.
- Introduction of digital services for exercise prescriptions, maternity care, and patient empowerment through apps.

2. **Remote Patient Monitoring:**

- Utilisation of technology for telehealth monitoring from home.
- Monitoring and supporting neonates in the community to prevent unnecessary hospital admissions.

3. Collaboration and Automation:

- Integration of collaborative tools such as Microsoft Office 365 for efficient communication.

- Ongoing efforts in the automation of routine processes to save time and reduce manual effort.

4. Initiatives and Programs:

- Implementation of specific initiatives like the Rapid Roster Improvement, UHSx Patient Flow and Early Discharge program, and Kaizen approach.
- Participation in targeted programs such as BHF funding for community HFNS and Targeted Lung Health Checks.

6 Digital Documentation and Integration:

- Adoption of integrated computer systems for streamlined processes.
- Implementation of initiatives like Choose and Book for efficient appointment scheduling.
- Focus on reducing steps and clicks in computer systems for increased operational efficiency.

7 Efficiency Improvements:

- Collaborative efforts to enhance efficiency between specialties.
- Automation of routine processes within the IT infrastructure.
- Development of clinical roles supporting tasks traditionally handled by medical professionals.

8 Patient-Centred Innovation:

- Commitment to improving patient care and experience through the implementation of digital services.
- Empowering patients to take a proactive role in their healthcare through accessible information.

9 Specialised Teams and Training:

- Introduction of specialised teams such as vascular access teams.
- Development of clinical roles to support tasks traditionally performed by medical professionals.

10 Patient Safety and Attendance:

- Implementation of initiatives aimed at reducing patient nonattendance at clinics.
- Establishment of Freedom to Speak Up Guardians for fostering open communication.

The ongoing work in this initiative demonstrates WHH's commitment to innovation, and these early findings provide valuable insights that will guide future strategies for enhancing healthcare delivery. The project remains dynamic, and further updates will be presented as the work progresses.

The Northwest Regional Nursing, Midwifery and Allied Health Professionals (NMAHP) Research Showcase

The Northwest Regional Nursing, Midwifery, and Allied Health Professionals (NMAHP) Research Showcase facilitated collaboration between NHIR, Greater Manchester, Northwest Coast CRNs, and NMAHPs. Discussions, led by Professor Ruth Endacott and various NMAHPs, emphasised embedding research into practice. Insights on Chief Nurses' commitments, learning opportunities, and regional/national NMAHP projects were shared, highlighting the significance of community involvement in research.

Representatives from WHH, including Senior Research Nurses and an AHP, participated, gaining valuable insights. This input informs WHH's strategic approach to embedding a research culture. WHH initiatives include implementing the Matrons and health leaders' research toolkit, introducing research champions, information boards, and revamping nursing student facilitation. NMAHP training sessions and the launch of the associate Principal scheme for non-medical roles demonstrate a comprehensive effort to integrate research into daily practice, fostering a culture of learning and leadership in healthcare research.

13. RECOMMENDATIONS

The Quality Assurance Committee is asked to note the report.

14. APPENDIX

Measuring the impact of learning plan.

Actions	Ownership	Timescales
Q4 2023/2024		
Evaluate the percentage of activity within QI and Audit which relates to patient safety, aim to build this up to deliver the strategic aims of the organisation.	Ernesto Quider Nicky Edmondson	Q4 2023/2024
Build baseline metrics to set trajectories for improvements across all the elements of the plan.	Ernesto Quider Nicky Edmondson	Q4 2023/2024
Development of a safety system plan working in partnership with the Patient Safety Partners and Patient Safety Specialists, which will aim to build the four phases of the plan and monitor the metrics.	Nicky Edmondson Deborah Carter	Q4 2023/2024
Monitor incident reporting numbers and take supportive action where reductions are identified.	Nicky Edmondson Lisa Davies	Q4 2023/2024

Explore innovative ways of sharing learning from safety events, share and trial during the programme to establish new ways of working.	Nicky Edmondson Deborah Carter	Q4 2023/2024

Actions	Ownership	Timescales
Phase 1 Q1 2024		
Test of change in Maternity Services to develop a system to understand the impact of learning.	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024
Training to be delivered to Maternity teams, to support optimisation.	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024
To enable an effective central repository for capturing the information for events reported initially by a review of Datix and explore the ability to add a field to capture what the learning is and how this can be measured for each event.	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024
Add a section which captures what learning has been gained from the incident review and how we measure the effectiveness of the learning response.	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024
Oversight sheet to be trialled at the Safety Oversight Meeting to facilitate discussion and greater understandings of the learning, its impact and how this be measured.	Nicky Edmondson Deborah Carter	Phase 1 Q1 2024
Extract data from the learning fields to understand and analyse the impacts of learning.	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024
Scope the safety system elements, e.g. the network that exists and this can be used to greatest effect.	Nicky Edmondson Deborah Carter	Phase 1 Q1 2024

Actions	Ownership	Timescales
Phase 1 Q1 2024 continued		
Promote staff excellence reporting: Review number and	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024

what we are doing to celebrate, tie into staff recognition process.		
Promote compassionate engagement training.	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024
Understand baseline numbers of anonymous reporting.	Nicky Edmondson Lisa Davies	Phase 1 Q1 2024
Review staff survey results with regard to staff psychosocial safety.	Nicky Edmondson Deborah Carter	Phase 1 Q1 2024
Review the numbers trained in line with the Patient Safety Strategy	Nicky Edmondson Deborah Carter	Phase 1 Q1 2024

Actions	**Ownership**	**Timescales**
Phase 2 Q2 2024		
Embed implementation in Maternity Services.	Nicky Edmondson Lisa Davies	Phase 2 Q2 2024
Evaluate the improvement work currently being undertaken in pharmacy, map against national objectives and explore opportunities for benchmarking.	Ernesto Quider Nicky Edmondson	Phase 2 Q2 2024
Re-run the safety questions from the staff survey to monitor progress and put in place remedial actions to drive improvement.	Ernesto Quider Nicky Edmondson	Phase 2 Q2 2024
Review the implementation of the PSIRF Policy and Plan with the CBUs/Care Groups	Nicky Edmondson Deborah Carter	Phase 2 Q2 2024
Review the numbers of staff trained in line with the Patient Safety Syllabus Training.	Nicky Edmondson Deborah Carter	Phase 2 Q2 2024
Evaluate the role of the Patient Safety Specialists and their contribution to the development of the safety system.	Nicky Edmondson Deborah Carter	Phase 2 Q2 2024

Actions	**Ownership**	**Timescales**
Phase 3 Q3 2024		
Evaluate implementation in maternity and begin roll out across other CBU's.	Nicky Edmondson Lisa Davies	Phase 3 Q3 2024

Trial the HSIB family inclusivity tool (FIT), to capture how many families are being engaged with and their levels of satisfaction with the process. Build outcomes of evaluations from this into compassionate engagement training.	Nicky Edmondson Lisa Davies	Phase 3 Q3 2024
Review incident profile to gain understanding of anonymised reporting and review for any reduction (ongoing reporting)	Nicky Edmondson Lisa Davies	Phase 3 Q3 2024
Review the numbers trained in line with the Patient Safety Strategy.	Nicky Edmondson Deborah Carter	Phase 3 Q3 2024

Actions	**Ownership**	**Timescales**
Phase 4 Q4 2024		
Review the numbers trained in line with the Patient Safety Strategy	Nicky Edmondson Deborah Carter	Phase 4 Q4 2024
Analyse the effect of the work programme to build the safety system and opportunities for strengthening this. This will include a focus on projects being undertaken which have a direct link to patient safety	Nicky Edmondson Deborah Carter	Phase 4 Q4 2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/24/03/325**			
SUBJECT:	**Learning from Deaths Report Q3 2023-2024**			
DATE OF MEETING:	12th March 2024			
ACTION REQUIRED:	**To note**			
AUTHOR(S):	Dr Lalitha Chinnappan, Consultant Gastroenterology and Trust Mortality Lead. Dr Judith Raper, Palliative Care Consultant and Deputy Trust Mortality Lead Emily Barnett, Clinical Effectiveness Manager			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients** ✓	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A** ✓
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper summarises 'Learning from Deaths' for Q3 2023 / 2024, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths.			
PURPOSE: (please select as appropriate)	Approval	To note ✓	Decision	
RECOMMENDATION:	Quality Assurance committee is asked to note the contents of the paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: *State whether this report needs to be*	Choose an item.			

referred to at another meeting or requires additional monitoring	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

QUALITY ASSURANCE COMMITTEE

SUBJECT	Learning from Deaths Report Q3 2023 / 2024	AGENDA REF:	QAC/24/03/325

1. BACKGROUND/CONTEXT

The National Guidance on Learning from Deaths requires all Trusts to have processes and systems in place to review, investigate and learn from deaths that occur with due focus on:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved families and carers.

The Trust is committed to learning from both positive and negative aspects of a patient's care with clear processes in place for completing mortality reviews. Learning identified during mortality reviews allows individual specialties to improve their processes; collated learning provides corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

This report provides an overview of the processes and systems that are in place to ensure that deaths are reviewed appropriately and summarises the data for this quarter.

2. KEY ELEMENTS

WHH uses the HED (Healthcare Evaluation Data) system to assess overall mortality data, highlighting any themes or trends that support the requirement for reviews of deaths. The HED report also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report includes:

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

The Mortality Review Group (MRG) at the Trust reviews the HED report monthly. Deaths subject to a Structured Judgement Review (SJR) as per the criteria defined in the Learning from Deaths policy are reviewed at MRG to identify learning and improvement actions.

3. MEASUREMENTS/EVALUATIONS

A Structured Judgement Review will be completed if a patient death meets one or more of the below criteria:

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with severe mental health needs.
- Death of a patient who had a 'standard' DOLs in place during their admission. A 10% random selection will be made for any death of a patient with an 'urgent' DOLs in place during their admission.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality review process.
- At the request of the Medical Director or Chief Nurse.

NB: If a death is subject to a PSII (Patient Safety Incident Investigation or other Learning Response then an SJR is not undertaken.

MRG – Forward planning

1) Themed workstream continues to be undertaken ensuring that any common pattern in issues identified are addressed with the aim to bring about clinical changes and positively impact both patient care and trust mortality. The current list of workstreams are as follows:
   - DNACPR.
   - Patient Transfers
   - Specialty Input
   - DoLS/ Capacity
   - SAFER
   - Trainee related learnings
   - Good practice- for positive commendation

2) The Clinical Effectiveness Coordinator continues to liaise with the Bereavement Team weekly to ensure that all deaths have been captured and are screened as part of the mortality process.

3) MRG will commence yearly appraisals, commencing in August 2024 with an aim to provide MRG reviewers feedback on their role within MRG and within wider

governance processes. This will also help us provide individualised feedback on their review completion rates, quality of reviews and help standardise reviewers performances.

4) Reminders continue to be sent out monthly with an aim to ensure that each SJR does not exceed the deadline of 8 weeks.

During Quarter 3 there were between 19 - 30 deaths per month that were flagged as requiring an SJR to be completed. Therefore, the average deaths requiring an SJR per month are 24 which is an increase of 7 from the last reporting period. Currently we have 7 Mortality reviewers, with each being allocated 5 cases per month, allowing a total monthly allocation of 35 SJRs.

We continue to remain up to date in the allocation of SJR's with currently no major delay from patients' death to ensure timely review. This is due to the changes in relation to the 10% criteria of 'urgent' DoLs cases and has allowed for more focused learning to be shared with the relevant teams to better improve our Quality of Care.

3.1 Mortality Review Data Q3 2023/2024

- During Quarter 3, 79 deaths met the criteria to be subject to a Structured Judgement Review (SJR). An increase of 27.
- During Quarter 3, 83 deaths were allocated to a reviewer for a Structured Judgement review to be completed.
- 54 SJRs have been completed in Q3, which is a reduction of 20 from Q2.
- Of the 54 SJRs completed, 28 were allocated in Q3 2023 / 2024 and 26 were allocated in previous quarters.

Fig. 1 – Key Mortality Data

Total deaths in Q3	Total LD Deaths Q3	PSII's commenced in Q3 relating to patient deaths	Those meeting SJR criteria Q3	Number of SJR reviews completed in Q3	Number of SJR Reviews that were allocated in Q3 23/24 and completed compared to Q2 22/23

325	6	1	79	54	Q2 23/24 Total SJR Completed – 74 Out of the 74 SJRs completed, 40 had been assigned in Q2. 54%	Q3 23/24 Total SJR Completed – 54 Out of the 54 SJRs completed, 28 had been assigned in Q3. 63%

Cases rated by reviewers as *1:* ***overall care very poor*** or *2:* ***overall care poor*** are reviewed by MRG to agree the overall care rating and then referred to the Governance Department if the consensus rating is Very Poor/Poor for further investigation.

A sample of cases rated as *3:* ***Adequate*** are referred to MRG for further discussion to identify themes for learning and improvement.

Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Specialty Governance meetings, a sample of these are also brought to MRG to highlight good care.

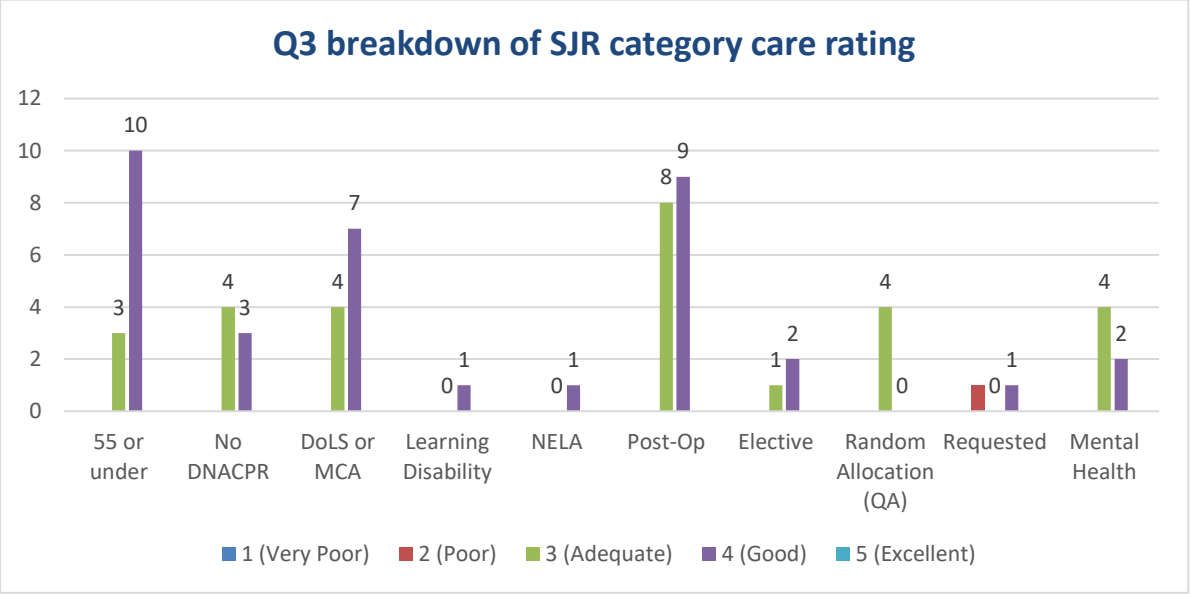
Fig. 2 – Shows the overall and phase of care ratings of the 54 SJRs completed in Quarter 3.

Phase of Care *	**N/A**	**Very Poor**	**Poor**	**Adequate**	**Good**	**Excellent**
First 24 hours/admission	4	0	1	16	33	0
Ongoing care	14	0	1	19	19	1
Care during procedure	39	0	0	5	10	0
End of life care	22	0	1	10	21	0
Patient records/documentation	4	0	0	7	43	0

Overall care	**4**	**0**	**1**	**22**	**27**	**0**

- In SJRs completed within Quarter 3, there has been no ‘very poor’ care ratings at any stage of admission.
- There was one SJR that was identified as overall poor care as follows:
  - SJR ID 15240 was rated as overall poor care. This case was discussed during the November 2023 MRG meeting and it was concluded that this was to be downgraded to an ‘overall’ rating as ‘poor’ and for this to be reviewed by the incident process.
  - An incident had already been raised (ID184903) and an ISR took had taken place in October 2023 which was closed with no further actions required. Further to this, the ME Team have raised several questions, which the incident team re-reviewed the ISR in February 2024 with the ED Consultant and again was closed as no further actions required.
- All phases of care and documentation records including overall care had a majority of ‘good’ ratings with 1 receiving an ‘excellent’ rating.

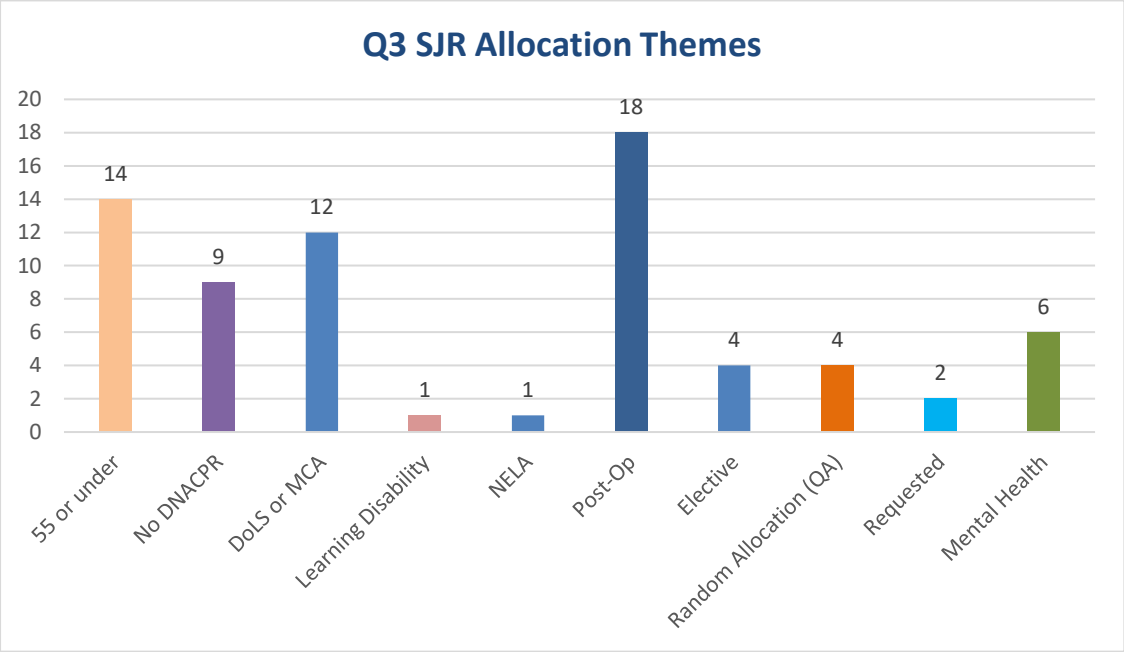
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 3.



- Most categories are predominantly receiving good / adequate care.
- Random Allocation patients shown all ‘adequate’ care ratings.
  Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.

NB Some care ratings are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

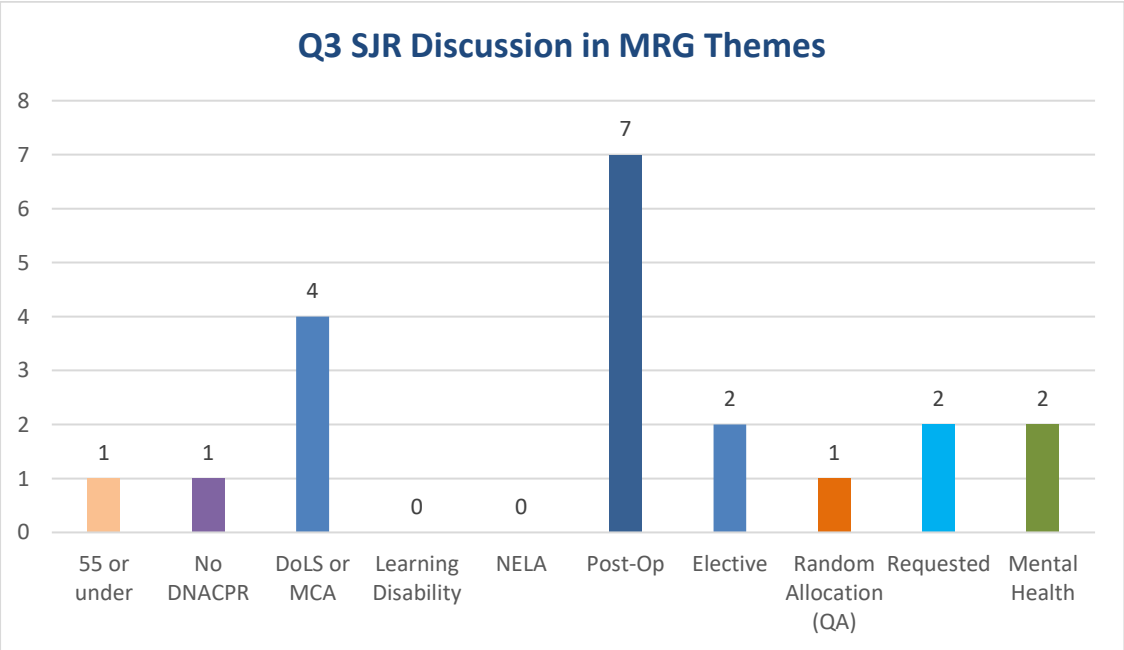
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 3



- 'Post-op' was the most frequently allocated category to reviewers in Q3.

NB Some allocations are duplicated on this graph as often a patient may die and fit in more than one SJR category, for example NELA/Post OP

Fig 5 - Shows the frequency of each SJR category presented at MRG in Quarter 3.



- The category with the highest number of SJR's requiring further discussion at MRG in Q3 is 'Post-Op'. This corresponds to the number that are allocated.

3.2 Learning from deaths

The below provides a sample of the learning following recent deaths and the actions taken.

Learning	**Action**
• 55 year old patient with a past medical history of metastatic lung cancer and Cerebral Mets. Stand by call following collapse. Patient was found on the floor after not responding to the phone or doorbell. Patient had appeared to have hit his head and was unresponsive when found. Paramedic review – unrousable.	• Palliative Medicine Consultant to investigate community DNAR list.
• 66 year old patient referred to ED by their GP. Presented with increased lethargy, reduced fluids/ diet and possible Sepsis.	• Will discuss this case further in the form of a newsletter. • Clinical effectiveness Coordinator will distribute the findings of this case to support further learning. • Trust Wide lead for Mortality will discuss this case with the Safeguarding Team.
• 86 year old admitted following a welfare concern of increasing forgetfulness. Patient lived alone with no package of care. PMH of AF, HTN and OA	• A commendation certificate has been created for the doctor caring for the patient.
Themes **Appendix 1** – MRG Newsletter 'She spent her last days in hospital with unmanaged pain'. Newsletters are included on CBU and Specialty Governance agendas each month.	

3.3 Learning from Serious Incident investigations:

A total of 1 PSII was reported during the quarter 3 period relating to a patient's death.

Mortality Indicators

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation.

To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

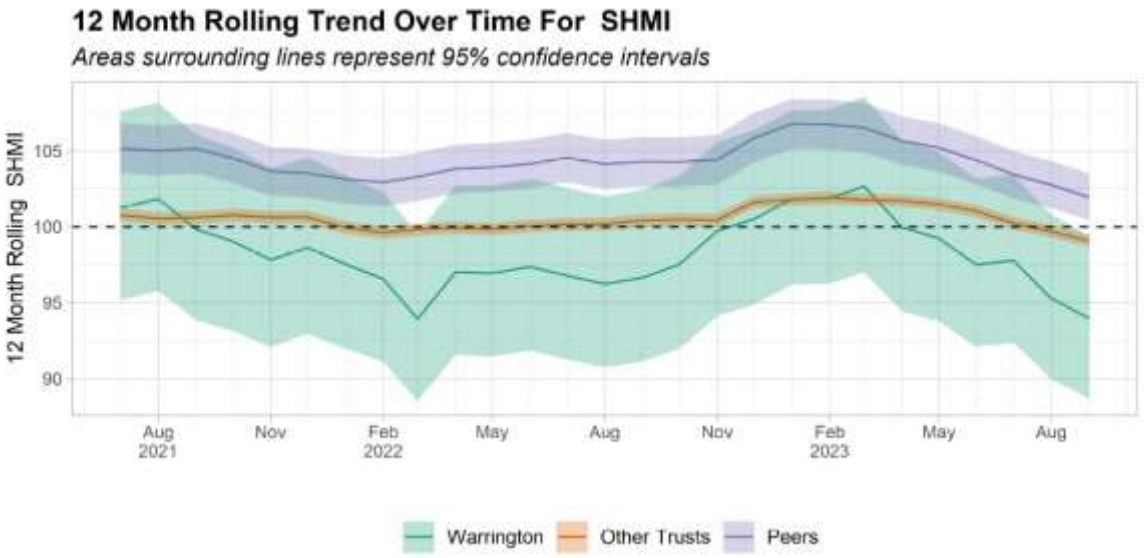
The SHMI data is the ratio between the actual number of patients who die within 30 days following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there.
The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected'.

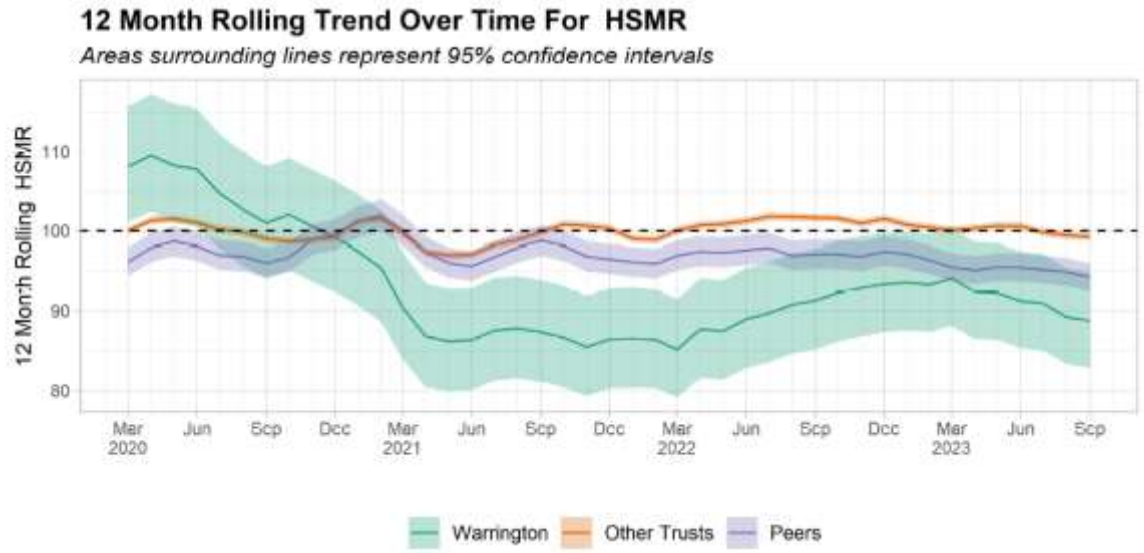
(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
August	90.64%	96.18%	80
September	88.97%	96.98%	93
October	88.78%	95.2%	102

HES SHMI (which is based on 12 months data up to and including October 2023) is 95.2%. This result is not an outlier using an overdispersed funnel plot and is not an outlier based on the stricter Poisson method.





Standard 56 CCS group HSMR (which is based on 12 months data up to and including October 2023) is 88.78%. This result is a low value outlier based on the 95% Poisson method.

- SHMI for Warrington is lower than other acute trusts on average, and lower than the average for the peer group.
- The 12-month rolling SHMI value has declined since the year ending March 2023.

4. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Sub Committee, quarterly to the Quality Assurance Committee and annually to both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

5. TIMELINES

Ongoing - the Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.

6. RECOMMENDATIONS

The Quality Assurance Committee are asked to note this report.

Appendix One: Monthly MRG Newsletter

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

MRG Theme of the month February 2024

A Case of Necrotising Faciitis and Fournier's Gangrene

This 66 year old gentleman was referred in by his GP due to increased lethargy, reduced diet, and fluids.
He was paraplegic and catheterised long term due to a spinal cord injury, he also had a background of chronic kidney disease stage 3, heart failure due to ischaemic heart disease, depression, atrial fibrillation, type II diabetes and he had had an abdominal aortic aneurysm repaired.

The cause of his presentation was found to be sepsis and he had extensive grade 4 necrotic pressure ulcers affecting his sacrum, scrotum, and gluteal areas, as well as a haematoma on his left heel. He had been having fevers for a week and the district nurses had been dressing his pressure ulcers which had become very deep. His GP had commenced antibiotics, but he had worsened.

Treated with intravenous antibiotics and fluids, he was thoroughly investigated including for fungal infection and for possible osteomyelitis. Two days following admission, he was diagnosed with necrotising fasciitis and Fournier's gangrene, with osteomyelitis to his right ischial tuberosity. He required surgery to excise a large area of boggy, necrotic tissue oozing foul smelling pus which extended over his scrotum and sacrum to his right buttock. He had infection around his penis where the catheter appeared to have eroded through.

Following surgery his care continued in ICU where he had ongoing IV antibiotics and VAC therapy. There was an episode 3 days after surgery when the VAC dressing had come away, being contaminated by loose stool and there was bleeding from his wound, but other than this he recovered well and was discharged from ICU to the ward a week after surgery. Due to ongoing incontinence of loose stool, the VAC dressing had to be abandoned. He continued to improve and discharge home to his wife and daughter was planned. However, due to ongoing contamination of the wound by loose stool, a stoma was suggested. He was reviewed by the surgeons, but it was clear that, due to adhesions from previous laparotomies, stoma formation would be risky, and it would be best to try and manage his loose stool with a regimen of loperamide to constipate him, and twice weekly manual evacuation.
By this time, he was desperate to get home and his mood and appetite was very low. He required a change in anti-depressants and input from the mental health team.

Working Together · Excellence · Inclusive · Kind · Embracing Change

As his bowels and his mental health were being managed, he started to deteriorate again, his renal function worsened, and his inflammatory markers started to rise despite the ongoing antibiotics. Although he was fluid deplete intravascularly, he was developing peripheral oedema. It was difficult to maintain his fluid balance and his oral intake, so NG feeding was discussed with him and his wife and commenced. However, he became more poorly, became agitated with a uraemic encephalopathy, and declined both wound dressing and NG feed. Despite optimisation of intravenous fluids and antibiotics, he continued to deteriorate and become drowsier, with acidosis and minimal urine output despite fluid challenges.

The critical care team, the renal team, and the ward team all agreed that further escalation would be very unlikely to be successful and, although they were unable to contact his family at that time, they did not delay the decisions and made a treatment escalation plan for ward based care including a uDNACPR form. A few days later, it was possible to update his wife who agreed that he was dying, and his care was supported by the IPOC for the last few days of his life.

Points Identified:

- Multiple co-morbidities in a man who was paraplegic left him at high risk of pressure ulcers and reduced ability to fight any subsequent infections.
- Admitted with worsening extensive infected pressure ulcers which had developed into necrotising fasciitis and Fournier's gangrene.
- Surgery and initial recovery in ICU were successful.
- Prolonged stay in hospital, clinical course, and abandoned plan to get home all affected his mental health and he felt low, and he was not in his preferred place of care for what turned out to be the last weeks of his life.
- Management of his wound and his bowel incontinence was as crucial as the antibiotics to reduce risk of ongoing re-infection and he deteriorated with pseudomonas in one of the bloods cultures.
- When it was clear that he was deteriorating and things were no longer reversible, prompt decisions were made and appropriate liaison with his family as soon as possible.

Learning:

- In this case, it was especially important to measure his fluid balance to help influence his management. There was evidence of multiple requests for strict input/ output fluid monitoring whilst he was on the ward, but this did not happen.
- Given the presentation with extensive pressure ulcers in someone under the care of the district nurses, it was important that the necessary safeguarding, Datix and liaison with the community took place- as it did in this case.
- It is common for people with spinal injuries to be incontinent of bowels, and this is often managed with a regimen of constipating them with a peripheral opioid such as loperamide (or a central opioid if they are also needing it to manage pain) and then using enemas or manual evacuation twice weekly. He had previously stopped this whilst at home as he was concerned it had led to his kidney disease.
- When someone is sick enough that they might die, it is important we tell them this, usually alongside their family, so that they can make informed decisions about their priorities before they potentially become too sick to be involved in such conversations and decisions, this is what the AMBER care enabler prompts.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Mortuary Compliance against Fuller Inquiry Recommendations

Hilary Stennings - Associate Director Clinical Support Services
Kimberley Salmon-Jamieson - Chief Nurse & Deputy Chief Executive

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Fuller Inquiry

Background

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

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

- Procedures
- Practices
- Security and dignity of the deceased

WHH Position: Mortuary status

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

WHH Gap Analysis and Inquiry Recommendations

WHH gap analysis of the 17 recommendations:

- **1 x areas of non-compliance**
- **9 x partial compliance**
- **7 x full compliance**

These are recommendations and are not currently mandated by the HTA.

WHH will take these recommendations forward as best practice standards.

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

Recommendations Identified Following Inquiry

Warrington and Halton Teaching Hospitals

Recommendation Number	Recommendation Descriptor	Assurance	Compliance

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

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

Recommendation Number	Recommendation Descriptor	Assurance	Compliance
4	The Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.	Qualifications are on record and have been checked. Accountability evidenced within Trust management structure.	Achieved
5	The role of Mortuary Manager should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.	Full time dedicated role in place. Banding review underway following benchmark as part gap analysis (band 6 vs band 7)	Partial
6	The Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.	Policies reviewed and updated: • Mortuary Viewing • Out of Hours Access • Release of Deceased	Partial – Policies submitted to Policy Review Group 27 March 2024
7	The Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.	• Access is routinely monitored • Internal CCTV monitoring monthly • Audit of policies to be reported to Clinical Support Services Governance Meeting and Patient Safety Clinical Effectiveness Sub Committee ahead of Quality Assurance Committee	Achieved

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

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

Next Steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Paediatric Audiology Incident and Service Review

February 2024

Background

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Scottish Public Services Ombudsman report May 2021
- NHS Lothian commission British Audiology Association (BAA) to undertake an Independent Review, June 2021
- December 2021 Independent Review published
- National Hearing Screening team commences engagement sessions with local audiology teams with low levels detection of permanent childhood hearing impairment (PCHI)
- NHSE/I commissioned an audit of sites with low levels of yield, this included WHH
- Samples of ABR tests provided to National Peer Review team by WHH
- Reviews revealed concerns within the Auditory Brainstem Response (ABR) testing process
- Four Trusts involved initially (crossing 5 sites). More have since been identified
- NHSE/I have convened a Strategic Oversight Group

WHH Background

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- 2nd February 2023 WHH declare serious incident based on information shared with the WHH executives and decision made to pause the ABR service
- Initially 54 cases were selected for review by the national Peer reviewers, with 34 of these being assessed as having issues.
- Full review of cases where ABR had been performed (2018-2023) identified 234 cases in total, all remaining traces were uploaded for peer review (15th February 2023), final cohort size was 200 children.
- Peer review categorised cases P1, P2, P3, P4
- Mutual aid package agreed with NCA on 22nd February 23
- 23rd February BWFT were identified by NHSP as having joint cases
- 3rd March WHH ABR service recommenced supported by NCA team
- Incident cell established supported by multiple stakeholders e.g. NHSEI/ICB etc
- Proactive case reviews have been undertaken and recall of patients where necessary
- Communication with families and other stakeholders
- MDT review team established with audiologist from WHH, NCA, BWFT, MFT to review all cases

MDT Case Review Summary

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Status	Number of cases
No harm determined	100
Care not determined - On going care	08
Care not determined - Parental Choice	10
Harm not determined	02
No harm/Near miss	03
Low harm	02
Moderate harm	02
Total	127

The existing cohort was 200 children, 73 families were able to be advised early in the live time of the incident that there were no concerns identified as a result of the testing.

Service Summary

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Independent ABR practice recommenced 31/10/23
- Ongoing peer review of all ABR traces agreed
- Mutual aid concluded 31/10/23
- Service & Incident review full report to Quality Assurance Committee 12th December 2023
- Project manager recruited to support IQIPS accreditation process with UKAS – benchmark assessment undertaken 9 &10 January 2024 (report expected shortly)
- PLACE pathway review recommends ongoing support of current model
- Audiology team remain engaged and supportive and are driving the local improvement plan
- Joint WHH & BW audiology team OD session 18th January 2024
- Ongoing monitoring of the 8 remaining children with a final summary to be provided in 2024, date dependant of individual child's assessment.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

<table>
<tr><td>AGENDA REF:</td><td colspan="4">FSC/24/03/247</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Digital Strategy Group (DSG) update</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="4">27th March 2024</td></tr>
<tr><td>ACTION REQUIRED:</td><td colspan="4">To note</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="4">Tom Poulter, Chief Information Officer</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="4">Paul Fitzsimmons, Executive Medical Director</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE</td><td colspan="4">SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.</td></tr>
<tr><td rowspan="4">EQUALITY CONSIDERATIONS: (Please select as appropriate)</td><td rowspan="2">Please indicate who is impacted by the equality considerations:</td><td>Patients</td><td>Workforce</td><td>Public</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td>✓</td><td></td></tr>
<tr><td colspan="4">Further Information / Comments:</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="4">The Digital Strategy Group (DSG) met on 27th March 2024. This report provides a summary of the updates received from the DSG feeder groups, providing the following assurance status for key delivery areas:

○ Laboratory Information management Update
Limited Assurance
○ Digital Transformation Highlight Report
Moderate Assurance
○ Digital Service Delivery Highlight Report
Moderate Assurance
○ Digital Analytics Highlight Report
Moderate Assurance
○ Digital Care Delivery Group Highlight Report
Limited Assurance
○ EPCMS (Electronic Patient Care Management System)
Moderate Assurance
○ EBCMS (Electronic Bed Care Management System)
Moderate Assurance

Items for escalation to Finance and Sustainability Committee (for information only):

○ Laboratory Information Management System (LIMS) is the digital system that supports all pathology disciplines. Cheshire and Merseyside pathology network are undertaking procurement of a system-wide solution for this, working to tight timescales to spend the £957,598 allocated capital by the end of the</td></tr>
</table>

	financial year. The business case has been delayed and will go through the usual WHH governance process and is scheduled for March Trust Board. ○ EBCMS – Accelerated 12-month programme and reduced revenue allocation expenditure in 2024/25 ○ EPCMS – Procurement deep dive. WHH current forecast go live January 2026 is flagged as an outlier and showing shorter procurement timelines than endorsed LPP procurement plans. The proposed go live 19 August 2026 impact of spend across years is unknown this will be worked through as part of the FBC (Full Business Case) once the procurement is complete		
PURPOSE: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The FSC is asked to note the contents of the report, including assurance levels. ○ Laboratory Information Management Update – The FBC is due to go to Trust Board in April for approval. ○ EBCMS –An accelerated 12-month programme and business case will need to be approved by the Trust board in April with a view to receiving the funding May this year. The new amount of allocated funding will be the original figure (£2.2m) in the business case minus 35% thus new allocation circa £1.4m consolidated into a single payment in 2024/25 ○ EPCMS – Re-Launch of the procurement commenced on the 31st of January 2024; this will be 8-week tender until 26th March 2024. Confirmed interest from 4 suppliers. A procurement planning deep dive took place on 29th February with NHSE/ICB/Regional colleagues WHH current forecast go live January 2026 is flagged as an outlier and shorter procurement timelines than the endorsed LPP procurement plans. The NHSE project calculator is showing a current forecast go live 19 August 2026. Proposed go live impact of spend across years is unknown this will be worked through as part of the FBC once the procurement is complete the region is currently going through finance reprofiling exercise WHH advised consider requesting additional funding beyond March 2026 and if there is funding available it will be considered moving into 2026/27.		

	○ PEP – All patient appointment letters will be sent digitally via Synertec from March 2024 in preparation for PEP go live mid-Spring.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Share with Finance & Sustainability Committee***	
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests	

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Digital Strategy Group update	AGENDA REF:	FSC/24/03/247

1. BACKGROUND/CONTEXT

This report provides an update on the status of the portfolio of programmes supporting delivery of the Trust's Digital Strategy and "business as usual" service delivery activities in Digital Services and Digital Analytics, providing the Board Committee with the latest internal assurance assessment for each area.

2. KEY ELEMENTS

Laboratory Information management Update

- The Full Business Case is due to go to trust board for approval in April. The latest version of the FBC was issued late Friday, amendments and clarifications are to be made accordingly so the full business case can be taken to the next trust board meeting.

- A significant change to highlight is around the funding arrangements. Initial intention was to make a big down payment to the preferred supplier to spend the capital monies within the program constraints.

- A review of the resource profile has taken place due to recognition that the resourcing level within the business currently is inadequate to meet what is recommended for the overall programme.

- Feedback from the CIO group and the Lab Mangers in terms of the proposed MOU was that we do not have sufficient detail to understand the rationale as to why MWL are best placed as a regional hosting arrangement when we have different arrangements for other digital diagnostic services like PACS.

Items for escalation:

- Uncertainty around the overall LIMS project.

Digital Transformation Delivery Highlight Report (Moderate Assurance)

- ***Diagnostic Update:*** Issues have been reported around the CRIS supplier contract not being fulfilled. Ongoing meetings around this between the Trusts that utilise CRIS.
- ***Pharmacy:*** Ongoing work around the use of logical printing. This needs to be in place before we can rollout the rest of Outpatient Prescribing and then we will be done with EPMA. It is believed to be related to the issue with the firewall, working with Dedalus currently to resolve this.
- ***Patient Engagement Portal (PEP):*** The link between DrDoctor and WHH is not live. We are now focussing on the full integration with DrDoctor. All services are now printing patient appointment letter via Synertec and the PRISM print service.

- PRISM printing is now live within Therapies. Some concerns have been raised around the training dashboards for PRISM. We have been given assurance that the EPR team are receiving the reports until they are set up with the dashboard.

Items for escalation:

- None raised due to not being quorate for the meeting.

Digital Service Delivery Highlight Report (Moderate Assurance)

- The aim is to create 4 versions of an SLA document covering all Digital Services for the Trust, one for Planned Care, Unplanned Care, Clinical Support Services and then one for Corporate Services.
- We have seen an increase in the call abandonment rate on our service desk. It is not currently possible to tell whether the nature of the incoming calls is deemed urgent or not. We need to encourage the use of the self-service ticketing solution to reduce the telephone traffic that is directed to the service desk.
- Initially proposing a target of 5 minutes as a maximum wait time for a call to be answered. Sign off required from each of the four areas that will have the SLA in place.

Items for escalation from the Digital Service Delivery Group

- None raised.

Digital Analytics Highlight Report (Moderate Assurance)

- ***eOutcome:*** The Server was migrated successfully, planning for the separation of the Datawarehouse from Fraxinus is underway.
- Re-write of Data Warehouse loads continues which supports the delivery of the Digital Analytics plan and forms part of the EPCMS readiness.
- There has been a surge of work relating to the PEP leading to a review of the annual plan being undertaken w/c 11th March 2024 to take account of emerging timescales for other major projects EPCMS and EBCMS.

Items for escalation

- None discussed.

Digital Care Delivery Highlight Report (Limited Assurance)

- ***Maternity:*** Transitional Care Documentation due to go live in April. This is to implement a Hybrid approach to TC documentation as this is a CQC requirement. Staff comms are in progress, to be circulated prior to the go live.
  Patients will be able to book elective C Sections using the BadgerNet system as of the 1st of April, all training for this is now complete.
  Test results currently being manually entered into BadgerNet due to an issue with the blood results importing. This has posed a risk of transcription errors; lab IT specialist is required to confirm the spec being utilised is appropriate.

Items for escalation

- None raised.

EPCMS Electronic Patient Care Management System Report (Moderate Assurance)

- Successful ITT Launch of the WHH Procurement on 31st January 2024, this will be an 8-week tender until 26th March 2024. Clarification questions are still being received by suppliers and answered by the Trust in a timely manner, deadline of 26th March.
- Work is ongoing on the FBC actions from EPRIB board, draft FBC to be sent in April.
- WHH current forecast go live January 2026 is flagging as an outlier and showing shorter procurement timelines than the endorsed LPP procurement plan.
- The NHSE standard project calculator is showing a current forecast go live 16th of December 2026. This date goes beyond Lorenzo contract end date November 2026 and will require Trust Board approval to fund a further extension.
- The Trust in agreement with FD Engagement team has localised the plan to safeguard the November 2026 Lorenzo contract end date. Currently the plan is showing a forecast go live 19 August 2026 - Forecast go live impact on spend across years is unknown this it will be worked through as part of the FBC once the procurement is complete.
- Overall delivery for readiness stage is Amber due to gaps in workstream leads causing delays in those areas, particularly around clinical safety and transformation/change management: CNIO previously leading on clinical safety and recruiting Digital Champions and Senior Programme Manager leading on transformation/change management.

Items for escalation

- Proposed go live 19 August 2026 - Forecast go live impact on spend across years is unknown this it will be worked through as part of the FBC once the procurement is complete.

EBCMS Electronic Bed Care Management System Report (Moderate Assurance)

- This Programme is being relaunched with a reprofiled approach to funding and timescales. The introduction of a Real Time Location Tracking solution will allow for the overseeing of equipment as well as the location of portering and cleaning staff. Looking to procure an RTLS solution with the view to go live with it in quarter 4 of financial year. Currently being positioned to be funded by through partial NHSE funding as an extension to our current Network Replacement programme.
- There is a potential significant risk around objection from staff members due to porters and cleaners being “tracked”. We would expect the reaction to this use of language to be immotive rather than logical and we need to be mindful of the language used and ensure this remains consistent and neutral.

Items for escalation

- Sensitivity around wording used in relation to the RTLS for project, particularly the term “tracking”.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Digital Strategy Group would like to highlight the following items the attention of FSC, but for information only:

- Laboratory Information Management System (LIMS) is the digital system that supports all pathology disciplines. Cheshire and Merseyside
- Proposed go live 19 August 2026 - Forecast go live impact on spend across years is unknown this it will be worked through as part of the FBC once the procurement is complete.
- EBCMS – Accelerated 12-month programme and reduced revenue allocation expenditure in 2024/25. Looking to procure an RTLS solution with the view to go live with it in quarter 4 of financial year.
- PEP – It is anticipated that the PEP will be live by in mid-Spring.

4. RECOMMENDATIONS

The FSC is asked to note the contents of the report, including internally assessed assurance levels.

- Laboratory Information Management Update – The FBC is due to go to trust board to receive approval in April.

- EBCMS – NHSE financial review confirmed funding will continue with all expenditure to happen in financial year 24/25. An accelerated 12-month programme and business case will need to be approved by the Trust board in April with a view to receiving the funding May this year. The new amount of allocated funding will be the original figure (£2.2m) in the business case minus 35% thus new allocation circa £1.5m consolidated into a single payment in 2024/25

- EPCMS – Re-Launch of the procurement commenced on the 31st of January 2024; this will be 8-week tender until 26th March 2024. Confirmed interest from 4 suppliers. A procurement planning deep dive took place on 29th February with NHSE/ICB/Regional colleagues WHH current forecast go live January 2026 is flagged as an outlier and shorter procurement timelines than the endorsed LPP procurement plans. The NHSE project calculator is showing a current forecast go live 19 August 2026. Proposed go live impact of spend across years is unknown this will be worked through as part of the FBC once the procurement is complete the region is currently going through finance reprofiling exercise WHH advised consider requesting additional funding beyond March 2026 and if there is funding available it will be considered moving into 2026/27.

- PEP – All patient appointment letters will be sent digitally via Synertec from March 2024 in preparation for PEP go live. Go Live Date for the PEP launch has been delayed. This is due to multifaceted integration between Lorenzo and DrDoctor, and the transformation of messages. Additional integration with Radiology and Breast Screening appointments has also added to the complexity. Friends and Family Tests will remain on Health Care Comms until Phase 2.